FUNDAMENTALS OF NURSING · STUDY GUIDE

Exam 11 Study Guide

This guide covers the last two chapters. Chapter 21 takes nursing beyond the bedside: preventing disease, matching care to each stage of life, keeping older adults safe, making homes and transitions safe, and using evidence to improve care. Chapter 22 is about leading on your first day as a licensed nurse: delegating safely, deciding who comes first, keeping a surgical patient safe from consent to discharge, and building a safe career. Priority and delegation questions fill this chapter, so practice the funnel until it is automatic.

WHAT THIS GUIDE COVERS

- Chapter 21 · primary, secondary and tertiary prevention, screening tests and blood pressure categories, adult immunizations and vaccine safety, the Health Belief Model, stages of change, motivational interviewing, growth and development principles, Erikson and Piaget, milestones, fears and injury risks by age, corrected age, normal aging by system, atypical presentation, falls, ADLs and IADLs, polypharmacy and prescribing cascades, elder abuse, home safety, community resources, discharge planning and reconciliation, PICO, the evidence hierarchy and PDSA.
- Chapter 22 · leadership versus management, leadership styles, followership and closed loop communication, conflict and change, delegation versus assignment, the five rights, typical RN, LPN and assistive personnel tasks, accountability and supervision, unsafe assignments, priority frameworks and the funnel, organizing a shift, interruptions, asking for help, informed consent and the preoperative checklist, fasting rules, preoperative teaching, the time out, postoperative assessment, complications by timing, malignant hyperthermia, transition shock, residency, novice to expert, the NCLEX and safe career habits.

CHAPTER 21

Health Promotion Across the Lifespan

Read it in full: **Chapter 21 in the textbook**. Practice it in the lab: **Prevention and Change Coach** and **Older Adult Safety Review**.

What to know

Primary prevention stops disease or injury before it starts in well people: immunizations, health teaching, seat belts and car seats, safe sleep, smoking prevention. **Secondary prevention** finds disease early, even in people who feel well: screening (mammography, colonoscopy, BP checks, Pap and HPV tests, glucose and TB tests) and prompt treatment. **Tertiary prevention** limits complications and disability from established disease: cardiac or stroke rehabilitation, diabetic foot care, daily weights in heart failure. Some frameworks add primordial (social and environmental conditions) and quaternary (protection from overmedicalization).

Commonly taught adult screening for average risk: blood pressure from age 18; colorectal cancer 45 to 75; mammography every 2 years at 40 to 74; cervical cytology every 3 years at 21 to 29, then options every 3 or 5 years at 30 to 65; yearly low dose CT for lung cancer at 50 to 80 with a **20 pack year** history who smoke now or quit within 15 years; one AAA ultrasound for men 65 to 75 who ever smoked; bone density for women 65 and older; diabetes screening at 35 to 70 with overweight; hepatitis C at least once 18 to 79; HIV 15 to 65; depression for all adults. BP categories: normal under 120 and under 80, elevated 120 to 129 and under 80, stage 1 130 to 139 or 80 to 89, stage 2 140 or 90 or higher; above 180 or 120 is severe. Recommendations change, so check current guidance.

Immunizations: influenza yearly from 6 months; one Tdap in adulthood then Td or Tdap every 10 years, and Tdap in **every pregnancy** (27 to 36 weeks); pneumococcal at 50 and older or with conditions; recombinant zoster two doses at 50 and older (not live); RSV for older adults by current criteria; hepatitis B 19 to 59; HPV at 11 to 12 (from 9), catch up through 26. **Live vaccines** (MMR, varicella, nasal influenza) are avoided in pregnancy and severe immunocompromise. A severe reaction to a prior dose is a contraindication; moderate or severe illness is a precaution; a mild cold is not. Give the information statement, document lot, site, route and date, and watch for fainting (often 15 minutes).

Behavior change: the **Health Belief Model** (perceived susceptibility, seriousness, benefits versus barriers, cues to action, self efficacy); the Health Promotion Model; the **stages of change**: precontemplation ("no problem": raise awareness gently), contemplation ("I know, but...": explore ambivalence), preparation ("next week": set a plan and date), action (reinforce, handle triggers),

maintenance (prevent relapse). Relapse is part of the process. **Motivational interviewing** uses open questions, affirmations, reflections and summaries to draw out the person's own change talk instead of lecturing.

Development is **cephalocaudal** (head to toe) and **proximodistal** (center to periphery), in a predictable order at individual rates. **Erikson**: trust versus mistrust (infant), autonomy versus shame (toddler), initiative versus guilt (preschool), industry versus inferiority (school age), identity versus role confusion (adolescent), intimacy versus isolation (young adult), generativity versus stagnation (middle adult), integrity versus despair (older adult). **Piaget**: sensorimotor (birth to 2; object permanence about 8 to 9 months), preoperational (2 to 7; egocentric, magical thinking), concrete operational (7 to 11; logic about real things, conservation), formal operational (11 and up; abstract reasoning).

Milestones: birth weight doubles by about 6 months and triples by 12; social smile by 2 months; sits about 6 to 8 months; stranger anxiety 6 to 8 months; first words and pulling to stand about 12 months; walking 12 to 15 months; two word phrases by 2 years. Injury risks: infants (sleep death, suffocation, falls, car crashes; back to sleep on a firm flat surface, rear facing car seat), toddlers (poisoning, drowning, burns), preschoolers (drowning, traffic, burns), school age (crashes, bikes, sports), adolescents (crashes, suicide, homicide, substances). Fears in hospital: toddlers **separation**, preschoolers **bodily injury**, adolescents loss of control, appearance and peers. Losing skills already gained is a red flag. For preterm infants use **corrected age** until about 2 years.

