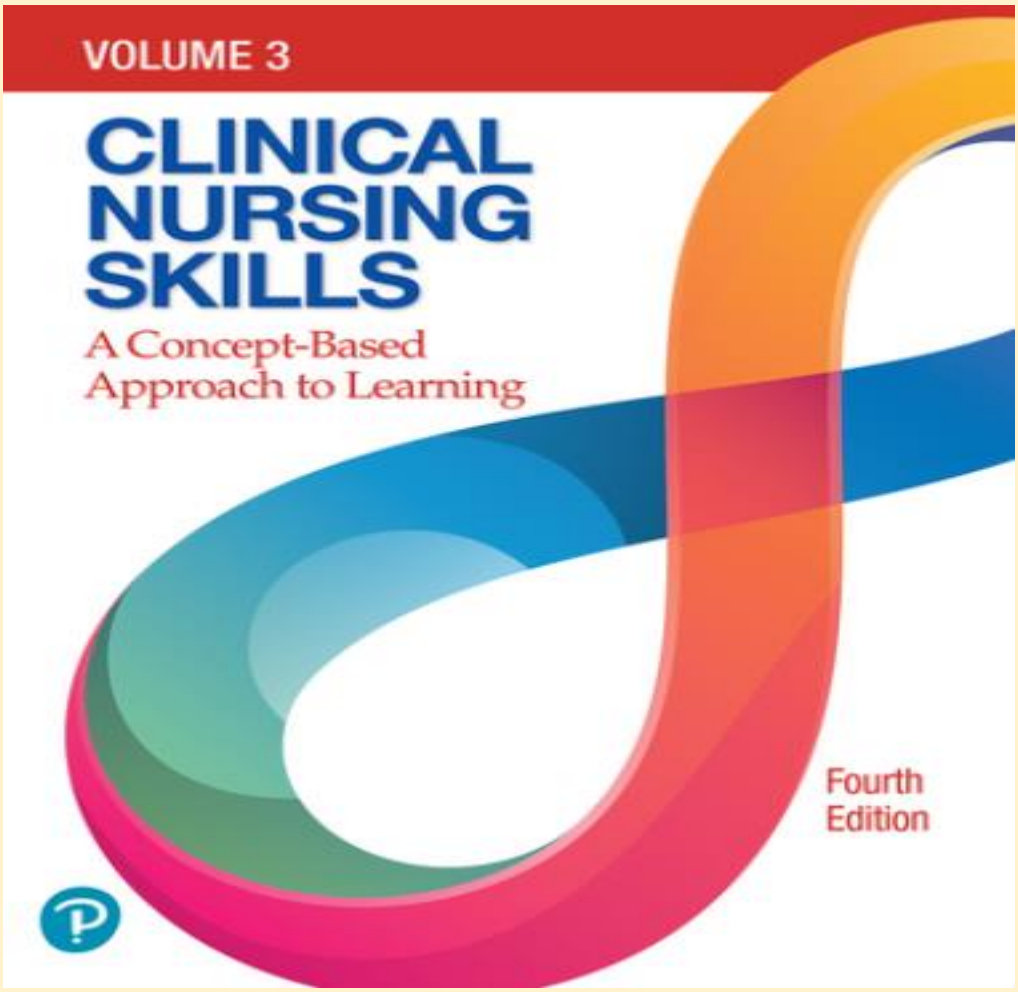
TEST BANK

CLINICAL NURSING SKILLS:

A Concept-Based Approach

4th Edition, Pearson Education



TEST BANK

Test Bank for Clinical Nursing Skills: A Concept-Based Approach 4th Edition Pearson Education

Table of Contents

Clinical Nursing Skills: A Concept-Based Approach, 4e **(Pearson) Education Test Bank**
Chapter 1: Assessment

1) A client on the medical/surgical unit complains of sudden chest pains. Which action will the nurse implement first?
A) Call the healthcare provider.
B) Administer pain medication.
C) Reassess a new set of vital signs.
D) Turn client from supine to lateral.
Answer: C
Explanation: A) The nurse will need to reassess the client first, before calling the healthcare provider.
B) The nurse will need to reassess the client first, before administering pain medication.
C) The nurse needs to implement a new set of vital signs first when there is a change in condition.
D) The nurse will need to reassess the client first, before moving the client, to avoid making the change in client's condition worse.
Page Ref: 2
Cognitive Level: Applying
Client Need/Sub: Physiological Integrity: Reduction of Risk Potential
Standards: Nursing Process: Assessment | Learning Outcome: 1.1 | QSEN Competencies: Patient-Centered Care
AACN Domains and Comps.: Domain 2: Person-Centered Care
NLN Competencies: Relationship Centered Care

