

# Silvestri: Saunders Comprehensive Review for the NCLEX-PN® Examination, 4<sup>th</sup> Edition

## Chapter 7: Ethical and Legal Issues

### Test Bank

#### MULTIPLE CHOICE

1. A nurse who works on the night shift enters the medication room and finds a co-worker with a tourniquet wrapped around the upper arm. The co-worker is about to insert a needle, attached to a syringe containing a clear liquid, into the antecubital area. The appropriate initial action by the nurse is which of the following?
  1. Call the police.
  2. Call security.
  3. Lock the co-worker in the medication room until help is obtained.
  4. Call the nursing supervisor.

ANS: 4

**Rationale:** Nurse practice acts require reporting impaired nurses. The board of nursing has jurisdiction over the practice of nursing and may develop plans for treatment and supervision. This incident needs to be reported to the nursing supervisor, who will then report to the board of nursing and other authorities as required. Option 3 is an inappropriate and unsafe action. Security may be called if a disturbance occurs, but there are no data in the question to support this. Therefore, this is not the appropriate initial action.

**Test-Taking Strategy:** Use the principles of prioritizing when answering this question. Note the strategic words “appropriate initial” in the query of the question. Eliminate option 3 first because this is an inappropriate and unsafe action. Recall the lines of organization structure to assist in directing you to option 4. If you had difficulty with this question, review the nurse’s responsibilities when substance abuse is suspected or occurs.

DIF: Level of Cognitive Ability: Application

REF: Harkreader, H., & Hogan, M. (2007). Fundamentals of nursing care (3rd ed.). St. Louis: Saunders. OBJ: Client Needs: Safe and Effective Care Environment

TOP: Content Area: Fundamental Skills

MSC: Integrated Process: Nursing Process/Implementation

2. A licensed practical nurse (LPN) is providing instructions to a nursing assistant who is preparing to care for a deceased client whose eyes will be donated. The nurse intervenes if the nursing assistant does which of the following?
  1. Elevates the head of the bed
  2. Closes the client’s eyes
  3. Places wet saline gauze pads and an ice pack on the eyes
  4. Closes the client’s eyes and places a dry sterile dressing over the eyes

ANS: 4

**Rationale:** When a corneal donor dies, the eyes are closed and gauze pads wet with saline are placed over them with a small ice pack. Within 2 to 4 hours the eyes are enucleated. The cornea is usually transplanted within 24 to 48 hours. The head of the bed should also be elevated. Option 4 would be an incorrect action by the nursing assistant.

**Test-Taking Strategy:** Note that the subject relates to donation of the eyes. Also note the strategic words “the nurse intervenes” in the query of the question. These words indicate a negative event query and the need to select the incorrect action by the nursing assistant. This should assist in directing you to option 4. Review this procedure if you had difficulty with the question.

DIF: Level of Cognitive Ability: Application

REF: Lewis, S., Heitkemper, M., & Dirksen, S. (2007). *Medical-surgical nursing: Assessment and management of clinical problems* (7th ed.). St. Louis: Mosby.

OBJ: Client Needs: Safe and Effective Care Environment

TOP: Content Area: Fundamental Skills

MSC: Integrated Process: Teaching and Learning

3. A hospitalized client tells the nurse that a living will is being prepared and that the lawyer will be bringing the will to the hospital today for witness signatures. The client asks the nurse for assistance in obtaining a witness to the will. The appropriate response to the client is which of the following?
1. “I will sign as a witness to your signature.”
  2. “You will need to find a witness on your own.”
  3. “I will call the nursing supervisor to seek assistance regarding your request.”
  4. “Whoever is available at the time will sign as a witness for you.”

ANS: 3

**Rationale:** Living wills are required to be in writing and signed by the client. The client’s signature must be either witnessed by specified individuals or notarized. Many states prohibit any employee, including a nurse of a facility where the declaring is receiving care, from being a witness. Option 2 is nontherapeutic and not a helpful response. The nurse should seek the assistance of the nursing supervisor.

**Test-Taking Strategy:** Use the process of elimination. Options 1 and 4 are comparable or alike and should be eliminated first. Option 2 is eliminated because it is a nontherapeutic response. Review legal implications associated with wills if you had difficulty with this question.

