MULTIPLE CHOICE

1. The patient is in isolation in a negative-pressure room for active tuberculosis. He coughs and spews large amounts of blood-tinged sputum but is too weak to cover his mouth and nose with a tissue. Which is the most important intervention for the nurse to implement for self-protection while providing nursing care?

   a. Cover the patient’s mouth and nose snugly with a surgical mask.
   b. Wear an N-95 mask, gloves, face shield, and isolation gown.
   c. Place tissues and a contaminated waste container within reach.
   d. Use a properly fitted surgical mask and gloves to help with tissues.

ANS: B

Wearing suitable protective barriers is the most important intervention to implement because it protects the nurse from the airborne particles and the pathogens that can land on surfaces from droplets of the patient’s coughing. The nurse wears a mask suitable for airborne precautions to prevent inhalation of suspended *Mycobacterium tuberculosis* in the air and gloves, gown, and goggles to protect clothing and mucous membranes from contact with body fluids because of the patient’s poor hygiene due to his weakened state. Respirator masks are used in airborne precautions because these masks filter what the wearer inhales. The
patient should wear a mask if he or she must leave the room because a surgical mask controls what the wearer exhales; a mask for the patient is not indicated in the isolation room. The nurse can inhale airborne particles through the pores of a surgical mask, regardless of how well it fits, because a surgical mask controls what is exhaled.

DIF: Cognitive Level: Analyze  
REF: Page 84  
OBJ: NCLEX: Safe and Effective Care  
TOP: Nursing Process: Implementation

2. The nurse is caring for several patients under contact precautions. Which option is possible for the nurse to use if two of her patients have “like” infections?

a. Double gloving
b. Single gloving
c. Cohorting
d. Hand sanitizer only

ANS: C

When a hospitalized patient has an infection, a nurse decides on the optimal room placement to minimize the chances of infection spreading to other patients. Two patients with “like” infections can be placed in the same room; this is called cohorting.

Double gloving is used during procedures to make it easier to remove one pair. Hand sanitizer is not effective against Clostridium difficile (“C. diff”) or when hands are visibly soiled.

DIF: Cognitive Level: Apply  
REF: Page 76| Page 83  
OBJ: NCLEX: Safe and Effective Care  
TOP: Nursing Process: Implementation
3. The nurse bathes a patient who has an infection transmitted by the oral-fecal route such as C. diff and notes a small tear in one glove. Which group of interventions does the nurse use for self-protection?

a. Finish the bath, apply fresh gloves, and use hand sanitizer.
b. Continue the bath and change gloves when finished.
c. Apply a new glove over the torn one to finish the bath.
d. Remove the gloves, wash hands, and apply new gloves.

ANS: D

For self-protection the nurse interrupts the bath to avoid additional exposure to a potential pathogen by removing the gloves, washing both hands with soap and water, and applying fresh gloves for protection against exposure so the nurse can finish the bath. The nurse risks infection by continuing the bath with a portal of entry on the glove. The nurse should perform hand hygiene before applying fresh gloves. Hand sanitizer is not effective with C. diff. Applying clean gloves over the torn gloves encases the potential pathogens and increases the risk of exposure to the pathogen.

DIF: Cognitive Level: Apply
REF: Page 76
OBJ: NCLEX: Safe and Effective Care
TOP: Nursing Process: Implementation

4. A patient is in isolation in a negative-pressure room for tuberculosis, and the nurse notes that the respirator mask is damaged slightly. What is the initial action that the nurse should take?

a. Ask to switch the assignment.
b. Check the mask for a tight seal.
c. Borrow a mask from a co-worker.
d. Use the mask if damage is minor.
ANS: B

Before using the mask to enter the patient’s room, the nurse checks the fit to ensure a tight seal because the purpose of this mask in airborne precautions is to filter inhaled air and thereby protect the nurse against pathogens suspended in the air. The nurse can use the mask if the damage is minor and does not affect the seal. Coworkers do not share respirator masks because each employee is fitted individually. If the mask seal is affected, a new mask will be required. Switching assignments is not an appropriate request.

