Fundamentals of Nursing 9th Edition by Taylor, Lynn, Bartlett Test Bank

Professional Nursing 1 (Youngstown State University)

Chapter 1, Introduction to Nursing

1. An oncology nurse with 15 years of experience, certification in the area of oncology nursing, and a master's degree is considered to be an expert in her area of practice and works on an oncology unit in a large teaching hospital. Based upon this description, which of the following career roles best describes this nurse's role, taking into account her qualifications and experience?

A) Clinical nurse specialist

B) Nurse entrepreneur

C) Nurse practitioner

D) Nurse educator

Ans: A

Feedback:

A clinical nurse specialist is a nurse with an advanced degree, education, or experience who is considered to be an expert in a specialized area of nursing. The clinical nurse specialist carries out direct patient care; consultation; teaching of patients, families, and staff; and research. A nurse practitioner has an advanced degree and works in a variety of settings to deliver primary care. A nurse educator usually has an advanced degree and teaches in the educational or clinical setting. A nurse entrepreneur may manage a clinic or health-related business.

2. What guidelines do nurses follow to identify the patient's health care needs and strengths, to establish and carry out a plan of care to meet those needs, and to evaluate the effectiveness of the plan to meet established outcomes?

A) Nursing process

B) ANA Standards of Professional Performance

C) Evidence-based practice guidelines

D) Nurse Practice Acts

Ans: A

Feedback:

The nursing process is one of the major guidelines for nursing practice. Nurses implement their roles through the nursing process. The nursing process is used by the nurse to identify the patient's health care needs and strengths, to establish and carry out a plan of care to meet those needs, and to evaluate the effectiveness of the plan to meet established outcomes.

3. Which of the following organizations is the best source of information when a nurse wishes to determine whether an action is within the scope of nursing practice?

A) American Nurses Association (ANA)

B) American Association of Colleges in Nursing (AACN)

C) National League for Nursing (NLN)

D) International Council of Nurses (ICN)

Ans: A

Feedback:

The ANA produces the 2003 *Nursing: Scope and Standards of Practice*, which defines the activities specific and unique to nursing. The AACN addresses educational standards, while the NLN promotes and fosters various aspects of nursing.

The ICN provides a venue for national nursing organizations to collaborate, but does not define standards and scope of practice.

4. Who is considered to be the founder of professional nursing?

A) Dorothea Dix

B) Lillian Wald

C) Florence Nightingale

D) Clara Barton

Ans: C

Feedback:

Florence Nightingale is considered to be the founder of professional nursing. She elevated the status of nursing to a respected occupation, improved the quality of nursing care, and founded modern nursing education. Although the other choices are women who were important to the development of nursing, none of them is considered the founder.

5. Which of the following nursing pioneers established the Red Cross in the United States in 1882?

A) Florence Nightingale

B) Clara Barton

C) Dorothea Dix

D) Jane Addams

Ans: B

Feedback:

Clara Barton volunteered to care for wounds and feed union soldiers during the civil war, served as the supervisor of nurses for the Army of the James, organized hospitals and nurses, and established the Red Cross in the United States in 1882.

6. A nurse practitioner is caring for a couple who are the parents of an infant diagnosed with Down Syndrome. The nurse makes referrals for a parent support group for the family. This is an example of which nursing role?

A) Teacher/Educator

B) Leader

C) Counselor

D) Collaborator

Ans: C

Feedback:

Counseling skills involve the use of therapeutic interpersonal communication skills to provide information, make appropriate referrals, and facilitate the patient's problem-solving and decision-making skills. The teacher/educator uses communication skills to assess, implement, and evaluate individualized teaching plans to meet learning needs of clients and their families. A leader displays an assertive, self-confident practice of nursing when providing care, effecting change, and functioning with groups. The collaborator uses skills in organization, communication, and advocacy to facilitate the functions of all members of the health care team as they provide patient care.

7. A nurse is providing nursing care in a neighborhood clinic to single, pregnant teens. Which of the following actions is the best example of using the counselor role as a nurse?

A) Discussing the legal aspects of adoption for teens wishing to place their infants with a family

B) Searching the Internet for information on child care for the teens who wish to return to school

C) Conducting a client interview and documenting the information on the client's chart

D) Referring a teen who admits having suicidal thoughts to a mental health care specialist

Ans: D

Feedback:

The role of the counselor includes making appropriate referrals. Discussing legal issues is the role of the advocate and searching for information on the Internet is the role of a researcher. Conducting a client interview would fall under the role of the caregiver.

8. A nurse instructor explains the concept of health to her students. Which of the following statements accurately describes this state of being?

A) Health is a state of optimal functioning.

B) Health is an absence of illness.

C) Health is always an objective state.

D) Health is not determined by the patient.

Ans: A

Feedback:

Health is a state of optimal functioning or well-being. As defined by the World Health Organization, one's health includes physical, social, and mental components and is not merely the absence of disease or infirmity. Health is often a subjective state; a person may be medically diagnosed with an illness but still consider himself or herself healthy.

9. A nurse incorporates the health promotion guidelines established by the U.S. Department of Health document: *Healthy People 2010*. Which of the following is a health indicator discussed in this document?

A) Cancer

B) Obesity

C) Diabetes

D) Hypertension

Ans: B

Feedback:

The 10 leading indicators of health established by *Healthy People 2010* are: physical activity, excessive weight and obesity, tobacco use, substance abuse, responsible sexual behavior, mental health, injury and violence, environmental quality, immunizations, and access to health care.

10. Which of the following is a criteria that defines nursing as profession?

A) an undefined body of knowledge

B) a dependence on the medical profession

C) an ability to diagnose medical problems

D) a strong service orientation

Ans: D

Feedback:

Nursing is recognized increasingly as a profession based on the following defining criteria: well-defined body of specific and unique knowledge; strong service orientation; recognized authority by a professional group; code of ethics; professional organization that sets standards; ongoing research; and autonomy.

11. After graduation from an accredited program in nursing and successfully passing the NCLEX, what gives the nurse a legal right to practice?

A) Enrolling in an advanced degree program

B) Filing NCLEX results in the county of residence

C) Being licensed by the State Board of Nursing

D) Having a signed letter confirming graduation

Ans: C

Feedback:

The Board of Nursing in each state has the legal authority to allow graduates of approved schools of nursing to take the licensing examination. Those who successfully meet the requirements for licensure are given a license to practice nursing in the state. It is illegal to practice nursing without a license issued by the State Board of Nursing. A nurse does not have the legal right to practice nursing by enrolling in an advanced degree program, filing NCLEX results, or having a letter confirming graduation.

12. A health care facility determined that a nurse employed on a medical unit was documenting care that was not being given, and subsequently reported the action to the State Board of Nursing. How might this affect the nurse's license to practice nursing?

A) It will have no effect on the ability to practice nursing.

B) The nurse can practice nursing at a less-skilled level.

C) The nurse's license may be revoked or suspended.

D) The nurse's license will permanently carry a felony conviction.

Ans: C

Feedback:

The license and the right to practice nursing can be denied, revoked, or suspended for professional misconduct, such as a crime. Other areas of professional misconduct include incompetence, negligence, and chemical impairment. Committing a felony does affect the legal right to practice nursing, does not allow the nurse to practice at a lower level, and is not attached to the license.

13. While providing care to the diabetic patient the nurse determines that the patient has a knowledge deficit regarding insulin administration. This nursing action is described in which phase of the nursing process?

A) evaluation

B) implementation

C) planning

D) nursing diagnosis

Ans: D

Feedback:

Nursing focuses on human responses to actual or potential health problems. Identifying the problems occur in the nursing diagnosis phase. Mutually establishing expected outcomes with the patient occurs in the planning phase. Implementation of the individualized interventions, and evaluation of outcomes are also phases in the nursing process.

14. A nurse is caring for a client who is a chronic alcoholic. The nurse educates the client about the harmful effects of alcohol and educates the family on how to cope with the client and his alcohol addiction. Which of the following skills is the nurse using?

A) Caring

B) Comforting

C) Counseling

D) Assessment

Ans: C

Feedback:

The nurse is using counseling skills to educate the client about the harmful effects of alcohol. The nurse can also suggest rehabilitative care for the client. The nurse uses therapeutic communication techniques to encourage verbal expression and to understand the client's perspective. Caring, comforting, and assessment may require active listening, but counseling is based upon the active listening and interaction between the client and the counselor.

15. A nurse is caring for a client with quadriplegia who is fully conscious and able to communicate. What skills of the nurse would be the most important for this client?

A) Comforting

B) Assessment

C) Counseling

D) Caring

Ans: D

Feedback:

The client needs assistance in performing activities of daily life. This would require implementation of caring skills from the nurse. Comforting, counseling, and assessment skills are also required, but the priority is the caring skill. Comforting skills involve providing safety and security to the client, whereas counseling skills are implemented while providing health education and emotional support. Assessment skills would be required when collecting data from the client.

16. A nurse is assigned the care of a client who has been admitted to the health care facility with high fever. Which nursing skill should be put into practice at the first contact with the client?

A) Assessment

B) Caring

C) Comforting

D) Counseling

Ans: A

Feedback:

On admission of the client to a health care facility, the nurse would be required to conduct an initial assessment of the client. Therefore, the nurse would implement his or her nursing skills in this case. This can be done by interviewing, observing, and examining the client. Caring skills are put into practice once the nursing needs are determined. Comforting and counseling skills may not have a major role in assessing client problems.

17. A nurse is caring for a client with a hernia. Which of the following statements should the nurse use while counseling the client about his condition?

A) "Open hernioplasty is the best surgery for you."

B) "Open and laparoscopic hernioplasty are available."

