PRACTICE IMPROVEMENT TEST QUESTIONS

Insights From a Tertiary Care Intraosseous Insertion Practice Improvement Registry: A 2-Year Descriptive Analysis (pp. 155-160)

1. The most common reason for intraosseous (IO) insertion in adult patients in the facility described in this article was
- **A.** gastrointestinal bleeding.
- **B.** nontraumatic cardiac arrest.
- **C.** traumatic cardiac arrest.

2. The most common placement location in adult and pediatric patients by all clinicians was the
- **A.** proximal tibia.
- **B.** proximal humerus.
- **C.** distal tibia.

3. The leading reason attributed to failed IO insertions was
- **A.** inserting the needle completely through the bone.
- **B.** leaking of the infused fluid, leading to extravasation.
- **C.** selecting a needle that was too short.

4. The authors suggest that, compared to pediatric patients, there were fewer IV attempts before IO access in adult patients because the adults
- **A.** were sicker.
- **B.** requested it, when given the option.
- **C.** had peripheral vascular disease.

5. As noted in the article, the difference in physician and ED nurse success rates in pediatric IO placement (40% and 86%, respectively) may be attributed to
- **A.** nurses having more support from additional nursing staff during IO insertion.
- **B.** minimal opportunities to practice this skill because of the number of ED attending physicians.
- **C.** physicians attempting most of the IO insertions in the younger than 12 months of age group.

6. As a result of this practice improvement, modifications were made to the data collection form to identify specific data on the
- **A.** number of successful IO insertions per clinician.
- **B.** shift during which the IO attempt was made.
- **C.** level of training of the physician.

7. Gazin et al. (2011) reported that didactic and practical training to improve IO successful placement to 97% after a maximum of 2 attempts can be as short as
- **A.** 30 minutes.
- **B.** 1 hour.
- **C.** 2 hours.

8. What did research by Engels et al. (2016) reveal had the largest association with increasing the likelihood that physicians would use IO placements?
- **A.** evidence-based research supporting IO use
- **B.** previous IO device training
- **C.** equipment readily available at each bedside

9. What do the authors suggest could be used in conscious patients prior to IO infusion for management of pain after IO insertion?
- **A.** lidocaine.
- **B.** opioids.
- **C.** local heat.

Evaluation of a Practice Improvement Protocol for Patient Transfer From the Emergency Department to the Surgical Intensive Care Unit After a Level I Trauma Activation (pp. 144-148)

10. What happens when the emergency department at the facility described in this article calls the surgical intensive care unit (SICU) to report that the patient is ready to be transferred to SICU?
- **A.** The admitting SICU nurse goes to the emergency department for report.
- **B.** The ED nurse initiates the transfer to SICU within 10 minutes of the call.
- **C.** Housekeeping will be called for STAT services.

11. In addition to the ED nurse, who assists with the transfer of the patient to SICU, as noted on the ED to ICU Transfer Time Reduction Flowsheet?
- **A.** an ED paramedic
- **B.** the SICU nurse
- **C.** a second ED nurse

12. According to the ED to SICU Transfer Time Reduction Flowsheet, if a patient is going to the SICU, the responsibilities of the assigned SICU nurse include
- **A.** responding to the emergency department to assist with the initial care of the patient.
- **B.** obtaining admitting orders from the patient's attending physician.
- **C.** transferring the "next" patient out of the SICU with the assistance of Bed Control.

13. The trauma patient ratio in this facility is
- **A.** 1:2.
- **B.** 2:1.
- **C.** 3:1.

14. If the patient is going to the operating room (OR) before going to SICU, the SICU RN will
- **A.** transfer the "next patient out with the assistance of the Admission Department."
- **B.** wait for a call from the OR before proceeding with any transfer time reduction measures.
- **C.** go to the OR to receive report from the circulating nurse prior to surgery.

15. Compared to an average time to transfer of 408.05 minutes in 2016, the average time to transfer in 2017 was
- **A.** 142.73 minutes.
- **B.** 261.3 minutes.
- **C.** 344.1 minutes.

16. The total number of nursing hours saved by this reduction in time to transfer was
- **A.** 84 hours.
- **B.** 112 hours.
- **C.** 146 hours.

17. Although not statistically significant, there was a decrease in the number of
- **A.** ventilator-free days.
- **B.** deaths.
- **C.** average ICU days.

18. One reason suggested for the insignificant difference in outcomes after the implementation of the program was
- **A.** patients on the lower end of "severely injured" may be treated adequately at the ED level.
- **B.** the difference in total transfer time was not sufficient to translate to a significant difference in outcomes.
- **C.** the SICU was undergoing a significant change in staffing with the introduction of several inexperienced nurses.

