Lewis: Medical-Surgical Nursin

g, 8th Edition

Chapter 1: Contemporary Nursing Practice

Test Bank

MULTIPLE CHOICE

1. The nurse has admitted a patient with a new diagnosis of pneumonia and explained to the patient that together they will plan the patient's care and set goals for discharge. The patient says, "How is that different from what the doctor does?" Which response by the nurse is most appropriate?
   a. "The role of the nurse is to administer medications and other treatments prescribed by your doctor."
   b. "The nurse's job is to help the doctor by collecting data and communicating when there are problems."
   c. "Nurses perform many of the procedures done by physicians, but nurses are here in the hospital for a longer time than doctors."
   d. "In addition to caring for you while you are sick, the nurses will assist you to develop an individualized plan to maintain your health."

   ANS: D
   This response is consistent with the American Nurses Association (ANA) definition of nursing, which describes the role of nurses in promoting health. The other responses describe some of the dependent and collaborative functions of the nursing role but do not accurately describe the nurse's role in the health care system.

   DIF: Cognitive Level: Comprehension REF: 3
   TOP: Nursing Process: Implementation MSC: NCLEX: Safe and Effective Care Environment

2. When providing patient care using evidence-based practice, the nurse uses
   a. clinical judgment based on experience.
   b. evidence from a clinical research study.
   c. evidence-based guidelines in addition to clinical expertise.
   d. evaluation of data showing that the patient outcomes are met.

   ANS: C
   Evidence-based practice (EBP) is the use of the best research-based evidence combined with clinician expertise. Clinical judgment based on the nurse's clinical experience is part of EBP, but clinical decision making also should incorporate current research and research-based guidelines. Evidence from one clinical research study does not provide an adequate substantiation for interventions. Evaluation of patient outcomes is important, but interventions should be based on research from randomized control studies with a large number of subjects.

   DIF: Cognitive Level: Comprehension REF: 6-8 TOP: Nursing Process: Planning

MSC: NCLEX: Safe and Effective Care Environment

3. The nurse primarily uses the nursing process in the care of patients
   a. to explain nursing interventions to other health care professionals
   b. as a problem-solving tool to identify and treat patients' health care needs
   c. as a scientific-based process of diagnosing the patient's health care problems
   d. to establish nursing theory that incorporates the biopsychosocial nature of humans

   ANS: B
   The nursing process is a problem-solving approach to the identification and treatment of patients' problems. Diagnosis is only one phase of the nursing process. The primary use of the nursing process is in patient care, not to establish nursing theory or explain nursing interventions to other health care professionals.

   DIF: Cognitive Level: Comprehension REF: 10
   TOP: Nursing Process: Implementation MSC: NCLEX: Safe and Effective Care Environment

4. The nurse plans an every 2-hour turning schedule to prevent skin breakdown for a critically ill patient in the intensive care unit. In this case, the nursing action is considered to be
   a. dependent.
   b. cooperative.
   c. independent.
   d. collaborative.

   ANS: D
   When implementing collaborative nursing actions, the nurse is responsible primarily for monitoring for complications of acute illness or providing care to prevent or treat complications. Independent nursing actions are focused on health promotion, illness prevention, and patient advocacy. A dependent action would require a physician order to implement. Cooperative nursing functions are not described as one of the formal nursing functions.

   DIF: Cognitive Level: Application REF: 10-11
   TOP: Nursing Process: Implementation MSC: NCLEX: Safe and Effective Care Environment

5. A patient who has been admitted to the hospital for surgery tells the nurse, "I do not feel right about leaving my children with my neighbor." Which action should the nurse take next?
   a. Reassure the patient that these feelings are common for parents.
   b. Have the patient call the children to ensure that they are doing well.
   c. Call the neighbor to determine whether adequate childcare is being provided.
   d. Gather more data about the patient's feelings about the childcare arrangements.

