Perry: Clinical Nursing Skills & Techniques, 7th Edition

Chapter 2: Admitting, Transfer, and Discharge

Test Bank

MULTIPLE CHOICE

1. The patient is scheduled to go home after having coronary angioplasty. The most effective way to provide discharge teaching to this patient would be to:
   a. Provide him with information on health care websites
   b. Provide him with written information on what he has to do
   c. Sit and carefully explain what is required before his follow up
   d. Use a combination of verbal and written information

   ANS: D
   For discharge teaching, use a combination of verbal and written information. This most effectively provides patients with standardized care information, which has been shown to improve patient knowledge and satisfaction.

   DIF: Cognitive Level: Application REF: Text Reference: Page 11
   OBJ: Identify the ongoing needs of patients in the process of discharge planning.
   TOP: Admission to Discharge Process KEY: Nursing Process Step: Implementation
   MSC: NCLEX: Physiological Integrity

2. While preparing for the patient's discharge, the nurse uses a discharge planning checklist and notes that the patient is concerned about going home because she lives alone. The nurse realizes that successful recovery at home is often based on:
   a. The patient's perception of readiness
   b. Family involvement
   c. The ability to live alone
   d. Allowing the patient to make her own arrangements

   ANS: A
   A patient's perception of readiness for discharge is related to postdischarge coping and improved outcomes. High-quality discharge teaching improves the patient's readiness for discharge. A positive perception of readiness helps the patient to successfully manage care and continue recovery at home without placing a burden on the family. A patient's perception of lack of readiness for discharge places an increased burden on the family, rather than the medical system, for support.

   DIF: Cognitive Level: Analysis REF: Text Reference: Page 11
   OBJ: Identify the ongoing needs of patients in the process of discharge planning.
   TOP: Medication Reconciliation KEY: Nursing Process Step: Assessment
   MSC: NCLEX: Physiological Integrity

3. The patient arrives at the emergency department complaining of severe abdominal pain and vomiting. The patient is severely dehydrated. The physician orders the patient to receive IV fluids for the dehydration and an IV antiemetic. However, the patient states that she is fearful of needles and adamantly refuses to have an IV started. The nurse explains the importance and rationale for the ordered treatment, but the patient continues to refuse. The nurse should:
   a. Summon the nurse technician to hold the arm down while the IV is inserted
   b. Use a numbing medication before inserting the IV
   c. Document the patient's refusal and notify the physician
   d. Tell the patient that she will be discharged without care unless she complies

   ANS: C
   The Patient Self-Determination Act, effective December 1, 1991, requires all Medicare- and Medicaid-recipient hospitals to provide patients with information about their right to accept or reject medical treatment.

   DIF: Cognitive Level: Application REF: Text Reference: Page 12
   OBJ: Describe the nurse's role in maintaining continuity of care through a patient's admission, transfer, and discharge from an acute care facility.
   TOP: Patient Self-Determination Act KEY: Nursing Process Step: Implementation
   MSC: NCLEX: Physiological Integrity

4. An unconscious patient is admitted through the emergency room. Identification of the patient should be:
   a. Determined only when the patient is able
   b. Postponed until family members arrive
   c. Given an anonymous name under the "blackout" procedure
   d. Determined before treatment is started

   ANS: B
   If a patient is unconscious, identification often is not made until family members arrive. Delaying treatment can cause deterioration of the patient's condition. Blackout procedures are intended mainly to protect crime victims.

   DIF: Cognitive Level: Application REF: Text Reference: Page 14
   OBJ: Describe the nurse's role in maintaining continuity of care through a patient's admission, transfer, and discharge from an acute care facility. TOP: The Unconscious Patient
   KEY: Nursing Process Step: Implementation
   MSC: NCLEX: Physiological Integrity

5. During admission of a patient, the nurse notes that the patient speaks another language and may have difficulty understanding English. The nurse should:
   a. Use hand gestures to explain
   b. Request and wait for an interpreter
   c. Work with the family to gather information
   d. Complete as much of the admission assessment as possible using simple phrases

   ANS: B

If the patient does not speak English or has a severe hearing impairment, the clerk must have access to an interpreter to assist during the admission procedure. Translation services are preferable to using family members to ensure correct translation of medical terminology.
Hand gestures and simple phrases may not be adequate for everything that will be discussed at the time of admission,.

