MULTIPLE CHOICE

1. After completing an initial assessment of a patient, the nurse has charted that his respirations are 18 breaths per minute and his pulse is 58 beats per minute. These types of data would be:
   a. Objective
   b. Reflective
   c. Subjective
   d. Introspective

   ANS: A
   Objective data are what the health professional observes by inspecting, percussing, palpating, and auscultating during the physical examination. Subjective data are what the person *says* about himself or herself during history taking. The terms *reflective* and *introspective* are not used to describe data.

   DIF: Cognitive Level: Understanding (Comprehension)
   MSC: Client Needs: Safe and Effective Care Environment: Management of Care

2. A patient tells the nurse that he is very nervous, is nauseated, and "feels hot." These types of data would be:
   a. Objective
   b. Reflective
   c. Subjective
   d. Introspective

   ANS: C
   Subjective data are what the person says about himself or herself during history taking. Objective data are what the health professional observes by inspecting, percussing, palpating, and auscultating during the physical examination. The terms *reflective* and *introspective* are not used to describe data.

   DIF: Cognitive Level: Understanding (Comprehension)
   MSC: Client Needs: Safe and Effective Care Environment: Management of Care

3. The patient's record, laboratory studies, objective data, and subjective data combine to form the:
   a. Database
   b. Admitting data
   c. Financial statement
   d. Discharge summary

   ANS: A
   Together with the patient's record and laboratory studies, the objective and subjective data form the database. The other items are not part of the patient's record, laboratory studies, or data.

   DIF: Cognitive Level: Remembering (Knowledge)
   MSC: Client Needs: Safe and Effective Care Environment: Management of Care

4. When listening to a patient's breath sounds, the nurse is unsure of a sound that is heard. The nurse's next action should be to:
   a. Immediately notify the patient's physician.
   b. Document the sound exactly as it was heard.
   c. Validate the data by asking a coworker to listen to the breath sounds.
   d. Assess again in 20 minutes to note whether the sound is still present.

   ANS: C
   When unsure of a sound heard while listening to a patient's breath sounds, the nurse validates the data to ensure accuracy. If the nurse has less experience in an area, then he or she asks an expert to listen.

   DIF: Cognitive Level: Analyzing (Analysis)
   MSC: Client Needs: Safe and Effective Care Environment: Management of Care

5. The nurse is conducting a class for new graduate nurses. During the teaching session, the nurse should keep in mind that novice nurses, with less experience, are more likely to base their decisions on:
   a. Intuition
   b. Clear-cut rules
   c. Articles in journals
   d. Advice from supervisors

   ANS: B
   Novice nurses operate from a set of defined, structured rules. Expert practitioners use critical thinking and their substantial background of experiences.

   DIF: Cognitive Level: Understanding (Comprehension) MSC: Client Needs: General

6. Expert nurses assess and make decisions through the use of:
   a. Critical thinking
   b. The nursing process
   c. Clinical knowledge
   d. Diagnostic reasoning

   ANS: A
   Critical thinking is a multidimensional, dynamic, and interactive thinking process by which expert nurses assess and make decisions in the clinical area.

   DIF: Cognitive Level: Understanding (Comprehension) MSC: Client Needs: General

7. The nurse is reviewing information about evidence-informed practice (EIP). Which statement *best* reflects EIP?
   a. EIP relies on tradition for support of best practices.
   b. EIP is simply the use of best practice techniques for the treatment of patients.
   c. EIP emphasizes the use of best and most appropriate evidence with clinician expertise and patient preference.
   d. The patient's own preferences are not important in EIP.

   ANS: C
   EIP is a problem-solving approach to decision making that emphasizes the use of best available evidence in combination with the clinician's experience, patient preferences and values, and comprehensive assessment to determine the best outcomes in care and treatment. EIP is more than simply using the best practice techniques to treat patients, and questioning tradition is important when no compelling and supportive research evidence exists.

   DIF: Cognitive Level: Applying (Application)
   MSC: Client Needs: Safe and Effective Care Environment: Management of Care

8. The nurse is conducting a class on priority setting for a group of new graduate nurses. Which is an example of a first-level priority problem?
   a. Patient with postoperative pain
   b. Patient newly diagnosed with diabetes needing diabetic teaching
   c. Individual with a small laceration on the sole of the foot
   d. Individual with shortness of breath and respiratory distress

   ANS: D
   First-level priority problems are those that are emergent, life-threatening, and immediate (e.g., establishing an airway, supporting breathing, maintaining circulation, monitoring abnormal vital signs) (see Table 1-1).

