CLINICALJUDGE™ · MASTER SERIES

FUNDAMENTALS OF NURSING

THE COMPLETE 2026 NGN NCLEX-RN MASTERY GUIDE

★ 100% Score Target | Vital Signs · VS Ranges | Infection Control & Asepsis | Safety · Restraints · Fire | Mobility & Positioning | Skin Integrity | Oxygenation | Nutrition & Enteral | Elimination | Fluids & Electrolytes | Medication Administration | Pain Management | Communication · SBAR | End-of-Life Care

COLOR KEY — Critical / Emergent | Physiology / Process | Safe / Expected | Complications / Priority | Key NCLEX Point | Medication | Patient Education

1 VITAL SIGNS & MEASUREMENT

ADULT NORMAL RANGES MEMORIZE

VITAL SIGN	NORMAL RANGE (ADULT)	NCLEX SIGNIFICANCE
Temperature	36.5–37.5°C / 97.7–99.5°F	Fever ≥38°C (100.4°F); >41°C is emergent. Hypothermia <35°C.
Heart Rate / Pulse	60–100 bpm	Tachycardia >100 (early shock sign); bradycardia <60.
Respiratory Rate	12–20 /min	Count full 1 min if irregular; <12 or >20 needs assessment.
Blood Pressure	<120 / <80 mmHg	Hypertensive crisis ≥180/120; hypotension <90 systolic.
SpO_2 (pulse ox)	95–100%	<90% = hypoxemia, act now. COPD goal often 88–92%.
Pain (5th VS)	0–10 scale	Self-report is the gold standard; treat & reassess.

AGE VARIATION HIGHLIGHTS

AGE GROUP	HEART RATE	RESPIRATORY RATE
Newborn	100–160	30–60
Infant (1–12 mo)	90–160	25–40
Toddler / Preschool	80–140	20–30
School-age	70–120	18–25
Adolescent / Adult	60–100	12–20

⚑ KEY NCLEX POINTS

- **Orthostatic (postural) hypotension** = drop ≥20 mmHg systolic or ≥10 mmHg diastolic within 3 min of standing. Measure lying → sitting → standing.
- **Korotkoff sounds:** first sound = systolic; disappearance = diastolic.
- Use the correct cuff size — too small cuff falsely **raises** BP; too large cuff falsely **lowers** it.
- Wait 30 min after caffeine/smoking/exercise before measuring BP.

2 INFECTION CONTROL & ASEPSIS

CHAIN OF INFECTION PROCESS

Infectious Agent → Reservoir → Portal of Exit → Mode of Transmission → Portal of Entry → Susceptible Host

Nursing focus: Break the chain — hand hygiene interrupts the mode of transmission and is the single most effective measure.

MEDICAL VS. SURGICAL ASEPSIS

MEDICAL ASEPSIS (CLEAN)

- ✓ Reduces number & spread of microbes
- ✓ Hand hygiene, gloves, clean technique
- ✓ Used for routine care, oral meds, bed baths
- ✓ "Clean to dirty" direction of cleaning

SURGICAL ASEPSIS (STERILE)

- ⚠ Eliminates ALL microbes & spores
- ⚠ Sterile field, sterile gloves/gown
- ⚠ Used for catheter insertion, dressing deep wounds, injections, surgery
- ⚠ 1-inch border of field is contaminated; below waist = contaminated

HAND HYGIENE

- **Alcohol-based rub** for routine hand hygiene when hands are not visibly soiled (≥20 sec).
- **Soap & water (≥20 sec)** when hands are visibly soiled, and ALWAYS for **C. difficile** and Norovirus (spores resist alcohol).

