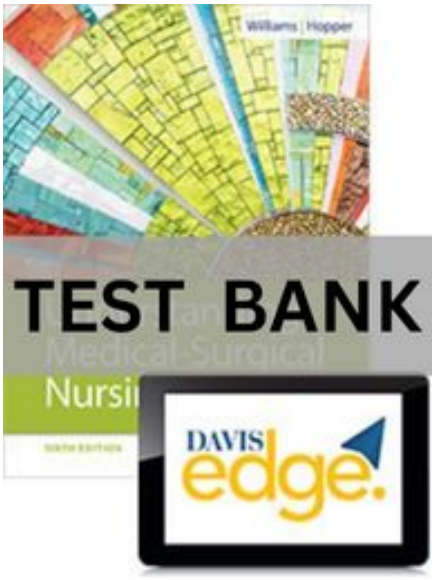
Understanding Medical-Surgical Nursing 6th Edition Test Bank

Chapter 1. Critical Thinking and the Nursing Process



Multiple Choice

Identify the choice that best completes the statement or answers the question.

____ 1. The nurse is caring for a group of patients on a medical-surgical unit. Which patient should the licensed practical nurse/licensed vocational nurse (LPN/LVN) assess first?
1. A patient with a blood glucose of 42 mg/dL
2. A patient who reports a pain level of 2
3. A patient who has just received a diagnosis of cancer
4. A patient who has a respiratory rate of 22

____ 2. The LPN/LVN enters the room of a patient who is angry and yells, "I asked 5 minutes ago for my pain medication. I'm going to call the CEO of the hospital if you don't get it for me now." Which statement by the nurse demonstrates intellectual empathy?
1. "We are short-staffed today, so it will take me longer to meet your needs."
2. "I am sorry you had to wait, I know you must be in a lot of pain."
3. "I had another patient who had severe pain, and I had to get to them first."
4. "I will get you the number for the CEO, but he is aware of how busy we are."

____ 3. The nurse is collecting data on a patient. Which data are described as subjective?
1. Respiratory rate of 26 per minute
2. Patient report of shortness of breath
3. Coarse lung sounds bilaterally
4. Cough producing green sputum

____ 4. A patient with a newly fractured femur reports a pain level of 8/10 and analgesic medication is not due for another 50 minutes. Which action should the nurse take first?
1. Reposition the patient.
2. Give the medication in 30 minutes.
3. Notify the registered nurse (RN) or physician.
4. Tell the patient it is too early for pain medication.

____ 5. The nurse is prioritizing care based on Maslow hierarchy of needs. Which need does the nurse identify as having the highest priority?
1. Job-related stress
2. Feeling of loneliness
3. Pain level of 9 on 0-to-10 scale
4. Lack of confidence

____ 6. The nurse is planning care and setting goals for a newly admitted patient. Who should the nurse include when conducting these nursing actions?
1. Patient

2. Nurse manager
3. Hospital chaplain
4. Patient's health care provider (HCP)

____ 7. While caring for a patient 4 hours after a surgical procedure, the LPN/LVN notes serosanguineous drainage on the dressing. Which statement should the nurse use to document this finding?
1. "Normal drainage noted."
2. "Moderate drainage recently noted."
3. "Scant serosanguineous drainage seen on dressing."
4. "Pale pink drainage 2 cm by 1 cm noted on dressing."

____ 8. The nurse is caring for a patient using the nursing process. Which step should the nurse take first?
1. Implementation
2. Planning
3. Nursing diagnosis
4. Assessment

____ 9. The nurse is administering morphine to a patient reporting a pain level of 8 on a 0-to-10 scale. This describes which step of the nursing process?
1. Assessment
2. Nursing diagnosis
3. Implementation
4. Evaluation

____ 10. The nurse is developing an outcome for a patient with exacerbation of asthma. Which is the most appropriate outcome for this patient?
1. The patient will not experience shortness of breath.
2. The patient will have a respiratory rate of 16 to 20 per minute.
3. The patient will ambulate without reporting shortness of breath.
4. The patient will not require use of an inhaler.

