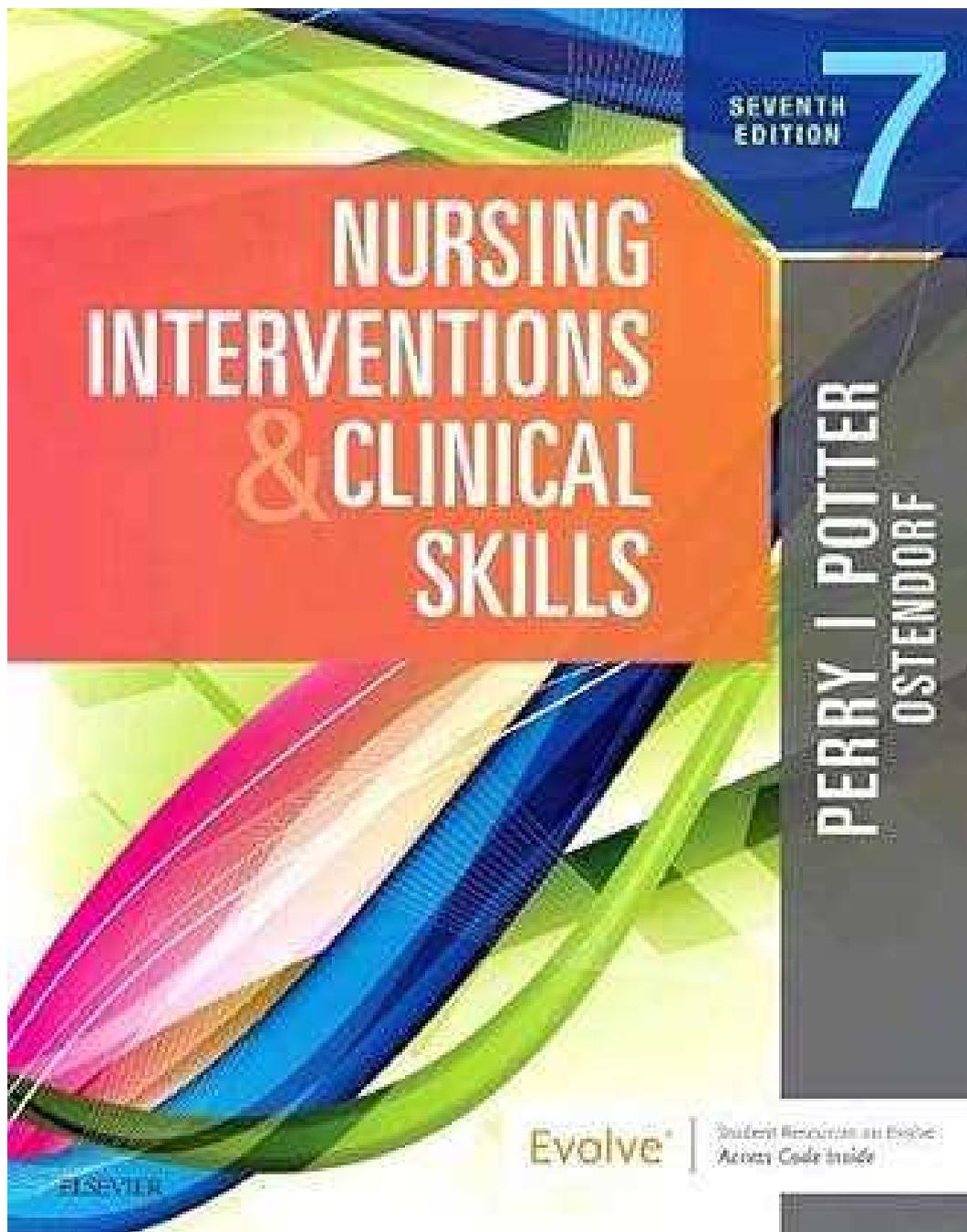


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# Nursing Interventions & Clinical Skills

