Coordinated Care

This chapter contains questions and answers from the following topic areas:

- Advance Directives
- Advocacy
- Client Care Assignments
- Client Rights
- Collaboration with Multidisciplinary Team
- Concepts of Management and Supervision
- Confidentiality
- Consultation
- Continuity of Care
- Delegation
- Establishing Priorities
- Ethical Practice
- Informed Consent
- Legal Rights Responsibilities
- Performance Improvement (Quality Assurance)
- Referral Process
- Resource Management
- Staff Education
- Supervision

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1. The intent of the Patient Self Determination Act (PSDA) of 1990 is to:

1. enhance personal control over legal care decisions.
2. encourage medical treatment decision making prior to need.
3. give one federal standard for living wills and durable powers of attorney.
4. emphasize patient education.

(2) The purpose of the PSDA is to promote decision making prior to need. The focus of the PSDA is healthcare decision making. A federal standard for advance directives does not exist. Each state has jurisdiction regarding these policies and protocols. The PSDA emphasizes the need for patient education in order to support an individual's treatment decisions.

2. The advanced directive in your patient's chart is dated August 12, 1998. The patient's daughter produces a Power of Attorney for Healthcare dated 2003 that contains different care direction(s). As the nurse you are to:

1. follow the 1998 version because it's part of the legal chart.
2. follow the 1998 version because the physician's "code" order is based on it.
3. follow the 2003 version, place it in the chart, and communicate the update appropriately.
4. follow neither until clarified by the unit manager.

(3) The document dated 2003 supersedes the previous version and should be used as a basis for care direction. Choice 1 and 2 are incorrect as the 1998 version is now outdated. Choice 4 is incorrect; the nurse could be held negligent for not responding to the 2003 document as directed.

3. An advance directive is written and notarized according to law in the state of Colorado. This document is legal and binding:

1. internationally.
2. in the state of Colorado only.
3. in the continental United States.
4. in the county of origination only.

(2) Choices 1, 3, and 4 are incorrect; advance directive protocols and documents are defined by each state.

4. The authority conveyed to a Power of Attorney is revocable by:

1. a primary care physician.
2. a court proceeding.
3. the family if all members agree.
4. the person who originally delegated the authority following proper documentation procedures.

(4) Only the person who delegates authority has the legal right to revoke the authority. Choices 1, 2, and 3, therefore, are incorrect.

5. Copies of advance care directives should be:

1. kept in a safe or safe deposit box only.
2. given to the attorney responsible for preparing the documents.
3. provided to each healthcare institution upon entry for services.
4. kept as private and confidential documents.

(3) Each healthcare facility is required to have advance directives on file. Choices 1, 2, and 4 are incorrect as advance directives are not considered confidential information. They are to be shared information in order to ensure their direction will be followed.

6. The legal age for expressing one's wishes through an advance directive is:

1. 21 years.
2. 18 years.
3. 65 years.
4. Any age.

(2) Eighteen years of age is the minimum legal age for establishing advance directives.

7. A patient is "competent" when he/she is:

1. able to understand risks and benefits of treatment options and manipulate the information rationally.
2. able to sign a consent form.
3. is oriented to person, place, and time.
4. is able to physically take care of him/herself.

(1) 2, 3, and 4 are incorrect. An individual can sign his name on a form without higher level comprehension of what he is signing, it's appropriateness, and so on. Orientation is one aspect of cognitive function that does not support decision making, concrete thinking, and problem solving. An individual may be able to perform basic activities of daily living (ADLs) but still have impaired thought processes, judgment, and decision making, which are also important factors in competency determination.

8. The night before an elective surgery, a client asks the nurse why he was asked to complete an advance directive on admission. The nurse's best response is:

1. "It's just a formality."
2. "This form helps the care team understand your wishes so we won't be sued."
3. "It is a legal requirement that all clients entering the hospital have the opportunity to express their wishes through an advance directive."
4. "Are you worried that you might not live through your surgery?"

(3) All patients entering the hospital for any reason are asked to complete advance directives according to JCAHO standards. Choices 1, 2, and 4 are incorrect. Advance directives are more than a formality as they give guidance to treatment based on the individual's wishes. The guiding ethical principle is patient autonomy, not liability protection for the healthcare providers. Choice 4 is an inappropriate response by the nurse as it reflects that she did not understand or interpret the patient's original question.

9. As the nurse caring for Mrs. Peet, you discover during her admission assessment that she does not have advance directives. She asks whether there are any specific rules about naming a Durable Power of Attorney for Healthcare (DPOAHC) or document requirements. You accurately answer:

1. "A person designated DPOAHC must be a family member."
2. "A DPOAHC must be a lawyer."
3. "The DPAOHC document must include the name, address, and contact information of the party named."
4. "The individual named as DPOAHC must agree with the designee's decisions."

(3) The document records contact information of the party named. Choice 1, 2, and 4 are incorrect. A person named as a DPOAHC can be anyone of choice. That person does not have to be any personal or professional relation. The DPOAHC does not have to agree with the designee's decisions but be willing and able to speak for them should decisions regarding care be needed.

10. For individuals who are no longer capable of speaking for themselves, the order of surrogacy for their healthcare decision making is:

1. guardian, DPOAHC, spouse, adult children of patient, parents of patient, adult brothers and sisters of patient.
2. spouse, DPOAHC, parents of patient, adult children of patient.
3. DPOAHC, spouse, adult children of patient, adult brothers and sisters of the patient.
4. spouse, guardian, adult children of patient, DPOAHC.

(1) Choices 2, 3, and 4 are incorrect according to state law definitions.

11. In the relationship between DNR orders and advance directives (AD), all of the following are true except:

1. an AD may help a physician decide whether a DNR order is the "right" decision for a particular patient.
2. it can be assumed that a patient with an AD is a DNR.
3. an AD is not necessary in order for a physician to write a DNR order (with the exception of New York State).
4. a hospital-based DNR order should not require the patient's or family's signature but does require the physician's signature.

(2) It is NOT a correct assumption that a patient with an AD is a DNR. Choices 1, 3, and 4 are true as written.

12. Patient self-determination is the primary focus of:

1. malpractice insurance.
2. nursing's advocacy for patients.
3. confidentiality.
4. healthcare.

(2) Advocacy for patients by nurses is centered around the patient's right to autonomy and self-determination. Confidentiality involves the maintenance of the privacy of the patient and information regarding them. Malpractice insurance is a type of insurance for professionals.

13. The nurse acts as an advocate for the nursing profession by all of the following except:

1. encouraging political involvement by nurses with their legislators.
2. acting as a first-aid provider for a children's athletic team.
3. precepting newly licensed nurses in the work situation.
4. encouraging as many persons to become nurses as possible.

(4) The nurse acts as an advocate for the nursing profession by encouraging appropriate persons to become nurses, by being a positive role model and mentor, and by communicating the needs of nurses to those making the laws in the most professional manner possible.

14. A nursing advocate is one who:

1. makes decisions for others.
2. encourages people to make decisions for themselves and acts with or on their behalf to support those decisions.
3. manages the care of others.
4. is the legal representative for a person.

(2) Nurse advocates work with patients to provide information and assistance in decision making. The decisions and care that occur from these decisions are based on the right of the patient to self-determination and the work of the nurse advocate supports this right.

15. All of the following support the nurse as a patient advocate except:

1. ANA Code of Ethics for Nurses.
2. institutional review boards for the protection of human subjects engaged in research.
3. federal nurse practice acts.
4. JCAHO.

(3) Nurse practice acts are based in state law, not federal law, as mandated for the advocacy of nurses; JCAHO, ANA, and institutional review boards all support nurse advocacy.

16. An ombudsman is:

1. an individual, usually an employee of the government or an institution, who investigates consumer complaints and assists in achieving a fair resolution.
2. a lawyer designated to try a case.
3. an individual hired by a family as their representative.
4. a family member designated to make decisions for an individual.

(1) An ombudsman is an individual who works for the government or an institution to investigate consumer complaints. The goal of the ombudsman is fair investigation, reporting, and resolution of the complaint.

17. In addition to a nursing advocate, an older adult might utilize which of these advocacy groups?

1. AARP
2. Gray Panthers
3. National Committee to Preserve Social Security and Medicare
4. all of the above

(4) Any and all of these organizations provide advocacy services to older persons.

18. Advocacy is defined as:

1. helping another.
2. arguing, supporting, or defending a client's cause.
3. the principle of doing no harm.
4. a duty to do good.

(2) The definition of advocacy is to argue, support, or defend a client's cause. Providing assistance is helping another; the principle of doing no harm is nonmaleficence; beneficence is the duty to do good.

19. When patients cannot make decisions for themselves, the nurse advocate relies on the ethical principles of:

1. justice and beneficence.
2. fidelity and nonmaleficence.
3. beneficence and nonmaleficence.
4. fidelity and justice.

(3) When a patient is not autonomous, the nurse must rely on the principles of doing no harm and doing good, or non-maleficence and beneficence, in order to assist in meeting the healthcare needs of the person to the best of the nurse's ability.

20. Client advocates might include all of the following except:

1. creditors.
2. family members.
3. nurses.
4. social workers.

(1) Family members, healthcare professionals, ombudsmen, and persons designated as such, act as advocates for clients and patients.

21. Political action committees in nursing organizations act as advocates:

1. for legislators.
2. for members of the nursing organizations.
3. for clients.
4. for collective bargaining or union groups.

(2) Nursing organizations utilize political action committees within their organizations in order to represent the needs of their membership to legislative and organizational persons.

22. In an acute care hospital, the patient might expect which persons to act as advocates for him/her?

1. the nurse
2. the social worker
3. the physical therapist
4. all members of the interdisciplinary team caring for the patient

(4) In a healthcare setting, all members of the interdisciplinary team are expected to act as advocates for the patient.

23. A nurse case manager's focus is:

1. nursing care needs only on discharge.
2. the comprehensive care needs of the client for continuity of care.
3. patient education needs upon discharge.
4. financial resources for needed care.

(2) By definition, case management is a process of providing for the comprehensive care needs of the client for continuity of care through the healthcare experience.

24. The physician's role in case management includes all of the following except:

1. participate in interdisciplinary planning for patients.
2. serve as the expert for resource utilization.
3. consult with the case management team in order to facilitate timely orders as needed.
4. contribute to the documentation of the patient's needs for services.

(2) The physician is an integral part of the case management process in terms of assisting with defining the patient's needs and the time frames for movement through the healthcare system; however, the physician is the expert for medical diagnosis and treatment rather than resource utilization.

25. A case management clinical pathway for congestive heart failure might include all of the following except:

1. physician follow-up appointments with transportation.
2. patient education regarding medication usage.
3. nutritional consult for diet review and accommodation.
4. insurance review for reimbursement.

(4) Clinical pathways include maps of care outcomes to be achieved prior to discharge or movement through a healthcare system. Insurance review for reimbursement is a function of an outside agency from the healthcare provider related to the amount of expected monetary compensation for services rendered to a patient.

26. Case management involves which disciplines for effective planning?

1. nursing, therapy, social work
2. nursing only
3. nursing, medicine, therapy, social work
4. an interdisciplinary team including medicine and nursing based upon the patient's individualized needs

(4) The correct team for case management will include those professionals whose expertise is needed to meet the continuity of care needs of the patient.

27. An 80-year-old client is being discharged from the hospital after a total knee replacement. Her only son has decided to take care of her at his home. During discharge planning, it is most appropriate for the nurse to ask the son:

1. "Are you sure this is the best thing for you to do?"
2. "Will caring for your mother affect your lifestyle?"
3. "Do you own your own car?"
4. "Is your home paid off?"

