Clayton: Basic Pharmacology for Nurses, 15th Edition

Chapter 8: Percutaneous Administration

Test Bank

MULTIPLE CHOICE

1. A patient has an infected wound with large amounts of drainage. Which type of dressing would the nurse use?
A. Telfa
B. OpSite
C. DuoDerm
D. AlgiDERM

ANS: D

	Feedback
A	Telfa does not absorb exudates.
B	OpSite does not absorb exudates.
C	DuoDerm is for light to moderate wound drainage. According to the manufacturer, it does absorb exudates, but it is best for wounds with moderate drainage.
D	AlgiDERM is manufactured from seaweed and is recommended for infected wounds because it is an exudate absorber.

DIF: Cognitive Level: Comprehension REF: 108
TOP: Nursing Process Step: Implementation
MSC: NCLEX Client Needs Category: Physiological Integrity

2. Where would the nurse apply nitroglycerin ointment on a male patient?
A. The same site that was previously used
B. A hairy area of the chest
C. The upper arm
D. The back of knee

ANS: C

	Feedback
A	Sites should be rotated.
B	Hairy areas should be avoided.
C	Any area without hair may be used. Most people prefer the chest, flank, or upper arm areas.
D	This area is not suitable for applying medication because of the joint motion and difficulty of keeping a dressing in place.

DIF: Cognitive Level: Comprehension REF: 112

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TOP: Nursing Process Step: Implementation
MSC: NCLEX Client Needs Category: Physiological Integrity

3. Where will the nurse administer a medication that was ordered to be given sublingually?
   A. Between the molar teeth and cheek
   B. Below the skin surface
   C. Under the tongue
   D. Into the conjunctival sac

ANS: C

	Feedback
A	Between the molar teeth and cheek is the buccal area.
B	Medication administered below the skin surface is intradermal administration.
C	The sublingual area is underneath the tongue.
D	The conjunctival sac is between the eyelids and eyeball.

DIF: Cognitive Level: Knowledge REF: 116
TOP: Nursing Process Step: Implementation
MSC: NCLEX Client Needs Category: Physiological Integrity

4. Why are sublingual and buccal medications rapidly absorbed?
   A. Their action is localized to the mouth.
   B. They are metabolized in the liver.
   C. Blood flow is diminished in these sites.
   D. These drugs pass directly into systemic circulation.

ANS: D

	Feedback
A	These routes do not contain drug effects to the oral area.
B	These routes bypass the liver.
C	These sites are highly vascular.
D	Sublingual medications are rapidly absorbed into systemic circulation because of the increased blood flow to these areas. These medications are rapidly absorbed into the systemic circulation and avoid the “first pass” effect of the liver where extensive metabolism usually takes place.

DIF: Cognitive Level: Comprehension REF: 116
TOP: Nursing Process Step: Assessment
MSC: NCLEX Client Needs Category: Physiological Integrity

5. Which medications must be sterile?
   A. Topical
   B. Vaginal
   C. Ophthalmic
   D. Nasal

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ANS: C

	Feedback
A	Topical applications do not need to be sterile.
B	Vaginal applications do not need to be sterile.
C	Ophthalmic (eye) medications must be sterile.
D	Nasal applications do not need to be sterile.

DIF: Cognitive Level: Knowledge REF: 116
TOP: Nursing Process Step: Implementation
MSC: NCLEX Client Needs Category: Physiological Integrity

6. Which action will the nurse perform when doing a wet-to-dry dressing every 4 hours on a patient with a deep wound?
   A. Pack the wound tightly with gauze.
   B. Saturate the dressing with as much liquid as possible.
   C. Use Montgomery tapes or a binder to secure the dressing.
   D. Apply the new moist dressing over the existing one.

ANS: C

	Feedback
A	The dressing should be packed into the wound loosely.
B	The dressings should be wrung out to prevent dripping.
C	The use of Montgomery tapes or a binder reduces the irritation of nearby skin tissue.
D	The previous dressing should always be completely removed.

DIF: Cognitive Level: Application REF: 109
TOP: Nursing Process Step: Implementation
MSC: NCLEX Client Needs Category: Physiological Integrity

7. When applying nitroglycerin topically, which nursing intervention is correct?
   A. Secure the paper on two sides with tape.
   B. Shave the area prior to application of the paper.
   C. Wear gloves while placing the new paper.
   D. Remind the patient to discontinue use of the medication if chest pain is relieved.

ANS: C

	Feedback
A	The area where the paper is placed should be covered with plastic wrap and taped into place to prevent medication from seeping out.
B	Shaving may cause skin irritation.
C	Wearing gloves prevents accidental exposure to the medication.
D	The dosage and frequency of application should be gradually reduced over 4 to 6

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	weeks, and the patient should contact the health care provider if adjustment is desired.