Anne G. Perry, Patricia A. Potter, Wendy R. Ostendorf

7th Edition



# Table of Contents

## **Unit 1: Quality and Safety in Nursing Practice**

1. Using Evidence in Nursing Practice
2. Communication & Collaboration
3. Documentation and Informatics
4. Patient Safety & Quality Improvement
5. Infection Control
6. Disaster Preparedness

## **Unit 2: Patient Assessment Skills**

7. Vital Signs
8. Health Assessment
9. Specimen Collection
10. Diagnostic Procedures

## **Unit 3: Basic Human Needs**

11. Bathing and Personal Hygiene
12. Care of the Eye and Ear
13. Promoting Nutrition
14. Parenteral Nutrition
15. Pain Management
16. Promoting Oxygenation

## **Unit 4: Activity and Mobility**

17. Safe Patient Handling
18. Exercise, Mobility & Immobilization Devices

## **Unit 5: Promoting Elimination**

19. Urinary Elimination
20. Bowel Elimination
21. Ostomy Care

## **Unit 6: Medication Administration**

22. Preparation for Safe Medication Administration
23. Nonparenteral Medications
24. Parenteral Medications

## **Unit 7: Dressings and Wound Care**

25. Wound Care and Irrigation
26. Pressure Injury Prevention and Care
27. Dressings Bandages and Binders

## **Unit 8: Complex Nursing Interventions**

28. Intravenous Therapy
29. Pre-Operative and Post-Operative Care
30. Emergency Measures for Life Support

## **Unit 9: Supportive Nursing Interventions**

31. End-of-Life Care
32. Home Care Safety

## Chapter 01: Using Evidence in Nursing Practice

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#### MULTIPLE CHOICE

1. A nursing educator is explaining how the best clinical practices are determined. Which statement best explains the purpose of evidence-based practice?
  - a. It ensures that all patients receive holistic care.
  - b. It provides a definite reason for providing care in a specific manner.
  - c. It prevents errors when care is being delivered.
  - d. It guarantees that care delivered is based on research.

ANS: B

Evidence-based practice is the use of the current best evidence in making patient care decisions. It applies to all types of health care professionals. Currently there is no method that can ensure that all patients receive holistic care, that all errors can be prevented, or that a guarantee exists that care given is based on research.

DIF: Cognitive Level: Understanding      OBJ: NCLEX: Safe and Effective Care Environment  
TOP: Nursing Process: Implementation

2. Which question is a problem-focused trigger for initiating the evidence-based practice method in nursing care?
  - a. What is known about reduction of urinary tract infections in the older adult with diabetes?
  - b. How can chronic pain best be described when the patient is nonverbal?
  - c. How long can an IV catheter remain in place in a patient with obesity?
  - d. What measures can the nurse take to reduce the rising incidence of urinary tract infections on the older adult care unit?

ANS: D

Evidence-based practice (EBP) questions tend to arise from two sources: recurrent problems or new knowledge. In the correct option, the increase in urinary tract infections indicates a trend or recurring problem in a specific group of patients. The other questions are general information questions, not based on what is happening in a specific area or to a group of specific patients in an area or relating to an observed trend.

DIF: Cognitive Level: Applying      OBJ: NCLEX: Safe and Effective Care Environment  
TOP: Nursing Process: Implementation

3. What does the “I” indicate in a “PICO” question?
  - a. Intervention of interest
  - b. Incorporation of concepts
  - c. Implementation by nursing
  - d. Interest of personnel

ANS: A

The “I” stands for intervention of interest, meaning what the nurse hopes to use in practice and believes is worthwhile or valuable. This could be a treatment for a specific type of wound or an approach on how to teach food preparation for a patient with impaired sight.

DIF: Cognitive Level: Remembering      OBJ: NCLEX: Safe and Effective Care Environment  
TOP: Nursing Process: Implementation

4. Who will the clinical research nurse contact to search relevant databases in preparation for an upcoming study?
- The physician whose patients may be involved in the study
  - The medical librarian
  - The nurse manager of the unit where the study will be conducted
  - The director of nursing of the facility

ANS: B

The medical librarian is most knowledgeable regarding databases relevant to a study. The other individuals do not have the knowledge regarding relevant databases.

