# *Davis Advantage for Medical-Surgical Nursing - Making Connections to Practice 3rd edition Hoffman Test Bank*

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# Chapter 2: Interprofessional Collaboration and Care Coordination

## MULTIPLE CHOICE

1. The nurse is working on a committee to improve transitional care outcomes. Which driving factor supports this need for change?
   A. Shortage of primary care healthcare providers
   B. Increase in the numbers of patients readmitted within 30 days of discharge
   C. Decrease in the numbers of acute care beds
   D. Shortage of registered nurses employed in hospitals

   ANS: B
   Chapter number and title: 2, Interprofessional Collaboration and Care Coordination
   Chapter learning objective: 2. Describing changes in the healthcare landscape
   Chapter page reference: pp. 10-11
   Heading: Overview of Transitional Care
   Integrated Processes: N/A
   Client Need: N/A
   Cognitive Level: Comprehension [Understanding]
   Concept: Healthcare Systems
   Difficulty: Moderate

| | Feedback |
|---|---|
| **A** | The shortage of physicians may impact access to care, but it is not one of the primary factors driving transitional care services. |
| **B** | The readmission rates of hospitalized patients, particularly Medicare beneficiaries, are one driving factor in the call for improved transitional care services. |
| **C** | The number of acute care beds should not impact transitional care services. The patient's condition and healthcare needs guide this decision. |
| **D** | The nursing shortage may impact the ability to provide direct care services, but it is not one of the driving forces. |

   PTS: 1 CON: Healthcare Systems

2. The nurse is discussing follow-up care with a patient who is being discharged. The patient and family cross their arms and state angrily that the team's suggestions are not acceptable. Which response by the nurse is **MOST** appropriate?
   A. "We only want what's best for you."
   B. "We will leave you alone to discuss your options."
   C. "Perhaps you did not understand the recommendations."
   D. "Let's discuss other options that might work well for you and your family."

   ANS: D
   Chapter number and title: 2, Interprofessional Collaboration and Care Coordination

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Chapter learning objective: 5. Defining interprofessional collaboration in the healthcare setting
Chapter page reference: pp. 10-11
Heading: Overview of Transitional Care
Integrated Processes: Communication
Client Need: Psychosocial Integrity
Cognitive Level: Application [Applying]
Concept: Communication
Difficulty: Moderate

| | Feedback |
|---|---|
| **A** | Telling the patient that the doctor only wants what is best sends the message that the patient does not know what is best, when, in fact, a well-informed patient does know what is best and should be able to make the correct choice. |
| **B** | By leaving the room, the nurse and doctor are not addressing the patient and family concerns. |
| **C** | The patient may not understand the recommendations but pointing that out can be seen as demeaning. This statement does encourage the patient to ask other questions. |
| **D** | The patient is the center of the team, and the goal is to facilitate healing. There are always other options to consider reaching that goal, and it is important to involve the patient and family in these options. |

PTS: 1 CON: Communication

3. The nurse is preparing a patient for discharge who will be requiring physical therapy (PT) for rehabilitation after a total knee replacement. Which action should the nurse take after reading the healthcare provider's order for PT?
   A. Teach the family the exercises needed for the patient.
   B. Call home health and schedule a therapist to visit the home for therapy.
   C. Set up appointments according to the order with the hospital PT department.
   D. Discuss the various types of settings for therapy and have the patient choose the venue.

   ANS: D
   Chapter number and title: 2, Interprofessional Collaboration and Care Coordination
   Chapter learning objective: 4. Exploring the role of the registered nurse in patient-centered transitional care programs
   Chapter page reference: p. 14
   Heading: Overview of Transitional Care
   Integrated Processes: Nursing Process: Planning
   Client Need: Safe and Effective Care Environment: Management of Care
   Cognitive Level: Application [Applying]
   Concept: Collaboration
   Difficulty: Moderate

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| | Feedback |
|---|---|
| **A** | The therapy that the patient requires must be performed by a professional physical therapist. To teach the family exercises encroaches on the expertise of the professional who will be performing the service. |
| **B** | Scheduling home physical therapy (PT) leaves the patient out of the decision-making process. The schedule for home visits are best made by the patient/family directly with the provider. |
| **C** | The patient may choose a facility that provides PT that is closer to their home, so it is best to have the patient/family make these arrangements. |
| **D** | The nurse best exhibits the characteristic that the patient has a right to self-determination by presenting the methods available for PT and answering the patient's questions about each so the patient can make an informed decision. |

PTS: 1 CON: Collaboration

4. A nurse is speaking with members of the healthcare team about a patient's frequent readmissions. What topic focus should the nurse reinforce during the discussions?
   A. The importance of preventing medication errors
   B. How coordination of care could improve outcomes
   C. The prevention of adverse clinical events
   D. Clarity of the roles of each member providing care

   ANS: B
   Chapter number and title: 2, Interprofessional Collaboration and Care Coordination
   Chapter learning objective: 1. Discussing the importance of successful transitions for medical-surgical patients
   Chapter page reference: p. 14
   Heading: Overview of Transitional Care
   Integrated Processes: Teaching and Learning
   Client Need: Safe and Effective Care Environment: Management of Care
   Cognitive Level: Comprehension [Understanding]
   Concept: Healthcare Systems
   Difficulty: Moderate

| | Feedback |
|---|---|
| **A** | The safety of the patient is at risk during transitions between care settings, particularly following an acute hospitalization. The patient's needs may go unmet, and there is the risk for medication errors; however, these are not the focus of an education session regarding readmission rates. |
| **B** | Hospital readmission rates are often attributed to a lack of coordination of care as patients are discharged to rehabilitation facilities, long-term care agencies, or back to their homes; therefore, this should be the focus of the educational session. |
| **C** | The safety of the patient is at risk during transitions between care settings, particularly following an acute hospitalization. The patient's needs may go unmet, and there is the risk for adverse clinical events; however, these are not |

