Lewis's Medical - Surgical Nursing 13th edition Harding Test Bank

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Test Bank - Chapter 01

Q1: A patient being admitted to the hospital asks, “What is the role of a nurse?” Which response would the nurse provide?

A. “Nurses care for you while you are sick, but also help you plan to maintain your health.” (Correct)

B. “The nurse administers medications and other treatments prescribed by your physician.”

C. “The nurse’s job is to collect information and communicate any problems that occur to the physician.”

D. “Nurses perform many of the same procedures as the physician, but nurses stay with the patients for a longer time.”

Rationale: The American Nurses Association (ANA) definition of nursing describes the role of nurses in promoting health. The other responses describe dependent and collaborative functions of the nursing role but do not accurately describe the nurse’s unique role in the health care system.

Q2: Which statement by the nurse accurately describes the use of evidence-based practice (EBP)?

A. “Patient care is based on the healthcare professional’s experience and traditions.”

B. “Data are analyzed later to show that the patient outcomes are consistently met.”

C. “Research from all internet sources are used as a guide for planning patient care.”

D. “Plans for care are based on research, clinical expertise, and patient preferences.” (Correct)

Rationale: Evidence-based practice (EBP) is the use of the best research-based evidence combined with clinician expertise and consideration of patient preferences. Traditions are not sufficient evidence for EBP. Evaluation of patient outcomes is important, but data analysis is not required to use EBP. All internet sources do not provide research evidence; interventions should be based on credible peer-reviewed research, preferably randomized controlled studies and systematic reviews with a large number of subjects.

Q3: Which statement by the nurse provides a clear explanation of the nursing process?

A. “The nursing process is a research method of diagnosing the patient’s health care problems.”

B. “The nursing process is a theory that incorporates the biopsychosocial nature of humans.”

C. “The nursing process is a problem-solving tool used to manage patients’ health care needs.” (Correct)

D. “The nursing process is used primarily to explain nursing interventions to other health care professionals.”

Rationale: The nursing process is a problem-solving approach to the identification and treatment of patients’ problems. Nursing process does not require research methods for diagnosis. The primary use of the nursing process is in patient care, not to establish nursing theory or explain nursing interventions to other health care professionals.

Q4: A patient admitted to the hospital for surgery tells the nurse, “I do not feel comfortable leaving my children with my parents.” Which action would the nurse take next?

A. Reassure the patient that these feelings are common for parents.
B. Have the patient call the children to ensure that they are doing well.
C. Gather information on the patient’s concerns about the child care arrangements. (Correct)
D. Call the patient’s parents to determine whether safe child care is being provided.

Rationale: The nurse’s first action should be to obtain more information; an assessment is necessary to identify a problem and choose an appropriate intervention. The other actions may be appropriate later, but more assessment is needed before the best intervention can be chosen.

Q5: Which statement describes the purpose of the evaluation phase of the nursing process?

A. To document the nursing care plan in the progress notes of the health record
B. To determine if interventions have been effective in meeting patient outcomes (Correct)
C. To establish if the patient agrees that the nursing care provided was satisfactory
D. To decide whether the patient’s health problems have been completely resolved

Rationale: Evaluation consists of determining whether the desired patient outcomes have been met and whether the nursing interventions were appropriate. The other responses do not describe the evaluation phase.

Q6: Which statement describes the purpose of the assessment phase of the nursing process?

A. To teach interventions that relieve health problems
B. To use patient data to evaluate patient care outcomes
C. To obtain data to diagnose patient strengths and problems (Correct)
D. To help the patient identify realistic outcomes for health problems

Rationale: During the assessment phase, the nurse gathers information about the patient to diagnose patient strengths and problems. The other responses are examples of the planning, intervention, and evaluation phases of the nursing process.

Q7: When developing the plan of care, which components would the nurse include in the clinical problem statement?

A. The problem, its causes, and the signs and symptoms (Correct)
B. The problem and the suggested patient goals or outcomes
C. The problem, its pathophysiology, and the expected outcome
D. The problem with the possible etiology and the planned interventions

Rationale: When writing clinical problems or nursing diagnoses, the subjective symptoms as well as objective signs to support the problem’s existence should be included. Goals, outcomes, and interventions are not included in the problem statement.

