Exam

Name_____

MULTIPLE CHOICE. Choose the one alternative that best completes the statement or answers the question.

1) The nurse is caring for a client who developed an infection after admission to the hospital. This infection would be classified as a:

A) Nosocomial infection.
B) Bacterial infection.
C) Health care-associated infection.
D) Therapeutic infection.

Answer: A

Explanation:
A) A nosocomial infection is an infection that originates specifically in the hospital, while a health care-associated infection can originate in any health care setting. Not enough information is provided to determine the nature of infection (option 2), and there is no such thing as a therapeutic infection.
Cognitive Level: Knowledge
Client Need: Physiological Integrity
Nursing Process: Assessment

B) A nosocomial infection is an infection that originates specifically in the hospital, while a health care-associated infection can originate in any health care setting. Not enough information is provided to determine the nature of infection (option 2), and there is no such thing as a therapeutic infection.
Cognitive Level: Knowledge
Client Need: Physiological Integrity
Nursing Process: Assessment

C) A nosocomial infection is an infection that originates specifically in the hospital, while a health care-associated infection can originate in any health care setting. Not enough information is provided to determine the nature of infection (option 2), and there is no such thing as a therapeutic infection.
Cognitive Level: Knowledge
Client Need: Physiological Integrity
Nursing Process: Assessment

D) A nosocomial infection is an infection that originates specifically in the hospital, while a health care-associated infection can originate in any health care setting. Not enough information is provided to determine the nature of infection (option 2), and there is no such thing as a therapeutic infection.
Cognitive Level: Knowledge
Client Need: Physiological Integrity
Nursing Process: Assessment

Objective: Learning Outcome 1-1: Define the key terms used in foundational skills and equipment that protect nurses and clients.

2) The nurse would use a Situation, Background, Assessment, and Recommendation (SBAR) process in which of the following situations? Select all that apply.

A) Discharging a client
B) Transferring a client to another unit
C) Contacting the primary care provider
D) Change of shift
E) Informing family members of client status

Answer: B, C, D

Explanation: A) The SBAR is used to enhance the safety of the client in situations where nurses are communicating with other members of the health care team such as when transferring the client to another unit, conducting change-of-shift report, or contacting the primary care provider. The SBAR is not used for discharge teaching or notifying family members of the client's status.
Cognitive Level: Application
Client Need: Safe, Effective Care Environment
Nursing Process: Implementation

B) The SBAR is used to enhance the safety of the client in situations where nurses are communicating with other members of the health care team such as when transferring the client to another unit, conducting change-of-shift report, or contacting the primary care provider. The SBAR is not used for discharge teaching or notifying family members of the client's status.
Cognitive Level: Application
Client Need: Safe, Effective Care Environment
Nursing Process: Implementation

C) The SBAR is used to enhance the safety of the client in situations where nurses are communicating with other members of the health care team such as when transferring the client to another unit, conducting change-of-shift report, or contacting the primary care provider. The SBAR is not used for discharge teaching or notifying family members of the client's status.
Cognitive Level: Application
Client Need: Safe, Effective Care Environment
Nursing Process: Implementation

D) The SBAR is used to enhance the safety of the client in situations where nurses are communicating with other members of the health care team such as when transferring the client to another unit, conducting change-of-shift report, or contacting the primary care provider. The SBAR is not used for discharge teaching or notifying family members of the client's status.
Cognitive Level: Application
Client Need: Safe, Effective Care Environment
Nursing Process: Implementation

E) The SBAR is used to enhance the safety of the client in situations where nurses are communicating with other members of the health care team such as when transferring the client to another unit, conducting change-of-shift report, or contacting the primary care provider. The SBAR is not used for discharge teaching or notifying family members of the client's status.
Cognitive Level: Application
Client Need: Safe, Effective Care Environment
Nursing Process: Implementation

Objective: Learning Outcome 1-1: Define the key terms used in foundational skills and equipment that protect nurses and clients.

3) The nurse is caring for a client with a medical diagnosis of HIV/AIDS admitted to the hospital with Pneumocystis carinii infection. The priority nursing intervention to reduce the spread of infection would be:

A) Teaching the client to provide self-care.
B) Teaching respiratory/cough etiquette.
C) Teaching the use of sexual barriers.
D) Teaching the use of standard precautions.

Answer: B

Explanation:

A) The client with a respiratory infection would benefit most from learning how to use respiratory hygiene/cough etiquette in order to reduce the risk of spreading infection to others. While teaching the use of sexual barriers would reduce the risk of sexually transmitted infections, it is not the priority need at this time. Teaching self-care might be indicated for this client, but it is not related to reducing the spread of infection. Standard precautions are used by the health care provider, and are not generally taught to clients.
Cognitive Level: Analysis
Client Need: Physiological Integrity
Nursing Process: Implementation

B) The client with a respiratory infection would benefit most from learning how to use respiratory hygiene/cough etiquette in order to reduce the risk of spreading infection to others. While teaching the use of sexual barriers would reduce the risk of sexually transmitted infections, it is not the priority need at this time. Teaching self-care might be indicated for this client, but it is not related to reducing the spread of infection. Standard precautions are used by the health care provider, and are not generally taught to clients.
Cognitive Level: Analysis
Client Need: Physiological Integrity
Nursing Process: Implementation

C) The client with a respiratory infection would benefit most from learning how to use respiratory hygiene/cough etiquette in order to reduce the risk of spreading infection to others. While teaching the use of sexual barriers would reduce the risk of sexually transmitted infections, it is not the priority need at this time. Teaching self-care might be indicated for this client, but it is not related to reducing the spread of infection. Standard precautions are used by the health care provider, and are not generally taught to clients.
Cognitive Level: Analysis
Client Need: Physiological Integrity
Nursing Process: Implementation

D) The client with a respiratory infection would benefit most from learning how to use respiratory hygiene/cough etiquette in order to reduce the risk of spreading infection to others. While teaching the use of sexual barriers would reduce the risk of sexually transmitted infections, it is not the priority need at this time. Teaching self-care might be indicated for this client, but it is not related to reducing the spread of infection. Standard precautions are used by the health care provider, and are not generally taught to clients.
Cognitive Level: Analysis
Client Need: Physiological Integrity
Nursing Process: Implementation

Objective: Learning Outcome 1-1: Define the key terms used in foundational skills and equipment that protect nurses and clients.

