Nursing Interventions and Clinical Skills 6th Edition Perry Test Bank
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MULTIPLE CHOICE

1. The nurse discovers a medication error on another nurse's documentation, so the nurse completes an incident report. Which statement should the nurse include in the report?
   a. "Nurse mistakenly gave the wrong dose of medication for pain."
   b. "Nurse gave incorrect dose of pain medication, but patient is all right."
   c. "Morphine 10 mg IM given rather than morphine 5 mg IM as ordered."
   d. "Physician will be notified of error when he makes rounds tomorrow."

   ANS: C
   Stating that the patient received morphine 10 mg instead of 5 mg is a factual statement to include on an incident report because it is objective and provides no interpretation or conjecture from the nurse. The remaining choices are incorrect statements that do not accurately reflect what occurred. The physician needs to be notified as soon as the patient has been assessed, not the following day.

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   OBJ: NCLEX: Safe and Effective Care TOP: Nursing Process: Implementation

2. The nurse is documenting the care of a patient. Which entry would be characteristic of charting by exception (CBE) as a documentation method?
   a. The patient needed to be turned every hour because of increasing pain.
   b. The patient's vital signs are stable.
   c. The patient's gait was steady with assistance from physical therapy.
   d. There was no odor when the dressing was removed.

   ANS: A
   CBE allows the nurse to specify exceptions to normal nursing assessments efficiently without documenting the normal assessment data and reducing the amount of narrative writing in patient documentation. The emphasis is on recording abnormal findings and trends in clinical care. It is a shorthand method for documenting based on defined standards for normal nursing assessments and interventions. CBE simply involves completing a flow sheet that incorporates these standards, thus minimizing the need for lengthy narrative notes. Increasing pain would not be expected and would be outside the "normal" or "expected."

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3. The nurse is documenting on a patient with a respiratory problem. Which patient datum documented by the nurse is the least objective?
   a. Cool and dusky skin
   b. Low flow rate oxygen
   c. 30 breaths per minute
   d. Very restless and drowsy

   ANS: B

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Low flow rate oxygen is the least objective datum and the datum most subject to interpretation because the quantity of oxygen is not as precise as "liters/minute" or the "percentage" of oxygen. The remaining options provide more verifiable data.

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4. The nurse runs into a co-worker whose family friend is a patient on the unit. The co-worker asks about the friend's health problems. Which is the correct response by the nurse?
   a. "Your friend told us to say nothing."
   b. "Why don't you ask your friend now?"
   c. "You know I can't talk about the patients."
   d. "Well, it was really a very difficult surgery."

   ANS: C
   The nurse can't talk about the co-worker's friend or acknowledge the friend's presence in the facility without breaching the friend's right to privacy, so the nurse reminds the co-worker about confidentiality.

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5. The nurse is providing home care for a patient with an infection that is not improving. The patient refuses to see an infectious disease specialist. What should the nurse include in the documentation of the patient teaching provided?
   a. The discussion about the consequences of refusing to see a specialist and the patient's response
   b. The explanation that avoiding the specialist will most likely lead to a terrible outcome
   c. A hopeful explanation that this will most likely be the last medical specialist that the patient will need to see
   d. The recommendation that the patient should discuss the decision with the family

   ANS: A
   The nurse documents the discussion about the consequences of refusing to see a specialist and the patient's response. Documenting the factual information presented about the risks of refusing treatment and the patient's specific response to it (continued refusal to seek a specialist) are key pieces of information to include. The nurse should neither try to scare the patient into seeing the specialist nor provide false hope that only one consultation will be required. As long as the patient is competent to make a decision, the nurse must accept his or her choice. It is a requirement to document the facts surrounding that choice.

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6. The nurse documents patient care using the SOAP format. Which should the nurse record under the "P" section?
   a. AM fasting serum glucose level at 122 mg/dL
   b. Patient states, "I am too tired to walk today."
   c. 2 cm–diameter open area on left lateral heel
   d. Check response to pain medication in 1 hour.

ANS: D
"P" in the SOAP format stands for "plan." Checking the response to pain medication is recorded at "P" because the plan is a future strategy for nursing care and the nurse chooses nursing interventions to accomplish the plan. Patient statements are subjective data recorded at "S." The serum glucose and the wound description are objective data, or facts, recorded at "O."

