HEALTH ASSESSMENT · STUDY GUIDE

Exam 1 Study Guide

This guide covers the first two chapters. You will learn what a nursing license allows, how to test a task against your scope, what you may delegate and what never leaves the RN, and how the law and the Code of Ethics meet at the bedside. Then you will work the nursing process as a loop: collect data you can defend, cluster cues into a nursing diagnosis, write outcomes you can measure, and escalate with SBAR when the numbers cross a line. Work one chapter at a time. Read the "what to know" paragraphs, study the tables, then try each worked case with the steps covered. Finish each chapter with its ten self-test items. The cram sheet at the end puts the numbers and rules in one place.

WHAT THIS GUIDE COVERS

- Chapter 1 · CNA, LPN or LVN, RN and APRN credentials, the NCLEX and the Nurse Licensure Compact, the Nurse Practice Act and board of nursing, the three-question scope test, assignment versus delegation, the five rights, ANA standards, ethical principles, negligence and torts, informed consent, restraints, the four exam techniques and the abdominal exception, adult and lifespan vital signs, color findings on every skin tone, charting, red flags, SBAR and the chain of command.
- Chapter 2 · ADPIE as a loop, the four kinds of assessment, subjective and objective data, sources and validation, percussion notes, vital sign technique, cue clusters, nursing versus medical diagnosis, PES and risk diagnoses, ABC and Maslow priorities, SMART outcomes, independent, dependent and collaborative interventions, reassessment windows, charting, evaluation, Tanner and the Clinical Judgment Measurement Model, qSOFA and SBAR.

CHAPTER 1

The Nurse, Professional Practice and Scope

Read it in full: **Chapter 1 in the textbook**. Practice it in the lab: **Delegation Decider: UAP, LPN or RN Only** and **Red Flags and the Rescue Call**.

What to know

Your authority to practice does not come from your employer, your degree or your job description. It comes from a state statute, the **Nurse Practice Act** (NPA), passed by the legislature. The NPA defines nursing practice, sets the rules for licensure and discipline, and creates the **board of nursing** (BON), the agency that issues your license and can suspend or revoke it. The board then writes rules and advisory opinions that fill in the detail.

The credentials are not interchangeable. A CNA holds a certification, not a license, after weeks to a few months of training, and gives personal care and routine data collection that an RN delegates. An LPN or LVN finishes a 12 to 18 month program, passes the NCLEX-PN, and works under RN or provider direction: data collection, most medications, sterile dressings, catheters and reinforcing teaching. The RN comes from a diploma, ADN or BSN program; all three sit the same NCLEX-RN and get the same license and the same legal scope. An APRN (NP, CNS, CRNA or CNM) adds a graduate degree, national certification and a second state authorization to diagnose and, in most states, prescribe.

The NCSBN develops the NCLEX and runs the **Nurse Licensure Compact**. A multistate license lets you practice in person or by telehealth in other compact states without a second license, but you practice under the law of the state where the **patient** is located. Licenses usually renew every two years. The common paths to discipline are drug diversion, practicing impaired, falsifying records, patient abandonment, boundary violations and practicing outside scope. You are also a mandatory reporter of suspected abuse or neglect, and that duty is personal: telling the charge nurse and letting it go does not meet it.

Before any unfamiliar task, run three questions in order. One: is it inside my state NPA and board rules? Two: does facility policy allow it, and do I have the order or protocol it needs? Three: am I personally educated, trained and validated to do it safely right now? A no at any step means you stop. Policy can narrow your scope but can never widen it. The safe sentence is "I am not checked off on that, I will get someone who is."

Assignment hands over both responsibility and accountability for work already inside the other person's scope. **Delegation** hands over the doing of a specific task while you keep the

accountability. Supervision follows: you cannot delegate and disappear. The five rights of delegation are right task, right circumstance, right person, right direction and communication, and right supervision and evaluation. A good instruction names the task, the patient, the method, the deadline and exactly what to report back.

Four things never leave the RN: assessment, nursing diagnosis and planning, teaching, and evaluation, plus any care of an unstable patient. A UAP may gather a number; only the RN decides what it means. When a test question asks what to delegate, first ask whether the patient is stable.

You are judged against the **standard of care**: what a reasonably prudent nurse with similar preparation would do in similar circumstances. The six ANA Standards of Practice map onto the nursing process (assessment, diagnosis, outcomes identification, planning, implementation, evaluation). The Code of Ethics puts the patient first and owes the same duties to self as to others. The ethical principles are autonomy, beneficence, nonmaleficence, justice, fidelity and veracity.

Negligence needs all four elements: duty, breach, causation and damages. Malpractice is professional negligence. The intentional torts are assault (the threat), battery (the contact, including a procedure the patient refused), false imprisonment (restraint without order or emergency), defamation and invasion of privacy. Informed consent belongs to the person doing the procedure. The nurse verifies the signature is voluntary and that the patient can explain the procedure in their own words, then witnesses it. Consent signed after a sedating premedication is not valid.

