

OFFICIAL COURSE STUDY GUIDE

Patient Care Fundamentals

The bedrock nursing fundamentals: infection control, positioning, hygiene, safety, and skin.

HEALTHCARE & CAREGIVING · BEGINNER · 7 MODULES · 5 HR 29 MIN

Course by Level Up RN · Curated and published by MegaCourse

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Patient Care Fundamentals: The Complete Study Guide

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INTRODUCTION

About This Course

This study guide supports the MegaCourse online course, "Patient Care Fundamentals." This course covers the bedrock nursing skills. You will learn essential practices for infection control, patient positioning, personal hygiene, safety protocols, and skin care. These fundamentals are critical for providing competent, compassionate patient support in any healthcare setting.

MegaCourse has organized this learning path into 7 modules and 43 lessons. The instruction comes from Level Up RN, known for clear, practical teaching. This guide complements the video lessons, offering a structured resource to reinforce your understanding. It helps you apply theoretical knowledge to real-world scenarios.

The course design ensures a complete learning experience. It combines original video content with curated reading materials, a final knowledge-check quiz, and clear learning outcomes. This structure supports your progress and prepares you for practical application.

Course Facts

FORMAT	7 modules · 43 lessons
VIDEO INSTRUCTION	About 5 hr 29 min
LEVEL	Beginner
CATEGORY	Healthcare & Caregiving
INSTRUCTOR	Level Up RN
CERTIFICATE	Included with course completion on MegaCourse
COURSE HOME	megacourse.app/courses/patient-care-fundamentals

What You Will Learn

- Apply infection control and hand hygiene the way surveyors expect to see it.
- Position, turn, and mobilize patients to protect skin and joints.
- Deliver hygiene, elimination, and comfort care with dignity.
- Recognize and report early signs of pressure injuries and patient decline.

Who This Course Is For

This course is designed for students beginning their clinical coursework. It serves as a strong foundation for anyone new to direct patient care. The material focuses on core skills required in various healthcare environments.

No prior experience in healthcare is required to begin this course. It is structured to introduce fundamental concepts clearly and progressively.

Before You Start

- No prior experience is required.

How to Use This Guide

The "Patient Care Fundamentals" course is structured into 7 modules and 43 lessons. The total instruction time is about 5 hours and 29 minutes. We recommend watching the video lessons first. Then, use this study guide to review key concepts and solidify your understanding.

Each module builds on previous knowledge. Pace yourself to absorb the material thoroughly. Use the guide's summaries and practice questions, if included, to test your recall. This dual approach of video instruction and written review enhances retention.

The final assessment helps confirm your mastery of the material. A shareable certificate of completion is available once you finish the course.

CHAPTER 1

Principles of Patient Care and the Nursing Profession

Welcome to Chapter 1 of the official study guide for Patient Care Fundamentals. This chapter lays the essential groundwork for your nursing career. It covers the core principles that define the nursing profession, establish patient rights, and guide ethical decision-making.

Mastering these foundational concepts is crucial. They are not merely theoretical ideas. They are practical tools you will use daily to provide safe, compassionate, and legally sound patient care. Understanding these principles will prepare you for clinical practice and help you meet the high standards expected by healthcare surveyors.

The Nursing Profession and Ethical Practice

Covers: Nursing Profession and Ethics - Fundamentals of Nursing · The Nursing Profession: Fundamentals of Nursing

The nursing profession is a dynamic and essential part of healthcare. Nurses serve as patient advocates, educators, caregivers, and collaborators. Understanding the scope of nursing practice is fundamental. It defines the boundaries of your role and responsibilities. The American Nurses Association (ANA) provides comprehensive standards of practice. These standards outline the competent level of nursing care. They guide nurses in all settings and at all levels of experience. Adhering to these standards ensures quality patient outcomes and professional accountability.

Ethical principles are the moral compass for nursing practice. They guide decision-making in complex patient situations. Key ethical principles include:

- **Autonomy:** Respecting the patient's right to make decisions about their own healthcare. This includes the right to refuse treatment, even if it is life-saving.
- **Beneficence:** Acting in the best interest of the patient. This means promoting good and preventing harm.
- **Non-maleficence:** The duty to do no harm. This is a primary ethical obligation in all healthcare interventions.
- **Justice:** Fair and equitable distribution of resources and care. This principle addresses issues of access to healthcare and treatment for all individuals.
- **Fidelity:** Keeping promises and maintaining loyalty. This applies to commitments made to patients, colleagues, and the profession.
- **Veracity:** Telling the truth. This is crucial for building trust with patients and their families.

Nurses frequently face ethical dilemmas. These situations require careful consideration and a structured approach to resolution. A common framework for ethical decision-making involves several steps:

1. **Assess the situation:** Gather all relevant facts. Identify the individuals involved and the core ethical problem.
2. **Diagnose the ethical problem:** Clearly state the ethical conflict. Identify the competing values or principles.
3. **Plan:** Explore possible courses of action. Consider the consequences of each option. Consult with ethics committees or experienced colleagues if needed.
4. **Implement the decision:** Take the chosen action.
5. **Evaluate the outcome:** Reflect on the effectiveness of the decision. Learn from the experience.

Maintaining professional boundaries is also an ethical imperative. This involves establishing clear limits in the nurse-patient relationship. It protects both the patient and the nurse. Effective communication, empathy, and respect are hallmarks of ethical nursing practice. They build a foundation of trust essential for patient care. Understanding and applying these ethical principles ensures that you provide compassionate, respectful, and high-quality care to every patient.

Legal and Patient Rights in Nursing

Covers: Informed Consent and the Right to Refuse - Fundamentals of Nursing - Principles · Advance Directives and HIPAA - Fundamentals of Nursing - Principles · Torts and Mandatory Reporting - Fundamentals of Nursing - Principles

Nurses operate within a complex legal framework designed to protect patients and healthcare providers. Understanding patient rights and legal responsibilities is non-negotiable. One critical right is **informed consent**. This means a patient must receive all necessary information about a proposed treatment or procedure. This includes its purpose, risks, benefits, and alternative options. The patient must understand this information. They must then voluntarily agree to the treatment without coercion. The nurse's role is often to witness the patient's signature. The nurse also confirms the patient received and understood the information. The nurse must notify the provider if the patient has questions or appears not to understand.

Patients also have the **right to refuse treatment**. This right stems from the principle of autonomy. Even if a treatment is recommended or life-sustaining, a competent adult patient can refuse it. The nurse must respect this decision. The nurse should document the refusal clearly. This documentation includes that the patient understood the potential consequences of their refusal. Education and clear communication are vital in these situations. However, the patient's final decision must be honored.

Advance directives are legal documents that allow individuals to make healthcare decisions in advance. They apply if the person becomes unable to communicate their wishes. Common types include a Living Will and a Durable Power of Attorney for Healthcare (DPOAHC). A Living Will specifies medical treatments a person does or does not want to receive. A DPOAHC designates a trusted person to make healthcare decisions on the patient's behalf. Nurses must identify if a patient has advance directives. They must ensure these directives are respected and documented in the patient's medical record.

HIPAA (Health Insurance Portability and Accountability Act) protects patient privacy. It establishes national standards for the security of protected health information (PHI). PHI includes any information about a patient's health status, treatment, or payment for healthcare. Nurses have a legal and ethical duty to protect PHI. This means not sharing patient information with unauthorized individuals. It

also means securing patient charts and computer screens. Breaching HIPAA can result in severe penalties for both the individual and the institution.

Nurses must also understand **torts**, which are civil wrongs that cause harm to another person. Torts can be intentional or unintentional. Intentional torts include:

- **Assault:** Threatening a patient with harm.
- **Battery:** Touching a patient without consent.
- **False Imprisonment:** Unlawfully restraining a patient.

Unintentional torts include **negligence** and **malpractice**. Negligence is failing to act as a reasonably prudent person would in a similar situation. Malpractice is professional negligence. It occurs when a healthcare professional deviates from the accepted standard of care. This deviation results in patient injury. For malpractice to be proven, four elements must be present: duty, breach of duty, causation, and damages. Nurses must always practice within their scope and adhere to professional standards to avoid these legal pitfalls.

Finally, **mandatory reporting** laws require nurses to report certain situations to authorities. This includes suspected child abuse, elder abuse, and certain communicable diseases. These laws protect vulnerable populations and public health. Nurses are legally protected when making such reports in good faith. Understanding these legal duties is crucial for safe and responsible nursing practice.

Understanding Health Behavior and Nursing Theories

Covers: Theoretical Foundations - Fundamentals of Nursing - Principles · Health Belief and Transtheoretical Models - Fundamentals of Nursing

Nursing theories provide a framework for understanding and guiding nursing practice. They help organize knowledge, explain phenomena, and predict outcomes. Theories allow nurses to systematically approach patient care. They move beyond simply performing tasks. They encourage a deeper understanding of why and how care impacts patients. These theoretical foundations are essential for developing critical thinking skills and evidence-based practice.

Two prominent models help nurses understand and influence health behaviors: the Health Belief Model and the Transtheoretical Model.

Health Belief Model

The **Health Belief Model (HBM)** explains why individuals engage in health-promoting behaviors or fail to do so. It suggests that a person's health behavior is influenced by their perceptions of:

- **Perceived Susceptibility:** How likely they believe they are to get a particular disease or condition.
- **Perceived Severity:** How serious they believe the consequences of that disease or condition would be.
- **Perceived Benefits:** The positive outcomes they expect from taking a health action.
- **Perceived Barriers:** The obstacles or negative aspects they anticipate from taking a health action (e.g., cost, pain, inconvenience).

- **Cues to Action:** Triggers that prompt a person to act (e.g., symptoms, advice from a healthcare professional, media campaigns).
- **Self-Efficacy:** Their confidence in their ability to successfully perform the health action.

As a nurse, you can apply the HBM by assessing these perceptions in your patients. For example, if a patient with diabetes does not adhere to their diet, you might explore their perceived severity of complications or their self-efficacy in preparing healthy meals. Interventions can then be tailored to address specific barriers or enhance perceived benefits and self-efficacy.

Transtheoretical Model (Stages of Change)

The **Transtheoretical Model (TTM)**, also known as the Stages of Change Model, describes the process of intentional behavior change. It identifies six stages:

1. **Precontemplation:** The individual has no intention to change behavior in the foreseeable future (usually within 6 months). They may be unaware or unwilling to acknowledge a problem.
2. **Contemplation:** The individual is considering changing within the next 6 months. They are aware of the problem but are ambivalent about changing.
3. **Preparation:** The individual intends to take action in the immediate future (e.g., next month). They have a plan and may have taken small steps.
4. **Action:** The individual has made specific, overt modifications in their lifestyle within the past 6 months.
5. **Maintenance:** The individual has sustained the behavior change for more than 6 months and is working to prevent relapse.
6. **Termination:** The individual has no temptation to return to the old behavior and has 100% self-efficacy.

Nurses can use the TTM to assess a patient's readiness for change. This allows for stage-matched interventions. For a patient in precontemplation regarding smoking cessation, a nurse might focus on raising awareness of risks. For a patient in preparation, the nurse might help develop a specific quit plan. Understanding these models helps nurses provide patient-centered care. It supports patients through their unique health journeys. This leads to more effective health promotion and disease prevention strategies.

KEY TAKEAWAYS

- The nursing profession requires adherence to ethical principles and professional standards, guiding all patient interactions.
- Patient autonomy, including informed consent and the right to refuse treatment, is a fundamental ethical and legal right.
- Nurses must understand and uphold legal protections like HIPAA and respect advance directives to ensure patient privacy and wishes are honored.
- Knowledge of torts, especially negligence and malpractice, is crucial for practicing safely and avoiding legal liabilities.
- Mandatory reporting laws protect vulnerable populations and public health, requiring nurses to report specific concerns.
- Health behavior models, such as the Health Belief Model and Transtheoretical Model, help nurses understand and support patient readiness for change.

CHECK YOUR UNDERSTANDING

Answer these before moving on. Model answers are in the Answer Key at the back of this guide.

1. What are the core ethical principles that guide nursing practice, and why are they important?
2. Explain the nurse's role in obtaining informed consent and respecting a patient's right to refuse treatment.
3. How does HIPAA impact a nurse's daily responsibilities?
4. Differentiate between negligence and malpractice in nursing.
5. Describe the stages of change in the Transtheoretical Model and how a nurse might apply this model.

CHAPTER 2

Principles of Patient Care and Safety

Chapter 2 builds upon foundational nursing concepts by focusing on effective communication, patient education, and the critical aspects of safety and infection control. This chapter equips you with essential skills for interacting respectfully with patients, understanding diverse needs, and maintaining a safe healthcare environment.

You will learn how to apply therapeutic communication techniques, document care accurately, and recognize the impact of cultural factors on health. Also, this chapter details the mechanisms of infection, strategies for prevention, and vital safety protocols, including proper patient positioning and body mechanics.