DIF: Cognitive Level: Application REF: Text Reference: Page 12
OBJ: Describe the nurse's role in maintaining continuity of care through a patient's admission, transfer, and discharge from an acute care facility.
TOP: The Patient Who Does Not Speak English
KEY: Nursing Process Step: Implementation
MSC: NCLEX: Physiological Integrity

6. The patient has been admitted to the Emergency Department after being beaten and raped. She is agitated and frightened that her attacker may find her in the hospital and try to kill her. The nurse informs the patient that:
   a. She is safe in the hospital, and that she needs to provide her name
   b. She can be admitted to the hospital without anyone knowing it
   c. Her records will be used as evidence in the trial
   d. Since she has come to the hospital, she has to be examined by the doctor

   ANS: B
   A patient who has been a victim of crime can be admitted anonymously under an agency's "blackout" or "do not publish" procedure. HIPAA places limits on the institution's ability to use or disclose the patient's PHI. The Patient Self-Determination Act prohibits the hospital from requiring her to submit to an examination.

   DIF: Cognitive Level: Analysis REF: Text Reference: Page 12
   OBJ: Describe the nurse's role in maintaining continuity of care through a patient's admission, transfer, and discharge from an acute care facility. TOP: Victim of Crime
   KEY: Nursing Process Step: Implementation
   MSC: NCLEX: Physiological Integrity

7. The patient is admitted to the ICU after having been in a motor vehicle accident. He was intubated in the Emergency Department and needs to receive two units of packed red blood cells. He is conscious but is indicating that he is in pain by guarding his abdomen. To admit this patient, the nurse first will focus on:
   a. Examining the patient and treating the pain
   b. Orienting the family to the ICU visitation policy
   c. Making sure that the consent forms are signed
   d. Informing the patient of his HIPAA rights

   ANS: A
   When a critically ill patient reaches a hospital's nursing division, the patient immediately undergoes extensive examination and treatment procedures. Little time is available for the nurse to orient the patient and family to the division or to learn of their fears or concerns.

DIF: Cognitive Level: Analysis REF: Text Reference: Page 14
OBJ: Describe the nurse's role in maintaining continuity of care through a patient's admission, transfer, and discharge from an acute care facility. TOP: Role of the Nurse
KEY: Nursing Process Step: Implementation
MSC: NCLEX: Physiological Integrity

8. The nurse is admitting the patient to the medical unit. The patient indicates that he has had several surgeries in the past and has been a diabetic for the last 15 years. He also states that he has allergies to sulfa and eggs. He claims that he had severe back pain earlier that morning, but the pain has finally gone since he received a "pain shot" in the Emergency Department. The nurse realizes that she must:
   a. Provide the patient with an allergy arm band and document his allergies
   b. Postpone routine admission procedures immediately
   c. Ask the patient if he wants a smoking room
   d. Have all family or friends leave the room

   ANS: A
   Provide the patient with an allergy arm band listing allergies to foods, drugs, latex, or other substances; document allergies according to hospital policy. Postpone routine admission procedures only if the patient is having acute physical problems. Smoking is prohibited throughout the hospital, and family or friends can remain if the patient wishes to have them assist with changing into a hospital gown or pajamas.

   DIF: Cognitive Level: Analysis REF: Text Reference: Page 16
   OBJ: Describe the nurse's role in maintaining continuity of care through a patient's admission, transfer, and discharge from an acute care facility. TOP: Allergies
   KEY: Nursing Process Step: Implementation
   MSC: NCLEX: Physiological Integrity

9. Separation anxiety is most common in:
   a. School-age children
   b. Preschoolers
   c. Middle infancy
   d. Newborns

   ANS: C
   Separation anxiety is most common from middle infancy throughout the toddler years, especially from ages 16 to 30 months. The child experiences protest, despair, and detachment. Preschoolers can tolerate brief periods of separation. School-age children can cope with separation but have an increased need for parental security and guidance.