Normal aging: thinner skin and slower healing, presbyopia and high frequency hearing loss, stiffer arteries with higher systolic pressure and orthostatic risk, weaker cough, slower bowels and less thirst, **lower GFR** (creatinine may look normal because of less muscle), sarcopenia and bone loss, slower processing with preserved knowledge, lower baseline temperature. **Confusion is never normal aging.** Illness presents atypically: infection as confusion, falls or poor appetite; heart attack as fatigue or dyspnea.

Falls are the leading cause of injury death in older adults. Screen: fallen in the past year, feeling unsteady, worried about falling; TUG 12 seconds or longer suggests risk. Prevent with strength and balance exercise, medication review, vision care, treating orthostasis, vitamin D if deficient, footwear and home changes. Assess **ADLs** (bathing, dressing, toileting, transferring, continence,

feeding) and **IADLs** (phone, shopping, cooking, housekeeping, laundry, transportation, medications, money); IADLs are usually lost first. **Polypharmacy** (often 5 or more drugs) raises falls, delirium and bleeding. A **prescribing cascade** treats a drug side effect as a new disease with another drug. Reconcile at every transition and avoid potentially inappropriate drugs such as diphenhydramine, benzodiazepines and long acting sulfonylureas.

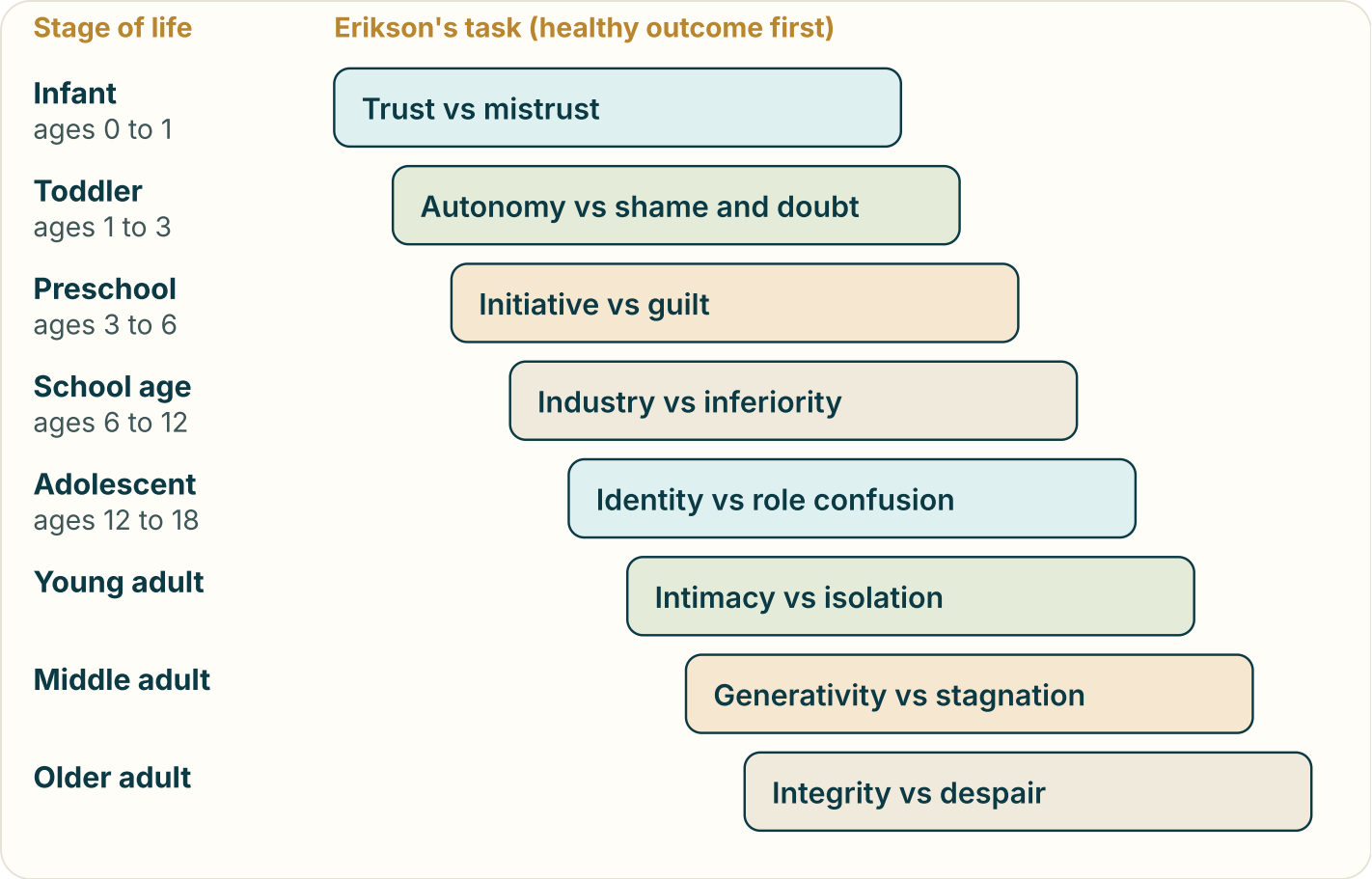
Elder abuse includes physical (bruises on upper arms, torso, ears or neck, patterned injuries, delayed care), sexual, emotional, financial exploitation, caregiver neglect (dehydration, malnutrition, pressure injuries, missing aids) and self neglect. Interview privately, ask gently and directly, document objectively with quotes and measurements, keep the person safe and report **reasonable suspicion** to adult protective services as state law requires; proof is not needed.

