1. This client has comorbid conditions—advanced age, obesity, and diabetes—which put this client at a higher risk for postoperative complications.

2. This client's risk factor of arthritis can make positioning in surgery and movement in the postoperative period more difficult, but this does not put the client at greater risk for postoperative complications. The NSAIDs can be held a few days prior to surgery to decrease the problems associated with NSAIDs.

3. The client with abdominal surgery may have respiratory complications, but the client is not at as high risk as the older client with diabetes and obesity.

4. The client's smoking increases the risk of pulmonary complications and increases the blood level of carboxyhemoglobin, but this client does not have the problems of delayed healing and age the 67-year-old client with diabetes has.


4. 1. This would be an outcome for the health-care team, not the client.

2. This would be an appropriate postoperative, not preoperative, outcome.

3. This would be the expected outcome for the client during the preoperative phase. After the teaching has been completed, the client should be able to demonstrate how to splint with the pillow while deep breathing and coughing.

4. This would not be an expected outcome for the preoperative client. All clients should be encouraged to complete an advance directive, but it is not required by law.


5. 1. This client problem would not be written until after the surgery.

2. This would be an appropriate client problem for the preoperative client who is scheduled for ankle repair. Teaching is priority.

3. This would not be a problem for a client scheduled for surgery.

4. This would not be a problem for a client scheduled for surgery.


6. 1. Teaching cannot be delegated.

2. Discussing the preoperative plans is part of the planning process and cannot be delegated.

3. Evaluation cannot be delegated to the UAP.

4. The UAP can assist a stable client to take a shower whether or not it is with Betadine.

7. 1. The teaching is effective if the client is able to demonstrate the use of the spirometer prior to surgery.
   2. The patient-controlled analgesia pump would not be available prior to surgery because the pumps are charged to the client on a daily basis and the client would not be able to demonstrate how to use it.
   3. Determining allergies to anesthesia medications is important prior to surgery, but the nurse would not teach the specific medication names.
   4. This would demonstrate increased mobility and would be encouraged after surgery, but it would not determine if teaching was effective.


8. 1. The surgical checklist is assessed when the client arrives in the surgery department holding area where clients wait for a short time before entering the operating room.
   2. Preparing the surgical site is completed in the surgery suite but not until the client and surgery have been verified.
   3. The client should have voided just prior to being transported to the surgery department.
   4. Securing the client onto the surgical table would be important in the operating room, not in the holding area.


9. 1. The nurse should never ask the client “why.” The client does not owe the nurse an explanation.
   2. This response defends the hospital and does not address the client’s feelings.
   3. This response is therapeutic and promotes communication of feelings.
   4. This statement is closed-ended and will not encourage the continued discussion of “fear.”


10. 1. Closing curtains will not keep loud conversations from being overheard.

11. 1. This hemoglobin is within normal limits and would not warrant immediate action.
   2. This glucose level indicates hypoglycemia, which requires medical intervention.
   3. This white blood cell value is within normal range and would not be reported.
   4. This potassium level is within normal limits and would not require intervention.


12. 1. This client problem would be appropriate for a postoperative client or, in some circumstances, a preoperative client, but not for a client in surgery.
   2. This is a problem of long-term immobility and would not apply during surgery.
   3. This problem would be appropriate for the intraoperative phase. The circulating nurse would strap and carefully pad areas to prevent damage to tissues and nerves.
   4. The client is receiving oxygen or breathing by the ventilator. The client should not have an alteration in gas exchange.


13. 1. The anesthesiologist, not the nurse in the operating room, manages the intravenous fluids.
   2. The lithotomy position has both legs elevated and placed in stirrups. The legs should be lowered one leg at a time to prevent hypotension from the shift of the blood.

3. Raising the foot of the bed would be a treatment of hypotension, but not hypotension resulting from the lithotomy position.
4. Epinephrine, a vasopressor, is used during codes to shunt blood from the periphery to the central circulation.


14. 1. All sponges must be included in the sponge count, but it is not the first intervention.
2. The circulating nurse should obtain another sterile pack for the operation to continue, but it is not the first intervention.
3. The circulating nurse should inform the surgical technologist of any break in sterile technique or field. This is the first intervention because the field is now contaminated.
4. This action is below standards of the Association of Operating Room Nurses and violates the principles of sterility. The sponge is included in the count and will not be discarded until the end of the case, and all sponges have been accounted for.