   DIF: Cognitive Level: Synthesis REF: Text Reference: Page 17
   OBJ: Explain the role of the patient's family in the admission, transfer, or discharge process.
   TOP: Pediatric Considerations KEY: Nursing Process Step: Assessment
   MSC: NCLEX: Physiological Integrity

10. The patient is an 83-year-old gentleman who has the beginning stages of dementia. To prevent the patient from falling or "escaping," the nurse should:
    a. Have the patient stay in his room

b. Have the family take all of the patient's belongings home
c. Allow the patient to be as independent as possible
d. Give the patient antianxiety medication

ANS: C
Hospitalized older adults with functional disabilities often rapidly regress into a helpless state during hospitalization. Interventions that retain functional status include daily orientation cues for the patient, allowing the patient to be as independent as can be tolerated, and providing reassurance about the probability of transient delirium and the use of physical therapy (PT) and occupational therapy (OT) daily.

Get the patient up and out of the room at least daily. Personalize the environment to make it more pleasant and comfortable. Medications with sedative or tranquilizing effects can increase the risk of falls.

DIF: Cognitive Level: Synthesis REF: Text Reference: Page 18
OBJ: Describe the nurse's role in maintaining continuity of care through a patient's admission, transfer, and discharge from an acute care facility.
TOP: Gerontological Considerations KEY: Nursing Process Step: Implementation
MSC: NCLEX: Physiological Integrity

11. The patient is in the Emergency Department of a small community hospital complaining of severe chest discomfort. The patient needs to have emergency cardiac catheterization with possible angioplasty, but to receive the procedure, he will have to be transferred to a larger hospital about 10 miles away. To transport this patient, the nurse will need to:
a. Call for basic ambulance service
b. Obtain the patient's consent
c. Make copies of the Emergency Department record
d. Keep the patient calm by not telling him only the benefits of the transfer

ANS: A
An appropriate transfer includes transporting the patient using qualified personnel and transportation equipment (i.e., ambulance with advanced cardiac life support [ACLS] versus basic life support [BLS]).
An appropriate transfer includes obtaining the patient's written consent for transfer.
An appropriate transfer includes making copies of all relevant medical records, including a transfer form sent by the transferring institution to the receiving facility.
An appropriate transfer includes informing the patient of the risks and benefits of the transfer.

DIF: Cognitive Level: Application REF: Text Reference: Page 18
OBJ: Describe the nurse's role in maintaining continuity of care through a patient's admission, transfer, and discharge from an acute care facility.
TOP: The Emergency Medical Treatment and Labor Act (EMTALA)
KEY: Nursing Process Step: Implementation
MSC: NCLEX: Physiological Integrity

12. The patient is being transferred from the Emergency Department to another institution for treatment. Which of the following cannot be delegated to nursing assistive personnel (NAP)?

a. Helping the patient get dressed
b. Gathering IV equipment to go with the patient
c. Escorting the patient to the transport area
d. Assessing the patient's respiratory status before transport

ANS: D
The assessment and decision making conducted during transfers cannot be delegated to nursing assistive personnel. The NAP can assist the patient with dressing, gather and secure the patient's personal belongings and any necessary equipment, and escort the patient to the nursing unit or transport area.

DIF: Cognitive Level: Application REF: Text Reference: Page 18
OBJ: Describe the nurse's role in maintaining continuity of care through a patient's admission, transfer, and discharge from an acute care facility. TOP: Delegation
KEY: Nursing Process Step: Implementation
MSC: NCLEX: Physiological Integrity

13. The plan for patient discharge from a health care facility begins:
a. At admission
b. After a medical diagnosis is determined
c. When the patient's physical needs are identified
d. After a home environment assessment is completed

ANS: A
Planning for discharge begins at admission and continues throughout the patient's stay in the agency.

DIF: Cognitive Level: Comprehension REF: Text Reference: Page 21
OBJ: Describe the nurse's role in maintaining continuity of care through a patient's admission, transfer, and discharge from an acute care facility. TOP: Discharge Planning
KEY: Nursing Process Step: Implementation
MSC: NCLEX: Physiological Integrity

14. The phase of the discharge process where medical attention dominates discharge planning efforts is known as:
a. The transitional phase
b. The continuing phase
c. The acute phase
d. The multidisciplinary phase

ANS: C
The discharge process occurs in three phases: acute, transitional, and continuing care. In the acute phase, medical attention dominates discharge planning efforts. During the transitional phase, the need for acute care is still present, but its urgency declines and patients begin to address and plan for their future health care needs. In the continuing care phase, patients participate in planning and implementing continuing care activities needed after discharge. There is no multidisciplinary stage; the discharge planning process is comprehensive and multidisciplinary.