(2) This open-ended question allows the son to express his thoughts and feelings regarding his mother's needs for care and changes that he may expect while he is providing this care. Information on his personal financial situation (ownership of home or car) or questioning his decision making in taking his mother home does not contribute to the plan of care.

28. Case managers work in which of the following settings?

1. hospitals and insurance companies
2. nursing homes only
3. community agencies
4. all of the above

(4) Case managers work in many different healthcare sites in order to encourage continuity of healthcare and provide services to a diverse group of clients.

29. Community-based case management has the goal of:

1. utilizing only community-based agencies.
2. optimizing health for community-based individuals.
3. only completing discharge plans from the hospital-based case manager.
4. managing illness-related states while excluding health promotion and wellness concerns.

(2) Community-based case management has the goal of support and empowerment of individuals to reach their optimal level of wellness through the use of community resources.

30. Case managers functions encompass a variety of roles including all of the following except:

1. financial planner.
2. clinical expert.
3. patient educator.
4. outcomes manager.

(1) Financial planning for individuals is not a role of a case manager. Case managers function as clinical experts, organizers of care, patient educators, monitors and evaluators of outcomes, and patient advocates.

31. The effect of managed care in healthcare systems has been to:

1. decrease length of stay in hospitals.
2. support the increased use of new technology.
3. focus care strategies on outcomes of care provision.
4. all of the above.

(4) Managed care has decreased the length of stay in hospitals, increased the use of home care services, encouraged technology use, and assisted in focusing healthcare on outcomes management.

32. The sequence of the case management process used by nurses is:

1. implementation, coordination, planning, evaluation, assessment, and monitoring.
2. assessment, planning, implementation, coordination, monitoring, and evaluation.
3. assessment, planning, coordination, implementation, monitoring, and evaluation.
4. assessment, planning, evaluation, coordination, monitoring, and implementation.

(2) The correct sequence of the case management process is assessment, planning, implementation, coordination, monitoring, and evaluation of care.

33. Case management processes are guided by:

1. standards of professional care.
2. protocols of healthcare delivery.
3. guidelines for clinical practice.
4. all of the above.

(4) Standards of professional care, protocols for healthcare delivery, clinical guidelines and pathways, law, and facility protocols all guide case management processes.

34. The patient's right to refuse to participate in research involves which of the following?

1. research on a new cancer medication
2. research on a new walker by physical therapy
3. research into the body's hormonal response to stress
4. all of the above

(4) The patient's right to refuse to participate in research extends to all types of research.

35. Mr. H. is upset regarding being in the hospital for another day because he states it costs too much. The rights that he may be expressing includes all of the following except:

1. the right to examine and question the bill.
2. the right to reasonable response to requests.
3. the right to refuse treatment.
4. the right to confidentiality.

(4) Confidentiality is the maintenance of privacy of information, which has not been breached. He is expressing the other rights and might exercise them in choosing to leave the hospital early, by requesting to see the actual costs of his care, and by requesting reasonable responses to his requests.

36. You and a colleague are on the elevator after your shift, and you hear a group of healthcare givers discussing a recent patient scenario. Which patient right might be breached?

1. right to refuse treatment
2. right to continuity of care
3. right to confidentiality
4. right to reasonable responses to requests

(3) The right to confidentiality of patient information might have been breached when patient care situations are discussed in public areas or without regard to maintaining the information as private and confidential. The other rights listed have not been breached in this instance.

37. Your patient requires an injection to maintain therapeutic levels of the medication. The client does not want the medication, but you give the medication per physician's order. You have violated which patient right?

1. Privacy.
2. Consideration and respect.
3. Refusal of treatment.
4. You have violated no patient rights as the medication was ordered by the physician.

(3) The right to refuse treatment is the patient right violated and exists even when the medication is ordered by a physician.

38. The nurse notices that a family is waiting at the nursing station desk for their loved one to be brought to the unit for admission during a change-of-shift report. The nurse:

1. requests that the family wait for their loved one in the patient's room and waits to resume the report until the family has left the desk area.
2. requests that a nursing assistant bring coffee for the family while they wait at the desk and continues with report.
3. requests that the family have a seat in the station rather than stand while awaiting their loved one.
4. requests that the family wait for their loved one in the emergency room waiting room.

(1) In order to protect the privacy of the patients and the confidentiality of the information shared in report, the family should be asked to wait in the patient's room, and the report should be resumed only after they can no longer hear it.

39. Our mother is being admitted to the hospital for elective surgery tomorrow. She has specifically not shared information regarding this event with her friends. Her best friend calls and says she knows something is terribly wrong. You have the right and duty to:

1. confirm her suspicions.
2. discuss your mother's upcoming surgery with her friend.
3. help your mother's friend to plan a homecoming party for your mother.
4. maintain your mother's privacy and the confidentiality of her medical information.

(4) Every patient has the right to privacy and to the confidentiality of their medical information. Even as her daughter, you do not have the right to discuss her medical care unless given permission by her to do that.

40. Your patient is being discharged from the hospital today. She has the right to expect:

1. a continuity of care plan will be initiated prior to discharge from the hospital.
2. all medical information will be available to her son after her discharge.
3. her bill will be sealed and unchangeable after discharge.
4. the information regarding her diagnosis and treatment will be given to her pastor when he comes to visit her before her discharge today.

(1) Medical information is not shared with family or clergy persons unless permission is given by the patient. Your patient has the right to examine and question her bill, even after discharge, and so the bill is open to change if needed after discharge. Your patient should expect a continuity of care plan to be initiated prior to discharge and communicated with her.

41. Your patient will be undergoing surgery in the morning. Ways in which you might support her patient rights include all of the following except:

1. completing the consent for research for your patient.
2. initiating discharge planning during the admission assessment.
3. educating the patient regarding post-op care and expected post-op care needs.
4. maintaining the medical record as a confidential document.

(1) Completion of informed consent procedures and documentation is the right of the patient in order to maintain self-direction and autonomy. Discharge planning is expected in continuity of care. The confidentiality of medical records and patient information is also a right. Patient education will help to meet the patient's right to information regarding diagnosis, treatment, and prognosis.

42. When a patient is admitted to a psychiatric facility, the patient:

1. has the right to expect that his medical information will not be kept confidential.
2. has no right to decline to participate in research.
3. does not require informed consent prior to procedures.
4. has all of the same rights as other patients in acute care facilities.

(4) Patients admitted to psychiatric facilities have all of the same rights as other patients in acute care facilities.

43. You are working in the ER when an unconscious multiple trauma victim is admitted. You know that:

1. emergency surgery may be completed if deemed necessary by two attending physicians when a patient is unable to give consent and the next of kin cannot be reached.
2. you must wake the patient and obtain consent for surgery.
3. his girlfriend can give consent when his parents cannot be reached.
4. consent must be obtained from the next of kin, so the patient must wait for surgery.

(1) Standards of practice and many state laws support the initiation of emergency surgery if deemed necessary by two attending physicians when a patient is unable to give consent and the next of kin is unavailable to give consent.

44. Your patient suffered a stroke and is being cared for by the interdisciplinary stroke team. She has a right to expect considerate and respectful care from:

1. the nursing staff.
2. each member of the interdisciplinary team.
3. her family.
4. the nursing assistants.

(2) Each patient has the right to expect considerate and respectful care from all members of the healthcare team as well as all individuals working within the healthcare facility.

45. You meet your new nurse manager for the first time. She makes eye contact, smiles, initiates a conversation about your previous work experience, and encourages your active participation in the dialogue. Her behavior is an example of:

1. aggressiveness.
2. passive-aggressiveness.
3. passiveness.
4. assertiveness.

(4) As aggressive behavior dominates or embarrasses, passive behavior is nervous or timid. Passive-aggressive behavior is dominating or manipulative without directness. This case exemplifies assertive behavior.

46. The power a nurse exerts when he/she works to accomplish goals and effect change in an agency or in policy is considered what type of power?

1. political
2. personal
3. positional
4. professional

(1) Political power results from one's ability to work within systems or agencies or through policy in order to effect change. Personal power is based upon one's charisma and self-confidence and is often found in informal leadership situations. Positional power is based on designated authority in a legitimized position within which the power is exercised. Professional power is based upon one's professional skills and abilities resulting from one's recognized expertise in an area of practice.

47. You belong to a professional nursing organization that provides social, educational, and political venues for nurses. You are active in the organization for almost two years, during which time you meet and work with nurses from several different nursing agencies and healthcare institutions in order to achieve a variety of goals, including obtaining advice regarding a personal career choice. This is an example of:

1. professional nurturing.
2. networking.
3. mentoring.
4. collegiality.

(2) Networking involves the process of developing and using contacts throughout one's professional career for information, advice, and support. Nurturing and mentoring are both examples of assistance to other colleagues in formal and informal relationships for support and career building. Collegiality is the professional camaraderie or rapport established among persons through shared experiences.

48. As a nurse on a 25-bed med-surg unit, you might expect your nurse manager to be involved in all of the following activities except:

1. evaluating nursing care given and ensuring appropriate documentation of such care.
2. providing clinical facilities and learning experiences for nursing students.
3. selecting laboratory personnel for hire.
4. providing for staff development and staff education.

(3) A nurse manager might appropriately select and hire nursing personnel but would not likely have the hiring authority for laboratory personnel. Nurse managers are responsible for all aspects of the nursing care on their units including documentation and do participate in providing education for their staff and for students.

49. The role of the clinical nurse specialist in the delivery of nursing care is:

1. consult with and collaborate with the interdisciplinary team to develop and implement a comprehensive plan of care for specific patients.
2. participate as the direct care delivery person for a select patient case load each day.
3. define the medical plan of care for specific patients.
4. act as a liaison for each patient with specific therapies during their hospital stay.

(1) The clinical nurse specialist works with complex patients in order to facilitate comprehensive plans of care by the interdisciplinary team. He/she is not regularly involved in direct patient care for only a select case load but is generally involved in the oversight of many patients; he/she might be involved in assisting with the medical plan of care but is not the sole definer of that care. Although the clinical nurse specialist might assist in discussions of therapy needs, the primary nurse for that patient would be responsible for the communication regarding specific therapy.

50. As a staff nurse, you participate on your unit's committee for quality care. The types of tools that you might use to evaluate nursing care include all of the following except:

1. nursing care audits.
2. nursing care outcome studies.
3. utilization review data.
4. performance appraisals.

(4) Performance appraisals are confidential forms between the manager and the employee and not available for open review. The results of nursing care audits, outcome studies, and aggregate data from utilization reviews are all appropriate sources of information for evaluating the delivery of nursing care.

51. Standards of practice for nursing:

1. define the highest level of nursing practice acceptable.
2. are utilized instead of nurse practice acts in states where there is no nurse practice act.
3. provide authoritative statements by which the quality of practice, service, or education might be evaluated.
4. are useful as guidelines only for the provision of care.

(3) Standards of practice do provide statements from which evaluations of the quality of practice, service, and education might be made. Standards of practice define the minimum level of practice and might take the form of specific protocols for care or general guidelines. Each state has a nurse practice act that regulates the practice of professional nursing in its state by law.

52. As a new nurse seeking employment, you must present to your potential employer with which of the following?

1. valid proof of residency
2. valid proof of malpractice insurance coverage
3. valid proof of nursing licensure
4. valid driver's license

(3) Proof of licensure as either a registered nurse or practical nurse is required prior to hire as a registered or practical nurse. Current residency, current driving privileges, and current malpractice insurance coverage are not required.

