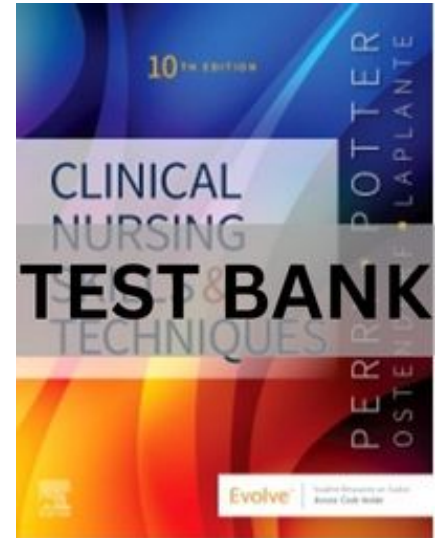


Clinical Nursing Skills and Techniques 10th Edition Test Bank

Chapter 01: Using Evidence in Nursing Practice

Perry et al.: Clinical Nursing Skills & Techniques, 10th Edition



MULTIPLE CHOICE

1. Evidence-based practice is a problem-solving approach to making decisions about patient care that is grounded in:
 - a. the latest information found in textbooks.
 - b. systematically conducted research studies.
 - c. tradition in clinical practice.
 - d. quality improvement and risk-management data.

ANS: B

The best evidence comes from well-designed, systematically conducted research studies described in scientific journals. Portions of a textbook often become outdated by the time it is published. Many health care settings do not have a process to help staff adopt new evidence in practice, and nurses in practice settings lack easy access to risk-management data, relying instead on tradition or convenience. Some sources of evidence do not originate from research. These include quality improvement and risk-management data; infection control data; retrospective or concurrent chart reviews; and clinicians' expertise. Although non-research-based evidence is often very valuable, it is important that you learn to rely more on research-based evidence.

DIF: Cognitive Level: Comprehension OBJ: Discuss the benefits of evidence-based practice.
TOP: Evidence-Based Practice KEY: Nursing Process Step: Assessment
MSC: NCLEX: Safe and Effective Care Environment (management of care)

2. When evidence-based practice is used, patient care will be:
 - a. standardized for all.
 - b. unhampered by patient culture.
 - c. variable according to the situation.
 - d. safe from the hazards of critical thinking.

ANS: C

Using your clinical expertise and considering patients' cultures, values, and preferences ensures that you will apply available evidence in practice ethically and appropriately. Even when you use the best evidence available, application and outcomes will differ; as a nurse, you will develop critical thinking skills to determine whether evidence is relevant and appropriate.

DIF: Cognitive Level: Application OBJ: Discuss the benefits of evidence-based practice.

Clinical Nursing Skills and Techniques 10th Edition Test Bank

TOP: Evidence-Based Practice

KEY: Nursing Process Step: Assessment

MSC: NCLEX: Safe and Effective Care Environment (management of care)

3. When a PICOT question is developed, the letter that corresponds with the usual standard of care is:
- P.
 - I.
 - CHOICE BLANK
 - O.

ANS: C

C = Comparison of interest. What standard of care or current intervention do you usually use now in practice?

P = Patient population of interest. Identify your patient by age, gender, ethnicity, disease, or health problem.

I = Intervention of interest. What intervention (e.g., treatment, diagnostic test, and prognostic factor) do you think is worthwhile to use in practice?

O = Outcome. What result (e.g., change in patient's behavior, physical finding, and change in patient's perception) do you wish to achieve or observe as the result of an intervention?

DIF: Cognitive Level: Knowledge

OBJ: Develop a PICO question.

TOP: PICO

KEY: Nursing Process Step: Implementation

MSC: NCLEX: Safe and Effective Care Environment (management of care)

4. A well-developed PICOT question helps the nurse:
- search for evidence.
 - include all five elements of the sequence.
 - find as many articles as possible in a literature search.
 - accept standard clinical routines.

ANS: A

The more focused a question that you ask is, the easier it is to search for evidence in the scientific literature. A well-designed PICOT question does not have to include all five elements, nor does it have to follow the PICOT sequence. Do not be satisfied with clinical routines. Always question and use critical thinking to consider better ways to provide patient care.

DIF: Cognitive Level: Analysis

OBJ: Describe the six steps of evidence-based practice.

