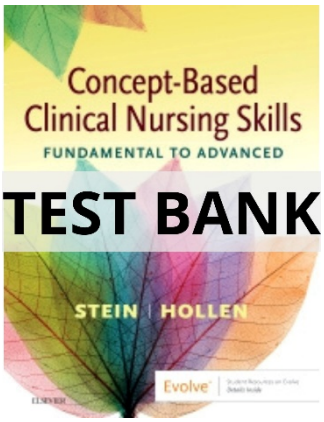
Chapter 01: Foundations of Safe Client Care
Hollen & Stein: Concept-Based Clinical Nursing Skills, 1st Edition



MULTIPLE CHOICE

1. What was the main finding of the Institute of Medicine's 1999 report *To Err is Human: Building a Better Healthcare System?*
   a. Nursing personnel need better training and education to prevent errors.
   b. Registered nurses should take the lead in reducing healthcare-associated errors.
   c. Faulty systems, processes, and conditions combined cause the majority of errors.
   d. Over 198,000 patients die each year when they are patients in a hospital.

   ANS: C
   The report *To Err is Human: Building a Better Healthcare System* provided the shocking information that as many as 98,000 patients die in hospital due to preventable errors. Instead of most errors being the fault of one person, the report stated that faulty systems, processes, and conditions combined were to blame. Although nurses are in a prime position to recognize and problem-solve these implicated contributors, the report did not specify that nurses should take the lead in solving the problem.

   DIF: Cognitive Level: Remembering TOP: Integrated Process: Teaching-Learning

2. A nurse meets the assigned clients at the start of a shift. After performing hand hygiene and introducing one's self, what does the nurse do *next*?
   a. Begin a head-to-toe assessment.
   b. Identify the client using two identifiers.
   c. Assess the client for pain.
   d. Ensure the call light is within reach.

   ANS: B
   A critical task in healthcare for safety, client identification is paramount for preventing errors. After performing hand hygiene and introducing him- or herself, the nurse identifies the client using two unique identifiers. The head-to-toe and pain assessments come shortly afterward. The nurse ensures the client can reach the call light prior to leaving the room.

   DIF: Cognitive Level: Understanding TOP: Nursing Process: Assessment

3. A nurse has worked with the same client for 2 days. When entering the room to administer medications, the nurse performs hand hygiene. What action does the nurse take *next*?
   a. Provide any needed teaching.
   b. Ask if the client has any care requests.
   c. Assess vital signs and pain.
   d. Identify the client using two identifiers.

   ANS: D

Every time the client is to receive medication, diagnostic studies, or any other healthcare intervention, the nurse must identify the client using two unique identifiers, even if the client is well known to the nurse. Assessments, teaching, and determining client requests would come afterward.

DIF: Cognitive Level: Applying TOP: Nursing Process: Assessment

4. A nurse's neighbor states "My father got a nosocomial infection after surgery!" What does the nurse understand happened to the client?
   a. The client received contaminated blood products.
   b. The client nearly died from a postoperative infection.
   c. The client acquired an infection while in the hospital.
   d. The client received poor preoperative skin preparation.

   ANS: C
   A nosocomial infection is one acquired in the hospital. It does not designate how the infection occurred, so the client might have become infected through contaminated blood products or from poor preoperative skin preparation. It does not mean the client had a life-threatening infection, only that is occurred in hospital.

   DIF: Cognitive Level: Understanding TOP: Integrated Process: Teaching-Learning

5. A nurse is making rounds on clients at risk for infection. Which client does the nurse see *first*?
   a. A client with an intravenous (IV) line
   b. A client who has a central line
   c. A client with an indwelling bladder catheter
   d. A client with an IV and bladder catheter

   ANS: D
   One of the biggest risk factors for hospital acquired infections (HAIs) is the presence of invasive lines. The more lines, the more risk. The client with both an IV and a catheter has the highest risk. The clients with an IV or a catheter have less risk. Nurses have adopted protocols that have dramatically reduced central line infections.