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| | the focus of an education session regarding readmission rates. |
| **D** | The role of each member of the interdisciplinary team is not the focus of an educational session to decrease hospital readmission rates. |

PTS: 1 CON: Healthcare Systems

5. Which is a basic principle of the Patient Protection and Affordable Care Act of 2010 that the nurse should include in a teaching session for members of the healthcare team?
   A. Limiting choices of healthcare providers to control costs
   B. Lowering the cost of care by decreasing readmissions
   C. Mandating insurance charges to increase hospital revenues
   D. Extending length of stays in acute care facilities

   ANS: B
   Chapter number and title: 2, Interprofessional Collaboration and Care Coordination
   Chapter learning objective: 2. Describing changes in the healthcare landscape
   Chapter page reference: p. 13
   Heading: Overview of Transitional Care
   Integrated Processes: Teaching and Learning
   Client Need: Safe and Effective Care Environment: Management of Care
   Cognitive Level: Application [Applying]
   Concept: Healthcare Systems
   Difficulty: Moderate

| | Feedback |
|---|---|
| **A** | Increasing access, improving quality and safety, and lowering costs are the basic principles of the Patient Protection and Affordable Care Act (ACA) signed in 2010. Limiting choices is not one of the guiding principles and could compromise patient outcomes. |
| **B** | Decreased cost of care is a basic principle of the Patient Protection and Affordable Care Act (ACA) of 2010. Readmissions to acute care facilities, particularly within 30 days of discharge, increase the cost of healthcare. |
| **C** | Increasing access, improving quality and safety, and lowering costs are the basic principles of the Patient Protection and Affordable Care Act (ACA), which does not address increasing hospital revenues. |
| **D** | Increasing access, improving quality and safety, and lowering costs are the basic principles of the Patient Protection and Affordable Care Act (ACA). Extending lengths of stay would increase healthcare costs when the patient can be managed in a less skilled environment. |

PTS: 1 CON: Healthcare Systems

6. In preparing a patient for transfer from the hospital to a rehabilitation facility after joint replacement surgery, which action does the nurse implement to manage the patient's transition of care?
   A. Reviewing newly prescribed medications with the patient and the family

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B. Notifying the insurance carrier of the patient's discharge
C. Teaching about clinical manifestations of infection
D. Initiating transition planning the day of discharge

ANS: C
Chapter number and title: 2, Interprofessional Collaboration and Care Coordination
Chapter learning objective: 1. Discussing the importance of successful transitions for medical-surgical patients
Chapter page reference: p. 13
Heading: Overview of Transitional Care
Integrated Processes: Nursing Process: Planning
Client Need: Safe and Effective Care Environment: Management of Care
Cognitive Level: Application [Applying]
Concept: Communication
Difficulty: Moderate

| | Feedback |
|---|---|
| **A** | The nurse performs a comprehensive medication review when managing a transition from an acute care facility to a rehabilitation facility, and this includes ALL medications, not just the newly ordered medications. |
| **B** | It is not a nursing responsibility to contact the insurance carrier. This is managed by other healthcare professionals, such as the care coordinator, case manager, or hospital business office, etc. |
| **C** | When managing the patient's transition of care, it is essential for the nurse to provide information that necessitates a follow-up. For this patient, clinical manifestations indicative of infection will need to be reported to the provider. |
| **D** | When managing a patient's transition of care, the nurse initiates this planning at least 24 hours prior to discharge. |

PTS: 1 CON: Communication

7. The case manager interviews a hospitalized patient who requires inpatient rehabilitation before being discharged home after hip replacement surgery. The case manager works with the hospital nursing staff, the rehabilitation center, the patient's family members, and other care providers to assist with a successful transition. Which is the primary goal of the care management model described here?
A. To provide greater peace of mind for the patient and their family members
B. To track a patient's progress to ensure that appropriate care is provided until discharge
C. To manage concerns that are related to the patient's medical care and treatment regimen only
D. To provide a continuum of clinical services to help contain costs and improve patient outcomes

ANS: D
Chapter number and title: 2, Interprofessional Collaboration and Care Coordination

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Chapter learning objective: 3. Describing models of transitional care
Chapter page reference: p. 12
Heading: Evidence-Based Models of Transitional Care
Integrated Processes: Nursing Process: Evaluation
Client Need: Safe and Effective Care Environment: Management of Care
Cognitive Level: Comprehensive [Understanding]
Concept: Leadership and Management
Difficulty: Moderate

| | Feedback |
|---|---|
| **A** | The involvement of case managers in care typically provides greater peace of mind for patients and family members, but this is not the primary goal of this service. |
| **B** | Tracking progress is an important aspect of care coordination by the case manager but is not the primary goal. |
| **C** | The focus includes not only medical care, but issues related to health promotion and disease prevention, the cost of healthcare received, and planning for the efficient use of resources. |
| **D** | Case managers coordinate patient care to help ensure that a continuum of clinical services is provided. The goal of case management is to improve patient outcomes and to help contain costs. |

PTS: 1 CON: Leadership and Management

8. The nurse provides discharge teaching for a patient who is being discharged after receiving intravenous antibiotics for pneumonia. Which statement by the nurse demonstrates effective use of the teach-back method?
   A. "Do you understand the information I have presented?"
   B. "Please show me how you would clean the site before infusing the medication."
   C. "You need to have another set of serum cultures before discharge."
   D. "Please complete this short quiz about your discharge instructions."