DIF: Cognitive Level: Application REF: 113
TOP: Nursing Process Step: Implementation
MSC: NCLEX Client Needs Category: Physiological Integrity

8. Where does the nurse correctly administer ophthalmic medication?
   A. At the inner canthus of the eye
   B. In the lower conjunctival sac
   C. Directly onto the eyeball
   D. To the outer corner of the eyelid

ANS: B

	Feedback
A	This site allows medication to flow out of the eye.
B	The lower conjunctival sac is exposed by applying gentle traction to the lower lid at the bony rim of the orbit.
C	This risks injury to the globe.
D	This site allows medication to flow out of the eye.

DIF: Cognitive Level: Knowledge REF: 117
TOP: Nursing Process Step: Implementation
MSC: NCLEX Client Needs Category: Physiological Integrity

9. Which effect would be important for the nurse to address when teaching a patient about the overuse of nose drops?
   A. Rebound
   B. Ceiling
   C. Idiosyncratic
   D. Measured

ANS: A

	Feedback
A	Rebound effect may occur with overuse of some medications.
B	An idiosyncratic effect may occur even with prudent use of nose drops.
C	Ceiling effect is the greatest attainable response.
D	Measured effect is the patient’s response to the medication.

DIF: Cognitive Level: Application REF: 120
TOP: Nursing Process Step: Implementation
MSC: NCLEX Client Needs Category: Physiological Integrity

10. Which nursing assessment accurately describes the results of an intradermal skin test?
   A. Itching and weeping

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B. Erythema and induration
C. Swelling and coolness
D. Pallor and drainage

ANS: B

	Feedback
A	Itching is not relevant to the results; weeping should be reported to the health care provider but is not pertinent to the evaluation of the skin test.
B	The result should be measured by diameter of erythema in millimeters, and the induration should be palpated and measured in millimeters.
C	Swelling and coolness are not relevant to evaluation; reporting this to the health care provider is appropriate, but not pertinent to the evaluation of the skin test.
D	Pallor and drainage are not relevant to evaluation; reporting this to the health care provider is appropriate, but not pertinent to evaluation of the skin test.

DIF: Cognitive Level: Comprehension REF: 111
TOP: Nursing Process Step: Evaluation
MSC: NCLEX Client Needs Category: Physiological Integrity

11. The nurse is teaching a patient about nitroglycerin ointment. Which is an advantage of this form of the medication?
A. It does not give the patient a bad taste in the mouth.
B. The amount of ointment does not matter in obtaining a therapeutic response.
C. It does not cause headaches as an adverse effect.
D. It provides relief of anginal pain for several hours longer than sublingual medication.

ANS: D

	Feedback
A	Nitroglycerin pills do not have a bad taste.
B	Dosage is critical to the success of use.
C	All nitroglycerin preparations may cause headaches because of vasodilation.
D	Nitroglycerin ointment provides relief of anginal pain for several hours longer than sublingual preparations.

DIF: Cognitive Level: Comprehension REF: 112
TOP: Nursing Process Step: Implementation
MSC: NCLEX Client Needs Category: Physiological Integrity

12. A patient with metastatic cancer is being admitted for pain control. Which action will the nurse perform in administering a transdermal patch?
A. After removal, dispose of the old patch in a receptacle in the patient’s room.
B. Change the fentanyl patch every day, either in the morning or at bedtime.
C. Hold the short-acting oral pain medication when a fentanyl patch is initiated.
D. Label the patch with date, time, dosage, and initials after patch placement.

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ANS: D

	Feedback
A	Patches are to be disposed of in a receptacle on the medication cart, not in the patient's room.
B	Fentanyl patches are changed every 72 hours.
C	Fentanyl patches take up to 12 hours to be effective; therefore, short-acting pain medication is continued.
D	Labeling is appropriate when transdermal disks are placed.

DIF: Cognitive Level: Application REF: 114
TOP: Nursing Process Step: Implementation
MSC: NCLEX Client Needs Category: Physiological Integrity

13. What is the rationale for the nurse applying gentle pressure to the inner corner of the eyelid after instilling eye drops?
A. Decreases the risk of infection
B. Maintains intraocular pressure
C. Prevents systemic effects
D. Provides comfort to the patient

ANS: C

	Feedback
A	Application of pressure to the inner corner of the eye does not decrease infection.
B	Application of pressure to the inner corner of the eye does not maintain intraocular pressure.
C	Application of pressure to the inner corner of the eye prevents the medication from entering the canal, where it would be absorbed in the vascular mucosa of the nose and produce systemic effects.
D	Application of pressure to the inner corner of the eye does not promote patient comfort.

