1. The nurse is caring for a postoperative client in contact isolation. Which actions should the nurse employ to reduce the spread of disease? Select all that apply.
   A) Wash hands after removing gloves before leaving the client's room.
   B) Wear clean gloves when performing a sterile dressing change.
   C) Place used syringes and uncapped needles in a puncture-resistant container after use.
   D) Instruct the client to ambulate in the hall several times a day.
   E) Use sealed items from the client's room when caring for other clients.

2. A nurse has implemented numerous practices with the goal of reducing the number and transfer of pathogens. Which actions are consistent with this goal? Select all that apply.
   A) Carry soiled items close to the body to prevent transfer of pathogens into the environment.
   B) Place soiled bed linen or any other items on the floor, instead of on the bed or furniture.
   C) Move equipment close to you when brushing, dusting, or scrubbing articles.
   D) Clean the least soiled areas first and then move to the more soiled ones.
   E) Use personal grooming habits, such as shampooing hair often, to prevent spreading microorganisms.
   F) Shake out linens and client clothing before placing them back on the bed.

3. An experienced nurse is teaching a student nurse about the proper use of hand hygiene. Which guideline should the nurse provide to the student?
   A) The use of gloves eliminates the need for hand hygiene.
   B) The use of hand hygiene eliminates the need for gloves.
   C) Hand hygiene is needed after contact with objects near the client.
   D) Hand lotions should not be used after hand hygiene.

4. In which situation is an alcohol-based rub an inappropriate option for hand hygiene?
   A) When the nurse's hands are visibly soiled
   B) When the nurse anticipates contact with the client's skin
   C) When the nurse leaves the room of an immunocompromised client
   D) When the nurse is caring for a client with an active infection

5. A nurse has been exposed to urine while changing the linens of a client's bed. Which guideline is followed for performing hand hygiene after this client encounter?
   A) Use an alcohol-based handrub to decontaminate the hands.
   B) Remove all jewelry, including wedding bands, before handwashing.
   C) Keep hands lower than elbows to allow water to flow toward fingertips.
   D) Pat dry with a paper towel, beginning with the forearms and moving down to fingertips.

6. A nurse is implementing the principles of surgical asepsis while inserting a client's indwelling urinary catheter. Which action should the nurse perform?
   A) Hold sterile objects above waist level to prevent accidental contamination.
   B) Consider the outside of the sterile package to be partially sterile.
   C) Consider the outer 3-in edge of a sterile field to be contaminated.
   D) Open sterile packages so that the first edge of the wrapper is directed toward you.

7. The nurse is performing a sterile change of a client's central line catheter dressing. The client receives a telephone call and stretches the phone cord across the open sterile dressing kit. What is the next **best** action the nurse should take?
   A) Determine what item was touched and replace it.
   B) Collect another sterile central line dressing kit.
   C) Remove the old central line dressing.
   D) Place surgical masks on the nurse and the client.

8. A nurse is adding a sterile solution to a sterile field and has just opened the bottle according to manufacturer's directions. What is the **next** step?
   A) Touch the tip of the bottle to the sterile container to start the flow of the solution and pour it into the container directly from the top of the container edge.
   B) Hold the bottle outside the edge of the sterile field with the label side facing the palm of the hand and prepare to pour from a height of 4 to 6 in.
   C) “Lip” a new or old bottle of solution before pouring it and hold the solution with the label facing out from a height of 4 to 6 in.
   D) Hold the bottle inside the 1-in edges of the sterile field with the label side facing the palm of the hand and pour from a height of 2 to 4 in.

9. In which order should the following steps for putting the first hand into a sterile glove be performed?
   1. Carefully open the inner package. Fold open the top flap, then the bottom and sides.
   2. Place the inner package on the work surface with the side labeled “cuff end” closest to the body.
   3. With the thumb and forefinger of the nondominant hand, grasp the folded cuff of the glove for the dominant hand, touching only the exposed inside of the glove.
   4. Keeping the hands above the waistline, lift and hold the glove up and off the inner package with fingers down.
   5. Place the sterile glove package on a clean, dry surface at or above your waist.
   6. Carefully insert dominant hand palm up into the glove and pull it on.
   7. Open the outside wrapper by carefully peeling the top layer back and remove inner package, handling only the outside of it.