DIF: Cognitive Level: Understand REF: Page 84

OBJ: NCLEX: Safe and Effective Care TOP: Nursing Process: Planning

5. The nurse completes care for the patient on droplet precautions. Which procedure does the nurse implement to prevent transmitting the pathogen to other people?

a. Removes gloves and mask at the bedside and gown in hallway
b. Removes all personal protective equipment (PPE) in the soiled utility room
c. Removes gloves first, gown second, and mask third in the patient’s doorway
d. Removes mask first, gloves second, and gown third outside the patient’s room

ANS: C
The nurse removes PPE to prevent self-contamination. He or she removes the gloves first to avoid contaminating the head, then removes the gown by unfastening neck ties and pulling it away and rolling into a bundle, then removing mask. These actions occur in the patient’s doorway to contain the pathogen and prevent transmission to people outside the room. The nurse risks contamination if the gloves and mask are removed at the bedside; if the mask is removed before the contaminated gloves, the nurse risks contaminating the head while untying the strings of the mask. PPE should be removed together, at the same location, and away from the source of contamination to facilitate containment of the pathogen. Removing PPE in the hallway or utility room would risk transmitting the pathogen to others.

DIF: Cognitive Level: Apply  REF: Page 87

OBJ: NCLEX: Safe and Effective Care  TOP: Nursing Process: Implementation

6. A patient on isolation precautions tries to leave the isolation room because of loneliness despite repeated instructions to remain in the room. Which action should the nurse implement as a patient advocate?

a. Allow visitors to remove masks while in the patient’s room.
b. Talk with the patient about ways to reduce the sense of loneliness.
c. Remind the patient that the isolation is for the patient’s benefit.
d. Leave the door open slightly so the patient can see into hallway.

ANS: B

The nurse sets specific times to remain in the patient’s room as a patient advocate to help him or her develop coping strategies for handling the loneliness of isolation and provide periodic company. Visitors should not enter the room without a properly fitted respirator mask for their protection. The nurse can remind the patient about the purpose of isolation to help him or her understand the plan of
care. The door cannot remain ajar because the risk of transmitting the infection is increased with the door open.

DIF: Cognitive Level: Apply          REF: Page 75
OBJ: NCLEX: Safe and Effective Care  TOP: Nursing Process: Planning

7. Gloves are effective protective barriers from pathogens when caring for patients in isolation. Which patient factor associated with the gloves should the nurse investigate for patients in isolation?

a. Patient resistance to therapy  
b. Transmission mode of organism  
c. Patient potential for latex allergy  
d. Virulence of infectious organism

ANS: C

The patient potential for latex allergy is the most important patient factor related to using gloves with patients in isolation. Allergic reactions to latex may be triggered even if latex does not touch the patient. Wear unpowdered latex-free gloves. Several alternatives to latex gloves exist. If the patient is allergic to latex, the nurse can use nonlatex gloves to prevent hypersensitivity reactions. Neither virulence nor transmission mode of a pathogen is a patient factor.

DIF: Cognitive Level: Understand          REF: Page 84
OBJ: NCLEX: Safe and Effective Care  TOP: Nursing Process: Assessment
8. The nurse is getting ready to provide a sterile dressing change. Which nursing action is consistent with principles used to prepare a sterile field?

a. Identify that items below waist height are contaminated.
b. Use opened packages of dressing supplies within the same shift. Identify that sterile drapes have a 5.08 cm (2-inch) contaminated border.
c. d. Replace bottle caps if the inside of the cap is not touched.

ANS: A

Items below waist level are considered contaminated and are discarded quickly to avoid contaminating the rest of the sterile field. Packages of sterile supplies must be sealed to be considered sterile. Sterile drapes have a 2.54 cm (1-inch) perimeter that is considered contaminated. Replace bottle caps if the inside of the cap and the edge of the bottle remain sterile.