DIF: Cognitive Level: Comprehension REF: Text Reference: Page 21
OBJ: Describe the nurse's role in maintaining continuity of care through a patient's admission, transfer, and discharge from an acute care facility. TOP: Discharge Planning
KEY: Nursing Process Step: Implementation
MSC: NCLEX: Physiological Integrity

15. When a patient's discharge is completed, an activity that may be delegated to assistive personnel is the:
    a. Provision of prescriptions to the patient
    b. Completion of the discharge summary
    c. Gathering of the patient's personal care items
    d. Provision of instructions on community health resources

    ANS: C
    The assessment, care planning, and instruction included in discharging patients cannot be delegated to nursing assistive personnel. The nurse may direct the NAP to gather and secure the patient's personal items and any supplies that accompany the patient.

    DIF: Cognitive Level: Application REF: Text Reference: Page 21
    OBJ: Describe the nurse's role in maintaining continuity of care through a patient's admission, transfer, and discharge from an acute care facility. TOP: Discharge Planning
    KEY: Nursing Process Step: Implementation
    MSC: NCLEX: Physiological Integrity

16. The nurse is providing discharge instruction to an 80-year-old patient and her daughter. The patient lives in a two-story home. When asked if the patient has difficulty climbing the stairs, the patient says "No," but the nurse notices a look of surprise on the daughter's face. The nurse should:
    a. Speak with the daughter separately
    b. Cancel the discharge immediately
    c. Order a Visiting Nurse consult
    d. Notify the physician

    ANS: A
    Patients and family members often disagree on the health care needs of a patient after discharge. Identifying these discrepancies early leads to more accurate development of the discharge plan. It often is necessary to talk with a patient and family separately to learn about their true concerns or doubts.

    DIF: Cognitive Level: Comprehension REF: Text Reference: Page 22
    OBJ: Explain the role of the patient's family in the admission, transfer, or discharge process.
    TOP: Discharge Planning KEY: Nursing Process Step: Implementation
    MSC: NCLEX: Physiological Integrity

17. The patient is an older male with the diagnosis of "dementia." He is confused and wanders and is occasionally combative. The physician orders "Posey vest (restraint vest) PRN." The nurse should:
    a. Place the Posey vest on the patient as needed
    b. Inform the physician that the order is inappropriate

c. Check the condition of the patient every 2 hours after application of the vest
d. Ignore the order

ANS: B
This order must never be written as a standing order or on an as-needed basis (i.e., prn); the condition of the restrained or secluded patient must be continually assessed, monitored, and reevaluated. Consultation with the patient's treating physician should occur as soon as possible if the restraint or seclusion is not ordered by the patient's treating physician.

DIF: Cognitive Level: Application REF: Text Reference: Page 13
OBJ: Describe the nurse's role in maintaining continuity of care through a patient's admission, transfer, and discharge from an acute care facility. TOP: Restraints
KEY: Nursing Process Step: Diagnosis MSC: NCLEX: Physiological Integrity

18. The patient has decided that he would like to create an advance directive. The nurse is asked if she would be a witness. The nurse should:
a. Agree to be a witness
b. Refuse to be a witness
c. Contact social work
d. Contact the physician

ANS: C
A social worker often fulfills this requirement. Witnesses for an advance directive document should not be medical personnel, and direct refusal does not meet the nurse's obligation to meet the patient's needs. Referral to a department that can ensure this service is required.

DIF: Cognitive Level: Application REF: Text Reference: Page 14
OBJ: Explain the purpose and importance of advance directives.
TOP: Advanced Directives KEY: Nursing Process Step: Implementation
MSC: NCLEX: Physiological Integrity

MULTIPLE RESPONSE

1. The patient is being admitted to the intensive care department with multiple fractures and internal bleeding. Which of the following are considered roles of the nurse in this situation? **(***Select all that apply.*)
a. Anticipate physical and social deficits to resuming normal activities
b. Involve the family and significant others in the plan of care
c. Assist in making health care resources available to the patient
d. Identify the psychological needs of the patient

ANS: A, B, C, D
The nurse identifies patients' ongoing health care needs; anticipates physical, psychological, and social deficits that have implications for resuming normal activities; involves family and significant others in a plan of care; provides health education; and assists in making health care resources available to the patient. To separate the processes of admission and discharge is a critical error; the two are simultaneous and continuous.