2) The nurse is observing the UAP taking the temperature of an unconscious client. Which route will the nurse question the UAP using?
A) Oral
B) Rectal
C) Scanner
D) Tympanic
Answer: A
Explanation: A) The temperature of an unconscious client is never taken by mouth. The rectal, tympanic, or scanner method is preferred.
B) The rectal, tympanic, or scanner method is preferred.
C) The rectal, tympanic, or scanner method is preferred.
D) The rectal, tympanic, or scanner method is preferred.
Page Ref: 24
Cognitive Level: Applying
Client Need/Sub: Safe and Effective Care Environment: Safety and Infection Control
Standards: Nursing Process: Evaluation | Learning Outcome: 1.1 | QSEN Competencies: Safety
AACN Domains and Comps.: Domain 5: Quality and Safety
NLN Competencies: Quality & Safety

3) The nurse is changing a 2-month-old client's diaper and notes the client feels warm to touch. Which method should the nurse use to check the baby's temperature?
A) Oral
B) Rectal
C) Axillary
D) Tympanic membrane
Answer: C
Explanation: A) Oral is used for age 3 or older.
B) The rectal route is the least desirable.
C) The axillary route may not be as accurate as other routes for detecting fevers in children.
D) The tympanic membrane may be used for 3 months or older.
Page Ref: 29
Cognitive Level: Applying
Client Need/Sub: Physiological Integrity: Reduction of Risk Potential
Standards: Nursing Process: Evaluating | Learning Outcome: 1.2 | QSEN Competencies: Safety
AACN Domains and Comps.: Domain 5: Quality and Safety
NLN Competencies: Quality & Safety

4) A client comes in with exacerbation of chronic obstructive pulmonary disease (COPD). Which noninvasive diagnostic test will the nurse implement to know that the client is receiving enough oxygen?
A) Chest x-ray
B) Pulse oximeter
C) Arterial blood gasses
D) Assessment of respiratory rate
Answer: B
Explanation: A) A chest x-ray is not an intervention a nurse completes.
B) A pulse oximeter provides a noninvasive method of measuring oxygenation, or oxygen saturation, in the blood and provides a pulse reading, which is especially helpful for the client with a respiratory illness or disease.
C) Arterial blood gases are an invasive diagnostic test.
D) Assessing a respiratory rate is important for the nurse to implement; however, it is not a diagnostic test.
Page Ref: 21
Cognitive Level: Applying
Client Need/Sub: Physiological Integrity: Reduction of Risk Potential
Standards: Nursing Process: Implementation | Learning Outcome: 1.3 | QSEN Competencies: Informatics
AACN Domains and Comps.: Domain 5: Quality and Safety
NLN Competencies: Quality & Safety

5) The nurse is preparing to assess a client's musculoskeletal system. Which question should the nurse ask before beginning this assessment?
A) "Do you exercise every day?"
B) "Do you have a history of any sports injuries?"
C) "Do you take a hot bath to relax your muscles?"
D) "Do you want pain medication before I begin?"
Answer: B
Explanation: A) Knowing if a client exercises is an important question but knowing if there are any sports injuries to know about first, is most important before doing a routine musculoskeletal assessment.
B) It is important to note if the client has a history of any sports injuries first to know what the client will or will not be able to do during a routine musculoskeletal assessment.
C) Knowing if the client takes a hot bath to relax the muscles is not the most important thing to ask before performing a routine musculoskeletal assessment.
D) To know if a client is experiencing any pain is an important question; however, this question is assuming the client is in pain by asking if the client wants a pain medication before beginning a routine musculoskeletal assessment.
Page Ref: 62
Cognitive Level: Applying
Client Need/Sub: Safe and Effective Care Environment: Safety and Infection Control
Standards: Nursing Process: Assessment | Learning Outcome: 1.5 | QSEN Competencies: Safety
AACN Domains and Comps.: Domain 5: Quality and Safety
NLN Competencies: Quality & Safety

