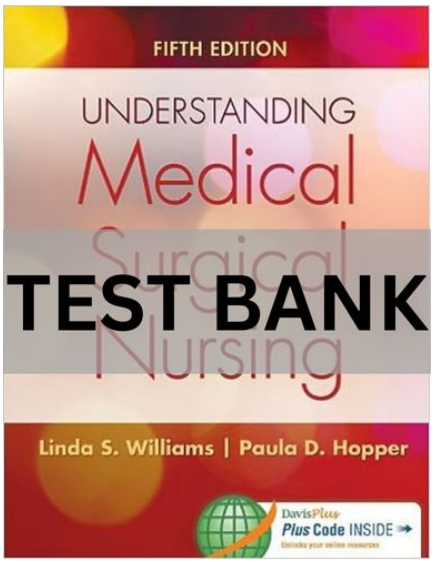
Understanding Medical Surgical Nursing 5th Edition Test Bank

Chapter 1. Critical Thinking and the Nursing Process



Multiple Choice

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

____ 1. After receiving morning report, which patient should the licensed practical nurse/licensed vocational nurse (LPN/LVN) assess first?
- **A.** A patient who needs discharge teaching
- **B.** A patient who needs assistance to ambulate
- **C.** A patient who states, "No one cares about me."
- **D.** A patient who has a temperature of 106°F (41.1°C)

____ 2. During a class discussion, two nursing students demonstrated intellectual courage. What action did the nursing students perform?
- **A.** Considered being in the other person's situation
- **B.** Expected proof that the use of restraints is safe
- **C.** Conducted additional research on the use of restraints in patient care
- **D.** Listened to each other's point of view regarding the use of patient restraints

____ 3. The nursing staff is planning a celebratory dinner and cake for a newly licensed practical nurse. Which of the new nurse's human needs is supported by these actions?
- **A.** Self-esteem
- **B.** Physiological
- **C.** Self-actualization
- **D.** Safety and security

____ 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 actions should the nurse take?
- **A.** Reposition the patient.
- **B.** Give the medication in 30 minutes.
- **C.** Notify the registered nurse (RN) or physician.
- **D.** Tell the patient it is too early for pain medication.

____ 5. The nursing instructor is planning a teaching session on critical thinking for students. What should the instructor say when explaining critical thinking?
- **A.** "Collect data concerning the patient's problem."
- **B.** "Think of different ways to help relieve a patient's problem."
- **C.** "Determine if an action worked to eliminate a patient problem."
- **D.** "Use knowledge and skills to make the best decision for patient care."

____ 6. The nurse is planning care and setting goals for a newly admitted patient. Who should the nurse include when conducting these nursing actions?
- **A.** Patient
- **B.** Nurse manager
- **C.** Patient's family members
- **D.** 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 patient's dressing. Which statement should the nurse use to document the finding?
A. "Normal drainage noted."
B. "Moderate drainage recently noted."
C. "Scant serosanguineous drainage seen on dressing."
D. "Pale pink drainage, 2 cm by 1 cm, noted on dressing."

____ 8. The nurse is caring for a patient who is scheduled for surgery. Which data should the nurse collect to identify safety and security needs?
A. Meal patterns
B. Sleep patterns
C. Anxiety about surgery
D. Effectiveness of pain medication

____ 9. The nurse is reviewing data collected during patient care. Which data should the nurse document as objective?
A. Patient is pleasant.
B. Urine output is 300 mL.
C. "It has been a good day."
D. Patient's appetite is poor.

____ 10. The nurse is determining diagnoses appropriate for a patient recovering from surgery. Which nursing diagnoses should the nurse identify as the highest priority for this patient?
A. Acute pain
B. Impaired mobility
C. Deficient knowledge
D. Impaired skin integrity

____ 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?
A. Sense of justice
B. Intellectual courage
C. Intellectual empathy
D. Intellectual perseverance

____ 12. The nurse is identifying outcomes for a patient with a Fluid Volume Deficit. Which outcome should the nurse use to guide the patient's care?
A. Patient's fluid intake will be measured daily.
B. Patient's intake will be 3000 mL daily.
C. Fluids will be at the bedside for the patient.
D. Fluids the patient likes will be at the bedside.

____ 13. The nurse is caring for a patient with the diagnosis of Fluid Volume Excess. Which information should the LPN/LVN use to determine if care was effective?
A. Restrict the patient's fluid intake.
B. Measure the patient's daily weight.
C. Teach the patient to monitor fluid balance.
D. Discuss the patient's care plan with the RN.