   DIF: Cognitive Level: Understanding (Comprehension)
   MSC: Client Needs: Safe and Effective Care Environment: Management of Care

9. Which critical thinking skill helps the nurse see relationships among the data?
   a. Validation
   b. Clustering related cues
   c. Identifying gaps in data
   d. Distinguishing relevant data from irrelevant data

   ANS: B
   Clustering related cues helps the nurse see relationships among the data.

   DIF: Cognitive Level: Understanding (Comprehension)
   MSC: Client Needs: Safe and Effective Care Environment: Management of Care

10. The nurse knows that developing appropriate nursing interventions for a patient relies on the appropriateness of the _____ diagnosis.
    a. Nursing
    b. Medical
    c. Admission
    d. Collaborative

    ANS: A
    An accurate nursing diagnosis provides the basis for the selection of nursing interventions to achieve outcomes for which the nurse is accountable. The other items do not contribute to the development of appropriate nursing interventions.

    DIF: Cognitive Level: Understanding (Comprehension)
    MSC: Client Needs: Safe and Effective Care Environment: Management of Care

11. The nursing process is a sequential method of problem solving that nurses use and includes which steps?
    a. Assessment, treatment, planning, evaluation, discharge, and follow-up
    b. Admission, assessment, diagnosis, treatment, and discharge planning
    c. Admission, diagnosis, treatment, evaluation, and discharge planning
    d. Assessment, diagnosis, outcome identification, planning, implementation, and evaluation

    ANS: D
    The nursing process is a method of problem solving that includes assessment, diagnosis, outcome identification, planning, implementation, and evaluation.

    DIF: Cognitive Level: Understanding (Comprehension)
    MSC: Client Needs: Safe and Effective Care Environment: Management of Care

12. A newly admitted patient is in acute pain, has not been sleeping well lately, and is having difficulty breathing. How should the nurse prioritize these problems?
    a. Breathing, pain, and sleep
    b. Breathing, sleep, and pain
    c. Sleep, breathing, and pain
    d. Sleep, pain, and breathing

    ANS: A
    First-level priority problems are immediate priorities focused on airway and breathing, followed by second-level problems, and then third-level problems.

    DIF: Cognitive Level: Analyzing (Analysis)
    MSC: Client Needs: Safe and Effective Care Environment: Management of Care

13. What step of the nursing process includes data collection through health history, physical examination, and interview?
    a. Planning
    b. Diagnosis
    c. Evaluation
    d. Assessment

    ANS: D
    Data collection, including performing the health history, physical examination, and interview, is the assessment step of the nursing process (see Figure 1-2).

    DIF: Cognitive Level: Remembering (Knowledge) MSC: Client Needs: General

14. What is an important concept when undertaking a life-cycle approach to health assessment?
    a. Consideration of the patient's cultural view of health
    b. Being responsive to the patient's gestures to build a relationship
    c. Acknowledgement of the effect of poverty on health
    d. Awareness of age-specific developmental factors

    ANS: D
    A life-cycle approach requires familiarity with the usual and expected developmental tasks for various age groups. Being aware of age-specific data can be helpful in determining normal and abnormal findings.

    DIF: Cognitive Level: Understanding (Comprehension)
    MSC: Client Needs: Safe and Effective Care Environment: Management of Care

15. The nurse identifies priorities and assesses risk factors with a generally healthy individual to:
    a. Identify patterns to discover missing information.
    b. Determine areas for health promotion and disease prevention.
    c. Distinguish normal from abnormal findings.
    d. Determine treatment for a medical diagnosis.

    ANS: B
    Identifying and working with patients to manage known risk factors for their age group and social context supports disease prevention and health promotion.

    DIF: Cognitive Level: Understanding (Comprehension) MSC: Client Needs: General

16. The nurse is performing a physical assessment on a newly admitted patient. An example of objective information obtained during the physical assessment includes the:
    a. Patient's history of allergies.
    b. Patient's use of medications at home.
    c. Last menstrual period 1 month ago.
    d. 2×5 cm scar on the right lower forearm.

    ANS: D
    Objective data are the patient's record, laboratory studies, and condition that the health professional observes by inspecting, percussing, palpating, and auscultating during the physical examination. The other responses reflect subjective data.