   DIF: Cognitive Level: Applying TOP: Nursing Process: Assessment

6. A nursing manager concerned about the infection rate on the unit wants to implement measures to reduce the transmission of infectious organisms. What action by the manager is *best*?
   a. Provide a stethoscope dedicated to each client.
   b. Ensure gloves are well-stocked in each room.
   c. Restrict all plants and fresh foods from rooms.
   d. Screen all visitors for contagious illnesses.

   ANS: A
   In the chain of infection, one of the most important components is the mode of transmission. Stethoscopes can serve as a mode of indirect contact transmission unless they are disinfected between clients. Providing each client with an individual stethoscope will reduce this risk. Gloves are important, but they can become contaminated too and serve as a mode of transmission. Plants and fresh foods are an uncommon source of transmission unless the client is immunosuppressed. Screening visitors for contagious illness is an unrealistic long-term action plan.

DIF: Cognitive Level: Applying TOP: Nursing Process: Implementation

7. A nurse is observing a student nurse. What action by the student demonstrates the need for *more* education on Standard Precautions?
   a. The student performs hand hygiene before all client contacts.
   b. The student conscientiously wears gloves when taking vital signs.
   c. The student confirms that urine possibly contains infectious microbes.
   d. The student wears a gown when cleaning liquid stool off the client.

   ANS: B
   Standard Precautions operates under the principle that all bodily fluids other than sweat could potentially contain infectious microbial agents that pose a risk to the healthcare worker. Contact with skin, if free of those fluids, does not require wearing gloves, so the nurse would provide more education to the student. Hand hygiene is the first step of Standard Precautions. The student is being prudent by confirming a possible source of contamination. Nurses determine which infection prevention practice to use based upon the type of client–nurse interaction and the possibility of exposure to blood, other body fluids, or pathogens, so wearing a gown while cleaning liquid stool is appropriate.

   DIF: Cognitive Level: Analyzing TOP: Nursing Process: Evaluation

8. A faculty member has taught the correct technique for taking gloves off (doffing). While observing students practice, which action by a student indicates the need to *review* the material?
   a. Pulls glove off dominant hand first
   b. Takes first glove off by grasping it on the outside
   c. Takes second glove off by grasping it under the cuff
   d. Turns the gloves inside out when second glove is removed

   ANS: A
   The correct way to remove gloves starts with doffing the glove on the nondominant hand first, without touching the bare skin. This student would need further review of the skill. Removing the first glove by grasping it on the outside, grasping the second glove under the cuff, and turning the gloves inside out to prevent microbe spread are all correct actions. These students would not need remediation.

   DIF: Cognitive Level: Analyzing TOP: Nursing Process: Evaluation

9. In order to move a client safely, which of the following actions does the nurse take *first*?
   a. Gather enough help for the task.
   b. Assess the client's ability to bear weight.
   c. Delegate using the lift chair.
   d. Administer pain medication.

   ANS: B
   The first thing the nurse does when preparing to transfer a client is to assess the client's ability to bear weight and follow instructions. The findings will determine how much assistance (if any) the client needs. If the client needs maximal assistance, then the nurse gathers enough help and any lifting devices needed and assigns roles to each team member. If the client has pain, the nurse would administer pain medication, but that is not related to safety.

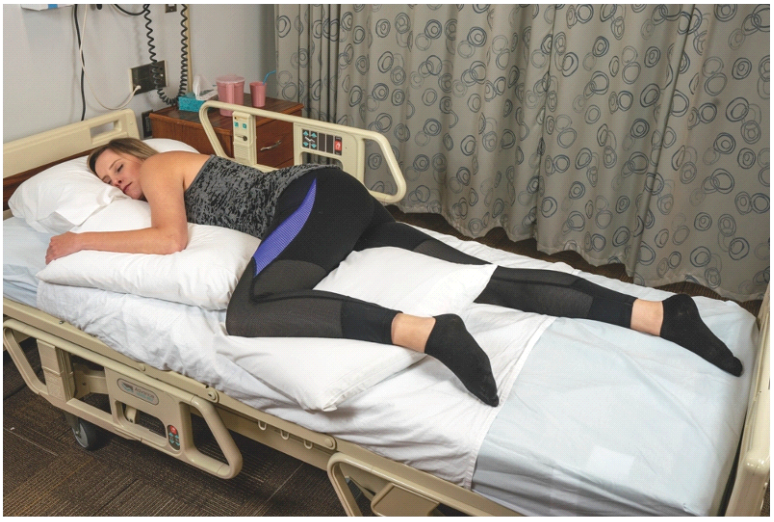
   DIF: Cognitive Level: Applying TOP: Nursing Process: Implementation

