FUNDAMENTALS OF NURSING · STUDY GUIDE

Final Exam Study Guide

This final guide puts the whole course in one place. Each chapter gets a short summary, the points to lock in, one table, one worked case, the most common traps and five new self-test items. The worked cases and tables come from the exam guides, so use those for the full version of any chapter that feels weak. Work the self-tests first; any miss tells you which chapter to reread.

WHAT THIS GUIDE COVERS

- Exam 1 · Chapters 1 and 2: Nursing as a Profession; Health Care Delivery and Nursing Theory.
- Exam 2 · Chapters 3 and 4: The Nursing Process and Clinical Judgment; Communication and the Therapeutic Relationship.
- Exam 3 · Chapters 5 and 6: Documentation, Informatics and Patient Teaching; Legal and Ethical Practice.
- Exam 4 · Chapters 7 and 8: Patient Safety and Quality; Infection Prevention and Control.
- Exam 5 · Chapters 9 and 10: Vital Signs; Health Assessment Foundations.
- Exam 6 · Chapters 11 and 12: Medication Administration; Activity, Mobility and Body Mechanics.
- Exam 7 · Chapters 13 and 14: Hygiene, Skin Integrity and Wound Care; Oxygenation.
- Exam 8 · Chapters 15 and 16: Fluid, Electrolyte and Acid Base Balance; Nutrition.
- Exam 9 · Chapters 17 and 18: Urinary and Bowel Elimination; Comfort, Pain, Sleep and Rest.
- Exam 10 · Chapters 19 and 20: Psychosocial Health, Culture and Spirituality; Loss, Grief and End of Life Care.
- Exam 11 · Chapters 21 and 22: Health Promotion Across the Lifespan; Leadership, Delegation and the New Graduate.

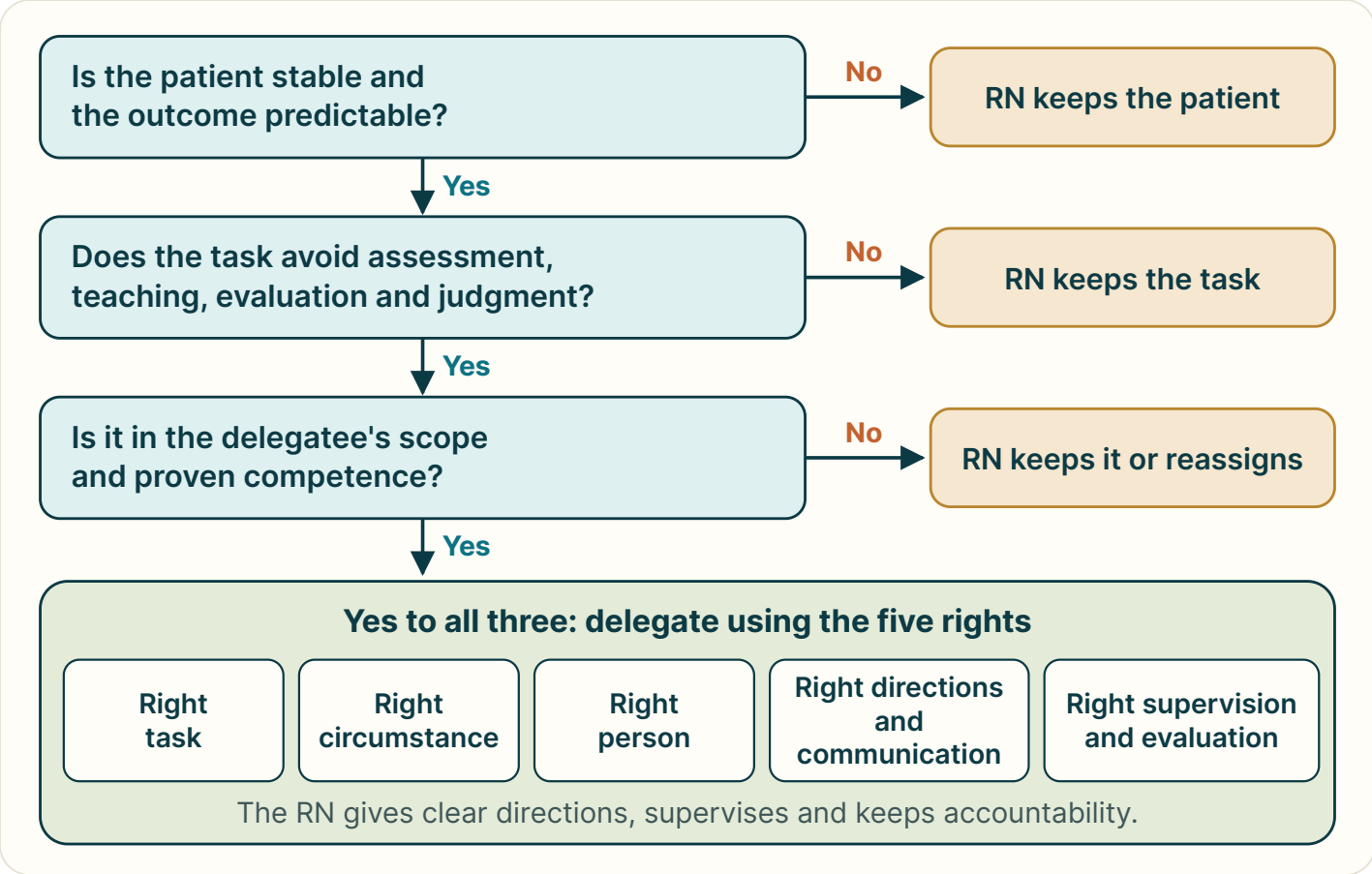
CHAPTER 1

Nursing as a Profession

Read it in full: **Chapter 1 in the textbook**. Practice it in the lab: **License Ladder: Pathways, Scope and Standards**.

What to know

Nursing diagnoses and treats human responses to health problems, while medicine diagnoses and treats disease. A state license protects the public and can be limited or revoked. What a nurse may do passes three filters: the state practice act, facility policy and personal competence. The RN keeps assessment, planning, initial teaching, evaluation and every unstable patient, and delegates only through the five rights while staying accountable. When a safety concern is ignored, the nurse speaks up in steps and climbs the chain of command.



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.

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 case

CASE 1.1 · 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.

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.

Chapter 1 self-test · five items

1. Which credential is voluntary and granted by a professional organization?

A. State nursing licensure
B. Specialty certification
C. Multistate licensure
D. Program accreditation

B. Specialty certification Certification is voluntary and comes from the profession. Licensure is mandatory and comes from the state.

2. An RN asks a newly hired assistant, who has not been trained on the mechanical lift, to transfer a patient with it. Which right of delegation is violated?

A. Right person
B. Right circumstance
C. Right supervision and evaluation
D. Right task

A. Right person The delegatee must be trained and competent for the task.

3. A nurse has twice voiced a safety concern to a provider, who ignores it both times. What is the next step?

A. Wait and raise it again tomorrow
B. Carry out the order as written
C. Take it up the chain of command
D. Document it and say no more about it

C. Take it up the chain of command After two unanswered challenges, escalate through the chain of command and document.

4. Which item is a nursing concern rather than a medical diagnosis?

A. Fracture of the left femur
B. Type 2 diabetes mellitus
C. Pneumonia of the right lower lobe
D. Anxiety about an upcoming surgery

D. Anxiety about an upcoming surgery Nursing addresses human responses, such as anxiety, to health problems.

5. A nurse is floated to a unit and asked to manage an epidural infusion she has never handled. Which scope filter is not met?

A. Personal competence
B. State practice law
C. Facility policy
D. Professional ethics code

A. Personal competence A skill can be legal and allowed by policy and still be outside a nurse's own competence.

CHAPTER 2

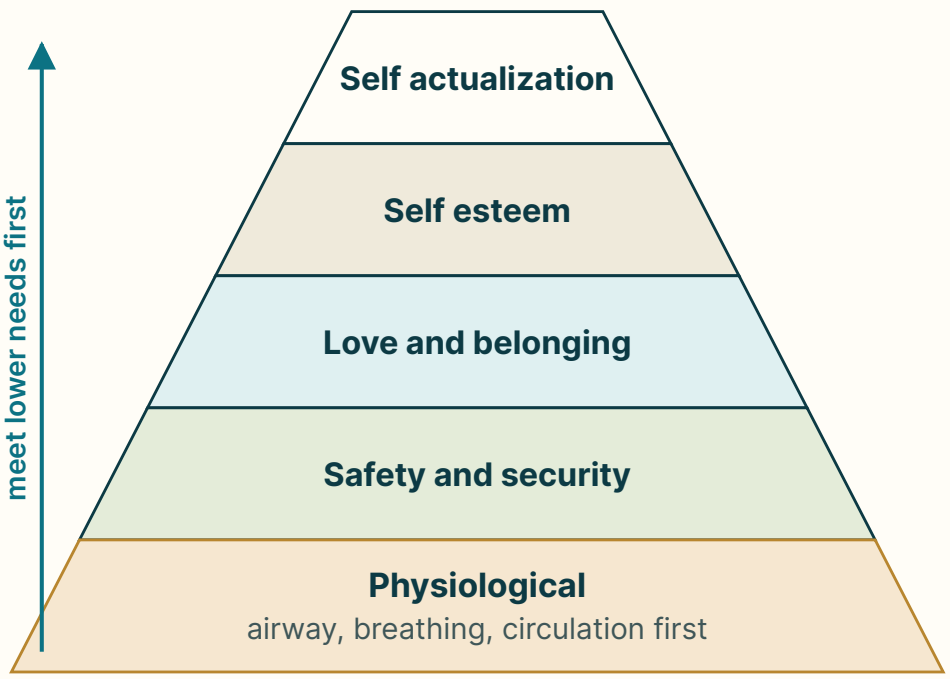
Health Care Delivery and Nursing Theory

Read it in full: **Chapter 2 in the textbook**. Practice it in the lab: **Coverage Calculator: What Will the Patient Pay?**.

What to know

Care happens in hospitals, clinics, rehabilitation units, skilled nursing facilities, homes and hospice, and each setting has entry rules: home health needs a homebound patient with an intermittent skilled need, inpatient rehabilitation needs about 3 hours of therapy a day, and hospice needs comfort goals with a prognosis of 6 months or less. Medicare Part A covers hospital care, B

outpatient, C combined plans and D drugs. Theories such as Orem and Maslow guide what the nurse does and in what order.



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.

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

Worked case

CASE 2.1 · 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.

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.

Chapter 2 self-test · five items

1. A patient after a stroke is stable and can tolerate three hours of therapy a day. Which setting fits best?

A. Weekly outpatient clinic visits
B. Skilled home health services
C. Custodial long term care home
D. Inpatient rehabilitation facility

D. Inpatient rehabilitation facility Inpatient rehabilitation requires tolerance of about 3 hours of therapy a day.

2. Which part of Medicare mainly pays for inpatient hospital care?

A. Part B
B. Part C
C. Part A
D. Part D

C. Part A Part A is hospital insurance; B outpatient, C combined plans, D drugs.

3. A patient cannot afford her inhaler and has stopped using it. Which team member should the nurse involve?

A. The physical therapist
B. The hospital social worker
C. The speech pathologist
D. The occupational therapist

B. The hospital social worker Social work helps with money, insurance and resources.

4. A patient with a new colostomy changes her pouch while the nurse coaches and teaches. Which Orem system applies?

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

A. Supportive educative The patient performs the care and the nurse supports and teaches.

5. Which care model divides work by task, such as one nurse giving all medications?

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

D. Functional nursing Functional nursing assigns tasks, which fragments care.

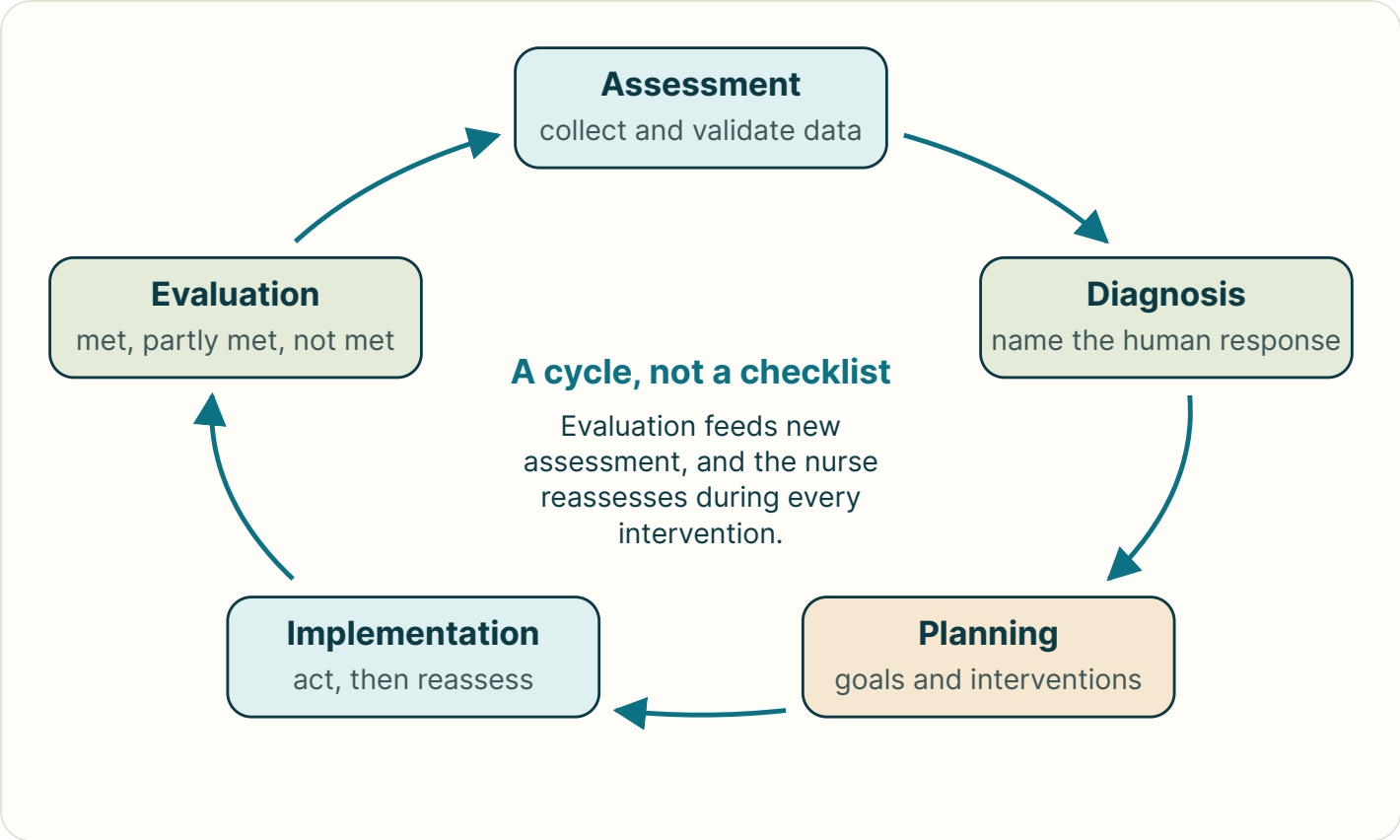
CHAPTER 3

The Nursing Process and Clinical Judgment

Read it in full: **Chapter 3 in the textbook**. Practice it in the lab: **Cue Clinic: Collect, Check and Cluster**.

What to know

The nursing process (assess, diagnose, plan, implement, evaluate) is a cycle, and clinical judgment runs through it in six steps: recognize cues, analyze cues, prioritize hypotheses, generate solutions, take action and evaluate outcomes. Read every value against the patient's baseline and trend. Diagnoses use PES for actual problems and risk factors for risk problems; outcomes are patient centered and measurable. The least stable patient comes first.



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.

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

Worked case

CASE 3.1 · 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.

Chapter 3 self-test · five items

1. Which nursing diagnosis is correctly written as a risk diagnosis?

A. Risk for falls related to dizziness on standing

B. Acute pain related to the surgical incision

C. Risk for falls as evidenced by a fall last night

D. Risk for infection as evidenced by a fever of 38.6 C

A. Risk for falls related to dizziness on standing Risk diagnoses name risk factors and have no signs or symptoms part.

2. A patient's heart rate is 118 when his chart shows a baseline of 70 to 80. What should the nurse do first?

A. Give the scheduled beta blocker now
B. Record it and recheck next shift
C. Ask the assistant to recheck it later
D. Recheck it and assess the patient

D. Recheck it and assess the patient Validate a surprising value against the baseline and assess the patient right away.

3. Which goal is written in patient centered terms?

A. Ambulation will be encouraged on every shift
B. The nurse will walk the patient three times today
C. The patient will walk to the bathroom using a walker
D. The nurse will teach walker use before discharge

C. The patient will walk to the bathroom using a walker Outcomes describe what the patient will do, not what the nurse will do.

