Basic Care & Comfort items test your ability to provide comfort and assistance in performing activities of daily living. On the Next Generation NCLEX, expect these concepts to surface inside **case-study clinical-judgment items** — bow-ties, matrices, cloze, and extended multiple response — where you must *recognize cues, analyze cues, prioritize hypotheses, generate solutions, take actions,* and *evaluate outcomes*. Use the reveals to test yourself; resist peeking.

# 01 Mobility & *Immobility*

## Hazards of immobility — system by system

| System | Complications | Priority assessment |
|---|---|---|
| **Cardiovascular** | Orthostatic hypotension, DVT/VTE, ↑ cardiac workload, thrombus formation | BP lying→sitting→standing, calf warmth/redness/asymmetry, Homan's is **not** diagnostic |
| **Respiratory** | Atelectasis, hypostatic pneumonia, ↓ chest expansion | Lung sounds q-shift, $SpO_2$, cough effectiveness, IS use |
| **Musculoskeletal** | Muscle atrophy, contractures, foot drop, disuse osteoporosis | Joint ROM, strength grading, alignment |
| **GI** | Constipation, ↓ peristalsis, anorexia | Bowel sounds, last BM, abdominal distention |
| **GU** | Urinary stasis, renal calculi, UTI, incontinence | I&O, urine color/odor, palpation for distention |
| **Integumentary** | Pressure injuries, shearing, friction wounds | Bony prominences q-shift, Braden scale |
| **Psychosocial** | Depression, sensory deprivation, altered sleep | Affect, orientation, sleep pattern |

— CLINICAL PEARL

**Reposition q2h** is the single most testable nursing action for an immobile client. **Active ROM** beats passive when the client can perform it. Encourage **incentive spirometry q1h while awake** and dorsiflex/plantarflex exercises to prevent VTE.

— RED FLAG

Sudden **unilateral calf pain, dyspnea, pleuritic chest pain, or tachycardia** in an immobile client = suspect VTE/PE. **Do not massage** a suspected DVT — emboli risk. Notify provider immediately and prepare for imaging/anticoagulation.

NGN ITEM · RECOGNIZE CUES

*Highlight / Extended Multiple Response*

A 72-year-old client is on day 3 of strict bed rest after open reduction internal fixation of a right hip fracture. The nurse's morning assessment finds: alert and oriented; lungs with diminished breath sounds at bases; $SpO_2$ 93% on room air; left calf 2 cm larger than right with mild redness; abdomen soft, last BM 4 days ago; sacral skin intact, non-blanchable redness. Vitals: T 99.7°F, HR 102, BP 118/74, RR 22.

**Which findings require immediate follow-up? Select all that apply.**

A. Diminished breath sounds at bases

B. $SpO_2$ 93% on room air

C. Left calf 2 cm larger than right with redness

D. Last BM 4 days ago

E. Non-blanchable redness on sacrum

F. Heart rate 102

G. Temperature 99.7°F

*Reveal answer & rationale*

# 02 Assistive *Devices*

## Cane

- Hold the cane on the **stronger** side.
- Advance the cane and the **weak leg together**, then step with the strong leg.
- Tip should be ~6 inches to the side and forward of the foot.
- Top of cane at **wrist crease** with arms relaxed; elbow flexed ~15–30°.

**COAL** Cane Opposite Affected Leg.

## Walker

- All four points/wheels on floor before stepping (standard walker — pick up and place).
- Advance walker 6–8 inches → step with weak leg → step with strong leg.
- Client stays inside the walker frame; **do not pull up** on a walker — push up from chair arms.

## Crutches

- **Fit:** 2–3 fingerwidths (or ~2 inches) below the axilla. Hand grip allows 15–30° elbow flexion.
- Weight bears on **hands and palms** — never the axilla (axillary/radial nerve injury, "crutch palsy").
- Wear well-fitting, non-skid shoes. Inspect rubber tips.

| Gait | Use case | Pattern |
|---|---|---|
| **2-point** | Partial WB both legs, mild bilateral weakness | Right crutch + left foot together → left crutch + right foot together |

| Gait | Use case | Pattern |
|---|---|---|
| **3-point** | Non-WB on one leg (post-op, fracture) | Both crutches + weak leg forward → strong leg swings through |
| **4-point** | Partial WB both legs, max stability | Right crutch → left foot → left crutch → right foot |
| **Swing-to / through** | Paralysis of both lower legs | Both crutches forward → swing both legs to/past crutches |

**UP & DOWN**

**Up with the good, down with the bad.** Going **up** stairs: *strong leg first*, then crutches and weak leg. Going **down** stairs: *crutches and weak leg first*, then strong leg.