Effective Communication, Education, and Cultural Competence

Covers: Communication: Therapeutic vs. Nontherapeutic - Fundamentals of Nursing - Principles · Patient Education and Nursing Documentation - Fundamentals of Nursing - Principles · Cultural Considerations; Complementary and Alternative Medicine - Fundamentals

Effective communication forms the cornerstone of patient care. It builds trust, fosters understanding, and promotes patient participation in their own health. Nurses use two main types of communication: therapeutic and nontherapeutic. Therapeutic communication is purposeful and goal-directed. It focuses on the patient's needs and promotes a positive nurse-patient relationship. Examples include active listening, using open-ended questions, demonstrating empathy, and employing silence to allow the patient to process thoughts. Nontherapeutic communication, in contrast, hinders effective interaction. Examples include giving unsolicited advice, offering false reassurance, changing the subject, or asking 'why' questions that can sound accusatory. Always prioritize patient-centered communication to achieve better health outcomes.

Patient education is an ongoing process that empowers individuals to manage their health effectively. It involves assessing the patient's readiness to learn, tailoring information to their learning style, and using clear, simple language. Always verify understanding by asking the patient to explain information back to you. Involving family members or caregivers can enhance the learning process and support adherence to treatment plans. Common topics include medication administration, wound care, dietary modifications, and recognition of warning signs.

Nursing documentation serves multiple vital purposes. It is a legal record of care provided, a communication tool among healthcare team members, and a basis for care planning and research. Good documentation is accurate, objective, timely, complete, concise, and legible. Use clear, factual language. Document only what you observe and do, avoiding personal opinions. Timely documentation ensures that the patient's most current status is available to all care providers. Common formats include narrative notes and problem-oriented charting methods like SOAP (Subjective, Objective, Assessment, Plan).

Cultural competence is essential for providing respectful and individualized care. It involves understanding and respecting diverse health beliefs, practices, and values. Culture influences how patients perceive illness, seek care, communicate pain, and involve family in decisions. Always approach patients with an open mind and a willingness to learn about their cultural background. Ask open-ended questions about their preferences and practices. For example, some cultures may prefer same-sex caregivers or have specific dietary restrictions. Respecting these considerations improves patient satisfaction and adherence to care plans. Complementary and Alternative Medicine (CAM) refers to practices outside of conventional medicine, such as acupuncture, herbal remedies, massage therapy, and yoga. Nurses must inquire about a patient's use of CAM, as these practices can interact with prescribed medications or treatments. Educate patients about potential risks and benefits, and ensure their safety by reporting all CAM use to the healthcare team.

Understanding and Preventing Infection

Covers: The Chain and Stages of Infection - Fundamentals of Nursing - Principles · Types of Immunity and Illnesses - Fundamentals of Nursing - Principles

Preventing the spread of infection is a core responsibility in patient care. Understanding the chain of infection helps identify points where interventions can break the cycle. The chain consists of six links: the infectious agent (e.g., bacteria, viruses), the reservoir (where the agent lives, such as a human, animal, or inanimate object), the portal of exit (how the agent leaves the reservoir, like coughing or open wounds), the mode of transmission (how it travels, such as direct contact, airborne, or vector-borne), the portal of entry (how it enters a new host, like respiratory tract or broken skin), and the susceptible host (an individual unable to resist the agent). Breaking any one of these links can prevent infection. For example, hand hygiene breaks the mode of transmission, and vaccination reduces host susceptibility.

Infections typically progress through four stages. The first is the *incubation period*, the time between exposure to the pathogen and the appearance of the first symptoms. During this stage, the individual may be contagious but unaware. The *prodromal stage* follows, characterized by general, non-specific symptoms like fatigue or low-grade fever. This is often when the pathogen is multiplying rapidly. The *illness stage* is when specific signs and symptoms of the infection are evident and most severe. Finally, the *convalescence stage* is the recovery period, as symptoms resolve and the body returns to normal. The length of these stages varies depending on the pathogen and the host's immune response.

Immunity is the body's ability to resist disease. There are two main types: innate and adaptive. *Innate immunity* is your body's natural, non-specific defense system, present from birth. It includes physical barriers like skin and mucous membranes, as well as cellular responses like phagocytosis. *Adaptive immunity* is acquired throughout life and is specific to particular pathogens. It involves memory cells that provide long-lasting protection. Adaptive immunity can be further divided into active and passive immunity. *Active immunity* develops when the body produces its own antibodies, either from natural infection or through vaccination. This type of immunity is long-lasting. *Passive immunity* occurs when antibodies are transferred from another source, such as from mother to baby through breast milk or through antitoxins. Passive immunity provides immediate but temporary protection.

Illnesses caused by infections can be categorized by the type of infectious agent. Common types include bacterial infections (e.g., strep throat, urinary tract infections), viral infections (e.g., common cold,

influenza, COVID-19), fungal infections (e.g., candidiasis, ringworm), and parasitic infections (e.g., malaria, scabies). Prevention strategies are crucial for all types of illnesses. These include meticulous hand hygiene, proper use of personal protective equipment (PPE), vaccination, and environmental cleaning. Understanding these principles allows nurses to implement effective infection control measures and protect both patients and themselves.

Patient Positioning and Safety Protocols

Covers: Patient Positions - Fundamentals of Nursing - Principles · Inpatient Safety - Fundamentals of Nursing - Principles · Sharps Injuries, Body Mechanics, & Brachytherapy - Fundamentals of Nursing

Proper patient positioning is vital for comfort, preventing complications, and facilitating medical procedures. Nurses must understand various therapeutic positions and their indications. Common positions include: **Fowler's position**, where the head of the bed is elevated 45 to 60 degrees, often used for patients with respiratory distress or during meals. **Semi-Fowler's position** is similar but with the head of the bed elevated 30 to 45 degrees. **Supine position** has the patient lying flat on their back. **Prone position** has the patient lying flat on their abdomen, sometimes used for specific respiratory conditions. **Lateral position** involves the patient lying on their side. **Sims' position** is a semi-prone position where the patient lies on their left side with the left arm behind the body and the right knee and thigh drawn up. This position is often used for rectal examinations or enema administration. **Trendelenburg position** involves lying supine with the head lower than the feet, sometimes used to promote venous return or during surgical procedures. **Reverse Trendelenburg** is the opposite, with the head higher than the feet, used to promote gastric emptying. Always ensure proper body alignment, use pillows for support, and regularly reposition patients to prevent pressure injuries.

Maintaining inpatient safety is a continuous priority. Fall prevention is critical. Assess patients for fall risk upon admission and regularly throughout their stay. Implement strategies such as keeping the call light within reach, using bed alarms, ensuring clear pathways, providing non-skid footwear, and orienting patients to their surroundings. Medication safety involves adhering to the 'five rights': the right patient, right drug, right dose, right route, and right time. Always use at least two patient identifiers before administering medications or performing procedures. Environmental safety includes keeping the patient's room free of clutter, ensuring adequate lighting, and promptly addressing spills or faulty equipment. Educate patients and families on how to contribute to a safe environment.

Sharps injuries pose a significant risk of bloodborne pathogen transmission to healthcare workers. Sharps include needles, scalpels, and broken glass. Prevention strategies are paramount: always use safety-engineered devices when available, never recap used needles, and immediately dispose of sharps in puncture-resistant containers at the point of use. If a sharps injury occurs, follow facility protocol for post-exposure management, which typically includes washing the wound, reporting the incident, and seeking prompt medical evaluation. Proper body mechanics are essential for protecting nurses from musculoskeletal injuries when lifting or moving patients. Key principles include assessing the load, maintaining a wide base of support, bending at the knees instead of the waist, keeping the load close to the body, and using leg muscles to lift. Avoid twisting movements. Always ask for assistance when needed, and use assistive devices like lifts or slide boards.

Brachytherapy is a type of internal radiation therapy where a radioactive source is placed inside or next to the area requiring treatment. Nurses caring for brachytherapy patients must adhere to strict safety precautions to minimize radiation exposure. These precautions are based on the principles of time, distance, and shielding. Limit the time spent in the patient's room. Maximize distance from the radiation source. Use shielding, such as lead aprons or portable shields, when direct care is necessary. Wear a dosimeter to monitor personal radiation exposure. Handle bodily fluids with extreme caution, as they may contain radioactive isotopes. Educate the patient about safety measures and activity restrictions during treatment.

KEY TAKEAWAYS

- Therapeutic communication builds trust and understanding, while nontherapeutic communication hinders effective patient interaction.
- Effective patient education assesses learning readiness, tailors information, and verifies understanding to empower patients.
- Accurate and timely nursing documentation is a legal record, communication tool, and basis for care planning.
- Cultural competence requires respecting diverse health beliefs and practices, including inquiry about complementary and alternative medicine use.
- Breaking any link in the chain of infection (agent, reservoir, exit, transmission, entry, host) prevents disease spread.
- Nurses must apply principles of time, distance, and shielding when caring for patients undergoing brachytherapy.
- Proper body mechanics protect healthcare providers from injury when assisting patients, emphasizing leg strength and avoiding twisting.

CHECK YOUR UNDERSTANDING

Answer these before moving on. Model answers are in the Answer Key at the back of this guide.

1. Describe two examples of therapeutic communication techniques and explain why they are effective.
2. What are the six links in the chain of infection, and how can a nurse break one of these links?
3. Explain the difference between active and passive immunity.
4. List three essential safety precautions a nurse should take when caring for a patient undergoing brachytherapy.
5. Why is proper body mechanics important for nurses, and what is one key principle to follow?

CHAPTER 3

Patient Care Planning, Infection Control, and Holistic Support

Chapter 3 introduces fundamental concepts for providing safe, effective, and compassionate patient care. You will learn the systematic approach nurses use to plan and deliver care, as well as essential communication techniques for collaborating with healthcare teams.

This chapter also covers critical infection control practices, including hand hygiene, personal protective equipment, and maintaining sterile environments. Finally, it addresses core aspects of patient comfort and safety, such as hygiene practices, seizure precautions, pain management, promoting sleep, and understanding grief and comfort care.

Foundations of Patient Care Communication and Planning

Covers: Nursing Process, Interdisciplinary Team, SBAR Report, Continuity of Care - Fundamentals | @LevelUpRN

Effective patient care begins with a structured approach and clear communication. The nursing process provides this framework. It is a five-step systematic method for delivering care: Assessment, Diagnosis, Planning, Implementation, and Evaluation.

The Nursing Process

- **Assessment:** This first step involves collecting comprehensive patient data. Nurses gather information through observation, physical examination, patient interviews, and reviewing medical records. This includes subjective data (what the patient states, like pain level) and objective data (measurable facts, like vital signs or lab results). Accurate assessment forms the basis for all subsequent care.
- **Diagnosis:** Based on the assessment data, nurses identify actual or potential health problems. These are often expressed as nursing diagnoses, which describe a patient's response to a health condition. For example, 'Acute Pain related to surgical incision' or 'Risk for Infection related to compromised skin integrity'. This step focuses on patient-centered problems that nurses can address.
- **Planning:** In this step, nurses work with the patient to set realistic, measurable goals and outcomes. They develop a plan of care that outlines specific nursing interventions designed to achieve these goals. The plan should be individualized and prioritize patient needs. An example goal might be 'Patient will report pain level of 3/10 or less within 30 minutes of medication administration'.
- **Implementation:** This is the action phase where nurses carry out the planned interventions. This could involve administering medications, performing wound care, educating the patient, assisting with mobility, or providing emotional support. All interventions must be documented accurately.
- **Evaluation:** The final step involves determining if the patient's goals have been met. Nurses reassess the patient's condition, compare it to the desired outcomes, and determine the effectiveness of the care.

plan. If goals are not met, the plan is revised, restarting the process. This continuous cycle ensures responsive and adaptive care.

The Interdisciplinary Team

Patient care is a collaborative effort involving many healthcare professionals. The interdisciplinary team may include physicians, nurses, physical therapists, occupational therapists, speech therapists, dietitians, social workers, case managers, and pharmacists. Each member contributes their specialized expertise to create a holistic care plan. Effective teamwork requires mutual respect and clear communication among all members.

SBAR Report

SBAR (Situation, Background, Assessment, Recommendation) is a standardized communication tool used to facilitate clear, concise, and organized information exchange, especially during handoffs or when communicating critical patient information to other healthcare providers. Using SBAR reduces misunderstandings and improves patient safety.

- **Situation:** Briefly state the patient's immediate problem or concern. "I am calling about Mr. Smith, room 205. He is experiencing sudden onset shortness of breath."
- **Background:** Provide relevant clinical history. "Mr. Smith is a 72-year-old post-op hip replacement patient. He has a history of COPD and was admitted three days ago."
- **Assessment:** Share your assessment findings. "His oxygen saturation is 88% on room air, respiratory rate is 28, and he has crackles in his lungs. He reports chest tightness."
- **Recommendation:** State what you believe needs to be done. "I recommend a stat chest X-ray, an order for oxygen, and a physician assessment immediately."