DIF: Cognitive Level: Understanding      OBJ: NCLEX: Safe and Effective Care Environment  
TOP: Nursing Process: Implementation

5. Which database contains summaries of clinical guidelines and their development?
- MEDLINE
  - CINAHL
  - Cochrane Database of Systematic Reviews
  - The National Guideline Clearinghouse

ANS: D

The National Guideline Clearinghouse is a database supported by the Agency for Healthcare Research and Quality. It contains summaries of clinical guidelines for practice. MEDLINE is a database for studies in medicine, nursing, dentistry, psychiatry, veterinary medicine, and allied health. CINAHL (Cumulative Index of Nursing and Allied Health Literature) includes studies in nursing, allied health, and biomedicine. The Cochrane Database Full text of regularly updated systematic reviews prepared by the Cochrane Collaboration includes completed reviews and protocols.

DIF: Cognitive Level: Remembering      OBJ: NCLEX: Safe and Effective Care Environment  
TOP: Nursing Process: Implementation

6. Which does the nurse researcher identify as the strongest type of research?
- Randomized controlled trials
  - A qualitative study
  - A descriptive study
  - A case controlled study

ANS: A

Individual randomized controlled trials are close to the top of the research pyramid. Only systematic reviews and meta-analyses are higher. This type of study tests an intervention against the usual standard of care. The other types of studies are useful but do not give the same type of information as a randomized controlled trial provides.

DIF: Cognitive Level: Remembering      OBJ: NCLEX: Safe and Effective Care Environment  
TOP: Nursing Process: Assessment

7. What is the nurse attempting to determine when critiquing the evidence related to a PICOT question?
- The ethical conduct of the research the nurse read
  - The strength of the evidence found in the literature
  - If there are any experts in the clinical question needing to be researched
  - If the study demonstrates cost-effectiveness if a change in practice occurs

ANS: B

Once a literature search is complete and data are gathered about the question, it is time to critique the evidence. Critiquing the evidence involves a systematic approach to looking at the strength of the work reviewed and its relevance. The other questions are not applicable to critiquing the evidence.

DIF: Cognitive Level: Understanding      OBJ: NCLEX: Safe and Effective Care Environment  
TOP: Nursing Process: Implementation

8. A nurse finds a cohort study comparing one group taking hormone treatment with another group not taking hormone treatment to determine the incidence of changes in bone density of the lower spine. What can the nurse imply from this study?
- Low level of strength makes the study limited in value.
  - Moderate level of strength makes the study probably useful.
  - Opinions of the individuals in the cohort are not research.
  - This could be the basis for a Quality Improvement project.

ANS: B

A cohort study is Level 4 evidence as it is a single, non-experimental study. This moderate level of evidence makes the study probably useful but the nurse should strive to find stronger evidence.

DIF: Cognitive Level: Applying      OBJ: NCLEX: Safe and Effective Care Environment  
TOP: Nursing Process: Evaluation

9. Which question would be the best example of a knowledge-focused trigger for conducting an evidence-based practice project?
- What is the best method for treatment of leg swelling when a patient is taking gabapentin (Neurontin)?
  - How can we decrease the incidence of skin cancer in adults over the age of 65?
  - What is the current evidence for improving oral intake for cancer patients with stomatitis?
  - What is the maximal length of time our hospital allows irrigation kits to be used?

ANS: C

Evidence-based practice (EBP) questions tend to arise from two sources: recurrent problems or new knowledge. In this example, the new knowledge that drives the question is the one looking at current evidence. The other questions do not look at the newest knowledge to form a question to research.

