ALL COMPLETED VERSIONS

ATI LEADERSHIP PROCTORED EXAM

VERSION 1

A nurse manager is preparing to institute a new system for scheduling staff. Several nurses have verbalized their concern over the possible changes that will occur. Which of the following is an appropriate method to facilitate the adoption of the new scheduling system?

A. Identify nurses who accept the change to help influence other staff nurses
B. Provide a brief overview of the new scheduling system immediately before it implementation
C. Introduce the new scheduling system by describing how it will save the institution money
D. Offer to reassign staff who do not support the change to another unit

2. A client who is febrile is admitted to the hospital for treatment of pneumonia. In accordance with the care pathway, antibiotic therapy is prescribed. Which of the following situations requires the nurse to complete a variance report with regard to the care pathway?

A. Antibiotic therapy was initiated 2 hr after implementation of the care pathway
B. A blood culture was obtained after antibiotic therapy has been initiated
C. The route of antibiotic therapy on the care pathway was changed from IV to PO
D. An allergy to penicillin required an alternative antibiotic to be prescribed.

3. A nurse should recognize that an incident report is required when

A. A client refuses to attend physical therapy
B. A visitor pinches his finger in the client's bed frame
C. A client throws a box of tissues at a nurse
D. A nurse gives a med 30 min late

5. Client satisfactory surveys from a med-surg unit indicate the pain is not being adequately relieved during the first 12 hr post-opt. The unit manager decides to identify post-opt pain as a quality indicator. Which of the following data sources will be helpful in determine the reason why clients are not receiving adequate pain management after surgery?

A. Prospective chart audit
B. Retrospective chart audit
C. Postoperative care policy
D. Pain assessment policy

6. A nurse precepting a newly licenced nurse who is caring for a client who is confused and has an IV infusion. The newly licensed nurse has placed the client in wrist restraints to prevent dislodging the IV catheter. Which of the following questions should the precepting nurse ask?

A. "Did you secure the restraints to the side rails of the bed?"
B. "Are you able to insert two fingers between the restraint and the client's skin?"
C. "Did you tie the restraints using double knot?"
D. "Are you removing the client's restraints every 4 hr?"

7. A nurse is caring for an older adult client who has stage III pressure ulcer. The nurse request a consultation with the wound care specialist. Which of the following actions by the nurse is appropriate when working with a consultant?

A. Arrange the consultation for time when the nurse is caring for the client is able to be present for consultation
B. Provide the consultant with subjective opinions and beliefs about the client's wound care
C. Request the consultation after several wound care treatment tried
D. Arrange for the wound care nurse specialist to see the client daily to provide the recommended treatment

8. A client is admitted wit TB and placed in a negative pressure room. Which of the following actions is appropriate?

A. Notify the local health department of the admission
B. Place a sign on the client's door with the diagnosis
C. Ensure that admitting staff undergo PPD skin tests
D. Determine who had contact with the client in the last 48 hr

9. A nurse is caring for a client who is unconscious and whose partner is health care proxy. The partner has spoken with the provider and wishes to discontinue the client's feeding tube. The provider states the nurse, "I will not discontinue the client's treatment. His partner has no right to make decisions regarding the client's care. "Which of the following responses by the nurse is appropriate?

A. You should consider speaking with the facility's ethics committee before making your decision
B. You have the right to make decision, even if the partner is the client's health care proxy
C. The client has designated his partner as health care proxy in his advance directives
D. We'll need to have the nursing supervisor review the client's advance directives

10. A nurse is caring for a client who has increased intracranial pressure and is receiving IV corticosteroids. Which of the following info is most important for the nurse to report at shift change?

A. Gasglow Coma scale score
B. Most recent blood glucose reading
C. Lab test scheduled for next shift
D. Reddened area on the coccyx

24.A nurse is caring for a client who is scheduled for surgery. The nurse's role in regard to informed consent is which of the following?

A. Ensuring the charge nurse is available to witness the client's signature on the consent form

Rationale:The nurse caring for the client can witness the client's signature on the consent form. It is not necessary to ask the charge nurse to serve as the witness.

B. Explaining the risks involved with the procedure

Rationale:The surgeon must explain the risks involved with the procedure. A nurse who attempts to explain the risks involved with the procedure faces the possibility of legal action if the information is incomplete or incorrect. Additionally, the nurse is interfering with the client-provider relationship.

C. Discussing alternate treatment options

Rationale:Discussing alternate treatment options is the responsibility of the surgeon. A nurse who

attempts to discuss alternate treatment options faces the possibility of legal action if the information is incomplete or incorrect. Additionally, the nurse is interfering with the client-provider relationship.

D. Determining the client's level of understanding about the procedure

Rationale:In the role of client advocate, the nurse is responsible for ensuring the client understands the information provided by the surgeon and must notify the surgeon if the client has questions.

