Test Bank for Adult Health Nursing 9th Edition by Cooper

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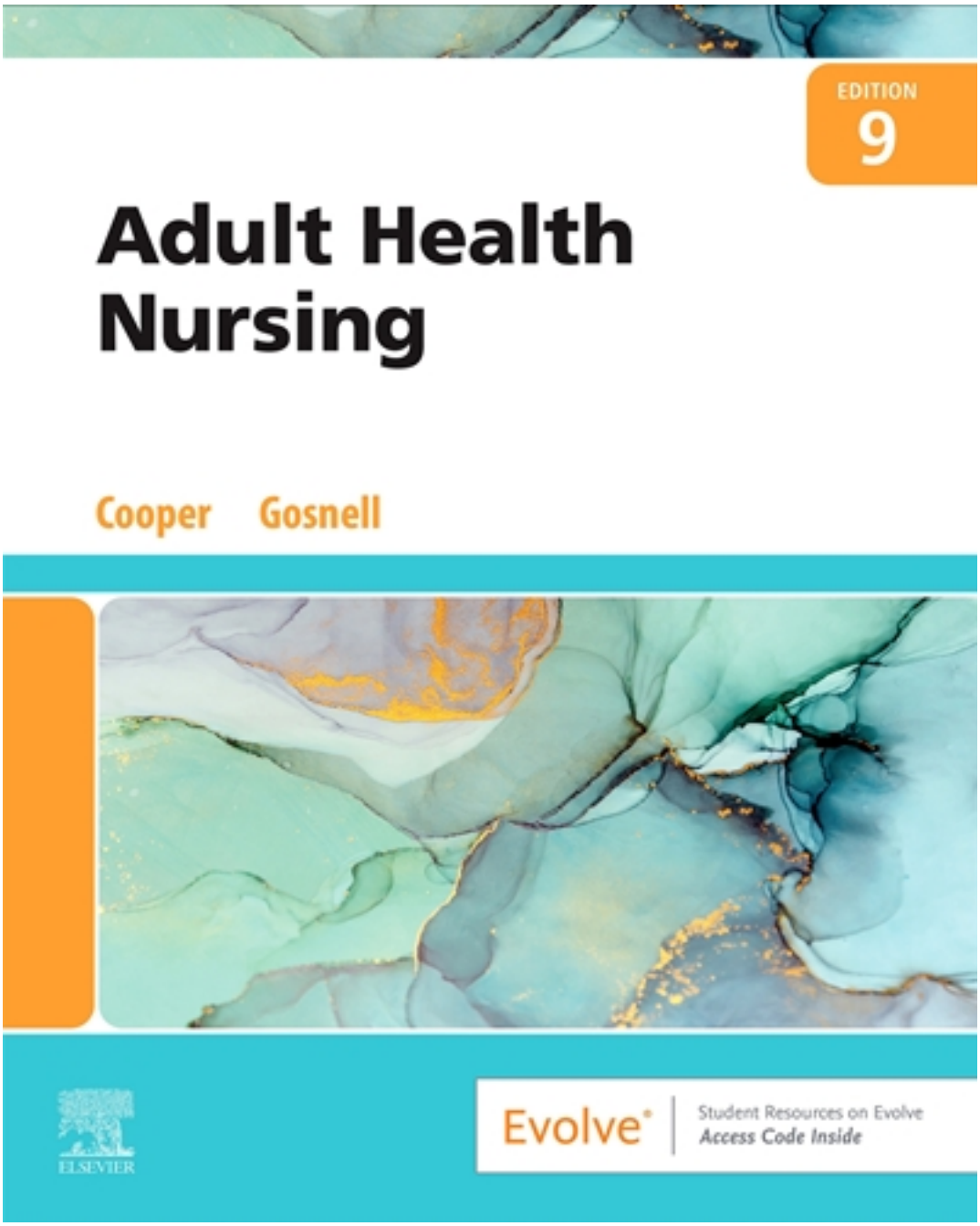

Test Bank

Chapter 02: Care of the Surgical Patient
Cooper: Adult Health Nursing, 9th Edition

MULTIPLE CHOICE

1. The patient who had a nephrectomy yesterday has not used the patient-controlled analgesia (PCA) delivery system but admits to being in pain but fearful of addiction. Which is the nurse's response?
   a. "Modern analgesic drugs do not cause addiction."
   b. "Pain relief is worth a short period of addiction."
   c. "Addiction rarely occurs in the brief time postsurgical analgesia is required."
   d. "Addiction could be a real concern."