Home safety looks at the home through the patient's abilities: falls (no throw rugs, night lights, grab bars, handrails), fire (smoke alarms on every level tested monthly, water heater 120 F or lower), **home oxygen** (no smoking or flames, distance from heat commonly 5 to 10 feet, no petroleum products, cylinders upright), carbon monoxide alarms, locked medicines and chemicals, firearms stored unloaded and locked with ammunition separate, constant water supervision for young children and showers instead of baths with seizures. Refer only to resources the patient can actually reach (transportation, phone, internet, literacy, language, cost).

Transitions are high risk. **Discharge planning starts at admission**: assess living situation, caregivers, function, equipment and payment; reconcile medications (preadmission, inpatient and discharge lists) and mark stopped drugs; teach with **teach back** and return demonstration to the person who will do the care; give plain written instructions in the preferred language; schedule follow up; hand off with SBAR. A capable patient may decline a placement or leave against advice after being told the risks.

Evidence based practice combines the best evidence, clinical expertise and patient preferences. It starts with a **PICO(T)** question (population, intervention, comparison, outcome, time), then search, appraise, integrate, implement, evaluate and share. The hierarchy runs from systematic reviews and meta analyses of RCTs and evidence based guidelines, to single RCTs, quasi experimental studies, cohort and case control studies, descriptive and qualitative studies, and expert opinion; qualitative work best answers experience questions. **Quality improvement** uses

local data and **PDSA** cycles (plan, do on a small scale, study the data, act: adopt, adapt or abandon), measured with structure, process and outcome measures. A staff nurse who doubts a practice asks a question and looks for evidence rather than changing practice alone.



Erikson's tasks, one per stage. The healthy outcome is named first in each pair. Match the stage to the behavior you see, such as a toddler insisting on doing it alone.

LOCK THESE IN

- Primary prevents; secondary screens; tertiary limits disability. Immunization is always primary.
- Lung CT: 50 to 80 with 20 pack years, smoking now or quit within 15 years.
- Tdap in every pregnancy; no live vaccines in pregnancy or severe immunocompromise.
- Match the approach to the stage of change; MI draws out the person's own reasons.
- Toddlers fear separation; preschoolers fear bodily harm; adolescents fear loss of control and privacy.
- Confusion is never normal aging; illness presents atypically.
- Polypharmacy is often 5 or more drugs; ask if a new symptom is a drug effect.
- Discharge planning starts at admission; PICO starts EBP; PDSA drives QI.

Key terms and comparisons: Erikson, Piaget and milestones

Stage (age)	Erikson task	Piaget and key milestones
Infant (0 to 1)	Trust vs mistrust	Sensorimotor; object permanence 8 to 9 mo; birth weight doubles by 6 mo, triples by 12 mo
Toddler (1 to 3)	Autonomy vs shame and doubt	Walks 12 to 15 mo; two word phrases by 2; fears separation
Preschool (3 to 6)	Initiative vs guilt	Preoperational; magical thinking; fears bodily injury
School age (6 to 12)	Industry vs inferiority	Concrete operational; logic, rules, competence
Adolescent (12 to 18)	Identity vs role confusion	Formal operational; privacy, peers, invulnerability
Young adult	Intimacy vs isolation	Careers, partners; injury and overdose risk
Middle adult	Generativity vs stagnation	Caring for children and parents; chronic disease screening
Older adult	Integrity vs despair	Life review; falls, drugs, isolation

Priority rules: prevention, aging and evidence

Item	Rule
Primary prevention	Vaccines, teaching, seat belts, safe sleep
Secondary prevention	Screening and early treatment
Tertiary prevention	Rehabilitation, foot care in diabetes, daily weights
Stages of change	Precontemplation, contemplation, preparation, action, maintenance
Corrected age	Chronologic age minus weeks born early, until about 2 years
Falls screen	Fall in past year, unsteady, worried; TUG 12 s or more
Elder abuse	Interview alone; document objectively; report reasonable suspicion
Evidence hierarchy	Systematic reviews of RCTs top; expert opinion bottom
QI measures	Structure, process, outcome; PDSA cycles

Worked cases

WORKED CASE 1 · CLASSIFYING PREVENTION

A clinic nurse does four things in one morning: (A) gives an influenza vaccine, (B) performs a blood pressure screening at a health fair, (C) teaches a patient with diabetes to inspect his feet daily, (D) teaches new parents to place their baby on its back to sleep.

STEP 1 · A

Vaccination prevents disease in a well person: **primary**.

STEP 2 · B

Screening seeks disease that may already be present: **secondary**.

STEP 3 · C

Limits complications of an existing disease: **tertiary**.

STEP 4 · D

Prevents injury before it happens: **primary**.

RULE

Ask where the person is on the course of disease: well, possibly sick but unaware, or already diagnosed.

WORKED CASE 2 · WHO QUALIFIES FOR LUNG SCREENING

Mr. Odell, 62, smoked 1.5 packs a day for 20 years and quit 10 years ago.

STEP 1 · PACK YEARS

1.5 packs per day x 20 years = **30 pack years**.

STEP 2 · CHECK AGE

62 is within 50 to 80.

STEP 3 · CHECK QUIT TIME

He quit 10 years ago, within 15 years.

STEP 4 · CONCLUDE

He meets the commonly taught criteria for yearly low dose CT.

PAIR IT

Screening is secondary prevention; keep supporting tobacco abstinence.