25.A client who fell and broke his hip while being assisted to the bathroom by a nurse states he plans to sue the nurse. The nurse should know that, in a legal proceeding, the standard that will be used to determine if the nurse was negligent is which of the following?

A. An expert nurse provides testimony that the nurse should have handled the situation differently.

Rationale:Although expert nurses can be called to testify by attorneys for both the plaintiff and the defendant, this is not the standard used to determine the nurse's liability.

B. Another staff nurse provides testimony about how a reasonable, prudent nurse would have handled the situation.

Rationale:The definition of negligence is practice that is below the standard of care. The benchmark for standard of care is what a reasonable, prudent person who has similar background and experience would do. Another staff nurse who has similar background is the correct person to provide testimony.

C. The client's attorney states that injury to the client could have been prevented.

Rationale:Although the client's attorney can offer an opinion regarding how injury to the client occurred and could have been prevented, this is not the standard used to determine the nurse's liability. D. The client's provider testifies the nurse was at fault for the injury.

Rationale:Although the client's provider can be called to testify about the injury, this is not the standard used to determine if the nurse was negligent.

26.A nurse in an acute care setting is serving on a committee whose charge is to use the auditing process to client care. Which of the following aspects of client care is measured by a process audit?

A. Availability of resources, such as fire extinguishers

Rationale:Structure audits evaluate the availability of resources.

B. Nursing staff ratios

Rationale:Structure audits measure staffing ratios.

C. Quality of nursing care provided

Rationale:Process audits evaluate the quality of care nurses provide. They also determine if the care provided by nurses is consistent with established facility policy.

D. Length of facility stay for a cohort of clients

Rationale:Outcome audits measure the outcome of the care provided and include elements such as morbidity, mortality, and length of facility stay.

1.A nurse is preparing an in-service for an annual skills fair at a community medical facility about fire safety. Place the steps in the order in which they should be performed in the case of a fire emergency. (Move the steps into the box on the right, placing them in the selected order of performance. Use all the steps.)

D. Rescue the clients.

A. Pull the fire alarm.

B. Confine the fire.

C. Extinguish the fire.

2.A nurse is caring for a client who is dying of metastatic breast cancer. She has a prescription for an opioid pain medication PRN. The nurse is concerned that administering a dose of pain medication might hasten the client's death. Which of the following ethical principles should the nurse use to support the decision not to administer the medication?

A. Utilitarianism

Rationale:Utilitarianism refers to actions that are right when they contribute to the greatest good.

B. Nonmaleficence

Rationale:Nonmaleficence is the duty to do no harm. The ethical mandate of nonmaleficence is that health care workers refrain from intentionally inflicting harm to clients.

C. Fidelity

Rationale:Fidelity is the duty to keep one's promises or word. It refers to the obligation to be faithful to the agreements, commitments, and responsibilities that one has made to oneself and others.

D. Veracity

Rationale:Veracity is the duty to tell the truth. It means that one does not intentionally deceive or mislead clients.

3.A charge nurse notes that a staff nurse delegates an unfair share of tasks to the assistive personnel (AP) and the nurses on next shift report the staff nurse frequently leaves tasks uncompleted. Which of the following statements should the charge nurse make to resolve this conflict?

A. "I need to talk to you about unit expectations regarding delegating and completing tasks."

Rationale:This statement opens the conversation in a nonthreatening way. The focus is on the issue of the equity of the assignment rather than on any personal characteristic of the individual.

B. "Several staff members have commented that you don't do your fair share of the work."

Rationale:This statement is accusatory.

C. "If you don't do your share of the work, I will have to inform the nurse manager."

Rationale:This statement is punitive.

D. "You have been very inconsiderate of others by not completing your share of the work."

Rationale:This statement is punitive.

4.A nurse is providing care for a surgeon on a medical-surgical unit. A nurse from another unit asks the nurse about the surgeon's medical diagnosis. The nurse responds that he is unable to provide the information requested. The nurse is displaying which of the following ethical principles?

A. Utility

Rationale:Utility is the ethical principle that the good of many people outweighs the good of one person.

B. Paternalism

Rationale:Paternalism is the belief that one individual has the right to make decisions for another. It negates the client's right to autonomy.

C. Justice

Rationale:Justice is the ethical principled based on the belief that everyone should be treated fairly.

 D. Nonmaleficence

Rationale:The nurse is obligated to protect the client's confidential information. A breach of confidentiality can place the client at risk of harm. Nonmaleficence is the ethical duty to prevent harm to the client.

5.When planning delegation of tasks to assistive personnel (AP), a nurse considers the five rights of delegation. Which of the following should the nurse consider when using one of the five rights of delegation?

A. The AP's ability to prioritize

Rationale:Although the nurse could determine the AP's ability to prioritize, this is not one of the rights of delegation.

