HEALTH ASSESSMENT · STUDY GUIDE

Exam 2 Study Guide

This guide covers chapters 3 and 4. First you will learn how assessment travels: to the patient through therapeutic communication, to the team through SBAR and read-back, and to the future through the chart and the handoff. Then you will learn the habits that keep care from causing harm: two identifiers, fall screening, restraints within legal limits, hand hygiene, the PPE order, the three precaution tiers and the rules of a sterile field. 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 3 · Peplau's phases, therapeutic and non-therapeutic responses, SOLER, communicating across the lifespan, qualified interpreters and teach-back, SBAR and ISBAR, call-now thresholds, closed loop communication, critical values, CUS and the two challenge rule, charting formats and rules, vague versus precise entries, error correction and late entries, the Do Not Use list, HIPAA, I-PASS and bedside shift report, delegation and hard conversations.
- Chapter 4 · just culture and event reports, rapid response triggers, two identifiers and the time-out, fall screening and the four Ps, restraint rules, RACE and PASS, the chain of infection, colonization versus infection, signs of infection across the lifespan and skin tones, qSOFA and neutropenic fever, the five moments, when soap and water is required, sharps and exposures, donning and doffing, contact, droplet and airborne precautions, sterile field rules and the CLABSI, CAUTI, VAP and SSI bundles.

CHAPTER 3

Communication, Documentation and Handoff

Read it in full: **Chapter 3 in the textbook**. Practice it in the lab: **The Therapeutic Encounter** and **The Handoff Room**.

What to know

Most serious harm in hospitals traces back to a communication failure: a concern said too softly, a handoff that skipped the one detail that mattered, or a chart entry too vague to show a trend. Assessment travels three ways: to the patient (therapeutic communication), to the team (SBAR and read-back) and to the future (the record and the handoff).

Therapeutic communication is goal directed, time limited and centered on the patient. Peplau's three phases still hold: **orientation** (your name, role, what you will do and how long), **working** (assessment, teaching, problem solving) and **termination** (summarize, confirm, say what happens next). Skipping orientation is the most common student error. The highest yield technique is **silence**: after a hard question, wait three to five seconds.

Therapeutic moves include open-ended questions, reflection ("You said you felt like a burden"), restating, clarification, focusing, offering self, making an observation and summarizing. Non-therapeutic responses close the door: false reassurance, "why" questions, giving advice, changing the subject, approval or disapproval, defensiveness and clichés. Ask "What made it hard to take?" instead of "Why didn't you take it?"

Sit down at or below eye level. SOLER means sit squarely, open posture, lean slightly forward, eye contact as fits the culture, relaxed. If a patient will not talk, check the mechanics first: hearing aids, glasses, dentures, noise, pain, position. For older adults with presbycusis, lower your pitch rather than shout, face them and slow down. Never use elderspeak.

For a patient with limited English proficiency, use a **qualified medical interpreter** in person, by video or by phone. It is a Title VI civil rights requirement. Never use a child, and do not use family except in a life threatening emergency while an interpreter is found. Speak to the patient in the first person and document the interpreter's name or ID and the mode. For low health literacy, use plain words, limit teaching to three points, and close with **teach-back**, which tests your teaching, not the patient.

SBAR (or ISBAR, adding Introduction) puts the headline first. The part new nurses leave out is the **Recommendation**: state what you want and by when, even if you are unsure. The chapter's call-now thresholds for adults are respirations under 8 or over 28, heart rate under 40 or over 130,

systolic under 90 or a drop over 40 from baseline, SpO_2 under 90% or a new oxygen need, any new confusion or a GCS drop of 2 or more, urine output under 30 mL/hour for 2 hours, and glucose under 70 (treat first) or over 400 mg/dL.

Closed loop communication has three legs: the sender states, the receiver repeats it back, the sender confirms. It is required for verbal and telephone orders and for critical values. Examples of critical values from the chapter: potassium below 2.5 or above 6.5 mmol/L, sodium below 120 or above 160, glucose below 50 or above 400, hemoglobin below 7, platelets below 50,000, INR above 5, a positive blood culture. Write it down, read it back, note the caller and time, notify the provider and document the notification. When you are not heard, use CUS (Concerned, Uncomfortable, Safety issue) and the two challenge rule, and go up the chain of command.

