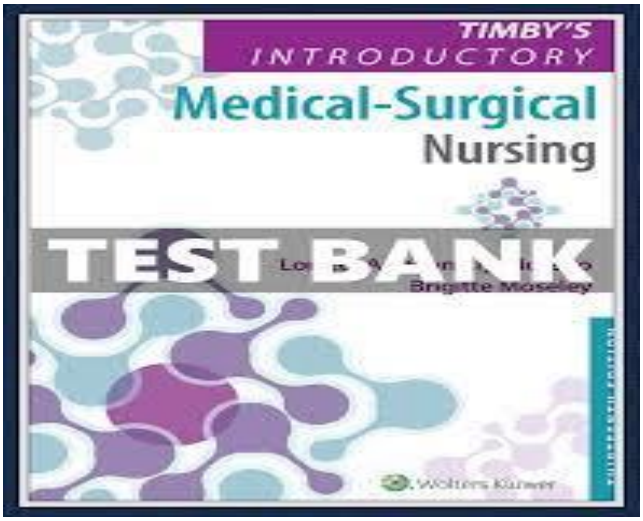
Test Bank for Timby's Introductory Medical-Surgical Nursing 13th Edition by Moreno Test Bank 2023 UPDATE



- Timby's Introductory Medical-Surgical Nursing 13th Edition Moreno Test Bank

Chapter 1 Concepts and Trends in Healthcare

- 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?

- Attending to holistic client needs
- Ensuring client safety
- Not making medication errors
- 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

- 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?
- Encourage the client and family to be active partners.
- Have the client monitor hand hygiene in caregivers.
- Offer the family the opportunity to stay with the client.
- 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

- 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?
- Call the Rapid Response Team.
- Document and continue to monitor.
- Notify the primary care provider.
- 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
    -

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

- 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?
- Bring a list of all medications and what they are for.
- Keep the doctors phone number by the telephone.
- Make sure all providers wash hands before entering the room.
- 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

- Which action by the nurse working with a client best demonstrates respect for autonomy?
  - Asks if the client has questions before signing a consent
  - Gives the client accurate information when questioned
  - Keeps the promises made to the client and family
  - 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

- 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?
- Avoid embarrassing the client by asking questions.
- Dont make assumptions about their health needs.
- Most LGBTQ people do not want to share information.
- 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

- 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: I would like you to order a different pain medication.
- B: This client has allergies to morphine and codeine.
- R: Dr. Smith doesnt like nonsteroidal anti-inflammatory meds.
- 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 on-call 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
-

- 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?
- Determining if the UAP knew how to take blood pressure
- Double-checking the UAP by taking another blood pressure
- Providing more appropriate supervision of the UAP
- 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
-

- 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?
- All staff nurses are required to participate in quality improvement here.
- Even being new, you can implement activities designed to improve care.
- Its easy to identify what indicators should be used to measure quality.
- 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
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- 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?
- Ask the hospitals there about standard nurse-client ratios.
- Choose the hospital that has the newest technology.
- Find a hospital that is accredited by The Joint Commission.
- 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

- MULTIPLE RESPONSE
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- 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.)
- Collaborating with an interdisciplinary team
-

- Implementing evidence-based care
- Providing family-focused care

- Routinely using informatics in practice
- 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

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

- The nurse utilizing evidence-based practice (EBP) considers which factors when planning care? (Select all that apply.)
- Cost-saving measures
- Nurses expertise
  -
- Client preferences

- Research findings
- 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
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  - 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.)

- Attend hand-off rounds to coach and mentor.
- Conduct audits of staff using a new template.
- Create a template of topics to include in report.
- Encourage staff to ask questions during hand-off.
- 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.
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  - Chapter 2 Settings and Models for Nursing Care

MULTIPLE CHOICE

- The nurse ensures that a clients bedspace is neat and clean with the call light within easy reach. The nurse is focusing on which nursing theorist who realized the importance of the environment for care?

