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# Core Clinical Concepts

### Core Nursing Essentials Core Clinical Concepts

Start with systematic observation, distinguish what the patient reports from what you measure, and organize a clear care plan. Use assessment tools to communicate findings rather than to replace clinical judgment.

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## Study guide

Start with systematic observation, distinguish what the patient reports from what you measure, and organize a clear care plan. Use assessment tools to communicate findings rather than to replace clinical judgment.

## How to revise this category

1. Choose a topic and explain its purpose.
2. Identify the observations, equipment or information needed.
3. Connect the findings to documentation, reassessment and escalation.
4. Practise under qualified supervision and review the current local protocol.

## Curriculum coverage

- Normal adult vital signs and abnormal findings
- Nursing process (ADPIE)
- Head-to-toe assessment
- ABCDE assessment
- Glasgow Coma Scale (GCS)
- AVPU scale
- Pain assessment and PQRST method
- Level of consciousness
- Clinical documentation
- Subjective and objective data

## Quick Revision

Use this curriculum guide to organize study. Published summaries are listed separately. Detailed drafts remain in the private content studio until source and clinical checks are recorded.

## References & review status

- WHO-ICRC Basic Emergency Care (https://www.who.int/publications/i/item/9789241513081) - 2018; course materials updated separately. ABCDE and recognition framework; original short synthesis, no copied diagrams.
- Glasgow Coma Scale - official structured approach (https://www.glasgowcomascale.org/) - Official resource and permissions page accessed 26 November 2026. Component arithmetic only. GCS University of Glasgow;

assessment aid Sir Graham Teasdale.

Sources checked for the stated scope on 26 November 2026. Original study synthesis; independent clinical review is not claimed. Source attribution is not a copyright-clearance certificate.

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## Practice questions

Choose one best answer. The answer key and explanations follow the questions.

**1. During admission, which finding is subjective data?**

A. Blood pressure 118/76 mmHg

B. The patient says, 'I feel nauseated.'

C. A measured temperature of 37 C

D. A laboratory potassium result

**2. A nurse reassesses pain after an intervention and compares it with the agreed goal. Which ADPIE step is this?**

A. Diagnosis

B. Planning

C. Evaluation

D. Initial assessment only

**3. A patient becomes unresponsive during routine observations. What is the best immediate approach?**

A. Finish the routine head-to-toe checklist first

B. Wait for the next observation round

C. Enter a normal score because the previous score was normal

D. Call for help and begin a systematic assessment of immediate threats

**4. An endotracheal tube prevents assessment of the verbal GCS response. How should this limitation be handled?**

A. Record verbal as not testable, report available components and avoid a misleading total

B. Assign verbal 1 and assume a complete total

C. Assign verbal 5 because the patient is intubated

D. Omit all neurological observations

**5. In a PQRST pain history, which question primarily explores region and radiation?**

A. When did it begin?

B. What makes it worse?

C. Where is it, and does it spread anywhere?

D. How would you rate the severity?

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**6. A patient who was previously alert now responds only when spoken to. What should the nurse do?**

A. Assume the patient is simply resting

B. Document the change and obtain prompt clinical assessment

C. Replace all observations with yesterday's findings

D. Wait for a complete GCS total before seeking help

**7. Which documentation practice best supports safe care?**

A. Delete an incorrect entry so no audit trail remains

B. Record treatment before it has been administered

C. Describe the patient using judgmental labels

D. Record observations, care, response and escalation promptly and objectively

**8. A resting adult has an unexpectedly fast pulse compared with their usual readings. Which response is most appropriate?**

A. Check the measurement and assess the patient, trend and associated symptoms

B. Ignore it because the other observations were previously normal

C. Diagnose the cause from pulse rate alone

D. Give a medicine based only on a study reference table

**9. Before beginning a head-to-toe examination, which action best supports a respectful assessment?**

A. Expose the patient fully before explaining the examination

B. Explain the examination, seek consent and protect privacy

C. Skip the patient's account of symptoms

D. Assume every student examination needs no consent

**10. Which statement correctly connects the steps of the nursing process?**

A. Evaluation ends the process permanently

B. Planning occurs without assessment data

C. New assessment findings may require the care plan to be revised

D. Implementation always replaces documentation

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## Answer key and explanations

**1. B - The patient says, 'I feel nauseated.'**

Subjective data are reported experiences. The measured observations and laboratory result are objective data.

**2. C - Evaluation**

Evaluation compares the response with the expected outcome and informs any revision of the care plan.

**3. D - Call for help and begin a systematic assessment of immediate threats**

New unresponsiveness requires prompt help and assessment. ABCDE organizes recognition and response; routine paperwork must not delay urgent care.

**4. A - Record verbal as not testable, report available components and avoid a misleading total**

An untestable component is not an observed score of 1. Report the components that can be assessed and the reason the verbal response is not testable.

**5. C - Where is it, and does it spread anywhere?**

Region and radiation describe the location and spread of pain. Timing, provocation and severity address other parts of the history.

**6. B - Document the change and obtain prompt clinical assessment**

A new reduction in responsiveness is a clinical change requiring assessment. AVPU describes the response but does not establish its cause.

**7. D - Record observations, care, response and escalation promptly and objectively**

Clear, timely and factual records support continuity and accountability. Corrections should preserve the approved audit trail.

**8. A - Check the measurement and assess the patient, trend and associated symptoms**

An unexpected observation needs technique checks and clinical assessment. One number does not identify its cause or authorize treatment.

**9. B - Explain the examination, seek consent and protect privacy**

Explanation, consent, privacy and a systematic approach support both dignity and the quality of the assessment.

**10. C - New assessment findings may require the care plan to be revised**

The nursing process is cyclical. New findings and responses can change priorities, goals and planned interventions.

## Source and attribution

Original curriculum guide. Source scope and versions are listed in the guide.

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