____ 14. A RN delegates a patient care assignment to the LPN/LVN. Which phase of the nursing process should the LPN/LVN perform independently?
A. Assessment
B. Planning care

C. Implementation
D. Nursing diagnosis

____ 15. The nurse is caring for a patient with a painful back injury that occurred 6 months ago. Which three-part nursing diagnosis should the nurse use to guide this patient's care?
A. Pain as evidenced by herniated lumbar disk
B. Acute pain related to inability to sit as evidenced by muscle spasms
C. Chronic pain related to muscle spasms as evidenced by patient pain rating of 8 and difficulty walking
D. Acute pain related to patient pain rating of 6 as evidenced by muscle spasms and nerve compression

____ 16. The RN implements an intervention to improve a patient's appetite. After implementing the intervention for two meals, the LPN/LVN notes no improvement in the patient's eating. What action should the LPN/LVN take?
A. Develop a new plan of care.
B. Revise the patient outcome to one that is achievable.
C. Collaborate on a new nursing diagnosis with the RN.
D. Provide data to the RN to assist in evaluation of the plan.

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

____ 18. The LPN/LVN is reviewing a patient's list of nursing diagnoses. Which diagnoses should the LPN/LVN identify as a priority for this patient?
A. Anxiety
B. Constipation
C. Deficient fluid volume
D. Ineffective airway clearance

____ 19. The nurse is using the nursing process when caring for a patient. In which order should the nurse implement this process?
A. Nursing diagnosis, intervention, rationale, evaluation, planning
B. Data collection, intervention, nursing diagnosis, rationale, evaluation
C. Assessment, nursing diagnosis, planning, implementation, evaluation
D. Data collection, evaluation, nursing diagnosis, implementation, rationale

____ 20. The nurse is determining a patient's problems. What step of the nursing process is the nurse performing?
A. Assessment
B. Outcome planning
C. Nursing diagnosis
D. Nursing intervention

____ 21. The nurse is preparing to determine if a patient is meeting planned outcomes. What measurable information should the nurse use to make this determination?
A. P-E-S format
B. Objective observations
C. Subjective terminology
D. Open-ended time frames

____ 22. The nurse is planning a patient's care based on Maslow's hierarchy of needs. Which human need should the nurse identify as requiring his or her immediate attention?
A. Heart rate 38 and irregular
B. Plans to return to college in a year
C. Needs walker adjusted to safely ambulate
D. Desire to learn how to self-inject medication

____ 23. While being taught to apply a topical medication, the patient begins to vomit. Which action should the nurse take to meet the patient's human needs?
A. Provide a clean gown before resuming the teaching.
B. Position an emesis basin for patient use while teaching.
C. Provide medication prescribed for nausea and vomiting.
D. Wait for the vomiting to stop and begin the teaching session again.

____ 24. The nurse approaches a person in a restaurant who appears to be experiencing respiratory distress. Which action should the nurse perform first?
A. Diagnose the problem.
B. Help the person lie down.
C. Gather data from other people.
D. Collect data about the person's condition.

____ 25. The nurse identifies the diagnosis Fluid Volume Overload as appropriate for a patient with heart failure. Which collected data should the nurse use to provide evidence for this diagnosis?
A. Skin warm to the touch
B. Oriented to person only
C. Respiratory rate 20 and shallow
D. +3 pitting edema of both feet and ankles

____ 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?
A. The patient will have less heartburn.
B. The patient will sleep through the night.
C. The patient's esophageal burning will resolve 30 minutes after taking oral antacids.
D. 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.)
A. Diabetes
B. Acute pain
C. Pancreatitis
D. Activity intolerance
E. 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.)
A. Diabetes
B. Dehydration
C. Risk for falls
D. Hyperglycemia
E. 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.)
A. Apply oxygen, 2 liters, per nasal cannula.
B. Turn and reposition in bed every 2 hours.
C. Coach to deep breathe and cough every hour.
D. Administer intramuscular antibiotic medication.
E. Encourage to drink 240 mL of fluid every 2 hours.