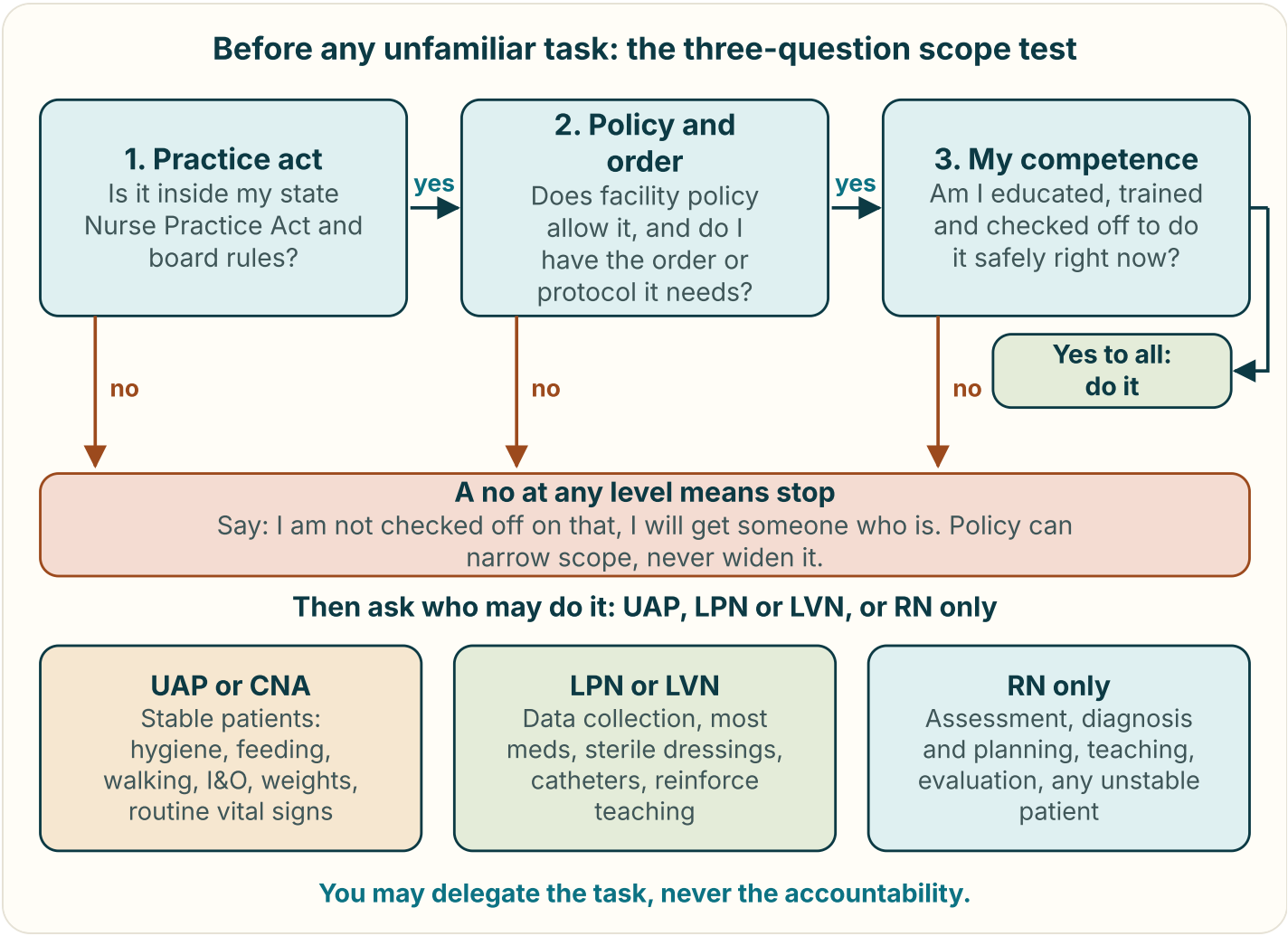
Restraints are a last resort after documented less restrictive measures. The order is never PRN and is time limited for violent or self destructive behavior: up to 4 hours for an adult, 2 hours for ages 9 to 17, 1 hour under age 9, with a face to face evaluation within 1 hour of starting. Restraint without an order outside an emergency is false imprisonment.

Every exam uses **inspection, palpation, percussion, auscultation**, except the abdomen, which is inspect, auscultate, percuss, palpate, because touching first changes the bowel sounds. Use finger pads for texture and pulses, the ulnar or palmar surface for vibration, and the dorsum for temperature. Light palpation goes about 1 cm deep, deep palpation 4 to 5 cm. Know adult vital signs cold, adjust for age and pregnancy, and look for color changes where melanin is least: oral

mucosa, conjunctivae, sclerae, palms and soles. When a red flag appears, escalate with SBAR and keep going up the chain until someone acts.

LOCK THESE IN

- The NPA is a state statute; the board of nursing enforces it. Policy can narrow scope, never widen it.
- Under the compact you follow the law of the state where the patient is located.
- Scope test in order: practice act, then policy and order, then your own validated competence.
- Delegate the task, keep the accountability. Assessment, diagnosis and planning, teaching, evaluation and any unstable patient stay with the RN.
- Five rights: task, circumstance, person, direction and communication, supervision and evaluation.
- Negligence needs duty, breach, causation and damages. Battery is the contact; assault is the threat.
- Inspect, palpate, percuss, auscultate, except the abdomen: inspect, auscultate, percuss, palpate.
- Restraint orders are never PRN: 4 hours adult, 2 hours ages 9 to 17, 1 hour under 9, face to face within 1 hour.