TRANSMISSION-BASED (ISOLATION) PRECAUTIONS HIGH-YIELD

PRECAUTION	PPE / ROOM	KEY DISEASES (MNEMONIC)
Standard	Applies to ALL patients — gloves for body fluids, hand hygiene, mask/eye protection as needed	Treat all blood & body fluids as infectious
Airborne	**N95 respirator** + negative-pressure private room, door closed	`M-T-V + C` **M**easles, **T**B, **V**aricella, disseminated zoster, **C**OVID/SARS
Droplet	Surgical mask + private room (or cohort), within 3–6 ft	Influenza, Pertussis, **N. meningitidis** meningitis, Mumps, Rubella, Pneumonia, Strep pharyngitis
Contact	Gown + gloves; dedicated equipment	`MRSA · VRE · C.diff · RSV · Scabies · Impetigo`

⚑ KEY NCLEX POINTS

• **C. diff** = Contact precautions + **soap and water** (not alcohol gel) + bleach for surfaces.

• **Negative pressure** = air flows IN; used for airborne (TB). **Positive pressure** (protective environment) = air flows OUT; used for immunocompromised (e.g., neutropenic, stem-cell transplant).

• Don a fresh N95 fit-tested respirator before entering an airborne room; perform a seal check.

PPE SEQUENCE — DON VS. DOFF ORDER MATTERS

DONNING (PUT ON)

- ✓ 1 — Hand hygiene
- ✓ 2 — Gown
- ✓ 3 — Mask or N95 respirator
- ✓ 4 — Goggles / face shield
- ✓ 5 — Gloves (over gown cuffs)

DOFFING (TAKE OFF)

- ⚠ 1 — Gloves (most contaminated)
- ⚠ 2 — Goggles / face shield
- ⚠ 3 — Gown
- ⚠ 4 — Mask / respirator (last, outside room for N95)
- ⚠ 5 — Hand hygiene immediately

Memory aid: Donning is alphabetical-ish (Gown → Mask → Goggles → Gloves); Doffing removes the dirtiest first (Gloves first, mask last).

3 PATIENT SAFETY & RISK REDUCTION

FALL PREVENTION & PATIENT IDENTIFICATION

SAFE / EXPECTED PRACTICES

- ✓ Two identifiers (name + DOB) before any care
- ✓ Bed in lowest position, wheels locked
- ✓ Call light & personal items within reach
- ✓ Nonskid footwear; clear pathways
- ✓ Hourly rounding; toileting schedule

CRITICAL RISK FLAGS

- ⚠ History of falls, age >65, sedatives/diuretics
- ⚠ Orthostatic hypotension, gait/balance deficit
- ⚠ Confusion, incontinence, sensory impairment
- ⚠ New environment / postoperative status

RESTRAINTS LEGAL + SAFETY

- Restraints are the **last resort** — try least-restrictive alternatives first (sitter, diversion, environment change).
- Require a **provider order** stating type, reason, and duration; **never PRN**.
- Use a **quick-release knot** tied to the bed frame, **never to side rails** or a movable part.
- Apply so 2 fingers fit underneath; check circulation, ROM, skin, toileting **q2h**.

⚑ ORDER RENEWAL & MONITORING

• **Violent/self-destructive behavior:** renew q4h (adults), q2h (ages 9–17), q1h (<9). Face-to-face provider eval within 1 hr.
• **Non-violent / medical-surgical:** order renewed every **24 hours**.
• Monitor violent-behavior restraints continuously / q15 min.

FIRE & ENVIRONMENTAL SAFETY

RACE — FIRE RESPONSE

Rescue patients in immediate danger
Alarm — activate & call
Confine — close doors/windows
Extinguish (small) or Evacuate

PASS — EXTINGUISHER USE

Pull the pin
Aim at the base of the fire
Squeeze the handle
Sweep side to side

⚑ KEY NCLEX POINTS

• Fire priority order: protect/rescue people first, then sound alarm. **Rescue is the first action.**
• During a fire, turn off oxygen sources to non-affected patients only after rescuing those in danger.
• Verify two patient identifiers; never use room number alone.