4. In the clinical judgment model, which step comes right after recognizing cues?

A. Evaluate outcomes
B. Analyze cues
C. Take action
D. Generate solutions

B. Analyze cues Recognize cues, analyze cues, prioritize hypotheses, generate solutions, take action, evaluate outcomes.

5. Which intervention requires a provider order?

A. Giving a scheduled IV antibiotic dose
B. Offering a backrub at bedtime
C. Teaching deep breathing exercises
D. Turning the patient every 2 hours

A. Giving a scheduled IV antibiotic dose Medications are dependent interventions. The others are independent.

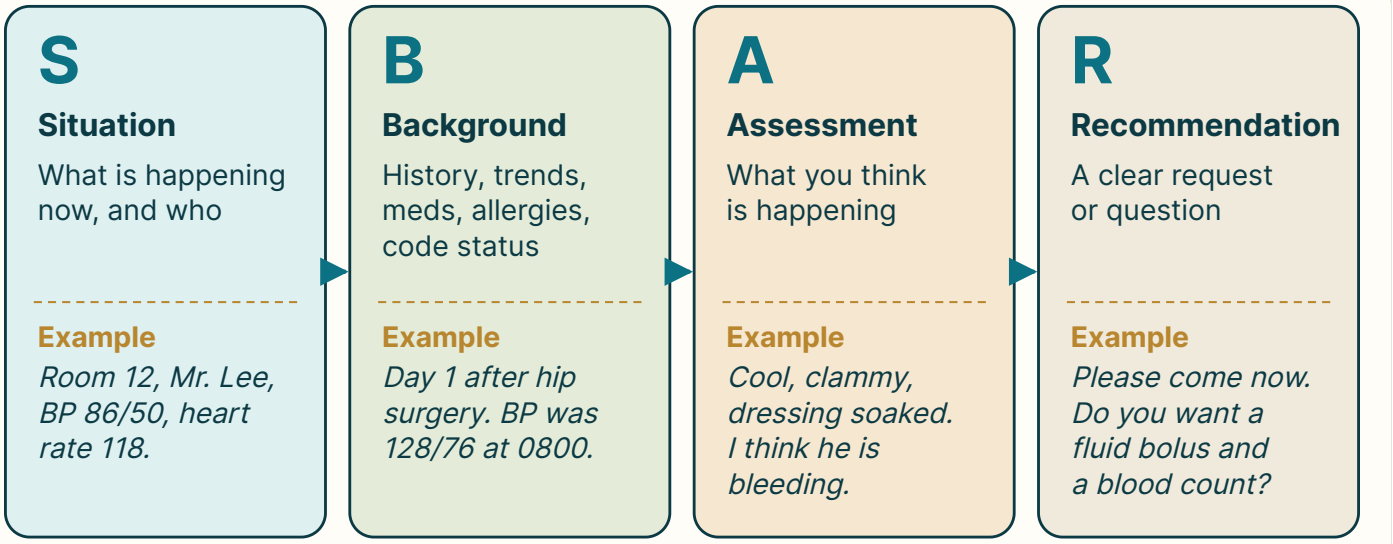
CHAPTER 4

Communication and the Therapeutic Relationship

Read it in full: **Chapter 4 in the textbook**. Practice it in the lab: **Boundary Line: Relationship, Space and Conflict**.

What to know

Therapeutic communication keeps the focus on the patient: open questions, reflection, silence and acknowledging feelings, with safety first. The relationship moves through preinteraction, orientation, working and termination, and the nurse owns the boundary. Team communication uses SBAR ending in a clear request, with read back of verbal orders and critical results. Qualified medical interpreters, speaking in the first person, are used for language needs; never a child.



An SBAR with no request is incomplete.

After the call, document the time, who was notified, what was said and the response.

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.

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

Worked case

CASE 4.1 · 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.

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.

Chapter 4 self-test · five items

1. A patient says, "I don't know how I'll manage at home." Which response is most therapeutic?

A. "Tell me more about what worries you at home."
B. "You should ask your family to move in with you."
C. "Why do you think you won't be able to manage?"
D. "Don't worry, everything will work out fine."

A. "Tell me more about what worries you at home." An open invitation explores the concern. False reassurance, "why" and advice close it down.

2. In which zone of personal space does most of a physical assessment take place?

A. Personal space, up to 4 feet
B. Intimate space, up to 18 inches
C. Social space, up to 12 feet
D. Public space, beyond 12 feet

B. Intimate space, up to 18 inches Physical assessment happens in intimate space, so explain and ask before touching.

3. When does the nurse begin preparing the patient for the end of the relationship?

A. In the working phase
B. In the termination phase
C. In the orientation phase
D. On the day of discharge

C. In the orientation phase Termination is planned from the start, when the nurse explains how long the relationship will last.

4. In an SBAR call, which part contains "He had a hip replacement two days ago"?

A. Situation
B. Recommendation
C. Assessment
D. Background

D. Background Background gives the relevant history and context.

5. A nurse notices she is spending off duty time with a patient's family. What does this represent?

A. An example of empathy
B. A boundary violation
C. Professional advocacy
D. Therapeutic use of self

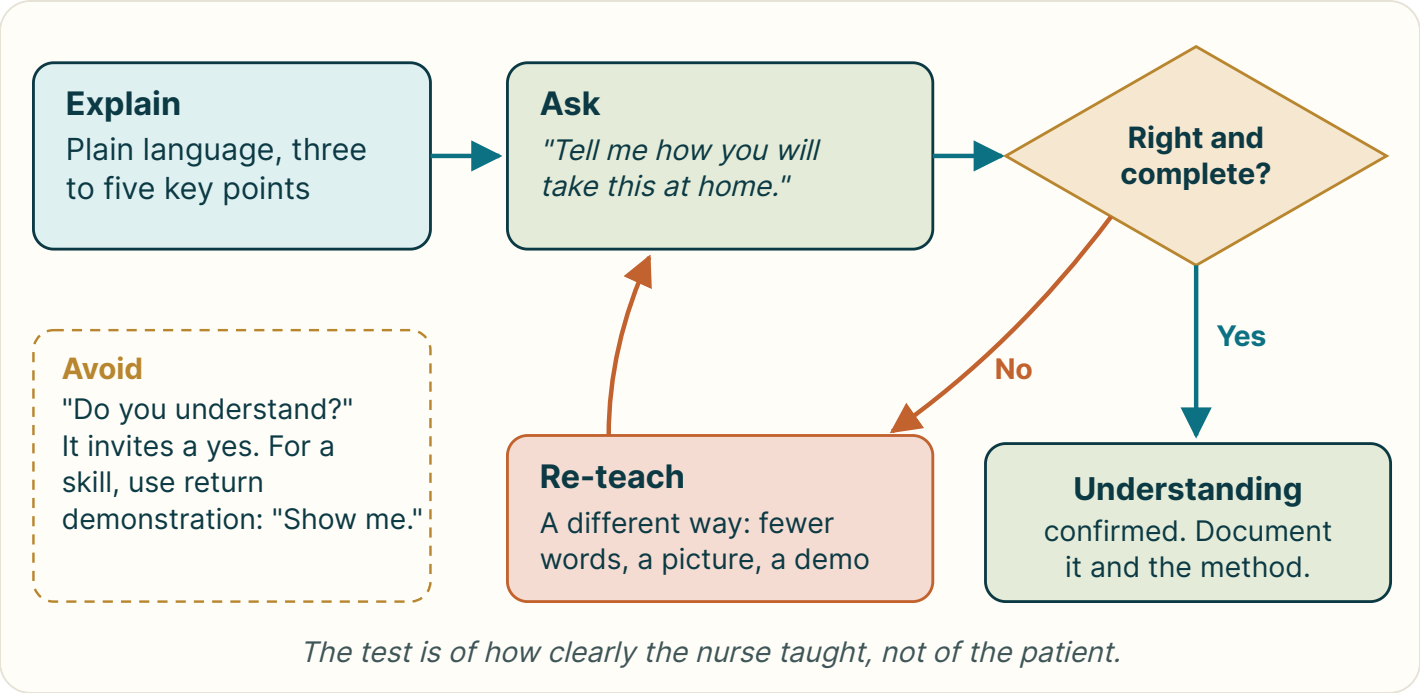
B. A boundary violation Social contact outside the professional role crosses the boundary, which the nurse owns.

Documentation, Informatics and Patient Teaching

Read it in full: **Chapter 5 in the textbook**. Practice it in the lab: **Privacy and Barcode Checkpoint**.

What to know

The record is a legal document: factual, accurate, complete, current and organized, always including the patient's response. Formats include narrative, SOAP, PIE, DAR and charting by exception. Correct paper errors with one line so the original stays readable, label late entries, follow safe abbreviation rules and keep the incident report out of the chart. Privacy means minimum necessary access. Teaching matches the domain: teach back for knowledge, return demonstration for skills.



Teach back is a loop, not a quiz. Ask the patient to say it in their own words, re-teach any gap a different way, and ask again until it is right.

LOCK THESE IN

- Factual, accurate, complete, current, organized; always chart the response.
- SOAP: quote in S, interpretation in A. PIE: problem, intervention, evaluation. DAR: data, action, response.
- Late entry: labeled, current date and time, names the event time.
- Correct with a single line so the original stays readable; never erase or white out.
- Lead yes, trail no: 0.5 mg, 5 mg. Write out "unit" and "daily."
- Never mention the incident report in the chart.
- A BCMA alert is a hard stop, and the pre drug assessment is still yours.

Priority rules: abbreviations and teaching

Item	Do not write	Write instead
Unit	U, u	"unit"
International unit	IU	"international unit"
Daily, every other day	QD, QOD	"daily," "every other day"
Trailing zero	5.0 mg	5 mg

Worked case

CASE 5.1 · A LATE ENTRY AND A CORRECTION

At 1430 a student helped Ms. Varga walk 30 m with a walker but was pulled away before charting. At 1620 she also notices she charted a dressing change on the left leg when it was the right.

STEP 1 · WRITE THE LATE ENTRY

"11/9 1620 LATE ENTRY for 1430: Patient ambulated 30 m in hall with walker and standby assist, no dizziness." Then sign it.

STEP 2 · CORRECT THE ERROR ON PAPER

Draw one line through "left," write "mistaken entry," add initials, date and time, then write "right." The word "left" stays readable.

STEP 3 · IN THE EHR

Use the amend or correct function, which keeps the original and an audit trail.

RULE

Do not squeeze the note between earlier lines, backdate it or erase anything.

TRAPS PEOPLE FALL INTO

- **Charting a dose before giving it.** Pre charting is falsification and invites missed or double doses.
- **Putting the patient's quote in A.** Quotes go in S. A is the interpretation.
- **Writing "incident report filed" in the chart.** Chart the facts only. Naming the report can make it discoverable.

Chapter 5 self-test · five items

1. How should an error in a paper record be corrected?

A. Thick marker over the error so it cannot be read
B. Tearing out the page and rewriting the whole note
C. Correction fluid over the error, then the new text
D. One line through the error, with initials and date

D. One line through the error, with initials and date A single line keeps the original readable.

2. In DAR charting, where does "Pain now 3 of 10" belong?

A. Assessment
B. Response
C. Action
D. Data

B. Response DAR is data, action, response; the result of the intervention is the response.

3. Which teaching objective is in the affective domain?

A. The patient will say she values checking her feet daily
B. The patient will describe how insulin lowers glucose
C. The patient will inject insulin using correct technique
D. The patient will list three signs of low blood sugar

A. The patient will say she values checking her feet daily Affective objectives concern values and attitudes.

4. A coworker's password is taped to a workstation. What should the nurse do?

A. Leave it, since it is not the nurse's login
B. Copy it down in case it is needed later
C. Remove it and report it as policy requires
D. Use it to chart when the nurse is locked out

C. Remove it and report it as policy requires Passwords are never shared or used by others; exposed credentials are reported.

5. What is the best way to begin teaching a patient newly diagnosed with heart failure?

A. Explain the disease in detail using medical terms
B. Hand over a booklet and ask her to read it tonight
C. Teach every topic at once before she goes home
D. Assess what the patient already knows and wants to learn

D. Assess what the patient already knows and wants to learn Teaching starts with assessing readiness, knowledge and needs.

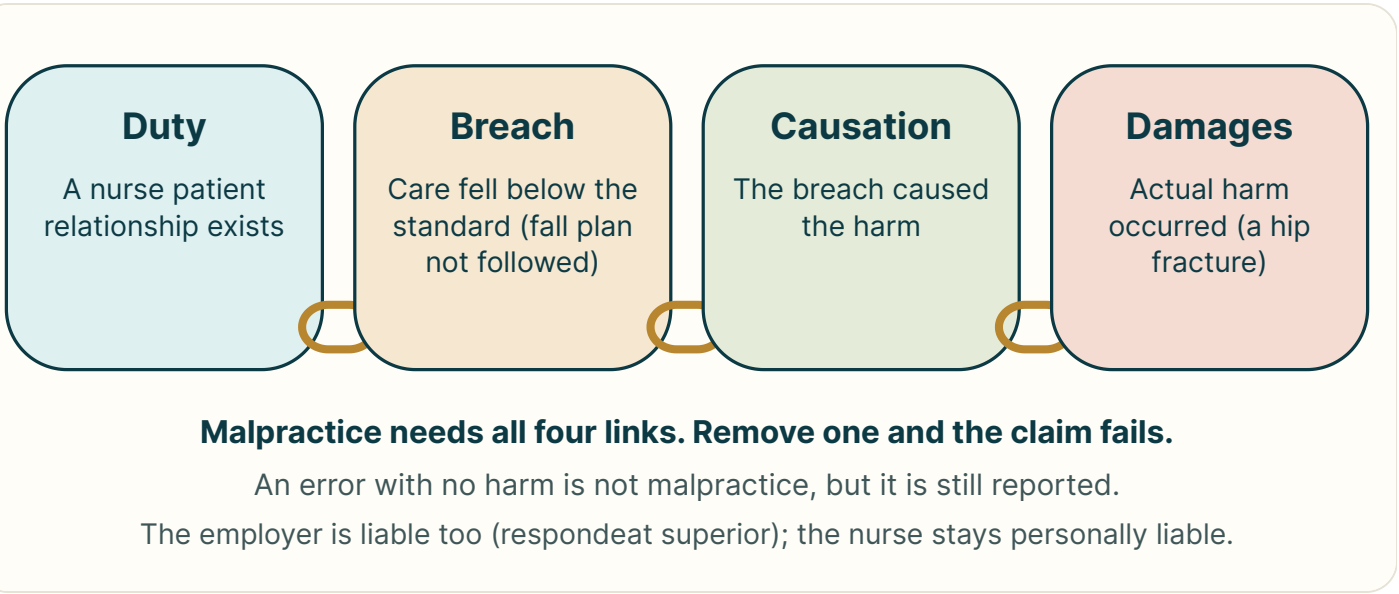
CHAPTER 6

Legal and Ethical Practice

Read it in full: **Chapter 6 in the textbook**. Practice it in the lab: **Four Links of Malpractice**.

What to know

Practice is governed by the state practice act, board rules and court precedent, and policy can narrow scope but never widen it. Malpractice needs duty, breach, causation and damages. Intentional torts include assault, battery, false imprisonment and defamation. Valid consent needs capacity, voluntariness and information from the provider; the nurse witnesses. Ethical principles (autonomy, beneficence, nonmaleficence, justice, fidelity, veracity) guide hard choices, and suspected abuse is reported on reasonable suspicion.



Malpractice needs all four links. Duty, breach, causation and damages. A near miss breaks the chain at damages, but it still gets reported.

LOCK THESE IN

- Statute (practice act) from the legislature; rules from the board; precedent from courts.
- Facility policy can narrow scope, never widen it.
- Malpractice needs duty, breach, causation and damages; no harm, no malpractice.
- Assault is a threat; battery is touch without consent; false imprisonment is confinement; slander spoken, libel written.
- Consent = capacity + voluntary + informed. The provider informs; the nurse witnesses.
- Capacity is clinical and decision specific; competence is a court ruling.
- DNR means no CPR, not "do not treat." No PRN restraint orders.

Priority rules: principles and who to call

Principle or duty	What it protects	Cue in a question
Autonomy	The patient's choice	A competent adult declines treatment
Beneficence	The patient's good	Advocating for pain control
Nonmaleficence	Avoiding harm	Refusing to give an unsafe dose
Justice	Fairness	Same care regardless of insurance

Worked case

CASE 6.1 · TESTING THE FOUR ELEMENTS

A nurse gives a patient another patient's antihypertensive. The patient's pressure is unchanged and there is no harm. A family member says they will sue for malpractice.

STEP 1 · DUTY

The nurse was caring for the patient, so a duty existed.

STEP 2 · BREACH

Giving the wrong drug falls below the standard of care.

STEP 3 · CAUSATION AND DAMAGES

No injury occurred, so there is nothing the breach caused.

STEP 4 · CONCLUDE

Malpractice fails because damages are missing. The error is still reported through an incident report and disclosed per policy.

RULE

All four links must be present for malpractice.

TRAPS PEOPLE FALL INTO

- **Thinking professional groups license nurses.** Associations set voluntary standards. The board of nursing licenses and disciplines.
- **Calling any error malpractice.** No harm means no damages. Report the error anyway.
- **Mixing up assault and battery.** Assault is the threat. Battery is the touch.

Chapter 6 self-test · five items

1. A nurse leaves a patient restrained in a chair without an order to keep him from wandering. Which tort is this?

A. Assault only
B. Invasion of privacy
C. Defamation by libel
D. False imprisonment

D. False imprisonment Unjustified confinement or restraint is false imprisonment.

2. A nurse gives a wrong dose, but the patient has no harm. Which element of malpractice is missing?

A. Breach
B. Damages
C. Causation
D. Duty

B. Damages Without harm there are no damages, so there is no malpractice.

3. Who determines that a patient is legally incompetent to manage her own affairs?

A. The charge nurse
B. The attending provider
C. A judge in court
D. The ethics committee

C. A judge in court Competence is a legal ruling. Capacity is a clinical judgment.

4. A capable adult refuses a blood transfusion and the nurse respects the choice. Which principle is honored?

A. Autonomy
B. Beneficence
C. Fidelity
D. Justice

A. Autonomy Autonomy is respect for a capable person's own decisions.

5. What must happen within 1 hour of starting a restraint for violent behavior?

A. A face to face evaluation by a provider
B. Removal of the restraint for a full hour
C. A report to the state board of nursing
D. A family meeting to obtain written consent

A. A face to face evaluation by a provider A face to face evaluation is required within 1 hour.

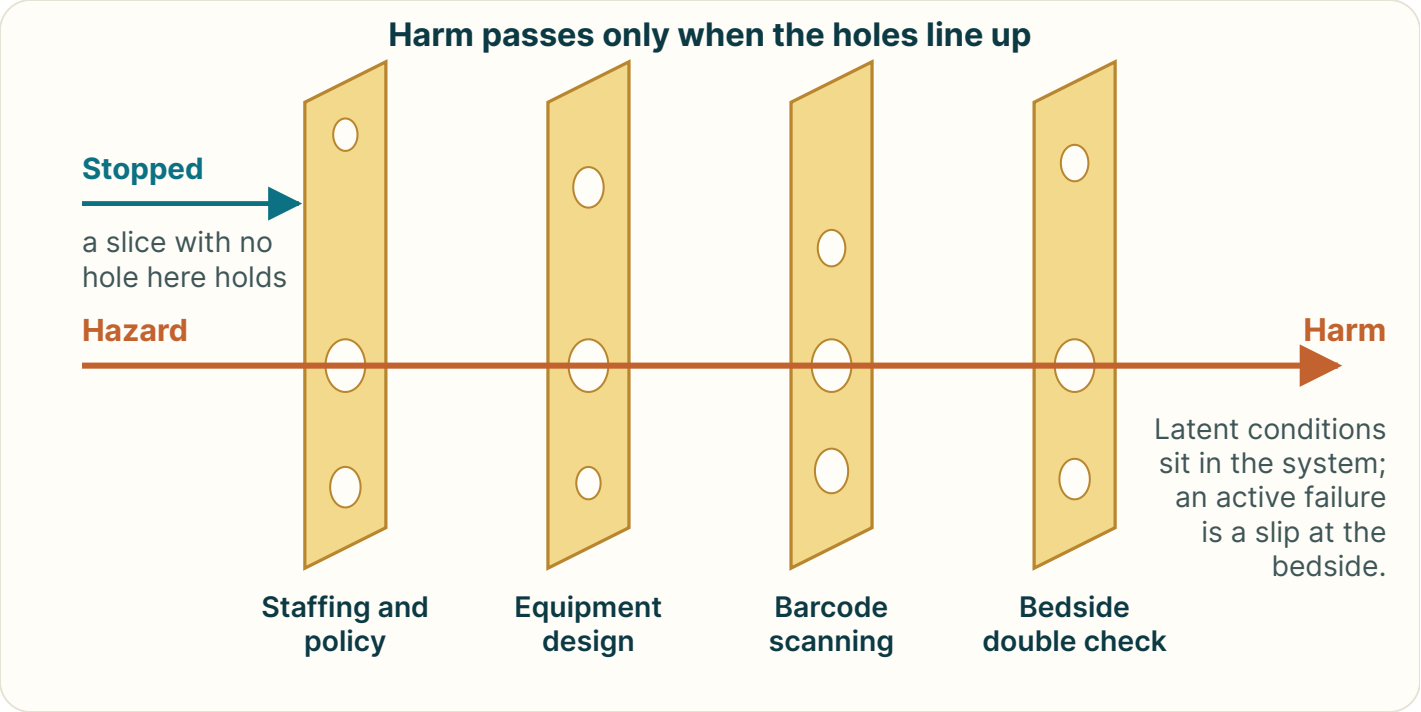
CHAPTER 7

Patient Safety and Quality

Read it in full: **Chapter 7 in the textbook**. Practice it in the lab: **Safety Response Desk: Events, Just Culture and Emergencies**.