DIF: Cognitive Level: Application REF: 117
TOP: Nursing Process Step: Implementation
MSC: NCLEX Client Needs Category: Physiological Integrity

14. The nurse is instructing a patient to use a corticosteroid inhaler. Which statement by the patient indicates the need for further teaching?
A. "I will shake the inhaler before I use it."
B. "I need to rinse my mouth after I use the inhaler."
C. "I will use this when I'm lying in bed in the morning."
D. "After I inhale, I will hold my breath and then breathe out slowly."

ANS: C

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	Feedback
A	Shaking the inhaler helps to disperse the medication.
B	The mouth needs to be rinsed after the inhalation of a corticosteroid.
C	The sitting position allows for maximum lung expansion.
D	Holding the breath then exhaling slowly allows the drug to settle into pulmonary tissue.

DIF: Cognitive Level: Application REF: 121
TOP: Nursing Process Step: Implementation
MSC: NCLEX Client Needs Category: Physiological Integrity

15. Which is the appropriate nursing action when administering a vaginal suppository?
    A. Ask the patient to urinate prior to insertion.
    B. Assist the patient to a side-lying position.
    C. Keep suppository refrigerated prior to insertion.
    D. Insert the suppository 1 inch into the vagina.

    ANS: A

	Feedback
A	An empty bladder facilitates insertion.
B	This position would not facilitate insertion of a vaginal suppository.
C	Suppository needs to be warmed to room temperature before it is administered.
D	The suppository is inserted more than 1 inch.

DIF: Cognitive Level: Application REF: 123
TOP: Nursing Process Step: Implementation
MSC: NCLEX Client Needs Category: Physiological Integrity

16. Which is an accurate nursing action when treating a patient's rash with a lotion?
    A. Avoid shaking the container prior to application.
    B. Cleanse area with alcohol prior to treatment.
    C. Cover the area with gauze due to the oil base.
    D. Pat on the area with a gloved hand.

    ANS: D

	Feedback
A	Shake all lotions thoroughly immediately before application.
B	Lotions are aqueous and are easily cleansed with water.
C	Lotions are not oil based.
D	To prevent increased circulation and itching, lotions should be gently but firmly patted on the skin, rather than rubbed in.

DIF: Cognitive Level: Application REF: 108
TOP: Nursing Process Step: Implementation

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MSC: NCLEX Client Needs Category: Physiological Integrity

MULTIPLE RESPONSE

1. Which orders are examples of percutaneous medication administration? (Select all that apply.)
   A. Timolol 0.5% 1 drop to each eye daily
   B. Albuterol nebulizer 2.5 mg qid
   C. Heparin 5000 units IV
   D. Lasix 20 mg PO every AM
   E. Silvadene 1% topically to affected area

   ANS: A, B, E

	Feedback
Correct	Percutaneous administration refers to applying medications to the skin or mucous membranes for absorption, such as eye drops. Percutaneous administration refers to applying medications to the skin or mucous membranes for absorption, such as nebulized inhalation therapy. Percutaneous administration refers to applying medications to the skin.
Incorrect	Percutaneous administration refers to applying medications to the skin or mucous membranes for absorption, not intravenous medications. Percutaneous administration refers to applying medications to the skin or mucous membranes for absorption, not oral medications.

DIF: Cognitive Level: Application REF: 108
TOP: Nursing Process Step: Implementation
MSC: NCLEX Client Needs Category: Physiological Integrity

2. Which actions will the nurse perform when preparing to administer a topical medication? (Select all that apply.)
   A. Wash hands before and after administration.
   B. Maintain a dry environment to encourage wound healing.
   C. Wear gloves during the application process.
   D. Use sterile dressings for all wounds.

   ANS: A, C

	Feedback
Correct	Handwashing is an essential part of medication administration. Gloves are worn with topical medication to prevent absorption into the practitioner’s own skin.
Incorrect	Dryness does not encourage wound healing. Sterile dressings do not work well for all wounds.

DIF: Cognitive Level: Application REF: 109
TOP: Nursing Process Step: Implementation

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MSC: NCLEX Client Needs Category: Physiological Integrity

3. Which dressings would be appropriate to use for treating wounds with exudates?
   A. AlgiDERM
   B. Telfa
   C. Kaltostat
   D. Sorbsan
   E. OpSite

ANS: A, C, D

	Feedback
Correct	AlgiDERM is an exudate absorber for use in treating infected wounds. Kaltostat is an exudate absorber for use in treating infected wounds. Sorbsan is an exudate absorber for use in treating infected wounds.
Incorrect	Telfa is not appropriate to use on wounds with exudates. OpSite is not appropriate to use on wounds with exudates.

DIF: Cognitive Level: Knowledge REF: 108
TOP: Nursing Process Step: Implementation
MSC: NCLEX Client Needs Category: Physiological Integrity

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