Berman/Snyder, Test Bank for *Skills in Clinical Nursing* 8th Edition
Chapter 1

Question 1
Type: MCSA

The nurse is caring for a client who developed an infection after admission to the hospital. Which term would the nurse use when documenting this infection?

1. Nosocomial infection

2. Bacterial infection

3. Health care-associated infection

4. Therapeutic infection

Correct Answer: 1

Rationale 1: A nosocomial infection is an infection that originates specifically in the hospital, whereas a health care-associated infection can originate in any health care setting. Not enough information is provided to determine whether the infection is bacterial in nature, and there is no such thing as a therapeutic infection.

Rationale 2: A nosocomial infection is an infection that originates specifically in the hospital, whereas a health care-associated infection can originate in any health care setting. Not enough information is provided to determine whether the infection is bacterial in nature, and there is no such thing as a therapeutic infection.

Rationale 3: A nosocomial infection is an infection that originates specifically in the hospital, whereas a health care-associated infection can originate in any health care setting. Not enough information is provided to determine whether the infection is bacterial in nature, and there is no such thing as a therapeutic infection.

Rationale 4: A nosocomial infection is an infection that originates specifically in the hospital, whereas a health care-associated infection can originate in any health care setting. Not enough information is provided to determine whether the infection is bacterial in nature, and there is no such thing as a therapeutic infection.

Global Rationale: A nosocomial infection is an infection that originates specifically in the hospital, whereas a health care-associated infection can originate in any health care setting. Not enough information is provided to determine whether the infection is bacterial in nature, and there is no such thing as a therapeutic infection.

Cognitive Level: Applying
Client Need: Physiological Integrity
Client Need Sub: Physiological Adaptation
QSEN Competencies: V.B.1. Demonstrate effective use of technology and standardized practices that support safety and quality
AACN Essential Competencies: II.5. Participate in quality and client safety initiatives, recognizing that these are complex system issues that involve individuals, families, groups, communities, populations, and other members of the health care team

NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe client care
Nursing/Integrated Concepts: Nursing Process: Assessment
Learning Outcome: Define the key terms used in foundational skills and equipment that protect nurses and clients.
Page Number: p. 6

Question 2
Type: MCMA

The nurse would use a Situation, Background, Assessment, and Recommendation (SBAR) process in which situations?

Standard Text: Select all that apply.

1. Discharging a client

2. Transferring a client to another unit

3. Contacting the primary care provider

4. Changing from day to evening shift

5. Informing family members of client status

Correct Answer: 2,3,4

Rationale 1: The SBAR is used to enhance the safety of the client in situations where nurses are communicating with other members of the health care team, such as when transferring the client to another unit, conducting change-of-shift report, or contacting the primary care provider. The SBAR is not used for discharge teaching or notifying family members of the client's status.

Rationale 2: The SBAR is used to enhance the safety of the client in situations where nurses are communicating with other members of the health care team, such as when transferring the client to another unit, conducting change-of-shift report, or contacting the primary care provider. The SBAR is not used for discharge teaching or notifying family members of the client's status.

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change-of-shift report, or contacting the primary care provider. The SBAR is not used for discharge teaching or notifying family members of the client's status.

Global Rationale: The SBAR is used to enhance the safety of the client in situations where nurses are communicating with other members of the health care team, such as when transferring the client to another unit, conducting change-of-shift report, or contacting the primary care provider. The SBAR is not used for discharge teaching or notifying family members of the client's status.

Cognitive Level: Applying
Client Need: Safe and Effective Care Environmnet
Client Need Sub: Management of Care
QSEN Competencies: V.B.1. Demonstrate effective use of technology and standardized practices that support safety and quality
AACN Essential Competencies: II.5. Participate in quality and client safety initiatives, recognizing that these are complex system issues, that involve individuals, families, groups, communities, populations, and other members of the health care team
NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe client care
Nursing/Integrated Concepts: Nursing Process: Implementation
Learning Outcome: Define the key terms used in foundational skills and equipment that protect nurses and clients.
Page Number: p. 15

Question 3
Type: MCSA

The nurse is caring for a client with a medical diagnosis of HIV/AIDS admitted to the hospital with *Pneumocystis carinii* infection. In order to reduce the spread of infection, which is the priority nursing intervention?

1. Teaching the client to provide self-care

2. Teaching respiratory/cough etiquette

3. Teaching the use of sexual barriers

4. Teaching the use of standard precautions

Correct Answer: 2

Rationale 1: The client with a respiratory infection would benefit most from learning how to use respiratory hygiene/cough etiquette in order to reduce the risk of spreading infection to others. Although teaching the use of sexual barriers would reduce the risk of sexually transmitted infections, it is not the priority need at this time. Teaching self-care might be indicated for this client, but it is not related to reducing the spread of infection. Standard precautions are used by the health care provider, and are not generally taught to clients.

Rationale 2: The client with a respiratory infection would benefit most from learning how to use respiratory hygiene/cough etiquette in order to reduce the risk of spreading infection to others. Although teaching the use of

sexual barriers would reduce the risk of sexually transmitted infections, it is not the priority need at this time. Teaching self-care might be indicated for this client, but it is not related to reducing the spread of infection. Standard precautions are used by the health care provider, and are not generally taught to clients.

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Global Rationale: The client with a respiratory infection would benefit most from learning how to use respiratory hygiene/cough etiquette in order to reduce the risk of spreading infection to others. Although teaching the use of sexual barriers would reduce the risk of sexually transmitted infections, it is not the priority need at this time. Teaching self-care might be indicated for this client, but it is not related to reducing the spread of infection. Standard precautions are used by the health care provider, and are not generally taught to clients.

Cognitive Level: Analyzing
Client Need: Physiological Integrity
Client Need Sub: Reduction of Risk Potential
QSEN Competencies: V.B.1. Demonstrate effective use of technology and standardized practices that support safety and quality
AACN Essential Competencies: II.5. Participate in quality and client safety initiatives, recognizing that these are complex system issues that involve individuals, families, groups, communities, populations, and other members of the health care team
NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe client care
Nursing/Integrated Concepts: Nursing Process: Implementation
Learning Outcome: Define the key terms used in foundational skills and equipment that protect nurses and clients.
Page Number: p. 4

Question 4
Type: MCMA

Which tasks would be appropriate for the nurse to delegate to the unlicensed assistive personnel (UAP)?

Standard Text: Select all that apply.

1. Taking vital signs

2. Measuring and recording intake and output

3. Postmortem care

4. Providing telephone advice

5. Weighing the client

Correct Answer: 1,2,3,5

Rationale 1: Tasks requiring advanced education such as assessment, interpretation of data, planning client care, or evaluating care are not delegated to the UAP. Telephone advice involves gathering data, analysis, and planning care, which would all be beyond the scope of practice. Vital sign measurement, recording intake and output, providing postmortem care, and weighing the client are all appropriate tasks to delegate to the UAP.

Rationale 2: Tasks requiring advanced education such as assessment, interpretation of data, planning client care, or evaluating care are not delegated to the UAP. Telephone advice involves gathering data, analysis, and planning care, which would all be beyond the scope of practice. Vital sign measurement, recording intake and output, providing postmortem care, and weighing the client are all appropriate tasks to delegate to the UAP.