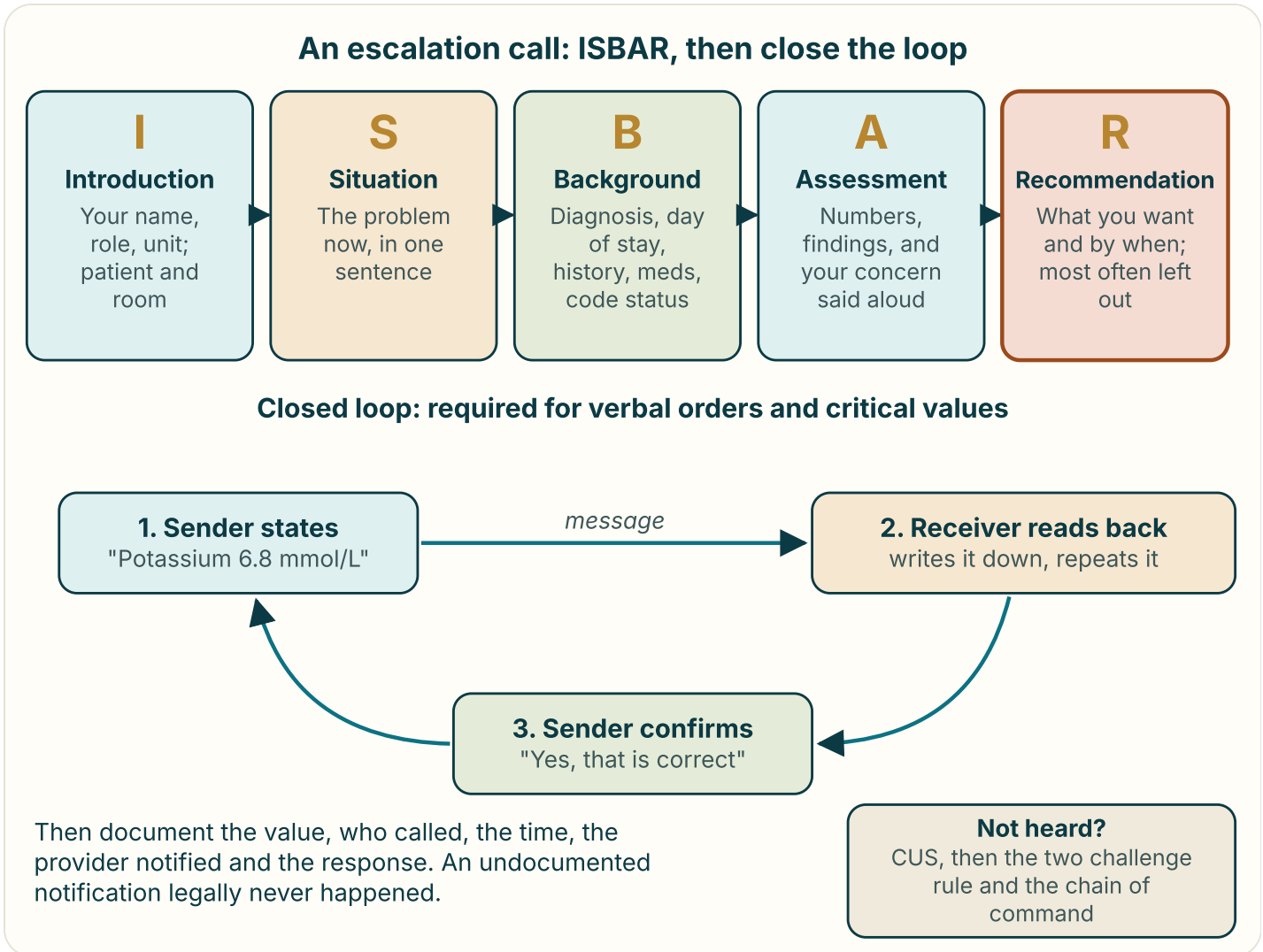
The record has to be timely, accurate and objective, complete, legible, attributed and chronological. If it was not documented, it was not done; if it was documented but not done, that is fraud. Chart measurements and quotations, not adjectives. Correct a paper error with a single line, "error," your initials, date and time. Label a late entry with both times and never backdate. Never chart "incident report filed." Avoid the Do Not Use list: U, IU, QD, QOD, trailing zeros, missing leading zeros, and MS, MSO_4, $MgSO_4$.

A handoff transfers responsibility and the information to act. **I-PASS**: illness severity (stable, watcher, unstable), patient summary, action list, situation awareness and contingency planning, and synthesis by the receiver. If the receiver did not say the plan back, the handoff is not complete. Bedside shift report happens in the room with a joint visual check of lines, drains, oxygen, pumps and safety items; sensitive information is discussed privately.

You may delegate tasks but never assessment, teaching, evaluation or the unstable patient. Feeding a patient with dysphagia and the first walk after an epidural stay with the nurse. Delegate in one sentence with numbers and a reporting threshold, then ask for a check-back. A competent adult may refuse care: make sure the refusal is informed, notify the provider and document the patient's own words.

LOCK THESE IN

- Orientation, working, termination. Do not skip the orientation.
- Silence, reflection and open questions open the door; false reassurance and "why" close it.
- Qualified interpreter, never a child; teach-back tests the teaching.
- SBAR ends with a specific Recommendation and a timeframe.
- Read back every verbal order and critical value, then document the notification.
- Not heard? CUS, two challenge rule, chain of command. A rapid response needs no permission.
- Chart measurements and quotes; correct with a single line; never "incident report filed."
- I-PASS ends with synthesis by the receiver.