What to know

Safety culture treats errors as system signals: console human error, coach at risk behavior and sanction recklessness, and report near misses. Use two identifiers stated by the patient. A previous fall is the strongest fall predictor, and after a fall the nurse assesses before moving the patient. Restraints are a last resort with strict time limits. In a fire use RACE then PASS; during a seizure protect the patient without restraining or putting anything in the mouth.



Harm passes only when the holes line up. Every defense has gaps. Fix the system so the holes stop aligning, rather than blaming the last person in line.

LOCK THESE IN

- Just culture: console error, coach at risk behavior, sanction recklessness.
- Report near misses; the purpose of reporting is system improvement.
- Two identifiers stated by the patient; never the room number.
- Previous fall is the strongest predictor. Morse 45 or more is commonly high risk; TUG 12 seconds or more.
- After a fall: stay, assess before moving, notify, neuro checks if head strike or anticoagulant, document, report.
- Restraints: no PRN; 4, 2 and 1 hour limits; face to face within 1 hour; bed frame and quick release knot.
- RACE then PASS; aim at the base; horizontal evacuation first.

Priority rules: timing for restraint and emergencies

Situation	Number or sequence
Violent restraint order, adult	Up to 4 hours
Violent restraint order, age 9 to 17 / under 9	2 hours / 1 hour
Maximum before provider reassesses	24 hours
Face to face evaluation	Within 1 hour of applying

Worked case

CASE 7.1 · SCORING THE MORSE FALL SCALE

Mr. Delacroix, 79, fell at home 2 months ago. He has heart failure and diabetes, walks with a walker, has a saline lock, takes short shuffling steps with difficulty rising (impaired gait) and keeps trying to get up alone, saying he does not need help.

STEP 1 · HISTORY OF FALLING
Fell within 3 months: 25.

STEP 2 · SECONDARY DIAGNOSIS
More than one diagnosis: 15.

STEP 3 · AMBULATORY AID
Walker: 15.

STEP 4 · IV ACCESS
Saline lock: 20.

STEP 5 · GAIT AND MENTAL STATUS
Impaired gait: 20. Forgets limitations: 15.

STEP 6 · ADD
25 + 15 + 15 + 20 + 20 + 15 = **110**, far above a common high risk cutoff of 45.

PLAN
Universal precautions plus scheduled toileting, a bed alarm, a room near the station, assistance with every transfer and a medication review.

TRAPS PEOPLE FALL INTO

- **Punishing every error.** Only reckless behavior is sanctioned. Slips get system fixes.
- **Skipping near miss reports.** Near misses show the same holes as harmful events, for free.
- **Asking "Are you Mr. Lee?"** A confused patient may say yes. Have the patient state name and date of birth.

Chapter 7 self-test · five items

1. Under a just culture, how is a nurse who skips a scan "because it is faster" handled?

A. Coached about the at risk behavior
B. Consoled for an honest human error
C. Punished for reckless disregard
D. Ignored because no harm occurred

A. Coached about the at risk behavior Shortcuts taken without recognizing risk are at risk behavior, which is coached.

2. A patient who takes apixaban fell and hit his head. What should the nurse add to routine post fall care?

A. Ice to the head and no further checks
B. Ambulate him to see if he is steady
C. Restraints to keep him in bed tonight
D. Neurologic checks and provider notification

D. Neurologic checks and provider notification A head strike on an anticoagulant needs neuro checks and prompt notification.

3. What does the A in PASS remind the nurse to do?

A. Aim at the top of the flames
B. Aim at the base of the fire
C. Alarm the whole unit first
D. Allow the fire to burn out

B. Aim at the base of the fire Pull, aim at the base, squeeze, sweep.

4. A seizure has lasted 6 minutes. What does this suggest?

A. A normal postictal phase for him
B. A simple absence seizure only
C. Status epilepticus, an emergency
D. A fainting spell, not a seizure

C. Status epilepticus, an emergency A seizure lasting 5 minutes or more is status epilepticus.

5. Which pair of identifiers is acceptable before a procedure?

A. Room and bed number
B. Name and room number
C. Name and date of birth
D. Diagnosis and bed number

C. Name and date of birth Use two person specific identifiers, never a location.

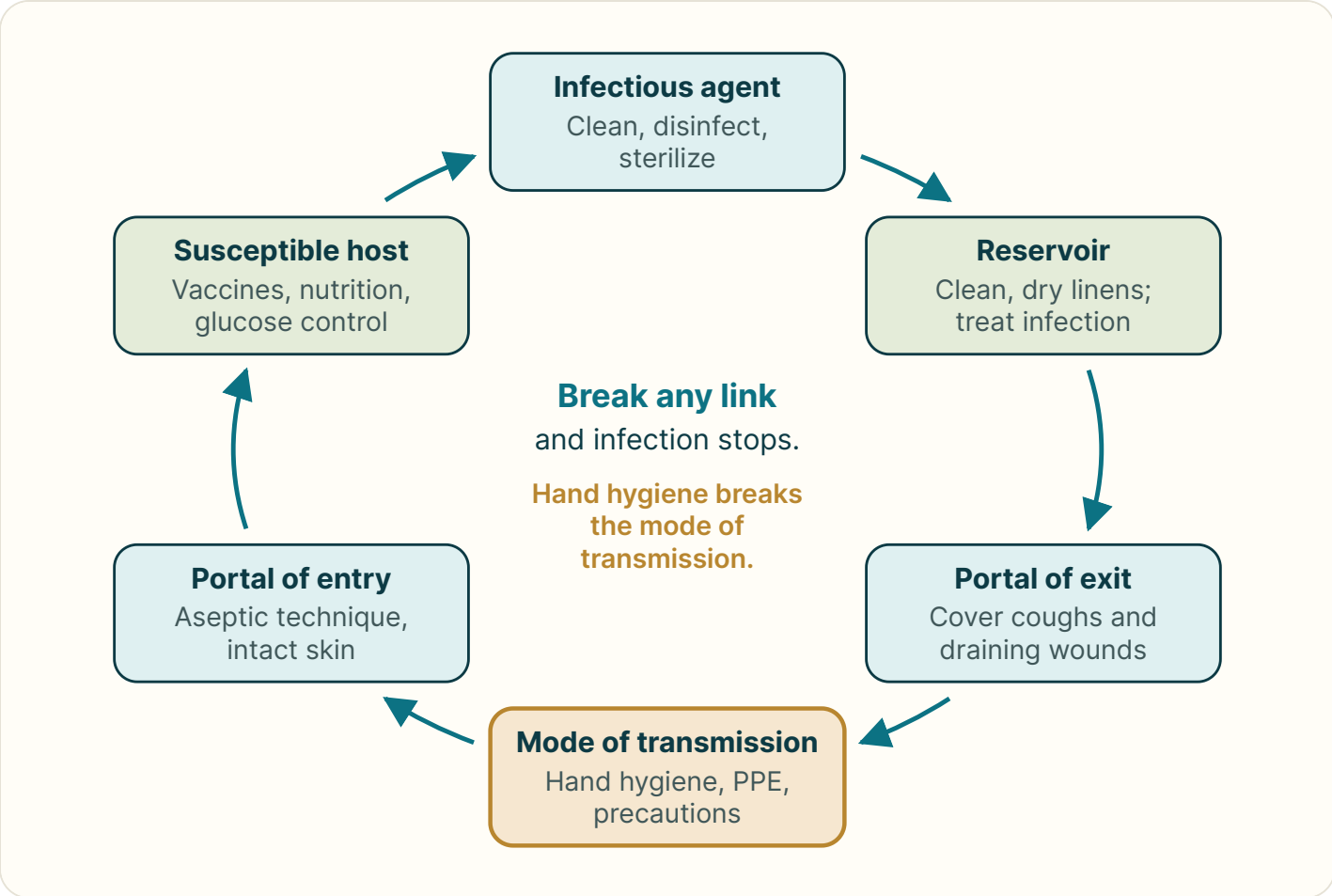
CHAPTER 8

Infection Prevention and Control

Read it in full: **Chapter 8 in the textbook**. Practice it in the lab: **PPE and Sterile Field Bench**.

What to know

Infection needs six links: agent, reservoir, portal of exit, mode of transmission, portal of entry and susceptible host. Hand hygiene is the single most effective measure, with soap and water for C. difficile. Standard precautions apply to everyone, and contact, droplet and airborne precautions are added by how the organism spreads. Device bundles prevent CAUTI, CLABSI and VAP. Sterile technique has firm rules, and when in doubt the item is contaminated.



Six links, one break. Each box shows a way to cut that link. Hand hygiene cuts the mode of transmission and is the single most effective measure.

LOCK THESE IN

- Six links: agent, reservoir, portal of exit, mode of transmission, portal of entry, susceptible host.
- Hand hygiene breaks the mode of transmission link and is the most effective single measure.
- Older adults: new confusion can be the fever. Cultures go before antibiotics.
- Every device: ask daily whether it is still needed. Bag below the bladder and off the floor.
- Alcohol rub unless visibly soiled or spores; C. difficile needs soap and water.
- PPE on: gown, mask, goggles, gloves. Off: gloves, goggles, gown, mask, hand hygiene.
- Airborne: negative pressure, door closed, N95 for staff, surgical mask for the patient in transport.

Priority rules: bundles, hand hygiene and exposures

Item	Rule
CAUTI	Indication only; closed system; bag below bladder, off floor; remove early
CLABSI	Maximal barriers; chlorhexidine; scrub the hub 5 to 15 s; transparent dressing every 7 days
SSI	Clip, do not shave; antibiotic within 60 min before incision; glucose control
VAP	Head of bed 30 to 45 degrees; sedation breaks; oral care

Worked case

CASE 8.1 · ISOLATION ON SUSPICION

Mr. Petrescu, 44, has a 6 week cough, night sweats, a 5 kg weight loss and blood in his sputum. He recently arrived from a country where tuberculosis is common.

STEP 1 · RECOGNIZE
The picture suggests pulmonary tuberculosis.

STEP 2 · START NOW
Airborne precautions begin on suspicion, not after sputum results.

STEP 3 · PLACE
Surgical mask on the patient, then the negative pressure room with the door closed.

STEP 4 · PROTECT STAFF
Everyone entering wears a fit tested N95 respirator.

RULE

The patient wears a surgical mask, not an N95, during transport.

TRAPS PEOPLE FALL INTO

- **Waiting for a fever in an older adult.** Confusion, falls or poor appetite may be the first sign.
- **Starting antibiotics before the culture.** Draw ordered cultures first when possible.
- **Using alcohol rub after C. difficile care.** Alcohol does not kill spores. Use soap and water with friction.

Chapter 8 self-test · five items

1. Covering a cough with a tissue breaks which link in the chain of infection?

A. Susceptible host
B. Reservoir
C. Portal of entry
D. Portal of exit

D. Portal of exit Respiratory secretions leave through the portal of exit.

2. Which precautions fit a patient with measles?

A. Droplet
B. Standard only
C. Airborne
D. Contact

C. Airborne Measles spreads by airborne nuclei and needs a negative pressure room and N95.

3. In what order should PPE be put on before entering an isolation room?

A. Gown, mask, goggles, gloves
B. Goggles, gloves, mask, gown
C. Gloves, gown, mask, goggles
D. Mask, gloves, gown, goggles

A. Gown, mask, goggles, gloves Gloves go on last so they cover the gown cuffs.

4. Which patient is at highest risk for a health care associated infection?

A. A teenager with a sprained ankle
B. An older adult with a urinary catheter
C. A young adult admitted for observation
D. A healthy adult visiting the clinic

B. An older adult with a urinary catheter Age and invasive devices increase risk.

5. Why are cultures drawn before the first antibiotic dose?

A. Cultures are needed to choose the IV site
B. Antibiotics can cause the culture to overgrow
C. The lab cannot process cultures after antibiotics
D. Antibiotics can make the culture falsely negative

D. Antibiotics can make the culture falsely negative Starting antibiotics first can hide the organism.

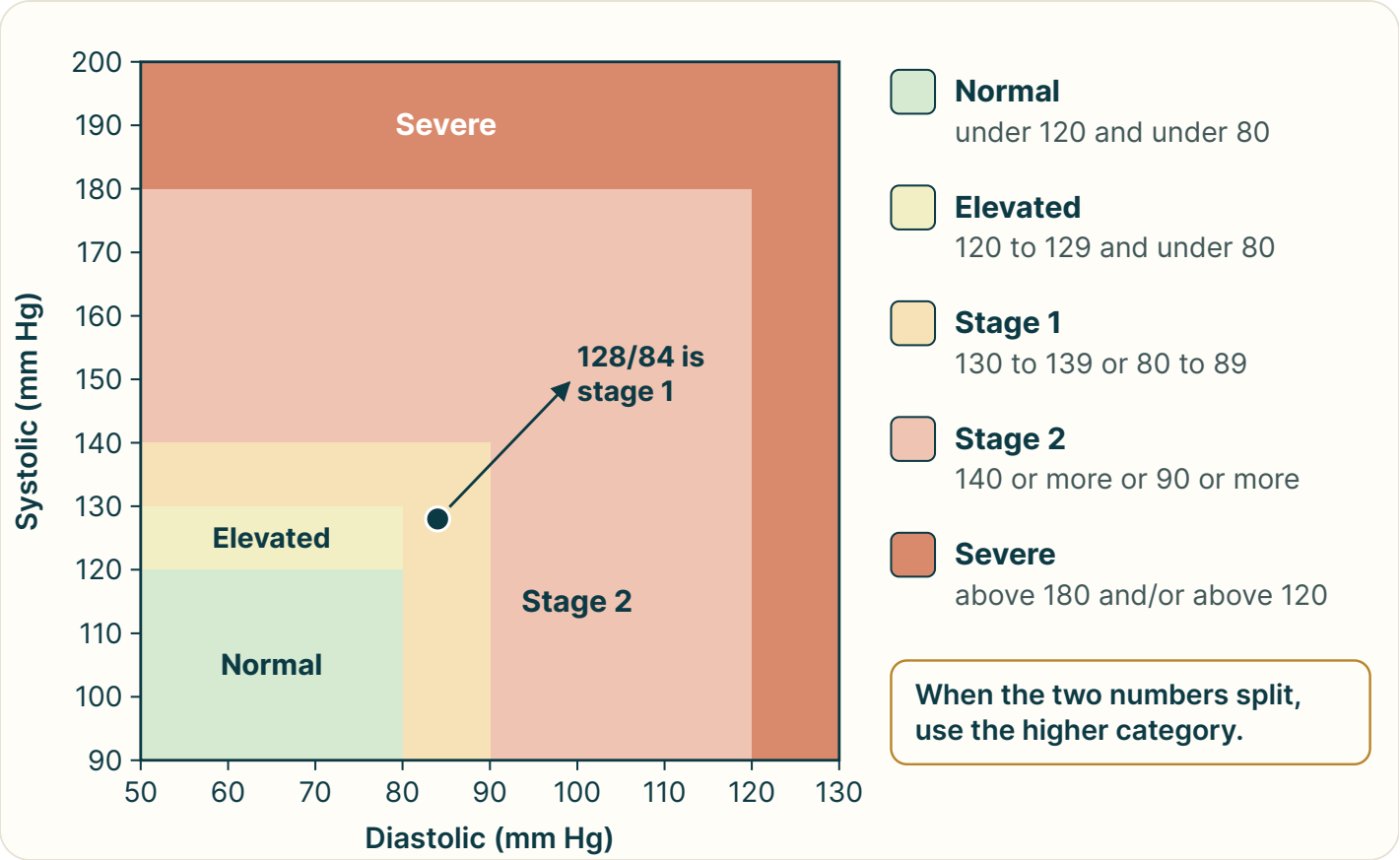
CHAPTER 9

Vital Signs

Read it in full: **Chapter 9 in the textbook**. Practice it in the lab: **Temperature and Oximetry Check**.

What to know

Vital signs are read as trends against the patient's baseline. Fever raises the set point; hyperthermia does not. Count an irregular pulse apically for a full minute and find the pulse deficit by counting apical and radial together. SpO2 shows oxygenation, not ventilation. MAP = (SBP + 2 DBP) / 3, with a target of at least 65. Cuff size and arm position change readings, and tachycardia and tachypnea come before hypotension.



Blood pressure categories, drawn to scale. The dot at 128/84 has a systolic in the elevated range but a diastolic in stage 1, so it is stage 1. Use the higher category.