NGN ITEM · TAKE ACTION

*Drag-and-Drop Cloze*

A nurse is teaching a 24-year-old client with a right tibial fracture (non-weight-bearing,

right leg) how to use crutches on stairs.

**Complete the teaching by selecting from the dropdowns.**

"When going **up** the stairs, lead with your [▾] first, then bring your crutches and right leg up. When going **down**, lead with your [▾] first, then your left leg."

Options for both blanks: *left leg · right leg · crutches and right leg · both crutches alone*

***Reveal answer & rationale***

## 03 Personal *Hygiene*

- **Bathing:** Wash from **cleanest to dirtiest**; use the principle of distal-to-proximal for venous return when massaging lotion into legs. Water temp ~105–110°F.
- **Eyes:** Inner canthus → outer canthus, separate cloth/section per eye to prevent cross-contamination.
- **Perineal care:** Front to back (clean → dirty); separate strokes; for uncircumcised males, retract foreskin, clean, then return foreskin.
- **Oral care, unconscious client:** Position in **side-lying with HOB elevated**, suction equipment on and ready, small amounts of fluid, soft toothbrush.
- **Denture care:** Clean over a basin of water/towel (prevents breakage), store in labeled container with water or denture solution.
- **Foot care, diabetic:** Inspect daily (mirror for soles), wash with mild soap and lukewarm water, **pat dry between toes**, lanolin lotion on tops/soles (**not between toes**), file nails straight across, never go barefoot, well-fitting closed-toe shoes. **Nurse does not cut diabetic toenails** — refer to podiatry.
- **Hair:** For lice — pediculicide shampoo, fine-tooth comb, contact precautions (laundry hot wash).

— RED FLAG

Never perform oral care on an unconscious client in supine position — high **aspiration risk**. Side-lying is mandatory, with suction immediately available.

# 04 Nutrition & *Oral Hydration*

## Therapeutic diets at a glance

| Diet | Indication | Key restrictions / additions |
|---|---|---|
| **Clear liquid** | Post-op, pre-procedure, GI rest | See-through at room temp: broth, gelatin, apple juice, ice pops (no red dyes if GI bleed) |
| **Full liquid** | Transition diet | Adds milk, ice cream, creamed soups |
| **Mechanical soft** | Chewing/swallowing difficulty, post-stroke | Ground/pureed meats, soft fruits; avoid raw veg, nuts, tough meats |
| **Cardiac (DASH)** | HTN, HF, post-MI | ↓ Na (<2 g/day), ↓ saturated fat, ↑ fruits/veg, low-fat dairy |
| **Renal (pre-dialysis)** | CKD | ↓ Na, ↓ K, ↓ phosphorus, fluid restriction; **limit** protein |
| **Renal (on dialysis)** | ESRD on HD | ↑ Protein (loss in dialysate); same Na/K/phos limits |
| **Diabetic** | DM type 1/2 | Consistent carbohydrates, complex over simple, fiber |
| **Low residue** | Acute diverticulitis, IBD flare, post-bowel surgery | Low fiber, no raw veg/seeds/nuts |
| **High fiber** | Constipation, diverticul**osis** | Whole grains, fruits/veg, legumes; ↑ fluids |

| Diet | Indication | Key restrictions / additions |
|---|---|---|
| **Low purine** | Gout | Avoid organ meats, sardines, anchovies, beer/alcohol |
| **Gluten-free** | Celiac disease | No **BROW**: **B**arley, **R**ye, **O**ats (often), **W**heat |
| **Neutropenic** | Immunocompromised | No raw fruits/veg, no soft cheese, well-cooked meats, pasteurized only |

## Enteral nutrition essentials

- **Verify NG/OG placement** before each feeding/med: gastric pH < 5.5 is supportive; **x-ray is the gold standard** for initial placement. Auscultation alone is unreliable — do not use as the sole method.
- **Position:** HOB ≥ 30° during and 30–60 min after feeding to prevent aspiration.
- **Residuals:** Check per facility policy. Hold tube feeding for residual > 250–500 mL or per protocol; reassess in 1 hr.
- **Flush** with 30 mL water before/after meds and feedings; do **not** mix meds with feeding.
- **Hang time:** Open system 4–8 hr; closed system per manufacturer (often 24–48 hr).
- **TPN:** Central line, monitor blood glucose q4–6h, never abruptly discontinue (rebound hypoglycemia — hang D10W if bag delayed), strict aseptic technique, change tubing q24h.

