MULTIPLE CHOICE

1. The *Perioperative Patient Focused Model* presents key components of nursing influence that guide patient care. Select the statement that best describes the dynamic relationship within the model.
   a. The patient experience and the nursing presence are in continuous interaction.
   b. Structure, process, and outcome are the foundation domains of the model.
   c. The perioperative nurse is the central dynamic core of the model.
   d. The interrelated nursing process rings bind the patient to the model.

   ANS: A
   The *Perioperative Patient Focused Model* consists of domains or areas of nursing concern: nursing diagnoses, nursing interventions, and patient outcomes. These domains are in continuous interaction with the health system that encircles the focus of perioperative nursing practice—the patient.

2. The Association of PeriOperative Registered Nurses' (AORN) *Standards of Perioperative Nursing* describes nursing interactions, interventions, and activities with patients. This is based on which standards category?
   a. Evidence-based
   b. Process
   c. Outcome
   d. Structural

   ANS: B
   Process standards relate to nursing activities, interventions, and interactions. They are used to explicate clinical, professional, and quality objectives in perioperative nursing.

3. Which order best describes the process used to implement evidence-based professional nursing?
   a. Literature search, theory review, data analysis, policy development
   b. Regional survey, literature search, meta-analysis, practice change
   c. Identify problem, scientific evidence, develop policy, evaluate outcome
   d. Identify issue, analyze scientific evidence, implement change, evaluate process

   ANS: D
   Evidence-based practice is a systematic, thorough process by which to identify an issue, to collect and evaluate the best evidence to design and implement a practice change, and to evaluate the process.

4. The ambulatory surgery unit is planning to develop a standardized skin preparation practice for their unit. The best process to gather scientific information is to:
   a. conduct a survey of skin prep policies at the next AORN chapter meeting.
   b. review their surgical site infection data from the last 6 months.
   c. conduct a literature search on antimicrobial agents and infection prevention.
   d. review the scientific literature from the leading manufacturers of prep solutions.

   ANS: C
   Perioperative nurses have an ethical responsibility to review practices and to modify them based on the best available scientific evidence. Using research to guide practice is called *evidence-based practice (EBP).*

5. The cardiac team is developing a standardized sterile back table setup and is unable to find sufficient research evidence for their project. Where might they look for information on best practices?
   a. Survey regional surgical technology programs for their back table models
   b. Review case studies and expert opinions on sterile back table setups
   c. Review AORN's *Guidelines for Perioperative Practice* on sterilization and disinfection
   d. Consult with facility instrument vendor representatives for their advice

   ANS: B
   When there is not enough evidence to guide practice, perioperative nurses should consider gathering information from varied trusted sources that reflect best practices.

6. How do institutional standards of care, such as policies and procedures, differ from national standards, such as AORN's *Standards of Perioperative Nursing*?
   a. They are written by nurses.
   b. They are written specifically to address responsibilities under specific circumstances.
   c. They are collaborative and collective agreement statements.
   d. They are rarely based on research.

   ANS: B
   Institutional standards apply to the system or facility that develops them and can be directive about specific actions in specific circumstances; national standards provide generalized authoritative statements that can be implemented in all settings.

7. Which of the following actions best describes an element of the perioperative nursing assessment?
   a. Scanning the surgical schedule for the day before morning report.
   b. Reading the pick/preference list attached to the case cart.
   c. Reviewing the patient medical record.
   d. Studying an on-line tutorial about the intended surgical procedure.

   ANS: C
   Assessment is the collection and analysis of relevant health data about the patient. Sources of data may be a preoperative interview with the patient and the patient's family; review of the planned surgical or invasive procedure; review of the patient's medical record; examination of the results of diagnostic tests; and consultation with the surgeon and anesthesia provider, unit nurses, or other personnel.

8. A frail 76-year-old diabetic woman is scheduled for major surgery. She is vulnerable and at high risk for harm because of several factors related to her preexisting conditions and overall health status. As part of developing a plan to guide her care, the nurse uses standardized descriptive terms. This step of the nursing process is called:
   a. nursing diagnosis.
   b. nursing assessment.
   c. nursing outcome.
   d. nursing intervention.

   ANS: A
   Nursing diagnosis is the process of identifying and classifying data collected in the assessment in a way that provides a focus to plan nursing care. Nursing diagnosis components include a definition of the diagnostic term, defining characteristics and risk factors.

9. During the admission interview, the nurse initiated the discharge teaching and demonstrated crutch-walking activities. The teaching activities are what stage of the nursing process?
   a. Assessment
   b. Implementation
   c. Outcome identification
   d. Evaluation

   ANS: B
   Implementation is performing the nursing care activities and interventions that were planned and responding with critical thinking and orderly action to changes in the surgical procedure, patient condition, or emergencies. Implementation is the "work" of nursing.

