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Chapter 01: Overview of Professional Nursing Concepts for Medical-Surgical Nursing

MULTIPLE CHOICE

1. A nurse wishes to provide client-centered care in all interactions. Which action by the nurse best demonstrates this concept?
a. Assesses for cultural influences affecting health care
b. Ensures that all the clients basic needs are met
c. Tells the client and family about all upcoming tests
d. Thoroughly orients the client and family to the room

ANS: A
Competency in client-focused care is demonstrated when the nurse focuses on communication, culture, respect compassion, client education, and empowerment. By assessing the effect of the clients culture on health care, this nurse is practicing client-focused care. Providing for basic needs does not demonstrate this competence. Simply telling the client about all upcoming tests is not providing empowering education. Orienting the client and family to the room is an important safety measure, but not directly related to demonstrating client-centered care.

DIF: Understanding/Comprehension REF: 3
KEY: Patient-centered care| culture MSC: Integrated Process: Caring
NOT: Client Needs Category: Psychosocial Integrity

2. A nurse is caring for a postoperative client on the surgical unit. The clients blood pressure was 142/76 mm Hg 30 minutes ago, and now is 88/50 mm Hg. What action by the nurse is best? a. Call the Rapid Response Team.
b. Document and continue to monitor.
c. Notify the primary care provider.
d. Repeat blood pressure measurement in 15 minutes.

ANS: A
The purpose of the Rapid Response Team (RRT) is to intervene when clients are deteriorating before they suffer either respiratory or cardiac arrest. Since the client has manifested a significant change, the nurse should call the RRT. Changes in blood pressure, mental status, heart rate, and pain are particularly significant.
Documentation is vital, but the nurse must do more than document. The primary care provider should be notified, but this is not the priority over calling the RRT. The clients blood pressure should be reassessed frequently, but the priority is getting the rapid care to the client.

DIF: Applying/Application REF: 3
KEY: Rapid Response Team (RRT)| medical emergencies MSC:
Integrated Process: Communication and Documentation
NOT: Client Needs Category: Physiological Integrity: Physiological Adaptation

3. A nurse is orienting a new client and family to the inpatient unit. What information does the nurse provide to help the client promote his or her own safety?
a. Encourage the client and family to be active partners.
b. Have the client monitor hand hygiene in caregivers.
c. Offer the family the opportunity to stay with the client.
d. Tell the client to always wear his or her armband.

ANS: A
Each action could be important for the client or family to perform. However, encouraging the client to be active in his or her health care as a partner is the most critical. The other actions are very limited in scope and do not provide the broad protection that being active and involved does.

DIF: Understanding/Comprehension REF: 3
KEY: Patient safety
MSC: Integrated Process: Teaching/Learning
NOT: Client Needs Category: Safe and Effective Care Environment: Safety and Infection Control

4. A new nurse is working with a preceptor on an inpatient medical-surgical unit. The preceptor advises the student that which is the priority when working as a professional nurse? a. Attending to holistic client needs
b. Ensuring client safety
c. Not making medication errors
d. Providing client-focused care

ANS: B
All actions are appropriate for the professional nurse. However, ensuring client safety is the priority. Up to 98,000 deaths result each year from errors in hospital care, according to the 2000 Institute of Medicine report. Many more clients have suffered injuries and less serious outcomes. Every nurse has the responsibility to guard the clients safety.

DIF: Understanding/Comprehension REF: 2
KEY: Patient safety
MSC: Integrated Process: Nursing Process: Intervention
NOT: Client Needs Category: Safe and Effective Care Environment: Safety and Infection Control

5. A client is going to be admitted for a scheduled surgical procedure. Which action does the nurse explain is the most important thing the client can do to protect against errors? a. Bring a list of all medications and what they are for.
b. Keep the doctors phone number by the telephone.
c. Make sure all providers wash hands before entering the room.
d. Write down the name of each caregiver who comes in the room.

ANS: A

Medication errors are the most common type of health care mistake. The Joint Commissions Speak Up campaign encourages clients to help ensure their safety. One recommendation is for clients to know all their medications and why they take them. This will help prevent medication errors.

DIF: Applying/Application REF: 4
KEY: Speak Up campaign| patient safety MSC: Integrated Process: Teaching/Learning
NOT: Client Needs Category: Safe and Effective Care Environment: Safety and Infection Control

6. Which action by the nurse working with a client best demonstrates respect for autonomy?
a. Asks if the client has questions before signing a consent
b. Gives the client accurate information when questioned
c. Keeps the promises made to the client and family
d. Treats the client fairly compared to other clients

ANS: A

Autonomy is self-determination. The client should make decisions regarding care. When the nurse obtains a signature on the consent form, assessing if the client still has questions is vital, because without full information the client cannot practice autonomy. Giving accurate information is practicing with veracity.

Keeping promises is upholding fidelity. Treating the client fairly is providing social justice.

DIF: Applying/Application REF: 4
KEY: Autonomy| ethical principles MSC: Integrated Process: Caring
NOT: Client Needs Category: Safe and Effective Care Environment: Management of Care

7. A student nurse asks the faculty to explain best practices when communicating with a person from the lesbian, gay, bisexual, transgender, and queer/questioning (LGBTQ) community. What answer by the faculty is most accurate?
a. Avoid embarrassing the client by asking questions.
b. Dont make assumptions about their health needs.
c. Most LGBTQ people do not want to share information.
d. No differences exist in communicating with this population.

ANS: B

Many members of the LGBTQ community have faced discrimination from health care providers and may be reluctant to seek health care. The nurse should never make assumptions about the needs of members of this population. Rather, respectful questions are appropriate. If approached with sensitivity, the client with any health care need is more likely to answer honestly.