   ANS: C
   Addiction rarely occurs in the short time that it is required after surgery. Modern, or older drugs, can cause addiction, but not generally in the brief post- operative time frame. Postsurgical analgesia, because of its brief application, does not usually produce a physical or a psychological dependence. The patient should be taught that addiction is not usually a concern after surgery.

   DIF: 6 Cognitive Level: Applying OBJ: 13 TOP: Fear of addiction
   KEY: Nursing Process Step: Implementation
   MSC: NCLEX: Physiological Integrity

2. A 73-year-old patient with diabetes was admitted for below the knee amputation of his right leg. Removal of his right leg is an example of which type of surgery?
   a. Palliative
   b. Diagnostic
   c. Reconstructive
   d. Ablative

   ANS: D
   Ablative is a type of surgery where an amputation, excision of any part of the body, or removal of a growth and harmful substance is performed.

   DIF: 4 Cognitive Level: Understanding OBJ: 2 TOP: Types of surgeries
   KEY: Nursing Process Step: Data Collection
   MSC: NCLEX: Physiological Integrity

3. A patient is in need of appendix removal surgery. In which situation might surgery be delayed?
   a. The patient has taken antiseizure medication today.
   b. An illegible signature is on the consent form.
   c. The patient is still taking anticoagulants.
   d. The admission office is unable to confirm insurance coverage.

   ANS: C

Anticoagulant therapy increases the threat of hemorrhage and may be a cause for delay. All medications should be cancelled before surgery, except for drugs such as antiseizure medication. If the signature is illegible, the consent form may need to be signed again. Inability to confirm insurance coverage is not a medical reason to delay the surgery, especially if the case is urgent.

DIF: 3 Cognitive Level: Knowledge OBJ: 7 TOP: Anticoagulant therapy
KEY: Nursing Process Step: Data Collection
MSC: NCLEX: Physiological Integrity

4. Which circumstance could prevent the patient from signing an informed consent form for a cholecystectomy?
   a. The patient complains of pain radiating to the scapula.
   b. The patient received an injection of antianxiety medication 1 hour ago.
   c. The patient is 85 years of age.
   d. The patient is concerned over his lack of insurance coverage.

   ANS: B
   Informed consent should not be obtained if the patient is disoriented and under the influence of sedatives. Age, illegibility, and lack of insurance coverage do not prevent signing the consent. Pain into the scapula is a symptom of colitis.

   DIF: 7 Cognitive Level: Applying OBJ: 7 TOP: Informed consent
   KEY: Nursing Process Step: Data Collection
   MSC: NCLEX: Physiological Integrity

5. The nurse anticipates that the patient will be given which type of anesthesia because of the extensive tissue manipulation involved in a hysterectomy?
   a. general
   b. regional
   c. specific
   d. preoperative

   ANS: A
   An anesthesiologist gives general anesthetics by IV and inhalation routes through four stages of anesthesia when the procedure requires extensive tissue manipulation. Regional anesthesia would not be sufficient in this case. The terms “specific” and “preoperative” are not terms associated with types of anesthesia.

   DIF: 3 Cognitive Level: Knowledge OBJ: 9 TOP: Anesthesia
   KEY: Nursing Process Step: Data Collection
   MSC: NCLEX: Physiological Integrity

6. The nurse caring for a patient who had spinal anesthesia for a vaginal repair should be alert for which sign of a serious complication?
   a. a flushing of the face and torso.
   b. numbness of the perineum.
   c. complaint of thirst.
   d. a sudden drop in blood pressure.

   ANS: D

Spinal anesthesia may cause a sudden drop in blood pressure or respiratory difficulty as the anesthetic agent moves up in the spinal cord. Elevating the patient's torso may prevent respiratory paralysis. Flushing of the face and torso may be a response to vasodilation, but it is not as serious a concern as hypotension. Numbness of the perineum is a desired response so that surgery can be performed without pain. A complaint of thirst is not as serious a concern as hypotension.

DIF: 4 Cognitive Level: Understanding OBJ: 9 TOP: Epidural block
KEY: Nursing Process Step: Data Collection
MSC: NCLEX: Physiological Integrity

7. Why might the older adult patient not respond to surgical treatment as well as a younger adult patient?
   a. Poor skin turgor
   b. Fear of the unknown
   c. Response to physiologic changes
   d. Decreased peristalsis related to anesthesia

ANS: C
Of specific concern in older adults is the body's response to temperature changes, cardiovascular shifts, respiratory needs, and renal function. Poor skin turgor is not a reason an older adult does not respond well to surgical treatment. Fear of the unknown and decreased peristalsis are common to all ages.