   ANS: B
   Chapter number and title: 2, Interprofessional Collaboration and Care Coordination
   Chapter learning objective: 1. Discussing the importance of successful transitions for medical-surgical patients
   Chapter page reference: p. 13
   Heading: Box 2.1 Teach-Back
   Integrated Processes: Teaching and Learning
   Client Need: Safe and Effective Care Environment: Management of Care
   Cognitive Level: Application [Applying]
   Concept: Communication
   Difficulty: Difficult

| | Feedback |
|---|---|
| **A** | When using the teach-back method, the nurse avoids asking close-ended |

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|---|---|
| | questions that require a “yes” or “no” answer from the patient. |
| **B** | The nurse reassesses patient understanding by asking the patient to repeat information or demonstrate an activity. |
| **C** | The nurse should avoid the use of medical terminology when providing information using the teach-back method. “Serum cultures” is not lay terminology and may confuse the patient. |
| **D** | The patient should be asked to provide information back to the nurse using their own words. Asking the patient to take a written quiz is not appropriate when using the teach-back method. |

PTS: 1 CON: Communication

9. The nurse prepares to present information for patients during multidisciplinary rounds (MDR). Which does the nurse plan to include when presenting information on assigned patients?
   A. The medical plan for the current shift
   B. A comprehensive overview of the patient’s clinical situation
   C. General actions that need to be completed before the patient’s discharge
   D. Results from a risk screen indicating potential post–acute care needs

   ANS: D
   Chapter number and title: 2, Interprofessional Collaboration and Care Coordination
   Chapter learning objective: 6. Identifying the roles of healthcare professionals coordinating care for patients
   Chapter page reference: p. 15
   Heading: Interprofessional Communication
   Integrated Processes: Communication and Documentation
   Client Need: Safe and Effective Care Environment
   Cognitive Level: Analysis [Analyzing]
   Concept: Collaboration/Communication
   Difficulty: Moderate

| | Feedback |
|---|---|
| **A** | The overall medical plan or the plan for the day is presented during the MDR, not the plan for one shift. |
| **B** | A brief, not comprehensive, overview of the patient’s clinical situation is presented during the MDR. |
| **C** | Specific, not general, action that needs to be completed prior to the patient’s discharge is presented during the MDR. |
| **D** | The nurse should share the results from any risk screens that indicate the patient’s potential needs for post-acute care during the MDR. |

PTS: 1 CON: Collaboration | Communication

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10. The nurse is caring for a patient who is reporting pain of 8 out of 10 on a 1 to 10 numerical pain scale. The nurse administers the prescribed pain medication. When the nurse reevaluates the patient 1 hour later, the patient is still reporting pain of 8 out of 10. Which action by the nurse is appropriate at this time?
    A. Wait for the healthcare provider to make rounds to report the problem.
    B. Report to the healthcare provider by telephone.
    C. Increase the dosage of the medication.
    D. Include in the nursing report that the medication is ineffective.

    ANS: B
    Chapter number and title: 2, Interprofessional Collaboration and Care Coordination
    Chapter learning objective: 5. Defining interprofessional collaboration in the healthcare setting
    Chapter page reference: p. 15
    Heading: Interprofessional Communication
    Integrated Processes: Communication and Documentation
    Client Need: Safe and Effective Care Environment: Management of Care
    Cognitive Level: Application [Applying]
    Concept: Communication
    Difficulty: Moderate

| | Feedback |
|---|---|
| **A** | Waiting for the provider to does not address the patient's immediate needs related to pain. |
| **B** | In this case reporting to the provider by telephone is appropriate to address the patient's unrelieved pain. |
| **C** | The nurse cannot alter the dose of medication without an order from the provider. |
| **D** | The nurse would address the patient's distress immediately and later include the event in the end-of-shift report to the oncoming nurse. |

    PTS: 1 CON: Communication

11. In providing a change-of-shift report to the oncoming nurse, which is the **main** objective for ensuring effective communication during a patient hand-off?
    A. Avoiding lawsuits
    B. Promoting patient safety
    C. Facilitating quality improvement
    D. Ensuring documentation is complete

    ANS: B
    Chapter number and title: 2, Interprofessional Collaboration and Care Coordination
    Chapter learning objective: 6. Identifying the roles of healthcare professionals coordinating care for patients
    Chapter page reference: p. 17
    Heading: Interprofessional Communication

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Integrated Processes: Communication and Documentation
Client Need: Safe and Effective Care Environment Management of Care
Cognitive Level: Comprehension [Understanding]
Concept: Communication
Difficulty: Easy

| | Feedback |
|---|---|
| **A** | Hand-off communication may be scrutinized during a lawsuit, but avoiding litigation is not a primary objective. |
| **B** | Ineffective communication is the primary cause of sentinel events, making patient safety the primary objective of the hand-off communication process. |
| **C** | Analysis of hand-off communication may be a quality improvement criterion, not a primary objective. |
| **D** | Hand-off communication may be verbal or written, but documentation is not the primary objective. |

PTS: 1 CON: Communication

12. The nurse managers in a community hospital have been charged with reviewing job descriptions of unlicensed assistive personnel (UAPs) and have questions about the delegation of certain patient care activities to UAPs by nurses. To whom would committee members direct their questions to obtain definitive answers about the parameters of nurse delegation to UAPs?
A. The State Board of Nursing's Nurse Practice Act
B. The American Nurses Association
C. The hospital's Chief Nursing Officer
D. The hospital's Chief Executive Officer