DIF: Understanding/Comprehension REF: 4
KEY: LGBTQ| diversity
MSC: Integrated Process: Teaching/Learning
NOT: Client Needs Category: Psychosocial Integrity

8. A nurse is calling the on-call physician about a client who had a hysterectomy 2 days ago and has pain that is unrelieved by the prescribed narcotic pain medication. Which statement is part of the SBAR format for communication?
a. A: I would like you to order a different pain medication.
b. B: This client has allergies to morphine and codeine.
c. R: Dr. Smith doesnt like nonsteroidal anti-inflammatory meds.
d. S: This client had a vaginal hysterectomy 2 days ago.

ANS: B
SBAR is a recommended form of communication, and the acronym stands for Situation, Background,
Assessment, and Recommendation. Appropriate background information includes allergies to medications the oncall physician might order. Situation describes what is happening right now that must be communicated; the clients surgery 2 days ago would be considered background. Assessment would include an analysis of the clients problem; asking for a different pain medication is a recommendation. Recommendation is a statement of what is needed or what outcome is desired; this information about the surgeons preference might be better placed in background.

DIF: Applying/Application REF: 5
KEY: SBAR| communication
MSC: Integrated Process: Communication and Documentation
NOT: Client Needs Category: Safe and Effective Care Environment: Management of Care

9. A nurse working on a cardiac unit delegated taking vital signs to an experienced unlicensed assistive personnel (UAP). Four hours later, the nurse notes the clients blood pressure is much higher than previous readings, and the clients mental status has changed. What action by the nurse would most likely have prevented this negative outcome?
a. Determining if the UAP knew how to take blood pressure
b. Double-checking the UAP by taking another blood pressure
c. Providing more appropriate supervision of the UAP
d. Taking the blood pressure instead of delegating the task

ANS: C
Supervision is one of the five rights of delegation and includes directing, evaluating, and following up on delegated
tasks. The nurse should either have asked the UAP about the vital signs or instructed the UAP to report them right away. An experienced UAP should know how to take vital signs and the nurse should not have to assess this at this point. Double-checking the work defeats the purpose of delegation. Vital signs are within the scope of practice for a UAP and are permissible to delegate. The only appropriate answer is that the nurse did not provide adequate
instruction to the UAP.

DIF: Applying/Application REF: 6
KEY: Supervision| delegation| unlicensed assistive personnel MSC:
Integrated Process: Communication and Documentation
NOT: Client Needs Category: Safe and Effective Care Environment: Management of Care

10. A nurse is talking with a client who is moving to a new state and needs to find a new doctor and hospital there. What advice by the nurse is best?

a. Ask the hospitals there about standard nurse-client ratios.
b. Choose the hospital that has the newest technology.
c. Find a hospital that is accredited by The Joint Commission.
d. Use a facility affiliated with a medical or nursing school.

ANS: C
Accreditation by The Joint Commission (TJC) or other accrediting body gives assurance that the facility has a focus on safety. Nurse-client ratios differ by unit type and change over time. New technology doesnt necessarily mean the hospital is safe. Affiliation with a health professions school has several advantages, but safety is most important.

DIF: Understanding/Comprehension REF: 2 KEY:
The Joint Commission (TJC)| accreditation
MSC: Integrated Process: Communication and Documentation
NOT: Client Needs Category: Safe and Effective Care Environment: Safety and Infection Control

11. A newly graduated nurse in the hospital states that, since she is so new, she cannot participate in quality improvement (QI) projects. What response by the precepting nurse is best? a. All staff nurses are required to participate in quality improvement here.
b. Even being new, you can implement activities designed to improve care.
c. Its easy to identify what indicators should be used to measure quality.
d. You should ask to be assigned to the research and quality committee.

ANS: B
The preceptor should try to reassure the nurse that implementing QI measures is not out of line for a newly licensed nurse. Simply stating that all nurses are required to participate does not help the nurse understand how that is possible and is dismissive. Identifying indicators of quality is not an easy, quick process and would not be the best place to suggest a new nurse to start. Asking to be assigned to the QI committee does not give the nurse information about how to implement QI in daily practice.

DIF: Applying/Application REF: 6
KEY: Quality improvement
MSC: Integrated Process: Communication and Documentation
NOT: Client Needs Category: Safe and Effective Care Environment: Management of Care

MULTIPLE RESPONSE

1. A nurse is interested in making interdisciplinary work a high priority. Which actions by the nurse best demonstrate this skill? (Select all that apply.)
a. Consults with other disciplines on client care
b. Coordinates discharge planning for home safety
c. Participates in comprehensive client rounding
d. Routinely asks other disciplines about client progress
e. Shows the nursing care plans to other disciplines

ANS: A, B, C, D
Collaborating with the interdisciplinary team involves planning, implementing, and evaluating client care as a team with all other disciplines included. Simply showing other caregivers the nursing care plan is not actively involving them or collaborating with them.

DIF: Applying/Application REF: 4
KEY: Collaboration| interdisciplinary team
MSC: Integrated Process: Communication and Documentation
NOT: Client Needs Category: Safe and Effective Care Environment: Management of Care

2. A nurse manager wishes to ensure that the nurses on the unit are practicing at their highest levels of competency. Which areas should the manager assess to determine if the nursing staff demonstrate competency according to the Institute of Medicine (IOM) report Health Professions Education: A Bridge to Quality? (Select all that apply.)
a. Collaborating with an interdisciplinary team

b. Implementing evidence-based care
c. Providing family-focused care
d. Routinely using informatics in practice
e. Using quality improvement in client care

ANS: A, B, D, E
The IOM report lists five broad core competencies that all health care providers should practice. These include collaborating with the interdisciplinary team, implementing evidence-based practice, providing client-focused care, using informatics in client care, and using quality improvement in client care.

