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MULTIPLE CHOICE

1. The patient is scheduled to go home after having coronary angioplasty. What would be the most effective way to provide discharge teaching to this patient?
   a. Provide him with information on health care websites.
   b. Provide him with written information on what he has to do.
   c. Sit and carefully explain what is required before his follow-up.
   d. Use a combination of verbal and written information.

   ANS: D
   For discharge teaching, use a combination of verbal and written information. This most effectively provides patients with standardized care information, which has been shown to improve patient knowledge and satisfaction.

   DIF: Cognitive Level: Application REF: Text reference: p. 26
   OBJ: Identify the ongoing needs of patients in the process of discharge planning.
   TOP: Admission to Discharge Process KEY: Nursing Process Step: Implementation
   MSC: NCLEX: Safe and Effective Care Environment

2. While preparing for the patient's discharge, the nurse uses a discharge planning checklist and notes that the patient is concerned about going home because she has to depend on her family for care. The nurse realizes that successful recovery at home is often based on:
   a. the patient's willingness to go home.
   b. the family's perceived ability to care for the patient.
   c. the patient's ability to live alone.
   d. allowing the patient to make her own arrangements.

   ANS: B
   Discharge from an agency is stressful for a patient and family. Before a patient is discharged, the patient and family need to know how to manage care in the home and what to expect with regard to any continuing physical problems. Family caregiving is a highly stressful experience. Family members who are not properly prepared for caregiving are frequently overwhelmed by patient needs, which can lead to unnecessary hospital readmissions.

   DIF: Cognitive Level: Analysis REF: Text reference: p. 26
   OBJ: Identify the ongoing needs of patients in the process of discharge planning.
   TOP: Medication Reconciliation KEY: Nursing Process Step: Assessment
   MSC: NCLEX: Psychosocial Integrity

3. The patient arrives in the emergency department complaining of severe abdominal pain and vomiting, and is severely dehydrated. The physician orders IV fluids for the dehydration and an IV antiemetic for the patient. However, the patient states that she is fearful of needles and adamantly refuses to have an IV started. The nurse explains the importance of and rationale for the ordered treatment, but the patient continues to refuse. What should the nurse do?
   a. Summon the nurse technician to hold the arm down while the IV is inserted.

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b. Use a numbing medication before inserting the IV.
c. Document the patient's refusal and notify the physician.
d. Tell the patient that she will be discharged without care unless she complies.

ANS: C
The Patient Self-Determination Act, effective December 1, 1991, requires all Medicare- and Medicaid-recipient hospitals to provide patients with information about their right to accept or reject medical treatment. The patient has the right to refuse treatment. Refusal should be documented and the health care provider consulted about alternate treatment.

DIF: Cognitive Level: Application REF: Text reference: p. 14
OBJ: Describe the nurse's role in maintaining continuity of care through a patient's admission, transfer, and discharge from an acute care facility.
TOP: Patient Self-Determination Act KEY: Nursing Process Step: Implementation
MSC: NCLEX: Safe and Effective Care Environment

4. An unconscious patient is admitted through the emergency department. How and when is identification of the patient made?
a. Determined only when the patient is able
b. Postponed until family members arrive
c. Given an anonymous name under the "blackout" procedure
d. Determined before treatment is started

ANS: B
If a patient is unconscious, identification often is not made until family members arrive. Delaying treatment can cause deterioration of the patient's condition. Blackout procedures are intended mainly to protect crime victims.

DIF: Cognitive Level: Application REF: Text reference: p. 14
OBJ: Describe the nurse's role in maintaining continuity of care through a patient's admission, transfer, and discharge from an acute care facility.
TOP: The Unconscious Patient KEY: Nursing Process Step: Implementation
MSC: NCLEX: Physiological Integrity

5. During admission of a patient, the nurse notes that the patient speaks another language and may have difficulty understanding English. What should the nurse do to facilitate communication?
a. Use hand gestures to explain.
b. Request and wait for an interpreter.
c. Work with the family to gather information.
d. Complete as much of the admission assessment as possible using simple phrases.

ANS: B
If the patient does not speak English or has a severe hearing impairment, the clerk must have access to an interpreter to assist during the admission procedure. Translation services are preferable to using family members to ensure correct translation of medical terminology. Hand gestures and simple phrases may not be adequate for everything that will be discussed at the time of admission.