## Aspiration precautions (dysphagia)

- HOB upright (≥ 90° during meals, ≥ 30° at rest), chin tucked while swallowing.
- Thickened liquids per swallow eval — thin liquids highest aspiration risk.
- Small bites, single textures, no straws, allow time, no rushing.
- Stay with client; suction available; oral care after meals (pocketed food).

NGN ITEM · TAKE ACTION / EVALUATE

*Matrix Multiple Choice*

A nurse is preparing to administer a continuous tube feeding through an NG tube to a client recovering from a stroke with dysphagia. The HOB is at 15°; the last gastric residual was 180 mL.

For each action, indicate whether it is **indicated, contraindicated, or non-essential** at this time.

| ACTION | INDICATED | CONTRAINDICATED | NON-ESSENTIAL |
|---|---|---|---|
| Raise HOB to 30–45° | ✓ | | |
| Verify tube placement with pH testing | ✓ | | |
| Hold the feeding due to residual of 180 mL | | ✓ | |
| Flush tube with 30 mL water before starting | ✓ | | |
| Auscultate over the stomach as the only placement check | | ✓ | |
| Mix client's crushed medications into the feeding bag | | ✓ | |

| ACTION | INDICATED | CONTRAINDICATED | NON-ESSENTIAL |
|---|---|---|---|
| Warm the formula in a microwave | | ✓ | |

*Reveal answer & rationale*

# 05 Elimination

## Indwelling urinary catheter

- Sterile insertion; clean perineum front to back before procedure.
- Drainage bag **always below bladder level**, never on the floor, never clamped during transport without short interval.
- Secure tubing to thigh to prevent traction and urethral injury.
- Maintain a closed system; empty bag when ⅔ full or per shift.
- **Remove ASAP** — every catheter day raises CAUTI risk. Bladder scan post-removal if no void in 4–6 hr.

## Bowel elimination & enemas

- Constipation interventions: ↑ fluids (≥ 2 L/day if not restricted), ↑ fiber, ambulation, scheduled toileting, privacy, footstool to flex hips.
- **Enema position:** Left lateral Sims' (follows colon anatomy).
- Cleansing enema solutions:
  - **Tap water** — hypotonic; one-time only (water intoxication if repeated)
  - **Normal saline** — isotonic; **safest**, especially for children
  - **Soapsuds** — irritant; pure castile soap only
  - **Hypertonic (Fleet)** — small volume, contraindicated in renal impairment / electrolyte imbalance
- Hang enema bag **12–18 inches** above the rectum (high cleansing); insert ~3–4 inches in adult.

## Ostomy care

| Type | Output | Risks & teaching |
|---|---|---|
| **Ileostomy** | Liquid → semi-formed; high volume | Dehydration, electrolyte loss; chew food well; avoid high-fiber/stringy foods early; ↑ fluids/Na+ |
| **Ascending colostomy** | Liquid → semi-liquid | Skin protection critical (enzymes) |
| **Transverse colostomy** | Soft, unformed | Skin protection, odor management |
| **Descending / sigmoid** | Formed | May regulate with irrigation |

- Healthy stoma: **pink/red, moist, slightly raised**. Concerning: pale, dusky, purple-black (ischemia); retracted or prolapsed.
- Empty pouch when **⅓ to ½ full** — heavier bags pull the seal off.
- Skin barrier sized to fit ⅛ inch larger than stoma (snug, not tight).
- Odor-causing foods: eggs, fish, broccoli, asparagus, garlic. Gas-producing: beans, cabbage, carbonated drinks.
- Burping a 2-piece system if it balloons; charcoal filters help.

