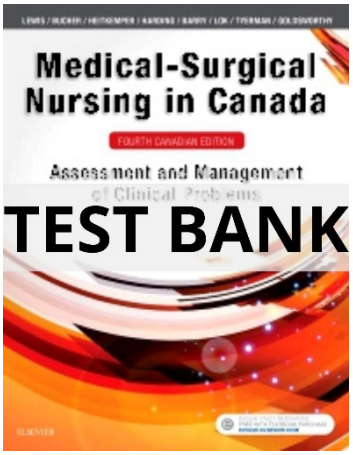
PN VERSION (PRACTICAL NURSE)

Chapter 01: Introduction to Medical-Surgical Nursing Practice in Canada
Lewis: Medical-Surgical Nursing in Canada, 4th Canadian Edition



MULTIPLE CHOICE

1. When caring for clients using evidence-informed practice, which of the following does the nurse use?
   a. Clinical judgement based on experience
   b. Evidence from a clinical research study
   c. The best available evidence to guide clinical expertise
   d. Evaluation of data showing that the client outcomes are met

   ANS: C
   Evidence-informed nursing practice is a continuous interactive process involving the explicit, conscientious, and judicious consideration of the best available evidence to provide care. Four primary elements are: (a) clinical state, setting, and circumstances; (b) client preferences and actions; (c) best research evidence; and (d) health care resources. Clinical judgement based on the nurse's clinical experience is part of EIP, 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 client outcomes is important, but interventions should be based on research from randomized control studies with a large number of subjects.

   DIF: Cognitive Level: Comprehension TOP: Nursing Process: Planning

2. Which of the following best explains the nurses' primary use of the nursing process when providing care to clients?
   a. To explain nursing interventions to other health care professionals
   b. As a problem-solving tool to identify and treat clients' health care needs
   c. As a scientific-based process of diagnosing the client's health care problems
   d. To establish nursing theory that incorporates the biopsychosocial nature of humans

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

   DIF: Cognitive Level: Comprehension TOP: Nursing Process: Implementation

3. The nurse is caring for a critically ill client in the intensive care unit and plans an every 2-hour turning schedule to prevent skin breakdown. Which type of nursing function is demonstrated with this turning schedule?
   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 client 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 TOP: Nursing Process: Implementation

4. The nurse is caring for a client who has been admitted to the hospital for surgery and tells the nurse, "I do not feel right about leaving my children with my neighbour." Which action should the nurse take next?
   a. Reassure the client that these feelings are common for parents.
   b. Have the client call the children to ensure that they are doing well.
   c. Call the neighbour to determine whether adequate childcare is being provided.
   d. Gather more data about the client'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 TOP: Nursing Process: Assessment

5. The nurse is caring for a client who has left-sided paralysis as the result of a stroke and assesses a pressure injury on the client's left hip. Which of the following is the most appropriate nursing diagnosis for this client?
   a. Impaired physical mobility related to decrease in muscle control (left-sided paralysis)
   b. Risk for impaired tissue integrity as evidenced by insufficient knowledge about protecting tissue integrity
   c. Impaired skin integrity related to pressure over bony prominence (impaired circulation)
   d. Ineffective tissue perfusion related to sedentary lifestyle

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

   DIF: Cognitive Level: Application TOP: Nursing Process: Diagnosis

6. The nurse caring for a client with an infection has a nursing diagnosis of deficient fluid volume related to excessive diaphoresis. Which of the following is an appropriate client outcome?
   a. Client has a balanced intake and output.
   b. Client's bedding is changed when it becomes damp.
   c. Client understands the need for increased fluid intake.
   d. Client'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 TOP: Nursing Process: Planning

7. Which of the following represents a nursing activity that is carried out during the evaluation phase of the nursing process?
   a. Determining if interventions have been effective in meeting client outcomes
   b. Documenting the nursing care plan in the progress notes in the medical record
   c. Deciding whether the client's health problems have been completely resolved
   d. Asking the client to evaluate whether the nursing care provided was satisfactory

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

   DIF: Cognitive Level: Comprehension TOP: Nursing Process: Evaluation

8. Which of the following would the nurse perform during the assessment phase of the nursing process?
   a. Obtains data with which to diagnose client problems
   b. Uses client data to develop priority nursing diagnoses
   c. Teaches interventions to relieve client health problems
   d. Assists the client to identify realistic outcomes to health problems