    - Florence Nightingale
    - Sister Callista Roy
    - Dorothea Orem
    - Martha Rogers

ANS: 1

Florence Nightingales theory focused on the environment for care. Sister Callista Roys model is based in systems theory and an individuals ability to adapt. Dorothea Orems model is the self- care deficit theory. Martha Rogers model is the science of unitary human beings.

PTS:1DIF:Apply

REF:Emergence of Contemporary Nursing in the United States

- The nurse is instructing a client on self-administration of insulin so that the client will not need a health care provider to do this activity. The nurse is implementing which of the following aspects of Virginia Hendersons theory of nursing?

    - A caring relationship
    - Helping the client achieve independence from the nurses assistance as quickly as possible
    - Integration of objective and subjective data
    - Application of critical thinking

ANS: 2

Virginia Hendersons theory of nursing is to help people achieve health or a peaceful death so that they can be independent from the nurses assistance as quickly as possible. A caring relationship, integration of objective and subjective data, and application of critical thinking are included in the American Nurses Associations essential features of professional nursing.

PTS:1DIF:Analyze

REF:Emergence of Contemporary Nursing in the United States

3.A client tells the nurse that he has an HMO for his health insurance. The nurse understands that the purpose of this type of health plan is to:

- ensure payment is made to Medicare for services rendered.
- maximize the utilization of health care resources.
- efficiently manage costs while providing quality care.
- focus on the illness when providing care.

ANS: 3

Health maintenance organizations (HMOs) were created to efficiently manage health care costs while providing quality care. An HMO is a type of managed care plan with the goal of providing wellness care and not focusing on the illness during the provision of care. HMOs do not ensure payment is made to Medicare for services rendered. HMOs also do not maximize the utilization of health care resources but rather uses financial incentives to decrease care costs.

PTS: 1 DIF: Understand REF: Cost of Care

- client tells the nurse that he does not have a primary care physician but rather makes an appointment with a doctor who specializes in the area in which he is experiencing a problem. The nurse realizes this client is at risk for which of the following?
  - Fragmented care

- Overpayment of services
- Inability to sustain health
- Finding an appropriate general practitioner

ANS: 1

In the 1980s, the close and trusting relationship between an individual and the individuals physician waned and was replaced by acquaintances with specialists based upon particular health care problems. These episodes of care cause fragmentation of care. The client who utilizes specialists is not at risk for overpayment of services, the inability to sustain health, or finding an appropriate general practitioner.

PTS:1DIF:AnalyzeREFroviders of Care

- The nurse is attending a masters degree program in efforts to be educationally prepared to serve as a hospital leader. The nurse realizes that this educational preparation will:
  - hinder the nurses ability to work with physicians.
  - be viewed as not supporting the profession of nursing by other nurses.
  - ensure the nurse is biased towards clinicians interests.

  prepare the nurse to serve as strong clinical support with the ability to integrate business and
  - caring.

ANS: 4

The nurse is attending an educational program to serve as a hospital leader. This education will prepare the nurse to serve as strong clinical support with the ability to integrate business and caring. This education will not hinder the nurses ability to work with physicians. This education will not be viewed as unsupportive to the profession of nursing. The

education will ensure that the nurse is not biased towards clinicians interests.

PTS: 1 DIF: Analyze REF: Clinical Systems Leadership

- client tells the nurse that all hospitals care about is doing the minimum for a client regardless of the outcome. Which of the following should the nurse respond to this client?

  - It does feel like that sometimes.

  - Health insurance companies have caused this problem.

  - The doctors will get paid regardless of the clients outcomes.

  There are quality programs in place to make sure clients receive the best quality of care regardless
  - of the cost.

ANS: 4

In response to concerns about safety and quality of care voiced by clients and providers, total quality management and continuous quality improvement programs were initiated. These programs ensure society that cost management is not compromising safety or quality. This is what the nurse should respond to the client. The other choices do not address the clients concerns nor do they explain quality management programs.

PTS: 1 DIF: Apply REF: Quality Measure Shift

- The nurse is providing care at a time that is the most beneficial to the client. The nurse is implementing which of the following Joint Commission Dimensions of Quality Performance?