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Cognitive Level: Analyzing
Client Need: Safe and Effective Care Environment
Client Need Sub: Management of Care
QSEN Competencies: II.B.5. Assume role of team member or leader based on the situation
AACN Essential Competencies: II.1.Apply leadership concepts, skills, and decision making in the provision of high-quality nursing care, health care team coordination, and the oversight and accountability for care delivery in a variety of settings
NLN Competencies: Teamwork: Manage delegation effectively.
Nursing/Integrated Concepts: Nursing Process: Planning
Learning Outcome: Recognize when it is appropriate to delegate skills to unlicensed assistive personnel.
Page Number: pp. 3-4

Question 5
Type: MCSA

The nurse observes the newly hired unlicensed assistive personnel (UAP) performing routine client care. Which behaviors would indicate the UAP understands the use of personal protective equipment?

1. The UAP removes his gown first and then his gloves after providing care.

2. The UAP applies gloves before emptying the client's indwelling catheter bag, then removes gloves and washes hands before measuring urine output.

3. The UAP applies gloves to clean the client's dentures, then removes gloves and performs hand hygiene prior to bathing the client.

4. The UAP wears gown and gloves when performing postmortem care.

Correct Answer: 3

Rationale 1: Gloves are required when providing denture care, but are not required for bathing the client. Whenever gloves are removed, the health care provider should perform hand hygiene. Gloves are removed before removing the gown. The nurse should not remove gloves until after measuring urine output and rinsing the measuring container and returning it to its storage location. Gloves should be worn when performing postmortem care, but a gown is generally not required.

Rationale 2: Gloves are required when providing denture care, but are not required for bathing the client. Whenever gloves are removed, the health care provider should perform hand hygiene. Gloves are removed before removing the gown. The nurse should not remove gloves until after measuring urine output and rinsing the measuring container and returning it to its storage location. Gloves should be worn when performing postmortem care, but a gown is generally not required.

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Cognitive Level: Applying

Client Need: Safe and Effective Care Environment
Client Need Sub: Safety and Infection Control
QSEN Competencies: V.B.1. Demonstrate effective use of technology and standardized practices that support safety and quality
AACN Essential Competencies: II.5. Participate in quality and client safety initiatives, recognizing that these are complex system issues, that involve individuals, families, groups, communities, populations, and other members of the health care team
NLN Competencies: Context and Environment: Apply health promotion/disease prevention strategies; apply health policy
Nursing/Integrated Concepts: Nursing Process: Evaluation
Learning Outcome: Describe factors that affect the use of personal protective equipment such as gloves, gowns, masks, and eyewear.
Page Number: pp. 10-12

Question 6
Type: MCSA

The nurse is caring for a client with a deep draining abdominal wound. Which factor would require the nurse to wear a mask and goggles when caring for this client?

1. The wound is infected.

2. The client is confused and disoriented.

3. The wound is covered by wet-to-damp dressings.

4. The client is HIV-positive.

Correct Answer: 2

Rationale 1: The client who is confused and disoriented might not cooperate with care, and could cause splashing of wound drainage, so the nurse should wear a mask and goggles when caring for this client. The other factors would cause the nurse to don gloves and a gown, but would not lead to the use of mask and goggles.

Rationale 2: The client who is confused and disoriented might not cooperate with care, and could cause splashing of wound drainage, so the nurse should wear a mask and goggles when caring for this client. The other factors would cause the nurse to don gloves and a gown, but would not lead to the use of mask and goggles.

Rationale 3: The client who is confused and disoriented might not cooperate with care, and could cause splashing of wound drainage, so the nurse should wear a mask and goggles when caring for this client. The other factors would cause the nurse to don gloves and a gown, but would not lead to the use of mask and goggles.

Rationale 4: The client who is confused and disoriented might not cooperate with care, and could cause splashing of wound drainage, so the nurse should wear a mask and goggles when caring for this client. The other factors would cause the nurse to don gloves and a gown, but would not lead to the use of mask and goggles.

Global Rationale: The client who is confused and disoriented might not cooperate with care, and could cause splashing of wound drainage, so the nurse should wear a mask and goggles when caring for this client. The other factors would cause the nurse to don gloves and a gown, but would not lead to the use of mask and goggles.

Cognitive Level: Analyzing
Client Need: Physiological Integrity
Client Need Sub: Reduction of Risk Potential
QSEN Competencies: V.B.1. Demonstrate effective use of technology and standardized practices that support safety and quality
AACN Essential Competencies: II.5. Participate in quality and client safety initiatives, recognizing that these are complex system issues, that involve individuals, families, groups, communities, populations, and other members of the health care team
NLN Competencies: Context and Environment: Apply health promotion/disease prevention strategies; apply health policy
Nursing/Integrated Concepts: Nursing Process: Planning
Learning Outcome: Describe factors that affect the use of personal protective equipment such as gloves, gowns, masks, and eyewear.
Page Number: p. 10

Question 7
Type: MCSA

The registered nurse effectively delegates which procedure to the unlicensed assistive personnel (UAP)?

1. Making a nursing diagnosis

2. Assisting a client to bedside commode

3. Performing assessments on client

4. Giving the client pain medication

Correct Answer: 2

Rationale 1: Tasks requiring advanced education such as assessment, interpretation of data, planning client care, or evaluating care are not delegated to the UAP. Formulating a nursing diagnosis is not a task that can be delegated to the UAP.

Rationale 2: Assisting a client to a bedside commode is an activity that can be delegated to the UAP.

Rationale 3: Tasks requiring advanced education such as assessment, interpretation of data, planning client care, or evaluating care are not delegated to the UAP. Assessment is not a task that can be delegated to the UAP.

Rationale 4: Tasks requiring advanced education such as assessment, interpretation of data, planning client care, or evaluating care are not delegated to the UAP. Administering pain medication is not an activity that can be delegated to the UAP.

Global Rationale: Assisting a client to a bedside commode is an activity that can be delegated to the UAP. Tasks requiring advanced education such as assessment, interpretation of data, planning client care, or evaluating care are not delegated to the UAP. Formulating a nursing diagnosis, performing an assessment, and administering pain medications are activities that cannot be delegated to the UAP.

Cognitive Level: Applying
Client Need: Safe and Effective Care Environment
Client Need Sub: Management of Care
QSEN Competencies: II.B.5.Assume role of team member or leader based on the situation
AACN Essential Competencies: II.1.Apply leadership concepts, skills, and decision making in the provision of high-quality nursing care, health care team coordination, and the oversight and accountability for care delivery in a variety of settings
NLN Competencies: Teamwork: Manage delegation effectively.
Nursing/Integrated Concepts: Nursing Process: Planning
Learning Outcome: Recognize when it is appropriate to delegate skills to unlicensed assistive personnel.
Page Number: pp. 3-4

Question 8
Type: MCMA

Principles guiding the nurse's decision to delegate ensure the safety and quality of outcomes. The decision to delegate requires clear communication. The nurse knows that the UAP understands all directions when the UAP makes which statement?

Standard Text: Select all that apply.

1. "I will bathe the client in room 402."

2. "I am done with the assigned tasks for Mr. Wells."

3. "I can give the medication for you."

4. "I will note all orders."

5. "I understand my assignment is to take and document the vital signs."

Correct Answer: 1,2,5

Rationale 1: Restating the task to the nurse indicates understanding and appropriate communication during delegation.

Rationale 2: Telling the nurse that the assigned tasks are done indicates understanding and appropriate communication during delegation.

Rationale 3: Medication administration cannot be delegated.

Rationale 4: The UAP cannot note orders on the medical record. This activity must be done by the nurse.