10. Hospital administration has rejected a request from nursing services for ceiling-mounted lifting/transferring devices pointing to the expense. What response by the Chief Nursing Officer would be *best*?
    a. "We need the equipment to stay competitive in hiring nurses."
    b. "They are required by The Joint Commission so we have to get them."
    c. "The cost of employee injuries from lifting is more expensive."
    d. "We will save money with fewer client-injury lawsuits being filed."

    ANS: C
    Data show that when hospitals implemented safe client handling equipment, hospitals achieved savings by reducing lost work days and reducing worker compensation costs that met or exceeded the cost of the equipment. This is not a main focus for nurse recruitment and the equipment is not mandated. Fewer client injuries leading to lawsuits is a probability, but the savings in reducing employee injury have been documented by the ANA.

    DIF: Cognitive Level: Understanding
    TOP: Integrated Process: Communication and Documentation

11. The nurse places a bed-bound client in the position shown. What other considerations would the nurse have for this client?



    a. Include a Trochanter roll to prevent of the neck.
    b. Assess whether the client needs support to prevent foot drop.
    c. Monitor for signs of increased intracranial pressure.
    d. Place a rolled-up washcloth in the client's hands.

    ANS: B
    The Sim's position is shown here. Considerations for the nurse include providing pillow support to keep the head and neck in alignment, to support the upper leg and prevent internal rotation, to support the upper arm and prevent internal rotation, and provide foot support to prevent foot drop. Hyperextension of the neck and increased intracranial pressure are concerns for clients in the Trendelenburg position. Placing something in the client's hands is not related to body position.

    DIF: Cognitive Level: Applying TOP: Nursing Process: Implementation

12. A nurse has applied restraints to a client. After documenting the care and ensuring the client is safe, what action does the nurse take *next*?
    a. Call the provider and request a prescription for the restraints.
    b. Alert the hospital's Risk Management department.
    c. Plan to check the client at a minimum of every 2 hours.
    d. Assign assistive personnel to sit with the client.

    ANS: C
    The standard required by the Centers for Medicaid and Medicare Services is to assess the restrained client at a minimum of every 2 hours. In most situations, the nurse requests the prescription before applying the restraints, however; if it is necessary to apply them first, a prescription from the provider is needed within 1 hour. Although restraints are often the source of litigation, there is no need to routinely notify the Risk Management department about the use of restraints. The client may or may not need someone to sit with him or her.

    DIF: Cognitive Level: Applying TOP: Nursing Process: Implementation

13. The nursing student applies restraints. What action by the student demonstrates the need for *more* education on this procedure?
    a. The student attempts other methods to prevent harm before applying the restraints.
    b. The student inserts two fingers between the restraint and client skin to check for tightness.
    c. The student secures the restraint by tying the restraint to the side rail but out of client reach.
    d. The student reassesses the client's need for the restraint at least every 2 hours.

    ANS: C
    The student should tie the restraint to a secure part of the bed frame, not to the side rail. Attempting alternatives to restraints, checking the tightness by placing two fingers under the restraint, and reassessing the client at least every 2 hours are all appropriate actions.