 B. The AP has the knowledge and skill to perform the task

Rationale:The right person is one of the five rights of delegation. The nurse should seek information from the AP about his individual skill level before delegating the task.

C. The AP's rapport with clients

Rationale:Although a positive rapport with clients is important, this is not one of the five rights of delegation.

D. The AP's ability to complete the task without assistance

Rationale:

The nurse does not relinquish accountability for supervising the AP; therefore, this is not one of the five rights of delegation.

6.While caring for a client, the nurse experiences a needle stick injury. Which of the following actions should the nurse take first?

A. Complete an incident report.

Rationale:The nurse should complete an incident report; however, there is another action the nurse should take first.

B. Request the risk manager obtain consent for HIV testing from the client.

Rationale:Although it is important that the client's HIV status is determined, there is another action the nurse should take first.

C. Wash the site of injury with soap and water.

Rationale:The greatest risk to the nurse is infection transmission; therefore, the nurse should first wash the area with soap and water to reduce the risk of transmission. D. Consent to postexposure treatment with antiretroviral medications.

Rationale:Although treatment with antiretroviral medications should be started within 1 to 2 hr after a needle stick injury and be continued for 28 days if the client's HIV status is positive, there is another action the nurse should take first.

7.A nurse is caring for a client who has named a person to serve as his health care proxy. The client states he needs clarification about this type of advance directives. Which of the following statements by the client indicates a need for clarification?

A. "I can change who I designate as my health care proxy at any time."

Rationale:This is a correct statement regarding a health care proxy.

B. "If I become incapacitated, end-of-life choices will be made by my proxy."

Rationale:This is a correct statement regarding a health care proxy.

C. "I have to choose a family member as my health proxy."

Rationale:The client should choose someone he trusts and knows about his wishes for day-to-day and end-of-life care. It can be a family member, but it does not have to be a family member.

D. "The health care proxy does not go into effect until I am incapable of making decisions."

Rationale:This is a correct statement regarding a health care proxy.

8.A nurse is serving on a continuous quality improvement (CQI) committee that has been assigned to develop a program to reduce the number of medication administration errors following a sentinel event at the facility. Which of the following strategies should the committee plan to initiate first?

A. Provide an inservice on medication administration to all the nurses.

Rationale:A recommendation for staff education may be indicated, but this does not assist the committee to identify factors that lead to medication errors.

B. Require staff nurses to demonstrate competency by passing a medication administration examination.

Rationale:Ensuring competency in medication administration may be indicated, but this does not assist the committee to identify factors that lead to medication errors. C. Review the events leading up to each medication administration error.

Rationale:After a sentinel event, the first step the committee should plan to take is to use root cause analysis to identify the underlying cause or causes that led to the medication errors. D. Develop a quality improvement program for nurses involved in medication administration errors.

Rationale:Although development of a quality improvement program for nurses involved in medication errors may be indicated, this does not assist the committee to identify factors that lead to medication errors.

9.A charge nurse has access to the facility's electronic client records. It is appropriate for the charge nurse to share her personal password with whom? A. The nurse manager

Rationale:A nurse manager authorized to have access to a computer will have a personal password.

B. No one

Rationale:Computer passwords cannot be shared with others for any reason. Any facility employee authorized to have access to the database on a computer will have a personal password.

C. A nursing student who is completing a preceptorship on the unit

Rationale:A nursing student who is authorized to have access to the database on a computer will have a personal password. D. The unit clerk

Rationale:A unit clerk authorized to have access to a computer will have a personal password.

10.A nurse on a medical-surgical unit is reconciling a newly admitted client's medication. The nurse is reviewing the process of medication reconciliation with a newly licensed nurse. The nurse should include which of the following information?

A. The American Hospital Association requires accredited facilities to have protocols in place requiring

medication reconciliation.

Rationale:The Joint Commission requires accredited facilities to have protocols in place requiring medication reconciliation.

B. The purpose of medication reconciliation is to prevent adverse medication reactions.

Rationale:Medication reconciliation includes reviewing an accurate list of all medications the client is taking and comparing that list to new medications the provider has prescribed. This action decreases the risk of medication interactions and adverse outcomes.

C. The nurse who performs medication reconciliation is demonstrating the ethical principal of veracity.

Rationale:This action by the nurse does not demonstrate the ethical principal veracity, which means telling the truth. The nurse who performs medication reconciliation is demonstrating the ethical principle beneficence, which means the nurse takes action to promote good, and nonmaleficence, which means the nurse takes action to prevent harm.

D. The International Council of Nurses Code of Ethics stipulates that the nurse performs medication reconciliation when a client is admitted to a facility, is transferred to another facility, and when a client is discharged from a facility.

Rationale:The International Council of Nurses Code of Ethics stipulates that nurses have a responsibility to promote health and prevent illness, but it does not mandate medication reconciliation. The Institute for Healthcare Improvement recommends the nurse perform medication reconciliation when a client is transferred and The Joint Commission requires medication reconciliation when a client is admitted and when a client is discharged.