DIF: Cognitive Level: Analyzing      OBJ: NCLEX: Safe and Effective Care Environment  
TOP: Nursing Process: Implementation

## MULTIPLE RESPONSE

1. When planning to implement an evidence-based practice strategy, what factors are most important for the nurse to consider and include? (*Select all that apply.*)
  - a. Time required to perform the strategy
  - b. Patient preferences and values
  - c. Clinical expertise
  - d. Scientific knowledge
  - e. Historical practices

ANS: B, C, D

When implementing evidence-based practice, the nurse considers and includes clinical expertise and patient preferences and values in addition to the scientific knowledge. Time required to perform the new strategy and customary practices are not vital to this approach. In fact, EBP seeks to ensure practices are based on evidence and not just historical practice.

DIF: Cognitive Level: Remembering      OBJ: NCLEX: Safe and Effective Care Environment  
TOP: Nursing Process: Implementation

2. A new nurse wants to ensure practice is based on the best knowledge available. What actions are best for this nurse to be involved in evidence-based practice? (*Select all that apply.*)
  - a. Design and conduct a study based on interest.
  - b. Join the hospital's policy review committee.
  - c. Remain vigilant for recurring problems.
  - d. Maintain a spirit of inquiry.
  - e. Read current literature appropriate to practice area.

ANS: B, C, D, E

This novice nurse would best maintain an evidence-based nursing practice by joining policy review committees, watching for and taking note of recurring problems in the practice area, maintaining a spirit of inquiry, and staying current in the literature. The nurse would not need to design and conduct a study.

DIF: Cognitive Level: Applying      OBJ: NCLEX: Safe and Effective Care Environment  
TOP: Nursing Process: Implementation

3. When explaining the value of evidence-based practice, what benefits does the nurse include? (*Select all that apply.*)
  - a. Improves quality of care.
  - b. Improves patient outcomes.
  - c. Improves stakeholder satisfaction.
  - d. Incorporates near real-time data in practice.
  - e. Helps nurses remain current in practice.

ANS: A, B, D, E

There are five ways that EBP adds value to the health care system: helps clinicians remain current on standardized, evidence-based protocols; uses near real-time scientific data to make care decisions; improves transparency, accountability, and value (e.g. safe care); improves quality of care; and improves outcomes. One would hope all stakeholders would be more satisfied with this method of determining care but that is not one of the specific benefits.

DIF: Cognitive Level: Remembering      OBJ: NCLEX: Safe and Effective Care Environment  
TOP: Nursing Process: Implementation

## Chapter 02: Communication and Collaboration

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#### MULTIPLE CHOICE

1. The nurse interviews a patient during admission. Which observation by the nurse identifies consistency between the patient's verbal and nonverbal communication?
  - a. Asserts she is eager to answer questions while reading a magazine.
  - b. States that he wants information while frequently changing the subject.
  - c. Asks the nurse to explain a surgical procedure while she listens intently.
  - d. Explains that he is relaxed while continuously shifting in his chair.

ANS: C

The patient demonstrates congruency, or consistency, between her verbal statement asking for an explanation and her nonverbal cue of listening intently. The verbal and nonverbal messages match; each indicates that the nurse's response is important to her. If she is eager to answer questions, the patient should focus on the nurse's questions or note taking; reading a magazine is a distraction and indicates a lack of interest. Changing the subject may indicate discomfort or reluctance to address the issue. Continually shifting position may be an indication of anxiety.

DIF: Cognitive Level: Applying

OBJ: NCLEX: Safe and Effective Care Environment

TOP: Nursing Process: Assessment

2. The nurse is interviewing a newly admitted patient. Which statement by the nurse is most likely to result in effective patient communication?
  - a. "I'm not sure why you're here. Can you explain it to me?"
  - b. "Tell me about things and people that are important to you."
  - c. "Tell me more about your pain. Where does it start?"
  - d. "If you think it's important, I'll try to notify the provider."

ANS: C

The nurse communicates effectively by using focused questions. This encourages the patient to give more information about the specific topic of concern. The remaining options are ineffective communication techniques because each potentially impairs the exchange of information between the nurse and the patient regarding care needs. The patient may be unwilling to express concerns openly after the nurse expresses lack of understanding and empathy. The patient will also likely lose confidence in the nurse if the nurse expresses confusion about suitability of the patient's presence. By asking what is important to the patient, the nurse loses focus of the objective of the communication and is likely to confuse the patient.