DIF: 6 Cognitive Level: Applying OBJ: 5 TOP: Older adult patients
KEY: Nursing Process Step: Planning MSC: NCLEX: Physiological Integrity

8. Which postoperative nursing intervention is contraindicated for a 45-year-old patient who has had a repair of a cerebral aneurysm?
   a. coughing every 2 hours.
   b. turning every 2 hours.
   c. monitoring intravenous therapy at 50 mL/hr.
   d. assessing vital signs every 2 hours.

ANS: A
After brain, head, neck, spinal or eye surgery, coughing is not performed. Coughing can increase intracranial pressure. The patient is still able to turn every 2 hours. Intravenous therapy is administered at the rate prescribed. Vital sign measurement is not contraindicated, and should be obtained as prescribed.

DIF: 8 Cognitive Level: Analyzing OBJ: 13 TOP: Postoperative complications
KEY: Nursing Process Step: Implementation
MSC: NCLEX: Physiological Integrity

9. The nurse acting as a circulating nurse has a responsibility for which activity?
   a. Observing for breaks in sterile technique.
   b. Performing surgical hand scrub
   c. assisting with surgical draping of the patient.
   d. maintaining count of sponges, needles, and instruments during surgery.

ANS: A

The circulating nurse is responsible for observing breaks in sterile technique. The scrub nurse performs a surgical hand scrub, , drapes the patient, and maintains needle and sponge count during surgery, then does a final sponge and needle check with the circulating nurse before closing.

DIF: 5 Cognitive Level: Understanding OBJ: 11 TOP: Duties of circulating nurse
KEY: Nursing Process Step: Data Collection
MSC: NCLEX: Safe, Effective Care Environment

10. Which statement made by a patient during a preoperative assessment would be significant to report to the charge nurse and surgeon?
    a. "I have been taking an herbal product of feverfew for my migraines."
    b. "I exercise for 3 hours a day."
    c. "I drink 2 cups of coffee a day."
    d. "I use eye drops for redness every day."

ANS: A
The herbal remedy of feverfew acts as an anticoagulant and increases the possibility of hemorrhage. The drug should be stopped before surgery, and bleeding and clotting times should be evaluated. Exercising does not need to be reported. Two cups of coffee every day or eye drops for redness would not need to be reported.

DIF: 6 Cognitive Level: Applying OBJ: 4 TOP: Preoperative assessment
KEY: Nursing Process Step: Data Collection
MSC: NCLEX: Physiological Integrity

11. A patient is on postoperative day 2 after a nephrectomy. Which intervention is an effective way to increase peristalsis?
    a. Ambulation
    b. An enema
    c. Encouraging hot liquids
    d. Administering a laxative

ANS: A
Encouraging activity (turning every 2 hours, early ambulation) assists GI activity. An enema or a laxative would be used only if ambulation did not increase the peristalsis. Hot liquids could cause a burn injury; warm liquids are encouraged.

DIF: 4 Cognitive Level: Understanding OBJ: 13 TOP: Postoperative complications
KEY: Nursing Process Step: Planning MSC: NCLEX: Physiological Integrity

12. A patient is transferred from the operating room to the recovery room after undergoing an open reduction and internal fixation (ORIF) of his left ankle. Which is the **first** assessment to make?
    a. Check ankle dressings for hemorrhage.
    b. Check airway for patency.
    c. Check intravenous site.
    d. Check pedal pulse.

ANS: B

Evaluation of the patient follows the ABCs of immediate postoperative observation: airway, breathing, consciousness, and circulation. While assessing for hemorrhage, IV site infiltration and pedal pulse is important, the priority assessment is the patency of the airway.

DIF: 7 Cognitive Level: Applying OBJ: 12 TOP: Nursing assessment
KEY: Nursing Process Step: Data Collection
MSC: NCLEX: Health Promotion and Maintenance

13. Frequent assessment of a postoperative patient is essential. Which are the **first** signs and symptoms of hemorrhage?
    a. Increasing blood pressure
    b. Decreasing pulse
    c. Restlessness
    d. Weakness, apathy

ANS: C
Restlessness is the first sign of hemorrhage, due to lack of oxygen flow to the brain. A pulse that increases and becomes thready combined with a declining blood pressure, cool and clammy skin, and reduced urine output may signal hypovolemic shock.

DIF: 5 Cognitive Level: Understanding OBJ: 12 TOP: Postoperative complications
KEY: Nursing Process Step: Data Collection
MSC: NCLEX: Physiological Integrity

14. The nurse instructing a postsurgical patient in the use of thrombolytic deterrent stockings will include which instruction?
    a. Disregard appearance of edema above the stocking.
    b. Massage legs to smooth wrinkles out of stockings.
    c. Wring stockings thoroughly before hanging to dry.
    d. Hand wash stockings in warm water and mild soap.