  - Safety

  - Timeliness

  - Efficiency

- Availability

ANS: 2

The dimension of timeliness means the degree in which interventions are provided at the most beneficial time to the client. Safety means the degree in which the risk of an intervention and risk to the environment are reduced for both client and health care provider. Efficiency means the degree in which care has the desired effect with a minimum of effort, waste, or expense.
Availability means the degree in which appropriate interventions are available to meet the clients needs.

PTS:1DIF:Analyze

REF:Box 1-1 Joint Commission Dimensions of Quality Performance

- The nurse is providing care while adhering to safety as a Joint Commission Dimension of Quality Performance. Which of the following did the nurse provide to the client?

    - Using a needleless device when providing intravenous medications

    - Keeping the siderails of the bed in the down position after providing a pain medication to a client

    - Having the client sit in a wheelchair with the wheels in the unlocked position

    - Placing cloth towels over a spill in the room of an ambulatory client

ANS: 1

The dimension of safety means the degree in which the risk of an intervention and risk to the environment are reduced for both client and health care provider. The nurse who uses a needleless device when providing intravenous medications is adhering to this dimension. Keeping the siderails in the down position is not a safe practice. Having a client sit in a wheelchair with the wheels unlocked is not a safe practice. Placing cloth towels over a spill in the room of an ambulatory client is not a safe practice.

PTS:1DIF:Analyze

REF:Box 1-1 Joint Commission Dimensions of Quality Performance

- The nurse is planning and providing care while adhering to the

American Nurses Association definition of professional nursing. Which of the following does the nurse include when implementing client care?

- Follows the NANDA nursing diagnoses process
- Integrates objective and subjective data
- Respects cultural diversity of peers
- Acknowledges the experience and training of physicians

ANS: 2

The American Nurses Association acknowledges six essential features of professional nursing. These include: 1) a caring relationship, 2) attention to the full range of human health and illness experiences, 3) integrates objective and subjective data, 4) applies scientific knowledge and critical thinking, 5) advances nursing knowledge through scholarly inquiry, and 6) promotes social justice. The nurse integrating objective and subjective data is implementing one of the six essential features of professional nursing. The other choices are not essential features of professional nursing.

PTS:1DIF:Analyze

- The nurse has shifted her practice from an illness focus to a health focus. Which of the following has this nurse implemented?
  - Standardized care plans
  - Critical pathways
  - Instructing a client on relaxation techniques to aid with sleep
  - Holding around-the-clock medication when a client is asleep

ANS: 3

The use of client education as a strategy to attain and maintain the potential for health is an example of the shift of care from an illness focus to a health focus. The nurse instructing a client on relaxation techniques to aid with sleep is implementing a health focus of care. The other choices do not support the shift from an illness focus to a health focus.

PTS: 1 DIF: Analyze REF: Leadership

- client is admitted with a highly communicable disease. The nurses do not want to participate in the care of this client. Which of the following should be done to ensure the client receives the highest quality of care?

    - Adhere to strict standard precautions.

    - Plan to have the client transferred to another health care organization.

    - Ask the physician if the client can be cared for in the home.

    - Suspend the nurses without pay who refuse to care for the client.

ANS: 1

When providing care in a highly global environment, the risks of communicable diseases increases. In the event that a client is admitted with a highly communicable disease and the nurses are fearing for their own health and safety, the only safe approach is to ensure all staff adhere to strict standard precautions. The other choices do not ensure that the client will receive the highest quality of care. The nurses must learn emotional intelligence and resolve issues under fire.

- The nurse has been an employee of an organization for 2 years and is considering a job change. Which of the following does this nurses plan suggest to any future employers?

    - The nurse moves to other jobs too frequently.

- The nurse is inflexible.

- The nurse is searching for a more challenging environment with career opportunities.

- The nurse is willing to sacrifice home and personal life for a job.

ANS: 3

At one point in time, job changes every 2 or 3 years was considered a red flag for employers. This does not hold true today. The nurse who changes jobs every 2 or 3 years is interested in career advancement and success. Creativity is valued and opportunities are desired. Moving to another job in 2 to 3 years does not mean the nurse is inflexible. The new generation of nurses does not want to sacrifice home and personal life for a job.