ANS: A
Chapter number and title: 2, Interprofessional Collaboration and Care Coordination
Chapter learning objective: 6. Identifying the roles of healthcare professionals coordinating care for patients
Chapter page reference: p. 17
Heading: Composition and Roles of the Interprofessional Care Team/Registered Nurse/Delegation/Table 2.1 – Five Rights of Delegation
Integrated Processes: Nursing Process: Implementation
Client Need: Safe and Effective Care Environment: Management of Care
Cognitive Level: Comprehension [Understanding]
Concept: Healthcare Systems
Difficulty: Moderate

| | **Feedback** |
|---|---|
| **A** | Delegating and monitoring of the UAP is defined in policy and under the Nurse Practice Act. |
| **B** | This organization does not provide definitive answers regarding tasks that nurses can delegate to UAPs. |

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|---|---|
| **C** | This individual does not provide definitive answers regarding tasks that nurses can delegate to UAPs. |
| **D** | This individual does not provide definitive answers regarding tasks that nurses can delegate to UAPs. |

PTS: 1 CON: Healthcare Systems

13. The nurse provides care to a patient who is newly diagnosed with type 2 diabetes mellitus. Which interprofessional care team member is most important for the nurse to include when planning care related to the patient's blood glucose levels and nutritional and energy needs?
A. Registered dietitian/nutritionist (RD)
B. Home care coordinator
C. Speech-language pathologist (SLP)
D. Physical therapist

ANS: A
Chapter number and title: 2, Interprofessional Collaboration and Care Coordination
Chapter learning objective: 7. Exploring unique patient situations requiring or enhanced by interprofessional collaboration
Chapter page reference: p. 19
Heading: Composition and Roles of the Interprofessional Care Team/ Registered Dietician/Nutritionist
Integrated Processes: Teaching and Learning
Client Need: Safe and Effective Care Environment: Management of Care
Cognitive Level: Analysis [Analyzing]
Concept: Collaboration, Healthcare Systems
Difficulty: Moderate

| | Feedback |
|---|---|
| **A** | The RD is the professional who assesses the patient's nutritional needs, develops meal plans, and provides education about dietary modifications related to the individual's disease process. |
| **B** | Although a home care coordinator may be appropriate to assist the patient with medication administration needs, this member of the interprofessional care team is not the most important to include when planning care based on the patient's dietary/nutritional needs related to the diagnosis of type 2 diabetes mellitus. |
| **C** | The SLP may be needed for the patient who has difficulty swallowing; however, there is no indication that this patient is having problems swallowing. |
| **D** | The physical therapist will be involved in facilitating this patient's strength and mobility and needs to be aware of the patient's glucose levels; however, this healthcare professional is not the primary person responsible for nutrition. |

PTS: 1 CON: Collaboration | Healthcare Systems

14. In providing an educational program to new graduate nurses, which statement by one of the participants indicates the need for further teaching related to the Five Rights of Delegation?

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A. "If the UAP has completed training, I can assign any task to them."
B. "I need to follow up on a patient when the UAP reports a change in the patient's condition."
C. "It is the UAP's responsibility to ask questions if unsure of the task to be completed."
D. "I am ultimately responsible for ensuring that all delegated tasks are completed."

ANS: A
Chapter number and title: 2. Interprofessional Collaboration and Care Coordination
Chapter learning objective: 6. Identifying the roles of healthcare professionals coordinating care for patients
Chapter page reference: p. 17
Heading: Composition and Roles of the Interprofessional Care Team /Delegation/Table 2.1 – Five Rights of Delegation
Integrated Processes: Teaching and Learning
Client Need: Safe and Effective Care Environment: Management of Care
Cognitive Level: Application [Applying]
Concept: Healthcare Systems/Collaboration
Difficulty: Difficult

| | Feedback |
|---|---|
| **A** | UAPs are accountable to and work under the supervision of the registered nurse when performing a delegated patient care activity and require ongoing monitoring. Even though the UAP has completed training, the nurse must still ensure that the delegated task is something that the UAP is competent to perform. Additionally, patient circumstances may require closer monitoring of the UAP. |
| **B** | The health condition of the patient must be stable. If there is a change, the delegate must communicate this to the licensed nurse, who reassesses the situation and the appropriateness of the delegation. |
| **C** | The licensed nurse is expected to communicate specific instructions for the delegated activity to the delegatee; the delegatee, as part of two-way communication, should ask any clarifying questions. The delegatee must understand the terms of the delegation and must agree to accept the delegated activity. |
| **D** | The licensed nurse, along with the employer and the delegatee, is responsible for ensuring that the delegatee possesses the appropriate skills and knowledge to perform the activity. |

PTS: 1 CON: Healthcare Systems | Collaboration

15. The nurse is managing care for a patient who recently had a stroke and has difficulty swallowing and is concerned about potential aspiration. Which member of the healthcare team can best assess this patient's swallowing ability?
A. Occupational therapist

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B. Dietician
C. Social worker
D. Speech pathologist

ANS: D
Chapter number and title: 2. Interprofessional Collaboration and Care Coordination
Chapter learning objective: 5. Defining interprofessional collaboration in the healthcare setting
Chapter page reference: p. 19
Heading: Composition and Roles of the Interprofessional Care Team/Rehabilitation Therapy
Integrated Processes: Nursing Process: Planning
Client Need: Safe and Effective Care Environment: Management of Care
Cognitive Level: Application [Applying]
Concept: Collaboration/Safety
Difficulty: Difficult

| | Feedback |
|---|---|
| **A** | The occupational therapist (OT) is the professional who assesses and retrains the patient to perform activities of daily living such as bathing, brushing teeth, dressing, cooking, doing laundry, and performing skills necessary to return to optimal functions. |
| **B** | The registered dietitian/nutritionist (RD) is the professional who assesses the patient's nutritional needs, develops meal plans, and provides education about dietary modifications related to the individual's disease process. |
| **C** | Social workers (SWs) are professionals who assess the psychosocial functioning of patients and families. They intervene as necessary, connecting patients and families to necessary support and resources in the community. |
| **D** | The speech-language pathologist (SLP) is the professional who assesses, diagnoses, and treats patients with disorders relating to speech, language, swallowing, voice, and cognitive communication. The SLP develops specific exercises and recommends food consistencies for patients with dysphagia, dysarthria, and a tracheostomy to help prevent complications. |

