Chapter 01: Concepts Basic to Perioperative Nursing

Test Bank

MULTIPLE CHOICE

1. The *Perioperative Patient Focused Model* presents key components of nursing influence that guide patient care. Select the statement that best describes the dynamic relationship within the model.
   a. The patient experience and the nursing presence are in continuous interaction.
   b. Structure, process, and outcome are the foundation domains of the model.
   c. The perioperative nurse is the central dynamic core of the model.
   d. The interrelated nursing process rings bind the patient to the model.

   ANS: A
   The *Perioperative Patient Focused Model* consists of domains or areas of nursing concern: nursing diagnoses, nursing interventions, and patient outcomes. These domains are in continuous interaction with the health system that encircles the focus of perioperative nursing practice—the patient.

   REF: Pages 2-3

2. AORN's *Standards of Perioperative Nursing Practice* that describe nursing interactions, interventions, and activities with patients fall under which standards category?
   a. Evidence-based
   b. Process
   c. Outcome
   d. Structural

   ANS: B
   Process standards relate to nursing activities, interventions, and interactions. They are used to explicate clinical, professional, and quality objectives in perioperative nursing.

   REF: Page 4

3. Which order best describes the process used to implement evidence-based professional nursing?
   a. Literature search, theory review, data analysis, policy development
   b. Regional survey, literature search, meta-analysis, practice change
   c. Identify problem, scientific evidence, develop policy, evaluate outcome
   d. Identify issue, analyze scientific evidence, implement change, evaluate process

   ANS: D
   Evidence-based practice is a systematic, thorough process by which to identify an issue, to collect and evaluate the best evidence to design and implement a practice change, and to evaluate the process.

   REF: Page 12

4. The ambulatory surgery unit is planning to develop a standardized skin preparation practice for their unit. The best process to gather scientific information is to:
   a. conduct a survey of skin prep policies at the next AORN chapter meeting.
   b. review their surgical site infection data from the last 6 months.
   c. conduct a literature search on antimicrobial agents and infection prevention.
   d. review the scientific literature from the leading manufacturers of prep solutions.

   ANS: C
   Perioperative nurses have an ethical responsibility to review practices and to modify them, based upon the best available scientific evidence, using research and other forms of high-quality evidence to guide practice.

   REF: Page 12

5. The cardiac team is developing a standardized sterile back table setup and is unable to find sufficient research evidence for their project. Where might they look for information on best practices?
   a. Survey regional facilities that perform cardiac surgery for their back table models.
   b. Review case studies and expert opinions on sterile back table setups.
   c. Review AORN's recommended practice on creating the sterile field.
   d. All of the options are correct.

   ANS: D
   When there is not enough evidence to guide practice, perioperative nurses should consider gathering information from varied trusted sources that reflect best practices.

   REF: Pages 13-14

6. How do institutional standards of care, such as policies and procedures, differ from national standards, such as AORN's *Standards of Perioperative Nursing Practice*?
   a. They are written by nurses.
   b. They are written specifically to address responsibilities and circumstances.
   c. They are collaborative and collective agreement statements.
   d. They are rarely based on research.

   ANS: B
   Institutional standards apply to the system or facility that develops them and can be directive about specific actions in specific circumstances; national standards provide generalized authoritative statements that can be implemented in all settings.

   REF: Pages 3, 12

7. Which of the following actions best describes an element of the perioperative nursing assessment?
   a. Scanning the surgical schedule for the day before morning report
   b. Reading the pick/preference list attached to the case cart
   c. Reviewing the patient medical record
   d. Studying an on-line tutorial about the intended surgical procedure

ANS: C
Assessment is the collection of relevant health data about the patient. Sources of data may be a preoperative interview with the patient and the patient's family; review of the planned surgical or invasive procedure; review of the patient's medical record; examination of the results of diagnostic tests; and consultation with the surgeon and anesthesia provider, unit nurses, or other personnel.

REF: Page 5

8. Lonna Weber is a frail 76-year-old diabetic woman who is scheduled for major surgery. She is vulnerable and at high risk for harm because of several factors related to her preexisting conditions and overall health status. As part of developing a plan to guide Lonna's care, the nurse uses standardized descriptive terms to guide care. This step of the nursing process is called:
    a. nursing diagnosis.
    b. nursing assessment.
    c. nursing outcome.
    d. nursing intervention.

