Case Study: Multiple Clients on a Medical-Surgical Unit
Prioritization, Delegation, and Assignment Textbook

The RN is the leader of a team providing care for six patients. The team includes the RN, an experienced LPN/LVN, and a newly educated assistive personnel (AP) who is in his fourth week of orientation to the acute care unit. (Note to student: Use the information from the shift change report below to make brief notes about these six patients and refer to the notes as you work through the case study.) The patients are as follows:

- *Mr. C, a 68-year-old male with unstable angina who needs reinforcement of teaching for a cardiac catheterization scheduled this morning*
- *Ms. J, a 45-year-old female who had chest pain during the night and is now experiencing chest pain. She is scheduled for a graded exercise test later today*
- *Mr. R, a 75-year-old male who had a left-hemisphere stroke 4 days ago*
- *Ms. S, an 83-year-old female with heart disease, a history of myocardial infarction, and mild dementia*
- *Mr. B, a 93-year-old newly admitted male from a long-term care facility, with decreased urine output, altered level of consciousness, and an elevated temperature of 99.5°F (37.5°C)*
- *Mr. L, a 59-year-old male with mild shortness of breath (SOB) and chronic emphysema*

1. Matrix Grid—Multiple Choice

Scenario: The RN is delegating and assigning patient care to his or her team members for the shift.	**Instructions:** Interventions are listed in the left-hand column. Place an X under the team member that the charge nurse would **best** assign or delegate to complete each intervention.

Intervention	**LPN/LVN**	**ASSISTIVE PERSONNEL (AP)**	**RN**
Check and record vital signs for each patient.			
Administer docusate sodium, 50 mg orally to a patient passing hard stool.			
Bathe bedridden confused patient.			
Complete an assessment on a newly admitted patient for altered level of consciousness.			
Measure output and empty patient's urinary catheter bag at end of shift.			
Place a urinary catheter as ordered by the health care provider (HCP).			
Teach a rehab patient to call for help when getting out of bed to the bathroom.			
Check fingerstick blood glucose and administer sliding-scale insulin as ordered if glucose is elevated.			

2. During the shift change report, the night RN informs the team that Ms. S is to be transferred back to her long-term care facility after lunch. What action should be taken for this patient?
   1. Instruct the assistive personnel (AP) to awaken her for vital signs and breakfast.
   2. Allow her to sleep for an hour or two while the other patients are assessed.
   3. Assign the LPN/LVN to immediately pack up the patient's belongings.
   4. Call the nursing home to find out if the transfer can wait until tomorrow.
3. Which patients should the team leader assign to the LPN/LVN for nursing care under the RN's supervision? **Select all that apply. One, some, or all responses may be correct.**
   1. Mr. C (unstable angina)
   2. Ms. J (chest pain)
   3. Mr. R (stroke)
   4. Ms. S (heart disease and dementia)
   5. Mr. B (decreased urine output, altered level of consciousness)
   6. Mr. L (shortness of breath and chronic emphysema)

4. Which patient should the RN assess **first**?
    1. Mr. C (unstable angina)
    2. Ms. J (chest pain)
    3. Mr. B (decreased urine output, altered level of consciousness)
    4. Mr. L (shortness of breath and chronic emphysema)
5. The RN is assessing Ms. J's chest pain. Which questions would the RN be sure to ask the patient? **Select all that apply. One, some, or all responses may be correct.**
    1. "When did you first notice the chest pain?"
    2. "Did your pain start suddenly or gradually?"
    3. "How long has the chest pain lasted?"
    4. "Have you experienced confusion or loss of memory with the pain?"
    5. "On a scale of 0 to 10, with 10 being the worst pain ever, how would you grade your pain?"
    6. "What were you doing when the chest pain started?"
6. The health care provider's prescribed interventions for Ms. J, who is currently experiencing chest pain, are as follows. Which intervention should be completed **first**?
    1. Administer nitroglycerin 0.6 mg sublingually as needed for chest pain.
    2. Administer morphine 2 mg IV push as needed for chest pain.
    3. Check blood pressure and heart rate.
    4. Complete lab tests including cardiac markers and daily electrocardiogram.
7. Which tasks should the nurse delegate to the newly hired assistive personnel (AP)? **Select all that apply. One, some, or all responses may be correct.**
    1. Asking Ms. S memory-testing questions
    2. Teaching Ms. J about treadmill exercise testing
    3. Checking vital signs on all six patients
    4. Recording oral intake and urine output for Mr. B
    5. Assisting Mr. L to walk to the bathroom
    6. Helping Mr. R with morning care
8. Which key point would the nurse be sure to include when teaching Mr. C about the postprocedural care for cardiac catheterization?
    1. "There are no restrictions after the procedure."
    2. "You will be able to get out of bed within 2 hours after the procedure."
    3. "You will have to stay almost flat in bed with limited position changes for 4 to 6 hours."
    4. "Family visitors will be restricted until the next day."
9. The cardiac lab calls to have Ms. J sent for her graded exercise test (GXT). What is the nurse's **best** action?
    1. Instruct the assistive personnel to put the patient in a wheelchair and take her to the lab.
    2. Call the cardiac lab and ask to delay the test until later in the day.
    3. Contact the health care provider (HCP) to ask if the patient should still have the GXT.
    4. Ask the patient if she is continuing to have chest pain.

