Chapter 01: Overview of Professional Nursing Concepts for Medical-Surgical Nursing Ignatavicius: Medical-Surgical Nursing, 10th Edition

MULTIPLE CHOICE

1. A new nurse is working with a preceptor on a medical-surgical unit. The preceptor advises the new nurse that which is the **priority** when working as a professional nurse?
   a. Attending to holistic client needs
   b. Ensuring client safety
   c. Not making medication errors
   d. Providing client-focused care

   ANS: B
   All actions are appropriate for the professional nurse. However, ensuring client safety is the priority. Health care errors have been widely reported for 25 years, many of which result in client injury, death, and increased health care costs. There are several national and international organizations that have either recommended or mandated safety initiatives. Every nurse has the responsibility to guard the client's safety. The other actions are important for quality nursing, but they are not as vital as providing safety. Not making medication errors does provide safety, but is too narrow in scope to be the best answer.

   DIF: Understanding TOP: Integrated Process: Nursing Process: Intervention
   KEY: Client safety
   MSC: Client Needs Category: Safe and Effective Care Environment: Safety and Infection Control

2. A nurse is orienting a new client and family to the medical-surgical unit. What information does the nurse provide to best help the client promote his or her own safety?
   a. Encourage the client and family to be active partners.
   b. Have the client monitor hand hygiene in caregivers.
   c. Offer the family the opportunity to stay with the client.
   d. Tell the client to always wear his or her armband.

   ANS: A
   Each action could be important for the client or family to perform. However, encouraging the client to be active in his or her health care as a safety partner is the most critical. The other actions are very limited in scope and do not provide the broad protection that being active and involved does.

   DIF: Understanding TOP: Integrated Process: Teaching/Learning
   KEY: Client safety
   MSC: Client Needs Category: Safe and Effective Care Environment: Safety and Infection Control

3. A nurse is caring for a postoperative client on the surgical unit. The client's blood pressure was 142/76 mm Hg 30 minutes ago, and now is 88/50 mm Hg. What action would the nurse take **first**?
   a. Call the Rapid Response Team.
   b. Document and continue to monitor.
   c. Notify the primary health care provider.
   d. Repeat the blood pressure in 15 minutes.

ANS: A
The purpose of the Rapid Response Team (RRT) is to intervene when clients are deteriorating before they suffer either respiratory or cardiac arrest. Since the client has manifested a significant change, the nurse would call the RRT. Changes in blood pressure, mental status, heart rate, temperature, oxygen saturation, and last 2 hours' urine output are particularly significant and are part of the Modified Early Warning System guide. Documentation is vital, but the nurse must do more than document. The primary health care provider would be notified, but this is not more important than calling the RRT. The client's blood pressure would be reassessed frequently, but the priority is getting the rapid care to the client.

DIF: Applying TOP: Integrated Process: Communication and Documentation
KEY: Rapid Response Team (RRT), Clinical judgment
MSC: Client Needs Category: Physiological Integrity: Physiological Adaptation

4. A nurse wishes to provide client-centered care in all interactions. Which action by the nurse **best** demonstrates this concept?
   a. Assesses for cultural influences affecting health care.
   b. Ensures that all the client's basic needs are met.
   c. Tells the client and family about all upcoming tests.
   d. Thoroughly orients the client and family to the room.

   ANS: A
   Showing respect for the client and family's preferences and needs is essential to ensure a holistic or "whole-person" approach to care. By assessing the effect of the client's culture on health care, this nurse is practicing client-focused care. Providing for basic needs does not demonstrate this competence. Simply telling the client about all upcoming tests is not providing empowering education. Orienting the client and family to the room is an important safety measure, but not directly related to demonstrating client-centered care.

   DIF: Understanding TOP: Integrated Process: Culture and Spirituality
   KEY: Client-centered care, Culture MSC: Client Needs Category: Psychosocial Integrity

5. A client is going to be admitted for a scheduled surgical procedure. Which action does the nurse explain is the **most** important thing the client can do to protect against errors?
   a. Bring a list of all medications and what they are for.
   b. Keep the provider's phone number by the telephone.
   c. Make sure that all providers wash hands before entering the room.
   d. Write down the name of each caregiver who comes in the room.

   ANS: A
   Medication reconciliation is a formal process in which the client's actual current medications are compared to the prescribed medications at the time of admission, transfer, or discharge. This National client Safety Goal is important to reduce medication errors. The client would not have to be responsible for providers washing their hands, and even if the client does so, this is too narrow to be the most important action to prevent errors. Keeping the provider's phone number nearby and documenting everyone who enters the room also do not guarantee safety.