C) "You are not a suitable candidate for hernioplasty."

D) "I had a bad experience when I underwent hernioplasty."

Ans: B

Feedback:

A counselor should provide the client with unbiased information from which to choose. Therefore, the statement that "Open and laparoscopic hernioplasty are available" should be used by the nurse when counseling a client with hernia. The nurse should, however, refrain from giving a personal opinion, so it should not be mentioned which surgery is best for the client; likewise, the nurse should not bring up his or her own past experiences. By reserving personal opinions, a nurse promotes the right of every person to make his or her own decisions and choices on matters affecting health and illness care. Telling the client about his suitability to surgery or the best surgery for him may be biased from the experiences of the past.

18. A registered nurse assigns the task of tracheostomy suctioning of a client to the LPN. The LPN informs the nurse that she has never done the procedure practically on a client. What should be the most appropriate response from the registered nurse?

A) "You are through with your theory class, so you should know."

B) "Take the help of the nurse who knows to perform the procedure."

C) "Take the help of the procedure manual and act accordingly."

D) "I will help you in performing the procedure on the client."

Ans: D

Feedback:

Although the registered nurse has assigned the task to the LPN, the overall responsibility lies with the registered nurse. The registered nurse is answerable for the client's care, not the LPN. Telling the LPN that she should know the procedure because it is taught in class is inappropriate; putting theory into application would require supervision. Asking the LPN to refer to the manual and perform the procedure is incorrect because the LPN may commit mistakes. The LPN is not confident about the procedure and therefore should not be asked to do the task alone or with another nurse who knows the procedure.

19. A nurse at a health care facility provides information, assistance, and encouragement to clients during the various phases of nursing care. In which of the following activities does the nurse use counseling skills?

A) Educating a group of young girls about AIDS

B) Telling a client to localize the pain in his abdomen

C) Encouraging a client to walk without support

D) Assisting a lactating mother in feeding her child

Ans: A

Feedback:

The activity of educating a group of young girls about AIDS is based on the nurse using counseling skills. Telling a client to localize his pain is an assessment skill. Encouraging a client to walk without support can be both a comforting skill and a caring skill. Assisting a lactating mother in feeding her baby is an example of a caring skill.

20. A student wants to join a nursing program that provides flexibility in working at both staff and managerial positions. Which nursing program should the nurse suggest for this student?

A) Hospital-based diplomas

B) Baccalaureate nursing programs

C) Associate degree programs

D) Continuing nursing programs

Ans: B

Feedback:

The student could opt for a baccalaureate nursing program. Baccalaureate-prepared nurses have the greatest flexibility in qualifying for nursing positions at both staff and managerial levels. Hospital-based diploma programs are three-year courses and provide maximum exposure to clinical nursing. Students becoming nurses through the associate degree program would not be expected to work in a management position. Continuing nursing programs are on-the-job educational programs.

21. Training schools for nurses were established in the United States after the Civil War. The standards of U.S. schools deviated from those of the Nightingale paradigm. Which of the following statements is true about U.S. training schools?

A) Training schools were affiliated with a few select hospitals.

B) Training of nurses provided no financial advantages to the hospital.

C) Training was formal, based on nursing care.

D) Training schools eliminated the need to pay employees.

Ans: D

Feedback:

Training schools in the U.S. profited by eliminating the need to pay employees because students worked without pay in return for training, which usually consisted of chores. U.S. training schools were established by any hospital; there was no formal training. Training was an outcome of work, which eliminated the need to pay employees. Nightingale training schools were affiliated with a few select hospitals, training of nurses provided no financial advantages to the hospital, and the training was formal, based on nursing care.

22. A student has completed a nursing program accredited by the Commission on Collegiate Nursing Education. Which of the following is true about the organization?

A) It fosters continued improvement in nursing education programs.

B) Accreditation is by governmental peer review process.

C) It ensures the quality and integrity of diploma nursing programs.

D) It uses state-recognized standards to evaluate the programs.

Ans: A

Feedback:

The Commission on Collegiate Nursing Education fosters continued improvement in nursing education programs. Accreditation is by nongovernmental, peer review process. It ensures the quality and integrity of baccalaureate and graduate nursing programs, not diploma nursing programs. It uses nationally-recognized, not state-recognized, standards to evaluate the programs.

23. A registered nurse adheres to the American Nurses Association's standard of professional performance by engaging in which of the following?

A) Assessment

B) Diagnosis

C) Evaluation

D) Collaboration

Ans: D

Feedback:

Collaboration is designated in ANA's standard of professional performance. Assessment, diagnosis, and evaluation are not designated in ANA's standard of professional performance. They are professional nursing responsibilities designated in ANA's standard of care list.

24. During the clinical rotation, a nurse documents the vital signs of a client on the bedside chart. What role is the nurse playing in such a situation?

A) Decision maker

B) Communicator

C) Coordinator

D) Client advocate

Ans: B

Feedback:

The nurse is providing, in written form, the client's vital signs to the health care provider checking the bedside chart during his or her clinical rounds, so the nurse acts as a communicator. The nurse is not making any decisions here, so the role is not that of a decision maker. The nurse is not playing the role of a coordinator or a client advocate. When the nurse coordinates services offered by a variety of health care professionals, the nurse acts as a coordinator. As a client advocate, the nurse should protect the client, understanding the client's needs and concerns.

25. A licensed practice nurse (LPN) is working as a staff nurse. What role do the LPNs working as staff nurses play?

A) Work only in long-term care facilities and at client's homes

B) Provide direct nursing care to the clients in the health care facility

C) Work only as care providers, team members, and communicators

D) Supervise the work of charge nurses working in different units

Ans: B

Feedback:

LPNs working as staff nurses provide direct nursing care to the clients in the health care facility. Staff nurses may work in hospitals, the community, clinics, long-term care facilities, or homes. They work not only as care providers, team

members, and communicators but also as decision makers, client advocates, and educators. They do not supervise the work of charge nurses working in different units. Their work is coordinated by the charge nurse or the team leader.

26. The Nurse Corps of the United States Army was established by whom?

A) Dorothea Dix

B) Lillian Wald

C) Florence Nightingale

D) Isabel Hampton Robb

Ans: A

Feedback:

Dorothea Dix established the Nurse Corps of the United States Army.

27. The director of nursing (DON) of a major hospital is seeking to hire a nurse with a strong technical background to care for patients on a busy surgical unit. The DON is most likely going to hire a nurse prepared at which level of nursing?

A) Doctoral level

B) Master's level

C) Baccalaureate level

D) Associate level

Ans: D

Feedback:

The ANA's 1965 resolution prompted the 1985 ANA statement adopting the titles of associate nurse (a nurse prepared in an associate degree program with an emphasis on technical practice) and professional nurse (a nurse possessing the baccalaureate degree in nursing) for these two levels. Master's and doctoral prepared nurses possess higher degrees and expertise.

28. A student is choosing her educational path and desires a nursing degree with a track that contains community nursing and leadership, as well as liberal arts. The student would best be suited in which type of program?

A) Licensed practical nursing program

B) Certification in a nursing specialty

C) Diploma nursing program

D) Baccalaureate program

Ans: D

Feedback:

The baccalaureate degree in nursing offers students a full college or university education with a background in the liberal arts.

29. A nurse is caring for a young victim of a terrorist attack. During the rehabilitative process, the nurse assists the client in bathing and dressing. What role the nurse is engaged in?

A) Advocate

B) Caregiver

C) Counselor

D) Educator

Ans: B

Feedback:

As providers of care, nurses assume responsibility for helping clients promote, restore, and maintain health and wellness. Communicating the client's needs and concerns, and protecting the client's rights are components of the advocacy role of nursing. The nurse is simply assisting in hygiene measures; no education or counseling is being provided.

30. A nurse receives an x-ray report on a newly admitted patient suspected of having a fractured tibia. The nurse contacts the physician to report the findings. What role is the nurse engaged in?

A) Communicator

B) Advocate

C) Caregiver

D) Researcher

Ans: A

Feedback:

Nurses are communicators when they report findings to the health care team. Advocacy involves actions such as protecting the patient's safety or rights. Administering care measures directly to the patient demonstrates the caregiver role. Research involves collecting and analyzing data.

31. The client's plan of care is created by the nurse using which guideline for nursing practice?

A) Nursing process

B) Nursing's Social Policy Statement

C) Nurse practice act

D) ANA Standards of Nursing Practice

Ans: A

Feedback:

Nursing process is used by nurses to identify the client's strengths, limitations, and health care needs; to formulate a plan of care to address the health care needs; to plan and implement a plan of care to meet those health care needs; and to evaluate the effectiveness of the plan to achieve established outcomes. The ANA Standards of Nursing Practice defines the activities of nurses that are specific and unique to nursing. Nurse practice acts are laws established by each state to regulate the practice of nursing. Nursing's Social Policy Statement describes the values and social responsibility of nursing, provides a definition and scope of practice for nursing and nursing's knowledge base, including the methods by which nursing is regulated.

32. The nurse is administering immunizations to a group of teens in a county health clinic. The nurse correctly identifies this action as:

A) Illness prevention

B) Restorative care

C) Treatment of disease

D) Supportive nursing care

Ans: A

Feedback:

The aim of illness prevention activities is to reduce the risk for illness, to promote good health habits, and to maintain optimal functioning. Immunization administration is an example of illness prevention. Assisting with crutch walking, and teaching medication administration would be examples of health restoration activities. Administering antibiotics to a patient to treat an infection would be an example of treatment of disease. Hospice care is an example of supportive care.

33. Which nursing role is the nurse exhibiting when collecting data about the number of urinary tract infections on the nursing unit?

