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## Question: 1

Which of the following best defines a "just culture" in the context of patient safety?

- A. A culture that emphasizes punishment and blame for errors.
- B. A culture that focuses on individual accountability and disciplinary action.
- C. A culture that promotes open communication, learning, and system improvement.
- D. A culture that prioritizes patient satisfaction and positive outcomes.

Answer: C

Explanation: A "just culture" in the context of patient safety refers to a culture that promotes open communication, learning, and system improvement. It recognizes that errors are often the result of systemic failures rather than individual negligence or misconduct. A just culture encourages healthcare professionals to report errors and near misses without fear of punishment, fostering a climate of transparency and accountability. Options A and B describe punitive cultures that hinder reporting and learning from errors. Option D focuses on patient satisfaction and outcomes but does not capture the essence of a just culture. Therefore, option C is the best definition of a "just culture" in patient safety.

## Question: 2

A patient is prescribed multiple medications to manage their chronic conditions. When providing medication education, which of the following strategies should the nurse employ to promote patient safety?

- A. Presenting all the medication information at once to ensure comprehensive understanding.

- B. Using plain language and avoiding complex medical terminology.
- C. Providing written materials without verbal explanations.
- D. Focusing solely on the medication's benefits and not discussing potential side effects.

**Answer: B**

**Explanation:** When providing medication education to a patient taking multiple medications, the nurse should employ the strategy of using plain language and avoiding complex medical terminology to promote patient safety. Using simple and understandable language helps ensure comprehension and reduces the risk of medication errors or misunderstandings. Presenting all medication information at once (option A) may overwhelm the patient and hinder their ability to retain important details. Providing written materials without verbal explanations (option C) may not be sufficient for addressing the patient's questions or clarifying any concerns. Focusing solely on the medication's benefits (option D) neglects the importance of discussing potential side effects, which is crucial for patient safety and informed decision-making. Therefore, option B is the most effective strategy for promoting patient safety during medication education.

### **Question: 3**

Which of the following is an example of a care bundle used to prevent healthcare-associated infections?

- A. Hand hygiene compliance checklist
- B. Medication reconciliation algorithm
- C. Fall risk assessment tool
- D. Pain assessment scale

**Answer: A**

Explanation: A care bundle refers to a set of evidence-based practices implemented together to improve patient outcomes. One example of a care bundle used to prevent healthcare-associated infections is a hand hygiene compliance checklist. This checklist includes specific steps and guidelines for proper hand hygiene, such as handwashing with soap and water or using alcohol-based hand sanitizers. By implementing a care bundle, healthcare providers can ensure consistent adherence to infection prevention practices and reduce the risk of healthcare-associated infections. Medication reconciliation algorithms, fall risk assessment tools, and pain assessment scales are not specific to preventing healthcare-associated infections.

**Question: 4**

Which of the following best describes the concept of "near miss reporting" in patient safety culture?

- A. Reporting incidents that result in patient harm.
- B. Reporting errors that were caught before reaching the patient.
- C. Reporting incidents of negligence or misconduct.
- D. Reporting incidents that occurred due to system failures.

Answer: B

Explanation: "Near miss reporting" in patient safety culture refers to reporting errors that were caught before reaching the patient. It involves identifying and reporting situations where an error or potential harm occurred but did not result in actual harm to the patient. Near miss reporting is crucial for identifying vulnerabilities in the healthcare system, analyzing the root causes of errors, and implementing preventive measures to improve patient safety. Reporting incidents that result in patient harm (option A) is important but falls under the category of adverse event reporting. Reporting incidents of negligence or misconduct (option C) is related to reporting professional misconduct and is not specific to near misses. Reporting incidents that occurred due to system failures



(option D) is a broader concept that encompasses near misses as well as adverse events resulting from system deficiencies. However, option B specifically captures the essence of near miss reporting by focusing on errors caught before reaching the patient.

### **Question: 5**

Which of the following patients is at the highest risk for medication errors?

- A. A 45-year-old patient with a single chronic illness.
- B. An 80-year-old patient taking multiple medications for various chronic conditions.
- C. A 30-year-old patient admitted for an acute illness.
- D. A 60-year-old patient with a history of medication compliance.

Answer: B

Explanation: The 80-year-old patient taking multiple medications for various chronic conditions is at the highest risk for medication errors. Polypharmacy, which refers to the use of multiple medications, increases the complexity of medication management and the likelihood of errors. Older adults are particularly vulnerable due to age-related physiological changes, multiple comorbidities, and potential cognitive impairment. The 45-year-old patient with a single chronic illness (option A) may have some risks, but the complexity of medication management is lower than that of the 80-year-old patient. The 30-year-old patient admitted for an acute illness (option C) may have fewer medications and a shorter duration of treatment, reducing the risk of errors. The 60-year-old patient with a history of medication compliance (option D) suggests a good track record but does not provide information about the complexity or number of medications. Therefore, option B represents the highest-risk scenario for medication errors.