4) The nurse uses which of the following with all clients to prevent the transmission of potentially infective organism among the nurse, client, and other individuals? Select all that apply.

A) Hand hygiene
B) Standard precautions
C) Personal protective equipment
D) Isolation procedures
E) Antimicrobial soap

Answer: A, B, C

Explanation:

A) The nurse should use hand hygiene, standard precautions, and personal protective equipment with all clients. Isolation procedures and antimicrobial soaps are indicated for some clients but not all.
Cognitive Level: Knowledge
Client Need: Physiological Integrity
Nursing Process: Implementation

B) The nurse should use hand hygiene, standard precautions, and personal protective equipment with all clients. Isolation procedures and antimicrobial soaps are indicated for some clients but not all.
Cognitive Level: Knowledge
Client Need: Physiological Integrity
Nursing Process: Implementation

C) The nurse should use hand hygiene, standard precautions, and personal protective equipment with all clients. Isolation procedures and antimicrobial soaps are indicated for some clients but not all.
Cognitive Level: Knowledge
Client Need: Physiological Integrity
Nursing Process: Implementation

D) The nurse should use hand hygiene, standard precautions, and personal protective equipment with all clients. Isolation procedures and antimicrobial soaps are indicated for some clients but not all.
Cognitive Level: Knowledge
Client Need: Physiological Integrity
Nursing Process: Implementation

E) The nurse should use hand hygiene, standard precautions, and personal protective equipment with all clients. Isolation procedures and antimicrobial soaps are indicated for some clients but not all.
Cognitive Level: Knowledge
Client Need: Physiological Integrity
Nursing Process: Implementation

Objective: Learning Outcome 1-2: Identify indications for hand hygiene and standard precautions.

5) The nurse observing the unlicensed assistive personnel (UAP) using alcohol-based rubs for hand hygiene would recognize that further teaching is required when the UAP does which of the following?
A) Rubs palm against palm when washing hands.
B) Applies a palmful of product into cupped hands.
C) Interlaces fingers palm to palm.
D) Dries hands with clean paper towel.

Answer: D

Explanation:
A) When using an alcohol-based hand rub, the hands should not be dried. Rubbing of hands palm to palm and interlacing fingers are continued until the product dries, which takes about 20-30 seconds. A palmful of product is generally required to coat all surfaces.
Cognitive Level: Application
Client Need: Safe, Effective Care Environment
Nursing Process: Evaluation

B) When using an alcohol-based hand rub, the hands should not be dried. Rubbing of hands palm to palm and interlacing fingers are continued until the product dries, which takes about 20-30 seconds. A palmful of product is generally required to coat all surfaces.
Cognitive Level: Application
Client Need: Safe, Effective Care Environment
Nursing Process: Evaluation

C) When using an alcohol-based hand rub, the hands should not be dried. Rubbing of hands palm to palm and interlacing fingers are continued until the product dries, which takes about 20-30 seconds. A palmful of product is generally required to coat all surfaces.
Cognitive Level: Application
Client Need: Safe, Effective Care Environment
Nursing Process: Evaluation

D) When using an alcohol-based hand rub, the hands should not be dried. Rubbing of hands palm to palm and interlacing fingers are continued until the product dries, which takes about 20-30 seconds. A palmful of product is generally required to coat all surfaces.
Cognitive Level: Application
Client Need: Safe, Effective Care Environment
Nursing Process: Evaluation

Objective: Learning Outcome 1-2: Identify indications for hand hygiene and standard precautions.

6) The nurse is working in a day care center for infants with special needs where there recently has been an outbreak of viral conjunctivitis. The nurse instructs the staff that the best way to stop the spread of infection is:
   A) Require all children with conjunctivitis to stay home until there is a reduction in drainage.
   B) Require all children with an infection to be on otic antibiotics for at least 24 hours prior to returning to school.
   C) Isolate all children with conjunctivitis in the same room away from those who are not infected.
   D) Perform hand hygiene after providing personal care for all children.

Answer: D

Explanation:
A) The best way to reduce the spread of infection is through thorough hand hygiene. There would be no need to place a child with a viral illness on antibiotics, to isolate children with conjunctivitis, or to keep children away from the daycare center.
Cognitive Level: Analysis
Client Need: Safe, Effective Care Environment
Nursing Process: Implementation

B) The best way to reduce the spread of infection is through thorough hand hygiene. There would be no need to place a child with a viral illness on antibiotics, to isolate children with conjunctivitis, or to keep children away from the daycare center.
Cognitive Level: Analysis
Client Need: Safe, Effective Care Environment
Nursing Process: Implementation

C) The best way to reduce the spread of infection is through thorough hand hygiene. There would be no need to place a child with a viral illness on antibiotics, to isolate children with conjunctivitis, or to keep children away from the daycare center.
Cognitive Level: Analysis
Client Need: Safe, Effective Care Environment
Nursing Process: Implementation

D) The best way to reduce the spread of infection is through thorough hand hygiene. There would be no need to place a child with a viral illness on antibiotics, to isolate children with conjunctivitis, or to keep children away from the daycare center.
Cognitive Level: Analysis
Client Need: Safe, Effective Care Environment
Nursing Process: Implementation

Objective: Learning Outcome 1-2: Identify indications for hand hygiene and standard precautions.

7) The nurse would don clean disposable gloves in which of the following situations?