Say it in order, then close the loop. ISBAR puts the headline first and ends with a specific request. Every verbal order and critical value is read back and confirmed, then charted with names and times.

Call now thresholds (chapter 3, adult)

Parameter	Expected	Escalate now
Temperature	36.5 to 37.5 °C	Above 38.0 °C or below 36.0 °C
Heart rate	60 to 100	Below 40 or above 130; new irregular rhythm with symptoms
Respirations	12 to 20	Below 8 or above 28
Blood pressure	Below 120/80	Systolic below 90, or a drop over 40 from baseline; over 180/120 with symptoms
SpO_2	95 to 100%	Below 90%, or a new oxygen need
Consciousness	Baseline	Any new confusion, agitation, or a GCS drop of 2 or more
Urine output	At least 0.5 mL/kg/hour	Below 30 mL/hour for 2 hours
Glucose	70 to 99 mg/dL fasting	Below 70 (treat, recheck in 15 min) or above 400
Older adult fever	Blunted	Single oral above 37.8 °C, persistent above 37.2 °C, or 1.1 °C over baseline

Therapeutic and non-therapeutic responses

Response	Example	Effect
Open-ended question	"Tell me what the pain has been like."	Gets the patient's own story
Reflection	"You said you felt like a burden."	Returns the feeling without judging it
Clarification	"Dizzy as in spinning, or faint?"	Separates vertigo from presyncope
Silence	Pause 3 to 5 seconds	Room to organize a hard thought
False reassurance	"Everything will be fine."	Dismisses the fear and ends the topic
"Why" question	"Why didn't you take your insulin?"	Sounds like an accusation
Giving advice	"If I were you, I'd have the surgery."	Replaces their values with yours
Defensiveness	"The night nurse is very experienced."	Shuts down a possible safety report

Do Not Use list

Do not write	Write instead	Why
U or u	"unit"	Read as 0 or 4
IU	"international unit"	Read as IV or 10
QD, QOD	"daily," "every other day"	Confused with QID
1.0 mg (trailing zero)	1 mg	Read as 10 mg
.5 mg (no leading zero)	0.5 mg	Read as 5 mg
MS, MSO_4, $MgSO_4$	"morphine sulfate" or "magnesium sulfate"	Confused with each other

Worked cases

WORKED CASE 1 · CHOOSING THE THERAPEUTIC REPLY

Mr. Bell says, "I don't think this surgery is going to help me." Four replies are on the table: "Don't worry, your surgeon is excellent." "Why do you feel that way?" "I'd have it if I were you." "You don't think it will help."

STEP 1 · NAME EACH ONE

False reassurance, a "why" question, giving advice, and reflection.

STEP 2 · PICK THE ONE THAT OPENS THE DOOR

Reflection: "You don't think it will help." An open question such as "Tell me more about that" also works.

STEP 3 · THEN WAIT

Count to five before you speak again. The reason he gives is the clinically useful part.

WORKED CASE 2 · A CRITICAL VALUE FROM THE LAB

At 1410 the lab calls a potassium of 6.8 mmol/L on Ms. Diaz.

STEP 1 · WRITE AND READ BACK

Write the value as spoken, read it back, get confirmation, and note the caller's name and the time.

STEP 2 · ASSESS THE PATIENT

Cardiac rhythm and monitoring, weakness. Ask whether the sample could have been hemolyzed.

STEP 3 · NOTIFY WITH SBAR

Call the provider at once and end with a request: "I am requesting orders to treat the potassium and a 12-lead ECG."

STEP 4 · DOCUMENT

Value, read-back, caller, time of notification, provider name, orders and the patient's response. An undocumented notification never happened.

WORKED CASE 3 · THREE DANGEROUS ORDERS

You receive: "Insulin 10 U SQ q.d.," "Digoxin .25 mg PO daily" and "MS 2.0 mg IV q4h PRN."

STEP 1 · INSULIN

"U" can be read as 0 or 4, and "q.d." as QID. It should read "10 units daily."

STEP 2 · DIGOXIN

".25" with no leading zero can be read as 25 mg. It should read "0.25 mg."

STEP 3 · MORPHINE

"MS" could be morphine or magnesium, and "2.0" can be read as 20. It should read "morphine sulfate 2 mg."

STEP 4 · ACT

Clarify all three with the prescriber. Do not interpret them yourself.

WORKED CASE 4 · A HANDOFF WITH I-PASS

You hand off Ms. Marks, 68, day one after a hip repair, who dropped to SpO_2 88% overnight and is now on 4 L/min.

STEP 1 · ILLNESS SEVERITY

"She is a watcher."

STEP 2 · PATIENT SUMMARY

Age, code status, surgery and day, and the overnight event: CT negative for clot, thought to be atelectasis.

STEP 3 · ACTION LIST

Incentive spirometer every hour while awake, chair with PT at 1000, CBC at 1200.

STEP 4 · SITUATION AWARENESS

"If her SpO_2 drops below 92 on 4 liters, get an ABG and call the provider."