    DIF: Cognitive Level: Applying (Application)
    MSC: Client Needs: Safe and Effective Care Environment: Management of Care

17. A visiting nurse is making an initial home visit for a patient who has many chronic medical problems. Which type of database is *most* appropriate to collect in this setting?
    a. A follow-up database to evaluate changes at appropriate intervals
    b. An episodic database because of the continuing, complex medical problems of this patient
    c. A complete health database because of the nurse's primary responsibility for monitoring the patient's health
    d. An emergency database because of the need to collect information and make accurate diagnoses rapidly

    ANS: C
    The complete database is collected in a primary care setting, such as a pediatric or family practice clinic, independent or group private practice, college health service, women's health care agency, visiting nurse agency, or community health agency. In these settings, the nurse is the first health care professional to see the patient and has the primary responsibility for monitoring the person's health care.

    DIF: Cognitive Level: Applying (Application)
    MSC: Client Needs: Safe and Effective Care Environment: Management of Care

18. Which situation is *most* appropriate during which the nurse collects episodic or problem-centred data?
    a. Patient is admitted to a long-term care facility.
    b. Patient has a sudden and severe shortness of breath.
    c. Patient is admitted to the hospital for surgery the next day.
    d. Patient in an outpatient clinic has cold and influenza-like symptoms.

    ANS: D
    In compiling the episodic or problem-centered database, the nurse collects a "mini-database," which is smaller in scope compared with the complete database. This mini database primarily concerns one problem, one cue complex, or one body system.

    DIF: Cognitive Level: Applying (Application)
    MSC: Client Needs: Safe and Effective Care Environment: Management of Care

19. A patient is at the clinic to have her blood pressure checked. She has been coming to the clinic weekly since she changed medications 2 months ago. The nurse should:
    a. Collect a follow-up database and then check her blood pressure.
    b. Ask her to read her health record and indicate any changes since her last visit.
    c. Check only her blood pressure because her complete health history was documented 2 months ago.
    d. Obtain a complete health history before checking her blood pressure because much of her history information may have changed.

    ANS: A
    A follow-up database is used in all settings to monitor short-term or chronic health problems. The other responses are not appropriate for the situation.

    DIF: Cognitive Level: Applying (Application)
    MSC: Client Needs: Safe and Effective Care Environment: Management of Care

20. A patient is brought by ambulance to the emergency department with multiple injuries received in an automobile accident. The patient is alert and cooperative, but his injuries are quite severe. How would the nurse proceed with data collection?
    a. Collect history information first and then perform the physical examination and institute life-saving measures.
    b. Simultaneously ask history questions while performing the examination and initiating life-saving measures.
    c. Collect all information on the history form, including social support patterns, strengths, and coping patterns.
    d. Perform life-saving measures and delay asking any history questions until the patient is transferred to the intensive care unit.

    ANS: B
    The emergency database calls for a rapid collection of the database, and often data are compiled concurrently with administration of life-saving measures. The other responses are not appropriate for the situation.

    DIF: Cognitive Level: Analyzing (Analysis)
    MSC: Client Needs: Safe and Effective Care Environment: Management of Care

21. A 38-year-old patient who is a recent refugee from Syria is attending the clinic for an initial examination. A potential intervention the nurse will implement is:
    a. Cognitive assessment.
    b. Fall risk screening.
    c. Fasting glucose test.
    d. Tuberculin skin test.

    ANS: D
    A tuberculin (TB) skin test is a potential intervention for an individual from a high-risk area, such as Syria, which is known to be endemic for TB.

    DIF: Cognitive Level: Understanding (Comprehension)
    MSC: Client Needs: Safe and Effective Care Environment: Reduction of Risk Potential

22. During a clinical examination of a 68-year-old patient, the nurse will:
    a. Remind the patient use medication wisely.
    b. Perform a tuberculin skin test.
    c. Discuss body image and dieting.
    d. Helping the consumer choose a healthier lifestyle.

    ANS: A
    For individuals age 65 years and greater, reminding them to use medication wisely is important in preventing injury (i.e., polypharmacy)

    DIF: Cognitive Level: Remembering (Knowledge)
    MSC: Client Needs: Safe and Effective Care Environment: Reduction of Risk Potential

23. The nurse has implemented several planned interventions to address the nursing diagnosis of acute pain. Which would be the *next* appropriate action?
    a. Establish priorities.
    b. Identify expected outcomes.
    c. Evaluate the individual's condition, and compare actual outcomes with expected outcomes.
    d. Interpret data, and then identify clusters of cues and make inferences.