   DIF: Applying TOP: Integrated Process: Teaching/Learning
   KEY: Client safety, Informatics
   MSC: Client Needs Category: Safe and Effective Care Environment: Safety and Infection Control

6. Which action by the nurse working with a client **best** demonstrates respect for autonomy?
   a. Asks if the client has questions before signing a consent.
   b. Gives the client accurate information when questioned.
   c. Keeps the promises made to the client and family.
   d. Treats the client fairly compared to other clients.

   ANS: A
   Autonomy is self-determination. The client would make decisions regarding care. When the nurse obtains a signature on the consent form, assessing if the client still has questions is vital, because without full information the client cannot practice autonomy. Giving accurate information is practicing with veracity. Keeping promises is upholding fidelity. Treating the client fairly is providing social justice.

   DIF: Applying TOP: Integrated Process: Caring KEY: Ethics, Autonomy
   MSC: Client Needs Category: Safe and Effective Care Environment: Management of Care

7. A nurse asks a more seasoned colleague to explain best practices when communicating with a person from the lesbian, gay, bisexual, transgender, and questioning/queer (LGBTQ) community. What answer by the faculty is **most** accurate?
   a. Avoid embarrassing the client by asking questions.
   b. Don't make assumptions about his or her health needs.
   c. Most LGBTQ people do not want to share information.
   d. No differences exist in communicating with this population.

   ANS: B
   Many members of the LGBTQ community have faced discrimination from health care providers and may be reluctant to seek health care. The nurse would never make assumptions about the needs of members of this population. Rather, respectful questions are appropriate. If approached with sensitivity, the client with any health care need is more likely to answer honestly.

   DIF: Understanding TOP: Integrated Process: Teaching/Learning
   KEY: Health care disparities, LGBTQ MSC: Client Needs Category: Psychosocial Integrity

8. A nurse is calling the on-call health care provider about a client who had a hysterectomy 2 days ago and has pain that is unrelieved by the prescribed opioid pain medication. Which statement comprises the background portion of the SBAR format for communication?
   a. "I would like you to order a different pain medication."
   b. "This client has allergies to morphine and codeine."
   c. "Dr. Smith doesn't like nonsteroidal anti-inflammatory meds."
   d. "This client had a vaginal hysterectomy 2 days ago."

   ANS: B

SBAR is a recommended form of communication, and the acronym stands for *Situation*, *Background*, *Assessment*, and *Recommendation*. Appropriate background information includes allergies to medications the on-call health care provider might order. *Situation* describes what is happening right now that must be communicated; the client's surgery 2 days ago would be considered background. *Assessment* would include an analysis of the client's problem; none of the options has assessment information. Asking for a different pain medication is a recommendation. *Recommendation* is a statement of what is needed or what outcome is desired.

DIF: Applying TOP: Integrated Process: Communication and Documentation
KEY: Teamwork and collaboration, SBAR
MSC: Client Needs Category: Safe and Effective Care Environment: Management of Care

9. A nurse working on a cardiac unit delegated taking vital signs to an experienced assistive personnel (AP). Four hours later, the nurse notes that the client's blood pressure taken by the AP was much higher than previous readings, and the client's mental status has changed. What action by the nurse would **most** likely have prevented this negative outcome?
   a. Determining if the AP knew how to take blood pressure
   b. Double-checking the AP by taking another blood pressure
   c. Providing more appropriate supervision of the AP
   d. Taking the blood pressure instead of delegating the task

   ANS: C
   Supervision is one of the five rights of delegation and includes directing, evaluating, and following up on delegated tasks. The nurse would either have asked the AP about the vital signs or instructed the AP to report them right away. An experienced AP would know how to take vital signs and the nurse would not have to assess this at this point. Double-checking the work defeats the purpose of delegation. Vital signs are within the scope of practice for a AP and are permissible to delegate. The only appropriate answer is that the nurse did not provide adequate instruction to the AP.

   DIF: Analyzing TOP: Integrated Process: Communication and Documentation
   KEY: Teamwork and collaboration, Delegation
   MSC: Client Needs Category: Safe and Effective Care Environment: Management of Care

10. A newly graduated nurse in the hospital states that because of being so new, participation in quality improvement (QI) projects is not wise. What response by the precepting nurse is **best**?
    a. "All staff nurses are required to participate in quality improvement here."
    b. "Even being new, you can implement activities designed to improve care."
    c. "It's easy to identify what indicators would be used to measure quality."
    d. "You should ask to be assigned to the research and quality committee."