4 MOBILITY, POSITIONING & BODY MECHANICS

THERAPEUTIC POSITIONS

POSITION	DESCRIPTION	INDICATION
High-Fowler's	60–90°	Eating, dyspnea, suctioning, ↓ aspiration risk
Semi-Fowler's	30–45°	Post-op, NG feeding, ↓ aspiration, cardiac/respiratory ease
Trendelenburg	Head lower than feet	Some shock protocols, central line insertion
Reverse Trendelenburg	Head higher than feet	↓ aspiration, promotes gastric emptying
Sims' (left lateral)	Semi-prone, left side	Enema administration, rectal exam, unconscious drainage
Prone	On abdomen	ARDS oxygenation, post some spinal procedures
Lateral / side-lying	On side	Pressure relief, post-op recovery, ↓ aspiration

⚑ BODY MECHANICS

- Bend at the knees/hips, keep back straight, hold load close, wide base of support — **push/pull/roll rather than lift**.
- Use assistive/mechanical lifts & get help to prevent injury; lock bed brakes before transfer.

AMBULATION AIDS — CANES, WALKERS, CRUTCHES

- **Cane:** hold on the STRONG (unaffected) side; advance cane and weak leg together, then strong leg.
- **Walker:** patient stands inside the frame, moves walker forward ~6–8 in, steps **weak leg first**, then strong leg. All four points on the floor before stepping.
- **Crutches — fit:** 2–3 finger-widths (~2 in) below axilla; weight on hands/palms, NOT axillae (prevents brachial plexus injury). Elbows flexed ~30°.
- **Stairs rule:** `UP with the GOOD, DOWN with the BAD` — good leg leads going up, affected leg leads going down. Crutches move with the affected leg.

4-point gait
Most stable; partial weight-bearing both legs.

3-point gait
Non-weight-bearing on one leg (e.g., fracture).

2-point gait
Faster; partial weight-bearing, more balance needed.

IMMOBILITY COMPLICATIONS — PRIORITY LADDER

1. **Airway/Respiratory:** atelectasis & pneumonia — encourage deep breathing, cough, incentive spirometry, reposition q2h.
2. **Circulatory:** VTE/DVT & orthostatic hypotension — SCDs, early mobility, ankle pumps, anticoagulation as ordered.
3. **Skin:** pressure injuries — turn q2h, offloading, moisture management.
4. **Musculoskeletal:** contractures, muscle atrophy, disuse osteoporosis — ROM exercises, splints.
5. **GI/GU:** constipation & urinary stasis/calculi — hydration, fiber, scheduled toileting.

5 SKIN INTEGRITY & PRESSURE INJURIES

PRESSURE INJURY STAGING (NPIAP) HIGH-YIELD

STAGE	DEFINING FEATURE	SKIN LAYERS
Stage 1	**Intact** skin, non-blanchable erythema	Epidermis intact
Stage 2	Partial-thickness loss; shiny/dry shallow ulcer or intact/ruptured blister	Through epidermis into dermis
Stage 3	Full-thickness; **adipose (fat) visible**; slough may be present but doesn't obscure depth	Into subcutaneous tissue
Stage 4	Full-thickness; **exposed bone, tendon, or muscle**; often slough/eschar	Through all tissue layers
Unstageable	Base obscured by slough/eschar — depth unknown until removed	Full-thickness (extent hidden)
Deep Tissue Injury	Persistent non-blanchable deep red/maroon/purple discoloration or blood-filled blister	Underlying soft-tissue damage

⚑ STAGING RULE

If the wound bed is covered by eschar/slough, it is **unstageable**. Stable, dry, intact eschar on a heel is generally **left intact** (acts as natural cover) — do not debride.

BRADEN SCALE & PREVENTION

The **Braden Scale** predicts pressure-injury risk across 6 subscales: `sensory perception · moisture · activity · mobility · nutrition · friction/shear`. Score range **6–23**; LOWER score = HIGHER risk (≤9 severe, ≤18 at risk).