LOCK THESE IN

- Fever raises the set point (antipyretics work); hyperthermia does not (cool actively).
- Rectal about 0.5 C higher, axillary about 0.5 C lower than oral. 38 C = 100.4 F.
- Irregular rhythm: full minute, apical. Pulse deficit = apical minus radial, counted together.
- SpO2 measures oxygenation, not ventilation. On oxygen, watch rate and sedation.
- MAP = (SBP + 2 DBP) / 3; target at least 65. Pulse pressure narrows in shock.
- Small cuff, big number. Arm below the heart also reads high.
- Orthostatic: drop of 20 systolic or 10 diastolic within 3 minutes of standing.

Priority rules: formulas and blood pressure errors

Item	Formula or effect
F from C	F = C x 9/5 + 32
C from F	C = (F minus 32) x 5/9
Pulse pressure	Systolic minus diastolic, about 40
MAP	(Systolic + 2 x diastolic) / 3; target at least 65

Worked case

CASE 9.1 · MAP, PULSE PRESSURE AND THE TREND

Over three checks after laparoscopic gallbladder surgery, Ms. Fiore, 46, goes from pulse 84, RR 16, BP 128/80 to pulse 116, RR 24, BP 112/86. She feels anxious.

STEP 1 · PULSE PRESSURE

First: 128 minus 80 = 48. Last: 112 minus 86 = **26**. It is narrowing.

STEP 2 · MAP NOW

(112 + 2 x 86) / 3 = (112 + 172) / 3 = **94.7**, still above 65.

STEP 3 · SHOCK INDEX

116 / 112 = **1.04**, above about 0.9.

STEP 4 · INTERPRET

Rising pulse and respirations, narrowing pulse pressure and anxiety form an early hypovolemia pattern, possibly bleeding, even though MAP looks fine.

STEP 5 · ACT

Assess the abdomen, incisions and level of consciousness, increase monitoring and call the surgeon now with SBAR.

RULE

Hypotension is late. Do not blame pain and wait for SBP under 90.

TRAPS PEOPLE FALL INTO

- **Treating hyperthermia with acetaminophen.** The set point is normal, so antipyretics fail. Cool actively.
- **Assuming a shivering patient is just cold.** Chills mean the temperature is still rising. Recheck in 30 minutes.
- **Counting an irregular pulse for 15 seconds.** Count a full minute, apically.

Chapter 9 self-test · five items

1. What is the MAP for a blood pressure of 120/84?

A. 84 mm Hg
B. 102 mm Hg
C. 96 mm Hg
D. 108 mm Hg

C. 96 mm Hg (120 + 2 x 84) / 3 = 288 / 3 = 96.

2. An oral temperature of 38.3 C is about how much in Fahrenheit?

A. 100.9 F
B. 99.5 F
C. 101.8 F
D. 102.5 F

A. 100.9 F 38.3 x 1.8 + 32 = 100.94, about 100.9 F.

3. Lying blood pressure is 128/80 and after 3 minutes standing it is 104/74. What does this show?

A. Stage 1 hypertension
B. Orthostatic hypotension
C. Isolated diastolic drop
D. Normal positional change

B. Orthostatic hypotension A systolic drop of 24 meets the 20 point criterion.

4. Counted together, the apical pulse is 96 and the radial pulse is 80. What is the pulse deficit?

A. 88
B. 8
C. 176
D. 16

D. 16 Apical minus radial: 96 minus 80 = 16.

5. Which change is usually the earliest sign that a patient is deteriorating?

A. A falling blood pressure
B. Cool and mottled extremities
C. A rising respiratory rate
D. A falling oxygen level

C. A rising respiratory rate Respiratory rate and heart rate rise before blood pressure falls.

CHAPTER 10

Health Assessment Foundations

Read it in full: **Chapter 10 in the textbook**. Practice it in the lab: **Cue Sorter and Interview Coach**.

What to know

Assessment gathers subjective data (what the patient reports) and objective data (what is observed or measured) with inspection, palpation, percussion and auscultation, in a changed order for the abdomen. Know normal and abnormal breath and heart sounds and the auscultation landmarks. The Glasgow Coma Scale runs from 3 to 15, and 8 or below means the airway needs protection. Compartment syndrome shows early as pain out of proportion. Braden lower is worse; Morse higher is worse.

Most body systems

1. Inspect → **2. Palpate** → **3. Percuss** → **4. Auscultate**

Inspection always comes first: sight, sound and smell.

The abdomen

1. Inspect → **2. Auscultate** → **3. Percuss** → **4. Palpate**

Listen before you touch: tapping and pressing can change bowel sounds.

Examine the painful area last, and watch the face while you palpate.
Light palpation (about 1 cm) comes before deep palpation (about 4 to 5 cm).

The abdomen changes the order. Everywhere else you palpate second and listen last. In the abdomen you listen second and touch last, saving the painful area for the very end.

LOCK THESE IN

- Subjective is reported; objective is observed or measured. Review of systems is subjective.
- Abdomen: inspect, auscultate, percuss, palpate. Everything else: inspect, palpate, percuss, auscultate.
- Diaphragm firm for high pitched; bell light for low pitched.
- Crackles do not clear with cough; rhonchi may. Stridor is an airway emergency.
- APE To Man; aortic is the only right sided landmark.
- Glasgow 3 to 15; 8 or below, protect the airway; drop of 2 is reportable.
- Compartment syndrome: pain out of proportion and paresthesia early; pulselessness late; limb at heart level.

Priority rules: scales and when to report at once

Scale or finding	Rule
Glasgow Coma Scale	3 to 15; 8 or below airway at risk; drop of 2 or more reported
Braden	6 to 23; lower is worse; 9 or below very high risk
Morse	Higher is worse; 45 or more commonly high risk
BMI	Under 18.5, 18.5 to 24.9, 25 to 29.9, 30 or more

Worked case

CASE 10.1 · SCORING THE GLASGOW COMA SCALE

After a fall, Mr. Ostrowski opens his eyes only to a painful stimulus, answers questions but is confused about where he is, and reaches toward the site of a painful stimulus.

STEP 1 · EYE OPENING

To pain: **2** of 4.

STEP 2 · VERBAL

Confused: **4** of 5.

STEP 3 · MOTOR

Localizes pain: **5** of 6.

STEP 4 · TOTAL

2 + 4 + 5 = **11** of 15.

USE

Compare with the next check. A fall of 2 or more points is reported at once, and 8 or below means the airway is at risk.

TRAPS PEOPLE FALL INTO

- **Palpating the abdomen before listening.** Touch can change bowel sounds. Listen before you percuss and palpate.
- **Pressing the bell firmly.** Pressure turns the bell into a diaphragm. Place it lightly.
- **Calling crackles rhonchi.** Rhonchi may clear with a cough; crackles do not.

Chapter 10 self-test · five items

1. When assessing the lungs, which technique follows inspection?

A. Palpation
B. Auscultation
C. Olfaction
D. Percussion

A. Palpation Except for the abdomen, the order is inspect, palpate, percuss, auscultate.

2. Fine crackles at the bases that do not clear with coughing suggest what?

A. Swelling of the upper airway
B. Narrowed lower airways in asthma
C. Fluid in the small airways or alveoli
D. Mucus in the large airways that moves

C. Fluid in the small airways or alveoli Crackles come from fluid in small airways and alveoli and do not clear with a cough.

3. Where is the mitral area heard?

A. Second intercostal space, left sternal border
B. Second intercostal space, right sternal border
C. Fourth intercostal space, left sternal border
D. Fifth intercostal space, midclavicular line

D. Fifth intercostal space, midclavicular line The mitral area is at the apex, 5th intercostal space, left midclavicular line.

4. A patient's Glasgow Coma Scale score is 7. What does this mean for the airway?

A. Only hourly checks are needed now
B. The airway may need protection
C. The score is in the normal range
D. The patient can be left to rest

B. The airway may need protection A score of 8 or below means the airway may need protection.

5. Which finding is a late sign of compartment syndrome?

A. Pain out of proportion
B. Tingling of the toes
C. Pain on passive stretch
D. Absent pulse in the limb

D. Absent pulse in the limb Pain and paresthesia are early; pulselessness is late.

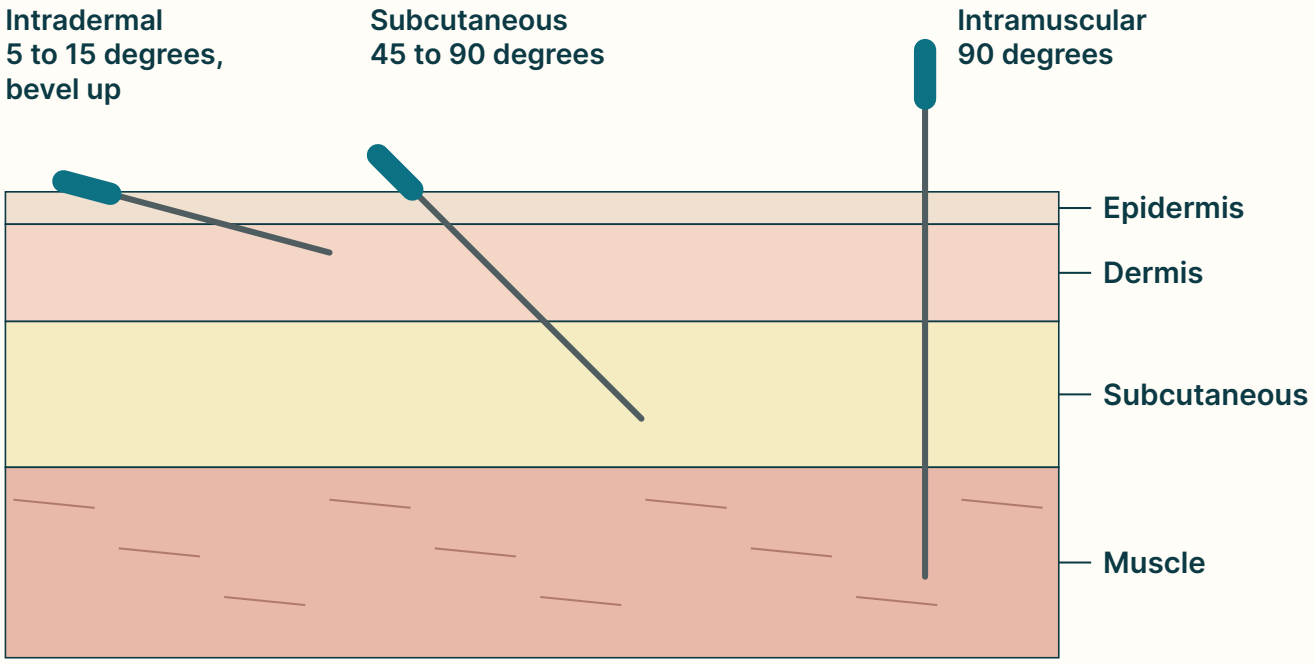
CHAPTER 11

Medication Administration

Read it in full: **Chapter 11 in the textbook**. Practice it in the lab: **Med Pass Safety Check**.

What to know

Safe medication practice combines pharmacology, checks and math. Protein binding, kidney and liver function change drug levels; troughs are drawn just before the dose. Clarify incomplete or unsafe orders, check three times against the MAR and assess before and after giving. High alert drugs get an independent double check, and potassium is never pushed. Injection angles, sites and dose calculations must be exact, and after an error the patient is assessed first.



Each needle ends in its target layer: a bleb in the dermis, the fat layer, or deep muscle. Ventrogluteal is preferred for most adult IM injections; deltoid takes up to about 1 mL.

Angle sets the depth. The flatter the angle, the shallower the dose: intradermal raises a bleb, subcutaneous reaches fat, and intramuscular goes straight down into muscle.

LOCK THESE IN

- Low albumin raises free drug; low eGFR lets drugs build up; liver disease slows metabolism.
- Trough just before the dose; peak at the expected high; four to five half lives to steady state.
- Clarify before giving: incomplete, out of range, allergy conflict or unsafe for current condition.
- Three checks against the MAR: removing, preparing, bedside. Assess before, evaluate after.
- Potassium never IV push. High alert drugs get an independent double check.
- ID 5 to 15 degrees; subcut 45 to 90; IM 90. Ventrogluteal for adults, vastus lateralis for infants.
- Clear before cloudy. Heparin: no aspiration, no massage.

Priority rules: conversions and formulas

Item	Rule
Mass	1 g = 1,000 mg; 1 mg = 1,000 mcg
Weight	1 kg = 2.2 lb; divide lb by 2.2
Household	1 tsp = 5 mL; 1 tbsp = 15 mL; 1 oz = 30 mL
Formula method	Desired / have x quantity

Worked case

CASE 11.1 · IV RATES BY PUMP AND BY GRAVITY

(A) Order: 1,000 mL normal saline over 6 hours on a pump. (B) Order: 500 mL over 4 hours by gravity with a drop factor of 20 gtt/mL.

STEP 1 · PUMP RATE

1,000 mL / 6 hr = 166.67, rounded to **166.7 mL/hr** (or as the pump allows).

STEP 2 · CONVERT TIME FOR GRAVITY

4 hr x 60 = 240 minutes.

STEP 3 · GRAVITY RATE

(500 mL x 20 gtt/mL) / 240 min = 10,000 / 240 = 41.67, rounded to **42 gtt/min**.

RULE

Round only at the end. With 60 gtt/mL microdrip tubing, gtt/min equals mL/hr.

TRAPS PEOPLE FALL INTO

- **Giving a scheduled drug because it is due.** Assess first. Hold and clarify if pulse or pressure makes it unsafe.
- **Asking "Are you Ms. Diaz?"** Have the patient state name and date of birth.
- **Crushing an extended release tablet for a tube.** It dumps the whole dose. Ask pharmacy for another form.

Chapter 11 self-test · five items

1. Amoxicillin 250 mg is ordered. The bottle reads 125 mg per 5 mL. How much is given?

A. 10 mL
B. 20 mL
C. 5 mL
D. 2.5 mL

A. 10 mL 250 / 125 x 5 mL = 10 mL.

2. 1,000 mL is to infuse over 8 hours by pump. What rate is set?

A. 150 mL/h
B. 100 mL/h
C. 125 mL/h
D. 80 mL/h

C. 125 mL/h 1,000 / 8 = 125 mL/h.

3. 100 mL is to infuse over 30 minutes with tubing of 15 gtt/mL. What is the drip rate?

A. 25 gtt/min
B. 33 gtt/min
C. 75 gtt/min
D. 50 gtt/min

D. 50 gtt/min 100 x 15 / 30 = 50 gtt/min.

4. Which needle angle is used for an intradermal skin test?

A. 90 degrees only
B. 5 to 15 degrees
C. 30 to 60 degrees
D. 45 to 90 degrees

B. 5 to 15 degrees Intradermal injections are nearly parallel to the skin.

5. Before giving an IV opioid, which assessment matters most?

A. Bowel sounds and last bowel movement
B. Urine output over the last shift
C. Respiratory rate and sedation level
D. Temperature and recent fluid intake

C. Respiratory rate and sedation level Opioids cause sedation and respiratory depression.

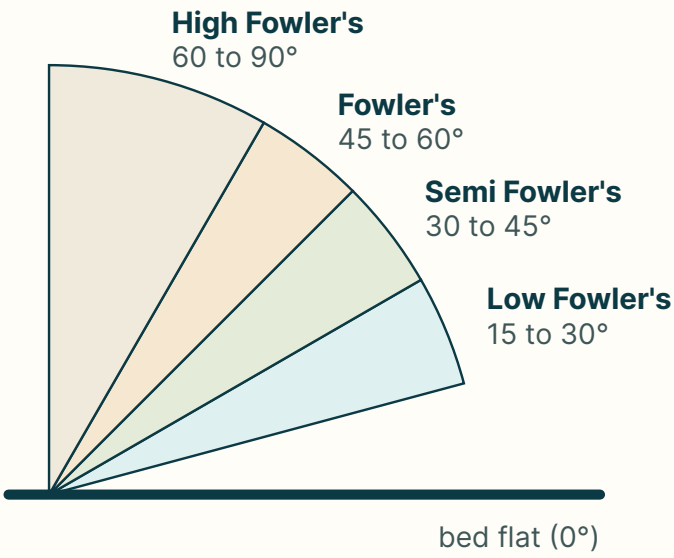
CHAPTER 12

Activity, Mobility and Body Mechanics

Read it in full: **Chapter 12 in the textbook**. Practice it in the lab: **Immobility and Skin Check**.

What to know

Safe patient handling relies on equipment rather than muscle above about 35 lb, with a wide base and no twisting. Transfers go toward the strong side with locked wheels and a gait belt. Positions have specific purposes, and range of motion stops at pain. Immobility harms every system, from pressure injuries to DVT and contractures. Assistive devices have set patterns: a cane opposite the weak leg, a walker then the weak leg, and on stairs up with the good, down with the bad.



Tube feeding
At least 30, commonly 30 to 45

Raised ICP
About 30, head midline

Ventilator (VAP bundle)
Head of bed 30 to 45

Severe dyspnea
Orthopneic (tripod)

Know the four Fowler's ranges. Many safety rules are an angle: at least 30 for tube feeding and the ventilator bundle, about 30 for raised intracranial pressure.

LOCK THESE IN

- Wide base, low center of gravity, load close, no twisting; slide instead of lift.
- About 35 lb is the manual limit; above that, use equipment.
- Chair on the strong side; lock wheels; dangle first; gait belt.
- Trendelenburg for central line insertion, not shock; legs up for hypotension per protocol.
- Active ROM builds strength; passive keeps motion only; stop at pain.
- Stage 2 dermis, 3 fat, 4 bone or muscle; base hidden = unstageable; maroon intact skin = deep tissue.
- Never massage red skin or a suspected DVT.

Priority rules: pressure injury stages and devices

Item	Rule
Stage 1	Intact, nonblanchable redness; check warmth and firmness in dark skin
Stage 2	Partial thickness, dermis or serum blister
Stage 3	Full thickness, fat visible
Stage 4	Fascia, muscle, tendon, cartilage or bone

Worked case

CASE 12.1 · CRUTCHES AND STAIRS

Mr. Lund, 23, has a right tibia fracture and is non weight bearing on the right. He rests by leaning on the crutch pads and plans to go upstairs "leading with the crutches."

STEP 1 · FIX THE FIT

Pads two to three finger widths below the axillae, weight on the hands, elbows flexed 20 to 30 degrees.

