FUNDAMENTALS OF NURSING · STUDY GUIDE

Exam 2 Study Guide

This guide covers chapters 3 and 4, the thinking and talking chapters. Chapter 3 teaches how nurses gather cues, name problems, write outcomes, act and evaluate, and how to decide who and what comes first. Chapter 4 teaches the words that open a conversation, the phases and limits of a professional relationship, and the tools that keep information safe between team members. Read the "what to know" paragraphs, study the tables, then cover the steps of each worked case and solve it yourself. Finish each chapter with its ten self-test items.

WHAT THIS GUIDE COVERS

- Chapter 3 · ADPIE, types of assessment, subjective and objective data, sources, normal adult values, validating and clustering cues, nursing versus medical diagnoses, PES and risk statements, SMART outcomes, independent, dependent and collaborative interventions, evaluation, the six step clinical judgment model, exam item types and priority frameworks.
- Chapter 4 · the communication process, verbal and nonverbal channels, personal space, cultural humility, health literacy, therapeutic and nontherapeutic responses, the phases of the relationship, empathy versus sympathy, boundaries, SBAR, closed loop communication, read back, handoff, escalation, conflict styles and special situations including interpreters.

CHAPTER 3

The Nursing Process and Clinical Judgment

Read it in full: **Chapter 3 in the textbook**. Practice it in the lab: **See First: Priority and Clinical Judgment** and **Care Plan Builder: PES, SMART and Evaluation**.

What to know

The **nursing process** is a systematic, patient centered, goal directed cycle: assessment, diagnosis, planning, implementation and evaluation (ADPIE). It is a cycle, not a checklist. Evaluation feeds new assessment, and the nurse reassesses during every intervention.

There are four kinds of assessment. A **comprehensive** (admission) assessment builds the baseline and is done by the RN. A **focused** assessment looks closely at one problem or system. An **emergency** assessment rapidly checks airway, breathing, circulation and level of consciousness. A **time lapsed** reassessment compares with baseline after an interval or an intervention, such as pain 30 to 60 minutes after an oral analgesic.

Subjective data are what the patient says and only the patient can verify: "my chest feels tight," a pain rating of 7. Record them in the patient's own words. **Objective data** are measured or observed by someone else: vital signs, crackles, a 3 cm red area, grimacing. The **primary source** is the patient. **Secondary sources** are family, the team, records and results; use them when the patient cannot communicate reliably, with the patient's permission, and with a qualified interpreter when needed.

Commonly taught adult normals: oral temperature about 36.0 to 37.5 C, heart rate 60 to 100, respiratory rate 12 to 20, blood pressure under 120 systolic and under 80 diastolic, oxygen saturation 95 to 100% on room air (often 88 to 92% targets for some people with chronic lung disease). Always read a value against the patient's **baseline and trend**. A pressure of 100/60 is fine for one person and shock for someone whose baseline is 160/90.

Validate data that are unexpected or conflict with other findings: recheck with other equipment or manually, compare subjective and objective data, ask the patient, ask another nurse. Recheck at once, not at the next scheduled time. **Cluster** cues into patterns. A heart rate of 112 alone could be many things. With falling pressure, cool clammy skin, restlessness and a soaked dressing, it points to hemorrhage. New confusion in an older adult is a physiological change until proven otherwise.

A **nursing diagnosis** is a clinical judgment about a human response that the nurse treats independently. It changes as responses change. A **medical diagnosis** names a disease and stays while the disease does. **Collaborative problems** (potential complications) are complications the nurse monitors and manages with the provider, such as hemorrhage after surgery or hypoglycemia on insulin.

A **problem focused** diagnosis is written in **PES** format: problem, etiology ("related to") and signs and symptoms ("as evidenced by"). A **risk** diagnosis has no signs and symptoms because the

problem has not happened. Health promotion diagnoses show readiness for enhanced wellbeing. Common errors: using a medical diagnosis as the problem, a legally risky etiology, restating the problem as its cause, or writing an intervention or a piece of equipment as a diagnosis.

