Christensen: Adult Health Nursing, 6th Edition

Chapter 02: Care of the Surgical Patient

Test Bank

MULTIPLE CHOICE

1. The patient is 38 years old and is in her second postoperative day after placement of an intramedullary rod in her left femur. She is receiving analgesia via a patient-controlled analgesia (PCA) device. The inappropriate intervention related to caring for a patient with a PCA is:
   a. Maintaining the system.
   b. Recording activations of the system.
   c. Administering the analgesia to the patient.
   d. Monitoring the patient's pain.

   ANS: C
   With the PCA system of medication administration, the patient can self-administer an analgesic by pressing a control button. The nurse should not give medication doses by pushing the control button.

   DIF: Cognitive Level: Application REF: Page 50 OBJ: 13
   TOP: Medication administration KEY: Nursing Process Step: Implementation
   MSC: NCLEX: Physiological Integrity

2. A 73-year-old patient with diabetes was admitted for below-the-knee amputation of his right leg. Removal of his right leg is an example of which type of surgery?
   a. Palliative
   b. Diagnostic
   c. Reconstructive
   d. Ablative

   ANS: D
   Ablative is a type of surgery where an amputation, excision of any part of the body, or removal of a growth and harmful substance is performed.

   DIF: Cognitive Level: Comprehension REF: Page 18, Table 2-1
   OBJ: 2 TOP: Types of surgery
   KEY: Nursing Process Step: Assessment MSC: NCLEX: Physiological Integrity

3. The Patient's Bill of Rights states that a patient must give his or her permission for any specific test or procedure to be performed. What is the legal term for this permission?
   a. Verbal consent
   b. Medical documentation
   c. Informed consent

d. Informed decision

ANS: C
The Patient's Bill of Rights affirms that the patients must give informed consent (permission obtained from the patient to perform a specific test or procedure) before the beginning of any procedure.

DIF: Cognitive Level: Knowledge REF: Page 24 OBJ: 6
TOP: Informed consent KEY: Nursing Process Step: Assessment
MSC: NCLEX: Safe, Effective Care Environment

4. An informed consent was to be obtained from the patient for his scheduled open cholecystectomy. Which circumstance could prevent the patient from signing his informed consent?
   a. Pain radiating to the scapula
   b. An injection of Demerol, 75 mg IM, 1 hour ago
   c. The presence of jaundice and scleral icterus
   d. His concern over his insurance company not covering the procedure

   ANS: B
   Informed consent should not be obtained if the patient is disoriented and under the influence of sedatives.

   DIF: Cognitive Level: Application REF: Page 25 OBJ: 6
   TOP: Informed consent KEY: Nursing Process Step: Implementation
   MSC: NCLEX: Safe, Effective Care Environment

5. The anesthesiologist provides ____ anesthesia by inhalation and IV administration routes.
   a. general
   b. regional
   c. specific
   d. preoperative

   ANS: A
   An anesthesiologist gives general anesthetics by IV and inhalation routes through four stages of anesthesia.

   DIF: Cognitive Level: Knowledge REF: Page 37 OBJ: 11
   TOP: Anesthesia KEY: Nursing Process Step: Assessment
   MSC: NCLEX: Physiological Integrity

6. A type of anesthesia that requires a depressed level of consciousness is
   a. regional anesthesia.
   b. specific anesthesia.
   c. optional sedation.

d. conscious sedation.

ANS: D
Conscious sedation is routinely used for procedures that do not require complete anesthesia but rather a depressed level of consciousness.

DIF: Cognitive Level: Knowledge REF: Page 40 OBJ: 12
TOP: Conscious sedation KEY: Nursing Process Step: Assessment
MSC: NCLEX: Physiological Integrity

7. The older adult patient may not respond to surgical treatment as well as a younger adult because of
   a. poor skin turgor resulting in dehydration.
   b. disturbed body image related to surgical incision.
   c. his or her body's response to physiological changes.
   d. decreased peristalsis related to general anesthesia.

   ANS: C
   Of specific concern in older adults is the body's response to temperature changes, cardiovascular shifts, respiratory needs, and renal function.

