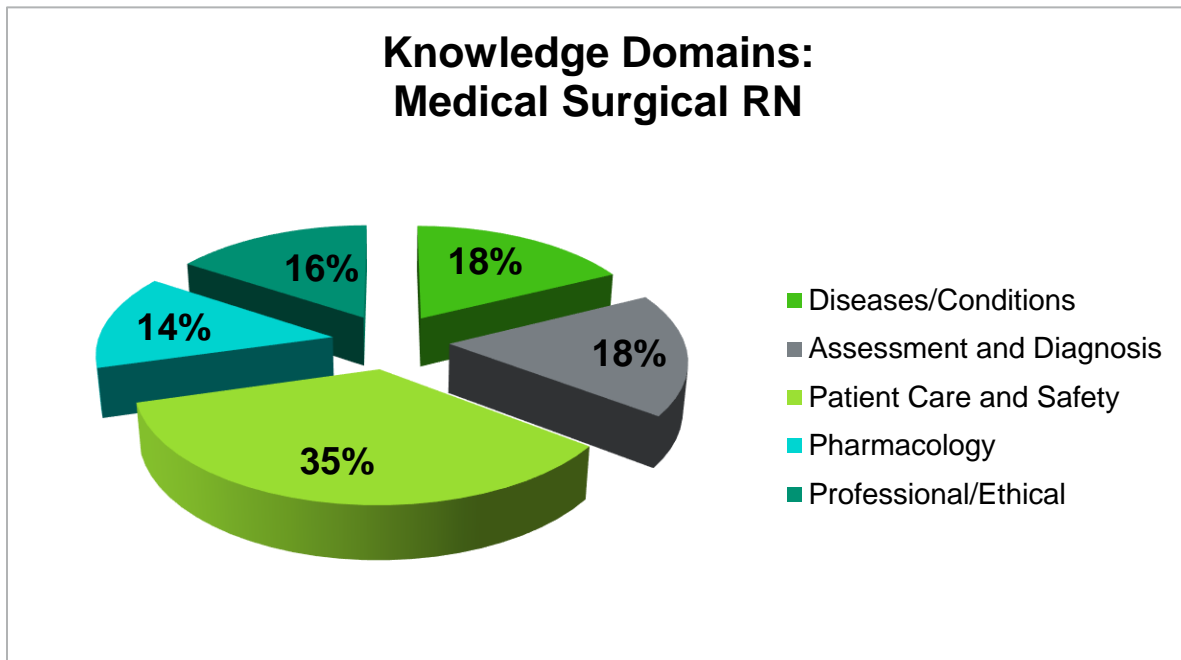


Medical Surgical RN Assessment Content Outline

Exam Objective

To measure the overall clinical knowledge of the RN working in the medical surgical setting.

Knowledge Domains



Each question in this assessment is categorized by a cognitive level that the test taker would use to respond. These categories are:

Recall: The ability to recall or recognize specific information.

Application: The ability to comprehend, relate, or apply knowledge to new or changing situations.

Analysis: The ability to analyze and synthesize information, determine solutions, and/or evaluate the usefulness of a solution.