DIF: Cognitive Level: Understand REF: Page 90

OBJ: NCLEX: Safe and Effective Care TOP: Nursing Process: Assessment

9. The nurse teaches the patient the proper handwashing technique before discharge and asks for a return demonstration. Which hand hygiene technique indicates that patient teaching by the nurse is effective?

a. The patient washes hands with running water.
b. Soap, water, and friction are used by the patient.
c. The patient washes hands with very hot water.
d. A basin with warm soapy water is used.

ANS: B
The patient understands that proper handwashing requires soap, water, and friction to remove microorganisms from the skin and rinse them away. Running water is insufficient to wash hands properly because water alone cannot remove as many microorganisms as soap and water can remove. The patient risks tissue damage, dry skin, and irritation from hot water. Washing hands in a basin may remove surface debris, but the hands are not decontaminated because the debris remains in the rinse water.

DIF: Cognitive Level: Apply
REF: Page 78

OBJ: NCLEX: Safe and Effective Care
TOP: Nursing Process: Evaluation

10. The nurse cared for a patient diagnosed with tuberculosis (TB) 3 days ago. Which of the following actions should the nurse implement in response to the potential exposure?

a. Take a leave of absence.
b. Have a chest x-ray taken.
c. Request a sputum culture.
d. Get a QFT-G blood test.

ANS: D

The CDC now recommends the QuantiFERON-TB Gold (QFT-G) blood test to determine the presence of TB antibodies followed by a sputum test or a chest x-ray to confirm the presence of Mycobacterium tuberculosis. A leave of absence is not necessary unless the nurse displays clinical indicators of TB such as fever, night sweats, weight loss, and coughing.

DIF: Cognitive Level: Apply
REF: Page 84
11. The nurse is caring for a patient who is 4 years old and in isolation. Which approach should the nurse implement to reduce the patient’s anxiety?

a. Put the child in a room with a locked door.
b. Ask the parents to keep the child in the room.
c. Explain isolation to the child by using a cartoon.
d. Put the mask, gown, and gloves on in view of the child.

ANS: D

The nurse should let the child see her face before putting on the mask so the child knows who is behind the mask and is not frightened. The nurse could even bring a mask for the child to play with in the nurse’s presence to reduce anxiety. The nurse should explain isolation to the child and use educational material suitable to the patient’s developmental level. However, the child is unlikely to grasp the meaning and implications of isolation, necessitating repeated explanations and guidance. Although the nurse may ask for the parents’ help in keeping the child in the room, the nurse retains the responsibility for maintaining transmission precautions and the child’s safety. Locking the door is a restraint and puts the child at risk in an emergency.

DIF: Cognitive Level: Apply

REF: Page 88

OBJ: NCLEX: Safe and Effective Care  TOP: Nursing Process: Planning

12. In which of the following situations should the nurse use surgical asepsis?

a. Performing urinary catheter care
b. Inserting a nasogastric tube
c. Inserting a Foley catheter
d. Performing nasogastric tube care

ANS: C

Nurses use surgical aseptic techniques at the patient’s bedside during procedures that involve inserting devices into normally sterile body cavities such as insertion of a Foley catheter. A nasogastric tube is not going into a sterile cavity. Clean technique is used for the other situations.

DIF: Cognitive Level: Apply       REF: Page 74
OBJ: NCLEX: Safe and Effective Care     TOP: Nursing Process: Planning

13. The nurse is caring for a 4-year-old child who has rubella. Which transmission precautions should the nurse implement to prevent rubella exposure?

a. Contact precautions
b. Droplet precautions
c. Airborne precautions
d. Standard precautions

ANS: B

The nurse implements droplet precautions for the patient with rubella because large droplets expelled by the patient during coughing, talking, or sneezing transmit the virus. Contact and airborne precautions are not indicated because rubella is not transmitted by direct contact or suspended particles in the air. Standard precautions
are suitable for all patients but do not prevent rubella transmission without additional droplet precautions.