DIF: Remembering/Knowledge REF: 3
KEY: Competencies| Institute of Medicine (IOM) MSC:
Integrated Process: Nursing Process: Assessment
NOT: Client Needs Category: Safe and Effective Care Environment: Safety and Infection Control

3. The nurse utilizing evidence-based practice (EBP) considers which factors when planning care? (Select all that apply.)
a. Cost-saving measures
b. Nurses expertise
c. Client preferences
d. Research findings
e. Values of the client

ANS: B, C, D, E
EBP consists of utilizing current evidence, the clients values and preferences, and the nurses expertise when planning care. It does not include cost-saving measures.

DIF: Remembering/Knowledge REF: 6
KEY: Evidence-based practice (EBP)
MSC: Integrated Process: Nursing Process: Planning
NOT: Client Needs Category: Safe and Effective Care Environment: Management of Care

4. A nurse manager wants to improve hand-off communication among the staff. What actions by the manager would best help achieve this goal? (Select all that apply.) a. Attend hand-off rounds to coach and mentor.
b. Conduct audits of staff using a new template.
c. Create a template of topics to include in report.
d. Encourage staff to ask questions during hand-off.
e. Give raises based on compliance with reporting.

ANS: A, B, C, D
A good tool for standardizing hand-off reports and other critical communication is the SHARE model. SHARE stands for standardize critical information, hardwire within your system, allow opportunities to ask questions, reinforce quality and measurement, and educate and coach. Attending hand-off report gives the manager opportunities to educate and coach. Conducting audits is part of reinforcing quality. Creating a template is hardwiring within the system. Encouraging staff to ask questions and think critically about the information is allowing opportunities to ask questions. The manager may need to tie raises into compliance if the staff is resistive and other measures have failed, but this is not part of the SHARE model.

DIF: Applying/Application REF: 5 KEY:
SHARE| hand-off communication
MSC: Integrated Process: Nursing Process: Intervention
NOT: Client Needs Category: Safe and Effective Care Environment: Management of Care

Chapter 02: Overview of Health Concepts for Medical-Surgical Nursing

MULTIPLE CHOICE

1. Acid-base balance occurs when the pH level of the blood is between: a.
7.3 and 7.5

b. 7.35 and 7.45
c. 7.4 and 7.5
d. 7.25 and 7.35

ANS: B
Acid-base balance is the maintenance of arterial blood pH between 7.35 and 7.45 through hydrogen ion production and elimination.

DIF: Understanding/Comprehension REF: 13
KEY: Assessment
MSC: Physiological Adaptation | Fluid and Electrolyte Imbalances NOT: Describe common fluid, electrolyte, and acid-base imbalances.

2. The nurse would expect a patient with respiratory acidosis to have an excessive amount of a.
Hydrogen ions.
b. Bicarbonate.
c. Oxygen.
d. Phosphate.

ANS: A
Respiratory acidosis occurs when the arterial blood pH level falls below 7.35 and is caused by either too many hydrogen ions in the body (respiratory acidosis) or too little bicarbonate (metabolic acidosis). Excessive oxygen and phosphate are not characteristic of respiratory acidosis.

DIF: Understanding/Comprehension REF: 13
KEY: Assessment
MSC: Physiological Adaptation | Fluid and Electrolyte Imbalances NOT: Describe common fluid, electrolyte, and acid-base imbalances.

3. The best way for an individual to maintain acid-base balance is to
a. avoid or quit smoking.
b. exercise regularly.
c. eat healthy and well-balanced meals.
d. All of the above.

ANS: D
Maintaining a healthy lifestyle is the best way to maintain acid-base balance. For example, most cases of COPD can be prevented by avoiding or quitting smoking, while regular exercise and a healthy diet can decrease the incidence of type-2 diabetes.

DIF: Patient education REF: 14 KEY:
Assessment
MSC: Integrated Process: Teaching/Learning
NOT: Client Needs Category: Health Promotion and Maintenance

4. The process to control cellular growth, replication, and differentiation to maintain homeostasis is called: a. cellular regulation.
b. cellular impairment.
c. cellular reproduction.
d. cellular tumor.

ANS: A
Cellular Regulation is the term used to describe both the positive and negative aspects of cellular function within the body.

DIF: Understanding/Comprehension REF: 14
KEY: Assessment
MSC: Integrated Process: Teaching/Learning

NOT: Client Needs Category: Health Promotion and Maintenance

5. A defining characteristic of malignant (cancerous) cells is:
a. they cannot spread to other tissues or organs.
b. they can invade healthy cells, tissues, and organs.
c. they are not usually a health risk.
d. none of the above.

ANS: B
Malignant (cancerous) cells have no comparison to the original cells from which they are derived, and they have the ability to invade healthy cells, tissues, and other organs through tumor formation and invasion. On the other hand, Benign cells do not have the ability to spread to other tissues or organs.

DIF: Understanding/Comprehension REF: 14
KEY: Assessment
MSC: Integrated Process: Teaching/Learning
NOT: Client Needs Category: Health Promotion and Maintenance

6. Specialized cells that circulate in the body to promote clotting are called: a. anticoagulants.
b. proteins.
c. emboli.
d. platelets.

ANS: D
Clotting is a complex, multi-step process through which blood forms a protein-based clot to prevent excessive bleeding. Platelets (thrombocytes) are the specialized cells that circulate in the blood and are activated when an injury occurs. Once activated, these cells become sticky, causing them to clump together to form a temporary, localized, solid plug.

DIF: Understanding/Comprehension REF: 15
KEY: Assessment
MSC: Integrated Process: Teaching/Learning
NOT: Client Needs Category: Health Promotion and Maintenance

7. An increase in platelet stickiness can lead to:
a. hypercoagulability
b. thromobocytopenia
c. embolus
d. atrial fibrillation

ANS: A
Hypercoagulability refers to an increase in clotting ability caused by an excess of platelets or excessive plately stickiness, which can impair blood flow. The opposite end of the spectrum involves an inability to form adequate clots, which often occurs when there is an inadequate number of circulating platelets or a reduction in platelet stickiness.