53. The basic legal requirement for employment as a nurse in any state is:

1. accreditation of the institution as an employer of nurses.
2. licensure of the nurse as a registered or practical nurse by that state.
3. certification of the nurse as a registered or practical nurse.
4. proof of malpractice insurance coverage of the employing healthcare agency.

(2) Licensure of the nurse as having met the requirements to practice nursing in that state is the basic minimum legal requirement to practice in that state. Malpractice insurance by the employing agency, certification for advanced practice, and agency accreditation to employ nurses are all not required in order to hire a nurse.

54. The scope of practice for a registered or practical nurse in a state is determined by:

1. professional standards of practice.
2. the state nurse practice act.
3. accreditation of the employing agency by nongovernmental organizations.
4. professional organization nursing certification.

(2) The nurse practice act of a state contains the legal definition of the scope of practice of the different levels of nursing within that state. Professional standards of practice are statements by which practice may be judged, which are delineated by professional nursing organizations. Although employing agencies define job responsibilities for certain job categories, the scope of practice for a nurse is defined by the state nurse practice act. Professional certification denotes meeting certain predetermined standards in specialty practice and is in addition to nursing licensure.

55. You are asked to assist in the evaluation of a nursing colleague with whom you practice. This type of evaluation may be termed:

1. peer review.
2. certification of practice patterns.
3. board of review.
4. accreditation of nursing practice.

(1) The peer review process involves professional review of work output and outcomes of colleagues at the same level or within the same job category. Each of the other evaluation mechanisms are not limited to the review of professional practice or necessarily utilized by professional nurses.

56. Legal protection of confidentiality:

1. extends only to written documentation.
2. extends to the electronic dissemination of information not identifiable to a specific patient.
3. is important only within the court system.
4. extends to both written and verbal information.

(4) Legal protection of confidentiality extends to both written and verbal information identifiable as individual private health information.

57. Confidentiality is a right of patients' that is supported by:

1. the American Hospital Association's "Patient's Bill of Rights."
2. the ANA "Code of Ethics."
3. HIPPA.
4. all of the above.

(4) Confidentiality is an ethical and legal right of the patient supported by the federal HIPPA legislation, the American Hospital Association's "Patient's Bill of Rights," and the American Nurses Association "Code of Ethics."

58. You are walking in the hallway of an acute care unit of the hospital in which you work when you realize you are overhearing the change of shift report. You should:

1. make the charge nurse on the unit aware of the situation so that she/he can take the necessary steps to maintain the confidentiality of the information being reported.
2. not worry about the information as it changes quickly on the acute care unit and will be outdated within two to three hours anyway.
3. mind your own business and return to your own unit as you would not want anyone to know you have overheard confidential information.
4. ignore the situation.

(1) In order to protect the confidentiality of the information being reported, you should make the charge nurse on the unit aware of the situation so that the information may be communicated in an appropriate way in privacy.

59. A legal right to confidentiality of patient information is waived when:

1. a court system subpoenas information.
2. a family member requests healthcare information of a patient.
3. a living will takes effect.
4. the patient is declared incompetent by the legal system.

(1) The legal right to confidentiality is waived when the court requires information to be given to the court in order for legal proceedings to occur (summonses, court orders, litigation information necessary for the court, subpoenas, and so on), when the state requires mandatory reporting of certain illnesses, when sharing of information is necessary as a patient has revealed an intent to harm himself or others, or if a patient cannot make a safe and rational decision (competence).

60. Your patient is a 27-year-old first-time mother who is giving her newborn up for adoption. Her family members have a right to what information?

1. the baby's sex
2. the name of the father of the baby
3. no information except that which is shared with them by the birth mother
4. a full medical chart review

(3) As a competent adult, the birth mother has the right to share or not share information regarding the birth and the child.

61. The legal requirement for the maintenance of confidentiality of patient information in healthcare extends to all of the following except:

1. physicians.
2. social workers.
3. physician's office receptionist.
4. the media.

(4) The legal requirement for the maintenance of confidentiality of patient information in healthcare legislated by HIPPA extends to all healthcare personnel (including the physician's office receptionist), but not to nonhealthcare personnel such as the media.

62. You find a medical record on the floor in the main hallway of the healthcare facility in which you work. You should:

1. open it and read it to find out to whom it belongs.
2. return the record to medical records unopened.
3. return the record to the nearby gift shop for them to take care of.
4. ask a nearby visitor to return the record to the lobby information desk.

(2) In this situation, in order to preserve the confidentiality of the information contained in a misplaced medical record, it should be returned to the medical record department unopened so that is may be correctly claimed by the person losing the record.

63. Confidential healthcare information is:

1. written information only.
2. verbal information only.
3. both written and verbal information.
4. found only in medical records.

(3) Confidential healthcare information is written, verbal, or electronic; it is found in a variety of sources including medical records, insurance records, demographic information, diagnostic test reporting, on computer systems, and in electronic transmittal systems such as fax transmissions, as well as other sources.

64. Healthcare information not covered by confidentiality legislation includes:

1. signed informed consent agreements.
2. information that identifies an individual.
3. information that could reasonably be believed to identify an individual.
4. information that could not reasonably be believed to identify an individual.

(4) The healthcare information that is protected information covered by HIPPA confidentiality regulations includes any information, including demographic information, that identifies an individual, or could reasonably be believed to identify an individual.

65. Disclosure of healthcare information might occur:

1. when permission is given by a competent patient.
2. under no circumstances.
3. when there is no risk to the safety of the public.
4. only after permission is granted by the court.

(1) Healthcare information may be disclosed when permission is given by a competent patient, when there is a risk of harm to self or others by a patient, when there is a threat of harm to the community (such as in communicable disease reporting), and when the courts request specific information.

66. Confidentiality is a legal right ensured by:

1. OBRA.
2. HIPPA.
3. Patient Self-Determination Act.
4. ANA's "Code of Ethics."

(2) Confidentiality is a legal right ensured by HIPPA. OBRA deals with nursing home regulation. The Patient Self-Determination Act is related to the right of choice of the patient. The ANA's "Code of Ethics" provides ethical standards for the practice of nursing.

67. As a nurse working in a free clinic, you realize that persons who are economically underprivileged are most likely to obtain healthcare from:

1. the primary care physician (family doctor).
2. neighborhood clinic.
3. specialists.
4. the emergency rooms/urgent care facilities.

(4) Statistical patterns of healthcare utilization indicate that the emergency rooms and urgent care facilities provide a large portion of healthcare to those with less economic or financial resources. This becomes problematic as routine care is often accessed in the higher cost healthcare sites.

68. As a nurse discharge planner preparing your patient for discharge from acute care, you assess that home care services are clinically indicated. Your assessment is based on all of the following indicators except:

1. your patient has been admitted to the hospital three times in the last two months.
2. your patient has a Foley catheter.
3. your patient's family will be there to care for him 24 hours/day.
4. your patient is ordered to continue IV antibiotics 5 days post discharge.

(3) 24-hour family availability to provide care and assistance is not an indicator for home care. In fact, the nurse might see some opportunity for family education in meeting the patient's needs so that less community support may be needed. This would need to be negotiated with the family. Frequent hospital readmissions imply that the patient has not been able to manage either due to condition instability or lack of care needs being met. This would be a red flag for home care services to be able to meet those needs and appropriately monitor the patient. A Foley catheter is an indication for home healthcare due to infection potential and care requirements. IV antibiotics involve home care due to maintaining line patency and assessment of the site.

69. Your patient has experienced a CVA with right hemiparesis and is ready for discharge from the hospital to a long-term care facility for rehab. To provide optimal continuity of care, the nurse should do all of the following except:

1. document current functional status.
2. have the physician phone report to the receiving facility.
3. copy appropriate parts of the medical record for transport to the receiving facility.
4. phone report to the facility.

(2) It is the nurse's responsibility to communicate the patient's condition and care plan to the receiving facility in order to support continuity of care. Documentation of the patient's baseline functional is important for the receiving facility to work with in further goal setting. A copy of select portions according to facility policy is another form of communication and will support continuity. A physician may be asked to be involved if there are specific medical needs or orders that he/she believes are important but is generally not involved.

70. An older adult man is being discharged from the hospital with lung cancer. He will be going to live with his daughter and her family. To promote continuity of care, the nurse should:

1. explore community service options with the patient and his family.
2. make a referral to hospice.
3. convince the family that a nursing home placement may be better.
4. support the family's decision and help him leave the hospital.

(1) The nurse should explore the support service options with the patient and family so that they can be aware of and obtain support as needed. Further assessment is needed before the hospice referral; it may be premature. It is never appropriate for the nurse to impose his/her opinions about what's best for the patient. A more educational approach needs to be taken presenting options so that the patient and family can make their best decisions.

71. A client who receives care at least in an overnight stay in a hospital or other healthcare facility is considered an inpatient. An implication for care is:

1. reimbursement at the same rate as outpatient care.
2. potentially delayed access to continuum of care services (for example, skilled nursing facility or home care services).
3. medical problems will be resolved upon discharge.
4. discharge planning services will assist in links to outpatient services as needed.

(4) Hospital discharge planners have a professional responsibility upon a patient's discharge to link the patient with necessary services. Reimbursement rates are generally higher in acute care compared to outpatient care. Medical problem resolution is generally completed after hospital discharge at home, with community-based support services or other facility-based care.

72. As a nurse, you identify that your diabetic patient has misunderstandings about her prescribed diet. For follow-up upon discharge, you refer her to:

1. an endocrinologist.
2. a physician's assistant.
3. dietician.
4. cooking classes.

(3) A patient who has misunderstandings about healthcare strategies needs further education. A major part of the dietician role is nutritional counseling and follow-up, which would be most appropriate in this scenario. An endocrinologist is a physician who specializes in diabetes; their focus is on the medical care aspects. A physician's assistant may be an educational support but does not have the background or expertise in nutrition. Cooking classes offer meal strategies but would not provide the educational support needed to clarify this patient's understanding.

73. The nurse is preparing a hospital discharge to home for a patient who has had a total knee replacement. Therapy is indicated to support the patient's recovery. The nurse understands that in order to have therapy services initiated, an order:

1. is not required for reimbursement.
2. may be written by discharge planner.
3. may be written by the therapists themselves.
4. requires a diagnosis to focus the therapist goals for treatment.

(4) An order for therapy must include direction for the need for therapy along with supportive diagnoses. An order is required for reimbursement as that helps to justify the need for therapy services. The order must be written by a physician or physician extender (NP) according to practice laws of the state. It may not be written by a nurse or social worker discharge planner or the therapists themselves.

74. Potential sites for breakdown of continuity of care are:

1. intra-unit transfers in an acute care setting.
2. hospital discharge to home care services.
3. nursing change-of-shift report.
4. all of the above.

(4) A potential for breakdown of continuity of care exists any time there is a change in caregiver or change in location. Thorough, concise communication is required to maximize a patient's opportunity to reach desired outcomes at all times.

75. Functionally impaired adults might receive care that is provided onsite in all of the following care settings except:

1. long-term care.
2. adult day care.
3. independent apartments.
4. home with 24-hour caregiver.

(3) Functional support services (that is, therapies according to reimbursement) are usually not available in independent living sites. Most insurance (Medicare included) requires that an individual be considered home bound to quality for in home services. People who are independent, even for short-term rehab generally are required to go to a therapy site of service.

76. A daytime community-based program for adults with functional and cognitive problems that provides individualized care is:

1. hospice.
2. home care.
3. adult day care.
4. respite care.