10. While conducting the preoperative interview with a patient scheduled for a septoplasty, the perioperative nurse learned that the patient was latex sensitive. Based on this knowledge, the nurse reviewed the pick/preference list and reassembled the surgical case cart setup to reflect this new information and change in care delivery. Which two phases of the nursing process are represented in the nurse's actions?
    a. Assessment and planning
    b. Assessment and implementation
    c. Planning and implementation
    d. Nursing diagnosis and intervention

    ANS: C
    Planning is preparing in advance for what will or may happen and determining the priorities for care. Planning is based on patient assessment results in knowing the patient and the patient's unique needs. *Implementation* is performing the nursing care activities and interventions that were planned and responding with critical thinking and orderly action. Implementation is the "work" of nursing.

11. The perioperative nurse implements protective measures to prevent skin or tissue injury caused by thermal sources. Successful accomplishment of this intervention would meet which of the following desired nursing outcomes?
    a. The patient is free from signs and symptoms of injury from anxiety.
    b. The patient is free from signs and symptoms of impaired skin integrity.
    c. The patient is free from signs and symptoms of surgical site infection.
    d. The patient is free from signs and symptoms of hyperthermia.

    ANS: B
    Chemical and thermal sources used in surgery can cause skin and tissue burns (e.g., electrosurgery, povidine-iodine, radiation, lasers). The patient being free from signs and symptoms of chemical injury, radiation injury, and electrical injury are approved NANDA International nursing diagnoses.

12. The nursing diagnosis is derived from:
    a. patient data retrieved from the nursing assessment.
    b. synthesized clues from the admitting diagnosis and surgery schedule.
    c. the approved NANDA International list attached to the patient medical record.
    d. the admission form on the front of the chart.

    ANS: A
    Nursing diagnosis is the process of identifying and classifying data collected in the assessment in a way that provides a focus to plan nursing care.

13. A 36-year-old woman was preoperatively admitted for laparoscopic cholecystectomy with operative cholangiogram. She was then interviewed by her perioperative nurse in the preoperative intake lounge. The patient's weight on admission was 245 lb. After the assessment, the nurse returned to the operating room (OR) and modified the standard plan of care by instituting risk reduction strategies that were derived from information from the preoperative assessment. A good example of this action would best be described by:
    a. replacing the regular OR bed with a bariatric-specific OR bed.
    b. providing protective lead aprons for all staff during the procedure.
    c. writing the patient's name, allergies, and body weight on the whiteboard.
    d. administering antibiotics to the patient 1 hour before the incision.

    ANS: A
    Planning is preparing in advance for what will or may happen and determining the priorities for care. Planning based on patient assessment results in knowing the patient and the patient's unique needs so that alterations in events, such as positioning the patient on a bariatric-specific OR bed as opposed to a regular OR bed, can be readily accommodated. Replacing the OR bed with a larger OR bed is a nurse-sensitive preventive intervention that provides equipment based on patient need.

14. Adoption of an electronic medical record requires the use of consistent terminology. Empirically validated, standardized perioperative nursing language may be found in the:
    a. Perioperative Patient Focused Model.
    b. Nursing Alliance for Quality Care (NAQC).
    c. Perioperative Nursing Data Set (PNDS).
    d. Standards of Perioperative Nursing.

    ANS: C
    After 6 years of research and validation, the Perioperative Nursing Data Set (PNDS) was recognized as a specialty nursing language, providing a uniform and systematic method to document the basic elements of perioperative nursing care.

15. When delegating a task, such as removing an intravenous (IV) catheter, to an unlicensed individual, the perioperative nurse:
    a. retains responsibility for evaluating the outcome of the task.
    b. must comply with the seven "rights" of delegation.
    c. transfers the authority to perform the related assessments.
    d. transfers the supervision of the competent person to another competent person.

    ANS: C
    Delegation transfers to a competent person the authority to perform a selected nursing task in a selected situation according to the "five rights" of delegation. When delegating care activities, perioperative nurses retain accountability for analyzing and evaluating the outcomes of delegated tasks.

16. A hospital nursing excellence center for education developed standards for nursing advancement that would reflect high-level achievement of professional performance. They developed a clinical advancement ladder based on the leading skill and knowledge acquisition model and established worthy criteria for each level. Select the response that might best describe the highest level of achievement for a perioperative staff nurse.
    a. Certified nurse, OR (CNOR) credential, BSN, and chair of the nursing research committee
    b. Published article in the hospital newsletter and 15 years' service pin
    c. BCLS instructor and weekend Emergency Medical Technician (EMT) transport
    d. Patient safety champion and nurses' union representative

    ANS: A
    Achieving certification (CNOR), pursuing lifelong learning, and maintaining competency and current knowledge in perioperative nursing are the hallmarks of the professional.

17. Performance improvement activities in the perioperative practice setting are designed to promote:
    a. cost savings by eliminating fines for near-misses and never events.
    b. customer satisfaction and loyalty.
    c. time measurement activities.
    d. efficient, effective, and ethical quality care.

