

Detailed Answer Key IM8_B Leadership Assessment

1. A charge nurse notes that a staff nurse delegates an unfair share of tasks to the assistive personnel (AP) and the nurses on next shift report the staff nurse frequently leaves tasks uncompleted. Which of the following statements should the charge nurse make to resolve this conflict?

- A. "I need to talk to you about unit expectations regarding delegating and completing tasks."

Rationale: This statement opens the conversation in a nonthreatening way. The focus is on the issue of the equity of the assignment rather than on any personal characteristic of the individual.

- B. "Several staff members have commented that you don't do your fair share of the work."

Rationale: This statement is accusatory.

- C. "If you don't do your share of the work, I will have to inform the nurse manager."

Rationale: This statement is punitive.

- D. "You have been very inconsiderate of others by not completing your share of the work."

Rationale: This statement is punitive.

2. When planning delegation of tasks to assistive personnel (AP), a nurse considers the five rights of delegation. Which of the following should the nurse consider when using one of the five rights of delegation?

- A. The AP's ability to prioritize

Rationale: Although the nurse could determine the AP's ability to prioritize, this is not one of the rights of delegation.

- B. The AP has the knowledge and skill to perform the task

Rationale: The right person is one of the five rights of delegation. The nurse should seek information from the AP about his individual skill level before delegating the task.

- C. The AP's rapport with clients

Rationale: Although a positive rapport with clients is important, this is not one of the five rights of delegation.

- D. The AP's ability to complete the task without assistance

Rationale: The nurse does not relinquish accountability for supervising the AP; therefore, this is not one of the five rights of delegation.

3. A nurse is teaching a class on torts. The nurse should include which of the following situations as an example of negligence?

- A. A nurse identifies the absence of peripheral pulsation in a casted extremity in the early morning and reports it to the provider in the early afternoon.

Rationale:

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Professional negligence is performing practice below the expected standard of care. It can be an act of omission, which is the failure to perform an act that a reasonable prudent person, under similar circumstances, would do. A reasonably prudent nurse would notify the provider of the neurovascular finding immediately.

- B. A client who is competent refuses an antidepressant medication. The nurse dissolves the medication in food and administers it to her without her knowledge.

Rationale: Battery is physical contact without the client's consent. Administering a medication against a client's wishes is an example of battery.

- C. A client who is alert and oriented makes an informed decision to leave the hospital against medical advice. The nurse applies restraints to the client to prevent him from leaving.

Rationale: False imprisonment is the act of detaining a client against his will without legal warrant.

- D. A nurse finds a client who is on a low-sodium diet eating salted potato chips. The nurse tells the client that she will apply wrist restraints if he does not stop eating the potato chips.

Rationale: Assault is the act of verbally threatening a client.

4. A charge nurse allows two nurses who are arguing about who gets to go to lunch first to go together. The charge nurse agrees to take care of both of the nurses' clients while they are at lunch. The charge nurse is demonstrating which of the following types of conflict management?

- A. Avoiding

Rationale: The charge nurse did not display avoiding, which is not to acknowledge or try to resolve the conflict.

- B. Competing

Rationale: The charge nurse did not display competing, which is when one person makes a quick or unpopular decision at the expense of another.

- C. Compromising

Rationale: The charge nurse did not display compromising, which is when all parties involved are willing to give up something in the resolution of the conflict.

- D. Cooperating

Rationale: The charge nurse displayed cooperating, which is the resolution of the conflict by sacrificing. In this situation, it allowed both staff nurses to get what they wanted.

5. A nurse is teaching a newly licensed nurse about methods to reduce costs of client care. Which of the following statements by the newly licensed nurse indicates understanding of the teaching?

- A. "I should wait to empty my client's drainable colostomy until it is three-fourths full."

Rationale: The nurse should empty the client's drainable colostomy when it is one-third to one-half full. If

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the nurse waits until it is three-fourths full, the skin seal can break and cause skin breakdown. Therefore, it is not cost-effective for the nurse to plan to take this action.

B. "I should delegate providing closed irrigation to the assistive personnel (AP)."

Rationale: It is cost-effective to delegate basic tasks to the AP, but the nurse should not delegate a skill requiring the use of sterile technique to the AP.