(3) Adult day care services provide a variety of services to community based adults, in particular older adults. Most people who use adult day services are cognitively impaired and/or have varying degrees of physical frailty. These programs help delay institutionalization for those who need some supervision but do not need continuous care. This allows family members/caregivers to maintain their lifestyles and employment and still keep their loved one at home. Hospice services provide end-of-life services in a variety of settings but do not offer daytime supervision. Respite care services provide short-term relief or time off for caregivers of ill, disabled, or frail older adults.

77. As a nurse discharge planner explaining available outpatient services to a family contemplating discharge, you explain that rehab or skilled care:

1. is focused on short-term functional outcomes.
2. deals with chronic decline in health status due to chronic illness.
3. maintains cognitive function.
4. includes respite care.

(1) Skilled or rehab services are generally short-term, goal-directed services geared toward specific functional outcomes. They do not encompass long-term chronic health issues. The majority of skilled services are physical in terms of therapy (that is, physical therapy, occupational therapy, and/or speech therapy). Respite services are not included as a component of skilled care.

78. Quality is defined as the cumulative combination of all of the following except:

1. conforming to standards.
2. performing at the minimally acceptable lower level.
3. meeting or exceeding customer requirements.
4. quality so good that efforts have significantly exceeded customer expectations.

(2) Minimal compliance or performance at the minimally acceptable level is not considered to be quality.

79. As a type of quality indicator, an example of a structure standard is:

1. a written philosophy.
2. a procedure for a straight catheterization.
3. a protocol for treatment of a patient with chest pain.
4. the diagnostic work-up for a patient with abdominal pain.

(1) Structure standards define all the conditions needed to operate, direct, and control a system. They do not address patient care but rather describe structure with regard to purpose; such as philosophy, objectives, goals, hours of operation, and management responsibility.

80. An example of a process standard on a med-surg unit is:

1. a procedure for changing IV tubing.
2. a policy for staffing.
3. the job description of the CEO (chief executive officer).
4. a procedure for checking waveforms on a patient being treated on an intra-aortic balloon pump.

(1) Process standards define the actions and behaviors required by staff to provide care. A procedure for changing IV tubing is a psychomotor skill that is applied to helping the patient meet their goals.

81. An example of an outcome standard in a rehab area is:

1. physical therapy involvement for all patients.
2. serving meals at consistent times so that other activities may be planned.
3. patients will achieve maximum functional ability including ambulation and transfer status post hip fracture repair.
4. a procedure for the use of a passive range on motion machine (PROM).

(3) Outcome standards indicate the change in the patient's condition following treatment. A procedure is a process standard.

82. Which of the following is a correctly stated threshold for evaluation in the continuous quality improvement process?

1. Diabetic patients are able to discuss their prescribed individualized meal plans.
2. Most of the patients following hip surgery will be able to ambulate with crutches.
3. 85 percent of the patients will verbalize satisfaction with the responsiveness of staff to their call light.
4. Most of the patients following hip surgery will maintain normal lung function with no evidence of pneumonia.

(3) A threshold is a quantitative measure (usually expressed as a percentage) that is used to define whether or not a problem exists.

83. The responsibility for defining the process, setting goals, monitoring activities and evaluating nursing care in a unit-based quality improvement program is assigned to:

1. the hospital administration.
2. the Director of Continuous Quality Improvement (CQI).
3. the professional staff nurses working on the unit.
4. the Director of Nursing.

(3) In a unit-based program, the responsibility for the program is decentralized to the professional staff nurses working on the unit.

84. "Patients receiving antibiotics through a central IV line will not experience infection" is an example of:

1. a structure indicator.
2. a process indicator.
3. a process goal.
4. an outcome indicator.

(4) An outcome indicator defines the intended result of a medical and/or nursing intervention.

85. The overall goal of a Continuous Quality Improvement (CQI) program is to:

1. ensure that patients receive quality care.
2. document nursing errors for performance monitoring.
3. protection from liability.
4. identify ways to improve healthcare.

(4) Quality of care is a dynamic and individualized concept in many cases. Continuous quality improvement programs are designed to make improvements in whatever the level of current "quality" provided is within an organization.

86. It is less challenging for nursing than other healthcare disciplines to embrace/work with the Continuous Quality Improvement (CQI) process because:

1. nurses are patient advocates.
2. the process is similar to the nursing process.
3. nurses like to do things right.
4. nurses take pride in their profession.

(2) The CQI process is similar to nursing process in that they are both problem-solving methods.

87. JCAHO's 10-step process for quality improvement and the Focus-PDCA model are two models commonly adopted for the organization of Continuous Quality Improvement programs. Similarities between these models include all of the following except:

1. they use a systematic approach ensuring that participants are on common ground in their efforts.
2. they generate unique findings based on the process used.
3. they are cyclical.
4. they identify a process or problem.

(2) The models used for Continuous Quality Improvement assist the development of an organized program using a systematic approach. They offer a structured means of problem identification and resolution that can be repeated over time according to need. The findings and problem solving that results is similar; although the steps of the process may have some differences.

88. Measuring patient satisfaction as a focus of Continuous Quality Improvement (CQI) is beneficial in that the results provide useful outcome measures for quality. Satisfaction reflects:

1. reduced risk of malpractice.
2. reduced hospitalization
3. reduced length of stay
4. patient perceptions of quality of care.

(4) Reduced risk of malpractice and reduced hospitalization and length of stay are benefits of the patient's perceptions of quality of care, which is expressed in terms of satisfaction.

89. Your 65-year-old female patient is having post-menopausal bleeding. You encourage her to see a physician of what type?

1. radiologist
2. gynecologist
3. physiatrist
4. oncologist

(2) A gynecologist is the physician who treats and manages disease of the female reproductive organs. A radiologist evaluates x-rays; a physiatrist is the physician manager of the rehabilitation team; an oncologist treats patients with cancer.

90. In the process of an annual physical exam, your father is diagnosed with benign prostatic hypertrophy (BPH). You may expect that he will have a consult to see which physician?

1. gynecologist
2. physiatrist
3. urologist
4. proctologist

(3) A urologist is the physician who specializes in urinary tract and prostate disease. A gynecologist specializes in disease of the female reproductive tract; a physiatrist specializes in rehabilitation care; a proctologist specializes in lower colonic digestive diseases.

91. A gastroenterologist would be consulted for patients suffering from:

1. digestive system diseases.
2. urinary system diseases.
3. female reproductive system diseases.
4. nervous system diseases.

(1) A gastroenterologist cares for patients with digestive system diseases. A urologist cares for patients with urinary system diseases; a gynecologist care for patients with female reproductive system diseases; a neurologist cares for patients with nervous system diseases.

92. The physiatrist at the skilled nursing facility:

1. cares for patients with wound care needs.
2. cares for patients with digestive diseases.
3. dares for patients with rehabilitation needs.
4. cares for patients with surgical needs.

(3) A physiatrist cares for patients with rehabilitation needs, such as a CVA or multiple trauma patients.

93. A patient you are caring for in home care has just lost her son. An appropriate consult for her at this time may be:

1. a minister or chaplain.
2. a psychologist.
3. a bereavement counselor.
4. any of the above.

(4) Bereavement counseling may be done by ministers or chaplains of a religious faith, by psychologists or by counselors trained in bereavement counseling.

94. You have a patient with rheumatoid arthritis who is starting a new medication treatment. This is likely managed by:

1. a pulmonologist.
2. an orthopedic surgeon.
3. a rheumatologist.
4. a physical therapist.

(3) A rheumatologist is the physician specialist who manages the medical treatment of diseases involving the bones, joints, and connective tissues (such as rheumatoid arthritis). A pulmonologist specializes in caring for patients with respiratory disease; an orthopedic surgeon specializes in surgical treatment of bones and joint diseases; and a physical therapist specializes in working with patients with mobility and balance disorders at the direction of a physician.

95. Your patient has had hip surgery and is now ready for therapy. You would expect their primary therapy to be:

1. physical therapy.
2. nutrition therapy.
3. occupational therapy.
4. speech therapy.

(1) Physical therapy for restoration of mobility, gait, and balance would be the primary therapy consulted after hip surgery. The other therapies would not be necessary as direct consultants.

96. Your patient suffered a second-degree burn to the right hand and forearm and is now ready for therapy. You would expect the primary therapy to be:

1. physical therapy.
2. speech therapy.
3. occupational therapy.
4. pulmonary rehabilitation.

(3) The primary therapy modality for an upper extremity burn would be occupational therapy in order to restore function and as much dexterity as possible of the extremity. Physical therapy deals with mobility, gait, and balance; speech therapy deals with speech, swallowing, and cognitive functioning; pulmonary rehabilitation deals with maximizing function in patients with respiratory diseases.

97. Your patient with schizophrenia would most likely be treated by which consultant?

1. physiatrist
2. psychologist
3. psychiatrist
4. social worker

(3) Persons with mental illnesses such as schizophrenia are treated by psychiatrists in order to combine psychiatric counseling and medications in the treatment plan. A physiatrist treats rehabilitation patients; a psychologist treats patients with counseling and support; a social worker might assist patients with the planning of support, obtaining material resources, or short-term counseling.

98. Your patient has a consult for a podiatrist. You would expect this consultant to:

1. care for your patient's hands.
2. care for your patient's hearing.
3. care for your patient's feet.
4. care for your patient's eyes.

(3) A podiatrist is a specialist in foot care.

99. An audiologist would be consulted for:

1. diminished hearing.
2. diminished vision.
3. retinal damage.
4. aphasia.

(1) An audiologist is a specialist in hearing abnormalities and hearing aides. An ophthalmologist cares for patients with retinal damage; an optometrist cares for patients with decreased vision; a speech therapist treats patients with aphasia.

100. All of the following are common reasons that nurses are reluctant to delegate except:

1. lack of self confidence.
2. desire to maintain authority.
3. confidence in subordinates.
4. getting trapped in the "I can do it better myself" mindset.

(3) If a delegator has confidence in their subordinates that the task will be done correctly, they will be more likely to delegate. Reasons that delegators are reluctant to delegate include their own lack of confidence, fear of losing authority or personal satisfaction, feeling that they need to do it themselves in addition to having difficulty letting go.

Scenario: Questions 101–102

Jack Stone, a 16 year old was in a bicycle accident earlier today and was hospitalized for a concussion and a compound fracture of his right homerus. He was taken to surgery for repair of the fracture and is 11 hours post-op now on the unit to which you are assigned. His right arm is casted. He is to be observed for possible internal injuries in addition to ongoing neural assessment. Vital signs are every hour. He has been ordered clear liquids as tolerated and has a maintenance IV at 75 ccs per hour until tolerating fluids. You are working with an LPN and nursing assistant.

101. All of the following tasks may be delegated to the LPN except:

1. the patient's admission assessment.
2. every 2-hour circulation checks of the right hand distal to the cast.
3. performing a straight catheterization if he is unable to void.
4. monitoring the vital signs.

(1) The patient's admission assessment is an RN responsibility. Performing a straight catheterization procedure, circulation checks, and vital sign monitoring are skills within the LPN's scope of practice.

102. In making the decision to delegate care of this patient to the LPN, what is the priority consideration that the RN needs to make?

1. the LPN's skill level
2. the LPN's experience level—is their familiarity/competence with the skills required?
3. the stability of the patient's status
4. the number of patients within each assignment

(3) The patient's stability would be a first consideration. If he were unstable, it would be appropriate that the RN be more directly involved in monitoring the aspects of care as part of an ongoing assessment.

103. All of the following tasks could be delegated to a nursing assistant or unlicensed assisting personnel (UAP) except:

1. performing the catheterization.
2. assisting the patient to the bathroom.
3. offering fluid intake every 1–2 hours.
4. monitoring/recording the amount of fluid taken.