   ANS: D

Since a complete assessment is necessary in order to identify a problem and choose an appropriate intervention, the nurse's first action should be to obtain more information. The other actions may be appropriate, but more assessment is needed before the best intervention can be chosen.

DIF: Cognitive Level: Application REF: 11
TOP: Nursing Process: Assessment MSC: NCLEX: Psychosocial Integrity

6. A patient with a stroke is paralyzed on the left side of the body and has developed a pressure ulcer on the left hip. The best nursing diagnosis for this patient is
   a. impaired physical mobility related to left-sided paralysis.
   b. risk for impaired tissue integrity related to left-sided weakness.
   c. impaired skin integrity related to altered circulation and pressure.
   d. ineffective tissue perfusion related to inability to move independently.

   ANS: C
   The patient's major problem is the impaired skin integrity as demonstrated by the presence of a pressure ulcer. The nurse is able to treat the cause of altered circulation and pressure by frequently repositioning the patient. Although left-sided weakness is a problem for the patient, the nurse cannot treat the weakness. The "risk for" diagnosis is not appropriate for this patient, who already has impaired tissue integrity. The patient does have ineffective tissue perfusion, but the impaired skin integrity diagnosis indicates more clearly what the health problem is.

   DIF: Cognitive Level: Application REF: 11 TOP: Nursing Process: Diagnosis
   MSC: NCLEX: Physiological Integrity

7. A patient with an infection has a nursing diagnosis of deficient fluid volume related to excessive diaphoresis. An appropriate patient outcome identified by the nurse is that the
   a. patient has a balanced intake and output.
   b. patient's bedding is changed when it becomes damp.
   c. patient understands the need for increased fluid intake.
   d. patient's skin remains cool and dry throughout hospitalization.

   ANS: A
   This statement gives measurable data showing resolution of the problem of deficient fluid volume that was identified in the nursing diagnosis statement. The other statements would not indicate that the problem of deficient fluid volume was resolved.

   DIF: Cognitive Level: Application REF: 13 TOP: Nursing Process: Planning
   MSC: NCLEX: Physiological Integrity

8. A nursing activity that is carried out during the evaluation phase of the nursing process is
   a. determining if interventions have been effective in meeting patient outcomes.
   b. documenting the nursing care plan in the progress notes in the medical record.
   c. deciding whether the patient's health problems have been completely resolved.
   d. asking the patient to evaluate whether the nursing care provided was satisfactory.

ANS: A
Evaluation consists of determining whether the desired patient outcomes have been met and whether the nursing interventions were appropriate. The other responses do not describe the evaluation phase.

DIF: Cognitive Level: Comprehension REF: 16 TOP: Nursing Process: Evaluation
MSC: NCLEX: Safe and Effective Care Environment

9. During the assessment phase of the nursing process, the nurse
   a. obtains data with which to diagnose patient problems.
   b. uses patient data to develop priority nursing diagnoses.
   c. teaches interventions to relieve patient health problems.
   d. helps the patient identify realistic outcomes to health problems.

ANS: A
During the assessment phase, the nurse gathers information about the patient. The other responses are examples of the intervention, diagnosis, and planning phases of the nursing process.

DIF: Cognitive Level: Knowledge REF: 11
TOP: Nursing Process: Assessment MSC: NCLEX: Safe and Effective Care Environment

10. An example of a correctly written nursing diagnosis statement is
   a. altered tissue perfusion related to heart failure.
   b. risk for impaired tissue integrity related to sacral redness.
   c. ineffective coping related to response to biopsy test results.
   d. altered urinary elimination related to urinary tract infection.

ANS: C
This diagnosis statement includes a NANDA nursing diagnosis and an etiology that describes a patient's response to a health problem that can be treated by nursing. The use of a medical diagnosis (as in the responses beginning "Altered tissue perfusion" and "Altered urinary elimination") is not appropriate. The response beginning "Risk for impaired tissue integrity" uses the defining characteristics as the etiology.

