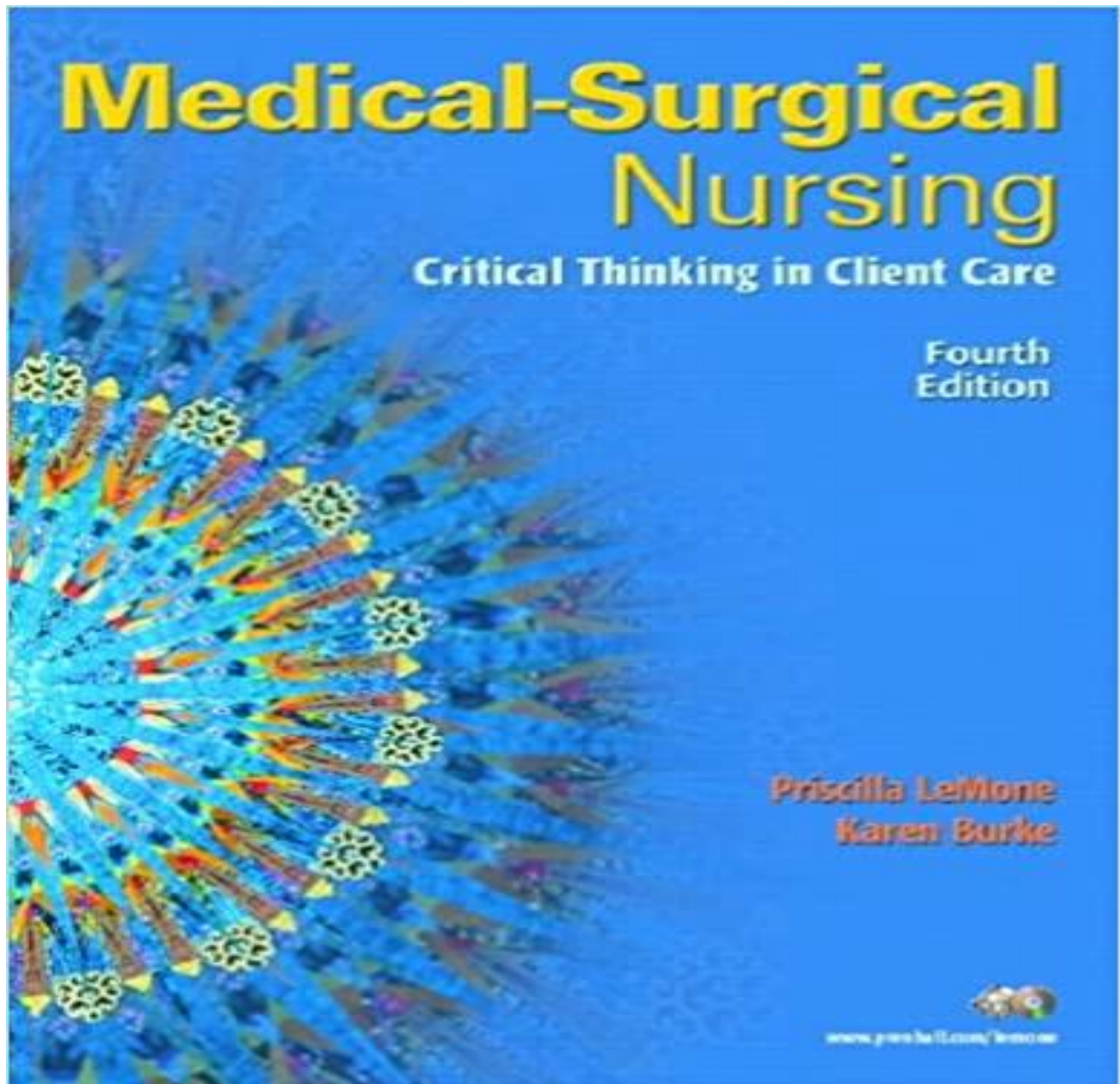


# TEST BANK



TEST BANK FOR MEDICAL-SURGICAL NURSING CRITICAL  
THINKING IN CLIENT CARE, 4TH EDITION PRISCILLA LEMON

# **Test Bank for Medical-Surgical Nursing Critical Thinking in Client Care, 4th Edition Priscilla LeMon**

## **Chapter 1**

1. The nurse is caring for four clients on a medical–surgical unit. Which client should the nurse see initially?

1. A client admitted with hepatitis A who has had severe diarrhea for the last 24 hours
2. A client admitted with pneumonia who is has small amounts of yellow productive sputum
3. A client admitted with fever of unknown origin (FUO) who has been without fever for the last 48 hours
4. A client admitted with a wound infection whose WBC is 8,500 mm<sup>3</sup>

Answer: 1

Rationale: The nurse must decide which client should be seen on the initial rounds of the day. The nurse must remember that the first client to be seen should be the client who needs the attention of the nurse initially. A client with hepatitis A does experience diarrhea, but diarrhea for the last 24 hours could cause the client to have a problem with dehydration and experience a state of fluid volume deficit.