11.A nurse is caring for a client on the medical-surgical unit. The client has been taking warfarin at home and her laboratory values reveal her INR is 3.5. The client states she is checking herself out of the hospital and refuses to wait until her provider can discuss the situation with her. Which of the following actions should the nurse take?

A. Tell the client she will not be permitted to leave the facility until she has signed the against medical advice (AMA) form.

Rationale:The nurse should attempt to get the client to sign the AMA form because this measure can help to defend the facility if a lawsuit ensues; however, the nurse should not tell the client she will not be permitted to leave the facility because this action could lead to charges of false imprisonment.

B. Tell the client if she leaves without a written prescription for discharge, her insurance will not pay for the facility visit.

Rationale:This action by the nurse is uncaring and the client could perceive it as a threat. C.

Explain the risk the client faces if she leaves the facility.

Rationale:The expected reference range for INR while a client is taking warfarin is 2 to 3.The nurse has an obligation to explain to the client that her INR is very high and she is at risk for bleeding. D. Ask the security department to guard the room to the client's door.

Rationale:This action could lead to charges of false imprisonment.

12.A nurse on a medical-surgical unit is planning to delegate tasks to an adult volunteer. Which of the following tasks should the charge nurse avoid assigning to the volunteer?

A. Delivering meal trays to clients in their rooms

Rationale:Delivering meal trays is an appropriate task to delegate to a volunteer.

B. Assisting a client who has difficulty seeing the foods on the tray while eating

Rationale:Assisting a client who has a vision deficiency to eat is an appropriate task to delegate to a volunteer.

C. Delivering a routine urine specimen to the laboratory

Rationale:Delivering a routine urine specimen is an appropriate task for a volunteer.

D. Observing a postoperative client who is confused

Rationale:A nurse who uses delegation is responsible for delegating tasks to the right person. A volunteer does not have the training to intervene if this client tries to get out of bed or starts pulling at tubes. The observation of this client should be assigned to a member of the nursing staff.

13.An assistive personnel (AP) tells the nurse manager that she observed a nurse on the unit removing a small amount of morphine from syringes prior to administering the medication to clients. Which of the following actions should the nurse manager take first?

A. Gather data about the nurse's work performance and attendance history.

Rationale:The first action the nurse should take is to conduct an investigation and determine if the allegations are true.

B. Approach the involved nurse to discuss the behavior.

Rationale:The nurse should approach the involved nurse to discuss the behavior; however, there is another action the nurse should take first. C. Notify the risk manager.

Rationale:The nurse should notify the risk manager; however, there is another action the nurse should take first.

D. Refer the nurse to the board of nursing diversion program.

Rationale:The nurse should report the incident to the board of nursing if the suspicion of drug diversion is founded; however, there is another action the nurse should take first.

14.A nurse is caring for a client who has severe head injuries and is declared brain dead. The transplant coordinator has spoken with the client's family about organ donation. The client's spouse states she is confused and does not know what she should do. Which of the following responses by the nurse is appropriate?

A. "There is such a shortage of organs in this country, so I think you should go ahead and consent to donate your spouse's organs."

Rationale:The nurse should avoid giving her personal opinion.

B. "What do you think your spouse would have wanted?"

Rationale:Federal law requires facilities to have policies and procedures in place about making a request for organ and tissue donation at the time of death. The request is made by an employee, often a social worker, who has advanced training and can request the donations in a caring, sensitive manner. The role of the nurse is to provide emotional support to the family. Family members should consider the deceased person's wishes when making their decision.

C. "Most religions support organ donation, so don't let that stand in the way."

Rationale:While it is true that most religions support organ donation, there is no indication that this is a concern felt by the client's spouse.

D. "Don’t you think you will feel a little better about the situation if you donate your spouse’s organs?"

Rationale:The nurse should not provide the client’s spouse with false reassurance.

15.A nurse manager is reviewing the Good Samaritan laws with a group of newly licensed nurses. Which of the following statements by the nurse manager is appropriate?

 A. "If you render aid in an accident, do not leave the scene until another competent person can take over."

Rationale:Once the nurse renders aid, she has entered a nurse-client relationship and must continue to provide care until competent help arrives.

B. "Good Samaritan laws prohibit the victim from filing a lawsuit against the nurse."

Rationale:Good Samaritan laws require the nurse to render the level of care expected by a competent, prudent nurse in a similar situation. To win a malpractice suit against the nurse, the victim must prove the nurse was grossly negligent or careless.

C. "Federal laws require a licensed nurse to render aid in an emergency."

Rationale:Good Samaritan laws are state laws. Only a few states have duty to rescue laws, for example: Vermont, Minnesota, and Wisconsin. The nurse should know the laws of the state.

