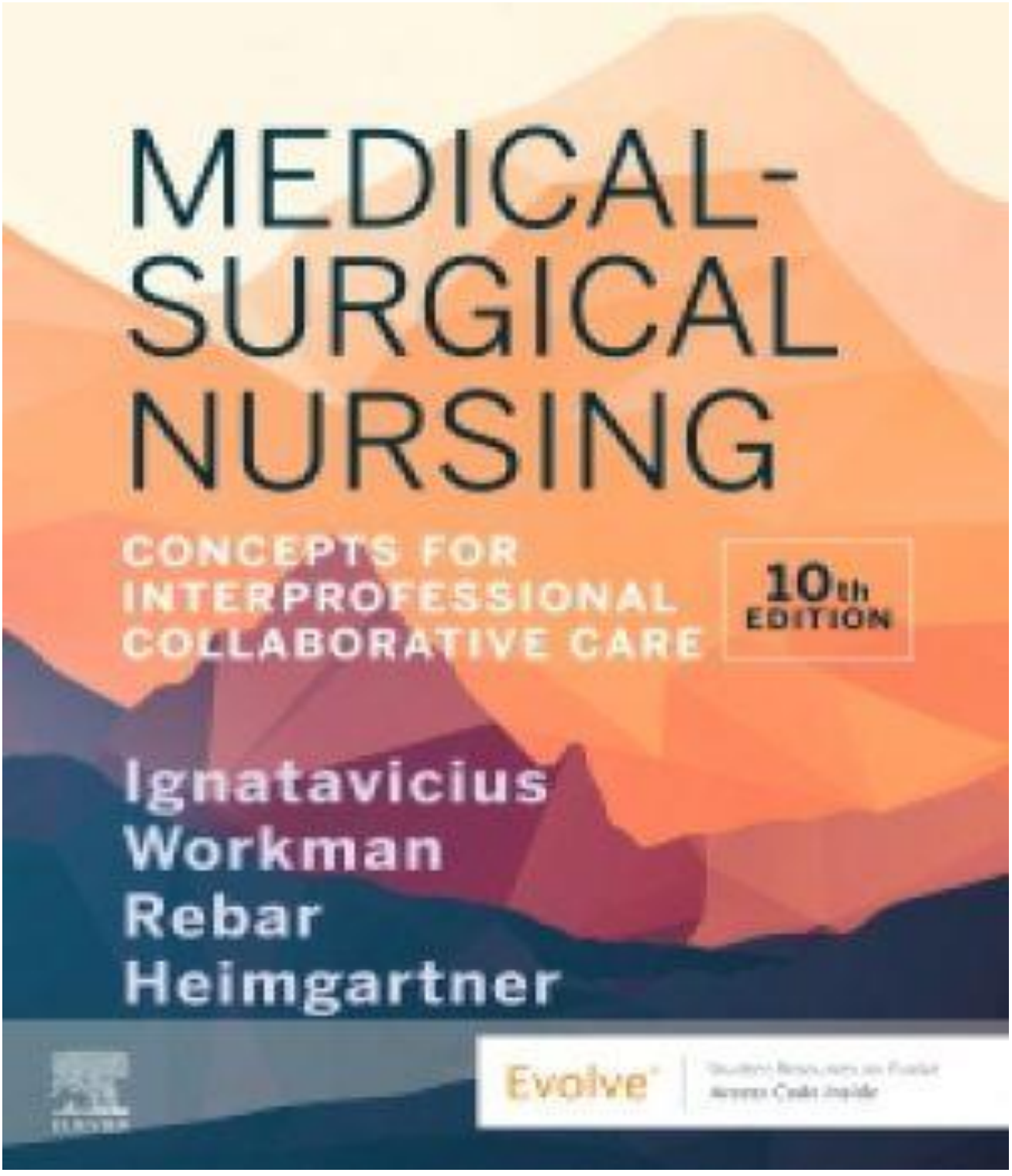
TEST BANK


MEDICAL-SURGICAL NURSING
CONCEPTS FOR INTERPROFESSIONAL COLLABORATIVE CARE
10th EDITION
Ignatavicius
Workman
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Evolve

Test Bank for Medical Surgical Nursing 10th Edition by Ignatavicius

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

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

   ANS: B
   All actions are appropriate for the professional nurse. However, ensuring client safety is the priority. Health care errors have been widely reported for 25 years, many of which result in client injury, death, and increased health care costs. There are several national and international organizations that have either recommended or mandated safety initiatives. Every nurse has the responsibility to guard the client's safety. The other actions are important for quality nursing, but they are not as vital as providing safety. Not making medication errors does provide safety, but is too narrow in scope to be the best answer.

   DIF: Understanding TOP: Integrated Process: Nursing Process: Intervention
   KEY: Client safety
   MSC: Client Needs Category: Safe and Effective Care Environment: Safety and Infection Control

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

   ANS: A
   Each action could be important for the client or family to perform. However, encouraging the client to be active in his or her health care as a safety 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 TOP: Integrated Process: Teaching/Learning
   KEY: Client safety
   MSC: Client Needs Category: Safe and Effective Care Environment: Safety and Infection Control

3. A nurse is caring for a postoperative client on the surgical unit. The client's blood pressure was 142/76 mm Hg 30 minutes ago, and now is 88/50 mm Hg. What action would the nurse take **first**?
   a. Call the Rapid Response Team.
   b. Document and continue to monitor.
   c. Notify the primary health care provider.
   d. Repeat the blood pressure in 15 minutes.

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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 would call the RRT. Changes in blood pressure, mental status, heart rate, temperature, oxygen saturation, and last 2 hours' urine output are particularly significant and are part of the Modified Early Warning System guide. Documentation is vital, but the nurse must do more than document. The primary health care provider would be notified, but this is not more important than calling the RRT. The client's blood pressure would be reassessed frequently, but the priority is getting the rapid care to the client.

DIF: Applying TOP: Integrated Process: Communication and Documentation
KEY: Rapid Response Team (RRT), Clinical judgment
MSC: Client Needs Category: Physiological Integrity: Physiological Adaptation

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

   ANS: A
   Showing respect for the client and family's preferences and needs is essential to ensure a holistic or "whole-person" approach to care. By assessing the effect of the client's 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 TOP: Integrated Process: Culture and Spirituality
   KEY: Client-centered care, Culture MSC: Client Needs Category: Psychosocial Integrity

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

   ANS: A
   Medication reconciliation is a formal process in which the client's actual current medications are compared to the prescribed medications at the time of admission, transfer, or discharge. This National client Safety Goal is important to reduce medication errors. The client would not have to be responsible for providers washing their hands, and even if the client does so, this is too narrow to be the most important action to prevent errors. Keeping the provider's phone number nearby and documenting everyone who enters the room also do not guarantee safety.

   DIF: Applying TOP: Integrated Process: Teaching/Learning
   KEY: Client safety, Informatics
   MSC: Client Needs Category: Safe and Effective Care Environment: Safety and Infection Control

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