A) When providing denture care
B) When bathing a client
C) When applying antiemboli stockings
D) When assessing vital signs

Answer: A

Explanation:

A) The purpose of gloves is to protect the hands when the nurse is likely to handle any potentially infective material. When providing denture care, the nurse is in contact with mucous membranes and body secretions, so gloves would be required. In most instances, unless the client has an open wound, gloves would not be required when bathing a client, applying stockings, or assessing vital signs.
Cognitive Level: Knowledge
Client Need: Safe, Effective Care Environment
Nursing Process: Implementation

B) The purpose of gloves is to protect the hands when the nurse is likely to handle any potentially infective material. When providing denture care, the nurse is in contact with mucous membranes and body secretions, so gloves would be required. In most instances, unless the client has an open wound, gloves would not be required when bathing a client, applying stockings, or assessing vital signs.
Cognitive Level: Knowledge
Client Need: Safe, Effective Care Environment
Nursing Process: Implementation

C) The purpose of gloves is to protect the hands when the nurse is likely to handle any potentially infective material. When providing denture care, the nurse is in contact with mucous membranes and body secretions, so gloves would be required. In most instances, unless the client has an open wound, gloves would not be required when bathing a client, applying stockings, or assessing vital signs.
Cognitive Level: Knowledge
Client Need: Safe, Effective Care Environment
Nursing Process: Implementation

D) The purpose of gloves is to protect the hands when the nurse is likely to handle any potentially infective material. When providing denture care, the nurse is in contact with mucous membranes and body secretions, so gloves would be required. In most instances, unless the client has an open wound, gloves would not be required when bathing a client, applying stockings, or assessing vital signs.
Cognitive Level: Knowledge
Client Need: Safe, Effective Care Environment
Nursing Process: Implementation

Objective: Learning Outcome 1-3: Describe factors that affect the use of personal protective equipment such as gloves, gowns, masks, and eyewear.

8) The nurse, working in an Emergency Department, is preparing to care for a client admitted with a traumatic amputation of the left hand. What personal protective equipment would the nurse wear?

A) Gloves
B) Gown and gloves
C) Gown, gloves, and mask
D) Gloves and mask

Answer: C

Explanation:
A) Because of the high risk of arterial blood spatter, the nurse would wear gown, gloves, and mask.
Cognitive Level: Application
Client Need: Physiological Integrity
Nursing Process: Planning

B) Because of the high risk of arterial blood spatter, the nurse would wear gown, gloves, and mask.
Cognitive Level: Application
Client Need: Physiological Integrity
Nursing Process: Planning

C) Because of the high risk of arterial blood spatter, the nurse would wear gown, gloves, and mask.
Cognitive Level: Application
Client Need: Physiological Integrity
Nursing Process: Planning

D) Because of the high risk of arterial blood spatter, the nurse would wear gown, gloves, and mask.
Cognitive Level: Application
Client Need: Physiological Integrity
Nursing Process: Planning

Objective: Learning Outcome 1-3: Describe factors that affect the use of personal protective equipment such as gloves, gowns, masks, and eyewear.

9) The charge nurse is observing a nurse caring for a client with extensive burns. Which of the following would indicate the nurse requires further teaching regarding infection-control procedures?

A) The nurse wears gloves and gown when dressing the client's wounds.
B) The nurse wears gloves when bathing the client.
C) The nurse wears gown, gloves, and mask when assisting the physician with debridement of the wound.
D) The nurse wears gloves when teaching a family member how to meet the client's nutritional needs after discharge.

Answer: D

Explanation:
A) There would be no need for a nurse to wear protective equipment when sitting at the client's bedside conducting nutrition counseling. However, because of the client's extensive skin damage, gloves would be worn when bathing the client; gloves and gown would be worn when dressing the wounds due to the potential for contamination of the nurse's uniform; and gown, glove and mask would be needed when debriding due to potential blood spatter.
Cognitive Level: Analysis
Client Need: Safe, Effective Care Environment
Nursing Process: Implementation

B) There would be no need for a nurse to wear protective equipment when sitting at the client's bedside conducting nutrition counseling. However, because of the client's extensive skin damage, gloves would be worn when bathing the client; gloves and gown would be worn when dressing the wounds due to the potential for contamination of the nurse's uniform; and gown, glove and mask would be needed when debriding due to potential blood spatter.
Cognitive Level: Analysis
Client Need: Safe, Effective Care Environment
Nursing Process: Implementation

C) There would be no need for a nurse to wear protective equipment when sitting at the client's bedside conducting nutrition counseling. However, because of the client's extensive skin damage, gloves would be worn when bathing the client; gloves and gown would be worn when dressing the wounds due to the potential for contamination of the nurse's uniform; and gown, glove and mask would be needed when debriding due to potential blood spatter.
Cognitive Level: Analysis
Client Need: Safe, Effective Care Environment
Nursing Process: Implementation

D) There would be no need for a nurse to wear protective equipment when sitting at the client's bedside conducting nutrition counseling. However, because of the client's extensive skin damage, gloves would be worn when bathing the client; gloves and gown would be worn when dressing the wounds due to the potential for contamination of the nurse's uniform; and gown, glove and mask would be needed when debriding due to potential blood spatter.
Cognitive Level: Analysis
Client Need: Safe, Effective Care Environment
Nursing Process: Implementation

Objective: Learning Outcome 1-3: Describe factors that affect the use of personal protective equipment such as gloves, gowns, masks, and eyewear.

10) The nurse wearing personal protective equipment would take what article off first?