C. "I should encourage clients to receive an annual flu immunization."

Rationale: Cost containment is the delivery of effective and efficient care. Cost is maintained without loss of quality. The nurse should encourage clients to receive an annual flu immunization to prevent the need for treatment and hospitalization necessary with influenza.

D. "I should recommend that my clients who have an established tracheostomy use sterile technique at home to provide ostomy care."

Rationale: The nurse should recommend that clients who have a tracheostomy older than 1 month use clean technique to perform tracheostomy care.

6. A nurse manager is preparing an inservice program about managing conflict for the nurses on the unit. The nurse manager should identify which of the following examples as interpersonal conflict?

A. Nurses on the unit disagree about what time of day daily client weights should be obtained

Rationale: This is an example of intergroup conflict.

B. A nurse is uncertain about joining a professional nursing organization

Rationale: This is an example of intrapersonal conflict.

C. A nurse who just lost his spouse does not want to be assigned to care for a terminally ill client

Rationale: This is an example of intrapersonal conflict.

D. An experienced nurse is uncivil to a newly licensed nurse

Rationale: Incivility and bullying are examples of interpersonal conflict. Interpersonal conflict arises from differing goals and value systems.

7. A nurse on an obstetrics-gynecology unit is planning care for four clients after receiving change of shift report. Which of the following clients should the nurse assess first?

A. A client who is a 1 day postpartum after a late term miscarriage

Rationale: A client who is 1 day postpartum after a late term miscarriage is stable. Therefore, there is another client the nurse should assess first.

B. A client who had a bilateral tubal ligation 12 hr previously

Rationale: A client who had a bilateral tubal ligation 12 hr previously is stable. Therefore, there is another

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client the nurse should assess first.

- C. A client who is 4 days postpartum and has mastitis

Rationale: A client who is 4 days postpartum and has mastitis is stable. Therefore, there is another client the nurse should assess first.

- D. A client admitted 1 hr ago for an ectopic pregnancy

Rationale: A client who has an ectopic pregnancy is unstable. The client is at risk for rupture of the fallopian tube, hemorrhage, and shock. Nursing care requires frequent monitoring every 15 min, IV access for fluid resuscitation. The client may also require blood transfusions, oxygen, and pain management. Therefore this client is the highest priority.

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8. A nurse manager observes an unknown man in a laboratory coat making copies of a client's medical record. Which of the following actions should the nurse plan to take first?

- A. Notify hospital security.

Rationale: The nurse should notify hospital security if the man is not authorized to be in possession of the client's medical record to protect the client's confidentiality. However, there is another action the nurse should take first. It is premature to call hospital security until the nurse knows more about the situation. The nurse should notify hospital security if the man is not authorized to be in possession of the medical record or there is any concern for the safety of staff or clients.

- B. Approach the man and ask why he is making copies.

Rationale: The first action the nurse should take using the nursing process is to assess the situation to determine whether this man is authorized to be in possession of the client's medical record to protect the client's confidentiality. Making copies from a client's medical record is allowed under specific circumstances. It is important to act in a timely fashion to protect the client's medical information. The nurse should approach the individual in a nonthreatening way to inquire about the copies being made.

- C. Inform the nursing supervisor.

Rationale: The nurse should inform the nursing supervisor if the man is not authorized to be in possession of the client's medical record to protect the client's confidentiality. However, there is another action the nurse should take first.

- D. Report the observation to the nurse caring for that client.

Rationale: The nurse should report the observation to the nurse caring for that client if the man is not authorized to be in possession of the client's medical record to alert the client of a possible breach in confidentiality. However, there is another action the nurse should take first.

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9. A nurse is supervising a licensed practical nurse (PN) who is providing care to a client who is postoperative. Which of the following statements by the client requires the nurse to follow up with the PN?

- A. "I do not know how to make the remote control work."

Rationale:

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It is not the responsibility of the PN to instruct the client about how to use the remote control. Supervision includes providing clear directions and expectations, monitoring performance, providing feedback and constructive criticism, intervening when necessary, and evaluating whether client needs were met.

B. "Do you know when I will be going home?"

Rationale: The nurse might not know the answer to this question, and it is not an expectation of the PN to know the answer to this question.

C. "My dressing was changed earlier this morning."

Rationale: The PN should change the client's dressing as prescribed. The RN should follow up to ensure that this was done as prescribed and in a timely manner. The RN should inspect the dressing and evaluate the condition of the wound.