DIF: Level of Cognitive Ability: Application

REF: Harkreader, H., & Hogan, M. (2007). *Fundamentals of nursing care* (3rd ed.). St. Louis: Saunders.

OBJ: Client Needs: Safe and Effective Care Environment

TOP: Content Area: Fundamental Skills

MSC: Integrated Process: Nursing Process/Implementation

4. A nurse is assigned to care for a newly admitted client and is reviewing the physician’s orders. The nurse notes that the physician has prescribed a medication dose that is twice the amount that the client reports taking prior to admission. The appropriate nursing action is to:

1. Question the client regarding the accuracy of the reported dosage.
2. Consult with the registered nurse (RN).
3. Administer the medication as prescribed.
4. Administer half of the prescribed dose and then notify the RN.

ANS: 2

**Rationale:** If the nurse determines that a physician's order is unclear or if the nurse has a question about an order, the nurse should consult with the RN, who will then contact the physician before implementing the order. Under no circumstances should the nurse carry out the order unless the order is clarified. Questioning the client regarding the accuracy of the dosage of the medication may seem like a viable option, but this action may also cause the client to become upset. The nurse would not administer the medication, nor would the nurse administer an altered dosage.

**Test-Taking Strategy:** Use the process of elimination to answer the question. Eliminate options 3 and 4 first by applying general principles related to medication administration and safety. For the remaining options, select option 2 because this is the action that will clarify the order and ensure a safe environment for the client. Review nursing guidelines related to implementing a physician's orders if you had difficulty with this question.

DIF: Level of Cognitive Ability: Application

REF: Harkreader, H., & Hogan, M. (2007). *Fundamentals of nursing* (3rd ed.). St. Louis: Saunders.

OBJ: Client Needs: Safe and Effective Care Environment

TOP: Content Area: Fundamental Skills

MSC: Integrated Process: Nursing Process/Implementation

5. A nurse is caring for a client with severe cardiac disease. While the nurse is caring for the client, the client states, "If anything should happen to me, please make sure that the doctors do not try to push on my chest and revive me." The appropriate nursing action is to:
  1. Tell the client that this procedure cannot legally be refused by a client if the physician feels that it is necessary to save the client's life.
  2. Tell the client that it is necessary to notify the physician of the client's request.
  3. Tell the client that the family must agree with the request.
  4. Plan a client conference with the nursing staff to share the client's request.

ANS: 2

**Rationale:** External cardiac massage is one type of treatment that a client can refuse. The most appropriate nursing action is to notify the physician because a written do not resuscitate (DNR) order from the physician must be present on the client's record. The DNR order must be reviewed or renewed on a regular basis per agency policy. Options 1 and 3 are inaccurate. Option 4 may be appropriate, but only after the physician is contacted and notified of the client's request.

**Test-Taking Strategy:** Focus on the subject, which is a DNR order. Options 1 and 3 are inaccurate and can be eliminated first. For the remaining options, the priority is to contact the physician. Review DNR procedures if you had difficulty with this question.

DIF: Level of Cognitive Ability: Application

REF: Harkreader, H., & Hogan, M. (2007). Fundamentals of nursing (3rd ed.). St. Louis: Saunders. OBJ: Client Needs: Safe and Effective Care Environment  
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MSC: Integrated Process: Nursing Process/Implementation

6. An adult client is brought to the emergency department by the emergency medical services team after being hit by a car. The name of the client is not known. The client has sustained a severe head injury and multiple fractures and is unconscious. An emergency craniotomy is required. In regard to informed consent for the surgical procedure, which of the following is the best initial action?
1. Call the police to identify the client and locate the family.
  2. Obtain a court order for the surgical procedure.
  3. Ask the emergency medical services team to sign the informed consent.
  4. Transport the victim to the operating room for surgery.

ANS: 4

**Rationale:** Generally there are only two instances in which the informed consent of an adult client is not needed. One instance is when an emergency is present and delaying treatment for the purpose of obtaining informed consent would result in injury or death to the client. The second instance is when the client waives the right to give informed consent. Option 2 is unnecessary, and option 3 is inappropriate. Although option 1 may be pursued, it is not the best initial action.

