Chapter 2: Care of the Surgical Patient

MULTIPLE CHOICE

1. The patient who had a nephrectomy yesterday has not used the patient-controlled analgesia (PCA) delivery system but admits to being in pain but fearful of addiction. What is the nurse's best response?
   a. "Modern analgesic drugs do not cause addiction."
   b. "Pain relief is worth a short period of addiction."
   c. "Addiction rarely occurs in the brief time postsurgical analgesia is required."
   d. "Addiction could be a real concern."

   ANS: C
   Addiction rarely occurs in the short time that it is required after surgery. Postsurgical analgesia, because of its brief application, does not usually produce a physical or a psychological dependence.

   DIF: Cognitive Level: Application REF: Page 34 OBJ: 13
   TOP: Fear of addiction 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 16, Table 2-1
   OBJ: 2 TOP: Types of surgeries
   KEY: Nursing Process Step: Assessment MSC: NCLEX: Physiological Integrity

3. In which situation might surgery be delayed?
   a. The patient has taken Dilantin today.
   b. An illegible signature is on the consent form..
   c. The patient is still taking anticoagulants.
   d. The admission office is unable to confirm insurance coverage.

   ANS: C
   All medications should be cancelled before surgery, except for drugs such as phenytoin (Dilantin). Anticoagulant therapy increases the threat of hemorrhage and may be a cause for delay.

   DIF: Cognitive Level: Knowledge REF: Page 34, Page 36 Table 2-6
   OBJ: 7 TOP: Anticoagulant therapy
   KEY: Nursing Process Step: Assessment MSC: NCLEX: Physiological Integrity

4. Which circumstance could prevent the patient from signing his informed consent for a cholecystectomy?
   a. The patient complains of pain radiating to the scapula.
   b. The patient received an injection of Demerol, 75 mg IM, 1 hour ago.
   c. The patient is 85 years of age.
   d. The patient is concerned over his lack of insurance coverage.

   ANS: B
   Informed consent should not be obtained if the patient is disoriented and under the influence of sedatives. Age, illegibility, and lack of insurance coverage do not prevent signing the consent. Pain into the scapula is a symptom of colitis.

   DIF: Cognitive Level: Application REF: Page 23 OBJ: 7
   TOP: Informed consent KEY: Nursing Process Step: Assessment
   MSC: NCLEX: Physiological Integrity

5. The nurse anticipates that the patient will be given _____anesthesia because of the extensive tissue manipulation involved in a hysterectomy.
   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 when the procedure requires extensive tissue manipulation.

   DIF: Cognitive Level: Knowledge REF: Page 34 OBJ: 9
   TOP: Anesthesia KEY: Nursing Process Step: Assessment
   MSC: NCLEX: Physiological Integrity

6. The nurse caring for a patient who had an epidural block for a vaginal repair should be alert for:
   a. a flushing of the face and torso.
   b. numbness of the perineum.
   c. complaint of thirst.
   d. a sudden drop in blood pressure.

   ANS: D
   Epidural anesthesia may cause a sudden drop in blood pressure or respiratory difficulty as the anesthetic agent moves up in the spinal cord. Elevating the patient's torso may prevent respiratory paralysis.

   DIF: Cognitive Level: Comprehension REF: Page 37 OBJ: 9
   TOP: Epidural block KEY: Nursing Process Step: Assessment
   MSC: NCLEX: Physiological Integrity

7. Why might the older adult patient not respond to surgical treatment as well as a younger adult patient?
   a. Poor skin turgor
   b. Fear of the unknown
   c. Response to physiological changes

d. Decreased peristalsis related to anesthesia

ANS: C
Of specific concern in older adults is the body's response to temperature changes, cardiovascular shifts, respiratory needs, and renal function. Fear of the unknown and decreased peristalsis are common to all ages.

DIF: Cognitive Level: Application REF: Page 17 OBJ: 5
TOP: Older adult patients KEY: Nursing Process Step: Planning
MSC: NCLEX: Physiological Integrity

8. The postoperative nursing intervention that would be contraindicated for a 45-year-old patient who has had a repair of a cerebral aneurysm and is presenting signs of increased intracranial pressure (ICP) would be:
   a. coughing every 2 hours.
   b. turning 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 28, Box 2-6
   OBJ: 12 TOP: Postoperative complications
   KEY: Nursing Process Step: Implementation
   MSC: NCLEX: Physiological Integrity

9. The nurse acting as a circulating nurse has a responsibility for:
   a. observing for breaks in sterile technique.
   b. identifying and handling surgical specimens correctly.
   c. assisting with surgical draping of the patient.
   d. maintaining count of sponges, needles, and instruments during surgery.