A) Gown
B) Gloves
C) Mask
D) Gloves and gown at the same time

Answer: B

Explanation:

A) Gloves are always removed first because they are the most soiled. If wearing a gown that is tied at the waist, the ties would be undone before removing the gloves, and then the gown and mask may be removed and hand hygiene should be performed.
Cognitive Level: Knowledge
Client Need: Safe, Effective Care Environment
Nursing Process: Implementation

B) Gloves are always removed first because they are the most soiled. If wearing a gown that is tied at the waist, the ties would be undone before removing the gloves, and then the gown and mask may be removed and hand hygiene should be performed.
Cognitive Level: Knowledge
Client Need: Safe, Effective Care Environment
Nursing Process: Implementation

C) Gloves are always removed first because they are the most soiled. If wearing a gown that is tied at the waist, the ties would be undone before removing the gloves, and then the gown and mask may be removed and hand hygiene should be performed.
Cognitive Level: Knowledge
Client Need: Safe, Effective Care Environment
Nursing Process: Implementation

D) Gloves are always removed first because they are the most soiled. If wearing a gown that is tied at the waist, the ties would be undone before removing the gloves, and then the gown and mask may be removed and hand hygiene should be performed.
Cognitive Level: Knowledge
Client Need: Safe, Effective Care Environment
Nursing Process: Implementation

Objective: Learning Outcome 1-4: Verbalize the steps used when:

A. Performing hand hygiene.
B. Using standard precautions.
C. Applying and removing personal protective equipment (gloves, gown, mask, and eyewear).
D. Assisting with invasive procedures.

11) The nurse is assisting the doctor with the insertion of a chest tube. What personal protective equipment would the nurse don?

A) Sterile gloves, gown, and mask
B) Clean gloves, gown, and mask with eye shield or goggles
C) Sterile gloves, gown, and mask with eye shields or goggles
D) Clean gloves, gown, and mask

Answer: B

Explanation:
A) Because of the risk of spray from the inserted chest tube, the nurse should wear gloves, mask with eye shield or mask and goggles, and a gown. There is no need for the nurse to wear sterile gloves during the procedure.
Cognitive Level: Application
Client Need: Physiological Integrity
Nursing Process: Implementation

B) Because of the risk of spray from the inserted chest tube, the nurse should wear gloves, mask with eye shield or mask and goggles, and a gown. There is no need for the nurse to wear sterile gloves during the procedure.
Cognitive Level: Application
Client Need: Physiological Integrity
Nursing Process: Implementation

C) Because of the risk of spray from the inserted chest tube, the nurse should wear gloves, mask with eye shield or mask and goggles, and a gown. There is no need for the nurse to wear sterile gloves during the procedure.
Cognitive Level: Application
Client Need: Physiological Integrity
Nursing Process: Implementation

D) Because of the risk of spray from the inserted chest tube, the nurse should wear gloves, mask with eye shield or mask and goggles, and a gown. There is no need for the nurse to wear sterile gloves during the procedure.
Cognitive Level: Application
Client Need: Physiological Integrity
Nursing Process: Implementation

Objective: Learning Outcome 1-4: Verbalize the steps used when:
A. Performing hand hygiene.
B. Using standard precautions.
C. Applying and removing personal protective equipment (gloves, gown, mask, and eyewear).
D. Assisting with invasive procedures.

12) The nurse is called into a client's room by the unlicensed assistive personnel (UAP), who informs the nurse that the obstetric client has no pulse or respirations and has profuse vaginal bleeding. The nurse's priority action is to:

A) Apply gloves and assess the client for pulse and respirations.
B) Assess the client for pulse and respirations, instruct UAP to notify code team while donning personal protective equipment, and begin CPR.
C) Quickly assess pulse and respirations, next assess for bleeding, call for the code team, and then apply personal protective equipment before beginning CPR.
D) Apply gown, gloves, mask, and goggles, then assess client for pulse, respirations, and bleeding.

Answer: B

Explanation: A) If the client is bleeding vaginally, it would be possible to assess carotid pulse and breathing without coming in contact with bloodborne pathogens. Once the nurse confirms that the client is pulseless, instruct the UAP to call a code while donning personal protective equipment and beginning CPR.
Cognitive Level: Analysis
Client Need: Physiological Integrity
Nursing Process: Implementation

B) If the client is bleeding vaginally, it would be possible to assess carotid pulse and breathing without coming in contact with bloodborne pathogens. Once the nurse confirms that the client is pulseless, instruct the UAP to call a code while donning personal protective equipment and beginning CPR.
Cognitive Level: Analysis
Client Need: Physiological Integrity
Nursing Process: Implementation

C) If the client is bleeding vaginally, it would be possible to assess carotid pulse and breathing without coming in contact with bloodborne pathogens. Once the nurse confirms that the client is pulseless, instruct the UAP to call a code while donning personal protective equipment and beginning CPR.
Cognitive Level: Analysis
Client Need: Physiological Integrity
Nursing Process: Implementation

D) If the client is bleeding vaginally, it would be possible to assess carotid pulse and breathing without coming in contact with bloodborne pathogens. Once the nurse confirms that the client is pulseless, instruct the UAP to call a code while donning personal protective equipment and beginning CPR.
Cognitive Level: Analysis
Client Need: Physiological Integrity
Nursing Process: Implementation

Objective: Learning Outcome 1-4: Verbalize the steps used when:
A. Performing hand hygiene.
B. Using standard precautions.
C. Applying and removing personal protective equipment (gloves, gown, mask, and eyewear).
D. Assisting with invasive procedures.

13) Which of the following tasks would be appropriate for the nurse to delegate to the unlicensed assistive personnel (UAP)? Select all that apply.
A) Taking vital signs
B) Measuring and recording intake and output
C) Postmortem care
D) Providing telephone advice
E) Weighing the client

Answer: A, B, C, E

Explanation: A) Tasks requiring advanced education such as assessment, interpretation of data, planning client care, or evaluating care are not delegated to the UAP. Telephone advice involves gathering data, analysis, and planning care, which would all be beyond the scope of practice. Vital sign measurement, recording intake and output, providing postmortem care, and weighing the client are all appropriate tasks to delegate to the UAP.
Cognitive Level: Knowledge
Client Need: Safe, Effective Care Environment
Nursing Process: Planning

B) Tasks requiring advanced education such as assessment, interpretation of data, planning client care, or evaluating care are not delegated to the UAP. Telephone advice involves gathering data, analysis, and planning care, which would all be beyond the scope of practice. Vital sign measurement, recording intake and output, providing postmortem care, and weighing the client are all appropriate tasks to delegate to the UAP.
Cognitive Level: Knowledge
Client Need: Safe, Effective Care Environment
Nursing Process: Planning

