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**Nursing**

# MEDSURG-BC

*ANCC Medical-Surgical Nursing Certification*

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### **Question: 1**

A patient is scheduled for a diagnostic test that requires fasting. Which nursing action is appropriate to ensure patient safety during the test?

- A. Administer the patient's regular medications as scheduled.
- B. Provide clear instructions about the fasting requirements.
- C. Encourage the patient to drink plenty of fluids before the test.
- D. Monitor vital signs every 30 minutes during the fasting period.

Answer: B

Explanation: To ensure patient safety during a diagnostic test that requires fasting, the nurse should provide clear instructions about the fasting requirements. This includes informing the patient about the duration of fasting, restrictions on food and drink, and any specific preparations or restrictions related to their medications. Clear instructions help prevent complications and ensure accurate test results.

### **Question: 2**

A patient with a recent diagnosis of major depressive disorder is at risk for suicide. Which nursing intervention would be the highest priority?

- A. Encouraging the patient to participate in group therapy sessions
- B. Monitoring the patient's vital signs regularly
- C. Initiating a safety plan and closely monitoring the patient's whereabouts
- D. Administering an antidepressant medication as prescribed

Answer: C

Explanation: The highest priority nursing intervention for a patient at risk for suicide is to initiate a safety plan and closely monitor the patient's whereabouts.

This is crucial to ensure the patient's immediate safety and prevent self-harm. While other interventions, such as group therapy, vital sign monitoring, and medication administration, may also be important aspects of the patient's care, addressing the immediate safety concerns takes precedence in this situation.

### **Question: 3**

A nurse is caring for multiple patients on a medical-surgical unit. Which nursing diagnosis should be prioritized for a patient with a postoperative wound drain?

- A. Risk for Infection related to surgical site
- B. Impaired Physical Mobility related to surgical procedure
- C. Acute Pain related to surgical incision
- D. Deficient Knowledge related to wound care

Answer: A

Explanation: The nursing diagnosis that should be prioritized for a patient with a postoperative wound drain is "Risk for Infection related to surgical site." This is because the presence of a wound drain creates a potential route for infection, and preventing infection is crucial in postoperative care. While other diagnoses, such as impaired physical mobility, acute pain, and deficient knowledge, are also important to address, the risk for infection takes priority due to its potential impact on the patient's overall recovery and well-being.

### **Question: 4**

A patient with a cognitive impairment is admitted to the medical-surgical unit. What is the nurse's priority when providing care for this patient?

- A. Promote independence in activities of daily living.
- B. Ensure a safe environment to prevent falls and injuries.

- C. Administer cognitive-enhancing medications as prescribed.
- D. Provide emotional support and social interaction.

Answer: B

Explanation: When caring for a patient with cognitive impairment, the nurse's priority is to ensure a safe environment to prevent falls and injuries. Cognitive impairments can affect a patient's judgment, orientation, and ability to perceive and respond to their surroundings. By creating a safe environment, the nurse reduces the risk of accidents and promotes the patient's well-being.

### Question: 5

A patient is prescribed multiple medications for various chronic conditions. The nurse recognizes the importance of assessing for potential medication interactions. Which action should the nurse take to minimize the risk of adverse drug interactions?

- A. Encourage the patient to consult with a pharmacist regarding potential interactions.
- B. Review the patient's medication list with the healthcare provider at each visit.
- C. Educate the patient about potential drug interactions and their symptoms.
- D. Monitor the patient's laboratory values for signs of adverse drug effects.

Answer: B

Explanation: To minimize the risk of adverse drug interactions in a patient taking multiple medications, the nurse should review the patient's medication list with the healthcare provider at each visit. This allows for a comprehensive assessment of potential interactions and provides an opportunity to make necessary adjustments to the medication regimen. While encouraging the patient to consult with a pharmacist, educating the patient about potential

interactions, and monitoring laboratory values are all important aspects of medication safety, reviewing the medication list with the healthcare provider ensures a collaborative approach to preventing and managing drug interactions.

### **Question: 6**

A nurse is providing patient teaching to a newly diagnosed diabetic patient. Which factor should the nurse prioritize when considering the patient's learning preferences?

- A. The patient's level of health literacy
- B. The patient's cultural background
- C. The patient's age and developmental stage
- D. The patient's previous experience with diabetes

Answer: C

Explanation: When considering a newly diagnosed diabetic patient's learning preferences, the nurse should prioritize the patient's age and developmental stage. Different age groups have varying learning styles and preferences, and tailoring the teaching approach to match the patient's developmental stage can enhance learning outcomes. While factors such as health literacy, cultural background, and previous experience with diabetes are also important to consider, the patient's age and developmental stage should be given priority in this situation.