DIF: Cognitive Level: Applying

OBJ: NCLEX: Safe and Effective Care Environment

TOP: Integrated Process: Communication and Documentation

3. After receiving a diagnosis of a fatal disease, the patient expresses sadness and states "I don't know what to do next". Which action by the nurse best facilitates communication at this time?
  - a. Sit quietly with the patient and observe nonverbal communication.
  - b. Reassure the patient that his family will take care of him.
  - c. Refer the patient to a church for spiritual counseling.

- d. Tell the patient that hospice care is available immediately.

ANS: A

Because of the grim diagnosis, the patient expresses confusion and lacks a clear direction. The patient is not able to process information at this time and is overwhelmed. Sitting quietly with the patient shows acceptance, empathy, and allows the nurse to observe nonverbal communication. The patient can benefit from a calming atmosphere and time to process the new information. Assuring the patient of family involvement requires consultation with the family first. Spiritual counseling may not be indicated for this patient if the patient does not wish to participate. Discussing hospice at this early stage is premature; the patient needs time to process the news and gather information but is not able to do so right now.

DIF: Cognitive Level: Applying                      OBJ: NCLEX: Safe and Effective Care Environment  
TOP: Integrated Process: Communication and Documentation

4. The nurse is preparing to begin the patient hand-off procedure for five patients. Who should the nurse include in this process?
- Only the licensed nurses
  - The nursing personnel caring for the patients
  - The entire interdisciplinary team
  - The nurses and health care provider

ANS: B

All the nursing personnel on the unit who will be interacting with this group of patients should actively participate in the patient hand-off. This would include nursing assistive personnel (NAP) and the nurses. An interdisciplinary team usually meets when there is a problem with a patient and all the team members need to discuss approaches and plans with and for a patient or as a routine meeting. The health care provider does not participate in the patient hand-off procedure.

DIF: Cognitive Level: Remembering                      OBJ: NCLEX: Safe and Effective Care Environment  
TOP: Integrated Process: Communication and Documentation

5. The nurse brings the patient's medications into the room, and the patient shouts, "You don't care if I take these, so get out of my room!" Which response by the nurse is most appropriate?
- "Who misinformed you about my feelings?"
  - "You seem very angry about the medications."
  - "We know each other; why are you saying this?"
  - "I cannot leave until you take these medications."

ANS: B

Stating observations encourages the patient to be aware of his or her behavior. This neutral response would allow the patient time to explain the meaning behind the anger. Asking who misinformed the patient is confrontational. "Why" questions tend to put people on the defensive. Stating that the nurse cannot leave until the medications are taken is also confrontational and would set up a possible power struggle between the two.

DIF: Cognitive Level: Applying                      OBJ: NCLEX: Safe and Effective Care Environment  
TOP: Integrated Process: Communication and Documentation

6. The patient shouts at the nurse, "No one answered my nurse call system all night!" Which response would the nurse use with this patient to restore therapeutic communication?

- a. "Shouting is going to disturb other patients."
- b. "I see how that would make you very angry."
- c. "Are you sure the nurses were avoiding you?"
- d. "The unit has many very sick patients right now."

ANS: B

Regardless of whether the nurses answered the patient's nurse call system during the night, the patient felt ignored. By empathizing with the patient's distress and reflecting feelings, the nurse displays respect and understanding of his or her experience. Reprimanding the patient is humiliating and conveys the nurse's lack of regard for the patient's feelings. Quieting the patient is achievable by displaying empathy, caring, respect, and willingness to hear his or her complaints. Questioning the patient's perception is demeaning and forces the patient to justify feelings, similar to asking a "why" question. Stating that the unit has very sick patients implies that the patient is not as important as the others are.