TOP: Evidence-Based Practice

KEY: Nursing Process Step: Implementation

MSC: NCLEX: Safe and Effective Care Environment (management of care)

5. The nurse is not sure that the procedure the patient requires is the best possible for the situation. Utilizing which of the following resources would be the quickest way to review research on the topic?
- CINAHL
 - PubMed
 - MEDLINE
 - The Cochrane Database

ANS: D

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The Cochrane Community Database of Systematic Reviews is a valuable source of synthesized evidence (i.e., pre-appraised evidence). The Cochrane Database includes the full text of regularly updated systematic reviews and protocols for reviews currently happening. MEDLINE, CINAHL, and PubMed are among the most comprehensive databases and represent the scientific knowledge base of health care.

DIF: Cognitive Level: Synthesis OBJ: Describe the six steps of evidence-based practice.
TOP: Evidence-Based Practice KEY: Nursing Process Step: Implementation
MSC: NCLEX: Safe and Effective Care Environment (management of care)

6. The nurse is getting ready to develop a plan of care for a patient who has a specific need. The best source for developing this plan of care would probably be:
- The Cochrane Database.
 - MEDLINE.
 - NGC.
 - CINAHL.

ANS: C

The National Guidelines Clearinghouse (NGC) is a database supported by the Agency for Healthcare Research and Quality (AHRQ). It contains clinical guidelines—systematically developed statements about a plan of care for a specific set of clinical circumstances involving a specific patient population. The NGC is a valuable source when you want to develop a plan of care for a patient. The Cochrane Community Database of Systematic Reviews, MEDLINE, and CINAHL are all valuable sources of synthesized evidence (i.e., pre-appraised evidence).

DIF: Cognitive Level: Synthesis OBJ: Describe the six steps of evidence-based practice.
TOP: Evidence-Based Practice KEY: Nursing Process Step: Implementation
MSC: NCLEX: Safe and Effective Care Environment (management of care)

7. The nurse has done a literature search and found 25 possible articles on the topic that she is studying. To determine which of those 25 best fit her inquiry, the nurse first should look at:
- the abstracts.
 - the literature reviews.
 - the “Methods” sections.
 - the narrative sections.

ANS: A

An abstract is a brief summary of an article that quickly tells you whether the article is research based or clinically based. An abstract summarizes the purpose of the study or clinical query, the major themes or findings, and the implications for nursing practice. The literature review usually gives you a good idea of how past research led to the researcher’s question. The “Methods” or “Design” section explains how a research study is organized and conducted to answer the research question or to test the hypothesis. The narrative of a manuscript differs according to the type of evidence-based article—clinical or research.

DIF: Cognitive Level: Application
OBJ: Discuss elements to review when critiquing the scientific literature.
TOP: Randomized Controlled Trials KEY: Nursing Process Step: Implementation
MSC: NCLEX: Safe and Effective Care Environment (management of care)

Clinical Nursing Skills and Techniques 10th Edition Test Bank

8. The nurse wants to determine the effects of cardiac rehabilitation program attendance on the level of postmyocardial depression for individuals who have had a myocardial infarction. The type of study that would best capture this information would be a:
- randomized controlled trial.
 - qualitative study.
 - case control study.
 - descriptive study.

ANS: B

Qualitative studies examine individuals' experiences with health problems and the contexts in which these experiences occur. A qualitative study is best in this case of an individual nurse who wants to examine the effectiveness of a local program. Randomized controlled trials involve close monitoring of control groups and treatment groups to test an intervention against the usual standard of care. Case control studies typically compare one group of subjects with a certain condition against another group without the condition, to look for associations between the condition and predictor variables. Descriptive studies focus mainly on describing the concepts under study.

DIF: Cognitive Level: Synthesis

OBJ: Discuss ways to apply evidence in nursing practice.

TOP: Randomized Controlled Trials KEY: Nursing Process Step: Implementation

MSC: NCLEX: Safe and Effective Care Environment (management of care)

9. Six months after an early mobility protocol was implemented, the incidence of deep vein thrombosis in patients was decreased. This is an example of what stage in the EBP process?
- Asking a clinical question
 - Applying the evidence
 - Evaluating the practice decision
 - Communicating your results

ANS: C

After implementing a practice change, your next step is to evaluate the effect. You do this by analyzing the outcomes data that you collected during the pilot project. Outcomes evaluation tells you whether your practice change improved conditions, created no change, or worsened conditions.

DIF: Cognitive Level: Application

OBJ: Discuss ways to apply evidence in nursing practice.

TOP: Evidence-Based Practice

KEY: Nursing Process Step: Evaluation

MSC: NCLEX: Safe and Effective Care Environment (safety and infection control)

MULTIPLE RESPONSE

1. To use evidence-based practice appropriately, you need to collect the most relevant and best evidence and to critically appraise the evidence you gather. This process also includes: (*Select all that apply.*)
- asking a clinical question.
 - applying the evidence.
 - evaluating the practice decision.
 - communicating your results.

