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Question: 1

Using what is known about the efficacy and safety of particular therapies or management strategies is known as which of the following?

A. research-informed practice
B. cognitive practice
C. evidence-informed practice
D. efficacy practice

Answer: C

Explanation:
Using the best evidence to plan and provide care for individuals is what is meant by evidence-informed practice. Best evidence refers to what is known about the efficacy and safety of particular therapies or management strategies.

Question: 2

A client tells the nurse he boils his urinary catheters for sterilization. The nurse should ask which of the following?

A. “What is the length and width of the catheter tubing?”
B. “How long do you boil them?”
C. “Tell me the procedure you use from start to finish.”
D. “Doesn’t insurance pay for sterile catheters?”

Answer: C

Explanation:
The question presented to the nurse about a client boiling his urinary catheters for sterilization pertains to ensuring that the client is following a safe and effective method for sterilizing his medical equipment. The nurse's primary concern should be whether the sterilization process being used by the client is adequate to prevent infections and maintain the integrity of the catheters.
The first response option, asking about the "length and width of the catheter tubing," is not directly relevant to the issue of sterilization. While the dimensions of the catheter are important for ensuring proper fit and function, they do not provide information about the sterilization process.
The second response option, “How long do you boil them?” is more pertinent but still incomplete. Knowing the duration of boiling is a critical component of the sterilization process, as insufficient time may not effectively sterilize the catheter, while excessive boiling could damage the material. However, this question alone does not address other important aspects of the sterilization procedure.

The third option, asking the client to “Tell me the procedure you use from start to finish,” is the most comprehensive approach. This response invites the client to explain his entire sterilization process, allowing the nurse to assess each step for correctness and safety. It opens up a detailed conversation that covers not only the duration of boiling but also how the catheters are handled before and after boiling, how they are stored, and whether the client uses any additional methods or substances to ensure sterilization.
The fourth option, “Doesn’t insurance pay for sterile catheters?” while potentially practical, might divert the conversation away from the immediate need to verify the client’s sterilization technique. It could be relevant in discussing long-term solutions or alternatives to boiling catheters, but it does not help in assessing the current practice's adequacy.
In summary, the best question for the nurse to ask in this situation is, “Tell me the procedure you use from start to finish.” This approach not only gathers comprehensive information about the client's current practice but also builds a foundation for educating the client on best practices and possibly discussing alternatives that could enhance safety and effectiveness.

Question: 3

Which clinical characteristic affects client compliance?

A. drug knowledge
B. psychosocial factors
C. the nurse-client relationship
D. disease duration and severity

Answer: C

Explanation:
Client compliance in healthcare is a critical factor that directly influences treatment outcomes and overall patient well-being. Compliance, or adherence, refers to how closely a client follows the medical advice provided by healthcare professionals. Several factors can affect this compliance, two of which are clinical characteristics: the nurse-client relationship and the therapeutic regimen.
Firstly, the nurse-client relationship is fundamental in fostering an environment where clients feel supported and understood. A strong, positive relationship between a nurse and a client can significantly enhance compliance. This relationship is built on trust, communication, and mutual respect. When clients trust their nurses and feel that they are genuinely cared for, they are more likely to follow medical advice and engage actively in their treatment plans. Effective communication ensures that clients understand their health conditions, the importance of following the prescribed treatments, and the potential consequences of non-compliance. Furthermore, a nurse who listens and responds empathetically to a client's concerns can help alleviate fears and misconceptions, which in turn can improve compliance.
Secondly, the therapeutic regimen itself can impact compliance. Complex regimens with multiple medications or demanding lifestyle changes can be overwhelming for clients. The clearer and simpler the regimen, the higher the likelihood of compliance. Moreover, if the regimen involves severe side effects or disrupts the client’s daily life significantly, compliance might decrease. Nurses play a crucial role in explaining these regimens, why they are necessary, and how to manage them effectively, which can alleviate concerns and enhance adherence.

It is important to note that while these are clinical characteristics impacting compliance, there are also several client-specific characteristics involved. These include the client's knowledge about the drug, psychosocial factors, and the duration and severity of the disease. Clients who are well-informed about their medications and treatment rationale tend to adhere better to their treatment plans. Psychosocial factors such as social support, mental health status, and personal beliefs about medicine also play a role. Lastly, the duration and severity of the disease can affect a client's motivation to comply; chronic or more severe conditions might either motivate compliance due to the desire for relief or hinder it due to treatment fatigue.
In summary, while client compliance is influenced by various factors, the nurse-client relationship and the therapeutic regimen are two key clinical characteristics that healthcare professionals can focus on to improve adherence. By strengthening the nurse-client relationship and simplifying therapeutic regimens as much as possible, nurses can significantly enhance client compliance, ultimately leading to better health outcomes.