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

   DIF: Cognitive Level: Knowledge TOP: Nursing Process: Assessment

9. Which of the following is an example of a correctly written nursing diagnosis statement?
   a. Altered tissue perfusion related to heart failure
   b. Risk for impaired tissue integrity related to sacral redness
   c. Ineffective coping related to insufficient sense of control.
   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 client'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 TOP: Nursing Process: Diagnosis

10. Which of the following includes the components required for a complete nursing diagnosis statement?
    a. A problem and the suggested client 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 TOP: Nursing Process: Diagnosis

11. Which of the following refers to a situation that results in unintended harm to the client and is related to the care or services provided rather than the client's medical condition?
    a. Negligence
    b. Adverse event
    c. Incident report
    d. Nonmaleficence

    ANS: B
    An adverse event is an event that results in unintended harm to the client and is related to the care or services provided to the client rather than to the client's underlying medical condition.

    DIF: Cognitive Level: Knowledge TOP: Nursing Process: Evaluation

12. When using the Five Steps of the **e**vidence-**i**nformed **p**ractice (EIP) Process, which of the flowing elements is the final step when constructing a clinical question?
    a. Comparison of interest
    b. Population of interest
    c. Outcome of interest
    d. Timeframe of interest

    ANS: D
    The order of the nurse's statements follows the PICOT format with the final step being the "T", or timeframe of interest.

    DIF: Cognitive Level: Application TOP: Nursing Process: Implementation

Chapter 02: Cultural Competence and Health Equity in Nursing Care
Lewis: Medical-Surgical Nursing in Canada, 4th Canadian Edition

MULTIPLE CHOICE

1. Which of the following terms refers to characteristics of a group whose members share a common social, cultural, linguistic, or religious heritage?
   a. Diversity
   b. Ethnicity
   c. Ethnocentrism
   d. Cultural imposition

   ANS: B
   Ethnicity is the common social, cultural, linguistic, or religious heritage of a group of people. Diversity is a presence of persons with differences from the majority or dominant group that is assumed to be the norm. Ethnocentrism is a tendency of individuals to believe that their way of viewing and responding to the world is the most correct, natural, and superior one. Cultural imposition is imposition of one person's own cultural beliefs and practices, intentionally or unintentionally, on another person or group of people.

   DIF: Cognitive Level: Comprehension TOP: Nursing Process: Planning

2. The nurse is caring for Indigenous clients in a community clinic setting. Which of the following would the nurse include when developing strategies to decrease health care disparities?
   a. Improve public transportation.
   b. Obtain low-cost medications.
   c. Update equipment and supplies for the clinic.
   d. Educate staff about Indigenous health beliefs.

   ANS: D
   Health care disparities are due to stereotyping, biases, and prejudice of health care providers; the nurse can decrease these through staff education. The other strategies also may be addressed by the nurse but will not impact health disparities.

   DIF: Cognitive Level: Application TOP: Nursing Process: Planning

3. A family member of an elderly Hispanic client admitted to the hospital tells the nurse that the client has traditional beliefs about health and illness. Which of the following actions is most appropriate for the nurse in this situation?
   a. Avoid asking any questions unless the client initiates conversation.
   b. Ask the client whether it is important that cultural healers are contacted.
   c. Explain the usual hospital routines for meal times, care, and family visits.
   d. Obtain further information about the client’s cultural beliefs from the daughter.

   ANS: B
   Because the client has traditional health care beliefs, it is appropriate for the nurse to ask whether the client would like a visit from a cultural healer. Nurses ask key questions with regard to language, diet, religion, and acculturation and eliciting the client’s explanatory model of health and illness. There is no cultural reason for the nurse to avoid asking the client questions, and questions may be necessary to obtain necessary health information. The client (rather than the daughter) should be consulted about personal cultural beliefs. The hospital routines for meals, care, and visits should be adapted to the client’s preferences rather than expecting the client to adapt to the hospital schedule.

   DIF: Cognitive Level: Application TOP: Nursing Process: Implementation

4. When caring for an Indigenous client, which of the following actions is the best initial approach in relation to eye contact for the nurse to take?
   a. Avoid all eye contact with the client.
   b. Observe the client's use of eye contact.
   c. Look directly at the client when interacting.
   d. Ask the family about the client's cultural beliefs.