ANS: A, B, C, D

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EBP comprises six steps (Melnik and Fineout-Overholt, 2010):

1. Ask a clinical question.
2. Search for the most relevant and best evidence that applies to the question.
3. Critically appraise the evidence you gather.
4. Apply or integrate evidence along with one's clinical expertise and patient preferences and values in making a practice decision or change.
5. Evaluate the practice decision or change.
6. Communicate your results.

DIF: Cognitive Level: Analysis

OBJ: Describe the six steps of evidence-based practice.

TOP: Evidence-Based Practice

KEY: Nursing Process Step: Implementation

MSC: NCLEX: Safe and Effective Care Environment (management of care)

2. In a clinical environment, evidence-based practice has the ability to improve: (*Select all that apply.*)
- a. the quality of care provided.
 - b. patient outcomes.
 - c. clinician satisfaction.
 - d. patients' perceptions.

ANS: A, B, C, D

EBP has the potential to improve the quality of care that nurses provide, patient outcomes, and clinicians' satisfaction with their practice. Your patients expect nursing professionals to be informed and to use the safest and most appropriate interventions. Use of evidence enhances nursing, thereby improving patients' perceptions of excellent nursing care.

DIF: Cognitive Level: Application

OBJ: Discuss the benefits of evidence-based practice.

TOP: Randomized Controlled Trials

KEY: Nursing Process Step: Implementation

MSC: NCLEX: Safe and Effective Care Environment (management of care)

3. During the application stage of evidence-based practice change, it is important to consider: (*Select all that apply.*)
- a. cost.
 - b. the need for new equipment.
 - c. management support.
 - d. adequate staff.

ANS: A, B, C, D

One important step for an individual or an interdisciplinary EBP committee is to consider the resources needed for a practice change project. Are added costs or new equipment involved with a practice change? Do you have adequate staff to make the practice change work as planned? Do management and medical staff support you in the change? If the barriers to practice change are excessive, adopting a practice change can be difficult, if not impossible.

DIF: Cognitive Level: Application

OBJ: Describe the six steps of evidence-based practice.

TOP: Evidence-Based Practice

KEY: Nursing Process Step: Implementation

MSC: NCLEX: Safe and Effective Care Environment (management of care)

COMPLETION

1. _____ is a guide for making accurate, timely, and appropriate clinical decisions.

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ANS:

Evidence-based practice

Evidence-based practice is a guide for making accurate, timely, and appropriate clinical decisions.

DIF: Cognitive Level: Knowledge

OBJ: Define the key terms listed.

TOP: Evidence-Based Practice

KEY: Nursing Process Step: Assessment

MSC: NCLEX: Safe and Effective Care Environment (management of care)

2. Evidence-based practice requires good _____.

ANS:

nursing judgment

Evidence-based practice requires good nursing judgment; it does not consist of finding research evidence and blindly applying it.

DIF: Cognitive Level: Comprehension

OBJ: Discuss the benefits of evidence-based practice.

TOP: Evidence-Based Practice

KEY: Nursing Process Step: Assessment

MSC: NCLEX: Safe and Effective Care Environment (management of care)

3. While caring for patients, the professional nurse must question _____.

ANS:

what does not make sense

Always think about your practice when caring for patients. Question what does not make sense to you, and question what you think needs clarification.

DIF: Cognitive Level: Analysis

OBJ: Describe the six steps of evidence-based practice.

TOP: Evidence-Based Practice

KEY: Nursing Process Step: Implementation

MSC: NCLEX: Safe and Effective Care Environment (management of care)

4. A systematic review explains whether the evidence that you are searching for exists and whether there is good cause to change practice. In _____, all entries include information on systematic reviews.

ANS:

The Cochrane Database

A systematic review explains whether the evidence that you are searching for exists and whether there is good cause to change practice. In The Cochrane Database, all entries include information on systematic reviews.

DIF: Cognitive Level: Analysis

OBJ: Describe the six steps of evidence-based practice.

TOP: Evidence-Based Practice

KEY: Nursing Process Step: Implementation

MSC: NCLEX: Safe and Effective Care Environment (management of care)

5. The researcher explains how to apply findings in a practice setting for the types of subjects studied in the _____ section of a research article.

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ANS:

“Clinical Implications”
Clinical Implications

A research article includes a section that explains whether the findings from the study have “clinical implications.” The researcher explains how to apply findings in a practice setting for the types of subjects studied.