Question: 4

Which of the following would be the least appropriate guideline for teaching plans for patients and families?

A. Establish the outcome of the teaching.
B. Determine what content needs to be taught.
C. Give the patient and family as much information as possible from every source possible.
D. Determine the most appropriate teaching strategy.

Answer: C

Explanation:
This is the least appropriate guideline. The teaching strategy for patients and families must be planned carefully. Patients and families in the care setting are stressed and an overload of information adds to their stress. When planning education, consider content and amount based on the assessment of the patient and family.

Question: 5

The school nurse is approached by a mother who explains that her kindergarten child is constantly scratching the perianal area and that the area is irritated. The PN understands that she should instruct the mother to obtain a rectal specimen by a tape test and that the mother should obtain the specimen when?

A. after bathing
B. when the child is put to bed
C. in the morning, when the child awakes
D. after toileting

Answer: C

Explanation:
The scenario described involves a common childhood condition known as pinworm infection. Pinworms are small, thread-like parasites that typically cause itching around the anus. The itching is most noticeable at night or early in the morning as the female worms move to the area around the anus to lay their eggs. This itchiness leads to scratching, which can cause irritation and discomfort in the perianal area.
To diagnose a pinworm infection, a simple and effective method known as the "tape test" is used. This involves using a piece of clear tape to pick up pinworm eggs from around the anus. The tape is then placed on a microscope slide for examination under a microscope. The reason the tape test is effective is that pinworm eggs stick to the tape and can be easily seen under a microscope.
The timing of the tape test is crucial for accurate results. The best time to perform this test is in the morning immediately after the child wakes up and before any morning toileting or bathing. This timing is recommended because pinworms lay their eggs at night, making the concentration of eggs around the anus highest at this time. Bathing or using the toilet might remove or disperse the eggs, making it difficult to obtain a sample that accurately reflects the presence of pinworms.
Therefore, the school nurse should instruct the mother to perform the tape test early in the morning, right after the child wakes up and before the child has bathed or used the toilet. This method ensures the highest likelihood of collecting eggs if they are present, thereby providing a reliable sample for diagnosis.
Understanding and following these instructions accurately is critical for diagnosing and subsequently treating pinworm infections effectively, ensuring relief from the persistent itching and discomfort for the child.

Question: 6

What element of therapeutic communication takes into consideration body language, tone, and rhythm of voice?

A. Sender.
B. Message.
C. Channel.
D. Receiver.
Explanation:

Answer: B

Therapeutic communication is a structured form of communication used primarily in healthcare settings to support, educate, or counsel patients. It consists of several elements which contribute to the effectiveness of the interaction. These elements include the sender, the message, the channel, the receiver, the environment, and feedback. Each of these components plays a vital role in the communication process, but it is the *message* that directly encompasses the use of body language, tone, and rhythm of voice.
The *message* refers to the content of the communication. It is not just what is said verbally but also how it is said and presented. Body language, tone, and rhythm of voice are crucial non-verbal cues that can significantly affect the clarity, reception, and interpretation of the message. For example, a calm and gentle tone can soothe an anxious patient, while a friendly and open posture can make the patient feel more comfortable and willing to share sensitive information.

Body language involves gestures, facial expressions, and postures that convey attitudes, feelings, and responses. A healthcare provider who maintains eye contact and an open posture is likely to appear more approachable and empathetic. *Tone* refers to the quality or inflection of the voice that expresses the speaker's emotions or attitudes. A caring and attentive tone can help in building trust and rapport with the patient. *Rhythm of voice* includes the pace and fluency of the speech. Speaking too fast may overwhelm the patient, while speaking too slowly might imply condescension or disinterest. Therefore, in therapeutic communication, the *message* is not merely about the words used but also about how these words are delivered through body language, tone, and rhythm of voice. These elements are essential in ensuring that the correct message is conveyed effectively and empathetically, aligning with the goals of therapeutic communication in healthcare settings.

Question: 7

Which of the following is not scored with the APGAR?