Rationale 5: Restating the task to the nurse indicates understanding and appropriate communication during delegation.

Global Rationale: Restating the task to the nurse indicates understanding and appropriate communication during delegation. Telling the nurse that the assigned tasks are done indicates understanding and appropriate

communication during delegation. Medication administration cannot be delegated. The UAP cannot note orders on the medical record. This activity must be done by the nurse.

Cognitive Level: Understanding
Client Need: Safe and Effective Care Environment
Client Need Sub: Management of Care
QSEN Competencies: II.B.5. Assume role of team member or leader based on the situation
AACN Essential Competencies: II.1. Apply leadership concepts, skills and decision making in the provision of high quality nursing care, health care team coordination, and the oversight and accountability for care delivery in a variety of settings
NLN Competencies: Teamwork: Manage delegation effectively.
Nursing/Integrated Concepts: Nursing Process: Planning
Learning Outcome: Recognize when it is appropriate to delegate skills to unlicensed assistive personnel.
Page Number: pp. 3-4

Question 9
Type: MCMA

Which items will the nurse use with all clients to prevent the transmission of potentially infective organisms among the nurse, client, and other individuals?

Standard Text: Select all that apply.

1. Hand hygiene

2. Standard precautions

3. Personal protective equipment

4. Isolation procedures

5. Antimicrobial soap

Correct Answer: 1,2,3

Rationale 1: The nurse should use hand hygiene, standard precautions, and personal protective equipment with all clients. Isolation procedures and antimicrobial soaps are indicated for some clients but not all.

Rationale 2: The nurse should use hand hygiene, standard precautions, and personal protective equipment with all clients. Isolation procedures and antimicrobial soaps are indicated for some clients but not all.

Rationale 3: The nurse should use hand hygiene, standard precautions, and personal protective equipment with all clients. Isolation procedures and antimicrobial soaps are indicated for some clients but not all.

Rationale 4: The nurse should use hand hygiene, standard precautions, and personal protective equipment with all clients. Isolation procedures and antimicrobial soaps are indicated for some clients but not all.

Rationale 5: The nurse should use hand hygiene, standard precautions, and personal protective equipment with all clients. Isolation procedures and antimicrobial soaps are indicated for some clients but not all.

Global Rationale: The nurse should use hand hygiene, standard precautions, and personal protective equipment with all clients. Isolation procedures and antimicrobial soaps are indicated for some clients but not all.

Cognitive Level: Remembering
Client Need: Physiological Integrity
Client Need Sub: Reduction of Risk Potential
QSEN Competencies: V.B.1. Demonstrate effective use of technology and standardized practices that support safety and quality
AACN Essential Competencies: II.5. Participate in quality and client safety initiatives, recognizing that these are complex system issues, that involve individuals, families, groups, communities, populations, and other members of the health care team
NLN Competencies: Context and Environment: Apply health promotion/disease prevention strategies; apply health policy
Nursing/Integrated Concepts: Nursing Process: Implementation
Learning Outcome: Identify indications for standard precautions and hand hygiene.
Page Number: pp. 4-12

Question 10
Type: MCSA

The nurse observing the unlicensed assistive personnel (UAP) using alcohol-based rubs for hand hygiene would recognize that further teaching is required when the UAP performs which act?

1. Rubs palm against palm when washing hands.

2. Applies a palmful of product into cupped hands.

3. Interlaces fingers palm to palm.

4. Dries hands with clean paper towel.

Correct Answer: 4

Rationale 1: When using an alcohol-based hand rub, the hands should not be dried. Rubbing of hands palm to palm and interlacing fingers are continued until the product dries, which takes about 20–30 seconds. A palmful of product is generally required to coat all surfaces.

Rationale 2: When using an alcohol-based hand rub, the hands should not be dried. Rubbing of hands palm to palm and interlacing fingers are continued until the product dries, which takes about 20–30 seconds. A palmful of product is generally required to coat all surfaces.

Rationale 3: When using an alcohol-based hand rub, the hands should not be dried. Rubbing of hands palm to palm and interlacing fingers are continued until the product dries, which takes about 20–30 seconds. A palmful of product is generally required to coat all surfaces.

Rationale 4: When using an alcohol-based hand rub, the hands should not be dried. Rubbing of hands palm to palm and interlacing fingers are continued until the product dries, which takes about 20–30 seconds. A palmful of product is generally required to coat all surfaces.

Global Rationale: When using an alcohol-based hand rub, the hands should not be dried. Rubbing of hands palm to palm and interlacing fingers are continued until the product dries, which takes about 20–30 seconds. A palmful of product is generally required to coat all surfaces.

Cognitive Level: Applying
Client Need: Safe and Effective Care Environment
Client Need Sub: Safety and Infection Control
QSEN Competencies: V.B.1. Demonstrate effective use of technology and standardized practices that support safety and quality
AACN Essential Competencies: II.5. Participate in quality and client safety initiatives, recognizing that these are complex system issues, that involve individuals, families, groups, communities, populations, and other members of the health care team
NLN Competencies: Context and Environment: Apply health promotion/disease prevention strategies; apply health policy
Nursing/Integrated Concepts: Nursing Process: Evaluation
Learning Outcome: Identify indications for standard precautions and hand hygiene.
Page Number: pp. 6-7

Question 11
Type: MCSA

The nurse is working in a day care center for infants with special needs where there recently has been an outbreak of viral conjunctivitis. Which instruction by the nurse to the staff is the best way to stop the spread of this infection?

1. Require all children with conjunctivitis to stay home until there is a reduction in drainage.

2. Require all children with an infection to be on otic antibiotics for at least 24 hours prior to returning to school.

3. Isolate all children with conjunctivitis in the same room away from those who are not infected.

4. Perform hand hygiene after providing personal care for all children.

Correct Answer: 4

Rationale 1: The best way to reduce the spread of infection is through thorough hand hygiene. There would be no need to place a child with a viral illness on antibiotics, to isolate children with conjunctivitis, or to keep children away from the day care center.

Rationale 2: The best way to reduce the spread of infection is through thorough hand hygiene. There would be no need to place a child with a viral illness on antibiotics, to isolate children with conjunctivitis, or to keep children away from the day care center.

Rationale 3: The best way to reduce the spread of infection is through thorough hand hygiene. There would be no need to place a child with a viral illness on antibiotics, to isolate children with conjunctivitis, or to keep children away from the day care center.

Rationale 4: The best way to reduce the spread of infection is through thorough hand hygiene. There would be no need to place a child with a viral illness on antibiotics, to isolate children with conjunctivitis, or to keep children away from the day care center.

Global Rationale: The best way to reduce the spread of infection is through thorough hand hygiene. There would be no need to place a child with a viral illness on antibiotics, to isolate children with conjunctivitis, or to keep children away from the day care center.

Cognitive Level: Analyzing
Client Need: Safe and Effective Care Environment
Client Need Sub: Safety and Infection Control
QSEN Competencies: V.B.1. Demonstrate effective use of technology and standardized practices that support safety and quality
AACN Essential Competencies: II.5. Participate in quality and client safety initiatives, recognizing that these are complex system issues, that involve individuals, families, groups, communities, populations, and other members of the health care team
NLN Competencies: Context and Environment: Apply health promotion/disease prevention strategies; apply health policy
Nursing/Integrated Concepts: Nursing Process: Implementation
Learning Outcome: Identify indications for standard precautions and hand hygiene.
Page Number: pp. 6-7

Question 12
Type: MCSA

The nurse would don clean disposable gloves in which situation?