STEP 5 · SYNTHESIS BY RECEIVER

The oncoming nurse says the plan back and asks what is pending. Until then, the patient has not been handed over.

TRAPS PEOPLE FALL INTO

- **Using a family member to interpret.** Use a qualified interpreter. A child is never the interpreter.
- **Shouting at an older adult with hearing loss.** Shouting raises pitch and makes presbycusis worse. Lower your pitch.
- **Ending SBAR after the Assessment.** Without a Recommendation, the provider has to guess what you want.
- **Calling the provider without read-back.** Verbal orders and critical values need closed loop confirmation.
- **Charting "pink and well perfused" by reflex.** Look at mucosa, conjunctivae and palms, especially in darker skin.
- **Writing "incident report filed" in the chart.** Chart the facts about the patient; the report is a separate document.
- **Backdating a missed entry.** Label it a late entry with both times.

- **Copying forward yesterday's assessment.** It copies yesterday's errors. Read and edit every line.

Chapter 3 self-test · ten items

1. A patient quietly says, "I feel like I am just a burden to everyone." Which nurse reply is a reflection?

A. "Don't worry, your family loves you very much."
B. "You feel like you are a burden to everyone."
C. "Why would you ever feel like that about yourself?"
D. "Let us talk about your lunch order for today."

B. "You feel like you are a burden to everyone." Reflection returns the feeling to the patient without judging it. The others are false reassurance, a "why" question and changing the subject.

2. A patient who speaks only Tagalog needs discharge teaching. Her 12 year old grandson offers to translate. What should the nurse do?

A. Arrange a qualified interpreter by phone or video
B. Let the grandson translate, since he knows her best
C. Give her the teaching sheet printed in English only
D. Teach slowly in plain English and use many gestures

A. Arrange a qualified interpreter by phone or video Title VI requires a qualified interpreter. A child is never used except in a life threatening emergency while one is found.

3. A new nurse calls a provider, gives a clear picture of the patient, and then stops talking. Which SBAR part was skipped?

A. The Situation line
B. The Background part
C. The Recommendation
D. The Assessment part

C. The Recommendation New nurses often deliver S, B and A and stop. State the request and the timeframe out loud.

4. Under the chapter's call-now thresholds, which adult finding needs a call right away?

A. Heart rate of 108 per minute
B. Systolic blood pressure of 104
C. Oral temperature of 37.6 °C
D. Respirations of 30 per minute

D. Respirations of 30 per minute A respiratory rate above 28 crosses the escalation line. The other values are abnormal or borderline but under the thresholds.

5. What are the three legs of closed loop communication?

A. Sender writes, receiver signs, charge nurse files
B. Sender pages, receiver calls back, sender charts
C. Sender states, receiver repeats, sender confirms
D. Receiver asks, sender answers, receiver documents

C. Sender states, receiver repeats, sender confirms Closed loop: state, read back, confirm. It is required for verbal orders and critical values.

6. Which value from the lab is a critical value by the chapter's list?

A. Platelets of 42,000/mm^3
B. Sodium of 131 mmol/L
C. Potassium of 5.4 mmol/L
D. Hemoglobin of 9.8 g/dL

A. Platelets of 42,000/mm^3 Platelets below 50,000 are critical. Sodium must be below 120, potassium above 6.5, and hemoglobin below 7.

7. At 1900 a nurse realizes a 1345 dressing change was never charted. What is correct?

A. Write it in at 1345 in the blank space that is left
B. Enter it now, labeled as a late entry for 1345
C. Ask the day nurse to chart it under her own login
D. Leave it out, since the change was already done

B. Enter it now, labeled as a late entry for 1345 Late entries carry both the current time and the event time. Backdating or charting under another login is falsification.

8. Which order is written in a safe form?

A. Insulin 8 U subcut before meals
B. Morphine 2.0 mg IV every 4 hours
C. Digoxin .125 mg by mouth daily
D. Metoprolol 25 mg by mouth daily

D. Metoprolol 25 mg by mouth daily "U," a trailing zero and a missing leading zero are all on the Do Not Use list.

9. During handoff, the oncoming nurse listens but repeats nothing back. Which I-PASS step is missing?

A. Illness severity rating
B. Action list review
C. Synthesis by receiver
D. Situation awareness

C. Synthesis by receiver The receiver saying the plan back is the whole point. Until then, the patient has not been accepted.

10. A provider says to "recheck in two hours" for a patient the nurse believes is septic, and the patient worsens. What should the nurse do next?

A. Use CUS, call a rapid response and notify the charge nurse
B. Recheck the vital signs again in two hours as ordered
C. Wait for the morning team and chart the vital signs
D. Page the same provider every 15 minutes until morning

A. Use CUS, call a rapid response and notify the charge nurse Under the two challenge rule, a concern raised twice and not addressed must go up the chain. No permission is needed for a rapid response.

CHAPTER 4

Safety, Asepsis and Infection Prevention

Read it in full: **Chapter 4 in the textbook**. Practice it in the lab: **Hands and Barriers** and **The Isolation Bench**.

