FUNDAMENTALS OF NURSING · STUDY GUIDE

Exam 1 Study Guide

This guide covers the first two chapters. You will learn what makes nursing a profession, who may legally do what, and how delegation and speaking up keep patients safe. Then you will follow a patient across the settings of care, meet the team, see who pays, and learn the theories and the needs hierarchy that nurses use to set priorities. 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 in one place.

WHAT THIS GUIDE COVERS

- Chapter 1 · definitions of nursing, art and science, caring, holistic and patient centered care, the eras of nursing, education pathways, licensure, scope of the RN, LPN, assistive personnel and APRN, delegation and the five rights, standards, the code of ethics, certification, accountability, burnout and speaking up.
- Chapter 2 · the continuum of care and its settings, levels of prevention, the interprofessional team and referrals, care delivery models, insurance, Medicare and Medicaid, value based care, social determinants of health, nursing theory, the metaparadigm, the health illness continuum and Maslow priorities.

CHAPTER 1

Nursing as a Profession

Read it in full: **Chapter 1 in the textbook**. Practice it in the lab: **Delegation Board: Who May Do It** and **Speak Up Ladder: Escalation, Civility and Self Care**.

What to know

A task is not yet nursing. A task becomes nursing care when assessment, judgment and a relationship with the person guide it. Giving a pill is a task. Giving it after checking the blood pressure, the allergy list and what the patient understands, with teaching and a plan to see if it worked, is nursing.

The professional definition says nursing protects, promotes and optimizes health, prevents illness and injury, eases suffering and advocates for people. The key phrase is the **diagnosis and treatment of human responses** to actual or potential health problems. A physician treats the pneumonia. The nurse treats the response to it: the poor airway clearance, the fatigue, the worry about missing work, the risk of falling on the way to the bathroom.

Nursing is a **science** because it rests on biology, physiology, pharmacology, psychology and nursing research. **Evidence based practice** joins three things: the best current research, clinical expertise and the patient's own values and preferences. Nursing is an **art** because the same evidence has to reach a unique person at a unique moment. The art is not vague intuition. It is pattern recognition from many patients, plus presence, respect and skilled communication.

Caring is a set of actions you can see: being present, knowing the patient as a person, doing what they cannot do, helping them do what they can, and believing they can cope. Patients name listening, explaining, answering call lights promptly and treating them with dignity. **Holistic care** treats the whole person: physical, emotional, social, spiritual, cultural, intellectual and environmental. A change in one dimension changes the others. **Patient centered care** lets the patient's preferences, needs and values guide decisions, and the patient decides who counts as family.

Nursing grew through recognizable eras: family and religious care (compassion and service), military nursing (sanitation, record keeping, triage), hospital training schools (diploma programs), professional registration and licensure laws, growth into higher education (ADN, BSN, APRN roles), and today's era of evidence, safety, informatics and teamwork. Practical nursing programs lead to the practical nurse exam. Diploma, ADN and BSN programs all lead to the **same** RN licensure exam. MSN, DNP and PhD build on the RN.

Licensure is legal permission from a state to practice. Its purpose is to **protect the public**, not the profession. A license is a privilege, not a right, and can be limited, suspended or revoked. The licensure exam tests safe, effective entry level practice, is organized by client needs, measures clinical judgment and is computerized adaptive. The **Nurse Licensure Compact** lets a nurse with a multistate license from the home state practice in other compact states, following the practice law of the state where the patient is.

Scope of practice passes through three filters: law, policy, competence. The **nurse practice act** is a state statute that defines nursing, sets licensure rules and scope, lists grounds for discipline and creates the **board of nursing**. The board writes rules with the force of law, approves programs, issues licenses, investigates and disciplines. Many boards offer alternative to discipline programs for nurses with substance use disorders.

The **RN** owns the full nursing process: admission assessment, nursing diagnosis, the plan of care, initial teaching, evaluation and care of unstable or unpredictable patients. The **LPN or LVN** cares for stable, predictable patients under direction, collects data, gives most nonintravenous medications, does procedures such as catheter insertion and reinforces teaching. **Assistive personnel** do routine delegated tasks such as hygiene, ambulation of stable patients, vital signs on stable patients, intake and output, and feeding without swallowing risk. They do not assess, teach, evaluate or give medications. **APRNs** (nurse practitioner, nurse midwife, nurse anesthetist, clinical nurse specialist) hold graduate education and national certification and may diagnose, treat and prescribe within their role.