Cognitive Level: Application

Client Needs: Safe, Effective Care Environment

Nursing Process: Planning

2. The nurse is preparing to administer influenza vaccines to a mass drive-through clinic. Which statement by a client would indicate further questioning prior to giving the client the influenza vaccine?

1. “I am allergic to horse hair.”
2. “I try to get my vaccine every year.”
3. “I am not allergic to anything except eggs.”
4. “My husband had a severe allergic reaction after he received his influenza vaccine.”

Answer: 3

Rationale: Influenza vaccines are recommended for person at high risk for serious sequelae of influenza. The nurse should be aware that client with a sensitivity to eggs should not receive the vaccine. Vaccines prepared from chicken or duck embryos are contraindicated in clients who are allergic to eggs.

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Cognitive Level: Application

Client Needs: Safe, Effective Care Environment

Nursing Process: Assessment

3. The nurse is caring for four clients on a medical–surgical unit. The secretary gives the nurse the morning labs. Which of the following labs would require that the nurse call the physician and inform the healthcare provider about the client’s abnormalities?

1. WBC 14,600 mm<sup>3</sup>
2. Serum protein 6.9 g/dL
3. I & D (incision and drainage) showing no growth for the last 24 hours
4. Albumin 4.2 g/dL

Answer: 1

Rationale: When the nurse is caring for several clients, all of the labs should be checked frequently throughout the shift to assess for any abnormalities. The WBC in option 1 is abnormal. (Normal WBC 4,000–10,000 mm<sup>3</sup>.) All of the other lab results are within acceptable range; therefore, the results should not be called in to the physician.

Cognitive Level: Application

Client Needs: Physiologic Integrity

Nursing Process: Assessment

4. The nurse is orienting a new graduate. The nurse is reinforcing the importance of standard precautions. Which of the following observations by the nurse would require further education regarding standard precautions?

1. The graduate nurse understands to wash hands when entering and exiting the client’s room.
2. The graduate nurse wears gloves when serving breakfast trays to various clients.
3. The graduate nurse wears a gown, gloves, and goggles when suctioning a client.
4. The graduate nurse leaves all supplies in the room of a client who is in contact isolation.

Answer: 2

Rationale: The nurse must have an understanding of standard precautions. Prevention is the most important measure to prevent nosocomial infections. Standard precautions were published in 1996 that provide guidelines for the handling of

blood and other body fluids. These guidelines are used with all clients, regardless of whether they have a known infectious disease. Standard precautions are used by all healthcare workers who have direct contact with clients or with their body fluids. It is not necessary for the nurse to wear gloves while delivering food trays to the client, because there is not contact with the client.

Cognitive Level: Application

Client Needs: Safe, Effective Care Environment

Nursing Process: Evaluation

5. The admitting department alerts the nurse on a medical–surgical unit that a client with active tuberculosis (TB) is being admitted to the unit. Which type of isolation is appropriate based on the client’s diagnosis?

1. Standard precautions
2. Airborne precautions
3. Droplet precautions
4. Contact precautions

Answer: 2

In addition to handwashing and standard precautions, the nature and spread of some infectious diseases require that special techniques be used to protect uninfected clients and workers. The client with pulmonary tuberculosis will be placed in airborne precautions. The client should be placed in a private room with special ventilation that does not allow air to circulate to general hospital ventilation; a mask or special filter respirators will be used for everyone entering the room.

Cognitive Level: Application

Client Needs: Safe, Effective Care Environment

Nursing Process: Assessment

6. A client is receiving IV vancomycin for the treatment of *Clostridium difficile*. The nurse understands that the client who develops flushing, tachycardia, and hypotension during the infusion of vancomycin indicates:

1. Ototoxicity effect.
2. Superinfection.
3. Red man syndrome.
4. Hives.

Answer: 3

Rationale: Vancomycin inhibits cell wall synthesis, and is used for serious infections. It is only effective against gram-positive bacteria, especially *Staphylococcus aureus* and *Staphylococcus epidermidis*. The nurse should infuse this medication slowly over 60 minutes or more to avoid “red man” syndrome. The syndrome is characterized by erythematous rash, flushing, tachycardia, and hypotension. Clients can become dizzy and agitated.