A) Advocate

B) Leader

C) Counselor

D) Researcher

Ans: D

Feedback:

Data collection is part of the research process. As an advocate, the nurse would implement actions to protect the rights of the client. Counseling involves the use of therapeutic, interpersonal communication skills to provide information, make appropriate referrals, and facilitate client problem-solving and decision-making skills. A nurse leader is assertive and self-confident when providing care, effecting change, and functioning within groups.

34. A client reports to the emergency department with ankle pain from a minor road accident. The nurse asks the client to fully describe the circumstances of the accident. Which ANA standard of nursing practice is best demonstrated by the nurse's action?

A) Assessment

B) Diagnosis

C) Ethics

D) Caring

Ans: A

Feedback:

According to the ANA Standard I, the registered nurse collects comprehensive data pertinent to the client's health or the situation. Standard 2 – Diagnosis is Standard 2, which occurs when the registered nurse analyzes the assessment data to determine the diagnoses or issues pertaining to the client. Standard 7 – Ethics pertains to the ethical guidelines of nursing practice. Caring, although an essential part of nursing practice, is not considered an ANA Standard.

35. Organize these events in chronological order, beginning with the earliest (1) and ending with the most recent (5).

1) During the Crusades, religious orders provided nursing care to the sick.

2) Florence Nightingale administered care to British soldiers during the Crimean War.

3) Clara Barton organized the American Red Cross.

4) Mary Elizabeth Mahoney graduated from the New England Hospital for Women and Children in 1879 as America's first African American nurse.

5) Margaret Sanger advocated for contraception and family planning in the United States.

A) 1, 2, 3, 4, 5

B) 1, 2, 4, 3, 5

C) 1, 2, 4, 5, 3

D) 1, 2, 3, 5, 4

E) 2, 1, 4, 3, 5

Ans: A

Feedback:

The correct order of these events is (1) during the Crusades, religious orders provided nursing care to the sick; (2) Florence Nightingale administered care to British soldiers during the Crimean War; (3) Clara Barton organized the American Red Cross; (4) Mary Elizabeth Mahoney graduated from the New England Hospital for Women and Children in 1879 as America's first African American nurse; and (5) Margaret Sanger advocated for contraception and family planning in the United States.

Chapter 2, Theory, Research, and Evidence-Based Practice

1. After reviewing several research articles, the clinical nurse specialist on a medical surgical unit rewrites the procedure on assessing placement of a nasogastric tube. What source of nursing knowledge did the nurse use in this situation?

A) Scientific knowledge

B) Traditional knowledge

C) Authoritative knowledge

D) Philosophical knowledge

Ans: A

Feedback:

The clinical nurse specialist utilized scientific knowledge, which is gained through the research-based scientific method. Philosophical knowledge is not a source of nursing knowledge, but is a type of general knowledge. Authoritative knowledge comes from an expert and is accepted as truth based upon the person's perceived expertise. Traditional knowledge is that part of nursing practice passed down from generation to generation and is not based upon scientific inquiry.

2. Which of the following theories emphasizes the relationships between the whole and the parts, and describes how parts function and behave?

A) General systems theory

B) Nursing theory

C) Adaptation theory

D) Developmental theory

Ans: A

Feedback:

General systems theory describes how to break whole things into parts and then learn how the parts work together in "systems." Nursing theory attempts to describe, explain, predict, and control desired outcomes of nursing care practices. Adaptation theory defines adaptation as the adjustment of living matter to other living things and to environmental conditions. Developmental theory outlines the process of growth and development of humans as orderly and predictable.

3. A nurse researcher is studying perceptions of vocational rehabilitation for clients after a spinal cord injury. What type of research method will be used to study the perceptions of this group of individuals?

A) Qualitative research

B) Quantitative research

C) Basic research

D) Applied research

Ans: A

Feedback:

The nurse researcher will use qualitative research methods to investigate perceptions, and the researcher will analyze words instead of numbers, which are analyzed in quantitative research. Basic and applied research are quantitative research methods.

4. A staff development nurse is asking a group of new staff nurses to read and be prepared to discuss a qualitative study that focuses on nursing events of the past. This is done in an attempt to increase understanding of the nursing profession today. What method of qualitative research is used in this article?

A) Historical

B) Phenomenology

C) Grounded theory

D) Ethnography

Ans: A

Feedback:

This article uses historical methodology, which examines events of the past to increase understanding of the nursing profession today. Phenomenology is used to describe experiences as they are lived by the subjects being studied. Grounded theory is the discovery of how people describe their own reality and how their beliefs are related to their actions in a social scene. Ethnography is used to examine issues of a culture that are of interest to nursing.

5. In understanding the historical influences on nursing knowledge, nursing as a profession struggled for years to establish its own identify and to receive recognition for its contributions to health care. Why?

A) The conceptual and theoretical basis for nursing practice came from outside the profession.

B) Nurses were too busy working in practice to increase the public awareness associated with the role of the nurse.

C) Nurses spent most of their time in laboratory settings conducting research.

D) Women were independent and refused to work collectively.

Ans: A

Feedback:

Despite Florence Nightingale's belief in the uniqueness of nursing, the training of nurses was initially carried out under the direction and control of the medical profession. Because the conceptual and theoretical basis for nursing practice

came from outside the profession, nursing struggled for years to establish its own identify and to receive recognition for its significant contributions to health care.

6. An obstetrical nurse wishes to identify whether clients' perceptions of a high level of support from their partner is associated with a decreased length of the second stage of labor. Which type of quantitative research is most appropriate for this research question?

A) Correlational research

B) Descriptive research

C) Quasi-experimental research

D) Experimental research

Ans: A

Feedback:

Correlational quantitative research is used to examine relationships between two or more variables. In this case, the variables are perceptions of partner support and length of Stage 2 labor. There is no manipulation of the variables as there would be in an experimental or quasi-experimental study. The focus on the relationship between the two variables goes beyond simple description of events.

7. Nurse researchers have predicted that a newly created mentorship program will result in decreased absenteeism, increased retention, and decreased attrition among a hospital's nursing staff. Which of the following does this predicted relationship represent?

A) Hypothesis

B) Dependent variable

C) Abstract

D) Methodology

Ans: A

Feedback:

A hypothesis is an expected statement of the relationship between variables in a study. In this study, the dependent variables are absenteeism, retention, and attrition while the independent variable is the mentorship program. The methodology of a study is the logistical framework that guides the planning and execution of the study. An abstract is a summary of a research study published in a journal.

8. The practice of changing patients' bedclothes each day in acute care settings is an example of what type of knowledge?

A) Authoritative

B) Traditional

C) Scientific

D) Applied

Ans: B

Feedback:

Changing bedclothes daily in acute care settings is an example of traditional knowledge. The practice is not based on research findings, but is rather a part of nursing practice passed down from generation to generation.

9. A student nurse learns how to give injections from the nurse manager. This is an example of the acquisition of what type of knowledge?

A) Authoritative

B) Traditional

C) Scientific

D) Applied

Ans: A

Feedback:

Authoritative knowledge comes from an expert and is accepted as truth, based on the person's perceived expertise. Authoritative knowledge generally remains unchallenged as long as the presumed authority maintains his or her perceived expertise.

10. A client undergoing chemotherapy for a brain tumor believes that having a good attitude will help in the healing process. This is an example of what type of knowledge?

A) Science

B) Philosophy

C) Process

D) Virtue

Ans: B

Feedback:

Philosophy is the study of wisdom, fundamental knowledge, and the processes used to develop and construct one's perceptions of life. Philosophy provides a viewpoint and implies a system of values and beliefs. Each individual develops a personal philosophy to give meaning to experiences and to guide behavior and attitudes. Personal philosophies are developed by learning from interpersonal relationships, through formal and informal educational experiences, through religion and culture, and from the environment.

11. Which of the following accurately describes Florence Nightingale's influence on nursing knowledge?

A) She defined nursing practice as the continuation of medical practice.

B) She differentiated between health nursing and illness nursing.

C) She established training for nurses under the direction of the medical profession.

D) She established a theoretical base for nursing that originated outside the profession.

Ans: B

Feedback:

Nightingale influenced nursing knowledge and practice by demonstrating efficient and knowledgeable nursing care, defining nursing practice as separate and distinct from medical practice, and differentiating between health nursing and illness nursing.

12. During the first half of the 20th century, a change in the structure of society resulted in changed roles for women and, in turn, for nursing. What was one of these changes?

A) More women retired from the workforce to raise families.

B) Women became more dependent and sought higher education.

C) The focus of nursing changed to “hands-on training.”

D) Nursing research was conducted and published.

Ans: D

Feedback:

As a result of World Wars I and II, women increasingly entered the workforce, became more *independent*, and sought higher education. At the same time, nursing began to focus more on education than hands-on training, and nursing research was conducted and published.

13. A staff nurse asks a student, “Why in the world are you studying nursing theory?” How would the student best respond?

A) “Our school requires we take it before we can graduate.”

B) “We do it so we know more than your generation did.”

C) “I think it explains how we should collaborate with others.”

D) “It helps explain how nursing is different from medicine.”

Ans: D

Feedback:

Nursing theory differentiates nursing from other disciplines and activities in that it serves the purpose of describing, explaining, predicting, and controlling desired outcomes of nursing care practices.

14. Why are the developmental theories important to nursing practice?

A) They describe how parts work together as a system.

B) They outline the process of human growth and development.

C) They define human adaptation to others and to the environment.

D) They explain the importance of legal and ethical care.