6) An adult child mentions that the client seems to have a decline in mental status and seems to be forgetting many things in their conversation since being hospitalized. Which response should the nurse make?
A) "Give your mom time, because it will take her a little longer when answering questions."
B) "Let me check the cranial nerve function to see if there is a defect in her mental status."
C) "You do not need to worry. This decline is part of the normal process of aging."
D) "If you bring some things from her home, it might reduce the confusion."
Answer: D
Explanation: A) This is expected to give some older adults time to respond, but the daughter is concerned about her forgetting, not the length of the response.
B) Cranial nerve function is an assessment of the cranial nerves and not the mental status of a client.
C) A decline in mental status is not a normal result of aging, so this response is not true.
D) The stress of being in unfamiliar situations can cause confusion in some older adults.
Page Ref: 75
Cognitive Level: Applying
Client Need/Sub: Psychosocial Integrity
Standards: Nursing Process: Planning | Learning Outcome: 1.6 | QSEN Competencies: Patient-Centered Care
AACN Domains and Comps.: Domain 2: Person-Centered Care
NLN Competencies: Context and Environment

7) When assessing breath sounds, the nurse hears moderate-intensity and moderate-pitch

"blowing" sounds between the scapulae and lateral to the sternum at the first and second intercostal spaces. Which action should the nurse take?
A) Encourage the client to cough and deep breathe.
B) Notify the healthcare provider of abnormal breath sounds.
C) Document assessment findings as normal breath sounds.
D) Raise the head of the bed to allow maximum air excursion.
Answer: C
Explanation: A) There is no reason to encourage the client to take deep breaths and cough.
B) The nurse would notify the healthcare provider if these were adventitious lung sounds; however, these are bronchovesicular sounds.
C) These are bronchovesicular sounds.
D) The nurse would implement this if these were adventitious lung sounds; however, these are bronchovesicular sounds.
Page Ref: 88
Cognitive Level: Applying
Client Need/Sub: Health Promotion and Maintenance
Standards: Nursing Process: Assessment | Learning Outcome: 1.7 | QSEN Competencies: Patient-Centered Care
AACN Domains and Comps.: Domain 2: Person-Centered Care
NLN Competencies: Context and Environment

8) A client seeks medical attention for shortness of breath and a fever. Which amount of time should the nurse count the peripheral pulse?
A) 15 seconds
B) 30 seconds
C) 1 minute
D) 2 minutes
Answer: C
Explanation: A) Count for a full minute if taking a client's pulse for the first time.
B) Count for a full minute if taking a client's pulse for the first time.
C) Count for a full minute if taking a client's pulse for the first time.
D) Count for a full minute if taking a client's pulse for the first time.
Page Ref: 19
Cognitive Level: Applying
Client Need/Sub: Health Promotion and Maintenance
Standards: Nursing Process: Assessment | Learning Outcome: 1.8 | QSEN Competencies: Patient-Centered Care
AACN Domains and Comps.: Domain 2: Person-Centered Care
NLN Competencies: Quality & Safety

9) The nurse is preparing a dose of digoxin for a client. Which assessment will the nurse complete prior to giving this medication?
A) Temperature
B) Apical pulse
C) Respiratory rate
D) Pain using a pain scale
Answer: B
Explanation: A) The temperature does not need to be assessed before giving digoxin.
B) The nurse should assess the apical pulse before the administration of a medication that could affect the cardiovascular system, such as before giving a digitalis preparation.
C) The respiratory rate does not need to be assessed before giving digoxin.
D) Pain level does not need to be assessed before giving digoxin.
Page Ref: 18
Cognitive Level: Applying
Client Need/Sub: Physiological Integrity: Pharmacological and Parenteral Therapies
Standards: Nursing Process: Assessment | Learning Outcome: 1.4 | QSEN Competencies: Patient-Centered Care
AACN Domains and Comps.: Domain 5: Quality and Safety
NLN Competencies: Quality & Safety

10) The nurse is completing a general assessment of a newborn. Which technique should the nurse use?
A) Wrap the tape measure around the head below the ears.
B) Wrap the tape measure around the head starting at the nose.
C) Wrap the tape measure around the abdomen at the umbilicus.
D) Wrap the tape measure around the chest below the nipple line.
Answer: C
Explanation: A) When measuring the head circumference, wrap the tape around the head at the supraorbital prominence above the eyebrows, above the ears, and around the occipital prominence.
B) When measuring the head circumference, wrap the tape around the head at the supraorbital prominence above the eyebrows, above the ears, and around the occipital prominence.
C) When measuring the abdomen circumference, wrap the tape around the abdomen at the level of the umbilicus.
D) When measuring the chest circumference, wrap the tape measure around the chest, placed just under the axilla and at the nipple line.
Page Ref: 31
Cognitive Level: Applying
Client Need/Sub: Health Promotion and Maintenance
Standards: Nursing Process: Assessment | Learning Outcome: 1.4 | QSEN Competencies: Patient-Centered Care
AACN Domains and Comps.: Domain 2: Person-Centered Care
NLN Competencies: Quality & Safety