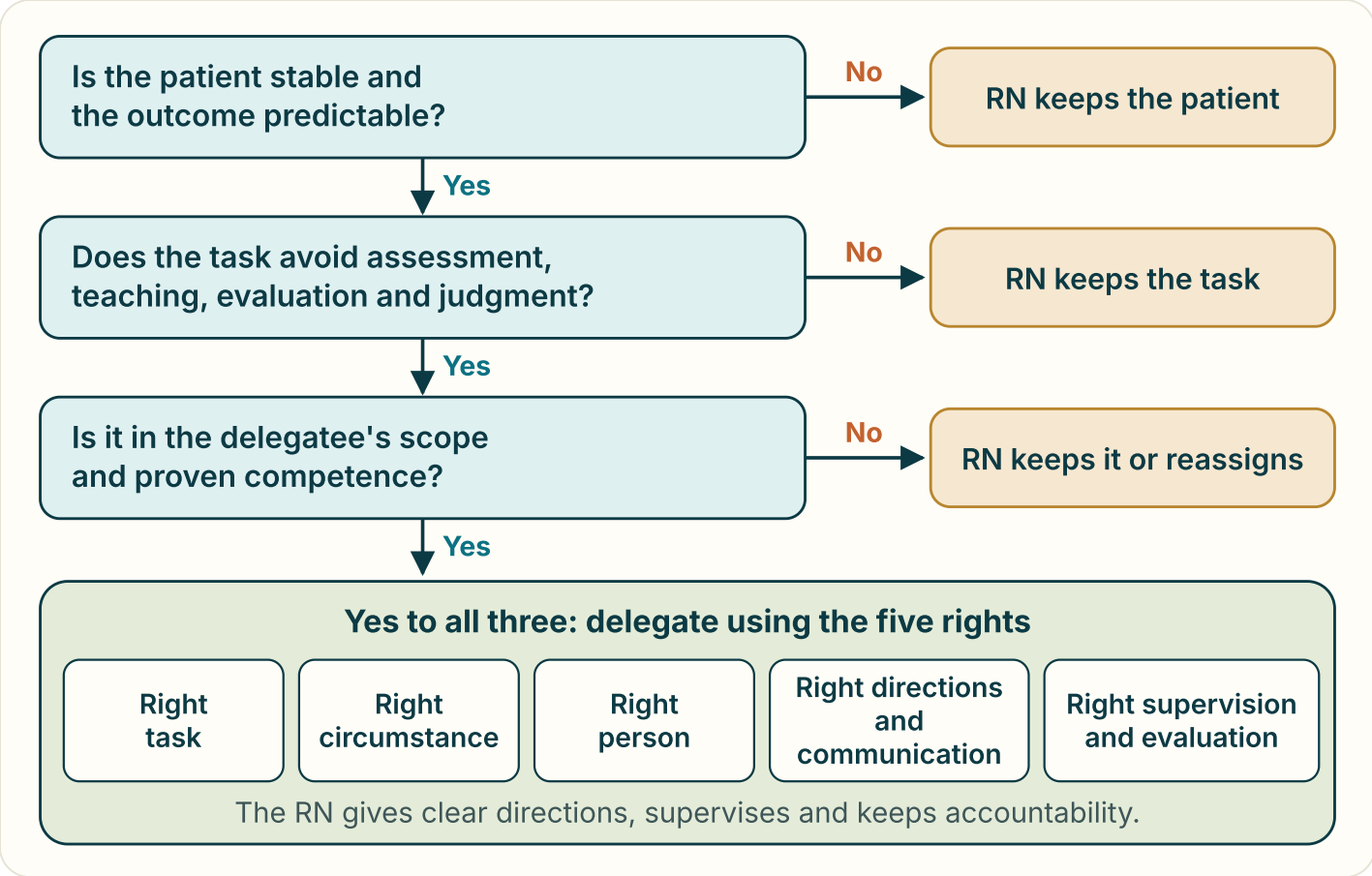
Delegation transfers authority to do a specific task to a competent person while the nurse keeps accountability. **Assignment** hands out work that each person is already authorized to do. The five rights of delegation are right task, right circumstance, right person, right directions and communication, and right supervision and evaluation. The RN never delegates anything that needs assessing, teaching, evaluating or judging, and never delegates care of an unstable patient. Stability is the first question.

The **standard of care** is what a reasonably prudent nurse with similar preparation would do in similar circumstances. It comes from the practice act, professional standards, accreditation, facility policy and current evidence. The code of ethics has nine provisions grouped as commitment to the patient (1 to 3), boundaries of duty and loyalty (4 to 6, including duties to self) and duties beyond the single encounter (7 to 9). Licensure is mandatory and set by the state. Certification is voluntary (except for APRNs) and set by the profession. Accreditation applies to programs, not people.

Responsibility is the duty to do your work competently. **Accountability** is being answerable for your actions and their outcomes. When the RN delegates, responsibility for the task moves, but

accountability for the decision and the supervision stays. Professional presence covers appearance, introductions, reliability, boundaries and confidentiality, including on social media. Burnout, compassion fatigue, secondary traumatic stress and moral distress are real risks, and self care is an ethical duty because tired nurses make more errors.

Incivility and bullying harm patients because frightened nurses stay quiet. Speaking up is an ethical duty. Use a clear statement of fact and request, the **CUS** words (concerned, uncomfortable, safety issue), the **two challenge rule**, then the **chain of command**. When a prescription seems unsafe, first clarify with the prescriber. If it is still unsafe, do not carry it out, go up the chain and document. An order never transfers the nurse's own accountability.



Delegate only after three yes answers. Stability, a task free of nursing judgment, and a competent delegatee come first. Then the five rights shape the handoff, and the RN stays accountable.

