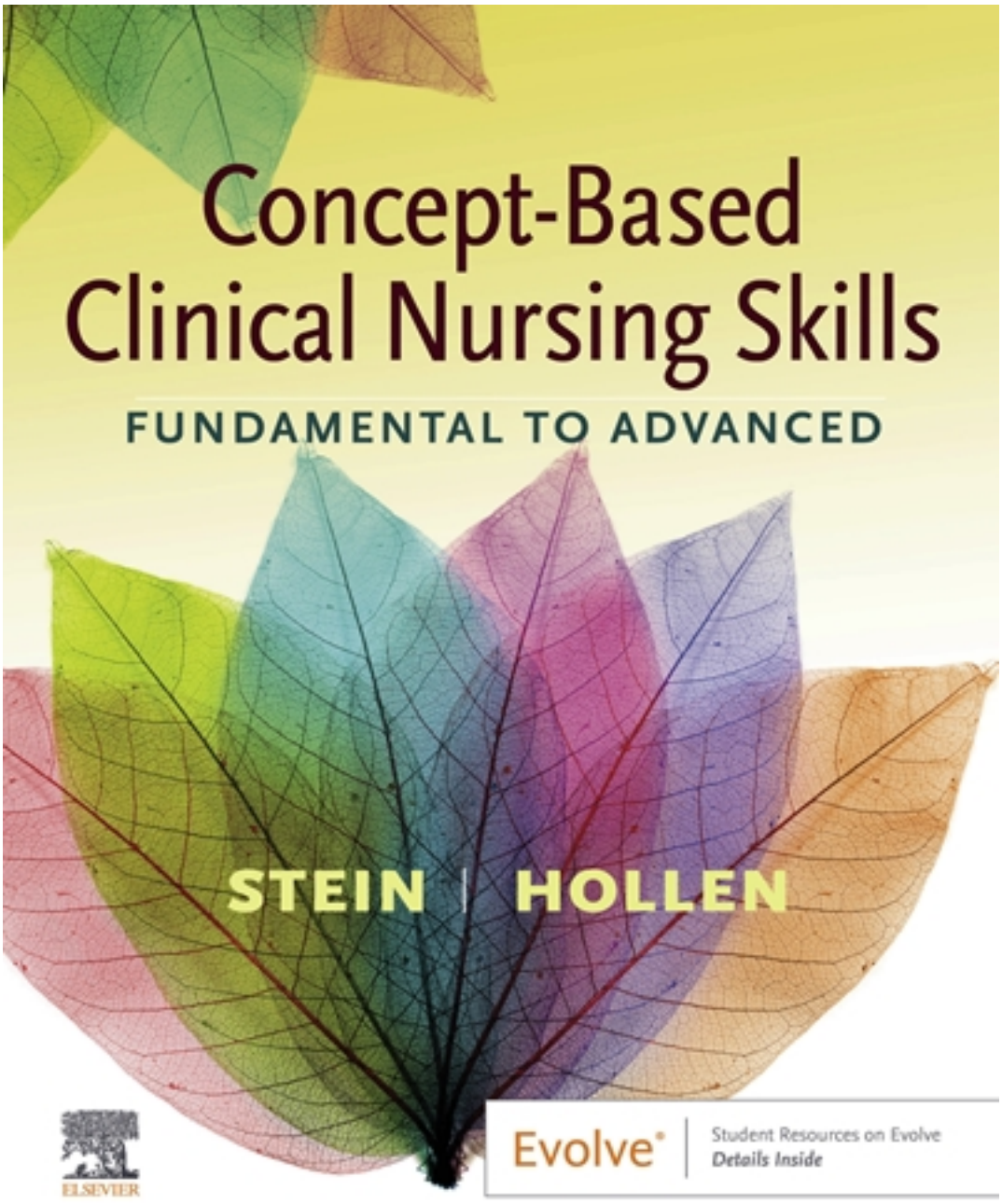
Test Bank for Concept Based Clinical Nursing Skills Fundamental to Advanced 1st Edition by Stein



Test Bank

Chapter 02: Personal Care and Hygiene
Hollen & Stein: Concept-Based Clinical Nursing Skills, 1st Edition

MULTIPLE CHOICE

1. A nurse chooses to bathe a client instead of delegating it to unlicensed assistive personnel (UAP). What rationale for this choice is *most* likely?
   a. The UAP is frequently too busy to provide adequate care.
   b. The nurse can assess the client's skin during the bath.
   c. The nurse understands the principles of hygiene better.
   d. The UAP is not permitted to provide this care.