10. The assistive personnel is delegated the task of measuring morning vital signs for all six patients. Which finding would the nurse instruct the AP to report immediately?
    1. Oral temperature higher than 102°F (38.9°C)
    2. Blood pressure higher than 140/80 mm Hg
    3. Heart rate lower than 65 beats/min
    4. Respiratory rate lower than 18 breaths/min

11. The assistive personnel (AP) asks the RN why it is important to notify someone whenever a patient with heart problems reports chest pain. What is the RN's **best** response?
    1. "It's important to keep track of the chest pain episodes so we can notify the health care provider (HCP)."
    2. "The patient may need morphine to treat the chest pain."
    3. "Chest pain may indicate coronary artery blockage and heart muscle damage that will need treatment."
    4. "Our unit policy includes specific steps to take in the treatment of patients with chest pain."

12. The health care provider's prescribed interventions for Mr. R, who had a stroke 4 days ago, include assisting the patient with meals. Which staff member would be **best** to assign this task?
    1. Physical therapist
    2. Assistive personnel (AP)
    3. LPN/LVN
    4. Occupational therapist

13. The LPN/LVN reports to the RN that Mr. R was unable to take his oral medications because of difficulty swallowing. The RN assesses Mr. R and finds that he is having dysphagia. What is the RN's **best** instruction for the LPN/LVN?
    1. "Keep Mr. R NPO, and I will contact his health care provider (HCP)."
    2. "Try giving his medications with applesauce or pudding."
    3. "Check with the pharmacy to find out if they have liquid forms of Mr. R's medications."
    4. "Assess Mr. R's ability to speak and move his tongue."

14. The assistive personnel reports to the RN that Mr. L, the patient with chronic emphysema, says he is feeling short of breath after walking to the bathroom. What action should the RN take **first**?
    1. Notify the health care provider (HCP).
    2. Increase oxygen flow to 6 L/min via nasal cannula.
    3. Assess oxygen saturation by pulse oximetry.
    4. Remind the patient to cough and deep breathe.

15. The oral temperature of Mr. B, the patient newly admitted from a long-term care facility with decreased urine output and altered level of consciousness, is now 102.6°F (39.2°C). What is the nurse's **best** action?
    1. Notify the health care provider (HCP).
    2. Administer acetaminophen 2 tablets orally.
    3. Assign the LPN/LVN to give an acetaminophen suppository.
    4. Remove extra blankets from the patient's bed.

16. Which factor does the nurse suspect **most** likely precipitated Mr. B's elevated temperature?
    1. Bladder infection
    2. Increased metabolic rate
    3. Kidney failure
    4. Nosocomial pneumonia