ANS: D
Stockings should be hand washed gently in warm water and mild soap and laid over a surface to dry. They should not be wrung out or hung. Massaging legs may dislodge a clot The appearance of edema indicates the stockings are too restrictive.

DIF: 5 Cognitive Level: Understanding OBJ: 13
TOP: Thrombolytic deterrent stockings KEY: Nursing Process Step: Implementation
MSC: NCLEX: Physiological Integrity

15. The patient is brought into PACU still unconscious. Which action will the nurse take **FIRST** when the nurse assesses a temperature of 94°F?
    a. Notify the charge nurse immediately.
    b. Offer warm fluids through a straw.
    c. Do nothing, this is a normal reaction to anesthesia.
    d. Cover with a warm blanket.

ANS: D

Hypothermia is a frequent assessment postsurgery. A warm blanket or a ventilated cover would be applied to bring up the temperature. While the charge nurse does need to be notified, the first action should be to apply a warm blanket. A patient who is unconscious should not be given fluids, due to risk of aspiration. Hypothermia, especially marked hypothermia, needs immediate intervention.

DIF: 7 Cognitive Level: Analyzing OBJ: 13 TOP: Hypothermia
KEY: Nursing Process Step: Planning MSC: NCLEX: Physiological Integrity

16. In which location are guidelines for ensuring that all nursing interventions on the day of surgery completed and documented?
    a. In the nurse's notes
    b. In the anesthesia record
    c. In the preoperative checklist
    d. In the progress notes

ANS: C
When the nurse signs the preoperative checklist, that nurse assumes responsibility for all areas of care included on the list. The nurse's notes are not the correct location for all of the pre-operative interventions. The anesthesia provider documents on the anesthesia record. The health care provider documents in the progress notes.

DIF: 3 Cognitive Level: Knowledge OBJ: 6 TOP: Preoperative checklist
KEY: Nursing Process Step: Implementation
MSC: NCLEX: Safe, Effective Care Environment

17. While turning a patient who had a bowel resection yesterday, the wound eviscerated. Which is the **initial** nursing intervention?
    a. Place the patient in the high Fowler's position.
    b. Give the patient fluids to prevent shock.
    c. Replace the dressing with sterile fluffy pads.
    d. Apply a warm, moist normal saline sterile dressing.

ANS: D
Cover the wound with a sterile towel moistened with sterile physiologic saline (warm). The patient is placed in the semi-Fowler's position with the knees slightly flexed to reduce tension on the incision. The patient will need emergency surgery to repair the evisceration and should not be given oral fluids. Fluffy pads are not used, due to the threads coming loose and entering the incision.

DIF: 7 Cognitive Level: Applying OBJ: 13 TOP: Evisceration
KEY: Nursing Process Step: Implementation
MSC: NCLEX: Physiological Integrity

18. When will the nurse offer prescribed analgesics to a patient who is 24 hours postoperative?
    a. Only when the patient asks.
    b. When the onset of pain is assessed.
    c. Sparingly to avoid drug dependence.
    d. Only when severe pain is assessed.

ANS: B

The nurse should assess for pain frequently to medicate at the onset of pain. Some patients do not ask for pain medication, due to cultural reasons, or a perception they are bothering the nurse. For those reasons, the nurse should not wait until the patient asks for pain medication. It is very unusual for patients to become dependent on pain medication when it is given for post-operative pain. Pain medication will be more effective if given at the onset of pain, rather than wait until severe pain is assessed.

DIF: 5 Cognitive Level: Applying OBJ: 14 TOP: Medication administration
KEY: Nursing Process Step: Planning MSC: NCLEX: Physiological Integrity

19. Which action will the nurse take to minimize the potential for venous stasis?
    a. Place pillows under the knee in a position of comfort.
    b. Assist patient to sit with feet flat on the floor.
    c. Assist with early ambulation.
    d. Perform gentle leg massage.

ANS: C
Early ambulation has been a significant factor in hastening postoperative recovery and preventing postoperative complications. Placing a pillow under the patient is contraindicated, as it will increase the risk for venous stasis. The patient may sit in a chair, but walking is the best intervention to reduce the risk of venous stasis. Massaging the legs is contraindicated, as the massage could cause a blood clot to travel toward the heart.