____ 11. The nurse suspects a patient is experiencing adverse effects to a newly prescribed antihypertensive medication. After being informed that the effects are expected, the nurse remains concerned and conducts an Internet search on the patient's manifestations. Which critical thinking behavior did the nurse implement?
1. Sense of justice
2. Intellectual courage
3. Intellectual empathy
4. Intellectual perseverance

____ 12. The nurse is identifying outcomes for a patient with fluid volume deficit. Which outcome should the nurse use to guide this patient's care?
1. Patient's intake will be measured daily.
2. Patient's intake will be 3,000 mL daily.
3. Fluids will be at the bedside for the patient.
4. Fluids the patient likes will be at the bedside.

____ 13. The nurse is formulating nursing diagnoses for a patient with chronic obstructive pulmonary disease (COPD). Which diagnosis is of the highest priority?
1. Activity intolerance
2. Impaired gas exchange

3. Risk for injury
4. Deficient knowledge

____ 14. An RN delegates a patient care assignment to the LPN/LVN. Which phase of the nursing process should the LPN/LVN perform independently?
1. Assessment
2. Planning care
3. Implementation
4. Nursing diagnosis

____ 15. The LPN/LVN is reviewing a care plan for a patient who underwent abdominal surgery 2 hours ago and has a priority nursing diagnosis of acute pain. Which intervention should the nurse implement first?
1. Teach the patient how to splint the abdomen when coughing.
2. Assist the patient with early ambulation.
3. Encourage the patient to increase fluid intake.
4. Administer hydromorphone (Dilaudid) per order as needed for pain.

____ 16. Which critical thinking trait is demonstrated when the LPN/LVN is unsure of how to perform a dressing change and asks the RN for assistance?
1. Intellectual courage
2. Intellectual integrity
3. Intellectual humility
4. Intellectual empathy

____ 17. During morning report, the LPN/LPN is assigned a group of patients. Which patient should the LPN/LPN see first?
1. A patient scheduled for magnetic resonance imaging (MRI) due to back pain
2. A patient reporting constipation and stomach cramps
3. A 2-day postsurgical patient reporting pain at a level of 6
4. A patient with pneumonia who is short of breath and anxious

____ 18. The LPN/LVN asks a patient who received 2 mg of Morphine IV 30 minutes ago to rate his or her pain. This describes which step of the nursing process?
1. Assessment
2. Planning
3. Implementation
4. Evaluation

____ 19. The LPN/LVN is assisting the RN in planning interventions for a patient. Which is an example of a collaborative action?
1. Administering a medication
2. Giving a back rub
3. Assessing a patient
4. Teaching relaxation techniques

____ 20. The LPN/LVN is reviewing nursing diagnoses for a patient. Which diagnosis should the nurse report to the RN as incorrect?
1. Risk for injury
2. Heart failure
3. Ineffective gas exchange
4. Activity intolerance

____ 21. The LPN/LVN is caring for a group of patients. Which patient should the nurse assess first?
1. A patient with an oxygen saturation level of 96% on room air
2. A patient who has a blood pressure of 208/114 mm Hg
3. A patient who reports a pain level of 7 on a scale of 0 to 10
4. A patient with a temperature of 100.2°F

____ 22. The LPN/LVN is caring for a patient who begins to exhibit shortness of breath and chest pain. Which action should the nurse take first?
1. Administer medication as ordered.
2. Notify the RN.
3. Document the findings in the chart.
4. Reposition the patient.

____ 23. While teaching how to apply a topical medication the patient begins to vomit. Which action should the nurse take to meet the patient's human needs?
1. Provide a clean gown before resuming the teaching.
2. Position an emesis basin for patient use while teaching.
3. Administer medication prescribed for nausea and vomiting.
4. Wait for the vomiting to stop and begin the teaching session again.

