

## Chapter 01: Foundations of Safe Client Care

### Hollen & Stein: Concept-Based Clinical Nursing Skills, 1st Edition

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#### MULTIPLE CHOICE

1. What was the main finding of the Institute of Medicine's 1999 report *To Err is Human: Building a Better Healthcare System*?
  - a. Nursing personnel need better training and education to prevent errors.
  - b. Registered nurses should take the lead in reducing healthcare-associated errors.
  - c. Faulty systems, processes, and conditions combined cause the majority of errors.
  - d. Over 198,000 patients die each year when they are patients in a hospital.

ANS: C

The report *To Err is Human: Building a Better Healthcare System* provided the shocking information that as many as 98,000 patients die in hospital due to preventable errors. Instead of most errors being the fault of one person, the report stated that faulty systems, processes, and conditions combined were to blame. Although nurses are in a prime position to recognize and problem-solve these implicated contributors, the report did not specify that nurses should take the lead in solving the problem.

DIF: Cognitive Level: Remembering TOP: Integrated Process: Teaching-Learning

2. A nurse meets the assigned clients at the start of a shift. After performing hand hygiene and introducing one's self, what does the nurse do *next*?
  - a. Begin a head-to-toe assessment.
  - b. Identify the client using two identifiers.
  - c. Assess the client for pain.
  - d. Ensure the call light is within reach.

ANS: B

A critical task in healthcare for safety, client identification is paramount for preventing errors. After performing hand hygiene and introducing him- or herself, the nurse identifies the client using two unique identifiers. The head-to-toe and pain assessments come shortly afterward. The nurse ensures the client can reach the call light prior to leaving the room.

DIF: Cognitive Level: Understanding TOP: Nursing Process: Assessment

3. A nurse has worked with the same client for 2 days. When entering the room to administer medications, the nurse performs hand hygiene. What action does the nurse take *next*?
  - a. Provide any needed teaching.
  - b. Ask if the client has any care requests.
  - c. Assess vital signs and pain.
  - d. Identify the client using two identifiers.

ANS: D

Every time the client is to receive medication, diagnostic studies, or any other healthcare intervention, the nurse must identify the client using two unique identifiers, even if the client is well known to the nurse. Assessments, teaching, and determining client requests would come afterward.

DIF: Cognitive Level: Applying

TOP: Nursing Process: Assessment

4. A nurse's neighbor states "My father got a nosocomial infection after surgery!" What does the nurse understand happened to the client?
- The client received contaminated blood products.
  - The client nearly died from a postoperative infection.
  - The client acquired an infection while in the hospital.
  - The client received poor preoperative skin preparation.

ANS: C

A nosocomial infection is one acquired in the hospital. It does not designate how the infection occurred, so the client might have become infected through contaminated blood products or from poor preoperative skin preparation. It does not mean the client had a life-threatening infection, only that it occurred in hospital.

DIF: Cognitive Level: Understanding

TOP: Integrated Process: Teaching-Learning

5. A nurse is making rounds on clients at risk for infection. Which client does the nurse see *first*?
- A client with an intravenous (IV) line
  - A client who has a central line
  - A client with an indwelling bladder catheter
  - A client with an IV and bladder catheter

ANS: D

One of the biggest risk factors for hospital acquired infections (HAIs) is the presence of invasive lines. The more lines, the more risk. The client with both an IV and a catheter has the highest risk. The clients with an IV or a catheter have less risk. Nurses have adopted protocols that have dramatically reduced central line infections.

DIF: Cognitive Level: Applying

TOP: Nursing Process: Assessment

6. A nursing manager concerned about the infection rate on the unit wants to implement measures to reduce the transmission of infectious organisms. What action by the manager is *best*?
- Provide a stethoscope dedicated to each client.
  - Ensure gloves are well-stocked in each room.
  - Restrict all plants and fresh foods from rooms.
  - Screen all visitors for contagious illnesses.

ANS: A

In the chain of infection, one of the most important components is the mode of transmission. Stethoscopes can serve as a mode of indirect contact transmission unless they are disinfected between clients. Providing each client with an individual stethoscope will reduce this risk. Gloves are important, but they can become contaminated too and serve as a mode of transmission. Plants and fresh foods are an uncommon source of transmission unless the client is immunosuppressed. Screening visitors for contagious illness is an unrealistic long-term action plan.

DIF: Cognitive Level: Applying

TOP: Nursing Process: Implementation

7. A nurse is observing a student nurse. What action by the student demonstrates the need for *more* education on Standard Precautions?
- The student performs hand hygiene before all client contacts.
  - The student conscientiously wears gloves when taking vital signs.
  - The student confirms that urine possibly contains infectious microbes.
  - The student wears a gown when cleaning liquid stool off the client.

ANS: B

Standard Precautions operates under the principle that all bodily fluids other than sweat could potentially contain infectious microbial agents that pose a risk to the healthcare worker. Contact with skin, if free of those fluids, does not require wearing gloves, so the nurse would provide more education to the student. Hand hygiene is the first step of Standard Precautions. The student is being prudent by confirming a possible source of contamination. Nurses determine which infection prevention practice to use based upon the type of client–nurse interaction and the possibility of exposure to blood, other body fluids, or pathogens, so wearing a gown while cleaning liquid stool is appropriate.