   ANS: A
   The circulating nurse is responsible for observing breaks in sterile technique. The scrub nurse handles the surgical specimens, drapes the patient, and maintains needle and sponge count during surgery, then does a final sponge and needle check with the circulating nurse before closing.

   DIF: Cognitive Level: Analysis REF: Page 43, Box 2-7
   OBJ: 11 TOP: Duties of circulating nurse
   KEY: Nursing Process Step: Assessment MSC: NCLEX: Safe, Effective Care Environment

10. Which statement made by a patient during a preoperative assessment would be significant to report to the charge nurse and surgeon?
    a. "I have been taking an herbal product of feverfew for my migraines."
    b. "I exercise for 3 hours a day."
    c. "I drink 2 glasses of wine a day."
    d. "I use atropine eyedrops every day."

    ANS: A

The herbal remedy of feverfew acts as an anticoagulant and increases the possibility of hemorrhage. The drug should be stopped before surgery, and bleeding and clotting times should be evaluated.

DIF: Cognitive Level: Application REF: Page 21, Table 2-3
OBJ: 14 TOP: Preoperative assessment
KEY: Nursing Process Step: Assessment MSC: NCLEX: Physiological Integrity

11. A patient is on postoperative day 2 after a nephrectomy. What is the most effective way to increase her peristalsis?
    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: Comprehension REF: Page 50 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 for hemorrhage.
    b. Check airway for patency.
    c. Check intravenous site.
    d. Check pedal pulse.

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

DIF: Cognitive Level: Application REF: Pages 42-43, Table 2-7
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. What is one of the first signs and symptoms of hemorrhage?
    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 45, Box 2-8
OBJ: 12 TOP: Postoperative complications
KEY: Nursing Process Step: Assessment MSC: NCLEX: Physiological Integrity

14. The nurse instructing a postsurgical patient in the use of thrombolytic deterrent stockings would include which of the following instructions?
    a. Disregard appearance of edema above the stocking
    b. Massage legs to smooth wrinkles out of stockings
    c. Wring stockings thoroughly before hanging to dry
    d. Wash stockings in warm water and mild soap

    ANS: D
    Stockings should be washed gently in warm water and mild soap and laid over a surface to dry. They should not be wrung out or hung. Massaging legs may dislodge a clot and the appearance of edema indicates the stockings are too restrictive.

    DIF: Cognitive Level: Comprehension REF: Page 31, Patient Teaching Box
    OBJ: 13 TOP: Thrombolytic deterrent stockings
    KEY: Nursing Process Step: Implementation
    MSC: NCLEX: Physiological Integrity

15. The patient is brought into PACU still unconscious. What should the nurse do when the nurse assesses an oral temperature of 94° F?
    a. Notify the charge nurse immediately
    b. Offer warm fluids through a straw
    c. Do nothing, this is a normal reaction to anesthesia
    d. Cover with a warm blanket

    ANS: D
    Hypothermia is a frequent assessment postsurgery. A warm blanket or a ventilated cover would be applied to bring up the temperature. Vital signs are checked every 15 minutes until stable.

    DIF: Cognitive Level: Analysis REF: Page 43, Page 45 Table 2-8
    OBJ: 13 TOP: Hypothermia
    KEY: Nursing Process Step: Planning MSC: NCLEX: Physiological Integrity

16. In which location are guidelines for ensuring that all nursing interventions on the day of surgery completed and documented?
    a. In the nurse's notes
    b. In the anesthesia record
    c. In the preoperative checklist
    d. In the progress notes

    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 40 OBJ: 6
    TOP: Preoperative checklistKEY: Nursing Process Step: Implementation
    MSC: NCLEX: Safe, Effective Care Environment

17. While turning a patient who had a bowel resection yesterday, the wound eviscerated. What is the initial nursing intervention?
    a. Place the patient in the 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: Pages 46-47, Figure 2-13
OBJ: 13 TOP: Evisceration KEY: Nursing Process Step: Implementation
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. When the onset of pain is assessed.
c. Sparingly to avoid drug dependence.
d. Only when severe pain is assessed.