C) Tasks requiring advanced education such as assessment, interpretation of data, planning client care, or evaluating care are not delegated to the UAP. Telephone advice involves gathering data, analysis, and planning care, which would all be beyond the scope of practice. Vital sign measurement, recording intake and output, providing postmortem care, and weighing the client are all appropriate tasks to delegate to the UAP.
Cognitive Level: Knowledge
Client Need: Safe, Effective Care Environment
Nursing Process: Planning

D) Tasks requiring advanced education such as assessment, interpretation of data, planning client care, or evaluating care are not delegated to the UAP. Telephone advice involves gathering data, analysis, and planning care, which would all be beyond the scope of practice. Vital sign measurement, recording intake and output, providing postmortem care, and weighing the client are all appropriate tasks to delegate to the UAP.
Cognitive Level: Knowledge
Client Need: Safe, Effective Care Environment
Nursing Process: Planning

E) Tasks requiring advanced education such as assessment, interpretation of data, planning client care, or evaluating care are not delegated to the UAP. Telephone advice involves gathering data, analysis, and planning care, which would all be beyond the scope of practice. Vital sign measurement, recording intake and output, providing postmortem care, and weighing the client are all appropriate tasks to delegate to the UAP.
Cognitive Level: Knowledge
Client Need: Safe, Effective Care Environment
Nursing Process: Planning

Objective: Learning Outcome 1-5: Recognize when it is appropriate to delegate skills requiring standard precautions to unlicensed assistive personnel.

14) The nurse observes the newly hired unlicensed assistive personnel (UAP) performing routine client care. Which of the following behaviors would indicate the UAP understands the use of personal protective equipment?

A) The UAP removes his gown first and then his gloves after providing care.
B) The UAP applies gloves before emptying the client's indwelling catheter bag, then removes gloves and washes hands before measuring urine output.
C) The UAP applies gloves to clean the client's dentures, then removes gloves and performs hand hygiene prior to bathing the client.
D) The UAP wears gown and gloves when performing postmortem care.

Answer: C

Explanation: A) Gloves are required when providing denture care, but are not required for bathing the client. Whenever gloves are removed, the health care provider should perform hand hygiene. Gloves are removed before removing the gown. The nurse should not remove gloves until after measuring urine output and rinsing the measuring container and returning it to its storage location. Gloves should be worn when performing postmortem care, but a gown is generally not required.
Cognitive Level: Application
Client Need: Safe, Effective Care Environment
Nursing Process: Evaluation

B) Gloves are required when providing denture care, but are not required for bathing the client. Whenever gloves are removed, the health care provider should perform hand hygiene. Gloves are removed before removing the gown. The nurse should not remove gloves until after measuring urine output and rinsing the measuring container and returning it to its storage location. Gloves should be worn when performing postmortem care, but a gown is generally not required.
Cognitive Level: Application
Client Need: Safe, Effective Care Environment
Nursing Process: Evaluation

C) Gloves are required when providing denture care, but are not required for bathing the client. Whenever gloves are removed, the health care provider should perform hand hygiene. Gloves are removed before removing the gown. The nurse should not remove gloves until after measuring urine output and rinsing the measuring container and returning it to its storage location. Gloves should be worn when performing postmortem care, but a gown is generally not required.
Cognitive Level: Application
Client Need: Safe, Effective Care Environment
Nursing Process: Evaluation

D) Gloves are required when providing denture care, but are not required for bathing the client. Whenever gloves are removed, the health care provider should perform hand hygiene. Gloves are removed before removing the gown. The nurse should not remove gloves until after measuring urine output and rinsing the measuring container and returning it to its storage location. Gloves should be worn when performing postmortem care, but a gown is generally not required.
Cognitive Level: Application
Client Need: Safe, Effective Care Environment
Nursing Process: Evaluation

Objective: Learning Outcome 1-5: Recognize when it is appropriate to delegate skills requiring standard precautions to unlicensed assistive personnel.

15) The nurse is caring for a client with a deep draining abdominal wound. Which of the following factors would require the nurse to wear a mask and goggles when caring for this client?

A) The wound is infected.
B) The client is confused and disoriented.
C) The wound is covered by wet-to-damp dressings.
D) The client is HIV-positive.

Answer: B

Explanation:

A) The client who is confused and disoriented might not cooperate with care, and could cause splashing of wound drainage, so the nurse should wear a mask and goggles when caring for this client. The other factors would cause the nurse to don gloves and a gown, but would not lead to the use of mask and goggles.
Cognitive Level: Analysis
Client Need: Physiological Integrity
Nursing Process: Planning

B) The client who is confused and disoriented might not cooperate with care, and could cause splashing of wound drainage, so the nurse should wear a mask and goggles when caring for this client. The other factors would cause the nurse to don gloves and a gown, but would not lead to the use of mask and goggles.
Cognitive Level: Analysis
Client Need: Physiological Integrity
Nursing Process: Planning

C) The client who is confused and disoriented might not cooperate with care, and could cause splashing of wound drainage, so the nurse should wear a mask and goggles when caring for this client. The other factors would cause the nurse to don gloves and a gown, but would not lead to the use of mask and goggles.
Cognitive Level: Analysis
Client Need: Physiological Integrity
Nursing Process: Planning

D) The client who is confused and disoriented might not cooperate with care, and could cause splashing of wound drainage, so the nurse should wear a mask and goggles when caring for this client. The other factors would cause the nurse to don gloves and a gown, but would not lead to the use of mask and goggles.
Cognitive Level: Analysis
Client Need: Physiological Integrity
Nursing Process: Planning

Objective: Learning Outcome 1-5: Recognize when it is appropriate to delegate skills requiring standard precautions to unlicensed assistive personnel.

16) Which of the following equipment would the nurse not place in the sharps container?