### **Question: 7**

A patient with a history of heart failure is scheduled for a cardiac catheterization. Which nursing action is essential in preparing the patient for the procedure?

- A. Administering anticoagulant medications preoperatively



- B. Assessing the patient's allergies to contrast dye
- C. Providing preoperative teaching on the procedure and expected sensations
- D. Ensuring the patient has an empty bladder before the procedure

**Answer: B**

**Explanation:** When preparing a patient with a history of heart failure for a cardiac catheterization, it is essential for the nurse to assess the patient's allergies to contrast dye. Contrast dye is commonly used during cardiac catheterization procedures to enhance visualization of the blood vessels. Allergies to contrast dye can lead to severe allergic reactions, including anaphylaxis, so it is crucial to identify any allergies beforehand. Administering anticoagulant medications, providing preoperative teaching, and ensuring an empty bladder are important aspects of preparation but are not as essential as assessing for allergies to contrast dye.

### **Question: 8**

A patient is prescribed multiple medications for different health conditions. The nurse is concerned about potential drug interactions and adverse effects. What action should the nurse take?

- A. Consult with the pharmacist regarding potential interactions.
- B. Discontinue all the medications and notify the healthcare provider.
- C. Educate the patient about potential adverse effects and monitor closely.
- D. Administer the medications as prescribed and monitor for adverse effects.

**Answer: A**

**Explanation:** In a situation where a patient is prescribed multiple medications, and there is concern about potential drug interactions and adverse effects, the nurse should consult with the pharmacist regarding potential interactions. Pharmacists are experts in medication management and can provide valuable

information on potential interactions, contraindications, and adverse effects. Collaborating with the pharmacist ensures patient safety and helps prevent medication-related complications.

### **Question: 9**

When prioritizing nursing diagnoses for a patient, which principle should guide the nurse's decision-making?

- A. Address the most life-threatening conditions first.
- B. Focus on the patient's most significant medical diagnosis.
- C. Prioritize nursing diagnoses related to psychosocial needs.
- D. Give priority to nursing diagnoses identified by the healthcare provider.

Answer: A

Explanation: When prioritizing nursing diagnoses for a patient, the nurse should address the most life-threatening conditions first. This approach ensures that immediate and critical patient needs are addressed promptly. By prioritizing life-threatening conditions, the nurse can provide timely interventions to stabilize the patient's condition and prevent further deterioration.

### **Question: 10**

A patient with a chronic illness is being discharged from the hospital. When providing patient teaching, the nurse should consider:

- A. The patient's learning preferences and barriers.
- B. The nurse's personal teaching style and preferences.
- C. Using complex medical terminology to enhance understanding.
- D. Providing all teaching materials in written format only.

Answer: A

Explanation: When providing patient teaching to a patient with a chronic illness, the nurse should consider the patient's learning preferences and barriers. Each patient has unique learning needs and preferences.

### Question: 11

A patient with chronic pain is interested in exploring complementary and alternative medicine (CAM) for pain management. Which nursing action is appropriate in this situation?

- A. Educating the patient about potential risks and benefits of CAM therapies
- B. Discouraging the patient from pursuing CAM therapies due to lack of scientific evidence
- C. Referring the patient to a CAM practitioner without further assessment
- D. Collaborating with the patient to develop an individualized pain management plan

Answer: A

Explanation: In a situation where a patient with chronic pain is interested in exploring complementary and alternative medicine (CAM) for pain management, the appropriate nursing action is to educate the patient about potential risks and benefits of CAM therapies. This allows the patient to make informed decisions regarding their healthcare and promotes patient autonomy. While it is important to discuss the scientific evidence of CAM therapies, discouraging the patient without consideration of their preferences may not be the most effective approach. Referring the patient to a CAM practitioner without further assessment can bypass a comprehensive evaluation of the patient's needs. Collaborating with the patient to develop an individualized pain management plan incorporates their preferences and goals into the overall care



plan.

### **Question: 12**

A nurse is conducting a health promotion session for a group of adults. Which topic should the nurse prioritize to address the prevention of chronic diseases?

- A. The importance of regular physical activity and exercise
- B. Strategies for stress management and mental well-being
- C. Screening guidelines for early detection of common cancers
- D. Nutritional recommendations for maintaining a healthy weight

Answer: A

Explanation: When addressing the prevention of chronic diseases in a health promotion session, the nurse should prioritize the topic of the importance of regular physical activity and exercise. Regular physical activity has been shown to have numerous health benefits and is a key factor in preventing chronic diseases such as cardiovascular diseases, diabetes, and certain types of cancers. While strategies for stress management, cancer screening guidelines, and nutritional recommendations are also important, regular physical activity serves as a foundational aspect of chronic disease prevention.