   ANS: B
   Eye contact varies greatly among and within cultures so the nurses' initial action is to assess the client's use of eye contact. Although nurses are often taught to maintain direct eye contact, clients who are Asian, Arab, or Indigenous may avoid direct eye contact and consider direct eye contact disrespectful or aggressive. Looking directly at the client or avoiding eye contact may be appropriate, depending on the client's individual cultural beliefs. The nurse should assess the client, rather than asking family members about the client's beliefs.

   DIF: Cognitive Level: Application TOP: Nursing Process: Implementation

5. A graduate nurse is assessing a newly admitted non–English-speaking Chinese client who complains of severe headaches. Which of the following actions by the graduate nurse would cause the charge nurse to intervene during this assessment interview?
   a. Sit down at the bedside.
   b. Palpate the client's scalp.
   c. Call for a medical interpreter.
   d. Avoid eye contact with the client.

   ANS: B
   Many people of Asian ethnicity believe that touching a person's head is disrespectful; the nurse should always ask permission before touching any client's head. The other actions are appropriate.

   DIF: Cognitive Level: Application TOP: Nursing Process: Implementation

6. The nurse is caring for a client who speaks a language different from the nurse's language and there is no interpreter available. Which of the following actions is the most appropriate for the nurse to implement?
   a. Use specific medical terms in the Latin form.
   b. Talk loudly and slowly so that each word is clearly heard.
   c. Repeat important words so that the client recognizes their importance.
   d. Use simple gestures to demonstrate meaning while talking to the client.

   ANS: D
   The use of gestures will enable some information to be communicated to the client. The other actions will not improve communication with the client.

   DIF: Cognitive Level: Comprehension TOP: Nursing Process: Implementation

7. According to the ABC(DE)s of cultural competence, awareness of and sensitivity to cultural values is in which of the following domains?
   a. Skills domain
   b. Affective domain
   c. Knowledge domain
   d. Behavioural domain

ANS: B
The affective domain reflects an awareness of and sensitivity to cultural values, needs, and biases. The skills domain does not reflect an awareness of and sensitivity to cultural values, needs, and biases. There is no skills or knowledge domain; with ABC(DE) it is affective, behavioural, and cognitive domains as well as dynamics of difference and environment.

DIF: Cognitive Level: Comprehension TOP: Nursing Process: Planning

8. Which of the following actions represents the best example of culturally appropriate nursing care when caring for a newly admitted client?
   a. Have family members provide most of the client's personal care.
   b. Maintain a personal space of at least 0.5 m when assessing the client.
   c. Ask permission before touching a client during the physical assessment.
   d. Consider the client's ethnicity as the most important factor in planning care.

   ANS: C
   Many cultures consider it disrespectful to touch a client without asking permission, so asking a client for permission is always culturally appropriate. The other actions may be appropriate for some clients but are not appropriate across all cultural groups or for all individual clients.

   DIF: Cognitive Level: Comprehension TOP: Nursing Process: Implementation

9. While talking with the nursing supervisor, a staff nurse expresses frustration that an Indigenous client always has several family members at the bedside. Which of the following actions is the most appropriate action for the nursing supervisor in this situation?
   a. Remind the nurse that family support is important to this family and client.
   b. Have the nurse explain to the family that too many visitors will tire the client.
   c. Suggest that the nurse ask family members to leave the room during client care.
   d. Ask about the nurse's personal beliefs about family support during hospitalization.

   ANS: D
   The first step in providing culturally competent care is to understand one's own beliefs and values related to health and health care. Asking the nurse about personal beliefs will help to achieve this step. Reminding the nurse that this cultural practice is important to the family and client will not decrease the nurse's frustration. The remaining responses (suggest that the nurse ask family members to leave the room, and have the nurse explain to family that too many visitors will tire the client) are not culturally appropriate for this client.

   DIF: Cognitive Level: Application TOP: Nursing Process: Implementation

10. An elderly Asian Canadian client tells the nurse that she has lived in Canada for 50 years. The client speaks English but lives in a predominantly Asian neighbourhood. Which of the following actions is most appropriate for the nurse?
    a. Arrange to have a folk healer available when planning the client's care.
    b. Ask the client about any special cultural beliefs or practices.
    c. Avoid making direct eye contact with the client during care.
    d. Involve the client's oldest son in making health care decisions.

    ANS: B
    Further assessment of the client's health care preferences is needed before making further plans for culturally appropriate care. The other responses indicate stereotyping of the client, based on ethnicity, and would not be appropriate initial actions.