    ANS: B
    The preceptor would try to reassure the nurse that implementing QI measures is not out of line for a newly licensed nurse. Simply stating that all nurses are required to participate does not help the nurse understand how that is possible and is dismissive. Identifying indicators of quality is not an easy, quick process and would not be the best place to suggest a new nurse to start. Asking to be assigned to the QI committee does not give the nurse information about how to implement QI in daily practice.

    DIF: Applying TOP: Integrated Process: Communication and Documentation

KEY: Systems thinking, Quality improvement
MSC: Client Needs Category: Safe and Effective Care Environment: Management of Care

11. A nurse is talking with a co-worker who is moving to a new state and needs to find new employment there. What advice by the nurse is **best**?
    a. Ask the hospitals there about standard nurse–client ratios.
    b. Choose the hospital that has the newest technology.
    c. Find a hospital that has achieved Magnet status.
    d. Work in a facility affiliated with a medical or nursing school.

    ANS: C
    Client Magnet status is awarded by The Joint Commission (TJC) and certifies that nurses can demonstrate how best current evidence guides their practice. New technology doesn't necessarily mean that the hospital is safe. Affiliation with a health profession school has several advantages, but safety is most important.

    DIF: Understanding
    TOP: Integrated Process: Communication and Documentation
    KEY: Evidence-based practice, Magnet status
    MSC: Client Needs Category: Safe and Effective Care Environment: Safety and Infection Control

MULTIPLE RESPONSE

1. A nurse manager wishes to ensure that the nurses on the unit are practicing at their highest levels of competency. Which areas would the manager assess to determine if the nursing staff demonstrate competency according to the Institute of Medicine (IOM) report *Health Professions Education: A Bridge to Quality?* (*Select all that apply.*)
    a. Collaborating with an interprofessional team
    b. Implementing evidence-based care
    c. Providing family-focused care
    d. Routinely using informatics in practice
    e. Using quality improvement in client care
    f. Formalizing systems thinking when implementing care

    ANS: A, B, D, E
    The IOM report lists five broad core competencies that all health care providers should practice. These include collaborating with the interprofessional team, implementing evidence-based practice, providing patient-focused care, using informatics in client care, and using quality improvement in client care. Systems thinking is required for quality improvement but is not a specified part of the IOM report.

    DIF: Remembering TOP: Integrated Process: Nursing Process: Assessment
    KEY: Competencies, Institute of Medicine (IOM)
    MSC: Client Needs Category: Safe and Effective Care Environment: Safety and Infection Control

2. A nurse is interested in making interprofessional work a high priority. Which actions by the nurse **best** demonstrate this skill? (*Select all that apply.*)
    a. Consults with other disciplines on client care.
    b. Coordinates discharge planning for home safety.
    c. Participates in comprehensive client rounding.
    d. Routinely asks other disciplines about client progress.

e. Shows the nursing care plans to other disciplines.
f. Delegate tasks to unlicensed personnel appropriately.

ANS: A, B, C, D, F
Collaborating with the interprofessional team involves planning, implementing, and evaluating client care as a team with all other involved disciplines included. Simply showing other caregivers the nursing care plan is not actively involving them or collaborating with them.

DIF: Applying TOP: Integrated Process: Communication and Documentation
KEY: Teamwork and collaboration, Interprofessional team
MSC: Client Needs Category: Safe and Effective Care Environment: Management of Care

3. The nurse utilizing evidence-based practice (EBP) considers which factors when planning care? (*Select all that apply.*)
a. Cost-saving measures
b. Nurse's expertise
c. Client preferences
d. Research findings
e. Values of the client
f. Plan-do-study-act model

ANS: B, C, D, E
EBP consists of utilizing current evidence, the client's values and preferences, and the nurse's expertise when planning care. It does not include cost-saving measures. The PDSA model is a systematic model for quality improvement, but is not a specific component of EBP.

DIF: Remembering TOP: Integrated Process: Nursing Process: Planning
KEY: Evidence-based practice (EBP)
MSC: Client Needs Category: Safe and Effective Care Environment: Management of Care

4. A nurse manager wants to improve hand-off communication among the staff. What actions by the manager would **best** help achieve this goal? (*Select all that apply.*)
a. Attend hand-off rounds to coach and mentor.
b. Create a template of suggested topics to include in report.
c. Encourage staff to ask questions during hand-off.
d. Give raises based on compliance with reporting.
e. Provide education on the SBAR method of communication

ANS: A, B, C, E
The SBAR method of communication has been identified as an excellent method of communication between health care professionals. It is a formalized structure consisting of Situation, Background, Assessment, and Recommendation/Request. Using a formalized mechanism for communication helps ensure successful hand-off and fewer client errors. When establishing this new format for report, the most helpful actions by the manager would be to provide initial education on the process, develop a template with suggested topics under each heading, attend rounds to coach and mentor, and encourage staff to ask questions to clarify information. Basing raises on compliance would not be the most helpful method because raises are often determined only once a year and are based on multiple criteria.