17. The RN is working on a care plan for Mr. B. Which care intervention is **most** appropriate to delegate to the assistive personnel (AP)?
    1. Checking the patient's level of consciousness every shift
    2. Assisting the patient with ambulation to the bathroom to urinate
    3. Teaching the patient the side effects of antibiotic therapy
    4. Administering sulfamethoxazole–trimethoprim orally every 12 hours
18. The assistive personnel reports that Mr. L's heart rate, which was 86 beats/min in the morning, is now 98 beats/min. What would be the **most** appropriate question for the nurse to ask Mr. L?
    1. "Have you just returned from the bathroom?"
    2. "Did you recently used your albuterol inhaler?"
    3. "Are you feeling short of breath?"
    4. "How much do you smoke?"
19. The LPN/LVN reports to the RN that Ms. S will not leave the chest leads for her cardiac monitor in place and asks if the patient can be restrained. What is the RN's **best** response?
    1. "Yes, this patient had a heart attack, and we must keep her on the cardiac monitor."
    2. "Yes, but be sure to use soft restraints so that the patient's circulation is not compromised."
    3. "No, we must have an health care provider's (HCP's) order before we can apply restraints in any situation."
    4. "No, but try covering the lead wires with the sheet so that the patient does not see them."
20. Mr. C has returned from the cardiac catheterization lab and requires close monitoring after the procedure. Which postprocedural tasks would be best assigned to the LPN/LVN? **Select all that apply. One, some, or all responses may be correct.**
    1. Check bilateral pedal pulses every 15 minutes during the first hour.
    2. Check right groin area for bleeding every 15 minutes during the first hour.
    3. Continue IV fluids normal saline at 50 mL/hr.
    4. Assist patient to bathroom as needed during first 6 hours after the procedure.
    5. Administer morphine sulfate 2 mg IV push as needed for pain.
    6. Give patient's daily multivitamin and stool softener on return to medical unit.
21. Near the end of the shift, the LPN/LVN reports that the AP has not totaled the patients' intake and output for the past 8 hours. What is the nurse's **best** action?
    1. Confront the assistive personnel (AP) and instruct him to complete this assignment at once.
    2. Assign this task to the LPN/LVN.
    3. Ask the AP if he needs assistance completing the intake and output records.
    4. Notify the nurse manager to include this on the AP's evaluation.

22. Drop Down Cloze

Instructions: Choose the correct words or phrases to complete the sentences and write the number for the words in the appropriate space.

Case Study A	A Options
The LPN/LVN is working with an assistive personnel (AP) to provide care for Ms. S before her transfer back to the long-term care facility. In preparation for the transfer, the LPN/LVN may delegate the AP to assist this patient with/by (a)_____, (b)_____, and (c)_____, as needed.	1. getting out of bed 2. washing her hands and face 3. feeding the patient rapidly and giving her fluids from her tray after every bite 4. notifying the long-term care facility that the patient is ready for transfer 5. ambulating to the bathroom

Case Study B	**B Options**
The AP informs the LPN/LVN that Mr. L now has a rapid heart rate of 118 per minute and that he states his chest hurts a little. The LPN/LVN would first (a)_____. Then the priority would be to (b)_____and (c)_____. The next priority would be to (d)_____.	1. notify the health care provider (HCP) 2. apply oxygen 3. assess the patient 4. gather more information 5. notify the RN

23. Multiple Response—Select All That Apply

Instructions: Read the case study on the left and circle the numbers that **best** answer the question.

Case Study	Question
Near the end of the shift the RN is assessing a new admission. Mr. E is an 88-year-old patient from long-term care. The patient was alert until early in the morning and after breakfast became confused. His history includes smoking cigarettes for 55 years, but he quit at age 70. He has a history of post-traumatic stress disorder (PTSD) and had surgery for appendicitis and gallbladder disease. Over the past 36 hours the patient developed headache, muscle aches, cough with thick clear sputum, and chest discomfort.	Which of the following findings with this patient are factors that increase the risk for a diagnosis of pneumonia? **Select all that apply. One, some, or all responses may be correct.** 1. Patient age 2. PTSD 3. Smoked cigarettes 55 years 4. Thick, clear sputum 5. Crackles and wheezes 6. Elevated WBC count 7. Altered level of consciousness 8. Electrolyte values 9. Temperature 101.4°F (38.6°C)

Vital signs: **Temperature 101.4°F (38.6°C)** **Heart rate 124 beats/min** **Respiratory rate 34 breaths/min** **Blood pressure 108/62 mm Hg**	
Assessment findings: Warm dry skin, crackles bilaterally with wheezes, tachycardia with normal heart sounds, and a pulse oximetry reading of 89% on oxygen at 2 L by nasal cannula. The patient does not tolerate lying flat in bed.	
Admission Lab: Complete blood count reveals elevated white blood cell (WBC) count. Electrolytes (Na+ 135, K+ 3.8, Cl-98)	

24. The health care provider prescribed an increase in Mr. E's oxygen to 3 L per nasal cannula. Which assessment finding by the nurse indicates an improvement in Mr. E's oxygenation status?

1. Heart rate decrease from 124/min to 108/min
2. Respiratory rate decrease from 34/min to 30/min
3. Coughing up increased greenish sputum
4. Pulse oximetry increase from 89% to 91%