PTS: 1 CON: Collaboration | Safety

16. A patient with type 1 diabetes mellitus has developed an open sore on the shin, is having trouble meeting daily goals for exercising, and is scheduled for discharge in a couple of days. When planning for this patient's continued care, who will the nurse notify to coordinate the patient's needs after discharge?
A. Pharmacist
B. Case manager
C. Physical therapist
D. Occupational therapist

ANS: B
Chapter number and title: 2, Interprofessional Collaboration and Care Coordination

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Chapter learning objective: 6. Identifying the roles of healthcare professionals coordinating care for patients
Chapter page reference: p. 19
Heading: Composition and Roles of the Interprofessional Care Team/Case Manager
Integrated Processes: Nursing Process: Implementation
Client Need: Safe and Effective Care Environment: Management of Care
Cognitive Level: Application [Applying]
Concept: Collaboration
Difficulty: Moderate

| | Feedback |
|---|---|
| **A** | The pharmacist will be involved in the management of the patient's medications but will not be the coordinator of care. |
| **B** | Because the patient's needs and progress have changed, the nurse notifies the case manager to coordinate changes in care needed after discharge. This patient's exercise program, as well as wound care, needs to be examined, and the case manager is the individual to coordinate this change. |
| **C** | A physical therapist may be needed, but this patient's complications are best coordinated by the case manager. |
| **D** | The occupational therapist mainly deals with the upper body areas needing rehabilitation and would not be coordinating all aspects of this patient's care. |

PTS: 1 CON: Collaboration

17. The home care nurse is planning care for a patient with diabetes mellitus who requires an extensive dressing change twice a day, assistance with activities of daily living (ADLs), and comprehensive education. Which role is the nurse assuming by coordinating the care this patient requires?
A. Collaborator
B. Case manager
C. Health educator
D. Health promoter

ANS: B
Chapter number and title: 2, Interprofessional Collaboration and Care Coordination
Chapter learning objective: 4. Exploring the role of the registered nurse in patient-centered transitional care programs
Chapter page reference: p. 19
Heading: Composition and Roles of the Interprofessional Care Team /Case Manager
Integrated Processes: Nursing Process: Implementation
Client Need: Safe and Effective Care Environment: Management of Care
Cognitive Level: Comprehension [Understanding]
Concept: Collaboration
Difficulty: Easy

| | Feedback |
|---|---|

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| **A** | Although collaboration is an aspect of care coordination, the role of the case manager includes more than collaboration. Collaboration involves a collegial working relationship with other healthcare providers to provide patient care that involves the discussion of diagnoses and management in the delivery of care. |
| **B** | The case manager (CM) utilizes the processes of assessing, planning, facilitating, advocating, and providing available resources to meet the individual's health needs with quality and cost-effective outcomes in mind. A CM incorporates the input of the Interprofessional Care Team (ICT) to plan in-hospital care and discharge transition care. This professional monitors services to ensure that the patient has the available resources to return to optimal health. |
| **C** | Health education would be included in this situation but represents only one role of the CM. |
| **D** | Health promotion activities include disease prevention and healthy lifestyle interventions and would be a component of this patient's transition but only reflect one role of the CM. |

PTS: 1 CON: Collaboration

18. A school-age patient is admitted to the pediatric intensive care unit (PICU), unconscious and with multiple traumatic injuries, after a skateboard accident that included a closed head injury. Many health professionals are involved in the patient's care and the scene is chaotic. The parents are extremely anxious and want to know what is happening. The case manager asks for an interdisciplinary team meeting to speak with the patient's parents. Which is the rationale for this meeting?
    A. To allow for each specialty to independently describe their roles in the patient's care
    B. To share information for care planning and to prevent priority conflicts, redundancy, and omissions in care
    C. To allow the primary healthcare provider to take the lead in the decision making regarding the patient's care
    D. To prevent the parents from trying to change the goals of care

    ANS: B
    Chapter number and title: 2, Interprofessional Collaboration and Care Coordination
    Chapter learning objective: 7. Exploring unique patient situations requiring or enhanced by interprofessional collaboration
    Chapter page reference: p. 21
    Heading: Unique Patient Situations Requiring or Enhanced by Interprofessional Collaboration
    Integrated Processes: Nursing Process: Planning
    Client Need: Safe and Effective Care Environment: Management of Care
    Cognitive Level: Analysis [Analyzing]
    Concept: Family /Collaboration
    Difficulty: Moderate

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| | Feedback |
|---|---|
| **A** | Interdisciplinary collaboration engages each professional's contribution to coordinated care, and the goal is not about each individual provider's role/input. |
| **B** | Interdisciplinary collaboration engages each professional's contribution to coordinated care planning, implementation, and accomplishment of patient goals, with possibly less redundancy, more efficiency, and fewer care omissions. The parents of a minor child should be involved in all aspects of care and decision making. |
| **C** | Interdisciplinary collaboration engages each professional's contribution to coordinated care. The primary provider is a member of the team, not automatically the decision maker. |
| **D** | Interdisciplinary collaboration engages each professional's contribution, and the parents of a minor child should be involved in all aspects of care and decision making. |

PTS: 1 CON: Family | Collaboration

19. The nurse is identifying patients on the nursing unit that would benefit from a Transitional Care Nurse (TCN). Which patient situations warrant this?
A. A patient being discharged to home who is independent with their care.
B. A patient who is uninsured and needs assistance in navigating the hospital bill.
C. A patient who is being transferred to a skilled care facility after hip surgery.
D. A patient whose condition has deteriorated and is being transferred to the intensive care unit.