ANS: B
The nurse should assess for pain frequently to medicate at the onset of pain.

DIF: Cognitive Level: Application REF: Page 48 OBJ: 14
TOP: Medication administration KEY: Nursing Process Step: Planning
MSC: NCLEX: Physiological Integrity

19. What should the nurse do to minimize the potential for venous stasis?
a. Place pillows under the knee in a position of comfort
b. Assist patient to sit with feet flat on the floor
c. Assist with early ambulation
d. Perform 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 49 OBJ: 13
TOP: Venous stasis KEY: Nursing Process Step: Planning
MSC: NCLEX: Physiological Integrity

20. The nurse clarifies that serum potassium levels are determined before surgery to:
a. assess kidney function.
b. determine respiratory insufficiency.
c. prevent arrhythmias 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, arrhythmias can occur during anesthesia.

DIF: Cognitive Level: Analysis REF: Page 23 OBJ: 4
TOP: Preoperative assessment KEY: Nursing Process Step: Implementation
MSC: NCLEX: Physiological Integrity

21. In performing the preoperative assessment, the nurse discovers that the patient is allergic to latex. What should the nurse do initially?
    a. Notify the diet kitchen to omit peaches from diet tray
    b. Apply a medical alert band to patient's wrist
    c. Tag chart with allergy alert
    d. Place patient in an isolation room

    ANS: B

    The initial intervention would be to place a medical alert band on the patient, then tag the chart. The charge nurse and the surgeon should be notified in the event the surgeon wants to order a preoperative prophylactic treatment.

    DIF: Cognitive Level: Knowledge REF: Pages 25-26, Box 2-5
    OBJ: 13 TOP: Latex allergy
    KEY: Nursing Process Step: Implementation
    MSC: NCLEX: Safe, Effective Care Environment

22. Which of the following early postoperative observations should be reported immediately?
    a. "Coffee ground" emesis
    b. Shivering
    c. Scanty urine output
    d. Evidence of pain

    ANS: A
    Any emesis that is red or coffee ground should be reported immediately as it indicates GI bleeding. Shivering, scanty urine output, and evidence of pain are within normal expectation of a postsurgical patient.

    DIF: Cognitive Level: Application REF: Page 45 OBJ: 10
    TOP: Postoperative assessment KEY: Nursing Process Step: Assessment
    MSC: NCLEX: Physiological Integrity

23. When the postoperative patient complains of sudden chest pain combined with dyspnea, cyanosis, and tachycardia, the nurse recognizes the signs 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 47 OBJ: 13
    TOP: Assessment and postoperative complications
    KEY: Nursing Process Step: Assessment MSC: NCLEX: Physiological Integrity

24. The removal of a nondiseased appendix during a hysterectomy is 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 16, Table 2-1
OBJ: 2 TOP: Types of surgery
KEY: Nursing Process Step: Planning MSC: NCLEX: Physiological Integrity

25. Which medication would cause surgery to be delayed if it had not been discontinued several days before surgery?
a. Analgesic agent
b. Antihypertensive agent
c. Anticoagulant agent
d. 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 36, Table 2-6
OBJ: 4 TOP: Individual's ability to tolerate surgery
KEY: Nursing Process Step: Planning MSC: NCLEX: Physiological Integrity

26. The most appropriate intervention by the nurse to decrease the pain of an abdominal incision while coughing would be to:
a. Support the surgical site with a pillow
b. Position patient in a side-lying position
c. Medicate with prescribed narcotic before coughing
d. Ask the patient to cross arms over the chest to increase force of cough

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: Page 47 OBJ: 8
TOP: Postoperative nursing interventions
KEY: Nursing Process Step: Planning MSC: NCLEX: Physiological Integrity

27. The nurse would include the nursing diagnosis of deficient knowledge, postoperative, when the patient scheduled for a bowel resection tomorrow remarks:
a. "I am going to have adequate pain medication after surgery."
b. "I know you all are going to make me cough and walk soon after surgery."
c. "I am glad I will get to go home tomorrow evening."
d. "I will have to put up with dressing changes."

ANS: C

The patient's lack of understanding about the length of time in the hospital following such a serious surgery indicates a knowledge deficit that needs to be addressed.