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Content Outline

I. Diseases/Conditions

- a. Knowledge of cardiovascular disease processes commonly seen in the med/surg setting, including but not limited to heart failure, pericarditis, valve disorders, MI, cardiomyopathy, etc., and the interventions used to treat such issues and how to assess their effectiveness.
- b. Knowledge of pulmonary disease processes commonly seen in the med/surg setting, including but not limited to COPD, pneumonia, asthma, PE, TB, bronchitis, emphysema, lung cancer, etc., and the interventions used to treat such issues and assess their effectiveness.
- c. Knowledge of neurological disease processes commonly seen in the med/surg setting, including but not limited to CVA, traumatic brain injury, TIA, Parkinson's disease, seizures, etc., and the interventions used to treat such issues and how to assess their effectiveness.
- d. Knowledge of gastrointestinal disease processes commonly seen in the med/surg setting, including but not limited to small bowel obstruction, GI bleed, appendicitis, gastroenteritis, liver disease, pancreatitis etc., the interventions used to treat such conditions, and how to assess their effectiveness.
- e. Knowledge of musculoskeletal disease processes and conditions commonly seen in the med/surg setting, including but not limited to rheumatoid arthritis, joint replacements, tendonitis, fibromyalgia, etc., the interventions used to treat such conditions, and how to assess their effectiveness.
- f. Knowledge of endocrine disease processes commonly seen in the med/surg setting, including but not limited to diabetes, thyroid disease, adrenal insufficiency, etc., the interventions used to treat such conditions, and how to assess their effectiveness.
- g. Knowledge of genitourinary disease processes commonly seen in the med/surg setting, including but not limited to renal calculi, UTI, glomerulonephritis, acute/chronic kidney disease, etc., the interventions used to treat such conditions, and how to assess their effectiveness.
- h. Knowledge of assessment of adequate oxygenation, including but not limited to, evaluating response, assessing capillary refill, skin color, respiratory effort and rate for signs of hypoxia; titrates oxygen in coordination with respiratory therapy based on patients' respiratory needs; monitors patient for CO₂ retention; assesses for potential skin breakdown related to oxygen delivery devices.
- i. Knowledge of wound care management based on type of wound (e.g., surgical, pressure, venous/arterial insufficiency), including but not limited to assessment (e.g., infection, size, color, intact), prevention (e.g., pressure relief, ointments, reduction of friction/wetness), treatment (e.g., debridement, topicals, dressing changes), documentation, and consulting specialist or provider when warranted.

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II. Assessment and Diagnosis

- a. Knowledge of obtaining personal and family history information needed to best inform the development of a comprehensive plan of care, including but not limited to current medical complaints/concerns; sensory, mobility, and functional status; diagnoses; past medical and surgical experiences; allergies, vaccinations, medications (including supplements, herbals, and OTC meds), and presence of advance directive.
- b. Knowledge of how to assess for nutritional intake problems for at-risk patients, including but not limited to, those with tube-feeding, TPN, lipids, altered GI status, or other problems that warrant the need for consultation with a dietitian, and when to initiate such referrals.
- c. Knowledge of normal and abnormal vital sign values, including blood pressure, pulse, respirations, and temperature while considering age, medical condition, pharmacology, etc., and interventions to treat.
- d. Knowledge of techniques and tools for assessing pain including, but not limited to, physical assessment (e.g., respiratory status, behavior, blood pressure), interviews (e.g., location, type, onset, radiation, and intensity) and pain scales (e.g., numeric pain scales, Wong-Baker faces scale, PAINAD) for the cognitively or language impaired patient.
- e. Knowledge of behavioral and physical signs and symptoms associated with pain, including, but not limited to grimacing, moaning, groaning, crying, restlessness, agitation, guarding, labored breathing, disrupted sleep patterns, increased respiratory rate, and increased blood pressure.
- f. Knowledge of normal and abnormal results of diagnostic tests, common protocols in treatment, and when to report critical values to the provider including but not limited to those in laboratory (e.g., hematology, chemistry, microbiology, pathology), radiology (e.g., X-ray, CT, MRI, US, nuclear medicine), cardiac diagnostics (e.g., ECG, echo, stress tests).
- g. Knowledge of techniques for formulating an effective and holistic nursing plan of care including but not limited to, how to initiate, maintain, and revise the plan of care, address diverse patient preferences based on physical assessment findings, patient history, and include input from the patient and family (shared decision making), and cultural and religious preferences.
- h. Knowledge of techniques for assessing patient and family educational needs for achieving health goals, including but not limited to, disease processes, medications, therapies, procedures, safety and preventive measures, nutrition, lifestyle, healthy coping mechanisms, and comfort options.
- i. Knowledge of patient signs that indicate a need for basic life support per BLS guidelines (e.g., American Heart Association) and techniques and algorithms used (e.g., pulse check, chest compressions, ventilation, one-way valve mask, use of AED, Heimlich maneuver).