DIF: 5 Cognitive Level: Applying OBJ: 13 TOP: Venous stasis
KEY: Nursing Process Step: Planning MSC: NCLEX: Physiological Integrity

20. The nurse clarifies that serum potassium levels are determined before surgery for which reason?
    a. Assessing kidney function.
    b. Determining respiratory insufficiency.
    c. Preventing arrhythmias related to anesthesia.
    d. Measuring functional liver capability.

ANS: C
Serum electrolytes are evaluated if extensive surgery is planned or the patient has extenuating problems. One of the essential electrolytes examined is potassium; if potassium is not available in adequate amounts, arrhythmias can occur during anesthesia. Assessing the kidney function is not accomplished by assessing just the kidney function. Respiratory insufficiency and liver function cannot be assess by a serum potassium level.

DIF: 7 Cognitive Level: Analyzing OBJ: 4 TOP: Preoperative assessment
KEY: Nursing Process Step: Implementation
MSC: NCLEX: Physiological Integrity

21. In performing the preoperative assessment, the nurse discovers that the patient is allergic to latex. What should the nurse do **initially?**
    a. Notify the diet kitchen to omit bananas from diet tray.
    b. Apply a medical alert band to patient's wrist.
    c. Tag chart with allergy alert.
    d. Place patient in an isolation room.

ANS: B
The initial intervention would be to place a medical alert band on the patient, then tag the chart. The charge nurse and the surgeon should be notified in the event the surgeon wants to order a preoperative prophylactic treatment. The patient will need to go to the designated operating room for patients with latex allergies, or be the first case in the operating room. Even though patients allergic to latex are frequently allergic to bananas, notifying the kitchen the patient is allergic to bananas is not a necessary initial action. The patient should be fasting. It is important to tag the chart, but it is more crucial to attach a medical alert band to the patient, in case the chart is misplaced. There is no need to place the patient in an isolation room.

DIF: 7 Cognitive Level: Analyzing OBJ: 13 TOP: Latex allergy
KEY: Nursing Process Step: Implementation
MSC: NCLEX: Safe, Effective Care Environment

22. Which early postoperative observation should be reported **immediately**?
a. "Coffee ground" emesis
b. Shivering
c. Scanty urine output
d. Evidence of pain

ANS: A
Any emesis that is red or coffee ground should be reported immediately as it indicates GI bleeding. Shivering, scanty urine output, and evidence of pain are within normal expectation of a postsurgical patient.

DIF: 7 Cognitive Level: Analyzing OBJ: 10 TOP: Postoperative assessment
KEY: Nursing Process Step: Data Collection
MSC: NCLEX: Physiological Integrity

23. When the postoperative patient complains of sudden chest pain combined with dyspnea, cyanosis, and tachycardia, the nurse recognizes the signs of which complication?
a. hypovolemic shock.
b. dehiscence.
c. atelectasis.
d. pulmonary embolus.

ANS: D
Sudden chest pain combined with dyspnea, tachycardia, cyanosis, diaphoresis, and hypotension is a sign of pulmonary embolism. Hypovolemic shock is indicated by hypotension, tachycardia, restlessness and cool, clammy skin. Dehiscence is the sudden opening of the surgical wound. Atelectasis is "collapsed lung", characterized by fever, and reduced breath sounds in the lower lobes.

DIF: 7 Cognitive Level: Analyzing OBJ: 13
TOP: Assessment and postoperative complications
KEY: Nursing Process Step: Data Collection
MSC: NCLEX: Physiological Integrity

24. The removal of a nondiseased appendix during a hysterectomy is classified in which way?
a. major, emergency, diagnostic.

b. major, urgent, palliative.
c. minor, elective, ablative.
d. minor, urgent, reconstructive.

ANS: C
Surgery is classified as elective, urgent, or emergency. Surgery is performed for various purposes, which include diagnostic studies, ablation (an amputation or excision of any part of the body or removal of a growth or harmful substance), and palliative (therapy to relieve or reduce intensity of uncomfortable symptoms without cure), reconstructive, transplant, and constructive purposes.

DIF: 4 Cognitive Level: Understanding OBJ: 2 TOP: Types of surgeries
KEY: Nursing Process Step: Planning MSC: NCLEX: Physiological Integrity

25. Which medication would cause surgery to be delayed if it had not been discontinued several days before surgery?
a. Analgesic agent
b. Antihypertensive agent
c. Anticoagulant agent
d. Antibiotic agent

ANS: C
Anticoagulants alter normal clotting factors and thus increase risk of hemorrhaging. They should be discontinued for 48 hours before surgery. It is not necessary to discontinue analgesic agents unless they contain aspirin, which alters the clotting function. Antihypertensive medications lower the blood pressure and prevent heart attack and stroke. Consult with the surgeon and/or anesthesia provider regarding use of this medication. Antibiotic agents are not generally discontinued before surgery. If given orally, consult with the surgeon and/or anesthesia provider.