The scope test, then the delegation split. Run the three questions in order before any new task. A no at any step ends it. Then match the task to the lowest role that may legally do it, keeping assessment, teaching, evaluation and unstable patients with the RN.

Adult vital signs and thresholds (chapter 1 values)

Measure	Expected adult value	Abnormal or red flag
Temperature, oral	36.5 to 37.5 °C (97.7 to 99.5 °F); mean 37.0 °C	Fever ≥ 38.0 °C (100.4 °F); hypothermia < 35.0 °C
Pulse	60 to 100 beats/min, regular	Red flag < 40 or > 130, or a new irregular rhythm
Respirations	12 to 20 breaths/min, effortless	Red flag < 8 or > 28, or new accessory muscle use
Blood pressure	Less than 120/80 mm Hg; MAP at least 65	Systolic < 90, a 40 mm Hg drop from baseline, or MAP < 65
Pulse pressure	30 to 40 mm Hg	Systolic minus diastolic
Orthostatic change	Minimal on standing	Systolic drop ≥ 20, diastolic drop ≥ 10, or pulse rise ≥ 20 within 3 minutes
SpO_2	95 to 100% on room air	Below 90% is hypoxemia; chronic CO_2 retainers often 88 to 92% (verify the order)
Urine output	At least 30 mL/hour or 0.5 mL/kg/hour	Less than 30 mL/hour for 2 hours in a row
Older adult fever	Blunted response	37.8 °C (100.0 °F) or a rise of 1.1 °C (2 °F) over baseline
Child 1 to 10 years	Hypotension is late and ominous	Systolic below 70 + (2 × age in years)

Who may do what

Task	UAP or CNA	LPN or LVN	RN
Vital signs, stable patient	Yes (RN interprets)	Yes	Yes
Vital signs, unstable patient	No	No	Yes: performs and interprets
Oral, subcut, IM medications	No	Yes (most states)	Yes
Sterile dressing, trach care, urinary catheter	No	Yes	Yes
IV push, blood products, titrating drips	No	No (rare exceptions)	Yes
Assessment, diagnosis, care planning	No	Collect data only	Yes
Teaching	No	Reinforce only	Yes: initial teaching
Evaluating the response	No	No	Yes

Worked cases

WORKED CASE 1 · RUNNING THE SCOPE TEST

Jordan, a new RN, is asked by a busy provider to "just adjust" a drip rate on a titrated infusion. The unit has no titration protocol, and Jordan has never been checked off on it.

STEP 1 · PRACTICE ACT

Titration of a drip can sit inside RN scope in the state, so question one may pass.

STEP 2 · POLICY AND ORDER

There is no protocol and no titration order. Question two fails, and that alone ends it.

STEP 3 · COMPETENCE

Jordan has never been validated on titration. Question three would fail too.

STEP 4 · THE WORDS

"I am not checked off on titrating that drip and we have no protocol. I will get someone who is, and can you write the titration order?"

WHY IT MATTERS

Titrating a drip without a protocol is one of the common first year scope traps. A yes on the first question never rescues a no on the second or third.

WORKED CASE 2 · DELEGATING TO A UAP, AND WHEN YOU CANNOT

You have two patients who need vital signs. Mr. Hale is stable on day three after a knee repair. Ms. Ortiz was just admitted and is receiving her first dose of an IV antibiotic. A UAP offers to take both sets.

STEP 1 · ASK ABOUT STABILITY FIRST

Mr. Hale is stable and predictable. Ms. Ortiz is a new admission on a first antibiotic dose, which can trigger anaphylaxis, so she is not predictable.

STEP 2 · APPLY THE RIGHT CIRCUMSTANCE

Vital signs on Mr. Hale may go to the UAP. Ms. Ortiz's vital signs stay with you, because the circumstance fails.

STEP 3 · GIVE DIRECTION

"Please take a manual blood pressure on Mr. Hale in room 9 within ten minutes, sitting, left arm, and tell me right away if the systolic is under 100 or over 160."

STEP 4 · SUPERVISE AND EVALUATE

Get the numbers back and interpret them yourself. If the UAP reports 86/50, the task was done right and the clinical problem is yours.

WORKED CASE 3 · SPOTTING A PEDIATRIC HYPOTENSION

A 3 year old has a heart rate of 158, respirations 40 and a blood pressure of 74/40. Which value worries you most?

STEP 1 · FIND THE FLOOR

For ages 1 to 10, hypotension is a systolic below 70 + (2 × age). Here: 70 + (2 × 3) = 76 mm Hg.

STEP 2 · COMPARE

74 is below 76, so this child is hypotensive.

STEP 3 · WEIGH IT

Children hold their pressure with tachycardia and vasoconstriction until they crash. Hypotension in a child is a late, pre-arrest sign.

STEP 4 · ACT

Escalate now. Do not wait for a repeat set.

WORKED CASE 4 · AN SBAR CALL THAT WORKS

Mr. Ruiz, 68, is one day after a bowel resection. His respirations rose to 28 and his SpO_2 fell to 88% on room air. His right calf is 3 cm larger than the left and tender.