PREVENTION (EXPECTED CARE)

- ✓ Reposition q2h (chair-bound q1h)
- ✓ Keep skin clean & dry; barrier creams
- ✓ Pressure-redistributing surfaces
- ✓ Optimize nutrition/hydration (protein)
- ✓ Float heels; avoid head-of-bed >30° when possible

CRITICAL DON'T-DO'S

- ⚠ Do NOT massage reddened bony prominences
- ⚠ Do NOT drag/shear when repositioning
- ⚠ Do NOT leave patient on wet/soiled linens
- ⚠ Do NOT use donut cushions (cause ischemia)

WOUND HEALING & DRESSINGS

Hemostasis (clot) → Inflammatory (0–3 d) → Proliferative (granulation) → Maturation/Remodeling

- **Wet-to-dry** dressing: mechanical debridement of necrotic tissue (now less favored).
- **Hydrocolloid:** retains moisture, autolytic debridement; for partial-thickness, minimal exudate.
- **Alginate:** highly absorbent; for heavy exudate.
- **Transparent film:** Stage 1 / IV sites; lets you see the wound, keeps moisture.
- **Negative-pressure (wound VAC):** removes exudate, promotes granulation.

⚑ DEHISCENCE & EVISCERATION

If a surgical wound separates (**dehiscence**) or organs protrude (**evisceration**): cover with **sterile saline-moistened gauze**, position supine with knees flexed (low-Fowler's), keep NPO, and notify the surgeon STAT.

6 OXYGENATION & AIRWAY BASICS

OXYGEN DELIVERY DEVICES FLOW RATES

DEVICE	FLOW (L/MIN)	FIO_2	NOTES
Nasal cannula	1–6	24–44%	Low-flow; humidify >4 L; comfortable, allows eating
Simple face mask	6–10	40–60%	Min 5–6 L to flush CO_2
Partial rebreather	6–11	60–75%	Keep reservoir bag partially inflated
Non-rebreather	10–15	80–95%	One-way valves; highest non-intubated O_2; bag must stay inflated
Venturi mask	4–12	24–60% precise	Best for COPD — exact, controlled FiO_2

⚑ KEY NCLEX POINTS

- For chronic **CO_2 retainers (COPD)**, give the **lowest effective O_2**; target SpO_2 88–92%. Don't withhold O_2 for true hypoxemia, but titrate carefully.
- Oxygen supports combustion — enforce **NO SMOKING / no open flame** signage.

AIRWAY CLEARANCE & SUCTIONING

SAFE TECHNIQUE

- ✓ Hyperoxygenate before suctioning
- ✓ Sterile technique for tracheal suction
- ✓ Apply suction only while withdrawing
- ✓ Limit to ≤10–15 sec per pass
- ✓ Incentive spirometer: slow deep inhale, hold 3–5 sec

CRITICAL CAUTIONS

- ⚠ Suctioning can cause hypoxia, bradycardia (vagal), dysrhythmias
- ⚠ Stop & oxygenate if SpO_2 drops or HR falls
- ⚠ Never instill saline routinely before suction
- ⚠ Watch for mucosal trauma/bleeding

7 NUTRITION & ENTERAL FEEDING

THERAPEUTIC DIETS

DIET	INCLUDES / PURPOSE
Clear liquid	Broth, gelatin, apple juice, tea — clear & see-through; pre-op/post-op transition
Full liquid	Milk, ice cream, cream soups, pudding; advance from clear
Mechanical soft / pureed	Dysphagia, chewing problems; thickened liquids may be ordered
Low-residue / low-fiber	Acute diverticulitis, IBD flare, pre-colonoscopy bowel rest
High-fiber	Constipation, diverticulosis (when not inflamed)
Renal	Restrict protein, Na, K, phosphorus, fluid
Cardiac / low-sodium	Limit Na & saturated fat; HF, HTN

NG / ENTERAL FEEDING & ASPIRATION PREVENTION SAFETY

1. **Verify placement:** X-ray is the GOLD standard after initial insertion. Check gastric aspirate **pH ≤5** and external tube length before each use/feeding.
2. **Position:** HOB elevated **30–45°** during feeding and ≥30–60 min after to prevent aspiration.
3. **Residuals:** check gastric residual volume per policy; hold feeding for high residual and reassess.
4. **Patency:** flush tube with 30 mL water before/after feeds & meds; give meds separately.
5. **Monitor:** watch for diarrhea, dehydration, hyperglycemia, refeeding syndrome (↓ K, ↓ phos, ↓ Mg).