D. "A nurse who volunteers at a summer camp for children is covered by Good Samaritan laws."

Rationale:Good Samaritan laws protect the nurse in an emergency. Even in volunteer situations, Good Samaritan laws do not provide protection because in most cases an emergency does not exist.

16.A nurse is caring for several clients. For which of the following situations should the nurse complete an incident report?

A. The nurse identifies a broken piece of equipment.

Rationale:

This issue should be resolved by removing the equipment from the client care area and placing a work order for its repair.

B. A staff member does not show up to work her assigned shift.

Rationale:This is a staff problem that should be resolved between the staff member and the nurse manager.

 C. A client discovers that his dentures are missing.

Rationale:This situation represents a variation from the normal standard of care. A change in the client's plan of care may be necessary if the client has difficulty eating or speaking without the dentures. In addition, the facility may be liable for replacing the missing dentures. D. The nurse has a disagreement with the nursing supervisor about inadequate staffing.

Rationale:An incident report is not necessary for this situation.

17.A staff nurse has applied for a promotion. The hiring manager insinuates that if there was a sexual relationship between the two of them, the nurse's promotion request would get increased consideration. Which of the following actions should the staff nurse take first?

 A. Tell the hiring manager in clear terms that this conduct causes feelings of discomfort and that the behavior should stop immediately.

Rationale:Sexual harassment is unwanted sexual advances made in the context of a relationship of unequal power or authority. It is experienced as offensive in nature. The nurse should first start by taking the most direct measure: confronting the hiring manager and insisting the harassment stop.

B. Report the behavior to the nurse manager.

Rationale:The nurse should report the behavior to the nurse manager; however, there is another action the nurse should take first.

C. Create a written document of the incident and store the document in a safe place.

Rationale:The nurse should create a written document of the incident and store the document in a safe place; however, there is another action the nurse should take first. D. Seek help from a trustworthy friend.

Rationale:The nurse should seek help from a trustworthy friend; however, there is another action the nurse should take first.

18.A nurse in a long-term care facility has assigned a task to an assistive personnel (AP). The AP refuses to perform the task. Which of the following is an appropriate statement for the nurse to make?

A. "I feel you are being inconsiderate of the other team members."

Rationale:This statement is accusatory and can create barriers to communication.

B. "I have to let the director of nursing know about this situation."

Rationale:Delaying conflict resolution or involving superiors without first attempting to resolve the situation can create adversarial feelings.

 C. "I need to talk to you about the unit policies regarding client assignments."

Rationale:This statement opens the conversation in a nonthreatening way and places the focus on the issue of policies rather than on any personal desire or characteristic of the individual.

D. "You always get your choice of assignment and don't work your fair share."

Rationale:This is an inflammatory statement that will only cause more barriers to the resolution of the conflict.

19.A nurse is caring for a client who is participating in a research study for an experimental chemotherapy medication. After three treatments, the experimental medication is discontinued due to evidence of rapidly advancing kidney

failure. The nurse should understand discontinuing this medication demonstrates which of the following ethical principles?

A. Veracity

Rationale:Veracity is truthfulness. It requires the nurse to tell the truth to every client and to make sure the client fully understands the message.

B. Autonomy

Rationale:Autonomy is the right to independence and personal freedom, which leads to the primacy of self-determination.

C. Fidelity

Rationale:Fidelity is the duty to keep promises. It refers to the obligation to be faithful to agreements, commitments, and responsibilities that are made.

 D. Nonmaleficence

Rationale:Nonmaleficence, as a principle in research, is the obligation to do no harm to the client. Intentionally exposing clients to serious or permanent harm is unacceptable. Should such a situation emerge during the conduct of a study, the study should be terminated immediately.

20.A nurse overhears two assistive personnel (AP) from the medical-surgical unit discussing a hospitalized client while in the cafeteria. Which of the following is the priority nursing action?  A. Quietly tell the APs that this is not appropriate.

Rationale:The nurse has a professional duty to protect the client's confidential information. When using the urgent vs. nonurgent approach to client care, the nurse determines the priority is to stop the APs before there is an additional breach of confidentiality.

B. Ask the nurse manager to provide an inservice program about confidentiality to the staff on the unit.

Rationale:

Although it might be appropriate to ask the manager to review the importance of maintaining confidentiality with the staff on the unit, there is another action that is the priority. C. Complete an incident report.

Rationale:Although the nurse has a responsibility to complete an incident report when there is an accident or unusual occurrence, there is another action that is the priority. D. Document the occurrence in a personal log.

Rationale:Although the nurse should keep notes about the occurrence for legal protection, there is another action that is the priority.

21.A nurse has several tasks to delegate to an assistive personnel (AP). Which of the following tasks should the nurse ask the AP to perform first?

A. Take an arterial blood gas (ABG) specimen to the laboratory.

Rationale:When using the urgent vs. nonurgent approach to client care, the nurse should determine the priority action is to take the ABG blood sample to the laboratory. ABG samples are placed on ice and must be transported to the laboratory immediately or the specimen will deteriorate, making any results inaccurate.