DIF: 7 Cognitive Level: Analyzing OBJ: 4
TOP: Individual's ability to tolerate surgery
KEY: Nursing Process Step: Planning MSC: NCLEX: Physiological Integrity

26. Which intervention by the nurse will decrease the pain of an abdominal incision while coughing?
a. support the surgical site with a pillow.
b. position patient in a side-lying position.
c. medicate with prescribed narcotic three hours before coughing.
d. ask the patient to cross arms over the chest to increase force of cough.

ANS: A
To ease the pressure on the incision, the nurse helps the patient support the surgical site with a pillow or rolled bath blanket. The heel of the hand can be used as well, but it is not the ideal method. Positioning the patient in a side-lying position would not reduce the pain while coughing. Medicating the patient with a narcotic three hours before coughing would not be effective, due to the fact that the medication level would be greatly reduced. Asking the patient to cross arms over the chest would not reduce the pain level.

DIF: 5 Cognitive Level: Applying OBJ: 8
TOP: Postoperative nursing interventions KEY: Nursing Process Step: Planning
MSC: NCLEX: Physiological Integrity

27. Which patient statement indicates the patient needs further education regarding tomorrow's scheduled bowel resection surgery?
    a. "I am going to have adequate pain medication after surgery."
    b. "I know you all are going to make me cough and walk soon after surgery."
    c. "I am glad I will get to go home tomorrow evening."
    d. "I will have to put up with dressing changes."

    ANS: C
    The patient's lack of understanding about the length of time in the hospital following such a serious surgery indicates a knowledge deficit that needs to be addressed. The patient should expect adequate pain control, coughing and early ambulation and dressing changes to occur after surgery.

    DIF: 7 Cognitive Level: Evaluating OBJ: 16 TOP: Nursing process
    KEY: Nursing Process Step: Evaluation MSC: NCLEX: Safe, Effective Care Environment

28. Which instruction will the nurse give when teaching the patient to cough effectively after surgery?
    a. Breathe through the nose, hold breath, and exhale slowly.
    b. Take three deep breaths and cough from the chest.
    c. Inhale while contracting the abdominal muscles and exhale while contracting the diaphragm.
    d. Take short, frequent panting breaths and cough from the throat to clear accumulated mucus.

    ANS: B
    Because lung ventilation is vital, the nurse assists the patient to turn, cough, and breathe deeply every 1 to 2 hours until the chest is clear. Having practiced this combination preoperatively, the patient is usually adequately able to remove trapped mucus and surgical gases. The patient should first take three deep breaths, and cough deeply from the chest. Breathing through the nose, holding the breath and exhaling slowly describes deep breathing, not coughing. Diaphragmatic breathing is not the same as coughing. The patient should breathe deeply and cough from the lungs, not take short, panting breathings or cough from the throat.

    DIF: 5 Cognitive Level: Applying OBJ: 8
    TOP: Prevention of postoperative complications
    KEY: Nursing Process Step: Implementation
    MSC: NCLEX: Physiological Integrity

29. Which is the responsibility of the nurse as a witness to informed consent?
    a. Explain the surgical options.
    b. Explain the operative risks.
    c. Verify/obtain the patient's signature.
    d. Verify the patient's understanding of the procedure.

    ANS: C

A witness is only verifying that this is the person who signed the consent and that it was a voluntary consent. The witness (often a nurse) is not verifying that the patient understands the procedure. It is the surgeon's responsibility to explain the surgical options, and operative risks. If the patient indicates not understanding the procedure, the nurse should contact the surgeon.

DIF: 3 Cognitive Level: Knowledge OBJ: 7 TOP: Informed consent
KEY: Nursing Process Step: Implementation
MSC: NCLEX: Safe, Effective Care Environment

30. On the patient's return to the medical-surgical unit, the nurse performing an abdominal assessment can affirm an absence of bowel sounds after listening in each quadrant for which length of time?
a. 30 seconds.
b. 1 minute.
c. 2 minutes.
d. 3 minutes.

ANS: D
Normal peristalsis is gauged by hearing 5 to 30 gurgles per minute. Absence of bowel sounds may be recorded if the nurse has listened to each quadrant 3 to 5 minutes.

