

Focus on Delegating Prioritizing Triage Disaster Practice Test (Sample)

Study Guide



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SAMPLE

Questions

- 1. Which patient should a registered nurse prioritize for an assigned care to themselves over an LPN or UAP?**
 - A. A client with a recent complex surgery**
 - B. A client with diabetes needing education**
 - C. A client receiving routine medication administration**
 - D. A client needing assistance with hygiene**
- 2. What is the nurse's first action upon observing signs of phlebitis at an IV site?**
 - A. Apply warm compresses to the site**
 - B. Slow the IV infusion rate**
 - C. Notify the healthcare provider**
 - D. Remove the IV catheter**
- 3. What should a nurse do next if constant bubbling is noted in the water seal chamber of a chest tube drainage system?**
 - A. Reduce the suctioning pressure**
 - B. Notify the healthcare provider immediately**
 - C. Clamp the chest tube temporarily**
 - D. Replace the drainage system**
- 4. In the case of a suspected trachea-innominate artery fistula, after removing the tracheostomy tube, the next immediate action is to:**
 - A. Insert a new smaller tracheostomy tube**
 - B. Apply direct pressure to the innominate artery at the stoma site**
 - C. Notify the respiratory therapist**
 - D. Start an IV line**
- 5. What is an appropriate nursing intervention for a client receiving a blood transfusion who shows signs of transfusion reaction?**
 - A. Administer the prescribed antihistamine**
 - B. Stop the transfusion and keep the IV line open with saline**
 - C. Check the client's temperature every 15 minutes**
 - D. Inform the family of the client's condition**

- 6. When assigning care, which client is most appropriate for the RN to manage?**
- A. A pediatric client with a temperature**
 - B. A client with newly diagnosed metastatic carcinoma**
 - C. A client post-craniotomy requiring frequent assessments**
 - D. A client discharged after chest pain**
- 7. When delegating care, which of the following assessments should be performed by a registered nurse instead of an LPN?**
- A. Neurovascular checks on a post-surgical patient**
 - B. Wound dressing changes on a stable client**
 - C. Routine vital sign monitoring for a stable patient**
 - D. Bedside glucose checks for diabetic patients**
- 8. After the insertion of an intestinal tube, what position should be used for the client?**
- A. Flat on the back**
 - B. On the left side**
 - C. On the right side**
 - D. Sitting upright**
- 9. Which client should the nurse assess first among those assigned for the shift?**
- A. A client post barium enema**
 - B. A client needing daily dressing changes**
 - C. A client with emphysema on 2 L/min oxygen**
 - D. A client recently discharged after angioplasty**
- 10. For a client with respiratory distress, what should be the immediate nursing priority?**
- A. Obtain a chest x-ray**
 - B. Administer bronchodilators**
 - C. Position the client for optimal breathing**
 - D. Monitor heart rate and rhythm**

Answers

SAMPLE

1. B
2. D
3. D
4. B
5. B
6. B
7. A
8. C
9. C
10. C

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Explanations

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1. Which patient should a registered nurse prioritize for an assigned care to themselves over an LPN or UAP?

- A. A client with a recent complex surgery**
- B. A client with diabetes needing education**
- C. A client receiving routine medication administration**
- D. A client needing assistance with hygiene**

Prioritizing patient care is essential in a healthcare setting, and understanding the responsibilities and competencies of different nursing roles is key. In this scenario, the registered nurse should focus on the client with diabetes needing education because patient education directly influences health outcomes. Nurses possess the expertise required to provide comprehensive education regarding diabetes management, which includes dietary considerations, medication administration, blood sugar monitoring, and recognizing signs of hypo- or hyperglycemia. This patient requires a tailored and in-depth discussion about their condition and management strategies, which exceeds the educational scope typically provided by licensed practical nurses (LPNs) or unlicensed assistive personnel (UAPs). Prioritizing this patient's needs ensures they receive the critical knowledge necessary to manage their diabetes effectively, empowering them to take control of their health and reduce the risk of complications. The other patients mentioned, while still needing care, may fall within the scope of practice for an LPN or UAP. A client with a recent complex surgery requires careful assessment and monitoring but may have their immediate care needs managed by an LPN who is trained to monitor post-operative patients. Routine medication administration is well within the capabilities of either an LPN or UAP. Similarly, assistance with hygiene is a task that is designed for U

2. What is the nurse's first action upon observing signs of phlebitis at an IV site?

- A. Apply warm compresses to the site**
- B. Slow the IV infusion rate**
- C. Notify the healthcare provider**
- D. Remove the IV catheter**

The most appropriate initial action when a nurse observes signs of phlebitis at an IV site is to remove the IV catheter. Phlebitis is an inflammatory response often caused by irritation of the vein, which can be exacerbated by the presence of the catheter. By removing the catheter, the nurse can prevent further irritation and potential complications from occurring. This action also ensures patient comfort and safety, reducing the risk of the condition worsening. Once the catheter is removed, the nurse can then take additional measures, such as assessing the site for further complications, documenting the findings, and potentially applying warm compresses to alleviate discomfort. Notifying the healthcare provider is also a critical step but typically occurs after assessing the immediate needs by removing the causative element—the IV catheter itself. Slowing the IV infusion rate may provide temporary relief, but it does not address the underlying issue of phlebitis, which necessitates catheter removal. Thus, removing the catheter is the foundational response that prioritizes patient safety and manages the condition effectively.