STEP 1 · SITUATION

Name yourself and the unit, then the patient, room and the problem: "Respiratory rate 28 and SpO_2 88% on room air."

STEP 2 · BACKGROUND

Age, surgery and day, history (COPD, type 2 diabetes), opioid doses and timing, and that he has not been out of bed.

STEP 3 · ASSESSMENT

Numbers, not adjectives: HR 122, BP 98/56, temperature 37.9 °C, diminished bases, the calf finding. Then say the concern out loud: "I am concerned about a pulmonary embolism."

STEP 4 · RECOMMENDATION

A specific request: come now, plus stat CT pulmonary angiogram, ECG and ABG, and the SpO_2 target given his COPD.

THEN

Read back any verbal order, document the call with times, and climb the chain of command if there is no response.

TRAPS PEOPLE FALL INTO

- **Trusting facility policy over the practice act.** Policy may restrict what the NPA allows. It can never permit what the NPA does not.
- **Thinking the license follows the nurse's location.** Under the compact, the law of the state where the patient sits governs the care.
- **Delegating a "simple" task on an unstable patient.** Instability overrides how easy the task looks. The RN keeps it.
- **Confusing assignment and delegation.** Assignment moves accountability; delegation never does.
- **Calling the threat battery.** "Hold still or I will hold you down" is assault. The touch is battery.
- **Thinking the nurse obtains informed consent.** The provider explains the procedure. The nurse checks understanding and voluntariness and witnesses.
- **Palpating the abdomen before listening.** Pressure changes peristalsis, so you would chart sounds you made.

- **Charting an older adult with 37.8 °C and new confusion as afebrile.** In older adults that is a significant fever and a sepsis cue.

Chapter 1 self-test · ten items

1. A hospital policy lets RNs perform a skill that the state Nurse Practice Act does not include in RN scope. What should the nurse do?

A. Perform the skill, since hospital policy protects the nurse
B. Decline the skill and raise the policy conflict with the manager
C. Perform it only when the charge nurse is present on the unit
D. Perform it once a provider writes an order for the skill

B. Decline the skill and raise the policy conflict with the manager Policy can narrow scope below the statute but can never widen it. The board of nursing, not the employer, holds the license.

2. A nurse with a multistate compact license lives in one compact state and gives telehealth care to a patient in another. Whose practice act applies?

A. The state where the nurse is sitting
B. The state that first issued the license
C. The state where the employer is based
D. The state where the patient is located

D. The state where the patient is located Under the Nurse Licensure Compact, you practice under the law of the state where the patient is.

3. Which statement best describes delegation?

A. Handing over both the task and the accountability for it
B. Assigning patients to staff who already hold that scope
C. Handing over a specific task while the RN keeps accountability
D. Sharing accountability equally with the person doing the task

C. Handing over a specific task while the RN keeps accountability Delegation transfers the doing of a task, not the accountability. Assignment is the one that moves accountability.

4. On a busy day shift, which of these tasks may the RN hand to a UAP?

A. Measuring intake and output on a stable patient
B. Teaching a patient to use an incentive spirometer
C. Taking vital signs on a newly admitted unstable patient
D. Judging whether a pain medication has worked

A. Measuring intake and output on a stable patient Intake and output on a stable patient is routine and predictable. Teaching and evaluation never leave the RN, and an unstable patient stays with the RN.

5. A nurse tells a patient, "Hold still or I will hold you down." Which tort is this?

A. Battery, the contact itself
B. Defamation of the patient
C. False imprisonment by threat
D. Assault, the threat of contact

D. Assault, the threat of contact Assault is the threat of unwanted contact. Battery would be the contact itself.

6. Before witnessing a consent form, the nurse finds the patient unsure which organ is being removed. What should the nurse do?

A. Explain the surgery, then have the patient sign
B. Stop and page the provider before any signature
C. Let the patient sign, then call the provider after
D. Ask a family member to confirm and witness instead

B. Stop and page the provider before any signature The nurse verifies understanding. A patient who cannot describe the procedure is not giving informed consent, and explaining it is the provider's duty.

7. A restraint order for violent behavior in an adult can be written for how long at most?

A. Up to 1 hour
B. Up to 2 hours
C. Up to 4 hours
D. Up to 24 hours

C. Up to 4 hours For violent or self destructive behavior: 4 hours for adults, 2 hours ages 9 to 17, 1 hour under age 9. Never PRN.

8. In what order should the nurse examine the abdomen?

A. Inspect, auscultate, percuss, palpate
B. Inspect, palpate, percuss, auscultate
C. Auscultate, inspect, palpate, percuss
D. Inspect, percuss, auscultate, palpate

A. Inspect, auscultate, percuss, palpate Auscultation moves to second because touching the abdomen changes bowel sounds.

9. Which part of the hand is most sensitive to temperature?

A. The pads of the fingertips
B. The ulnar surface of the hand
C. The palmar base of the fingers
D. The dorsum, or back, of the hand

D. The dorsum, or back, of the hand The dorsum senses heat best. The ulnar or palmar surface is for vibration, and the finger pads for texture and pulses.