LOCK THESE IN

- Nursing diagnoses and treats human responses. Medicine diagnoses and treats disease.
- Licensure protects the public. It is a privilege that a board can limit, suspend or revoke.
- Scope passes three filters: state law, facility policy, personal competence.
- RN keeps assessment, care planning, initial teaching, evaluation and every unstable patient.
- Five rights of delegation: task, circumstance, person, directions and communication, supervision and evaluation.
- Delegation moves the task, not the accountability. The delegating RN stays accountable.
- Licensure is mandatory and from the state; certification is voluntary and from the profession; accreditation is for programs.
- Speak up in steps: clear statement, CUS, two challenge rule, chain of command, document.

Key terms and comparisons: who may do what

Role	Usually may do	Usually may not do
Registered nurse	Admission and ongoing assessment, nursing diagnosis, care plan, initial teaching, evaluation, unstable patients, IV push and blood per policy, delegation	Medical diagnosis, prescribing (unless an APRN), acting outside policy or personal competence
Licensed practical or vocational nurse	Stable, predictable patients; data collection; most nonintravenous medications; procedures such as catheter insertion; reinforcing teaching	Admission assessment, independent care planning, initial teaching, evaluation, unstable patients; IV therapy limited by state
Assistive personnel	Hygiene, ambulation and transfers of stable patients, vital signs and I and O on stable patients, feeding without swallowing risk, routine specimens	Assessment, teaching, evaluation, medications, sterile procedures, unstable patients
APRN	All RN work plus diagnosis, treatment and prescribing within the certified role and population	Practice outside the certified role, population or state authority

Priority rules: delegation and escalation

Question to ask	If yes	If no
Is the patient stable and the outcome predictable?	Go to the next question	RN keeps the patient
Does the task avoid assessment, teaching, evaluation and judgment?	Go to the next question	RN keeps the task
Is it in the delegatee's scope and proven competence?	Delegate with clear directions and report limits, then supervise	RN keeps it or reassigns
Is an order or action unsafe?	Clarify with the prescriber; if unresolved, hold, go up the chain of command, document	Carry out and evaluate the response

Worked cases

WORKED CASE 1 · WHO TAKES WHICH PATIENT

An RN works with an LPN and a nursing assistant. Patients: (A) Mr. Varga, 66, admitted 15 minutes ago with chest discomfort; (B) Ms. Ilse, 52, two days after a stable abdominal surgery, needs a scheduled sterile dressing change; (C) Mrs. Duarte, 79, four days after a knee replacement, stable, wants to walk to the bathroom; (D) Mr. Kimani, 58, back from surgery 40 minutes ago with a blood pressure that fell from 128/76 to 98/60.

STEP 1 · FIND THE UNSTABLE PATIENT

Mr. Kimani's pressure is falling soon after surgery. That can mean bleeding or low volume. He is unstable, so he is the RN's first patient.

STEP 2 · FIND WHAT CANNOT BE DELEGATED

Mr. Varga needs an admission assessment. Only the RN may do it, so he is the RN's second patient.

STEP 3 · MATCH STABLE WORK TO THE LPN

Ms. Ilse is stable and needs a sterile procedure, which fits LPN scope.

STEP 4 · MATCH ROUTINE WORK TO ASSISTIVE PERSONNEL

Mrs. Duarte is stable and needs help walking. That is a routine task for the nursing assistant.

RULE

Instability always stays with the RN. Asking the assistant to "watch" Mr. Kimani's vital signs would delegate monitoring of an unstable patient.

WORKED CASE 2 · AN UNSAFE PRESCRIPTION

Ms. Okeke, a nurse with one year of experience, cares for Mr. Halvorsen, 84. His heart rate is 46 and he feels lightheaded. A beta blocker is due. The provider says on the phone, "Give it anyway."

STEP 1 · NAME THE CUES

Bradycardia plus dizziness, and the drug slows the heart further. Giving it could cause severe hypotension or heart block.

STEP 2 · HOLD AND STATE THE CONCERN

She holds the dose and uses CUS language: "I am concerned. His heart rate is 46 and he is dizzy. Giving this is a safety issue."

STEP 3 · USE THE TWO CHALLENGE RULE

She states the concern a second time with the facts.

STEP 4 · GO UP THE CHAIN OF COMMAND

If the provider still insists, she notifies the charge nurse or supervisor.

STEP 5 · DOCUMENT

She records the findings, who she told, when, and the response, and makes sure the team knows the dose was held.

RULE

The nurse is accountable for every dose given. "The provider said so" does not move that accountability.

WORKED CASE 3 · PRACTICE BEFORE THE LICENSE POSTS

Mr. Ferreira, 23, passed the RN exam on Monday. On Friday the board has not yet posted his license. His manager asks him to take a full RN assignment this weekend.

STEP 1 · FIND THE KEY CUE

No license has been issued (and the state may or may not allow a temporary permit).

STEP 2 · APPLY THE PURPOSE OF LICENSURE

The license is what makes a nurse legally accountable to the public. Without it he may not practice as an RN or use the title.