Cognitive Level: Application

Client Needs: Physiological Integrity

Nursing Process: Evaluation

7. The physician has ordered for the client to receive a trough blood level to evaluate the therapeutic effect of an antibiotic. The nurse understands that the trough should be ordered:

1. A few minutes before the next scheduled dose of medication.
2. 1–2 hours after the oral administration of the medication.
3. 30 minutes after the IV administration.
4. During the infusion of the antibiotic.

Answer: 1

Rationale: Antibiotic peak and trough levels monitor therapeutic blood levels of the prescribed medication. The therapeutic range—the minimum and maximum blood levels at which the drug is effective—is known for a given drug. By measuring blood levels at the predicted peak (1–2 hours after oral administration, 1 hour after intramuscular administration, and 30 minutes after IV administration) and trough (usually a few minutes before the next scheduled dose), it is also possible to determine whether the drug is reaching a toxic or harmful level during therapy, increasing the likelihood of adverse effects.

Cognitive Level: Application

Client Needs: Safe, Effective Care Environment

Nursing Process: Assessment

8. The nurse needs to change a dressing on the client’s abdomen. Which of the following techniques should be implemented?

1. Contact precautions
2. Standard precautions
3. Droplet precautions

4. Airborne precautions

Answer: 2

Rationale: Standard precautions are used on all clients, regardless of whether they have a known infectious disease. Standard precautions are used by all healthcare workers who have direct contact with clients or with their body fluids. Since the client has an abdominal dressing, the nurse will use standard precautions.

Cognitive Level: Application

Client Needs: Safe, Effective Care Environment

Nursing Process: Planning

9. The physician has ordered for the nurse to obtain a sputum specimen. The nurse understands that the sputum specimen should be collected:

1. Immediately after the first dose of antibiotic is administered.
2. 30 minutes after the first dose of antibiotics is administered.
3. During the first dose of antibiotics.
4. Before the first dose of antibiotics is administered.

Answer: 4

Rationale: When the physician orders a specimen to be collected, the nurse should collect the specimen before the first dose of antibiotics is administered, to ensure adequate organisms for culture.

Cognitive Level: Comprehension

Client Needs: Safe, Effective Care Environment

Nursing Process: Planning

10. Which of the following manifestations indicates a systemic reaction associated with an inflammatory response?

1. Erythema
2. Pain
3. Tachypnea (RR 26)
4. Edema

Answer: 3

Rationale: If the nurse observes a systemic reaction, the client will exhibit manifestations including temperature, increased pulse, tachypnea, and leukocytosis. Erythema, warmth, pain, edema, and functional impairment indicate a local reaction.

Cognitive Level: Application

Client Needs: Physiological Integrity

Nursing Process: Assessment

11. A client develops hyperthermia related to a diagnosis of Pneumonia. Which of the following nursing interventions would be effective in the treatment of hyperthermia? Select all that apply.

1. Increase the temperature of the room environment to prevent shivering.
2. Use ice packs and a tepid bath as needed.
3. Administer antipyretic medications per physician's orders.
4. Promote frequent rest periods to increase energy reserve.
5. Restrict fluids during periods of hyperthermia because of the risk of electrolyte imbalance.

Answer: 2; 3; 4

Rationale: Hyperthermia is an expected consequence of the infectious disease process. Fever can produce mild, short-term effects or, when prolonged, can cause life-threatening effects. The nurse should administer antipyretic medications as indicated for elevated temperatures. The nurse should use ice packs, cool/tepid baths, or hypothermia blanket with caution. The nurse should enforce frequent rest periods because rest increases energy reserve, which is depleted by an increased metabolic, heart, and respiratory rate. The nurse should encourage fluids rather than restrict fluids because of the risk of electrolyte imbalance.

Cognitive Level: Assessment

Client Needs: Physiological Integrity

Nursing Process: Implementation

12. The nurse is assessing a client's wound for signs and symptoms of inflammation. Which of the following would alert the nurse that the client is exhibiting signs of inflammation? Select all that apply.

1. Leg edema
2. Leg cool to touch
3. Severe pain from swelling