3. What should a nurse do next if constant bubbling is noted in the water seal chamber of a chest tube drainage system?

- A. Reduce the suctioning pressure**
- B. Notify the healthcare provider immediately**
- C. Clamp the chest tube temporarily**
- D. Replace the drainage system**

When constant bubbling is observed in the water seal chamber of a chest tube drainage system, it indicates that there is a potential air leak in the system. This bubbling should not be continuous under normal functioning conditions, as it may signify that air is leaking into the pleural space or that the drainage system itself has a malfunction. Replacing the drainage system is the appropriate action because it ensures both the integrity of the system and the safety of the patient. A malfunctioning system can lead to ineffective drainage and potentially compromise the patient's respiratory status. By replacing the drainage system, the nurse can help maintain optimal functioning and prevent further complications related to air leaks. The other options, while they might seem reasonable in different situations, do not directly address the potential air leak or the malfunction indicated by the constant bubbling. Reducing suctioning pressure would not resolve the underlying issue, notifying the healthcare provider is necessary but not an immediate corrective action, and clamping the chest tube can increase the risk of tension pneumothorax without fixing the problem.

4. In the case of a suspected trachea-innominate artery fistula, after removing the tracheostomy tube, the next immediate action is to:

- A. Insert a new smaller tracheostomy tube**
- B. Apply direct pressure to the innominate artery at the stoma site**
- C. Notify the respiratory therapist**
- D. Start an IV line**

In the case of a suspected trachea-innominate artery fistula, applying direct pressure to the innominate artery at the stoma site is critical for controlling potential bleeding and stabilizing the situation. When a fistula occurs, there is a high risk of significant hemorrhage due to the proximity of the innominate artery to the trachea. Immediate direct pressure can help to occlude the artery, reduce blood loss, and prevent exsanguination, which is essential in a potentially life-threatening scenario. This action takes priority because it addresses the most immediate threat - controlling the bleeding - rather than focusing on airway management or other supportive measures. Other options such as inserting a new tracheostomy tube or starting an IV line would not provide the urgent intervention needed to manage bleeding in this situation, and notifying a respiratory therapist, while important for continued patient care, is not a critical immediate measure when faced with an emergency involving arterial bleeding.

5. What is an appropriate nursing intervention for a client receiving a blood transfusion who shows signs of transfusion reaction?

- A. Administer the prescribed antihistamine**
- B. Stop the transfusion and keep the IV line open with saline**
- C. Check the client's temperature every 15 minutes**
- D. Inform the family of the client's condition**

The correct choice highlights a critical first step in managing a transfusion reaction. When a client exhibits signs of a transfusion reaction, such as fever, chills, or rash, the priority nursing intervention is to stop the blood transfusion immediately. This action prevents further exposure to potentially harmful substances in the transfusion product. In addition to stopping the transfusion, it is essential to maintain venous access for potential administration of saline, which helps to keep the intravenous line open and allows for the administration of emergency medications if needed. This dual action ensures that patient safety is prioritized while the healthcare team can assess the situation, prepare for further intervention, and possibly administer treatments such as antihistamines, corticosteroids, or fluids as necessary. While checking the client's temperature regularly is important in assessing the extent of the reaction and monitoring the patient's condition, it should occur after the transfusion is halted. Similarly, while informing the family about the client's condition is a vital aspect of patient care, it also comes after ensuring the immediate safety and stabilization of the patient. Thus, maintaining the IV line with saline is the most appropriate nursing intervention in the event of a transfusion reaction.

6. When assigning care, which client is most appropriate for the RN to manage?

- A. A pediatric client with a temperature**
- B. A client with newly diagnosed metastatic carcinoma**
- C. A client post-craniotomy requiring frequent assessments**
- D. A client discharged after chest pain**

The correct choice is the client with newly diagnosed metastatic carcinoma, as this situation presents a complex and chronic health condition that requires comprehensive assessment, ongoing education, and management strategies that a registered nurse (RN) is well-equipped to handle. The RN's role is crucial here, as they will be responsible for monitoring the patient's overall health, providing emotional support, coordinating care plans with other healthcare professionals, and educating the patient about their condition and treatment options. This client's needs extend beyond basic care, encompassing pain management, understanding treatment implications, and navigating the emotional and psychological impacts of a cancer diagnosis. The RN's skilled assessment capabilities will be essential to detect subtle changes that may indicate further complications related to the cancer or its treatment. Other clients, such as those requiring frequent assessments post-craniotomy or those with significant acute symptoms, may also seem appropriate for RN management but may actually require more intensive oversight or specialized nursing staff. In the case of a pediatric client with a temperature, the situation might be simple and could be managed by less experienced nursing staff, depending on the underlying cause of the fever. Similarly, a client discharged after experiencing chest pain may need transitional care that can often be delegated to less experienced staff under the supervision of an RN. In contrast