A) Scalpels B) Lancets C) Bloody bandage D) Needles

Answer: C

Explanation: A) The sharps container is used for anything sharp, so a bloody bandage would go into the red-bagged trash can, not the sharps container. The other products would go into the puncture-resistant sharps container.
Cognitive Level: Knowledge
Client Need: Safe, Effective Care Environment
Nursing Process: Implementation

B) The sharps container is used for anything sharp, so a bloody bandage would go into the red-bagged trash can, not the sharps container. The other products would go into the puncture-resistant sharps container.
Cognitive Level: Knowledge
Client Need: Safe, Effective Care Environment
Nursing Process: Implementation

C) The sharps container is used for anything sharp, so a bloody bandage would go into the red-bagged trash can, not the sharps container. The other products would go into the puncture-resistant sharps container.
Cognitive Level: Knowledge
Client Need: Safe, Effective Care Environment
Nursing Process: Implementation

D) The sharps container is used for anything sharp, so a bloody bandage would go into the red-bagged trash can, not the sharps container. The other products would go into the puncture-resistant sharps container.
Cognitive Level: Knowledge
Client Need: Safe, Effective Care Environment
Nursing Process: Implementation

Objective: Learning Outcome 1-6: Demonstrate appropriate disposal of equipment and supplies.

17) The nurse has just changed a client's dressing. Which of the following actions by the nurse would follow standard precaution guidelines for proper disposal of contaminated materials?
A) The old dressing is discarded in the trash can.
B) The unsoiled disposable gown is removed and discarded in the hazardous waste container.
C) The gloves are discarded in the trash can.
D) The mask is discarded in the trash can.

Answer: D

Explanation: A) The old dressing and gloves should be discarded in the hazardous waste container because they are contaminated. The disposable gown does not need to be placed in the hazardous waste container unless it is contaminated with blood or body fluids. The mask, unless contaminated with blood or body fluids, would be discarded in the trash can.
Cognitive Level: Application
Client Need: Safe, Effective Care Environment
Nursing Process: Implementation

B) The old dressing and gloves should be discarded in the hazardous waste container because they are contaminated. The disposable gown does not need to be placed in the hazardous waste container unless it is contaminated with blood or body fluids. The mask, unless contaminated with blood or body fluids, would be discarded in the trash can.
Cognitive Level: Application
Client Need: Safe, Effective Care Environment
Nursing Process: Implementation

C) The old dressing and gloves should be discarded in the hazardous waste container because they are contaminated. The disposable gown does not need to be placed in the hazardous waste container unless it is contaminated with blood or body fluids. The mask, unless contaminated with blood or body fluids, would be discarded in the trash can.
Cognitive Level: Application
Client Need: Safe, Effective Care Environment
Nursing Process: Implementation

D) The old dressing and gloves should be discarded in the hazardous waste container because they are contaminated. The disposable gown does not need to be placed in the hazardous waste container unless it is contaminated with blood or body fluids. The mask, unless contaminated with blood or body fluids, would be discarded in the trash can.
Cognitive Level: Application
Client Need: Safe, Effective Care Environment
Nursing Process: Implementation

Objective: Learning Outcome 1-6: Demonstrate appropriate disposal of equipment and supplies.

18) The nurse working in the Emergency Department is caring for a client who is projectile vomiting. The nurse is wearing personal protective equipment (PPE). How would the nurse properly discard the PPE?
A) All PPE would be discarded in the hazardous waste container whenever leaving the client's room, and new PPE would be donned when returning to the room.
B) The nurse could wear the same PPE if only leaving the room briefly and discard in the hazardous waste container when the client is transferred to the floor.
C) The nurse removes the PPE and places it just inside the room to put back on when reentering the client's room, then discards into the hazardous waste container when the client is transferred.
D) If the PPE is soiled, the nurse discards it when leaving the room, but if it is not visibly contaminated, the nurse can reapply the same PPE when reentering the client's room.

Answer: A

Explanation: A) When a client is projectile vomiting, there is a high risk of splatter that might not be seen by the nurse. The PPE should be discarded in the hazardous waste container when exiting the client's room, and clean PPE should be donned when reentering the room. Reapplying the same soiled PPE when reentering the room, whether visibly contaminated or not, would risk the nurse's exposure to body fluids, and would be incorrect technique. Under no circumstances should the nurse walk around the unit in contaminated PPE.
Cognitive Level: Analysis
Client Need: Safe, Effective Care Environment
Nursing Process: Implementation

B) When a client is projectile vomiting, there is a high risk of splatter that might not be seen by the nurse. The PPE should be discarded in the hazardous waste container when exiting the client's room, and clean PPE should be donned when reentering the room. Reapplying the same soiled PPE when reentering the room, whether visibly contaminated or not, would risk the nurse's exposure to body fluids, and would be incorrect technique. Under no circumstances should the nurse walk around the unit in contaminated PPE.
Cognitive Level: Analysis
Client Need: Safe, Effective Care Environment
Nursing Process: Implementation

C) When a client is projectile vomiting, there is a high risk of splatter that might not be seen by the nurse. The PPE should be discarded in the hazardous waste container when exiting the client's room, and clean PPE should be donned when reentering the room. Reapplying the same soiled PPE when reentering the room, whether visibly contaminated or not, would risk the nurse's exposure to body fluids, and would be incorrect technique. Under no circumstances should the nurse walk around the unit in contaminated PPE.
Cognitive Level: Analysis
Client Need: Safe, Effective Care Environment
Nursing Process: Implementation

D) When a client is projectile vomiting, there is a high risk of splatter that might not be seen by the nurse. The PPE should be discarded in the hazardous waste container when exiting the client's room, and clean PPE should be donned when reentering the room. Reapplying the same soiled PPE when reentering the room, whether visibly contaminated or not, would risk the nurse's exposure to body fluids, and would be incorrect technique. Under no circumstances should the nurse walk around the unit in contaminated PPE.
Cognitive Level: Analysis
Client Need: Safe, Effective Care Environment
Nursing Process: Implementation

Objective: Learning Outcome 1-6: Demonstrate appropriate disposal of equipment and supplies.