WORKED CASE 3 · STAGE OF CHANGE AND THE RIGHT APPROACH

Mr. Lachance, 47, with stage 1 hypertension, smokes a pack a day. He says, "I know it's bad. I've thought about it, but it's how I handle stress at work."

STEP 1 · NAME THE STAGE

He sees the problem and is ambivalent: **contemplation**.

STEP 2 · CHOOSE THE APPROACH

Explore ambivalence with motivational interviewing.

STEP 3 · EXAMPLE WORDS

"Smoking helps you cope with stress, and you're also worried about your health. What would you gain by quitting?"

RULE

Handing him a quit date skips ahead to preparation, and stern warnings are lecturing. Respect autonomy and revisit each visit.

WORKED CASE 4 · POSSIBLE ELDER MISTREATMENT

Mrs. Varady, 86, with mild dementia, is brought in by her grandson for "a fall." She has bruises of different colors on both upper arms, looks thin and dehydrated, looks at her grandson before answering, and he refuses to leave the room.

STEP 1 · RECOGNIZE

Bruises of different ages on the upper arms (gripping), neglect and a controlling caregiver.

STEP 2 · GET HER ALONE

Arrange a private interview, for example during imaging.

STEP 3 · TREAT AND DOCUMENT

Treat dehydration; document objectively with quotes, measurements and a body diagram.

STEP 4 · REPORT

Notify the provider and social worker and report reasonable suspicion to adult protective services.

RULE

Do not confront him, accept "a fall" at face value or wait for proof.

TRAPS PEOPLE FALL INTO

- **Calling screening primary prevention.** Screening finds disease already present: secondary.
- **Giving a live vaccine in pregnancy.** MMR and varicella are avoided in pregnancy.
- **Skipping a vaccine for a mild cold.** A mild illness is not a reason to delay.
- **Pushing a quit date on a patient in contemplation.** Explore ambivalence first.
- **Explaining a procedure to a preschooler the day before.** Explain just before; early warning raises fear.
- **Calling new confusion in an older adult normal aging.** It is a change in condition; look for a cause.
- **Treating a drug side effect with another drug.** Ask whether a new symptom is a medication effect.
- **Starting discharge teaching on the day of discharge.** Discharge planning starts at admission.
- **Changing a practice on your own because it seems outdated.** Ask a PICO question and follow the approval process.

Chapter 21 self-test · ten items

1. A nurse teaches a patient who already has heart failure to weigh himself daily. Which level of prevention is this?

A. Primordial prevention
B. Secondary prevention
C. Tertiary prevention
D. Primary prevention

C. Tertiary prevention Teaching that limits complications of an established disease is tertiary.

2. Which person meets the commonly taught criteria for yearly lung cancer screening with low dose CT?

A. A 70 year old who quit 25 years ago after 30 pack years
B. A 45 year old who currently smokes 10 pack years
C. A 66 year old who has never smoked at all
D. A 58 year old who quit 5 years ago after 25 pack years

D. A 58 year old who quit 5 years ago after 25 pack years Ages 50 to 80 with at least 20 pack years who smoke now or quit within 15 years qualify.

3. Which vaccine should be avoided during pregnancy?

A. Measles, mumps and rubella
B. Tdap given at 28 weeks
C. Hepatitis B vaccine series
D. Inactivated influenza vaccine

A. Measles, mumps and rubella MMR is a live vaccine. Tdap is recommended in every pregnancy.

4. A patient says, "I'm going to stop smoking on the first of next month." Which stage of change is this?

A. Precontemplation
B. Preparation
C. Contemplation
D. Maintenance

B. Preparation Planning a specific start date is preparation.

5. A 4 year old is about to have an IV started. Which approach fits his development?

A. Tell him that big boys do not cry during these
B. Explain the whole procedure in detail the day before
C. Ask the parent to wait outside until it is done
D. Explain simply just before and offer a bandage

D. Explain simply just before and offer a bandage Preschoolers fear bodily harm and think magically. Brief, concrete preparation and a bandage help.

6. A baby born at 32 weeks is now 6 months old by birth date. What corrected age should be used for milestones?

A. About 8 months
B. About 6 months
C. About 4 months
D. About 2 months

C. About 4 months Born 8 weeks (about 2 months) early, so 6 minus 2 = about 4 months.

7. An 84 year old has new confusion and a poor appetite but no fever. What should the nurse suspect?

A. A possible infection presenting atypically
B. Normal aging of the brain over time
C. A sign that dementia has just begun
D. Expected effects of being in hospital

A. A possible infection presenting atypically Older adults often show infection as confusion or appetite loss. Confusion is never normal aging.

8. A patient started a new blood pressure drug and now has ankle swelling. A second drug is ordered to treat the swelling. What does this illustrate?

A. An allergic reaction
B. A prescribing cascade
C. Medication adherence
D. Therapeutic duplication

B. A prescribing cascade A side effect mistaken for a new condition and treated with another drug is a prescribing cascade.

9. When should discharge planning begin for a patient admitted with pneumonia?

A. On the day the patient is admitted to the unit
B. After the antibiotic course has been completed
C. The day the provider writes the discharge order
D. The morning the patient is going home

A. On the day the patient is admitted to the unit Discharge planning starts at admission so needs can be met before discharge.

10. Which source sits at the top of a common evidence hierarchy for intervention questions?

A. A single well designed cohort study
B. A descriptive qualitative interview study
C. An expert committee opinion report
D. A systematic review of randomized trials

D. A systematic review of randomized trials Systematic reviews and meta analyses of RCTs give the strongest evidence for interventions.