A. Breathing rate
B. Pulse rate
C. Hand/foot size
D. Muscle tone

Answer: C

Explanation:
The APGAR score is a quick test performed on a newborn baby at 1 and 5 minutes after birth. The name "APGAR" itself is an acronym derived from the aspects it measures: Appearance, Pulse, Grimace, Activity, and Respiration. Each category is scored on a scale from 0 to 2, with a maximum total score of 10. This test assesses the immediate physical condition of the newborn and determines any immediate need for extra medical or emergency care.
When evaluating the options provided in the question, we focus on determining which of the listed items is not part of the APGAR scoring system. The correct answer is "Hand/foot size." Here's a breakdown of each component:
1. **Appearance**: This refers to the skin color of the baby. A score of 0 is given if the baby's skin color is pale blue; 1 if the body is pink and the extremities are blue; and 2 if the entire body is pink.
2. **Pulse**: This is the heart rate of the baby. A score of 0 means no heartbeat is detected; 1 means a heartbeat is fewer than 100 beats per minute; 2 indicates a rate over 100 beats per minute.
3. **Grimace** (reflex irritability): This tests the baby's reflexes to stimulation, such as a light pinch. A score of 0 is given if there's no reaction; 1 for grimacing; and 2 for grimacing and a cough, sneeze, or vigorous cry.
4. **Activity** (muscle tone): This assesses muscle tone and physical activity. A score of 0 is given if muscles are floppy; 1 if there is some muscle tone and motion; and 2 if there is active motion.
5. **Respiration**: This measures the breathing effort of the baby. A score of 0 is given if the baby is not breathing; 1 if the breathing is slow or irregular; and 2 if the baby cries well, indicating normal breathing.
From this explanation, it is clear that hand/foot size is not included in the APGAR scoring system. The size of extremities does not correlate with the immediate health concerns addressed by the APGAR score. Thus, assessments of extremity size would not provide immediate clinically relevant data for

newborn vitality just after birth. Therefore, the correct answer to the original question is "Hand/foot size," as it is not a factor considered in the APGAR score.

Question: 8

A nurse has obtained packed red blood cells from the blood bank to administer to a client. The nurse should begin to administer the blood product within

A. an hour
B. 30 minutes
C. 2 hours
D. 45 minutes

Answer: B

Explanation:
The correct protocol for administering packed red blood cells, once they are obtained from the blood bank, is to begin the infusion within 30 minutes. This timeframe is crucial to ensure the safety and integrity of the blood product.
Once a nurse retrieves packed red blood cells from the blood bank, a countdown essentially begins. This 30-minute window is established for several reasons, primarily revolving around the maintenance of the blood's optimal temperature and quality. Blood products are stored under strict conditions in the blood bank to preserve their usability and prevent any bacterial growth. Once outside of these controlled environments, the potential for temperature changes and contamination increases.
The guideline to start administering within 30 minutes ensures that the blood is infused when it is still within a safe temperature range and hasn't been compromised in any way. Delaying beyond this window can increase the risk of bacterial proliferation, which is a serious health risk for the recipient. Furthermore, adherence to this timeframe helps to align with various regulatory and accrediting agency standards that hospitals and healthcare facilities must follow.
The actual infusion of packed red blood cells typically takes about 2 hours. This duration allows for a slow, controlled introduction of blood into the client’s system, minimizing the risk of adverse reactions and allowing for careful monitoring of the patient's response to the transfusion. It is important for the healthcare provider to continuously assess the patient for any signs of transfusion reactions during and after the procedure.
In summary, the 30-minute rule for initiating the administration of packed red blood cells is a critical part of transfusion protocols that helps safeguard patient health by ensuring the blood product is as safe as possible when administered.

Question: 9

A healthy first time pregnant client asks the nurse, "How long will I stay in the hospital after my baby is born." The client is scheduled for a Caesarean section. The nurse understands the average timeframe for the hospital stay for a Caesarean section is what?

A. 12-24 hours.
B. 30-36 hours.

C. 37-48 hours.
D. 72 hours.
Explanation:

Answer: D

When a pregnant woman undergoes a Caesarean section, commonly referred to as a C-section, the hospital stay is typically longer compared to a vaginal birth. This extended stay is primarily due to the nature of the procedure, which is a surgical operation. During a C-section, the baby is delivered through an incision made in the mother's abdomen and uterus.
Post-operative care is crucial to ensure both the mother and the newborn are healthy and recovering well. This care includes managing pain, monitoring for any signs of infection at the incision site, ensuring proper healing, and assisting the mother with initial breastfeeding and caring for the newborn.
For a C-section that is planned and occurs without any complications, the average hospital stay is around 72 hours. This timeframe allows healthcare professionals adequate time to monitor the mother's recovery from surgery and ensure that both mother and baby are ready to go home. During this period, the mother receives support and education from nurses and other healthcare staff about how to care for the wound and her baby.
The 72-hour stay is considered standard for uncomplicated C-sections under normal circumstances. However, the duration of the hospital stay can vary based on individual health conditions, the presence of any complications during or after the surgery, and the specific policies of the hospital. It's important for patients to discuss their specific case with their healthcare provider to get tailored information regarding their expected hospital stay.

Question: 10

Which of the following is a requirement for a patient to meet the functional standard for determining decision-making capacity?

A. ability to comprehend
B. ability to communicate
C. ability to form and express a preference
D. all of the above

Answer: D

Explanation:
All of the choices are requirements for a patient to meet the functional standard for determining decision-making capacity. The functional standard of determining capacity focuses on the patient's abilities as a decision maker rather than on the condition of the patient or the projected outcome of the decision.

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