   A) 5, 2, 7, 1, 3, 4, 6
   B) 5, 7, 2, 1, 3, 4, 6
   C) 5, 1, 2, 7, 3, 4, 6
   D) 5, 3, 4, 7, 2, 1, 6

10. The nurse is providing care for a client whose diagnosis requires the nurse to use PPE. In which order should the nurse's actions be performed?
    1. Put on goggles and place over eyes and adjust to fit.
    2. Put on the mask or respirator over your nose, mouth, and chin.
    3. Put on the gown, with the opening in the back. Tie gown securely at neck and waist.
    4. Perform hand hygiene.
    5. Put on clean, disposable gloves and extend gloves to cover the cuffs of the gown.
    6. Provide instruction about precautions to client, family members, and visitors.

    A) 6, 4, 5, 3, 2, 1
    B) 4, 3, 2, 1, 5, 6
    C) 4, 6, 3, 2, 1, 5
    D) 6, 4, 3, 5, 1, 2

11. A nurse's gloves became soiled while providing morning care for a client. Which action **best** demonstrates that the nurse applied principles of infection control?
    A) Use the nondominant hand to grasp the opposite glove near the cuffed end on the outside exposed area.
    B) Remove the glove on the nondominant hand by pulling it straight off, keeping the contaminated area on the outside.
    C) After removing the glove on the nondominant hand, hold the removed glove in the remaining gloved hand.
    D) After removing the first glove, slide the fingers of the ungloved hand between the remaining glove and the wrist and pull the glove straight off with the contaminated area on the outside.

12. A nurse has finished giving care to a client who has a communicable respiratory infection. In which order should the personal protective equipment (PPE) be removed?
    1. Gloves
    2. Respirator
    3. Gown
    4. Goggles
    A) 1, 4, 3, 2
    B) 4, 2, 3, 1
    C) 1, 2, 4, 3
    D) 4, 2, 1, 3

13. A nurse is inserting a client's urinary catheter and notices a hole in one of the sterile gloves and that his hands are soiled. What would be the **most** appropriate action to take in order to maintain a sterile field?
    A) Finish the procedure and perform handwashing immediately afterward.
    B) Finish the procedure, remove damaged glove, and open new sterile gloves.
    C) Stop the procedure, remove damaged glove, and open new sterile gloves.
    D) Stop the procedure, remove damaged glove, perform handwashing, and open new sterile gloves.

14. For which client would the use of Standard Precautions alone be appropriate?
    A) A client with diphtheria who needs assistance with hygiene
    B) A client with tuberculosis who needs medications administered
    C) An incontinent client in a nursing home who has diarrhea
    D) A child with chicken pox who is treated in the ER

15. A nurse is in charge of client care for a client who has an infection caused by a multidrug resistant microorganism. The nurse should intervene when the unlicensed assistive personnel (UAP) performed which action?
    A) Placed dirty linens into the linen receptacle
    B) Obtained blood pressure on a portable vital sign machine
    C) Removed the lunch tray after recording the intake
    D) Wore gloves when providing the bath

16. A nurse is caring for a child who is hospitalized for diphtheria. Which guideline would be appropriate when caring for this client?
    A) Use a private room with the door closed at all times.
    B) Wear personal protective equipment (PPE) when entering the room for all interactions that may involve contact with the client.
    C) Place client in a private room that has monitored negative air pressure.
    D) Ensure that hard surfaces in the room are disinfected at least once per day.

17. The nurse is caring for a client admitted with rubella. The prescriber ordered a chest x-ray. What is the nurse's **best** action?
    A) Place a surgical mask on the client and send the client to radiology.
    B) Modify the order to a portable chest x-ray so the client stays in the room.
    C) Place a respirator on the client and send the client to radiology.
    D) Call the prescriber and ask if the procedure is essential or can wait.

18. A nurse is applying the principles of Standard Precautions on a hospital unit. In which instances should the nurse perform hand hygiene? Select all that apply.
    A) Before touching a surface in a common area
    B) Immediately after touching a client
    C) Before performing a clean procedure
    D) Between each phase of a client's assessment
    E) After touching a client's surroundings

19. A client has tested positive for colonization with a multidrug-resistant organism (MDRO) and has been placed on Contact Precautions. Which actions should be included in this client's care? Select all that apply.
    A) Ensure that all care providers have current immunizations against the microorganism.
    B) Appoint one specific nurse to provide all of the client's care for the duration of a shift.
    C) Arrange for the client to be housed in a single room.
    D) Use appropriate PPE.
    E) Change the client's linens and gown at least twice daily.