— RED FLAG

**Dusky/dark stoma** indicates ischemia — notify provider **immediately**. **No output for > 4–6 hours** in an ileostomy may indicate obstruction.

## 06 Rest & *Sleep*

- Sleep architecture: **NREM** (stages 1–3, deepest in N3 = restorative) and **REM** (dreaming, memory consolidation).
- Older adults: more time in bed, less time asleep; reduced N3 and REM; frequent awakenings normal but daytime function should be preserved.
- Sleep hygiene teaching:
  - Consistent bed/wake times — even on weekends.
  - Cool, dark, quiet room; bed for sleep and intimacy only.
  - No caffeine after midday; avoid alcohol/nicotine near bedtime.
  - No screens or heavy meals 1–2 hr before bed.
  - Exercise daily but **not within 2 hr** of bedtime.
  - If awake > 20 min, get out of bed and do something quiet, then return.
- **Insomnia** — tackle non-pharm first (CBT-I is first-line). Avoid chronic benzodiazepine use, especially in older adults (Beers criteria).
- **Sleep apnea** — CPAP adherence teaching, weight management, side-lying sleep, avoid alcohol/sedatives.

— TEST TIP

If a question asks the **best** intervention for hospitalized client insomnia, choose **environmental/non-pharm** options (cluster care, dim lights, reduce noise, earplugs) before sleep aids.

# 07 Non-Pharmacological *Comfort*

| Modality | Mechanism | Best for | Caution / Contraindication |
|---|---|---|---|
| **Cold** | Vasoconstriction, ↓ swelling, ↓ nerve conduction | Acute injury (first 24–48 h), post-op edema, sprains, fever | Raynaud's, peripheral vascular disease, impaired circulation; never directly on skin; max 20 min |
| **Heat** | Vasodilation, ↑ circulation, muscle relaxation | Chronic pain, muscle spasm, joint stiffness | **Not** in first 24–48 h post-injury, active bleeding, acute infection, malignancy in area, decreased sensation; max 20 min |
| **Massage** | Relaxation, ↑ circulation, gate-control | Muscle tension, anxiety, mild pain | Avoid over DVT, fresh surgical incisions, infection, bony metastases |
| **TENS** | Gate control theory | Chronic pain, post-op pain | Pacemakers, pregnancy (over uterus), broken skin |
| **Distraction / Music / Guided imagery** | Cognitive reframing, ↓ perception of pain | Mild–moderate pain, anxiety, procedures | Use as adjunct, not substitute, for moderate–severe pain |
| **Acupressure / Acupuncture** | Endorphin release, gate control | Chronic pain, nausea (P6 point) | Bleeding disorders / anticoagulation (acupuncture) |
| **Aromatherapy** | Limbic stimulation | Anxiety, nausea (peppermint, ginger) | Asthma, allergies; never ingest essential oils |

**20 / 20** **Heat or cold therapy:** apply for **20 minutes on, 20 minutes off**, with a barrier between the device and skin. Reassess skin every 5–10 min the first time.

NGN ITEM · GENERATE SOLUTIONS

*Extended Multiple Response · Select 4*

A client with chronic low back pain reports a 6/10 pain level. They prefer to limit opioid use. The nurse plans non-pharmacological interventions.

**Which interventions are appropriate? Select four.**

A. Apply moist heat to the lumbar area for 20 minutes

B. Provide an ice pack for 60 minutes continuously

C. Teach guided imagery and slow diaphragmatic breathing

D. Encourage gentle ambulation and position changes

E. Offer a TENS unit per provider order

F. Massage directly over a known DVT in the calf

G. Place a heating pad set to "high" directly on bare skin

***Reveal answer & rationale***

# 08 Pain *Management*

- Pain is the **5th vital sign** and is what the client says it is — subjective by definition.
- Acute (< 6 mo, signaling injury, sympathetic response) vs Chronic (> 6 mo, may show no autonomic signs).
- **Assessment**: **OPQRSTU / PQRSTU** — Onset, Provoking/Palliating, Quality, Region/Radiation, Severity, Timing, Understanding/impact.