Ans: B

Feedback:

Developmental theories outline the process of growth and development of humans as orderly and predictable, beginning with conception and ending with death. Nurses apply this knowledge to develop interventions for people across the life span. Systems theory, adaptation theories, and legal/ethical care are also important to nursing, but these do not explain the importance of human growth and development in nursing care.

15. There are four concepts common in all nursing theories. Which one of the four concepts is the focus of nursing?

A) Person

B) Environment

C) Health

D) Nursing

Ans: A

Feedback:

The four concepts listed are all common in nursing theory, but the most important—and the focus of nursing—is the person (client).

16. What is the ultimate goal of expanding nursing knowledge through nursing research?

A) Learn improved ways to promote and maintain health.

B) Develop technology to provide hands-on nursing care.

C) Apply knowledge to become independent practitioners.

D) Become full-fledged partners with other care providers.

Ans: A

Feedback:

The ultimate goal of expanding nursing's body of knowledge through nursing research is to learn improved ways to promote and maintain health. Ongoing practice-based research reflects the nursing profession's commitment to meet the ever-changing demands of health care consumers. While doing research also facilitates the development of technology, helps produce independent practitioners, and provides partnerships with other providers of care, those are not the ultimate goals of nursing research.

17. What was significant about the promotion of the National Center for Nursing Research to the current National Institute of Nursing Research (NINR)?

A) Increased numbers of articles are published in research journals.

B) NINR gained equal status with all other National Institutes of Health.

C) NINR became the major research body of the International Council of Nurses.

D) It decreased emphasis on clinical research as an important area for nursing.

Ans: B

Feedback:

The National Center for Nursing Research was promoted to the National Institute of Nursing Research (NINR) in 1993, gaining equal status with all other National Institutes of Health.

18. Which of the following is a responsibility of an institutional review board (IRB)?

A) Secure informed consent for researchers

B) Review written accuracy of research proposals

C) Determine risk status of all studies

D) Secure funding for institutional research

Ans: C

Feedback:

Federal regulations require that institutions receiving federal funding, or conducting studies of drugs or medical devices regulated by the Food and Drug Administration establish IRBs. The IRB reviews all studies conducted in the institution to determine risk status and to ensure that ethical principles are followed. The IRB does not secure informed consent, review the accuracy of proposals, or secure funding.

19. Before developing a procedure, a nurse reviews all current research-based literature on insertion of a nasogastric tube. What type of nursing will be practiced based on this review?

A) Institutional practice

B) Authoritative nursing

C) Evidence-based nursing

D) Factual-based nursing

Ans: C

Feedback:

Evidence-based nursing practice (EBNP) is the conscientious, explicit, and judicious use of research-based information in making decisions about the delivery of care. EBNP does not include institutional practice, authoritative nursing, or factual-based nursing.

20. One step in implementing evidence-based practice is to ask a question about a clinical area of interest or an intervention. The most common method is the PICO format. Which of the following accurately defines the letters in the PICO acronym?

A) P = population

B) I = institution

C) C = compromise

D) O = output

Ans: A

Feedback:

P = patient, population, or problem of interest, I = intervention of interest, C = comparison of interest, and O = outcome of interest

21. The nurse understands that general systems theory has important implications in nursing. Which of the following is an assumption of the general systems theory?

A) Human systems are open and dynamic.

B) All humans are born with instinctive needs.

C) Human needs are motivational forces.

D) People grow and change throughout their lives.

Ans: A

Feedback:

General systems theory assumes that human systems are open and dynamic with implicit boundaries. Human needs theory assumes that all humans are born with instinctive needs and human needs are motivational forces. Change theory assumes that people grow and change throughout their lives.

22. A nursing student is conducting a literature review via the Internet to identify a problem area that may be applicable in scope for nursing. When conducting the search, which of the following would be most important for the student to keep in mind?

A) The Internet should be the last resort for scientific literature review.

B) Very few nursing sites are available through the Internet.

C) Most websites that provide nursing information are reliable.

D) MedLine is a reputable online database of nursing information.

Ans: D

Feedback:

MedLine is a highly reputable online database of nursing information. The Internet is continuously growing as a resource for nursing research and has developed into a sophisticated tool for information retrieval, as well as research for the general public and for nursing and health professionals. Hundreds of sites are available through the World Wide Web. However, not all websites that provide nursing information are reliable.

23. A group of students is reviewing information about evidence-based practice in preparation for an exam. The students demonstrate understanding of the information when they identify which of the following as associated with evidence-based practice?

A) It emphasizes personal experience over science.

B) Clinical expertise is integrated with external evidence.

C) It involves gaining solutions to problems.

D) The purpose is to learn about a specific problem.

Ans: B

Feedback:

Evidence-based practice (EBP) is an approach to health care that realizes that pathophysiologic reasoning and personal experience are necessary, but not sufficient for making decisions. Advocates argue that medical decisions should be based, as much as possible, on a firm foundation of high-grade scientific evidence, rather than on experience or opinion. Its practice involves integrating individual clinical expertise with the best available external evidence from systematic research. Nursing research aims to gain solutions to problems, learn about a specific problem, or to understand a situation.

24. A nurse researcher decides to conduct a qualitative research study. With which of the following would the researcher be involved?

A) Collection of numerical data

B) Determination of cause and effect

C) Controlling personal biases

D) Real world data collection

Ans: D

Feedback:

Qualitative research strives for an understanding of the whole and requires the researcher to become the instrument as data is collected in the real-world, naturalistic setting. Numerical data, cause and effect and control of personal bias are key aspects of quantitative research.

25. In what way can a nurse differentiate strong research from poor research?

A) By conducting the research

B) Through author dialogue

C) By critiquing the study

D) Through the nurse's own informal investigation

Ans: C

Feedback:

Nurses must have a working knowledge of research methods, and a beginning ability to read for application and to critique research.

26. Nursing research is linked most closely to what?

A) Propositions

B) Outcome measures

C) Treatments

D) Nursing process

Ans: D

Feedback:

Many similarities are found between the formalized research process and the nursing process format that is an integral part of nursing education.

27. Which of the following research studies would be of most interest to a nurse manager?

A) Sister Callista Roy's theory on adaptation

B) Patricia Benner's From Novice to Expert

C) Kleinpell and Ferrans' older intensive-care clients

D) Madeleine Leininger's transcultural nursing theory

Ans: B

Feedback:

Research affects the clinical practice of nurses in all areas, particularly in relation to the goals of nursing. Benner's research will assist a nurse manager to support all levels of his or her staff.

28. How are the first stages of the nursing process and nursing research linked?

A) They will answer a posed question.

B) Each begins with goal development.

C) The nurse assesses problems initially.

D) There is a period of evaluation.

Ans: C

Feedback:

The first step for the practicing nurse is to assess a problem; for the researcher, the first step is to recognize the general problem area.

29. A nursing instructor would like to study the effect peer tutoring has on student success. What is the independent variable?

A) Nursing student

B) Nursing education

C) Peer tutoring

D) Student success

Ans: C

Feedback:

The independent variable is the presumed cause or influence on the dependent variable.

30. A nursing student has been asked to correlate her clinical experiences with two different theories of nursing. The student will recognize that which of the following concepts are common to all theories of nursing? Select all that apply.

A) The client

B) The environment

C) Illness

D) Needs

E) Nursing

Ans: A, B, E

Feedback:

While nursing theories vary significantly in their conceptualizations, the elements that are common to all include the client (person), the environment, health, and nursing. The concepts of needs and illness are addressed by some theories but these are not explicitly defined by other theories.

31. Which of the following are examples of characteristics of evidence-based practice? Select all that apply.

A) It is a problem-solving approach.

B) It uses the best evidence available.

C) It is generally accepted in clinical practice.

D) It is based on current institutional protocols.

E) It blends the science and art of nursing.

Ans: A, B, E

Feedback:

Evidence-based nursing is a problem-solving approach to making clinical decisions, using the best evidence available. EBP may meet resistance in clinical practice as a result of the nursing shortage, the acuity level of clients, nurse's skill in reading and evaluating published research, and an organizational culture that does not support change. EBP blends both the science and the art of nursing so that the best client outcomes are achieved. EBP takes into consideration client preferences and values as well as the clinical experiences of the nurse.

32. Which of the following are characteristics of nursing theories? Select all that apply.

A) They provide rational reasons for nursing interventions.

B) They are based on descriptions of what nursing should be.

C) They provide a knowledge base for appropriate nursing responses.

D) They provide a base for discussion of nursing issues.

E) They help resolve current nursing issues and establish trends.

Ans: A, C, D, E

Feedback:

Nursing theory provides rational and knowledgeable reasons for nursing interventions, based on descriptions of what nursing is and what nurses do. Additionally, nursing theory gives nurses the knowledge base necessary for acting and responding appropriately in various situations. It also provides a base for discussion, and, ideally, helps resolve current nursing issues. Nursing theories should be simple and general; simple terminology and broadly applicable concepts ensure their usefulness in a wide variety of nursing practice situations.

33. Which of the following examples represents the type of knowledge known as process? Select all that apply.

A) A nurse dispenses medications to clients.

B) A nurse changes the linens on a client's bed.

C) A nurse studies a nursing journal article on infection control.

D) A nurse consults an ethics committee regarding an ethical dilemma.

E) A nurse believes in providing culturally competent nursing care.

Ans: A, B

Feedback:

A process is a series of actions, changes, or functions intended to bring about a desired result. During a process, one takes systematic and continuous steps to meet a goal and uses both assessments and feedback to direct actions that meet the goal. Reading a nursing journal is considered science. Consulting an ethics committee and providing culturally competent nursing care is considered philosophy.

34. Which qualitative research method is described as follows: to describe experiences as they are lived by the subjects being studied?