    ANS: D
    Performance improvement efforts encompass improvements in quality and effectiveness, based on ethical and economic perspectives. A performance measurement and improvement approach facilitates the delivery of safe, high-quality perioperative patient care.

18. Perioperative nursing diagnoses and interventions are directed toward, and guided by, the tremendous risks for harm to the patient inherent in surgery and interventional procedures; therefore, nursing actions can generally be categorized as:
    a. therapeutic/restorative.
    b. preventive/protective.
    c. caring/comforting.
    d. advocating/justifying.

    ANS: B
    In contrast to some nursing specialties in which nursing diagnoses are derived from signs and symptoms of a condition, much of perioperative nursing care is preventive in nature, based on knowledge of inherent risks to patients undergoing surgical and invasive procedures. Perioperative nurses identify these risks and potential problems in advance and direct nursing interventions toward prevention of undesirable outcomes, such as injury and infection. Much of the work of perioperative nursing involves patient safety, protecting patients from risks related to the procedure, positioning, equipment, and the environment.

19. A registered nurse first assistant (RNFA) is considered an advanced practice nurse (APN) when he/she has achieved:
    a. RNFA certification.
    b. clinical performance ladder Level 4 or above.
    c. graduate degree in nursing (MSN).
    d. facility practice privileges.

    ANS: C
    APNs must have graduate nursing education (at least a master's degree).

20. Emerging perioperative nursing roles are defined by the tremendous growth in science and technology combined with the increasing complexity of surgery and the interventional disciplines. An example of an emerging nursing role is:
    a. sterile processing clinical specialist.
    b. general surgery service liaison.
    c. weekend resource nurse.
    d. informatics nurse specialist.

    ANS: D
    Informatics is another specialty in which some perioperative nurses are focusing. Pressures for more efficient management of fiscal, material, and human resources have stimulated the development of electronic information systems for diverse functions in perioperative patient care settings.

21. The relationship between the *Perioperative Patient Focused Model* and the PNDS is evidenced by their unique language and use of the nursing process to guide care. The most notable feature of their similarity is that the PNDS:
    a. promotes standardized perioperative documentation.
    b. fosters research on best practices.
    c. begins with outcome statements.
    d. promotes standardized perioperative documentation and begins with outcome statements.

    ANS: C
    Similar to the *Perioperative Patient Focused Model*, the PNDS begins with patient outcomes. Each outcome is defined and interpreted and presents criteria by which to measure outcome achievement.

22. In a research study by Kleiner and colleagues (2014), use of crew resource management (CRM) principles was a practical and effective means to:
    a. identify potential surgical defects in the OR.
    b. monitor central processing productivity.
    c. promote teamwork.
    d. improve the quality of OR briefings and debriefings.

    ANS: D
    Kleiner and colleagues (2014) found while there was no difference in the frequency of briefings and debriefings observed in this study, there were significant differences in the quality of the communication observed. Coaching appeared to be an effective intervention, improving the quality of communication among team members.

23. In a research study by Steelman and colleagues (2013), perioperative nurses were surveyed to prioritize perioperative patient safety issues. The majority of nurses placed the highest priority and heightened awareness on preventing which patient safety risk?
    a. Surgical fires
    b. Wrong-site/procedure/patient surgery
    c. Retained surgical items
    d. Medication errors

    ANS: B
    The majority of nurses considered preventing wrong-site, procedure, or patient surgery (69%) and preventing retained surgical items (61%) to be high-priority safety issues in need of heightened attention.

24. Malley and colleagues (2015) conducted a focus group survey to identify nursing's contributions to transitions in care in the perioperative environment. The study suggests the preoperative assessment:
    a. serves as not just as a clearance for surgery, but also for managing the transitions of patient care throughout the perioperative experience.
    b. significantly impacted circulator nurse performance due to increased knowledge of the patient.
    c. primarily identifies risk factors impacting the intraoperative period.
    d. has little application for intraoperative to postoperative transitions.

    ANS: A
    Malley concluded that the nurse's role in the preoperative assessment during the transition of preoperative care is that of advocate who identifies the patient's needs and risk factors that may be affected by the surgical experience. This study suggests that the nursing preoperative assessment can be useful in identifying and defining patients' risk factors not just for surgery, but for the entire perioperative care trajectory. The study did not include intraoperative staff.

25. Ensuring a rapid recovery from anesthesia and discharging the patient when it is safe to so is one goal of ambulatory surgery. Factors that may contribute to a delayed discharge include:
    a. prompt administration of opiates for pain relief.
    b. early postoperative oral intake.
    c. use of a forced air–warming blanket.
    d. administration of a preoperative fluid bolus.

    ANS: A
    Enhanced recovery after surgery (ERAS) protocols include avoidance of opiated for pain management, prevention of hypothermia, early oral intake and replacement of any intraoperative vascular volume loss.