19) When assisting the physician with an invasive procedure, the role of the nurse includes which of the following? Select all that apply.
A) Observe appropriate infection-control procedures.
B) Provide for client privacy and safety.
C) Prepare the client.
D) Monitor the client's condition throughout the procedure.
E) Label and send all specimens to the lab.

Answer: A, B, C, D

Explanation: A) The nurse observes appropriate infection-control procedures, provides for client privacy and safety, prepares the client for the procedure—including explaining what will happen—and then monitors the client while the physician performs the procedure. Specimens are not sent to the lab until after the procedure is completed, and this can be delegated to an unlicensed assistive personnel if the nurse is needed to care for the client.
Cognitive Level: Knowledge
Client Need: Safe, Effective Care Environment
Nursing Process: Planning

B) The nurse observes appropriate infection-control procedures, provides for client privacy and safety, prepares the client for the procedure—including explaining what will happen—and then monitors the client while the physician performs the procedure. Specimens are not sent to the lab until after the procedure is completed, and this can be delegated to an unlicensed assistive personnel if the nurse is needed to care for the client.
Cognitive Level: Knowledge
Client Need: Safe, Effective Care Environment
Nursing Process: Planning

C) The nurse observes appropriate infection-control procedures, provides for client privacy and safety, prepares the client for the procedure—including explaining what will happen—and then monitors the client while the physician performs the procedure. Specimens are not sent to the lab until after the procedure is completed, and this can be delegated to an unlicensed assistive personnel if the nurse is needed to care for the client.
Cognitive Level: Knowledge
Client Need: Safe, Effective Care Environment
Nursing Process: Planning

D) The nurse observes appropriate infection-control procedures, provides for client privacy and safety, prepares the client for the procedure—including explaining what will happen—and then monitors the client while the physician performs the procedure. Specimens are not sent to the lab until after the procedure is completed, and this can be delegated to an unlicensed assistive personnel if the nurse is needed to care for the client.
Cognitive Level: Knowledge
Client Need: Safe, Effective Care Environment
Nursing Process: Planning

E) The nurse observes appropriate infection-control procedures, provides for client privacy and safety, prepares the client for the procedure—including explaining what will happen—and then monitors the client while the physician performs the procedure. Specimens are not sent to the lab until after the procedure is completed, and this can be delegated to an unlicensed assistive personnel if the nurse is needed to care for the client.
Cognitive Level: Knowledge
Client Need: Safe, Effective Care Environment
Nursing Process: Planning

Objective: Learning Outcome 1-7: Demonstrate safety measures used by the nurse when assisting others with invasive procedures.

20) The nurse is assisting the physician insert a chest tube into a client with a hemothorax following a motor vehicle crash. Which of the following would the nurse don? Select all that apply.
A) Sterile gown
B) Sterile gloves
C) Mask with eye shield
D) Mask
E) Clean gown

Answer: C, E

Explanation: A) The nurse would not need to don sterile gown or gloves, because the role of the nurse is to monitor the client during the procedure. However, due to the risk of splatter, the nurse would wear a gown and mask with eye shield.
Cognitive Level: Application
Client Need: Safe, Effective Care Environment
Nursing Process: Planning

B) The nurse would not need to don sterile gown or gloves, because the role of the nurse is to monitor the client during the procedure. However, due to the risk of splatter, the nurse would wear a gown and mask with eye shield.
Cognitive Level: Application
Client Need: Safe, Effective Care Environment
Nursing Process: Planning

C) The nurse would not need to don sterile gown or gloves, because the role of the nurse is to monitor the client during the procedure. However, due to the risk of splatter, the nurse would wear a gown and mask with eye shield.
Cognitive Level: Application
Client Need: Safe, Effective Care Environment
Nursing Process: Planning

D) The nurse would not need to don sterile gown or gloves, because the role of the nurse is to monitor the client during the procedure. However, due to the risk of splatter, the nurse would wear a gown and mask with eye shield.
Cognitive Level: Application
Client Need: Safe, Effective Care Environment
Nursing Process: Planning

E) The nurse would not need to don sterile gown or gloves, because the role of the nurse is to monitor the client during the procedure. However, due to the risk of splatter, the nurse would wear a gown and mask with eye shield.
Cognitive Level: Application
Client Need: Safe, Effective Care Environment
Nursing Process: Planning

Objective: Learning Outcome 1-7: Demonstrate safety measures used by the nurse when assisting others with invasive procedures.

21) The nurse has assisted the physician with the collection of cerebrospinal fluid. An important safety measure for the nurse to follow immediately after collection of the sample is:
A) Maintain sterility of the procedure tray.
B) Discard all sharps in a puncture-proof container.
C) Label specimens and send to the lab.
D) Remove PPE and discard.

Answer: B

Explanation: A) The nurse's first action would be to discard sharps in the puncture-proof container to prevent potential injury. This should be performed before removing PPE. The next step would be to label the specimens and bag them, prior to removal of PPE due to potential contamination of the outside of the specimen tubes. Once the procedure is completed, there is no need to maintain sterility of the procedure tray.
Cognitive Level: Analysis
Client Need: Safe, Effective Care Environment
Nursing Process: Implementation

B) The nurse's first action would be to discard sharps in the puncture-proof container to prevent potential injury. This should be performed before removing PPE. The next step would be to label the specimens and bag them, prior to removal of PPE due to potential contamination of the outside of the specimen tubes. Once the procedure is completed, there is no need to maintain sterility of the procedure tray.
Cognitive Level: Analysis
Client Need: Safe, Effective Care Environment
Nursing Process: Implementation

C) The nurse's first action would be to discard sharps in the puncture-proof container to prevent potential injury. This should be performed before removing PPE. The next step would be to label the specimens and bag them, prior to removal of PPE due to potential contamination of the outside of the specimen tubes. Once the procedure is completed, there is no need to maintain sterility of the procedure tray.
Cognitive Level: Analysis
Client Need: Safe, Effective Care Environment
Nursing Process: Implementation

D) The nurse's first action would be to discard sharps in the puncture-proof container to prevent potential injury. This should be performed before removing PPE. The next step would be to label the specimens and bag them, prior to removal of PPE due to potential contamination of the outside of the specimen tubes. Once the procedure is completed, there is no need to maintain sterility of the procedure tray.
Cognitive Level: Analysis
Client Need: Safe, Effective Care Environment
Nursing Process: Implementation

Objective: Learning Outcome 1-7: Demonstrate safety measures used by the nurse when assisting others with invasive procedures.