____ 24. A nurse approaches a person in a restaurant who appears to be experiencing respiratory distress. Which action should the nurse perform first?
1. Diagnose the problem.
2. Assist the person to lie down.
3. Gather data from other people.
4. Collect data about the person's condition.

____ 25. The nurse is reviewing nursing diagnoses. Which is an example of a correctly written nursing diagnosis?
1. Acute pain related to tissue trauma as evidenced by facial grimacing and rating pain at a level of 9 on a 0-to-10 scale
2. Pain related to appendicitis as evidenced by moaning and guarding
3. Acute pain related to guarding abdomen and rating pain at a level of 9 on a 0-to-10 scale
4. Pain as evidenced by status postsurgical procedure

____ 26. After identifying nursing diagnoses the nurse plans outcomes for a patient with gastroesophageal reflux disease. Which outcome should the nurse use to evaluate this patient's care?
1. The patient will have less heartburn.
2. The patient will sleep through the night.
3. The patient's esophageal burning will resolve 30 minutes after taking oral antacids.
4. The patient will state that burning only occurs when eating foods high in acid content.

Multiple Response
Identify one or more choices that best complete the statement or answer the question.

____ 27. After collecting data, the nurse identifies diagnoses to guide the patient's care. Which diagnoses did the nurse document correctly? (Select all that apply.)
1. Diabetes

2. Acute pain
3. Pancreatitis
4. Activity intolerance
5. Impaired physical mobility

____ 28. A patient with a family history of diabetes is experiencing high blood glucose levels, confusion, an unsteady gait, and dehydration. Which nursing diagnoses should the nurse identify as appropriate for this patient's care? (Select all that apply.)
1. Diabetes
2. Dehydration
3. Risk for falls
4. Hyperglycemia
5. Deficient fluid volume

____ 29. The nurse identifies the diagnosis potential for ineffective gas exchange as appropriate for a patient with pneumonia. Which independent nursing actions should the nurse plan for this problem? (Select all that apply.)
1. Apply oxygen 2 liters per nasal cannula.
2. Turn and reposition in bed every 2 hours.
3. Coach to deep-breathe and cough every hour.
4. Administer intramuscular antibiotic medication.
5. Encourage to drink 240 mL of fluid every 2 hours.

____ 30. The nurse is planning outcomes for a patient with acute pain who is exhibiting tachypnea and hypertension. Which outcomes should be included in the patient's care?
1. Patient will rate pain at a level of 2 on a 0-to-10 scale 30 minutes after receiving Morphine.
2. Patient will ambulate without pain.
3. Patient will not exhibit signs or symptoms of pain.
4. Patient will maintain respiratory rate between 16 and 20.
5. Patient's blood pressure will remain within normal limits.

Other

31. The nurse is caring for a group of patients. Place in order the patients the nurse should see from highest to lowest priority (1 to 5).
1. A patient who underwent abdominal surgery yesterday and reports a pain level of 5 on a 0-to-10 scale
2. A patient with deep vein thrombosis (DVT) who reports shortness of breath
3. A patient awaiting education from the diabetes educator
4. A patient with eczema who reports itching
5. A patient who reports nausea after chemotherapy

32. The nurse is caring for a patient recovering from a stroke. Place in the order of the nursing process the observations or actions provided while caring for this patient.
1. Hand grasp absent left hand
2. Alteration in cerebral perfusion
3. Flexed left thumb and index finger
4. Coached to squeeze rubber ball placed in left hand
5. Self-feed using left hand

Understanding Medical-Surgical Nursing 6th Edition Test Bank

Chapter 1. Critical Thinking and the Nursing Process
Answer Section

MULTIPLE CHOICE

1. ANS: 1
   Chapter: Chapter 1 Critical Thinking and the Nursing Process
   Objective: 7. Prioritize patient care activities based on the Maslow hierarchy of human needs.
   Pages: 6–7
   Heading: Prioritize Care
   Integrated Process: Clinical Problem-Solving Process (Nursing Process)
   Client Need: SECE—Coordinated Care
   Cognitive Level: Application [Applying]
   Concept: Patient-Centered Care
   Difficulty: Difficult

	Feedback
1	This patient has a dangerously low blood glucose level and requires immediate intervention.
2	This patient will need to be assessed, but is not as high a priority.
3	According to Maslow, psychosocial needs are not as high of a priority as physiological needs.
4	A respiratory rate of 22 is within normal range.