1. When providing denture care

2. When bathing a client

3. When applying antiemboli stockings

4. When assessing vital signs

Correct Answer: 1

Rationale 1: The purpose of gloves is to protect the hands when the nurse is likely to handle any potentially infective material. When providing denture care, the nurse is in contact with mucous membranes and body secretions, so gloves would be required. In most instances, unless the client has an open wound, gloves would not be required when bathing a client, applying stockings, or assessing vital signs.

Rationale 2: The purpose of gloves is to protect the hands when the nurse is likely to handle any potentially infective material. When providing denture care, the nurse is in contact with mucous membranes and body

secretions, so gloves would be required. In most instances, unless the client has an open wound, gloves would not be required when bathing a client, applying stockings, or assessing vital signs.

Rationale 3: The purpose of gloves is to protect the hands when the nurse is likely to handle any potentially infective material. When providing denture care, the nurse is in contact with mucous membranes and body secretions, so gloves would be required. In most instances, unless the client has an open wound, gloves would not be required when bathing a client, applying stockings, or assessing vital signs.

Rationale 4: The purpose of gloves is to protect the hands when the nurse is likely to handle any potentially infective material. When providing denture care, the nurse is in contact with mucous membranes and body secretions, so gloves would be required. In most instances, unless the client has an open wound, gloves would not be required when bathing a client, applying stockings, or assessing vital signs.

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Cognitive Level: Remembering
Client Need: Safe and Effective Care Environment
Client Need Sub: Safety and Infection Control
QSEN Competencies: V.B.1. Demonstrate effective use of technology and standardized practices that support safety and quality
AACN Essential Competencies: II.5. Participate in quality and client safety initiatives, recognizing that these are complex system issues, that involve individuals, families, groups, communities, populations, and other members of the health care team
NLN Competencies: Context and Environment: Apply health promotion/disease prevention strategies; apply health policy
Nursing/Integrated Concepts: Nursing Process: Implementation
Learning Outcome: Describe factors that affect the use of personal protective equipment such as gloves, gowns, masks, and eyewear.
Page Number: p. 10

Question 13
Type: MCSA

The nurse, working in an emergency department, is preparing to care for a client admitted with a traumatic amputation of the left hand. Which personal protective equipment would the nurse wear?

1. Gloves

2. Gown and gloves

3. Gown, gloves, and mask

4. Gloves and mask

Correct Answer: 3

Rationale 1: Because of the high risk of arterial blood spatter, the nurse would wear gown, gloves, and mask.

Rationale 2: Because of the high risk of arterial blood spatter, the nurse would wear gown, gloves, and mask.

Rationale 3: Because of the high risk of arterial blood spatter, the nurse would wear gown, gloves, and mask.

Rationale 4: Because of the high risk of arterial blood spatter, the nurse would wear gown, gloves, and mask.

Global Rationale: Because of the high risk of arterial blood spatter, the nurse would wear gown, gloves, and mask.

Cognitive Level: Applying
Client Need: Physiological Integrity
Client Need Sub: Reduction of Risk Potential
QSEN Competencies: V.B.1. Demonstrate effective use of technology and standardized practices that support safety and quality
AACN Essential Competencies: II.5. Participate in quality and client safety initiatives, recognizing that these are complex system issues, that involve individuals, families, groups, communities, populations, and other members of the health care team
NLN Competencies: Context and Environment: Apply health promotion/disease prevention strategies; apply health policy
Nursing/Integrated Concepts: Nursing Process: Planning
Learning Outcome: Describe factors that affect the use of personal protective equipment such as gloves, gowns, masks, and eyewear.
Page Number: p. 10

Question 14
Type: MCSA

The charge nurse is observing a staff nurse caring for a client with extensive burns. Which action by the staff nurse would indicate the need for further teaching regarding infection-control procedures?

1. The nurse wears gloves and gown when dressing the client's wounds.

2. The nurse wears gloves when bathing the client.

3. The nurse wears gown, gloves, and mask when assisting the physician with debridement of the wound.

4. The nurse wears gloves when teaching a family member how to meet the client's nutritional needs after discharge.

Correct Answer: 4

Rationale 1: There would be no need for a nurse to wear protective equipment when sitting at the client's bedside conducting nutrition counseling. However, because of the client's extensive skin damage, gloves would be worn when bathing the client; gloves and gown would be worn when dressing the wounds due to the potential for contamination of the nurse's uniform; and gown, glove, and mask would be needed when debriding due to potential blood spatter.

Rationale 2: There would be no need for a nurse to wear protective equipment when sitting at the client's bedside conducting nutrition counseling. However, because of the client's extensive skin damage, gloves would be worn when bathing the client; gloves and gown would be worn when dressing the wounds due to the potential for contamination of the nurse's uniform; and gown, glove, and mask would be needed when debriding due to potential blood spatter.

Rationale 3: There would be no need for a nurse to wear protective equipment when sitting at the client's bedside conducting nutrition counseling. However, because of the client's extensive skin damage, gloves would be worn when bathing the client; gloves and gown would be worn when dressing the wounds due to the potential for contamination of the nurse's uniform; and gown, glove, and mask would be needed when debriding due to potential blood spatter.

Rationale 4: There would be no need for a nurse to wear protective equipment when sitting at the client's bedside conducting nutrition counseling. However, because of the client's extensive skin damage, gloves would be worn when bathing the client; gloves and gown would be worn when dressing the wounds due to the potential for contamination of the nurse's uniform; and gown, glove, and mask would be needed when debriding due to potential blood spatter.

Global Rationale: There would be no need for a nurse to wear protective equipment when sitting at the client's bedside conducting nutrition counseling. However, because of the client's extensive skin damage, gloves would be worn when bathing the client; gloves and gown would be worn when dressing the wounds due to the potential for contamination of the nurse's uniform; and gown, glove, and mask would be needed when debriding due to potential blood spatter.

Cognitive Level: Analyzing
Client Need: Safe and Effective Care Environment
Client Need Sub: Safety and Infection Control
QSEN Competencies: V.B.1. Demonstrate effective use of technology and standardized practices that support safety and quality
AACN Essential Competencies: II.5. Participate in quality and client safety initiatives, recognizing that these are complex system issues, that involve individuals, families, groups, communities, populations, and other members of the health care team
NLN Competencies: Context and Environment: Apply health promotion/disease prevention strategies; apply health policy
Nursing/Integrated Concepts: Nursing Process: Implementation
Learning Outcome: Describe factors that affect the use of personal protective equipment such as gloves, gowns, masks, and eyewear.
Page Number: p. 10

Question 15
Type: MCSA

When planning care for a client, the nurse uses which equipment?

1. Personal protective equipment

2. Sterile gloves

3. Biohazard suit

4. Mask and eyewear

Correct Answer: 1

Rationale 1: All health care providers must apply PPE (clean or sterile gloves, gowns, masks, and protective eyewear) according to the risk of exposure to potentially infective materials.

Rationale 2: Sterile gloves may or may not be required, depending on the risk of exposure to potentially infective materials.

Rationale 3: Biohazardous waste is placed in a container with special labeling and may require the use of PPE, but not a biohazard suit.

Rationale 4: Mask and eyewear may or may not be required, depending on the risk of exposure to potentially infective material.