DIF: Applying TOP: Integrated Process: Communication and Documentation
KEY: Teamwork and collaboration, Communication

Chapter 02: Clinical Judgment and Systems Thinking
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MULTIPLE CHOICE

1. A nurse asks the charge nurse to explain the difference between critical thinking and clinical judgment. What statement by the charge nurse is **best**?
   a. "Clinical judgment is often clouded by erroneous hypotheses."
   b. "Clinical judgment is the observable outcome of critical thinking."
   c. "Critical thinking requires synthesizing interactions within a situation."
   d. "Critical thinking is the highest level of nursing judgment."

   ANS: B
   Clinical judgment is the observable outcome of critical thinking and decision making. It can be, but most often is not, clouded by erroneous hypotheses. Recognizing, understanding, and synthesizing interactions and interdependencies in a set of components designed for a specific purpose is systems thinking. Critical thinking is not the highest level of nursing judgment.

   DIF: Understanding TOP: Integrated Process: Teaching/Learning
   KEY: Clinical judgment
   MSC: Client Needs Category: Safe and Effective Care Environment: Management of Care

2. The nurse understands which information regarding patient-centered care?
   a. A competency recognizing the client as the source of control of his or her care
   b. A project addressing challenges in implementing patient-centered care
   c. Purposeful, informed, and outcome-focused care of clients or families
   d. The ability to use best evidence and practice when making care-related decisions

   ANS: A
   Patient-centered care is a QSEN competency that recognizes the patient or caregiver as the source of control and full partner in providing compassionate and coordinated care based on respect for the patient's preferences, values, and needs. QSEN is a project addressing the challenge of preparing future nurses with the knowledge, skills, and attitudes (KSAs) necessary to continuously improve the quality and safety of the health care systems in which they work. Critical thinking is the application of purposeful, informed, and outcome-focused care. The ability to use best evidence and practice when making care-related decisions is evidence-based practice.

   DIF: Understanding TOP: Integrated Process: Teaching/Learning
   KEY: Patient-centered care
   MSC: Client Needs Category: Safe and Effective Care Environment: Management of Care

3. A nurse wishes to participate in an activity that will influence health outcomes. What action by the nurse **best** meets this objective?
   a. Creating a transportation system for health care appointments
   b. Lobbying with a national organization for health care policy
   c. Organizing a food pantry in an impoverished community
   d. Running for election to the county public health board

   ANS: B

All options are good choices for an altruistic nurse wishing to influence health outcomes; however, being involved in policy creation and health care reform is an activity specifically recognized to improve health outcomes. This action will also affect a wider population than the more local options.

DIF: Applying TOP: Integrated Process: Communication and Documentation
KEY: Health outcomes
MSC: Client Needs Category: Safe and Effective Care Environment: Management of Care

4. What factor **best** predicts a nurse's willingness to employ critical thinking?
   a. Caring
   b. Knowledge
   c. Presence
   d. Skills

ANS: A
All attributes are important in nursing, however; the nurse's willingness to think critically is predicted by caring behaviors, self-reflection, and insight.

DIF: Remembering TOP: Integrated Process: Nursing Process: Assessment
KEY: Critical thinking
MSC: Client Needs Category: Safe and Effective Care Environment: Management of Care

5. To demonstrate clinical reasoning skills, what action does the nurse take?
   a. Collaborating with co-workers to buddy up for lunch breaks
   b. Delegating frequent vital signs on a new postoperative patient
   c. Documenting a complete history and physical on an admission
   d. Requesting the provider order medication for a client with high potassium

ANS: D
The components of clinical reasoning include assessing, analyzing, planning, implementing, and evaluating. This nurse shows the ability to analyze by interpreting the meaning of the lab value, to plan by anticipating the consequences of the lab value, and to implement by taking action.

DIF: Analyzing TOP: Integrated Process: Nursing Process: Implementation
KEY: Clinical judgment
MSC: Client Needs Category: Safe and Effective Care Environment: Management of Care

6. The new nurse asks the preceptor how context affects clinical judgment. What response by the preceptor is **best**?
   a. "Context considers the whole of the patient's story and circumstances."
   b. "It shouldn't, only nursing knowledge would affect clinical judgment."
   c. "Outside influences such as environment in which you provide care, influence your decisions."
   d. "The context of the situation provides an extra layer of complexity to consider."