Continuity of Care

Continuity of care ensures a smooth and consistent transition of patient care from one setting to another, or between different providers. This involves thorough handoff reports, accurate documentation, and patient education. It prevents gaps in care and promotes better patient outcomes.

Infection Control and Aseptic Techniques

Covers: Hospital-Acquired Infections (HAIs) and Hand Hygiene - Fundamentals of Nursing | @LevelUpRN · Donning/Doffing PPE and Isolation/Transmission Precautions - Fundamentals of Nursing | @LevelUpRN · Sterile Field: Indications, Best Practices, Preparation - Fundamentals of Nursing | @LevelUpRN

Preventing the spread of infection is a cornerstone of patient care. Hospital-Acquired Infections (HAIs), also known as healthcare-associated infections, are infections patients acquire while receiving medical care. Common HAIs include Catheter-Associated Urinary Tract Infections (CAUTI), Central Line-Associated Bloodstream Infections (CLABSI), Surgical Site Infections (SSI), and *Clostridioides difficile* (C. diff) infections. Strict infection control practices are essential to minimize these risks.

Hand Hygiene

Hand hygiene is the most effective way to prevent the spread of infection. Nurses must perform hand hygiene frequently and correctly. The 'Five Moments for Hand Hygiene' are:

1. Before touching a patient.
2. Before a clean/aseptic procedure.
3. After body fluid exposure risk.
4. After touching a patient.
5. After touching patient surroundings.

Use soap and water when hands are visibly soiled, after using the restroom, or when caring for patients with C. diff. Otherwise, an alcohol-based hand rub is acceptable. When washing with soap and water, wet hands, apply soap, rub hands vigorously for at least 20 seconds, rinse thoroughly, and dry with a clean paper towel. Use the towel to turn off the faucet.

Personal Protective Equipment (PPE)

PPE creates a barrier between the healthcare worker and infectious agents. The type of PPE needed depends on the anticipated exposure. Common PPE includes:

- **Gloves:** Protect hands from contact with blood, body fluids, secretions, excretions, and contaminated items.
- **Gowns:** Protect skin and clothing from splashes or sprays of blood or body fluids.
- **Masks:** Protect the nose and mouth from splashes or sprays. N95 respirators are used for airborne precautions.
- **Eye Protection (Goggles/Face Shields):** Protect the eyes from splashes or sprays.

Donning (Putting On) PPE Sequence:

1. Gown
2. Mask or N95 respirator
3. Eye protection
4. Gloves

Doffing (Taking Off) PPE Sequence: (Remove in a way that minimizes self-contamination)

1. Gloves
2. Eye protection
3. Gown
4. Mask or N95 respirator (removed outside the patient room after exiting)

Isolation and Transmission Precautions

These precautions are used in addition to standard precautions for patients with suspected or confirmed infections that can be transmitted through specific routes.

- **Standard Precautions:** Apply to all patients, regardless of diagnosis. Involve hand hygiene, use of PPE when handling body fluids, safe injection practices, and safe handling of contaminated equipment.
- **Contact Precautions:** For infections spread by direct or indirect contact (e.g., C. diff, MRSA). Require gown and gloves upon entry to the room.
- **Droplet Precautions:** For infections spread by large respiratory droplets (e.g., influenza, mumps). Require a surgical mask when working within 3 feet of the patient.
- **Airborne Precautions:** For infections spread by small airborne particles that can remain suspended in the air (e.g., tuberculosis, measles, chickenpox). Requires an N95 respirator and a negative pressure isolation room.

Sterile Field

A sterile field is an area free of all microorganisms, created to prevent contamination during invasive procedures. Indications for a sterile field include surgical procedures, insertion of indwelling catheters, and certain wound care procedures. Maintaining a sterile field requires strict adherence to principles:

- Only sterile items can be placed within the sterile field.
- The outer 1-inch border of a sterile drape is considered unsterile.
- Sterile objects become unsterile when touched by unsterile objects.
- Do not turn your back on a sterile field or reach over it.
- Keep sterile items above waist level.
- Prolonged exposure to air can contaminate a sterile field.
- Moisture that passes through a sterile barrier makes it unsterile.

Preparation Steps for a Sterile Field:

1. Perform hand hygiene.
2. Gather all necessary sterile supplies.
3. Select a clean, dry, flat work surface.
4. Open the sterile package away from your body, touching only the outer wrapper.
5. Carefully unfold the sterile drape, touching only the edges. Position it on the work surface.
6. Add sterile items to the field without reaching over it or contaminating the field edges.
7. Don sterile gloves before touching any items within the sterile field.

Essential Patient Comfort and Safety

Covers: Bed Baths, Bed Making, Oral & Denture Care, Seizure Precautions - Fundamentals | @LevelUpRN

Providing basic hygiene and ensuring patient safety are fundamental aspects of nursing care. These practices promote comfort, prevent complications, and uphold patient dignity.

Bed Baths

Bed baths are given to patients who cannot bathe themselves, providing hygiene and promoting skin integrity. The procedure involves washing the patient in bed, typically from head to toe, using a systematic approach.

Steps for a Bed Bath:

1. **Preparation:** Gather all supplies: bath basin, warm water, soap, washcloths, towels, clean gown, lotion, clean linen, and gloves. Explain the procedure to the patient and ensure privacy by closing curtains or doors. Raise the bed to a comfortable working height.
2. **Wash Face and Neck:** Begin by washing the patient's eyes with water only, using a separate part of the washcloth for each eye, wiping from inner to outer canthus. Wash the rest of the face, ears, and neck with a small amount of soap, then rinse and pat dry.
3. **Wash Arms and Hands:** Wash one arm, starting at the shoulder and moving down to the wrist. Wash the hand, paying attention to between fingers. Rinse and dry. Repeat for the other arm. You may offer a basin for the patient to soak their hands.
4. **Wash Chest and Abdomen:** Uncover the chest and abdomen. Wash, rinse, and dry, paying attention to skin folds.
5. **Wash Legs and Feet:** Uncover one leg. Wash from thigh to ankle. Wash the foot, including between the toes. Rinse and dry. Repeat for the other leg. You may offer a basin for the patient to soak their feet.
6. **Wash Back and Buttocks:** Assist the patient to turn onto their side. Wash the back from the neck to the buttocks. Rinse and dry. Apply lotion if desired.
7. **Perineal Care:** Change water and washcloth. Provide perineal care (genital and anal area). For female patients, wipe from front to back. For male patients, retract the foreskin if uncircumcised, clean, and replace. This step is often performed last to prevent spreading microorganisms.
8. **Completion:** Apply lotion, assist with dressing in a clean gown, comb hair, and make the bed with clean linen. Ensure the patient is comfortable and the call light is within reach. Dispose of soiled linen and wash hands.

Bed Making

Clean, wrinkle-free bed linen promotes comfort and prevents skin breakdown. Nurses make both unoccupied (empty) and occupied (patient in bed) beds.

Steps for an Unoccupied Bed:

1. Gather clean linen. Perform hand hygiene.
2. Place clean linen on a clean surface, not on the floor.
3. Remove soiled linen, avoiding contact with your uniform. Place it in a linen hamper.
4. Wipe down the mattress if needed. Apply a fitted sheet, ensuring it is smooth and tucked under the mattress.
5. Place a draw sheet or incontinence pad if needed, positioning it under the patient's torso.

6. Apply the top sheet, blanket, and bedspread. Create a toe pleat at the foot of the bed to allow for foot movement.
7. Miter corners at the foot of the bed to secure the top linen. Fold the top sheet over the blanket and bedspread at the head of the bed.
8. Replace pillowcases. Ensure the bed is in the lowest position with side rails up as appropriate.

Oral and Denture Care

Oral hygiene prevents dental caries, gum disease, and halitosis. It also reduces the risk of aspiration pneumonia, especially in unconscious or debilitated patients.

- **Conscious Patient:** Provide a toothbrush, toothpaste, and water. Assist as needed. Encourage brushing teeth, gums, and tongue.
- **Unconscious Patient:** Position the patient on their side with the head turned to prevent aspiration. Use a soft toothbrush or sponge swab with a small amount of toothpaste or mouthwash. Clean all surfaces of the mouth. Suction secretions as needed.
- **Denture Care:** Remove dentures using a gauze pad to improve grip. Brush dentures with a soft brush and denture cleaner or toothpaste. Rinse thoroughly. Store in a labeled cup with water or denture solution when not in use.

Seizure Precautions

These are measures taken to protect patients who are at risk for or are experiencing a seizure.

Before a Seizure:

- Pad side rails of the bed.
- Keep the bed in the lowest position.
- Have suction equipment readily available.
- Ensure privacy.

During a Seizure:

- Stay with the patient. Call for help.
- Protect the patient from injury: move furniture away, loosen restrictive clothing around the neck. Do not restrain the patient.
- Turn the patient gently onto their side to prevent aspiration and maintain an open airway.
- Do not force anything into the patient's mouth.
- Time the seizure duration.
- Observe and document characteristics of the seizure (e.g., body parts involved, movements, incontinence).

After a Seizure:

- Maintain a side-lying position.
- Assess airway, breathing, and circulation.

- Perform a neurological assessment.
- Provide a quiet environment for rest.
- Document the event thoroughly.

Understanding and Managing Patient Needs

Covers: Pain: Types, Etiology, and Treatments - Fundamentals of Nursing - Practice & Skills | @LevelUpRN · Sleep Basics, Sleep Disorders, & General Adaptation Syndrome - Fundamentals of Nursing | @LevelUpRN · Stages and Types of Grief, Types of Comfort Care - Fundamentals of Nursing | @LevelUpRN

Holistic patient care requires understanding and addressing a patient's physical, psychological, and emotional needs. This includes managing pain, promoting adequate sleep, and providing support during times of stress, grief, and end-of-life.

Pain: Types, Etiology, and Treatments

Pain is a subjective experience, meaning it is whatever the patient says it is, existing whenever they say it does. It is a complex sensation that can significantly impact a patient's quality of life. Nurses play a crucial role in assessing and managing pain.

Types of Pain:

- **Acute Pain:** Sudden onset, usually sharp, short duration (less than 3 to 6 months), often associated with a specific injury or illness (e.g., post-surgical pain, broken bone).
- **Chronic Pain:** Persistent pain lasting longer than 3 to 6 months, often debilitating, and may not have a clear cause (e.g., arthritis, back pain).
- **Nociceptive Pain:** Caused by damage to body tissue (e.g., cuts, burns, inflammation). It is typically aching, throbbing, or sharp.
- **Neuropathic Pain:** Caused by damage to nerves (e.g., diabetic neuropathy, phantom limb pain). Often described as burning, tingling, shooting, or numbness.

Pain Assessment (PQRSTU Mnemonic):

- **Provokes/Palliates:** What makes the pain better or worse?
- **Quality:** What does the pain feel like (sharp, dull, throbbing, burning)?
- **Radiation:** Where is the pain located, and does it spread?
- **Severity:** How severe is the pain on a scale of 0 to 10?
- **Timing:** When did the pain start? How long does it last? Is it constant or intermittent?
- **Understanding:** What does the patient think is causing the pain?

Pain Treatments:

- **Non-pharmacological:** Repositioning, massage, heat/cold therapy, distraction, guided imagery, relaxation techniques.
- **Pharmacological:** Analgesics (e.g., NSAIDs, opioids), adjuvant medications (e.g., antidepressants, anticonvulsants).

Sleep Basics, Sleep Disorders, and General Adaptation Syndrome

Adequate sleep is vital for physical and mental health. Sleep occurs in cycles of Non-Rapid Eye Movement (NREM) and Rapid Eye Movement (REM) sleep. NREM has three stages, progressing from light sleep to deep sleep. REM sleep is characterized by vivid dreams and muscle atonia.

Sleep Disorders: Common disorders include insomnia (difficulty falling or staying asleep), sleep apnea (interrupted breathing during sleep), and restless legs syndrome. Nurses can promote sleep by:

- Creating a quiet, dark, and cool environment.
- Establishing a consistent bedtime routine.
- Avoiding caffeine and heavy meals before bed.
- Administering prescribed sleep aids as ordered.
- Minimizing nighttime disturbances in the hospital setting.

General Adaptation Syndrome (GAS): This describes the body's physiological response to stress. It has three stages:

1. **Alarm Reaction:** The body's initial fight-or-flight response to a stressor. Hormones like adrenaline are released, increasing heart rate and blood pressure.
2. **Resistance Stage:** The body attempts to adapt to the stressor. If the stress continues, the body remains in a state of arousal, but symptoms may lessen.
3. **Exhaustion Stage:** If the stressor persists, the body's resources become depleted. This can lead to weakened immunity, burnout, and increased susceptibility to illness.

Stages and Types of Grief, Types of Comfort Care

Grief is a natural emotional response to loss. Understanding grief and providing comfort care are essential aspects of supporting patients and their families.