DIF: Cognitive Level: Application REF: Text reference: p. 13

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OBJ: Describe the nurse's role in maintaining continuity of care through a patient's admission, transfer, and discharge from an acute care facility.
TOP: The Patient Who Does Not Speak English
KEY: Nursing Process Step: Implementation
MSC: NCLEX: Safe and Effective Care Environment

6. The patient has been admitted to the emergency department after being beaten and raped. She is agitated and is frightened that her attacker may find her in the hospital and try to kill her. What should the nurse tell her?
   a. She is safe in the hospital, and she needs to provide her name.
   b. She can be admitted to the hospital without anyone knowing it.
   c. Her records will be used as evidence in the trial.
   d. Since she has come to the hospital, she has to be examined by the doctor.

   ANS: B
   A patient who has been a victim of crime can be admitted anonymously under an agency's "blackout" or "do not publish" procedure. HIPAA places limits on the institution's ability to use or disclose the patient's PHI. The Patient Self-Determination Act prohibits the hospital from requiring her to submit to an examination.

   DIF: Cognitive Level: Analysis REF: Text reference: p. 14
   OBJ: Describe the nurse's role in maintaining continuity of care through a patient's admission, transfer, and discharge from an acute care facility. TOP: Victim of Crime
   KEY: Nursing Process Step: Implementation
   MSC: NCLEX: Psychosocial Integrity

7. The patient is admitted to the ICU after having been in a motor vehicle accident. He was intubated in the emergency department and needs to receive two units of packed red blood cells. He is conscious but is indicating that he is in pain by guarding his abdomen. To admit this patient, the nurse first will focus on:
   a. examining the patient and treating the pain.
   b. orienting the family to the ICU visitation policy.
   c. making sure that the consent forms are signed.
   d. informing the patient of his HIPAA rights.

   ANS: A
   When a critically ill patient reaches a hospital's nursing division, the patient immediately undergoes extensive examination and treatment procedures. Little time is available for the nurse to orient the patient and family to the division, or to learn of their fears or concerns.

   DIF: Cognitive Level: Analysis REF: Text reference: p. 15
   OBJ: Describe the nurse's role in maintaining continuity of care through a patient's admission, transfer, and discharge from an acute care facility. TOP: Role of the Nurse
   KEY: Nursing Process Step: Implementation
   MSC: NCLEX: Physiological Integrity

8. The nurse is admitting the patient to the medical unit. The patient indicates that he has had several surgeries in the past and has been a diabetic for the past 15 years. He also stated that he is allergic to Morphine. What does this information prompt the nurse to do next?
   a. Provide the patient with an allergy armband and document his allergies.

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b. Postpone routine admission procedures immediately.
c. Ask the patient if he wants a smoking room.
d. Have all family or friends leave the room.

ANS: A
Provide the patient with an allergy armband listing allergies to foods, drugs, latex, or other substances; document allergies according to hospital policy. Postpone routine admission procedures only if the patient is having acute physical problems. Smoking is prohibited throughout the hospital, and family or friends can remain if the patient wishes to have them assist with changing into a hospital gown or pajamas.

DIF: Cognitive Level: Analysis REF: Text reference: p. 17
OBJ: Describe the nurse's role in maintaining continuity of care through a patient's admission, transfer, and discharge from an acute care facility. TOP: Allergies
KEY: Nursing Process Step: Implementation
MSC: NCLEX: Physiological Integrity

9. At what age is separation anxiety a common problem?
a. School-aged children
b. Preschoolers
c. Middle infancy
d. Newborns

ANS: C
Separation anxiety is most common from middle infancy throughout the toddler years, especially from ages 16 to 30 months. Preschoolers are better able to tolerate brief periods of separation, but their protest behaviors are more subtle than those of younger children (e.g., refusal to eat, difficulty sleeping, withdrawing from others). School-aged children are able to cope with separation but have an increased need for parental security and guidance.