⚑ DYSPHAGIA / ASPIRATION SIGNS

Coughing/choking with meals, wet "gurgly" voice, pocketing food, delayed swallow. Keep upright, chin-tuck, thickened liquids, suction available, never rush feeding.

8 BOWEL & URINARY ELIMINATION

URINARY CATHETERS & CAUTI PREVENTION

SAFE / EXPECTED

- ✓ Sterile technique for insertion
- ✓ Keep drainage bag below bladder, off the floor
- ✓ Maintain a closed system; secure to leg
- ✓ Remove ASAP — earliest day reduces CAUTI
- ✓ Perineal care & adequate hydration

CRITICAL CAUTIONS

- ⚠ No urine output: assess for kink/clot before assuming retention
- ⚠ Adult output <30 mL/hr = notify provider (renal perfusion)
- ⚠ Never raise the bag above the bladder
- ⚠ Cloudy/foul urine, fever = possible CAUTI

BOWEL ELIMINATION, ENEMAS & OSTOMY

- **Enema position:** left lateral (Sims') — follows the natural sigmoid colon curve; insert 3–4 in adult, instill slowly, lower bag if cramping.
- **Constipation:** ↑ fiber, fluids, activity; assess for impaction (oozing liquid stool around hard mass).
- **Colostomy stoma:** should be **pink/red & moist**. **Dark/dusky/black = ischemia → notify provider.**
- **Stoma care:** appliance opening ~1/8 in larger than stoma; empty pouch when 1/3–1/2 full; ileostomy = liquid output & high fluid-loss risk.

9 FLUID & ELECTROLYTE FUNDAMENTALS

CORE LAB VALUES MEMORIZE

LAB	NORMAL RANGE	NCLEX SIGNIFICANCE
Sodium (Na^+)	135–145 mEq/L	Neuro changes; ↑Na = thirst/edema, ↓Na = confusion/seizures
Potassium (K^+)	3.5–5.0 mEq/L	Cardiac dysrhythmias; check before digoxin/diuretics; never IV push K
Calcium (Ca^{2+})	9.0–10.5 mg/dL	↓Ca = Trousseau/Chvostek, tetany; ↑Ca = bone pain, stones
Magnesium (Mg^{2+})	1.5–2.5 mEq/L	↓Mg often with ↓K/↓Ca; affects neuromuscular & cardiac
Chloride (Cl^-)	98–106 mEq/L	Follows Na; tracks acid–base balance
Phosphorus (PO_4)	3.0–4.5 mg/dL	Inverse relationship with calcium
BUN	10–20 mg/dL	↑ with dehydration, renal impairment, GI bleed
Creatinine	0.6–1.2 mg/dL	Best indicator of renal function
Glucose (fasting)	70–99 mg/dL	<70 hypoglycemia (treat fast-acting carb)
Hgb	M 14–18 / F 12–16 g/dL	Oxygen-carrying capacity
WBC	5,000–10,000 /µL	↑ infection; ↓ = neutropenia/immunosuppression

FLUID VOLUME IMBALANCE

DEFICIT (HYPOVOLEMIA)

- ✓ ↑ HR, ↓ BP, orthostatic drop
- ✓ Dry mucous membranes, poor turgor
- ✓ ↓ urine output, ↑ urine specific gravity
- ✓ Weight loss, flat neck veins, ↑ BUN/Hct
- ✓ Treat: oral/IV isotonic fluids, monitor I&O

EXCESS (HYPERVOLEMIA)

- ⚠ ↑ BP, bounding pulse, JVD
- ⚠ Edema, weight gain, crackles
- ⚠ Dyspnea — risk of pulmonary edema
- ⚠ ↓ Hct/BUN (dilution)
- ⚠ Treat: diuretics, Na/fluid restriction, daily weights

⚑ BEST INDICATORS

Daily **weight** is the most reliable measure of fluid status (1 kg ≈ 1 L). Accurate **intake & output** tracking is essential. Always report a urine output <30 mL/hr.