Q8: Which patient care task would the nurse delegate to experienced assistive personnel (AP)?

A. Instruct the patient about the need to alternate activity and rest.
B. Monitor level of shortness of breath or fatigue after ambulation.
C. Obtain the patient's blood pressure and pulse rate after ambulation. (Correct)
D. Determine whether the patient is ready to increase the activity level.

Rationale: AP education includes accurate vital sign measurement. Assessment and patient teaching require registered nurse education and scope of practice and cannot be delegated.

Q9: A nurse is caring for a group of patients on the medical-surgical unit with the help of one float registered nurse (RN), one assistive personnel (AP), and one licensed practical/vocational nurse (LPN/VN). Which assignment, if delegated by the nurse, would be outside that individual's scope of practice?

A. Check for the presence of bowel sounds by AP (Correct)
B. Administration of oral medications by LPN/VN
C. Insulin administration by float RN from the pediatric unit
D. Measurement of a patient's urinary catheter output by AP

Rationale: Assessment requires RN education and scope of practice so it cannot be delegated to an LPN/VN or AP. The other assignments made by the RN are appropriate for the role of the team member.

Q10: Which task is appropriate for the nurse to delegate to a licensed practical/vocational nurse (LPN/VN)?

A. Complete the initial admission assessment and plan of care.
B. Measure bedside blood glucose before administering insulin. (Correct)
C. Document teaching completed before a diagnostic procedure.
D. Instruct a patient about low-fat, reduced sodium dietary restrictions.

Rationale: The education and scope of practice of the LPN/LVN include activities such as obtaining glucose testing using a finger stick and administering insulin. Patient teaching and the initial assessment and development of the plan of care are nursing actions that require registered nurse education and scope of practice.

Q11: A nurse is assigned as a case manager for a hospitalized patient who has a spinal cord injury. Which activity can the patient expect the nurse in this role to perform?

A. Care for the patient during hospitalization for the injuries.
B. Assist the patient with home care activities during recovery.
C. Coordinate the services the patient receives in the hospital and at home. (Correct)
D. Determine what medical care the patient needs for optimal rehabilitation.

Rationale: The role of the case manager is to coordinate the patient's care through multiple settings and levels of care to allow the maximal patient benefit at the least cost. The case manager does not

provide direct care in the acute or home setting. The case manager coordinates and advocates for care. The HCP determines what medical care is needed.

Q12: The nurse is caring for an older adult patient who needs continued nursing care and physical therapy to improve mobility after surgery to repair a fractured hip. The nurse would help to arrange for transfer of the patient to which type of facility?

A. A skilled care facility
B. A transitional care facility (Correct)
C. A residential care facility
D. An intermediate care facility

Rationale: Transitional care settings are appropriate for patients who need continued rehabilitation before discharge to home or to long-term care settings. The patient is no longer in need of the more continuous assessment and care given in acute care settings. There is no indication that the patient will need the permanent and ongoing medical and nursing services available in intermediate or skilled care. The patient is not yet independent enough to transfer to a residential care facility.

Q13: A home care nurse is planning care for a patient who has just been diagnosed with type 2 diabetes. Which task would the nurse delegate to the home health aide?

A. Assist the patient to plan a nutritious diet.
B. Help the patient with a daily bath and oral care. (Correct)
C. Check the patient's feet for signs of breakdown.
D. Teach the patient how to monitor blood glucose.

Rationale: Assisting with patient hygiene is included in home health-aide education and scope of practice. Assessment of the patient and instructing the patient in new skills, such as diet and blood glucose monitoring, are complex skills that are included in registered nurse education and scope of practice.

Q14: The nurse is providing education to nursing staff on quality care initiatives. Which statement is an accurate description of the impact of health care financing on quality care?

A. "Third-party payment for patient care is primarily based on clinical outcomes." (Correct)
B. "It is not nursing's responsibility to monitor the quality of care delivered by others."
C. "If a patient develops a catheter-related infection, the hospital receives more funding."
D. "Hospitals are reimbursed for all costs incurred if care is documented electronically."