    ANS: A
    Nursing diagnosis is the process of identifying and classifying data collected in the assessment in a way that provides a focus to plan nursing care.

    REF: Page 7

9. During the admission interview, the nurse initiated the discharge teaching and demonstrated crutch-walking activities. The teaching activities are what stage of the nursing process?
    a. Nursing assessment
    b. Nursing implementation
    c. Nursing outcome preparation
    d. Nursing evaluation

    ANS: B
    Implementation is performing the nursing care activities and interventions that were planned and responding with critical thinking and orderly action. Implementation is the "work" of nursing.

    REF: Page 9

10. While conducting the preoperative interview with Clair Conners, a patient scheduled for a septoplasty, the perioperative nurse learned that Clair was latex sensitive. Based on this knowledge, the nurse reviewed the pick/preference list and reassembled the surgical case cart setup to reflect this new information and change in care delivery. Which two phases of the nursing process are represented in the nurse's actions?
    a. Assessment and planning
    b. Assessment and implementation
    c. Planning and implementation

d. Nursing diagnosis and intervention

ANS: C
Planning is preparing in advance for what will or may happen and determining the priorities for care. Planning is based on patient assessment results in knowing the patient and the patient's unique needs. *Implementation* is performing the nursing care activities and interventions that were planned and responding with critical thinking and orderly action. Implementation is the "work" of nursing.

REF: Pages 8-9

11. The perioperative nurse implements protective measures to prevent skin or tissue injury caused by thermal sources. Successful accomplishment of this intervention would meet which of the following desired nursing outcomes?
    a. The patient is free from signs and symptoms of chemical injury.
    b. The patient is free from signs and symptoms of electrical injury.
    c. The patient is free from signs and symptoms of radiation injury.
    d. All of the options are correct.

    ANS: D
    Chemical and thermal sources used in surgery can cause skin and tissue burns (e.g., electrosurgery, povidine-iodine, radiation, lasers). The patient is free from signs and symptoms of chemical injury, radiation injury, and electrical injury are approved NANDA-International nursing diagnoses.

    REF: Pages 8, 10

12. The nursing diagnosis is derived from:
    a. patient data retrieved from the nursing assessment.
    b. synthesized clues from the admitting diagnosis and surgery schedule.
    c. the approved NANDA-International list attached to the patient medical record.
    d. the admission form on the front of the chart.

    ANS: A
    Nursing diagnosis is the process of identifying and classifying data collected in the assessment in a way that provides a focus to plan nursing care.

    REF: Page 7

13. Doreen Jasper, a preoperative admission for laparoscopic cholecystectomy with operative cholangiogram, was interviewed by her perioperative nurse in the preoperative intake lounge. Doreen's weight on admission was 245 lb. After the assessment, the nurse returned to the OR and modified the standard plan of care by instituting risk reduction strategies that were derived from information from the preoperative assessment. A good example of this action would best be described by:
    a. replacing the regular OR bed with a bariatric-specific OR bed.
    b. providing protective lead aprons for all staff during the procedure.
    c. writing the patient's name, allergies, and body weight on the white board.
    d. administering antibiotics to the patient 1 hour before the incision.

ANS: A

Planning is preparing in advance for what will or may happen and determining the priorities for care. Planning based on patient assessment results in knowing the patient and the patient's unique needs so that alterations in events, such as positioning the patient on a bariatric-specific OR bed as opposed to a regular OR bed, can be readily accommodated. Replacing the OR bed with a larger OR bed is a nurse-sensitive preventive intervention that provides equipment based on patient need.

REF: Page 8

14. Accurate documentation is an integral part of all phases of the nursing process. For this reason, perioperative nursing care documentation:
    a. should not include technical care.
    b. must include a description of patient care delivered and patient response to that care.
    c. must be aligned with appropriate PNDS elements.
    d. will have PNDS integrated into all mandatory fields.

ANS: B

Documentation of the nursing care given should include more than the technical aspects of care, such as the sponge count or the application of the electrosurgical dispersive pad. Nursing care documentation should be associated with the assessment and nursing diagnoses, with preestablished outcomes against which the appropriateness and effectiveness of care may be judged.