DIF: Cognitive Level: Application REF: Text Reference: Page 11
OBJ: Describe the nurse's role in maintaining continuity of care through a patient's admission, transfer, and discharge from an acute care facility.
TOP: Admission to Discharge Process KEY: Nursing Process Step: Planning
MSC: NCLEX: Physiological Integrity

2. Under the Health Insurance Portability and Accountability Act (HIPAA), a patient must: (*Select all that apply.*)
   a. Provide his true name in order to be treated
   b. Be informed of his privacy rights
   c. Have his personal health information used for treatment or payment only
   d. Have his personal health information used on a need-to-know basis only

   ANS: B, C, D
   HIPAA is a federal law designed to protect the privacy of patient health information, referred to as PHI or protected health information. Three key concepts of HIPAA are (1) institutions are required to inform patients of the privacy rights they have and how the institution will handle their PHI; (2) the institution and health care providers are to use or disclose the patient's PHI only for the purpose of treatment or payment or for health care operations; and (3) health care providers disclose only the minimum amount of PHI necessary on a need-to-know basis to accomplish the purpose of the use.

   DIF: Cognitive Level: Knowledge REF: Text Reference: Page 12
   OBJ: Describe the nurse's role in maintaining continuity of care through a patient's admission, transfer, and discharge from an acute care facility. TOP: HIPAA
   KEY: Nursing Process Step: Implementation
   MSC: NCLEX: Physiological Integrity

3. The patient is admitted to the unit for a cardiac catheterization. Which of the following can be delegated to nursing assistive personnel (NAP)? (*Select all that apply.*)
   a. Obtaining admission vital signs
   b. Preparing the patient's room
   c. Gathering and securing personal care items.
   d. Orienting the patient and family to the nursing unit

   ANS: B, C, D
   The nursing assessment conducted during admission to a health care facility cannot be delegated to NAP. You cannot delegate admission vital signs as they provide a baseline for all further comparisons. The nurse directs NAP to (1) prepare the patient's room with necessary equipment before admission; (2) gather and secure the patient's personal care items; (3) escort and orient the patient and family to the nursing unit; and (4) collect ordered specimens.

   DIF: Cognitive Level: Analysis REF: Text Reference: Page 14
   OBJ: Describe the nurse's role in maintaining continuity of care through a patient's admission, transfer, and discharge from an acute care facility. TOP: Delegation Considerations
   KEY: Nursing Process Step: Implementation

MSC: NCLEX: Physiological Integrity

4. Which of the following are considered "advance directives?" *(Select all that apply.)*
   a. A living will
   b. A power of attorney for health care
   c. A notarized handwritten document
   d. A nursing progress note

   ANS: A, B, C
   Advance directives may include a living will, power of attorney for health care, or a notarized handwritten document.

   DIF: Cognitive Level: Analysis REF: Text Reference: Page 14
   OBJ: Explain the purpose and importance of advance directives.
   TOP: Advanced Directives KEY: Nursing Process Step: Implementation
   MSC: NCLEX: Physiological Integrity

COMPLETION

1. The Joint Commission (2007) has stated that matching an individual's ongoing needs with the appropriate level and type of medical, psychological, health, or social care or services within an organization or across multiple organizations is known as _____.

   ANS:
   the continuum of care
   The Joint Commission (2007) defines the continuum of care as matching an individual's ongoing needs with the appropriate level and type of medical, psychological, health, or social care or services within an organization or across multiple organizations.

   DIF: Cognitive Level: Knowledge REF: Text Reference: Page 11
   OBJ: Describe the nurse's role in maintaining continuity of care through a patient's admission, transfer, and discharge from an acute care facility. TOP: Continuity of Care
   KEY: Nursing Process Step: Planning MSC: NCLEX: Physiological Integrity

2. Completing and documenting an accurate medication history from the patient is the important first step in the _____ process.