7. When delegating care, which of the following assessments should be performed by a registered nurse instead of an LPN?

A. Neurovascular checks on a post-surgical patient

B. Wound dressing changes on a stable client

C. Routine vital sign monitoring for a stable patient

D. Bedside glucose checks for diabetic patients

The assessment that should be performed by a registered nurse instead of a licensed practical nurse (LPN) is the neurovascular checks on a post-surgical patient. This task requires a deeper level of critical thinking, analysis, and comprehensive nursing judgment, which aligns with the scope of practice of a registered nurse. Neurovascular assessments involve evaluating the motor function, sensory function, circulation, and vital signs in the affected limb, which could reveal complications such as compartment syndrome or vascular insufficiency. Given the potential for significant changes in a post-surgical patient, a registered nurse is better equipped to interpret these findings, make clinical decisions, and act upon them if any issues arise. In contrast, the other options—wound dressing changes, routine vital sign monitoring, and bedside glucose checks—are generally considered within the LPN's scope of practice and require less complex judgment compared to performing neurovascular checks. LPNs are trained to handle these tasks competently, but the critical nature of post-surgical assessments necessitates a registered nurse's expertise to ensure that any complications are identified and managed promptly.

8. After the insertion of an intestinal tube, what position should be used for the client?

A. Flat on the back

B. On the left side

C. On the right side

D. Sitting upright

When an intestinal tube is inserted, placing the client in the right side position is beneficial for promoting proper digestion and preventing complications. This position allows gravity to assist in the movement of intestinal contents through the gastrointestinal tract, which is particularly important for patients with an intestinal tube that may be used for feeding or drainage. The right side position aligns the stomach and intestines in a way that facilitates the flow and reduces the chance of aspiration, making it more comfortable and effective for the patient. Additionally, this position can help prevent kinks or obstructions in the tube, ensuring it functions as intended. Other positions, such as lying flat on the back, may not provide the same benefits in terms of promoting gastrointestinal movement and could lead to increased risk of complications, such as aspiration or ineffective drainage. Being on the left side while beneficial for some conditions, is less effective than the right side position in this specific context. Sitting upright, although beneficial in certain instances, may not always be feasible or comfortable immediately after tube insertion for all patients. Therefore, the right side position is the most effective choice in this scenario.

9. Which client should the nurse assess first among those assigned for the shift?

- A. A client post barium enema**
- B. A client needing daily dressing changes**
- C. A client with emphysema on 2 L/min oxygen**
- D. A client recently discharged after angioplasty**

The correct choice is to assess the client with emphysema on 2 L/min oxygen first due to the potential for acute respiratory issues. In patients with emphysema, maintaining adequate oxygenation is critical, particularly since they may have compromised lung function and are at an increased risk for respiratory distress. Adequate breathing support is essential to avoid complications such as hypoxia or hypercapnia, which can escalate quickly and become life-threatening. In contrast, while the other clients require attention, they do not present with immediate risks to their respiratory status. The client post barium enema may require monitoring for gastrointestinal effects, but this situation is typically less urgent than respiratory compromise. The client needing daily dressing changes may have ongoing care needs but is stable and does not have urgent physiological concerns. Similarly, the client recently discharged after angioplasty should be monitored for potential complications, but this situation typically allows for a longer assessment window compared to the immediate needs of a patient experiencing respiratory issues. Therefore, prioritizing the assessment of the client with emphysema is aligned with nursing practice standards that emphasize addressing life-threatening conditions first.

10. For a client with respiratory distress, what should be the immediate nursing priority?

- A. Obtain a chest x-ray**
- B. Administer bronchodilators**
- C. Position the client for optimal breathing**
- D. Monitor heart rate and rhythm**

In a situation involving a client experiencing respiratory distress, the immediate nursing priority is to position the client for optimal breathing. This intervention is crucial because the positioning can significantly affect the patient's ability to breathe effectively. By placing the client in a position that facilitates lung expansion, such as sitting upright or leaning forward, the nurse can help decrease the work of breathing and improve airflow to the lungs. Optimal positioning also helps to minimize the effects of gravity on the diaphragm and enhances lung capacity, which is vital in managing respiratory distress. Other interventions, such as administering bronchodilators or obtaining diagnostic tests like a chest x-ray, are important but come after ensuring the client's airway and breathing are maximized through proper positioning. Monitoring vital signs, including heart rate and rhythm, is essential for comprehensive care but does not directly address the immediate needs related to breathing. Therefore, prioritizing the client's comfort and ability to breathe is the most critical action in this emergency situation.