ANS: C
Chapter number and title: 2, Interprofessional Collaboration and Care Coordination
Chapter learning objective: 7. Exploring unique patient situations requiring or enhanced by interprofessional collaboration
Chapter page reference: pp. 11-12
Heading: Evidence-Based Models of Transitional Care
Integrated Processes: Nursing Process: Planning
Client Need: Safe and Effective Care Environment: Management of Care
Cognitive Level: Analysis [Analyzing]
Concept: Collaboration
Difficulty: Moderate

| | Feedback |
|---|---|
| **A** | Patients who are independent with their care are not in need of a TCN nurse. |
| **B** | Patient with financial concerns should be connected with the specialists in the billing department who can set up payment plans and assist with hospital bills. |
| **C** | Transitional care nurses manage patients as they transition across the care continuum from inpatient settings to other settings, including skilled nursing facilities and home. |

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| | |
|---|---|
| D | Transferring to a higher level of care within a facility does not require a TCN. |

PTS: 1 CON: Collaboration

20. A nurse admits an older adult patient to the medical-surgical unit for pneumonia. An 8P Scale assessment is completed. Which finding is concerning to the nurse?
A. The patient takes 9 medications daily.
B. The patient can no longer see to drive at night.
C. The patient used to work in healthcare.
D. The patient has had 12 previous surgeries.

ANS: A
Chapter number and title: 2, Interprofessional Collaboration and Care Coordination
Chapter learning objective: 7. Exploring unique patient situations requiring or enhanced by interprofessional collaboration
Chapter page reference: p. 12
Heading: Evidence-Based Models of Transitional Care
Integrated Processes: Nursing Process: Planning
Client Need: Safe and Effective Care Environment: Management of Care
Cognitive Level: Application [Applying]
Concept: Safety
Difficulty: Moderate

| | Feedback |
|---|---|
| A | 8P Scale is an assessment tool that is completed on admission and identifies risk factors such as polypharmacy, problem medications, physiological issues, poor health literacy, principal diagnosis, patient support, prior hospitalizations, and palliative care. The 8P Scale is used by the ICT to determine appropriate post-discharge needs. |
| B | Driving at night is not a concern for discharge planning. |
| C | The patient's history of working in healthcare can be beneficial to discharge since they likely have health literacy understanding. |
| D | The quantity of previous surgeries are not a concern for discharge. |

PTS: 1 CON: Safety

**MULTIPLE RESPONSE**

1. Which initiatives were instrumental to the United States addressing healthcare that is coordinated, safe, and focused on the patient's unique needs across all setting care settings? *Select all that apply.*
A. Project RED (Re-engineered Discharge)
B. To Err Is Human: Building a Safer Health Care System

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C. Crossing the Quality Chasm: A New Health System for the 21st Century
D. Transforming Care at the Bedside Project
E. Project BOOST (Better Outcomes for Older Adults through Safe Transitions)

ANS: B, C
Chapter number and title: 2, Interprofessional Collaboration and Care Coordination
Chapter learning objective: 2. Describing changes in the healthcare landscape
Chapter page reference: p. 10
Heading: Overview of Transitional Care Model
Integrated Processes: N/A
Client Need: N/A
Cognitive Level: Comprehension [Understanding]
Concept: Healthcare Systems
Difficulty: Moderate

| | Feedback |
|---|---|
| **A** | This is incorrect. Project RED is a research group that develops and tests strategies that improve hospital discharge processes. The RED is based on 12 interrelated components that promote patient safety and decrease readmissions. |
| **B** | This is correct. The Institute of Medicine (IOM) released To Err Is Human: Building a Safer Health System (2000), which addresses the quality and fragmentation of healthcare throughout the United States and recommends necessary transformations in healthcare needed to provide safe, effective, patient-centered, efficient, timely, and equitable care. |
| **C** | This is correct. The IOM released Crossing the Quality Chasm: A New Health System for the 21st Century, which addresses the quality and fragmentation of healthcare throughout the United States and recommends necessary transformations in healthcare needed to provide safe, effective, patient-centered, efficient, timely, and equitable care. |
| **D** | This is incorrect. The Transforming Care at the Bedside (TCAB) project was implemented in 2003 to address the recommendations related to improving the quality and safety of patient care on medical-surgical units. |
| **E** | This is incorrect. The objectives of Project BOOST are to identify patients at risk for readmission on admission, reduce 30-day readmission rates, decrease length of stay, and improve communication of patient care information during discharge. |

PTS: 1 CON: Healthcare Systems

2. The nurse case manager has been extensively involved with a shooting victim and members of the patient's family in coordinating care of providers from many disciplines as the patient progressed from the emergency department (ED) to the intensive care unit (ICU), and then onto the medical-surgical unit. After 3 weeks of hospitalization, the case manager is helping to prepare the patient for discharge to a rehabilitation center. Which outcomes have been documented in the literature as benefits of such collaboration? *Select all that apply.*

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A. Improved patient outcomes
B. Decreased duplication of healthcare services
C. Increased overall cost of healthcare services
D. Decreased patient morbidity and mortality
E. Decreased level of job satisfaction