   ANS: B
   During a bath is an opportune time to assess the client's skin condition. Bathing also allows time for communication and touch. The UAP may be too busy to do a good job, and the nurse may understand the principles of hygiene better than the UAP, but this does not explain the most likely reason the nurse is choosing to do it him- or herself. The UAP is permitted to provide hygiene.

   DIF: Cognitive Level: Understanding TOP: Nursing Process: Assessment

2. The nurse knows the relationship between the skin and infection is which of the following?
   a. Intact skin provides a barrier to infection.
   b. Skin harbors many dangerous microbes.
   c. Skin has very little to do with infection.
   d. Skin contains glands that secrete antibodies.

   ANS: A
   Intact skin is the first line of defense against infection. Any time there is a break in the skin, there is a potential for microbes to gain entry. The skin does harbor many microbes, but most are not dangerous. The skin, which is important for infection, does not contain antibody-secreting glands.

   DIF: Cognitive Level: Remembering TOP: Nursing Process: Assessment

3. The client with an IV and bladder catheter has finished bathing and the nurse assists with changing the client's gown. After completing this activity, what action does the nurse take *next*?
   a. Empty the catheter bag.
   b. Document the activity.
   c. Assess the IV site.
   d. Medicate the client for pain.

   ANS: C
   For client safety and to reduce the possibility of treatment error, the nurse assesses the IV site next. The catheter bag may need emptying, but that does not take priority over the safety of IV therapy. The nurse documents the activity and client tolerance, but this also does not take priority. There is no indication that the client needs to have pain medication.

   DIF: Cognitive Level: Applying TOP: Nursing Process: Assessment

4. A hospitalized client asks the nurse to cut fingernails and toenails. What response by the nurse is *best*?
   a. "I cannot trim either fingernails or toenails."
   b. "I can trim your fingernails only."
   c. "Let me check the hospital's policy."
   d. "Let me go get the supplies I need."

   ANS: C
   The nurse would check the policy because some facilities prohibit nurses from cutting toenails and sometimes even fingernails. Before stating "I cannot trim either fingernails or toenails," "I can trim your fingernails only," or "Let me go get the supplies I need," the nurse would verify the policy.

   DIF: Cognitive Level: Understanding TOP: Nursing Process: Implementation

5. A nurse is preparing to give a newborn a bath. What action does the nurse take *first*?
   a. Check the baby's temperature.
   b. Determine if the baby has eaten recently.
   c. Ask if a parent would rather do it.
   d. Get a stocking cap to keep baby's head dry.

   ANS: A
   Immersion in water can lead to cold stress in an infant. Before the first bath, infants must reach and maintain an appropriate temperature. It is not necessary to determine if the baby has eaten recently. Asking if a parent would like to bathe the infant instead is a caring gesture, but does not take priority over maintaining thermoregulation and safety. The infant's hair/head may need to be washed so a stocking cap is not needed. The nurse will dry the baby's hair/head thoroughly to keep him or her warm.

   DIF: Cognitive Level: Understanding TOP: Nursing Process: Implementation

6. A student is providing oral care to clients in the Intensive Care Unit (ICU). What action by the student demonstrates a need for *further* education?
   a. Uses a small, soft toothbrush on a client who is on a ventilator
   b. Uses baking soda for tooth brushing in a client with bad breath
   c. Checks the mouth for leftover sponge when using a sponge toothette
   d. Requests a prescription for oral chlorhexidine rinses

   ANS: B
   Baking soda (sodium bicarbonate), unless properly diluted, is not used routinely as it alters the pH of the teeth and can cause burns. This action by the student indicates he or she needs further education. Using a soft toothbrush removes plaque better than swabs and so is an appropriate action. When using sponge toothettes, it is possible for small pieces of the sponge to be left in the mouth and possibly enter the airway so checking this client's mouth for residual sponge is appropriate. Oral chlorhexidine rinses appear to decrease the incidence of nosocomial infections and would also be an appropriate action.

   DIF: Cognitive Level: Analyzing TOP: Nursing Process: Evaluation

7. What is an important safety consideration for the nurse when providing oral care to an unconscious client?
   a. Place the client in a high Fowler's position.
   b. Use only moistened toothettes to avoid injury.
   c. Do not provide oral care if the client has a bleeding disorder.
   d. Turn the client to a side-lying position.

   ANS: D
   An unconscious client depends on the nurse for all of his or her safety needs. The nurse would turn the client onto a side-lying position so that liquids drain out of the mouth, reducing the chances of aspiration. A high Fowler's position would encourage aspiration. Unconscious clients can have their teeth brushed with a toothbrush. Clients with bleeding disorders need special care in order to not cause bleeding during oral care.