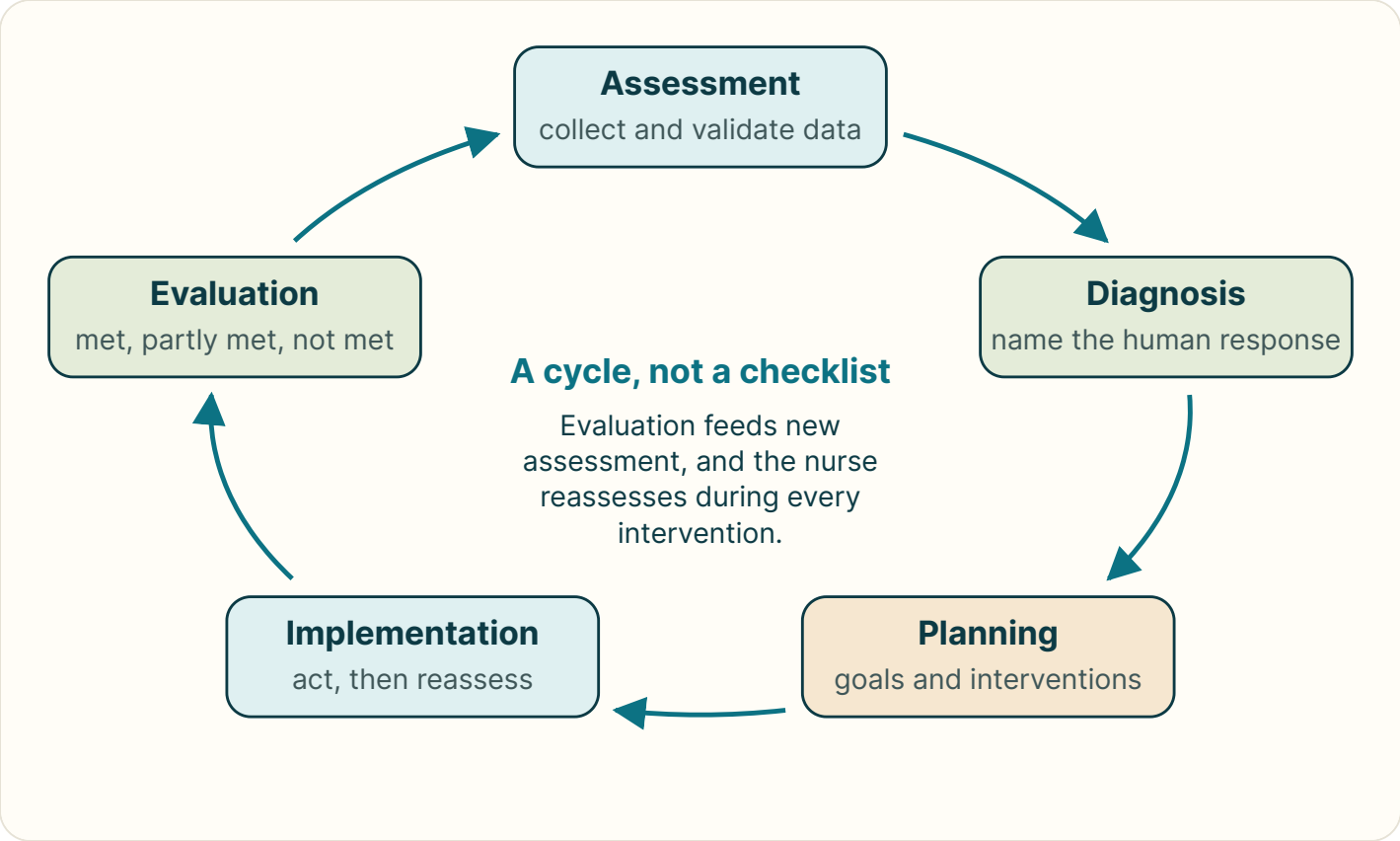
Planning sets priorities, then writes **goals** and patient centered **expected outcomes**. Outcomes pass the **SMART** test: specific, measurable (walk, state, demonstrate, rate, not "understand" or "know"), achievable, relevant and time bound. Each intervention is specific and backed by a **rationale**.

Before acting, **reassess**. Interventions are **independent** (nurse initiated: repositioning, teaching, comfort, fall precautions), **dependent** (need a prescription: medications, IV fluids, catheter insertion) or **collaborative** (done with other disciplines or under a protocol or standing order). Dependent does not mean automatic; the nurse still must know the reason, effects and risks and question an unsafe order. Document what was done and the response, never before it is done.

Evaluation compares patient data with the outcome and concludes met, partially met or not met, written as a conclusion plus supporting data. When an outcome is not met, look back through every phase: were the data complete, the diagnosis accurate, the outcome realistic, the interventions right and actually done? Then revise.

Clinical judgment is the observed outcome of critical thinking and decision making. The exam's model has six steps that repeat: recognize cues, analyze cues, prioritize hypotheses, generate solutions, take action, evaluate outcomes. Individual factors (knowledge, experience) and environmental factors (time, resources, risk) shape it. Unfolding case studies test each step, using item types such as matrix, extended multiple response, drop down, drag and drop, highlight, bow tie and trend, often with partial credit. Select an option only when you can justify it from the cues.

Prioritization uses several frameworks together: ABCs, Maslow, acute over chronic, actual over potential, unexpected over expected, unstable over stable, safety first, least restrictive first, and assess before acting unless the data already show an emergency. In cardiac arrest, adult basic life support starts with compressions. Outside arrest, airway comes first. A potential problem can outrank a minor actual one when the threat is life threatening and imminent, such as neck tightness after thyroid surgery.



ADPIE is a loop. Evaluation sends you back to assessment, and reassessment happens inside every intervention, not only at the end.

LOCK THESE IN

- ADPIE is a cycle; evaluation leads back to assessment.
- Subjective is what the patient says; objective is measured or observed. The patient is the primary source.
- Read every value against the patient's baseline and trend, and validate surprises at once.
- PES for problem focused diagnoses; risk diagnoses have no S part.
- Outcomes are patient centered and SMART; "understand" is not measurable.
- Independent needs no order; dependent needs a prescription; collaborative is shared or by protocol.
- Six steps: recognize cues, analyze cues, prioritize hypotheses, generate solutions, take action, evaluate outcomes.
- The least stable patient wins a tie; compressions come first only in cardiac arrest.