ANS: A, B, D
Chapter number and title: 2, Interprofessional Collaboration and Care Coordination
Chapter learning objective: 3. Describing models of transitional care
Chapter page reference: pp. 11-12
Heading: Overview of Transitional Care
Integrated Processes: Nursing Process: Evaluation
Client Need: Safe and Effective Care Environment: Management of Care
Cognitive Level: Comprehension [Understanding]
Concept: Collaboration
Difficulty: Moderate

| | Feedback |
|---|---|
| **A** | This is correct. Research findings suggest that collaboration in healthcare among patients, family members, caregivers, and communities leads to improved patient outcomes, a reduction in duplicated healthcare services, and a decrease in patient morbidity and mortality. |
| **B** | This is correct. Research findings suggest that collaboration in healthcare among patients, family members, caregivers, and communities leads to improved patient outcomes, a reduction in duplicated healthcare services, and a decrease in patient morbidity and mortality. |
| **C** | This is incorrect. Research findings suggest that collaboration in healthcare among patients, family members, caregivers, and communities leads to a decreased, not increased, cost of care. |
| **D** | This is correct. Research findings suggest that collaboration in healthcare among patients, family members, caregivers, and communities leads to improved patient outcomes, a reduction in duplicated healthcare services, and a decrease in patient morbidity and mortality. |
| **E** | This is incorrect. Collaborative efforts have also been found to contribute to an enhanced sense of autonomy. This increase in sense of autonomy has been linked to nurses' greater job satisfaction. |

PTS: 1 CON: Collaboration

3. The nurse recognizes which factors as important to a successful transitional care program? *Select all that apply.*
A. Patient-centered approach
B. Agency-centered approach
C. Outcomes focused
D. Disease management focused
E. Patient education focused

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ANS: A, C, E
Chapter number and title: 2. Interprofessional Collaboration and Care Coordination
Chapter learning objective: 1. Discussing the importance of successful transitions for medical-surgical patients
Chapter page reference: p. 10
Heading: Overview of Transitional Care
Integrated Processes: N/A
Client Need: N/A
Cognitive Level: Comprehension [Understanding]
Concept: Healthcare Systems
Difficulty: Moderate

| | Feedback |
|---|---|
| **A** | This is correct. Transitional care programs are patient-centered and typically manage the transitions of patients from acute care to post-acute care settings. |
| **B** | This is incorrect. Transitional care programs are patient-centered and typically manage the transitions of patients from acute care to post-acute care settings. |
| **C** | This is correct. The goals of successful transitional are to avoid poor health outcomes, ensure continuity of care, and facilitate safe transition between care settings. |
| **D** | This is incorrect. Transitional care programs are time limited, whereas disease management programs are ongoing and not as patient centered. |
| **E** | This is correct. The emphasis of transitional care programs is on coordination of care, patient engagement, and education, addressing causes of poor outcomes, and avoiding preventable readmissions. |

PTS: 1 CON: Healthcare Systems

4. Which statements by a patient indicates that teaching was effective about the role of the transition care nurse in the plan of care. *Select all that apply*.
   A. "This nurse will visit me in my home for the next month."
   B. "This nurse will call me every day to make sure that I take my medications."
   C. "This nurse will visit be before I am discharged."
   D. "This nurse will monitor my progress for the next year."
   E. "This nurse will make follow-up phone calls during the second month that I am at home."

   ANS: A, C, E
   Chapter number and title: 2. Interprofessional Collaboration and Care Coordination
   Chapter learning objective: 4. Exploring the role of the registered nurse in patient-centered transitional care programs
   Chapter page reference: pp. 11-12
   Heading: Evidence-Based Models of Transitional Care
   Integrated Processes: Nursing Process: Evaluation
   Client Need: Safe and Effective Care Environment: Management of Care

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Cognitive Level: Application [Applying]
Concept: Collaboration/Professionalism
Difficulty: Difficult

| | Feedback |
|---|---|
| **A** | This is correct. The transition care nurse (TCN) visits the patient in the hospital and, after discharge, visits the patient weekly at home for a month. |
| **B** | This is incorrect. The TCN will visit weekly but will not call the patient daily to remind them to take medications. |
| **C** | This is correct. The TCN visits the patient in the hospital and, after discharge, visits the patient weekly at home for a month. |
| **D** | This is incorrect. The TCN conducts follow-up phone calls during the second month. The patient is followed for approximately 8 weeks. |
| **E** | This is correct. The TCN conducts follow-up phone calls during the second month. The patient is followed for approximately 8 weeks. |

PTS: 1 CON: Collaboration | Professionalism

5. The post-discharge call nurse provides care to a patient after discharge. Which actions does the nurse implement when assuming this role? *Select all that apply*.
   A. Calling the patient within 12 hours after discharge
   B. Connecting the patient to home care based on current needs
   C. Identifying potential challenges, the patient may be experiencing
   D. Diagnosing new medical problems that necessitate the patient to seek further follow-up
   E. Answering questions from the patient's caregiver, who was not present during discharge teaching

   ANS: B, C, E
   Chapter number and title: 2, Interprofessional Collaboration and Care Coordination
   Chapter learning objective: 6. Identifying the roles of healthcare professionals coordinating care for patients
   Chapter page reference: p. 20
   Heading: Composition and Roles of the Interprofessional Care Team /Ad Hoc Members
   Integrated Processes: Teaching and Learning
   Client Need: Safe and Effective Care Environment: Management of Care
   Cognitive Level: Application [Applying]
   Concept: Communication/Health Promotion
   Difficulty: Difficult

| | Feedback |
|---|---|
| **A** | This is incorrect. The post-discharge call nurse calls the patient 24 to 48 hours after discharge, not 12 to 24 hours post-discharge. |
| **B** | This is correct. The post-discharge call nurse often identifies patient needs that may necessitate a referral to home healthcare. |