(1) A urinary catheterization is a sterile procedure that must be completed by an RN or LPN. Assisting during activity, offering fluids, and recording intake are in the job scope of the nursing assistant.

Scenario: Questions 104–105

Mrs. B has type 2 diabetes, which has been fairly stable until the last 2 weeks. She is now experiencing blood sugars greater than 200. She has a diagnosis of cellulites of the left foot with dressings to be changed every 2 hours. Her vital signs are stable, and she feeds herself. She is taking a vicodin every 4 hours for pain, which gives her some short-term relief.

104. All of the following tasks may be delegated to the LPN except:

1. developing a patient teaching plan regarding the patient's diet, exercise, and medications.
2. monitoring Mrs. B's blood sugars via accucheck.
3. performing dressing changes to the infected foot.
4. administering the patient's pain medication.

(1) Developing a patient teaching plan is a professional nursing function that is in the scope of RN responsibilities. RNs may delegate specific teaching activities to an LPN in order to execute the plan using the same five rights of delegation. Accuchecks, dressing changes, and medication administration are tasks within the role of the LPN (in most states).

105. On the third day during which you are caring for Mrs. B., she complains of chills. Checking her temperature, the nursing assistant comes to you, and reports that it is 101.8.

As you assess Mrs. B., you discover that her wound looks more inflamed, feels hot to touch, and is oozing some yellow/green drainage. The patient tells you that it's been like that the last two days. Checking the chart, you see that the LPN who had done the dressing changes documented a similar appearance two days ago. Who is responsible?

1. the nursing assistant who checked her temperature
2. the LPN who did the dressing changes
3. you are, as the RN
4. you, as the RN, and the LPN

(4) Both the RN and the LPN are responsible in this situation. The LPN who performed the dressing changes did not recognize signs of infection, and/or if she did she failed to bring them to the attention of the RN. As the RN, you are also responsible for the care that you delegated to this LPN. The RN retains responsibility for tasks that are delegated and must perform necessary supervision.

106. Which direction given to the nursing assistant is most likely to accomplish the task of getting a urine specimen delivered to the lab immediately after collection?

1. "Make it a stat delivery."
2. "Please do it as soon as you can after break."
3. "This patient is delirious, and we're worried about a urinary sepsis."
4. "Take this patient to the bathroom now and collect a urine specimen from this voiding. Take the specimen to the lab immediately."

(4) Effective delegation depends on clear, concise direction that leaves no room for question or interpretation on the part of the one being delegated to. Nursing assistants have a limited understanding of medical conditions and terminology and should not be relied on to prioritize accordingly.

107. In communicating a delegated task to a nursing assistant (UAP), an example of optimal direction is:

1. "Let me know if you see any signs of a heart attack."
2. "Please offer the patient the bedpan every two hours on the even hours. Let me know the total urine output at 2:00 P.M."
3. "Let me know whether anything happens with this confused patient."
4. "Keep an eye on this hallway while I'm at lunch."

(2) When delegating, the use of specific, behavioral direction will be most likely to obtain desired results.

108. Decisions regarding which tasks may be delegated by the RN are made by:

1. the American Medical Association (AMA).
2. JCAHO.
3. each State Board of Nursing.
4. the ANA.

(3) The definition of the scope of nursing practice is the responsibility of each state board of nursing.

109. Who has the responsibility for ensuring that nursing staff at all levels have the appropriate competencies in order to safely function in their job description?

1. the ANA
2. the State Boards of Nursing
3. the agency or institution of employment
4. the RN in charge

(3) Each agency or institution of employment has the responsibility of ensuring that staff have appropriate competencies as guided by the state practice acts. This is accomplished through the process of orientation, ongoing staff development, and management practices of supervision and quality assurance.

110. The manager making the delegation is the:

1. delegee.
2. delegator.
3. supervisor.
4. delegate.

(2) The person responsible for delegating in the delegator. The delegate is the person receiving the delegated task. The supervisor is the person who provides guidance for the accomplishment of a task or activity. Delegee is an incorrect term.

111. Mrs. T is an 80-year-old client admitted to your nursing unit with a diagnosis of weakness, status post fall. The admission face sheet indicates that she is widowed and lives alone. As you work through your nursing admission assessment, which of the following would be the least priority concern?

1. Ask Mrs. T about the details of her fall.
2. Does Mrs. T like to read?
3. Ask Mrs. T about her ability to shop and cook for herself.
4. What medications has she been taking?

(2) Mrs. T's reason for admission is weakness and a fall. Priority concerns in assessment would be to identify any intrinsic or extrinsic factors that lead to her fall. Her interest in reading, although it be important in determining possible activities to incorporate into her care plan while in the hospital, is a lesser priority.

112. You are caring for several patients on a busy step-down unit. You are changing a patient's sacral decubitus dressing when an nursing assistant comes to tell you that the pharmacy has just delivered the lasix to be given IV for another patient experiencing dyspnea secondary to CHF. What is the most appropriate action?

1. Ask the nurse aide to find someone else to give the lasix.
2. Slap on a piece of the old dressing on the patient with whom you're currently working and go and give the lasix.
3. Quickly cleanse the decubitus per procedure; apply wet-dry packing as ordered, and ask the nursing assistant to tape down the edges.
4. Finish the dressing, redress the patient, and ambulate to the bathroom per patient's request. When finished with this patient, go and check on the lasix and the other patient.

(3) The appropriate priority in this situation is to finish the immediate task in an adequate manner, and then quickly move to the care of the patient who is symptomatic needing intervention. To ask the nurse's aid to find someone else would involve a time delay; perhaps take even more time in responding to the patient as another nurse would need to stop and assess to understand the situation in order to intervene appropriately. Completing care on the current patient including assisting with toileting is not appropriate and could be putting the patient with dyspnea symptoms at risk.

113. Following change of shift report, you analyze your information and set priorities according. When a plan has been determined, at what point during the shift can or should your plan be altered or modified?

1. halfway through the shift
2. at the end of the shift before reporting off
3. at any given moment
4. after your "top priority" tasks have been completed

(3) After priorities are established, as a nurse you need to realize that they might change at any given point in time.

114. All of the following factors may influence a nurse's change of priorities except:

1. a change in patient status.
2. a physician making rounds who writes new orders.
3. a family member with concerns and questions.
4. a personal call about after work activities.

(4) There are a multitude of factors that could influence priority setting at any given moment. using good time management principles. Factors to be acknowledged should be patient care centered only.

115. The nurse uses priorities to determine all of the following except:

1. time allotment for certain tasks.
2. appropriate interventions.
3. treatment procedures.
4. the need for patient education.

(3) Treatment procedures are standards of care as defined by the facility or nursing unit. If a treatment is indicated, the nurse is obligated to follow the established procedure in order to be compliant with practice standards. Established priorities will contribute to the determination of time management, appropriate interventions, and the need for patient education as a potential intervention.

116. Priorities to be considered "intermediate" are:

1. the nonemergency, nonlife-threatening needs of the patient.
2. those tasks that can be delegated to assistive personnel.
3. those tasks that can be done at the end of the shift.
4. those task that can be done at any time.

(1) Priorities designated as "intermediate" by the nurse are those that are nonurgent. They do not affect the patient's immediate physiological status. That does not imply that they are not important or not necessary. Intermediate priorities may still require the skill level of the RN for completion. There may be specific time requirement for completion as well.

117. Of the tasks listed, which would be considered an intermediate priority?

1. a patient post-extubation that O_2 stats are ranging from 83–88 percent
2. a post-op patient with a colon resection whose wound dehisced
3. an elderly patient with chronic diarrhea for three weeks
4. a patient that pulled out her central line and is bleeding

(3) The elderly patient with chronic diarrhea for three weeks would be categorized an intermediate priority in the context of the other answer choices. The diarrhea needs to be addressed as it is a significant problem with potential risks and negative consequences; however, the other situations would command high-priority attention.

118. An 85-year-old female resident (Mrs. A) who has Alzheimer's disease is extremely upset because she can't find her clothes. She comes to the nurse's station in tears, hyperventilating and shaking. You are in the midst of assessing and treating another resident (Mr. B) with COPD, who is having breathing problems, and you are in the process of setting up oxygen therapy ordered and a nebulizer treatment with albuterol. What becomes your immediate top priority?

1. Stay focused on treating Mr. B.
2. Set aside the respiratory treatments and go and help Mrs. A find her clothes.
3. Explain to Mrs. A that her clothes are not missing.
4. Ask a nursing assistant passing by in the hallway to assist Mrs. A and focus on the treatments ordered for Mr. B.

(4) Your nursing priority in this case should be dealing with Mr. B who is physiologically unstable. However, Mrs. B's psychological distress should not be considered less important. Delegating the task of providing assistance to Mrs. A to the nursing assistant will help to meet her immediate needs for attention and buy some time for you to address Mr. B's problem.

119. A low-priority patient concern:

1. is one that is optional to address.
2. is the priority problem for the patient, not the nurse.
3. needs that may not be related to a specific illness or problem being treated.
4. is one that is not important in the overall quality of patient care.

(3) The nurse has an obligation to assist a patient in meeting their needs. Low-priority concern may still be significant in the overall picture and deserve the nurse's attention at some point.

120. An important aspect to consider when dealing with a low-priority concern is:

1. the patient's agreement that it is a low priority as well.
2. cost-benefit.
3. available resources.
4. all of the above.

(4) All aspects should be considered in dealing with a patient's concern that is considered a low priority.

121. The nursing diagnosis "risk for infection" related to a 50–pack-per-year history of smoking would be considered:

1. a low priority.
2. an intermediate priority.
3. a high priority.
4. priority decision depends on the care setting.

(1) This would be considered a low priority as it reflects the client's long-term health needs.

122. According to the ANA Code for Nursing, professional nurses have an ethical obligation to:

1. clients (patients).
2. profession of nursing.
3. provide high quality care.
4. all of the above.

(4) Quality of care, professional standards, and patient-centered care are all elements of the ANA Ethical Code for Nurses.

123. The ethical principle of keeping professional promises or obligations is:

1. veracity.
2. autonomy.
3. fidelity.
4. beneficence.

(3) The ethical principle of veracity is truth telling. Autonomy is patient self-determination (that is, patients making their own decision). Beneficence is the principle of "doing good," which is a foundation of nursing care.

124. Issues addressed in ethics committees include all of the following except:

1. nonpayment of bills.
2. euthanasia.
3. starting or stopping treatment.
4. use of feeding tubes.

(1) Ethics committees do not deal with financial matters of payment. Euthanasia, stating or stopping treatment, and the use of feeding tubes to maintain nutritional status are topics within the ethical scope of the committee's function.

125. The ethical principle of nonmaleficience is:

1. doing good.
2. freedom of choice.
3. do no harm.
4. truth telling.

(3) Nonmaleficience is the ethical principle of "doing no harm," which the main concept of medicine's Hippocratic Oath. The ethical principle of beneficence is "doing good." Freedom of choice is patient autonomy. Veracity is truth telling.

126. The purpose of ethics committees is to:

1. have legal authority.
2. satisfy JCAHO requirement of all hospitals.
3. provide education and guide policy making regarding clinical issues.
4. provide healthcare personnel with legal protection from lawsuits.

(3) Ethics committees are formed in order to provide a resource to patients, families, and staff. They are not a requirement of JCAHO; many small hospitals do not have them. Committee work/decisions are presented as recommendations and are not considered "law." Their purpose does not include determination of innocence versus guilt; thus, their action does not imply legal protection.