20. A nurse has put on personal protective equipment (PPE) to perform the dressing change of a client's surgical wound. While the nurse is cleansing the incision, the client begins bleeding and blood hits the nurse's wrist, running down under the cuff of her glove. What is the nurse's **best** action?
    A) Perform thorough hand hygiene immediately after completing the dressing change.
    B) Rinse the infected hand with hydrogen peroxide after applying a sterile bandage to the client's wound.
    C) Interrupt the dressing change to perform thorough handwashing, and document the exposure according to protocol.
    D) Remove the contaminated gloves and apply a clean pair of gloves.

21. A nurse is inserting a male client's indwelling urinary catheter. After preparing the sterile field and cleansing the client's meatus, the nurse realizes that he has brought the wrong-sized catheter to the bedside. What is the nurse's **best** action?
    A) Place a sterile drape over the client's penis, obtain the right catheter, and proceed with insertion.
    B) Teach the client the importance of not touching his penis or the sterile field and obtain the correct catheter.
    C) Dismantle the sterile field, obtain a new dressing tray and the correct catheter, and then begin the procedure from the beginning.
    D) Illuminate the client's call light and have a colleague bring the correct catheter to the bedside.

22. A nurse is applying the principles of Standard and Contact Precautions in the care of a hospital client. What action violates these principles?
    A) The nurse performs hand hygiene after touching the client's surroundings.
    B) The nurse removes her gown and then removes her gloves.
    C) The nurse performs hand hygiene before putting on gloves.
    D) The nurse applies nonmedicated hand cream after performing hand hygiene.

23. A nurse has finished providing care for a client who is on Contact Precautions. When removing the protective gown, the nurse should do which action?
    A) Avoid touching the outer surfaces of the gown.
    B) Remove the gown before removing gloves.
    C) Remove the gown immediately after exiting the room.
    D) Perform hand hygiene before removing the gown.

Answer Key

1. A, C
2. D, E
3. C
4. A
5. C
6. A
7. B
8. B
9. B
10. C
11. C
12. A
13. D
14. C
15. B
16. B
17. B
18. B, C, E
19. C, D
20. C
21. D
22. B
23. A

1. A nurse is attempting to obtain vital signs from a 4-year-old child who is clinging to his mother's legs and asking to go home. How can the nurse **best** facilitate a complete and accurate assessment?
   A) Perform the blood pressure assessment first because it is the most frightening procedure for a child.
   B) Perform as many of the assessments as possible with the child seated on the mother's lap.
   C) Avoid showing the child equipment until it is about to be used.
   D) Remove any distractions from the room in order to improve the child's focus.

2. A nurse will assess the oral temperature of a postoperative client. Prior to performing this assessment, which should the nurse identify?
   A) Preferred site for temperature assessment
   B) The client's nutritional status
   C) The client's most recent temperature
   D) The client's wellness goals

3. The nurse instructs a mother of young children how to properly use a nonmercury glass thermometer. Which statement made by the client indicates a need for further instruction?
   A) "I will clean the thermometer with the dishwasher."
   B) "I will store the thermometer in the case which it came with."
   C) "I will wait 30 minutes before taking an oral temperature if my child ate or drank."
   D) "The thermometer is placed under the tongue and mouth and lips closed."

4. The nurse assesses a client admitted with multiple trauma including basilar skull fracture and rhinorrhea (drainage from nose), bilateral otorrhea (drainage from ear), and multiple fractures requiring a full body cast. The client is on a 40% Venturi oxygen mask. What is the **best** way to evaluate the client's temperature?
   A) Temporal artery
   B) Oral
   C) Tympanic
   D) Axillary

5. The nurse prepares to take a temperature of a client admitted with a myocardial infarction. The client is eating breakfast. Which action should the nurse choose?
   A) Take the temperature using the axillary route.
   B) Wait 3 to 5 minutes after breakfast to take the oral temperature.
   C) Assess the temperature using the rectal route.
   D) Cleanse the temporal artery thermometer to prevent a false high reading.