### Question: 6

A patient who has undergone major abdominal surgery is at risk for postoperative complications. Which of the following nursing interventions should be prioritized to promote patient safety in this situation?

- A. Encouraging early ambulation to prevent deep vein thrombosis.
- B. Administering pain medication as ordered to promote comfort.
- C. Providing nutritional support to enhance wound healing.
- D. Assisting with early mobilization to prevent respiratory complications.

Answer: D

Explanation: After major abdominal surgery, one of the primary nursing interventions to promote patient safety is assisting with early mobilization to prevent respiratory complications. Early mobilization helps prevent the development of atelectasis and pneumonia by improving lung ventilation and preventing pooling of respiratory secretions. Encouraging early ambulation (option A) is important to prevent deep vein thrombosis, but respiratory complications should be addressed first. Administering pain medication (option B) is essential for promoting comfort, but it does not directly address postoperative complications. Providing nutritional support (option C) is important for wound healing, but it is not the highest priority in this situation. Therefore, option D is the most appropriate nursing intervention for promoting patient safety after major abdominal surgery.

### Question: 7

A nurse suspects that a patient may be a victim of human trafficking. What action should the nurse take?

- A. Notify the appropriate authorities or social services.
- B. Document the suspicion in the patient's medical record.

- C. Confront the patient about the suspicion.
- D. Discuss the situation with the nursing supervisor.

Answer: A

Explanation: If a nurse suspects that a patient may be a victim of human trafficking, the appropriate action is to notify the appropriate authorities or social services. Human trafficking is a serious crime and a violation of human rights. Nurses have a responsibility to advocate for the safety and well-being of their patients. By reporting suspicions to the appropriate authorities, such as law enforcement or social services, healthcare providers can ensure that the patient receives the necessary support and intervention. While documenting the suspicion in the patient's medical record and discussing the situation with the nursing supervisor are important actions, notifying the appropriate authorities should be the priority when human trafficking is suspected.

### Question: 8

A patient admitted to the medical-surgical unit has a history of falls. Which intervention should the nurse prioritize to ensure patient safety?

- A. Implement a bed alarm system.
- B. Place the patient in a room close to the nursing station.
- C. Provide the patient with a walker for mobility.
- D. Conduct fall risk assessments every shift.

Answer: A

Explanation: Implementing a bed alarm system is a priority intervention to ensure patient safety in this case. Bed alarms are effective tools for monitoring and preventing falls in patients at high risk. When the patient attempts to get out of bed unassisted, the alarm will alert the nursing staff, allowing for a timely response to prevent falls. While placing the patient in a room close to

the nursing station, providing a walker, and conducting fall risk assessments are important measures to address falls, implementing a bed alarm system directly addresses the immediate risk of falls and promotes patient safety.

### Question: 9

The following day, the patient complains of left-sided neck pain. The nurse observes swelling of the patient's left arm. The physician is notified and an internal jugular and subclavian vein thrombosis is diagnosed. The central line is removed, and a heparin infusion is initiated using a peripheral line. The patient's orders include warfarin sodium (Coumadin) 5 mg PO daily.

At what time will the patient's heparin be discontinued?

- A. When the patient's INR is within the therapeutic range.
- B. When the patient's platelets are greater than 150,000 mm<sup>3</sup>.
- C. When the patient's PTT level is subtherapeutic.
- D. When the patient's hematocrit is 35%.

Answer: A

Explanation: Heparin therapy is typically overlapped with warfarin therapy until the INR (International Normalized Ratio) is within the therapeutic range (usually 2-3 for most indications). The INR indicates the patient's clotting ability and helps monitor the effectiveness of warfarin therapy. Once the INR is within the therapeutic range, it is safe to discontinue heparin therapy, as the patient's anticoagulation needs are being adequately managed by warfarin alone. Platelet count, PTT (Partial Thromboplastin Time), and hematocrit levels are not directly related to the discontinuation of heparin therapy in this scenario.

### Question: 10



A patient with an advanced access device, such as a port or central line, requires nursing care to ensure patient safety. Which of the following actions should the nurse prioritize?

- A. Performing frequent dressing changes to maintain sterile technique.
- B. Assessing for signs of infection and complications regularly.
- C. Administering medications through the device without additional precautions.
- D. Using the access device for blood draws to minimize patient discomfort.