PTS: 1 DIF: Analyze REF: Care Delivery Models

- The nurse is experiencing pain and fatigue in both arms when using the computer to document client care. Which of the following can the nurse do to reduce these symptoms?

    - Refuse to use the computer and document using a pen and paper.

    - Stand up when using the computer.

    - Adjust the keyboard and chair to reduce the pressure on the wrists and arms.

    - Ask another nurse to input the information for client care activities.

ANS: 3

Ergonomic hazards are increasing with health care providers and nurses in particular. Many of these hazards are because of the implementation of computers for documentation. The nurse should adjust the keyboard and chair to reduce the pressure on the wrists and arms when documenting with the computer. The nurse cannot refuse to use the computer. Standing up may not reduce the nurses symptoms. The nurse cannot legally ask another nurse to document client care.

MULTIPLE RESPONSE

- The nurse is planning care for a client and reviewing appropriate educational materials to use for discharge instructions. Which domains of nursing is this nurse implementing? (Select all that apply.)
    - Nursing process
    - Clinical practice
    - Education
    - Literature
    - Administration
    - Research

ANS: 2, 3

The four domains of nursing are: 1) clinical practice, 2) education, 3) administration, and 4) research. When the nurse plans care for a client, the domain being implemented is clinical practice. When reviewing appropriate educational materials to use for discharge instructions, the domain being implemented is education. The nurse is not utilizing the domains of research or administration. Nursing process and literature are not domains of nursing.

PTS:1DIF:Apply
REF:Emergence of Contemporary Nursing in the United States

- The nurse suspects that another health care colleague may be chemically dependent when which of the following is assessed? (Select all that apply.)
    - Prolonged work breaks
    - Clinical care omissions

- Mood stability
- Extraordinary accomplishments
- Heavy use of fragrances
- Inability to recall recent events

ANS: 1, 2, 4, 5, 6

Clues of possible chemical dependency include tardiness, late sick calls, frequent or prolonged work breaks, inability to recall recent events, heavy use of fragrances, clinical care omissions or errors, patient complaints or requests for a change in care provider, mood instability, and extraordinary accomplishments. Mood stability is not a characteristic of a colleague who is experiencing chemical dependency.

PTS:1DIF:Apply

REF:Box 1-6 Clues to the Possibility of Chemical Dependence

- The nurse is a member of a health care team that includes a physician and other health care providers. These providers work together to ensure the client is relieved of suffering, has diseases cured, and experiences enhanced health and performance. Which of the following are the levels of care represented by this team of health care providers? (Select all that apply.)
    - Sustain life
    - Maintain health
    - Regain health
    - Minimize injury

- Maximize cost

- Attain enhanced health

ANS: 1, 2, 3, 6

The medical teams mission is to relieve suffering and cure disease. This involved the three levels of care: 1) sustain life, 2) regain health, and 3) maintain health. Once the shift toward health care occurred, the fourth level of attaining enhanced health was added. Minimize injury and maximize cost is not a level of care.

PTS:1DIF:AnalyzeREFroviders of Care

- client tells the nurse that she is disappointed that her employer is offering a health maintenance organization for a health care benefit. Which of the following can the nurse use as responses to the client as advantages of this type of health plan? (Select all that apply.)

    - Since there is a nursing shortage, clients need to stay out of the hospital.

    - This type of plan provides wellness care at a minimal cost to keep people healthy.

    - This type of plan helps clients avoid illnesses with high costs.

    - An HMO standardizes diagnostic and treatment decisions across the nation.

    - This type of plan ensures coordinated services from wellness to death.

    This type of plan costs as much as the traditional plans, but the insurance companies get the extra

    - money from premiums.

ANS: 2, 3, 4, 5

There are several missions and visions of managed care. The first is to provide wellness care at a minimal cost to keep people healthy and avoid providing illness care at a higher cost. Another mission is to standardize diagnostic and treatment decisions across the nation. Managed care emphasizes the delivery of coordinated services across the care spectrum from wellness to death and uses financial incentives to decrease length of stay and achieve cost efficiency. Managed care was not implemented to address the nursing shortage. This type of plan does not cost as much as a traditional health plan nor do the insurance companies receive the extra money from premiums.