A) Historical

B) Ethnography

C) Grounded theory

D) Phenomenology

Ans: D

Feedback:

The purpose of phenomenology, which is both a philosophy and a research method, is to describe experiences as they are lived by the subjects being studied. Historical research examines events of the past to increase understanding of the nursing profession today. Ethnography is used to examine issues of a culture that are of interest to nursing. The basis of grounded theory methodology is the discovery of how people describe their own reality, and how their beliefs are related to their actions in a social scene.

35. The nurse working in research correctly identifies which of the following to be mandatory for the ethical conduction of research in a hospital setting?

A) Clients must grant informed consent if they are to participate.

B) All interventions must benefit all clients.

C) The client must directly and personally benefit from the research.

D) Descriptive studies are more ethical than experimental studies.

Ans: A

Feedback:

Informed consent is an absolute prerequisite for clients who are asked to participate as subjects in a research study. Not all interventions will benefit all (or even any) clients. The risks and benefits of research are considered carefully in light of ethical principles, but this does not necessarily mean that every participant in a study stands to benefit from it. Ethical standards are applicable and achievable in every type of research, and descriptive studies are not necessarily more ethical than experiments.

Chapter 3, Health, Illness, and Disparities

1. The nurse is preparing a care plan for an African American man age 68 years who was recently diagnosed with hypertension. Age, race, gender, and genetic inheritance are examples of what human dimension?

A) Physical

B) Emotional

C) Environmental

D) Sociocultural

Ans: A

Feedback:

The physical dimension includes genetic inheritance, age, developmental level, race, and gender. These components strongly influence a person's health status and health practices. The emotional dimension focuses on how the mind affects body function and responds to body conditions. The environmental dimension includes influences such as housing, sanitation, climate, and pollution of food, air, and water. Sociocultural dimensions are health practices and beliefs strongly influenced by economic status, lifestyle, family, and culture.

2. The mother of a toddler with asthma seeks support from the parents of other children with asthma. The nurse recognizes that seeking and utilizing support systems is an example of which human dimension?

A) Sociocultural dimension

B) Physical dimension

C) Environmental dimension

D) Intellectual and spiritual dimension

Ans: A

Feedback:

Communicating with others and the use of support systems relate to the sociocultural dimension. An individual's relationship with others, being connected to a community, and feeling accepted and loved by others are also related to the sociocultural dimension.

3. A nurse educator uses models of health and illness when teaching. Which model of health and illness places high-level health and death on opposite ends of a graduated scale?

A) Health-Illness Continuum

B) Agent-Host-Environment Model

C) Health Belief Model

D) Health Promotion Model

Ans: A

Feedback:

The Health-Illness Continuum views health as a constantly changing state, with high-level wellness and death being on opposite ends of a graduated scale. The Agent-Host-Environment Model is useful in examining the causes of disease in an individual. The Health Belief Model describes health behaviors. The Health Promotion Model incorporates individual characteristics and experiences, as well as behavior-specific knowledge and beliefs, to motivate healthy behavior.

4. A homeless client has been brought to the emergency department (ED) by ambulance after being found unresponsive outside a mall. The client is known to the ED staff as having bipolar disorder, and assessment reveals likely cellulitis on his left ankle. He is febrile with a productive cough, and the care team suspects pneumonia. A sputum culture for tuberculosis has been obtained and sent to the laboratory. Which of the following aspects of the client's medical condition would be considered a chronic condition?

A) Bipolar disorder

B) Pneumonia

C) Cellulitis

D) Tuberculosis

Ans: A

Feedback:

Bipolar disorder is a long-standing diagnosis that requires the lifelong education and treatment associated with chronic conditions. Pneumonia, tuberculosis, and cellulitis are all acute, infectious diseases that may be treated with antibiotic regimens of varying length.

5. Which of the following activities related to respiratory health is an example of tertiary health promotion and illness prevention?

A) Administering a nebulized bronchodilator to a client who is short of breath

B) Assisting with lung function testing of a client to help determine a diagnosis

C) Teaching a client that "light" cigarettes do not prevent lung disease

D) Advocating politically for more explicit warning labels on cigarette packages

Ans: A

Feedback:

The use of medications is characteristic of tertiary health promotion and illness prevention. Testing and screening are examples of secondary health promotion and illness prevention, while client education and political advocacy are associated with primary prevention.

6. An elderly resident of a long-term care facility has developed diarrhea and dehydration as a result of exposure to *clostridium difficile* during a recent outbreak. The resident's primary care provider has consequently prescribed the antibiotic metronidazole (Flagyl). Which model of health promotion and illness prevention is most clearly evident in these events?

A) The Agent-Host-Environment Model

B) The Health-Illness Continuum

C) The Health Promotion Model

D) The Health Belief Model

Ans: A

Feedback:

The presence of an infectious microorganism and the act of treating that agent are associated with the Agent-Host-Environment Model of health promotion and illness prevention. The client's beliefs about health are not central in this scenario, and health promotion and the pursuit of health are not the most important priorities during this active treatment of illness. This client is not being characterized as existing on a point on a health continuum.

7. The nurse is performing a routine assessment of a male client who has an artificial arm as a result of a small plane crash many years earlier. How should the nurse best understand this client's health?

A) Despite the loss of his limb, the client may consider himself to be healthy.

B) The client may be well, but his loss of limb means that he is unhealthy.

C) The loss of his limb prevents the client from achieving wellness, though he may be healthy.

D) Because the client's injury is far in the past, it does not have a bearing on his health or wellness.

Ans: A

Feedback:

Individuals who live with chronic conditions, such as the loss of a limb, may accommodate their condition fully and consider themselves to be healthy and well. This is not a certainty, however, and the passage of time does not guarantee such acceptance.

8. What phrase best describes health?

A) Individually defined by each person

B) Experienced by each person in exactly the same way

C) The opposite of illness

D) The absence of disease

Ans: A

Feedback:

Health is individually defined by each person and is affected by many factors. The most widely accepted definition of health is that it is a state of complete physical, mental, and social well-being—not the absence of disease or infirmity. Health is experienced differently by each person; it is not the opposite of illness, and does not indicate the absence of disease.

9. Which of the following most accurately defines "illness"?

A) The inability to carry out normal activities of living

B) A pathologic change in mind or body structure or function

C) The response of a person to a disease

D) Achieving maximum potential and quality of life

Ans: C

Feedback:

Illness is the response of a person to a disease, an abnormal process in which one's level of function is changed when compared with the previous level. A disease (a medical term) means there is a pathologic change in the structure or function of the body or mind. Wellness is a term used to describe a person achieving maximum potential and quality of life despite disease or illness.

10. Which of the following statements accurately describes the concepts of disease and illness?

A) A disease is traditionally diagnosed and treated by a nurse.

B) The focus of nurses is the person with an illness.

C) A person with an illness cannot be considered healthy.

D) Illness is a normal process that affects level of functioning.

Ans: B

Feedback:

A disease is traditionally diagnosed and treated by a physician (although nurses with advanced educations are increasingly doing so), while nurses focus on the person with an illness. A person may have an illness or injury but still achieves maximum functioning and quality of life, and considers himself or herself to be healthy. Illness is the response of the person to a disease; it is an *abnormal*process in which the person's level of functioning is changed when compared with a previous level.

11. A nurse calls in to his unit to report he has the flu and will not be at work. What stage of illness behavior is he exhibiting?

A) Experiencing symptoms

B) Assuming the sick role

C) Assuming a dependent role

D) Achieving recovery and rehabilitation

Ans: B

Feedback:

When assuming the sick role, the person defines himself or herself as sick, seeks validation from others, and gives up normal activities such as going to work. Although the other choices are stages of illness, they are not defined by the behavior presented.

12. A cleint accepts the fact that he needs bypass surgery for a blocked artery and is admitted into the hospital. Which one of the following stages of illness is this client experiencing?

A) Stage 1

B) Stage 2

C) Stage 3

D) Stage 4

Ans: C

Feedback:

In Stage 3, assuming a dependent role, the patient decides to accept the diagnosis and follow the prescribed treatment plan. The person conforms to the opinions of others, often requires assistance in carrying out activities of daily living, and needs emotional support through acceptance, approval, physical closeness, and protection.

13. A child age 4 years has leukemia but is now in remission. What does it mean to be in remission when one has a chronic illness?

A) The chronic disease has been cured.

B) Nothing further can be done in terms of treatment.

C) Severe symptoms of the chronic illness have reappeared.

D) The disease is present, but symptoms are not experienced.

Ans: D

Feedback:

Many chronic illnesses have periods of remission and exacerbation. During remission, the disease is present but the person does not experience symptoms. During exacerbation, the symptoms of the illness reappear.

14. What may happen to the family when one of the family members suffers an illness?

A) Alterations in values and religious beliefs

B) More public displays of affection

C) Changes in roles for the client and family

D) Increased resistance to stress

Ans: C

Feedback:

When an illness occurs, roles change for both the client and the family. Chronic illnesses often result in increased stress for the family, but responses by all members are individualized.

15. A baby is born with Down syndrome, which influences his health–illness status. This is an example of which of the following human dimensions?

A) Physical

B) Emotional

C) Environmental

D) Sociocultural

Ans: A

Feedback:

The physical dimension includes genetic inheritance, age, developmental level, race, and gender. These components strongly influence the person's health status and health practices.

16. Which of the following statements illustrates the effect of the sociocultural dimension on health and illness?

A) "Why shouldn't I drink and drive? Everyone else does."

B) "My mother has sickle cell anemia, and so do I."

C) “I know I have heart problems, so I have changed my diet.”

D) “I used biofeedback to lower my blood pressure.”