DIF: 3 Cognitive Level: Knowledge OBJ: 12 TOP: Bowel sounds
KEY: Nursing Process Step: Data Collection
MSC: NCLEX: Physiological Integrity

31. When the patient asks the nurse "please make sure no one sees me with my dentures out", the nurse recognizes which common preoperative fear?
a. anesthesia.
b. loss of control.
c. fear of separation from family.
d. mutilation.

ANS: B
Fear of loss of control may be partially related to concerns about anesthesia, but this patient's concern is about self-image. Preoperative anxiety from any cause may affect the amount of anesthesia and postoperative analgesia needed. Asking to not be seen without dentures does not reflect separation fear or fear of mutilation.

DIF: 4 Cognitive Level: Understanding OBJ: 4 TOP: Nursing process
KEY: Nursing Process Step: Data Collection
MSC: NCLEX: Health Promotion and Maintenance

32. Which is the ideal time for preoperative teaching?
a. Immediately before surgery to eliminate fear
b. 2 months in advance so the patient can prepare
c. 1 to 2 days before the surgery when anxiety is not as high
d. In the surgical holding area

ANS: C
Preoperative teaching is provided when the surgery is scheduled if the patient is being seen in the surgeon's office, when anxiety is not as high.

DIF: 3 Cognitive Level: Knowledge OBJ: 4 TOP: Preoperative teaching
KEY: Nursing Process Step: Implementation
MSC: NCLEX: Health Promotion and Maintenance

33. In preparation for the return of the patient following surgery, the patient's bed and equipment should be in which position?
    a. Lowest position with side rails elevated with oxygen and suction equipment available
    b. Highest position with side rails elevated with IV pole and pump at bedside
    c. Lowest position with side rails down on the receiving side
    d. Highest position with the side rails down on receiving side and up on opposite side

ANS: D
In preparation for the return of the patient following surgery, the patient's bed should be in the highest position to be level with the surgical gurney and should have the side rail down on the receiving side, with the opposite side rail up to prevent the patient from falling out of bed during transfer.

DIF: 3 Cognitive Level: Knowledge OBJ: 12 TOP: Postoperative preparation
KEY: Nursing Process Step: Planning MSC: NCLEX: Health Promotion and Maintenance

34. A patient is transferred from the operating room to the recovery room after undergoing an amputation of his left foot. Which intervention is the last step for immediate assessment once the patient enters the PACU?
    a. System review
    b. Breathing
    c. Circulation
    d. Airway
    e. Level of consciousness

ANS: A
The assessment of an adequate airway is primary in the postanesthesia assessment, followed by breathing assessment, level of consciousness, circulation, and finally system review.

DIF: 5 Cognitive Level: Applying OBJ: 12 TOP: Nursing assessment
KEY: Nursing Process Step: Implementation
MSC: NCLEX: Health Promotion and Maintenance

35. Which is the first step a patient should take to control coughing?
    a. Inhale deeply and hold breath for a count of three.
    b. Document exercise and patient reaction.
    c. Cough two or three times without inhaling then relax.
    d. Take several deep breaths, inhaling through the nose.

ANS: D
The patient should be instructed to take several deep breaths, inhale through the nose, exhale through pursed lips, inhale deeply and hold for a count of three, cough two or three times without exhaling, relax. The procedure may be repeated before documentation.

DIF: 3 Cognitive Level: Knowledge OBJ: 8 TOP: Controlled coughing
KEY: Nursing Process Step: Implementation
MSC: NCLEX: Physiological Integrity

MULTIPLE RESPONSE

1. A postoperative patient who had a left inguinal hernia repair is ready for discharge instructions. Which information should the nurse provide? *(Select all that apply.)*
   a. Care of the wound site and any dressings
   b. When he may operate a motor vehicle
   c. Signs and symptoms to report to the surgeon
   d. Call the physician's office once the patient arrives home
   e. Report bowel movements to the surgeon
   f. Actions and side effects of any medications

   ANS: A, B, C, F
   The nurse should provide instructions regarding wound and dressing care, when operating a motor vehicle is allowed, when to contact the surgeon and the actions and side effects of medications. It is not necessary for the patient to contact the surgeon's office once the patient arrives home or to report bowel movements unless there is an abnormality.

   DIF: 7 Cognitive Level: Applying OBJ: 15 TOP: Discharge instructions
   KEY: Nursing Process Step: Planning MSC: NCLEX: Safe, Effective Care Environment

2. Which is a consideration for the older adult surgical patient? *(Select all that apply.)*
   a. The need for specific clear preoperative and postoperative teaching
   b. Awareness of lower morbidity and mortality rate
   c. Presence of coexisting conditions
   d. Increased risk of respiratory complications
   e. Expectation of normal recovery time

   ANS: A, C, D
   Surgery places greater stress on older than on younger patients. Teaching should be given at the older person's level of understanding. Teaching should be specific and clear. Presence of coexisting conditions may delay recovery time and response to surgery. Older adults have a higher morbidity and mortality rate. Recovery time is generally longer than young adults.