STEP 3 · CHOOSE THE ACTION

He declines the RN assignment, explains why, and works only in a role the state and facility allow, such as a supervised graduate nurse role if permitted.

RULE

Passing the exam is not the same as holding a license. Working under another nurse's name is practicing without a license.

TRAPS PEOPLE FALL INTO

- **Calling a disease a nursing diagnosis.** "Pneumonia" is a medical diagnosis. "Ineffective airway clearance" is a human response a nurse can treat.
- **Thinking licensure protects nurses.** It protects the public. Every board action, complaint and duty to report traces back to public safety.
- **Delegating "monitoring" of an unstable patient.** Vital signs on a stable patient can be delegated. Watching a patient whose status is changing cannot.
- **Mixing up delegation and assignment.** Assignment hands out work a person is already authorized to do. Delegation transfers authority for a task the person would not otherwise have.
- **Letting the LPN do the first teaching.** The LPN reinforces teaching the RN has already given. Initial teaching needs assessment and stays with the RN.
- **Treating certification as required.** Certification is voluntary except for APRN roles. Licensure is the mandatory one.
- **Quietly skipping an unsafe dose.** Holding is right, but the team must know. Clarify, escalate and document.
- **Treating self care as optional.** Duties to self are in the code of ethics, and fatigue causes errors.

Chapter 1 self-test · ten items

1. Which statement about the focus of nursing is most accurate?

A. Nurses perform tasks while physicians apply clinical judgment
B. Nurses carry out treatments for diseases that physicians identify
C. Nurses identify and treat human responses to health problems
D. Nurses manage chronic disease while physicians manage acute disease

C. Nurses identify and treat human responses to health problems The professional definition centers on diagnosing and treating human responses. The disease itself is the physician's focus.

2. What is the main purpose of state licensure for nurses?

A. To let professional associations control who may join
B. To protect the public by confirming minimum safe competence
C. To guarantee nurses a right to practice in every state
D. To protect the title of nurse from other health workers

B. To protect the public by confirming minimum safe competence Licensure exists for public safety. It is a privilege, not a right, and it creates accountability to a board.

3. A nurse may legally perform a skill under state law but has never been trained in it. What should the nurse do?

A. Decline the skill until trained and competent
B. Perform it, because the practice act permits it
C. Perform it with a coworker watching this time
D. Ask the patient for permission before starting

A. Decline the skill until trained and competent Scope passes three filters: law, policy and competence. Lacking competence is enough reason to not do the task.

4. Which task is appropriate to delegate to assistive personnel?

A. Teaching a patient how to use a new incentive spirometer
B. Evaluating whether a pain medication relieved the pain
C. Checking vital signs on a patient whose pressure is dropping
D. Measuring urine output for a patient who is stable after surgery

D. Measuring urine output for a patient who is stable after surgery Output on a stable patient is routine. Teaching, evaluating and monitoring an unstable patient need the RN.

5. Which assignment is appropriate for the LPN?

A. A patient whose oxygen saturation fell over the past hour
B. A new admission who needs a full initial assessment
C. A stable resident who needs a scheduled urinary catheter change
D. A patient who needs first teaching on a new anticoagulant

C. A stable resident who needs a scheduled urinary catheter change LPNs care for stable, predictable patients and may do procedures. Admission assessment, initial teaching and changing patients stay with the RN.

6. After an RN delegates a task to a trained assistant, who is accountable for the decision to delegate?

A. The RN who delegated and supervises the task
B. The assistant who accepted the task
C. The charge nurse who made the shift assignment
D. The facility that wrote the delegation policy

A. The RN who delegated and supervises the task Delegation moves responsibility for doing the task. The RN keeps accountability for the decision and the supervision.

7. Which statement correctly compares licensure and certification?

A. Certification is state issued; licensure is from a specialty group
B. Licensure is mandatory; certification is voluntary specialty recognition
C. Licensure applies to programs; certification applies to people
D. Both are mandatory, but certification renews more often

B. Licensure is mandatory; certification is voluntary specialty recognition Licensure is state mandated. Certification is voluntary specialty recognition, except where APRN roles require it. Accreditation is for programs.

8. A provider insists that a nurse give a dose the nurse believes is unsafe. After clarifying, what is the next step?

A. Hold the dose without telling anyone to avoid conflict
B. Give the dose because the provider accepted responsibility
C. Give half the dose and recheck the patient in one hour
D. Hold the dose, notify the charge nurse or supervisor, and document

D. Hold the dose, notify the charge nurse or supervisor, and document Use the chain of command and document. An order does not transfer the nurse's accountability, and the team must know a dose was held.

9. A nurse says, "I am concerned, I am uncomfortable, this is a safety issue." What is the nurse using?

A. The CUS words that signal the team to stop and listen
B. The five rights of delegation in short form
C. A formal complaint to the state board of nursing
D. A request for an ethics committee consultation

A. The CUS words that signal the team to stop and listen CUS is a structured speaking up tool. The words are agreed signals that the concern must be heard.