### **Question: 13**

A nurse is implementing patient safety measures in a medical-surgical unit. Which action is an example of utilizing a screening tool for fall risk assessment?

- A. Providing regular toileting and bathroom assistance to patients
- B. Placing nonslip mats on the floors in patient rooms and bathrooms
- C. Conducting hourly rounding to check on patients' safety and comfort

D. Administering a standardized fall risk assessment tool to all patients

Answer: D

Explanation: Utilizing a screening tool for fall risk assessment involves administering a standardized fall risk assessment tool to all patients. This tool helps to systematically identify patients who are at a higher risk of falling, allowing nurses to implement appropriate interventions and safety measures. While providing toileting assistance, using nonslip mats, and conducting hourly rounding are all important fall prevention strategies, they do not specifically involve the use of a screening tool for assessment.

**Question: 14**

A patient is recovering from surgery and is at risk for developing complications such as deep vein thrombosis (DVT). What nursing intervention is important for preventing DVT in this patient?

- A. Administering anticoagulant medications as prescribed.
- B. Applying warm compresses to the affected area.
- C. Assisting with early ambulation and leg exercises.
- D. Using sequential compression devices on the lower extremities.

Answer: D

Explanation: To prevent deep vein thrombosis (DVT) in a postoperative patient, an important nursing intervention is to use sequential compression devices (SCDs) on the lower extremities. SCDs help prevent DVT by promoting venous blood flow and preventing stasis. They provide intermittent compression to the legs, mimicking the natural pumping action of the calf muscles. This intervention is especially beneficial for patients who are immobile or have limited mobility.

### Question: 15

A patient is scheduled for a surgical procedure. Which nursing intervention is important for preventing postoperative complications?

- A. Administering preoperative antibiotics as prescribed.
- B. Encouraging deep breathing and coughing exercises.
- C. Applying cold compresses to reduce swelling.
- D. Assisting with early ambulation after surgery.

Answer: B

Explanation: To prevent postoperative complications, encouraging deep breathing and coughing exercises is an important nursing intervention. Deep breathing and coughing exercises help prevent respiratory complications such as atelectasis and pneumonia by promoting lung expansion, clearing secretions, and improving oxygenation. It also aids in preventing postoperative respiratory complications related to anesthesia and immobility.

### Question: 16

A patient with a traumatic brain injury is experiencing cognitive deficits. Which nursing action is appropriate for promoting cognitive stimulation?

- A. Encouraging physical exercise to improve overall brain function
- B. Providing a quiet and low-stimulus environment to reduce cognitive overload
- C. Engaging the patient in mentally challenging activities and puzzles
- D. Administering cognitive-enhancing medications as prescribed

Answer: C

Explanation: To promote cognitive stimulation in a patient with cognitive

deficits, the nurse should engage the patient in mentally challenging activities and puzzles. This helps to activate and exercise cognitive skills, promoting cognitive improvement and recovery. While physical exercise is beneficial for overall brain health, it may not directly address cognitive deficits. Providing a quiet environment and administering cognitive-enhancing medications may be appropriate in certain situations, but engaging the patient in mentally challenging activities is specifically aimed at promoting cognitive stimulation.

### **Question: 17**

During a psychosocial assessment, the nurse identifies that a patient has a history of substance use disorder. Which action should the nurse prioritize in the patient's plan of care?

- A. Implement a safety plan to prevent relapse.
- B. Provide education on the risks of substance use.
- C. Encourage participation in support groups or counseling.
- D. Assess the patient's readiness for change.

Answer: D

Explanation: When a patient has a history of substance use disorder, assessing the patient's readiness for change should be prioritized in the plan of care. Understanding the patient's motivation and readiness to address the substance use disorder is crucial for developing an effective care plan. It allows the nurse to tailor interventions and support based on the patient's individual needs and stage of change.

### **Question: 18**

A patient with a history of deep vein thrombosis (DVT) is at risk for developing postoperative complications. Which nursing intervention is most effective in preventing postoperative DVT?

- A. Administering prophylactic anticoagulant medication as prescribed
- B. Applying sequential compression devices (SCDs) to the patient's lower extremities
- C. Encouraging early ambulation and leg exercises postoperatively
- D. Educating the patient on the signs and symptoms of DVT

Answer: A

Explanation: The most effective nursing intervention in preventing postoperative deep vein thrombosis (DVT) is administering prophylactic anticoagulant medication as prescribed. Anticoagulant medications help to prevent blood clots from forming, reducing the risk of DVT. While applying sequential compression devices (SCDs), encouraging early ambulation and leg exercises, and educating the patient on DVT signs and symptoms are also important interventions, medication administration plays a key role in preventing DVT formation.





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