Setting Priorities When Caring for Clients

1. This client should be categorized as black, priority 4, which means the injury is extensive and chances of survival are unlikely even with definitive care. Clients should receive comfort measures and be separated from other casualties but not abandoned.

2. This client should be categorized as red, priority 1, which means the injury is life threatening but survivable with minimal intervention. These clients can deteriorate rapidly without treatment.

3. This client should be categorized as green, priority 3, which means the injury is minor and treatment can be delayed hours to days. These clients should be moved away from the main triage area.

4. The client should be categorized as a yellow, priority 2, which means the injury is significant and requires medical care but can wait hours without threat to life or limb. Clients in this category receive treatment only after immediate casualties are treated.

**MAKING NURSING DECISIONS:** The nurse should remember the traffic light; red is first to be treated, yellow is treated next, green is treated last, and black is not treated until everyone else has been treated.

2. Right lower abdominal pain may indicate appendicitis, which requires surgery. This client needs a stat white blood cell count to obtain a definite diagnosis. This client should be assessed first. Right lower quadrant pain could indicate other conditions such as ectopic pregnancy, ovarian cyst, or exacerbation of Crohn's disease, which all should be assessed before UTI, back pain, or sore throat.

3. More than likely, this client has a urinary tract infection, which requires a midstream urinalysis. Because this is not life threatening, the client would not need to be assessed first.

4. This client may have a bulging herniated disc and will need x-rays to confirm the herniated disc, but this is not potentially life threatening. This client would not need to be assessed first.

4. A sore throat is not life threatening; therefore, this client does not need to be assessed first.

**MAKING NURSING DECISIONS:** When deciding which client to assess first, the test taker should determine whether the signs/symptoms the client is exhibiting are normal for the client situation. After eliminating the expected options, the test taker should determine which situation is more life threatening.

3. The normal white blood cell count is 5.0 to 10.0 mm$^3$; therefore, this client does not require immediate intervention.

2. The client's cholesterol level is elevated, but this would not require immediate intervention by the nurse. An elevated cholesterol level is not life threatening and can be discussed at the client's next appointment.

3. The client's calcium level is within the normal range of 9.0 to 10.5 mg/dL; therefore, this client does not require an immediate intervention.

4. The therapeutic range for an INR is 2 to 3. This client is at risk for bleeding and requires immediate intervention by the nurse. The nurse should call the client and instruct the client to stop taking warfarin (Coumadin), an anticoagulant.

**MAKING NURSING DECISIONS:** The test taker must know normal laboratory data. See Appendix A for normal laboratory data.

3. These are signs of otitis media (ear infection), which is not life threatening; therefore, this child does not need to be assessed first.

2. These are signs/symptoms of rheumatic fever, which is not life threatening; therefore, this child does not need to be assessed first.

3. These are signs of bacterial meningitis, which can be potentially life threatening. This child should be isolated and be assessed first.

4. This adolescent does not need to be assessed first because possible pregnancy is not life threatening.

**MAKING NURSING DECISIONS:** When deciding which client to assess first, the
1. The first intervention is for the nurse to ensure the client is safe in the home. Assessing for grab bars in the bathroom is addressing the safety of the client.
2. Taking a shower in a stall shower may be safer than getting in and out of a bathtub, but the nurse should first determine whether the client has grab bars and safety equipment even when taking a shower.
3. According to the NCSBN NCLEX-RN test blueprint for management of care, the nurse must be knowledgeable of referrals. The physical therapist is able to help the client with transferring, ambulation, and other lower extremity difficulties and is an appropriate intervention, but it is not the nurse’s first intervention. Safety is priority.
4. NSAIDs are used to decrease the pain of osteoarthritis, but this intervention will not address safety issues for the client getting into and out of the bathtub.

Making Nursing Decisions: The test taker should apply some systematic approach when answering a priority question. Maslow’s Hierarchy of Needs should be used when determining which intervention to implement first. Safety is a priority.

5. 1. The test taker should determine whether the signs/symptoms the client is exhibiting are normal for the client situation. After eliminating the expected options, the test taker should determine which situation is more life threatening.
2. The employee health nurse should keep the clients at the clinic or send them to the emergency department. The clients should be kept together until the cause of their illness is determined. If it is determined that the clients are stable and not contagious, they should be driven home.
3. Abdominal cramping is not life threatening, and this client’s call can be returned after the call to the client who is possibly experiencing orthostatic hypotension is completed.
4. Nausea and vomiting are not life threatening. The nurse needs to talk to the client but not before returning the call from the client who is possibly experiencing orthostatic hypotension.

