1. **What is the most frequent cause of the spread of infection among institutionalized patients?**

A) Airborne microbes from other patients

B) Contact with contaminated equipment

C) Hands of healthcare workers

D) Exposure from family members

2. **Which of the following is the <u>FIRST priority</u> in preventing infections when providing care for a client?**

A) Handwashing

B) Wearing gloves

C) Using a barrier between client's furniture and nurse's bag

D) Wearing gowns and goggles

3. **A nurse is explaining basic principles of asepsis and infection control to a client who has a respiratory tract infection following birth. The nurse determines the <u>client understands principles of infection control</u> to follow <u>when the client says</u>:**

A) "I must use barrier isolation."

B) "I must wear a gown and gloves."

C) "I must use individual client care equipment."

D) "I must practice frequent handwashing."

4. **To assure <u>effectiveness</u>, when should the nurse <u>stop rubbing antiseptic hand solution</u> over all surfaces of the hands?**

A) When fingers feel sticky

B) After 5 to 10 seconds

C) When leaving the clients room

D) Once fingers and hands feel dry

5. **For which <u>range of time</u> must a nurse <u>wash her hands</u> before working in the <u>operating room?</u>**

A) 1 to 2 minutes

B) 2 to 4 minutes

C) 2 to 6 minutes

D) 6 to 10 minutes

6. How much liquid soap should the nurse use for effective hand washing? At least:

A) 2 mL

B) 3 mL

C) 6 mL

D) 7 mL

7. The nurse is preparing to assist with a sterile procedure in the surgical suite. An <u>appropriate technique</u> that the nurse includes in the <u>surgical scrub</u> is to:

A) Keep the hands below the elbows throughout the scrub

B) Use a brush on the palms and dorsal surface of the hands

C) Maintain the scrub for at least 2 to 5 minutes

D) Wash well around all jewelry

8. <u>Surgical aseptic</u> techniques are employed by a nurse when:

A) Inserting an intravenous catheter

B) Placing soiled linen in moisture-resistant bags

C) Disposing of syringes in puncture-proof containers

D) Washing hands before changing a dressing

9. The nurse recognizes the appropriate procedures for sterile asepsis. Of the following, which action is consistent with sterile asepsis?

A) Clean forceps may be used to move items on the sterile field.

B) Sterile fields may be prepared well in advance of the procedures.

C) The first small amount of sterile solution should be poured and discarded .

D) Wrapped sterile packages should be opened starting with the flap closest to the nurse.

10. A nurse is changing the dressing and accidentally <u>drops the packing onto the clients abdomen.</u> The client has a large, deep abdominal incision that is packed with sterile half-inch packing and covered with a dry 4 4 gauze. <u>The nurse should:</u>

A) Add alcohol to the packing and insert it into the incision

B) Throw the packing away, and prepare a new one

C) Pick up the packing with sterile forceps, and gently place it into the incision

D) Rinse the packing with sterile water, and put the packing into the incision with sterile gloves

11. A client has requires a mid-abdominal surgical incision which necessitates a sterile dressing. An appropriate intervention for the nurse to implement in maintaining sterile asepsis is to:

A) Put sterile gloves on before opening sterile packages

B) Discard packages that may have been in contact with the area below waist level

C) Place the cap of the sterile solution well within the sterile field

D) Place sterile items on the very edge of the sterile drape

12. The nurse is observing the new staff member work with the client. Of the following activities, which one has the <u>greatest possibility of contributing</u> to a <u>nosocomial infection</u> and requires correction?

A) Washing hands before applying a dressing

B) Taping a plastic bag to the bed rail for tissue disposal

C) Placing a Foley catheter bag on the bed when transferring a client

D) Using alcohol to cleanse the skin before starting an intravenous line

13. In a small rural hospital they work with a wide variety of clients. Of this afternoon clients admitted, the nurse acknowledges the client with the highest susceptibility to infection is the individual with:

A) Burns

B) Diabetes

C) Pulmonary emphysema

D) Peripheral vascular disease

14. An appropriate isolation procedure for the nurse to implement when working with a client who is found to have methicillin-resistant Staphylococcus aureus (MRSA) is to:

A) Leave all linen in the clients room

B) Place specimen containers in plastic bags for transport

C) Wipe the stethoscope off before removing it from the room

15. The nurse is helping the physician perform a sterile procedure at the bedside. Halfway through the procedure, the <u>nurse believes the physician has contaminated the sterile field.</u> The nurse should:

A) report the physician for violating surgical asepsis and endangering the patient.

B) ask the physician whether she contaminated her glove and the sterile field.

C) point out the possible break in surgical asepsis and provide another set of sterile gloves and a fresh sterile field.

D) not say anything, because it is near the end of the procedure.

16. The nurse can **best minimize the risk for infection** when **initiating an intravenous site** by:

A) Proper vein site selection

B) Effective topical skin preparation

C) Appropriate site dressing

D) doning surgical gloves

17. A client admitted for an abdominal hysterectomy reports that she has been under a lot of stress since the death of her mother and wonders how that will affect her surgery and recovery.

Which of the following nursing interventions reflects the most therapeutic understanding of the relationship **stress** has on the body and its **ability to recover from surgery?**

A) Suggest a demonstration of relaxation techniques

B) Arrange for the hospital chaplain to visit the client

C) Offer to call and get an order for an antianxiety medication

D) Share a personal antidote concerning a similarly stressful situation

18. The nurse is providing care for a client who postoperatively has developed an **infected incisional wound** and is **depressed** and **anorexic**. Which of the following nursing interventions **has priority**?