Stages of Grief (Kubler-Ross Model): While not everyone experiences all stages in order, this model provides a framework:

1. **Denial:** Refusal to accept the reality of the loss.
2. **Anger:** Frustration, irritation, and bitterness directed at self, others, or a higher power.
3. **Bargaining:** Attempts to negotiate with a higher power to reverse or postpone the loss.
4. **Depression:** Sadness, despair, withdrawal, and feelings of hopelessness.
5. **Acceptance:** Coming to terms with the reality of the loss and finding a way to move forward.

Types of Grief:

- **Normal Grief:** A healthy, adaptive response to loss, characterized by a range of emotional, cognitive, physical, and spiritual reactions.
- **Anticipatory Grief:** Grieving that occurs before an actual loss, common in terminal illness.
- **Complicated Grief:** Intense, prolonged, and debilitating grief that interferes with daily functioning and may require professional intervention.

Types of Comfort Care: Comfort care focuses on relieving suffering and improving the quality of life for patients with serious illnesses. It is not about curing the disease but about managing symptoms and providing support.

- **Palliative Care:** Can be initiated at any stage of a serious illness, alongside curative treatments. Its goal is to improve quality of life for both the patient and their family by addressing physical, emotional, spiritual, and social needs.
- **Hospice Care:** A specific type of palliative care for patients with a life expectancy of six months or less, who have decided to forgo curative treatments. It provides comprehensive comfort care and support for the patient and their family during the end-of-life period.

KEY TAKEAWAYS

- The nursing process (ADPIE) provides a systematic framework for delivering patient-centered care.
- SBAR is a vital communication tool for clear and concise information exchange among healthcare professionals.
- Hand hygiene and proper use of PPE are the most critical steps in preventing healthcare-associated infections.
- Maintaining a sterile field is essential for invasive procedures to prevent microbial contamination.
- Basic hygiene practices like bed baths and oral care promote patient comfort, dignity, and prevent complications.
- Nurses must implement specific precautions to ensure patient safety during and after a seizure.
- Pain is a subjective experience that requires thorough assessment and a combination of pharmacological and non-pharmacological treatments.

CHECK YOUR UNDERSTANDING

Answer these before moving on. Model answers are in the Answer Key at the back of this guide.

1. Describe the five steps of the nursing process and explain why each step is important.
2. When should healthcare providers use soap and water for hand hygiene instead of an alcohol-based hand rub?
3. List the correct sequence for donning and doffing personal protective equipment (PPE).
4. What are three critical actions a nurse should take if a patient begins to have a seizure?
5. Explain the difference between palliative care and hospice care.

CHAPTER 4

Patient Mobility, Skin Integrity, and Fluid Balance

Chapter 4 provides foundational knowledge and practical skills essential for maintaining patient well-being. It covers critical aspects of patient care, including safe movement, protecting skin health, and understanding the body's fluid and electrolyte balance. Mastery of these topics helps prevent common complications and promotes recovery.

This chapter teaches you how to assess risks, apply preventive measures, and perform basic care interventions. You will learn to support patient independence while ensuring safety, recognize early signs of potential problems, and contribute to a comprehensive care plan.

Patient Mobility, Safety, and Assistive Devices

Covers: Effects of Immobility, Deep Vein Thrombosis (DVT) - Fundamentals of Nursing | @LevelUpRN · Canes, Walkers, and Crutches - Fundamentals of Nursing - Practice & Skills | @LevelUpRN · Fall Prevention and Restraints - Fundamentals of Nursing - Practice & Skills | @LevelUpRN

Immobility can lead to a cascade of negative effects across multiple body systems. Musculoskeletal changes include muscle atrophy, decreased bone density, and joint contractures. Cardiovascular complications involve orthostatic hypotension and an increased risk of Deep Vein Thrombosis (DVT). A DVT is a blood clot, usually in a deep vein of the leg. Signs of a DVT include unilateral leg swelling, pain, warmth, and redness. Prevention is crucial and includes early ambulation, leg exercises, anti-embolism stockings (TED hose), and sequential compression devices (SCDs). Never massage a leg suspected of having a DVT, as this can dislodge the clot.

Respiratory issues from immobility include atelectasis and pneumonia. Gastrointestinal problems can manifest as constipation and decreased appetite. Urinary stasis can lead to urinary tract infections. Integumentary complications include pressure injuries. To mitigate these risks, nurses must promote mobility safely and effectively.

Assistive devices like canes, walkers, and crutches aid patient mobility. Proper fitting and teaching correct use are vital. Canes provide minimal support and are used on the strong side of the body. The patient moves the cane forward, then the weak leg, then the strong leg. Walkers offer more stability. The patient pushes the walker forward, then steps into it. Crutches require more coordination and strength. A common gait is the three-point gait, where both crutches and the affected leg move forward together, followed by the unaffected leg. Always ensure the patient is wearing non-skid footwear and that the environment is clear of hazards.

Fall prevention is a primary nursing responsibility. Risk factors include age, impaired vision, gait or balance problems, medications, and environmental hazards. Implement universal fall precautions for all patients. These include orienting the patient to their surroundings, ensuring the call light is within reach,

keeping the bed in the lowest position, and using non-skid socks. Regularly assess the patient's risk for falls using a validated tool like the Morse Fall Scale. Document all assessments and interventions.

Restraints are a last resort to ensure patient safety and require a physician's order. They are used only when less restrictive alternatives have failed and the patient poses a danger to themselves or others. Types include physical restraints (wrist, vest) and chemical restraints (medication). Always choose the least restrictive restraint necessary. Apply restraints according to policy, ensuring two fingers can fit under the restraint to prevent neurovascular compromise. Monitor patients with restraints frequently, typically every 15 minutes, for skin integrity, circulation, and range of motion. Release restraints every two hours for repositioning, toileting, and offering fluids. Document the reason for restraint, alternatives attempted, type of restraint, patient response, and all monitoring.

Skin Integrity and Wound Care Management

Covers: Pressure Injuries (Risk Factors, Prevention, and Staging) - Fundamentals of Nursing | @LevelUpRN · Wound Healing - Fundamentals of Nursing | @LevelUpRN · Wound Care and Diabetic Foot Care - Fundamentals of Nursing - Practice & Skills | @LevelUpRN

Maintaining skin integrity is fundamental to patient care. Pressure injuries, formerly called pressure ulcers or bedsores, are localized injuries to the skin and underlying tissue, usually over a bony prominence, resulting from prolonged pressure or pressure in combination with shear. Common risk factors include immobility, poor nutrition, incontinence (moisture), friction, and shear. Patients with impaired sensation, poor circulation, or chronic illnesses are also at higher risk. The Braden Scale is a common tool used to assess a patient's risk for developing pressure injuries.

Prevention strategies are paramount. Repositioning immobile patients every two hours, or more frequently if in a chair, is critical. Use pressure-relieving devices such as specialized mattresses and cushions. Maintain skin hygiene by keeping the skin clean and dry, especially in incontinent patients. Provide adequate nutrition and hydration. Teach patients and caregivers how to inspect skin daily for any redness or breakdown. Early detection is key to preventing progression.

Pressure injuries are staged to describe the extent of tissue damage:

- **Stage 1:** Non-blanchable erythema of intact skin. Skin is red and does not turn white when pressed.
- **Stage 2:** Partial-thickness skin loss with exposed dermis. It may present as an open ulcer with a red-pink wound bed or an intact or ruptured serum-filled blister.
- **Stage 3:** Full-thickness skin loss. Adipose (fat) tissue is visible, but muscle and bone are not exposed.
- **Stage 4:** Full-thickness skin and tissue loss. Exposed fascia, muscle, tendon, ligament, cartilage, or bone.
- **Unstageable:** Full-thickness skin and tissue loss in which the extent of tissue damage within the ulcer cannot be confirmed because it is obscured by slough or eschar.
- **Deep Tissue Pressure Injury (DTPI):** Persistent non-blanchable deep red, maroon, or purple discoloration.

Wound healing occurs in three phases: inflammatory, proliferative, and maturation. Primary intention healing occurs when wound edges are approximated, such as with a surgical incision. Secondary intention

healing involves open wounds that heal from the bottom up, like pressure injuries. Tertiary intention (delayed primary closure) involves leaving a wound open for a period before closing it.

Effective wound care involves assessing the wound, cleaning it, and applying appropriate dressings. Assess for size, depth, drainage (exudate), odor, and signs of infection. Clean wounds from the least contaminated area to the most contaminated. Dressings protect the wound, absorb exudate, maintain a moist environment, and can debride tissue. Examples include hydrocolloids, foams, alginates, and transparent films. Diabetic foot care requires special attention due to neuropathy and poor circulation. Daily foot inspections for cuts, blisters, or redness are essential. Proper footwear, blood glucose control, and prompt treatment of any injury are crucial to prevent severe complications, including amputation.

Fluid and Electrolyte Balance

Covers: Fluid Balance, Intake/Output, Fluid Volume Deficit and Excess - Fundamentals of Nursing | @LevelUpRN · Electrolytes and Electrolyte Imbalances - Fundamentals of Nursing | @LevelUpRN

Fluid balance refers to the state where the amount of fluid taken into the body equals the amount of fluid leaving the body. Water is the largest component of the body, essential for all physiological processes. Intake includes oral fluids, food, and intravenous fluids. Output includes urine, stool, emesis (vomit), wound drainage, and insensible losses (sweat, respiration). Accurate measurement of intake and output (I&O) is a critical nursing skill. All fluid consumed and excreted over a 24-hour period is recorded. For example, if a patient drinks 500 mL of water, eats soup (150 mL), and receives 1000 mL IV fluid, their intake is 1650 mL. If they void 800 mL and have 200 mL of emesis, their output is 1000 mL. This indicates a positive fluid balance of 650 mL.

Fluid volume deficit, or hypovolemia, occurs when the body loses both water and electrolytes from the extracellular fluid. Causes include hemorrhage, vomiting, diarrhea, excessive sweating, and diuretic use. Signs and symptoms include dry mucous membranes, decreased skin turgor, thirst, concentrated urine, rapid weak pulse, and hypotension. Interventions focus on replacing fluids orally or intravenously and treating the underlying cause.

Fluid volume excess, or hypervolemia, occurs when the body retains too much water and sodium in the extracellular fluid. Causes include heart failure, kidney failure, and excessive intake of sodium or IV fluids. Signs and symptoms include peripheral edema, crackles in the lungs (pulmonary edema), distended neck veins, weight gain, and shortness of breath. Interventions include restricting fluid and sodium intake, administering diuretics, and monitoring respiratory status.

Electrolytes are minerals in your body that have an electric charge. They are found in blood, urine, tissue, and other body fluids. Electrolytes are vital for muscle contraction, nerve function, and maintaining fluid balance. Key electrolytes include sodium (Na^+), potassium (K^+), calcium (Ca^{2+}), and magnesium (Mg^{2+}).

Sodium (Na^+) is the primary electrolyte in extracellular fluid, crucial for fluid balance and nerve impulses.

- **Hyponatremia** (low sodium) can result from excessive water intake, diuretic use, or certain endocrine disorders. Symptoms include confusion, seizures, and muscle weakness.

- **Hypernatremia** (high sodium) can result from inadequate water intake or excessive water loss. Symptoms include thirst, dry mucous membranes, and altered mental status.

Potassium (K⁺) is the primary intracellular electrolyte, vital for cardiac function and muscle contraction.

- **Hypokalemia** (low potassium) can result from diuretics, diarrhea, or vomiting. Symptoms include muscle weakness, dysrhythmias, and constipation.
- **Hyperkalemia** (high potassium) can result from kidney failure, certain medications, or massive tissue injury. Symptoms include muscle weakness, dysrhythmias, and cardiac arrest.

Nurses monitor electrolyte levels through blood tests, assess for clinical manifestations of imbalances, and administer prescribed interventions such as fluid replacement, electrolyte supplements, or diuretics. Prompt recognition and intervention are critical to prevent life-threatening complications.

KEY TAKEAWAYS

- Immobility poses significant risks to multiple body systems, including the cardiovascular system with a risk of Deep Vein Thrombosis (DVT).
- Proper use and fitting of assistive devices like canes, walkers, and crutches are essential for safe patient mobility.
- Effective fall prevention strategies include environmental modifications, patient education, and consistent use of safety protocols.
- Pressure injuries are preventable skin and tissue damage caused by pressure and shear, requiring vigilant assessment and repositioning.
- Wound healing progresses through distinct phases, and appropriate wound care involves assessment, cleaning, and specific dressing applications.
- Maintaining fluid balance through accurate intake and output monitoring is crucial for preventing fluid volume deficit or excess.
- Electrolytes like sodium and potassium are vital for bodily functions, and imbalances can lead to serious health complications.

CHECK YOUR UNDERSTANDING

Answer these before moving on. Model answers are in the Answer Key at the back of this guide.

1. What are three common complications of immobility, and how can nurses help prevent them?
2. Describe the proper use of a walker for a patient with generalized weakness.
3. A patient has a non-blanchable red area on their sacrum. How would you stage this pressure injury, and what is the immediate nursing action?
4. Explain the difference between primary and secondary intention wound healing.
5. List three signs of fluid volume deficit and three signs of fluid volume excess.

