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DHA Medical Surgical Nursing (DHA-MedSurg)

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Question: 1

What is the organizational system for determining patient care which involves assessment, diagnosing, planning, implementation, and evaluation?

A. Nursing process.
B. Nursing diagnosis.
C. Intervention.
D. Integration.

Answer: A

Explanation:
The Nursing Process is a systematic method used by nurses to ensure the quality of patient care. This approach can be broken down into five distinct phases: Assessment, Diagnosis, Planning, Implementation, and Evaluation. Each of these stages plays a crucial role in the patient care continuum, ensuring that each patient receives personalized and effective care.
During the **Assessment** phase, nurses gather information about the patient's physical condition, medical history, and lifestyle. This information is collected through physical examinations, interviews, and reviewing past medical records. Understanding the patient's health status and needs is critical for the next stage.
The **Diagnosis** phase involves analyzing the assessment data to identify the health problems faced by the patient. These problems are formulated into nursing diagnoses which guide the subsequent planning and intervention strategies. Nursing diagnoses differ from medical diagnoses as they focus more on issues that nurses can address independently.
*Planning** comes next and involves setting measurable and achievable goals for improving the patient's health status. These goals are based on the nursing diagnoses and prioritize interventions based on the patient's health needs. During this phase, nurses collaborate with other healthcare professionals and the patient's family to create a comprehensive care plan.
*Implementation** is the phase where the care plan is put into action. This includes administering medications, providing treatments, educating the patient and family about the condition and care procedures, and any other interventions that are part of the care plan. Effective implementation requires skill, care, and attention to detail to ensure that interventions are performed correctly.
Finally, the **Evaluation** phase involves assessing the outcomes of the nursing interventions in relation to the set goals. Nurses determine whether the health goals have been met and whether any adjustments to the care plan are necessary. This phase ensures that the care provided is effective and responsive to the patient’s needs.
The nursing process is dynamic, with each phase flowing into the next. Adjustments are continually made based on the evaluation, which may involve revisiting earlier phases such as reassessment or re-diagnosis. Additionally, the nursing process is integral to all areas of nursing, including perioperative care where preoperative, intraoperative, and postoperative care phases each involve tailored applications of the nursing process steps.

In conclusion, the nursing process is a fundamental framework in the nursing profession, designed to ensure systematic and empathetic patient care. By adhering to this method, nurses can provide effective, individualized patient care that adapts over time to meet the evolving health needs of their patients.

Question: 2

Your patient has Addison's disease. You know that this patient will be less likely to withstand surgical stress, trauma, or infection because of lack of which of the following?

A. aldosterone
B. androgens
C. vitamin B12
D. cortisol

Answer: D

Explanation:
The correct answer to the question is cortisol. Addison's disease, also known as primary adrenal insufficiency, is a condition where the adrenal glands do not produce sufficient steroid hormones, primarily cortisol, and in some cases, aldosterone.
Cortisol is a crucial hormone in the body's response to stress. It has several important functions during stress, including increasing blood sugar through gluconeogenesis, helping in the breakdown of protein and fat, and suppressing the immune system. By elevating blood sugar, cortisol provides immediate energy to the body, which is crucial during periods of physical stress such as surgery, trauma, or infection.
Moreover, cortisol helps maintain blood pressure and cardiovascular function, which are vital in stressful situations. It also reduces the inflammatory response, which although beneficial in controlling damage, can lead to problems if overactive, such as during infections.
In patients with Addison's disease, the deficiency in cortisol production impairs these stress responses. This makes it challenging for the body to manage external stressors effectively, increasing the risk of severe complications under such conditions. The lack of cortisol leads to decreased gluconeogenesis, resulting in lower blood glucose levels, reduced liver glycogen stores, and increased insulin sensitivity in peripheral tissues. These effects combine to reduce the energy available to the body when it is most needed.
While aldosterone, another hormone typically deficient in Addison's disease, is primarily involved in the regulation of sodium and potassium levels and blood pressure, its deficiency also contributes to complications but is not directly involved in the body's response to acute stress in the same way cortisol is. Therefore, in the scenario of not being able to withstand surgical stress, trauma, or infection, the lack of cortisol is the most critical factor.