6. The nurse provides a hypothermia blanket as ordered for an unconscious client with an uncontrolled fever. The client develops facial muscle and extremity twitching. Which **best** action should the nurse take?
   A) Turn the client and reapply lanolin cream as needed.
   B) Observe skin, lips, and nails for change in color or edema.
   C) Increase the temperature of the hypothermiablanket.
   D) Discontinue the hypothermiablanket and notify the primary care provider.

7. Which client would be an appropriate candidate for the use of a radiant heater?
   A) An older adult suffering from hypothermia
   B) A premature infant
   C) An infant with jaundice
   D) A child recovering from a near-drowning incident

8. A nurse implements an order to place an infant in an overhead radiant warmer. Which guideline should the nurse follow?
   A) Attach the probe to the infant's skin over a bony prominence.
   B) Allow the blankets to warm before placing the infant under the warmer.
   C) Make sure nothing is covering the probe to allow it to register an accurate temperature.
   D) Keep the setting of the warmer on manual and adjust it at 15-minute intervals according to the temperature registered.

9. A nurse is using a hypothermia blanket as ordered on an adult client with an uncontrolled fever. Which statement accurately describes the safe and effective use of this type of equipment?
   A) Position the blanket under the client so that the top edge of the pad is aligned with the client's neck.
   B) For clients who are comatose or anesthetized, use a rectal probe to monitor core body temperature.
   C) Cover the hypothermia blanket with a thick blanket or mattress pad in order to promote thermoregulation.
   D) Avoid applying lotions or ointments to the client's skin where it will be in contact with the blanket.

10. A nurse records a pulse rate of 170 beats per minute on a client's electronic health record. For which client would this be considered a normal assessment finding?
   A) A healthy newborn infant
   B) A school-aged child who is visibly anxious
   C) A woman in the third trimester of her pregnancy
   D) An older adult with chronic lung disease

11. A nurse reviews a client's health record and reads that the client had a +3 pulse at the left dorsalis pedis. How should the nurse interpret this finding?
   A) The client's pulse rate was higher than baseline.
   B) The client had a bounding pulse at this site.
   C) The nurse assessed a pulse deficit at the client's dorsalis pedis.
   D) The nurse needed three attempts to palpate the client's pulse.

12. On assessment, a nurse notes that a client's posterior tibial pulse is difficult to palpate and that applying light pressure causes it to disappear. How should the nurse document this finding in the client's health record?
   A) 0
   B) +1
   C) +2
   D) +3

13. The nurse is preparing to administer a medication that the client takes to treat a cardiac arrhythmia. Which site should the nurse use to assess pulse in this client?
    A) Brachial
    B) Radial
    C) Carotid
    D) Apical

14. The nurse assessed the client's blood pressure (BP) and heart rate (HR) for orthostatic hypotension. In which step should the nurse intervene?
    A) Client in supine position for 3 minutes and BP 120/70; HR 70; asymptomatic.
    B) Client sitting at edge of bed, feet dangling for 3 minutes; asymptomatic.
    C) After 3 minutes of sitting, BP 100/50; HR 90.
    D) Client stands at bedside, becomes pale, diaphoretic.

15. The nurse has completed an assessment and notes that the client's blood pressure is 132/92 mm Hg. What is this client's pulse pressure?
    A) 224 mm Hg
    B) 132 mm Hg
    C) 112 mm Hg
    D) 40 mm Hg

16. A nurse attempts to count the respiratory rate of a client via inspection and finds that the client is breathing at such a shallow rate that it cannot be counted. What is an alternative method of determining the respiratory rate for this client?
    A) Auscultate lung sounds, count respirations for 30 seconds, and multiply by 2.
    B) Palpate the posterior thorax excursion, count respirations for 30 seconds, and multiply by 2.
    C) Use a pulse oximeter to count the respirations for 1 minute.
    D) Monitor arterial blood gas results for 1 minute.

17. Which action is acceptable for the nurse to perform when assessing blood pressure?
    A) During the initial nursing assessment of a client, take the blood pressure on both arms and use the arm with the lower reading for subsequent pressures.
    B) Use electronic-monitoring devices on clients with irregular heartbeats, tremors, or the inability to hold the arm still.
    C) Raise the client's arm over the head for 30 seconds to help relieve congestion of blood in the limb and make the sounds louder and more distinct.
    D) In newborns, take the blood pressure in one arm and one leg and document the difference to check for heart defects.