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7. At 9:15 AM the nurse repeatedly instructs the patient to remain in bed. At 9:30 the nurse enters the patient's room, finds the patient on the floor, and hears the patient say, "I need pain medicine." Which should the nurse do to document this event?
   a. Label the late entry using the time of 9:15 AM
   b. Enclose the patient statement within quotations
   c. Document completion of an incident report
   d. Record medication before its administration

   ANS: B
   The nurse encloses patient statements in quotations to indicate the patient's precise statement. Subjective information is documented using the patient's words in quotes. The nurse should document instructions given at 9:15 and verify any indications of patient comprehension. A second entry noted at 9:30 documents finding patient on floor.
   Completion of an incidence report is not documented in the patient record since it is an internal evaluation report. Administration of medication is only documented after it occurs to make sure that the documentation is accurate in terms of time and patient response.

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8. A nurse passes by a computer screen that has patient information that can be seen by visitors. What is the appropriate action for the nurse to take at this time?
   a. Leave the computer screen alone.
   b. Try to find the nurse caring for this patient.
   c. Document this situation on an incident report.
   d. Close the computer screen.

   ANS: D
   The nurse should minimize or close the computer screen so patient information cannot be seen by visitors. He or she should talk with the nurse caring for this patient about what happened. It happens frequently and can be prevented easily. All facility staff have a responsibility to maintain patient confidentiality and should not leave a computer displaying patient information open. Incident reports are only filed when a patient experiences an adverse event. This situation does not require an incident report.

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9. Nursing assistive personnel (NAP) finds a patient on the floor 30 minutes after the patient ambulated with physical therapy. What information should be charted by the NAP on the incident report?

a. “Patient fell out of bed and landed on the floor.”
b. “Patient found on floor. Upper side rails up. Bed in low position.”
c. “Patient got dizzy and fell although ambulated with physical therapy earlier.”
d. “Patient unfortunately slipped and fell.”

ANS: B
Documentation should state facts: “Patient found on floor. Upper side rails up. Bed in low position.” Only objective data with no interpretation can be documented by the NAP. The NAP does not evaluate the situation. Words such as “unfortunately” are never used in documentation. The NAP found the patient on the floor and did not see the patient slip and fall.

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10. An incident report is completed as a result of the pharmacy sending the wrong medication to the unit, even though the medication wasn’t administered. Why would the nurse initiate an incident report?
a. To make sure that the pharmacy was blamed for the error and not the nurse
b. To help the pharmacy identify risks and prevent this situation from occurring again
c. To prevent the hospital from a medical malpractice suit
d. To get the healthcare provider’s attention about ordering medications

ANS: B
The incident report is a risk management tool that enables healthcare providers to identify risks within an agency, analyze them, and act to reduce the risks and evaluate the results. This is also true when deviations from standards occur and not only when actual adverse events happen. Alerting the pharmacy to this type of error should help prevent it from occurring again. There was no problem with the healthcare provider’s order, only with how it was filled.

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11. The “PIE” format is used on the nursing unit. Which entry should the nurse place in the “E” part of the format?
a. Pain level 4/10 gnawing and constant.
b. Lung sounds clear bilaterally.
c. Patient states, “I don’t want the blood transfusion because of the problems I had before.”
d. Pain level 2/10 30 minutes after receiving pain medication.

ANS: D
In PIE, E stand for evaluation. “Pain level 2/10 30 minutes after receiving pain medication” is an evaluation based on an action taken in response to a problem. None of the other options are evaluation statements.

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12. The nursing staff has been using the SBAR format to structure communication for the past few months. Successful implementation of this system would be present if the nurse manager made which statement?

a. "There are fewer omissions in patient care than before implementing this system."
b. "Fewer nurses are coming in late when they are scheduled to work."
c. "The medications are given on time now."
d. "The patient length of stay has decreased since last year."

ANS: A
Noting fewer omissions in patient care would indicate successful implementation of the SBAR format. SBAR promotes the provision of safe, efficient, timely, and patient-centered communication. Staff timeliness, medication preparation, and length of patient stays are not affected by implementation of SBAR.