Key terms and comparisons: adult values and first actions

Finding	Commonly taught normal	Abnormal cue and first nursing actions
Oral temperature	About 36.0 to 37.5 C	38.0 C or higher: look for a source, check other vital signs, notify per protocol
Heart rate	60 to 100 per minute	Over 100 or under 60: check rhythm, pressure and symptoms; hold rate lowering drugs per parameters
Respiratory rate	12 to 20 per minute	Over 24 or under 10: assess work of breathing and saturation, raise head of bed, report
Blood pressure	Under 120 and under 80	Systolic under 90 with symptoms: assess perfusion, report; 180 or 120 or higher: recheck, assess, report urgently
Oxygen saturation	95 to 100% on room air (often 88 to 92% target in some chronic lung disease)	Below target: check probe, raise head of bed, oxygen per protocol, report
Urine output	At least 0.5 mL/kg per hour (about 30 mL per hour for an average adult)	Lower: assess fluid status and perfusion, report

Priority rules: frameworks and the funnel

Framework	Rule	Example
ABCs	Airway, then breathing, then circulation	Stridor before wheezing before a weak pulse
Acute versus chronic	New and acute before chronic and stable	New chest pain before usual arthritis pain
Actual versus potential	Present problem before a risk, unless the risk is imminent and deadly	Active bleeding before risk for infection
Unexpected versus expected	Unexpected finding before one expected for the condition	Rigid abdomen before day 1 incisional pain
Safety first	Remove an immediate danger	Confused patient pulling at a breathing tube
Least restrictive	Safest effective option first	Reorientation and a bed alarm before restraints
Funnel for many patients	ABC threat, then safety threat, then acute change, then time sensitive tasks, then routine	Insulin with a meal tray before discharge teaching

Worked cases

WORKED CASE 1 · CLUSTERING CUES OVERNIGHT

Mrs. Lindqvist, 77, is one day after bowel surgery. At 0300 her heart rate is 106 (it was 80 at midnight), temperature 38.3 C, respiratory rate 24, pressure 96/58 (baseline 134/80), and she seems confused. Urine output was 55 mL over 4 hours.

STEP 1 · RECOGNIZE CUES

Fever, tachycardia, tachypnea, falling pressure, new confusion and low urine output.

STEP 2 · ANALYZE THE CLUSTER

Each cue is mild alone. Together they fit sepsis or hypovolemia, possibly a leak at the surgical site.

STEP 3 · CHECK THE URINE MATH

Four hours at about 30 mL per hour would be about 120 mL. She made 55 mL, under half the expected amount.

STEP 4 · TAKE ACTION

Go to the bedside, assess ABCs and level of consciousness, and call the provider or rapid response team with SBAR and all the clustered data.

RULE

Do not recheck in an hour, blame "sundowning" or give acetaminophen and wait.

WORKED CASE 2 · FIXING A DIAGNOSIS AND AN OUTCOME

Mr. Sato, 63, has COPD and pneumonia. Walking to the bathroom his heart rate rises to 120 and his saturation falls from 92% to 87%, recovering in 3 minutes at rest. A student writes "Pneumonia related to bacteria" and "Patient will feel better."

STEP 1 · SPOT THE ERRORS

The first is a medical diagnosis. The second is not measurable or time bound.

STEP 2 · WRITE THE PES STATEMENT

Activity intolerance related to imbalance between oxygen supply and demand as evidenced by dyspnea, heart rate 120 and saturation falling to 87% with exertion.

STEP 3 · WRITE A SMART OUTCOME

Patient will walk to the bathroom with saturation at or above 88% and heart rate under 110 by day 3.

STEP 4 · CHOOSE INTERVENTIONS

Cluster care with rest periods, teach pursed lip breathing, oxygen as prescribed with exertion, increase activity gradually.

RULE

His saturation target follows the provider's prescription because of chronic lung disease.

WORKED CASE 3 · AN OUTCOME NOT MET

Ms. Feld, 56, had a hip replacement. The plan is an oral opioid as needed, ice and elevation. On day 2 she rates pain 7 of 10 most of the day and has refused therapy. She waits until pain is severe to ask because she fears addiction.

STEP 1 · CONCLUDE

Outcome not met.

STEP 2 · LOOK BACK THROUGH THE PHASES

The interventions were reasonable but were not carried out well, because fear delayed her requests.

STEP 3 · REVISE

Teach that short term opioid use as prescribed for acute surgical pain carries a low addiction risk; ask for medication before pain is severe and 30 to 60 minutes before therapy; add nondrug measures; ask the provider about scheduled nonopioid analgesics.

RULE

Do not just ask for a stronger opioid. Fix the real barrier, and watch sedation and breathing with any opioid change.