ANS: C
The context of a situation considers and supports clinical judgment. The factors within this layer—such as environment, time pressure, availability or content of electronic health records, resources, and individual nursing knowledge—have a direct impact on clinical judgment. The other two options are too vague to provide appropriate information.

DIF: Understanding TOP: Integrated Process: Teaching/Learning
KEY: Clinical judgment
MSC: Client Needs Category: Safe and Effective Care Environment: Management of Care

7. Once the nurse has considered all possible collaborative and client problems, what action does the nurse take next?
   a. Act on the observed cues.
   b. Determine desired outcomes.
   c. Generate solutions.
   d. Prioritize the hypotheses.

   ANS: D
   Analyzing cues lead to a list of potential hypotheses. The nurse prioritizes them, determines the desired outcomes, generates solutions, and acts. This is part of the six-step clinical judgment model.

   DIF: Understanding TOP: Integrated Process: Nursing Process: Diagnosis
   KEY: Clinical judgment
   MSC: Client Needs Category: Safe and Effective Care Environment: Management of Care

8. A nurse working in a medical home would do which of the following as part of the job?
   a. Advocate with insurance companies.
   b. Coordinate interprofessional care.
   c. Hold monthly team meetings.
   d. Provide out-of-network specialty referrals.

   ANS: B
   The medical home concept came into being to decrease the fragmentation of care. On a daily basis, this nurse would expect to coordinate with the interprofessional care team. Advocating with insurance companies would not be a daily function. Monthly team meetings may or may not be needed. Out of network referrals would not be needed as the interprofessional team strives to provide comprehensive care.

   DIF: Remembering
   TOP: Integrated Process: Nursing Process: Implementation KEY: Medical home
   MSC: Client Needs Category: Safe and Effective Care Environment: Management of Care

9. A nurse is confused on why systems thinking is important since working on the unit involves caring for a few specific clients. What explanation by the nurse manager is **best**?
   a. “It’s a good way to conduct root-cause analysis.”
   b. “It is important for quality improvement and safety.”
   c. “Systems thinking helps you see the bigger picture.”
   d. “You may enter management 1 day and need to know this.”

   ANS: B
   A systems thinking approach to care reinforces the nurse’s role in safety and quality improvement while expanding clinical judgment to include the patient’s place within the greater health care system in the context of care decisions. Root-cause analyses would be a small portion of systems thinking. It does give the nurse a big-picture view, but this answer is vague. The nurse may or may not ever join management.

DIF: Understanding TOP: Integrated Process: Teaching/Learning
KEY: Systems thinking
MSC: Client Needs Category: Safe and Effective Care Environment: Management of Care

MULTIPLE RESPONSE

1. The expert nurse understands that critical thinking requires which elements to be present? (*Select all that apply.*)
   a. Based on logic, creativity, and intuition
   b. Driven by needs
   c. Focused on safety and quality
   d. Grounded in a specific theory
   e. Guided by standards
   f. Requires forming options about evidence

   ANS: A, B, C, E
   Critical thinking must be based on logic, creativity, and intuition; driven by patient, family, or community needs; focused on safety and quality; guided by standards, policies, ethics, and laws; based on principles of nursing process, problem-solving, and the scientific method (requires forming opinions and making decisions based on evidence); centered on identification of the key problems, issues, and risks; and grounded in strategies that make the most of human potential. It is not dependent on using a specific theory.

   DIF: Understanding TOP: Integrated Process: Nursing Process: Planning
   KEY: Critical thinking
   MSC: Client Needs Category: Safe and Effective Care Environment: Management of Care

2. The nurse manager is conducting an annual evaluation of a staff nurse and is appraising the nurse's clinical reasoning. What nurse actions does the manager observe to help form this judgment? (*Select all that apply.*)
   a. Anticipating consequences of actions
   b. Delegating appropriately
   c. Interpreting data
   d. Noticing cues
   e. Setting priorities

   ANS: A, C, D, E
   The phases of clinical reasoning include assessing (noticing cues), analyzing (interpreting data), planning (anticipating consequences and setting priorities), implementing, and evaluating. Delegating appropriately is not included in this model.

   DIF: Applying TOP: Integrated Process: Nursing Process: Evaluation
   KEY: Clinical reasoning
   MSC: Client Needs Category: Safe and Effective Care Environment: Management of Care

3. According to the WHO, what does primary care involve? (*Select all that apply.*)
   a. Empowered people and communities
   b. Essential public functions
   c. Multisectoral policy and action
   d. Primary care
   e. Priority consideration of chronic diseases