10. A nurse knows the ethically right action but the unit's staffing prevents taking it. What is this called?

A. Burnout
B. Compassion fatigue
C. Lateral violence
D. Moral distress

D. Moral distress Moral distress is knowing the right action but being constrained from taking it. Compassion fatigue is depletion from repeated exposure to suffering.

CHAPTER 2

Health Care Delivery and Nursing Theory

Read it in full: **Chapter 2 in the textbook**. Practice it in the lab: **Right Setting, Right Referral** and **Theory at the Bedside**.

What to know

Care happens along a **continuum of care**, from intensive care to the community. Settings differ in how sick patients are, how much monitoring they need, how long they stay and who pays. **Discharge planning** starts on admission, and every move between settings is a **transition**, the point where medication and information errors are most likely.

Prevention has three levels. **Primary** prevention stops disease before it starts (immunization, seat belt teaching). **Secondary** prevention finds it early (screening mammography, blood pressure screening, colonoscopy). **Tertiary** prevention limits complications and disability (cardiac rehabilitation, diabetic foot care, stroke rehabilitation).

Acute care hospitals treat serious illness with shorter stays and higher acuity. **Observation status** is an outpatient designation that can affect later Medicare coverage of a skilled nursing stay. **Ambulatory care** sends patients home the same day. A **skilled nursing facility** gives short term daily skilled care or therapy after a hospital stay. A **nursing home** gives long term custodial care,

which Medicare does not cover. **Assisted living** helps with some daily activities and is usually private pay.

Inpatient rehabilitation is for patients who can tolerate intensive therapy, about 3 hours a day at least 5 days a week. Patients who cannot go to a skilled facility for subacute rehabilitation. **Home health** needs a homebound patient with an intermittent skilled need under a provider certified plan. **Palliative care** relieves symptoms at any stage and can go alongside curative treatment. **Hospice** is for comfort goals when life expectancy is 6 months or less if the illness runs its usual course, and it includes bereavement support.

The **interprofessional team** shares values, knows each other's roles, communicates clearly and works as a team. The nurse often coordinates because the nurse is there around the clock. Refer by need: coughing with meals or a wet voice goes to speech language pathology; walking and walkers to physical therapy; dressing, bathing and eating skills to occupational therapy; cost, placement or abuse concerns to social work; complex discharge to the case manager; spiritual distress to the chaplain; dose and compatibility questions to the pharmacist.

Care delivery models organize nursing work. **Total patient care**: one nurse gives all care for a few patients during a shift (standard in intensive care). **Functional nursing**: work divided by task, efficient but fragmented. **Team nursing**: an RN team leader directs a mixed team. **Primary nursing**: one RN holds 24 hour responsibility for the plan from admission to discharge. **Case management**: coordination of the whole episode across settings using **critical pathways** and tracking **variances**.

Insurance words matter for advocacy. The **premium** keeps coverage. The **deductible** is paid before the plan pays. A **copayment** is a fixed fee; **coinsurance** is a percentage. The **out of pocket maximum** caps yearly spending. **Medicare** covers people 65 and older, some people with long term disability, and people with end stage kidney disease or ALS, regardless of income: Part A hospital, Part B outpatient, Part C combined private plans, Part D drugs. **Medicaid** is a joint federal and state program for people with low income and is the largest payer for long term nursing home care.

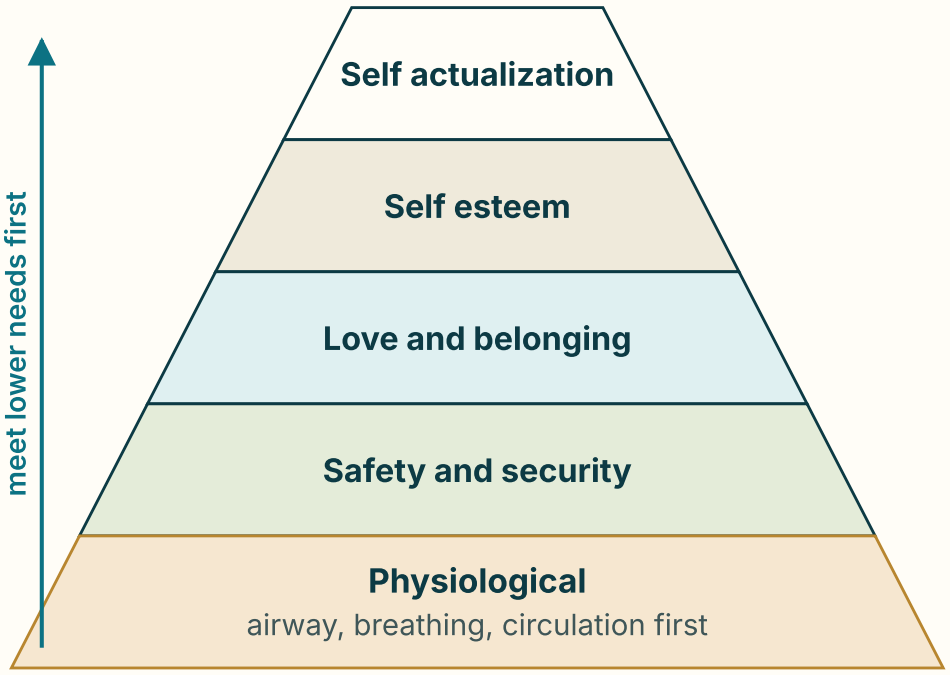
Value based care pays for outcomes instead of volume. Hospitals get a fixed payment per admission by **diagnosis related group**. They lose money for high 30 day readmissions (heart failure, heart attack, pneumonia, COPD, elective hip or knee replacement) and are not paid extra for certain **hospital acquired conditions** such as stage 3 and 4 pressure injuries, falls with injury, catheter associated urinary tract infections and central line infections. Many of these are nurse sensitive outcomes.