Making Nursing Decisions: The test taker should apply some systematic approach when answering priority questions. All of the clients are experiencing physiologic problems, the first priority according to Maslow’s Hierarchy of Needs. Once that is established, then the test taker should determine which physiologic problem is most life threatening—in this case, dizziness when standing because of its possible cause, hypotension, which can be life threatening.
9. 1. This child needs an x-ray to rule out a fractured left leg, but this is not life threatening.
2. Drooling and not wanting to swallow are the cardinal signs of epiglottitis, which is potentially life threatening. This child should be assessed first. The nurse should not attempt to visualize the throat area and should allow the HCP to do this in case an emergency tracheostomy is required.
3. A child usually does not complain of a headache and this child should be assessed, but this is not life threatening.
4. This client may have type 1 diabetes mellitus and should be assessed, but this is not life threatening at this time.

10. 1. A spokesperson should address the media away from the victim care area as soon as possible. This could be a nurse in some situations, but it is not the priority intervention when triaging victims.
2. The disaster tag number and the client’s name should be recorded in the disaster log book, but it is not the priority intervention. The disaster tag must be attached to the client prior to logging the client into the disaster log book.
3. Client tracking is a critical component of casualty management. Disaster tags, which include name, address, age, location, description of injuries, and treatments or medications administered, must be securely attached to the client.
4. Family and friends arriving at the disaster must be cared for by the disaster workers, but it is not the first intervention for the nurse who is triaging disaster victims.

Delegating and Assigning Nursing Tasks

11. 1. The nurse should not delegate medication administration, including giving the client boxes of sample medications, to a UAP.
2. Showing the client how to use a glucometer is teaching the client, and the nurse cannot delegate teaching.
3. The UAP should not talk to clients who are requesting health-care advice. The UAP is not trained to assess and ask pertinent questions.
4. The UAP is trained to take vital signs on a client who is stable. This task could safely be delegated by the nurse.

MAKING NURSING DECISIONS: The nurse cannot delegate assessment, evaluation, teaching, administration of medications, or care of an unstable client to a UAP.

12. 1. An induration greater than 10 mm is positive for tuberculosis. This client needs to be assessed and followed up to rule out tuberculosis. This client should not be assigned to an LPN.
2. A pulse oximeter reading less than 93% is life threatening; therefore, this client should not be assigned to an LPN.
3. This blood pressure is high, but not life threatening; therefore, the LPN could be assigned this client.
4. The adolescent client who is pregnant will need teaching; therefore, this client should not be assigned to an LPN.

MAKING NURSING DECISIONS: The nurse should assign the LPN the client who has the lowest level of need but for whom the task still remains in the LPN’s scope of practice. The nurse cannot assign assessing, teaching, evaluating, or an unstable client to an LPN.

13. 1. The UAP may or may not be able to perform an ECG, but the stem asks which task is most appropriately delegated to a UAP. The nurse should delegate the task that requires the least amount of education, which, in this case, is collecting a urine specimen.
2. The UAP can request the client to urinate into a specimen cup. This is the task that requires the least amount of expertise and therefore is the most appropriate task to assign the UAP.
3. The UAP cannot start an intravenous line. This is an invasive procedure.
4. The client with a head injury must be taught and must understand the signs/symptoms that require a visit to the emergency department. This task, which involves teaching, should not be delegated to a UAP.

MAKING NURSING DECISIONS: The nurse cannot delegate assessment, evaluation, teaching, administering medications, or an unstable client to a UAP.

14. 1. The UAP cannot administer oxygen to a client. Oxygen is considered a medication.
2. The nurse should not depend on the UAP to care for the client who is experiencing a potentially life-threatening condition.

3. This is the first intervention because the nurse must assess the client. Asking the UAP to accompany the nurse will allow the nurse to stay with the client while the UAP obtains any needed equipment.

4. The nurse should immediately assess the client. The UAP does not have the knowledge or skills to care for the client experiencing shortness of breath.

**MAKING NURSING DECISIONS:** Any time the nurse receives information from another staff member about a client who may be experiencing a new problem, complication, or life-threatening problem, the nurse must assess the client. The nurse should not make decisions about client needs based on another staff member’s information.

15. 1. The LPN can contact the HCP and give pertinent information. The INR is high (therapeutic is 2 to 3), and the HCP should be informed.

2. The RN cannot assign assessment to an LPN.

3. The INR is elevated, but this will not affect the client’s atrial fibrillation. The client is at risk for abnormal bleeding, not a life-threatening dysrhythmia.

4. The normal INR is 2 to 3; therefore, some action should be implemented.

16. 1. In a disaster, the nurse should utilize as many individuals as possible to help control the situation; therefore, this is an inappropriate intervention.