DIF: Cognitive Level: Analyzing

TOP: Nursing Process: Evaluation

8. A faculty member has taught the correct technique for taking gloves off (doffing). While observing students practice, which action by a student indicates the need to *review* the material?
- Pulls glove off dominant hand first
  - Takes first glove off by grasping it on the outside
  - Takes second glove off by grasping it under the cuff
  - Turns the gloves inside out when second glove is removed

ANS: A

The correct way to remove gloves starts with doffing the glove on the nondominant hand first, without touching the bare skin. This student would need further review of the skill. Removing the first glove by grasping it on the outside, grasping the second glove under the cuff, and turning the gloves inside out to prevent microbe spread are all correct actions. These students would not need remediation.

DIF: Cognitive Level: Analyzing

TOP: Nursing Process: Evaluation

9. In order to move a client safely, which of the following actions does the nurse take *first*?
- Gather enough help for the task.
  - Assess the client's ability to bear weight.
  - Delegate using the lift chair.
  - Administer pain medication.

ANS: B

The first thing the nurse does when preparing to transfer a client is to assess the client's ability to bear weight and follow instructions. The findings will determine how much assistance (if any) the client needs. If the client needs maximal assistance, then the nurse gathers enough help and any lifting devices needed and assigns roles to each team member. If the client has pain, the nurse would administer pain medication, but that is not related to safety.

DIF: Cognitive Level: Applying

TOP: Nursing Process: Implementation

10. Hospital administration has rejected a request from nursing services for ceiling-mounted lifting/transferring devices pointing to the expense. What response by the Chief Nursing Officer would be *best*?
- “We need the equipment to stay competitive in hiring nurses.”
  - “They are required by The Joint Commission so we have to get them.”
  - “The cost of employee injuries from lifting is more expensive.”
  - “We will save money with fewer client-injury lawsuits being filed.”

ANS: C

Data show that when hospitals implemented safe client handling equipment, hospitals achieved savings by reducing lost work days and reducing worker compensation costs that met or exceeded the cost of the equipment. This is not a main focus for nurse recruitment and the equipment is not mandated. Fewer client injuries leading to lawsuits is a probability, but the savings in reducing employee injury have been documented by the ANA.

DIF: Cognitive Level: Understanding

TOP: Integrated Process: Communication and Documentation

11. The nurse places a bed-bound client in the position shown. What other considerations would the nurse have for this client?



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- Include a Trochanter roll to prevent of the neck.
- Assess whether the client needs support to prevent foot drop.
- Monitor for signs of increased intracranial pressure.
- Place a rolled-up washcloth in the client's hands.

ANS: B

The Sim's position is shown here. Considerations for the nurse include providing pillow support to keep the head and neck in alignment, to support the upper leg and prevent internal rotation, to support the upper arm and prevent internal rotation, and provide foot support to prevent foot drop. Hyperextension of the neck and increased intracranial pressure are concerns for clients in the Trendelenburg position. Placing something in the client's hands is not related to body position.

DIF: Cognitive Level: Applying

TOP: Nursing Process: Implementation

12. A nurse has applied restraints to a client. After documenting the care and ensuring the client is safe, what action does the nurse take *next*?
- Call the provider and request a prescription for the restraints.
  - Alert the hospital's Risk Management department.
  - Plan to check the client at a minimum of every 2 hours.
  - Assign assistive personnel to sit with the client.

ANS: C

The standard required by the Centers for Medicaid and Medicare Services is to assess the restrained client at a minimum of every 2 hours. In most situations, the nurse requests the prescription before applying the restraints, however; if it is necessary to apply them first, a prescription from the provider is needed within 1 hour. Although restraints are often the source of litigation, there is no need to routinely notify the Risk Management department about the use of restraints. The client may or may not need someone to sit with him or her.

DIF: Cognitive Level: Applying

TOP: Nursing Process: Implementation

13. The nursing student applies restraints. What action by the student demonstrates the need for *more* education on this procedure?
- The student attempts other methods to prevent harm before applying the restraints.
  - The student inserts two fingers between the restraint and client skin to check for tightness.
  - The student secures the restraint by tying the restraint to the side rail but out of client reach.
  - The student reassesses the client's need for the restraint at least every 2 hours.

ANS: C

The student should tie the restraint to a secure part of the bed frame, not to the side rail. Attempting alternatives to restraints, checking the tightness by placing two fingers under the restraint, and reassessing the client at least every 2 hours are all appropriate actions.

DIF: Cognitive Level: Analyzing

TOP: Nursing Process: Evaluation

14. The new nurse grumbles "Why are there so many regulations on using restraints?" What response by the mentor is *best*?
- "Clients have the right to be free from restraint or seclusion unless medically necessary."
  - "Following all these regulations helps prevent law suits."
  - "Accrediting bodies aren't in favor of using restraints so they make up regulations."
  - "Because restraints have been shown to actually increase injuries."

ANS: A

The guiding principle for restraint use is that clients have the right to be free from unnecessary restraint or seclusion unless it is medically necessary. This is a basic human right and protects client dignity. Following regulations won't necessarily prevent lawsuits, but will help prevent negative outcomes from the legal action. Accrediting bodies don't "just make up regulations." There are sound reasons for them. Restraints have been shown to increase injury, but that is secondary to the fact that clients have the right to be free from them unless absolutely needed.

DIF: Cognitive Level: Understanding

TOP: Integrated Process: Teaching-Learning