DIF: Cognitive Level: Applying                      OBJ: NCLEX: Safe and Effective Care Environment  
TOP: Integrated Process: Communication and Documentation

7. A patient with a history of violence directed toward others becomes very excited and agitated during the nurse's interview. Which intervention does the nurse implement to foster therapeutic communication?
  - a. Call the security staff for assistance.
  - b. Ask the patient to use self-control.
  - c. Lean forward and touch the patient's arm.
  - d. Assume an open, nonthreatening posture.

ANS: D

The nurse should use neutralizing skills and assume an open, nonthreatening posture that conveys respect and acceptance, creating an atmosphere in which the patient can communicate without feeling threatened or defensive. Calling security in the patient's presence is likely to aggravate the patient and escalate the potential for violence because it is humiliating, conveys the nurse's rejection of the patient, and threatens to take all control away. Asking the patient to use self-control is reprimanding, humiliating, and conveys rejection and lack of respect by the nurse. The patient can perceive leaning in and touching as threatening.

DIF: Cognitive Level: Applying                      OBJ: NCLEX: Safe and Effective Care Environment  
TOP: Integrated Process: Communication and Documentation

8. The nurse admits a patient who is nonverbal and agitated. What can the nurse do to communicate effectively with the patient?
  - a. Use a communication aid.
  - b. Wait for family to arrive.
  - c. Call interpreter services.
  - d. Treat the patient for pain.

ANS: A

Patients with sensory losses require communication techniques that maximize existing sensory and motor functions. Some patients are unable to speak because of physical or neurological alterations such as paralysis; a tube in the trachea to facilitate breathing; or a stroke resulting in aphasia, difficulty understanding, or verbalizing. Many types of communication aids are available for use, including writing boards, flash cards, and picture boards. The nurse needs to determine what will work for the patient. Waiting for family is unacceptable because the patient needs care and the family may be delayed or not come at all. Interpreter services are for patients who do not speak the language. The nurse should not assume the patient has pain before completing an assessment.

DIF: Cognitive Level: Applying                      OBJ: NCLEX: Safe and Effective Care Environment  
 TOP: Nursing Process: Assessment

9. A patient's mother died several days ago. The patient begins to cry and states, "The pain of her death is impossible to bear." Which statement by the nurse is the most effective response?
  - a. "I was depressed last year when my mother died, too."
  - b. "I know things seem bleak, but you are doing so well."
  - c. "I can see this is a very difficult time for you right now."
  - d. "Should I cancel your appointment with the cardiologist?"

ANS: C

The nurse conveys empathy and respect by acknowledging the patient's grief. This is an effective response and is likely to enhance the nurse-patient relationship because it is patient centered, displays caring and respect, and helps to make the patient feel accepted. Relating personal details about the nurse's life redirects the focus of the communication to the nurse and fails to support the objectives of the nurse-patient relationship. Responding with a comment about the patient's progress and asking about the cardiologist's appointment ignores the patient's grief and conveys a lack of respect and consideration.

DIF: Cognitive Level: Applying                      OBJ: NCLEX: Safe and Effective Care Environment  
 TOP: Integrated Process: Communication and Documentation

10. A patient who says that both parents died of heart disease early in life is waiting for diagnostic testing results. The patient is biting fingernails and pacing around the room. Which statement should the nurse use to clarify patient information?
  - a. "I can see that you are anxious about dying."
  - b. "Tell me more about your family's history."
  - c. "Do you have your parents' medical records?"
  - d. "I'm not sure that I understand what you mean."

ANS: B

Asking for more information about the family's history directs the patient to expand on a specific, pertinent topic and relate key details before moving to another topic. "Early in life" and "heart disease" need to be defined by the patient; "early in life" can indicate a wide range of ages, depending on the definition of "early," and "heart disease" can mean conditions such as heart failure, coronary artery disease, valve disease, and arrhythmias. Until the patient discusses his particular concerns, the nurse cannot be sure about the source of his anxiety. Asking for the records can display a lack of respect by implying that the patient is an unreliable source for information. Stating that the nurse is not sure what the patient means is vague, leaving the patient to guess what the nurse wants to know.