WORKED CASE 4 · WHICH PATIENT FIRST

Report on four adults: (A) Mr. Novak, 70, COPD, saturation 89% on 2 L, at baseline and talking easily; (B) Ms. Salcedo, 38, 5 hours after thyroid surgery, says her dressing feels tight and her voice is hoarse; (C) Mr. Ito, 55, glucose 186 mg/dL, breakfast in 30 minutes; (D) Ms. Grant, 47, day 2 after appendectomy, pain 4 of 10, asking for her as needed analgesic.

STEP 1 · SCAN FOR ABC THREATS

Ms. Salcedo has a possible neck hematoma or airway swelling. That is a potential airway obstruction that can move fast.

STEP 2 · RANK THE REST

Ms. Grant's expected pain and Mr. Ito's time sensitive insulin come next.

STEP 3 · CHECK THE BASELINE

Mr. Novak has the lowest number, but it is his baseline and he is comfortable.

RULE

An airway threat outranks a lower but stable number.

TRAPS PEOPLE FALL INTO

- **Choosing "assess further" when the stem already shows the threat.** If the data already show danger, act. Assess first only when no emergency is shown.
- **Calling a pain rating objective.** The rating is what the patient reports, so it is subjective. Grimacing and guarding are objective.
- **Writing a risk diagnosis with "as evidenced by" signs.** A risk has not happened, so there are no signs and symptoms to list.
- **Writing outcomes about the nurse.** "Nurse will teach" is an intervention. Outcomes say what the patient will do.
- **Thinking dependent means automatic.** The nurse must still know the reason and risks and must question an unsafe order.
- **Repeating the same plan when an outcome is not met.** Look back through every phase before revising.

- **Picking the lowest number as the priority.** A value at the patient's baseline can be less urgent than a new, unstable change.
- **Using CAB outside cardiac arrest.** Compressions come first only in arrest. Otherwise airway comes first.
- **Selecting every option in a "select all" item.** Partial credit scoring can subtract for wrong picks. Judge each option on its own.

Chapter 3 self-test · ten items

1. Which of these findings counts as subjective data?

A. The nurse sees her grip the bed rail when sitting
B. The patient states the room is spinning when she sits up
C. Blood pressure falls 25 points when she sits up
D. Heart rate rises from 76 to 104 when she stands

B. The patient states the room is spinning when she sits up Only the patient can report vertigo. Pressure, heart rate and observed behavior are objective.

2. An automatic cuff reads 74/40 on an alert, warm patient who is talking. What should the nurse do first?

A. Call the rapid response team immediately
B. Recheck at the next scheduled vital signs
C. Recheck the pressure manually right away
D. Raise the legs and start oxygen at once

C. Recheck the pressure manually right away An unexpected value that does not fit the other data needs validation, and it is done immediately.

3. A student drafts four nursing diagnoses. Which one is written in an acceptable form?

A. Risk for falls related to orthostatic hypotension
B. Pneumonia related to infection as evidenced by fever
C. Acute pain related to the nurse not giving medicine
D. Needs suctioning related to thick tracheal secretions

A. Risk for falls related to orthostatic hypotension A risk diagnosis names the problem and risk factors with no signs. The others use a medical diagnosis, an intervention or a legally risky cause.

4. Which outcome meets SMART criteria?

A. Patient will know how to manage diabetes once at home
B. Nurse will teach the signs of low blood glucose by noon
C. Patient will understand all the signs of low blood glucose
D. Patient will state three signs of low glucose by discharge

D. Patient will state three signs of low glucose by discharge It is patient centered, uses a measurable verb and has a deadline. "Understand" and "know" are not measurable.

5. Which intervention is independent?

A. Starting IV fluids at 100 mL per hour
B. Teaching coughing and deep breathing
C. Giving an oral antibiotic every 8 hours
D. Inserting an indwelling urinary catheter

B. Teaching coughing and deep breathing Teaching and positioning come from nursing knowledge. Drugs, IV fluids and catheter insertion need a prescription.

6. A goal of walking 100 feet was set. The patient walks 60 feet with saturation 90%. How should the nurse document the evaluation?

A. Partially met, with the distance and vital signs
B. Not met, so the walking plan should be stopped
C. Met, with a note to increase the oxygen flow
D. Met, because the patient walked safely today

A. Partially met, with the distance and vital signs Some progress is partial. The evaluation states a conclusion plus the supporting data.

7. In the clinical judgment model, which step asks which explanation is most likely and most dangerous?

A. Evaluate the outcomes
B. Generate solutions
C. Recognize the cues
D. Prioritize hypotheses

D. Prioritize hypotheses Prioritizing hypotheses ranks possible explanations by urgency, likelihood and risk.

8. In a bow tie item, what should the test taker decide first?

A. The parameters the nurse will monitor afterward
B. The actions the nurse will take for the patient
C. The condition the patient is most likely experiencing
D. The order in which to place the final answers

C. The condition the patient is most likely experiencing Both the actions and the monitoring must fit the condition, so the condition comes first.

9. An adult collapses and is unresponsive with no pulse. What comes first?

A. Apply oxygen by face mask
B. Open the airway with a head tilt
C. Give two rescue breaths
D. Begin chest compressions

D. Begin chest compressions In adult cardiac arrest, basic life support starts with compressions. Outside arrest, airway comes first.