2. The unlicensed assistive personnel cannot assess clients; therefore, this is not an appropriate action.

3. Unlicensed assistive personnel have the ability to keep the victims calm; therefore, this is an appropriate action. This action is not critical to the safety of the victims.

4. The paramedics do not need civilians assisting them as they stabilize and transport the victims. This is not an appropriate action.

17. 1. The clinic nurse should not correct the UAP in front of the client. This is embarrassing to the UAP and makes the client uncomfortable.

2. The clinic nurse must correct the UAP’s behavior. The client’s weight gain should not be announced in the office area so that all staff, clients, and visitors can hear. This is a violation of confidentiality.

3. The clinic nurse should correct the UAP’s behavior, but it should be done in private and with an explanation as to why the action is inappropriate. This is a violation of confidentiality because the scale is located in the office area and any client or visitor passing by, as well as other staff members, can hear the comment.

4. The clinic nurse should handle this situation. If the UAP’s behavior shows a pattern of behavior, then it should be reported to the director of nurses.

**MAKING NURSING DECISIONS:** In any business, including a health-care facility, argument or discussion of confidential information should not occur among staff of any level where the customers—in this case, the clinic clients—can hear it or see it.

18. 1. The UAP could escort the clients to the room so that the LPN could be assigned tasks that are within the LPN’s scope of practice.

2. The UAP can make sure the room is clear of the previous client’s gown and equipment used with the previous client. The UAP can also make sure there are gowns, tongue blades, and additional equipment in the examination room.

3. The LPN can administer medication; therefore, it would be more appropriate to assign this task to the LPN, so that the RN could be assigned tasks that are beyond the scope of practice of an LPN and within the RN scope of practice.

4. The clinic secretary is unlicensed personnel and does not have the authority to call in a new prescription for a client.

**MAKING NURSING DECISIONS:** When the test taker is deciding which option is the most appropriate task to delegate/assign, the test taker should choose the task that requires each member of the staff to function within his or her full scope of practice. Do not assign a task to a staff member that requires a higher level of expertise than the staff member has, and do not assign a task to a staff member when the task could be delegated/assigned to a staff member with a lower level of expertise.
19. 1. The nurse should discuss the client's comment, but it is not the nurse's first intervention.
2. The nurse should first take the client's BP correctly and address the client's concern.
3. If the nurse's BP reading and the UAP's BP reading are close to the same, the nurse could reassure the client that the UAP does know how to take BP readings. However, this is not the nurse's first intervention.
4. This is an appropriate action, but it is not the first intervention. The nurse is responsible for making sure the UAP has the ability to perform any delegated tasks correctly.

20. 1. Intravenous push medications cannot be assigned to an LPN. It is the most dangerous route for administering medication, and only an RN (or HCP) can perform this task.
2. The client who is having an asthma attack is not stable; therefore, this client should not be assigned to the LPN.
3. GERD is not a life-threatening disease process, and an antacid is an oral medication that the LPN can administer. Therefore, this task would be the most appropriate to assign to the LPN.
4. The client may be having a myocardial infarction; therefore, this client is unstable and should not be assigned to an LPN.

MAKING NURSING DECISIONS: The test taker must determine which option absolutely is included within the LPN's scope of practice. LPNs are not routinely taught how to administer intravenous push medications. The test taker must also determine which client is the most stable, which makes this an "except" question. Three clients are either unstable or have potentially life-threatening conditions and should not be assigned to an LPN.

Managing Clients and Nursing Staff

21. 1. A secondary nursing intervention includes screening for early detection. The bone density evaluation will determine the density of the bone and is diagnostic for osteoporosis.
2. Spinal screening examinations are performed on adolescents to detect scoliosis. This is a secondary nursing intervention, but not to detect osteoporosis.
3. Teaching the client is a primary nursing intervention. This is an appropriate intervention to help prevent osteoporosis, but it is not a secondary intervention.
4. Discussing risk factors is an appropriate intervention, but it is not a secondary nursing intervention.

22. 1. The parent/guardian must sign the consent for surgery because the client is under the age of 18.
2. The client has already been diagnosed with tonsillitis; therefore, a throat culture is not needed prior to surgery.
3. The client should not cough after this surgery because it could cause bleeding from the incision site.
4. A PT/PTT will assess the client for any bleeding tendencies. This is priority before this surgery because bleeding is a life-threatening complication.

23. 1. This may be an appropriate intervention, but the nurse should first assess the client's food intake to determine whether the symptoms may be caused by food poisoning or by a viral infection.
2. This is the priority intervention because the nurse should first attempt to determine the cause of the signs/symptoms—which will then guide further instructions.
3. This may be an appropriate intervention, but the nurse should first assess the client's food intake to determine whether this may be food poisoning or a viral infection.
4. This may be an appropriate intervention, but the nurse should first assess the client's food intake to determine whether this may be food poisoning or a viral infection.