DIF: Understanding/Comprehension REF: 15
KEY: Assessment
MSC: Integrated Process: Teaching/Learning
NOT: Client Needs Category: Health Promotion and Maintenance

8. Signs and symptoms of_____thromobsis include localized redness, swelling, and warmth: a. arterial
b. venous
c. partial
d. atrial

ANS: B

Venous thrombosis is a clot formation in either superficial or deep veins, usually in the leg, and can be observed locally.

DIF: Understanding/Comprehension REF: 16
KEY: Assessment
MSC: Integrated Process: Teaching/Learning
NOT: Client Needs Category: Health Promotion and Maintenance

9. A serious condition which is not locally observable and is typically manifested by decreased blood flow to a distal extremity is known as_____thrombosis. a. arterial
b. venous
c. partial
d. atrial

ANS: A
Arterial thrombosis is manifested by decreased blood flow (perfusion) to a distal extremity or internal organ. For example, the distal leg can become pale and cool in the case of a femoral arterial clot due to blockage of blood to the leg. This is an emergent condition and requires immediate intervention.

DIF: Understanding/Comprehension REF: 16
KEY: Assessment
MSC: Integrated Process: Teaching/Learning
NOT: Client Needs Category: Health Promotion and Maintenance

10. A high-level thinking process that allows an individual to make decisions and judgments is known as: a. amnesia
b. personality
c. reasoning
d. memory

ANS: C
Reasoning is the high-level cognitive thinking process that helps individuals make decisions and judgments. Personality is the way an individual feels and behaves, while Memory is the ability of an individual to retain and recall information. Amnesia refers to a loss of memory caused by brain trauma, congenital disorders, or acute health problems.

DIF: Understanding/Comprehension REF: 16
KEY: Assessment
MSC: Integrated Process: Teaching/Learning
NOT: Client Needs Category: Psychosocial Integrity

11. A form of inadequate cognition in older adults which is manifested by an acute, fluctuating confusional state is known as: a. dementia
b. delerium
c. amnesia
d. depression

ANS: B
Delerium is the form of acute, fluctuating confusion which lasts from a few hours to less than 1 month and that may be treatable. Dementia is a chronic state of confusion that may last from a few months to many years and that may not be reversible. Amnesia refers to a loss of memory caused by brain trauma, congenital disorders, or acute health problems.

DIF: Understanding/Comprehension REF: 16
KEY: Assessment
MSC: Integrated Process: Teaching/Learning
NOT: Client Needs Category: Psychosocial Integrity

12. The most common causes of decreased comfort for a patient are pain and_____. a. light-headedness
b. nausea
c. emotional stress
d. depression

ANS: C
Pain and emotional stress are the two leading causes of discomfort for a patient. For example, patients who are having surgery are often anxious and feel stressed about the procedure. This emotional stress may negatively impact the outcome of surgery.

DIF: Understanding/Comprehension REF: 17
KEY: Assessment
MSC: Integrated Process: Teaching/Learning
NOT: Client Needs Category: Safe and Effective Care Environment

13. The inability to pass stool is known as_____.
a. constipation
b. obstipation
c. diarrhea
d. incontinence

ANS: B
Obstipation is the inability to pass stool during bowel elimination. Constipation refers to the condition where stool can be hard, dry, and difficult to pass through the rectum. Diarrhea is at the opposite end of the continuum from constipation, and occurs when stool is watery and without solid form. Elimination is the general term to describe the excretion of waste from the body by the gastrointestinal tract and by the urinary system.

DIF: Understanding/Comprehension REF: 18
KEY: Assessment
MSC: Integrated Process: Teaching/Learning
NOT: Client Needs Category: Health Promotion and Maintenance

14. Hypokalemia can occur in patients with prolonged diarrhea and is caused by a decrease in: a. calcium
b. magnesium
c. sodium
d. potassium

ANS: D
Hypokalemia occurs when there is a decrease in serum potassium. It can be a life-threatening condition because it often causes rhythm abnormalities. An excess of potassium is referred to as Hyperkalemia.

DIF: Understanding/Comprehension REF: 18
KEY: Assessment
MSC: Integrated Process: Teaching/Learning
NOT: Client Needs Category: Health Promotion and Maintenance

15. The minimum hourly urinary output in a patient should be at least:
a. 5 mL per hour
b. 10 mL per hour
c. 30 mL per hour
d. 60 mL per hour

ANS: C
30 mL per hour is the minimum hourly urinary output in a normal healthy adult. A decrease in urinary output i a sign of diminished kidney activity and fluid deficit.

DIF: Understanding/Comprehension REF: 20
KEY: Assessment
MSC: Integrated Process: Teaching/Learning
NOT: Client Needs Category: Health Promotion and Maintenance

16. The best indicator of fluid volume changes in the body is:
a. skin dryness
b. weight changes
c. blood pressure
d. pulse rate

ANS: C
Changes in weight are the best indicator of fluid volume changes in the body. Monitoring blood pressure, checking pulse rate and quality, and assessing skin and mucous membranes for dryness are strong secondary indicators.

DIF: Understanding/Comprehension REF: 20
KEY: Assessment
MSC: Integrated Process: Teaching/Learning
NOT: Client Needs Category: Health Promotion and Maintenance

17. Immunity which occurs when antibodies are passed from the mother to the fetus through the placenta or through breast milk is called: a. natural passive
b. artifical passive
c. natural active
d. artifical active

ANS: A
Artifical passive immunity occurs via a specific transfusion. Natural active immunity occurs when an antigen enters the body and the body creates antibodies to fight off the antigen. Artifical active immunity occurs via vaccination or immunization.

DIF: Understanding/Comprehension REF: 21-22
KEY: Assessment
MSC: Integrated Process: Teaching/Learning
NOT: Client Needs Category: Health Promotion and Maintenance

18. A major serum protein that is below normal in patients who have inadequate nutrition is: a. Albumin
b. Globulin
c. Fibrinogen
d. Transferrin

ANS: A
A serum laboratory test to measure Albumin is the most common assessment for generalized malnutrition.