DIF: Cognitive Level: Apply REF: Page 83
OBJ: NCLEX: Safe and Effective Care TOP: Nursing Process: Planning

14. The nurse evaluates the handwashing technique of nursing assistive personnel (NAP). Which behavior by NAP requires additional training by the nurse?

a. Rubs sudsy hands for 5 to 10 seconds
b. Uses warm running water and soap
c. Dries the hands from the fingers to the wrists
d. Keeps the hands and forearms below the elbows

ANS: A

The nurse improves the NAP’s handwashing technique by providing feedback to increase the length of hand scrubbing to 15 to 30 seconds for thorough removal of microorganisms. The nurse finishes the feedback by directing the NAP to rinse the hands under running water without recontaminating them. Using warm, running water and soap effectively loosens microorganisms from the skin and rinses them off the hands. Drying hands from fingers to wrists is good technique because the hands are dried from the cleanest to the least clean area. Keeping the hands in a dependent position is good handwashing technique because it prevents hand contamination from water that touched the unwashed section of the arm.

DIF: Cognitive Level: Apply REF: Page 78
OBJ: NCLEX: Safe and Effective Care TOP: Nursing Process: Evaluation
15. The nurse assists the healthcare provider during the insertion of a central venous catheter. Which is the most effective intervention for the nurse to implement to prevent patient infection?

a. Adhere to the principles of surgical asepsis.
b. Close the door of the sterile procedure room.
c. Sterilize working surfaces for the procedure.
d. Restrict foot traffic into the sterile procedure room.

ANS: A

Adhering to principles of surgical asepsis is the best method of preventing an infection during a sterile procedure because it is the most comprehensive step. The remaining options are proper actions for the nurse who is adhering to the principles of the surgical asepsis.

DIF: Cognitive Level: Analyze  REF: Page 74

OBJ: NCLEX: Safe and Effective Care  TOP: Nursing Process: Implementation

16. The nurse sets up a sterile field and notes several tiny holes in the sterile drape of the table that served as the wrap for the pack. What does the nurse do to facilitate completion of the procedure?

a. Uses a sterile towel to cover the existing holes
b. Replaces the entire sterile field and the supplies
c. Moves the sterile supplies to a replacement drape
d. Avoids using any of the sterile items near the holes
ANS: B

The nurse removes the entire sterile field, including any supplies added to the setup, because the holes compromised the sterility of the pack and its contents; in addition, contacting the contaminated drape contaminates every sterile item added to the sterile field. Even if the contents of the pack remained sterile, once the drape was used as a sterile field, the field was contaminated by the holes. The nurse cannot proceed with a sterile procedure using a contaminated field despite the goal of facilitating the procedure. Ignoring the potential contamination increases the risk of infection.

DIF: Cognitive Level: Apply
REF: Page 89
OBJ: NCLEX: Safe and Effective Care
TOP: Nursing Process: Implementation

17. The nurse completes preparation of the sterile field to change a patient’s dressing when the patient’s dinner tray arrives. Which action should the nurse take?

a. Use the sterile field on another patient in another room.
b. Change the dressing using clean technique to save time.
c. Set the tray aside and proceed with the dressing change.
d. Cover the setup with a sterile drape and let the patient eat.

ANS: C

The nurse should set the dinner tray aside and proceed with the dressing change. Discarding the sterile setup would waste both time and money. The nurse avoids moving the sterile field to another patient’s room to decrease the risk of contamination from air currents and accidental contact. The nurse should explain to the patient why the dinner tray is being set aside, efficiently finish the dressing, offer to rewarm the meal, delegate serving the tray to nursing assistive personnel
(NAP), and thank the patient for patience and understanding. The timing of the dressing change should be rescheduled to prevent this from happening again.

18. While setting up a sterile field for a procedure, the nurse knocks a linen-wrapped sterile package to the floor. Which reaction allows the nurse to maintain safe practice?

a. Inspect the package for tears.
b. Brush away the visible debris.
c. Record the procedure as clean.
d. Replace the sterile package.