CHAPTER 5

Fluid Balance, Nutrition, and Elimination Fundamentals

This chapter provides a foundational understanding of critical patient care areas: fluid and acid-base balance, nutritional support, and elimination processes. As a healthcare provider, your ability to assess, intervene, and manage these aspects directly impacts patient safety and recovery.

We will cover essential concepts from interpreting acid-base imbalances to administering nutritional support and assisting with urinary and bowel elimination. Mastering these skills ensures you can provide comprehensive, dignified care while recognizing and responding to changes in a patient's condition.

Understanding Acid-Base Balance

Covers: Acid/Base Imbalances - Fundamentals of Nursing - Principles & Skills | @LevelUpRN (video, 9 min)

Maintaining acid-base balance is vital for cellular function. The body constantly produces acids and bases, and intricate buffer systems, along with the respiratory and renal systems, work to keep the blood pH within a narrow range of 7.35 to 7.45. A pH below 7.35 indicates acidosis, while a pH above 7.45 indicates alkalosis.

The Role of the Respiratory System

The lungs regulate carbon dioxide (CO₂) levels, which is an acid. Rapid, deep breathing expels more CO₂, increasing pH. Slow, shallow breathing retains CO₂, decreasing pH. Respiratory acidosis occurs with hypoventilation (CO₂ retention), and respiratory alkalosis occurs with hyperventilation (excessive CO₂ exhalation).

The Role of the Renal System

The kidneys regulate bicarbonate (HCO₃⁻), which is a base, and excrete hydrogen ions (H⁺), an acid. They can reabsorb bicarbonate or excrete it, and excrete more or less hydrogen ions, to adjust pH. Metabolic acidosis results from a loss of bicarbonate or an increase in other acids. Metabolic alkalosis results from an excess of bicarbonate or a loss of acids (e.g., from vomiting).

Interpreting Arterial Blood Gases (ABGs)

ABG analysis is crucial for diagnosing acid-base imbalances. Key values to assess are:

- **pH:** Overall acidity or alkalinity of the blood (7.35-7.45).
- **PaCO₂:** Partial pressure of carbon dioxide, indicating respiratory component (35-45 mmHg).
- **HCO₃⁻:** Bicarbonate, indicating metabolic component (22-26 mEq/L).

Steps for ABG Interpretation:

1. **Analyze pH:** Is it acidic (<7.35), alkaline (>7.45), or normal? This tells you the primary problem.
2. **Analyze PaCO₂:** Is it opposite the pH (respiratory)? If pH is low and PaCO₂ is high, it's respiratory acidosis. If pH is high and PaCO₂ is low, it's respiratory alkalosis.
3. **Analyze HCO₃⁻:** Is it in the same direction as the pH (metabolic)? If pH is low and HCO₃⁻ is low, it's metabolic acidosis. If pH is high and HCO₃⁻ is high, it's metabolic alkalosis.
4. **Determine Compensation:** If all three values are abnormal, the body is attempting to compensate. If pH is normal but PaCO₂ and HCO₃⁻ are abnormal, it's fully compensated. If pH is abnormal but PaCO₂ and HCO₃⁻ are also abnormal, it's partially compensated.

Example: A patient has pH 7.28, PaCO₂ 55 mmHg, HCO₃⁻ 24 mEq/L.

1. pH is low (acidic).
2. PaCO₂ is high (acidic, opposite the pH). This indicates respiratory acidosis.
3. HCO₃⁻ is normal. This indicates no metabolic involvement. **Conclusion:** Uncompensated respiratory acidosis.

Understanding these fundamentals allows for prompt recognition and intervention, which is critical for patient outcomes. Always monitor patient's respiratory status, fluid balance, and electrolyte levels.

Nutrition Fundamentals and Management

Covers: Macronutrients, Micronutrients, and BMI - Fundamentals of Nursing | @LevelUpRN (video, 5 min) · Dysphagia, Diet Types, Foodborne Illnesses, Blood Glucose Measurement - Fundamentals | @LevelUpRN (video, 6 min)

Nutrition is foundational to health and healing. Understanding its components and common challenges is essential for patient care.

Macronutrients and Micronutrients

Macronutrients provide energy and are needed in large amounts: carbohydrates, proteins, and fats. Carbohydrates are the body's primary energy source. Proteins are vital for tissue repair and growth. Fats are essential for hormone production and nutrient absorption.

Micronutrients are vitamins and minerals, required in smaller amounts but crucial for metabolic processes and overall health. Examples include Vitamin C for immunity and iron for oxygen transport.

Body Mass Index (BMI)

BMI is a screening tool for weight categories. It is calculated using a person's weight and height.

$$\text{BMI} = (\text{weight in kg}) / (\text{height in m})^2$$

Or, if using pounds and inches:

$$\text{BMI} = (\text{weight in lbs} / (\text{height in inches})^2) * 703$$

BMI Categories:

- Underweight: <18.5

- Normal weight: 18.5-24.9
- Overweight: 25-29.9
- Obesity (Class I): 30-34.9
- Obesity (Class II): 35-39.9
- Obesity (Class III): >40

Dysphagia

Dysphagia is difficulty swallowing. It poses a significant risk for aspiration (food or liquid entering the airway). Signs include coughing or choking during or after eating, a wet or gurgly voice, pocketing food, or recurrent pneumonia. Nursing interventions include:

- Positioning the patient upright (90 degrees) during meals and for 30-60 minutes afterward.
- Providing thickened liquids (nectar, honey, or pudding consistency) as ordered.
- Offering small, frequent meals.
- Encouraging slow eating and thorough chewing.
- Performing oral care before and after meals.
- Ensuring suction equipment is readily available.

Diet Types and Foodborne Illnesses

Common Diet Types:

- **Clear Liquid:** Water, broth, gelatin, clear juice (apple, cranberry).
- **Full Liquid:** Includes clear liquids plus milk, cream soups, ice cream, strained cereals.
- **Soft/Pureed:** Easy to chew and swallow, low fiber (mashed potatoes, pureed meats).
- **Regular:** No restrictions.
- **NPO (nil per os):** Nothing by mouth. This is a medical order.

Foodborne Illnesses: Prevention is key. Teach patients to wash hands, cook foods to proper temperatures, avoid cross-contamination, and refrigerate perishables promptly. Common pathogens include Salmonella, E. coli, and Listeria.

Blood Glucose Measurement

Capillary blood glucose monitoring is a common nursing skill. Steps include:

1. Gather supplies: glucometer, test strip, lancet, alcohol wipe, cotton ball.
2. Perform hand hygiene and don gloves.
3. Prepare the glucometer and test strip.
4. Clean the patient's finger (usually side of fingertip) with an alcohol wipe and allow it to dry.
5. Prick the finger with the lancet.
6. Gently squeeze the finger to obtain a drop of blood.
7. Touch the test strip to the blood drop, allowing it to wick up.

8. Apply pressure to the puncture site with a cotton ball.
9. Read the glucose result from the glucometer.
10. Document the result and dispose of sharps safely.

Nutritional Support: Tubes and IVs

Covers: Nasogastric (NG) Tubes - Fundamentals of Nursing - Practice & Skills | @LevelUpRN (video, 8 min) · Practice & Skills: Enteral and Parenteral Nutrition - Fundamentals of Nursing | @LevelUpRN (video, 7 min)

When patients cannot meet their nutritional needs orally, alternative methods like nasogastric (NG) tubes, enteral nutrition, and parenteral nutrition become essential.

Nasogastric (NG) Tubes

An NG tube is a flexible tube inserted through the nostril, down the esophagus, and into the stomach. It is used for:

- **Decompression:** Removing gas and fluids from the stomach (e.g., after surgery or in bowel obstruction).
- **Feeding:** Delivering liquid nutrition when oral intake is impossible or unsafe.
- **Medication administration:** Giving medications directly into the stomach.
- **Lavage:** Washing out the stomach (e.g., in poisoning).

Key Nursing Responsibilities for NG Tubes:

1. **Insertion:** Requires proper measurement (nose to earlobe to xiphoid process), lubrication, and careful advancement. Patient cooperation is key (swallowing helps).
2. **Verification of Placement: X-ray is the most reliable method.** Other methods include aspirating gastric contents and checking pH (stomach pH is typically 1-5.5). Air auscultation is *not* a reliable indicator of placement.
3. **Maintenance:** Secure the tube to the nose to prevent dislodgement. Mark the tube at the nostril to monitor for migration. Provide frequent oral and nasal care. Keep the head of the bed elevated to prevent aspiration, especially during feeding.
4. **Irrigation:** Flush the tube regularly with water or saline to maintain patency.
5. **Removal:** Remove gently and steadily, instructing the patient to hold their breath.

Enteral Nutrition

Enteral nutrition involves delivering nutrients directly into the gastrointestinal (GI) tract via a tube (NG, gastrostomy, or jejunostomy tube). It is preferred over parenteral nutrition when the GI tract is functional because it maintains gut integrity and has fewer complications.

Administration Methods:

- **Bolus feeding:** Administering a specific volume over a short period (e.g., 15-30 minutes), mimicking meal times.

- **Continuous feeding:** Administering formula continuously over 12-24 hours using an infusion pump.
- **Cyclic feeding:** Continuous feeding administered over a shorter period (e.g., overnight).

Nursing Care for Enteral Feedings:

- **Elevate the head of the bed** to at least 30-45 degrees during feeding and for 30-60 minutes afterward to prevent aspiration.
- **Verify tube placement** before each bolus feeding and every 4-8 hours for continuous feeding (e.g., by checking markings, aspirating gastric contents and checking pH).
- **Check gastric residual volumes (GRVs)** per policy (e.g., every 4 hours for continuous feeds). Return aspirated contents to the stomach unless contraindicated. High GRVs may indicate delayed gastric emptying and require holding the feed.
- **Flush the tube** with water before and after feedings and medication administration to prevent clogging.
- **Monitor for complications:** Nausea, vomiting, diarrhea, constipation, abdominal distention, aspiration, and tube occlusion.

Parenteral Nutrition (PN)

Parenteral nutrition (also known as Total Parenteral Nutrition, TPN) provides nutrients intravenously, bypassing the GI tract. It is used when the GI tract is non-functional or cannot absorb nutrients (e.g., severe Crohn's disease, short bowel syndrome, prolonged ileus).

Key Considerations for PN:

- **Administration:** PN is a hypertonic solution administered through a central venous catheter (e.g., PICC line, subclavian line) due to its osmolality, which can damage peripheral veins. Lipids can be given separately or mixed with the PN solution (3-in-1).
- **Monitoring:** Close monitoring is essential:
- **Blood glucose:** Frequent checks (e.g., every 4-6 hours) due to high dextrose content. Insulin may be added to the PN or given separately.
- **Fluid and electrolytes:** Daily weights, intake and output, and electrolyte levels to prevent imbalances.
- **Liver function tests:** Long-term PN can affect liver function.
- **Infection:** Central lines are a high risk for bloodstream infections. Strict aseptic technique is paramount during dressing changes and line access.
- **Complications:** Sepsis, hyperglycemia, hypoglycemia (if PN is abruptly stopped), fluid overload, electrolyte imbalances, and liver dysfunction.
- **Administration:** Always use an infusion pump. Do not abruptly stop PN; gradually decrease the rate to prevent rebound hypoglycemia. If a new bag is unavailable, hang D10W (10% dextrose in water) to prevent hypoglycemia until the new bag arrives.

Urinary Elimination Management

Covers: Urinary Specimen Collection, Incontinence, and UTI's - Fundamentals of Nursing | @LevelUpRN (video, 8 min) · Bladder Scanner Use and Urinary Catheters - Fundamentals of Nursing @LevelUpRN (video, 7 min)

Effective management of urinary elimination is a core nursing responsibility, encompassing collection, addressing incontinence, preventing infections, and managing assistive devices.

Urinary Specimen Collection

Accurate collection ensures reliable diagnostic results.

- **Routine Urinalysis:** A clean-catch midstream specimen is preferred. Instruct the patient to clean the perineal area, void a small amount into the toilet, then collect the midstream urine in a sterile cup. For non-ambulatory patients, a clean voided specimen may be collected from a bedpan or urinal.
- **Culture and Sensitivity (C&S):** Requires a sterile specimen, often obtained via a clean-catch midstream or directly from a urinary catheter using a sterile technique.
- **24-Hour Urine Collection:** Collect all urine voided over a 24-hour period, typically starting after the first morning void. Discard the first void, then collect all subsequent voids in a special container, often kept on ice or refrigerated. If any specimen is missed, the collection must be restarted.

Urinary Incontinence

Incontinence is the involuntary loss of urine. It is not a normal part of aging. Types include:

- **Stress Incontinence:** Leakage with increased abdominal pressure (coughing, sneezing, laughing, lifting).
- **Urge Incontinence:** Sudden, strong urge to void, followed by involuntary leakage.
- **Overflow Incontinence:** Involuntary leakage when the bladder is overdistended (e.g., from an obstruction or nerve damage).
- **Functional Incontinence:** Inability to reach the toilet in time due to physical or cognitive impairments.