10. Which report should the nurse act on first?

A. New hoarseness 4 hours after thyroid surgery
B. Mild ankle swelling in a patient with heart failure
C. Saturation of 90% in a patient with COPD at baseline
D. Pain of 3 of 10 on day 2 after a hernia repair

A. New hoarseness 4 hours after thyroid surgery New hoarseness after thyroid surgery can signal airway compromise. The other findings are expected or stable.

CHAPTER 4

Communication and the Therapeutic Relationship

Read it in full: **Chapter 4 in the textbook**. Practice it in the lab: **Response Coach: Therapeutic Communication** and **SBAR Builder: Team Communication**.

What to know

Communication is the exchange of meaning. Its parts are the **referent** (what prompts it), the **sender**, the **channel**, the **receiver**, **feedback** and the context. Each person's perceptions, emotions, culture and knowledge filter what is sent and heard. A message has arrived only when feedback shows it, which is why asking the patient to explain in their own words is a safety habit.

Good verbal communication uses plain words instead of jargon, watches connotation ("positive test" can be bad news), keeps a steady pace and a warm tone, says one idea at a time and picks the right moment. **Nonverbal** messages (face, eye contact, posture, gestures, touch, silence, space) are often more believable than words. When they conflict with words, that is **incongruence**: name what you see and invite the patient to talk. Task touch is explained first; caring touch is offered only when welcome.

Personal space zones for North American adults are a guide: **intimate** 0 to 18 inches (assessment, bathing), **personal** 18 inches to 4 feet (interviews), **social** 4 to 12 feet (rounds, groups), **public** beyond 12 feet. Much nursing care happens in the intimate zone, so explain each step and ask before touching.

Culture shapes eye contact, touch, silence, how pain is shown and who makes decisions. Memorizing trait lists leads to **stereotyping**. Practice **cultural humility**: notice your own assumptions and ask the patient about preferences, preferred name and pronouns. **Health literacy** is the ability to find, understand and use health information. You cannot see it. Use universal precautions: plain language, two or three key points per session, pictures and demonstration, and teach back.

Therapeutic communication is purposeful and patient centered. It rests on **active listening**: full attention to words and feelings. Helpful techniques include broad openings, open ended questions, general leads, restating, reflecting, clarifying, focusing, sharing observations, acknowledging feelings, silence, offering self, giving information, presenting reality and summarizing.

Nontherapeutic responses close the conversation: false reassurance ("Don't worry"), giving advice ("If I were you"), approval or disapproval, asking "why," changing the subject, clichés, belittling, defending staff, probing, arguing and excessive self disclosure. On exams, the best answer usually acknowledges the feeling or opens the topic. A physical or safety need still comes first: "I can't breathe" needs assessment, not reflection.

The **therapeutic relationship** is professional and goal directed, focused on the patient's needs and time limited. Its phases are **preinteraction** (review the record, examine your own feelings), **orientation** (introductions, trust, roles, goals, confidentiality and its limits, the time frame),

working (explore problems, teach, build coping) and **termination** (review progress, prepare for discharge, discuss feelings about ending). Termination is planned from the orientation phase.

Empathy is understanding the patient's feelings from their point of view and saying so, while staying separate. **Sympathy** is feeling sorry or sharing the emotion as your own; it shifts the focus to the nurse. Trust, genuineness, respect, warmth and competence also matter. **Boundaries** belong to the nurse, always, even when the patient starts the crossing. A **crossing** is brief and returns to limits. A **violation** meets the nurse's needs at the patient's expense. Sexual contact with a patient is always a violation. Warning signs include extra time with one patient, secrets, gifts or money, personal phone or social media contact.