10. A 4 year old has a systolic pressure of 76 mm Hg. How should the nurse read it?

A. Normal, since it is above 70 mm Hg
B. Borderline, since the floor is 74 mm Hg
C. Hypotensive, since the floor is 78 mm Hg
D. Hypertensive for a child of that age

C. Hypotensive, since the floor is 78 mm Hg For ages 1 to 10, hypotension is below 70 + (2 × age). For age 4 that is 70 + 8 = 78, so 76 is hypotensive.

CHAPTER 2

The Nursing Process and Clinical Judgment

Read it in full: **Chapter 2 in the textbook**. Practice it in the lab: **From Cue to Nursing Diagnosis** and **The Planning Desk**.

What to know

The nursing process is ADPIE: assessment, diagnosis, planning, implementation and evaluation. It is a loop, not a line. Evaluation feeds straight back into assessment. You reassess after every intervention, every position change, every dose and at the start of every shift. A plan built at 0730 is a hypothesis, not a contract.

Assessment comes first because bad data corrupts every later step. There are four kinds. The **initial comprehensive** assessment on admission sets the baseline. A **focused** assessment targets one system or complaint. An **emergency** assessment is the rapid primary survey (airway, breathing, circulation, disability, exposure) and is incomplete on purpose. The **ongoing** or time lapsed assessment detects change, and change tells you a patient is in trouble.

Subjective data are symptoms the patient reports, charted in their own words when the wording matters. **Objective** data are signs you observe, measure or elicit, and another clinician could verify them. The patient is the primary source. Family, the record, the last nurse and lab results are secondary sources and must be named as such.

Validation is the step students skip. When data conflict, such as a monitor heart rate of 148 with a radial pulse of 74, you recheck: apical pulse for a full minute, manual blood pressure with the right cuff, or the question asked again in different words. A surprising finding is either an artifact or an emergency, and repeating the measurement tells you which.

Technique matters. Percussion strikes the pleximeter finger with the plexor using wrist motion only, twice, and reads about 5 to 7 cm deep. Resonance is normal lung. Hyperresonance means trapped air. Tympany is normal over the gastric bubble and bowel. Dullness is normal over the liver and a full bladder but means consolidation or effusion over lung. Flatness is muscle and bone. For blood pressure, the patient sits five minutes with the back supported, feet flat, arm at heart level, and the cuff bladder is about 40% of arm circumference wide and encircles 80% of the arm.

A **cue** is one piece of relevant data. Cues mean something when they are **clustered**. Heart rate 118, temperature 38.4 °C, respirations 24, systolic 96 and new confusion in an older adult with a catheter is one pattern: sepsis until proven otherwise. Analysis separates relevant from irrelevant data, finds the unexpected cues first, and compares each value to population norms and to the patient's own baseline.

A **medical diagnosis** names the disease and is made by a provider. A **nursing diagnosis** names the patient's response, belongs to the RN, is treated with nursing interventions and can change within a shift. An actual diagnosis uses **PES**: problem, related to etiology, as evidenced by signs

and symptoms. The etiology must be something you can treat, never a medical diagnosis. A **risk** diagnosis has only two parts, the label and the risk factors, with no "as evidenced by."

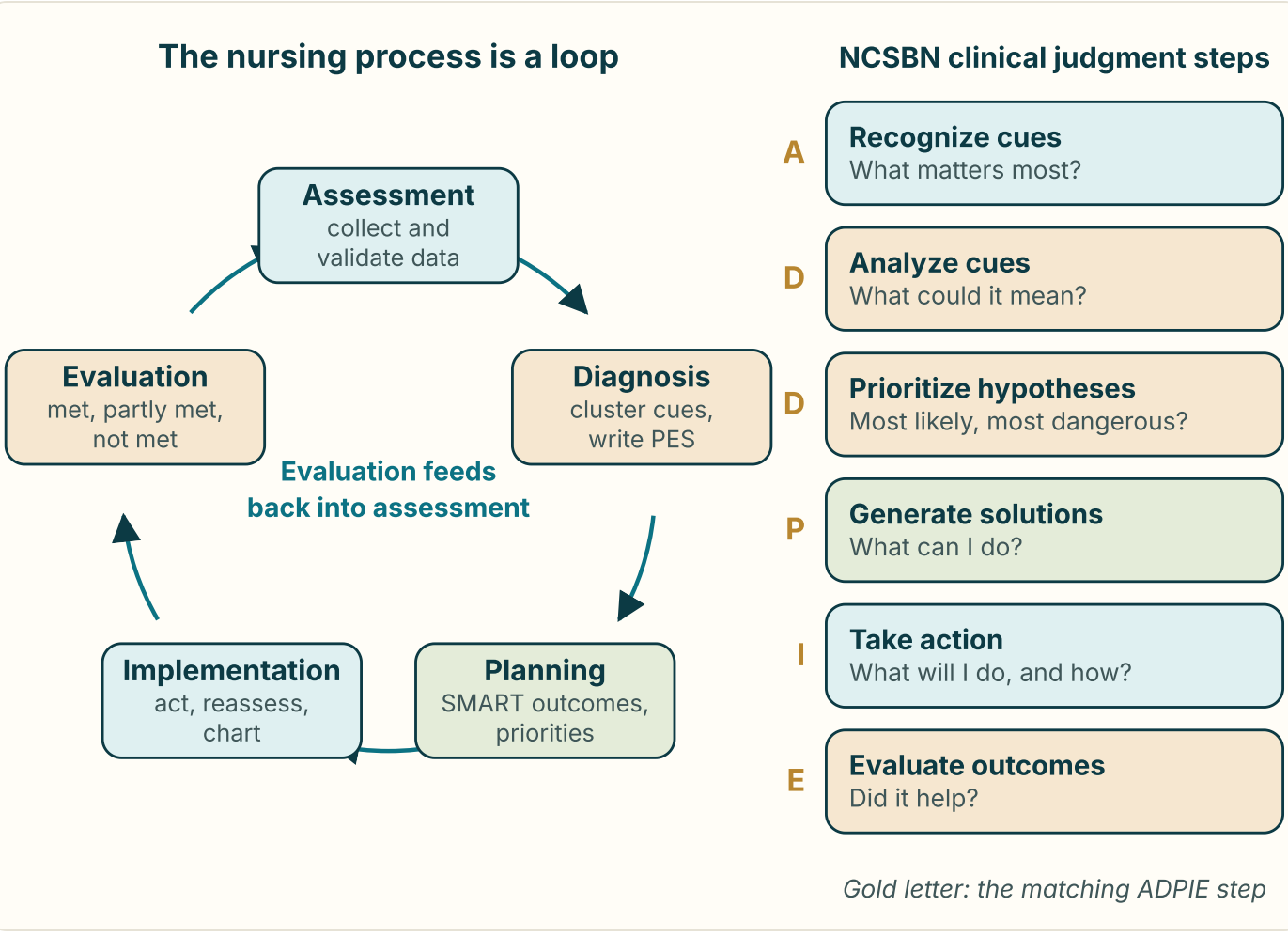
Priorities: airway, then breathing, then circulation. Then Maslow, with oxygenation at the top of physiologic needs. Then actual before risk, acute before chronic, unexpected before expected, and problems that will worsen without action before those that will not. Outcomes are written as what the patient will do, and they are **SMART**: specific, measurable, attainable, relevant and time bound. Interventions are independent (no order needed), dependent (need an order) or collaborative (with other disciplines).