Social determinants of health are the conditions where people are born, live, learn, work, play, worship and age. The five domains are economic stability, education access and quality, health care access and quality, neighborhood and built environment, and social and community context. They are thought to shape outcomes more than medical care itself. **Equality** gives everyone the same thing; **equity** gives each person what they need to reach the same outcome. A patient who skips an expensive inhaler is not "noncompliant" if cost is the barrier. Assess the reason first.

A **nursing theory** tells the nurse what to notice and what care should achieve. Grand theories are broad; middle range theories are narrower and easier to test. **Orem's self care deficit** theory uses three nursing systems: wholly compensatory (nurse does it), partly compensatory (shared) and supportive educative (patient does it with teaching). **Roy's adaptation model** names focal, contextual and residual stimuli and four adaptive modes: physiologic, self concept, role function and interdependence. **Watson's human caring** theory centers on a transpersonal caring relationship and caritas processes. **Meleis's transitions** theory, a middle range theory, covers developmental, situational, health and illness, and organizational transitions.

Every theory shares the **metaparadigm**: person, environment, health and nursing. Health sits on a **health illness continuum** from high level wellness to major illness and death. Illness is the person's experience; disease is a pathological change. Acute illness is short; chronic illness lasts or is expected to last 6 months or longer.

Maslow's hierarchy helps set priorities: physiological needs first (airway, breathing, circulation at the top of that level), then safety and security, love and belonging, self esteem and self actualization. Two refinements: an immediate safety threat can outrank a nonurgent physiological need, and an actual problem usually outranks a potential one. Always ask which problem will cause harm soonest.



Refinement 1
An immediate safety threat can outrank a nonurgent physiological need.

Refinement 2
An actual problem usually outranks a potential one.

Always ask
Which problem will cause harm soonest?

Maslow's hierarchy sets priorities. Start at the base with airway, breathing and circulation, then climb. A threat to safety that is happening now can jump ahead of a routine physical need.

LOCK THESE IN

- Primary prevents, secondary detects early, tertiary limits disability.
- Home health: homebound plus intermittent skilled need. Hospice: comfort goals and 6 months or less. Palliative: any stage.
- Inpatient rehabilitation needs tolerance of about 3 hours of therapy a day, 5 days a week.
- Medicare A hospital, B outpatient, C combined plans, D drugs; no long term custodial care. Medicaid is income based.
- Swallowing to speech language pathology; walking to PT; daily activities to OT; money and placement to social work.
- Primary nursing gives one accountable RN for 24 hours; functional nursing fragments care.
- Orem: wholly compensatory, partly compensatory, supportive educative. Move patients toward more self care.
- Maslow: airway, breathing, circulation first, but an immediate safety threat can jump the line.

Key terms and comparisons: settings of care

Setting	Who fits	Nursing focus and payer
Acute care hospital	Acutely ill, unstable or surgical	Frequent assessment, rapid response, discharge planning; private, Medicare A, Medicaid
Skilled nursing facility	Daily skilled care or therapy after a hospital stay	Wound care, IV therapy, rehabilitation; Medicare A for limited days after a qualifying stay
Nursing home (custodial)	Chronic dependence in daily activities	Function, safety, comfort; private pay or Medicaid, not Medicare
Inpatient rehabilitation	Can tolerate intensive daily therapy	Independence, retraining, family teaching
Home health	Homebound with an intermittent skilled need	Teaching, wound and IV care, home safety, caregiver support
Hospice	Comfort goals, prognosis 6 months or less	Symptom control, family support, bereavement
Palliative care	Serious illness at any stage	Symptom relief alongside curative treatment

Priority rules: Maslow and theory cues

Rule or cue	What it means
Airway, breathing, circulation	Break ties inside the physiological level
Immediate safety threat	Can outrank a nonurgent physiological need (a confused patient climbing out of bed)
Actual over potential	An existing problem usually comes before a risk
Acute over chronic and stable	A new change comes before a long standing, controlled one
"Do for, do with, teach"	Orem's self care deficit theory
Focal, contextual, residual stimuli	Roy's adaptation model
Transpersonal caring, caritas	Watson's human caring theory
A new diagnosis, a move, becoming a parent	Meleis's transitions theory

Worked cases

WORKED CASE 1 · MATCHING THE SETTING

Mr. Lindgren, 81, is ready to leave the hospital 5 days after a hip repair. He lives alone, walks 15 feet with a walker and a lot of help, tires after a few minutes, and needs daily therapy and wound checks. His son asks for inpatient rehabilitation.