STEP 2 · CHOOSE THE GAIT

Non weight bearing on one leg calls for the three point gait.

STEP 3 · GOING UP

Left (good) leg up first, then the crutches and right leg.

STEP 4 · GOING DOWN

Crutches and right (bad) leg down first, then the left leg.

RULE

Confirm with a return demonstration on stairs before discharge.

TRAPS PEOPLE FALL INTO

- **Thinking good technique makes lifting safe.** Use equipment above about 35 lb of patient weight.
- **Placing the chair on the weak side.** The strong leg leads the pivot, so the chair goes on the strong side.
- **Using Trendelenburg for shock.** It impairs breathing and raises ICP. Raise the legs with the trunk flat per protocol.

Chapter 12 self-test · five items

1. When should lift equipment be used instead of a manual lift?

A. For any patient load above about 35 lb

B. Only for patients who weigh over 300 lb

C. Only for loads above about 100 lb

D. Only when two nurses are not free

A. For any patient load above about 35 lb About 35 lb is the commonly cited limit for manual lifting.

2. A patient with left leg weakness uses a walker. Which sequence is correct?

A. Left leg, then walker, then right leg
B. Right leg, then left leg, then walker
C. Walker, then left leg, then right leg
D. Walker, then right leg, then left leg

C. Walker, then left leg, then right leg Advance the walker, then the weak leg, then the strong leg.

3. A patient on crutches is going up stairs. What moves first?

A. Both crutches and the weak leg
B. The strong leg
C. The weak leg
D. The crutches

B. The strong leg Up with the good, down with the bad.

4. Which position eases breathing for a patient with dyspnea?

A. Flat supine with legs raised
B. Trendelenburg with head down
C. Prone with arms at the sides
D. High Fowler's, leaning forward

D. High Fowler's, leaning forward Upright positions lower the diaphragm and ease breathing.

5. A patient on bed rest has a swollen, warm right calf. Which complication is suspected?

A. Orthostatic hypotension
B. Contracture of the knee
C. Disuse muscle atrophy
D. Deep vein thrombosis

D. Deep vein thrombosis One sided calf swelling and warmth suggest DVT. Do not massage it.

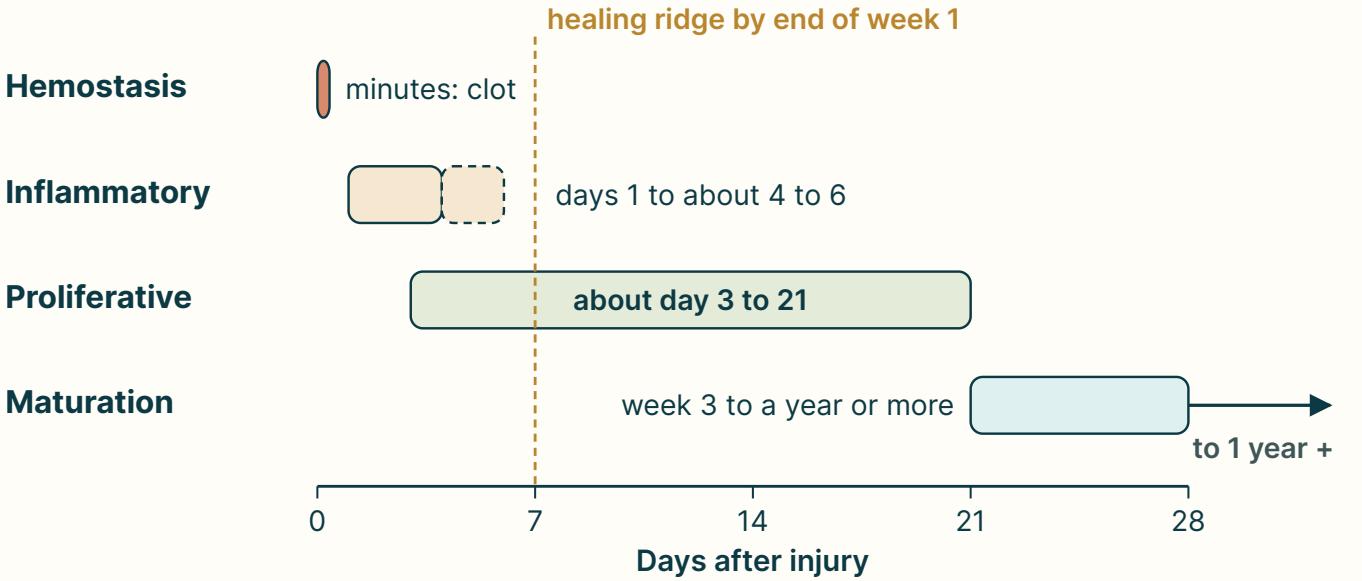
CHAPTER 13

Hygiene, Skin Integrity and Wound Care

Read it in full: **Chapter 13 in the textbook**. Practice it in the lab: **Pressure Injury Stager**.

What to know

Hygiene goes from clean to dirty and doubles as a full skin check. The Braden scale (6 to 23) predicts pressure injury, and lower is worse. Pressure injuries are staged by the deepest tissue seen and never reverse staged. Wounds heal by first, second or third intention; infection appears about days 3 to 5 and dehiscence about days 5 to 8. Describe drainage accurately, irrigate at safe pressure, empty drains when half full and apply heat or cold for 15 to 20 minutes.



A mature scar reaches only about 80% of the original strength.

Wound healing phases overlap. Mild redness in the first days is expected inflammation. A healing ridge should be felt by the end of week 1, and the scar never regains full strength.

LOCK THESE IN

- Clean to dirty; eyes inner to outer; female front to back; return the foreskin.
- Diabetic feet: inspect daily, dry between toes, no soaking, no lotion between toes.
- Braden 6 to 23; lower is worse; 10 to 12 high, 9 or below very high.
- Stage 1 skin intact, 2 shallow dermis, 3 fat, 4 structures; hidden base unstageable; maroon intact is DTPI.
- Never reverse stage, never massage red skin, no donut cushions.
- Infection about days 3 to 5; dehiscence about days 5 to 8.
- Evisceration: stay, sterile saline moistened cover, low Fowler's with knees bent, NPO.

Priority rules: healing timeline and emergencies

Item	Rule
Hemorrhage	First 24 to 48 h; check under the patient
Infection	About days 3 to 5; culture after cleansing, before antibiotics
Dehiscence	About days 5 to 8; splint when coughing
Evisceration	Sterile saline moist cover, low Fowler's, knees bent, NPO, stay

Worked case

CASE 13.1 · EVISCERATION ON DAY 6

Mr. Ortega, 59, BMI 41, with diabetes, is on day 6 after an open colectomy. While coughing he says, "Something popped," and loops of bowel are visible.

STEP 1 · RECOGNIZE

Day 6, obesity, diabetes and coughing are risks for dehiscence; visible bowel is evisceration.

STEP 2 · STAY AND CALL

Stay with him and have someone else notify the surgeon.

STEP 3 · COVER

Sterile towels or dressings moistened with sterile saline over the bowel. Do not push it back. No dry gauze.

STEP 4 · POSITION AND PREPARE

Low Fowler's with knees bent, NPO, watch for shock.

PREVENTION

Splint with a pillow when coughing and control blood glucose after surgery.

TRAPS PEOPLE FALL INTO

- **Soaking diabetic feet.** Soaking macerates skin. Wash, dry well, inspect.
- **Massaging a reddened sacrum.** Massage injures fragile deep tissue.
- **Calling a maroon intact area stage 1.** That is a deep tissue pressure injury.

Chapter 13 self-test · five items

1. A Braden score of 9 places the patient at what risk?

A. Very high risk
B. Moderate risk
C. High risk
D. Mild risk

A. Very high risk A score of 9 or below is very high risk.

2. Which wound must be called unstageable?

A. A shallow, pink, open base
B. A base covered by eschar
C. A deep base with bone exposed
D. Red skin that does not blanch

B. A base covered by eschar When slough or eschar hides the base, the injury is unstageable.

3. Which solution and pressure are correct for wound irrigation?

A. Normal saline at 30 to 40 psi
B. Hydrogen peroxide at 4 to 15 psi
C. Povidone iodine at 20 to 25 psi
D. Normal saline at 4 to 15 psi

D. Normal saline at 4 to 15 psi Saline at 4 to 15 psi cleans without harming new tissue.

4. How long is a warm or cold pack usually applied?

A. 45 to 60 minutes
B. 5 to 10 minutes
C. 15 to 20 minutes
D. 60 to 90 minutes

C. 15 to 20 minutes Longer application causes rebound effects and tissue injury.

5. Which drainage suggests infection?

A. Thick, yellow and foul smelling
B. Bright red and flowing freely
C. Thin, pale pink and watery
D. Clear yellow and odorless

A. Thick, yellow and foul smelling Purulent drainage is thick and may smell.

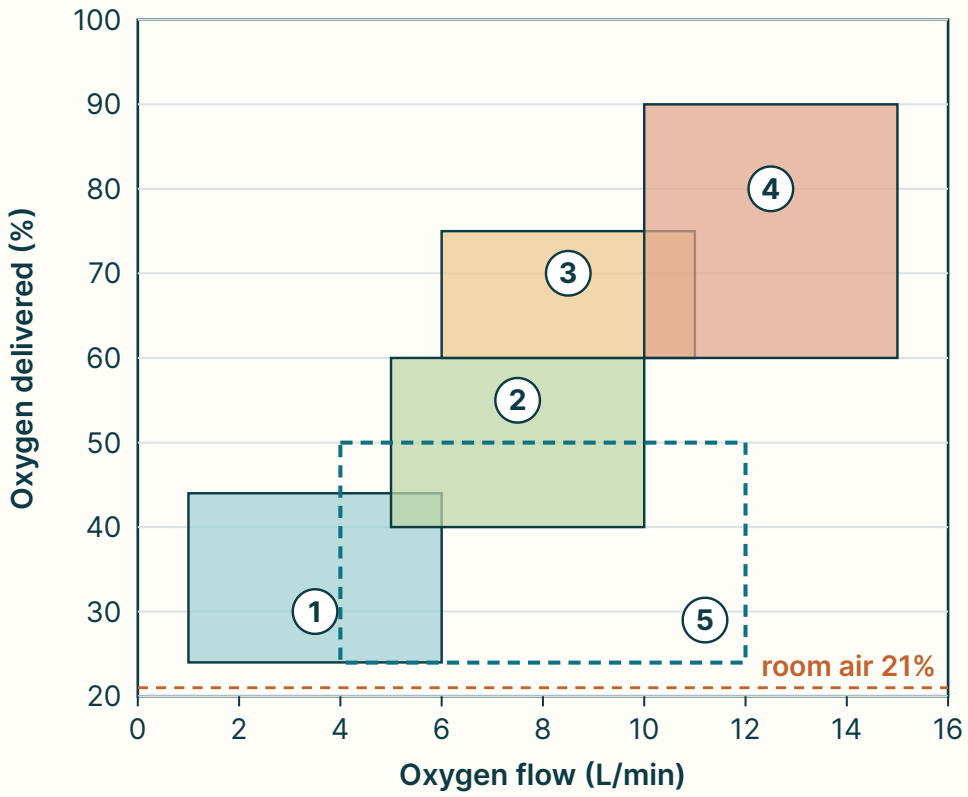
CHAPTER 14

Oxygenation

Read it in full: **Chapter 14 in the textbook**. Practice it in the lab: **Airway Bench**.

What to know

Early hypoxia shows as behavior (restlessness, confusion) with tachycardia and tachypnea; cyanosis is late. Normal SpO2 is 95 to 100%, often 88 to 92% for chronic CO2 retainers. Match the oxygen device to the need, from a 1 to 6 L cannula to a non-rebreather at 10 to 15 L or a precise Venturi mask. Suction in short passes with suction applied only on withdrawal, keep tracheostomy spares at the bedside and know chest tube rules.



1. **Nasal cannula**
   1 to 6 L/min, 24 to 44%
2. **Simple mask**
   5 to 10 L/min, 40 to 60%
3. **Partial rebreather**
   6 to 11 L/min, 60 to 75%
4. **Non-rebreather**
   10 to 15 L/min, 60 to 90%
5. **Venturi (dashed)**
   4 to 12 L/min, 24 to 50%

Cannula adds about 4% per liter. Simple mask needs at least 5 L/min.

Each device has a flow range and an oxygen range. Read across for flow and up for percent. The Venturi is the choice when a precise, low concentration matters.

LOCK THESE IN

- Early hypoxia is behavior: restlessness, confusion, tachycardia, tachypnea. Cyanosis is late.
- SpO2 95 to 100%; target often 88 to 92% in CO2 retainers; CO poisoning reads falsely high.
- ABG: pH 7.35 to 7.45, PaCO2 35 to 45, HCO3 22 to 26, PaO2 80 to 100.
- Incentive spirometer: inhale slowly, hold 3 to 5 seconds, 10 times an hour.
- Suction: preoxygenate, none on insertion, intermittent on withdrawal, 10 to 15 seconds.
- Cannula 1 to 6 L; simple mask at least 5 L; non-rebreather 10 to 15 L with bag inflated; Venturi precise.
- Obturator and spare tubes at every tracheostomy bedside.

Priority rules: airway skills, chest tubes and BLS

Item	Rule
Suction pressure (adult)	About 100 to 150 mm Hg
Suction pass	No more than 10 to 15 s; 2 or 3 passes
Trach cuff pressure	About 20 to 25 mm Hg
Trach ties	One finger fits under; second person holds the tube

Worked case

CASE 14.1 · RESTLESS AFTER SURGERY

Mrs. Pham, 72, on the first night after a hip replacement, is suddenly pulling at her gown and trying to get up. Pulse 118, RR 26, SpO2 87% on room air, fine crackles at both bases.

STEP 1 · RECOGNIZE

Acute restlessness with tachycardia, tachypnea and low saturation.

STEP 2 · ANALYZE

This is hypoxia until proven otherwise, possibly atelectasis, fluid overload or a pulmonary embolism.

STEP 3 · ACT

Stay, raise the head of the bed, apply oxygen per protocol, reassess SpO2 and breath sounds, call the rapid response team or provider.

RULE

Restraints or a sedative for "delirium" treat the symptom and can worsen hypoventilation.

TRAPS PEOPLE FALL INTO

- **Sedating a newly restless patient.** Restlessness may be hypoxia. Check airway, breathing and SpO2 first.
- **Trusting a normal SpO2 after smoke or a generator in the garage.** Carbon monoxide reads as saturated. Give 100% oxygen by non-rebreather.
- **Blowing into an incentive spirometer.** The patient inhales slowly and deeply.

Chapter 14 self-test · five items

1. A patient with chronic CO2 retention is on oxygen. Which SpO2 target is often ordered?

A. 88 to 92%
B. 98 to 100%
C. 80 to 85%
D. 95 to 100%

A. 88 to 92% A lower target avoids worsening CO2 retention.

2. Which device can deliver the highest oxygen concentration?

A. Venturi mask at 28%
B. Nasal cannula at 4 L
C. Simple face mask at 6 L
D. Non-rebreather mask

D. Non-rebreather mask A non-rebreather at 10 to 15 L with the bag inflated gives the highest concentration.

3. Interpret this gas: pH 7.30, PaCO2 52, HCO3 24.

A. Metabolic alkalosis
B. Metabolic acidosis
C. Respiratory acidosis
D. Respiratory alkalosis

C. Respiratory acidosis Low pH with high PaCO2 and normal HCO3 is respiratory acidosis.

4. How long should a single suction pass last?

A. 20 to 30 seconds
B. 10 to 15 seconds
C. 45 to 60 seconds
D. Up to 1 minute

B. 10 to 15 seconds Short passes limit hypoxia.

5. A patient is becoming hypoxic. Which finding usually appears last?

A. Tachycardia
B. Restlessness
C. Tachypnea
D. Cyanosis

D. Cyanosis Behavior changes, tachycardia and tachypnea come early; cyanosis is late.

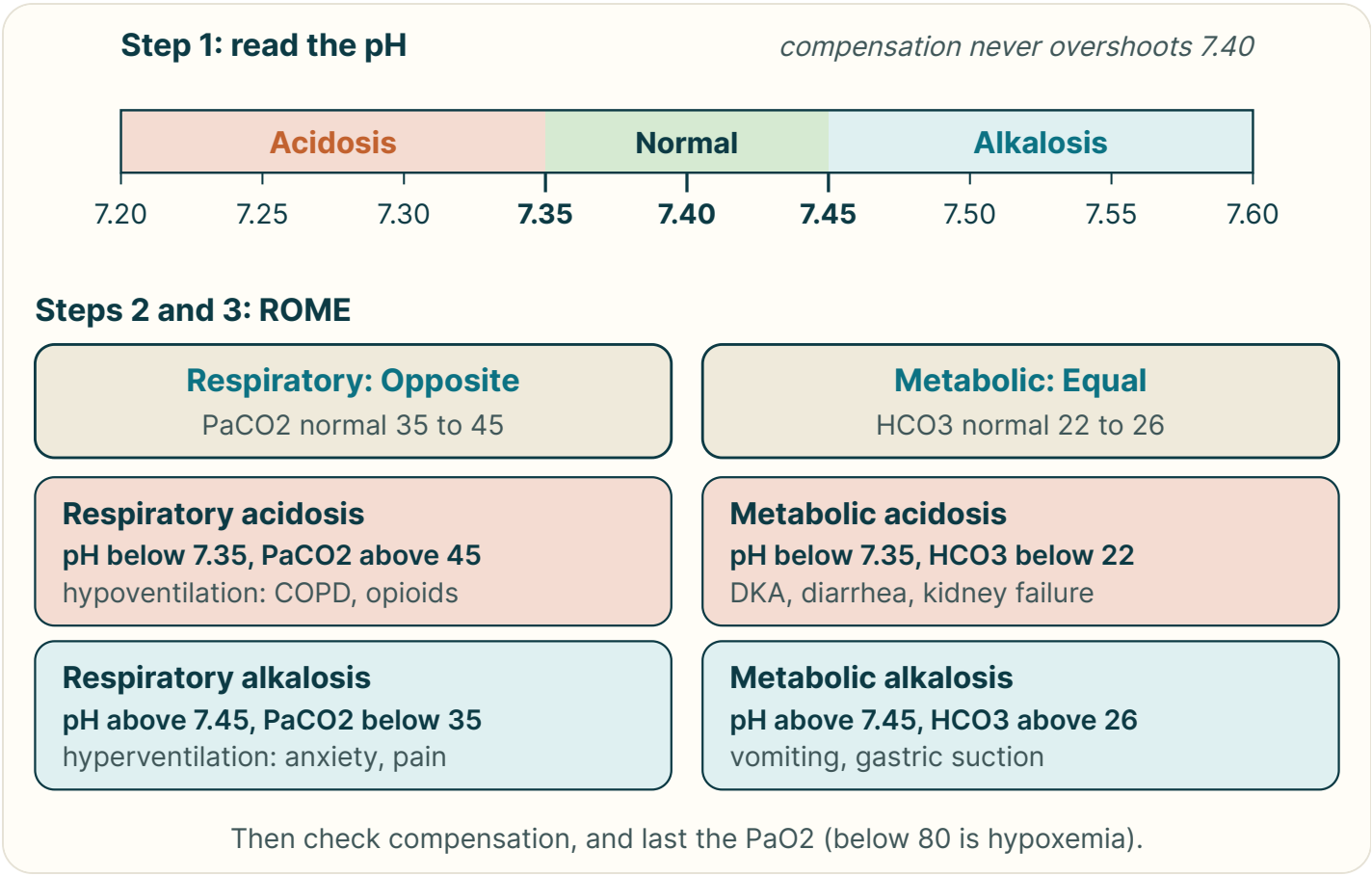
CHAPTER 15

Fluid, Electrolyte and Acid Base Balance

Read it in full: **Chapter 15 in the textbook**. Practice it in the lab: **Electrolytes and IV Fluids**.