## Pain scales by population

| Scale | Population | Notes |
|---|---|---|
| **Numeric Rating (0–10)** | Adults, older children, alert | Most common; document the number |
| **Wong-Baker FACES** | Children ≥ 3 yr, cognitive impairment | Self-report |
| **FLACC** | Pre-verbal children (2 mo–7 yr) | Face, Legs, Activity, Cry, Consolability — observational |
| **CRIES** | Neonates (0–6 mo) | Crying, Requires $O_2$, ↑ Vitals, Expression, Sleeplessness |
| **PAINAD** | Advanced dementia, non-verbal adults | Breathing, vocalization, facial expression, body language, consolability |
| **CPOT** | Critically ill / intubated adults | Behavioral; used with sedation/ventilation |

## WHO analgesic ladder (general framework)

1. **Step 1 — Mild pain:** Non-opioid (acetaminophen, NSAIDs) ± adjuvant.
2. **Step 2 — Moderate pain:** Weak opioid (codeine, tramadol) ± non-opioid ± adjuvant.

3. **Step 3 — Severe pain:** Strong opioid (morphine, hydromorphone, fentanyl) ± non-opioid ± adjuvant.

Adjuvants: anticonvulsants (gabapentin) for neuropathic pain, antidepressants (TCAs, SNRIs), corticosteroids, muscle relaxants.

— CLINICAL PEARL

**PCA pumps:** Only the *client* presses the button — never family ("PCA by proxy"). Monitor RR and sedation level frequently; have **naloxone** available. Basal rate raises overdose risk in opioid-naïve clients.

# 09 Pressure *Injuries*

## Staging (NPIAP/2016)

| Stage | Defining feature | Care priorities |
|---|---|---|
| **Stage 1** | Intact skin, **non-blanchable erythema** over bony prominence | Off-load pressure; protective dressing if at risk; reassess |
| **Stage 2** | Partial-thickness loss; shallow open ulcer or intact/ruptured serum-filled blister | Moisture-retentive dressing (hydrocolloid, foam); protect peri-wound |
| **Stage 3** | Full-thickness loss; **fat visible**; no bone, tendon, muscle exposed | Moist wound healing; debride slough as ordered; pack dead space |
| **Stage 4** | Full-thickness with **bone, tendon, or muscle exposed** | Possible surgical debridement; advanced dressings; nutrition critical |
| **Unstageable** | Base obscured by slough/eschar — depth unknown | Debridement (unless dry, stable eschar on heel — leave intact) |
| **Deep tissue injury** | Persistent non-blanchable **maroon/purple** discoloration or blood-filled blister | Off-load immediately; may evolve rapidly to full-thickness |

## Braden scale — risk stratification

Six subscales (sensory perception, moisture, activity, mobility, nutrition, friction/shear). **Lower score = higher risk.**

- ≤ 9 — severe risk · 10–12 high · 13–14 moderate · 15–18 mild ·

19–23 minimal

### Prevention bundle

- Reposition **q2h** in bed, q1h in chair; use a 30° lateral tilt — avoid direct trochanter pressure.
- **Heels float** — pillow lengthwise under calves; heels off the bed entirely for high-risk clients.
- Pressure-redistribution surface; minimize HOB elevation (< 30°) when not contraindicated to reduce shear.
- Manage moisture: barrier creams for incontinence, prompt linen changes, no harsh soaps.
- Optimize nutrition: protein, calories, hydration, vitamin C, zinc; consult dietitian.
- Use lift sheets/devices — never drag.

— RED FLAG

**Do NOT massage** reddened bony prominences — increases tissue damage. **Do NOT remove** stable, dry eschar on a heel without a vascular workup — it serves as a biological dressing.

NGN ITEM · ANALYZE CUES

*Drop-down Cloze*

A nurse assesses a 78-year-old client with limited mobility. The sacrum has a **3 cm area of partial-thickness skin loss with a shallow pink wound bed and a small intact serum-filled blister adjacent to it.** There is no slough or eschar.

Complete the documentation:

"This is a ▾ pressure injury. The most

appropriate dressing is a ▾ ."