DIF: Understanding/Comprehension REF: 25
KEY: Assessment
MSC: Integrated Process: Teaching/Learning
NOT: Client Needs Category: Health Promotion and Maintenance

Chapter 03: Common Health Problems of Older Adults

MULTIPLE CHOICE

1. A nurse working with older adults in the community plans programming to improve morale and emotional health in this population. What activity would best meet this goal? a. Exercise program to improve physical function
b. Financial planning seminar series for older adults
c. Social events such as dances and group dinners
d. Workshop on prevention from becoming an abuse victim

ANS: A
All activities would be beneficial for the older population in the community. However, failure in performing ones own activities of daily living and participating in society has direct effects on morale and life satisfaction. Those who lose the ability to function independently often feel worthless and empty. An exercise program designed to maintain and/or improve physical functioning would best address this need.

DIF: Applying/Application REF: 32
KEY: Independence| autonomy| older adult
MSC: Integrated Process: Nursing Process: Planning
NOT: Client Needs Category: Psychosocial Integrity

2. A nurse caring for an older client on a medical-surgical unit notices the client reports frequent constipation and only wants to eat softer foods such as rice, bread, and puddings. What assessment should the nurse perform first?
a. Auscultate bowel sounds.
b. Check skin turgor.
c. Perform an oral assessment.
d. Weigh the client.

ANS: C
Poorly fitting dentures and other dental problems are often manifested by a preference for soft foods and constipation from the lack of fiber. The nurse should perform an oral assessment to determine if these problems exist. The other assessments are important, but will not yield information specific to the clients food preferences as they relate to constipation.

DIF: Applying/Application REF: 30 KEY:
Nutrition| dentures| older adult
MSC: Integrated Process: Nursing Process: Assessment
NOT: Client Needs Category: Physiological Integrity: Basic Care and Comfort

3. A nursing faculty member working with students explains that the fastest growing subset of the older population is which group? a. Elite old
b. Middle old
c. Old old
d. Young old

ANS: C
The old old is the fastest growing subset of the older population. This is the group comprising those 85 to 99 years of age. The young old are between 65 and 74 years of age; the middle old are between 75 and 84 years of age; and the elite old are over 100 years of age.

DIF: Remembering/Knowledge REF: 29
KEY: Adulthood| aging| old old MSC: Integrated Process: Teaching/Learning NOT:
Client Needs Category: Health Promotion and Maintenance

4. A nurse is working with an older client admitted with mild dehydration. What teaching does the nurse provide to best address this issue?

a. Cut some sodium out of your diet.
b. Dehydration can cause incontinence.
c. Have something to drink every 1 to 2 hours.
d. Take your diuretic in the morning.

ANS: C
Older adults often lose their sense of thirst. Since they should drink 1 to 2 liters of water a day, the best remedy is to have the older adult drink something each hour or two, whether or not he or she is thirsty. Cutting some sodium from the diet will not address this issue. Although dehydration can cause incontinence from the irritation of concentrated urine, this information will not help prevent the problem of dehydration. Instructing the client to take a diuretic in the morning rather than in the evening also will not directly address this issue.

DIF: Applying/Application REF: 31
KEY: Dehydration| older adult| hydration MSC: Integrated Process: Teaching/Learning
NOT: Client Needs Category: Physiological Integrity: Physiological Adaptation

5. A nurse caring for an older adult has provided education on high-fiber foods. Which menu selection by the client demonstrates a need for further review? a. Barley soup
b. Black beans
c. White rice
d. Whole wheat bread

ANS: C
Older adults need 25 to 50 grams of fiber a day. White rice is low in fiber. Foods high in fiber include barley, beans, and whole wheat products.

DIF: Applying/Application REF: 31 KEY:
Nutrition| fiber| older adult
MSC: Integrated Process: Nursing Process: Evaluation
NOT: Client Needs Category: Physiological Integrity: Physiological Adaptation

6. A home health care nurse is planning an exercise program with an older client who lives at home independently but whose mobility issues prevent much activity outside the home. Which exercise regimen would be most beneficial to this adult? a. Building strength and flexibility
b. Improving exercise endurance
c. Increasing aerobic capacity
d. Providing personal training

ANS: A
This older adult is mostly homebound. Exercise regimens for homebound clients include things to increase functional ability for activities of daily living. Strength and flexibility will help the client to be able to maintain independence longer. The other plans are good but will not specifically maintain the clients functional abilities.

DIF: Applying/Application REF: 32
KEY: Exercise| functional ability| older adult
MSC: Integrated Process: Nursing Process: Planning
NOT: Client Needs Category: Physiological Integrity: Reduction of Risk Potential

7. An older adult recently retired and reports being depressed and lonely. What information should the nurse assess as a priority?
a. History of previous depression
b. Previous stressful events
c. Role of work in the adults life
d. Usual leisure time activities

ANS: C
Often older adults lose support systems when their roles change. For instance, when people retire, they may

lose their entire social network, leading them to feeling depressed and lonely. The nurse should first assess the role that work played in the clients life. The other factors can be assessed as well, but this circumstance is commonly seen in the older population.

DIF: Applying/Application REF: 32 KEY:
Depression| older adult
MSC: Integrated Process: Nursing Process: Assessment
NOT: Client Needs Category: Psychosocial Integrity

8. A nurse is assessing coping in older women in a support group for recent widows. Which statement by a participant best indicates potential for successful coping? a. I have had the same best friend for decades.
b. I think I am coping very well on my own.
c. My kids come to see me every weekend.
d. Oh, I have lots of friends at the senior center.

ANS: A
Friendship and support enhance coping. The quality of the relationship is what is most important, however. People who have close, intimate, stable relationships with others in whom they confide are more likely to cope with crisis.