127. An ethical dilemma is one in which:

1. there is a clear-cut treatment decision.
2. there is no duty to provide care or treatment.
3. a problem exists in decision making because there is no right or wrong choice.
4. all involved parties agree on actions to be taken.

(3) An ethical dilemma is one in which there is no clear-cut treatment decision or there is disagreement about the course of action to take. There is usually a clear duty to provide care, but the type of care is under contention.

128. Withdrawal of medical care includes:

1. withdrawal of comfort care.
2. withdrawal of nursing care.
3. withdrawal of socialization.
4. withdrawal of curative treatment.

(4) Cure is no longer a goal of therapy when the decision has been made to withdraw treatment. A discussion of potential outcomes will have been part of the discussion leading to the decision of withdrawing care. Choices 1, 2, and 3 are incorrect. Nursing care, socialization, and comfort continue to be mechanisms to provide quality end-of-life care.

129. Nursing qualities described in ANA code of ethics include all of the following except:

1. maintenance of competence.
2. providing care with respect for privacy and dignity.
3. collaborating with colleagues to meet public health need.
4. care for patients without professional boundaries.

(4) The code of ethics supports all of these aspects of professional nursing and delineates the practice of nursing within the profession.

130. Types of patient care scenarios in which ethical dilemmas arise include all of the following except:

1. technology versus cost.
2. withholding food and fluids.
3. private room versus patient's preference.
4. right to die at home versus remaining in the hospital.

(3) Ethical dilemmas occur when there is conflict resulting in two conflicting choices that have major consequences. A private room for convenience does not meet this definition.

131. The term *ethics* has no simple definition but encompasses:

1. human relationships with others.
2. establishing norms/standards for conduct.
3. moral judgment.
4. all of the above.

(4) The definition of ethics includes all of these elements.

132. At the end of the shift, you and a co-worker ride down the elevator discussing your challenging shift's events. Which of the following ethical principles did you both breach?

1. HIPPA
2. confidentiality
3. fidelity
4. beneficence

(2) Confidentiality is a patient right that nurses are bound to honor according to ethical codes. HIPPA is a law that mandates protection of personal information. Fidelity is the ethical principle of keeping promises. Beneficence is the ethical principle to do good for others.

133. A patient with massive chest and head injuries is admitted to the ICU from the ER. You know that all of the following are true except:

1. a declaration of wishes or documentation of wishes regarding organ donation by the donor is not necessary for organ harvesting.
2. the physician in charge of the case is the only person allowed to decide whether organ donation will occur.
3. only the patient's legally responsible party may make the decision for organ donation for the donor if the patient is unable to do so.
4. the organ procurement organization is involved in the decision regarding which organs to harvest.

(2) The donor or legally responsible party for the donor, the physician, and the organ procurement organization are all involved in the decision regarding whether organ donation is appropriate for a specific donor.

134. Because I carry a donor card for organ donation, I know that:

1. my medical care will be altered if I have serious injuries in order to get my organs for donation.
2. my family and legally responsible party will have no decision-making authority in the event that I am considered as an organ donor.
3. I am allowed to revoke my decision for organ donation at any time.
4. I will be considered as an organ donor for only one organ or tissue.

(3) Revocation of the decision for organ donation may occur at any time, by either the patient or responsible party. When organ donation is considered, as many organs as the donor wished to donate are considered and accepted for donation if found appropriate. Medical care for an individual during immediate care and/or resuscitation are not altered in order to declare a patient dead and ready for organ donation.

135. You are the ICU nurse caring for a patient who has just been declared brain dead. You know that one place you might find evidence of the patient's wishes regarding organ donation is:

1. on the driver's license of the patient.
2. in the patient's safety deposit box.
3. in the patient's last will and testament.
4. on the patient's insurance company card.

(1) In most states, indication of organ donor status is found on the driver's license. Evidence in a last will and testament or in a safety deposit box would not be readily accessible for decision making if the need arose. Insurance company cards do not contain such information. Another source might be the patient's primary care physician's health record documentation.

136. Transplantation of organs occurs:

1. between donor and recipient of the same sex only.
2. 24 hours a day, 7 days a week.
3. with the consent of the physician only.
4. only in the United States and Canada.

(2) Donors and recipients are not matched for age, sex, or race. All donations must be with the consent of the donor and/or the legally responsible party for the donor. Transplantation is done all over the world, 24 hours a day, 7 days a week, whenever organs are available.

137. Transplantation of organs in the United States:

1. is commonly done as a means to make money for a donor.
2. is organized for single tissue donation only.
3. is not accepted by most adult Americans.
4. is organized into a national waiting list with state affiliates acting as area organ procurement organizations.

(4) Organ donation in the United States is nationally organized with state affiliates acting as the organ procurement organizations in their respective areas. Organ donation in the United States is not done for monetary gain and includes both organ and tissue donations. More than 85 percent of adult Americans approve of organ donation.

138. Organ and tissue donation currently includes in the United States:

1. tissue donation of eyes, skin, and heart valves only.
2. donation of bone marrow between donor and recipient only.
3. organ donation of intestines, stomach, liver, and pancreas.
4. organ donation of heart, lungs, pancreas, liver, kidney, and intestines.

(4) Organs that may be transplanted include heart, kidney, pancreas, lungs, liver, and intestines. Tissues that may be transplanted include cornea, skin, bone marrow, heart valves, and connective tissue.

139. The role of the nurse in the care of a potential organ donor involves all of the following except:

1. resuscitation of patients who have expressed the desire of organ donation should the situation arise.
2. facilitating decision making in families and responsible parties of potential donors.
3. focusing the goals of care to encourage recipient-donor communication.
4. assistance in coordinating educational and counseling efforts for potential donor families.

(3) Communication among donors and/or their families and responsible parties with recipients of organ donation is not encouraged in order to protect the privacy and confidentiality of the donor. Potential donors who have organs for donation must be resuscitated in the event of death in order to procure viable organs for donation. Education, facilitation of decision making, and provision of counseling are all appropriate interventions for the nurse.

140. As a nurse working in home care with kidney failure patients, you know:

1. fourteen persons die each day waiting for an organ transplant.
2. more than two-thirds of the persons awaiting organ transplantation in the United States await liver transplants.
3. one in four persons awaiting a kidney transplant will receive the needed organ.
4. in 2003, more than 100,000 organ donations occurred in the United States.

(3) Only one-fourth of the almost 60,000 persons awaiting kidney transplants in 2004 will receive the needed organ donation, and two-thirds of those awaiting transplants are awaiting kidneys. Seventeen persons die daily awaiting transplants. In 2003, only 25,460 individuals received organ donations nationally.

141. A 77-year-old man suffers a traumatic CVA and is determined to be brain dead. He is currently on life support, and the physicians are preparing to talk with his wife and family about their findings. As the patient's nurse, you:

1. follow your agency protocol for notifying the organ procurement organization, which is mandated by federal law.
2. call the counselor or chaplain to be with the team when the physicians talk with the family.
3. make sure that all current documentation of the patient's status is on the chart for the organ procurement representative to evaluate when needed.
4. all of the above.

(4) The nurse is the first link in notification of the organ procurement organization for mandatory reporting by federal law. All result reporting and appropriate documents should be available to the organ procurement representatives for their timely evaluation. Support of the family at the time of the discussion of death is important in helping to answer questions and support of the grieving process.

142. You are caring for a 78-year-old Chinese man with heart disease who desires to be an organ donor. He is not a U.S. citizen, but has completed organ donation documentation, and his family is supportive of his decision. He suffers a massive myocardial infarction and requires resuscitation but does not recover. You know that all of the following are true except:

1. organ donation is possible after resuscitation if the resuscitation efforts are continued until harvesting of the organs can occur.
2. nonresident aliens may donate and receive organs in the United States.
3. up to 5 percent of the organs transplanted in a transplant center may be from other countries.
4. donation of organs by non-resident aliens will be for other nonresident alien recipients only.

(4) In a resuscitation effort, organ donation is possible as long as the organs are maintained as viable until harvesting. Non-resident aliens may be organ donors in the United States, and their organs may be used according to medical need and not only for other non-resident aliens. The policies of the Organ Procurement and Transplantation Network, which oversees international organ donation and transplantation, allow up to 5 percent of the recipients at a transplant center to be from other countries.

143. You are caring for a multiple trauma victim in the ICU who has just been evaluated as brain dead. You know:

1. most religions approve of organ donation as an act of charity.
2. the age of the donor will determine whether organs may be donated or not.
3. organ donation will disfigure the body and alter funeral arrangements such as arrangements for an open casket funeral.
4. many religions prohibit organ donation.

(1) Most religions do not prohibit organ donation, and view it as an act of compassion and charity. Age is not a determinant of organ donation ability. Organ donation does not disfigure the body for viewing at the funeral.

144. The following individuals may legally give informed consent:

1. Mr. C, an 86 year old with advanced Alzheimer's disease.
2. a 14-year-old girl, who is *not* an emancipated minor, needing an appendectomy.
3. a 72-year-old female scheduled for a heart transplant.
4. a 6-month-old baby needing bowel surgery.

(3) The 72 year old scheduled for heart transplant surgery may give informed consent for the surgery. There are no age limitations with the exception of minors. An individual with advanced Alzheimer's disease is incompetent to make decisions. Only an emancipated minor may give consent (a 14 year old who lives alone away from family and is totally independent).

145. Which of the following factors could impact an individual's ability to give informed consent?

1. IQ
2. educational level
3. pain medications
4. financial status

(3) Pain medications might alter alertness, thought processes, and reactions. It is recommended that a client be approached for consent at least 4 hours after the last dose of pain medicine to allow minimal impact. IQ and educational level might have a bearing on how information is presented through the discussion process but do not have a bearing on informed consent decision making.

146. The only time that an individual may receive medical care without giving informed consent is:

1. when the Durable Power at Attorney for Healthcare is not available.
2. in an emergency life or death situation.
3. when the physician is not available for discussion with the client.
4. when they (clients) are not able to speak for themselves.

(2) Treatment may be given without consent in a life-threatening situation. All attempts to notify a Durable Power of Attorney for Healthcare will be made. If not available, the physician assumes responsibility for treatment within facility protocol. The physician is obligated to have a discussion with the client in all nonlife-threatening situations. If clients are not able to speak for themselves, their Power of Attorney for Healthcare or responsible party is involved in the consent process.

147. Informed consent:

1. is always verbally obtained.
2. must be obtained in writing only.
3. includes an explanation of the intended procedure.
4. includes an explanation of the procedure, and the client must understand the potential outcome including harmful results.

(4) The process of obtaining informed consent includes a discussion of the procedure and possible consequences. Informed consent may be obtained verbally, in writing, or be implied.

148. Implied consent is a type of informed consent in which:

1. a client has listened to an explanation of a specific procedure and has agreed to allow the procedure to be carried out.
2. a client has listened to an explanation of a procedure and states that he will sign a consent form in 24 hours.
3. a client agrees with the goals of care and, thus, agrees to any/all treatments that will help accomplish those goals.
4. only a client having surgery requires.

(1) Implied consent is obtained for routine procedures—many of which are nursing—for example blood pressure monitoring, finger stick glucose monitoring, and dressing changes. Consent is informally expressed by the client as they are in acceptance of the procedure taking place. There is no specific formal documentation. Surgical procedures require formal, documented informed consent.

149. Key component activities of informed consent are:

1. discussion with the physician regarding risks, benefits, and possible outcomes of the procedure and witness to signature.
2. client reading pre-op brochure and witness to signature.
3. explanation of what is to be done.
4. the nurse signing the consent form with the client and completing the pre-op checklist.