   ANS:
   medication reconciliation
   Medication reconciliation compares the patient's home medication list versus the medication orders at admission, transfer, or discharge to avoid medication errors such as omissions, duplications, dosing errors, or drug interactions.

   DIF: Cognitive Level: Knowledge REF: Text Reference: Page 11
   OBJ: Describe the nurse's role in maintaining continuity of care through a patient's admission, transfer, and discharge from an acute care facility. TOP: Medication Reconciliation
   KEY: Nursing Process Step: Planning MSC: NCLEX: Physiological Integrity

3. If a patient is having acute physical problems, postpone routine admission procedures until the patient's immediate needs are met. A _____ assessment is needed at this point.

   ANS:
   focused
   If a patient is having acute physical problems, postpone routine admission procedures until you meet the patient's immediate needs. Complete a focused assessment at this point.

   DIF: Cognitive Level: Analysis REF: Text Reference: Page 15
   OBJ: Describe the nurse's role in maintaining continuity of care through a patient's admission, transfer, and discharge from an acute care facility. TOP: Admission Process
   KEY: Nursing Process Step: Implementation
   MSC: NCLEX: Physiological Integrity

4. When transferring a patient, the nurse must ensure that the patient will receive _____.

   ANS:
   continuity of nursing care
   When patients transfer, you need to ensure continuity of nursing care. The aim is to continue health care so as to avoid therapeutic interruptions that may hinder progress toward recovery.

   DIF: Cognitive Level: Synthesis REF: Text Reference: Page 18
   OBJ: Describe the nurse's role in maintaining continuity of care through a patient's admission, transfer, and discharge from an acute care facility. TOP: Continuity of Care
   KEY: Nursing Process Step: Planning MSC: NCLEX: Physiological Integrity

5. _____is a federal law intended to protect patients from being transferred against their wishes to another hospital.

   ANS:
   Emergency Medical Treatment and Labor Act (EMTALA)
   In the ED, when a patient is transferred from one institution to another, the nurse completes the transfer in compliance with the EMTALA (CMS, 2003). EMTALA is a federal law intended to protect patients from being transferred against their wishes; it thus defines how an appropriate facility-to-facility transfer is accomplished.

   DIF: Cognitive Level: Knowledge REF: Text Reference: Page 18
   OBJ: Describe the nurse's role in maintaining continuity of care through a patient's admission, transfer, and discharge from an acute care facility.
   TOP: The Emergency Medical Treatment and Labor Act (EMTALA)
   KEY: Nursing Process Step: Planning MSC: NCLEX: Physiological Integrity

6. The greatest challenge in effective discharge planning is _____.

ANS:
communication
The greatest challenge in effective discharge planning is communication. The communication problem is minimized when an organization has a discharge coordinator or case manager responsible for discharge planning

DIF: Cognitive Level: Comprehension REF: Text Reference: Page 21
OBJ: Describe the nurse's role in maintaining continuity of care through a patient's admission, transfer, and discharge from an acute care facility. TOP: Discharge Planning
KEY: Nursing Process Step: Implementation
MSC: NCLEX: Physiological Integrity

7. Any manual method or physical or mechanical device, material, or equipment attached or adjacent to the patient's body that he or she cannot easily remove that restricts freedom of movement or normal access to one's body is defined as a _____.

ANS:
restraint
A restraint is any manual method or physical or mechanical device, material, or equipment attached or adjacent to the patient's body that he or she cannot easily remove that restricts freedom of movement or normal access to one's body.

DIF: Cognitive Level: Knowledge REF: Text Reference: Page 13
OBJ: Describe the nurse's role in maintaining continuity of care through a patient's admission, transfer, and discharge from an acute care facility. TOP: Restraints
KEY: Nursing Process Step: Diagnosis MSC: NCLEX: Physiological Integrity

8. A document that gives a patient instructions about future medical care or that designates another person(s) to make medical decisions if the individual loses decision-making capacity is known as an _____.

ANS:
advance directive
An advance directive is a document that gives a patient instructions about future medical care or that designates another person(s) to make medical decisions if the individual loses decision-making capacity.

DIF: Cognitive Level: Knowledge REF: Text Reference: Page 14
OBJ: Explain the purpose and importance of advance directives.
TOP: Advanced Directives KEY: Nursing Process Step: Diagnosis
MSC: NCLEX: Physiological Integrity