A) Sterile wound care

B) Frequent small meals

C) Administration of antidepressant medication

D) Educating the client regarding wound care at home

19. The nurse is educating a client diagnosed with type 2 diabetes, who is susceptible to foot wounds, on how **to minimize the risk for infection** related to poor wound healing by not being a susceptible host.

The most appropriate suggestion would be to:

A) Inspect feet and legs daily for skin breakdown

B) See a podiatrist regularly for appropriate foot care

C) Keep blood sugar levels within normal range to maximize the ability to heal

D) Eat well-balanced meals in order to provide the nutrients necessary for healing

20. A patient has an inguinal hernia repair and later develops a methicillin-resistant Staphylococcus aureus infection. What is the most important factor to prevent this infection?

A) Surgical asepsis

B) Increased T cells

C) Decreased antibiotics

D) Increased vitamin C

21. To eliminate needlesticks as potential hazards to nurses, the nurse should

A) Place the uncapped needle on a tray, carry it to the medicine room for disposal

B) Immediately deposit uncapped needles into puncture-proof plastic container

C) Stick the uncapped needle into a Styrofoam block and deposit in a plastic container

D) Slide the needle into the cap and deposit it in a puncture-proof plastic container

22. The nurse is preparing a presentation on Standard Precautions. Which statement should be included in the presentation?

A) Cut the needle off a syringe after using it to give a client an injection.

B) Dispose of blood-contaminated materials in a biohazard container.

C) Gloves should not be worn for client care unless body fluids are seen.

D) Wear a mask when in direct contact with all clients.

23. A patient is discharged home with a draining wound that was infected and for which he was on Contact Precautions while in the hospital. He lives at home with his 48-year-old wife and their 17-year-old daughter.

It is most important to emphasize to this patient that:

A) he should maintain a safe distance from his family.

B) he should use paper plates and disposable utensils.

C) soiled dressings should be disposed of in plastic bags that are tied securely.

D) his family members should wear gloves when handling his plate and eating utensils.

24. While irrigating a clients abdominal wound, the irrigate splashes into the nurses nose and eyes. What should the nurse do?

A) Flush the nose and eyes for 510 minutes with water or normal saline.

B) Begin HIV high-risk exposure prophylaxis within 24 hours.

C) Wash the areas with soap and water.

D) Have blood drawn for hepatitis B antibodies.

25. A nurse is splashed in the face by body fluid during a procedure. Prioritize the nurses actions, listing the most important one first.

A. Contact employee health

B. Complete an incident report

C. Wash the exposed area

D. Report to another nurse that she is leaving the immediate area.

(A) 1, 2, 3, 4

(B) 2, 3, 4, 1

(C) 3, 4, 1, 2

(D) 4, 1, 2, 3

26. The patient suddenly develops hives, shortness of breath, and wheezing after receiving an antibiotic. Which antibody is primarily responsible for this patients response?

(A) IgA

(B) IgE

(C) IgG

(D) IgM

27. What type of immunity is provided by intravenous (IV) administration of immunoglobulin G?

(A) Cell-mediated

(B) Passive

(C) Humoral

(D) Active

28. Which of the following circumstances would cause a client to develop <u>active immunity</u>?

(A) Becoming ill with tetanus and receiving tetanus toxoid

(B) Having chickenpox

(C) Receiving a rabies shot after being bitten by a rabid dog

(D) Receiving an injection of gamma globulin

29. When the patient complains of vague symptoms of malaise and fatigue and has a low grade fever, but has no other specific signs of illness, the nurse suspects that this patient is in the prodromal phase of infection (the time immediately before the illness is diagnosed).

The nurse should include in the plan of care to:

A) assessments for specific signs of illness

B) increase fluid intake.

C) place the patient in isolation.

D) report findings to the Infection Preventionist Officer.

30. A patient has a nursing diagnosis of Infection, related to inadequate primary defenses, as evidenced by surgical incision and intravenous (IV) line access.

An appropriate nursing intervention for this patient is to:

A) assess and document skin condition around the incision and IV site at each shift.

B) limit visitors to immediate family to decrease exposure to infection.

C) require the use of a face mask by nursing staff when they are providing care.

D) maintain clean technique in the change of wound dressing and IV site.

31. What instructions is the most important for the nurse to give a client who is about to be discharged and has a surgical wound?

A) Adjust the diet so it contains more fruits and vegetables.

B) Apply lubricating lotion to the edges of the wound.

C) Notify the physician if with any edema, heat, or tenderness at the wound site.

D) Thoroughly irrigate the wound with hydrogen peroxide.

32. The nursing intervention most likely to decrease the chance of health care-associated infections (HAIs) for a 76-year-old patient following bowel resection surgery would be to have the patient:

A) turn, cough, and deep-breathe every 2 hours.

B) limit ambulation.

C) get blood pressure, pulse, and respirations assessed every 4 hours.

D) keep the room door closed.

33. The nurse observes a patient demonstrating wound cleaning. What action indicates the need for further instruction?

A) Using sterile gloves to perform the cleaning

B) Applying an antiseptic to the area

C) Cleaning the area from the outside in

D) Washing hands with soap

34. Question : The RN has just been stuck with a syringe while dropping it into a sharps container that was too full in a clients room. Which of the following steps should be taken first for a puncture?

A) Complete an injury report.

B) Encourage bleeding.

C) Initiate first aid.

D) Wash the area with soap and water.