(1) Key activities are both obtaining the consent through a discussion process and witnessing consent as described. Obtaining consent must be done personally. Supplemental teaching aids may be used to reinforce or elaborate important points but cannot take the place of personal explanation.

150. Mrs. Ruff is having gastric surgery in the morning. Obtaining her consent for the surgery is the role of:

1. the nurse taking care of the patient.
2. the operating room staff.
3. the primary care physician.
4. the surgeon.

(4) The surgeon is responsible for the explanation of what is to be done and the risks of the procedure to that client, along with alternative procedures and probable outcomes. The nurse taking care of the patient can clarify, define a medical term, or add more details to the physician's initial information, usually expanding on the corresponding nursing care. The operating room staff does not have a role in the consent process, nor does the primary care physician.

151. Obtaining consent is not a nursing function because:

1. the nurse may not know the exact methods the surgeon will use.
2. it is not considered nursing care.
3. nurses' knowledge and scope of practice are limited.
4. the physicians like to be in charge.

(3) Nursing is not trained or licensed to practice medicine. Only the physician can accurately explain what will be done and the risks of the procedure along with alternatives and probable outcomes.

152. Witnessing consent:

1. requires two signatures.
2. must be done by an RN.
3. has no age specifications or limitations.
4. implies that you have observed the client personally signing the consent form with no coercion.

(4) Signing witness to a consent implies willing signature of the client. Only one signature is required as a witness. The witness does not have to be an RN. A witness is required to be over the age of 18.

153. All of the following are myths regarding informed consent except:

1. informed consent is designed primarily to protect the legal interests of the medical staff.
2. the most important part of the informed consent process is signing the form.
3. after the consent is signed, the client is committed to the procedure.
4. no one, not even medical experts, can predict whether a treatment, screening, prevention, or supportive care method will prove successful. The informed consent process is designed to support the individual's best choice for themselves.

(4) Regardless of expertise, there is never a certainty regarding outcomes because of the uniqueness of the client's holistic health state. Each person must assimilate the information and make the best choice for themselves. Informed consent is designed to protect the client or consumer of healthcare. The most important part of the informed consent process is the discussion that occurs between the provider of care and the client. Informed consents are revocable at any time for any reason.

154. Once signed, informed consents are legally valid:

1. as defined by facility policy.
2. for one year.
3. until discharge.
4. for 30 days.

(1) Facility policy addresses this most usually with a policy statement that indicates that the consent is valid as long as all the circumstances are the same. If a client's status should change, for example, thus changing the risks, a new informed consent would need to be obtained.

155. A wrong committed by a person against another person or his or her property, which generally results in a civil trial is:

1. a tort.
2. a crime.
3. a misdemeanor.
4. a felony.

(1) Torts are common patient offenses. A crime is also defined as a wrong against a person or his or her property, considered to be against the public as well. Misdemeanors are crimes that are commonly punishable with fines or imprisonment for less than 1 year, with both, or with parole. A felony is a serious crime punishable by imprisonment in a state or federal penitentiary for more than 1 year.

156. There are many types of torts that can be committed against patients. They include all of the following except:

1. assault.
2. battery.
3. negligence.
4. felonies.

(4) Felonies are serious crimes punishable by time imprisoned. Types of torts are: assault, battery, and negligence in addition to slander, invasion of privacy, false imprisonment, and fraud.

157. The acts enacted by states to provide immunity from liability to persons who provide emergency care at an accident scene are called:

1. Good Samaritan.
2. HIPPA.
3. Patient Self Determination Act (PSDA).
4. OBRA.

(1) The Good Samaritan Laws protect providers of care in an emergency situation. HIPPA's focus is confidentiality of information and right to privacy. The PSDA concerns a patient's autonomous decision making. OBRA was passed in the late 1980s to promote nursing home reform due to quality issues.

158. What type of tort is committed when a nurse is intentionally physically rough with a resident in the nursing home following the patient's fifth incontinent episode during the morning?

1. slander
2. battery
3. fraud
4. negligence

(2) The nurse is guilty of battery, which is legally defined as touching someone without consent. Slander is verbalizing a false statement about another that harms their reputation. Fraud is misrepresentation of the truth. Negligence is a careless act of omission or commission that results in injury to another.

159. Malpractice is:

1. the improper performance of professional duties that results in injury to another.
2. a type of documentation.
3. advice given to a neighbor.
4. care given to a patient that results in a positive clinical outcome.

(1) Malpractice contains the four elements of duty, breach of duty, standard of practice, and negative outcomes or damages.

160. Which of the following is the federal law that requires hospitals to request patients for advance directives?

1. PSDA
2. HIPPA
3. Social Security Act
4. TEFRA

(1) HIPPA is a recent legislation designed to mandate protection of patient information and right to privacy. The Social Security Act was set up to establish national and state health insurance programs for certain segments of the population (Medicare and Medicaid). TEFRA was a law in the early 1980s that set up prospective reimbursement based on DRGs.

161. A nurse is required by law to report to designated authorities all of the following except:

1. child abuse.
2. older adult abuse.
3. certain communicable diseases.
4. suspected negligence of a colleague.

(4) The law does mandate that a nurse report child abuse to Children's Services; older adult abuse to Adult Protective Services; and communicable diseases to the Center for Disease Control (CDC). Suspected negligence of a colleague is not in the realm of mandatory reporting to authorities, but the nurse should discuss with the supervisor.

162. Mr. T is taking HCTZ. His blood pressure is 92/64. Based on this reading the nurse should:

1. give the medication as ordered.
2. hold the medication and call the physician for further direction.
3. give the patient the choice on whether or not to take the medication.
4. discontinue the medication based on nursing judgment.

(2) The correct response is to hold the medication and notify the physician for his/her awareness and further direction. The other responses are inappropriate and wrong according to nursing practice guidelines.

163. The physician writes an order that the nurse recognizes as not making sense in the patient's care plan. The nurse should:

1. follow the order as written.
2. disregard the order.
3. not complete the order and document the reason in the patient's chart.
4. notify the supervisor per facility protocol and contact the physician to discuss concerns.

(4) If a nurse disagrees with an order written by a physician, he/she is obligated to notify the physician to discuss concern. The nurse should also let the immediate nursing supervisor know of his/her actions. A nurse should always use her nursing judgment and not follow orders that he/she doesn't understand or believe to be in the best interest of the patient. The nurse is not in a position to independently choose to ignore the order without further follow through.

164. You are helping the charge nurse pass medication when Mrs. C asks for a pain pill. Going to the narcotic box, you find a discrepancy in the number of pills remaining versus the documentation on the narcotic sheet. Your appropriate action is to:

1. give Mrs. C the pill and document later.
2. immediately report the discrepancy to the nursing supervisor/designee per facility protocol.
3. document your best guess as to who/when the medication was given.
4. tell Mrs. C she can't have her pill now.

(2) A discrepancy of the narcotic count, if not easily resolved at the time of discovery, should be reported to the nursing supervisor as guided by facility policy. From that point, his/her direction should be followed. It is incorrect to administer the medication and document later. The patient should not be denied care. Accounting for narcotic or scheduled medication doses is a serious concern that should not be handled by a best guess.

165. The statute of limitations is a time limit:

1. not used in healthcare malpractice games.
2. in which a lawsuit may be filed for court action.
3. that is 5 years or 60 months from the date of occurrence.
4. that applies to physicians only.

(2) The statute of limitations as established by state law is the period of time following an incident that a lawsuit may be filed. It applies to all healthcare providers.

166. A 45-year-old Type 1 diabetic is in need of support services upon discharge from skilled rehabilitation. Which of the following is an example of such a service?

1. shopping for groceries
2. house cleaning
3. transportation to physician's visits
4. medication instruction

(4) Grocery shopping, house cleaning, and transportation services are all examples of nonskilled services offered by volunteer and fee-for-service agencies. The only skilled service listed is medication instruction.

167. Referral for patient education in the community may be accomplished through all of the following except:

1. community agencies such as the American Heart Association.
2. parish nurses.
3. home healthcare agencies.
4. unlicensed massage therapist.

(4) Patient education should be completed by an individual or individuals with acknowledged expertise in the subject area and credentials to support activity within the healthcare community.

168. Your 85-year-old client is eligible for Medicare-reimbursable home care services. Referral is contingent upon meeting which of the following criteria?

1. is homebound and requires skilled therapy care
2. immediate previous hospitalization for acute care
3. age
4. requires nursing and social work support

(1) The requirements for Medicare-reimbursable home care services include that the client is homebound and must require a skilled service such as PT/OT/ST/nursing/social work.

169. You have been assigned to Mrs. Jacobs as her home care nursing case manager upon her discharge from the hospital. Your role includes:

1. following the plan of care as relayed from the hospital.
2. independently collaborating with and directing other healthcare team members.
3. following the direction of the physical therapist who is the team leader for Mrs. Jacobs.
4. saving the client money by buying supplies in case lots.

(2) The role of the home care nursing case manager is to independently assess the needs of the client, collaborate with the team in planning for and implementing care strategies, and direct and evaluate strategies to meet the team goals.

170. The challenges of community case management include all of the following except:

1. limited caseload due to shifting care environments to long-term care.
2. obtaining funding for client needs in the community.
3. coordinating multiple services and providers in a timely manner.
4. maintaining service provision with limited staffing alternatives.

(1) The challenges of community case management include obtaining funding, timely coordination of services, and the availability of qualified staff to deliver care. Case loads are actually shifting toward the community and away from inpatient and long-term care settings.

171. Referrals for community-based skilled care:

1. are not necessary for skilled care.
2. must be written by a physician.
3. are not specific to an agency or type of skilled service.
4. may be completed at the completion of the skilled service.

(2) A referral for skilled care in a community-based agency is required to be completed by a physician prior to the start of services and have specific direction for the skilled service to be provided.

172. In community case management, the role of the nurse as a case manager is:

1. to follow through with care as defined by the physician.
2. as a provider of direct patient care.
3. to collaborate with the physician for needed medical interventions.
4. to complete insurance forms.

(3) In community case management, the nurse case manager is an indirect provider of care responsible for assessing, coordinating, implementing, and evaluating the care of the client. She/he collaborates with the physician and care team to meet the client goals.

173. The nurse discharge planner in your acute care hospital has made arrangements for the discharge of your patient to a long-term care facility based on the patient's needs and wishes. Your responsibility as the nurse caring for the patient includes:

1. notification of the patient's insurance agency of the impending discharge.
2. completion of the acute care agency's referral forms prior to the patient's discharge.
3. calling the patient's pharmacy for the delivery of medications to the home.
4. notification of the primary care physician of the patient's discharge.

(2) The nurses caring for the patient are not responsible for insurance or primary care physician notification of a patient's discharge from acute care. You are responsible for the completion of documentation between the acute care agency and the agency referred to for continuity of care. Pharmacy notification for medication delivery to home is not required at this time because the patient is not going home now.

174. Your patient has end-stage colorectal cancer and is going home to die. Referral to which agency is the most appropriate?

1. hospice
2. home care
3. physical therapy
4. respite care

(1) Hospice referral is appropriate for terminally ill patients who require assistance at home. Some home care agencies may provide these services if no hospice is available. Respite care is care of a patient so that the caregiver may complete other functions or take a break from providing care, usually provided by an unlicensed attendant. Skilled physical therapy is not a priority usually at this stage in terminal care.

175. Which of the following are sources for the completion of referrals for continuity of care?

1. skilled therapy notes
2. nursing assessments
3. physician orders
4. all of the above

(4) Sources of information for completion of continuity of care referrals include the patient, the chart notes from various providers, assessments and evaluation of need for the patient, and the specific orders of the physician.