Ans: A

Feedback:

Health practices and beliefs are strongly influenced by one’s sociocultural dimension, including lifestyle, family, and culture. These factors are involved in patterns of living (such as drinking and driving) and values about health and illness. Sickle cell anemia involves the physical dimension; changing one’s diet involves the intellectual dimension; and biofeedback involves the emotional dimension.

17. A middle-aged woman is 40 pounds over her ideal weight. Which of the following statements best illustrates the effect of her self-concept on health and illness?

A) “I am just too busy with my kids to bother about a diet.”

B) “Why should I lose weight? I’ll still be fat.”

C) “My sister is thin, but I don’t think she looks that good.”

D) “My husband loves me this way.”

Ans: B

Feedback:

Self-concept is an important variable affecting health and illness. People who are overweight may believe that nothing can change the way they look and refuse to follow a diet and exercise program.

18. A camp nurse is teaching a group of adolescent girls about the importance of monthly breast self-examination. What level of preventive care does this activity represent?

A) Primary

B) Secondary

C) Tertiary

D) Restorative

Ans: A

Feedback:

Primary preventive care activities are directed toward promoting health and preventing the development of disease. Teaching breast self-examination is an example of a primary preventive care activity.

19. Which of the following models of health promotion and illness prevention was developed to illustrate how people interact with their environment as they pursue health?

A) The health promotion model

B) The health belief model

C) The health–illness continuum

D) The agent–host–environment model

Ans: A

Feedback:

The health promotion model (Pender, Murdaugh, & Parsons, 2006) was developed to illustrate how people interact with their environment as they pursue health. The model incorporates individual characteristics and experiences and behavior-specific knowledge and beliefs, to motivate healthy behavior.

20. A nurse is caring for a client who is in the remission state of leukemia. The client expresses anxiety about the recurrence of leukemia. The client feels depressed when thinking about the outcome of leukemia. Which aspect of health is the client talking about?

A) Physical health

B) Emotional health

C) Social health

D) Spiritual health

Ans: B

Feedback:

Anxiety and depression are components of emotional health. The client is not feeling emotionally well because of worry about the disease outcomes. Currently the client is in remission and thus is physically healthy. The client does not mention anything about social interactions and spiritual health.

21. A nurse is educating women on the need for calcium to prevent bone loss. What level of prevention does this represent?

A) Primary prevention

B) Secondary prevention

C) Tertiary prevention

D) Residual prevention

Ans: A

Feedback:

Primary prevention or primary health care involves the education of clients in the prevention of disease.

22. A client states, “I must be in poor health because I am a senior citizen. That’s what my neighbor says and she is older than I am.” This statement is based on which of the following factors?

A) Age

B) Gender

C) Peer influence

D) Illness factors

Ans: C

Feedback:

Peer influence, personality characteristics, ethnicity, and socioeconomic factors may affect a person’s response to illness.

23. An woman 80 years of age has had a cerebrovascular accident. She has flaccidity of her right side with aphasia. For this client, which of the following activities constitutes tertiary prevention?

A) Assessment of her blood pressure

B) Daily bleeding and clotting times

C) Gait training and speech therapy

D) Education on the symptoms of a CVA

Ans: C

Feedback:

Tertiary prevention occurs when a person already has been diagnosed with a long-term disease or disability.

24. Which of the following statements accurately describes how risk factors may increase a person's chances for illness or injury? Select all that apply.

A) Risk factors are unrelated to the person or event.

B) All risk factors are modifiable.

C) An increase in risk factors increases the possibility of illness.

D) A family history of breast cancer is not a modifiable risk factor.

E) School-aged children are at high risk for communicable diseases.

Ans: C, D, E

Feedback:

A risk factor is something that increases a person's chances for illness or injury. Like other components of health and illness, risk factors are often interrelated. Risk factors may be further defined as modifiable (able to be changed, such as quitting smoking) or nonmodifiable (unable to be changed, such as a family history of cancer). As the number of risk factors increases, so does the possibility of illness. School-aged children are at high risk for communicable diseases. Multiple sexual relationships increase the risk for sexually transmitted diseases (e.g., gonorrhea or acquired immunodeficiency syndrome AIDS).

25. Which of the following statements explains why models of health promotion and illness prevention are useful when planning health care? Select all that apply.

A) They help health care providers understand health-related behaviors.

B) They are useful for adapting care to people from diverse backgrounds.

C) They help overcome barriers related to increased number of people without health care.

D) They overcome barriers to care for the predicted downward trend in minority populations.

E) They overcome barriers to care for low-income and rural populations.

Ans: A, B, C, E

Feedback:

Models of why and how individuals carry out behaviors to promote health and prevent illness are useful in helping health care providers understand health-related behaviors, and adapt care to people from diverse economic and cultural backgrounds. This knowledge can be used to overcome barriers to health from disparities in care resulting from such factors as the increasing number of people without health insurance; a predicted upward trend in minority populations; and a lack of accessible and essential health care services for low-income and rural populations. Many people do not take advantage of low-cost screens and health care information.

26. On which of the following components is Rosenstock's health belief model based? Select all that apply.

A) Perceived susceptibility to a disease

B) Perceived consequences of treating disease

C) Perceived seriousness of a disease

D) Perceived benefits of action

E) Perceived immunity to disease

Ans: A, C, D

Feedback:

The health belief model (Rosenstock, 1974) is concerned with what people perceive, or believe, to be true about themselves in relation to their health. This model is based on three components of individual perceptions of threat of a disease: (1) perceived susceptibility to a disease, (2) perceived seriousness of a disease, and (3) perceived benefits of action.

27. Which of the following nursing interventions is an example of health promotion and preventive care on the primary level? Select all that apply.

A) A nurse counsels a teenager to stop smoking.

B) A nurse conducts a health fair for high blood pressure screening.

C) A nurse counsels the family of a client diagnosed with lung cancer.

D) A home health care nurse arranges for rehabilitation services for a patient.

E) A school nurse arranges for a career seminar for graduating seniors.

Ans: A

Feedback:

Primary health promotion and illness prevention are directed toward promoting health and preventing the development of disease processes or injury. Nursing activities at the primary level may focus on individuals or groups. Examples are immunization clinics, family planning services, providing poison-control information, counseling about obesity and smoking cessation, and accident-prevention education. Conducting a high blood pressure screening and providing family counseling are secondary level preventive measures. Rehabilitation and career counseling fall under the tertiary level of preventive care.

28. The nursing instructor has given an assignment to a group of nurse practitioner students. They are to break into groups of four and complete a health-promotion teaching project, then present a report back to their fellow students. What project is the best example of health-promotion teaching?

A) Demonstrating an injection technique to a client for anticoagulant therapy

B) Explaining the side effects of a medication to an adult client

C) Discussing the importance of preventing sexually transmitted disease to a group of 12th-grade students

D) Instructing an adolescent client about safe food preparation

Ans: C

Feedback:

Health promotion encourages people to live a healthy lifestyle and to achieve a high level of wellness. Discussing the importance of STD prevention to a group of 12th-grade students is the best example of a health-promotion teaching project. This makes the other options incorrect.

29. A nurse is providing an educational event to a local group of disabled citizens. What would be important for the nurse to be aware of when planning this event?

A) The health promotion needs of the group the nurse is speaking to

B) What the disability of each person is

C) Wellness needs of each individual person

D) What the families want you to talk about

Ans: A

Feedback:

The nurse must be aware of the health promotion needs when teaching specific groups of people. The other options are incorrect because the nurse doesn ‘t need to aware of them when planning the event.

30. Which of the following is not one of the six general types of risk factors in regard to increasing an individual ‘s chances for illness and injury?

A) Gender

B) Age

C) Environment

D) Lifestyle

Ans: A

Feedback:

The six general types of risk factors are age, genetics, physiologic factors, health habits, lifestyle, and environment. Gender is not a risk factor per se, but certain conditions, such as pregnancy, can contribute to risk.

31. After teaching the students about health and wellness, the nursing instructor identifies a need for further instruction when one of the students makes which of the following statements?

A) “Health is more than just the absence of illness.”

B) “Health is an active process.”

C) “Health means the same to every person.”

D) “Health is dynamic and ever-changing.”

Ans: C

Feedback:

Health is more than just the absence of illness; it is an active process in which a person moves toward his or her maximum potential. It also has different definitions for different people. It is not stagnant, but changes frequently.

32. A client is admitted to the hospital with abrupt symptoms of increasing shortness of breath, fever, and a productive cough with green sputum. Upon further exam the client is diagnosed with chronic obstructive pulmonary disease (COPD) exacerbation. The nurse identifies this as which type of illness?

A) Acute

B) Chronic

C) Terminal

D) Contagious

Ans: B

Feedback:

Chronic illness encompasses many different physical and mental alterations in health. Chronic illnesses usually have a slow onset and many periods of remission (disease is present, but there are no symptoms) and exacerbation (symptoms of the disease reappear). COPD is not terminal (although there is no cure) and it is not contagious.

33. A nurse is giving a talk to a local community group on the importance of proper diet and regular exercise. This is an example of which type of health promotion?

A) Primary health promotion

B) Secondary health promotion

C) Tertiary health promotion

D) Chronic health promotion

Ans: A

Feedback:

Primary health promotion is aimed at promoting health and preventing the development of a disease. Examples of primary promotion are immunizations, family planning, the teaching of healthy diet, regular exercise, safety, and safe sex. Secondary health promotion is aimed at early detection of the disease and treatment. Tertiary promotion begins after the disease is diagnosed and treated, with the goal of reducing disability and helping in rehab. The term chronic is not related to health promotion.