15. 1. If the needle count does not correlate, the surgical technologist and the other surgical team members should be informed. After repeating the count, a search for the missing needle should be conducted.
2. Assuming the original count was wrong is illegal and dangerous for the client.
3. If the needle is not located, an x-ray will be done, but this is not the first intervention.
4. If the missing needle is not located, an occurrence report should be completed and sent to the risk manager, but this is not the first intervention.


16. 1. When the client in the holding area states the surgery site differs from the scheduled surgery, the nurse should identify the client and review the client’s chart.
2. If there is a discrepancy, the nurse should notify the surgeon to explain the situation and resolve the issue.
3. The Joint Commission surgical standards state a “time-out” period is called and everything stops until the discrepancy is resolved.
4. The nurse should not change a permit. If an error is discovered, the nurse should correct the situation within legal and ethical guidelines.

5. Clients are encouraged to mark the correct side or site with indelible ink.


17. 1. These are symptoms of hypovolemic shock and require immediate intervention.
2. This is a common response to anesthesia. Clients are sleepy until the anesthesia wears off.
3. Pain management is required, but this does not indicate a life-threatening complication.
4. Urine outputs should be monitored in the postoperative period, but indwelling catheter bags are emptied in the PACU prior to transferring the client to the floor, so 20 mL would not warrant immediate intervention.


18. 1. Narcan does not alter the urinary elimination; therefore, this is not an appropriate intervention for this client.
2. Anesthesia may alter sleep patterns, but this nursing intervention does not take into account the need for Narcan to be administered to the client.
3. This nursing intervention does not address the use of Narcan.
4. Narcan is given to reverse respiratory depression from opioid analgesic medications and has a short half-life. The client may experience a rebound respiratory depression in 15 to 20 minutes, so this nursing intervention of monitoring respirations every 15 to 30 minutes is appropriate.
19. 1. The surgeon usually removes the first surgical dressing. The nurse performs surgical dressing changes so asepsis is maintained and the incision can be assessed.
2. Nurses cannot delegate teaching and assessment.
3. Emptying the drainage devices and recording the amounts on the bedside intake and output forms can be delegated.
4. Listening to bowel sounds is assessing and cannot be delegated.

20. 1. Bowel sounds should be assessed, but it is not priority for the surgical client in the PACU.
2. The post-anesthesia care unit nurse should follow the ABCs format described by the American Heart Association. “A” is for airway, “B” is for breathing, and “C” is for circulation. Vital signs assess for hemodynamic stability; this is priority in the PACU.
3. Intravenous fluids should be assessed after breathing and circulation have been assessed.
4. The surgical site should be assessed after the intravenous fluid rate is assessed.

21. 1. This intervention is invasive, increases the client’s risk for infection, and should be the last resort.
2. Increasing the IV fluids might increase the amount of urine in the bladder and cause further discomfort.
3. Helping the male client to stand can offer the assistance needed to void. The safety of the client should be ensured.
4. Drinking more fluids helps to increase urinary output but will not assist the client to empty the bladder.

22. 1. The nurse should assess the client before notifying the surgeon the client felt or heard a “pop” and “something opening.”
2. The surgery department may or may not need to be notified. The incision should be assessed.
3. The nurse should assess the surgical site and, if the site has eviscerated, cover the opening with a sterile dressing moistened with sterile 0.9% saline. This will prevent the tissues from becoming dry and infected.
4. The nurse should not dismiss any complaint from a client without further assessment.

23. 1. Anytime the nurse has a client who is disoriented, the nurse must initiate fall safety precautions.
2. Confusion would not indicate a change in comfort level.
3. Sudden confusion is usually not a circulation problem.
4. Impaired skin integrity would not cause confusion.

24. 1. When a postoperative client develops a fever within the first 24 hours, the cause is usually in the respiratory system. The client should increase deep breathing and coughing to assist the client to expand the lungs and decrease pulmonary complications.
2. Drinking fluid can bring down temperature, but 200 mL would not be a sufficient amount to accomplish this. Unless contraindicated, the client should drink from one (1) to two (2) L/day.
3. Wound infections may cause the fever later in the recovery but will usually not elevate within the first 24 hours after surgery.
4. A urinary tract infection may occur later but would probably not be the cause of...