Chapter 01: Concepts Basic to Perioperative Nursing
Rothrock: Alexander's Care of the Patient in Surgery, 16th Edition

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.