19. What did Chalfin et al. (2007) designate as the time spent in the emergency department before developing poor outcomes?
- **A.** 4 hours
- **B.** 5 hours
- **C.** 6 hours

20. An additional benefit from the implementation of this program, noted in anecdotal reports, was
- **A.** greater efficiency in room cleaning procedures by housekeeping staff.
- **B.** improvements between ED nurse and SICU nurse relations.
- **C.** improved satisfaction of the families of the trauma patients.

Nurse-Leader Collaborative Improvement Project: Improving Patient Experience in the Emergency Department (pp. 137-143)

21. Research by Meade et al. (2006) revealed that the most common reason why patients use their call lights is for
- **A.** pain medication.
- **B.** to request a nurse.
- **C.** bathroom assistance.

22. As a result of hourly rounding in the Meade et al. (2006) study, falls were decreased by
- **A.** 35%.
- **B.** 50%.
- **C.** 65%.

23. When added to hourly nurse rounding, the Studer Group suggested that daily rounding by nurse leaders would have a positive effect on patient
- **A.** satisfaction.
- **B.** treatment.
- **C.** cooperation.

24. In the 2006 study by Carroll and Carrigan, following leader rounding, many patients reported
- **A.** increased patience despite long waiting times.
- **B.** a greater likelihood of recommending the facility.
- **C.** greater confidence in their care providers.

25. Restraining forces surrounding hourly and leader rounding in the facility described in this article included
- **A.** nursing staff skepticism.
- **B.** the Health Insurance Portability and Accountability Act (HIPAA).
- **C.** inadequate staffing in the emergency department.

26. Which of the following occurred during the "Unfreezing" phase of this practice improvement project?
- **A.** The process owners and teams conducted random audits and were available to offer support and feedback.
- **B.** The stakeholders were able to understand the gap that existed between current and desired practices and outcomes.
- **C.** Revised policies and objectives were put into place, leading to the implementation of new processes.

27. Leader rounds were kept to a maximum of
- **A.** 5 minutes.
- **B.** 8 minutes.
- **C.** 10 minutes.

28. To reinforce the desired behavior and recognize nurses' success and hard work, the leader
- **A.** provided weekly information to the staff regarding the outcomes of the program.
- **B.** surveyed the patients regarding nurses' compliance with the hourly rounding process.
- **C.** provided feedback to the nurses from the patients.

29. The hourly rounding process including checking on the 4 Ps, one of which is
- **A.** pampering.
- **B.** positioning.
- **C.** preparing.

30. What derailed the bedside care providers' focus on hourly rounding in January and February 2018?
- **A.** the retirement of several nurses
- **B.** the flu season
- **C.** a Joint Commission survey

31. Compared to a baseline percentile rank of 8 on the Hospital Consumer Assessment of Healthcare Providers and Services (HCAHPS) survey question related to "overall rating of institution," the total percentile rank in December of 2017 was
- **A.** 35.
- **B.** 55.
- **C.** 75.

32. Scores for which HCAHPS survey question increased from a baseline percentile rank of 9 to 99 by March of 2018?
- **A.** staff identified themselves
- **B.** degree to which hospital staff worked as a team
- **C.** response to concerns/complaints during stay

Implementing Bedside Handoff in the Emergency Department: A Practice Improvement Project (pp. 149-154)

33. The Situation portion of the SBAR report contains which of the following?
- **A.** code status
- **B.** surrounding circumstances
- **C.** recent vital signs

34. What part of the SBAR report includes medications administered?
- **A.** Situation
- **B.** Background
- **C.** Assessment

35. Compared to 57% of nurses who agreed with the statement, "I have had a personal incidence of a poor patient outcome related to incomplete shift report," what percentage of nurses agreed with this statement post-bedside handoff implementation?
- **A.** 16%
- **B.** 24%
- **C.** 31%

36. After bedside handoff implementation, 77% of nurses agreed with the statement, "I believe all nurses on staff provide complete and accurate handoffs," compared to what percentage who agreed with the statement *before* bedside handoffs were implemented?
- **A.** 32%
- **B.** 43%
- **C.** 56%

37. Post-implementation of bedside handoffs, what percentage of nurses reported that they preferred bedside handoff to other methods?
- **A.** 62%
- **B.** 73%
- **C.** 81%

38. What component of the patient safety survey showed an improvement in scores from 50% pre-implementation to 62% post-implementation?

A. "patient handoff during shift change takes too much time."

B. "important patient care information is often lost during shift change."

C. "shift changes are problematic in this hospital."

39. The biggest challenge identified during observations was that the nurses did not always

A. conduct handoff reports at the bedside.

B. use the SBAR format for providing patient care information.

C. use the electronic medical record to review patients' treatment plans.