   DIF: Cognitive Level: Analysis REF: Page 20 OBJ: 7
   TOP: Older adult patient KEY: Nursing Process Step: Assessment
   MSC: NCLEX: Physiological Integrity

8. A 45-year-old patient has had a repair of a cerebral aneurysm and is presenting signs of increased intracranial pressure (ICP). Which postoperative nursing interventions would be contraindicated?
   a. Coughing every 2 hours
   b. Leg exercises every 2 hours
   c. Monitoring intravenous therapy at 50 ml/hr
   d. Assessing vital signs every 2 hours

   ANS: A
   Coughing increases ICP.

   DIF: Cognitive Level: Analysis REF: Page 32, Box 2-6
   OBJ: 5 TOP: Postoperative complications
   KEY: Nursing Process Step: Implementation
   MSC: NCLEX: Physiological Integrity

9. A male patient, age 80, has had a total hip replacement. Anxiety, hypotension, and jarring during transfer from the recovery room to his room can cause a postoperative increase in which of his vital signs?
   a. Pulse rate
   b. Temperature

c. Blood pressure
d. Pain

ANS: A
An increase in pulse rate is an objective, detectable sign that the body is responding to "pain." Other objective changes include a decrease in blood pressure in the immediate postoperative period, restlessness, diaphoresis, and pallor.

DIF: Cognitive Level: Analysis REF: Page 48, Box 2-8
OBJ: 10 TOP: Postoperative complications
KEY: Nursing Process Step: Assessment MSC: NCLEX: Physiological Integrity

10. A patient, age 65, underwent a right hemicolectomy. On postoperative day 4, her surgical wound dehisced. This means that
a. there is partial or complete wound separation.
b. there has been inadequate wound closure.
c. abdominal viscera protrude through the walls.
d. the wound will not heal well when it is resutured.

ANS: A
A surgical incision may separate; this action of dehiscence (the separation of a surgical incision or rupture of a wound closure) may occur within 3 days to over 2 weeks postoperatively.

DIF: Cognitive Level: Knowledge REF: Page 48, Figure 2-15
OBJ: 1 TOP: Postoperative complications
KEY: Nursing Process Step: Assessment MSC: NCLEX: Physiological Integrity

11. A patient is on postoperative day 2 after a nephrectomy. The nurse is aware that the most effective way to increase her peristalsis is
a. ambulation.
b. an enema.
c. encouraging hot liquids.
d. administering a laxative.

ANS: A
Encouraging activity (turning every 2 hours, early ambulation) assists GI activity.

DIF: Cognitive Level: Application REF: Page 52, Box 2-10
OBJ: 13 TOP: Postoperative complications
KEY: Nursing Process Step: Planning MSC: NCLEX: Physiological Integrity

12. A patient is transferred from the operating room to the recovery room after undergoing an open reduction and internal fixation (ORIF) of his left ankle. Which is the first assessment to make?
a. Check ankle dressings.
b. Check airway for patency.
c. Check intravenous site.

d. Check vital signs.

ANS: B
Evaluation of the patient follows the ABCs of immediate postoperative observation: airway, breathing, consciousness, and circulation.

DIF: Cognitive Level: Application REF: Page 45, Table 2-6
OBJ: 12 TOP: Nursing assessment
KEY: Nursing Process Step: Assessment
MSC: NCLEX: Health Promotion and Maintenance

13. Frequent assessment of a postoperative patient is essential. One of the first signs and symptoms of hemorrhage may be
a. increasing blood pressure.
b. decreasing pulse.
c. restlessness.
d. weakness, apathy.

ANS: C
A pulse that increases and becomes thready combined with a declining blood pressure, cool and clammy skin, reduced urine output, and restlessness may signal hypovolemic shock.

DIF: Cognitive Level: Comprehension REF: Page 48 OBJ: 10
TOP: Postoperative complications KEY: Nursing Process Step: Assessment
MSC: NCLEX: Physiological Integrity

14. Frequent monitoring of the postoperative patient's vital signs assesses which body system?
a. Gastrointestinal
b. Endocrine
c. Neurological
d. Cardiovascular

ANS: D
Hypotension and cardiac dysrhythmias are the most common cardiovascular complications of the surgical patient, and early recognition and management of these complications before they become serious enough to diminish cardiac output depend on frequent assessment of the patient's vital signs.