DIF: Cognitive Level: Synthesis REF: Text reference: p. 20
OBJ: Explain the role of the patient's family in the admission, transfer, or discharge process. TOP: Pediatric Considerations
KEY: Nursing Process Step: Assessment MSC: NCLEX: Psychosocial Integrity

10. The patient is being transferred from the emergency department to another institution for treatment. Which of the following cannot be delegated to nursing assistive personnel (NAP)?
a. Helping the patient get dressed
b. Gathering IV equipment to go with the patient
c. Escorting the patient to the transport area
d. Assessing the patient's respiratory status before transport

ANS: D
The assessment and decision making conducted during transfers cannot be delegated to nursing assistive personnel. NAP can assist the patient with dressing, can gather and secure the patient's personal belongings and any necessary equipment, and can escort the patient to the nursing unit or transport area.

DIF: Cognitive Level: Application REF: Text reference: p. 21

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OBJ: Describe the nurse's role in maintaining continuity of care through a patient's admission, transfer, and discharge from an acute care facility. TOP: Delegation
KEY: Nursing Process Step: Implementation
MSC: NCLEX: Safe and Effective Care Environment

11. When does the plan for patient discharge from a health care facility begin?
    a. At admission
    b. After a medical diagnosis has been determined
    c. When the patient's physical needs are identified
    d. After a home environment assessment is completed

    ANS: A
    Planning for discharge begins at admission and continues throughout the patient's stay in the agency. Separating the processes of admission and discharge is a critical error; the two are simultaneous and continuous.

    DIF: Cognitive Level: Comprehension REF: Text reference: p. 25
    OBJ: Describe the nurse's role in maintaining continuity of care through a patient's admission, transfer, and discharge from an acute care facility.
    TOP: Discharge Planning KEY: Nursing Process Step: Implementation
    MSC: NCLEX: Safe and Effective Care Environment

12. The phase of the discharge process where medical attention dominates discharge planning efforts is known as the _____ phase.
    a. transitional
    b. continuing
    c. acute
    d. multidisciplinary

    ANS: C
    The discharge process occurs in three phases: acute, transitional, and continuing care. In the acute phase, medical attention dominates discharge planning efforts. During the transitional phase, the need for acute care is still present, but its urgency declines and patients begin to address and plan for their future health care needs. In the continuing care phase, patients participate in planning and implementing continuing care activities needed after discharge. There is no multidisciplinary stage; the discharge planning process is comprehensive and multidisciplinary.

    DIF: Cognitive Level: Comprehension REF: Text reference: p. 24
    OBJ: Describe the nurse's role in maintaining continuity of care through a patient's admission, transfer, and discharge from an acute care facility.
    TOP: Discharge Planning KEY: Nursing Process Step: Implementation
    MSC: NCLEX: Physiological Integrity

13. Once a patient's discharge has been completed, which activity may be delegated to assistive personnel?
    a. Provision of prescriptions to the patient
    b. Completion of the discharge summary
    c. Gathering of the patient's personal care items
    d. Provision of instructions on community health resources

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ANS: C
The assessment, care planning, and instruction included in discharging patients cannot be delegated to nursing assistive personnel. The nurse may direct the NAP to gather and secure the patient's personal items and any supplies that accompany the patient.

DIF: Cognitive Level: Application REF: Text reference: p. 25
OBJ: Describe the nurse's role in maintaining continuity of care through a patient's admission, transfer, and discharge from an acute care facility.
TOP: Discharge Planning KEY: Nursing Process Step: Implementation
MSC: NCLEX: Safe and Effective Care Environment

14. The nurse is providing discharge instruction to an 80-year-old patient and her daughter. The patient lives in a two-story home. When asked if the patient has difficulty climbing stairs, the patient says "No," but the nurse notices a look of surprise on the daughter's face. What should the nurse do in this circumstance?
a. Speak with the daughter separately.
b. Cancel the discharge immediately.
c. Order a visiting nurse consult.
d. Notify the physician.

ANS: A
Patients and family members often disagree on the health care needs of a patient after discharge. Identifying these discrepancies early leads to more accurate development of the discharge plan. It is often necessary to talk with the patient and family separately to learn about their true concerns or doubts.

DIF: Cognitive Level: Application REF: Text reference: p. 26
OBJ: Explain the role of the patient's family in the admission, transfer, or discharge process. TOP: Discharge Planning
KEY: Nursing Process Step: Implementation
MSC: NCLEX: Safe and Effective Care Environment

15. The patient has decided that he would like to create an advance directive. The nurse is asked if she would be a witness. What is the best response for the nurse to make to this request?
a. Agree to be a witness.
b. Refuse to be a witness.
c. Contact social work.
d. Contact the physician.