B. Transport a client to the radiology department for an x-ray.

Rationale:It is appropriate to delegate this task to the AP, but there is another task that is the priority. C. Pass

fresh water to clients on the unit.

Rationale:It is appropriate to delegate this task to the AP, but there is another task that is the priority. D. Obtain a

routine urine sample from a newly-admitted client.

Rationale:It is appropriate to delegate this task to the AP, but there is another task that is the priority.

22.A nurse is caring for an older adult client who has a terminal illness and is ventilator-dependent. The client is alert and oriented and he wants to discontinue use of the ventilator. The nurse should be aware that continued treatment against the client's wishes is a violation of which of the following ethical principles?

A. Veracity

Rationale:The ethical principle of veracity requires the nurse to tell the truth and not to intentionally deceive or mislead clients.

B. Autonomy

Rationale:The issue here is the client's right to choose. The ethical principle of autonomy applies to an individual's right to choose and control what happens to him. Respecting autonomy requires the nurse to recognize the client's choice is based on personal values and those values do not have to be shared by the nurse.

C. Fidelity

Rationale:The ethical principle of fidelity requires the nurse to keep promises by being faithful to agreements, commitments, and responsibilities.

D. Justice

Rationale:The ethical principle of justice requires the nurse to treat everyone fairly.

23.A nurse and an experienced licensed practical nurse (LPN) are caring for a group of clients. Which of the following tasks should the nurse delegate to the LPN? (Select all that apply.) A. Provide discharge instructions to a confused client's spouse.

B. Obtain vital signs from a client who is 6 hr postoperative.

C. Administer a tap-water enema to a client who is preoperative.

D. Initiate a plan of care for a client who is postoperative from an appendectomy.

E. Catheterize a client who has not voided in 8 hr.

Rationale:Providing discharge instructions to a confused client's spouse is incorrect. The nurse is responsible for delegating a task to the person who has proper training and skill. Client education is the responsibility of the registered nurse.
Obtaining vital signs from a client who is 6 hr postoperative is correct. Obtaining is a task that is appropriate to the education and skills of an LPN.
Administering a tap-water enema to a client who is preoperative is correct. Administering a tap-water enema is a task that is appropriate to the education and skills of an LPN.
Initiating a plan of care for a client who is postoperative from an appendectomy is incorrect. Planning care is the responsibility of the registered nurse.
Catheterizing a client who has not voided in 8 hr is correct. Urinary catheterization is a task that is appropriate to the education and skills of an LPN.

27.Following a tornado, a nurse is determining which of the clients assigned to her care can be discharged to free up beds for injured clients. Which of the following clients should the nurse recommend for discharge?

A. A young adult client who has Crohn's disease and is 1 day preoperative for an ileostomy

Rationale:A client who is scheduled for an elective surgery is medically stable and is not bedridden; therefore, the nurse should recommend this client for discharge.

B. An adolescent client who was admitted 24 hr ago due to a spontaneous pneumothorax

Rationale:A client who has a pneumothorax is unstable and needs rest, oxygen, and observation. If the client's condition becomes worse, a chest tube may be required. Therefore, the nurse should not recommend this client for discharge.

C. A middle adult who is 36 hr postoperative from an open laminectomy

Rationale:A client who is postoperative from an open laminectomy is at risk for complications, especially 24 to 48 hr after surgery. Therefore, this client is not stable and the nurse should not recommend this client for discharge.

D. An older adult client who was admitted for diabetic ketoacidosis and his most recent ABGs show his pH is now 7.32

Rationale:Diabetic ketoacidosis is a serious complication of diabetes mellitus. It usually develops in conjunction with an infection, but it can also develop due to poor nonadherence to prescribed care. This client's pH is below the expected reference range; therefore, this client is not stable and the nurse should not recommend this client for discharge.

28.A nurse is caring for a client who is preoperative. The nurse signs as a witness on the client's consent form. The nurse's signature on the consent form indicates which of the following?

A. Determines the client does not have a mental illness

Rationale:Clients who have a mental illness have the right to make decisions about their health care unless they have been found to be incompetent by a court of law.

B. Confirms the client appears competent to provide consent

Rationale:By signing as a witness on a procedural consent form, the nurse is confirming the client was the one who signed the consent form and that he seems to be competent to give consent.

C. Asserts the nurse has explained the risks and benefits of the procedure

Rationale:It is the responsibility of the provider to explain the risks and benefits of the procedure to the client.

D. Records that the client's spouse agrees the procedure is necessary

Rationale:Although support from the client's spouse can be a factor when the client considers surgery, the ethical principle autonomy is a fundamental principle and it supports the client's right to self-determination.