What to know

Body water is two thirds intracellular. Intake and output, daily weights (1 kg is about 1 L) and labs reveal deficit (concentrated values) or excess (diluted values). Sodium affects the brain and potassium the heart; potassium is never given IV push. Read blood gases with ROME: respiratory opposite, metabolic equal. IV solutions are isotonic, hypotonic or hypertonic, and blood is given with saline only, with close watching in the first 15 minutes.



pH first, then ROME. In respiratory problems pH and PaCO2 move in opposite directions; in metabolic problems pH and HCO3 move the same way.

LOCK THESE IN

- Two thirds ICF, one third ECF; plasma is the smallest compartment.
- Ice chips count as half; report urine below about 30 mL/h.
- Daily weight: 1 kg is about 1 L; same time, scale and clothing.
- Deficit concentrates (high Hct, BUN); excess dilutes (low Hct, BUN).
- Na 135 to 145 (brain); K 3.5 to 5.0 (heart); Ca about 9 to 10.5; Mg about 1.5 to 2.5.
- Potassium never IV push. Peaked T in high K; U wave in low K.
- ROME: respiratory opposite, metabolic equal; compensation never overshoots.

Priority rules: acid base patterns and IV fluids

Pattern or fluid	Rule
Respiratory acidosis	pH below 7.35, PaCO2 above 45: hypoventilation
Respiratory alkalosis	pH above 7.45, PaCO2 below 35: hyperventilation
Metabolic acidosis	pH below 7.35, HCO3 below 22: DKA, diarrhea, kidney failure
Metabolic alkalosis	pH above 7.45, HCO3 above 26: vomiting, suction

Worked case

CASE 15.1 · READING THREE BLOOD GASES

Interpret: (A) pH 7.30, PaCO2 55, HCO3 24. (B) pH 7.48, PaCO2 40, HCO3 33. (C) pH 7.36, PaCO2 30, HCO3 17.

STEP 1 · GAS A

pH low is acidosis. PaCO2 high moves opposite: respiratory. HCO3 normal: **uncompensated respiratory acidosis** (think opioid oversedation).

STEP 2 · GAS B

pH high is alkalosis. PaCO2 normal. HCO3 high moves the same way: metabolic. PaCO2 normal: **uncompensated metabolic alkalosis** (think vomiting or suction).

STEP 3 · GAS C

pH normal but on the acid side of 7.40. HCO3 low explains acidosis: metabolic. PaCO2 low is the lungs compensating, and pH is normal: **fully compensated metabolic acidosis**.

RULE

When both values are abnormal and pH is normal, the side of 7.40 names the primary problem.

TRAPS PEOPLE FALL INTO

- **Counting ice chips at full volume.** Ice chips count as about half.
- **Relying on skin turgor in an older adult.** Turgor is unreliable with age. Use weight, orthostatics, urine and labs.
- **Weighing on different scales at different times.** Same scale, same time, same clothing.

Chapter 15 self-test · five items

1. Which lab result fits a fluid volume deficit?

A. A low urine specific gravity
B. A lowered BUN level
C. A raised hematocrit
D. A lowered hematocrit

C. A raised hematocrit A deficit concentrates the blood and urine.

2. A patient's weight drops 2 kg in one day. About how much fluid was lost?

A. About 500 mL
B. About 1 L
C. About 4 L
D. About 2 L

D. About 2 L 1 kg is about 1 L of fluid.

3. Which ECG change goes with hypokalemia?

A. A short QT
B. An extra U wave
C. Peaked T waves
D. ST elevation

B. An extra U wave Low potassium produces U waves; high potassium produces peaked T waves.

4. Interpret this gas: pH 7.48, PaCO2 30, HCO3 23.

A. Respiratory alkalosis
B. Respiratory acidosis
C. Metabolic alkalosis
D. Metabolic acidosis

A. Respiratory alkalosis High pH with low PaCO2 and normal HCO3 is respiratory alkalosis.

5. Ten minutes into a transfusion, the patient reports back pain and chills. What should the nurse do first?

A. Give acetaminophen
B. Call the blood bank
C. Slow the transfusion
D. Stop the transfusion

D. Stop the transfusion Stop at the first sign of a reaction, keep the line open with saline, then notify.

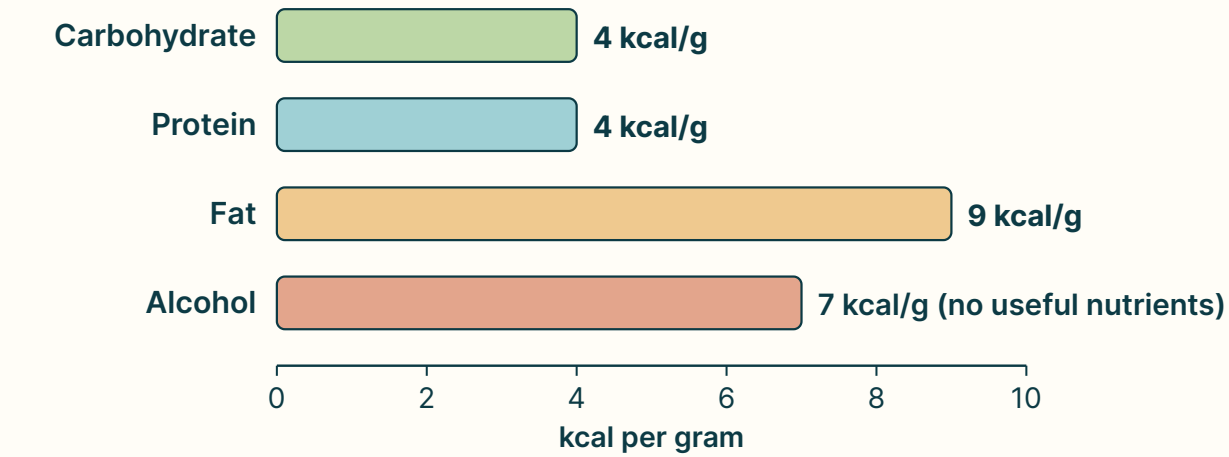
CHAPTER 16

Nutrition

Read it in full: **Chapter 16 in the textbook**. Practice it in the lab: **Safe Swallow Mealtime Rounds**.

What to know

Carbohydrate and protein give 4 kcal per gram, fat 9 and alcohol 7. Protein needs rise from 0.8 g/kg to 1.2 to 2.0 g/kg with wounds and illness, and fluid needs are about 30 to 35 mL/kg. Unintentional weight loss and poor intake are better warning signs than albumin. Screen swallowing before anything by mouth after a stroke, confirm a blind feeding tube by X ray, keep the head of the bed at 30 to 45 degrees and watch for refeeding syndrome.



Worked example: 30 g carbohydrate, 10 g protein and 8 g fat
= (30 × 4) + (10 × 4) + (8 × 9) = 120 + 40 + 72 = 232 kcal

Four, four, nine. Multiply grams by 4 for carbohydrate and protein and by 9 for fat, then add. Vitamins and minerals add no calories.

LOCK THESE IN

- 4, 4, 9, 7 kcal per gram: carbohydrate, protein, fat, alcohol.
- Protein 0.8 g/kg, rising to 1.2 to 2.0 g/kg with wounds and illness; fluid 30 to 35 mL/kg.
- A, D, E, K are fat soluble. On warfarin keep vitamin K steady.
- No honey or cow's milk before 12 months; folic acid 400 mcg before pregnancy.
- Unintentional weight loss and poor intake beat albumin as warning signs.
- Swallow screen before anything by mouth after stroke; chin tuck, no straws, upright.
- X ray before first use of a blind tube; whoosh test is unreliable; HOB 30 to 45 degrees.

Priority rules: energy math and feeding safety

Item	Rule
Energy	kcal = (carb g x 4) + (protein g x 4) + (fat g x 9)
Weight loss	% = (usual minus current) / usual x 100; over 5% in 1 month is significant
BMI	kg / m2; 18.5 to 24.9 healthy
Placement	X ray first; then external mark and pH 5 or below

Worked case

CASE 16.1 · ENERGY FROM A SNACK

A snack has 12 g fat, 30 g carbohydrate and 8 g protein. How many kcal does it supply?

STEP 1 · FAT

12 g x 9 = 108 kcal.

STEP 2 · CARBOHYDRATE

30 g x 4 = 120 kcal.

STEP 3 · PROTEIN

8 g x 4 = 32 kcal.

STEP 4 · TOTAL

108 + 120 + 32 = **260 kcal**.

NOTE

Fat supplies almost as much energy as the carbohydrate here despite weighing less than half as much.

TRAPS PEOPLE FALL INTO

- **Telling a patient on warfarin to avoid greens.** The rule is consistent vitamin K intake, not avoidance.
- **Giving cow's milk or honey to an infant.** Both wait until 12 months.
- **Assuming food practices from religion or ethnicity.** Ask each patient.

Chapter 16 self-test · five items

1. A meal has 15 g fat, 30 g carbohydrate and 20 g protein. How many kcal does it provide?

A. 335 kcal

B. 455 kcal

C. 260 kcal

D. 385 kcal

A. 335 kcal 15 x 9 + 30 x 4 + 20 x 4 = 135 + 120 + 80 = 335.

2. A 70 kg patient with a wound needs 1.5 g/kg of protein. How much is that per day?

A. 56 g
B. 105 g
C. 70 g
D. 140 g

B. 105 g 70 x 1.5 = 105 g.

3. Which vitamin is fat soluble?

A. Thiamine
B. Vitamin C
C. Vitamin D
D. Vitamin B12

C. Vitamin D A, D, E and K are fat soluble.

4. During a continuous tube feeding, the patient must be placed flat for an X ray. What should the nurse do?

A. Keep it running and lower the bed flat
B. Increase the rate to finish it sooner
C. Flush the tube and leave it running
D. Pause the feeding before lowering the bed

D. Pause the feeding before lowering the bed Lying flat with feeding running risks aspiration.

5. Which lab change is a hallmark of refeeding syndrome?

A. A rising phosphate level
B. A falling glucose level
C. A falling phosphate level
D. A rising albumin level

C. A falling phosphate level Refeeding shifts phosphate into cells, causing low phosphate.

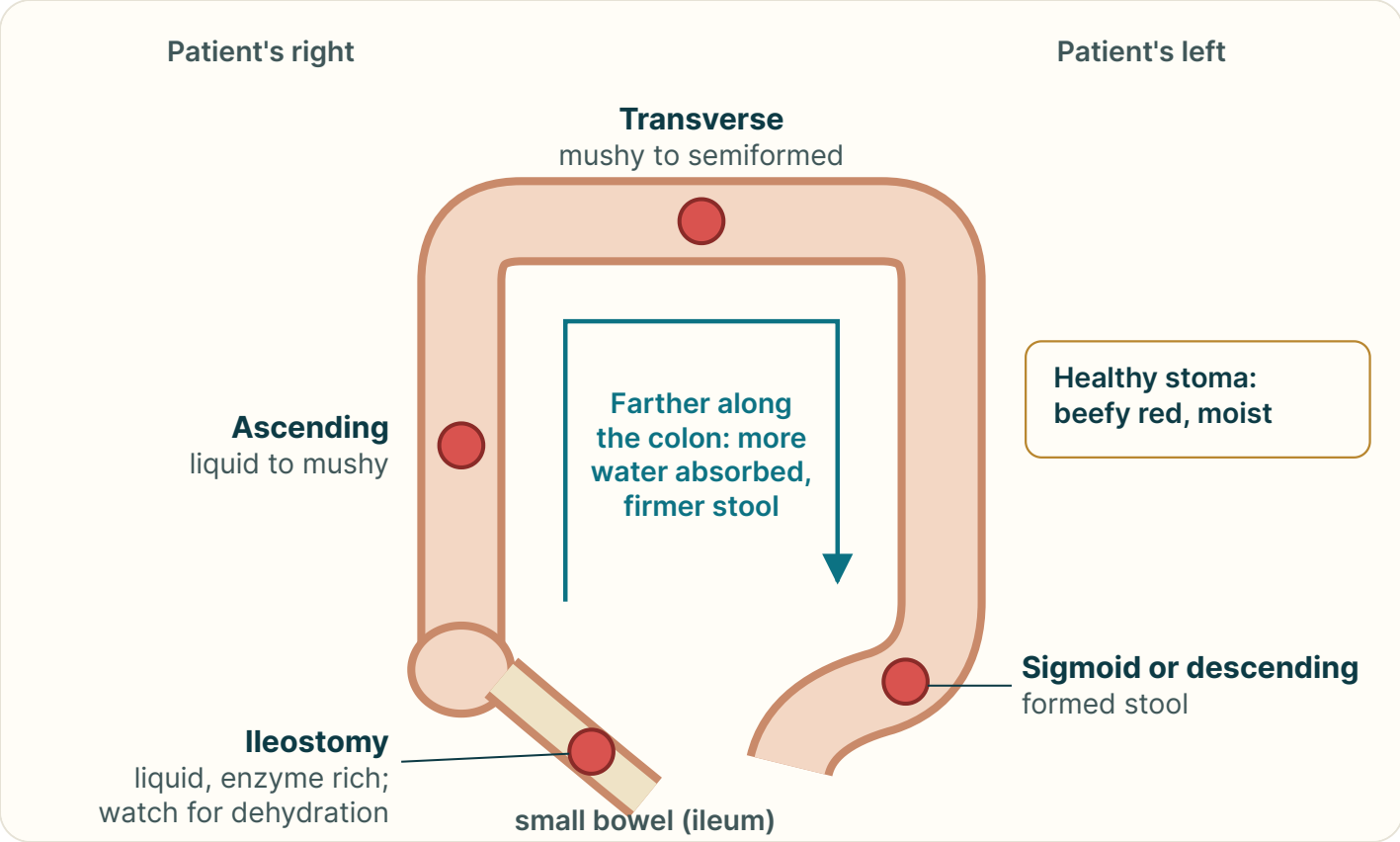
CHAPTER 17

Urinary and Bowel Elimination

Read it in full: **Chapter 17 in the textbook**. Practice it in the lab: **Catheter Rounds: Stop CAUTI**.

What to know

Report adult urine output under 30 mL/h, but check the catheter first. Scan the bladder before catheterizing, match teaching to the incontinence type and suspect a UTI when an older adult turns confused. Inflate a catheter balloon only after urine flows and remove catheters early. Give a bowel regimen with every opioid, recognize impaction behind liquid stool, give enemas in left Sims and watch stomas closely: moist red is healthy, dusky is an emergency.



The farther along the colon, the firmer the output. An ileostomy drains liquid, enzyme rich effluent and risks dehydration; a sigmoid colostomy passes formed stool.

LOCK THESE IN

- Report adult urine under 30 mL/h for 2 hours; check the catheter first.
- Scan before you catheterize; residual over about 300 to 400 mL often means intermittent catheterization.
- Stress: Kegels. Urge: bladder training. Overflow: catheterize. Functional: prompted toileting.
- Older adult with a UTI may show only confusion or falls.
- Inflate the balloon only after urine flows; remove catheters early; specimen from the port.
- Bowel regimen with every opioid; liquid oozing without formed stool means impaction.
- Enema: left Sims, bag 30 to 45 cm, tip 7.5 to 10 cm, warm solution.

Priority rules: catheters, enemas and ostomies

Item	Rule
Catheter insertion depth	Female about 5 to 7 cm, then 2.5 to 5 cm more; male about 17 to 22 cm to the bifurcation
Balloon	Inflate after urine flows; stop if painful
CAUTI	Closed, secured, below bladder, off floor; remove early
24 hour urine	Discard first void; keep all after; include final void

Worked case

CASE 17.1 · IMPACTION THAT LOOKS LIKE DIARRHEA

Mr. Ferraro, 88, with dementia, has been on oxycodone after a hip fracture. He passes small amounts of liquid stool every few hours, his abdomen is distended, he is eating less and more agitated, and his last formed stool was 5 days ago.

STEP 1 · RECOGNIZE

Opioids, immobility and no formed stool for 5 days with liquid seepage point to fecal impaction.

STEP 2 · ASSESS

Examine the abdomen and check for urinary retention.

STEP 3 · REPORT AND TREAT

Expect an oil retention enema then a cleansing enema, or digital removal, plus a scheduled bowel regimen.

RULE

An antidiarrheal would worsen the impaction. Watch the pulse during digital removal.

TRAPS PEOPLE FALL INTO

- **Giving fluid for low output in a full bladder.** Check for retention first with a scanner.
- **Restricting fluids for incontinence.** Concentrated urine irritates the bladder and promotes infection.
- **Inflating the balloon before urine flows.** The balloon may be in the urethra.