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III. Patient Care and Safety

- a. Knowledge of common nursing interventions used to treat abnormal assessment findings, including but not limited to raising the head of bed during periods of dyspnea or increased intracranial pressure (ICP), elevating lower extremities when edema is present, encouraging ambulation, utilizing therapeutic communication techniques to encourage patient verbalization of feelings, etc.
- b. Knowledge of resources and interventions when a patient experiences a change in condition, including but not limited to consulting clinicians, rapid response teams, initiating standing orders (e.g., chest pain protocol, apply oxygen), stroke alert, and emergency codes.
- c. Knowledge of non-pharmacologic modalities for managing pain, including but not limited to, heat therapy, repositioning, environmental modifications, and relaxation techniques.
- d. Knowledge of patient identifiers and the type of information used to verify identity prior to each procedure, medication administration, etc., including how to verify in populations who are non-verbal or cognitively impaired.
- e. Knowledge of the medication reconciliation process and when to perform (e.g., admission, discharge, transfer).
- f. Knowledge of how to determine timed and timed intervals, including the ability to calculate start and stop times, and the ability to tell ordinary and military time.
- g. Knowledge of various oxygen therapy delivery devices, including indications for therapy, safety precautions, expected outcomes, conditions needing titration or adjustments, interpretation of respiratory data (O₂ sat, ABG), interventions such as cough and deep breathing exercises and use of incentive spirometry, as well as other considerations for device selection (e.g. nasal cannula, mask, non-rebreather, CPAP, etc.).
- h. Knowledge of peripheral IV management, including but not limited to proper insertion technique, complications and treatment (e.g., erythema, infiltration, leaking, tenderness, infection), site rotation, maintenance and care, tubing changes, common IV solutions including high risk or contraindicated (vesicants, TPN), etc.
- i. Knowledge of various central venous catheter types (e.g., PICC, temporary, implanted, dialysis), including but not limited to characteristics, indications for device, maintenance and care (e.g., flushing techniques) dressing (e.g., chlorhexidine , sterile dressing changes), complications (e.g., infection, thrombosis), tubing changes, accessing/discontinuing, and safety (e.g., avoid BPs near PICC).
- j. Knowledge of indication, procedure, documentation for point of care testing commonly performed in the med/sure setting such as capillary glucose, O₂ saturation, urinalysis for ketones, bladder scans, occult blood, pH test, etc.
- k. Knowledge of specimen collection, including technique in how to collect, handle, label, and transport specimens using appropriate methods and containers including but not limited to blood, urine, sputum, stool, wounds, etc.
- l. Knowledge of actual and potential safety issues and precautions related to patient care, including knowledge of how to implement nursing interventions related to each issue, including but not limited to fall preventions, bleeding precautions, aspiration precautions, seizure precautions, medication administration, suicide precautions, elopement precautions, hospital- acquired conditions (e.g., pressure injury, C-diff, CAUTI, CLABSI,

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SSI).

- m. Knowledge of principles and implementation of infection control including but not limited to personal protective equipment, hand hygiene protocol, isolation precautions such as standard, droplet, contact, airborne, and which PPE is indicated for each, etc. Includes knowledge on interventions used to decrease the risk of spread of infection and communicable diseases.
- n. Knowledge of how to safely and effectively operate, troubleshoot, and locate resources for equipment common in med/surg, including but not limited to IV pumps, PCA pumps, suction, oxygen, pulse oximeters, incentive spirometers, feeding pumps, intermittent pneumatic compression, drainage systems, glucometers, urinary catheters, ostomy equipment, dressing change materials, bladder scanners, non-invasive blood pressure cuffs, remote cardiac monitors, specialty beds, patient transfer devices.
- o. Knowledge of pre-op checklists and patient prep for procedures and/or diagnostic tests, including but not limited to educating the patient, obstructive sleep apnea risk screening, anti-microbial bath, diet/NPO, confirmation of allergies, IV gauge size for procedures, enemas, hair removal, medications to be given/held, prophylactic VTE equipment, screen for metal prior to MRI.
- p. Knowledge of assistive nursing interventions during bedside procedures (e.g., lumbar punctures, paracentesis, central line insertion, wound debridement, tube removal) to facilitate optimal patient comfort and outcomes.
- q. Knowledge of evidence-based techniques for planning and delivering education based on patient learning styles (e.g., written materials, demonstration, auditory), preferences (e.g., language, time of day/week, presence of family members or caregivers), and needs (e.g., avoiding use of medical language and jargon, hearing and vision assistive devices, moderating educational level). Knowledge of teach-back techniques to deliver and assess patient and family understanding of information provided on various health-related topics.
- r. Knowledge of palliative and end-of-life care nursing interventions, including but not limited to, management of symptoms, emotional support, educating families on dying process/expectations, multidisciplinary resources including chaplains and other spiritual needs.