29.A nurse has been reassigned from her regular area of work to a unit that is short staffed. Which of the following actions should the nurse take first?

A. Ask what she will be assigned to do.

Rationale:Before accepting the assignment, the nurse should clarify the complexity of the assignment, such as how many clients she will be assigned to care for, what skills are needed, and what resources are available to her.

B. Determine if she has the skills to complete the assignment.

Rationale:The nurse should perform a self-evaluation to determine if there are discrepancies between expectations and skills. Discrepancies can lead to unsafe client care. C. Identify her options.

Rationale:After the nurse gains knowledge about the assignment and completes a self-evaluation, the nurse can either accept or refuse the assignment. D. Notify the nurse manager about her concerns for client safety.

Rationale:The nurse should not notify the nurse manager about her concerns for client safety until she has determined she has the skills to safely provide client care.

30.A nurse manager hears a staff nurse on the unit speak openly about her dislike of a recent policy change regarding client care. When discussing the issue with the nurse, which of the following statements by the nurse manager is appropriate?

A. "Let's talk about your concerns about the new policy."

Rationale:The nurse manager should meet with the nurse to allow an open forum for the nurse to verbalize the reasons for her reluctance to adopt the new policy.

B. "Why didn't you voice your concerns before the new policy was implemented?"

Rationale:This statement is accusatory and will likely make the nurse defensive.

C. "Being open to change is an expectation of the nurses who work on this unit."

Rationale:While being open to change is an expectation of a professional nurse, this statement does not address the issue. It avoids the issue at hand.

D. “You should support this policy change because it was based on evidence-based practice.”

Rationale:Evidence-based practice is the use of knowledge from research to support delivery of nursing

care. Its use is important when nurses consider a policy change related to client care; however, this statement does not address the issue. It avoids the issue at hand.

31.A nurse is caring for a client who falls in his room. After the nurse assesses the client, notifies the client’s provider, and completes an incident report, which of the following actions should the nurse take? A. Make a copy of the incident report for the provider.

Rationale:Incidence reports are confidential tools used by the facility to improve client care. They are never copied.

 B. Submit the incident report to the risk manager.

Rationale:The purpose of an incident report is to provide information to the risk manager who will investigate the incident and work with other members of the health care team to control risks of client injury.

C. Place the incident report in the client's chart.

Rationale:Incident reports are confidential tools used by the facility to improve client care. They are never placed in the client's chart. If there is a lawsuit and the incident report is in the client’s chart, the attorney can subpoena the document and use its contents as evidence. D. Document in the chart that an incidence report has been filed.

Rationale:Incident reports are confidential tools used by the facility to improve client care. They are never referred to in a client's chart. If there is a lawsuit and the incident report is referenced in the client’s chart, the attorney can subpoena the document and use its contents as evidence.

32.A volunteer assigned to the pediatric unit reports to the charge nurse for an assignment. Which of the following assignments is unsafe for the volunteer?

 A. Transporting a school-age client who is in traction to another department

Rationale:To ensure client safety, the nurse is responsible for delegating tasks to the right people. The nurse should avoid assigning this task to the volunteer because the individual who performs this task must understand the principles of traction. A volunteer does not have the requisite skill to perform this task.

B. Playing a computer video game with an adolescent who has sickle cell disease

Rationale:This is an appropriate and safe assignment for the volunteer. It provides both socialization and diversional activity to the client in traction.

C. Reading a book to a preschool client who has AIDS

Rationale:This is an appropriate and safe assignment for the volunteer. It provides a diversional activity for the client.

D. Rocking an infant who was admitted for croup

Rationale:

This is an appropriate and safe assignment for the volunteer. It provides comfort for the client.

33.A coworker puts an arm around a nurse and says, "I bet you are a great lover." Which of the following is an appropriate response by the nurse?

A. "Let's talk about something else."

Rationale:While this appears to be a response meant to change the subject, this response does not make it clear that this type of sexually-oriented conversation and physical contact is undesired by the nurse.

B. "Whether or not I am a good lover is irrelevant."

Rationale:While this appears to be a response meant to change the subject, this response does not make it clear that this type of sexually-oriented conversation and physical contact is undesired by the nurse.

 C. "Speaking to me like that makes me uncomfortable."

Rationale:This assertive response makes it clear that this type of sexually-oriented conversation and physical contact is undesired by the nurse.

D. "You need to lower your voice. Others can hear you."

Rationale:This response does not make it clear that this type of sexually-oriented conversation and physical contact is undesired by the nurse. In fact, it could be considered by the harasser as encouragement.

34.A nurse in a provider’s office is reviewing the laboratory findings for a client who is scheduled for surgery. Which of the following findings requires follow up by the nurse?

A. BUN 15 mg/dL

Rationale:This BUN level is within the expected reference range. It does not require follow up by the nurse.