PTS: 1 DIF: Apply REF: Cost of Care

- The nurse has incorporated several criteria that are essential for being a member of a profession. Which of the following has this nurse done? (Select all that apply.)
    - Has passed the licensure examination
    - Works regularly scheduled shifts
    - Completed a bachelors degree in nursing
    - Limits absences from work
    - Joined the American Nurses Association
    - Reads evidenced-based information to incorporate into planning client care

ANS: 1, 3, 5, 6

There are seven essential criteria for a profession. The nurse has incorporated four of these criteria by passing the licensure examination, the nurse has implemented a code of ethics; by completing a bachelors degree in nursing, the nurse has been educated in an institution of higher education; by joining the American Nurses Association and reading evidenced-based information, the nurse is affiliated with a professional association that promotes and ensures quality practice. Working regularly

scheduled shifts and limiting absences from work are not essential criteria for a profession.

- Chapter 4-Chapter 6 Interviewing and Physical Assessment
- Chapter 5 Legal and Ethical Issues Chapter 6 Leadership Roles and Management Functions

- When a nurse becomes involved in a legal action, the first step to occur is that a document is filed in an appropriate court. What is this document called?

a.	Deposition
b.	Appeal
c.	Complaint
d.	Summons

ANS: C

A document called a complaint is filed in an appropriate court as the first step in litigation. A deposition is when witnesses are required to undergo questioning by the attorneys. An appeal is a request for a review of a decision by a higher court. A summons is a court order that notifies the defendant of the legal action.

PTS: 1 DIF: Cognitive Level: Knowledge REF: Page 23 OBJ: 1 TOP: Legal KEY: Nursing Process Step: N/A MSC:NCLEX: N/A

- The nurse caring for a patient in the acute care setting assumes responsibility for a patients care. What is this legally binding situation?

a.	Nurse-patient relationship
b.	Accountability
c.	Advocacy
d.	Standard of care

ANS: A

When the nurse assumes responsibility for a patients care, the nurse-patient relationship is formed. This is a legally binding contract for which the nurse must take responsibility.
Accountability is being responsible for ones own actions. An advocate is one who defends or pleads a cause or issue on behalf of another. Standards of care define acts whose performance is required, permitted, or prohibited.

PTS: 1 DIF: Cognitive Level: Comprehension REF:
Page 24 OBJ: 3 TOP: Legal KEY: Nursing Process
Step: N/A MSC:NCLEX: N/A

- What are the universal guidelines that define appropriate measures for all nursing interventions?

a.	Scope of practice
b.	Advocacy
c.	Standard of care
d.	Prudent practice

ANS: C

Standards of care define actions that are permitted or prohibited in most nursing interventions. These standards are accepted as legal guidelines for appropriateness of performance. The laws that formally define and limit the scope of nursing practice are called nurse practice acts. An advocate is one who defends or pleads a cause or issue on behalf of another. Prudent is a term that refers to careful and/or wise practice.

PTS: 1 DIF: Cognitive Level: Knowledge REF:
Page 25 OBJ: 4 TOP: Legal KEY: Nursing
Process Step: N/A MSC:NCLEX: N/A

- An LPN/LVN is asked by the RN to administer an IV chemotherapeutic agent to a patient in the acute care setting. What law should this nurse refer to before initiating this intervention?

a.	Standards of care
b.	Regulation of practice
c.	American Nurses Association Code
d.	Nurse practice act

ANS: D

It is the nurses responsibility to know the nurse practice act in his or her state. Standards of care, regulation of practice, and the American Nurses code are not laws that the nurse should refer to

before initiating this treatment.

PTS: 1 DIF: Cognitive Level: Application REF:
Page 25 OBJ: 5 TOP: Legal KEY: Nursing

Process Step: N/A MSC:NCLEX: N/A
5.A nurse fails to irrigate a feeding tube as ordered, resulting in harm to the patient. This nurse could be found guilty of:

a.	malpractice.
b.	harm to the patient.
c.	negligence.
d.	failure to follow the nurse practice act.