DIF: Cognitive Level: Application

OBJ: Discuss elements to review when critiquing the scientific literature.

TOP: Randomized Controlled Trials KEY: Nursing Process Step: Implementation

MSC: NCLEX: Safe and Effective Care Environment (management of care)

6. _____ is the extent to which a study’s findings are valid, reliable, and relevant to your patient population of interest.

ANS:

Scientific rigor

Scientific rigor is the extent to which a study’s findings are valid, reliable, and relevant to your patient population of interest.

DIF: Cognitive Level: Application

OBJ: Define the key terms listed.

TOP: Randomized Controlled Trials KEY: Nursing Process Step: Implementation

MSC: NCLEX: Safe and Effective Care Environment (management of care)

7. Patient fall rates are an example of an _____.

ANS:

outcome measurement

Data collected within a health care agency offer important trending information about clinical conditions and problems. Staff in the agency review the data periodically to identify problem areas and to seek solutions.

DIF: Cognitive Level: Application

OBJ: Define the key terms listed.

TOP: Quality Improvement

KEY: Nursing Process Step: Implementation

MSC: NCLEX: Safe and Effective Care Environment (management of care)

Chapter 02: Communication and Collaboration

Perry et al.: Clinical Nursing Skills & Techniques, 10th Edition

MULTIPLE CHOICE

1. The patient is a 54-year-old man who has made a living as a construction worker. He dropped out of high school at age 16 and has been a laborer ever since. He never saw any need for “book learning,” and has lived his life “my way” since he was a teenager. He has smoked a pack of cigarettes a day for 40 years and follows no special diet, eating a lot of “fast food” while on the job. He now is admitted to the coronary care unit for complaints of chest pain and is scheduled for a cardiac catheterization in the morning. Which of the following would be the best way for the nurse to explain why he needs the procedure?

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- a. “The doctor believes that you have atherosclerotic plaques occluding the major arteries in your heart, causing ischemia and possible necrosis of heart tissue.”
- b. “There may be a blockage of one of the arteries in your heart, causing the chest discomfort. He needs to know where it is to see how he can treat it.”
- c. “We have pamphlets here that can explain everything. Let me get you one.”
- d. “It’s just like a clogged pipe. All the doctor has to do is ‘Roto-Rooter’ it to get it cleaned out.”

ANS: B

To send an accurate message, the sender of verbal communication must be aware of different developmental perspectives as well as cultural differences between sender and receiver, such as the use of dialect or slang.

DIF: Cognitive Level: Application OBJ: Explain the communication process.
TOP: Verbal Communication KEY: Nursing Process Step: Implementation
MSC: NCLEX: Psychosocial Integrity

2. The nurse is assessing a patient who says that she is feeling fine. The patient, however, is wringing her hands and is teary eyed. The nurse should respond to the patient in which of the following ways?
 - a. “You seem anxious today. Is there anything on your mind?”
 - b. “I’m glad you’re feeling better. I’ll be back later to help you with your bath.”
 - c. “I can see you’re upset. Let me get you some tissue.”
 - d. “It looks to me like you’re in pain. I’ll get you some medication.”

ANS: A

When assessing a patient’s needs, assess both the verbal and the nonverbal messages and validate them. In this case, if you see a patient wringing her hands and sighing, it is appropriate to ask, “You seem anxious today. Is there anything on your mind?” It is not enough to accept only the verbal message if nonverbal signals conflict, and it is inappropriate to jump to conclusions about what the nonverbal signals mean.

DIF: Cognitive Level: Application OBJ: Explain the communication process.
TOP: Nonverbal Communication KEY: Nursing Process Step: Implementation
MSC: NCLEX: Psychosocial Integrity

3. Nonverbal communication incorporates messages conveyed by:
 - a. touch.
 - b. cadence.
 - c. tone quality.
 - d. use of jargon.

ANS: A

Nonverbal communication describes all behaviors that convey messages without the use of words. This type of communication includes body movement, physical appearance, personal space, and touch. Cadence, tone quality, and the use of jargon are all part of verbal communication.

DIF: Cognitive Level: Knowledge OBJ: Explain the communication process.
TOP: Nonverbal Communication KEY: Nursing Process Step: Implementation
MSC: NCLEX: Psychosocial Integrity

Clinical Nursing Skills and Techniques 10th Edition Test Bank

4. The patient is an elderly male who had hip surgery 3 days ago. He states that his hip hurts, but he does not like how the medicine makes him feel. He believes that he can tolerate the pain better than he can tolerate the medication. What would be the best response from the nurse?
- Explain the need for the pain medication using a slower rate of speech.
 - Explain the need for the pain medication using a simpler vocabulary.
 - Explain the need for the pain medication, but ask the patient if he would like the doctor called and the medication changed.
 - Explain in a loud manner the need for the pain medication.