    ANS: C
    Evaluation is the next step after the implementation phase of the nursing process. During this step, the nurse evaluates the individual's condition and compares the actual outcomes with expected outcomes. See Figure 1-2.

    DIF: Cognitive Level: Applying (Application)
    MSC: Client Needs: Safe and Effective Care Environment: Management of Care

24. Which statement *best* describes an experienced nurse? An experienced nurse is one who:
    a. Has little experience with a specified population and uses rules to guide performance.
    b. Takes a linear approach to the nursing process.
    c. Is focused only on a patient's disease.
    d. Understands a patient's situation as a whole, rather than a list of tasks, and recognizes the long-term goals for the patient.

    ANS: D
    The experienced nurse, who has more experience compared with the novice nurse, is able to understand a patient situation as a whole, rather than as a list of tasks. The experienced nurse is able to see how today's nursing actions can apply to the point the nurse wants the patient to reach at a future time.

    DIF: Cognitive Level: Applying (Application) MSC: Client Needs: General

MULTIPLE RESPONSE

1. The nurse is reviewing data collected after an assessment. Of the data listed below, which would be considered related cues that would be clustered together during data analysis? (*Select all that apply*.)
    a. Inspiratory wheezes noted in left lower lobes
    b. Hypoactive bowel sounds
    c. Nonproductive cough
    d. Edema, +2, noted on left hand
    e. Patient reports dyspnea upon exertion
    f. Rate of respirations 16 breaths per minute

    ANS: A, C, E, F
    Clustering related cues help the nurse recognize relationships among the data. The cues related to the patient's respiratory status (e.g., wheezes, cough, report of dyspnea, respiration rate and rhythm) are all related. Cues related to bowels and peripheral edema are not related to the respiratory cues.

    DIF: Cognitive Level: Analyzing (Analysis)
    MSC: Client Needs: Safe and Effective Care Environment: Management of Care

2. When considering priority setting of problems, the nurse keeps in mind that second-level priority problems include which of these aspects? (*Select all that apply.*)
    a. Low self-esteem
    b. Lack of knowledge
    c. Abnormal laboratory values
    d. Severely abnormal vital signs
    e. New confusion and forgetfulness

    ANS: C, D, E
    Second-level priority problems are those that require prompt intervention to prevent further deterioration (e.g., mental status change, acute pain, acute urinary elimination problems, untreated medical problems, abnormal laboratory values, risks of infection, or risk to safety or security) (see Table 1-1). Low self-esteem and knowledge deficit are third-level priority, which will require longer time for treatment and improvement.

    DIF: Cognitive Level: Understanding (Comprehension)
    MSC: Client Needs: Safe and Effective Care Environment: Management of Care

3. What is the purpose of a nursing diagnosis? (*Select all that apply.*)
    a. To evaluate the cause of disease
    b. To evaluate a patient's response to treatment
    c. To determine the need to initiate supportive measures
    d. To order specific diagnostic tests
    e. To determine the need for health education

    ANS: B, C, E
    The nursing diagnosis is used to evaluate the response of the whole person to actual or potential health problems; to monitor a patient's response to treatment; and to initiate supportive measures and health education, as needed.

    DIF: Cognitive Level: Understanding (Comprehension) MSC: Client Needs: General

4. Which of the following are social determinants of health with potential to influence a patient's health? (*Select all that apply.*)
   a. Poverty
   b. Poor research studies
   c. Unaffordable housing
   d. Lack of education
   e. Poor nursing skills

   ANS: A, C, D
   Social determinants of health are the social, economic, and political factors that shape the health of individuals, families, and communities. They are founded on the *Ottawa Charter for Health Promotion, Canada* and include peace, shelter, education, food, income, a stable ecosystem, sustainable resources, social justice, and equity to support health.

   DIF: Cognitive Level: Understanding (Comprehension) MSC: Client Needs: General

5. The nurse wants to take a relational approach in her nursing practice. The nurse needs to: (*Select all that apply.*)
   a. Identify unit policies and procedures.
   b. Identify and manage personal assumptions.
   c. Promote the use of best practice guidelines.
   d. Determine what is important to patients in the context of their situations.
   e. Form decisions based on prevalent stereotyping.

   ANS: B, D
   A relational approach in nursing focuses attention on what is significant to people in the context of their everyday lives and how capacities and socioenvironmental limitations shape people's choices. An important skill of relational practice is examination of how one views and responds to patients based on personal assumptions.

   DIF: Cognitive Level: Applying (Application)
   MSC: Client Needs: Safe and Effective Care Environment: Management of Care