Chapter 17 self-test · five items

1. A bladder scan shows 450 mL after the patient voids. What is likely ordered?

A. Pelvic floor exercises
B. Fluid restriction overnight
C. Intermittent catheterization
D. Prompted voiding schedule

C. Intermittent catheterization A residual over about 300 to 400 mL often calls for intermittent catheterization.

2. A patient with severe arthritis cannot reach the toilet in time. Which type of incontinence is this?

A. Stress incontinence
B. Reflex incontinence
C. Overflow incontinence
D. Functional incontinence

D. Functional incontinence The bladder works, but mobility or access keeps the patient from the toilet.

3. How far is an enema tube inserted in an adult?

A. 25 to 30 cm
B. 7.5 to 10 cm
C. 15 to 20 cm
D. 2.5 to 5 cm

B. 7.5 to 10 cm 7.5 to 10 cm reaches past the internal sphincter safely.

4. What does a healthy stoma look like?

A. Moist, pink to red
B. Dry and pale white
C. Dark purple and dry
D. Black and firm

A. Moist, pink to red A healthy stoma is moist and red; dusky or black is an emergency.

5. Where should a urine culture be taken from a patient with an indwelling catheter?

A. The bag spout into a clean cup
B. The sampling port, cleaned first
C. The drainage bag after emptying it
D. The tubing after disconnecting it

B. The sampling port, cleaned first The port keeps the system closed and gives a fresh sample.

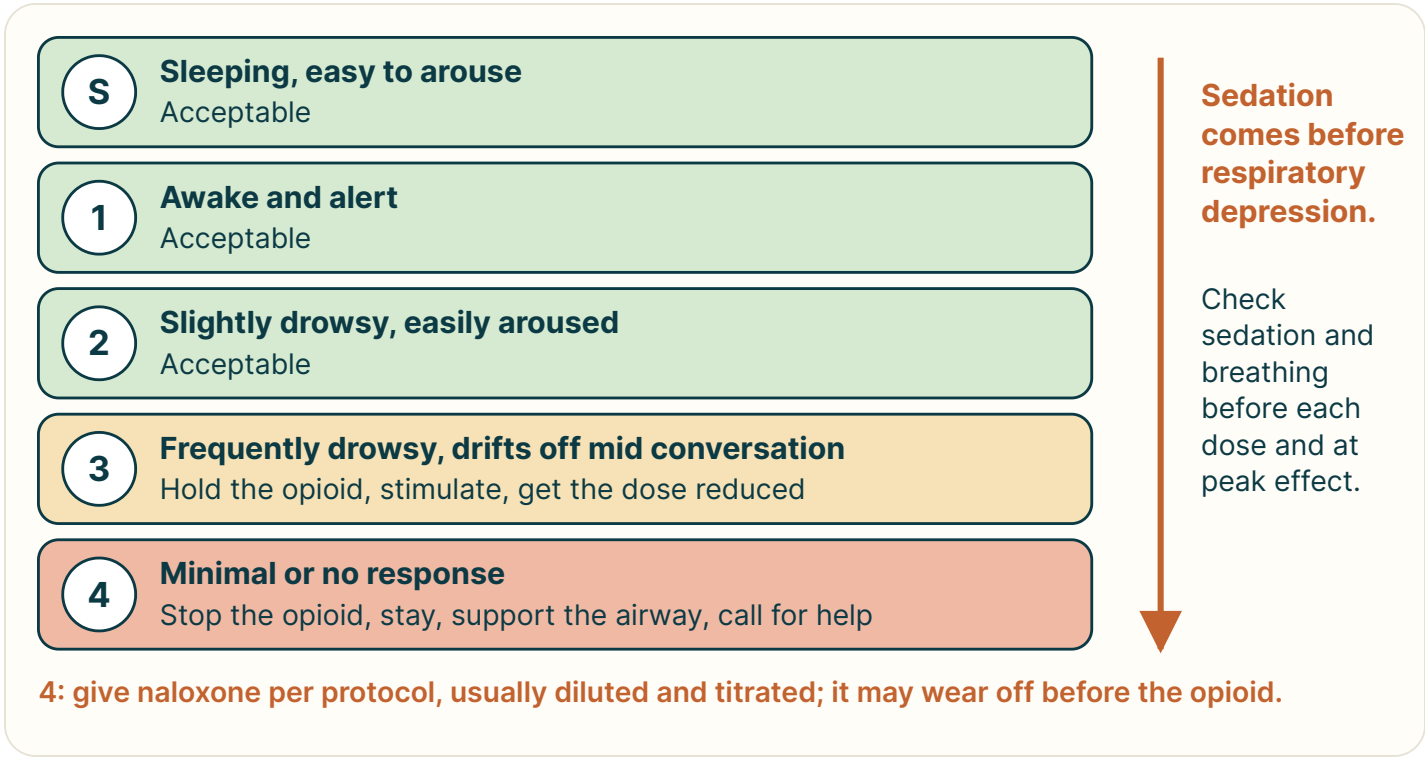
CHAPTER 18

Comfort, Pain, Sleep and Rest

Read it in full: **Chapter 18 in the textbook**. Practice it in the lab: **Protect the Sleep Window**.

What to know

Pain is what the patient says it is; vital signs and behavior never overrule self report. Nociception has four steps (transduction, transmission, perception, modulation), and neuropathic pain needs adjuvants. Choose the scale by patient: numeric, faces or FLACC, PAINAD or CPOT. Reassess after every dose, watch sedation before breathing, keep the PCA button for the patient only and protect sleep, which runs in 90 minute cycles.



Watch sedation, not just oxygen saturation. Levels S, 1 and 2 are acceptable. Level 3 means hold the dose; level 4 is an emergency that calls for naloxone.

LOCK THESE IN

- Self report is the standard; never let vital signs or behavior overrule it.
- Transduction, transmission, perception, modulation.
- Neuropathic pain burns and shoots and needs adjuvants.
- Numeric for adults; faces or FLACC for children; PAINAD for dementia; CPOT for intubated adults.
- Reassess 15 to 30 minutes after IV, 30 to 60 minutes after oral.
- Sedation before respiratory depression: hold at level 3, naloxone at level 4.
- Only the patient presses the PCA button. Bowel regimen with every opioid.

Priority rules: opioid sedation scale and sleep

Level or item	Action
S: sleeping, easy to arouse	Acceptable
1: awake and alert	Acceptable; may give opioid
2: slightly drowsy, easily aroused	Acceptable; keep watching
3: frequently drowsy, drifts off mid sentence	Hold opioid, stimulate, notify to reduce dose

Worked case

CASE 18.1 · TITRATING NALOXONE

Protocol: dilute naloxone 0.4 mg in 10 mL of saline and give 1 mL IV every 2 minutes until the respiratory rate improves.

STEP 1 · CONCENTRATION

0.4 mg / 10 mL = **0.04 mg per mL**.

STEP 2 · EACH DOSE

1 mL = **0.04 mg** (40 mcg).

STEP 3 · WHY SMALL DOSES

Small steps restore breathing without abruptly reversing all analgesia, which would cause severe pain, vomiting and withdrawal.

WATCH

Naloxone lasts 30 to 90 minutes and may wear off before the opioid. Keep monitoring; repeat doses or an infusion may be needed.

TRAPS PEOPLE FALL INTO

- **Doubting a pain rating because the patient is laughing.** Accept the report, assess further and treat.
- **Relying on vital signs to rule out pain.** Chronic pain often has normal vital signs.
- **Increasing the opioid for neuropathic pain.** Neuropathic pain needs adjuvants.

Chapter 18 self-test · five items

1. Which pain scale fits an intubated adult?

A. FACES
B. FLACC
C. CPOT
D. PAINAD

C. CPOT The Critical Care Pain Observation Tool is for adults who cannot speak, such as when intubated.

2. When should pain be rechecked after an IV opioid?

A. 4 hours later
B. 15 to 30 minutes
C. 30 to 60 minutes
D. 1 to 2 hours

B. 15 to 30 minutes IV drugs peak quickly; reassess in 15 to 30 minutes.

3. About how long is one sleep cycle?

A. About 90 minutes
B. About 30 minutes
C. About 15 minutes
D. About 4 hours

A. About 90 minutes Cycles last about 90 minutes, so cluster care to protect them.

4. Which drug reverses opioid induced respiratory depression?

A. Flumazenil
B. Protamine
C. Atropine
D. Naloxone

D. Naloxone Naloxone is the opioid antagonist.

5. Which type of pain usually needs adjuvants such as gabapentin?

A. Visceral pain
B. Somatic pain
C. Neuropathic pain
D. Acute incision pain

C. Neuropathic pain Burning, shooting nerve pain responds poorly to opioids alone.

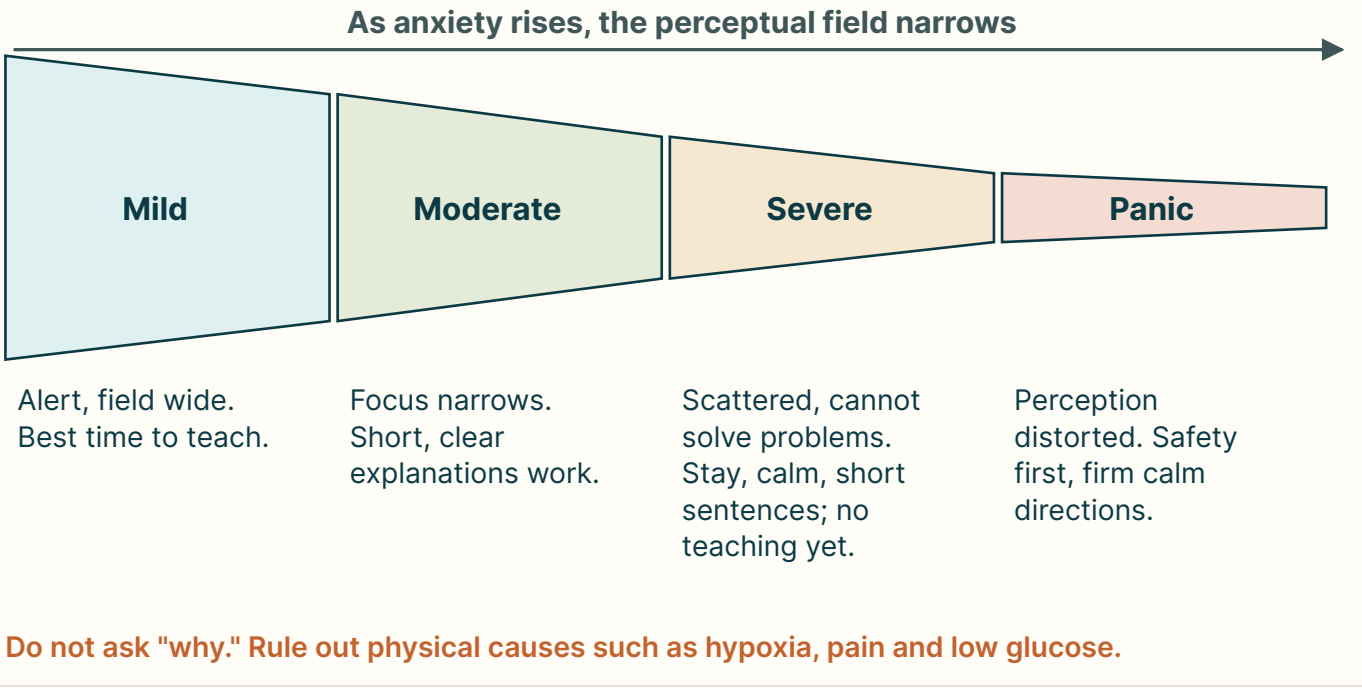
CHAPTER 19

Psychosocial Health, Culture and Spirituality

Read it in full: **Chapter 19 in the textbook**. Practice it in the lab: **Delirium or Dementia**.

What to know

Psychosocial care looks at self concept, stress, coping and anxiety. Stress acts through the sympathetic system in seconds and cortisol over hours. Teach at mild and moderate anxiety and stay with a patient in severe anxiety or panic, after ruling out hypoxia and hypoglycemia. Delirium is acute and fluctuating; dementia is gradual. Cultural and spiritual care starts by asking rather than assuming, with a qualified interpreter when needed.



Teach only while the field is open. As anxiety climbs, what the person can take in shrinks. Teach at mild or moderate; at severe or panic, stay and keep it safe and simple.

LOCK THESE IN

- Self concept: identity, body image, role performance, self esteem.
- Stress: sympathetic in seconds, cortisol over hours; hyperglycemia, low urine, slow healing.
- GAS: alarm, resistance, exhaustion. Suppression is the only conscious defense mechanism.
- Crisis lasts about 4 to 6 weeks; first action is safety, including asking directly about suicide.
- Teach at mild and moderate anxiety; stay and lower stimulation at severe and panic.
- Rule out hypoxia and hypoglycemia before calling a patient anxious.
- Delirium: acute, fluctuating, inattention, reversible. Dementia: gradual, progressive.

Priority rules: defense mechanisms and religious practices

Item	Example or rule
Denial	New chest pain called "just indigestion"
Displacement	Anger at a diagnosis aimed at the nurse
Regression	A toilet trained child wets the bed in hospital
Suppression (conscious)	"I'll think about the biopsy after the wedding"

Worked case

CASE 19.1 · ANXIETY OR HYPOXIA

Mr. Calloway, 58, is two days after a hip replacement. He suddenly grips the rails and says, "Something terrible is happening." RR 28, HR 118, SpO2 88% on room air. His family says he has always been a worrier.

STEP 1 · RECOGNIZE

Sudden dread with tachypnea, tachycardia and low saturation after orthopedic surgery.

STEP 2 · ANALYZE

This points to a physiologic emergency such as pulmonary embolism, not simple anxiety.

STEP 3 · ACT

Raise the head of the bed, apply oxygen per protocol, stay with him and call the rapid response team or provider.

RULE

Anxiety is a diagnosis of exclusion when vital signs are abnormal. An anxiolytic could hide the cause.

TRAPS PEOPLE FALL INTO

- **Calling sudden restlessness with low SpO2 anxiety.** Check airway, breathing and oxygen first.
- **Teaching during severe anxiety or panic.** Lower the anxiety first; learning is not possible.
- **Asking an anxious patient "why."** It cannot be answered and feels accusing.

Chapter 19 self-test · five items

1. A man angry at his boss comes home and yells at his wife. Which defense mechanism is this?

A. Projection
B. Displacement
C. Regression
D. Sublimation

B. Displacement Feelings are moved onto a safer target.

2. Which stage of the general adaptation syndrome follows alarm?

A. Resistance
B. Recovery
C. Denial
D. Exhaustion

A. Resistance Alarm, resistance, exhaustion.

3. Before deciding that a restless older adult is anxious, what should the nurse check?

A. Meal preferences and diet order
B. Religious needs and practices
C. Oxygen saturation and blood glucose
D. Recent visitors and phone calls

C. Oxygen saturation and blood glucose Rule out hypoxia and hypoglycemia first.

4. Which finding points to dementia rather than delirium?

A. Symptoms worse since the infection
B. Sudden onset over one day
C. Attention that comes and goes
D. A slow decline over two years

D. A slow decline over two years Dementia is gradual; delirium is acute and fluctuating.

5. A patient declines pork at meals for religious reasons. What should the nurse do?

A. Note it and arrange other meal choices
B. Ask the family to bring in all meals
C. Serve it and let the patient decide
D. Explain that protein is needed to heal

A. Note it and arrange other meal choices Respect the practice and adjust the plan.

CHAPTER 20

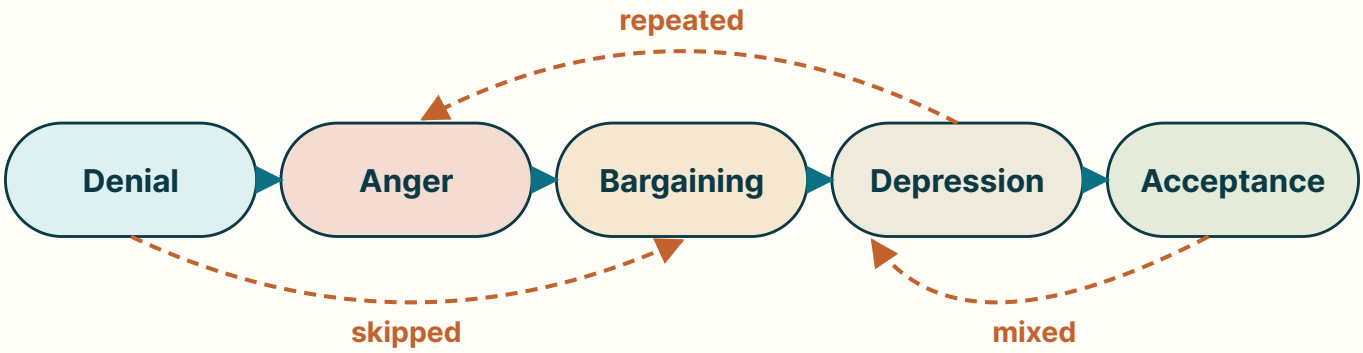
Loss, Grief and End of Life Care

Read it in full: **Chapter 20 in the textbook**. Practice it in the lab: **Goals of Care Desk**.

What to know

Grief is the inner response to loss, mourning its outward expression and bereavement the state of having lost someone. Grief theories describe, not schedule. Offer presence and open questions instead of clichés. Palliative care fits any stage alongside treatment; hospice fits a prognosis of 6 months or less with comfort goals. A DNR order means no CPR, not no care. Manage end of life symptoms, then give postmortem care, keeping tubes in place for a medical examiner case.

Kübler-Ross stages: a way to recognize grief, not a timetable



Normal grief comes in waves and flares at anniversaries.

The stages are not a timetable. People skip, repeat and mix the stages. Name what you see and support it; do not push anyone to the next box.

LOCK THESE IN

- Grief inner; mourning outward; bereavement the state of loss.
- Theories describe grief; they are not schedules.
- Prolonged grief: intense yearning with impairment about 12 months or more in adults.
- Presence and open questions; no clichés, "at least" or "why."
- Preschoolers think death is reversible; say "died," not "went to sleep."
- Palliative at any stage with treatment; hospice at 6 months or less with comfort goals.
- DNR means no CPR, not no care; a capable patient decides.

Priority rules: end of life symptoms and after death

Item	Rule
Pain	Around the clock plus breakthrough; titrate opioids; laxative always; no IM
Dyspnea	Upright, fan across the face, low dose opioid, oxygen if hypoxemic
Terminal secretions	Side lying, mouth suction only, anticholinergic early; no deep suction
Terminal agitation	Check pain, bladder, bowels, hypoxia, drugs first

Worked case

CASE 20.1 · TERMINAL SECRETIONS

Mrs. Ibarra, 72, in her last days with pancreatic cancer, has loud gurgling respirations. She is unresponsive with a relaxed face. Her son asks the nurse to "suction her lungs so she can breathe."