DIF: Remembering/Knowledge REF: 32 KEY:
Coping| relationships| older adult
MSC: Integrated Process: Nursing Process: Assessment
NOT: Client Needs Category: Psychosocial Integrity

9. A home health care nurse has conducted a home safety assessment for an older adult. There are five concrete steps leading out from the front door. Which intervention would be most helpful in keeping the older adult safe on the steps?
a. Have the client use a walker or cane on the steps.
b. Install contrasting color strips at the edge of each step.
c. Instruct the client to use the garage door instead.
d. Tell the client to use a two-footed gait on the steps.

ANS: B
As a person ages, he or she may experience a decreased sense of touch. The older adult may not be aware of where his or her foot is on the step. Installing contrasting color strips at the end of each step will help increase awareness. If the client does not need an assistive device, he or she should not use one just on stairs. Using an alternative door may be necessary but does not address making the front steps safer. A two-footed gait may not help if the client is unaware of where the foot is on the step.

DIF: Applying/Application REF: 33 KEY:
Safety| falls| older adult
MSC: Integrated Process: Nursing Process: Implementation
NOT: Client Needs Category: Safe and Effective Care Environment: Safety and Infection Control

10. An older adult is brought to the emergency department because of sudden onset of confusion. After the client is stabilized and comfortable, what assessment by the nurse is most important? a. Assess for orthostatic hypotension.
b. Determine if there are new medications.
c. Evaluate the client for gait abnormalities.
d. Perform a delirium screening test.

ANS: B
Medication side effects and adverse effects are common in the older population. Something as simple as a new antibiotic can cause confusion and memory loss. The nurse should determine if the client is taking any new medications. Assessments for orthostatic hypotension, gait abnormalities, and delirium may be important once more is known about the clients condition.
DIF: Applying/Application REF: 33
KEY: Medications| medication safety| older adult MSC:

Integrated Process: Nursing Process: Assessment
NOT: Client Needs Category: Physiological Integrity: Pharmacological and Parenteral Therapies

11. An older adult client takes medication three times a day and becomes confused about which medication should be taken at which time. The client refuses to use a pill sorter with slots for different times, saying Those are for old people. What action by the nurse would be most helpful? a. Arrange medications by time in a drawer.
b. Encourage the client to use easy-open tops.
c. Put color-coded stickers on the bottle caps.
d. Write a list of when to take each medication.

ANS: C
Color-coded stickers are a fast, easy-to-remember system. One color is for morning meds, one for evening meds, and the third color is for nighttime meds. Arranging medications by time in a drawer might be helpful if the person doesnt accidentally put them back in the wrong spot. Easy-open tops are not related. Writing a list might be helpful, but not if it gets misplaced. With stickers on the medication bottles themselves, the reminder is always with the medication.

DIF: Applying/Application REF: 34
KEY: Medications| medication safety| older adult
MSC: Integrated Process: Nursing Process: Implementation
NOT: Client Needs Category: Safe and Effective Care Environment: Safety and Infection Control

12. An older adult client is in the hospital. The client is ambulatory and independent. What intervention by the nurse would be most helpful in preventing falls in this client? a. Keep the light on in the bathroom at night.
b. Order a bedside commode for the client.
c. Put the client on a toileting schedule.
d. Use siderails to keep the client in bed.

ANS: A
Although this older adult is independent and ambulatory, being hospitalized can create confusion. Getting up in a dark, unfamiliar environment can contribute to falls. Keeping the light on in the bathroom will help reduce the likelihood of falling. The client does not need a commode or a toileting schedule. Siderails used to keep the client in bed are considered restraints and should not be used in that fashion.

DIF: Applying/Application REF: 41 KEY:
Falls| safety| older adult
MSC: Integrated Process: Nursing Process: Implementation
NOT: Client Needs Category: Safe and Effective Care Environment: Safety and Infection Control

13. An older client had hip replacement surgery and the surgeon prescribed morphine sulfate for pain. The client is allergic to morphine and reports pain and muscle spasms. When the nurse calls the surgeon, which medication should he or she suggest in place of the morphine? a. Cyclobenzaprine (Flexeril)
b. Hydromorphone hydrochloride (Dilaudid)
c. Ketorolac (Toradol)
d. Meperidine (Demerol)

ANS: B
Cyclobenzaprine (used for muscle spasms), ketorolac, and meperidine (both used for pain) are all on the Beers list of potentially inappropriate medications for use in older adults and should not be suggested. The nurse should suggest hydromorphone hydrochloride.

DIF: Remembering/Knowledge REF: 36 KEY:
Medications| Beers list| older adult
MSC: Integrated Process: Communication and Documentation
NOT: Client Needs Category: Physiological Integrity: Pharmacological and Parenteral Therapies

14. A nurse admits an older client from a home environment where she lives with her adult son and daughter- in-law. The client has urine burns on her skin, no dentures, and several pressure ulcers. What action by the nurse is most appropriate?

a. Ask the family how these problems occurred.
b. Call the police department and file a report.
c. Notify Adult Protective Services.
d. Report the findings as per agency policy.

ANS: D
These findings are suspicious for abuse. Health care providers are mandatory reporters for suspected abuse. The nurse should notify social work, case management, or whomever is designated in policies. That person can then assess the situation further. If the police need to be notified, that is the person who will notify them. Adult Protective Services is notified in the community setting.

DIF: Applying/Application REF: 39 KEY:
Abuse| older adult
MSC: Integrated Process: Communication and Documentation
NOT: Client Needs Category: Safe and Effective Care Environment: Management of Care

15. A nurse caring for an older client in the hospital is concerned the client is not competent to give consent for upcoming surgery. What action by the nurse is best? a. Call Adult Protective Services.
b. Discuss concerns with the health care team.
c. Do not allow the client to sign the consent.
d. Have the clients family sign the consent.