D. "I have not received any of my medications today."

Rationale: Failure to receive prescribed medications in a timely manner can have a negative effect on client outcomes. The nurse should immediately follow up with the PN to determine if medications have been administered and, if not, to learn why. It is possible that the client does not remember receiving medications or that no medications were prescribed as of this time. Effective supervision requires that any issue that can negatively impact client care is followed up on immediately.

10. A nurse is preparing to administer a prescribed medication to a client. Which of the following actions should the nurse plan to take to demonstrate client advocacy?

A. Encourage the client to verbalize questions.

Rationale: The nurse acts as a client advocate by providing the client with information needed to make informed decisions regarding care.

B. Insist the client take prescribed medications.

Rationale: Forcing or insisting that the client take the medication does not respect the client's right to an informed decision. The client has a right to information regarding their treatment and management of care.

C. Inform the client that the medication is the same as taken at home.

Rationale: In this response, the nurse does not encourage the client to ask questions regarding the medications prescribed. The nurse, as a client advocate, should teach the client about each medication, including its expected effects and adverse effects.

D. Tell the client that refusal of the medication is considered noncompliance.

Rationale: In this response, the nurse does not support the client or demonstrate client advocacy. The client has a right to refuse care and treatment after receiving full disclosure of information regarding prescribed medication, such as its action, expected effects, and adverse effects.

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11. A nurse is caring for four clients who are postoperative from surgery 24 hr ago. At 1200 the nurse assesses the clients. Which of the following clients is the nurse's priority?

- A. A client who has a prescription for insulin and his premeal capillary blood glucose was 110 mg/dL and his post-meal capillary blood glucose is now 160 mg/dL

Rationale: Both blood glucose levels are within the expected reference range. This client is stable; therefore, he is not the nurse's priority.

- B. A client whose wound drainage at 0800 was sanguineous and now it is serosanguineous

Rationale: A change in the color of wound drainage from sanguineous to serosanguineous is an expected finding for a client who is 24 hr postoperative from surgery. Therefore, this client is not the nurse's priority.

- C. A client who reports pain as 4 on a scale of 1 to 10 at 0800 now reports pain as 6

Rationale: The nurse should ask the client to rate his pain on a scale of 0 to 10 and provide care to manage the client's pain. However, this client is not the nurse's priority.

- D. A client whose blood pressure at 0800 was 138/86 mm Hg and at 1200 is 106/60 mm Hg

Rationale: A client who is postoperative is at risk for hemorrhage. A blood pressure decrease of 15 to 20 points is significant. This client is unstable; therefore, this client is the nurse's priority.

12. A nurse manager is observing the care provided by a nurse who is in orientation to the unit. Which of the following actions by the nurse indicates the nurse manager should intervene?

- A. The nurse uses clean gloves when discontinuing a client's intravenous infusion.

Rationale: The nurse should wear clean gloves when performing the procedure because they reduce the risk of transferring microorganisms from the client.

- B. The nurse empties a client's drainable colostomy pouch when it is one-third full.

Rationale: The nurse should empty the client's colostomy pouch when it is one-third to one-half full. If the pouch becomes too heavy, it can cause the seal on the pouch to break the skin and subsequently expose the area around the ostomy to stool.

- C. The nurse uses the client's telephone number as one form of identification when administering medications to a client.

Rationale: The nurse should use two forms of identification prior to administering medications to a client. Acceptable forms of identification include telephone number, as well as the client's name and birthdate.

- D. The nurse opens the top flap of a sterile tray toward the body when assisting the provider with a thoracentesis.

Rationale: The nurse should avoid reaching across a sterile field; therefore, the nurse should place the sterile tray on the work surface so the top flap opens away from the body.

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13. A nurse manager received a client request not to have a specific staff nurse care for her while at the acute care facility. Which of the following is the appropriate action by the nurse manager?

- A. Ask other staff nurses about the level of care the specific staff nurse provides.

Rationale: This action is inappropriate because it does not directly address the issue and does not show respect for the specific staff nurse.

- B. Address the concern with the specific staff nurse.

Rationale: The nurse manager should use the conflict management skill collaborating to resolve the conflict. The nurse manager should be assertive and ask the specific staff nurse about the problem.