   DIF: 7 Cognitive Level: Applying OBJ: 5 TOP: Older adult considerations
   KEY: Nursing Process Step: Planning MSC: NCLEX: Physiological Integrity

3. Which preoperative condition may affect the patient's response to surgery? *(Select all that apply.)*
   a. Age
   b. Religion
   c. Mental status
   d. Occupation
   e. Nutritional status

   ANS: A, C, E

Each system of the body is affected by the patient's age, health, nutritional status, and mental state. Religion and occupation do not affect the physiologic response to the surgery.

DIF: 7 Cognitive Level: Understanding OBJ: 4
TOP: Factors influencing toleration to surgery
KEY: Nursing Process Step: Data Collection
MSC: NCLEX: Health Promotion and Maintenance

4. Which intervention in preparing the patient for abdominal surgery may be delegated to unlicensed assistive personnel (UAP)? *(Select all that apply.)*
   a. Vital signs
   b. Insertion of N/G tube
   c. Enema
   d. Height and weight
   e. Obtaining operative consent
   f. Sterile gowning

   ANS: A, C, D
   Vital signs, enema, and height and weight can be safely performed by UAP. Insertion of an N/G tube, obtaining an operative consent, and sterile gloving are interventions requiring critical thinking and knowledge unique to a nurse.

   DIF: 7 Cognitive Level: Applying OBJ: 3 TOP: Delegation
   KEY: Nursing Process Step: Implementation
   MSC: NCLEX: Health Promotion and Maintenance

COMPLETION

1. _____ therapy is performed to alleviate or decrease uncomfortable symptoms without curing the problem.

   ANS:
   Palliative

   Palliative therapy is designed to relieve or reduce intensity of uncomfortable symptoms without cure.

   DIF: 1 Cognitive Level: Knowledge OBJ: 1 TOP: Palliative therapy
   KEY: Nursing Process Step: Data Collection
   MSC: NCLEX: Safe, Effective Care Environment

2. Discharge planning for a surgical procedure begins in the preoperative period and continues through the _____ period.

   ANS:
   recuperative

   When discharge planning is begun in the preoperative period and all through the postoperative period, the patient can assume greater responsibility for self-care and will experience less stress about going home.

DIF: 2 Cognitive Level: Knowledge OBJ: 15 TOP: Discharge planning
KEY: Nursing Process Step: Planning MSC: NCLEX: Health Promotion and Maintenance

3. The type of anesthesia that uses a combination of drugs to reduce the level of consciousness and provides amnesia is conscious (or moderate) _____.

ANS:
sedation

Conscious/moderate sedation uses a combination of drugs to produce a reduced level of consciousness and amnesia, as well as pain control, but allows the patient to control his or her own breathing. The recovery is more rapid than with general anesthesia.

DIF: 1 Cognitive Level: Knowledge OBJ: 10 TOP: Conscious sedation
KEY: Nursing Process Step: Planning MSC: NCLEX: Physiological Integrity

4. The nurse is aware that there is a loss of _____ during catabolism after severe tissue injury.

ANS:
potassium

The injured cells loose potassium as catabolism (tissue breakdown) occurs.

DIF: 2 Cognitive Level: Knowledge OBJ: 4 TOP: Catabolism
KEY: Nursing Process Step: Planning MSC: NCLEX: Physiological Integrity

5. The nurse explains that to promote deep breathing and improve lung expansion and oxygenation the patient should use the _____ _____ at regular intervals during the day.

ANS:
incentive spirometer

The incentive spirometer is a device to encourage deep breathing and lung expansion. The usual rate of usage is 10 breaths hourly during waking hours.

DIF: 2 Cognitive Level: Knowledge OBJ: 13 TOP: Incentive spirometer
KEY: Nursing Process Step: Implementation
MSC: NCLEX: Physiological Integrity

6. The nurse caring for a postsurgical patient is aware that the patient should void ____ to 8 hours postsurgery.

ANS:
6

Urinary output should be obvious 6 to 8 hours postsurgery. If urinary output has not begun, a catheter may be inserted.

DIF: 2 Cognitive Level: Knowledge OBJ: 13 TOP: Resumption of urinary flow
KEY: Nursing Process Step: Data Collection
MSC: NCLEX: Physiological Integrity