**Test-Taking Strategy:** Use the process of elimination, and note the strategic words “best initial action.” Recall that when an emergency is present, delaying treatment for the purpose of obtaining informed consent will result in injury or death. This will direct you to option 4. Review the issues surrounding informed consent if you had difficulty with this question.

DIF: Level of Cognitive Ability: Application

REF: Harkreader, H., & Hogan, M. (2007). Fundamentals of nursing (3rd ed.). St. Louis: Saunders. OBJ: Client Needs: Safe and Effective Care Environment  
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7. A client brought to the emergency department is dead on arrival (DOA). The family of the client tells the physician that the client had terminal cancer. The emergency department physician examines the client and asks the nurse to contact the medical examiner regarding an autopsy. The family of the client tells the nurse that they do not want an autopsy performed. Which response to the family is appropriate?
1. “It is required by federal law. Why don’t we talk about it, and why don’t you tell me how you feel?”
  2. “The decision is made by the medical examiner.”
  3. “I will contact the medical examiner regarding your request.”
  4. “An autopsy is mandatory for any client who is DOA.”

ANS: 3

**Rationale:** An autopsy is required by state law in certain circumstances, including the sudden death of a client and a death that occurs under suspicious circumstances. The client may have provided oral or written instructions regarding an autopsy following death. If an autopsy is not required by law, these oral or written requests will be granted. If no oral or written instructions were provided, state law determines who has the authority to consent for an autopsy. Most often, the decision rests with the surviving relative or next of kin.

**Test-Taking Strategy:** Use knowledge regarding the laws and issues surrounding autopsy and therapeutic communication techniques to answer the question. Eliminate options 1 and 4 because these statements are not completely accurate. For the remaining options, option 3 is the therapeutic and appropriate response to the family. Review the issues and laws surrounding autopsy if you had difficulty with this question.

DIF: Level of Cognitive Ability: Application

REF: Harkreader, H., & Hogan, M. (2007). Fundamentals of nursing (3rd ed.). St.

Louis: Saunders. OBJ: Client Needs: Safe and Effective Care Environment

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8. A nurse witnesses an accident on a highway and stops to provide assistance to the victim. The nurse notes that the client sustained a head injury and a compound fracture to the left leg. The nurse provides the appropriate care prior to transport of the victim to the hospital by ambulance. The client develops a severe bone infection at the site of the fracture that requires amputation of the leg and files suit against the nurse who provided care at the scene of the accident. Which of the following is accurate regarding the nurse's immunity from this suit?
1. A Good Samaritan law will protect the nurse.
  2. A Good Samaritan law will not protect the nurse.
  3. A Good Samaritan law will provide immunity from suit even if the nurse accepted compensation for the care provided.
  4. A Good Samaritan law protects laypersons and not professional health care providers.

ANS: 1

**Rationale:** A Good Samaritan law is passed by state legislators to encourage nurses and other health care providers to provide care to a person when an accident, emergency, or injury occurs, without fear of being sued for the care provided. Its protection lies in preventing nurses or other health care providers from being sued for negligence in the care provided at the scene of the accident or during the emergency, even if further injury occurred because of the health care providers' care. Called immunity from suit, this protection usually applies only if all of the conditions of the law are met, such as that the health care provider receives no compensation for the care provided and that the care given is not willfully and wantonly negligent.

**Test-Taking Strategy:** Knowledge regarding the issues surrounding a Good Samaritan law is required to answer this question. Eliminate options 2 and 4 because they are comparable or alike. For the remaining options focus on the data in the question to direct you to option 1. Review the Good Samaritan law if you had difficulty with this question.

DIF: Level of Cognitive Ability: Comprehension

REF: Harkreader, H., & Hogan, M. (2007). Fundamentals of nursing (3rd ed.). St.

Louis: Saunders. OBJ: Client Needs: Safe and Effective Care Environment

TOP: Content Area: Fundamental Skills

MSC: Integrated Process: Nursing Process/Evaluation