DIF: Cognitive Level: Comprehension REF: Pages 35, 51, Table 2-4
OBJ: 14 TOP: Postoperative patient
KEY: Nursing Process Step: Implementation
MSC: NCLEX: Safe, Effective Care Environment

15. Decreased activity in an obese surgical patient predisposes the patient to which complication?

a. Cardiac arrest
b. Pneumonia
c. Incisional hernias
d. Hypoventilation

ANS: D
Immediate postoperative hypoventilation can result from drugs (anesthetics, narcotics, tranquilizers, sedatives) incisional pain, obesity, chronic lung disease, or pressure on the diaphragm.

DIF: Cognitive Level: Analysis REF: Page 48 OBJ: 13
TOP: Postoperative complications KEY: Nursing Process Step: Planning
MSC: NCLEX: Physiological Integrity

16. The nurse acknowledges that all preoperative nursing interventions have been performed by signing which document?
a. Nurse's notes
b. Anesthesia record
c. Preoperative checklist
d. Physician's order sheet

ANS: C
When the nurse signs the preoperative checklist, that nurse assumes responsibility for all areas of care included on the list.

DIF: Cognitive Level: Knowledge REF: Page 41, Figure 2-10
OBJ: 9 TOP: Preoperative checklist
KEY: Nursing Process Step: Implementation
MSC: NCLEX: Safe, Effective Care Environment

17. Which nursing interventions would be appropriate after a wound evisceration?
a. Place the patient in high Fowler's position.
b. Give the patient fluids to prevent shock.
c. Replace the dressing with sterile fluffy pads.
d. Apply a warm, moist normal saline sterile dressing.

ANS: D
Cover the wound with a sterile towel moistened with sterile physiological saline (warm).

DIF: Cognitive Level: Application REF: Page 48, Figure 2-15
OBJ: 13 TOP: Postoperative interventions
KEY: Nursing Process Step: Planning MSC: NCLEX: Physiological Integrity

18. When should the nurse offer prescribed analgesics to a patient who is 24 hours postoperative?
a. Only when the patient asks.
b. Regularly every three to four hours before pain gets severe.

c. Only when the physician orders.
d. Only when the patient is in severe pain.

ANS: B
The nurse should ask the patient every 3-4 hours if something is needed for pain because some patients will not ask for an analgesic.

DIF: Cognitive Level: Application REF: Page 49 OBJ: 10
TOP: Medication administration KEY: Nursing Process Step: Planning
MSC: NCLEX: Physiological Integrity

19. What nursing interventions will minimize the effects of venous stasis?
a. Pillows under the knee in a position of comfort
b. Sitting with the feet flat on the floor
c. Early ambulation
d. Gentle leg massage

ANS: C
Early ambulation has been a significant factor in hastening postoperative recovery and preventing postoperative complications.

DIF: Cognitive Level: Application REF: Page 52, Box 2-10
OBJ: 13 TOP: Interventions
KEY: Nursing Process Step: Planning MSC: NCLEX: Physiological Integrity

20. Serum potassium levels are usually determined before surgery to
a. assess kidney function.
b. determine respiratory insufficiency.
c. prevent dysrhythmias related to anesthesia.
d. measure functional liver capability.

ANS: C
Serum electrolytes are evaluated if extensive surgery is planned or the patient has extenuating problems. One of the essential electrolytes examined is potassium; if potassium is not available in adequate amounts, dysrhythmias can occur during anesthesia.

DIF: Cognitive Level: Analysis REF: Page 24 OBJ: 9
TOP: Preoperative assessment KEY: Nursing Process Step: Assessment
MSC: NCLEX: Physiological Integrity

21. The nurse is assisting with the sponge and instrument count in the operating room. The operative phase in which the nurse is assisting is called the
a. perioperative phase.
b. preoperative phase.
c. intraoperative phase.
d. postoperative phase.

ANS: C
Counting of sponges, needles, and instruments with the scrub nurse before surgery and before closing the wound is done during the intraoperative phase of the surgery.