CHAPTER 22

Leadership, Delegation and the New Graduate

Read it in full: **Chapter 22 in the textbook**. Practice it in the lab: **Team Delegation Board** and **Shift Priority Board**.

What to know

Leadership is influence toward a goal and does not need a title. **Management** is formal coordination of people, time and resources (planning, organizing, staffing, directing, controlling). Styles: **autocratic** (leader decides; best in emergencies such as a code or fire), **democratic** (shared decisions; planning and experienced teams), **laissez-faire** (little direction; rarely right in clinical care), situational, transactional, **transformational** (shared vision, mentoring; linked to satisfaction and retention) and servant leadership.

Followership is active: think critically, take initiative, raise concerns respectfully, support decisions and use **closed loop communication** ("Giving epinephrine 1 mg IV now," then "Epinephrine given"). Speak up with SBAR or graded assertiveness (concerned, uncomfortable, safety issue). Manage the assignment: gather information, plan around time critical tasks, delegate, communicate, handle conflict early and privately (collaborating is best when time allows; competing fits emergencies; avoiding only for trivial issues) and use resources. Change moves through unfreezing, moving and refreezing; involving staff reduces resistance.

Delegation lets a delegatee do a specific task beyond their usual role while the RN keeps accountability. **Assignment** directs a person to do work already within their scope and job description. Both depend on the state nurse practice act, facility policy and each person's competence. The **five rights**: right task (routine, predictable, within scope), right circumstance (stable patient, no nursing judgment needed), right person (trained and competent), right directions and communication (what, for whom, by when, limits and exactly what to report) and right supervision and evaluation.

The RN keeps **assessment**, nursing diagnosis and care planning, **initial teaching**, **evaluation** and **unstable or unpredictable patients**. Data collection can be delegated; interpreting it cannot. LPNs: focused data on stable patients, oral, subcutaneous, IM and topical medications, sterile procedures, trach care, suctioning and tube feedings on stable patients, reinforcing teaching; generally not IV push, blood initiation or central lines. Assistive personnel: vital signs, I and O and weights on stable patients, hygiene, ambulation, turning, feeding without swallowing risk, glucose checks and specimens if trained; no medications, sterile procedures or teaching.

Responsibility is doing the task well; **accountability** is answering for actions and outcomes. The delegatee answers for doing the task and reporting; the RN answers for the decision, directions and follow up. Verify competence (do not assume a float can do it), follow up abnormal findings by assessing personally, take back the task if the patient changes, and give feedback privately. With an unsafe assignment, discuss it with the charge nurse, clarify support, document per policy and accept if it can be made safe; leaving after accepting can be **abandonment**.

Priority frameworks: **ABCs** first (stridor before chest pain before a controlled bleed), Maslow, acute over chronic, unstable over stable, actual over potential, unexpected over expected, and safety (a confused patient climbing out of bed). In adult cardiac arrest, compressions come first. The **funnel**: life threats, then unstable or acute changes, then safety risks, then time critical tasks, then expected problems, then teaching and paperwork. Re prioritize after every new piece of information; the least stable patient wins.

Organize with a confidential **brain sheet**, round first on the sickest, identify time critical tasks (meal insulin, scheduled antibiotics, anticoagulants, preoperative drugs), cluster care, delegate early, chart as you go. Protect medication preparation from interruptions; if a new demand is not

more urgent, say when you will be available, and if it is, secure the current task first. Ask for help when a patient deteriorates or something feels wrong (call rapid response), a skill is unfamiliar, an order is unsafe (question it, then the chain of command), the workload is unsafe, or an error occurs (assess the patient first).