____ 30. The nurse finishes collecting data on a patient with injuries from a motor vehicle crash. Which data should the nurse document as objective? (Select all that apply.)
A. Patient in no acute distress
B. "I can't believe I wrecked my car."
C. Complains of pain when moving arms
D. Oxygen saturation level 92% on room air
E. Mid-forehead wound 3 cm long, oozing blood

Other

31. A patient with a history of respiratory disease is recovering from total hip replacement surgery. In which order should the nurse address the patient's diagnoses? (Place in order from 1 to 4.)
A. _____ Acute pain related to surgery
B. _____ Risk for injury related to unsteady gait
C. _____ Deficient knowledge related to use of a walker
D. _____ Impaired gas exchange related to compromised respiratory system

32. The nurse is caring for a patient recovering from a stroke. Use the nursing process to order the observations made or actions performed while caring for this patient (A–E).
A. Hand grasp absent left hand
B. Alteration in Cerebral Perfusion
C. The patient flexed left thumb and index finger.
D. Coached to squeeze rubber ball placed in left hand.
E. The patient will be able to self-feed using left hand.

Understanding Medical Surgical Nursing 5th Edition Test Bank

Chapter 1. Critical Thinking and the Nursing Process
Answer Section

MULTIPLE CHOICE

1. ANS: D
   D. According to Maslow, humans' basic physiological needs have the highest priority, and these patients' health problems should be addressed first. Life-threatening needs are ranked first; health-threatening needs are second; and health-promoting needs are last. The elevated temperature has the greatest urgency. A, B, and C are not as high priority.

   PTS: 1 DIF: Moderate REF: Page 8
   KEY: Client Need: Safe and Effective Care Environment—Management of Care | Cognitive Level: Application
2. ANS: D
   D. Intellectual courage is looking at other points of view. A. Intellectual empathy allows a person to consider another's situation. B. Intellectual integrity is seeking the same level of proof for comparable items. C. Intellectual perseverance is continuing to search for evidence about a concern.

   PTS: 1 DIF: Moderate REF: Page 3
   KEY: Client Need: Safe and Effective Care Environment—Management of Care| Cognitive Level: Application
3. ANS: A
   A. Recognizing a person's accomplishments enhances self-esteem. B. C. D. The staff's actions are not meeting physiological, self-actualization, or safety and security needs of the new nurse.

   PTS: 1 DIF: Moderate REF: Page 8 KEY: Client Need: Psychosocial Integrity
4. ANS: C
   C. The patient should not have to wait for pain relief. The LPN should inform the RN or physician, so new pain relief orders can be obtained. A. The patient who has a fractured femur is experiencing acute pain. Repositioning a patient with a new fracture is not likely to relieve pain. B. Giving the medication before the prescribed time is beyond the nurse's scope of practice. D. The nurse needs to do more than expect the patient to wait for pain relief.

   PTS: 1 DIF: Moderate REF: Page 4
   KEY: Client Need: Safe and Effective Care Environment—Management of Care | Cognitive Level: Application
5. ANS: D
   D. Critical thinking is using knowledge and skills to make the best decisions possible in patient care situations. A. Collecting data describes assessment. B. Thinking of different ways to help a patient with a problem is planning. C. Determining if an action worked to eliminate a patient problem is evaluation.

   PTS: 1 DIF: Moderate REF: Page 3
   KEY: Client Need: Safe and Effective Care Environment—Management of Care | Cognitive Level: Application
6. ANS: A

A. Planning care and setting goals are actions performed with the patient. The patient must be in agreement with the plan for it to be successful in meeting the desired outcomes. B. The nurse manager may or may not be aware of the patient's care needs. C. The patient's family may or may not be aware of the patient's care needs. D. The focus of nursing care is different from that of the HCP.

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KEY: Client Need: Safe and Effective Care Environment—Management of Care | Cognitive Level: Application

7. ANS: D
D. Objective data are pieces of factual information obtained through physical assessment and diagnostic tests observable or knowable through the five senses. The nurse should document exactly what is seen. A. B. C. These statements are interpretations of the data and use words that have vague meanings, which should be avoided when documenting.

PTS: 1 DIF: Moderate REF: Page 6
KEY: Client Need: Physiological Integrity—Physiological Adaptation | Cognitive Level: Application

8. ANS: C
C. A threat to a person's safety and security, such as surgery, creates anxiety. The patient's anxiety level will help the nurse plan care to meet safety and security needs. A, B, and D describe data used to support the patient's physiological needs.

PTS: 1 DIF: Moderate REF: Page 5
KEY: Client Need: Psychosocial Integrity | Cognitive Level: Application

9. ANS: B
B. Objective data are factual information such as the volume of urine output. A. This is an opinion that the nurse has about the patient's behavior and is too vague to document as objective data. C. This statement is in quotations, so it is something that the patient subjectively stated. D. This is an opinion the nurse has about the patient's appetite and is too vague to document as objective data.