- C. Recommend the specific staff nurse be transferred to another unit.

Rationale: This action is inappropriate because it does not directly address the issue and does not show respect for the specific nurse.

- D. Notify the human resources department about the request.

Rationale: This action is inappropriate because it does not directly address the issue and does not show respect for the specific nurse.

14. A nurse notes a provider frequently arrives to the unit with bloodshot eyes and smells like alcohol after lunch. Which of the following actions should the nurse take?

- A. Counsel the provider to determine the cause of the substance abuse.

Rationale: The responsibility of the nurse is to protect clients from injury. It is not the responsibility of the nurse to counsel the provider.

- B. Encourage clients to change to a different provider.

Rationale: Encouraging clients to change services based on assumptions is defamation and could result injury to the reputation of the provider. The nurse could be sued for this action.

- C. Inform the state medical board for an immediate investigation.

Rationale: It is the responsibility of hospital management and administration to follow up with any state licensure boards in cases of impairment or client negligence or harm.

- D. Notify the nursing supervisor of the concerns.

Rationale: The nurse should notify hospital or nursing management of the concerns, and then ensure client safety. It is the responsibility of management to conduct an investigation. Client safety is the responsibility of the nurse.

15. A nurse is planning to assign tasks for a group of clients. Which of the following tasks should the nurse plan to assign to an assistive personnel (AP)? (Select all that apply.)

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- A. Ambulate an older adult client who has hypertension.
- B. Provide discharge instructions for a client who has a new skin graft.
- C. Perform an admission assessment on a client.
- D. Check a blood product with another nurse prior to administration.
- E. Weigh a client who has heart failure.

Rationale: Ambulate an older adult client who has hypertension is correct. An AP can ambulate an older adult client who has hypertension.

Provide discharge instructions for a client who has a new skin graft is incorrect. An RN should provide discharge teaching for a client.

Perform an admission assessment on a client is incorrect. An RN should perform an admission assessment on a client.

Check a blood product with another nurse prior to administration is incorrect. Two RNs or one RN and one licensed practical nurse (LPN) should check a blood product before administration.

Weighing a client who has heart failure is correct. An AP can weigh a client who is stable.

16. A nurse is obtaining informed consent from a client who is preoperative. Which of the following actions should the nurse take? (Select all that apply.)

- A. Establish that the client is able to pay for the surgical procedure.
- B. Explain the surgical procedure to the client.
- C. Validate the signature is authentic.
- D. Verify the client understands the surgical procedure.
- E. Confirm that the consent is voluntary.

Rationale: Establish that the client is able to pay for the surgical procedure is incorrect. The client's ability to pay for the procedure is not required prior to obtaining an informed consent.

Explain the surgical procedure to the client is incorrect. It is the surgeon's responsibility to explain the procedure to the client.

Validate the signature is authentic is correct. The nurse must validate the signature on the consent is made by the client or the client's legal guardian.

Verify that the client understands the surgical procedure is correct. The nurse should verify the client understands the procedure and the risks.

Confirm that the consent is voluntary is correct. The nurse should confirm the client is giving voluntary consent without coercion.

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17. A nurse is caring for an older adult client who is disoriented and has a history of falls. Which of the following actions should the nurse take? (Select all that apply.)

- A. Raise all side rails on the client's bed.
- B. Obtain a prescription to restrain the client PRN.
- C. Check on the client hourly.
- D. Instruct the client in the use of the call light.
- E. Apply an ambulation alarm to the client's leg.

Rationale: Raise all side rails on the client's bed is incorrect. Raising all side rails is considered a restraint. For a client who is disoriented, the risk for injury is greater with all side rails of the bed raised. If the client attempts to get out of bed, she may try to climb over the side rail or climb out at the foot of the bed. The nurse should place the bed in the lowest position.

Obtain a prescription to restrain the client PRN is incorrect. Restraints are not prescribed PRN. Written restraint prescriptions are for a specific event and must have start and end times. Temporary restraints might be needed for clients who are confused, disoriented, repeatedly fall, or try to remove medical devices.

Check on the client hourly is correct. Implementation of hourly rounds facilitates safety by reducing client falls. Hourly nursing actions should include toileting, turning, and ensuring that possessions and call lights are within reach.