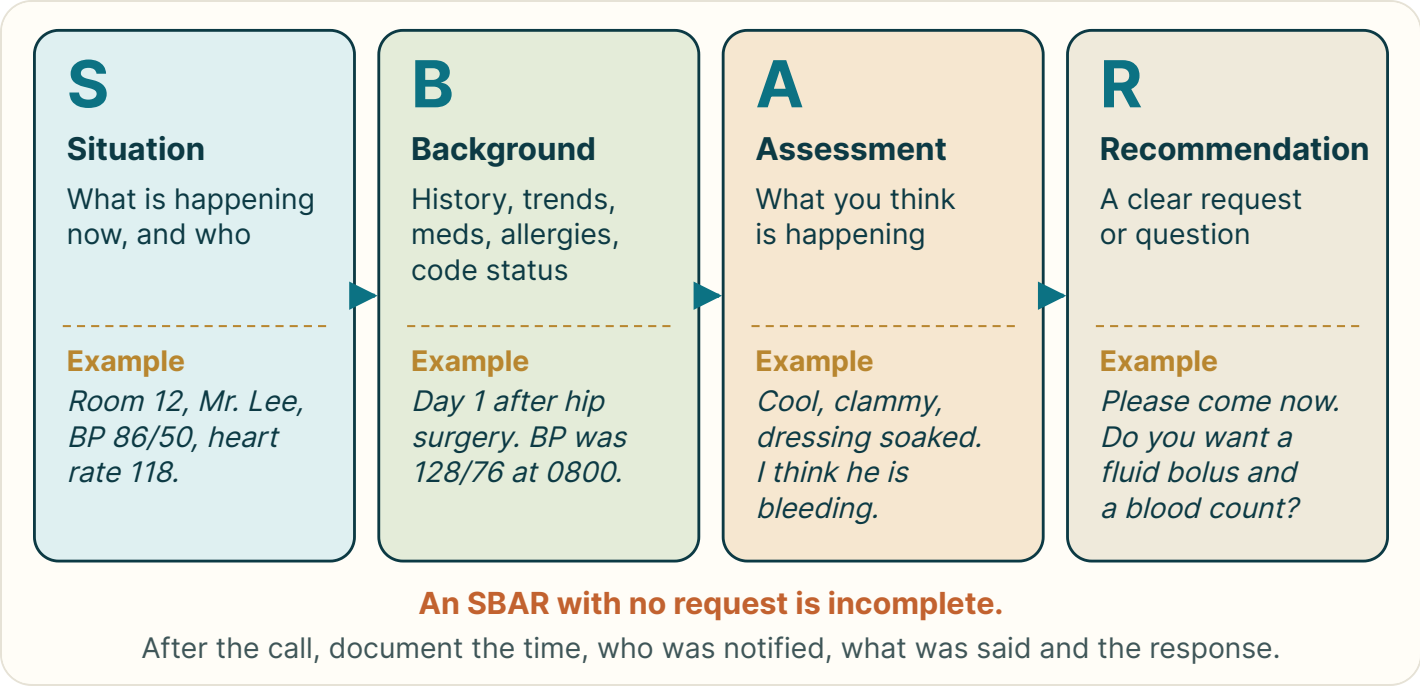
SBAR gives a report in order: situation, background, assessment (what you think is happening) and recommendation (a clear request). Have the record, trends, medications, allergies, labs and code status ready. After the call, document the time, who was notified, what was said and the response. An SBAR with no request is incomplete.

Closed loop communication: a clear message to a named person, read back, confirmed, then reported done. Verbal and telephone orders and critical results must be written down and **read back**. Spell look alike drug names and say numbers digit by digit. Students do not take verbal orders. **Handoffs** are structured, quiet and ideally at the bedside, and include code status, allergies, isolation, fall and skin risk, pain, lines and drains, pending results and what to watch for. One format is I PASS (illness severity, patient summary, action list, situation awareness, synthesis by receiver).

If a concern is not resolved, **escalate**: rapid response team for deterioration (or simply worry), then the **chain of command**, documenting each step. Conflict styles are avoiding, accommodating, competing (emergencies), compromising and **collaborating** (preferred when time allows). Use "I" statements and focus on the patient.

Special situations: with anger, keep safety first (arm's length, clear exit for both, call for help early), stay calm, acknowledge the feeling and set limits. Anxiety runs mild, moderate, severe and panic; no teaching at severe or panic. For hearing loss face the patient with light on your face, lower your pitch, reduce noise, do not shout. For aphasia use yes or no questions, boards and time;

expressive aphasia understands but struggles to speak, receptive aphasia speaks but does not understand. Use a **qualified medical interpreter**, never a child and not family for health information, and speak to the patient in the first person. Match explanations to a child's stage, and avoid elderspeak with older adults.



SBAR ends with a request. Situation, background, your assessment, then a specific recommendation. A call that stops after the assessment leaves the provider guessing.

LOCK THESE IN

- Feedback is the only proof a message arrived; teach back is feedback.
- When words and body language conflict, name the observation and invite more.
- Intimate 0 to 18 inches, personal to 4 feet, social to 12 feet, public beyond.
- Best response: acknowledge the feeling or ask an open ended question, unless a safety need comes first.
- Phases: preinteraction, orientation, working, termination; termination is planned from the start.
- Empathy understands while staying separate; sympathy shifts focus to the nurse. The nurse owns the boundary.
- SBAR ends with a request; verbal orders and critical results are written down and read back.
- Qualified medical interpreter, first person, never a child.

Key terms and comparisons: responses that open and close

Nontherapeutic response	Example	Better response
False reassurance	"Don't worry, it will be fine."	"You're worried about the biopsy. What concerns you most?"
Giving advice	"If I were you, I'd have the surgery."	"What do you see as the benefits and risks?"
Asking why	"Why didn't you take your insulin?"	"What made it hard to take your insulin?"
Changing the subject	Patient mentions death; nurse asks about lunch	"You mentioned death. Are you thinking about dying?"
Defending	"Our nurses are very busy."	"You felt ignored when you called. Tell me what happened."
Belittling	"Lots of people have this surgery."	"Even common surgery can feel scary."
Sympathy	"That's awful. I'd be so angry."	Empathy: "You sound hurt that he hasn't come."