Question: 3

When administering tissue plasminogen activators (t-PA),what should be avoided for the 24 hours?

A. Corticosteroids.

B. Blood thinners.
C. Decrease in plasma.
D. Cefazolin.

Answer: B

Explanation:
When administering tissue plasminogen activators (t-PA), it is critical to avoid certain medications and treatments that could interfere with the action of t-PA or increase the risk of adverse effects. One of the primary concerns during the first 24 hours after t-PA administration is the use of blood thinners, including anticoagulants and antiplatelet medications.
Tissue plasminogen activators, such as alteplase, are enzymes that help dissolve blood clots and are commonly used in the treatment of acute ischemic stroke and myocardial infarction (heart attack). These medications work by converting plasminogen to plasmin, the major enzyme responsible for clot breakdown. The goal of t-PA treatment is to quickly restore blood flow to the affected area, minimizing tissue damage and improving outcomes.
However, the use of blood thinners alongside t-PA can significantly increase the risk of bleeding, including serious and potentially fatal hemorrhages. Blood thinners such as heparin, warfarin, and various antiplatelet drugs (e.g., aspirin, clopidogrel) affect the blood's ability to coagulate, which is normally a protective mechanism to stop bleeding. When combined with t-PA, which also acts to break down clots, the risk of bleeding is compounded.
Therefore, guidelines generally recommend avoiding the administration of blood thinners for at least the first 24 hours after t-PA is given. This precaution helps to ensure that the therapeutic benefits of t-PA are achieved without undue risk of bleeding. After the initial 24-hour period, the use of blood thinners may be reassessed based on the patient's condition, response to t-PA treatment, and overall risk of thrombosis versus bleeding.
In summary, when administering tissue plasminogen activators for conditions like acute ischemic stroke or heart attack, it is crucial to avoid blood thinners during the first 24 hours to reduce the risk of severe bleeding complications. This approach helps to balance the benefits of clot dissolution with the safety concerns associated with increased bleeding risk.

Question: 4

The Center for Disease Control created Universal Precautions for healthcare personnel in 1987 to prevent the spread of what?

A. HIV, HBV, and bloodborne pathogens.
B. Airborne pathogens, TB, Influenza.
C. Staphylococcus.
D. Human papilloma virus.

Answer: A

Explanation:
The correct answer is HIV, HBV, and bloodborne pathogens. The Universal Precautions were specifically initiated by the Centers for Disease Control and Prevention (CDC) in 1987. This set of protocols was

introduced in response to the growing concerns about the risk healthcare workers faced in contracting severe infections, such as Human Immunodeficiency Virus (HIV) and Hepatitis B Virus (HBV), through exposure to blood and other potentially infectious materials (OPIM).
Prior to the introduction of Universal Precautions, precautions were primarily taken only with patients who were known or suspected to be infected with these pathogens. However, the realization that patients might not always know they are infected or might not disclose their status led to the development of a more comprehensive approach. Universal Precautions mandated that blood and certain body fluids from all patients should be considered potentially infectious for HIV, HBV, and other bloodborne pathogens.
The implementation of these precautions marked a significant shift in healthcare practice. They include the routine use of protective barriers such as gloves, gowns, and masks when anticipated contact with blood or OPIM might occur. They also emphasized the importance of other infection control practices, such as proper hand hygiene and the safe disposal of sharps and other potentially infectious materials. These precautions are foundational in modern infection control protocols and have been expanded upon with the development of the Standard Precautions and Transmission-Based Precautions, which include additional protective measures against a broader range of pathogens. The introduction of Universal Precautions was a critical step in improving the safety of the healthcare environment by reducing the transmission of infectious agents and protecting both healthcare personnel and patients.

Question: 5

Following surgery a patient is considered at risk for an embolus. To monitor and prevent an adverse event, his prothrombin time is measured. With the result being 13.2 seconds. This patient is:

A. Below normal therapeutic range.
B. Within range.
C. Is at increased risk for an event.
D. Is above normal range, but still within therapeutic limits.