22) It is critically important for the nurse to document all client care activities in the medical record for which of the following reasons? Select all that apply.
A) Facilitate continuity of care.
B) Promote effective care.
C) Meet legal and accreditation requirements.
D) In order to prove what was done
E) Provide data for research and reimbursement.

Answer: A, B, C, E

Explanation:
A) The nurse documents to meet legal and accreditation requirements. Facilitating continuity of care by careful documentation leads to improved communication and promotes more effective care. Data from nursing documentation are used for both research and reimbursement.
Cognitive Level: Knowledge
Client Need: Safe, Effective Care Environment
Nursing Process: Implementation

B) The nurse documents to meet legal and accreditation requirements. Facilitating continuity of care by careful documentation leads to improved communication and promotes more effective care. Data from nursing documentation are used for both research and reimbursement.
Cognitive Level: Knowledge
Client Need: Safe, Effective Care Environment
Nursing Process: Implementation

C) The nurse documents to meet legal and accreditation requirements. Facilitating continuity of care by careful documentation leads to improved communication and promotes more effective care. Data from nursing documentation are used for both research and reimbursement.
Cognitive Level: Knowledge
Client Need: Safe, Effective Care Environment
Nursing Process: Implementation

D) The nurse documents to meet legal and accreditation requirements. Facilitating continuity of care by careful documentation leads to improved communication and promotes more effective care. Data from nursing documentation are used for both research and reimbursement.
Cognitive Level: Knowledge
Client Need: Safe, Effective Care Environment
Nursing Process: Implementation

E) The nurse documents to meet legal and accreditation requirements. Facilitating continuity of care by careful documentation leads to improved communication and promotes more effective care. Data from nursing documentation are used for both research and reimbursement.
Cognitive Level: Knowledge
Client Need: Safe, Effective Care Environment
Nursing Process: Implementation

Objective: Learning Outcome 1-8: Demonstrate appropriate documentation and recording of foundational skills.

23) The nurse has assisted the physician with the collection of cerebrospinal fluid via a lumbar puncture, and would document all of the following except:
A) Specimen collection and disposition.
B) Physician's contamination of first needle, requiring the nurse to obtain a second needle.
C) Client response during and after the procedure.
D) Sterile technique followed throughout the collection process.

Answer: B

Explanation: A) There would be no need to document that the first needle was contaminated, requiring a second, because no error was made, the client was not injured in any way, and it could appear to be an error. The nurse should document what specimens were collected and where they were sent, how the client responded both during and after the procedure, and that sterile technique was followed.
Cognitive Level: Application
Client Need: Safe, Effective Care Environment
Nursing Process: Implementation

B) There would be no need to document that the first needle was contaminated, requiring a second, because no error was made, the client was not injured in any way, and it could appear to be an error. The nurse should document what specimens were collected and where they were sent, how the client responded both during and after the procedure, and that sterile technique was followed.
Cognitive Level: Application
Client Need: Safe, Effective Care Environment
Nursing Process: Implementation

C) There would be no need to document that the first needle was contaminated, requiring a second, because no error was made, the client was not injured in any way, and it could appear to be an error. The nurse should document what specimens were collected and where they were sent, how the client responded both during and after the procedure, and that sterile technique was followed.
Cognitive Level: Application
Client Need: Safe, Effective Care Environment
Nursing Process: Implementation

D) There would be no need to document that the first needle was contaminated, requiring a second, because no error was made, the client was not injured in any way, and it could appear to be an error. The nurse should document what specimens were collected and where they were sent, how the client responded both during and after the procedure, and that sterile technique was followed.
Cognitive Level: Application
Client Need: Safe, Effective Care Environment
Nursing Process: Implementation

Objective: Learning Outcome 1-8: Demonstrate appropriate documentation and recording of foundational skills.

24) The nurse is exposed to the client's blood and body fluids via an accidental used needle stick. Which of the following would be appropriate nursing documentation of the event?

A) Document "Nurse stuck by used needle" in the client's medical record.
B) Document "Accidental exposure of nurse to blood and body fluid" in the client's medical record.
C) There is no need to document the exposure as long as the nurse takes the proper actions and notifies the charge nurse.
D) Completion of an incident report

Answer: D

Explanation:
A) When an incident occurs that does not involve the client directly (no harm is done or potentially done to the client), there is no need to document it in the client's medical record. The nurse would complete an incident report and notify the nursing supervisor or charge nurse.
Cognitive Level: Analysis
Client Need: Safe, Effective Care Environment
Nursing Process: Implementation

B) When an incident occurs that does not involve the client directly (no harm is done or potentially done to the client), there is no need to document it in the client's medical record. The nurse would complete an incident report and notify the nursing supervisor or charge nurse.
Cognitive Level: Analysis
Client Need: Safe, Effective Care Environment
Nursing Process: Implementation

C) When an incident occurs that does not involve the client directly (no harm is done or potentially done to the client), there is no need to document it in the client's medical record. The nurse would complete an incident report and notify the nursing supervisor or charge nurse.
Cognitive Level: Analysis
Client Need: Safe, Effective Care Environment
Nursing Process: Implementation

D) When an incident occurs that does not involve the client directly (no harm is done or potentially done to the client), there is no need to document it in the client's medical record. The nurse would complete an incident report and notify the nursing supervisor or charge nurse.
Cognitive Level: Analysis
Client Need: Safe, Effective Care Environment
Nursing Process: Implementation

Objective: Learning Outcome 1-8: Demonstrate appropriate documentation and recording of foundational skills.