Implementation is bracketed by assessment: before, during and after. Reassess pain 15 to 30 minutes after an IV analgesic and 45 to 60 minutes after an oral one, and recheck SpO_2 within 15 minutes of an oxygen change. Evaluation asks whether each outcome was met, partly met or not met, using data. If it was not met, check the four reasons in order: bad assessment data, wrong diagnosis or etiology, an unrealistic outcome or timeframe, or interventions that were never actually done.

Clinical judgment is the reasoning inside the loop. Tanner's model has four phases: noticing, interpreting, responding and reflecting. The NCSBN Clinical Judgment Measurement Model has six: recognize cues, analyze cues, prioritize hypotheses, generate solutions, take action and evaluate outcomes. A qSOFA screen is positive with any two of respirations ≥ 22, altered mentation or systolic ≤ 100. Failure to rescue usually follows six to eight hours of abnormal vital signs, most often a rising respiratory rate. Count it.

LOCK THESE IN

- ADPIE is a loop: evaluation is the next assessment.
- Subjective is reported, objective is measured. The patient is the primary source.
- A surprising number gets rechecked before you act on it.
- PES for an actual diagnosis; a risk diagnosis has two parts and no "as evidenced by."
- Never write a medical diagnosis as the etiology. You must be able to treat it.
- ABC, then Maslow, then actual before risk and acute before chronic.
- SMART outcomes describe the patient's behavior with a deadline, not the nurse's action.
- qSOFA: any two of RR ≥ 22, altered mentation, systolic ≤ 100.



One loop, two vocabularies. ADPIE never stops: every evaluation is a new assessment. The six NCSBN steps make the reasoning between assessment and action explicit and line up with ADPIE almost step for step.

Percussion notes

Note	Normal over	Abnormal meaning
Resonance	Normal lung	Expected over all lung fields
Hyperresonance	A child's thin chest; not normal in an adult	Trapped air: emphysema, asthma flare, pneumothorax
Tympany	Gastric air bubble, air filled bowel	Over the whole abdomen: gas distention or obstruction
Dullness	Liver, spleen, full bladder, heart border	Over lung: consolidation, effusion, atelectasis, mass
Flatness	Muscle, bone, sternum, thigh	Over the chest: a large pleural effusion

Diagnosis, outcomes and reassessment

Item	Rule	Example
Actual diagnosis	Problem r/t etiology AEB signs and symptoms	Impaired gas exchange r/t alveolar capillary changes AEB SpO_2 88%, RR 28
Risk diagnosis	Label r/t risk factors, two parts only	Risk for falls r/t postural hypotension and a new sedative
SMART outcome	Patient behavior, measure, deadline	Maintains SpO_2 ≥ 94% on 2 L/min with RR 12 to 20 by end of shift
Independent	No order needed	Reposition, raise head of bed, teach, assess
Dependent	Needs a provider order	Medications, IV fluids, diet and activity orders
Collaborative	With other disciplines	PT mobility plan, RT nebulizers, dietitian feeding plan
IV analgesic	Reassess in 15 to 30 minutes	Pain score, sedation, respirations
Oral analgesic	Reassess in 45 to 60 minutes	Pain score and function
Oxygen change	Recheck within 15 minutes	SpO_2 and work of breathing

Worked cases

WORKED CASE 1 · FIXING TWO BROKEN DIAGNOSES

A student writes: "Risk for infection related to surgery as evidenced by incision and temperature 37.6 °C." A second student writes: "Acute pain related to surgery."