Global Rationale: All health care providers must apply PPE (clean or sterile gloves, gowns, masks, and protective eyewear) according to the risk of exposure to potentially infective materials. Sterile gloves and mask and eyewear may or may not be required, depending on the risk of exposure to potentially infective materials. Biohazardous waste is placed in a container with special labeling and may require the use of PPE, but not a biohazard suit.

Cognitive Level: Remembering
Client Need: Safe and Effective Care Environment
Client Need Sub: Safety and Infection Control
QSEN Competencies: V.B.1. Demonstrate effective use of technology and standardized practices that support safety and quality
AACN Essential Competencies: II.5. Participate in quality and client safety initiatives, recognizing that these are complex system issues, that involve individuals, families, groups, communities, populations, and other members of the health care team
NLN Competencies: Context and Environment: Apply health promotion/disease prevention strategies; apply health policy
Nursing/Integrated Concepts: Nursing Process: Planning
Learning Outcome: Describe factors that affect the use of personal protective equipment such as gloves, gowns, masks, and eyewear.
Page Number: p. 10

Question 16
Type: MCSA

The nurse is caring for a client on respiratory isolation and will use which protective equipment?

1. Face mask

2. Gown only

3. Gloves only

4. Mask and gloves

Correct Answer: 4

Rationale 1: Although a face mask will be used, this answer is only partially correct as gloves are also required.

Rationale 2: The nurse will require the use of more than a gown when caring for a client on respiratory isolation.

Rationale 3: The nurse will require the use of more than gloves when caring for a client on respiratory isolation.

Rationale 4: A face mask and gloves are essential equipment when providing care to a client on respiratory isolation.

Global Rationale: A face mask and gloves are essential equipment when providing care to a client on respiratory isolation. The nurse will require the use of more than a gown when caring for a client on respiratory isolation. The nurse will require the use of more than gloves when caring for a client on respiratory isolation.

Cognitive Level: Remembering
Client Need: Safe and Effective Care Environment
Client Need Sub: Safety and Infection Control
QSEN Competencies: V.B.1. Demonstrate effective use of technology and standardized practices that support safety and quality
AACN Essential Competencies: II.5. Participate in quality and client safety initiatives, recognizing that these are complex system issues, that involve individuals, families, groups, communities, populations, and other members of the health care team
NLN Competencies: Context and Environment: Apply health promotion/disease prevention strategies; apply health policy
Nursing/Integrated Concepts: Nursing Process: Planning
Learning Outcome: Describe factors that affect the use of personal protective equipment such as gloves, gowns, masks, and eyewear.
Page Number: p. 10

Question 17
Type: MCMA

The nurse is assisting the health care provider insert a chest tube into a client with a hemothorax following a motor vehicle crash. Which would the nurse don in order to assist with this procedure?

Standard Text: Select all that apply.

1. Sterile gown

2. Sterile gloves

3. Mask with eye shield

4. Mask

5. Clean gown

Correct Answer: 3,5

Rationale 1: The nurse would not need to don sterile gown or gloves, because the role of the nurse is to monitor the client during the procedure. However, due to the risk of splatter, the nurse would wear a gown and mask with eye shield.

Rationale 2: The nurse would not need to don sterile gown or gloves, because the role of the nurse is to monitor the client during the procedure. However, due to the risk of splatter, the nurse would wear a gown and mask with eye shield.

Rationale 3: The nurse would not need to don sterile gown or gloves, because the role of the nurse is to monitor the client during the procedure. However, due to the risk of splatter, the nurse would wear a gown and mask with eye shield.

Rationale 4: The nurse would not need to don sterile gown or gloves, because the role of the nurse is to monitor the client during the procedure. However, due to the risk of splatter, the nurse would wear a gown and mask with eye shield.

Rationale 5: The nurse would not need to don sterile gown or gloves, because the role of the nurse is to monitor the client during the procedure. However, due to the risk of splatter, the nurse would wear a gown and mask with eye shield.

Global Rationale: The nurse would not need to don sterile gown or gloves, because the role of the nurse is to monitor the client during the procedure. However, due to the risk of splatter, the nurse would wear a gown and mask with eye shield.

Cognitive Level: Applying
Client Need: Safe and Effective Care Environment
Client Need Sub: Safety and Infection Control.
QSEN Competencies: V.B.1. Demonstrate effective use of technology and standardized practices that support safety and quality
AACN Essential Competencies: II.5. Participate in quality and client safety initiatives, recognizing that these are complex system issues, that involve individuals, families, groups, communities, populations, and other members of the health care team
NLN Competencies: Context and Environment: Apply health promotion/disease prevention strategies; apply health policy
Nursing/Integrated Concepts: Nursing Process: Planning
Learning Outcome: Describe factors that affect the use of personal protective equipment such as gloves, gowns, masks, and eyewear.
Page Number: pp. 10, 12-14

Question 18
Type: MCSA

The nurse wearing personal protective equipment would take which article off first?

1. Gown

2. Gloves

3. Mask

4. Gloves and gown at the same time

Correct Answer: 2

Rationale 1: Gloves are always removed first because they are the most soiled. If wearing a gown that is tied at the waist, the ties would be undone before removing the gloves, and then the gown and mask may be removed and hand hygiene should be performed.

Rationale 2: Gloves are always removed first because they are the most soiled. If wearing a gown that is tied at the waist, the ties would be undone before removing the gloves, and then the gown and mask may be removed and hand hygiene should be performed.

Rationale 3: Gloves are always removed first because they are the most soiled. If wearing a gown that is tied at the waist, the ties would be undone before removing the gloves, and then the gown and mask may be removed and hand hygiene should be performed.

Rationale 4: Gloves are always removed first because they are the most soiled. If wearing a gown that is tied at the waist, the ties would be undone before removing the gloves, and then the gown and mask may be removed and hand hygiene should be performed.

Global Rationale: Gloves are always removed first because they are the most soiled. If wearing a gown that is tied at the waist, the ties would be undone before removing the gloves, and then the gown and mask may be removed and hand hygiene should be performed.

Cognitive Level: Remembering
Client Need: Safe and Effective Care Environment
Client Need Sub: Safety and Infection Control
QSEN Competencies: V.B.1. Demonstrate effective use of technology and standardized practices that support safety and quality
AACN Essential Competencies: II.5. Participate in quality and client safety initiatives, recognizing that these are complex system issues, that involve individuals, families, groups, communities, populations, and other members of the health care team
NLN Competencies: Context and Environment: Apply health promotion/disease prevention strategies; apply health policy
Nursing/Integrated Concepts: Nursing Process: Implementation
Learning Outcome: Verbalize the steps used in:
a. Using standard precautions.
b. Performing hand hygiene.
c. Applying and removing personal protective equipment (gloves, gown, mask, eyewear).
d. Assisting with invasive procedures.
Page Number: pp. 10-12

Question 19
Type: MCSA

The nurse is assisting the health care provider with the insertion of a chest tube. Which personal protective equipment would the nurse don?

1. Sterile gloves, gown, and mask

2. Clean gloves, gown, and mask with eye shield or goggles

3. Sterile gloves, gown, and mask with eye shields or goggles

4. Clean gloves, gown, and mask

Correct Answer: 2

Rationale 1: Because of the risk of spray from the inserted chest tube, the nurse should wear gloves, mask with eye shield or mask and goggles, and a gown. There is no need for the nurse to wear sterile gloves during the procedure.

Rationale 2: Because of the risk of spray from the inserted chest tube, the nurse should wear gloves, mask with eye shield or mask and goggles, and a gown. There is no need for the nurse to wear sterile gloves during the procedure.