   DIF: Cognitive Level: Applying TOP: Nursing Process: Implementation

8. What is the preferred way to remove an artificial eye?
   a. Grasp it on both sides with your dominant hand and pull out gently.
   b. Open the eyelid with the dominant hand and depress the lower lid.
   c. Pull the outer canthus of the eye outward and have the client blink.
   d. Using your dominant hand, squeeze the skin on the outside of the eyeball.

   ANS: B
   To safely remove an artificial eye, hold the eye open using the nondominant hand by positioning your thumb on the lower lid and forefinger on the upper lid. Depress the lower lid and slide the prosthesis out. You would not grasp the artificial eye on both sides and pull it out or "pop" it out by squeezing the skin on either side of the eyeball. Pulling on the outer canthus and having the client blink is the way to remove hard contact lenses.

   DIF: Cognitive Level: Remembering TOP: Nursing Process: Implementation

9. In order to reduce falls on the inpatient unit, what directive by the nurse manager would have the *biggest* impact?
   a. Supply client socks with traction.
   b. Label doors with a "fall precautions" sign.
   c. Stay with clients using the bathroom or commode.
   d. Have two personnel walk clients who need assistance.

   ANS: C
   Studies have shown that about half of the falls in hospitals are elimination-related and the more serious falls with serious injuries are too. Instructing staff to stay with clients in the bathroom or on the commode (and frequent assessment of elimination needs) would have the biggest impact on reducing falls. Socks with traction, "Fall precautions" signs, and extra assistance are all good interventions, but would not have as big of an impact.

   DIF: Cognitive Level: Understanding TOP: Nursing Process: Implementation

10. What is the *best* way to position the client on this bedpan?

a. Have client lift hips and slide it underneath of him or her.
b. Roll the client on the side, place it against the buttocks, roll the client back.
c. Raise the head of the bed and have client use the overhead trapeze.
d. Assist client to standing position, then assist to sitting on the pan.

ANS: B
This is a fracture pan used for clients who cannot lift their hips. The nurse rolls the client on one side, places the bedpan against the client's buttocks, then rolls the client back to the supine position. Lifting the hips, using the trapeze bars, and standing are not ways of placing this bedpan.

DIF: Cognitive Level: Remembering TOP: Nursing Process: Implementation

11. When making a bed, which action by the nurse is *most* important for infection control?
a. Have a laundry hamper designated for each room.
b. Put the dirty sheets in the bathroom for housekeeping.
c. Fold the dirty linens and avoid shaking them out.
d. Clean the mattress with every linen change.

ANS: C
Shaking linens will disperse microorganisms into the air, increasing the client's risk of acquiring a nosocomial infection. Dirty linen does go right away into a hamper (and not left for housekeeping), but each room does not need one designated for it alone. The mattress is cleaned per facility policy and when visibly soiled.

DIF: Cognitive Level: Understanding TOP: Nursing Process: Implementation

12. A client on bedrest perspires heavily in dependent areas and has developed a fungal rash from the heat and moisture. What type of bed does the nurse order to *best* assist this client?
a. Lateral rotation
b. Low air loss
c. Alternating pressure
d. Multizoned surfaces

ANS: B
A low air loss mattress is best for managing the heat and moisture of the skin through airflow. A lateral rotation bed partially turns the client by rotating the axis of the bed. The alternating pressure mattress provides cyclic pressure redistribution. The multizoned surface mattress has different segments, each of which can provide different amounts of pressure redistribution.

DIF: Cognitive Level: Remembering TOP: Nursing Process: Planning

13. In order to reduce bathing-related heat loss in a neonate, what action by the nurse is *best*?
    a. Swaddle the neonate in warm towels before dressing.
    b. Put the neonate back in the incubator immediately.
    c. Ensure the bath water is hot enough to maintain baby's temperature.
    d. Only use warmed, premoistened bathing wipes for a bath.

    ANS: A
    According to the Association of Women's Health, Obstetric and Neonatal Nurses (AWHONN) practice guidelines, wrapping the infant in a warm towel for 10 minutes before dressing significantly reduces evaporative heat loss and resultant hypothermia. Not all neonates are in incubators. The bath water should be warm, not hot enough to maintain body temperature. Immersion baths are the most relaxing method for stable preterm infants and normal newborns.

    DIF: Cognitive Level: Understanding TOP: Nursing Process: Implementation

14. A new nurse has not cared for African-American hair before. What information does the charge nurse share?
    a. African-American hair is much oilier than Caucasian hair so it needs daily shampooing.
    b. To comb through the hair without breaking it, apply petroleum jelly to it first.
    c. Because of the dense structure of each individual hair, it is strong and not prone to breakage.
    d. Leave-in conditioners, shea butter, or coconut oil are good products for this dry hair type.