ANS: C
A social worker often fulfills this requirement. Witnesses for an advance directive document should not be medical personnel, and direct refusal does not meet the nurse's obligation to meet the patient's needs. Referral to a department that can ensure this service is required.

DIF: Cognitive Level: Application REF: Text reference: p. 15
OBJ: Explain the purpose and importance of advance directives.
TOP: Advance Directives KEY: Nursing Process Step: Implementation
MSC: NCLEX: Safe and Effective Care Environment

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MULTIPLE RESPONSE

1. The patient is being admitted to the intensive care department with multiple fractures and internal bleeding. Which of the following are considered roles of the nurse in this situation? (*Select all that apply.*)
   a. Anticipate physical and social deficits to resuming normal activities.
   b. Involve the family and significant others in the plan of care.
   c. Assist in making health care resources available to the patient.
   d. Identify the psychological needs of the patient.

   ANS: A, B, C, D
   The nurse identifies patients' ongoing health care needs; anticipates physical, psychological, and social deficits that have implications for resuming normal activities; involves family and significant others in a plan of care; provides health education; and assists in making health care resources available to the patient. Separating the processes of admission and discharge is a critical error; the two are simultaneous and continuous.

   DIF: Cognitive Level: Application REF: Text reference: p. 15
   OBJ: Describe the nurse's role in maintaining continuity of care through a patient's admission, transfer, and discharge from an acute care facility.
   TOP: Admission to Discharge Process KEY: Nursing Process Step: Planning
   MSC: NCLEX: Physiological Integrity

2. Under the Health Insurance Portability and Accountability Act (HIPAA), a patient must: (*Select all that apply.*)
   a. provide his true name before he can be treated.
   b. be informed of his privacy rights.
   c. have his personal health information used for treatment or payment only.
   d. have his personal health information used on a need-to-know basis only.

   ANS: B, C, D
   HIPAA is a federal law designed to protect the privacy of patient health information, referred to as PHI, or protected health information. Three key concepts of HIPAA are (1) institutions are required to inform patients of the privacy rights they have and how the institution will handle their PHI; (2) the institution and health care providers are to use or disclose the patient's PHI only for the purpose of treatment or payment or for health care operations; and (3) health care providers disclose only the minimum amount of PHI necessary on a need-to-know basis to accomplish the purpose of the use.

   DIF: Cognitive Level: Knowledge REF: Text reference: p. 14
   OBJ: Describe the nurse's role in maintaining continuity of care through a patient's admission, transfer, and discharge from an acute care facility. TOP: HIPAA
   KEY: Nursing Process Step: Implementation
   MSC: NCLEX: Safe and Effective Care Environment

3. The patient is admitted to the unit for a cardiac catheterization. Which of the following can be delegated to nursing assistive personnel (NAP)? (*Select all that apply.*)
   a. Obtaining admission vital signs
   b. Preparing the patient's room
   c. Gathering and securing personal care items

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d. Orienting patient and family to the nursing unit

ANS: B, C, D
The nursing assessment conducted during admission to a health care facility cannot be delegated to NAP. You cannot delegate admission vital signs as they provide a baseline for all further comparisons. The nurse directs NAP to (1) prepare the patient's room with necessary equipment before admission; (2) gather and secure the patient's personal care items; (3) escort and orient the patient and family to the nursing unit; and (4) collect ordered specimens.

DIF: Cognitive Level: Analysis REF: Text reference: p. 16
OBJ: Describe the nurse's role in maintaining continuity of care through a patient's admission, transfer, and discharge from an acute care facility.
TOP: Delegation Considerations KEY: Nursing Process Step: Implementation
MSC: NCLEX: Safe and Effective Care Environment

4. Which of the following are considered "advance directives"? (*Select all that apply.*)
   a. Living will
   b. Power of attorney for health care
   c. Notarized handwritten document
   d. Nursing progress note

   ANS: A, B, C
   Advance directives may include a living will, power of attorney for health care, or a notarized handwritten document.