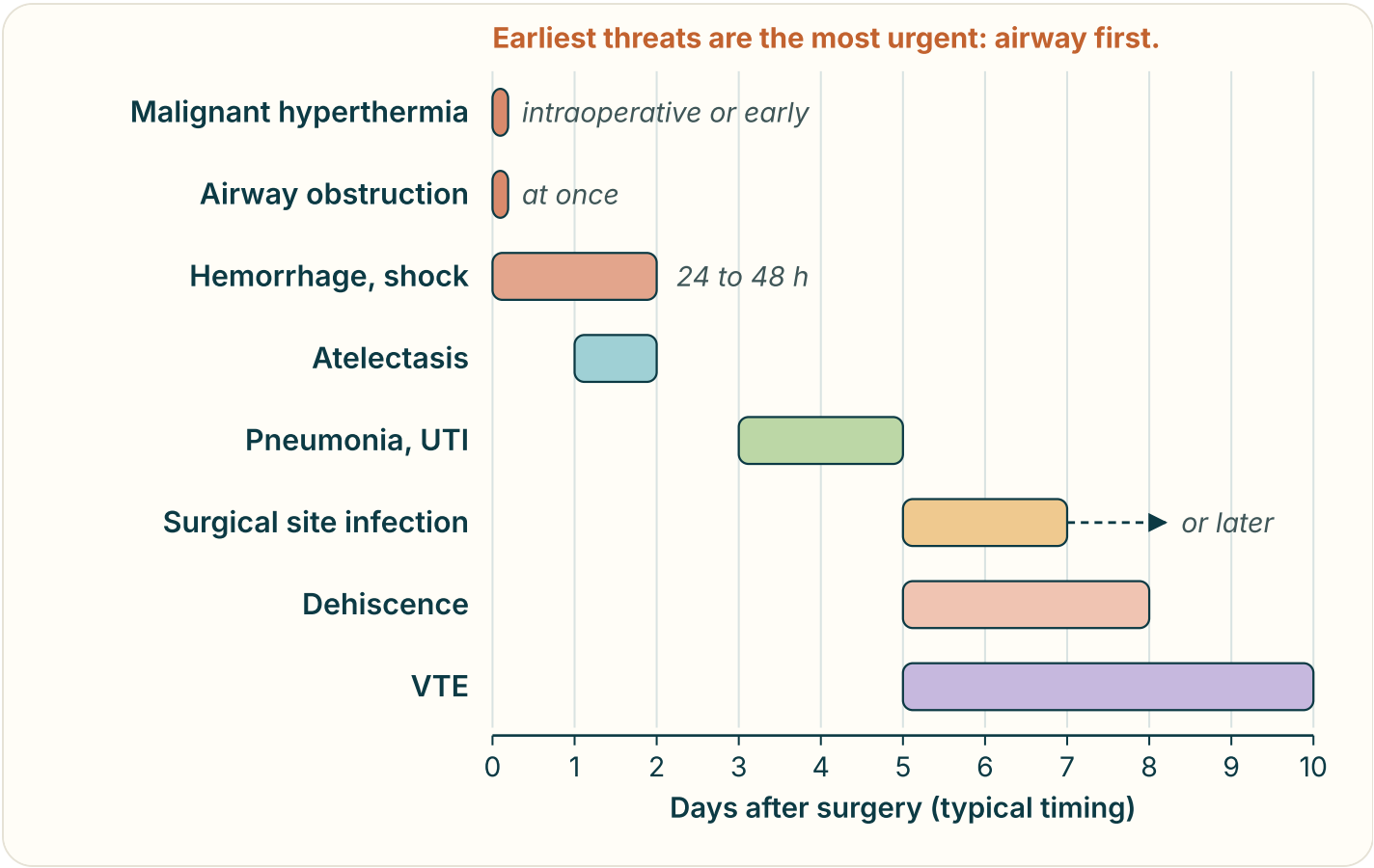
Perioperative phases: preoperative, intraoperative and postoperative. The **surgeon obtains informed consent**; the nurse witnesses the signature, confirms the patient is not sedated and seems to understand, and calls the surgeon if the patient has questions; the nurse does not explain the surgery to fill the gap. The checklist covers ID and allergy bands, consent, history and physical, labs (report low potassium or high INR), NPO status, site marked by the surgeon with the patient awake, medications given or held as ordered (anticoagulants often held; beta blockers often continued with a sip), removal of jewelry, dentures, contacts, prostheses, nail polish per policy, voiding and baseline vital signs.

Fasting for healthy elective patients commonly allows **clear liquids up to 2 hours** before anesthesia, breast milk up to 4 hours, a light meal or nonhuman milk up to 6 hours, fatty meals 8 hours or more; follow the specific order. Teach before surgery: incentive spirometry (inhale slowly, hold, about 10 times an hour), deep breathing and splinted coughing, leg exercises and compression devices, pain reporting and PCA, and what to expect. The **Universal Protocol** has preprocedure verification, site marking and a **time out** just before incision; every team member confirms patient, procedure, site and side, and anyone can stop the case.

After surgery assess **airway and breathing first**, then circulation, consciousness, the site and dressing, drains, pain, nausea, fluids and urine (report under 30 mL/hour or no void in about 6 to 8 hours) and temperature. Complications by timing: airway obstruction and hypoventilation immediately; **hemorrhage** in the first 24 to 48 hours (check under the patient); **atelectasis** days 1 to 2 (low grade fever, diminished bases); **pneumonia** and UTI about days 3 to 5; surgical site infection about days 5 to 7 or later; **VTE** often days 5 to 10; ileus in the first days; **dehiscence and evisceration** about days 5 to 8 (stay, sterile saline moistened dressing, low Fowler's with knees bent, NPO, call the surgeon). **Malignant hyperthermia**: rising end tidal CO2, tachycardia, jaw rigidity, then high fever; stop the trigger and give dantrolene. Ask about family reactions to anesthesia.

New graduates often feel **transition shock** and move through doing, being and knowing in the first year; orientation with a preceptor, nurse residency programs (often about 12 months) and mentors help retention. Skill grows from novice, advanced beginner (most new graduates), competent and proficient to expert through reflected experience. The NCLEX is a **computerized adaptive test** that measures clinical judgment (recognize cues, analyze cues, prioritize hypotheses, generate solutions, take actions, evaluate outcomes) with matrix, cloze, highlight, drag and drop and bow tie items. Prepare with a schedule, many questions with rationales, case items and weak areas, and answer as if resources were ideal.

Safe career habits: know scope and policy, document accurately and promptly, keep boundaries, never post about patients, report errors and near misses in a **just culture** (console human error, coach at risk behavior, discipline reckless behavior), recognize impairment in yourself or colleagues and report it to the charge nurse or manager (peer assistance programs help recovery while protecting patients), address incivility through the chain of command, keep learning and protect your own rest. After a medication error: assess the patient, notify the provider, follow orders, then complete an incident report that is not mentioned in the chart.



Match the complication to the day. Airway and bleeding threats come first; lung, urinary, wound and clot problems follow over the first ten days.

LOCK THESE IN

- Autocratic in emergencies; democratic or transformational for change; laissez faire rarely.
- Five rights: task, circumstance, person, directions and communication, supervision and evaluation.
- RN keeps assess, plan, teach (initial), evaluate and every unstable patient.
- Delegation moves the task; accountability stays with the RN.
- Funnel: ABC threats, unstable change, safety, time critical, expected, teaching.
- Surgeon obtains consent; nurse witnesses and calls the surgeon if the patient is unsure.
- Time out just before incision; anyone can stop it.
- Bleeding 24 to 48 h; atelectasis days 1 to 2; pneumonia days 3 to 5; dehiscence days 5 to 8.