Management strategies: Pelvic floor exercises (Kegel exercises), bladder training, scheduled toileting, absorbent products, and addressing underlying causes.

Urinary Tract Infections (UTIs)

UTIs are common, especially in women. Symptoms include dysuria (painful urination), frequency, urgency, cloudy or foul-smelling urine, and fever. In older adults, confusion may be the primary symptom.

Prevention: Encourage adequate fluid intake, wipe front to back, void after intercourse, avoid irritating products, and promote good perineal hygiene. For catheterized patients, strict aseptic technique during insertion and maintenance is crucial to prevent catheter-associated UTIs (CAUTIs).

Bladder Scanner Use

A bladder scanner is a non-invasive device used to measure post-void residual (PVR) urine volume or to assess for bladder distention. It helps identify urinary retention without catheterization. The nurse applies gel to the suprapubic area, selects the appropriate gender setting, and positions the probe to obtain an accurate reading. This tool guides decisions about catheterization or further intervention.

Urinary Catheters

Urinary catheters are tubes inserted into the bladder to drain urine. They are used for various reasons, including urinary retention, accurate output measurement in critically ill patients, and during certain surgeries.

Types:

- **Straight (intermittent) catheter:** Single-use, inserted to drain the bladder and then immediately removed.
- **Indwelling (Foley) catheter:** Left in place for a period, secured by an inflated balloon in the bladder. Connected to a drainage bag.

Nursing Care for Indwelling Catheters:

- **Insertion:** Requires strict sterile technique to prevent infection.
- **Maintenance:** Keep the drainage bag below bladder level to prevent backflow. Ensure tubing is free of kinks. Provide daily perineal and catheter care (cleaning around the meatus and catheter). Empty the drainage bag regularly. Monitor for signs of infection.
- **Removal:** Deflate the balloon completely before gently withdrawing the catheter. Monitor the patient for voiding patterns after removal.

Bowel Elimination and Ostomy Care

Covers: Constipation, Diarrhea, and Ostomies - Fundamentals of Nursing | @LevelUpRN (video, 9 min)

Bowel elimination is a fundamental bodily function, and disruptions can significantly impact patient comfort and health. Nurses play a critical role in assessing, managing, and educating patients about bowel health and ostomy care.

Constipation

Constipation is characterized by infrequent bowel movements, hard stools, and difficulty passing stools. Common causes include inadequate fiber intake, insufficient fluid intake, lack of physical activity, certain medications (e.g., opioids), and ignoring the urge to defecate.

Nursing Interventions for Constipation:

- **Increase fiber intake:** Encourage foods like fruits, vegetables, whole grains.
- **Promote fluid intake:** Recommend 6-8 glasses of water daily, unless contraindicated.
- **Encourage mobility:** Regular physical activity stimulates bowel motility.

- **Establish a routine:** Encourage patients to try to defecate at the same time each day, often after a meal.
- **Administer laxatives or stool softeners** as ordered.
- **Avoid prolonged use of stimulant laxatives** as they can lead to dependence.
- **Assess for fecal impaction:** If constipation is severe, a digital rectal exam may be performed by a qualified healthcare professional to check for impaction.

Diarrhea

Diarrhea is characterized by frequent, loose, watery stools. Causes include infections (bacterial, viral, parasitic), food intolerances, medications (e.g., antibiotics), stress, and inflammatory bowel diseases.

Nursing Interventions for Diarrhea:

- **Identify and treat the underlying cause:** This might involve stool cultures to identify pathogens.
- **Maintain hydration and electrolyte balance:** Encourage oral fluids (water, clear broths, electrolyte solutions). Intravenous fluids may be necessary for severe dehydration.
- **Protect perineal skin:** Frequent cleansing and application of barrier creams to prevent skin breakdown.
- **Avoid irritating foods:** Limit spicy foods, caffeine, and high-fat items. Introduce bland foods gradually.
- **Administer antidiarrheal medications** as ordered, but use cautiously if an infectious cause is suspected, as it can prolong the pathogen's presence.
- **Implement contact precautions** if *Clostridioides difficile* (C. diff) is suspected or confirmed. C. diff is a highly contagious bacterium causing severe diarrhea, often following antibiotic use.

Ostomies

An ostomy is a surgically created opening (stoma) on the abdomen that allows for the elimination of feces or urine. It is created when a portion of the bowel or urinary tract is removed or bypassed.

Types of Bowel Ostomies:

- **Colostomy:** A portion of the colon is brought to the abdominal surface. Stool consistency varies based on the location (more formed in descending/sigmoid colostomies, more liquid in ascending/transverse colostomies).
- **Ileostomy:** A portion of the ileum (small intestine) is brought to the abdominal surface. Stool is typically liquid and continuous, containing digestive enzymes that can irritate the skin.

Nursing Care for Ostomies:

- **Stoma Assessment:** Regularly assess the stoma for color (should be reddish-pink and moist), size, and presence of bleeding. Report any pallor, cyanosis, necrosis, or excessive bleeding immediately.
- **Peristomal Skin Care:** The skin around the stoma (peristomal skin) must be kept clean, dry, and intact. Fecal output can cause irritation and breakdown. Use skin barriers and powders as needed.

- **Appliance Management:** Teach patients how to empty and change their ostomy appliance (pouching system). Ensure a proper fit to prevent leakage and skin irritation. Empty the pouch when it is one-third to one-half full.
- **Odor Control:** Discuss dietary modifications and use of deodorizers in the pouch.
- **Patient Education:** Provide comprehensive education on diet, fluid intake, activity, potential complications, and when to seek medical attention. Encourage support groups and resources to help patients adapt to life with an ostomy.

KEY TAKEAWAYS

- Acid-base balance is critical for health, with pH, PaCO₂, and HCO₃⁻ values indicating respiratory or metabolic imbalances.
- Proper nutrition, including macronutrients and micronutrients, is essential for healing, and BMI helps assess weight status.
- Dysphagia requires careful nursing interventions to prevent aspiration, while specific diet types address various patient needs.
- Nasogastric tubes and enteral nutrition provide vital nutritional support when oral intake is compromised, requiring diligent placement verification and monitoring.
- Parenteral nutrition delivers nutrients intravenously for non-functional GI tracts, demanding strict aseptic technique and close metabolic monitoring.
- Managing urinary elimination involves accurate specimen collection, addressing incontinence, preventing UTIs, and proper care of bladder scanners and catheters.
- Effective bowel elimination care includes interventions for constipation and diarrhea, along with comprehensive education and support for patients with ostomies.

CHECK YOUR UNDERSTANDING

Answer these before moving on. Model answers are in the Answer Key at the back of this guide.

1. A patient's ABG results show pH 7.50, PaCO₂ 30 mmHg, HCO₃⁻ 24 mEq/L. Interpret these results.
2. What are three essential nursing interventions to prevent aspiration in a patient with dysphagia?
3. How is NG tube placement primarily verified, and what is a less reliable method?
4. List two key nursing responsibilities when caring for a patient receiving continuous enteral nutrition.
5. What are two critical aspects of care for a patient with an indwelling urinary catheter to prevent complications?
6. Describe proper peristomal skin care for a patient with an ostomy.

CHAPTER 6

Foundations of Bedside Care

This chapter covers two fundamental skills that form the bedrock of safe patient care: infection control and patient mobility. Mastering these practices is essential for preventing harm and promoting healing in any healthcare setting. You will learn precise techniques for hand hygiene and personal protective equipment, as well as strategies to prevent pressure injuries and ensure safe patient handling.

Effective bedside care relies on diligence and attention to detail. This guide provides the practical knowledge you need to apply these critical skills confidently, protecting both your patients and yourself.

Infection Control: Your First and Best Skill

Covers: Infection Control: Your First and Best Skill (reading, 2 min)

Healthcare-associated infections (HAIs) pose a significant risk to hospitalized patients. Statistics show that roughly 1 in 31 patients will contract an HAI on any given day. Your hands are the primary route for germ transmission in healthcare. Therefore, hand hygiene is the single most effective countermeasure against infections. It is the foundational skill that supports every other task you perform.

Understanding the Chain of Infection

Infection occurs when six links in a chain remain unbroken: an infectious agent, a reservoir, a portal of exit, a mode of transmission, a portal of entry, and a susceptible host. All infection control efforts aim to break one or more of these links. As a healthcare provider, you have direct control over the **mode of transmission**, primarily through your hands. By breaking this link, you can prevent most infections from spreading.

Hand Hygiene, Precisely

Proper hand hygiene involves specific techniques and timing. Always follow these guidelines:

- **Alcohol-based hand rub (ABHR):** This is the preferred method for most situations. Apply enough product to cover all surfaces of your hands. Rub your hands together, covering palms, backs of hands, between fingers, and under fingernails, until they are completely dry. This should take at least 20 seconds.
- **Soap and water:** This method is mandatory in specific circumstances. Always use soap and water when your hands are visibly soiled, after using the restroom, and after caring for patients with *C. difficile* (C. diff) or norovirus. Alcohol-based rubs do not kill C. diff spores. Scrub your hands for at least 20 seconds. A good timing cue is to hum the "Happy Birthday" song twice.

The WHO's Five Moments for Hand Hygiene

These are critical times when hand hygiene is required:

1. Before touching a patient.
2. Before a clean or aseptic task.
3. After body fluid exposure risk.
4. After touching a patient.
5. After touching the patient's surroundings. This includes bed rails, IV poles, and other surfaces in the patient's immediate environment, which are common germ reservoirs.

Precautions Ladder: Protecting Patients and Yourself

Personal Protective Equipment (PPE) is used to prevent the spread of infection. The type of PPE depends on the anticipated exposure:

- **Standard Precautions:** Apply to every patient, always. This includes hand hygiene, wearing gloves for contact with body fluids, and other PPE (like masks or eye protection) if splash risk is present.
- **Contact Precautions:** Used for infections spread by direct or indirect contact, such as MRSA or C. diff. Requires a gown and gloves, and dedicated patient equipment if possible.
- **Droplet Precautions:** Used for infections spread by large respiratory droplets, such as influenza or pertussis. Requires a surgical mask when working within 3 to 6 feet of the patient.
- **Airborne Precautions:** Used for infections spread by small airborne particles, such as tuberculosis (TB), measles, or varicella. Requires an N95 respirator mask and placement of the patient in a negative-pressure room.

Donning and Doffing PPE

Donning (putting on) order: Gown, mask, eye protection, gloves. **Doffing (taking off) order:** This is where self-contamination most often occurs. Remove gloves first, then eye protection, then gown, and finally the mask. Perform hand hygiene immediately after doffing all PPE. Always assume the outside of all PPE is contaminated and remove it slowly and carefully.

Fostering a Culture of Safety

In effective healthcare units, it is normal and expected to remind colleagues about hand hygiene, regardless of their rank. Speaking up about a missed hand rub is not impolite; it is a vital part of the safety system. Practice a phrase like, "Hey, I think we forgot to gel coming in. I do it all the time too," so you are ready to use it when needed.

Mobility, Positioning, and Pressure Injury Prevention

Covers: Mobility, Positioning, and Pressure Injury Prevention (reading, 2 min)

Immobility is a serious health risk that can lead to a cascade of complications. Within just a few days of bed rest, patients can experience muscle weakness, pooling of lung secretions, blood clot formation in the

legs, slowed bowel function, bone calcium loss, and skin breakdown. Much of fundamental nursing care involves actively combating the negative effects of stillness.

Understanding Pressure Injuries

Pressure injuries, also known as pressure ulcers or bedsores, occur when skin and underlying tissue are compressed between a bony prominence and an external surface. This compression chokes off blood flow, leading to tissue death in as little as a few hours for high-risk patients.

Common sites for pressure injuries include:

- Sacrum and coccyx (tailbone area)
- Heels
- Hips (trochanters)
- Ischial tuberosities (sit bones, especially in chair-bound patients)
- Elbows
- Back of the head

Two factors accelerate pressure injury development:

- **Shear:** This occurs when the skin is held in place by a sheet while the patient's skeleton slides downward, such as when the head of the bed is elevated. This causes stretching and tearing of underlying tissues.
- **Moisture:** Sweat, urine, or other bodily fluids soften the skin, making it more fragile and susceptible to breakdown.

The Prevention Bundle: Protecting Skin and Joints

Implementing a consistent prevention bundle is critical:

- **Repositioning:** Turn and reposition patients in bed at least every 2 hours. For patients in chairs, reposition at least every 1 hour. Teach alert, chair-bound patients to shift their weight every 15 minutes.
- **30-degree side-lying position:** When positioning a patient on their side, use a 30-degree angle rather than a full 90-degree side lie. A full side lie places direct pressure on the hip's bony prominence (trochanter). Use pillows behind the back and between the knees and ankles to maintain the 30-degree angle and prevent bone-on-bone contact.
- **Float the heels:** Heels are the second most common site for pressure injuries and are relatively easy to protect. Use a pillow to elevate the calves, ensuring the heels are completely suspended off the mattress.
- **Head of Bed (HOB) angle:** Keep the head of the bed at or below 30 degrees when clinically permitted. This helps reduce shear forces on the sacrum.
- **Never massage reddened areas:** An old practice, massaging reddened skin over bony prominences is now known to worsen tissue damage. Avoid it.