DIF: Cognitive Level: Analysis REF: Page 52, Box 2-11
OBJ: 16 TOP: Nursing process/diagnosis
KEY: Nursing Process Step: Planning MSC: NCLEX: Safe, Effective Care Environment

28. What instruction should a nurse give when teaching the patient to cough effectively after surgery?
    a. Breathe through the nose, hold breath, and exhale slowly.
    b. Take three deep breaths and cough from the chest.
    c. Inhale while contracting the abdominal muscles and exhale while contracting the diaphragm.
    d. Take short, frequent panting breaths and cough 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 adequately able to remove trapped mucus and surgical gases.

DIF: Cognitive Level: Application REF: Page 29, Skill 2-3
OBJ: 8 TOP: Prevention of postoperative complications
KEY: Nursing Process Step: Implementation
MSC: NCLEX: Physiological Integrity

29. What is the responsibility of the nurse as a witness to informed consent?
    a. Explain the surgical options
    b. Explain the operative risks
    c. Verify/obtain the patient's signature
    d. Verify the patient's understanding of the procedure

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 23 OBJ: 7
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 performing an abdominal assessment can affirm an absence of bowel sounds after listening in each quadrant for at least:
    a. 30 seconds.
    b. 1 minute.
    c. 2 minutes.
    d. 3 minutes.

ANS: D
Normal peristalsis is gauged by hearing 5 to 30 gurgles per minute. Absence of bowel sounds may be recorded if the nurse has listened to each quadrant 3 to 5 minutes.

DIF: Cognitive Level: Knowledge REF: Page 50 OBJ: 12
TOP: Bowel sounds KEY: Nursing Process Step: Assessment
MSC: NCLEX: Physiological Integrity

31. When the patient asks the nurse to make sure no one sees her with her dentures out, the nurse recognizes the common preoperative fear of:
    a. anesthesia.
    b. loss of control.
    c. fear of separation from family.
    d. mutilation.

    ANS: B
    Fear of loss of control may be partially related to concerns about anesthesia, but this patient's concern is about self-image. Preoperative anxiety from any cause may affect the amount of anesthesia and postoperative analgesia needed.

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

32. What is the ideal time for preoperative teaching?
    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
    Preoperative teaching is provided 1 to 2 days prior to surgery when anxiety is low.

    DIF: Cognitive Level: Implementation REF: Page 22 OBJ: 4
    TOP: Preoperative teaching KEY: Nursing Process Step: Implementation
    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 40 OBJ: 12
    TOP: Postoperative preparation KEY: Nursing Process Step: Planning
    MSC: NCLEX: Health Promotion and Maintenance

MULTIPLE RESPONSE

34. 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 53, Box 2-13
    OBJ: 15 TOP: Discharge instructions
    KEY: Nursing Process Step: Planning MSC: NCLEX: Safe, Effective Care Environment

35. Which of the following are considerations for the older adult surgical patient? (Select all that apply.)
    a. The need for specific clear preoperative and postoperative teaching
    b. Awareness of lower morbidity and mortality rate
    c. Presence of coexisting conditions
    d. Increased risk of respiratory complications
    e. Expectation of normal recovery time

    ANS: A, C, D
    Surgery places greater stress on older than on younger patients. Teaching should be given at the older person's level of understanding. Teaching should be specific and clear. Presence of coexisting conditions may delay recovery time and response to surgery.

    DIF: Cognitive Level: Application REF: Page 17, Life Span Considerations
    OBJ: 7 TOP: Older adult considerations
    KEY: Nursing Process Step: Planning MSC: NCLEX: Physiological Integrity

36. Which of the following are preoperative conditions that may affect the patient's response to surgery? (Select all that apply.)
    a. Age
    b. Religion
    c. Mental status
    d. Occupation
    e. Nutritional status

    ANS: A, C, E
    Each system of the body is affected by the patient's age, health, nutritional status, and mental state. Religion and occupation do not affect the physiological response to the surgery.

    DIF: Cognitive Level: Comprehension REF: Page 17 OBJ: 4
    TOP: Factors influencing toleration to surgery
    KEY: Nursing Process Step: Assessment MSC: NCLEX: Health Promotion and Maintenance

37. Which interventions in preparing the patient for abdominal surgery may be delegated to unlicensed assistive personnel (UAP)?
    a. Vital signs
    b. Insertion of N/G tube
    c. Enema
    d. Height and weight
    e. Obtaining operative consent
    f. Sterile gowning

    ANS: A, C, D
    Vital signs, enema, and height and weight can be safely performed by UAP. Insertion of an N/G tube, obtaining an operative consent, and sterile gloving are interventions requiring critical thinking and knowledge unique to a nurse.