Key terms and comparisons: who can do what

Activity	LPN (typical)	Assistive personnel (typical)
Admission assessment, care plan, evaluation	No (contributes data)	No
Focused data on stable patients	Yes	No
Vital signs, I and O, weight on stable patients	Yes	Yes
Bathing, turning, ambulating, feeding	Yes	Yes, feeding only without swallowing risk
Oral, subcut, IM, topical medications	Yes	No (medication aides in some settings)
IV push, starting blood, central lines	Generally no	No
Sterile procedures, trach care, suctioning on stable patients	Yes	No
Initial or discharge teaching	Reinforces only	No
Unstable or new postoperative patient	No	No

Priority rules: postoperative complications by timing

Complication	Typical timing	First actions
Airway obstruction, hypoventilation	Immediately	Jaw thrust, oxygen, suction, stimulate, call for help
Hemorrhage, hypovolemic shock	First 24 to 48 h	Pressure, check under patient, notify surgeon, fluids per order
Atelectasis	Days 1 to 2	Incentive spirometry, deep breathing, walking, pain control
Pneumonia, UTI	About days 3 to 5	Report, cultures and antibiotics per order
Surgical site infection	About days 5 to 7 or later	Culture, report, aseptic wound care
VTE	Often days 5 to 10	No massage; PE: head up, oxygen, rapid response
Dehiscence, evisceration	About days 5 to 8	Stay, sterile saline moist dressing, low Fowler's, knees bent, NPO
Malignant hyperthermia	Intraoperative or early	Stop trigger, dantrolene; rising end tidal CO2 is early

Worked cases

WORKED CASE 1 · WHAT CAN GO TO THE ASSISTANT

An RN with one nursing assistant considers four tasks: (1) vital signs on a patient 2 days after knee replacement whose vital signs have been stable; (2) feeding a patient who had a stroke yesterday and coughs when swallowing; (3) teaching a new diabetic to use a glucose meter; (4) assessing a new reddened area on a patient's sacrum.

STEP 1 · TEST TASK 1

Stable patient, routine task, clear report limits: meets all five rights. Delegate it, with values to report.

STEP 2 · TEST TASK 2

Aspiration risk and swallowing judgment: not delegated to the assistant.

STEP 3 · TEST TASKS 3 AND 4

Initial teaching and skin assessment need RN judgment.

RULE

The RN still reviews the vital signs the assistant records and assesses any abnormal value personally.

WORKED CASE 2 · THE FIRST PATIENT AFTER HANDOFF

A new graduate has four patients: (A) 68, day 1 after colon resection, pain 5/10, due for an analgesic; (B) 45 with pneumonia, SpO2 down from 94% to 88% and now restless; (C) 77 awaiting discharge teaching; (D) 30 with diabetes whose breakfast tray just arrived and needs insulin.

STEP 1 · LIFE THREAT

B has an acute breathing change with restlessness, an early sign of hypoxia: first.

STEP 2 · ACT FOR B

Assess, raise the head of the bed, apply or increase oxygen per protocol, notify the provider or rapid response.

STEP 3 · TIME CRITICAL

D next, because meal insulin is time critical.

STEP 4 · EXPECTED AND ROUTINE

Then A for expected pain, then C for teaching.

RULE

Do not clear the "quick" discharge teaching first or go in the order patients asked.

WORKED CASE 3 · FASTING TIMES BEFORE SURGERY

Ms. Gallo, a healthy adult, has elective surgery at 0800 with anesthesia at 0800. Her surgeon follows the commonly taught fasting guidance.

STEP 1 · CLEAR LIQUIDS

Up to 2 hours before: until **0600**.

STEP 2 · LIGHT MEAL

Up to 6 hours before: until **0200**.

STEP 3 · FATTY OR FRIED MEAL

8 hours or more before: nothing fatty after **0000** (midnight).

RULE

Follow the specific order, which may be longer. Prolonged fasting causes dehydration and hypoglycemia.

WORKED CASE 4 · A COLLEAGUE WHO MAY BE IMPAIRED

Three months into her first job, a new graduate notices that an experienced colleague often smells of alcohol at the start of night shift and has made two documentation errors on controlled substances.

STEP 1 · PUT SAFETY FIRST

Patients are at risk, and the nurse has a professional duty.

STEP 2 · REPORT

Report the concerns promptly and factually to the charge nurse or nurse manager.

STEP 3 · LET POLICY WORK

Policy may remove the colleague from care and refer to a peer assistance program.

RULE

Confronting the colleague alone at the bedside can escalate things, and silence leaves patients at risk.

TRAPS PEOPLE FALL INTO

- **Choosing laissez faire leadership in a clinical scenario.** It is rarely right; use autocratic in emergencies.
- **Delegating "assess" or "evaluate."** Those words stay with the RN.
- **Giving the new admission to the LPN.** Admission assessment stays with the RN.
- **Letting the assistant feed a patient with dysphagia.** Swallowing risk needs licensed judgment.
- **Seeing the patient who asked first.** Rank by threat, not by order of requests.
- **Explaining the surgery yourself when the patient is unsure.** Notify the surgeon before sedation.
- **Skipping the time out because the team is sure.** Every case gets a time out; anyone can stop it.
- **Pushing eviscerated bowel back.** Cover with sterile saline moistened dressings and call the surgeon.
- **Charting "incident report filed."** The report is never mentioned in the chart.