STEP 1 · RECOGNIZE

Terminal respiratory secretions in a patient showing no distress.

STEP 2 · POSITION

Turn her to the side with the head slightly raised.

STEP 3 · TREAT

Gently suction the mouth only if secretions are visible and give the ordered anticholinergic.

STEP 4 · TEACH

Explain that the sound is saliva in the throat, she is not choking, and deep suctioning would hurt without lasting benefit.

RULE

Deep suctioning or more IV fluid adds discomfort or more secretions.

TRAPS PEOPLE FALL INTO

- **Calling a widow who briefly hears her husband's voice psychotic.** That can be a normal grief response.
- **Treating grief stages as a checklist.** People skip, repeat and mix them.
- **Telling a child that Grandpa "went to sleep."** Use the word "died"; euphemisms cause fear and confusion.

Chapter 20 self-test · five items

1. Which term best describes the outward, culturally shaped expression of grief?

A. Bereavement state
B. Complicated grief
C. Anticipatory grief
D. Mourning practices

D. Mourning practices Mourning is how grief is expressed outwardly.

2. Which statement to a grieving son is most helpful?

A. "I'm so sorry. Would you tell me about her?"
B. "She lived a long and full life, after all."
C. "I know exactly how you must be feeling."
D. "At least she is not suffering anymore now."

A. "I'm so sorry. Would you tell me about her?" Presence and an open invitation help; "at least" and clichés do not.

3. Which condition is usually required for hospice eligibility?

A. A prognosis of 1 year or less
B. Agreeing to a feeding tube first
C. A prognosis of 6 months or less
D. Being bedbound in a nursing home

C. A prognosis of 6 months or less Hospice requires comfort goals and a prognosis of 6 months or less.

4. A dying patient has noisy breathing from secretions. What should the nurse do first?

A. Give more IV fluids to thin them
B. Turn the patient onto the side
C. Start deep suction every hour
D. Lay the patient flat on the back

B. Turn the patient onto the side Repositioning helps drain secretions; deep suction is distressing.

5. A patient died after a fall and the case is reported to the medical examiner. What should the nurse do with tubes and lines?

A. Remove all of them
B. Leave them in place
C. Cut them flush to the skin
D. Remove only the IV lines

B. Leave them in place In an examiner case or autopsy, tubes stay in place.

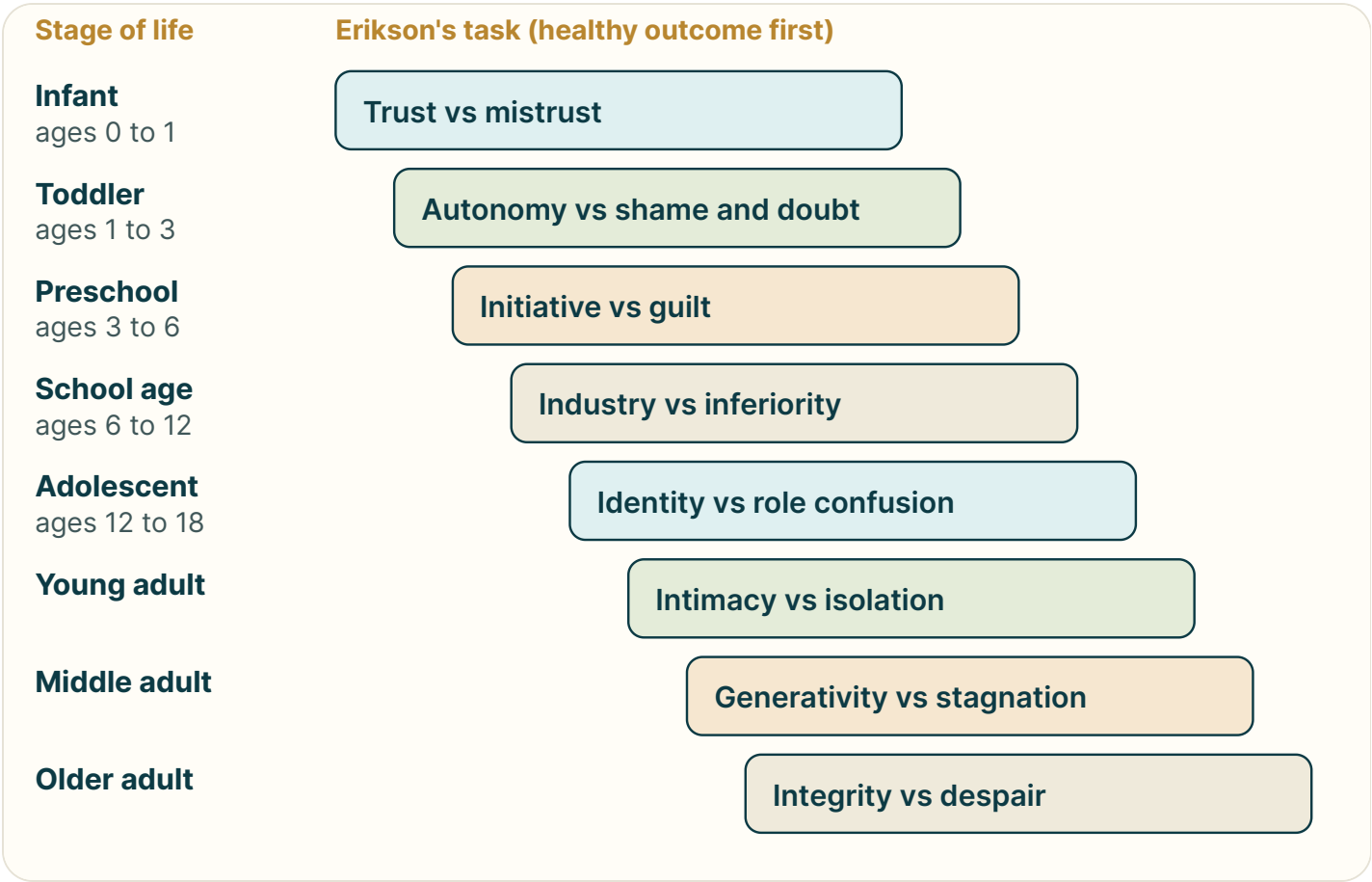
CHAPTER 21

Health Promotion Across the Lifespan

Read it in full: **Chapter 21 in the textbook**. Practice it in the lab: **Transitions and Evidence**.

What to know

Prevention is primary (stop it), secondary (screen for it) or tertiary (limit its harm). Screening and immunization schedules, behavior change models and motivational interviewing support healthy choices. Development follows Erikson and Piaget, with stage specific milestones, fears and injury risks. In older adults confusion is never normal, illness presents atypically and falls, polypharmacy and abuse need active screening. Transitions, evidence based practice and PDSA cycles keep care safe and current.



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.

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

Worked case

CASE 21.1 · 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.

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.

Chapter 21 self-test · five items

1. A clinic gives a pneumococcal vaccine. Which level of prevention is this?

A. Quaternary
B. Primary
C. Secondary
D. Tertiary

B. Primary Immunization prevents disease before it starts.

2. Which Erikson task belongs to adolescence?

A. Industry versus inferiority
B. Intimacy versus isolation
C. Initiative versus guilt
D. Identity versus role confusion

D. Identity versus role confusion Adolescents work on identity.

3. By about what age does a typical infant triple birth weight?

A. 12 months
B. 6 months
C. 18 months
D. 9 months

A. 12 months Birth weight doubles by about 6 months and triples by 12.

4. Which of these daily tasks is classed as an IADL rather than an ADL?

A. Bathing and grooming
B. Feeding oneself
C. Managing medications
D. Dressing each morning

C. Managing medications IADLs include medications, money, shopping and transport.

5. In a PICO question, what does the C stand for?

A. Context
B. Condition
C. Cohort
D. Comparison

D. Comparison Population, intervention, comparison, outcome.

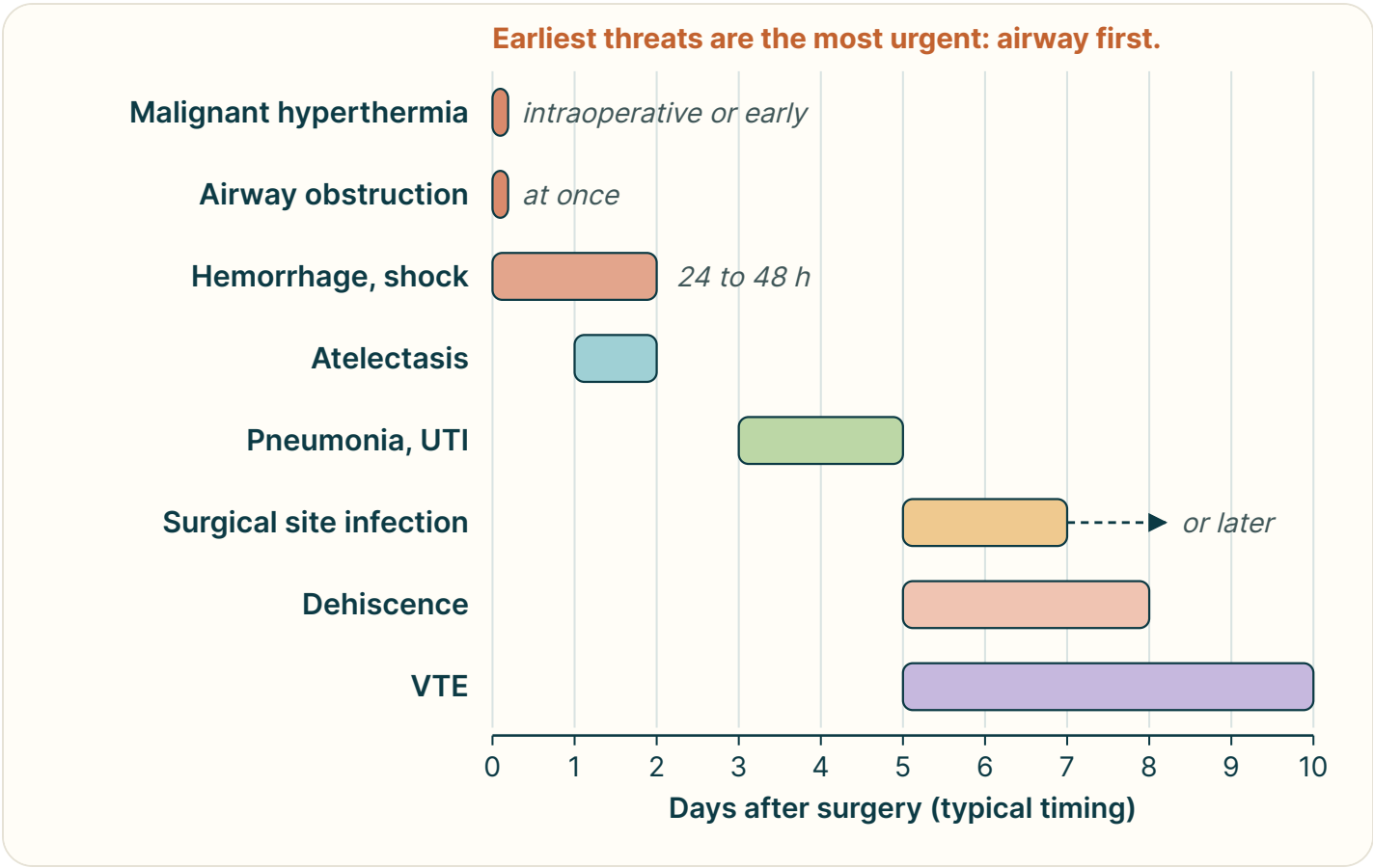
CHAPTER 22

Leadership, Delegation and the New Graduate

Read it in full: **Chapter 22 in the textbook**. Practice it in the lab: **Perioperative Safety Check**.

What to know

Leaders influence and managers coordinate, and the right style depends on the situation: autocratic in emergencies, democratic or transformational for change. Delegation follows the five rights while accountability stays with the RN. Prioritize with the funnel: airway and breathing threats first, then unstable changes, safety, time critical tasks, expected problems and teaching. Perioperative safety runs from consent and fasting rules to the time out and complications by postoperative day.



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.

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

Worked case

CASE 22.1 · 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.

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.

Chapter 22 self-test · five items

1. Which task should the RN keep rather than assign to an LPN?

A. Oral medications for a stable patient
B. Tube feeding for a stable resident
C. A dressing change on a stable wound
D. Initial teaching for a new diabetic

D. Initial teaching for a new diabetic Initial teaching stays with the RN; LPNs reinforce it.

2. Up to how long before anesthesia may a healthy adult usually drink clear liquids?

A. 2 hours
B. 8 hours
C. 6 hours
D. 12 hours

A. 2 hours Commonly taught: clear liquids up to 2 hours, follow the specific order.

3. Which postoperative complication typically appears around days 5 to 10?

A. Airway obstruction
B. Hemorrhage at the site
C. Venous thromboembolism
D. Atelectasis of the bases

C. Venous thromboembolism VTE often appears days 5 to 10; atelectasis and bleeding come earlier.

4. Which early sign suggests malignant hyperthermia?

A. Falling heart rate
B. Rising end tidal CO2
C. Low body temperature
D. Flaccid jaw muscles

B. Rising end tidal CO2 Rising end tidal CO2 and tachycardia come before the fever.

5. In Benner's model, at which stage does a nurse grasp situations intuitively?

A. Novice
B. Expert
C. Competent
D. Proficient

B. Expert Experts act from deep intuitive understanding built on experience.

ONE PAGE

Cram sheet

The whole course on a few pages: the top rows of every exam guide's cram tables. Cover the right column and recite it.

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

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

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

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

Documentation, privacy, technology and teaching

Item	Rule
Good entry	Factual, accurate, complete, current, organized; include the response
SOAP	S quote, O measured, A interpretation, P plan; IE and R extend it
PIE and DAR	Problem, intervention, evaluation; data, action, response
Never	Chart in advance, chart for others, share a login

Law, consent and ethics

Item	Rule
Sources of law	Constitution, statute, administrative rule, common law
Board of nursing	Protects the public; licenses and disciplines
Standard of care	Reasonably prudent nurse in similar circumstances
Malpractice	Duty, breach, causation, damages

Safety, falls, restraints and emergencies

Item	Rule
Just culture	Error: console and fix; at risk: coach; reckless: sanction
Events	Near miss, no harm, adverse, sentinel, never event; report all
RCA versus FMEA	After the event versus before it
Identification	Two identifiers stated by the patient; never the room

Infection prevention

Item	Rule
Chain	Agent, reservoir, exit, transmission, entry, host
Best single measure	Hand hygiene
Shift to the left	More bands with WBC above about 10,000/mm3
HAI timing	Not present on admission; commonly 48 h or more after

Vital signs

Item	Rule
Set point	Fever raises it; hyperthermia does not
Heat loss	Radiation, conduction, convection, evaporation
Routes	Rectal about 0.5 C higher; axillary about 0.5 C lower
Conversions	F = C x 9/5 + 32; 38 C = 100.4 F; 40 C = 104 F

Physical assessment

Item	Rule
Data	Subjective reported; objective observed; validate
Technique order	IPPA; abdomen IAPP
Hand parts	Finger pads detail; back temperature; ulnar vibration
Stethoscope	Diaphragm firm, high pitch; bell light, low pitch

Medications

Item	Rule
ADME	Absorption, distribution, metabolism, excretion
Levels	Trough before dose; peak at expected high; 4 to 5 half lives to steady state
Complete order	Patient, date, time, drug, dose, route, frequency, PRN reason, signature
Three checks	Removing, preparing, at the bedside; two identifiers

Mobility

Item	Rule
Body mechanics	Wide base, low center of gravity, load close, no twisting
Manual limit	About 35 lb; otherwise equipment
Transfer	Strong side, wheels locked, dangle, gait belt
Logroll	Three or more staff; spine straight

Hygiene, skin and wounds

Item	Rule
Hygiene	Clean to dirty; water about 43 to 46 C; distal to proximal strokes
Oral care, unconscious	Side lying, suction ready, no fingers
Diabetic feet	Inspect daily, dry between toes, no soaking
Perineal	Female front to back; male meatus outward; return foreskin

Oxygenation

Item	Rule
Steps	Ventilation, diffusion, perfusion, transport, delivery
Hypoxia	Early restless, tachycardic; late cyanosis, bradycardia
Sounds	Crackles fluid; wheezes narrowing; rhonchi secretions; stridor emergency
SpO2	95 to 100%; 88 to 92% in CO2 retainers; CO reads high

Fluids, electrolytes and acid base

Item	Rule
Compartments	Two thirds ICF; one third ECF; plasma smallest
Hormones	ADH holds water; aldosterone holds Na and water, loses K; BNP excretes Na and water
I and O	Ice chips half; urine at least 30 mL/h
Deficit vs excess	Concentration vs dilution; weak vs bounding; flat vs distended veins

Nutrition

Item	Rule
Energy	4, 4, 9, 7 kcal/g
Protein	0.8 g/kg; 1.2 to 2.0 g/kg with wounds
Fluid	30 to 35 mL/kg/day
Guidelines	Added sugar and saturated fat under 10%; sodium under 2,300 mg

Elimination

Item	Rule
Output	About 1,500 mL a day; report under 30 mL/h for 2 h
Retention	Scan first; residual over about 300 to 400 mL often means catheterize
Incontinence	Stress Kegels; urge training; overflow catheter; functional prompting
UTI in older adults	Confusion, falls, incontinence

Pain and sleep

Item	Rule
Definition	Sensory and emotional; self report is the standard
Nociception	Transduction, transmission, perception, modulation
Types	Acute vs chronic; nociceptive vs neuropathic
Scales	Numeric, faces, FLACC, PAINAD, CPOT

Psychosocial health, culture and spirituality

Item	Rule
Self concept	Identity, body image, role performance, self esteem
Stress response	Sympathetic seconds; cortisol hours; glucose up, healing down
GAS	Alarm, resistance, exhaustion
Coping	Problem focused vs emotion focused; suppression is conscious

Loss, grief and end of life

Item	Rule
Terms	Grief inner; mourning outward; bereavement state
Prolonged grief	About 12 months or more with impairment in adults
Responses	Presence, name, "died," open prompts; no clichés
Children	Preschool thinks reversible; reassure they did not cause it

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

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

---

Dr. Garg Learning · CC BY-SA 4.0