IV. Pharmacology

- a. Knowledge of various medications and their attributes commonly administered in the Med-Surg unit, including classification, indications and actions, side effects, adverse reactions, and when they are contraindicated.
- b. Knowledge of medication administration, including safe administration principles (right patient, right drug, right dose, right time, right route right reason, and right documentation), various routes and locations (oral, topical, intradermal, IM, IV, SQ, GT, etc.), documentation requirements, evaluation of effectiveness, disposal protocols, etc.
- c. Knowledge of how to prepare medication according to drug and patient needs, including but not limited to dilution, syringe/needle type, compatibility, appropriateness of crushing or splitting.

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- d. Ability to perform basic mathematical calculations such as addition, subtraction, multiplication, and division, in order to calculate measurements, time intervals, heart rates, etc. WITH and/or WITHOUT the use of a calculator. Includes ability to use a variety of formulas in order to ensure correct dosage, IV drip rates, IV flow rates, etc.
- e. Knowledge on retrieving, administering, documenting, wasting, reconciliation, and reporting according to policies.
- f. Knowledge of administering blood products according to policy, including but not limited to identifying orders, obtaining consent, selecting and preparing equipment based on product, monitoring and assessing the patient's response during and after transfusion, infection control, and identifying adverse reactions and implementing interventions if needed.
- g. Knowledge of components of effective patient handoffs of care and best practices for performing written and verbal handoffs across the continuum of care (e.g., next shift, critical care, OR, radiology, extended care facility) using techniques such as SBAR to assist in coordination of care and maintain patient safety.

V. Professional/Ethical

- a. Knowledge of provider orders, including but not limited to how to receive and/or translate provider's orders in the medical record, verbal orders, telephone orders, verifying correct transcription, and the read-back process. Includes the knowledge of evaluating provider order appropriateness based on evidence-based practice, when to contact the provider for order clarification, and using the chain of command if necessary.
- b. Knowledge of risk factors and signs and symptoms associated with suspected abuse and/or neglect and reporting to the appropriate authorities according to organizational policy.
- c. Knowledge of regulatory standards published by federal and/or state agencies and accrediting bodies such as Joint Commission, CDC, and HIPAA, and how to apply and abide by them in the clinical setting.
- d. Knowledge of the roles of other disciplines on the healthcare team and when to communicate with them, including but not limited to physicians, case managers, pharmacists, pain specialist, RT, PT, OT, SLP, wound care clinicians, social workers, dietitians, and spiritual counselors or ministers. This includes identifying information to report to ensure continuity across disciplines and provide coordinated care to maximize patient outcomes and satisfaction.
- e. Knowledge of required areas and expectations to document in the medical record, including but not limited to assessments, interventions, medications, communication to clinicians/patients/families, plans of care, while using approved abbreviations and standard terminology.
- f. Knowledge of the nursing scope of practice, including but not limited to, activities performed, delegation of tasks to licensed and unlicensed personnel, competency, floating to other departments, and issues that require reporting to the state Board of Nursing.
- g. Knowledge of policies of when and how to report unexpected events, including but not limited to medication errors, adverse events, patient falls, error/delay/inappropriate

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treatment/order, equipment failure/malfunction, patient/family/visitor/staff violence, patient/employee safety issue, or any sentinel event. Report of an event within timely manner using channels such as occurrence reports, chain of command, risk management department, FDA, OSHA are mandated.

- h. Knowledge of a variety of emergency codes and special procedures found in the acute care setting, including but not limited to fire, patient emergency, bomb threat, infant abduction, natural disaster, need for security, and the knowledge of how to appropriately respond to such emergencies.