ANS: A

The nurse can be held liable for malpractice for acts of omission. Failure to meet a legal duty, thus causing harm to another, is malpractice. The nurse practice act has general guidelines that can support the charge of malpractice.

PTS: 1 DIF: Cognitive Level: Application REF: Pages 22-23 OBJ: 2 TOP: Legal KEY: Nursing Process Step: N/A MSC:NCLEX: N/A

- Patients have expectations regarding the health care services they receive. To protect these expectations, which of the following has become law?

a.	American Hospital Associations Patients Bill of Rights
b.	Self-determination act
c.	American Hospital Associations Standards of Care
d.	The Joint Commissions rights and responsibilities of patients

ANS: A

Patients have expectations regarding the health care services they receive. In 1972, the American Hospital Association (AHA) developed the Patients Bill of Rights. The Self-determination act, American Hospital Associations Standards of Care, and The Joint Commissions rights and responsibilities do not address patients expectations regarding health care.

PTS: 1 DIF: Cognitive Level: Comprehension REF: Page 26 OBJ: 3 | 4 TOP: Legal KEY: Nursing Process Step: N/A MSC:NCLEX: N/A

- The nurse is preparing the patient for a thoracentesis. What must be completed before the procedure may be performed?

a.	Physical assessment

b.	Interview
c.	Informed consent
d.	Surgical checklist

ANS: C

The doctrine of informed consent refers to full disclosure of the facts the patient needs to make an intelligent (informed) decision before any invasive treatment or procedure is performed. A physical assessment, interview, and surgical checklist are not required before this procedure.

PTS: 1 DIF: Cognitive Level: Application REF: Pages 26-27 OBJ: 8 TOP: Legal KEY: Nursing Process Step: N/A MSC:NCLEX: N/A

- When a nurse protects the information in a patients record what ethical responsibility is the nurse fulfilling?

a.	Privacy

b.	Disclosure
c.	Confidentiality
d.	Absolute secrecy

ANS: C

The nurse has an ethical and legal duty to protect information about a patient and preserve confidentiality. Some disclosures are legal and anticipated, and may not be subject to the rules of confidentiality. None of the information in a chart is considered secret.

PTS: 1 DIF: Cognitive Level: Comprehension REF: Page 28 OBJ: 9 TOP: Confidentiality KEY: Nursing Process Step: N/A MSC:NCLEX: N/A

- An older adult is admitted to the hospital with numerous bodily bruises, and the nurse suspects elder abuse. What is the best nursing action?

a.	Cover the bruises with bandages.
b.	Take photographs of the bruises.
c.	Ask the patient if anyone has hit her.
d.	Report the bruises to the charge nurse.

ANS: D

The law stipulates that the health care professional is required to report certain information to the appropriate authorities. The report should be given to a supervisor

or directly to the police, according to agency policy. When acting in good faith to report mandated information (e.g., certain communicable diseases or gunshot wounds), the health care professional is protected from liability.

PTS: 1 DIF: Cognitive Level: Application REF:
Page 29 OBJ: 9 TOP: Elder abuse KEY: Nursing
Process Step: N/A

MSC:NCLEX: N/A

- What is the best way for a nurse to avoid a lawsuit?

a.	Carry malpractice insurance
b.	Spend time with the patient
c.	Provide compassionate, competent care
d.	Answer all call lights quickly

ANS: C

The best defense against a lawsuit is to provide compassionate and competent nursing care. Carrying malpractice insurance is prudent, but it will not avoid a lawsuit. Spending time with patients and answering call lights quickly will not necessarily help avoid a lawsuit.