    ANS: D
    African-American hair is much drier than Caucasian hair, so leave-in conditioners, shea butter, and coconut oil are good products to restore moisture. Because of the dryness, it should be shampooed about once a week. Petroleum jelly is not absorbed into African-American hair and should not be used. African-American hair is more fragile than Caucasian hair.

    DIF: Cognitive Level: Understanding TOP: Integrated Process: Teaching-Learning

15. A nurse in the pediatric clinic sees a parent with a young daughter. The parent is concerned that several children in the grade school have head lice. What teaching by the nurse is *best*?
    a. "Don't sit next to anyone who has lice."
    b. "She should stay home for a few days."
    c. "We can treat her now if you are worried."
    d. "Don't use anyone else's brushes and combs."

    ANS: D
    Head lice are generally spread through direct contact with someone who has them. However, they are sometimes spread by items such as towels, scarves, and hats, and hair items, such as brushes and combs. The child should be taught not to use anyone else's brushes and combs and to not share hers. Lice don't jump so it doesn't matter where the child sits. There is no need for the child to miss school or for the parent to treat her before without having signs of an infestation.

    DIF: Cognitive Level: Understanding TOP: Integrated Process: Teaching-Learning

16. Parents call the nurse at the clinic distraught because the school says their child has head lice and cannot return until the infestation has been treated. One parent states "I can't believe they think we are so filthy!" What response by the nurse is *best*?
    a. "There's no need to be upset over lice."
    b. "Head lice have no relationship to cleanliness."
    c. "You don't have pets in the home, do you?"
    d. "Do you have help with household cleaning?"

    ANS: B
    Nurses provide dignity and caring in all interactions. The nurse should gently correct the parent's misinformation. Head lice infestations are not related to either personal or environmental cleanliness. Stating there is no need to be upset is dismissive of the parent's feelings. Asking about pets is irrelevant, plus adding "do you?" sounds judgmental and will put clients on the defensive if they do have pets. There is no reason to inquire about cleaning.

    DIF: Cognitive Level: Understanding TOP: Integrated Process: Caring

17. The registered nurse is discussing oral care with a unlicensed assistive personnel (UAP). The UAP has not provided oral care to several clients by the end of the shift. The UAP states "What's the big deal? Sometimes I don't brush my teeth twice a day." What response by the nurse is *best*?
    a. "Oral care is important to our clients' comfort."
    b. "You don't brush your teeth twice a day?"
    c. "It's important to help prevent infections."
    d. "It's in the policy and in your job description."

    ANS: C
    Oral care is vital to help prevent nosocomial infections. Poor oral care can lead to pneumonia and systemic infections. While oral care is important for comfort, that is not the best answer because client safety is more important. Asking the UAP about his or her own habits is irrelevant. Providing oral care probably is in the facility's policies and in the UAP job description, but this answer does not provide the UAP with any useful information.

    DIF: Cognitive Level: Understanding TOP: Integrated Process: Teaching-Learning

18. A nurse has been assigned several bed baths and is very busy. One client requests to have the bath and hygiene care provided on the evening shift instead of now. What response by the nurse is *most* appropriate?
    a. "The evening shift expects that all bathing is completed on the day shift."
    b. "Of course. I will let the evening shift know this is your preference."
    c. "What if I come back later and we can do your bath then?"
    d. "I have to do your bath now. I have other clients waiting for me."

    ANS: B
    Nurses provide sound nursing care influenced by clients' cultures and preferences. Unless there is a compelling reason not to, the nurse defers to the client's request. The nurse is not honoring the client's dignity by answering the bath is expected by another shift, or that other clients are waiting for care. It is appropriate to negotiate some cares, but something non-time restricted would be scheduled according to client wishes.

DIF: Cognitive Level: Applying TOP: Integrated Process: Caring

MULTIPLE RESPONSE

1. The nurse wants to delegate various aspects of hygiene care to unlicensed assistive personnel (UAP). What actions by the nurse are *most* important? (*Select all that apply.*)
   a. Providing the UAP clear and specific directions
   b. Directly supervising the UAP carry out the tasks
   c. Instructing the UAP to report back to the nurse
   d. Ensuring the UAP understands the directions
   e. Informing the UAP about assessments to make while providing care

   ANS: A, C, D
   Clear communication is key to successful delegation. The nurse provides clear and specific directions, including that feedback from the UAP about the activity and client response is required. The nurse validates understanding before the UAP performs the tasks. Direct supervision is not required. The nurse is responsible for all assessments.