DIF: Cognitive Level: Knowledge REF: Page 24, Box 2-7
OBJ: 8 TOP: Intraoperative responsibilities
KEY: Nursing Process Step: Implementation
MSC: NCLEX: Safe, Effective Care Environment

22. Which early postoperative observation is abnormal and should be reported immediately?
    a. Emesis that is red
    b. Complaint of feeling cold
    c. Nausea
    d. Complaint of pain

ANS: A
Any emesis that is red should be reported immediately.

DIF: Cognitive Level: Analysis REF: Page 46, Box 2-7
OBJ: 10 TOP: Assessment KEY: Nursing Process Step: Assessment
MSC: NCLEX: Physiological Integrity

23. Sudden chest pain combined with dyspnea, cyanosis, and tachycardia is an indication of
    a. hypovolemic shock.
    b. dehiscence.
    c. atelectasis.
    d. pulmonary embolus.

ANS: D
Sudden chest pain combined with dyspnea, tachycardia, cyanosis, diaphoresis, and hypotension is a sign of pulmonary embolism.

DIF: Cognitive Level: Analysis REF: Page 49 OBJ: 13
TOP: Assessment and postoperative complications
KEY: Nursing Process Step: Assessment MSC: NCLEX: Physiological Integrity

24. An appendectomy during a hysterectomy would be classified as
    a. major, emergency, diagnostic.
    b. major, urgent, palliative.
    c. minor, elective, ablative.
    d. minor, urgent, reconstructive.

ANS: C

Surgery is classified as elective, urgent, or emergency. Surgery is performed for various purposes, which include diagnostic studies, ablation (an amputation or excision of any part of the body or removal of a growth or harmful substance), and palliative (therapy to relieve or reduce intensity of uncomfortable symptoms without cure), reconstructive, transplant, and constructive purposes.

DIF: Cognitive Level: Comprehension REF: Page 18, Table 2-1
OBJ: 2 TOP: Types of surgery
KEY: Nursing Process Step: Planning MSC: NCLEX: Physiological Integrity

25. Which patients would be at greatest risk during surgery?
    a. 78-year-old taking an analgesic agent
    b. 43-year-old taking an antihypertensive agent
    c. 27-year-old taking an anticoagulant agent
    d. 10-year-old taking an antibiotic agent

    ANS: C
    Anticoagulants alter normal clotting factors and thus increase risk of hemorrhaging. They should be discontinued for 48 hours before surgery.

    DIF: Cognitive Level: Analysis REF: Page 21, Box 2-3, Table 2-5
    OBJ: 4 TOP: Individual's ability to tolerate surgery
    KEY: Nursing Process Step: Planning MSC: NCLEX: Physiological Integrity

26. A patient will have an incision in the lower left abdomen. Which intervention by the nurse will help decrease discomfort in the incisional area when she coughs postoperatively?
    a. Apply a splint directly over the lower abdomen.
    b. Keep the patient flat with feet flexed.
    c. Turn her on her right side.
    d. Apply a splint above and below the incision.

    ANS: A
    To ease the pressure on the incision, the nurse helps the patient support the surgical site with a pillow, rolled bath blanket, or the heel of the hand.

    DIF: Cognitive Level: Application REF: Pages 31-32, Skill 2-4 Step 10, NCP 2-1
    OBJ: 14 TOP: Postoperative nursing interventions
    KEY: Nursing Process Step: Planning MSC: NCLEX: Physiological Integrity

27. Although informed about the proposed surgical procedure, the patient has only vague responses about the postoperative period. A nursing diagnosis at this time would be
    a. Impaired verbal communication.
    b. Impaired gas exchange.
    c. Deficient knowledge, postoperative.
    d. Acute pain.

ANS: C
Knowledge, deficient regarding implications of surgery related to information misinterpretation is a correct nursing diagnosis.

DIF: Cognitive Level: Analysis REF: Page 20, Box 2-11
OBJ: 14 TOP: Nursing process/diagnosis
KEY: Nursing Process Step: Planning
MSC: NCLEX: Safe, Effective Care Environment

28. A patient and a nurse develop a preoperative teaching plan. In teaching the patient to cough effectively after surgery, the nurse should tell her to practice
    a. breathing through her nose, holding her breath, and exhaling slowly.
    b. taking three deep breaths and coughing from the chest.
    c. inhaling while contracting the abdominal muscles and exhaling while contracting the diaphragm.
    d. taking short, frequent panting breaths and coughing from the throat to clear accumulated mucus.