Priority rules: team communication and special situations

Situation	Rule
Calling about a change	SBAR, ending with a specific request
Verbal or phone order, critical result	Write it down, read it back, get confirmation
Emergency with many voices	Closed loop: named person, read back, confirm, report done
Provider does not respond	Rapid response if deteriorating; chain of command; document each step
Severe or panic anxiety	Stay, calm voice, short sentences, reduce stimuli; no teaching
Hearing loss	Face the patient, light on your face, lower pitch, reduce noise
Limited English proficiency	Qualified interpreter in person, video or phone; speak in first person
Angry patient	Safety first, clear exit, calm voice, acknowledge, set limits

Worked cases

WORKED CASE 1 · CHOOSING THE BEST RESPONSE

Mrs. Dube, 46, learned today that she has ovarian cancer. She looks out the window and says, "I don't know how I'll tell my sons."

STEP 1 · NAME THE CUES

Shock and grief plus a specific worry about her family.

STEP 2 · RULE OUT CLOSERS

"Your sons will be strong for you" is false reassurance. "Why not wait for the treatment plan?" is advice and a why question. "Many women do well now" minimizes.

STEP 3 · CHOOSE

Reflect the feeling and invite more: "Telling your sons feels overwhelming right now." Then allow silence.

STEP 4 · FOLLOW UP

Later offer resources for talking with children, and assess coping and support.

RULE

Watch for statements of hopelessness after a devastating diagnosis.

WORKED CASE 2 · AN SBAR CALL

Mr. Petrakis, 66, had a bowel resection this morning. At 1800 his pressure is 86/52 (it was 130/78 at 1400) and his heart rate is 124. He is pale, his dressing is soaked and his urine output was 20 mL in 2 hours. His morning hemoglobin was 11.0.

STEP 1 · SITUATION

"This is the nurse on 5 East calling about Mr. Petrakis in room 8. His pressure is 86/52 and heart rate 124."

STEP 2 · BACKGROUND

"He is 66 and had a bowel resection this morning. At 1400 his pressure was 130/78. Hemoglobin this morning was 11.0."

STEP 3 · ASSESSMENT

"He is pale, his dressing is saturated and urine output was 20 mL in 2 hours. I am concerned he is bleeding."

STEP 4 · RECOMMENDATION

"I would like you to see him now. Do you want a fluid bolus, a stat hemoglobin and a type and crossmatch?"

STEP 5 · CLOSE THE LOOP

Write down and read back any new orders, then document the time, the person called, the report and the response.

WORKED CASE 3 · AN INTERPRETER, NOT A GRANDCHILD

Mr. Haddad, 75, speaks Arabic and little English and is admitted with abdominal pain. His 11 year old granddaughter offers to translate the admission history, which includes bowel habits and past surgeries. His son arrives in 3 hours.

STEP 1 · NAME THE CUES

Limited English proficiency, sensitive questions, a child volunteer and a possibly urgent problem.

STEP 2 · RULE OUT THE SHORTCUTS

The granddaughter may lack medical words, it breaches privacy and burdens a child. Waiting 3 hours delays assessment.

STEP 3 · ACT

Request a qualified medical interpreter now, by video or phone if no one is on site.

STEP 4 · DURING THE INTERVIEW

Speak to Mr. Haddad in the first person, use short segments, use teach back through the interpreter, and document the interpreter's ID and language.

WORKED CASE 4 · A BOUNDARY DRIFTING

A nurse has cared for a young adult patient through a long stay. On the last day the patient asks to connect on social media. The nurse realizes they have been spending extra time in the room and thinking about the patient on days off.

STEP 1 · NAME THE WARNING SIGNS

Extra time, off duty thoughts and a request for personal contact signal overinvolvement.

STEP 2 · RESPOND

Decline warmly and clearly: "I've enjoyed working with you. Our relationship is professional, so I don't connect with patients on social media."

STEP 3 · FINISH THE RELATIONSHIP WELL

Use the remaining time for termination tasks such as the discharge review. Do not abruptly avoid the patient.

STEP 4 · GET SUPPORT

Talk with a trusted colleague or manager about the feelings.

RULE

The nurse owns the boundary even after discharge, because the power difference persists.

TRAPS PEOPLE FALL INTO

- **Treating nodding as understanding.** Nodding can be politeness. Only teach back confirms understanding.
- **Picking the reassuring answer.** "Don't worry" sounds kind but closes the topic. Acknowledge the feeling instead.
- **Reflecting when the need is physical.** "I can't breathe" needs assessment first. Communication technique comes second.
- **Confusing empathy with sympathy.** Empathy names the patient's feeling. Sympathy shares it as the nurse's own.
- **Thinking the patient can waive the boundary.** The nurse is always responsible, even if the patient starts it.
- **Ending SBAR without a request.** The R is a specific ask: see the patient, a test, a treatment.
- **Letting family interpret consent or teaching.** Family may help with nonclinical matters only. Use a qualified interpreter.
- **Shouting at a patient with hearing loss.** Lower pitch and face the patient. Shouting distorts speech.

- **Teaching during severe anxiety.** Lower the anxiety first. Learning is not possible at severe or panic levels.

Chapter 4 self-test · ten items

1. A patient says "I'm fine" while gripping the rails and wincing. Which response is best?

A. "Good, I will come back in an hour to check on you then."
B. "Why are you holding the rails so tight if nothing hurts?"
C. "You say you're fine, but you look uncomfortable. Tell me."
D. "Everyone says that. I can tell when someone is hurting."

