HESI MED SURG PROCTORED EXAM 2023/2024 QUESTIONS AND ANSWERS GRADED A LATEST VERSION DOWNLOAD TO SCORE A

1. The nurse is caring for a patient with a wound. The patient appears anxious as the nurse is preparing to change the dressing. Which action should the nurse take?
   a. Turn on the television.
   b. Explain the procedure.
   c. Tell the patient "Close your eyes."
   d. Ask the family to leave the room.

ANS: B

Explaining the procedure educates the patient regarding the dressing change and involves him in the care, thereby allowing the patient some control in decreasing anxiety. Telling the patient to close the eyes and turning on the television are distractions that do not usually decrease a patient's anxiety. If the family is a support system, asking support systems to leave the room can actually increase a patient's anxiety.

2. The nurse is cleansing a wound site. As the nurse administers the procedure, which intervention should be included?
   a. Allow the solution to flow from the most contaminated to the least contaminated.
   b. Scrub vigorously when applying noncytotoxic solution to the skin.
   c. Cleanse in a direction from the least contaminated area.
   d. Utilize clean gauze and clean gloves to cleanse a site.

ANS: C

Cleanse in a direction from the least contaminated area, such as from the wound or incision, to the surrounding skin. While cleansing surgical or traumatic wounds by applying noncytotoxic solution with sterile gauze or by irrigations is correct, vigorous scrubbing is inappropriate and can cause damage to the skin. Use gentle friction when applying solutions to the skin, and allow irrigation to flow from the least to the most contaminated area.

3. The nurse is caring for a patient after an open abdominal aortic aneurysm repair. The nurse requests an abdominal binder and carefully applies the binder. Which is the **best** explanation for the nurse to use when teaching the patient the reason for the binder?

a. It reduces edema at the surgical site.

b. It secures the dressing in place.
c. It immobilizes the abdomen.
d. It supports the abdomen.

ANS: D

The patient has a large abdominal incision. This incision will need support, and an abdominal binder will support this wound, especially during movement, as well as during deep breathing and coughing. A binder can be used to immobilize a body part (e.g., an elastic bandage applied around a sprained ankle). A binder can be used to prevent edema, for example, in an extremity but in this case is not used to reduce edema at a surgical site. A binder can be used to secure dressings such as elastic webbing applied around a leg after vein stripping.

4. The nurse is caring for a postoperative medial meniscus repair of the right knee. Which action should the nurse take to assist with pain management?

a. Monitor vital signs every 15 minutes.

b. Check pulses in the right foot.
c. Keep the leg dependent.
d. Apply ice.

ANS: D

Ice assists in preventing edema formation, controlling bleeding, and anesthetizing the body part. Elevation (not dependent) assists in preventing edema, which in turn can cause pain. Monitoring vital signs every 15 minutes is routine postoperative care and includes a pain assessment but in itself is not an intervention that decreases pain. Checking the pulses is important to monitor the circulation of the extremity but in itself is not a pain management intervention.

5. The patient has a risk for skin impairment and has a 15 on the Braden Scale upon admission. The nurse has implemented interventions. Upon reassessment, which Braden score will be the **best** sign that the risk for skin breakdown is removed?

a. 12
b. 13
c. 20

d. 23

ANS: D

The best sign is a perfect score of 23. The Braden Scale is composed of six subscales: sensory perception, moisture, activity, mobility, nutrition, and friction and shear. The total score ranges from 6 to 23, and a lower total score indicates a higher risk for pressure ulcer development. The cutoff score for onset of pressure ulcer risk with the Braden Scale in the general adult population is 18.

MULTIPLE RESPONSE

1. The nurse is caring for a patient with a surgical incision that eviscerates. Which actions will the nurse take? (*Select all that apply*.)

a. Place moist sterile gauze over the site.

b. Gently place the organs back.

c. Contact the surgical team.

d. Offer a glass of water.

e. Monitor for shock.

ANS: A, C, E

The presence of an evisceration (protrusion of visceral organs through a wound opening) is a surgical emergency. Immediately place damp sterile gauze over the site, contact the surgical team, do not allow the patient anything by mouth (NPO), observe for signs and symptoms of shock, and prepare the patient for emergency surgery.

2. The nurse is caring for a patient with a wound healing by full-thickness repair. Which phases will the nurse monitor for in this patient? (*Select all that apply*.)

a. Hemostasis

b. Maturation

c. Inflammatory

d. Proliferative

e. Reproduction

f. Reestablishment of epidermal layers

ANS: A, B, C, D

The four phases involved in the healing process of a full-thickness wound are hemostasis, inflammatory, proliferative, and maturation. Three components are involved in the healing process of a partial-thickness wound: inflammatory response, epithelial proliferation (reproduction) and migration, and reestablishment of the epidermal layers.

3. The nurse is completing a skin assessment on a medical-surgical patient. Which nursing assessment questions should be included in a skin integrity assessment? (*Select all that apply*.)

a. "Can you easily change your position?"

b. "Do you have sensitivity to heat or cold?"

c. "How often do you need to use the toilet?"

d. "What medications do you take?"

e. "Is movement painful?"

f. "Have you ever fallen?"

ANS: A, B, C, E

Changing positions is important for decreasing the pressure associated with long periods of time in the same position. If the patient is able to feel heat or cold and is mobile, she can protect herself by withdrawing from the source. Knowing toileting habits and any potential for incontinence is important because urine and feces in contact with the skin for long periods can increase skin breakdown. Knowing whether the patient has problems with painful movement will alert the nurse to any potential for decreased movement and increased risk for skin breakdown. Medications and falling are safety risk questions.

4. The nurse is caring for a patient with potential skin breakdown. Which components will the nurse include in the skin assessment? (*Select all that apply*.)

a. Vision

b. Hyperemia

c. Induration

d. Blanching

e. Temperature of skin

ANS: B, C, D, E

Assessment of the skin includes both visual and tactile inspection. Assess for hyperemia and palpate for blanching or nonblaching. Early signs of skin damage include induration, bogginess (less-than-normal stiffness), and increased warmth at the injury site compared to nearby areas. Changes in temperature can indicate changes in blood flow to that area of the skin. Vision is not included in the skin assessment