ANS: B
Because lung ventilation is vital, the nurse assists the patient to turn, cough, and breathe deeply every 1 to 2 hours until the chest is clear. Having practiced this combination preoperatively, the patient is usually able to adequately remove trapped mucus and surgical gases.

DIF: Cognitive Level: Application REF: Pages 29-30, Skills 2-2, 2-3
OBJ: 13 TOP: Prevention of postoperative complications
KEY: Nursing Process Step: Implementation
MSC: NCLEX: Physiological Integrity

29. What is the responsibility of the nurse regarding informed consent?
    a. Explain the surgical options.
    b. Explain the operative risks.
    c. Obtain the patient's signature.
    d. Check form for appropriate signatures.

ANS: C
A witness is only verifying that this is the person who signed the consent and that it was a voluntary consent. The witness (often a nurse) is not verifying that the patient understands the procedure.

DIF: Cognitive Level: Knowledge REF: Page 25 OBJ: 6
TOP: Informed consent KEY: Nursing Process Step: Implementation
MSC: NCLEX: Safe, Effective Care Environment

30. On the patient's return to the medical-surgical unit, the nurse performs an abdominal assessment. To assess bowel sounds, the nurse auscultates the lower abdomen for

a. 1 minute.
b. 5 to 20 seconds.
c. as long as it takes to hear a bowel sound.
d. one full inspiration and expiration.

ANS: A
Normal peristalsis is gauged by hearing 5 to 30 gurgles per minute.

DIF: Cognitive Level: Knowledge REF: Page 52, Box 2-10
OBJ: 10 TOP: Assessment KEY: Nursing Process Step: Assessment
MSC: NCLEX: Physiological Integrity

31. Which preoperative fear is linked to postoperative behavior?
a. Fear of anesthesia and death
b. Fear of death and malnutrition
c. Fear of unknown and lack of respect
d. Fear of malnutrition and addiction to new medications

ANS: A
The preoperative anxiety level influences the amount of anesthesia required, the amount of postoperative pain medication needed, and the speed of recovery from surgery.

DIF: Cognitive Level: Assessment REF: Pages 20, 24, Box 2-4
OBJ: 4 TOP: Nursing diagnosis
KEY: Nursing Process Step: Assessment
MSC: NCLEX: Health Promotion and Maintenance

32. Ideally, preop teaching should be done
a. immediately before surgery to eliminate fear.
b. 2 months in advance so the patient can prepare.
c. 1 to 2 days before the surgery when anxiety is not as high.
d. in the surgical holding area.

ANS: C
Preop teaching is provided 1 to 2 days prior to surgery when anxiety is low.

DIF: Cognitive Level: Implementation REF: Page 24 OBJ: 8
TOP: Nursing diagnosis KEY: Nursing Process Step: Assessment
MSC: NCLEX: Health Promotion and Maintenance

33. In preparation for the return of the surgical patient, the patient's bed and equipment should be in what position?
a. Lowest position with side rails elevated with oxygen and suction equipment available
b. Highest position with side rails elevated with IV pole and pump at bedside

c. Lowest position with side rails down on the receiving side
d. Highest position with the side rails down on receiving side and up on opposite side

ANS: D
In preparation for the return of the surgical patient, the patient's bed should be in the highest position to be level with the surgical gurney and should have the side rail down on the receiving side, with the opposite side rail up to prevent the patient from falling out of bed during transfer.

DIF: Cognitive Level: Implementation REF: Page 43 OBJ: 13
TOP: Nursing diagnosis KEY: Nursing Process Step: Planning
MSC: NCLEX: Health Promotion and Maintenance

34. Southeast Asian and Native American patients often do not make eye contact when preoperative teaching is being performed because
a. they aren't educated.
b. they aren't paying attention.
c. they believe eye contact is disrespectful.
d. they believe they are superior to the nurse.

ANS: C
Southeast Asians and Native Americans may believe eye contact is disrespectful.