- **Skin care:** Keep the patient's skin clean and dry. Use barrier creams for patients with incontinence to protect the skin from moisture. Inspect the skin at every repositioning, paying close attention to the heels and sacrum.
- **Warning sign:** A stage 1 pressure injury is indicated by redness that does **not blanch** (whiten) when pressed with a fingertip. Non-blanchable redness is a critical finding and must be reported to the nursing staff during the same shift, not merely documented quietly.

Safe Patient Handling: Protecting Yourself

Your physical health, particularly your back, is a valuable career asset with a finite load limit. Protect it by consistently using safe patient handling techniques and available equipment:

- **Body mechanics:** Always raise the patient's bed to a comfortable working height. Keep the load (patient) close to your body. Bend your knees, not your waist, to lift. Pivot your feet to turn instead of twisting your spine.
- **Use equipment:** Rely on gait belts for ambulation assistance, friction-reducing slide sheets for repositioning, sit-to-stand devices, and mechanical lifts for transfers. Proper body mechanics alone are insufficient for safely lifting adults; equipment and teamwork are essential.
- **Teamwork:** Do not attempt solo heroics. Two-person turns or transfers are a sign of good clinical judgment, not weakness. Working with a colleague protects both you and the patient.

Finally, encourage early and frequent mobilization of patients as ordered. Even a short walk to the bathroom serves multiple purposes: it acts as respiratory therapy, helps prevent blood clots, promotes bowel function, and provides essential skin care in one intervention.

KEY TAKEAWAYS

- Hand hygiene is the single most effective measure to prevent healthcare-associated infections.
- Always use soap and water for visibly soiled hands, after restroom use, and after caring for patients with C. diff or norovirus.
- Follow the WHO's five moments for hand hygiene, including after touching a patient's surroundings.
- Properly donning and doffing PPE is crucial, with careful removal of gloves first to prevent self-contamination.
- Immobility leads to serious complications, including pressure injuries, muscle weakness, and blood clots.
- Reposition patients at least every two hours in bed and every hour in a chair to prevent pressure injuries.
- Non-blanchable redness over a bony prominence is a critical sign of a stage 1 pressure injury and requires immediate reporting.
- Always use safe patient handling equipment and teamwork to protect your back and ensure patient safety.

CHECK YOUR UNDERSTANDING

Answer these before moving on. Model answers are in the Answer Key at the back of this guide.

1. When is it mandatory to use soap and water for hand hygiene instead of an alcohol-based hand rub?
2. List the correct order for donning (putting on) personal protective equipment (PPE).
3. A patient has redness over their sacrum that does not turn white when you press on it. What does this indicate, and what action should you take?
4. Describe two specific techniques to prevent pressure injuries in a bed-bound patient.
5. Why is it important to use equipment like slide sheets or mechanical lifts for patient handling, even if you know proper body mechanics?

CHAPTER 7

Final Assessment: Patient Care Fundamentals

This chapter guides you through the final assessment for the Patient Care Fundamentals course. This assessment is designed to test your comprehensive understanding of all the core principles covered in the preceding modules. It serves as a critical opportunity to evaluate your mastery of essential nursing fundamentals, identify areas of strength, and pinpoint any topics that may require further review. Approaching this assessment thoughtfully will reinforce your learning and prepare you for practical application.

What You Should Have Mastered

Covers: Final Assessment: Patient Care Fundamentals (quiz, 5 min)

By the time you reach this final assessment, you should have a solid grasp of the fundamental concepts and skills in patient care. This includes the ability to:

- Apply proper infection control techniques and hand hygiene practices consistently.
- Position, turn, and mobilize patients safely to prevent complications like pressure injuries and joint stiffness.
- Provide respectful and dignified care for patient hygiene, elimination needs, and overall comfort.
- Recognize and accurately report early signs of pressure injuries and other indicators of patient decline.
- Implement general patient safety measures to create a secure care environment.

Approaching the Final Assessment

Covers: Final Assessment: Patient Care Fundamentals (quiz, 5 min)

Treat the final assessment as a formal evaluation of your knowledge. Even for a short quiz, a structured approach can improve your performance.

Read Carefully

Always read each question and all provided answer options completely before making a selection. Do not assume you know what the question is asking based on a quick glance.

Eliminate Options

For multiple-choice questions, eliminate any answer choices that are clearly incorrect. This narrows down your options and increases your chances of selecting the correct response.

Choose the Best Answer

Sometimes, more than one answer option may seem plausible. Your goal is to identify the *best* answer among the choices, which often requires applying critical thinking to the scenario presented.

Manage Your Time

While this specific quiz is short, practice managing your time effectively. Do not dwell too long on a single question. If you are stuck, make your best guess and move on, returning to it later if time permits.

Common Mistakes and How to Avoid Them

Covers: Final Assessment: Patient Care Fundamentals (quiz, 5 min)

Students often make similar mistakes during assessments. Being aware of these can help you avoid them.

- **Rushing:** Hurrying through questions can lead to misreading or overlooking crucial details. Take your time with each question.
- **Misinterpreting Keywords:** Pay close attention to words like 'first,' 'best,' 'most important,' 'except,' or 'least.' These words significantly alter the meaning of a question.
- **Overthinking:** While critical thinking is vital, sometimes the most straightforward answer is the correct one. Avoid adding extra layers of complexity to a simple question.
- **Failing to Review:** Always review your answers before submitting the quiz. This allows you to catch any accidental selections or reconsider answers you were initially unsure about.

Interpreting Your Results

Covers: Final Assessment: Patient Care Fundamentals (quiz, 5 min)

Your score on the final assessment provides valuable feedback on your learning path. It is not just a grade, but a diagnostic tool.

High Score

A high score indicates a strong understanding of the course material. This is excellent, but still take time to review any questions you answered incorrectly. Understanding why you missed even one question can deepen your knowledge.

Lower Score

If your score is lower than you hoped, do not be discouraged. Instead, use it as a guide. Identify the specific topics or modules where you struggled. Revisit those sections of the study guide and course materials. Focus your review on strengthening those weaker areas.

Review Feedback

If the assessment provides feedback on incorrect answers, use it. Understand the rationale behind the correct answer. This process of self-correction is crucial for solidifying your knowledge and preventing

similar mistakes in the future.

KEY TAKEAWAYS

- The final assessment evaluates your comprehensive understanding of all core patient care fundamentals.
- Approach the quiz strategically by reading each question and all answer options carefully before responding.
- Actively eliminate incorrect options to increase your chances of selecting the best answer for multiple-choice questions.
- Identify and avoid common test-taking errors, such as rushing or misinterpreting critical keywords.
- Use your assessment results as a diagnostic tool to pinpoint specific areas needing further review and focused study.
- A strong grasp of these patient care fundamentals is essential for providing safe, effective, and dignified care.

CHECK YOUR UNDERSTANDING

Answer these before moving on. Model answers are in the Answer Key at the back of this guide.

1. What is the primary purpose of taking a final assessment in a course like Patient Care Fundamentals?
2. Describe one effective strategy for approaching multiple-choice questions.
3. Why is it important to review your answers before submitting a quiz?
4. How should you interpret a lower-than-expected score on the final assessment?
5. List two common mistakes students make when taking quizzes and how to avoid them.

REFERENCE

Glossary

Acidosis

A condition in which the blood pH falls below 7.35, indicating an excess of acid or a deficit of base.

Active immunity

Immunity developed when the body produces its own antibodies in response to an antigen, either from natural infection or vaccination, providing long-lasting protection.

Advance directives

Legal documents, such as Living Wills or Durable Powers of Attorney for Healthcare, that specify a person's healthcare wishes if they become unable to make decisions.

Alkalosis

A condition in which the blood pH rises above 7.45, indicating an excess of base or a deficit of acid.

Autonomy

The patient's right to make independent decisions about their own healthcare.

Body mechanics

The coordinated effort of muscles, bones, and the nervous system to maintain balance, posture, and alignment during moving, transferring, and positioning patients or objects.

Brachytherapy

A type of radiation therapy where a radioactive source is placed inside or next to the area requiring treatment, delivering a high dose of radiation directly to the tumor.

Braden scale

A widely used risk assessment tool for predicting the likelihood of a patient developing a pressure injury based on six criteria.

Catheter-associated urinary tract infection (cauti)

A urinary tract infection that develops in a patient with an indwelling urinary catheter or within 48 hours of catheter removal.

Chain of infection

A model describing the six elements (infectious agent, reservoir, portal of exit, mode of transmission, portal of entry, susceptible host) that must be present for an infection to occur and spread.

Critical thinking

The objective analysis and evaluation of information in order to form a judgment, essential for effective patient care decisions.

Cultural competence

The ability of healthcare providers to understand, appreciate, and interact effectively with people from cultures different from their own.

Deep vein thrombosis (dvt)

A blood clot that forms in a deep vein, most commonly in the legs, posing a risk for pulmonary embolism.

Dysphagia

Difficulty swallowing, which increases the risk of aspiration.

Electrolytes

Minerals in the body fluids that carry an electric charge, essential for nerve and muscle function, and maintaining fluid balance.

Enteral nutrition

Delivery of nutrients directly into the gastrointestinal tract via a tube (e.g., NG tube, gastrostomy tube).

Final assessment

A comprehensive evaluation designed to measure a student's overall understanding and mastery of all course material.

Fluid volume deficit (hypovolemia)

A state where the body loses both water and electrolytes from the extracellular fluid, leading to dehydration.

Fluid volume excess (hypervolemia)

A state where the body retains too much water and sodium in the extracellular fluid, leading to edema and circulatory overload.

General adaptation syndrome (gas)

The body's physiological response to stress, consisting of three stages: alarm, resistance, and exhaustion.

Hand hygiene

The practice of cleaning hands to remove or kill microorganisms, using either an alcohol-based hand rub or soap and water.

Health belief model

A psychological model that attempts to explain and predict health behaviors based on an individual's perceptions of susceptibility, severity, benefits, barriers, cues to action, and self-efficacy.

Healthcare-associated infection (hai)

An infection acquired by a patient during the course of receiving medical care, which was not present at the time of admission.

Hipaa

The Health Insurance Portability and Accountability Act, a federal law protecting patient privacy and the security of protected health information (PHI).

Hospice care

A type of palliative care for patients with a life-limiting illness, typically with a prognosis of six months or less, focusing on comfort and quality of life rather than cure.

Hospital-acquired infection (hai)

An infection acquired by a patient while receiving medical care in a healthcare facility.

Infection control

Policies and procedures used to prevent the spread of infectious diseases in healthcare settings.

Informed consent

A patient's voluntary agreement to a treatment or procedure after receiving comprehensive information about its purpose, risks, benefits, and alternatives.

Malpractice

Professional negligence by a healthcare provider that results in injury to a patient due to a deviation from the accepted standard of care.

Non-blanchable redness

Redness of the skin that does not whiten or turn pale when pressed with a fingertip, indicating potential tissue damage and a stage 1 pressure injury.

Nursing process

A systematic, five-step method (Assessment, Diagnosis, Planning, Implementation, Evaluation) used by nurses to provide patient-centered care.

Orthostatic hypotension

A sudden drop in blood pressure when a person stands up from a sitting or lying position, often due to immobility.

Ostomy

A surgically created opening (stoma) on the abdomen that allows for the elimination of feces or urine.

Palliative care

Care focused on providing relief from the symptoms and stress of a serious illness, aiming to improve quality of life for both the patient and the family.

Parenteral nutrition (pn)

Delivery of nutrients intravenously, bypassing the gastrointestinal tract, typically through a central venous catheter.

Patient safety

The prevention of errors and adverse effects to patients associated with healthcare.

Personal protective equipment (ppe)

Specialized clothing or equipment worn to protect against infectious materials, including gloves, gowns, masks, and eye protection.

Pressure injury

Localized damage to the skin and underlying soft tissue, usually over a bony prominence, resulting from prolonged pressure or pressure combined with shear.

Sbar report

A standardized communication tool (Situation, Background, Assessment, Recommendation) used for clear and concise information exchange in healthcare.

Sharps injury

An injury caused by a needle, scalpel, or other sharp medical instrument that can pierce the skin, posing a risk of bloodborne pathogen transmission.

Shear

A force that occurs when skin remains stationary while underlying tissue and bone move, causing stretching and tearing of blood vessels and tissue.

Standard precautions

Infection control practices used for all patients, regardless of their diagnosis or presumed infection status, including hand hygiene and appropriate use of PPE.