What to know

Safety is a system, not a personality trait. **Just culture** sorts events into human error (console and fix the system), at-risk behavior (coach) and reckless behavior (discipline). That is why reporting near misses is safe. Complete an event report for falls, medication errors, near misses, equipment

failures and exposures, chart the clinical facts in the record, and never mention the report in the chart.

A **rapid response team** can be called by any staff member, often by the patient or family, without an order. Typical triggers: heart rate below 40 or above 130, respirations below 8 or above 28, systolic below 90, SpO_2 below 90% despite oxygen, a new seizure, acute chest pain, a sudden drop in consciousness or urine output, or a staff member who is worried. That last one is a written criterion. Call early.

Use **two identifiers** (full name, date of birth, medical record number) before every medication, blood product, specimen, treatment or procedure. A room number is never an identifier. Ask open-ended: "Tell me your full name and date of birth." Before invasive procedures, the team does a **time-out**, and anyone, including a student, may stop it.

Falls are the most common reported hospital adverse event. Screen with a validated tool on admission, transfer, change in condition, after a fall and per policy each shift. On the **Morse Fall Scale**, 45 or higher is high risk and 25 to 44 is moderate. On the Hendrich II, 5 or more is high risk. The score tells you to act. Universal precautions: bed low and locked, call light and items in reach, light, nonskid footwear, clear paths. High risk adds hourly rounding on the four Ps: **pain, potty, position, possessions**. Four side rails up is a restraint, not a precaution. After a fall, assess in place before you move the patient.

Restraint orders are never PRN and use the least restrictive method. For violent or self destructive behavior: 4 hours for adults, 2 hours for ages 9 to 17, 1 hour under 9, a face to face evaluation within 1 hour, renewal up to 24 hours before an in-person re-evaluation, and monitoring commonly every 15 minutes. Release every 2 hours for skin, circulation, sensation, range of motion, toileting and fluids. Tie to the movable bed frame with a quick release knot, two fingers of slack, never to a side rail, never prone. For fire: **RACE** (rescue, alarm, confine, extinguish or evacuate) and **PASS** (pull, aim at the base, squeeze, sweep).

Infection needs all six links of the chain: infectious agent, reservoir, portal of exit, mode of transmission, portal of entry and a susceptible host. Break any one and there is no infection. **Colonization** is presence without tissue damage or host response and is not treated with

antibiotics, though it may still need precautions. A healthcare associated infection was not present or incubating at admission.

Signs of infection change with age and skin tone. A neonate under 28 days with a rectal 38.0 °C is an emergency. Older adults may never pass 38.0 °C; long term care criteria define fever as a single oral above 37.8 °C, repeated above 37.2 °C, or a rise over 1.1 °C from baseline, and new delirium, falls or not eating may be the only sign. In darker skin, inflammation may look violaceous, brown, gray or just darker, so compare sides and palpate for warmth and induration. Mark the border of cellulitis with a skin pen and the time.

Red flags: qSOFA of 2 or more (RR ≥ 22, altered mentation, systolic ≤ 100) with suspected infection; **neutropenic fever** (38.3 °C, or a sustained 38.0 °C, with ANC below 500), where antibiotics are due within one hour; fever with a petechial rash; pain out of proportion with crepitus; lactate ≥ 2 mmol/L.

Hand hygiene at the WHO **five moments**: before touching a patient, before a clean or aseptic procedure, after body fluid exposure risk, after touching a patient, after touching the surroundings. Alcohol rub (60 to 95%) for 20 to 30 seconds until dry is preferred. Soap and water for at least 20 seconds is required when hands are visibly soiled, after C. difficile, during norovirus outbreaks, after anthrax exposure, and before eating or after the restroom, because alcohol does not kill spores. PPE goes on gown, mask, goggles, gloves and comes off gloves, goggles, gown, mask; the N95 comes off only outside an airborne room.

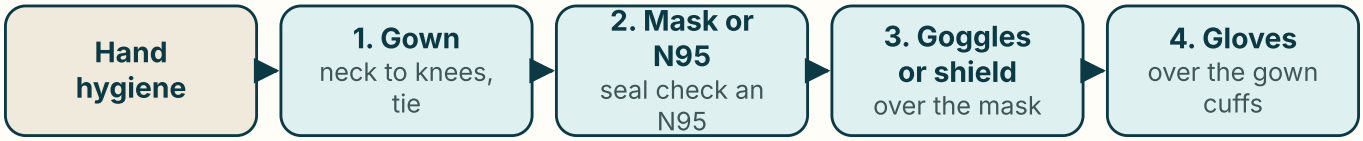
Contact precautions: gown and gloves (MRSA, VRE, C. difficile, norovirus, scabies). **Droplet**: a surgical mask on entry (influenza, pertussis, meningococcus, mumps). **Airborne**: fit tested N95 and a negative pressure room with the door closed (tuberculosis, measles, varicella, disseminated zoster). Start on suspicion. Surgical asepsis is required to enter a sterile cavity or the bloodstream. Only sterile touches sterile, the outer 1 inch is not sterile, keep the field in view and above the waist, and doubt equals contamination. Device bundles (CLABSI, CAUTI, VAP, SSI) work only when every element is done every time.