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13. The nursing staff is assisting nursing students in learning military time for documenting. Instruction by the nurses has been effective if the students identify that which entry reflects 40 minutes after midnight?
a. 0040
b. 1240
c. 0004
d. 0400

ANS: A
0040 is 12:40 AM. 1240 is 12:40 PM. 0004 is 12:04 AM. 0400 is 4:00 AM.

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14. The nursing staff is using a worksheet that contains information for change-of-shift report and facilitates access to information when referring to the patient's computerized record. Which document is the nursing staff using?
a. The graphic sheet
b. The nursing Kardex
c. The problem-oriented medical record
d. The Joint Commission standards

ANS: B
The nursing Kardex contains information for change-of-shift report and facilitates access to information when referring to the patient's computerized record. It is not part of the patient's permanent record and is often recorded in pencil so changes can be made to provide an updated status report of the patient. The graphic sheet contains places for frequently monitored situations done on a repeated basis such as vital signs, bathing, turning, and intake and output. The problem-oriented medical record is a method of organizing data by the patient problem or diagnosis. Each member of the healthcare team can document on the same problems and add new ones. The Joint Commission sets the standards for documentation of health care but has not developed a specific form for everyone to use.

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15. The following is an example of what part of the SBAR communication mnemonic?

"Her blood pressure has decreased from 140/90 to 100/50 and she vomited 400 mL of bright red blood."

a. S
b. A
c. R
d. B

ANS: A
This is an example of S-Situation—what is happening at the present time. Background (explain the circumstances leading up to the situation). Assessment (what you think the problem is). Recommendation (what you would do to correct the problem)

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MULTIPLE RESPONSE

1. Electronic health records (EHRs) can improve patient care. The following is an example of an alert in an EHR. *(Select all that apply.)*
   a. Notification of medication being overdue
   b. Change in patient's blood pressure that exceeds parameters
   c. Order entered for a medication the patient is allergic to
   d. Routine lab orders
   e. Critical lab value

   ANS: A, B, C, E
   Alerts in EHRs notify nurses of critical changes in data that affect patient care and can be used to help nurses prioritize care. Overdue medications, critical lab values, and medication allergies are some of the examples of standard alerts. Alerts can also be tailored to patients to monitor for changes in their vital signs above certain parameters. When electronic health record alerts are used in the nurse's practice, patient outcomes can be improved.

   DIF: Cognitive Level: Apply REF: Page 36
   OBJ: NCLEX: Safe and Effective Care TOP: Nursing Process: Evaluation

2. The Joint Commission standards require all patients admitted to a healthcare facility to have the following documented. *(Select all that apply.)*
   a. Self-care assessment
   b. Discharge planning needs
   c. Environment assessment
   d. Physical assessment
   e. Psychosocial assessment

   ANS: A, B, C, D, E
   Current TJC (2012) standards require that all patients who are admitted to a healthcare facility have an assessment of physical, psychosocial, environmental, self-care, patient education, and discharge planning needs.

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3. The following is an excerpt of a discharge planning note. What elements of discharge planning are present in this example? *(Select all that apply.)*
"Discussed learning about insulin injection technique. Patient will administer his own injection next time."
   a. Measurable patient goal
   b. Progress toward goal
   c. Need for referral
   d. Discharge date

   ANS: A, B
   The information within a recorded entry must be complete, containing appropriate and essential information. There are criteria for thorough communication for certain health situations. For example, when recording discharge planning, measurable patient goals or expected outcomes, progress toward goals, and need for referrals are always included.

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4. In a POMR charting method of documentation, which of the following items are used? *(Select all that apply.)*
   a. Progress notes
   b. Database
   c. Medical diagnosis
   d. Problem list
   e. Care plan

   ANS: A, B, D, E
   The problem-oriented medical record (POMR) is a structured method of documentation that emphasizes a patient's problems. It is organized using the nursing process. Organization of data is by problem or diagnosis. Ideally each member of the healthcare team contributes to a single list of identified patient problems. Each recording includes a database, problem list, care plan, and progress notes.

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