STEP 1 · COUNT THE PARTS

The first is a risk diagnosis, so it has two parts. "As evidenced by" must go: evidence would mean the problem already exists.

STEP 2 · CHECK THE ETIOLOGY

"Surgery" is an event you cannot treat. Name the treatable factors.

STEP 3 · REWRITE THE FIRST

Risk for infection related to surgical incision, indwelling urinary catheter and steroid therapy.

STEP 4 · REWRITE THE SECOND

Acute pain related to surgical tissue trauma and guarding with movement. Now you can act: positioning, splinting, premedicating before walking.

WORKED CASE 2 · CLUSTERING CUES

Mrs. Abbott, 82, has a urinary catheter. Today: HR 118, temperature 38.4 °C, RR 24, systolic 96, new confusion. Her hypothyroidism is well controlled.

STEP 1 · DROP WHAT IS NOT DRIVING TODAY

Stable, treated hypothyroidism is not the cause of today's picture.

STEP 2 · GROUP THE REST

Fever, fast heart, fast breathing, low pressure and new confusion share one likely cause.

STEP 3 · SCORE QSOFA

RR 24 (≥ 22): yes. Altered mentation: yes. Systolic 96 (≤ 100): yes. Score 3 of 3, positive.

STEP 4 · NAME THE STEP

Grouping cues into one explanation is "analyze cues." Treating sepsis as likelier and more dangerous than dehydration is "prioritize hypotheses."

STEP 5 · ACT

Escalate for cultures, lactate and antibiotics within the sepsis bundle.

WORKED CASE 3 · WHO FIRST?

Four patients call at once: one wants pain medication for 6/10 incisional pain, one is due for a scheduled antibiotic, one has new stridor, and one asks about discharge teaching.

STEP 1 · APPLY ABC

Stridor means a partly blocked airway that can close. Airway outranks everything.

STEP 2 · THEN MASLOW AND ACUTE FIRST

Pain is an acute physiologic need, so it comes next.

STEP 3 · THEN THE SCHEDULED CARE

The antibiotic is time sensitive but not an emergency.

ORDER

Stridor, then pain, then the antibiotic, then teaching.

WORKED CASE 4 · EVALUATING AN OUTCOME

The outcome said: "$SpO_2 \geq 94\%$ on 2 L/min by end of shift." At 1900 the SpO_2 is 92% on 3 L/min with RR 22.

STEP 1 · COMPARE DATA TO THE OUTCOME

92% is below 94%, and the oxygen is higher than planned.

STEP 2 · JUDGE IT

Not met.

STEP 3 · LOOK FOR THE REASON

Check in order: was the assessment data wrong, was the diagnosis or etiology wrong, was the outcome unrealistic, or were the interventions not done?

STEP 4 · REVISE AND ACT

Revising the plan is the process working. Carrying the outcome forward unchanged for three shifts is the failure.

TRAPS PEOPLE FALL INTO

- **Charting a number someone else took.** A value you did not obtain yourself is a rumor. Recheck before you escalate on it.
- **Picking the convenient number when data conflict.** Validate: apical pulse for a full minute, manual pressure, ask again.
- **Using a medical diagnosis as the etiology.** "Related to pneumonia" gives you nothing to treat.
- **Adding "as evidenced by" to a risk diagnosis.** If there is evidence, it is no longer a risk.

- **Writing the nurse's action as an outcome.** "Encourage fluids" is an intervention. Outcomes describe the patient.
- **Treating a normal value as safe.** A value inside the range can still be a sharp change from this patient's baseline.
- **Skipping reassessment.** An intervention with no documented reassessment looks, in a chart and in court, like one that failed.
- **Waiting for a number before calling.** "Something is wrong" is a valid rapid response trigger.

Chapter 2 self-test · ten items

1. A patient says, "It feels like an elephant is on my chest." What kind of data is this?

A. Subjective data from the primary source
B. Objective data from the primary source
C. Subjective data from a secondary source
D. Objective data from a secondary source

A. Subjective data from the primary source It is a symptom the patient reports, and the patient is the primary source.

2. The monitor shows a heart rate of 146, but the radial pulse feels slow and regular. What should the nurse do first?

A. Chart the monitor value as the heart rate
B. Count an apical pulse for one full minute
C. Call the rapid response team right away
D. Chart the radial value and move on

B. Count an apical pulse for one full minute Conflicting data must be validated before acting. An apical pulse for a full minute settles it.

3. Which assessment is incomplete on purpose?

A. The initial assessment done on admission
B. A focused assessment of a single system
C. The ongoing check at the start of a shift
D. The emergency assessment of a crashing patient

D. The emergency assessment of a crashing patient The emergency primary survey trades completeness for speed.

4. A student drafts four nursing diagnoses for a frail patient. Which one follows the rules?

A. Risk for falls as evidenced by two falls at home last month
B. Risk for falls related to postural hypotension and new sedative use
C. Risk for falls related to Parkinson disease as evidenced by gait
D. Acute pain related to surgery as evidenced by a pain score of 8

B. Risk for falls related to postural hypotension and new sedative use A risk diagnosis has two parts and no "as evidenced by," and the etiology must be treatable by nursing.