LOCK THESE IN

- Two identifiers, never the room number; anyone may stop a time-out.
- Morse 45 or more is high risk; round on pain, potty, position, possessions.
- Four rails up is a restraint. Restraint orders are never PRN.
- Six links: agent, reservoir, exit, transmission, entry, susceptible host.
- Soap and water for soiled hands, C. difficile, norovirus, anthrax, before eating and after the restroom.
- Don gown, mask, goggles, gloves. Doff gloves, goggles, gown, mask; N95 off outside the airborne room.
- Contact: gown and gloves. Droplet: surgical mask. Airborne: N95 and negative pressure.
- Sterile field: 1 inch border, above the waist, in view; doubt means contaminated.

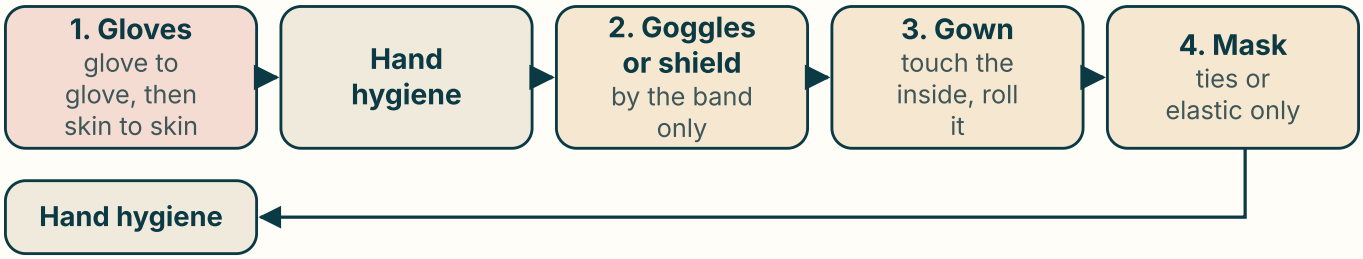
PPE: the order is the safety feature

DONNING, before entering



Memory hook: gown, mask, goggles, gloves (gloves last, covering the cuffs)

DOFFING, at the doorway inside the room



Memory hook: gloves, goggles, gown, mask (dirtiest off first, mask last)

Airborne precautions exception

Remove the N95 respirator only AFTER you leave the room and close the door. It is the only item ever removed outside.

On in size order, off dirtiest first. Donning ends with gloves so they overlap the gown. Doffing starts with gloves and ends with the mask, with hand hygiene between and at the end. In an airborne room the respirator comes off outside.

Transmission-based precautions

Tier	Spread and examples	Room and PPE
Contact	Hands, equipment, surfaces: MRSA, VRE, CRE, C. difficile, norovirus, RSV, scabies, lice	Private room or cohort; gown and gloves on entry; dedicated equipment
Droplet	Large particles, 3 to 6 feet: influenza, pertussis, meningococcus, Hib, mumps, rubella	Private room or beds 3 feet apart; surgical mask on entry; patient masks for transport
Airborne	Nuclei of 5 µm or less that stay suspended: TB, measles, varicella, disseminated zoster	Negative pressure, door closed; fit tested N95; patient wears a surgical mask to travel
Protective environment	Keeps organisms out for stem cell transplant patients	Positive pressure, HEPA, 12 or more air changes; no flowers or plants

Safety and infection numbers

Item	Value	Note
Morse Fall Scale	45 or more high; 25 to 44 moderate	Hendrich II: 5 or more high
Orthostatic change	Systolic drop ≥ 20, diastolic ≥ 10, or HR rise ≥ 20	Within 3 minutes of standing
Restraint, violent behavior	4 h adult; 2 h ages 9 to 17; 1 h under 9	Face to face within 1 h; renew up to 24 h
Restraint release	Every 2 hours	Skin, circulation, ROM, toileting, fluids
Alcohol rub	60 to 95% alcohol, 20 to 30 seconds	Rub until dry
Handwashing	At least 20 seconds of friction	Whole process 40 to 60 seconds
Sharps container	Replace at three quarters full	Never recap; never reach in
Exposure transmission risk	HIV about 0.3%; HCV about 1.8%; HBV up to 30% unvaccinated	HIV PEP within hours, no later than 72 h
Airborne room clearance	12 ACH: 23 min (99%), 35 min (99.9%)	6 ACH: 46 and 69 minutes
Neutropenic fever	38.3 °C, or sustained 38.0 °C, with ANC below 500	Antibiotics within 1 hour
WBC	4,500 to 11,000/mm^3	Above 12,000, below 4,000, or over 10% bands
Lactate	Below 2 mmol/L	≥ 2, especially ≥ 4, drives sepsis care

Worked cases

WORKED CASE 1 · WHICH HAND HYGIENE?