10 MEDICATION ADMINISTRATION

RIGHTS OF MEDICATION ADMINISTRATION SAFETY CORE

- Right **Patient** (two identifiers)
- Right **Medication**
- Right **Dose**
- Right **Route**
- Right **Time**
- Right **Documentation**
- Right **Reason / Indication**
- Right **Response** (evaluate effect)
- Right to **Refuse / Education**
- Check label **3 times** against the MAR

ROUTES, SITES & ANGLES

INJECTION	ANGLE	KEY SITES / NOTES
Intradermal (ID)	5–15°	TB/allergy testing; inner forearm; raise a wheal/bleb
Subcutaneous (SubQ)	45–90°	Insulin, heparin; abdomen/thigh; **do NOT aspirate or massage heparin/insulin**; rotate sites
Intramuscular (IM)	90°	**Ventrogluteal** = preferred/safest adult site; deltoid (≤1 mL); vastus lateralis = infants
Z-track IM	90°	Irritating meds (iron dextran); seals med in muscle, prevents tracking

⚑ KEY NCLEX POINTS

- **Insulin:** when mixing, draw up **clear (regular) before cloudy (NPH)** — "RN: Regular then NPH." Only regular insulin is IV.
- Verify **high-alert meds** (insulin, heparin, opioids, chemo) with an independent double-check.
- Never crush **enteric-coated** or **extended-release** tablets.
- Use the leading zero (0.5 mg), never a trailing zero (5.0 mg) — avoid 10-fold errors.

DOSAGE CALCULATION QUICK REFERENCE

CORE FORMULA

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Dose = (Desired ÷ Have) × Quantity
IV rate (mL/hr) = Total volume ÷ Total hours
gtt/min = (Volume × drop factor) ÷ time (min)
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Common drop factors: macrodrip 10/15/20 gtt/mL; microdrip 60 gtt/mL.

11 PAIN MANAGEMENT & COMFORT

PAIN ASSESSMENT SCALES

SCALE	POPULATION
Numeric Rating (0–10)	Verbal adults & older children
Wong-Baker FACES	Children ≥3 yrs & nonverbal who can point
FLACC (Face, Legs, Activity, Cry, Consolability)	Infants & nonverbal children (~2 mo–7 yr)
PAINAD	Advanced dementia / nonverbal adults
CRIES	Neonates

⚑ KEY NCLEX POINTS

- Pain is whatever the patient says it is — **self-report is the most reliable indicator**. Believe the patient.
- Always **reassess** after intervening (≈30–60 min for PO, 15–30 min for IV).
- Monitor opioid patients for **respiratory depression & sedation**; rising sedation precedes resp depression; keep naloxone available.

NON-PHARMACOLOGIC COMFORT MEASURES

- Heat (chronic, stiffness) & cold (acute injury, inflammation) — limit ~20 min, protect skin.
- Repositioning, massage, guided imagery, distraction, music, relaxation breathing.
- TENS units, splinting incision during cough.

REST & SLEEP FUNDAMENTALS

- Promote sleep hygiene: consistent schedule, dim/quiet environment, cluster care to allow uninterrupted rest.
- Limit caffeine & screens before bed; avoid heavy meals.
- Sleep stages: NREM (N1–N3, deep restorative) and REM (dreaming, memory). Sleep deprivation impairs healing, immunity, & cognition.