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| | |
|---|---|
| **C** | This is correct. The calls are typically scripted and involve data collection for outcome measures or identification of missed discharge planning opportunities and activities. The post-discharge call nurse hopes to identify potential challenges early to prevent a readmission. |
| **D** | This is incorrect. It is outside the scope of practice for the nurse to diagnose medical problems. However, the post-discharge call nurse can collect data that would support the need to schedule a follow-up based on the data collected. |
| **E** | This is correct. The post-discharge call nurse may also have the opportunity to answer questions for a caregiver who was not present during the discharge teaching process. |

PTS: 1 CON: Communication | Health Promotion

6. When discussing the importance of interprofessional collaboration, which advantages should the nurse include? *Select all that apply.*
   A. Improved team member satisfaction
   B. Increased division among team members
   C. Increased safety with medication administration
   D. Enhanced communication among team members
   E. Increased patient satisfaction with discharge transition process

   ANS: A, D, E
   Chapter number and title: 2, Interprofessional Collaboration and Care Coordination
   Chapter learning objective: 7. Exploring unique patient situations requiring or enhanced by interprofessional collaboration
   Chapter page reference: p. 21
   Heading: Unique Patient Situations Requiring or Enhanced By Interprofessional Collaboration/(Box 2.3 Advantages of Interprofessional Collaboration)
   Integrated Processes: Teaching and Learning
   Client Need: Safe and Effective Care Environment: Management of Care
   Cognitive Level: Application [Applying]
   Concept: Collaboration
   Difficulty: Moderate

| | Feedback |
|---|---|
| **A** | This is correct. Improved team member satisfaction is an advantage of interprofessional collaboration. |
| **B** | This is incorrect. There is a decreased, not increased, division among team members with interprofessional collaboration. |
| **C** | This is incorrect. There is increased safety with the discharge transition process, but this collaboration is not directly related to medication administration. |
| **D** | This is correct. Enhanced communication among team members is an advantage of interprofessional collaboration. |
| **E** | This is correct. Increased patient satisfaction with the discharge transition process is an advantage of interprofessional collaboration. |

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PTS: 1 CON: Collaboration

7. The nurse is caring for a patient newly diagnosed with terminal cancer who is new to this country and only speaks their native language. They are in this country illegally without family and only a few friends. A friend tells the nurse that there is no way that the hospital bill can be paid. Which ad hoc team members should the nurse include to provide care? *Select all that apply.*

A. Interpreter
B. Chaplain
C. Legal counsel
D. Palliative care coordinator
E. Substance abuse counselor

ANS: A, B, C, D
Chapter number and title: 2, Interprofessional Collaboration and Care Coordination
Chapter learning objective: 7. Exploring unique patient situations requiring or enhanced by interprofessional collaboration
Chapter page reference: pp. 16-21
Heading: Composition and Roles of the Interprofessional Care Team
Integrated Processes: Caring
Client Need: Safe and Effective Care Environment: Management of Care
Cognitive Level: Application [Applying]
Concept: Collaboration
Difficulty: Moderate

| | Feedback |
|---|---|
| **A** | This is correct. The interpreter is the professional who facilitates the understanding of medical information by translating the information from English to the patient's native tongue, and vice versa. |
| **B** | This is correct. The chaplain is a professional who has an educational background in religion. The chaplain provides spiritual comfort to patients and family members in need. |
| **C** | This is correct. The legal counsel is a professional who has judicial education, particularly in healthcare law, and provides legal perspective and support when resolving legal matters in the healthcare setting. Questions about the patient's illegal status and inability to pay can be addressed by the legal counsel. |
| **D** | This is correct. The palliative care coordinator is an advanced practice RN who provides information and support for the patient and family members when the patient needs disease, pain, or symptom management or needs hospice care when the patient has a terminal illness. |
| **E** | This is incorrect. The substance abuse counselor can be an SW, counselor, or RN but is typically a professional with a degree or certificate in addiction. Nothing indicates that the patient has a substance use issue. |

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PTS: 1 CON: Collaboration

8. The nurse is caring for a patient readmitted to the hospital with diabetic ketoacidosis, 4 days after being discharged with a new diagnosis of diabetes mellitus Type 1. The nurse learns that the patient has not been able to obtain insulin or a blood glucose monitor since discharge because of the cost. The patient's family member tells the nurse that the patient has a fear of needles and does not want to take injections. How could this situation have been avoided? *Select all that apply*.

A. Assessment of the patient's health goal and preferences.
B. Creating an evidence-based plan of care.
C. Engaging the patient in planning and implementing the plan of care.
D. Engaging the caregivers in planning and implementing the plan of care.
E. Using better interdisciplinary communication.

ANS: A, C, E
Chapter number and title: 2, Interprofessional Collaboration and Care Coordination
Chapter learning objective: 4. Exploring the role of the registered nurse in patient-centered transitional care programs
Chapter page reference: p. 10
Heading: Overview of Transitional Care
Integrated Processes: Teaching and Learning
Client Need: Safe and Effective Care Environment: Management of Care
Cognitive Level: Application [Applying]
Concept: Collaboration
Difficulty: Moderate

| | Feedback |
|---|---|
| **A** | This is correct. Before discharge the nurse and team should have learned that the patient is anxious about needles and taken actions to overcome this fear. |
| **B** | This is incorrect. Creating an evidence-based plan of care would include one that incorporates best practices for care of a patient with type 2 diabetes. |
| **C** | This is correct. Engaging the patient would have made the healthcare team more aware of the fears and financial limitations so that the plan would have built on solutions. |
| **D** | This is incorrect. Involving the family is not where the breakdown in transition occurred. Engaging the patient is more important. |
| **E** | This is correct. Improved communication among the team members would have built a plan of care that would have prevented this readmission. |

PTS: 1 CON: Collaboration

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