Instruct the client about the use of the call light is correct. Call lights are used for communication with nursing staff. When clients call for and wait for assistance before getting out of bed, the occurrence of accidents and falls is minimized. Nursing staff should make sure the call light is within the client's reach and should instruct the client frequently about its use.

Apply an ambulation alarm to the client's leg is correct. The ambulation alarm signals when the client's leg is in a dependent position, such as over the side rail or on the floor. The signal alerts the staff to check on the client immediately.

18. A nurse finds that a client did not receive a scheduled dose of furosemide (Lasix). Which of the following should the nurse include in the incident/variance report? (Select all that apply.)

- A. The date of the incident
- B. The name of the provider who prescribed the medication
- C. The potential adverse effects of the medication
- D. The time the client was to receive the medication
- E. The client's vital signs

Rationale: The date of the incident is correct. When a nurse discovers a medication error, it is her legal responsibility to complete an incident report. A health care agency can use incident reports to monitor incidents and accidents in order to prevent future occurrences. The report should only

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include factual information about the incident such as the date.

The name of the provider who prescribed the medication is incorrect. The nurse does not need to include the name of the provider who prescribed the medication as this information is part of the client's medical record.

The potential adverse effects of the medication is incorrect. The nurse should only include factual information about the incident and not potential effects.

The time the client was to receive the medication is correct. The nurse should include the time the client was to receive the medication because this pertains directly to the incident of the omitted medication.

The client's vital signs is correct. The nurse should assess the client as soon as she discovers the error and should include the assessment data in the report.

19. A nurse in a provider's office is collecting a health history from a client who has a new prescription for glyburide to treat type 2 diabetes mellitus. Which of the following statements by the client indicates a contraindication for taking this medication?

A. "I had strep throat about one year ago."

Rationale: Having streptococcal infection of the throat is not a contraindication for taking glyburide.

B. "I plan to continue nursing my baby until he is at least a year old."

Rationale: Glyburide is a sulfonylurea that is used to treat type 2 diabetes, but it is contraindicated during pregnancy and breastfeeding.

C. "I got my flu shot at the pharmacy two weeks ago."

Rationale: Getting an immunization for influenza is not a contraindication for taking glyburide.

D. "I am allergic to shellfish."

Rationale: Although an allergy to shellfish may be a contraindication to the use of contrast media in some diagnostic tests, it is not a contraindication for taking glyburide.

20. A nurse is caring for a client who is dying of metastatic breast cancer. She has a prescription for an opioid pain medication PRN. The nurse is concerned that administering a dose of pain medication might hasten the client's death. Which of the following ethical principles should the nurse use to support the decision not to administer the medication?

A. Utilitarianism

Rationale: Utilitarianism refers to actions that are right when they contribute to the greatest good.

B. Nonmaleficence

Rationale: Nonmaleficence is the duty to do no harm. The ethical mandate of nonmaleficence is that health care workers refrain from intentionally inflicting harm to clients.

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C. Fidelity

Rationale: Fidelity is the duty to keep one's promises or word. It refers to the obligation to be faithful to the agreements, commitments, and responsibilities that one has made to oneself and others.

D. Veracity

Rationale: Veracity is the duty to tell the truth. It means that one does not intentionally deceive or mislead clients.

21. A nurse suspects that a coworker is diverting opioid analgesics. Which of the following is an adverse effect of opioid medications?

A. Euphoria

Rationale: Euphoria is an adverse effect of opioid analgesics and is due to activation of mu receptors.

B. Rhinorrhea

Rationale: Rhinorrhea can occur with opiate withdrawal, but it is not an effect from the medication.

C. Hallucinations

Rationale: Hallucinations are an adverse effect of cannabis.

D. Dilated pupils

Rationale: Constricted pupils are an adverse effect of opioid analgesics.

22. A nurse is caring for a client who has advanced lung cancer. The client's provider has recommended hospice services for the client. Which of the following statements by the client indicates a correct understanding of hospice care?

A. "I will have to be admitted to a long-term care facility in order to receive hospice care."

Rationale: Hospice care is provided in a long-term care facility; however, hospice care is also provided in a number of other settings, including the client's home and in an assisted living facility.