176. Which of the following information provided to the patient prior to discharge might decrease their anxiety about referral to a community home care agency?

1. the contact person's name and phone number in the community home care agency that will be providing care
2. the date and time of the first expected visit from the agency
3. written instructions regarding the care the patient should expect to receive from the home care agency
4. all of the above

(4) All specific contact information for both the discharging agency and the agency to which the patient is being referred should be given to the patient so that they may contact the agencies if needed. An expected appointment date for the home care agency to first visit the patient helps to establish continuity between the agencies.

177. The greatest time savers are all of the following except:

1. reacting to the crisis of the moment.
2. setting goals.
3. planning.
4. specifying priorities.

(1) The greatest time savers are those things that encourage focus and completion of priority items for patient care. These include setting goals and priorities, planning work, delegating where appropriate, and reassessment and evaluation of needs as the plan is enacted.

178. Delegation of tasks to appropriate personnel allows the nurse to:

1. take a break.
2. keep other members of the team productive.
3. maintain tight control of all aspects of the workflow.
4. realize the importance of her role by making all decisions.

(2) Maintaining the productivity of all team members by delegating tasks appropriate to the job descriptions of the personnel increases work effectiveness and efficiency.

179. In order to manage time most effectively, the nurse responds to urgency expressed by:

1. the physician's loud verbal direction.
2. the nursing supervisor who is going to a meeting.
3. unit staff leaving on a break.
4. the care needs of the returning post-operative patient just exiting the elevator.

(4) Although many environmental stimuli may compete for attention and time, the patient care needs of complex or unstable patients and those requiring assessment and care must take priority.

180. Ineffective time management may lead to all of the following except:

1. nursing burnout.
2. perfection.
3. physical illness.
4. interference in relationships.

(2) Ineffective time management does not lead to perfection in either the personal or professional lives of nurses. However, it might lead to burnout in career, physical problems, psychological illness, and/or interference in relationships with others.

181. The realities of time management and multi-tasking in nursing require the nurse to possess skills in:

1. denial.
2. priority-setting.
3. avoidance.
4. dealing with guilt.

(2) In order to effectively deal with the current nursing world and the complex care delivery requirements of patient care, the nurse's ability to effectively set priorities is essential.

182. Time is:

1. an unlimited resource.
2. an ineffective resource.
3. a finite resource.
4. unmanageable.

(3) Time is a finite resource that must be managed effectively and efficiently in order to best meet the needs of the clients cared for by the nurse.

183. The best time manager:

1. utilizes an individualized approach to using time, best fitted to one's personal needs.
2. is the oldest nurse.
3. is the nurse with the most experience working on the unit.
4. uses the same priority plan each day.

(1) The best nurse time manager will use an approach to care delivery, which is individualized to fit the patient's needs, which fits his or her personal needs, and which realizes the integration of multiple competing duties in the completion of the plan. The most experienced or oldest nurse is not necessarily the best time manager.

184. "Monkies" are situations that come about as a result of our own failure to do a task right the first time. Ways to avoid "monkies" include all of the following except:

1. complete all of the work yourself.
2. utilize effective delegation.
3. match the right task to the right personnel for delegation.
4. complete task responsibilities instead of utilizing a fragmented approach.

(1) Avoidance of "monkies" includes effective delegation strategies and effective time management strategies such as task completion rather than fragmentation.

185. The outlook that avoidance of a task will allow the task to go away is:

1. denial.
2. procrastination.
3. priority-setting.
4. organization.

(2) Procrastination is the avoidance of a task by setting it back for completion later. It is not an effective method of organization or priority-setting and might set the nurse up for poor job performance outcomes.

186. Reasons for procrastination include all of the following except:

1. lack of knowledge or skill.
2. rear.
3. insubordination.
4. poor time management skills.

(3) Procrastination may be caused by lack of knowledge, poor time management skills, fear of the thing to be done, competing priorities, and overload.

187. In the upcoming decades, the number of persons requiring more complex healthcare will increase. As we face the limitations of finite fiscal resources, which of the following ethical issues will increase in urgency?

1. autonomy
2. beneficence
3. rationing of limited resources
4. fidelity

(3) The issue of the use of limited resources and correspondingly increasing healthcare needs will be one of the most controversial and critical issues in the upcoming decades.

188. Pitfalls and difficulties in supervision are all of the following except:

1. supervisor enjoys facilitating other's work.
2. supervisor engages in excessive supervision.
3. supervisor cannot reconcile the different way in which the individual does the task.
4. supervisor still wants to do it all.

(1) Facilitating the work of those being supervised is a significant goal of a supervisor. One who enjoys that aspect of supervision will have increased effectiveness. Excessive supervision, intolerance for individual style differences, and feeling the need or desire to personally perform the work will interfere with relationships and overall effectiveness.

189. Activities of effective supervisors can be task-related or people-related activities. An example of a task-related supervisory activity is:

1. coaching.
2. evaluating.
3. delegating.
4. facilitating.

(3) Delegating is the act (or task) of assigning work to those who are capable and competent to do the work. Coaching, evaluating, and facilitating are supervisory activities that are people related.

190. People-related supervisory tasks include all of the following except:

1. coaching.
2. encouraging.
3. target setting.
4. rewarding.

(3) Target setting is the projection of goals or objectives to be accomplished and is considered to be a task-centered supervisory responsibility. Coaching, evaluating, and facilitating are supervisory activities that are people related as they involve direct interaction with those doing the work.

191. In preparing the shift's assignment, the nurse is aware that the delegation and supervision of patient care tasks is legally defined by:

1. the state board of nursing.
2. the American Nurse's Association.
3. the AHA (American Hospital Association).
4. facility policy.

(1) Each state board of nursing is responsible for the nurse practice acts. Responsibilities for the various levels (RN and LPN) are defined, including delegation and supervision of patient care tasks. Neither the ANA nor AMA have a role. Facilities may set policies that are more limiting for staff working within their premises, but they may not extend responsibilities beyond the State defined practice acts.

192. A nurse supervising care given to a group of patients identifies which of the following as a measure of success?

1. patient care completed in a timely efficient manner with patients perceiving their needs have been met
2. being asked by the staff to participate in a social outing
3. lack of incidents during the shift
4. stability of the patients

(1) A nurse in a supervisory role is responsible for ensuring that care is given appropriately, as ordered with some degree of patient satisfaction. Supervising is not a popularity contest; at times the supervisor may need to portray authority. Lack of incidents per shift is one possible indicator that safety was maintained but is not as significant as answer choice one. The stability of the patients often cannot be controlled by a supervisor—changes occur dependent on the illness or disease.

193. It is a busy night in the ICU, which is short staffed due to ill calls. The house supervisor assigns a nurse from pediatrics to fill in. This nurse has never worked in a critical care unit. As the RN making assignments, you should assign which patient to this nurse?

1. an 72-year-old fresh post-op open heart surgery patient, who is having problems maintaining his blood pressure and has considerable chest tube drainage
2. a 63-year-old man, trached with COPD and pneumonia, who is on the vent for total support
3. a 56-year-old woman who 3 days ago had a partial gastrectomy and esophageal resection due to GI bleeding
4. the new admission yet to arrive on the unit from the ER with an admitting diagnosis of blunt trauma

(3) The 56-year-old 3-day post op patient is the best choice for the pediatric nurses assignment because this patient is probably the most stable, and her care involves aspects of care that are generally involved in any post-op patient regardless of age. The post-op open heart patient and the patient on the ventilator require more critical care skills. The new admission that hasn't even arrived on the unit is unknown as to care needs and stability; therefore, it would be optimal to have a critical care nurse assigned.

194. As the supervisor to the pediatric nurse who has been floated to help cover in the ICU, what would be your primary role in working with this nurse?

1. taking her to dinner with you
2. orienting her to the location of the unit's linens and supplies
3. helping her to pull a patient up in bed
4. reviewing her assignment with her and discussing her skills

(4) When communicating the patient assignment to the float pediatric nurse, as the supervisor the nurse should spend some time communicating expectations, discussing the unit, unit routines, and any background information about the patient(s) being assigned. Offering her company at mealtime would be a very nice gesture, but not a primary goal. Orienting her to the location of supplies would be a helpful gesture, but this could be delegated to an UAP. Assisting her with care (that is, pulling a patient up in bed), would be a good way to observe her interaction with patients as well as offering bedside support.

195. As the RN assigned to night shift on a general med-surg unit, one of the nursing assistants reports that they are concerned about one of the LPNs . The nursing assistant witnessed this LPN coming out of a strict isolation room with gowns, masks, and gloves still on. She went down the hall to the med cart, unlocked it to get something, and then stopped to chart. She proceeded to re-enter the patient's room and approach the bedside to continue care. The nursing assistant is worried that this LPN may be spreading infection. As a supervisor, you would:

1. do nothing. It is within the LPNs scope of practice to work with patients in isolation.
2. confront the LPN with the report to get her side of the story.
3. realize that this LPN has been newly hired from home care. Have a conversation with her, asking for her to clarify her understanding of isolation procedures.
4. thank the nursing assistant, and ask her to let you know if she sees the LPN do it again.

(3) Since many procedures in home care are not performed with strict sterility, it would be appropriate for the nurse to clarify the LPN's understanding of the concept of sterile technique as required by strict isolation. To ignore the aide's report would be to allow the problem behavior to potentially continue. If a knowledge deficit exists, then education and support is appropriate. Confrontation in this case would not be positive as it could become accusatory and have negative team effects. It is not appropriate to ask the nursing assistant to monitor the LNP's performance; that is the role of the supervisor.

196. The nurse is assigning the care of a patient with a Foley catheter to the unlicensed assistant (UAP or nursing assistant). Which of the following responsibilities cannot be delegated to the UAP?

1. routine catheter care
2. emptying the Foley bag at the end of the shift
3. reinserting the catheter if the patient pulls it out
4. securing the drainage tubing on the bed in order to avoid dependent loops

(3) A Foley catheter must be inserted by an RN or LPN. Routine catheter care, emptying the Foley drainage bag, and securing the tubing to maintain patency and prevent backflow can be safely delegated to the UAP.

197. An 80-year-old patient is scheduled for a colonoscopy. Which of the following pre-procedural activities would be appropriate for the nurse to delegate to the unlicensed assistant (UAP or nursing assistant)?

1. instructing the patient about the procedure
2. assisting the patient to the bathroom to ensure safety
3. obtaining the informed consent
4. discussing the potential diagnoses with the family

(2) It would be appropriate for the nurse to instruct the nursing assistant to assist the patient to the bathroom to promote safety and minimize fall potential. It is the responsibility of the physician performing the procedure to obtain the informed consent. It is the responsibility of the registered nurse to teach patients and families regarding the diagnosis and treatment plan. These responsibilities cannot be delegated to UAPs.

198. A nurse assigns a confused, older adult with a diagnosis of early dementia to a UAP. The nursing assistant states, “I will, but I’ve never taken care of anybody like that before.” Sensing the UAP’s discomfort, the role of the nurse in providing supervision is to:

1. ask the nursing assistant for a full report at the end of the shift.
2. tell the nursing assistant that the nurse will cover for dinner time.
3. go into the patient room with the nursing assistant for the first time and role model methods of communication with the patient as care is given.
4. assign the nursing assistant to another patient.

(3) The nurse must decide whether the nursing assistant has the skill set to take care of this patient. If she proceeds with the assignment the supervisor should take some time and discuss care strategies for this patient and offer the nursing assistant help. Role modeling communication techniques would be a helpful educational strategy. To reassign the patient would not give the nursing assistant the opportunity and experience for his/her growth.