    DIF: Cognitive Level: Analyzing TOP: Nursing Process: Evaluation

14. The new nurse grumbles "Why are there so many regulations on using restraints?" What response by the mentor is *best*?
    a. "Clients have the right to be free from restraint or seclusion unless medically necessary."
    b. "Following all these regulations helps prevent law suits."
    c. "Accrediting bodies aren't in favor of using restraints so they make up regulations."
    d. "Because restraints have been shown to actually increase injuries."

    ANS: A
    The guiding principle for restraint use is that clients have the right to be free from unnecessary restraint or seclusion unless it is medically necessary. This is a basic human right and protects client dignity. Following regulations won't necessarily prevent lawsuits, but will help prevent negative outcomes from the legal action. Accrediting bodies don't "just make up regulations." There are sound reasons for them. Restraints have been shown to increase injury, but that is secondary to the fact that clients have the right to be free from them unless absolutely needed.

    DIF: Cognitive Level: Understanding TOP: Integrated Process: Teaching-Learning

15. A nurse is caring for a client in Droplet Precautions. What action does the nurse take to decrease a common complaint from clients in isolation?
    a. Keeps the temperature comfortable for the client, not personnel wearing gowns and gloves
    b. Stops by to see the client frequently, even if it's only by standing in the doorway
    c. Calls the hospital chaplain to come visit with the client each morning
    d. Asks volunteer services to bring the client books and magazines to read

    ANS: B
    Clients in isolation sometimes feel isolated. They have less contact and communication with nurses and other members of the healthcare team. The nurse would make extra effort to stop by frequently. Temperature control is not related to this common feeling. A visitor once a day would not do much to mitigate the situation plus the nurse should not call the chaplain without first asking the client. Books and magazines will help boredom, not isolation.

    DIF: Cognitive Level: Applying TOP: Integrated Process: Caring

16. After assessing a client, the nurse cleans the stethoscope. What cleaning agent chosen by the nurse is *most* appropriate?
    a. 70% isopropyl alcohol
    b. Diluted bleach 1:10 solution
    c. Cidex®
    d. Hydrogen peroxide

    ANS: A
    70% to 90% isopropyl or ethyl alcohol is appropriate for low-level disinfecting needs such as cleaning stethoscopes, blood pressure cuffs, and table tops. Diluted bleach is considered an intermediate level disinfectant and used for client rooms (including isolation rooms) and visible blood spills. Cidex® is a high-level disinfectant used for equipment that comes into contact with mucous membranes, for example, an endoscope.

    DIF: Cognitive Level: Understanding TOP: Nursing Process: Implementation

17. After giving an injection, which action by the nurse is *most* appropriate?
    a. Breaks needle off the syringe and places it in the sharps box
    b. Recaps the needle and carries the syringe to the sharps box
    c. Engages the syringe's safety device to cover the needle
    d. Twists the needle off and throws the syringe away

    ANS: C
    Needle-stick injury is an occupational hazard. Current guidelines for handling sharps include not recapping, bending, breaking, or hand-manipulating used needles. If recapping is required, use a one-handed scoop technique only. Use safety features when available. Place used sharps in a puncture-resistant container. The correct action would be to engage the safety feature on the syringe to cover the needle.

    DIF: Cognitive Level: Remembering TOP: Nursing Process: Implementation

18. The nurse is working in a neonatal intensive care unit. When an infant's oxygen saturation drops, what action does the nurse take *first*?
    a. Place the neonate prone.

b. Call a code blue.
c. Inform the provider.
d. Call respiratory therapy.

ANS: A
Neonates and infants improve ventilation and oxygenation in the prone position, at least for the short term. When the baby's oxygen saturation drops, the nurse would place the baby in the prone position. The nurse would call the provider afterward. There is no indication that the baby is in cardiopulmonary arrest, so a code blue is not called. There is no indication to call respiratory therapy.

DIF: Cognitive Level: Applying TOP: Nursing Process: Implementation

MULTIPLE RESPONSE

1. The nurse learns that which of the following must be demonstrated to prove a claim of malpractice? (*Select all that apply.*)
   a. Duty
   b. Breach of duty
   c. Physical injury
   d. Emotional distress
   e. Cause: the injury was caused by the breach of duty

   ANS: A, B, C, E
   The four elements which must be demonstrated to prove a case of malpractice are duty, breach of duty, injury (sometimes called harm), and causation; in other words the injury must have occurred due to the breach of duty. Emotional distress is not an element.