DIF: Cognitive Level: Application TOP: Nursing Process: Planning

11. Which of the following statements is true related to immigrants to Canada?
    a. Decreased risk of social exclusion related to Canada's multicultural population.
    b. New immigrants tend to be in overall better health than the resident population.
    c. Health status of immigrants is not related to length of time in Canada.
    d. Unemployment is not associated with poorer health outcomes for immigrants.

    ANS: B
    The *healthy immigrant effect* indicates that new immigrants tend to be in better overall health than the general resident population. This finding is not surprising inasmuch as immigrants are screened before being granted admittance to Canada. Health status is related to length of time in Canada, the health of immigrants, 20 years after immigration, as determined by age-standardized mortality rates, is generally poorer than those of the Canadian-born population. Underemployment, unemployment, and workplace stress place immigrants at increased health risks as well as the risk for social exclusion.

    DIF: Cognitive Level: Comprehension TOP: Nursing Process: Planning

12. Which of the following question formats is the most appropriate for the nurse to ask when communicating with a client that has limited English proficiency?
    a. Are you tired and in discomfort?
    b. You have taken your pills right?
    c. Are you alright?
    d. Are you in pain?

    ANS: D
    When communicating with a client that has limited English proficiency, the best questions to ask are ones that are in simple language a couple of words, plain simple terms, such as "Are you in pain?" Asking about tiredness and discomfort in the same sentence should be avoided —ask one item at a time and use the term 'pain', not discomfort. Asking the client "are you alright" is vague and will elicit a yes or no answer. "You have taken your pills right?" is accusatory and should be avoided.

    DIF: Cognitive Level: Application TOP: Nursing Process: Implementation

13. An Indigenous client tells the nurse that he thinks his abdominal pain is caused by eating too much seal fat and that strong massage over the stomach will help it. Which of the following statements depicts what the client is describing to the nurse?
    a. Evidence-informed national guidelines
    b. Awareness and knowledge of his own culture
    c. The explanatory model of health and health practices
    d. Knowledge about the difference in modern and folk health practices

    ANS: C
    The explanatory model is a set of beliefs regarding what causes the disease or illness and the methods that would potentially treat the condition best. Different cultural groups have different beliefs about the causes of illness and the appropriateness of various treatments. The situation is not reflective of national guidelines. There is no comparison between modern and folk health practices. The client is explaining experiences and beliefs' rather than awareness and knowledge.

    DIF: Cognitive Level: Application TOP: Nursing Process: Assessment

14. Which of the following statements represents a health inequity currently experienced in Canada?
    a. Indigenous adults are less likely to smoke tobacco than other adults in Canada.
    b. Overall suicide rate among First Nation communities is about twice the rate of the general population.
    c. Individuals from lower income neighbourhoods undergo preventive health screening more that their higher income counterparts.
    d. Recent immigrants are more likely to have a primary care physician than Canadian-born individuals.

    ANS: B
    Suicide rates are five to seven times higher among Indigenous youth than among non-Indigenous youth. Suicide rates among Indigenous youth are among the highest in the world, at 11 times the national average. Smoking rates are more than two times higher among the three Indigenous groups than among the non-Indigenous population. Individuals from higher income neighbourhoods undergo preventive health screening more than those from lower income neighbourhoods. Recent immigrants are less likely to have a primary care physician than Canadian-born individuals.

    DIF: Cognitive Level: Comprehension TOP: Nursing Process: Assessment

15. When performing a cultural assessment with a client of a different culture, which of the following actions is the initial action to be taken by the nurse?
    a. Wait until a cultural healer is available to help with the assessment.
    b. Obtain a list of any cultural remedies that the client currently uses.
    c. Ask the client about any affiliation with a particular cultural group.
    d. Tell the client what the nurse already knows about the client's culture.

    ANS: C
    An early step in performing a cultural assessment is to determine the cultural group with which the client identifies. The other actions may be appropriate if the client does identify with a particular culture.

    DIF: Cognitive Level: Application TOP: Nursing Process: Assessment

16. Equity in health care is concerned with creating equal opportunities for good health for everyone in which one of the following ways?
    a. Increase negative effect of social determinants of health.
    b. Increase awareness of acute care programs.
    c. Decrease non-modifiable risk factors.
    d. Reduce exclusion.

    ANS: D
    Health equity is concerned with creating equal opportunities for good health for everyone in two ways: (a) decreasing the negative effect of the social determinants of health and (b) by improving services to enhance access and reduce exclusion.