Answer: B

Explanation: When caring for a patient with an advanced access device, such as a port or central line, the nurse should prioritize assessing for signs of infection and complications regularly to ensure patient safety. Advanced access devices pose an increased risk of infection and other complications, including catheter-related bloodstream infections. Therefore, vigilant assessment for signs of infection, such as redness, swelling, warmth, or drainage at the insertion site, is crucial. Performing frequent dressing changes (option A) is important to maintain sterile technique and prevent infection, but it is not the highest priority compared to ongoing assessment. Administering medications through the device without additional precautions (option C) is incorrect as it is essential to follow strict aseptic technique and proper medication administration protocols. Using the access device for blood draws (option D) is not recommended, as it increases the risk of infection and may compromise the device's function. Thus, option B is the most appropriate action to prioritize for patient safety in this scenario.

### Question: 11

Which of the following is an example of a safe medication administration practice?

- A. Checking the patient's identification before administering a medication.
- B. Administering a medication without verifying the dosage.
- C. Crushing a medication that is labeled "do not crush."
- D. Administering a medication without assessing the patient's allergies.

Answer: A

Explanation: Checking the patient's identification before administering a medication is an example of a safe medication administration practice. Patient identification is crucial to ensure that the right medication is given to the right patient. Verifying the patient's identity using two patient identifiers, such as name and date of birth, helps prevent medication errors and promotes patient safety. Administering a medication without verifying the dosage, crushing a medication labeled "do not crush," and administering a medication without assessing the patient's allergies are all unsafe practices that can lead to medication errors and adverse drug reactions.

### Question: 12

Which method is commonly used to assess and address patient safety risks in healthcare organizations?

- A. Root Cause Analysis (RCA)
- B. Failure Mode and Effects Analysis (FMEA)
- C. Safety rounds conducted by senior leaders
- D. Safety huddles among frontline staff

Answer: B

Explanation: Failure Mode and Effects Analysis (FMEA) is a commonly used method to assess and address patient safety risks in healthcare organizations. FMEA is a systematic approach that identifies potential failures or hazards in a

process, determines their possible effects, and prioritizes actions to address them based on their severity and likelihood of occurrence. It helps healthcare organizations proactively identify and mitigate risks before they lead to patient harm. While Root Cause Analysis (RCA) is another method used to investigate and learn from adverse events, FMEA focuses on proactive risk assessment. Safety rounds conducted by senior leaders and safety huddles among frontline staff are important components of a patient safety culture, but they are not specific methods for assessing and addressing patient safety risks like RCA and FMEA.

### **Question: 13**

Which of the following risk factors is most likely to contribute to the development of pressure ulcers in a patient?

- A. Advanced age
- B. Frequent repositioning
- C. Adequate nutrition
- D. Healthy skin integrity

Answer: A

Explanation: Advanced age is a significant risk factor for the development of pressure ulcers. As individuals age, their skin becomes thinner and more susceptible to damage, and the ability to perceive pressure and discomfort may be diminished. Additionally, older adults often have underlying health conditions that further increase their vulnerability to pressure ulcers. While frequent repositioning, adequate nutrition, and healthy skin integrity are important preventative measures for pressure ulcers, advanced age remains a primary risk factor that needs to be addressed and managed to prevent the development of pressure ulcers.

### **Question: 14**

Which of the following best describes the concept of a "just culture" in relation to patient safety?

- A. A blame-free environment that encourages open reporting of errors and near misses.
- B. A system of strict rules and regulations to prevent errors and adverse events.
- C. A culture of individual accountability and punishment for errors.
- D. A focus on financial incentives and reimbursement related to patient safety outcomes.

Answer: A

Explanation: A "just culture" refers to a blame-free environment that encourages open reporting of errors and near misses. It recognizes that errors are often the result of system failures rather than individual negligence, and it promotes learning and improvement rather than punishment. In a just culture, healthcare organizations prioritize understanding the root causes of errors, implementing system-level changes to prevent recurrence, and fostering a culture of transparency and shared learning. Strict rules and regulations, individual accountability and punishment, and financial incentives are not central tenets of a just culture.

### Question: 15

A patient with a history of falls is admitted to the medical-surgical unit. Which of the following interventions should the nurse prioritize to enhance patient safety?

- A. Keeping the patient's bed in the lowest position.
- B. Using a bed alarm to alert staff when the patient attempts to get out of bed.
- C. Placing the patient's personal items within easy reach.
- D. Assigning a sitter to provide constant supervision.

Answer: D

Explanation: Assigning a sitter to provide constant supervision is the most appropriate intervention to enhance patient safety in a patient with a history of falls. A sitter can closely monitor the patient's movements, assist with mobility, and provide immediate assistance if the patient attempts to get out of bed or exhibits any signs of instability. Keeping the patient's bed in the lowest position (option A) is a standard safety measure but may not provide adequate prevention for a patient at high risk for falls. Using a bed alarm (option B) is helpful, but it may not be sufficient to prevent falls if the patient is particularly determined or agile. Placing personal items within easy reach (option C) is a good practice to promote independence and reduce fall risks, but it may not provide continuous supervision. Therefore, option D is the most effective intervention in this situation.





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