C. "You say you're fine, but you look uncomfortable. Tell me." Naming the incongruence and inviting more explores the cue. A why question and accepting the words both miss it.

2. A patient asks, "Do you think I should have the surgery?" Which response is therapeutic?

A. "If I were you, I would have it done this week."
B. "What are your own thoughts about the surgery?"
C. "Your doctor knows best, so I would go ahead."
D. "Don't worry, this surgery is very common now."

B. "What are your own thoughts about the surgery?" Reflecting returns the question so the patient can explore it. The others give advice or false reassurance.

3. In which phase does the nurse tell the patient how long the relationship will last?

A. Working
B. Termination
C. Preinteraction
D. Orientation

D. Orientation Roles, goals, confidentiality and the time frame are set in orientation, which also begins planning for termination.

4. A patient says, "My wife hasn't visited once." Which reply shows empathy?

A. "You sound hurt that she hasn't come."
B. "That's terrible. I would be furious too."
C. "My husband did the same thing once."
D. "I'm sure she has a good reason."

A. "You sound hurt that she hasn't come." Empathy names the patient's feeling. The others are sympathy, false reassurance and self disclosure.

5. A patient offers the nurse $50 as thanks at discharge. What should the nurse do?

A. Accept it only if the manager agrees later
B. Thank the patient kindly and decline the money
C. Accept it, since the patient is leaving today
D. Accept it and give it to the unit fund

B. Thank the patient kindly and decline the money Money is never accepted. The nurse keeps the boundary and stays warm and professional.

6. In an SBAR call, what belongs in the A?

A. The nurse's judgment of what is happening
B. The name of the nurse and the unit
C. The request for the provider to come
D. The patient's age and admitting diagnosis

A. The nurse's judgment of what is happening Assessment is what you found and what you think it means. Background holds history; recommendation holds the request.

7. A provider gives a telephone order. What must the nurse do before acting?

A. Ask a second nurse to listen to the call
B. Repeat the drug name once and hang up
C. Write it down and read it back for confirmation
D. Wait for the order to appear electronically

C. Write it down and read it back for confirmation Read back of verbal and telephone orders is required to catch mishearing before action.

8. A patient who is deaf uses sign language. Who should interpret a consent discussion?

A. Written notes passed back and forth
B. The patient's adult daughter
C. A staff member who knows some signs
D. A qualified sign language interpreter

D. A qualified sign language interpreter A qualified interpreter is the standard for health information and consent. Notes are a backup for simple matters.

9. An older adult with hearing loss does not understand a question. What should the nurse do?

A. Speak more slowly and exaggerate lip movements
B. Repeat the very same words much more loudly
C. Ask a family member to answer the question
D. Face the patient and rephrase in a lower pitch

D. Face the patient and rephrase in a lower pitch High pitches are lost first. Rephrase, face the patient and lower the pitch; do not shout or exaggerate.

10. A patient is pacing, swearing and clenching his fists. What is the nurse's first priority?

A. Keep a safe distance and a clear exit, and call for help
B. Ask him why he is so upset with everyone this morning
C. Explain the unit rules about behavior toward staff
D. Start teaching about the new medications he will take

A. Keep a safe distance and a clear exit, and call for help Safety comes first with escalating anger. De escalation and limit setting follow.

ONE PAGE

Cram sheet

Chapters 3 and 4 on one page. Cover the right column and say each rule out loud.

Nursing process and clinical judgment

Item	Rule
ADPIE	Assessment, diagnosis, planning, implementation, evaluation; a cycle
Subjective or objective	What the patient says versus what is measured or observed
Primary source	The patient; secondary sources need validation and permission
Baseline and trend	Interpret every value against the patient's own normal
Validate	Recheck unexpected data right away
PES	Problem, related to etiology, as evidenced by signs; risk diagnoses have no S
SMART	Specific, measurable, achievable, relevant, time bound; patient centered
Interventions	Independent, dependent, collaborative; accountable for all
Evaluation	Met, partially met, not met, plus supporting data
Six steps	Recognize, analyze, prioritize hypotheses, generate solutions, take action, evaluate
Priority	ABCs, safety, acute, unexpected, unstable, actual; compressions first only in arrest
Urine output	At least 0.5 mL/kg per hour, about 30 mL per hour for an average adult

Communication and the relationship

Item	Rule
Feedback	Teach back proves the message arrived
Incongruence	Name what you see and invite more
Space zones	Intimate 0 to 18 in, personal to 4 ft, social to 12 ft, public beyond
Best response	Acknowledge feeling or open question; physical safety first
Avoid	False reassurance, advice, why, changing subject, defending, clichés
Phases	Preinteraction, orientation, working, termination
Boundaries	Nurse owns them; no money, secrets or social media contact
SBAR	Situation, background, assessment, recommendation (a request)
Read back	Verbal and phone orders and critical results
Escalation	Rapid response, chain of command, document
Interpreter	Qualified, first person, never a child
Anxiety	No teaching at severe or panic levels

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