    DIF: Cognitive Level: Application REF: Page 18, Box 2-2
    OBJ: 3 TOP: Delegation KEY: Nursing Process Step: Implementation
    MSC: NCLEX: Health Promotion and Maintenance

COMPLETION

38. _____ 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 16, Table 2-1
    OBJ: 1 TOP: Palliative therapy
    KEY: Nursing Process Step: Assessment MSC: NCLEX: Safe, Effective Care Environment

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

    ANS:
    preoperative, recuperative

    When discharge planning is begun in the preoperative period and all through the postoperative period, the patient can assume greater responsibility for self-care and will experience less stress about going home.

    DIF: Cognitive Level: Comprehension REF: Page 52 OBJ: 15
    TOP: Discharge planning KEY: Nursing Process Step: Planning
    MSC: NCLEX: Health Promotion and Maintenance

40. The type of anesthesia that uses a combination of drugs to reduce the level of consciousness and provides amnesia is _____ _____.

    ANS:

conscious sedation

Conscious sedation uses a combination of drugs to produce a reduced level of consciousness and amnesia, as well as pain control, but allows the patient to control his or her own breathing. The recovery is more rapid than with general anesthesia.

DIF: Cognitive Level: Comprehension REF: Page 48 OBJ: 10
TOP: Conscious sedation KEY: Nursing Process Step: Planning
MSC: NCLEX: Physiological Integrity

41. The nurse is aware that there is a loss of _____ during catabolism after severe tissue injury.

ANS:
potassium

The injured cells loose potassium as catabolism (tissue breakdown) occurs.

DIF: Cognitive Level: Knowledge REF: Page 51 OBJ: 13
TOP: Catabolism KEY: Nursing Process Step: Planning
MSC: NCLEX: Physiological Integrity

42. The nurse explains that to promote deep breathing and improve lung expansion and oxygenation the patient should use the _____ _____ at regular intervals during the day.

ANS:
incentive spirometer

The incentive spirometer is a device to encourage deep breathing and lung expansion. The usual rate of usage is 8 to 10 breaths hourly during waking hours.

DIF: Cognitive Level: Comprehension REF: Page 26 OBJ: 13
TOP: Incentive spirometer KEY: Nursing Process Step: Implementation
MSC: NCLEX: Physiological Integrity

43. The nurse caring for a postsurgical patient is aware that the patient should void ____ to _____ hours postsurgery.

ANS:
6 to 8
6, 8

Urinary output should be obvious 6 to 8 hours postsurgery. If urinary output has not begun, a catheter may be inserted.

DIF: Cognitive Level: Comprehension REF: Page 48 OBJ: 13
TOP: Resumption of urinary flow KEY: Nursing Process Step: Assessment
MSC: NCLEX: Physiological Integrity

OTHER

44. 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. *(Separate letters by a comma and space as follows: A, B, C, D)*

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

ANS:
D, B, E, C, A

The assessment of an adequate airway is primary in the postanesthesia assessment, followed by breathing assessment, level of consciousness, circulation, and finally system review.

DIF: Cognitive Level: Application REF: Page 44, Table 2-7
OBJ: 12 TOP: Nursing assessment
KEY: Nursing Process Step: Implementation
MSC: NCLEX: Health Promotion and Maintenance

45. Place the instructions for controlled coughing in the correct sequence. *(Separate letters by a comma and space as follows: A, B, C, D)*

a. Inhale deeply and hold breath for a count of three
b. Document exercise and patient reaction
c. Cough 2 or 3 times without inhaling then relax
d. Take several deep breaths
e. Inhale through nose
f. Exhale through pursed lips

ANS:

D, E, F, A, C, B

The patient should be instructed to take several deep breaths, inhale through the nose, exhale through pursed lips, inhale deeply and hold for a count of three, cough two or three times without exhaling, relax. The procedure may be repeated before documentation.

DIF: Cognitive Level: Application REF: Pages 29-30, Skill 2-3
OBJ: 13 TOP: Controlled coughing
KEY: Nursing Process Step: Implementation
MSC: NCLEX: Physiological Integrity