PTS: 1 DIF: Cognitive Level: Comprehension REF:
Pages 29-30 OBJ: 8 TOP: Avoiding a lawsuit KEY:
Nursing Process Step: N/A MSC:NCLEX: N/A

- The nurse is caring for a patient with a do-not-resuscitate (DNR) order. Although the nurse may disagree with this order, what is his or her legal obligation?

a.	To question the doctor
b.	To seek advice from the family
c.	To discuss it with the patient
d.	To follow the order

ANS: D

When a DNR order is written in the chart, the nurse has a duty to follow the order. Questioning the doctor, seeking advice from the family, and discussing it with the patient are not legal obligations of the nurse.

- Although the patient denies pain, the nurse observes the patient breathing rapidly with clenched fists and facial grimacing. What is

the nurses best response to these observations?

a.	I am glad you are feeling better and have no discomfort.
b.	Where do you hurt?
c.	What you are saying and what I am observing dont seem to match.
d.	It makes me uncomfortable when you are not honest with me.

ANS: C

The nonverbal communication should be clarified to prevent miscommunication.

PTS: 1 DIF: Cognitive Level: Application REF: Pages
59-61 OBJ:2 | 3TOP:Communication
KEY: Nursing Process Step: Assessment MSC: NCLEX: Physiological Integrity

- The nurse considers the feelings and needs of a patient by stating, I know you are concerned about your surgery tomorrow. How can I help you? What type of communication is this?

a.	Intrusive
b.	Aggressive
c.	Closed
d.	Assertive

ANS: D

Assertive communication takes a patients feelings and needs into account, yet honors the patients rights as an individual.

PTS: 1 DIF: Cognitive Level: Comprehension REF: Page 61
OBJ:4TOP:Communication
KEY:Nursing Process Step:
Implementation MSC: NCLEX:
Psychosocial Integrity

- If the nurse aggressively says to a patient, Why couldnt you have asked me to give you your pain medication when I was in here

earlier? what feeling is the patient most likely to demonstrate?

a.	Anger
b.	Satisfaction that his needs are met
c.	Humiliation and worthlessness
d.	Confidence that his request will be granted

ANS: C

Aggressive communication is highly destructive. Although anger may eventually come, the patient most likely feels humiliated first.

PTS: 1 DIF: Cognitive Level: Application REF: Page 62
OBJ:7TOP:Communication
KEY: Nursing Process Step: Assessment MSC: NCLEX: Psychosocial Integrity 4.What does therapeutic communication accomplish?

a.	Facilitates the formation of a positive nurse-patient relationship
b.	Manipulates the patient
c.	Assigns the patient a passive role
d.	Requires the patient to accept what the nurse says

ANS: A

A positive nurse-patient relationship is facilitated by therapeutic communication. PTS: 1 DIF: Cognitive Level: Comprehension REF: Page 62
OBJ: 10 TOP: Communication KEY: Nursing Process Step: N/A MSC:NCLEX: N/A

- The nurse is sitting in a chair near the patients bed, leaning forward to hear what the patient is saying, and does not interrupt. What is the nurse demonstrating?

a.	Support

b.	Caring

c.	Active listening
d.	Interest

ANS: C

When demonstrating active listening, the nurse must give his or her full attention and make an effort to understand both the verbal and nonverbal message.

PTS: 1 DIF: Cognitive Level: Comprehension REF: Page 63
OBJ:5TOP:Communication
KEY:Nursing Process Step:
Implementation MSC: NCLEX:
Psychosocial Integrity

- What therapeutic communication technique requires a great deal of skill and is not used as frequently as other communication techniques?

a.	Touch
b.	Silence
c.	Listening
d.	Summarizing

ANS: B

Silence is an extremely effective therapeutic communication skill that is frequently underused because the nurse feels uncomfortable applying it.

PTS: 1 DIF: Cognitive Level: Comprehension REF:
Page 63 OBJ: 5 TOP: Communication KEY: Nursing
Process Step: N/A MSC:NCLEX: N/A
7.A patient does not speak English; therefore, the nurse cannot use words to provide comfort during a painful procedure. What is another intervention that may provide comfort to this

patient?

a.	Silence
b.	Listening
c.	Touch
d.	Restating

ANS: C

Holding the hand of a nonEnglish-speaking patient is effective and comforting. PTS: 1 DIF: Cognitive Level: Application REF: Page 63