Rationale: Payment for health care services programs reimburses hospitals for their performance on overall quality-of-care measures. These measures include clinical outcomes and patient satisfaction. Nurses are responsible for coordinating complex aspects of patient care, including the care delivered by others, and identifying issues that are associated with poor quality care. The healthcare agency may not receive reimbursement for care if a patient experiences a negative outcome that is considered preventable (e.g., acquiring a catheter-related urinary tract infection).

Q15: The nurse documenting the patient's progress in the electronic health record is demonstrating competency in which area?

A. Patient-centered care
B. Quality improvement
C. Evidence-based practice
D. Informatics and technology (Correct)

Rationale: The nurse is displaying competency in informatics and technology. Using a computerized information system to document patient needs and progress and communicate vital information about the patient with the interprofessional care team members provides evidence that nursing practice standards related to the nursing process have been maintained during the care of the patient.

Q16: The nurse is calling a health care provider about a patient's change in status. Which statement by the nurse is an example of the background step of the Situation-Background-Assessment-Recommendation (SBAR) technique?

A. "I would like you to order IV fluids and lab tests and come evaluate the patient as soon as possible."
B. "This is Nurse XX. I am calling from the unit because your patient, XX, has just vomited bright red blood."
C. "The vomiting started about 10 minutes ago. The patient's heart rate is 120; BP 90/60. The patient reports feeling dizzy."
D. "Patient XX, who is 1 day postoperative for a bowel resection for malignancy, has a history of myocardial infarction 2 years ago." (Correct)

Rationale: Providing background or circumstances leading up to the situation is part of the background step of SBAR. The nurse introducing self and reporting the current problem briefly occurs in the situation step of SBAR. Providing information such as signs and symptoms is in the assessment step. Making suggestions for a plan of interprofessional care is the recommendation step.

Q17: Which information will the nurse consider when deciding what nursing actions to delegate to a licensed practical/vocational nurse (LPN/VN) who is working on a medical-surgical unit? (Select all that apply.) *(Select all that apply.)*

A. Agency policies (Correct)
B. Stability of the patients (Correct)
C. State nurse practice act (Correct)
D. LPN/VN teaching abilities
E. Experience of the LPN/VN (Correct)

Rationale: The nurse should assess the experience of LPN/VNs when delegating. In addition, state nurse practice acts and agency policies must be considered. In general, the LPN/VN scope of practice includes caring for patients who are stable, while registered nurses should provide most of the care for unstable patients. Because the LPN/VN scope of practice does not include patient education, this will not be part of the delegation process.

Q18: Which actions by the nurse administering medications are consistent with promoting safe delivery of patient care? (Select all that apply.) *(Select all that apply.)*

A. Discards a medication that is not labeled. (Correct)
B. Uses hand sanitizer before preparing a medication. (Correct)
C. Identifies the patient by the room number on the door.
D. Checks laboratory test results before administering a diuretic. (Correct)
E. Gives the patient a list of current medications upon discharge. (Correct)

Rationale: National Patient Safety Goals have been established to promote safe delivery of care. The nurse should use at least 2 reliable ways to identify the patient such as asking the patient's full name and date of birth before medication administration. Other actions that improve patient safety include performing hand hygiene, disposing of unlabeled medications, completing appropriate assessments before administering medications, and giving a list of the current medicines to the patient and caregiver before discharge.

Q19: Which actions by a nurse would demonstrate an aspect of nursing clinical judgment? (Select all that apply.) *(Select all that apply.)*

A. Identifying priority problems (Correct)
B. Noticing a change in patient status (Correct)
C. Memorizing the steps of a procedure
D. Assessing data about a patient situation (Correct)
E. Generating possible solutions to a patient problem (Correct)
F. Making decisions based on the implications of a patient's situation (Correct)

Rationale: Clinical judgment is evident when the nurse assesses data or situations, notices a change in a patient's status, identifies priority problems, generates the best possible solutions, and makes decisions about patient care based on analysis of the situation. Clinical judgment is not memorizing a list of facts or the steps of a procedure.