   DIF: Cognitive Level: Remembering TOP: Integrated Process: Teaching-Learning

2. The nurse learns that which of the following are principles of body mechanics? (*Select all that apply.*)
   a. Make a wide, stable base with your feet.
   b. Put the bed at the correct height.
   c. Put the work directly in front of you.
   d. Keep the client as far away from you as possible.
   e. Keep the bed in the same position.

   ANS: A, B, C
   The principles of body mechanics include maintaining a wide, stable base with your feet; having the bed at the correct height (depending on what you are doing); keeping the work directly in front of you; and keeping the client as close as possible to you.

   DIF: Cognitive Level: Remembering TOP: Nursing Process: Implementation

3. Which of the following devices are *inconsistent* with the nurse's knowledge of types of restraint devices? (*Select all that apply.*)
   a. A seat belt on a stroller
   b. A thumbless mitten
   c. A single raised side rail
   d. A device applied during a dental procedure
   e. A positioning restraint in the operating room

ANS: A, C, D, E
A stroller seat belt, one side rail, and devices applied temporarily to immobilize the client during medical, dental, diagnostic, or surgical procedures are not considered as restraints. The thumbless mitten is a restraint.

DIF: Cognitive Level: Remembering TOP: Nursing Process: Evaluation

4. A nurse needs to transfer a client from a bed directly onto a stretcher. The client weighs 274 pounds (124.54 kg). Which of the following are appropriate options for the nurse gather prior to performing this transfer? (*Select all that apply.*)
   a. 1 to 2 caregivers
   b. A lateral transfer board
   c. Air assisted device
   d. Mechanical lateral assistive device
   e. Nonskid slippers
   f. Friction-reducing device

   ANS: C, D
   To transfer a client who weighs >200 pounds safely from a bed to a stretcher, the nurse would choose a ceiling lift with sling, a mechanical lateral transfer device, or an air-assisted device and 3 caregivers. 1 to 2 caregivers, a friction-reducing device, and the lateral transfer board would all be appropriate for a client weighing under 200 pounds (90.0 kg). Since the client is not standing on the floor, the nonskid slippers are not needed.

   DIF: Cognitive Level: Applying TOP: Nursing Process: Intervention

5. The charge nurse is conducting an audit on compliance with Transmission-Based Precautions. Which action by the nursing staff shows *good* understanding and *correct* application of these precautions? (*Select all that apply.*)
   a. Contact Precautions: Dons gloves and a gown before entering the room
   b. Droplet Precautions: Cares for the client only if immunity to the disease is present
   c. Standard Precautions: Combines Standard Precautions with any other precautions
   d. Droplet Precautions: Wears a mask when taking client vital signs
   e. Two levels of Precautions: Maintains compliance with both types of precautions
   f. Contact Precautions: Places two patients with MRSA in the same room

   ANS: A, C, D, E, F
   Transmission-based precautions are determined by the illness and mode of transmission. The minimum required for Contact Precautions is donning gloves and a gown when entering the room. Nurses always use Standard Precautions for every client, no matter what other type of precautions the client is on. Nurses put on a mask when entering the room of a client on Droplet Precautions if close contact with the client is expected, such as when taking vital signs. When a client has two (or more) levels of Transmission-based Precautions, nurses correctly maintain compliance with all types. While private rooms are preferred for clients on Transmission-Based Precautions, cohorting clients with the same infectious agent is acceptable. Immunity is an important consideration for nurses caring for clients on Airborne Precautions.

   DIF: Cognitive Level: Analyzing TOP: Nursing Process: Evaluation

6. What does the nurse remember about appropriate hand hygiene? (*Select all that apply.*)
   a. Alcohol-based hand sanitizers are the gold standard for hand hygiene.