   DIF: Cognitive Level: Analysis REF: Text reference: p. 15
   OBJ: Explain the purpose and importance of advance directives.
   TOP: Advance Directives KEY: Nursing Process Step: Implementation
   MSC: NCLEX: Safe and Effective Care Environment

5. The patient is being transferred from the intensive care unit to the acute care unit. The nurse must ensure that the following activities are completed: (*Select all that apply.*)
   a. providing the receiving nurse with a report before the transfer.
   b. determining any equipment needs for the patient during the transfer.
   c. providing an updated report after transferring the patient to the receiving unit.
   d. making sure a registered nurse accompanies the patient.

   ANS: A, B, C
   When providing a "hand-off" of a patient to another unit, it is essential that information about the patient's care, treatment, services, and current condition and any recent or anticipated changes are communicated accurately to meet patient safety goals. The nurse first provides a telephone report to the receiving nurse. This allows the receiving nurse to prepare for the patient (e.g., preparing the room, securing necessary equipment). As clinically appropriate, a nurse or technician accompanies the patient during transport, providing the receiving nurse with the patient's medical record; introducing the patient to the receiving nurse; and providing an updated report, including any changes in clinical status or plan of care.

   DIF: Cognitive Level: Application REF: Text reference: p. 21

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OBJ: Describe the nurse's role in maintaining continuity of care through a patient's admission, transfer, and discharge from an acute care facility.
TOP: Continuum of Care KEY: Nursing Process Step: Implementation
MSC: NCLEX: Safe and Effective Care Environment

COMPLETION

1. Completing and documenting an accurate medication history from the patient is the important first step in the _____ process.

   ANS:
   medication reconciliation

   Medication reconciliation compares the patient's home medication list versus the medication orders at admission, transfer, or discharge to avoid medication errors such as omissions, duplications, dosing errors, or drug interactions.

   DIF: Cognitive Level: Knowledge REF: Text reference: p. 13
   OBJ: Describe the nurse's role in maintaining continuity of care through a patient's admission, transfer, and discharge from an acute care facility.
   TOP: Medication Reconciliation KEY: Nursing Process Step: Planning
   MSC: NCLEX: Physiological Integrity

2. If a patient is having acute physical problems, postpone routine admission procedures until the patient's immediate needs are met. A _____ assessment is needed at this point.

   ANS:
   focused

   If a patient is having acute physical problems, postpone routine admission procedures until you meet the patient's immediate needs. Complete a focused assessment at this point.

   DIF: Cognitive Level: Analysis REF: Text reference: p. 16
   OBJ: Describe the nurse's role in maintaining continuity of care through a patient's admission, transfer, and discharge from an acute care facility.
   TOP: Admission Process KEY: Nursing Process Step: Implementation
   MSC: NCLEX: Physiological Integrity

3. When transferring a patient, the nurse must ensure that the patient will receive _____.

   ANS:
   continuity of nursing care

   When patients transfer, you need to ensure continuity of nursing care. The aim is to continue health care so as to avoid therapeutic interruptions that may hinder progress toward recovery.

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DIF: Cognitive Level: Synthesis REF: Text reference: p. 20
OBJ: Describe the nurse's role in maintaining continuity of care through a patient's admission, transfer, and discharge from an acute care facility.
TOP: Continuity of Care KEY: Nursing Process Step: Planning
MSC: NCLEX: Safe and Effective Care Environment

4. The greatest challenge in effective discharge planning is _____.

ANS:
communication

The greatest challenge in effective discharge planning is communication. The communication problem is minimized when an organization has a discharge coordinator or a case manager who is responsible for discharge planning.

DIF: Cognitive Level: Comprehension REF: Text reference: p. 24
OBJ: Describe the nurse's role in maintaining continuity of care through a patient's admission, transfer, and discharge from an acute care facility.
TOP: Discharge Planning KEY: Nursing Process Step: Implementation
MSC: NCLEX: Safe and Effective Care Environment

5. A document that provides a patient's instructions in terms of future medical care or that designates another person(s) to make medical decisions if the individual loses decision-making capacity is known as an _____.

ANS:
advance directive

An advance directive is a document that provides a patient's instructions about future medical care or that designates another person(s) to make medical decisions if the individual loses decision-making capacity. An advance directive conveys the patient's choice in continuing medical care when the patient is unable to speak or make decisions.

DIF: Cognitive Level: Knowledge REF: Text reference: p. 15
OBJ: Explain the purpose and importance of advance directives.
TOP: Advance Directives KEY: Nursing Process Step: Diagnosis
MSC: NCLEX: Safe and Effective Care Environment

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