B. "I should expect the hospice team to help me manage my dyspnea."

Rationale: Dyspnea is a manifestation of terminal lung cancer. The primary purpose of hospice care is to provide relief of symptoms related to a terminal illness.

C. "Hospice care services are available to patients who are terminally ill regardless of their life expectancy."

Rationale: Hospice care is available to clients who have a prognosis of 6 months or fewer to live.

D. "My oncologist will continue to look for a cure for my cancer while I am receiving hospice care."

Rationale: Hospice care provides comfort care for the client, but does not include curative treatment.

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23. A nurse in the emergency department is caring for a client who has a compression fracture of a spinal vertebra. During transport to the facility, the client was medicated with intravenous morphine. On arrival, the neurosurgeon determined urgent surgical intervention is indicated for the fracture. Staff members have been unable to reach the client's family. Which of the following actions should the nurse anticipate the neurosurgeon taking?

- A. Invoking implied consent

Rationale: The client is unable to sign the consent form because he is sedated from the morphine. The neurosurgeon has the legal right to invoke implied consent and proceed with the surgery if it is determined an emergency and surgery is in the client's best interest. The neurosurgeon should document the specifics of the situation in the client's medical record.

- B. Delaying the surgery until a member of the client's family is reached

Rationale: This action places the client at risk for a poor outcome; therefore, this is not the action the nurse should anticipate.

- C. Asking the client to sign the surgical consent form

Rationale: The neurosurgeon should not ask the client to sign the consent form because he is sedated from the morphine. A client who is disoriented or unable to function because of the administration of a medication, such as morphine, is not competent to sign the surgical consent form.

- D. Prescribing naloxone to reverse the effects of the morphine

Rationale: The purpose of naloxone is to reverse the effects of opioid toxicity. The neurosurgeon should not prescribe naloxone for the client because it can reverse the analgesic effects of morphine.

24. A charge nurse is delegating tasks to nursing personnel on a 10-bed medical-surgical nursing unit. Which of the following assignments is an example of overdelegation?

- A. Assigning two assistive personnel (AP) to ambulate all clients

Rationale: Assigning two APs to ambulate 10 clients follows the rights of delegation and expectations of the APs. It is not an example of overdelegation.

- B. Assigning a new graduate nurse to perform a wet-to-dry dressing change

Rationale: Assigning a new graduate nurse to perform a wet-to-dry dressing change follows the rights of delegation and expectations of the nurse. It is not an example of overdelegation.

- C. Assigning the most efficient AP to perform glucometer monitoring for each client

Rationale: Asking the most efficient AP to perform glucometer testing based on her efficiency in performing this task is an example of overdelegation. This can result in the AP becoming overworked and tired, thus decreasing productivity.

- D. Assigning the most competent RN to perform a central line dressing change

Rationale: Assigning the most competent RN to perform a central line dressing change follows the rights of delegation and expectations of the nurse. It is not an example of overdelegation.

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25. A nurse is working with a limited staff because of a severe storm in the area. The facility incident commander has initiated disaster protocols. Which of the following actions should the nurse take?

- A. Focus on providing care that prevents life-threatening emergencies.

Rationale: The triage method in a disaster focuses on providing care to clients who have any immediate threat to life.

- B. Reinforce discharge teaching to clients.

Rationale: In the event of a disaster, the nurse should focus on urgent client care. Discharge teaching should not be the nurse's focus at this time.

- C. Instruct the assistive personnel (AP) to focus on clients' ADLs.

Rationale: The triage method in a disaster focuses on meeting critical needs, which does not include having the AP assist clients with ADLs.

- D. Stock additional unit supplies.

Rationale: In a disaster, facilities implement the triage method, which calls for ancillary personnel to stock additional unit supplies for nursing personnel. The nurse should focus on urgent client care needs.

26. A charge nurse delegates to a licensed practical nurse (LPN) the task of changing a client's dressing. Several hours later the client reports the dressing has not been changed. Which of the following actions should the charge nurse take?

- A. Change the client's dressing.

Rationale: Changing the client's dressing does not clarify the reason for lack of action by the assigned LPN.

- B. Reassign the task to another nurse.

Rationale: Reassigning the task to another nurse does not clarify the reason for lack of action by the LPN.

- C. Verify the LPN knows how to do a dressing change.