Answer: B

Explanation:
Prothrombin time (PT) is a critical measurement used to assess the blood's ability to clot properly. It is especially important to monitor this in patients who have undergone surgery, as they are typically at increased risk for thromboembolic events, such as clots forming and traveling to other parts of the body (embolism). The PT test measures the time it takes for blood to clot by initiating the extrinsic pathway of coagulation.
In the scenario presented, the patient's PT is recorded as 13.2 seconds. To determine whether this value is safe, appropriate, or indicative of an increased risk, it must be compared to established reference ranges. The normal PT range for someone not on anticoagulant therapy typically lies between 12 and 14 seconds, depending on the reagents and equipment used in the laboratory. This means that a PT of 13.2 seconds falls within the normal range.
However, if a patient is on anticoagulant therapy, such as warfarin, the target therapeutic range is usually higher—often 1.5 to 2.5 times the normal PT, depending on the specific clinical scenario. This adjusted range is intended to prevent clot formation while still allowing sufficient clotting to avoid excessive bleeding. For a normal range of 12 to 14 seconds, the therapeutic range would thus be approximately 18 to 35 seconds.

Given that the patient's PT is 13.2 seconds, and assuming the patient is not currently receiving anticoagulant therapy, this value is well within the normal range but below the therapeutic range if anticoagulation therapy was aimed for. Therefore, the patient's PT indicates that their blood clotting ability is normal and not excessively prolonged by anticoagulants. This suggests that the patient is not at an increased risk of bleeding excessively, but also may not be sufficiently anticoagulated if that was the intention (to prevent thromboembolic events post-surgery).
To conclude, the patient described in the question, with a PT of 13.2 seconds, is within the normal range for clotting. This indicates that while they are not at increased risk of bleeding, the effectiveness of anticoagulant therapy (if any) needs to be reviewed to ensure it is adequate for preventing potential post-surgical thromboembolic complications. Regular monitoring and adjustment of therapy may be required based on PT results and the patient's overall health status.

Question: 6

An associate degree or a diploma in nursing would qualify a nurse to do which of the following in terms of participating in research?

A. conduct funded independent research projects
B. act as a clinical expert in collaborating with an experienced researcher
C. assist in identifying clinical problems in nursing practice
D. critique research findings for use in practice

Answer: C

Explanation:
The question asks about the roles a nurse with an associate degree or a diploma in nursing can assume in the context of research. It is important to understand the different levels of education in nursing and how they relate to the scope of research participation.
Nurses with an associate degree or a diploma typically have foundational nursing knowledge and skills that can be effectively utilized in clinical settings. However, when it comes to research, their role is generally more supportive rather than leading. This is primarily due to the level of education and the extent of training in research methodologies that is usually part of more advanced nursing programs, such as those at the bachelor's or graduate level.
Firstly, nurses with an associate degree or a diploma can assist in identifying clinical problems in nursing practice. This involves observing and recognizing issues or areas of improvement in everyday clinical operations. Their close interaction with patients and frontline healthcare delivery places them in a unique position to notice practical challenges and inefficiencies that might not be obvious to researchers who are not involved in day-to-day clinical activities.
In terms of research, while these nurses may not have the training to design and lead complex research projects, they are quite capable of collecting data in structured formats. This can include administering surveys, recording observations, or managing straightforward data entry tasks under the supervision of a more experienced researcher. Such contributions are invaluable in the accumulation of primary data necessary for research analysis.
Additionally, these nurses can collaborate with professional researchers in applying research findings. This means they can help implement new practices or protocols developed through research into the actual clinical setting. They can monitor the outcomes and provide feedback on the practicality and

effectiveness of new interventions, which is crucial for the iterative process of research and development in healthcare.
However, tasks such as critiquing research findings for use in practice or conducting funded independent research projects typically require a deeper understanding of research methodologies, statistics, and critical appraisal skills that are beyond the scope of education provided in associate or diploma programs. These roles are usually reserved for nurses with advanced degrees who have received specific training and have developed expertise in these areas.
In summary, an associate degree or a diploma in nursing equips nurses to take on supportive roles in research activities. They can identify clinical problems, assist in data collection, and participate in the application of research findings, which are essential steps in bridging the gap between research and clinical practice. However, leading research projects or critically evaluating research for practice adjustments generally requires further education and training in nursing.