STEP 1 · LIST THE CUES

Low activity tolerance, daily skilled therapy and wound needs, lives alone.

STEP 2 · TEST INPATIENT REHABILITATION

It needs tolerance of about 3 hours of therapy a day. He cannot tolerate that yet.

STEP 3 · TEST HOME WITH HOME HEALTH

He needs a lot of help and lives alone, so home is unsafe right now.

STEP 4 · CHOOSE

A skilled nursing facility for subacute rehabilitation matches his current function. The nurse shares findings with the case manager and includes him and his son.

RULE

The right setting matches current function and needs, not the most intensive option or the family's first wish.

WORKED CASE 2 · FIRST REFERRAL AFTER A STROKE

Mrs. Abebe, 74, is on day 2 after a stroke. At lunch the assistant reports she coughed after each sip and her voice sounds wet. Her right hand is weak and she drops her spoon.

STEP 1 · RANK THE PROBLEMS

Coughing with liquids and a wet voice point to dysphagia and aspiration risk. That is an airway problem. The weak hand is a function problem.

STEP 2 · ACT ON AIRWAY FIRST

Stop oral intake, keep her upright and assess the lungs.

STEP 3 · REFER BY NEED

Request a swallow evaluation by speech language pathology through the provider per policy.

STEP 4 · THEN FUNCTION

Occupational therapy can address adaptive utensils later.

RULE

Airway safety comes before convenience. The nurse does not change liquid thickness on personal judgment before an evaluation.

WORKED CASE 3 · THE "NONCOMPLIANT" LABEL

Mr. Osorio, 57, is back with heart failure for the second time in a month. He stopped his diuretic because he drives a delivery route without restroom access, and he lives far from a grocery store with low sodium foods.

STEP 1 · NAME THE DOMAINS

Economic stability (job conditions, food cost) and neighborhood and built environment (food access, transportation).

STEP 2 · TREAT THE ACUTE PROBLEM

Address the current fluid overload first.

STEP 3 · BUILD A PLAN THAT FITS HIS LIFE

Ask the provider about dose timing so the peak effect falls outside work hours, refer to social work for food resources, teach affordable low sodium choices.

RULE

Assess the reason before teaching again. Writing "noncompliant" ignores the barriers and does not prevent readmission.

WORKED CASE 4 · MASLOW AT THE START OF A SHIFT

Four requests come in at once: (1) Ms. Han, 41, wants to talk about job worries; (2) Mr. Sallah, 29, with sickle cell disease, rates pain 9 of 10; (3) Mrs. Petit, 90, with dementia and a high fall risk, is climbing over the side rail; (4) Mr. Yusuf, 68, wants help with his menu. Vital signs are stable.

STEP 1 · FIND THE SOONEST HARM

Mrs. Petit can fall and break a hip within seconds. She is first, or someone is sent to her at once.

STEP 2 · NEXT PHYSIOLOGICAL NEED

Mr. Sallah's severe crisis pain needs prompt treatment, so he is next.

STEP 3 · THEN THE REST

The menu and the job worry come after, with a possible social work referral for the job worry.

RULE

"Physiological always first" is not absolute. The imminent fall is the more immediate threat.

TRAPS PEOPLE FALL INTO

- **Sending a patient to inpatient rehabilitation who cannot tolerate it.** About 3 hours of therapy a day is the test. Low tolerance points to a skilled facility.
- **Thinking Medicare pays for nursing home custodial care.** It does not. Medicaid is the largest payer once a person qualifies financially.
- **Mixing up palliative care and hospice.** Palliative care fits any stage and can go with cure. Hospice needs comfort goals and a prognosis of 6 months or less.
- **Referring a swallowing problem to occupational therapy.** Swallowing goes to speech language pathology. OT handles daily activity skills.
- **Calling functional nursing holistic.** Functional nursing splits care by task. No one sees the whole patient.
- **Treating equality and equity as the same.** Equity gives each person what they need to reach the same outcome.
- **Mixing up Roy and Orem.** Stimuli and adaptive modes are Roy. Nursing systems and self care deficits are Orem.
- **Ranking every physiological need above every safety need.** An immediate safety threat can outrank a nonurgent physiological problem.

Chapter 2 self-test · ten items

1. A clinic offers blood pressure checks at a community fair. Which level of prevention is this?

A. Health restoration
B. Primary prevention
C. Secondary prevention
D. Tertiary prevention

C. Secondary prevention Screening detects disease early, which is secondary prevention. Primary prevention stops disease before it starts.

2. Which adult is the best candidate for skilled visits in the home?

A. An adult who can tolerate 3 hours of therapy every day
B. A homebound adult who needs wound care visits three times a week
C. An adult who drives to work daily and needs a flu vaccine
D. An adult who needs 24 hour help with bathing and dressing

B. A homebound adult who needs wound care visits three times a week Home health needs a homebound patient with an intermittent skilled need. Continuous custodial help and intensive therapy belong elsewhere.