   DIF: Cognitive Level: Applying TOP: Nursing Process: Implementation

2. The nursing manager is orienting several new nurses and states “Here, we maintain the concentric rings of privacy.” Which of the following are components included in this concept? (*Select all that apply.*)
   a. HIPAA rules
   b. Curtains
   c. Closed door
   d. Signs
   e. Gown
   f. Covers

   ANS: B, C, D, E, F
   The concentric rings of privacy include client, gown, covers, curtain, closed door, and signage. HIPAA protects clients’ privacy by guarding their identifiable health information.

   DIF: Cognitive Level: Remembering TOP: Integrated Process: Teaching-Learning

3. What information does the student learn about head lice in children? (*Select all that apply.*)
   a. Head lice usually occur on dirty, oily hair.
   b. Head lice can jump from one host to another.
   c. Because of the new vaccine, head lice are uncommon.
   d. Head lice are usually spread by contact with an infected person.
   e. African-Americans and Hispanics have higher rates of infestations.
   f. Infestations are not related to cleanliness.

   ANS: D, F
   Head lice are spread by direct head-to-head contact with a person who already has head lice. Infestation with lice is not related to the cleanliness of the child or the child’s home environment. Head lice are very common with 6 to 12 million children becoming infested each year. There is no vaccination for head lice. African-Americans have a lower rate of infestations.

DIF: Cognitive Level: Remembering TOP: Integrated Process: Teaching-Learning

4. A nurse is frustrated that the specific skin-care regime on an older client is not working as well as possible to protect the client's fragile skin. What assessments by the nurse take *priority* for this client? (*Select all that apply.*)
   a. Fluid status
   b. Laboratory values
   c. Blood pressure
   d. Nutritional status
   e. 24-hour intake and output trend

   ANS: A, D, E
   Adequate nutrition and hydration are vital for protecting and maintaining the fragile skin of an older client. The nurse would place priority on assessing the client's fluid status, which includes the 24-hour I&O trend, and nutrition status. "Laboratory values" is too vague to know if this would be a priority. Blood pressure would be relatively important to assess perfusion, but it is not the priority.

   DIF: Cognitive Level: Applying TOP: Nursing Process: Assessment

5. A new nurse has never taken care of hearing aids before. What information does the charge nurse provide about care of these devices? (*Select all that apply.*)
   a. Plain soap and water are used for cleaning debris off the hearing aids.
   b. Tell the client he or she must remove the aids before showering.
   c. Place a towel in the sink to avoid breaking them when cleaning them.
   d. Instruct the client to not spray hairspray or perfume/cologne over the aids.
   e. The hearing aids need to be stored in the storage box they came with.

   ANS: B, D, E
   Hearing aids should not get wet or exposed to body products, such as hairspray or cologne. To keep them from breaking, they should always be stored in their designated storage box. A dry cloth is used for cleaning. Since water is not used for cleaning hearing aids, there is no reason to have them over a sink.

   DIF: Cognitive Level: Understanding TOP: Integrated Process: Teaching-Learning

6. A nurse is delegating hygiene tasks to a unlicensed assistive personnel (UAP). For which clients does the nurse tell the UAP not to provide a foot soak? (*Select all that apply.*)
   a. Client with a fever
   b. Client with diabetes mellitus
   c. Client with diabetic neuropathy
   d. Client with swollen feet
   e. Client with an infectious disease

   ANS: B, C
   Clients with diabetes, diabetic neuropathy, or peripheral vascular disease may not be able to feel water being too hot and are at risk for injury. The UAP should not provide a foot soak for these clients. Clients with fevers, swollen feet, or an infectious disease can use foot soaks.

   DIF: Cognitive Level: Understanding TOP: Nursing Process: Implementation

7. What does the nurse know about hygiene? (*Select all that apply.*)
   a. Cleaning proceeds from clean to dirty.
   b. Culture may influence hygiene practices.
   c. Hygiene needs may change from day to day.
   d. Most soaps change the pH of healthy skin.
   e. Preventing cold stress is important in the older client.

   ANS: A, B, C, D
   Cleaning from the cleanest to dirtiest area prevents cross-contamination of the cleaner area. Culture and personal preferences influence hygiene practices by the nurse and should be respected. Hygiene needs vary, sometimes daily, depending on client condition. Most soaps are alkaline which damages the “acid mantle” that helps create a barrier to infection. Preventing cold stress is important for newborns and babies.

   DIF: Cognitive Level: Remembering TOP: Nursing Process: Implementation