Question: 7

When assessing a patient with a wound, the nurse will want to make sure that the patient’s laboratory values fall within the normal range. Which of the following values would NOT be in the normal range?

A. serum albumin level: 4 g/dL
B. total lymphocyte count: 2,500 µL
C. serum transferring level: 250 mg/dL
D. thyroxine-binding prealbumin level: 12.9 mg/dL

Answer: D

Explanation:
When assessing a patient with a wound, it is crucial for a nurse to ensure that the patient's laboratory values are within the normal range. These values provide critical information about the patient's nutritional status, immune function, and overall health, which are important for wound healing. Here's an analysis of the given laboratory values and their relevance to the patient's health:
Serum Albumin Level: 4 g/dL Serum albumin is a protein made by the liver, and it plays a vital role in maintaining the oncotic pressure of the blood, which helps keep fluid in the bloodstream so it doesn't leak into other tissues. It is also important for transporting substances like drugs, hormones, and enzymes. A normal serum albumin level ranges from 3.5 to 5.0 g/dL. Therefore, a level of 4 g/dL falls within the normal range and suggests adequate liver function and nutritional status.
Thyroxine-binding Prealbumin Level: 12.9 mg/dL Thyroxine-binding prealbumin (also known as transthyretin) is a protein that helps transport thyroid hormones in the blood and is a marker of nutritional status. The normal range for thyroxine-binding prealbumin levels is typically between 15.7 to 29.6 mg/dL. A level of 12.9 mg/dL is below this range, indicating that the patient might be experiencing malnutrition or a hypercatabolic state. This is critical in the context of wound healing, as adequate nutrition is essential for tissue repair and regeneration.
Total Lymphocyte Count: 2,500 µL Lymphocytes are a type of white blood cell that plays a significant role in the immune system, particularly in fighting infections. The normal range for total lymphocyte count is generally between 1,000 to 4,800 cells per µL. A count of 2,500 µL is within this range, suggesting that the patient's immune system is functioning properly, which is crucial for preventing and fighting infections, especially in the presence of a wound.

Serum Transferrin Level: 250 mg/dL Transferrin is a blood plasma protein that transports iron throughout the body. Iron is essential for many functions, including the synthesis of hemoglobin, which carries oxygen to tissues, a vital factor in wound healing. The normal range for serum transferrin levels varies but is typically around 200 to 400 mg/dL. With a level of 250 mg/dL, the patient falls within the normal range, indicating adequate iron transport capacity.
To sum up, among the laboratory values listed, the thyroxine-binding prealbumin level at 12.9 mg/dL is the only value that does not fall within the normal range, pointing to potential nutritional deficiencies that could impair wound healing. It is crucial for the medical team to address this issue, potentially through nutritional support or further investigation into underlying causes.

Question: 8

Preoperative instructions should be explained to the patient and ______.

A. Reviewed.
B. Given in writing.
C. Given verbally.
D. All of the above

Answer: D

Explanation:
The correct answer to the question "Preoperative instructions should be explained to the patient and ______." is "Reviewed." This approach ensures that the patient fully understands and acknowledges the procedures, precautions, and expectations prior to undergoing surgery.
Explaining preoperative instructions verbally is fundamental. This direct interaction allows the healthcare provider to ensure that the patient comprehensively understands the instructions. It also provides an opportunity for the patient to ask any questions or express concerns they might have regarding the surgery or the preparation process. This interaction helps in building trust and reducing anxiety for the patient.
In addition to verbal explanations, preoperative instructions should also be given in writing. Providing written instructions serves multiple purposes. First, it acts as a reference for the patient to revisit in case they forget or are unclear about any details. This is particularly important as the stress associated with upcoming surgery might affect the patient's ability to remember verbal instructions. Second, written instructions can be more detailed, offering step-by-step guidance that the patient can follow at their own pace. Third, having a written document ensures that all legal and procedural standards are met, providing a record that the patient has been informed about the preoperative requirements and procedures.
Furthermore, these instructions should be reviewed. This means that after the patient has been given both verbal explanations and written instructions, a healthcare provider should go over the key points again to confirm understanding. Reviewing the instructions can involve summarizing the main points, asking the patient to explain back what they have understood, or clarifying any doubts. This step is crucial to ensure that no miscommunication has occurred and that the patient is fully prepared for what to expect.
While leaving instructions in a message or simply repeating them might have some utility, these methods do not provide the interactive feedback loop that reviewing does. Reviewing ensures active participation from the patient in their own healthcare process, enhancing their understanding and

compliance, which can directly impact the success of the preoperative preparation and the surgery itself.