Chapter 22 self-test · ten items

1. A patient arrests on the unit. Which leadership style is most appropriate for the code leader?

A. Servant
B. Democratic
C. Laissez-faire
D. Autocratic

D. Autocratic In emergencies, one leader giving clear directions saves time.

2. An RN is working with an assistant. Which task is appropriate to hand off?

A. Measuring output for a stable patient after surgery
B. Feeding a patient who coughs with each swallow
C. Teaching a patient to use a new glucose meter
D. Assessing a new reddened area on the sacrum

A. Measuring output for a stable patient after surgery Routine data collection on a stable patient meets the five rights. Teaching, assessment and dysphagia need licensed judgment.

3. Four patients need a nurse. Which one fits an LPN's scope best?

A. A patient who just returned from the recovery unit
B. A stable patient needing a scheduled sterile dressing change
C. A patient admitted 10 minutes ago with abdominal pain
D. A patient whose blood pressure is steadily falling

B. A stable patient needing a scheduled sterile dressing change LPNs care for stable patients with predictable outcomes. New admissions, fresh postoperative and unstable patients stay with the RN.

4. The RN delegates vital signs to an assistant, who reports a systolic pressure of 88. What should the RN do?

A. Document the value and continue the shift
B. Ask the assistant to recheck it in an hour
C. Assess the patient personally right away
D. Tell the assistant to notify the provider

C. Assess the patient personally right away Abnormal findings from a delegated task are followed up by RN assessment.

5. After handoff, which patient should the nurse see first?

A. A patient whose SpO2 fell to 88% and who is restless
B. A patient due for an oral pain pill, pain 5 of 10
C. A patient with chronic back pain that is stable today
D. A patient who is waiting for discharge teaching now

A. A patient whose SpO2 fell to 88% and who is restless An acute breathing change with restlessness is a possible airway or breathing threat.

6. A nurse is preparing medications when a visitor asks for an extra blanket. What should the nurse do?

A. Ask the visitor to find the blanket in the supply room
B. Stop at once and go get the blanket for the visitor
C. Leave the medications on the cart and bring the blanket
D. Say when the nurse will be free, then finish the medications

D. Say when the nurse will be free, then finish the medications Interruptions cause medication errors. A nonurgent request waits.

7. Before surgery, the patient says, "I'm not sure what they're going to do." Consent is signed. What should the nurse do?

A. Ask the family to explain the procedure
B. Notify the surgeon before any sedation
C. Proceed, since the form is already signed
D. Explain the surgery to the patient now

B. Notify the surgeon before any sedation The surgeon obtains consent and must clarify. The nurse does not fill the gap.

8. When does the surgical time out take place?

A. When the patient is admitted
B. After the patient reaches recovery
C. Immediately before the incision
D. During the preoperative teaching

C. Immediately before the incision The time out is the final check just before the procedure starts.

9. On postoperative day 1, a patient has a temperature of 37.9 C and diminished breath sounds at the bases. What is the most likely cause?

A. Paralytic ileus
B. Early atelectasis
C. Pulmonary embolus
D. Wound infection

B. Early atelectasis Low grade fever with diminished bases on days 1 to 2 suggests atelectasis.

10. A patient on day 6 after abdominal surgery says, "Something popped," and bowel is visible. What should the nurse do first?

A. Cover the wound with dry sterile gauze and tape
B. Leave to call the surgeon from the nurses' station
C. Stay and cover it with sterile saline moist dressings
D. Push the bowel back in with sterile gloved hands

C. Stay and cover it with sterile saline moist dressings Stay, cover with moist sterile dressings, low Fowler's with knees bent, NPO, and have someone call the surgeon.

ONE PAGE

Cram sheet

Chapters 21 and 22 on one page. Run the priority funnel and the five rights on a made up assignment before the exam.

Health promotion and the lifespan

Item	Rule
Prevention	Primary prevents; secondary screens; tertiary limits disability
Screening	Colorectal 45 to 75; mammogram 40 to 74 every 2 y; lung CT 50 to 80, 20 pack years
Vaccines	Flu yearly; Tdap every pregnancy; no live vaccines in pregnancy
Change	Precontemplation, contemplation, preparation, action, maintenance; MI
Erikson	Trust, autonomy, initiative, industry, identity, intimacy, generativity, integrity
Piaget	Sensorimotor, preoperational, concrete, formal
Fears	Toddler separation; preschool bodily harm; teen control and privacy
Aging	Confusion is never normal; atypical illness; lower GFR
Older adult risks	Falls, polypharmacy, prescribing cascade, elder abuse
Home	Smoke and CO alarms; water heater 120 F; oxygen away from flame; locked firearms
Transitions	Plan at admission; reconcile; teach back; follow up
EBP and QI	PICO; systematic reviews top; PDSA; structure, process, outcome

Leadership, delegation and surgery

Item	Rule
Styles	Autocratic in emergencies; democratic or transformational for change
Followership	Critical thinking, closed loop, speak up
Five rights	Task, circumstance, person, directions, supervision
RN keeps	Assess, plan, initial teaching, evaluate, unstable patients
Accountability	Stays with the delegating RN; take back if the patient changes
Funnel	ABC, unstable, safety, time critical, expected, teaching
Interruptions	Protect medication prep; secure the task before switching
Consent	Surgeon obtains; nurse witnesses; unsure patient means call surgeon
Fasting	Clear liquids to 2 h; light meal to 6 h; fatty 8 h or more
Time out	Just before incision; anyone can stop
Post op timing	Bleed 24 to 48 h; atelectasis d1 to 2; pneumonia d3 to 5; dehiscence d5 to 8
Career	Just culture; report impairment; incident report not in chart

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