ANS: D

The nurse replaces the linen-wrapped sterile package dropped on the floor because touching the floor contaminates the package. If the package had a plastic wrapper, the contents may be usable, depending on agency policy, because dust and moisture do not penetrate plastic like they can penetrate the linen. Clean technique may not be substituted when sterile technique is required.

19. The nurse helps the healthcare provider get supplies and monitor the patient during an emergency insertion of a femoral line at the patient’s bedside. Which nursing behavior helps to maintain the sterile environment?
a. Avoid reaching over the field.
b. Wear a sterile cap and booties.
c. Use sterile examination gloves.
d. Place a face mask on the patient.

ANS: A

The nurse avoids reaching over the sterile field to avoid contamination. A head cover and booties are not sterile, even when used during a sterile procedure. Sterile gloves are not indicated for the tasks the nurse is performing to assist the healthcare provider. There is no need to place a face mask on the patient for a procedure occurring on the upper thigh.

DIF: Cognitive Level: Apply
REF: Page 90
OBJ: NCLEX: Safe and Effective Care
TOP: Nursing Process: Evaluation

20. The nurse is preparing to put on sterile gloves. What should the nurse do to begin this procedure?

a. Pull the first glove up and over the nondominant hand.
b. Place the fingers of the dominant hand under the cuff of the first glove.
c. Let the cuff of the glove roll up over the hand for more coverage.
d. Hold the inside surface of the first glove to pull over the hand.

ANS: D

To begin donning sterile gloves, the nurse slips the fingers of the nondominant hand into the glove to lift it and pull it over the dominant hand. As long as the cuff does not roll up and the glove remains intact, the exterior of the glove remains sterile.
21. The nurse has just finished a sterile dressing change. Which technique should he or she use to remove sterile gloves?

a. Pull the first glove off with the sterile glove hand.
b. Reach inside the first glove to pull it off quickly.
c. Pull the edge of the glove down to create a cuff.
d. Wipe off the gloves with an antiseptic wipe first.

ANS: A

To remove sterile gloves, the nurse pulls the first glove off with the opposite sterile hand and discards the glove; then he or she inserts a bare finger under the remaining glove to pull it down and inside out. The nurse discards this glove as well. He or she avoids reaching inside the first glove with a gloved hand to prevent self-contamination.

22. The nurse is caring for a patient with C. diff. What type of precautions should she use?

a. Airborne
b. Droplet
c. Contact
d. Protective

ANS: C

The nurse implements contact precautions because *C. difficile* spores live in the environment and on surfaces, including healthcare workers’ hands, and are spread through contact. There is no need for airborne or droplet precautions because *C. difficile* spores are not transmitted by those routes. Protective precautions are used for immunocompromised patients.

DIF: Cognitive Level: Apply

REF:  Page 82-83

OBJ:  NCLEX: Safe and Effective Care

TOP: Nursing Process: Planning

23. The nurse is preparing a sterile field with several items on it. Which action should the nurse implement to maintain a sterile field?

a. Flip sterile objects onto the sterile field.
b. Put fluid holders near the edge of the field.
c. Wear sterile gloves to open sterile packs.
d. Open the inner flaps of the sterile packages first.

ANS: B

The nurse places holders for fluid near the edge of the sterile field, allowing the circulating nurse to pour fluids into the holders without reaching over and contaminating the sterile field. Flipping sterile objects onto the sterile field increases the risk of contamination. Sterile gloves are unnecessary to open sterile packages because the outside of the package is clean; the nurse can use bare hands to open the package and retain package sterility. The nurse opens the outer flaps of
sterile packages first because it is impossible to open the inner flaps first since they are covered with an outer wrap.

24. The nurse is orientating a nursing assistant and is discussing handwashing principles. Which statement from the nursing assistant indicates a good understanding of those principles?

a. If my hands are visibly soiled, I cannot use an alcohol rub.
b. I do not need to wash my hands if I have used gloves.
c. I must always use soap and water after a dressing change.
d. I can always use an alcohol rub instead of soap and water.