Rationale 3: Because of the risk of spray from the inserted chest tube, the nurse should wear gloves, mask with eye shield or mask and goggles, and a gown. There is no need for the nurse to wear sterile gloves during the procedure.

Rationale 4: Because of the risk of spray from the inserted chest tube, the nurse should wear gloves, mask with eye shield or mask and goggles, and a gown. There is no need for the nurse to wear sterile gloves during the procedure.

Global Rationale: Because of the risk of spray from the inserted chest tube, the nurse should wear gloves, mask with eye shield or mask and goggles, and a gown. There is no need for the nurse to wear sterile gloves during the procedure.

Cognitive Level: Applying
Client Need: Physiological Integrity
Client Need Sub: Reduction of Risk Potential
QSEN Competencies: V.B.1. Demonstrate effective use of technology and standardized practices that support safety and quality
AACN Essential Competencies: II.5. Participate in quality and client safety initiatives, recognizing that these are complex system issues, that involve individuals, families, groups, communities, populations, and other members of the health care team
NLN Competencies: Context and Environment: Apply health promotion/disease prevention strategies; apply health policy
Nursing/Integrated Concepts: Nursing Process: Implementation
Learning Outcome: Verbalize the steps used in:
a. Using standard precautions.
b. Performing hand hygiene.
c. Applying and removing personal protective equipment (gloves, gown, mask, eyewear).
d. Assisting with invasive procedures.

Page Number: pp. 12-14

Question 20
Type: MCSA

The nurse is called into a client's room by the unlicensed assistive personnel (UAP), who informs the nurse that the obstetric client has no pulse or respirations and has profuse vaginal bleeding. Which is the priority action by the nurse?

1. Apply gloves and assess the client for pulse and respirations.

2. Assess the client for pulse and respirations, instruct UAP to notify code team while donning personal protective equipment, and begin CPR.

3. Quickly assess pulse and respirations, next assess for bleeding, call for the code team, and then apply personal protective equipment before beginning CPR.

4. Apply gown, gloves, mask, and goggles, then assess client for pulse, respirations, and bleeding.

Correct Answer: 2

Rationale 1: If the client is bleeding vaginally, it would be possible to assess carotid pulse and breathing without coming in contact with bloodborne pathogens. Once the nurse confirms that the client is pulseless, instruct the UAP to call a code while donning personal protective equipment and beginning CPR.

Rationale 2: If the client is bleeding vaginally, it would be possible to assess carotid pulse and breathing without coming in contact with bloodborne pathogens. Once the nurse confirms that the client is pulseless, instruct the UAP to call a code while donning personal protective equipment and beginning CPR.

Rationale 3: If the client is bleeding vaginally, it would be possible to assess carotid pulse and breathing without coming in contact with bloodborne pathogens. Once the nurse confirms that the client is pulseless, instruct the UAP to call a code while donning personal protective equipment and beginning CPR.

Rationale 4: If the client is bleeding vaginally, it would be possible to assess carotid pulse and breathing without coming in contact with bloodborne pathogens. Once the nurse confirms that the client is pulseless, instruct the UAP to call a code while donning personal protective equipment and beginning CPR.

Global Rationale: If the client is bleeding vaginally, it would be possible to assess carotid pulse and breathing without coming in contact with bloodborne pathogens. Once the nurse confirms that the client is pulseless, instruct the UAP to call a code while donning personal protective equipment and beginning CPR.

Cognitive Level: Analyzing
Client Need: Physiological Integrity
Client Need Sub: Reduction of Risk Potential
QSEN Competencies: V.B.1. Demonstrate effective use of technology and standardized practices that support safety and quality
AACN Essential Competencies: II.5. Participate in quality and client safety initiatives, recognizing that these are complex system issues, that involve individuals, families, groups, communities, populations, and other members of the health care team

NLN Competencies: Context and Environment: Apply health promotion/disease prevention strategies; apply health policy
Nursing/Integrated Concepts: Nursing Process: Implementation
Learning Outcome: Verbalize the steps used in:
a. Using standard precautions.
b. Performing hand hygiene.
c. Applying and removing personal protective equipment (gloves, gown, mask, eyewear).
d. Assisting with invasive procedures.
Page Number: pp. 12-14

Question 21
Type: MCSA

Nurses must care for several clients during each shift. Which action by the nurse demonstrates appropriate hand hygiene?

1. Putting on gloves

2. Washing hands with soap and water

3. Wiping hands off when entering room

4. Using the client's soap on hands

Correct Answer: 2

Rationale 1: Putting on gloves does not demonstrate appropriate hand hygiene.

Rationale 2: Washing hands with soap and water demonstrates appropriate hand hygiene.

Rationale 3: Wiping hands off when entering the room does not demonstrate appropriate hand hygiene.

Rationale 4: The use of the client's soap on the hand is not appropriate when performing hand hygiene.

Global Rationale: Washing hands with soap and water demonstrates appropriate hand hygiene. Putting on gloves and wiping hands off when entering the client's room does not demonstrate appropriate hand hygiene. The use of the client's soap on the hand is not appropriate when performing hand hygiene.

Cognitive Level: Remembering
Client Need: Safe and Effective Care Environment
Client Need Sub: Safety and Infection Control
QSEN Competencies: V.B.1. Demonstrate effective use of technology and standardized practices that support safety and quality
AACN Essential Competencies: II.5. Participate in quality and client safety initiatives, recognizing that these are complex system issues, that involve individuals, families, groups, communities, populations, and other members of the health care team
NLN Competencies: Context and Environment: Apply health promotion/disease prevention strategies; apply health policy
Nursing/Integrated Concepts: Nursing Process: Assessment

Learning Outcome: Verbalize the steps used in:
a. Using standard precautions.
b. Performing hand hygiene.
c. Applying and removing personal protective equipment (gloves, gown, mask, eyewear).
d. Assisting with invasive procedures.
Page Number: pp. 6-7

Question 22
Type: MCSA

Which equipment would the nurse not place in the sharps container?

1. Scalpels

2. Lancets

3. Bloody bandage

4. Needles

Correct Answer: 3

Rationale 1: The sharps container is used for anything sharp, so a bloody bandage would go into the red-bagged trash can, not the sharps container. The other products would go into the puncture-resistant sharps container.

Rationale 2: The sharps container is used for anything sharp, so a bloody bandage would go into the red-bagged trash can, not the sharps container. The other products would go into the puncture-resistant sharps container.

Rationale 3: The sharps container is used for anything sharp, so a bloody bandage would go into the red-bagged trash can, not the sharps container. The other products would go into the puncture-resistant sharps container.

Rationale 4: The sharps container is used for anything sharp, so a bloody bandage would go into the red-bagged trash can, not the sharps container. The other products would go into the puncture-resistant sharps container.

Global Rationale: The sharps container is used for anything sharp, so a bloody bandage would go into the red-bagged trash can, not the sharps container. The other products would go into the puncture-resistant sharps container.

Cognitive Level: Remembering
Client Need: Safe and Effective Care Environment
Client Need Sub: Safety and Infection Control
QSEN Competencies: V.B.1. Demonstrate effective use of technology and standardized practices that support safety and quality
AACN Essential Competencies: V.7. Examine the roles and responsibilities of the regulatory agencies and their effect on client care quality, workplace safety, and the scope of nursing and other health professionals' practice
NLN Competencies: Context and Environment: Apply health promotion/disease prevention strategies; apply health policy
Nursing/Integrated Concepts: Nursing Process: Implementation

Learning Outcome: Demonstrate appropriate disposal of equipment and supplies.
Page Number: pp. 14-15

Question 23
Type: MCSA

The nurse has just changed a client's surgical dressing. Which action by the nurse would follow standard precaution guidelines for proper disposal of contaminated materials?

