SATA Task

What will this question apply to and what will your answer be?

Using just the answers to this SATA question, guess what the question will apply to. Then try to solve the problem.

SATA #1

1. The main value of informed consent is for protection against lawsuits.
2. Clients may withdraw consent after signing the consent form.
3. Clients must sign the informed consent form before receiving procedural medication.
4. Nurses witness the signing of the informed consent form to confirm that consent is voluntary.
5. The signed consent form serves as evidence that informed consent has taken place.

SATA #2

1. Assess the threat of violence toward another.
2. Identify the person being threatened.
3. Notify the identified victim.
4. Notify only law enforcement authorities to protect confidentiality.
5. Consider petitioning the court for continued commitment.

1) The hospice nurse has taught an in-home caregiver about comfort care for a client at the end of life. Which of the following statement would require follow up?

1. I have been applying petroleum jelly to keep the client's lips moist.
2. I have been offering healthy foods frequently to keep up the client's strength.
3. A blowing fan seems to be less anxiety-producing than an oxygen mask.
4. Sitting upright seems to reduce the client's noisy breathing more than lying down.

2) The nurse has taught a client scheduled for a PET scan in 24 hours. Which of the following statements made by client would require follow up?

1. "I should drink a lot of fluids after the procedure."
2. "I may have an invasive line inserted for the isotopic injection and another for ABG sampling."
3. "I will be able to drive home after the procedure and resume normal activities."
4. "My anxiety will not interfere with the test results."

3) The nurse is planning care for a client with Alzheimer's disease (AD.) Which of the following interventions should the nurse include in the client's plan of care?

1. Encourage the client to reminisce about happy memories.
2. Confront the client when inappropriate or agitated behaviors occur.
3. Administer to the client the prescribed cholinesterase to reverse the course of AD.
4. Provide the client with information about activity choices in the morning so the client can make plans for the day.

4) The nurse is conducting an initial interview with a 10-year-old boy who has been brought to the mental health clinic by his parents. The nurse can establish rapport and credibility with the child by asking the child which question?

1. "Do you have an idea of what you said or did that led your parents to bring you here today?"
2. "Can you tell me a little bit about some of your hobbies or other things that you like to do?"
3. "How do you think you get along with members of your family and friends?"
4. "Do you remember any medical problems or illnesses you had in the past?"

5) The nurse is setting up the breakfast tray for a client with gastroesophageal reflux disease (GERD) and notices one food that the client should not eat. Which food should the nurse remove from the meal tray?

1. Egg white omelet
2. Dry toast
3. Coffee with cream
4. Skim milk

6) A mother brings a 3-year-old child to the clinic for a well-child checkup. The child has not been to the clinic since 6 months of age. The nurse determines that which activity is the priority of care for this child?

1. Assess growth and development.
2. Begin dental care.
3. Complete hearing screening.
4. Update vaccinations.

7) A nursing student states to the instructor, "I'm afraid of mentally ill clients. They are all violent." Which statement would the instructor use to clarify this perception for the student?

1. "Even though mentally ill clients are often violent, there are ways to de-escalate these behaviors."
2. "A very few clients with mental illness exhibit violent behaviors."
3. "There are medications that can be given to clients to avoid violent behaviors."
4. "Only paranoid clients exhibit violent behaviors."

8) A client has been placed in seclusion because the client has been deemed a danger to others. Which is the priority nursing intervention for this client?

1. Have little contact with the client to decrease stimulation.
2. Provide the client with privacy to maintain confidentiality.
3. Maintain contact with the client and assure the client that seclusion is a way to maintain the client's safety.
4. Teach the client relaxation techniques and effective coping strategies to deal with anger.

9) The nurse on an in-patient psychiatric unit documents the following in a client's chart: "Seems to have no regard for legal or ethical standards. A problem client who needs constant limit-setting." Which response by the nurse manager reflects the potential liability related to this charting entry?

1. "Documenting this breeches the client's right to confidentiality."
2. "Documenting this puts you at risk for malpractice."
3. "Documenting this puts you at risk for defamation of character."
4. "Documenting this breeches the client's right to informed consent."

10) A nursing student uses a client's full name on an interpersonal process recording submitted to the student's instructor. What is the instructor's priority intervention?

1. Reinforce the importance of accurate documentation, including the client's name.
2. Correct and remind the student of the importance of maintaining client confidentiality.
3. Tell the student that because the client has been deemed incompetent, confidentiality is not an issue.
4. Tell the student that because the client is involuntarily committed, confidentiality is not an issue.

11) An unconscious client is admitted to the emergency department with a self-inflicted gunshot wound to the head. Family members state that they know of the existence of a living will in which the client insists that life support not be implemented. What is the legal obligation of the health-care team?

1. Follow the family's wishes because of the family's knowledge of the living will.
2. Follow the directions given in the living will because of mandates by state law.
3. Follow the ethical concept of nonmaleficence and place the client on life support.
4. Follow the ethical concept of beneficence by implementing life-saving interventions.

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