5. Which is a SMART outcome?

A. Patient will walk 30 feet twice today with a pain score of 3 or less
B. Patient will have less pain and walk more over the next few days
C. Nurse will give pain medication before each walk in the hallway
D. Patient will understand the importance of walking after surgery

A. Patient will walk 30 feet twice today with a pain score of 3 or less It names a patient behavior, a measure and a time frame. The others are vague or describe the nurse.

6. After an IV opioid, when should the nurse reassess pain?

A. Within 5 to 10 minutes
B. Within 45 to 60 minutes
C. Within 15 to 30 minutes
D. At the next scheduled vital signs

C. Within 15 to 30 minutes IV analgesics are reassessed in 15 to 30 minutes; oral analgesics in 45 to 60.

7. Which intervention is independent?

A. Starting an IV fluid bolus for low pressure
B. Raising the head of the bed to 30 to 45 degrees
C. Giving a nebulizer treatment on a set schedule
D. Changing the diet to a clear liquid diet

B. Raising the head of the bed to 30 to 45 degrees Positioning needs no order. Fluids and diet changes need orders, and scheduled nebulizers are collaborative with respiratory therapy.

8. A patient has RR 23, is newly confused and has a systolic of 104. What is the qSOFA score?

A. 1, a negative screen
B. 3, a positive screen
C. 0, a negative screen
D. 2, a positive screen

D. 2, a positive screen RR 23 meets ≥ 22 and confusion counts. Systolic 104 is above 100, so it does not count. Two of three is positive.

9. In the Clinical Judgment Measurement Model, deciding that sepsis is more likely and more dangerous than dehydration is which step?

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

C. Prioritize hypotheses Ranking possible explanations by likelihood and danger is prioritizing hypotheses.

10. Over the right lower lung, the nurse hears a dull note on percussion. What does it most likely suggest?

A. Consolidation or fluid in that area
B. Normal, healthy air filled lung
C. Air trapped in the alveoli there
D. A normal finding near the stomach

A. Consolidation or fluid in that area Dullness over lung means something solid or fluid has replaced air: consolidation, effusion or atelectasis.

ONE PAGE

Cram sheet

Everything from chapters 1 and 2 in one place. Cover the right column and see if you can rebuild each row.

Numbers to know

Item	Value	Note
Temperature, oral	36.5 to 37.5 °C; fever ≥ 38.0 °C	Rectal about 0.5 °C higher, axillary about 0.5 °C lower
Pulse and respirations	60 to 100; 12 to 20	Count a full 60 s if irregular, and count respirations unobserved
Blood pressure	Below 120/80; MAP at least 65	Stage 1: 130 to 139 or 80 to 89; stage 2: ≥ 140 or ≥ 90; crisis > 180 and/or > 120
SpO_2	95 to 100% room air	Below 90% is hypoxemia
Urine output	≥ 0.5 mL/kg/hour, about 30 mL/hour	Red flag below that for 2 hours
Orthostatics	Drop of 20 systolic or 10 diastolic, or pulse up 20	Within 3 minutes of standing
Pediatric hypotension, ages 1 to 10	Systolic below 70 + 2 × age	Late, pre-arrest sign
Pregnancy	HR up 10 to 20; blood volume up 30 to 50%	Left lateral tilt after about 20 weeks
Cuff size	Bladder width 40%, length 80% of arm	Too small reads high; too large reads low
Palpation depth	Light about 1 cm; deep 4 to 5 cm	Tender areas last
Restraint orders	4 h adult; 2 h ages 9 to 17; 1 h under 9	Face to face within 1 hour; never PRN
Red flags (adult)	RR < 8 or > 28; HR < 40 or > 130; SBP < 90	SpO_2 < 90%; any new confusion

Formulas and formats

Name	Formula or format	Use
MAP	(systolic + 2 × diastolic) ÷ 3	At least 65 mm Hg to perfuse organs
Pulse pressure	Systolic minus diastolic	30 to 40 mm Hg normal
Actual diagnosis	P r/t E AEB S	Three parts
Risk diagnosis	Label r/t risk factors	Two parts, no AEB
SBAR	Situation, Background, Assessment, Recommendation	Headline first, numbers not adjectives
qSOFA	RR ≥ 22, altered mentation, SBP ≤ 100	Two or more is positive

Rules that are not numbers

Topic	The rule
Scope test	Practice act, then policy and order, then your own competence. A no anywhere means stop.
Never delegate	Assessment, diagnosis and planning, teaching, evaluation, unstable patients.
Five rights	Task, circumstance, person, direction and communication, supervision and evaluation.
Negligence	Duty, breach, causation, damages: all four.
Exam order	Inspect, palpate, percuss, auscultate. Abdomen: inspect, auscultate, percuss, palpate.
Skin tone	Look at oral mucosa, conjunctivae, sclerae, palms and soles; palpate for warmth and induration.
Priorities	ABC, then Maslow, then actual before risk and acute before chronic.
Speaking up	Two challenge rule and CUS: Concerned, Uncomfortable, Safety issue. Anyone may call a rapid response.

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