34. An older adult male client is admitted to the cardiac ICU after suffering a heart attack. Upon taking a history after the client is stable, the nurse charts that he weighs over 275 pounds, has a history of heart disease in his family, suffers frequent stress at work, drinks alcohol daily, and smokes two packs of cigarettes daily. What are some modifiable risks factors for this client that has attributed to his heart attack? Select all that apply.

A) Alcohol intake

B) Smoking

C) Stress

D) Age

E) Family history

F) Sex

Ans: A, B, C

Feedback:

The modifiable risk factors related to this client's heart attack include stress, alcohol intake, and smoking. These are things that a person can change. The others are nonmodifiable, as the client cannot change his age, family history, or sex.

35. A nurse is giving a talk to a local community group on health promotion and illness prevention. The nurse explains the different levels of promotion. Which of the following does the nurse include when talking about primary promotion? Select all that apply.

A) Immunization clinics

B) Poison control information

C) Screenings for blood pressure

D) Recommending mammograms for women

E) Teaching about a healthy diet

Ans: A, B, E

Feedback:

Primary health promotion is directed toward promoting good health and preventing disease. Examples include immunization clinics, providing poison control information, and accident prevention. Teaching about a healthy diet, regular exercise, and using seat belts are other examples. Secondary health promotion focuses on screening for early detection of diseases with prompt diagnosis. Things included are screenings for blood pressure and cholesterol, recommending gynecologic exams, and recommending mammograms for women at appropriate ages.

Chapter 4, Health of the Individual, Family, and Community

1. The nurse who is caring for a child admitted after an automobile accident recognizes the importance of including the child's family in the plan of care. Inclusion of the family meets which of Maslow's basic human needs?

A) Love and belonging

B) Physiologic

C) Self-esteem

D) Self-actualization

Ans: A

Feedback:

Love and belonging needs include the understanding and acceptance of others in both giving and receiving love, and the feeling of belonging to families, peers, friends, a neighborhood, and a community. The inclusion of family and friends in the care of a client is a nursing intervention to meet this need.

2. The community health nurse is creating a plan of care for a client with Parkinson's disease. The client's spouse has provided care to the client for the past five years and the client's care needs are increasing. What is an appropriate nursing diagnosis for the client and family?

A) Risk for Caregiver Role Strain.

B) Health Seeking Behaviors.

C) Parental Role Conflict.

D) Readiness for Enhanced Family Processes.

Ans: A

Feedback:

Long-term care of a family member with a chronic illness may lead to caregiver role strain, so the most appropriate nursing diagnosis is "Risk for Caregiver Role Strain."

3. During the course of assessing the family structure and behaviors of a pediatric patient's family, the nurse has identified a number of highly significant risk factors. Which of the following actions should the nurse prioritize when addressing these risk factors?

A) Engage in appropriate health promotion activities.

B) Validate the family's unique way of being.

C) Enlist the help of community and social support.

D) Introduce the family to another family that possesses fewer risk factors.

Ans: A

Feedback:

The role of the nurse in reducing risk factors involves activities that promote health for all family members at any level of development. This consideration supersedes the importance of validating the family's current way of being or enlisting the help of others. Introducing the family to a "model" family is ethically and logistically questionable.

4. According to Maslow's basic human needs hierarchy, which needs are the most basic?

A) Physiologic

B) Safety and security

C) Love and belonging

D) Self-esteem

Ans: A

Feedback:

Physiologic needs, the most basic in the hierarchy of needs, are the most essential to life and have the highest priority. Physiologic needs include oxygen, water, food, temperature, elimination, sexuality, physical activity, and rest.

5. Which of the following is a tenant of Maslow's basic human needs hierarchy?

A) A need that is unmet prompts a person to seek a higher level of wellness.

B) A person feels ambivalence when a need is successfully met.

C) Certain needs are more basic than others and must be met first.

D) People have many needs and should strive to meet them simultaneously.

Ans: C

Feedback:

Maslow arranged the hierarchy to show that certain needs are more basic than others. Although all people have all the needs all the time, people generally strive to meet priority needs (at least to a minimal level) before attending to other needs. The hierarchy is also based on the theory that something is a basic need if it has the following characteristics: (1) its absence results in illness, (2) its presence helps prevent illness or signals health, (3) meeting the need restores health, (4) it is preferred over other satisfactions when unmet, (5) one feels something is missing when the need is not met, and (6) one feels satisfaction when the need is met.

6. An woman 80 years of age states, "I have successfully raised my family and had a good life." This statement illustrates meeting which basic human need?

A) Safety and security

B) Love and belonging

C) Self-esteem

D) Self-actualization

Ans: D

Feedback:

The highest level on the hierarchy of basic human needs is for self-actualization, which includes acceptance of self and others, reaching one's full potential, and feelings of happiness and affection for others.

7. A boy age 2 years arrives at the emergency department of a local hospital with difficulty breathing from an asthmatic attack. Which of the following would be the priority nursing intervention?

A) Giving him his favorite stuffed animal to hold

B) Assessing respirations and administering oxygen

C) Raising the side rails and restraining his arms

D) Asking his mother what are his favorite foods

Ans: B

Feedback:

The priority need for a child having respiratory difficulty is for oxygen. Therefore, the nurse's immediate interventions should be to meet physiologic oxygen needs by assessing respirations and administering oxygen. Oxygen needs are more basic than are needs for food or safety and security.

8. A man 75 years of age is being discharged to his home following a fall in his kitchen that resulted in a fractured pelvis. The home health nurse makes a home assessment that will be used to design interventions to meet which priority need?

A) Sleep and rest

B) Support from family members

C) Protection from potential harm

D) Feeling a sense of accomplishment

Ans: C

Feedback:

Physical safety and security means being protected from potential or actual harm. Assessing potential risks for harm in the home environment is necessary to meet physical safety needs. For this situation, protecting the patient from potential harm has a higher priority than interventions that focus on sleep and rest, support from family members, and feeling a sense of accomplishment.

9. A nurse caring for a client in a long-term health care facility measures his intake and output and weighs him to assess water balance. These actions help to meet which of Maslow's hierarchy of needs?

A) Physiologic

B) Safety and security

C) Love and belonging

D) Self-actualization

Ans: A

Feedback:

A balance between the intake and elimination of fluids is essential to life and is, therefore, a physiologic need, according to Maslow's hierarchy of needs. Measuring intake and output, testing the resiliency of the skin, checking the condition of the skin and mucous membranes, and weighing the patient all help the nurse assess water balance.

10. What action by a nurse will help a client meet self-esteem needs?

A) Verbally negate the client's negative self-perceptions

B) Freely give compliments to increase positive self-regard

C) Independently establish goals to improve self-esteem

D) Respect the client's values and belief systems

Ans: D

Feedback:

Self-esteem needs include the need to feel good about oneself, to feel pride and a sense of accomplishment, and to believe others respect and appreciate those accomplishments. By respecting the client's values and beliefs, the nurse can meet self-esteem needs.

11. A nurse caring for a female client in isolation with tuberculosis is aware that the client's love and belonging needs may not be properly met. Which of the following nursing actions would help to meet these needs?

A) Respecting the patient's values and beliefs

B) Focusing on the client's strengths rather than problems

C) Using hand hygiene and sterile technique to prevent infection

D) Encouraging family to visit and help in the care of the client

Ans: D

Feedback:

Love and belonging needs are met by including family and friends in the care of the client, establishing a nurse–client relationship based on mutual understanding and trust, and referring clients to specific support groups.

12. Which of the following statements accurately describes how Maslow's theory can be applied to nursing practice?

A) Nurses can apply this theory to the nursing process.

B) Nurses can identify met needs as health care needs.

C) Nurses cannot use the theory on infants or children.

D) Nurses use the theory for ill, as opposed to healthy, patients.

Ans: A

Feedback:

Nurses can apply Maslow's hierarchy of basic needs in the assessment, planning, implementation, and evaluation of patient care. The hierarchy can be used with patients at any age, in all settings where care is provided, and in both health and illness. It helps the nurse identify unmet needs as they become health care needs.

13. A couple recently married. Both the husband and the wife have previously been married and had two children. What name is given to this type of family?

A) Extended family

B) Nuclear family

C) Blended family

D) Cohabiting family

Ans: C

Feedback:

The blended family is one that is formed when parents bring unrelated children from previous relationships together to form a new family. An extended family includes relatives; a nuclear family is the traditional father/mother/children; a cohabiting family is composed of members who live together but are not married.

14. Which of the following groups involves all parts of a person's life and is concerned with meeting basic human needs to promote health?

A) Peers

B) Family

C) Community

D) Health care providers

Ans: B

Feedback:

Almost every person is a member of a number of groups, such as friends, colleagues at work, or members of a church or school class. Each of these groups involves a specific part of the person's life and is important to the person. Only the family, however, is concerned with all parts of a person's life and with meeting his or her basic human needs to promote health.

15. An unmarried couple in a committed relationship live together with their adopted twin boys. Which of the following best describes this type of family?

A) Nuclear family

B) Extended family

C) Blended family

D) Adoptive family

Ans: A

Feedback:

The nuclear family, also called the traditional family, is composed of two parents and their children. The parents might be heterosexual or homosexual, are often married or in a committed relationship, and all members of the family live in the same house until the children leave home as young adults. The nuclear family may be composed of biologic parents and children, adoptive parents and children, surrogate parents and children, or stepparents and children.

16. When providing nursing care to a client, the nurse provides family-centered nursing care. What is one rationale for this nursing action?

A) The nurse does not want the client to feel lonely.

B) The client will be more compliant with medical instructions.

C) The family will be more willing to listen to instructions.

D) Illness in one family member affects all family members.