Sterile field

An area free of all microorganisms, created for performing aseptic procedures to prevent contamination.

Therapeutic communication

Purposeful, goal-directed communication focused on the patient's needs, promoting a positive nurse-patient relationship and fostering understanding.

Transtheoretical model

Also known as the Stages of Change Model, this model describes the process of intentional behavior change through distinct stages: precontemplation, contemplation, preparation, action, maintenance, and termination.

Urinary incontinence

The involuntary leakage of urine.

REFERENCE

Answer Key

Chapter 1: Principles of Patient Care and the Nursing Profession

1. What are the core ethical principles that guide nursing practice, and why are they important?

The core ethical principles include autonomy, beneficence, non-maleficence, justice, fidelity, and veracity. They are important because they provide a moral framework for decision-making in patient care. These principles help nurses navigate complex situations and ensure they provide compassionate, respectful, and high-quality care while upholding professional standards.

2. Explain the nurse's role in obtaining informed consent and respecting a patient's right to refuse treatment.

The nurse's role in informed consent is typically to witness the patient's signature and confirm they received and understood the information. If the patient has questions or appears not to understand, the nurse must notify the provider. Regarding the right to refuse treatment, the nurse must respect the competent patient's decision, document it clearly, and ensure the patient understood the potential consequences of their refusal.

3. How does HIPAA impact a nurse's daily responsibilities?

HIPAA requires nurses to protect patient privacy and the security of protected health information (PHI). This impacts daily responsibilities by mandating secure handling of patient charts, protecting computer screens from unauthorized viewing, and refraining from discussing patient information with anyone not directly involved in their care. Adherence to HIPAA prevents breaches and maintains patient trust.

4. Differentiate between negligence and malpractice in nursing.

Negligence is a general term for failing to act as a reasonably prudent person would in a similar situation, resulting in harm. Malpractice is a specific type of professional negligence. It occurs when a healthcare professional, such as a nurse, deviates from the accepted standard of care, and this deviation directly causes injury or damage to a patient. Malpractice requires the presence of duty, breach of duty, causation, and damages.

5. Describe the stages of change in the Transtheoretical Model and how a nurse might apply this model.

The Transtheoretical Model includes precontemplation, contemplation, preparation, action, maintenance, and termination. A nurse applies this model by assessing a patient's current stage of readiness for behavior change. For example, a nurse would use different interventions for a patient in precontemplation (raising awareness) compared to a patient in the action stage (providing support and resources for continued change).

Chapter 2: Principles of Patient Care and Safety

1. Describe two examples of therapeutic communication techniques and explain why they are effective.

Active listening involves fully concentrating on what the patient is saying, both verbally and nonverbally, which makes the patient feel heard and valued. Using open-ended questions encourages patients to elaborate on their feelings and experiences, providing more comprehensive information than simple 'yes' or 'no' answers.

2. What are the six links in the chain of infection, and how can a nurse break one of these links?

The six links are infectious agent, reservoir, portal of exit, mode of transmission, portal of entry, and susceptible host. A nurse can break the mode of transmission link by performing thorough hand hygiene, which removes pathogens from their hands before they can transfer them to a patient.

3. Explain the difference between active and passive immunity.

Active immunity occurs when the body produces its own antibodies, either through exposure to an infection or vaccination, leading to long-term protection. Passive immunity involves receiving pre-formed antibodies from an external source, such as from a mother to her baby or via antitoxins, providing immediate but temporary protection.

4. List three essential safety precautions a nurse should take when caring for a patient undergoing brachytherapy.

When caring for a brachytherapy patient, a nurse should limit the time spent in the patient's room, maximize the distance from the radiation source, and use shielding such as lead aprons or portable shields. These measures help minimize the nurse's exposure to radiation.

5. Why is proper body mechanics important for nurses, and what is one key principle to follow?

Proper body mechanics are crucial for nurses to prevent musculoskeletal injuries when lifting or moving patients. One key principle is to bend at the knees and use leg muscles to lift, rather than bending at the waist and using back muscles, to distribute the weight more safely.

Chapter 3: Patient Care Planning, Infection Control, and Holistic Support

1. Describe the five steps of the nursing process and explain why each step is important.

The nursing process involves Assessment (collecting data), Diagnosis (identifying patient problems), Planning (setting goals and interventions), Implementation (carrying out interventions), and Evaluation (determining if goals were met). This systematic approach ensures comprehensive, individualized, and effective patient care, allowing for continuous adjustment based on patient response.

2. When should healthcare providers use soap and water for hand hygiene instead of an alcohol-based hand rub?

Healthcare providers should use soap and water when their hands are visibly soiled with dirt or body

fluids. Also, soap and water are required after using the restroom and when caring for patients with known or suspected *Clostridioides difficile* (C. diff) infection, as alcohol-based rubs are not effective against C. diff spores.

3. List the correct sequence for donning and doffing personal protective equipment (PPE).

The correct sequence for donning PPE is Gown, Mask or N95 respirator, Eye protection, then Gloves. The correct sequence for doffing PPE, to minimize self-contamination, is Gloves, Eye protection, Gown, then Mask or N95 respirator (removed outside the patient room).

4. What are three critical actions a nurse should take if a patient begins to have a seizure?

If a patient begins to have a seizure, the nurse should immediately protect the patient from injury by moving objects away and loosening restrictive clothing. The nurse must gently turn the patient onto their side to prevent aspiration. It is also crucial to time the seizure's duration and observe its characteristics for documentation.

5. Explain the difference between palliative care and hospice care.

Palliative care can be provided at any stage of a serious illness, alongside curative treatments, focusing on symptom relief and improving quality of life. Hospice care is a specific type of palliative care for patients with a life expectancy of six months or less, who have chosen to forgo curative treatments, emphasizing comfort and support during the end-of-life period.

Chapter 4: Patient Mobility, Skin Integrity, and Fluid Balance

1. What are three common complications of immobility, and how can nurses help prevent them?

Three common complications of immobility are Deep Vein Thrombosis (DVT), pressure injuries, and pneumonia. Nurses can prevent DVT by promoting early ambulation, using anti-embolism stockings, and encouraging leg exercises. Pressure injuries are prevented through frequent repositioning, skin assessment, and adequate nutrition. Pneumonia can be prevented by encouraging deep breathing and coughing exercises.

2. Describe the proper use of a walker for a patient with generalized weakness.

When using a walker, the patient should first push the walker forward a short distance, keeping all four legs of the walker on the ground. Then, the patient steps into the walker, moving their weaker leg first, followed by the stronger leg. Ensure the patient maintains an upright posture and does not lean over the walker, which can compromise balance.

3. A patient has a non-blanchable red area on their sacrum. How would you stage this pressure injury, and what is the immediate nursing action?

This describes a Stage 1 pressure injury. The immediate nursing action is to relieve pressure on the area by repositioning the patient, ensuring the skin is clean and dry, and assessing for other risk factors. Document the finding and interventions, and continue to monitor the area closely.

4. Explain the difference between primary and secondary intention wound healing.

Primary intention healing occurs when wound edges are well-approximated, such as with a surgical incision, resulting in minimal tissue loss and scarring. Secondary intention healing involves wounds with extensive tissue loss or edges that cannot be approximated, such as pressure injuries. These

wounds heal from the bottom up by granulation tissue formation, typically taking longer and resulting in more scarring.

5. List three signs of fluid volume deficit and three signs of fluid volume excess.

Signs of fluid volume deficit (hypovolemia) include dry mucous membranes, decreased skin turgor, and a rapid, weak pulse. Signs of fluid volume excess (hypervolemia) include peripheral edema, crackles in the lungs, and distended neck veins.

Chapter 5: Fluid Balance, Nutrition, and Elimination Fundamentals

1. A patient's ABG results show pH 7.50, PaCO₂ 30 mmHg, HCO₃⁻ 24 mEq/L. Interpret these results.

The pH of 7.50 is high, indicating alkalosis. The PaCO₂ of 30 mmHg is low, which is acidic and moves the pH towards alkalosis. The HCO₃⁻ of 24 mEq/L is within the normal range. Therefore, this patient is experiencing uncompensated respiratory alkalosis.

2. What are three essential nursing interventions to prevent aspiration in a patient with dysphagia?

Three essential nursing interventions to prevent aspiration in a patient with dysphagia are to position the patient upright at 90 degrees during meals and for 30-60 minutes afterward, provide thickened liquids as ordered, and ensure suction equipment is readily available. Also, encourage slow eating and thorough chewing.

3. How is NG tube placement primarily verified, and what is a less reliable method?

NG tube placement is primarily and most reliably verified by X-ray. A less reliable method, which should not be used as the sole confirmation, is auscultating for an air bolus over the stomach, as sounds can be misleading.

4. List two key nursing responsibilities when caring for a patient receiving continuous enteral nutrition.

Two key nursing responsibilities for continuous enteral nutrition are to elevate the head of the bed to at least 30-45 degrees to prevent aspiration and to check gastric residual volumes (GRVs) regularly according to policy. Also, verify tube placement and flush the tube periodically.

5. What are two critical aspects of care for a patient with an indwelling urinary catheter to prevent complications?

Two critical aspects of care for a patient with an indwelling urinary catheter are maintaining the drainage bag below bladder level to prevent backflow and providing daily perineal and catheter care. These actions help prevent catheter-associated urinary tract infections (CAUTIs) and maintain hygiene.

6. Describe proper peristomal skin care for a patient with an ostomy.

Proper peristomal skin care involves keeping the skin around the stoma clean, dry, and intact. This includes gently cleaning the skin with warm water and mild soap, ensuring it is completely dry before applying a new appliance, and using skin barriers or powders as needed to protect against irritation and breakdown from fecal or urinary output.

Chapter 6: Foundations of Bedside Care

1. When is it mandatory to use soap and water for hand hygiene instead of an alcohol-based hand rub?

It is mandatory to use soap and water when hands are visibly soiled, after using the restroom, and after caring for patients with *C. difficile* or norovirus. Alcohol-based rubs are ineffective against *C. diff* spores.

2. List the correct order for donning (putting on) personal protective equipment (PPE).

The correct order for donning PPE is: gown, then mask, followed by eye protection, and finally gloves. This sequence helps ensure proper coverage and protection.

3. A patient has redness over their sacrum that does not turn white when you press on it. What does this indicate, and what action should you take?

This indicates non-blanchable redness, which is a warning sign of a stage 1 pressure injury. You should report this finding to the nursing staff immediately during the same shift, as it requires prompt intervention.

4. Describe two specific techniques to prevent pressure injuries in a bed-bound patient.

Two techniques are repositioning the patient at least every two hours and using the 30-degree side-lying position with pillows to offload pressure from the trochanter. Also, floating the heels off the mattress with a pillow under the calves is crucial.

5. Why is it important to use equipment like slide sheets or mechanical lifts for patient handling, even if you know proper body mechanics?

Proper body mechanics alone are often insufficient for safely lifting or moving adult patients. Equipment like slide sheets and mechanical lifts significantly reduce the physical strain on caregivers, preventing back injuries, and also enhance patient safety during transfers. Teamwork with colleagues is also vital.

Chapter 7: Final Assessment: Patient Care Fundamentals

1. What is the primary purpose of taking a final assessment in a course like Patient Care Fundamentals?

The primary purpose is to evaluate your overall comprehension of the course material. It helps you identify strengths and pinpoint specific areas where further study or practice may be needed. This assessment serves as a valuable tool for self-reflection and reinforcement of learning.

2. Describe one effective strategy for approaching multiple-choice questions.

One effective strategy is to read the entire question and all answer choices before selecting a response. Eliminate obviously incorrect options first. Then, consider which remaining option is the *best* answer, even if multiple options seem plausible.

3. Why is it important to review your answers before submitting a quiz?

Reviewing answers allows you to catch careless mistakes, such as misreading a question or selecting

the wrong option by accident. It also provides a final opportunity to reconsider any answers you were unsure about, potentially improving your overall score.

4. How should you interpret a lower-than-expected score on the final assessment?

A lower score should be viewed as an opportunity for targeted learning, not as a failure. It indicates specific topics or modules that require more attention. Use the results to guide your review, focusing on the areas where you struggled to strengthen your foundational knowledge.

5. List two common mistakes students make when taking quizzes and how to avoid them.

Two common mistakes are rushing through questions and misinterpreting keywords. To avoid rushing, take your time to read each question and all options thoroughly. To avoid misinterpretation, pay close attention to words like 'first,' 'best,' 'most,' 'least,' or 'except' in the question stem.

CLOSING

Where to Go Next

After completing "Patient Care Fundamentals," consolidate your skills through practice. Seek opportunities to apply infection control, positioning, and hygiene techniques in a simulated lab or supervised clinical setting. Regular review of this material will reinforce your foundational knowledge.

Consider exploring additional MegaCourse offerings in advanced patient assessment, pharmacology, or specialized areas of nursing. These subjects naturally follow the fundamentals you have mastered here. Continued learning and practical application will build your expertise in patient care.



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