PTS: 1 DIF: Moderate REF: Page 6
KEY: Client Need: Safe and Effective Care Environment—Management of Care | Cognitive Level: Application

10. ANS: A
A. Using Maslow's hierarchy, pain is the highest priority nursing diagnosis for a postoperative patient. B. D. These diagnoses would be equally important after the patient's pain is addressed, because they focus on physiological needs. C. This diagnosis can be addressed at a later time once physiological needs have been met.

PTS: 1 DIF: Moderate REF: Page 7
KEY: Client Need: Safe and Effective Care Environment—Management of Care | Cognitive Level: Application

11. ANS: D
D. Intellectual perseverance is not giving up. A. A sense of justice examines motives when making decisions. B. Intellectual courage looks at other points of view, even when the nurse does not agree with them. C. Intellectual empathy understands how another person feels when making decisions.

PTS: 1 DIF: Moderate REF: Page 3
KEY: Client Need: Safe and Effective Care Environment—Management of Care | Cognitive Level: Analysis

12. ANS: B
B. This outcome provides objective measurable data. A. C. D. These statements are nursing actions.

PTS: 1 DIF: Moderate REF: Page 9
KEY: Client Need: Physiological Integrity—Physiological Adaptation | Cognitive Level: Application

13. ANS: B
B. To evaluate the effectiveness of the plan of care and the actions implemented, the nurse must assess the outcome for the patient's nursing diagnosis and determine if the outcome has been achieved or if revisions are needed. For this patient, a change in weight is an objective measurement for determining if interventions to address Fluid Volume Excess have been effective. A. Restricting fluid intake is a nursing action. Evaluation is required to determine patient outcome and effective care. C. Teaching the patient to monitor fluid balance is an intervention and will not help determine the effectiveness of care. D. Although discussing the plan of care with the RN is relevant to the patient's care, it will not help determine effectiveness of care provided.

PTS: 1 DIF: Difficult REF: Page 9
KEY: Client Need: Safe and Effective Care Environment—Management of Care | Cognitive Level: Analysis

14. ANS: C
C. The LPN/LVN independently provides direct patient care. A. B. D. The LPN/LVN assists the RN with collecting data, formulating nursing diagnoses, determining outcomes, and planning care to meet patient needs.

PTS: 1 DIF: Moderate REF: Page 10
KEY: Client Need: Safe and Effective Care Environment—Management of Care | Cognitive Level: Application

15. ANS: C
C. "Chronic pain related to muscle spasms as evidenced by patient pain rating of 8 and difficulty walking" uses the three-part, or Problem, Etiology, and Signs/Symptoms, system with measurable data as evidence. This best guides the nurse's care and evaluation of the outcome. A. This statement includes a medical diagnosis. B. D. There is not enough measurable evidence for these nursing diagnosis statements.

PTS: 1 DIF: Moderate REF: Page 7
KEY: Client Need: Physiological Integrity—Basic Care and Comfort | Cognitive Level: Application

16. ANS: D
D. The role of the LPN/LVN includes data collection and assisting in evaluating outcomes. The LPN/LVN should provide new data to the RN, so they can revise the plan of care together. A. B. This is not done independently. C. A new diagnosis may be appropriate, but is not carried out independently of the RN.

PTS: 1 DIF: Moderate REF: Page 10
KEY: Client Need: Safe and Effective Care Environment—Management of Care | Cognitive Level: Application

17. ANS: D
D. Using Maslow's hierarchy of needs and considering which patient problems are life-threatening, shortness of breath is most important. A. B. C. Problems of pain, constipation, and scheduled tests are all important, but not immediately life-threatening.

PTS: 1 DIF: Difficult REF: Page 8
KEY: Client Need: Physiological Integrity—Physiological Adaptation | Cognitive Level: Analysis

18. ANS: D

D. Ineffective airway clearance is the highest priority, because it can be life-threatening. B. C. These diagnoses are important; however they are not immediately life-threatening. A. Anxiety is the lowest priority, because physiological needs must be addressed first.

PTS: 1 DIF: Moderate REF: Page 8
KEY: Client Need: Physiological Integrity—Physiological Adaptation | Cognitive Level: Analysis

19. ANS: C
C. The nurse should implement the steps of the nursing process by beginning with assessment, formulating nursing diagnoses, planning care, implementing care, and then evaluating care. A. B. D. These lists do not implement the steps of the nursing process in appropriate order. Rationale is not a step in the nursing process.