DIF: Cognitive Level: Comprehension REF: 11-13 TOP: Nursing Process: Diagnosis
MSC: NCLEX: Safe and Effective Care Environment

11. The nurse writes a complete nursing diagnosis statement by including
   a. a problem and the suggested patient goals or outcomes.
   b. a problem, its cause, and objective data that support the problem.
   c. a problem with all its possible causes and the planned interventions.
   d. a problem with its etiology and the signs and symptoms of the problem.

ANS: D

The PES format is used when writing nursing diagnoses. The subjective, as well as objective, data should be included in the defining characteristics. Interventions and outcomes are not included in the nursing diagnosis statement.

DIF: Cognitive Level: Knowledge REF: 11-13 TOP: Nursing Process: Diagnosis
MSC: NCLEX: Safe and Effective Care Environment

12. Using the Situation-Background-Assessment-Recommendation (SBAR) format, in which order should the nurse make these statements to communicate a change in patient status to a health care provider?
    a. Mr. A was admitted 2 days ago with heart failure and has been receiving furosemide (Lasix) for diuresis, but his urine output has been low.
    b. I think that he needs to be evaluated immediately and may need intubation and mechanical ventilation.
    c. This is the nurse on the surgical unit. I am calling about Mr. A in room 3. After assessing him, I am very concerned about his shortness of breath.
    d. Today, he has crackles audible throughout the posterior chest and his O_2 saturation is 89%. His condition is very unstable.

    ANS: C
    A, D, B
    The order of the nurse's statements follows the SBAR format.

    DIF: Cognitive Level: Application REF: 5-6
    TOP: Nursing Process: Implementation MSC: NCLEX: Safe and Effective Care Environment

13. Which of these nursing actions for the patient with heart failure is appropriate for the nurse to delegate to experienced nursing assistive personnel (NAP)?
    a. Assess for shortness of breath or fatigue after ambulation.
    b. Instruct the patient about the need to alternate activity and rest.
    c. Obtain the patient's blood pressure and pulse rate after ambulation.
    d. Determine whether the patient is ready to increase the activity level.

    ANS: C
    NAP education includes accurate vital sign measurement. Assessment and patient teaching require RN education and scope of practice and cannot be delegated.

    DIF: Cognitive Level: Application REF: 15-16 | eFig. 1-1
    OBJ: Special Questions: Delegation TOP: Nursing Process: Planning
    MSC: NCLEX: Safe and Effective Care Environment

14. Which action by a newly graduated RN working on the postsurgical unit indicates that more education about delegation and assignment is needed?
    a. The nurse delegates measurement of patient oral intake and urine output to NAP.
    b. The nurse delegates assessment of a patient's bowel sounds to experienced NAP.
    c. The nurse assigns an LPN/LVN to administer oral medications to several patients.
    d. The nurse assigns a "float" RN from pediatrics to care for a patient with diabetes.

ANS: B
Assessment requires RN education and scope of practice and cannot be delegated to NAP. The other actions by the new RN are appropriate.

DIF: Cognitive Level: Application REF: 15-16 | eFig. 1-1
OBJ: Special Questions: Delegation TOP: Nursing Process: Planning
MSC: NCLEX: Safe and Effective Care Environment

15. Which of these tasks is appropriate for the registered nurse to delegate to a licensed practical/vocational nurse?
    a. Perform a sterile dressing change for an infected wound.
    b. Complete the initial admission assessment and plan of care.
    c. Teach a patient about the effects of prescribed medications.
    d. Document patient teaching about a routine surgical procedure.

ANS: A
The education and scope of practice of the LPN/LVN include activities such as sterile dressing changes. Patient teaching and the initial assessment and development of the plan of care are nursing actions that require RN-level education and scope of practice.

DIF: Cognitive Level: Comprehension REF: 15
OBJ: Special Questions: Delegation TOP: Nursing Process: Planning
MSC: NCLEX: Safe and Effective Care Environment