ANS: C

Suggesting, which is presenting alternative ideas for patient consideration relative to problem solving, can be effective in helping the patient maintain control by increasing the patient's perceived options or choices. Nurses often use elder-speak, which includes a slower rate of speech, greater repetition, and simpler grammar than normal adult speech, when caring for older adults. However, many older patients perceive this type of communication as patronizing.

DIF: Cognitive Level: Application

OBJ: Identify the purpose of therapeutic communication, communication in various phases of the nurse-patient relationship, and special issues related to communication.

TOP: Communication with the Elderly KEY: Nursing Process Step: Implementation

MSC: NCLEX: Psychosocial Integrity

5. When comparing therapeutic communication versus social communication, the professional nurse realizes that therapeutic communication:
- allows equal opportunity for personal disclosure.
 - allows both participants to have personal needs met.
 - is goal directed and patient centered.
 - provides an opportunity to compare intimate details.

ANS: C

Therapeutic communication empowers patients to make decisions but differs from social communication in that it is patient centered and goal directed with limited disclosure from the professional. Social communication involves equal opportunity for personal disclosure, and both participants seek to have personal needs met. Nurses do not share with patients intimate details of their personal lives.

DIF: Cognitive Level: Application

OBJ: Develop skills for therapeutic communication in various phases of the nurse-patient relationship. TOP: Establishing the Nurse-Patient Relationship

KEY: Nursing Process Step: Implementation

MSC: NCLEX: Psychosocial Integrity

6. The nurse is explaining a procedure to a 2-year-old child. Which is the best approach to use?
- Showing the needles and bandages in advance
 - Telling the patient exactly what discomfort to expect
 - Using dolls and stories to demonstrate what will be done
 - Asking the child to draw pictures of what he or she thinks will happen

ANS: C

Some age-appropriate communication techniques for a 2-year-old child include storytelling and drawing. Showing the child needles or telling the child about discomfort would increase anxiety. Having a child draw what he expects does not explain what is going to happen.

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DIF: Cognitive Level: Application

OBJ: Develop skills for therapeutic communication in various phases of the nurse-patient relationship. TOP: Establishing the Nurse-Patient Relationship—Pediatric Considerations

KEY: Nursing Process Step: Implementation

MSC: NCLEX: Psychosocial Integrity

7. The nurse is about to go over the patient's preoperative teaching per hospital protocol. She finds the patient sitting in bed wringing her hands, which are sweaty, and acting slightly agitated. The patient states, "I'm scared that something will go wrong tomorrow." How should the nurse respond?
- Redirect her focus to dealing with the patient's anxiety.
 - Tell the patient that everything will be all right and continue teaching.
 - Tell the patient that she will return later to do the teaching.
 - Give the patient antianxiety medication.

ANS: A

Anxiety interferes with comprehension, attention, and problem-solving abilities and thus interferes with the patient's care and treatment. To ensure the effectiveness of treatment, the nurse should try to help the patient understand the source of the anxiety. Ignoring the anxiety, medicating for it, and postponing the discussion are all inappropriate.

DIF: Cognitive Level: Application

OBJ: Develop therapeutic communication skills for communicating with anxious, angry, and depressed patients. TOP: Establishing the Nurse-Patient Relationship

KEY: Nursing Process Step: Implementation

MSC: NCLEX: Psychosocial Integrity

8. The nurse is attempting to teach the patient and his family about his care after discharge. The patient and the family demonstrate signs of anxiety during the teaching session. The nurse should consider doing what?
- Using more gestures or pictures
 - Focusing on the physical complaints
 - Getting another staff member to speak to the patient
 - Repeating information to the patient and the family at a later time

ANS: D

Remember that patients and their family members who are under stress often require repeated explanations. Increasing gestures and pictures is additional stimulation that may increase anxiety. Physical complaints should be acknowledged, but dwelling on them can also increase the patient's anxiety. Involving another staff member would cause a break in the continuity of care.

DIF: Cognitive Level: Application

OBJ: Develop therapeutic communication skills for communicating with anxious, angry, and depressed patients. TOP: Establishing the Nurse-Patient Relationship

KEY: Nursing Process Step: Implementation

MSC: NCLEX: Psychosocial Integrity