You just repositioned Mr. Ford, who has C. difficile. Your hands look clean, and there is alcohol rub by the door.

STEP 1 · ASK WHAT ALCOHOL CAN KILL

Alcohol does not kill C. difficile spores.

STEP 2 · CHOOSE SOAP AND WATER

Only friction and rinsing remove spores from the skin.

STEP 3 · DO IT RIGHT

Wet with warm water, lather, rub all surfaces at least 20 seconds, rinse fingertips down, dry with a paper towel, and turn off the tap with the towel.

ROOM CLEANING

The room also needs an EPA registered sporicidal agent such as 1:10 bleach.

WORKED CASE 2 · ASSIGNING PRECAUTIONS

Four new admissions: measles, MRSA in a draining wound, pertussis, and chickenpox.

STEP 1 · MEASLES

Airborne: negative pressure, door closed, fit tested N95, immune staff only. The particles stay infectious in the air up to 2 hours after the patient leaves.

STEP 2 · MRSA WOUND

Contact: gown and gloves on entry, dedicated equipment.

STEP 3 · PERTUSSIS

Droplet: surgical mask on entry; the patient masks for transport.

STEP 4 · CHICKENPOX

Airborne plus contact, because the vesicles also spread by touch.

WORKED CASE 3 · WHEN CAN THE AIRBORNE ROOM BE CLEANED?

A patient with tuberculosis left an airborne room at 1015. The room has 12 air changes per hour. Housekeeping asks when they may enter.

STEP 1 · FIND THE CLEARANCE TIME

At 12 air changes per hour, 99% removal takes about 23 minutes and 99.9% about 35 minutes.

STEP 2 · ADD IT TO THE CLOCK

1015 + 35 minutes = 1050 for 99.9% removal.

STEP 3 · POST IT

Post the vacate time on the door so everyone uses the same clock, and check facility policy.

AT 6 AIR CHANGES

The times would be about 46 and 69 minutes instead.

WORKED CASE 4 · A FALL, CHARTED RIGHT

At 0215 the bed alarm sounds. Mrs. Kim is sitting on the floor by her bed and says, "I was trying to get to the bathroom and my legs gave out."

STEP 1 · DO NOT LIFT FIRST

Assess in place: consciousness, airway, breathing, circulation, head strike, pain, deformity, neuro status.

STEP 2 · MEASURE

Full vital signs. Escalate right away if she is on an anticoagulant or struck her head.

STEP 3 · MOVE SAFELY

Use a lift or two staff per safe patient handling policy.

STEP 4 · CHART ONLY FACTS

Where and how she was found, her words in quotes, findings with numbers, what you did, who you called and when. No "fell," no blame, and no mention of the event report.

TRAPS PEOPLE FALL INTO

- **Using the room number as an identifier.** Patients move. Use name, date of birth or record number.
- **Raising all four side rails to prevent a fall.** That is a restraint, and a climb over the rail makes the fall worse.
- **Tying a restraint to the side rail.** Tie it to the movable bed frame with a quick release knot.
- **Using alcohol rub after C. difficile care.** Spores need soap, water and friction.
- **Taking off the N95 inside the airborne room.** The respirator comes off only after you leave and close the door.
- **Putting an N95 on the patient for transport.** The patient wears a surgical mask; the N95 protects the wearer.
- **Treating a positive nasal MRSA swab with antibiotics.** No symptoms means colonization; precautions may still apply.
- **Reasoning "no fever, so no infection" in an older adult.** Delirium, falls and poor intake can be the only signs.

Chapter 4 self-test · ten items

1. Before giving a medication, which question best confirms the patient's identity?

A. "You are Mr. Alvarez in bed 4B, correct?"
B. "Tell me your full name and date of birth."
C. "Are you the patient getting this medicine?"
D. "Can you tell me your room number, please?"

B. "Tell me your full name and date of birth." An open-ended request for two identifiers is safest. A confused patient may agree to any name, and a room is never an identifier.

2. A patient scores 50 on the Morse Fall Scale. How is this read?

A. Moderate risk, so universal precautions are enough
B. Low risk, so no change in care is needed today
C. A score that cannot be read without a second tool
D. High risk, so targeted fall interventions are needed

D. High risk, so targeted fall interventions are needed On the Morse scale, 45 or more is high risk and 25 to 44 is moderate.

3. An adult is restrained for violent behavior. Within what time must a face to face evaluation occur?

A. Within 1 hour of starting
B. Within 4 hours of starting
C. Within 2 hours of starting
D. Within 24 hours of starting

A. Within 1 hour of starting The face to face evaluation is due within 1 hour. The order itself lasts up to 4 hours in an adult.

4. In the chain of infection, an indwelling urinary catheter is best described as which link?

A. The reservoir
B. The portal of exit
C. The mode of transmission
D. The portal of entry

D. The portal of entry Devices such as catheters, IV lines and tubes give organisms a way into the host.

5. A nurse's hands look clean after caring for a patient with norovirus during an outbreak. What hand hygiene is correct?