ANS: B
In this situation, each facility will have a policy designed for assessing competence. The nurse should bring these concerns to an interdisciplinary care team meeting. There may be physiologic reasons for the client to be temporarily too confused or incompetent to give consent. If an acute condition is ruled out, the staff should follow the legal procedure and policies in their facility and state for determining competence. The key is to bring the concerns forward. Calling Adult Protective Services is not appropriate at this time. Signing the consent should wait until competence is determined unless it is an emergency, in which case the next of kin can sign if there are grave doubts as to the clients ability to provide consent.

DIF: Applying/Application REF: 36 KEY:
Competence| autonomy| older adult
MSC: Integrated Process: Communication and Documentation
NOT: Client Needs Category: Safe and Effective Care Environment: Management of Care

MULTIPLE RESPONSE

1. A nursing student working in an Adult Care for Elders unit learns that frailty in the older population includes which components? (Select all that apply.) a. Dementia
b. Exhaustion
c. Slowed physical activity
d. Weakness
e. Weight gain

ANS: B, C, D
Frailty is a syndrome consisting of unintentional weight loss, slowed physical activity and exhaustion, and weakness. Weight gain and dementia are not part of this cluster of manifestations.

DIF: Remembering/Knowledge REF: 29 KEY:
Frailty| frail elderly| older adult
MSC: Integrated Process: Nursing Process: Assessment

NOT: Client Needs Category: Health Promotion and Maintenance

2. A home health care nurse assesses an older client for the intake of nutrients needed in larger amounts than in younger adults. Which foods found in an older adults kitchen might indicate an adequate intake of these nutrients? (Select all that apply.) a. 1% milk
b. Carrots
c. Lean ground beef
d. Oranges
e. Vitamin D supplements

ANS: A, B, D, E
Older adults need increased amounts of calcium; vitamins A, C, and D; and fiber. Milk has calcium; carrots have vitamin A; the vitamin D supplement has vitamin D; and oranges have vitamin C. Lean ground beef is healthier than more fatty cuts, but does not contain these needed nutrients.

DIF: Applying/Application REF: 30
KEY: Nutrition| nutritional requirements| older adults MSC:
Integrated Process: Nursing Process: Assessment
NOT: Client Needs Category: Physiological Integrity: Basic Care and Comfort

3. A nurse working with older adults assesses them for common potential adverse medication effects. For what does the nurse assess? (Select all that apply.) a. Constipation
b. Dehydration
c. Mania
d. Urinary incontinence
e. Weakness

ANS: A, B, E
Common adverse medication effects include constipation/impaction, dehydration, and weakness. Mania and incontinence are not among the common adverse effects, although urinary retention is.

DIF: Remembering/Knowledge REF: 34 KEY:
Medications| adverse effects
MSC: Integrated Process: Nursing Process: Assessment
NOT: Client Needs Category: Physiological Integrity: Pharmacological and Parenteral Therapies

4. A nurse manager institutes the Fulmer Spices Framework as part of the routine assessment of older adults in the hospital. The nursing staff assesses for which factors? (Select all that apply.) a. Confusion
b. Evidence of abuse
c. Incontinence
d. Problems with behavior
e. Sleep disorders

ANS: A, C, E
SPICES stands for sleep disorders, problems with eating or feeding, incontinence, confusion, and evidence of falls.

DIF: Remembering/Knowledge REF: 40 KEY:
SPICES| older adult
MSC: Integrated Process: Nursing Process: Assessment
NOT: Client Needs Category: Physiological Integrity: Reduction of Risk Potential

5. A visiting nurse is in the home of an older adult and notes a 7-pound weight loss since last months visit. What actions should the nurse perform first? (Select all that apply.) a. Assess the clients ability to drive or transportation alternatives.
b. Determine if the client has dentures that fit appropriately.

c. Encourage the client to continue the current exercise plan.
d. Have the client complete a 3-day diet recall diary.
e. Teach the client about proper nutrition in the older population.

ANS: A, B, D

Assessment is the first step of the nursing process and should be completed prior to intervening. Asking about transportation, dentures, and normal food patterns would be part of an appropriate assessment for the client. There is no information in the question about the older adult needing to lose weight, so encouraging him or her to continue the current exercise regimen is premature and may not be appropriate. Teaching about proper nutrition is a good idea, but teaching needs to be tailored to the clients needs, which the nurse does not yet know.

DIF: Applying/Application REF: 30 KEY:
Nutrition| older adult

MSC: Integrated Process: Nursing Process: Assessment

NOT: Client Needs Category: Physiological Integrity: Physiological Adaptation

6. A hospitalized older adult has been assessed at high risk for skin breakdown. Which actions does the registered nurse (RN) delegate to the unlicensed assistive personnel (UAP)? (Select all that apply.) a. Assess skin redness when turning.
b. Document Braden Scale results.
c. Keep the clients skin dry.
d. Obtain a pressure-relieving mattress.
e. Turn the client every 2 hours.

ANS: C, D, E

The nurses aide or UAP can assist in keeping the clients skin dry, order a special mattress on direction of the RN, and turn the client on a schedule. Assessing the skin is a nursing responsibility, although the aide should be directed to report any redness noticed. Documenting the Braden Scale results is the RNs responsibility as the RN is the one who performs that assessment.

DIF: Applying/Application REF: 42
KEY: Skin breakdown| older adult| delegation| unlicensed assistive personnel MSC:
Integrated Process: Communication and Documentation

NOT: Client Needs Category: Safe and Effective Care Environment: Management of Care

7. A nurse admits an older client to the hospital who lives at home with family. The nurse assesses that the client is malnourished. What actions by the nurse are best? (Select all that apply.) a. Contact Adult Protective Services or hospital social work.
b. Notify the provider that the client needs a tube feeding.
c. Perform and document results of a Braden Scale assessment.
d. Request a dietary consultation from the health care provider.
e. Suggest a high-protein oral supplement between meals.