PTS: 1 DIF: Moderate REF: Page 5
KEY: Client Need: Safe and Effective Care Environment—Management of Care | Cognitive Level: Application

20. ANS: C
C. A nursing diagnosis is a clinical judgment about individual, family, or community response to actual or potential health problems or life processes. Nursing diagnoses are standardized labels that make an identified problem understandable to all nurses. A. Assessment is the collection of data used to identify patient problems. B. Outcome planning occurs after a patient's problems have been identified. D. Interventions are provided after the problems, plan, and outcome have been identified.

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KEY: Client Need: Safe and Effective Care Environment—Management of Care | Cognitive Level: Application

21. ANS: B
B. Measurable means that an outcome can be observed or is objective. It should not be vague or open to interpretation. A. Problem-Etiology-Symptoms (PES) format refers to nursing diagnoses, not outcomes measurement. C. Subjective terminology is the use of patient statements to support objective data. D. Open-ended time frames do not help with measurement.

PTS: 1 DIF: Moderate REF: Page 6
KEY: Client Need: Safe and Effective Care Environment—Management of Care | Cognitive Level: Application

22. ANS: A
A. According to Maslow, basic needs or physiological needs must be met first. A heart rate of 38 and irregular is a physiological need. C. Safety and security needs are met after physiological needs have been satisfied. Safe ambulation would be addressed next. D. Self-esteem needs are met after safety and security needs have been addressed. The desire to be independent with medication injections can be addressed after safety and security needs. B. Planning to return to college is an example of self-actualization, which is a need that can be addressed last.

PTS: 1 DIF: Moderate REF: Page 8
KEY: Client Need: Safe and Effective Care Environment—Management of Care | Cognitive Level: Analysis

23. ANS: C
C. Basic physiological needs must be met first. Since the patient is vomiting, the nurse should provide the medication prescribed for nausea and vomiting. A. B. D. These actions do not take the patient's physiological needs into consideration. The patient will not be able to achieve a higher level of the hierarchy before basic physiological needs are met.

PTS: 1 DIF: Moderate REF: Page 8
KEY: Client Need: Safe and Effective Care Environment—Management of Care | Cognitive Level: Application

24. ANS: D
D. The first step in the nursing process is to collect data, and the patient should come first. C. The nurse can collect data from other people if necessary. A. Diagnosing the problem would occur after collecting data. B. Helping the person lie down is implementing an action to address the problem.

PTS: 1 DIF: Moderate REF: Page 5
KEY: Client Need: Physiological Integrity—Physiological Adaptation | Cognitive Level: Analysis

25. ANS: D
D. Collected data that the nurse should use as evidence for the diagnosis are signs and symptoms related to the diagnosis. For Fluid Volume Overload, edema would be used as evidence that the patient's tissue is accumulating extra fluid. A. Skin warm to the touch is an opinion. B. Oriented to person only is objective data; however, it does not apply to the nursing diagnosis. C. Respiratory rate 20 and shallow is objective data; however, it does not apply to the nursing diagnosis.

PTS: 1 DIF: Moderate REF: Page 6
KEY: Client Need: Physiological Integrity—Physiological Adaptation | Cognitive Level: Analysis

26. ANS: C
C. Outcomes should be measurable and realistic for the patient; they should include an appropriate time frame for achievement. A. Outcomes should not be vague or open to interpretation, with the use of subjective words such as "normal," "large," "small," or "moderate." B. Sleeping through the night may or may not be associated with the patient's problem. D. Stating that the burning only occurs when eating foods high in acid content is a patient observation that could be used for subjective data collection.

PTS: 1 DIF: Moderate REF: Page 9
KEY: Client Need: Physiological Integrity—Physiological Adaptation | Cognitive Level: Analysis

MULTIPLE RESPONSE

27. ANS: B, D, E
B. D. E. Acute Pain, Activity Intolerance, and Impaired Physical Mobility are nursing diagnoses. A. C. Diabetes and Pancreatitis are medical diagnoses.

PTS: 1 DIF: Moderate REF: Page 7
KEY: Client Need: Safe and Effective Care Environment—Management of Care | Cognitive Level: Analysis

28. ANS: C, E
C. E. Deficient fluid volume and Risk for falls are nursing diagnoses related to the patient's symptoms and condition. A. B. D. Diabetes, Dehydration, and Hyperglycemia are medical problems. The nurse assists with medical diagnoses; however, the nurse does not diagnose and treat medical problems.

PTS: 1 DIF: Moderate REF: Page 7
KEY: Client Need: Physiological Integrity—Physiological Adaptation | Cognitive Level: Application

29. ANS: B, C, E