A. Use alcohol rub for 20 to 30 seconds until dry
B. Wash with soap and water for at least 20 seconds
C. Put on a fresh pair of gloves and move on
D. Wipe the hands with a disinfectant surface wipe

B. Wash with soap and water for at least 20 seconds Norovirus is a non-enveloped virus that resists alcohol. Soap, water and friction are required.

6. What is the correct order for removing PPE in a contact plus droplet room?

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

C. Gloves, goggles, gown, mask Doffing removes the dirtiest item first and the mask last, with hand hygiene after gloves and at the end.

7. A patient with suspected pulmonary tuberculosis needs a CT scan. How should the patient travel?

A. Wearing a fit tested N95 respirator mask
B. Wearing a surgical mask, lesions covered
C. With no mask, since the transporter is masked
D. Wearing a face shield and clean gloves only

B. Wearing a surgical mask, lesions covered The patient wears a surgical mask for source control. An N95 is never fit tested to the patient and adds work of breathing.

8. Which patient needs droplet precautions?

A. An adult with measles
B. A patient with C. difficile
C. A patient with varicella
D. A child with pertussis

D. A child with pertussis Pertussis is droplet. Measles is airborne, C. difficile is contact, and varicella is airborne plus contact.

9. While opening a sterile kit, the nurse is not sure whether the drape edge brushed the bed rail. What should the nurse do?

A. Treat it as contaminated and open a new kit
B. Continue, since there is no proof of contact
C. Wipe the drape edge with alcohol and continue
D. Move the brushed edge to the far side and go on

A. Treat it as contaminated and open a new kit In sterile technique, doubt equals contamination.

10. Which CAUTI prevention step is correct?

A. Irrigate the catheter each shift to keep it clear
B. Change the catheter every 3 days as a routine
C. Keep the bag below the bladder, off the floor
D. Clamp the tubing whenever the patient is moved

C. Keep the bag below the bladder, off the floor A closed system with the bag below the bladder and off the floor prevents backflow. Routine irrigation and changes are not part of the bundle.

ONE PAGE

Cram sheet

Everything from chapters 3 and 4 in one place. Cover the right column and see if you can rebuild each row.

Numbers to know

Item	Value	Note
Call now (adult)	RR < 8 or > 28; HR < 40 or > 130; SBP < 90	SpO_2 < 90%; any new confusion
Urine output	Below 30 mL/hour for 2 hours	Hypovolemia, kidney injury, obstruction
Glucose	Below 70: treat, recheck in 15 min	Above 400: call
Critical values	K < 2.5 or > 6.5; Na < 120 or > 160; glucose < 50 or > 400	Hgb < 7; platelets < 50,000; INR > 5
Morse Fall Scale	45 or more high risk	25 to 44 moderate
Restraints	4 h adult, 2 h ages 9 to 17, 1 h under 9	Face to face within 1 h; release every 2 h
Hand hygiene	Rub 20 to 30 s; wash at least 20 s	Alcohol 60 to 95%
Airborne room	Negative pressure; 6 ACH existing, 12 or more new	Clear: 35 min at 12 ACH, 69 min at 6 ACH (99.9%)
Neonate fever	Rectal ≥ 38.0 °C under 28 days	Full sepsis evaluation
Neutropenic fever	38.3 °C or sustained 38.0 °C, ANC < 500	Antibiotics within 1 hour
qSOFA	RR ≥ 22, altered mentation, SBP ≤ 100	Two or more is a red flag

Sequences and formats

Name	Sequence	Use
ISBAR	Introduction, Situation, Background, Assessment, Recommendation	Escalation with a specific request
I-PASS	Illness severity, Patient summary, Action list, Situation awareness, Synthesis	Handoff
Closed loop	State, read back, confirm	Verbal orders, critical values
CUS	Concerned, Uncomfortable, Safety issue	Formal stop signal
Donning	Hand hygiene, gown, mask, goggles, gloves	Gloves over the cuffs
Doffing	Gloves, goggles, gown, mask, hand hygiene	N95 removed outside
RACE and PASS	Rescue, Alarm, Confine, Extinguish; Pull, Aim, Squeeze, Sweep	Fire
Four Ps	Pain, potty, position, possessions	Hourly rounding

Rules that are not numbers

Topic	The rule
Interpreters	Qualified interpreter; never a child; document name or ID and mode.
Teach-back	Tests your teaching, not the patient.
Charting	Measurements and quotes; single line correction; label late entries; never mention the event report.
Soap and water	Soiled hands, C. difficile, norovirus, anthrax, before eating, after the restroom.
Precautions	Start on suspicion. Varicella and disseminated zoster are airborne plus contact.
Sterile field	Only sterile touches sterile; 1 inch border; in view, above the waist; never unattended.
Never delegate	Assessment, teaching, evaluation, unstable patients, sterile procedures, restraint assessment.

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