REF: Page 10

15. When delegating a task, such as a preoperative skin prep, to an unlicensed individual, the perioperative nurse:
    a. still retains responsibility and authority for the outcome of the task.
    b. must comply with the seven "rights" of delegation.
    c. transfers the authority to perform the task to a competent person.
    d. transfers the supervision of the competent person to another competent person.

ANS: C

Delegation transfers to a competent person the authority to perform a selected nursing task in a selected situation according to the five "rights" of delegation. When the perioperative nurse delegates a task, he or she retains accountability for that delegation.

REF: Page 10

16. The nursing excellence center for education at Sunny Shores Hospital developed standards for nursing advancement that would reflect high-level achievement of professional performance. They developed a clinical advancement ladder based on the leading skill and knowledge acquisition model and established worthy criteria for each level. Select the response that might best describe the highest level of achievement for a perioperative staff nurse.
    a. CNOR credential, BSN, and chair of the nursing research committee

b. Published article in the Sunny Shores newsletter and 15 years' service pin
c. BCLS instructor and weekend EMT transport
d. All of the options are correct.

ANS: A
Achieving certification (certified nurse, operating room [CNOR]), pursuing lifelong learning, and maintaining competency and current knowledge in perioperative nursing are the hallmarks of the professional.

REF: Page 4

17. Performance improvement activities in the perioperative practice setting are designed to promote:
a. cost savings by eliminating fines for near-misses and never events.
b. customer satisfaction and loyalty.
c. performance measurement activities.
d. efficient, effective quality care.

ANS: D
Performance improvement efforts encompass improvements in quality and effectiveness, based on ethical and economic perspectives. A performance measurement and improvement approach facilitates the delivery of safe, high-quality perioperative patient care.

REF: Page 14

18. Perioperative nursing diagnoses and interventions are directed toward, and guided by, the tremendous risks for harm to the patient inherent in surgery and interventional procedures; therefore nursing actions can generally be categorized as:
a. therapeutic/restorative.
b. preventive/protective.
c. caring/comforting.
d. advocating/justifying.

ANS: B
Perioperative nurses possess a unique understanding of desired outcomes that apply to all patients. In contrast to some nursing specialties in which nursing diagnoses are derived from signs and symptoms of a condition, much of perioperative nursing care is preventive in nature, based upon knowledge of inherent risks to patients undergoing surgical and invasive procedures. Perioperative nurses identify these risks and potential problems in advance and direct nursing interventions toward prevention of undesirable outcomes, such as injury and infection.

REF: Page 3

19. A registered nurse first assistant (RNFA) is considered an advanced practice nurse when he/she has achieved:
a. RNFA certification.
b. clinical performance ladder level 4 or above.

    c.   graduate degree in nursing (MSN).
    d.   facility practice privileges.

ANS: C
APNs must have graduate nursing education (at least a master's degree).

REF: Page 16

20. Emerging perioperative nursing roles are defined by the tremendous growth in science and technology combined with the increasing complexity of surgery and the interventional disciplines. An example of an emerging nursing role is:
    a.   sterile processing clinical specialist.
    b.   general surgery service liaison.
    c.   weekend resource nurse.
    d.   Informatics nurse specialist.

ANS: D
Informatics is another specialty in which some perioperative nurses are focusing. Pressures for more efficient management of fiscal, material, and human resources have stimulated the development of electronic information systems for diverse functions in perioperative patient care settings.

REF: Page 16

21. The relationship between the *Perioperative Patient Focused Model* and the Perioperative Nursing Data Set (PNDS) is evidenced by their unique language and use of the nursing process to guide care. The most notable feature of their similarity is that the PNDS:
    a.   promotes standardized perioperative documentation.
    b.   fosters research on best practices.
    c.   begins with outcome statements.
    d.   promotes standardized perioperative documentation and begins with outcome statements.

ANS: C
Similar to the *Perioperative Patient Focused Model,* the PNDS begins with patient outcomes. Each outcome is defined and interpreted, and presents criteria by which to measure outcome achievement.

REF: Page 11