Options: *Stage 1 · Stage 2 · Stage 3 · Stage 4 / dry gauze · hydrocolloid · wet-to-dry · transparent film over open area only*

***Reveal answer & rationale***

# 10 End-of-Life & *Palliative Care*

## Signs of imminent death (hours to days)

- Cool, mottled extremities; cyanosis; weak/thready pulse.
- **Cheyne–Stokes respirations** — alternating apnea and tachypnea.
- Decreased LOC, restlessness, terminal delirium.
- Decreased urine output, incontinence.
- Loss of appetite, dysphagia, dry mouth.
- **Death rattle** — pooled secretions; reposition, anticholinergic per orders (glycopyrrolate, scopolamine); do not deep-suction.

— CLINICAL PEARL

**Hearing is the last sense to go.** Always speak normally, identify yourself, explain care, and avoid bedside conversation that might distress the dying client or family.

## Palliative comfort priorities

- Treat pain aggressively — **opioid tolerance is not addiction**. Around-the-clock dosing with breakthrough PRN.
- Manage dyspnea (low-dose opioids, fan, positioning), nausea, anxiety.
- Frequent oral care for dry mouth; mouth swabs; lip balm.
- Position for comfort — turn gently; pressure injury prevention continues but goals shift toward comfort.
- Reduce stimuli; soft lighting; presence over interventions.

- Honor cultural, spiritual, and religious practices — ask, don't assume.

### Kübler-Ross stages of grief

**D**enial · **A**nger · **B**argaining · **D**epression · **A**cceptance — non-linear; clients may move back and forth.

### Postmortem care

- Confirm pronouncement per facility/state. Note time.
- Allow family time before care. Honor cultural/religious practices.
- Position supine, head slightly elevated to prevent discoloration. Close eyes, replace dentures if possible (jaw stiffens within 2–4 hr).
- Remove tubes/lines **only if not a coroner's case**; otherwise leave everything in place.
- Bathe, apply clean gown, comb hair. ID tags per policy (often body and toe).
- Document time, persons notified, belongings disposition.

CS

# Unfolding *Case Study*

Practice the full clinical-judgment cycle. Six items mirror the NGN case-study format. Read carefully and reveal each rationale only after committing to your answer.

— CASE STEM

A 68-year-old client with type 2 diabetes was admitted 4 days ago after a left total hip arthroplasty. They are non-weight-bearing on the left leg and use a walker for transfers. The client lives alone, has a BMI of 32, and reports difficulty preparing meals and bathing since admission. Today, the nurse begins the morning assessment.

**Vital signs (0800):** T 99.4°F · HR 96 · BP 132/78 · RR 20 · $SpO_2$ 95% RA · Pain 5/10 left hip.

**Assessment:** Alert and oriented ×4. Surgical incision left lateral hip — clean, dry, intact, staples. Sacrum: **2 cm area of non-blanchable erythema**. Heels: bilateral pinkness, blanching. Bowel sounds present, last BM 3 days ago. Voiding small amounts of dark amber urine. Reports poor sleep "from the noise." Blood glucose 168 mg/dL.

Q1 · RECOGNIZE CUES

*Highlight in passage (multi-select equivalent)*

**Which findings indicate the client is at risk for further complications? Select all that apply.**

A. Non-blanchable erythema on sacrum

B. Last BM 3 days ago

C. Dark amber urine, small volumes

D. Reports poor sleep

E. Pain 5/10

F. Lives alone, BMI 32

G. Surgical incision clean, dry, intact

*Reveal answer & rationale*

Q2 · ANALYZE CUES

*Drop-down Rationale*

**Complete the statement:**

"The client's [ ▾ ] places them at **highest immediate risk** for further skin breakdown because [ ▾ ]."

Blank 1: *non-blanchable erythema on sacrum · poor sleep · constipation · BMI 32*
Blank 2: *obesity increases recovery time · the area indicates a Stage 1 pressure injury that can rapidly progress without offloading · disrupted sleep impairs cytokine response · constipation increases abdominal pressure on the incision*

*Reveal answer & rationale*

Q3 · PRIORITIZE HYPOTHESES

*Bow-Tie*

ACTIONS TO TAKE (CHOOSE 2)

- Reposition the client off the sacrum and elevate heels with a pillow under calves
- Encourage fluids ≥ 2 L/day if not contraindicated

**Risk for skin breakdown**

PARAMETERS TO MONITOR (CHOOSE 2)

- Skin integrity over sacrum and heels q2h
- Intake & output, urine color/concentration

Distractor pool considered: massage the reddened area; apply heat to sacrum; restrict

fluids; check Homan's sign; monitor incisional drainage only.