1. The old dressing is discarded in the trash can.

2. The unsoiled disposable gown is removed and discarded in the hazardous waste container.

3. The gloves are discarded in the trash can.

4. The mask is discarded in the trash can.

Correct Answer: 4

Rationale 1: The old dressing and gloves should be discarded in the hazardous waste container because they are contaminated. The disposable gown does not need to be placed in the hazardous waste container unless it is contaminated with blood or body fluids. The mask, unless contaminated with blood or body fluids, would be discarded in the trash can.

Rationale 2: The old dressing and gloves should be discarded in the hazardous waste container because they are contaminated. The disposable gown does not need to be placed in the hazardous waste container unless it is contaminated with blood or body fluids. The mask, unless contaminated with blood or body fluids, would be discarded in the trash can.

Rationale 3: The old dressing and gloves should be discarded in the hazardous waste container because they are contaminated. The disposable gown does not need to be placed in the hazardous waste container unless it is contaminated with blood or body fluids. The mask, unless contaminated with blood or body fluids, would be discarded in the trash can.

Rationale 4: The old dressing and gloves should be discarded in the hazardous waste container because they are contaminated. The disposable gown does not need to be placed in the hazardous waste container unless it is contaminated with blood or body fluids. The mask, unless contaminated with blood or body fluids, would be discarded in the trash can.

Global Rationale: The old dressing and gloves should be discarded in the hazardous waste container because they are contaminated. The disposable gown does not need to be placed in the hazardous waste container unless it is contaminated with blood or body fluids. The mask, unless contaminated with blood or body fluids, would be discarded in the trash can.

Cognitive Level: Applying
Client Need: Safe and Effective Care Environment
Client Need Sub: Safety and Infection Control
QSEN Competencies: V.B.1. Demonstrate effective use of technology and standardized practices that support safety and quality

AACN Essential Competencies: V.7. Examine the roles and responsibilities of the regulatory agencies and their effect on client care quality, workplace safety, and the scope of nursing and other health professionals' practice
NLN Competencies: Context and Environment: Apply health promotion/disease prevention strategies; apply health policy
Nursing/Integrated Concepts: Nursing Process: Implementation
Learning Outcome: Demonstrate appropriate disposal of equipment and supplies.
Page Number: pp. 14-15

Question 24
Type: MCSA

The nurse working in the emergency department is caring for a client who has projectile vomiting. The nurse is wearing personal protective equipment (PPE). How would the nurse properly discard the PPE?

1. All PPE would be discarded in the hazardous waste container whenever leaving the client's room, and new PPE would be donned when returning to the room.

2. The nurse could wear the same PPE if only leaving the room briefly and discard in the hazardous waste container when the client is transferred to the floor.

3. The nurse removes the PPE and places it just inside the room to put back on when reentering the client's room, then discards into the hazardous waste container when the client is transferred.

4. If the PPE is soiled, the nurse discards it when leaving the room, but if it is not visibly contaminated, the nurse can reapply the same PPE when reentering the client's room.

Correct Answer: 1

Rationale 1: When a client is projectile vomiting, there is a high risk of splatter that might not be seen by the nurse. The PPE should be discarded in the hazardous waste container when exiting the client's room, and clean PPE should be donned when reentering the room. Reapplying the same soiled PPE when reentering the room, whether visibly contaminated or not, would risk the nurse's exposure to body fluids, and would be incorrect technique. Under no circumstances should the nurse walk around the unit in contaminated PPE.

Rationale 2: When a client is projectile vomiting, there is a high risk of splatter that might not be seen by the nurse. The PPE should be discarded in the hazardous waste container when exiting the client's room, and clean PPE should be donned when reentering the room. Reapplying the same soiled PPE when reentering the room, whether visibly contaminated or not, would risk the nurse's exposure to body fluids, and would be incorrect technique. Under no circumstances should the nurse walk around the unit in contaminated PPE.

Rationale 3: When a client is projectile vomiting, there is a high risk of splatter that might not be seen by the nurse. The PPE should be discarded in the hazardous waste container when exiting the client's room, and clean PPE should be donned when reentering the room. Reapplying the same soiled PPE when reentering the room, whether visibly contaminated or not, would risk the nurse's exposure to body fluids, and would be incorrect technique. Under no circumstances should the nurse walk around the unit in contaminated PPE.

Rationale 4: When a client is projectile vomiting, there is a high risk of splatter that might not be seen by the nurse. The PPE should be discarded in the hazardous waste container when exiting the client's room, and clean PPE should be donned when reentering the room. Reapplying the same soiled PPE when reentering the room,

whether visibly contaminated or not, would risk the nurse's exposure to body fluids, and would be incorrect technique. Under no circumstances should the nurse walk around the unit in contaminated PPE.

Global Rationale: When a client is projectile vomiting, there is a high risk of splatter that might not be seen by the nurse. The PPE should be discarded in the hazardous waste container when exiting the client's room, and clean PPE should be donned when reentering the room. Reapplying the same soiled PPE when reentering the room, whether visibly contaminated or not, would risk the nurse's exposure to body fluids, and would be incorrect technique. Under no circumstances should the nurse walk around the unit in contaminated PPE.

Cognitive Level: Analyzing
Client Need: Safe and Effective Care Environment
Client Need Sub: Safety and Infection Control
QSEN Competencies: V.B.1. Demonstrate effective use of technology and standardized practices that support safety and quality
AACN Essential Competencies: V.7. Examine the roles and responsibilities of the regulatory agencies and their effect on client care quality, workplace safety, and the scope of nursing and other health professionals' practice
NLN Competencies: Context and Environment: Apply health promotion/disease prevention strategies; apply health policy
Nursing/Integrated Concepts: Nursing Process: Implementation
Learning Outcome: Demonstrate appropriate disposal of equipment and supplies.
Page Number: pp. 10-12

Question 25
Type: MCSA

The nurse assists the health care provider with the collection of cerebrospinal fluid. Which is an important safety measure for the nurse to follow immediately after collection of the sample?

1. Maintain sterility of the procedure tray.

2. Discard all sharps in a puncture-proof container.

3. Label specimens and send to the lab.

4. Remove PPE and discard.

Correct Answer: 2

Rationale 1: The nurse's first action would be to discard sharps in the puncture-proof container to prevent potential injury. This should be performed before removing PPE. The next step would be to label the specimens and bag them, prior to removal of PPE, due to potential contamination of the outside of the specimen tubes. Once the procedure is completed, there is no need to maintain sterility of the procedure tray.

Rationale 2: The nurse's first action would be to discard sharps in the puncture-proof container to prevent potential injury. This should be performed before removing PPE. The next step would be to label the specimens and bag them, prior to removal of PPE, due to potential contamination of the outside of the specimen tubes. Once the procedure is completed, there is no need to maintain sterility of the procedure tray.

Rationale 3: The nurse's first action would be to discard sharps in the puncture-proof container to prevent potential injury. This should be performed before removing PPE. The next step would be to label the specimens and bag them, prior to removal of PPE, due to potential contamination of the outside of the specimen tubes. Once the procedure is completed, there is no need to maintain sterility of the procedure tray.