 B. Platelet count 60,000/mm3

Rationale:This platelet count is below the expected reference range. A low platelet count places the client at risk for bleeding; therefore, the nurse should follow up on this finding.

C. WBC 6,000/mm3

Rationale:This WBC is within the expected reference range and does not require follow up by the nurse.

D. Hemoglobin 14 g/dL

Rationale:This hemoglobin level is within the expected reference range and does not require follow up by the nurse.

35.A nurse is working with an assistive personnel (AP) to care for a group of clients on the pediatric unit. Which of the following tasks should the nurse have the AP perform first?

A. Collect a stool sample for ova and parasites from a school-age child

Rationale:Although the AP should collect a stool sample for ova and parasites, there is another task the AP should perform first. B. Engage a toddler in play.

Rationale:Engaging a toddler in play is important because it provides diversion and promotes the toddler's sense of security, but there is another task that the AP should perform first.

C. Wash the hair of an adolescent who reports extreme fatigue and is scheduled for radiation therapy for the treatment of Hodgkin lymphoma.

Rationale:Although the AP should provide personal hygiene measures for the adolescent, including washing the client's hair, there is another task the AP should perform first.

 D. Check to see if the elbow restraint is in place for an infant who is postoperative from a surgical correction of a cleft palate.

Rationale:The infant who is postoperative from a surgical correction of a cleft palate is at risk for damage to the suture line and an elbow immobilizer decreases the risk of this complication; therefore, this is the task the AP should perform first.

36.A nurse is caring for a group of clients. The nurse demonstrates adherence to the ethical principle of fidelity by doing which of the following?

 A. Keeping an appointment with a client

Rationale:Fidelity is the duty to keep one's promises or word. Keeping an appointment the nurse has made with the client is an example of fidelity.

B. Allowing a new mother to hold her stillborn infant

Rationale:Beneficence is the duty to do good for others. Allowing a grieving mother an opportunity to spend time with her infant helps her to process her loss and is an example of beneficence.

C. Confirming that a client going for surgery has signed a consent form

Rationale:The ethical principle of autonomy describes an individual's right to choose. In health care, autonomy is the principle underlying informed consent, the right to refuse treatment, and the right to appoint a surrogate decision maker.

D. Refusing to disclose information about a client to the media

Rationale:Confidentiality is not disclosing a client's personal health care information to unauthorized individuals or other entities.

37.A nurse is participating in a disaster simulation in which a toxic substance is released into a crowded stadium. Multiple clients are transported to the facility. Which of the following activities would be the lowest priority for the nurse?

A. Preventing cross-contamination of clients

Rationale:In a disaster, the nurse must be able to segregate clients to prevent contamination of a nonexposed client with an exposed client, and thereby limiting the spread of the unknown toxin.

B. Performing concise client assessment

Rationale:In the triage setting, the nurse provides essential care; therefore, the nurse must conduct concise client assessments for triage purposes.

 C. Transferring a client to the discharge location

Rationale:Nursing care in a disaster setting focuses on essential care. The nurse should recognize nonskilled interventions, such as transferring a client to the discharge location, can be performed by nonmedical personnel.

D. Maintaining a client tracking system

Rationale:It is imperative for the nurse to maintain a client tracking system in a disaster situation. Disaster tags are numbered and include information such as triage priority, name, address, medications given, and treatments provided. These tags should remain with the client throughout his movement within the facility.

38.A nurse on a medical-surgical unit is providing care for a group of clients. The nurse should delegate collection of which of the following specimens to the assistive personnel (AP)?

A. Wound drainage for culture

Rationale:Collecting drainage from a wound for culture requires the use of sterile technique; therefore, the nurse should not delegate this task to the AP.

B. Urine from an indwelling catheter

Rationale:Urine from an indwelling catheter requires the use of sterile technique; therefore, the nurse should not delegate this task to the AP.

C. Blood for PaCO2

Rationale:$PaCO_2$ is one component of arterial blood gases (ABGs). Only individuals who are specially trained to draw blood from a radial, brachial, or femoral artery, such as nurses, medical technicians, and respiratory therapists, should perform this task; therefore, the nurse should not delegate this task to the AP.

 D. Random stool specimen

Rationale:The nurse should delegate collection of a random stool specimen to the AP because it does not require the skills of a licensed nurse. However, the nurse, not the AP, should collect a stool specimen if a culture using a sterile swab is required.

39.A nurse on a medical-surgical unit is preparing to contact a provider about a client's condition. The client is 6 hr postoperative from a total hysterectomy. The nurse notes the client's postoperative oxygen saturation is 94% and her apical heart rate is 110. The nurse should include information about the client's oxygen saturation level and heart rate in which component of the SBAR report?

A. Situation

Rationale:The nurse should state his name, the client's name, the name of the facility, the client's medical diagnosis, and a general description of what is going on in this section of the report.

B. Background

Rationale:The nurse should provide information about the client's postoperative status in this section of the report.