12 COMMUNICATION & DOCUMENTATION

SBAR HANDOFF COMMUNICATION STANDARD

Situation — what's happening now → Background — relevant history → Assessment — your findings/concern → Recommendation — what you need

THERAPEUTIC VS. NON-THERAPEUTIC COMMUNICATION

THERAPEUTIC

- ✓ Open-ended questions
- ✓ Active listening & silence
- ✓ Reflecting & restating
- ✓ Clarifying & focusing
- ✓ Offering self / presence
- ✓ Acknowledging feelings

NON-THERAPEUTIC (AVOID)

- ⚠ False reassurance ("Everything will be fine")
- ⚠ Giving advice / approval-disapproval
- ⚠ Asking "Why?" (sounds accusatory)
- ⚠ Changing the subject
- ⚠ Minimizing feelings / clichés
- ⚠ Closed yes/no questions when exploring

DOCUMENTATION & LEGAL ESSENTIALS

- Chart **objectively, timely, factually**; if it isn't documented, it wasn't done.
- Correct errors with a single line, "error," initials — **never erase or use white-out**.
- Maintain **confidentiality (HIPAA)**; share only on a need-to-know basis.
- Know events requiring an **incident/occurrence report** (falls, med errors) — factual, not part of the chart.
- **Informed consent:** provider explains risks/benefits; the nurse witnesses the signature & confirms understanding.

13 END-OF-LIFE & PALLIATIVE BASICS

COMFORT-FOCUSED CARE

- **Palliative care** = comfort/symptom management at any disease stage; **hospice** = comfort care typically when prognosis ≤6 months.
- Prioritize comfort: pain control, manage dyspnea, oral care, reposition, skin care.
- Expected near-death changes: cool mottled extremities, irregular breathing (Cheyne-Stokes), decreased intake, "death rattle" secretions — provide reassurance & positioning.
- Respect **advance directives, DNR, living will, durable power of attorney**; support patient autonomy.
- Kübler-Ross stages (not always linear): Denial, Anger, Bargaining, Depression, Acceptance — meet patient where they are.

> ⚑ **KEY NCLEX POINT**
>
> At end of life, comfort takes priority over routine vitals/labs. Never withhold ordered opioids for fear of hastening death when treating pain/dyspnea (principle of double effect).

✓ PATIENT EDUCATION CHECKLIST

☑ CORE TEACHING POINTS — CONFIRM PATIENT UNDERSTANDING

- ☐ Demonstrate proper hand hygiene technique & when to perform it
- ☐ Explain isolation precautions to patient & visitors
- ☐ Use call light before getting up; nonskid footwear
- ☐ Report dizziness on standing (orthostatic precautions)
- ☐ Correct use of cane/walker/crutches & stair rule
- ☐ Reposition frequently & inspect skin for redness
- ☐ Incentive spirometer use 10×/hour while awake
- ☐ Oxygen safety: no smoking, no open flames
- ☐ Stay upright 30–60 min after meals/tube feeding
- ☐ Increase fluids & fiber for bowel regularity (as allowed)
- ☐ Recognize stoma color changes to report
- ☐ Daily weight technique & when to report gain
- ☐ Medication name, purpose, dose, timing, side effects
- ☐ Never crush extended-release/enteric-coated tablets
- ☐ Insulin rotation, storage, & hypoglycemia signs
- ☐ Report pain early; use the 0–10 scale
- ☐ Non-drug comfort: heat/cold limits & relaxation
- ☐ Sleep hygiene strategies
- ☐ Know advance directive / DNR options & rights
- ☐ Teach-back: have patient restate instructions

PDF EXPORT & PRINT INSTRUCTIONS

1. Open this file in **Google Chrome** or **Microsoft Edge** for best fidelity.
2. Press **Ctrl + P** (Windows) or **Cmd + P** (Mac) to open the print dialog.
3. Set **Destination → Save as PDF**.
4. Set **Scale → 65–70%** (or "Fit to page width") so panels stay intact.
5. Under **More settings**, enable **"Background graphics"** so colors & legend print.
6. Set margins to **Default** or **None**; orientation **Portrait**.
7. Click **Save** — your printable Fundamentals MASTER guide is ready.