ANS: C, D, E

Malnutrition in the older population is multifactorial and has several potential adverse outcomes. Appropriate actions by the nurse include assessing the clients risk for skin breakdown with the Braden Scale, requesting a consultation with a dietitian, and suggesting a high-protein meal supplement. There is no evidence that the client is being abused or needs a feeding tube at this time.

DIF: Applying/Application REF: 40
KEY: Nutrition| malnutrition| older adult| Braden Scale MSC:
Integrated Process: Nursing Process: Implementation

NOT: Client Needs Category: Safe and Effective Care Environment: Management of Care

Chapter 04: Assessment and Care of Patients with Pain

MULTIPLE CHOICE

1. A student asks the nurse what is the best way to assess a clients pain. Which response by the nurse is best? a. Numeric pain scale
b. Behavioral assessment
c. Objective observation
d. Clients self-report

ANS: D
Many ways to measure pain are in use, including numeric pain scales, behavioral assessments, and other objective observations. However, the most accurate way to assess pain is to get a self-report from the client.

DIF: Remembering/Knowledge REF: 46 KEY:
Pain| pain assessment
MSC: Integrated Process: Nursing Process: Assessment
NOT: Client Needs Category: Health Promotion and Maintenance

2. A new nurse reports to the precepting nurse that a client requested pain medication, and when the nurse brought it, the client was sound asleep. The nurse states the client cannot possibly sleep with the severe pain the client described. What response by the experienced nurse is best? a. Being able to sleep doesnt mean pain doesnt exist.
b. Have you ever experienced any type of pain?
c. The client should be assessed for drug addiction.
d. Youre right; I would put the medication back.

ANS: A
A clients description is the most accurate assessment of pain. The nurse should believe the client and provide pain relief. Physiologic changes due to pain vary from client to client, and assessments of them should not supersede the clients descriptions, especially if the pain is chronic in nature. Asking if the new nurse has had pain is judgmental and flippant, and does not provide useful information. This amount of information does not warrant an assessment for drug addiction. Putting the medication back and ignoring the clients report of pain serves no useful purpose.

DIF: Understanding/Comprehension REF: 49
KEY: Pain| pain assessment
MSC: Integrated Process: Communication and Documentation NOT:
Client Needs Category: Health Promotion and Maintenance

3. The nurse in the surgery clinic is discussing an upcoming surgical procedure with a client. What information provided by the nurse is most appropriate for the clients long-term outcome? a. At least you know that the pain after surgery will diminish quickly.
b. Discuss acceptable pain control after your operation with the surgeon.
c. Opioids often cause nausea but you wont have to take them for long.
d. The nursing staff will give you pain medication when you ask them for it.

ANS: B
The best outcome after a surgical procedure is timely and satisfactory pain control, which diminishes the likelihood of chronic pain afterward. The nurse suggests that the client advocate for himself and discuss acceptable pain control with the surgeon. Stating that pain after surgery is usually short lived does not provide the client with options to have personalized pain control. To prevent or reduce nausea and other side effects from opioids, a multimodal pain approach is desired. For acute pain after surgery, giving pain medications around the clock instead of waiting until the client requests it is a better approach.

DIF: Applying/Application REF: 47 KEY:
Pain| acute pain
MSC: Integrated Process: Teaching/Learning

NOT: Client Needs Category: Health Promotion and Maintenance

4. A nurse is assessing pain on a confused older client who has difficulty with verbal expression. What pain assessment tool would the nurse choose for this assessment? a. Numeric rating scale
b. Verbal Descriptor Scale
c. FACES Pain Scale-Revised
d. Wong-Baker FACES Pain Scale

ANS: C
All are valid pain rating scales; however, some research has shown that the FACES Pain Scale-Revised is preferred by both cognitively intact and cognitively impaired adults.

DIF: Applying/Application REF: 51 KEY:
Pain assessment| FACES
MSC: Integrated Process: Nursing Process: Assessment
NOT: Client Needs Category: Health Promotion and Maintenance

5. The nurse is assessing a clients pain and has elicited information on the location, quality, intensity, effect on functioning, aggravating and relieving factors, and onset and duration. What question by the nurse would be best to ask the client for completing a comprehensive pain assessment? a. Are you worried about addiction to pain pills?
b. Do you attach any spiritual meaning to pain?
c. How high would you say your pain tolerance is?
d. What pain rating would be acceptable to you?

ANS: D
A comprehensive pain assessment includes the items listed in the question plus the clients opinion on a functional goal, such as what pain rating would be acceptable to him or her. Asking about addiction is not warranted in an initial pain assessment. Asking about spiritual meanings for pain may give the nurse important information, but getting the basics first is more important. Asking about pain tolerance may give the client the idea that pain tolerance is being judged.

DIF: Applying/Application REF: 50 KEY:
Pain assessment
MSC: Integrated Process: Nursing Process: Assessment
NOT: Client Needs Category: Physiological Integrity: Reduction of Risk Potential

6. A nurse is assessing pain in an older adult. What action by the nurse is best?
a. Ask only yes-or-no questions so the client doesnt get too tired.
b. Give the client a picture of the pain scale and come back later.
c. Question the client about new pain only, not normal pain from aging.
d. Sit down, ask one question at a time, and allow the client to answer.

ANS: D
Some older clients do not report pain because they think it is a normal part of aging or because they do not want to be a bother. Sitting down conveys time, interest, and availability. Ask only one question at a time and allow the client enough time to answer it. Yes-or-no questions are an example of poor communication technique. Giving the client a pain scale, then leaving, might give the impression that the nurse does not have time for the client. Plus the client may not know how to use it. There is no normal pain from aging.

DIF: Applying/Application REF: 53 KEY:
Pain assessment| older adult
MSC: Integrated Process: Communication and Documentation
NOT: Client Needs Category: Psychosocial Integrity

7. The nurse receives a hand-off report. One client is described as a drug seeker who is obsessed with even tiny changes in physical condition and is on the light constantly asking for more pain medication. When assessing this clients pain, what statement or question by the nurse is most appropriate?