24. 1. This is a breach of confidentiality. The LPN should not discuss the client's health problem in the waiting room area where everyone can hear.
2. The RN should remove the LPN from the situation without embarrassing the LPN. Asking the LPN to come to the office area is the appropriate action for the RN to take. The LPN's action is a violation of HIPAA.
3. The RN should not correct the LPN's behavior in front of the client. This is embarrassing to both the LPN and the client.
4. The RN does not have to report this to the HCP. The RN can talk to the LPN concerning this breach of confidentiality.
**MAKING NURSING DECISIONS:** The nurse is responsible for knowing and complying with local, state, and federal standards of care. The LPN’s discussion of a confidential matter in a public area is a violation of HIPAA.

25. 1. The charge nurse must address this situation because it has been going on for more than a week.
   2. Writing a memo does not find out what is causing the tense atmosphere.
   3. The charge nurse should call a meeting and attempt to determine what is causing the staff’s behavior and the tense atmosphere. The charge nurse could then problem-solve, with the goal being to have a more relaxed atmosphere in which to work.
   4. This is threatening, which is not an appropriate way to resolve a staff problem.

**MAKING NURSING DECISIONS:** In any business, including a health-care facility, arguing should not occur among staff of any level where the customers—in this case, the clients—can hear it or see it. The nurse should address the situation directly with the staff.

26. 1. Obtaining a urine sample is not an invasive procedure and does not require informed consent.
   2. The urine specimen must adhere to a chain of custody so that the client cannot dispute the results.
   3. The bathroom for drug testing should not have access to any water via a sink so that the client cannot dilute the urine specimen.
   4. The tympanic temperature is taken in the client’s ear and is not required for a urine drug sample.

27. 1. The nurse should realize the client probably has a deep vein thrombosis, which is a medical emergency. The HCP should be notified immediately so the client can be started on IV heparin and admitted to the hospital.
   2. This data may be needed, but the nurse should notify the HCP based on the signs/symptoms alone.
   3. A neurovascular assessment should be completed, but not before notifying the HCP. The signs/symptoms alone indicate a potentially life-threatening condition.
   4. The client’s leg should be elevated, not placed hanging over the side of the bed, which would be appropriate for an arterial occlusion.

**MAKING NURSING DECISIONS:** The test taker needs to read all of the options carefully before choosing the option that says, “Notify the HCP.” If any of the options will provide information the HCP needs to know in order to make a decision, the test taker should choose that option. If, however, the HCP does not need any additional information to make a decision and the nurse suspects the condition is serious or life threatening, the priority intervention is to call the HCP.

28. 1. The nurse should first determine whether there is a fire or whether someone accidentally or on purpose pulled the fire alarm. Because this is a clinic, not a hospital, the nurse should keep calm and determine the situation before taking action.
   2. The nurse should not evacuate clients, visitors, and staff unless there is a real fire.
   3. The nurse should assess the situation before contacting the fire department.
   4. This is an appropriate intervention, but this is not the first intervention. The nurse should first assess to determine whether there is a fire.

**MAKING NURSING DECISIONS:** The nurse must be knowledgeable of emergency preparedness. Employees receive this information in employee orientation and are responsible for implementing procedures correctly. The NCSBN NCLEX-RN blueprint includes questions on safe and effective care environment.

29. 1. The clinic nurse should allow the director to address sexual harassment allegations. This is a matter that should be handled legally.
   2. This is an appropriate question to ask when investigating sexual harassment allegations, but the clinic nurse should allow the director of nurses to pursue this situation.
   3. The clinic nurse is responsible for taking the appropriate action when sexual allegations are reported. This is not taking the allegations seriously and could result in disciplinary action against the nurse.
   4. This is the most appropriate response because sexual harassment allegations are a legal matter. The clinic nurse implemented the correct action by making sure the UAP reported the allegation to the director of nurses.
MAKING NURSING DECISIONS: The nurse is responsible for knowing and complying with local, state, and federal standards of care.

30. 1. The clinic nurse should not discuss the staff nurses’ statement with the pharmaceutical representative because the staff member’s behavior is unethical and could have repercussions. The clinic nurse should notify the director of nurses.

2. This behavior is unethical and is making promises that the staff nurse may or may not be able to keep. Because this situation includes the HCP, an outside representative, and the staff nurse, this situation should be reported to the director of nurses for further action.

3. This behavior must be reported. This is bribing the pharmaceutical representative and using a meeting with the HCP as the reward.

4. The clinic nurse should maintain the chain of command and report this to the nursing supervisor, not to the HCP.