*Reveal answer & rationale*

Q4 · GENERATE SOLUTIONS

*Extended Multiple Response · Select all that apply*

**Which interventions support the client's basic care & comfort needs? Select all that apply.**

A. Place the walker on the client's left side for transfers

B. Offer warm fluids and a high-fiber breakfast; document last BM each shift

C. Cluster nighttime care, dim lights, and reduce alarm noise

D. Apply a pressure-redistribution mattress overlay

E. Massage the sacral redness vigorously

F. Use a 30° lateral tilt position when side-lying

G. Restrict oral fluids to "rest" the kidneys

*Reveal answer & rationale*

Q5 · TAKE ACTION

*Drag-and-Drop Ordering*

**Place the steps for assisting the client out of bed using a walker in the correct order.**

1. Help the client dangle legs at the bedside; assess for orthostatic dizziness.
2. Position the walker directly in front of

the client, close to the bed.

3. Apply a gait belt; instruct the client to push up from the bed (not pull on the walker).
4. Lower the bed and lock the wheels; ensure non-skid footwear on the unaffected foot.
5. Have the client step into the walker frame and stand with weight on the right leg, both crutch-tips/walker-points firmly on the floor.

*Reveal answer & rationale*

Q6 · EVALUATE OUTCOMES

*Matrix · Effective vs. Ineffective*

After 24 hours of nursing interventions, the nurse evaluates outcomes. Indicate whether each finding shows the plan was **effective** or **ineffective**.

| FINDING AT 24 HOURS | EFFECTIVE | INEFFECTIVE |
|---|---|---|
| Sacral skin now blanches; redness resolved | ✓ | |
| Soft formed BM ×1; reports relief | ✓ | |
| Pain 5/10 unchanged after non-pharm and PRN dose | | ✓ |
| Slept ~6 hours overnight; reports feeling rested | ✓ | |

| FINDING AT 24 HOURS | EFFECTIVE | INEFFECTIVE |
|---|---|---|
| Urine output 1500 mL/24 hr, light yellow | ✓ | |
| New 1 cm shallow open area on right heel | | ✓ |

*Reveal answer & rationale*

## QR Quick *Reference*

| Concept | Memorize this |
|---|---|
| Cane | Hold on **strong** side; advance with **weak** leg (COAL). |
| Crutch fit | 2–3 fingers below axilla; weight on **palms**. |
| Stairs | **Up** with the good, **down** with the bad. |
| Reposition | q2h in bed, q1h in chair; 30° lateral tilt; heels float. |
| NG feeding HOB | ≥ 30° during & 30–60 min after. |
| Tube placement | **X-ray** = gold standard; pH < 5.5 supportive. |
| Aspiration precautions | HOB up, chin tuck, thickened liquids, no straws. |
| Enema position | Left lateral Sims'; bag 12–18 in above hip. |
| Stoma color | Pink/red good; **dusky/dark = call provider**. |
| Heat / Cold | 20 min on / 20 min off; barrier on skin. |
| Pressure injury Stage 1 | Intact skin, **non-blanchable** redness. |
| Pressure injury Stage 3 | Full thickness, fat visible, no bone/tendon/muscle. |
| Braden | Lower score = higher risk; ≤ 18 at risk. |
| Imminent death | Cheyne–Stokes, mottling, ↓ LOC, death rattle. |
| Last sense | **Hearing**. |
| Diabetic foot | Inspect daily, lukewarm water, no soaking, no barefoot, podiatry trims nails. |
| Celiac avoid | **BROW**: barley, rye, oats, wheat. |

| Concept | Memorize this |
|---|---|
| Renal (HD) | ↑ protein, ↓ Na/K/phosphorus, fluid restrict. |
| Gout | Avoid organ meats, anchovies, sardines, beer. |
| Pain assessment | OPQRSTU; pain is what the client says it is. |
| PCA | Patient only — never family. Naloxone available. |

— FINAL TEST-TAKING STRATEGY

On NGN case studies, anchor every decision in **safety first**, then **physiologic priority** (Maslow / ABCs), then **least invasive / least restrictive**. For Basic Care & Comfort, this almost always means: **non-pharmacological → repositioning → patient-controlled measures → escalation**.