3. A family asks whether their father can receive palliative care while still getting chemotherapy. What is the best answer?

A. Only if his life expectancy is 6 months or less
B. Only if he moves into an inpatient hospice unit
C. No, it starts only after all treatment has stopped
D. Yes, it can be given at any stage alongside treatment

D. Yes, it can be given at any stage alongside treatment Palliative care has no prognosis requirement. Hospice is the benefit tied to comfort goals and a prognosis of 6 months or less.

4. An older adult has trouble buttoning a shirt and cutting food after a stroke. Which referral fits best?

A. Occupational therapy
B. Speech language pathology
C. Physical therapy
D. Respiratory therapy

A. Occupational therapy Occupational therapy addresses activities of daily living and fine motor skills. Physical therapy focuses on gait and mobility.

5. Which care delivery model gives one RN 24 hour responsibility for a patient's plan from admission to discharge?

A. Functional nursing
B. Total patient care
C. Primary nursing
D. Team nursing

C. Primary nursing In primary nursing, one RN plans care across the whole stay and associate nurses carry out the plan on other shifts.

6. A patient asks what Medicare Part D covers. What should the nurse say?

A. Provider visits and screenings
B. Inpatient hospital stays and hospice
C. Long term custodial nursing care
D. Outpatient prescription drugs

D. Outpatient prescription drugs Part D is drugs. Part A is hospital, Part B is outpatient medical care, and Medicare does not cover custodial care.

7. A patient with diabetes has stopped buying test strips. What should the nurse do first?

A. Ask what is making it hard to buy or use the strips
B. Document that the patient is not following the plan
C. Tell the provider the patient refuses glucose testing
D. Teach again why glucose testing is important

A. Ask what is making it hard to buy or use the strips Assess the reason before teaching or labeling. Cost or access is common, and the fix is often a referral.

8. A patient who had a below knee amputation is physically stable but says, "Nobody will want to look at me now." In Roy's model, which mode does this reflect?

A. Interdependence
B. Self concept
C. Physiologic
D. Role function

B. Self concept Body image is part of the self concept mode. Role function would be worry about job or family roles.

9. A patient after abdominal surgery washes her face and arms while the nurse washes her back and legs. Which Orem nursing system is this?

A. Wholly compensatory
B. Supportive educative
C. Self care agency
D. Partly compensatory

D. Partly compensatory Nurse and patient share the work in the partly compensatory system. The goal is to move toward supportive educative care.

10. Four patients call at once. Whom does the nurse go to first?

A. An adult who feels lonely and wants to call family
B. An adult who asks for help planning tomorrow's menu
C. A confused adult climbing over the bed rail
D. An adult with a glucose of 190 mg/dL and no symptoms

C. A confused adult climbing over the bed rail An imminent fall can cause injury within seconds. The mildly high glucose is a nonurgent physiological finding.

ONE PAGE

Cram sheet

Everything from chapters 1 and 2 on one page. Read it the night before, then cover the right column and recite.

Scope, delegation and the profession

Item	Rule
Nursing versus medicine	Nursing treats human responses; medicine treats disease
Licensure	Protects the public; a privilege; the board can limit, suspend or revoke
Scope filters	State law, facility policy, personal competence
RN keeps	Admission assessment, care plan, initial teaching, evaluation, unstable patients
LPN	Stable, predictable patients; reinforces teaching; IV role varies by state
Assistive personnel	Routine tasks on stable patients; no assessing, teaching, evaluating or medications
Five rights of delegation	Task, circumstance, person, directions and communication, supervision and evaluation
Accountability	Stays with the delegating RN
Standard of care	What a reasonably prudent nurse would do in similar circumstances
Code of ethics	Nine provisions; 1 to 3 patient, 4 to 6 duty and self, 7 to 9 beyond the encounter
Licensure, certification, accreditation	Mandatory and state; voluntary and profession; programs
Speaking up	Clear statement, CUS, two challenge rule, chain of command, document

Settings, payers, theory and priorities

Item	Rule
Prevention	Primary prevents, secondary screens, tertiary limits disability
Home health	Homebound plus intermittent skilled need
Hospice	Comfort goals, prognosis 6 months or less, bereavement support
Inpatient rehabilitation	About 3 hours of therapy a day, 5 days a week
Medicare	65 and older, some disability, ESKD, ALS; A hospital, B outpatient, C combined, D drugs
Medicaid	Low income; state run with federal funds; main payer for custodial care
Value based care	DRG payment, readmission penalties, no extra pay for hospital acquired conditions
SDOH domains	Economic stability, education, health care access, neighborhood, social and community context
Orem	Wholly compensatory, partly compensatory, supportive educative
Roy	Focal, contextual, residual stimuli; physiologic, self concept, role function, interdependence
Metaparadigm	Person, environment, health, nursing
Maslow	ABC first, then safety, belonging, esteem, self actualization; imminent danger can jump the line

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