ANS: A

The nurse must always use soap and water when hands are visibly soiled or when caring for a patient with C. diff. Hand hygiene with an alcohol-based hand rub can be used in all other situations and also must be done after removing gloves.

25. The nurse is preparing to transfer a sterile voided urine specimen from the patient’s bathroom to the laboratory. What supplies should he or she gather to complete this procedure?
a. Clean gloves, biohazard bag, mask  
b. Plastic bag, gown, gloves  
c. Sterile gloves, gown, biohazard bag  
d. Clean gloves, plastic bag, biohazard label

ANS: D

Clean gloves are used even though the specimen is sterile. After the outside of the container is dried, the clean gloves are removed; the specimen container is placed in a plastic bag, and a biohazard label is attached if not already printed on the bag. A mask or gown is not needed unless splashing is a possibility, and there is no information in the question about the chance of splashing. Sterile gloves are not needed to obtain a sterile voided urine specimen.

DIF: Cognitive Level: Apply

REF: Page 74-75| Page 83| Page 86

OBJ: NCLEX: Safe and Effective Care

TOP: Nursing Process: Planning

26. The nurse is preparing to enter a room for the patient on contact precautions. In which order should she put on her personal protection equipment?

a. Gloves, gown, cap, eyewear  
b. Gown, cap, eyewear, gloves  
c. Cap, eyewear, gown, gloves  
d. Eyewear, cap, gloves, gown

ANS: B
The nurse should don her PPE in the following order: Gown, cap, mask (if worn), protective eyewear (goggles, face shield), and then gloves, which should pull over the sleeves of the gown.

DIF: Cognitive Level: Apply
REF: Page 80-81
OBJ: NCLEX: Safe and Effective Care
TOP: Nursing Process: Planning

MULTIPLE RESPONSE

1. Which of the follow elements are present in the chain of infections? (Select all that apply.)
   
   a. Source of growth
   b. Mode of transmission
   c. Infectious agent
   d. Susceptible host
   e. Portal of exit
   f. Catalyst
   g. Port of entrance

ANS: A, B, C, D, E, G

The presence of a pathogen does not mean that an infection will begin. An infection develops in a cyclical process called the chain of infection, which includes six elements: (1) an infectious agent or pathogen, (2) a reservoir or source for pathogen growth, (3) a portal of exit from the reservoir, (4) a method or mode of transmission, (5) a portal of entrance into the host, and (6) a susceptible host. An infection develops if the chain remains intact.
2. The nurse is screening a patient for latex allergy. Which factors should she consider that place the patient at a higher risk for latex allergies? *(Select all that apply.)*

a. High latex exposure  
b. History of using condom catheters  
c. Urogenital defects  
d. History of multiple childhood surgeries

ANS: A, B, C, D

Risk factors for latex allergies include spina bifida, congenital or urogenital defects, history of indwelling catheters or repeated catheterization, history of using condom catheters, high latex exposure (e.g., healthcare workers, housekeepers, food handlers, tire manufacturers, workers in industries that use gloves routinely), history of multiple childhood surgeries, and people with family history of allergies such as hay fever or hives.

DIF: Cognitive Level: Apply REF: Page 93

OBJ: NCLEX: Safe and Effective Care TOP: Nursing Process: Assessment

3. The nurse is orientating a new graduate nurse. Which statement by the orientee indicates a high level of understanding about the principles of hand hygiene? *(Select all that apply.)*
I need to perform hand hygiene before and after having direct contact
a. with patients.
b. I can use alcohol rub when my hands are not visibly soiled.
c. I need to perform hand hygiene after I remove my gloves.
   I only need to wash my hands with soap and water when they are
d. visibly soiled.
e. I should perform hand hygiene before a sterile procedure.

ANS: A, B, C, E

Hand hygiene is performed before and after contact with patients, after removing
gloves, and before performing sterile procedures. Alcohol-based rubs can be used
except when hands are visibly soiled or when caring for patients with \textit{C. difficile}. 