   PTS: 1 CON: Patient-Centered Care
2. ANS: 2
   Chapter: Chapter 1 Critical Thinking and the Nursing Process
   Objective: 2. Describe attitudes and skills that promote good critical thinking
   Page: 2
   Heading: Intellectual Empathy
   Integrated Process: Communication and Documentation
   Client Need: Psychosocial Integrity
   Cognitive Level: Application [Applying]
   Concept: Communication
   Difficulty: Moderate

	Feedback
1	This statement does not consider an individual's situation.
2	This statement demonstrates intellectual empathy by considering this patient's situation and will likely alleviate the patient's anger.
3	This statement does not consider a patient's situation and does not demonstrate intellectual empathy.

4	This statement addresses the patient's statement of wanting to call the CEO, but does not demonstrate intellectual empathy by considering the patient's situation.

PTS: 1 CON: Communication

3. ANS: 2
Chapter: Chapter 1 Critical Thinking and the Nursing Process
Objective: 5. Differentiate between objective and subjective data.
Page: 4
Heading: Subjective Data
Integrated Process: Communication and Documentation
Client Need: Communication and Documentation
Cognitive Level: Application (Applying)
Concept: Communication
Difficulty: Moderate

	Feedback
1	Respiratory rate of 26 per minute is an example of objective data.
2	A patient reporting symptoms to the nurse is an example of subjective data.
3	Coarse lung sounds is an example of objective data.
4	A productive cough is an example of objective data.

PTS: 1 CON: Communication

4. ANS: 3
Chapter: Chapter 1 Critical Thinking and the Nursing Process
Objective: 4. Identify the role of a licensed practical nurse/licensed vocational nurse in using the nursing process.
Page: 3
Heading: Clinical Judgement
Integrated Process: Clinical Problem-solving Process (Nursing Process)
Client Need: SECE—Coordinated Care
Cognitive Level: Application [Applying]
Concept: Patient-Centered Care
Difficulty: Moderate

	Feedback
1	The patient who has a fractured femur is having acute pain. Repositioning a patient with a new fracture is not likely to relieve pain.
2	Giving the medication before the prescribed time is beyond the nurse's scope of practice.
3	The patient should not have to wait for pain relief, so the LPN should inform the RN or physician so new pain relief orders can be obtained.
4	The nurse needs to do more than expect the patient to wait for pain relief.

PTS: 1 CON: Patient-Centered Care

5. ANS: 3
Chapter: Chapter 1 Critical Thinking and the Nursing Process
Objective: 7. Prioritize patient care activities based on the Maslow hierarchy of human needs
Page: 7
Heading: Prioritize Care
Integrated Process: Caring
Client Need: SECE – Coordinated Care
Cognitive Level: Application [Applying]
Concept: Patient-Centered Care
Difficulty: Moderate

	Feedback
1	Job-related stress falls under safety according to Maslow and is addressed after physiological needs.
2	According to Maslow, loneliness is addressed under social needs following physiological and safety.
3	Pain is a physiological need and is the highest priority.
4	Lack of confidence falls under esteem according to Maslow and is addressed following physiological, safety, and social needs.