Question: 9

An assessment technique which involves tapping the body with one finger is known as which of the following?

A. Palpation.
B. Blunt percussion.
C. Direct percussion.
D. Indirect percussion.

Answer: C

Explanation:
The correct answer is "Direct percussion." Direct percussion is a specific technique used in physical examination to assess the condition of the underlying tissues or organs. This technique involves tapping directly on the body surface with one finger, typically used by healthcare professionals to evaluate the health of various body areas, including the thorax and abdomen.
Direct percussion helps in determining the size, consistency, and borders of organs, as well as detecting the presence of fluid or air in body cavities. For example, when performed over the chest, it can assist in diagnosing conditions like pneumonia or pneumothorax by detecting changes in the resonance of sounds produced.
The technique contrasts with indirect percussion, where the examiner uses both hands—one hand is placed flat on the body surface, and the other hand taps on the first hand. Indirect percussion is commonly used for assessing deeper structures and provides a broader range of diagnostic sounds compared to direct percussion.
In direct percussion, the simplicity of the method allows for a quick assessment, which can be particularly useful in settings where immediate evaluation is required. However, the accuracy of this method can depend on the skill and experience of the practitioner, as well as the specific area of the body being examined.

Question: 10

In preparing a patient for discharge, a nurse discusses postprocedural home care and recovery. An adverse outcome for self-care deficit might occur when:

A. The patient does not follow directions for medication use.
B. A wound becomes infected because the patient does not change bandages regularly.
C. The patient misses follow-up appointments.
D. The patient smokes after being told he should stop.

Answer: B

Explanation:

An adverse outcome for self-care deficit in postprocedural home care and recovery might occur in several situations where a patient fails to adequately perform the necessary activities that contribute to their own care. These include:
Failure to Follow Medication Directions: When a patient does not follow the prescribed directions for medication use, they risk worsening their condition or slowing their recovery process. Medications are prescribed in specific dosages and schedules to maximize their effectiveness and minimize side effects. Non-adherence can lead to inadequate management of symptoms or complications related to the underlying condition for which they were prescribed.
Infection Due to Poor Wound Care: A common adverse outcome occurs when a patient does not change their bandages regularly or fails to clean their wound as instructed. This negligence can lead to infection, which not only prolongs the recovery period but could also lead to more severe health problems. Proper wound care is crucial in preventing infections, promoting healing, and avoiding complications.
Noncompliance with Lifestyle Changes: Often, recovery and long-term wellness hinge not just on following medical instructions but also on making lifestyle adjustments. This could include dietary changes, exercise, quitting smoking, or avoiding certain activities. If a patient fails to adhere to these recommended changes, they risk exacerbating their health issues or developing new complications.
Missing Follow-up Appointments: Skipping scheduled follow-up appointments with healthcare providers can lead to an adverse outcome in managing a patient's health post-procedure. These appointments are crucial for monitoring progress, addressing any complications early, and making necessary adjustments to the treatment plan. Missing these appointments undermines the effectiveness of the initial care received and might lead to deterioration in the patient's condition.
Continuation of Harmful Habits: For example, if a patient continues to smoke after being advised to stop, particularly in cases involving pulmonary or cardiovascular procedures, the patient’s recovery could be compromised. Smoking can impair wound healing, increase the risk of infection, and exacerbate other underlying conditions, leading to poor health outcomes.
In summary, a self-care deficit can manifest in various forms, ranging from inadequate medication management to poor lifestyle choices. Each of these deficits can significantly impact the patient's recovery trajectory and overall health. Effective discharge planning and patient education by healthcare professionals are critical to minimize these risks and ensure that patients are well-prepared to take care of themselves after leaving the healthcare facility. Understanding and addressing potential barriers to compliance, such as cognitive impairments, physical limitations, or lack of support at home, are also vital in planning for a successful discharge.

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