    DIF: Cognitive Level: Comprehension TOP: Nursing Process: Assessment

MULTIPLE CHOICE

1. An older-adult client who is having difficulty breathing is admitted to the hospital. Which of the following approaches is the best for the nurse to use to obtain a complete health history?
   a. Obtain subjective data about the client from family members.
   b. Omit subjective data collection and obtain the physical examination.
   c. Use the health care provider's medical history to obtain subjective data.
   d. Schedule several short sessions with the client to gather subjective data.

   ANS: D
   In the case of an older-adult client with a low energy level, several short sessions may have to be scheduled. Allowing time for the client to volunteer information about particular areas of concern enables the nurse to work with the client to identify existing and potential health problems. In an emergency situation, the nurse may need to ask only the most pertinent questions for a specific problem and obtain more information later. A complete health history will include subjective information that is not available in the health care provider's medical history. Family members may be able to provide some subjective data, but only the client will be able to give subjective information about the shortness of breath. Since the subjective data about the client's respiratory status will be essential, obtaining the physical examination alone will not provide sufficient information.

   DIF: Cognitive Level: Application TOP: Nursing Process: Assessment

2. Immediate surgery is planned for a client with acute abdominal pain. Which of the following questions will elicit the most complete information about the client's coping-stress tolerance pattern?
   a. "Can you tell me how intense your pain is now?"
   b. "What do you think caused this abdominal pain?"
   c. "How do you feel about yourself and your hospitalization?"
   d. "Are there other major problems that are a concern right now?"

   ANS: D
   The coping-stress tolerance pattern includes information about other major stressors confronting the client. The health perception–health management pattern includes information about the client's ideas about risk factors. Feelings about self and the hospitalization are assessed in the self-perception–self-concept pattern. Intensity of pain is part of the cognitive–perceptual pattern.

   DIF: Cognitive Level: Comprehension TOP: Nursing Process: Assessment

3. During the health history interview, a client tells the nurse about periodic fainting spells. Which question by the nurse will be most helpful in determining the setting in which the fainting spells occur?
   a. "How frequently do you have the fainting spells?"
   b. "Where are you when you have the fainting spells?"
   c. "Do the spells tend to occur at any special time of day?"
   d. "Do you have any other symptoms along with the spells?"

   ANS: B

Information about the setting is obtained by asking where the client was and what the client was doing when the symptom occurred. The other questions from the nurse are appropriate for obtaining information about chronology, frequency, and associated clinical manifestations.

DIF: Cognitive Level: Comprehension TOP: Nursing Process: Assessment

4. The nurse records the following general survey of a client: "The client is a 68-year-old male Asian accompanied by his wife and two daughters. Alert and oriented. Does not make eye contact with the nurse and responds slowly, but appropriately, to questions. No apparent disabilities or distinguishing features." Which of the following information should be added to this general survey documentation?
   a. Nutritional status
   b. Intake and output
   c. Reasons for contact with the health care system
   d. Comments of family members about his condition

   ANS: A
   The general survey also describes the client's general nutritional status. The other information will be obtained when doing the complete nursing history and examination but is not obtained through the initial scanning of a client.

   DIF: Cognitive Level: Application TOP: Nursing Process: Assessment

5. A nurse is performing a health history and physical examination for a client with right-sided rib fractures. Which of the following data is a pertinent negative finding?
   a. Client states that there have been no other health problems recently.
   b. Client denies having pain when the area over the fractures is palpated.
   c. Client has several bruised and swollen areas on the right anterior chest.
   d. Client refuses to take a deep breath because of the associated chest pain.

   ANS: B
   The nurse expects that a client with rib fractures will have pain over the fractured area. The first statement is neither a positive nor a negative finding with regard to the rib fractures. The bruising and swelling and pain with breathing are positive findings.

   DIF: Cognitive Level: Application TOP: Nursing Process: Assessment

6. As the nurse assesses the client's neck, the client says, "My neck is so stiff I can hardly move it." This client statement indicates the nurse should perform which of the following assessments?
   a. Focused
   b. Screening
   c. Emergency
   d. Comprehensive

   ANS: A
   The focused assessment is needed when a client has clinical manifestations that indicate a problem. An emergency assessment is done when the nurse needs to obtain information about life-threatening problems quickly while simultaneously taking action to maintain vital function. The screening assessment is not recognized as one of the three main types of assessment. A comprehensive assessment is a detailed health history and physical examination.