PTS: 1 CON: Patient-Centered Care

6. ANS: 1
Chapter: Chapter 1 Critical Thinking and the Nursing Process
Objective: 4. Identify the role of a licensed practical nurse/licensed vocational nurse is using the nursing process.
Page: 6
Heading: Prioritize Care
Integrated Process: Communication and Documentation
Client Need: SECE—Management of Care
Cognitive Level: Application [Applying]
Concept: Communication
Difficulty: Moderate

	Feedback
1	Planning care and setting goals is an action performed with the patient. The patient must be in agreement with the plan for it to be successful in meeting the desired outcomes.
2	The nurse manager may or may not be aware of the patient's care needs.
3	The hospital chaplain may not be aware of the patient's needs.
4	The focus of nursing care is different from that of the HCP.

PTS: 1 CON: Communication

7. ANS: 4
Chapter: Chapter 1 Critical Thinking and the Nursing Process

Objective: 6. Document subjective and objective data.
Page: 5
Heading: Documentation of Data
Integrated Process: Communication and Documentation
Client Need: PHYS—Physiological Adaptation
Cognitive Level: Application [Applying]
Concept: Communication
Difficulty: Moderate

	Feedback
1	These statements are interpretations of the data and use words that have vague meanings, which should be avoided when documenting.
2	These statements are interpretations of the data and use words that have vague meanings, which should be avoided when documenting.
3	These statements are interpretations of the data and use words that have vague meanings, which should be avoided when documenting.
4	Objective data are pieces of factual information obtained through physical assessment and diagnostic tests that are observable or knowable through the five senses. The nurse should document exactly what is seen.

PTS: 1 CON: Communication

8. ANS: 4
Chapter: Chapter 1 Critical Thinking and the Nursing Process
Objective: 4. Identify the role of a licensed practical nurse/licensed vocational nurse in using the nursing process.
Page: 4
Heading: Data Collection
Integrated Process: Clinical Problem-Solving Process (Nursing Process)
Client Need: SECE: Coordinated Care
Cognitive Level: Application [Applying]
Concept: Patient-Centered Care
Difficulty: Moderate

	Feedback
1	The steps of the nursing process are data collection/assessment, nursing diagnosis, planning, implementation, and evaluation.
2	The steps of the nursing process are data collection/assessment, nursing diagnosis, planning, implementation, and evaluation.
3	The steps of the nursing process are data collection/assessment, nursing diagnosis, planning, implementation, and evaluation.
4	Assessment, or data collection, is the first step in the nursing process and is used to evaluate a patient's condition before providing care. The other steps, in order, are nursing diagnosis, planning, implementation, and evaluation.

PTS: 1 CON: Patient-Centered Care

9. ANS: 3
Chapter: Chapter 1 Critical Thinking and the Nursing Process
Objective: 4. Identify the role of a licensed practical nurse/licensed vocational nurse in using the nursing process.
Page: 8
Heading: Identify Interventions
Integrated Process: Clinical Problem-Solving Process (Nursing Process)
Client Need: SECE – Coordination of Care
Cognitive Level: Application [Applying]
Concept: Patient-Centered Care
Difficulty: Moderate

	Feedback
1	Administering medication does not describe assessment.
2	Administering medication does not describe nursing diagnosis.
3	Administering medication describes the implementation process, since an action is being taken to help the patient meet a desired outcome.
4	Administering medication does not describe the evaluation phase of the nursing process.

PTS: 1 CON: Patient-Centered Care

10. ANS: 2
Chapter: Chapter 1 Critical Thinking and the Nursing Process
Objective: 3. Describe the thinking that occurs in each step of the nursing process.
Page: 8
Heading: Establish Outcomes
Integrated Process: Clinical Problem-solving (Nursing Process)
Client Need: SECE: Coordinated Care
Cognitive Level: Application [Applying]
Concept: Patient-Centered Care
Difficulty: Moderate

	Feedback
1	This is a vague outcome and is not measurable.
2	This is a measurable outcome and is not vague.
3	This is a vague outcome and is not measurable.
4	This is a vague outcome and is not measurable.

PTS: 1 CON: Patient-Centered Care

11. ANS: 4
Chapter: Chapter 1 Critical Thinking and the Nursing Process
Objective: 2. Describe attitudes and skills that promote critical thinking.
Page: 2