DIF: Cognitive Level: Application REF: Page 22, Cultural Considerations box
OBJ: N/A TOP: Nursing diagnosis
KEY: Nursing Process Step: Assessment
MSC: NCLEX: Health Promotion and Maintenance

35. What are the high-risk conditions that may affect perioperative procedures? (Select all that apply):
a. Age, health, occupation, mental status
b. Financial income, health, nutritional status
c. Age, mental state, nutritional status, health
d. Occupation, age, nutritional status, health
e. Financial Income, occupation, age, health

ANS: C
Each system of the body is affected by the patient's age, health, nutritional status, and mental state.

DIF: Cognitive Level: Assessment REF: Page 24 OBJ: 4
TOP: Nursing diagnosis KEY: Nursing Process Step: Assessment
MSC: NCLEX: Health Promotion and Maintenance
MULTIPLE RESPONSE

36. A postoperative patient who had a left inguinal hernia repair is ready for his discharge instructions. Which information should the nurse provide? (Select all that apply.)
    a. Care of the wound site and any dressings
    b. When he may operate a motor vehicle
    c. Signs and symptoms to report to the physician
    d. Call the physician's office once he arrives home
    e. Report bowel movements to the physician
    f. Actions and side effects of any medications

    ANS: A, B, C, F
    As the day of discharge approaches, the nurse should be certain that the patient has vital information.

    DIF: Cognitive Level: Analysis REF: Page 56, Box 2-13
    OBJ: 13 TOP: Discharge instructions
    KEY: Nursing Process Step: Planning
    MSC: NCLEX: Safe, Effective Care Environment

37. Two considerations for the older adult surgical patient include (Select the two that apply.)
    a. pre- and postoperative teaching.
    b. lower morbidity and mortality.
    c. quick assessment skills.
    d. surgery causes much physiological stress.

    ANS: A, D
    Surgery places greater stress on older than on younger patients. Teaching should be given at the older person's level of understanding.

    DIF: Cognitive Level: Application REF: Page 20, Life Span Considerations box
    OBJ: 7 TOP: Older adult considerations
    KEY: Nursing Process Step: Planning MSC: NCLEX: Physiological Integrity

38. In preparing the patient for abdominal surgery, the Assistive Personnel (AP) can perform which interventions? (Select all that apply.)
    a. Vital signs
    b. Insertion of N/G tube
    c. Enema
    d. Height and weight
    e. Obtain operative consent
    f. Sterile gowning

    ANS: A, C, D
    The AP can perform vital signs, enema, and height and weight.

    DIF: Cognitive Level: Application REF: Page 38 OBJ: 16
    TOP: Nursing diagnosis KEY: Nursing Process Step:

Implementation
MSC: NCLEX: Health Promotion and Maintenance

COMPLETION

39. _____ therapy is performed to alleviate or decrease uncomfortable symptoms without curing the problem.

ANS:
Palliative

Palliative therapy is designed to relieve or reduce intensity of uncomfortable symptoms without cure.

DIF: Cognitive Level: Knowledge REF: Page 18, Table 2-1
OBJ: 1 TOP: Palliative therapy
KEY: Nursing Process Step: Assessment MSC: NCLEX: Comprehension

40. Discharge planning for a surgical procedure begins in the _____ period and continues through the _____ period.

ANS:
preoperative, recuperative

Discharge planning for a surgical procedure begins in the preoperative and continues through the recuperative period.

DIF: Cognitive Level: Knowledge REF: Page 55 OBJ: 15
TOP: Nursing diagnosis KEY: Nursing Process Step: Assessment
MSC: NCLEX: Health Promotion and Maintenance

41. A patient is transferred from the operating room to the recovery room after undergoing an amputation of his left foot. Place the interventions in the correct order for immediate assessment once the patient enters the PACU. Place a comma between each answer choice (a, b, c, d, etc.).

a. System review
b. Breathing
c. Circulation
d. Airway
e. Level of consciousness

ANS: D, B, E, C, A

DIF: Cognitive Level: Application REF: Page 45, Table 2-6

OBJ: 12 TOP: Nursing assessment
KEY: Nursing Process Step: Implementation
MSC: NCLEX: Health Promotion and Maintenance