Rationale: The charge nurse should attempt to see the delegated task from the perspective of the individual being delegated to. This approach clarifies the reason for lack of action by the LPN.

- D. Report the issue to the unit manager.

Rationale: Reporting the issue to the unit manager does not clarify the reason for lack of action by the LPN.

27. A nurse on the pediatric unit is providing room assignments for children who are to be admitted to the unit. The nurse should plan to place a child who is postoperative from an appendectomy with which of the following clients?

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A. A child who is experiencing sickle cell crisis

Rationale: The nurse should not place these clients together. The child who is experiencing sickle cell crisis requires rest and pain management, and the child who is postoperative from an appendectomy requires frequent assessments and interventions.

B. A child who has streptococcal pharyngitis

Rationale: The nurse should not place these clients together. A child who has streptococcal pharyngitis requires contact precautions and a private room.

C. A child who has a head injury

Rationale: The nurse should not place these clients together. The child who has a head injury requires a quiet, low stimulus environment, and the child who is postoperative from an appendectomy requires frequent assessments and interventions.

D. A child who has a new diagnosis of type 1 diabetes mellitus

Rationale: The nurse should place these clients together. It is appropriate because the child who has diabetes requires monitoring and teaching and the child who is postoperative from an appendectomy requires frequent assessments and interventions.

28. A nurse manager is preparing an inservice program for the nurses on the unit about the use of a new infusion pump. Which of the following teaching strategies is the most effective way to ensure that the staff can use the device correctly?

A. Provide a written procedure for the use of the device for the staff to review.

Rationale: This strategy might be useful for learners who wish to prepare beforehand or check a detail afterward, but it does not ensure the staff can use the device correctly.

B. Demonstrate using the device and observe the staff returning the demonstration.

Rationale: The most effective strategy to ensure the staff nurses can perform a psychomotor skill, such as using an infusion pump, is to show them how to use the device and provide the opportunity for a return demonstration.

C. Remind the staff to review the procedure manual prior to using the new pump.

Rationale: This strategy might be useful for learners who wish to accept responsibility for learning, but it does not ensure the staff can use the device correctly.

D. Identify the differences and new features of the device in a written brochure.

Rationale: This strategy might be useful for learners who wish to accept responsibility for learning, but it does not ensure the staff can use the device correctly.

29. A nurse tells another nurse that she thinks he did not provide adequate care for a client who underwent hip arthroplasty. Which of the following responses by the nurse demonstrates assertiveness?

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- A. "I feel as though I met the standard of care. Would you tell me more about your concerns?"

Rationale: Communicating assertively is expressing thoughts in an open, honest, and direct manner that demonstrates respect for self and others. The use of "I" statements, maintaining eye contact, and congruent verbal and facial expressions are all components of assertiveness skills. The nurse demonstrates respect for the opinion of the other nurse by asking for feedback and the reason for the concerns.

- B. "You shouldn't make accusations. Your nursing care doesn't always set a good example."

Rationale: This response is aggressive because the nurse is directly insulting the other nurse.

- C. "I am at a loss for words. I always do my best to give good care to my clients."

Rationale: This response is submissive because the nurse is accepting the opinion of the other nurse without regard to his own opinions.

- D. "What do you have against me? It must be something or you wouldn't be criticizing my care."

Rationale: This response is aggressive because the nurse is disregarding and insulting the other nurse.

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30. A nurse is serving on a continuous quality improvement (CQI) committee that has been assigned to develop a program to reduce the number of medication administration errors following a sentinel event at the facility. Which of the following strategies should the committee plan to initiate first?

- A. Provide an inservice on medication administration to all the nurses.

Rationale: A recommendation for staff education may be indicated, but this does not assist the committee to identify factors that lead to medication errors.

- B. Require staff nurses to demonstrate competency by passing a medication administration examination.

Rationale: Ensuring competency in medication administration may be indicated, but this does not assist the committee to identify factors that lead to medication errors.

- C. Review the events leading up to each medication administration error.

Rationale: After a sentinel event, the first step the committee should plan to take is to use root cause analysis to identify the underlying cause or causes that led to the medication errors.

- D. Develop a quality improvement program for nurses involved in medication administration errors.

Rationale: Although development of a quality improvement program for nurses involved in medication errors may be indicated, this does not assist the committee to identify factors that lead to medication errors.