Rationale 4: The nurse's first action would be to discard sharps in the puncture-proof container to prevent potential injury. This should be performed before removing PPE. The next step would be to label the specimens and bag them, prior to removal of PPE, due to potential contamination of the outside of the specimen tubes. Once the procedure is completed, there is no need to maintain sterility of the procedure tray.

Global Rationale: The nurse's first action would be to discard sharps in the puncture-proof container to prevent potential injury. This should be performed before removing PPE. The next step would be to label the specimens and bag them, prior to removal of PPE, due to potential contamination of the outside of the specimen tubes. Once the procedure is completed, there is no need to maintain sterility of the procedure tray.

Cognitive Level: Analyzing
Client Need: Safe and Effective Care Environment
Client Need Sub: Safety and Infection Control
QSEN Competencies: V.B.1. Demonstrate effective use of technology and standardized practices that support safety and quality
AACN Essential Competencies: V.7. Examine the roles and responsibilities of the regulatory agencies and their effect on client care quality, workplace safety, and the scope of nursing and other health professionals' practice
NLN Competencies: Context and Environment: Apply health promotion/disease prevention strategies; apply health policy
Nursing/Integrated Concepts: Nursing Process: Implementation
Learning Outcome: Demonstrate appropriate disposal of equipment and supplies.
Page Number: pp. 12-14

Question 26
Type: MCMA

Why is it critically important for the nurse to document all client care activities in the medical record?

Standard Text: Select all that apply.

1. To facilitate continuity of care

2. To promote effective care

3. To meet legal and accreditation requirements

4. To prove care was completed

5. To provide data for research and reimbursement

Correct Answer: 1,2,3,5

Rationale 1: The nurse documents to meet legal and accreditation requirements. Facilitating continuity of care by careful documentation leads to improved communication and promotes more effective care. Data from nursing documentation are used for both research and reimbursement. Documenting care does not prove it was completed.

Rationale 2: The nurse documents to meet legal and accreditation requirements. Facilitating continuity of care by careful documentation leads to improved communication and promotes more effective care. Data from nursing documentation are used for both research and reimbursement. Documenting care does not prove it was completed.

Rationale 3: The nurse documents to meet legal and accreditation requirements. Facilitating continuity of care by careful documentation leads to improved communication and promotes more effective care. Data from nursing documentation are used for both research and reimbursement. Documenting care does not prove it was completed.

Rationale 4: The nurse documents to meet legal and accreditation requirements. Facilitating continuity of care by careful documentation leads to improved communication and promotes more effective care. Data from nursing documentation are used for both research and reimbursement. Documenting care does not prove it was completed.

Rationale 5: The nurse documents to meet legal and accreditation requirements. Facilitating continuity of care by careful documentation leads to improved communication and promotes more effective care. Data from nursing documentation are used for both research and reimbursement. Documenting care does not prove it was completed.

Global Rationale: The nurse documents to meet legal and accreditation requirements. Facilitating continuity of care by careful documentation leads to improved communication and promotes more effective care. Data from nursing documentation are used for both research and reimbursement. Documenting care does not prove it was completed.

Cognitive Level: Remembering
Client Need: Safe and Effective Care Environment
Client Need Sub: Management of Care
QSEN Competencies: V.B.1. Demonstrate effective use of technology and standardized practices that support safety and quality
AACN Essential Competencies: IV.5. Use standardized terminology in a care environment that reflects nursing's unique contribution to client outcomes
NLN Competencies: Quality and Safety: Carefully maintain and use electronic and/or written health records
Nursing/Integrated Concepts: Nursing Process: Implementation
Learning Outcome: Demonstrate appropriate documentation and recording of foundational skills.
Page Number: pp. 15-16

Question 27
Type: MCSA

The nurse assists a health care provider with the collection of cerebrospinal fluid via a lumbar puncture. Which would not be included in the nurse's documentation of this procedure?

1. Specimen collection and disposition

2. Health care provider's contamination of first needle, requiring the nurse to obtain a second needle

3. Client response during and after the procedure

4. Sterile technique followed throughout the collection process

Correct Answer: 2

Rationale 1: There would be no need to document that the first needle was contaminated, requiring a second, because no error was made, the client was not injured in any way, and it could appear to be an error. The nurse should document what specimens were collected and where they were sent, how the client responded both during and after the procedure, and that sterile technique was followed.

Rationale 2: There would be no need to document that the first needle was contaminated, requiring a second, because no error was made, the client was not injured in any way, and it could appear to be an error. The nurse should document what specimens were collected and where they were sent, how the client responded both during and after the procedure, and that sterile technique was followed.

Rationale 3: There would be no need to document that the first needle was contaminated, requiring a second, because no error was made, the client was not injured in any way, and it could appear to be an error. The nurse should document what specimens were collected and where they were sent, how the client responded both during and after the procedure, and that sterile technique was followed.

Rationale 4: There would be no need to document that the first needle was contaminated, requiring a second, because no error was made, the client was not injured in any way, and it could appear to be an error. The nurse should document what specimens were collected and where they were sent, how the client responded both during and after the procedure, and that sterile technique was followed.

Global Rationale: There would be no need to document that the first needle was contaminated, requiring a second, because no error was made, the client was not injured in any way, and it could appear to be an error. The nurse should document what specimens were collected and where they were sent, how the client responded both during and after the procedure, and that sterile technique was followed.

Cognitive Level: Applying
Client Need: Safe and Effective Care Environment
Client Need Sub: Management of Care
QSEN Competencies: V.B.1. Demonstrate effective use of technology and standardized practices that support safety and quality
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Learning Outcome: Demonstrate appropriate documentation and recording of foundational skills.
Page Number: pp. 12-14, 15-16

Question 28
Type: MCSA

The nurse is exposed to the client's blood and body fluids via an accidental used needlestick. Which would be appropriate nursing documentation of the event?

1. Document "Nurse stuck by used needle" in the client's medical record.

2. Document "Accidental exposure of nurse to blood and body fluid" in the client's medical record.

3. There is no need to document the exposure as long as the nurse takes the proper actions and notifies the charge nurse.

4. Completion of an incident report.

Correct Answer: 4

Rationale 1: When an incident occurs that does not involve the client directly (no harm is done or potentially done to the client), there is no need to document it in the client's medical record. The nurse would complete an incident report and notify the nursing supervisor or charge nurse.

Rationale 2: When an incident occurs that does not involve the client directly (no harm is done or potentially done to the client), there is no need to document it in the client's medical record. The nurse would complete an incident report and notify the nursing supervisor or charge nurse.

Rationale 3: When an incident occurs that does not involve the client directly (no harm is done or potentially done to the client), there is no need to document it in the client's medical record. The nurse would complete an incident report and notify the nursing supervisor or charge nurse.

Rationale 4: When an incident occurs that does not involve the client directly (no harm is done or potentially done to the client), there is no need to document it in the client's medical record. The nurse would complete an incident report and notify the nursing supervisor or charge nurse.

Global Rationale: When an incident occurs that does not involve the client directly (no harm is done or potentially done to the client), there is no need to document it in the client's medical record. The nurse would complete an incident report and notify the nursing supervisor or charge nurse.

Cognitive Level: Analyzing
Client Need: Safe and Effective Care Environment
Client Need Sub: Management of Care
QSEN Competencies: V.B.1. Demonstrate effective use of technology and standardized practices that support safety and quality
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