Ans: D

Feedback:

Family-centered nursing care is important because the family is composed of interdependent members who affect one another. An illness in one family member affects all other members of the family; the role of the family is essential in nursing care; the level of health can be improved in all family members; illness in one family member may suggest the same problem in other family members.

17. A mother teaches her son to respect his elders. This is an example of which of the following family functions?

A) Physical

B) Economic

C) Affective and coping

D) Socialization

Ans: D

Feedback:

Families have functions that are important in how individual family members meet their basic human needs and maintain their health. Through socialization, the family teaches; transmits beliefs, values, attitudes, and coping mechanisms; provides feedback; and guides problem solving (Friedman, Bowden, & Jones, 2003).

18. What is the purpose of the affective and coping function of the family?

A) Providing a safe environment for growth and development

B) Ensuring financial assistance for family members

C) Providing emotional comfort and identity

D) Transmitting values, attitudes, and beliefs

Ans: C

Feedback:

The affective and coping function of the family is necessary to provide emotional comfort to family members and to help members establish an identity to be maintained in times of stress. The physical function provides a safe environment for growth and development, the economic function ensures financial assistance, and the socialization function transmits values, attitudes, and beliefs.

19. A nurse provides health promotion and accident prevention programs for a family with adolescents and young adults. Which of the following is a task of a family at this stage?

A) Establish a mutually satisfying marriage.

B) Adjust to cost of family life.

C) Maintain supportive home base.

D) Maintain ties with younger and older generations.

Ans: C

Feedback:

Families at this stage must maintain open communication, support moral and ethical family values, balance teenagers' freedom with responsibility, maintain supportive home bases, and strengthen marital relationships.

20. Which of the following individuals would the nurse assess as being most at risk for altered family health?

A) An unmarried adolescent with a newborn

B) A newly married couple who ask about birth control

C) A middle-aged man and woman with no children

D) An older adult, living in an assisted-living community

Ans: A

Feedback:

It is important for the nurse to assess a client's family for family risk factors that may cause health problems. A developmental risk factor for family health is an unmarried adolescent mother who lacks personal, economic, and educational resources.

21. What is the major effect of a health crisis on family structure?

A) Adaptation to stress

B) Change in roles of family members

C) Respect for family values

D) Loss of individual identities

Ans: B

Feedback:

Illness may precipitate a health crisis in a family. Serious illness or injury may result in changes in family roles, responsibilities, and functions. Regardless of how the family adapts to an illness, members of the family must constantly adjust roles and responsibilities to manage the needs of the ill family member.

22. Which of the following statements accurately describes a characteristic of a community?

A) Communities do not exist in rural areas.

B) Communities are formed by the characteristics of people and other factors.

C) Communities are not limited by geographic boundaries.

D) Communities have little or no effect of the health of residents.

Ans: B

Feedback:

A community is a specific population or group of people living in the same geographic area under similar regulations and having common values, interests, and needs. A community may be a small neighborhood in a major urban city or a large rural area encompassing a small town. Communities are formed by the characteristics of people, area, social interaction, and common familial, cultural, or ethnic heritage and ties. Within a community, people interact and share resources. Many community factors affect the health of residents.

23. Which of the following is an example of a community factor that may affect health?

A) Rural setting

B) Air and water quality

C) Number of residents

D) Educational level

Ans: B

Feedback:

The health of a community is affected by the social support systems, the community health structure, environmental factors, and types of agencies providing assistance for those in need of shelter, housing, and food. Air pollution and water pollution are community risk factors that may affect health. Living in a rural setting, the number of residents, and/or educational level are not factors in the community that are considered to affect health.

24. Which of the following factors may be a barrier to health care services for those living in rural areas?

A) Inadequate health care insurance

B) Lack of knowledge about needed care

C) Living long distances from services

D) Decreased interest in health promotion

Ans: C

Feedback:

The size and location of a community often determines the size and availability of health care services. Although urban residents have various means of transportation to a variety of health care services, rural residents may have to travel long distances for care. Rural residents do not necessarily have inadequate health care insurance, lack knowledge of needed care, or have decreased interest in health promotion.

25. Which of the following definitions best describes community-based nursing?

A) A focus on populations within the community

B) A focus on older adults living in nursing homes

C) Care provided in the client's home for chronic illnesses

D) care centered on individual and family health care needs

Ans: D

Feedback:

In contrast to community health nursing, which focuses on populations within a community, community-based nursing is centered on individual and family health care needs. Interventions are designed to manage health problems, promote good health, and facilitate self-care. Public health nursing focuses on populations.

26. What is one method by which a nurse can be a role model to promote health in the community?

A) Demonstrating a healthy lifestyle

B) Becoming a member of a family

C) Meeting own basic needs

D) Exhibiting self-actualization

Ans: A

Feedback:

Nurses promote health in the community by providing health care services in a variety of settings, by serving as volunteers in health-related activities, and by being role models for health practices and lifestyles.

27. A nurse assigned to a client's care schedules a family assessment of the client. Which of the following should the nurse use for basic family assessment?

A) Interview

B) Physical assessment

C) Survey

D) Poll

Ans: A

Feedback:

The nurse should use an interview for the basic family assessment. Physical assessment is used for individual assessment. Surveys and polls are used for community assessment.

28. When a family visits the counseling clinic for the first time, which of following activities will the nurse complete as part of the initial family assessment?

A) Discuss the roles of the parents.

B) Outline the basic needs of the family.

C) Resolve all family conflicts.

D) Interview the family members.

Ans: D

Feedback:

At the beginning level, a basic family assessment requires observation, comparison, and interview.

29. The nurse is planning interventions to promote the health of a family struggling with loss of energy and privacy for the parents. In which family stage is the family?

A) Family with young children

B) Family with adolescents and young adults

C) Family with middle-aged adults

D) Family with older adults

Ans: A

Feedback:

A family with young children needs to cope with loss of energy and privacy of the parents. A family with adolescents and young adults must balance the teenagers' freedom with responsibility. A family with middle-aged adults strives to maintain ties with both younger and older generations. A family with older adults may contemplate moving from the family home they have lived in for years.

30. The nursing student asks the nurse about the difference between family-centered nursing and client-centered nursing. Which of the following would be inappropriate for the nurse to include when responding to the student?

A) The family is composed of interdependent members who affect one another.

B) The health of the family can be improved through health promotion activities.

C) A strong relationship exists between the family and the health status of its members.

D) Illness of one family member infrequently occurs in other members.

Ans: D

Feedback:

According to Friedman and associates, family-centered nursing is based on four premises: (1) The family is composed of interdependent members who affect one another; (2) a strong relationship exists between the family and the health status of its members; (3) the health of the family can be improved through health promotion activities; and (4) illness of one family member may suggest the possibility of the same problem in other members.

31. The nurse is assessing the functions of a family. Which items are functions of the family? Select all that apply.

A) Provide a safe, comfortable home in which to reside.

B) Communicate cultural values and beliefs to family members.

C) Provide emotional support to family members.

D) Secure adequate income to meet the needs of the family.

E) Make referrals to community-based healthcare resources

Ans: A, B, C, D

Feedback:

Family functions include: (1) providing a safe, comfortable home; (2) securing adequate income; (3) providing emotional support; and (4) communicating cultural values and beliefs. Nurses make referrals to community-based health care agencies to secure resources for families in need.

32. Based on a community assessment, the nurse has set the following outcomes. Which outcome reflects Maslow's level of safety and security needs?

A) The community will establish an effective wastewater disposal system by January 22.

B) The community will demonstrate pride by posting a welcome sign and flowers at the edge of town by April 8.

C) The community will open a senior citizens center by March 9.

D) The community will identify a walking path through the community by February 2.

Ans: A

Feedback:

Availability of an effective wastewater disposal system will promote the safety of the community. Physical activity, such as availability of a walking path, is essential for Maslow's physiologic needs. Availability of a senior citizens center represents a solution to feeling love and belonging for older adults. Self-esteem and pride is demonstrated by welcome signs and flowers at the edge of town.

33. The nursing student is assessing a community in regard to safety and security. Which of the following would be inappropriate for the nursing student to include under this basic need category?

A) Parks and swimming pools

B) Police and fire departments

C) Sanitation facilities

D) Housing and zoning codes

Ans: A

Feedback:

Police and fire departments, sanitation facilities, and housing and zoning codes protect the safety of the members of the community. Parks and swimming pools provide recreation for the members, meeting physiological needs.

34. Five functions have been identified as being essential to the growth of individuals and families. One of these functions is education and support. How is support manifested in the context of coping with crisis and illness situations?

A) Making clear distinctions between the generations

B) Actions that tell family members they are cared about and loved

C) The promotion of exercise in the lifestyle

D) Transmitting culture and acceptable behaviors

Ans: B

Feedback:

Five family functions are viewed as essential to the growth of individuals and families. The first function, management, involves the use of power, decision making about resources, establishment of rules, provision of finances, and future planning —responsibilities assumed by the adults of the family. The second function, boundary setting, makes clear distinctions between the generations and the roles of adults and children within the family structure. The third function, communication, is important to individual and family growth; healthy families have a full range of clear, direct, and meaningful communication among their members. The fourth function is education and support. Education involves modeling skills for living a physically, emotionally, and socially healthy life. Support is manifested by actions that tell family members they are cared about and loved; it promotes health and is seen as a critical factor in coping with crises and illness situations. The fifth function, socialization, involves families' transmission of culture and the acceptable behaviors needed to perform adequately in the home and in the world.

35. The nurse conducting a community emergency preparedness education class includes which of the following as an example of a natural disaster?

A) Toxic spill

B) Earthquake

C) War

D) Terrorist event

Ans: B

Feedback:

A disaster is broadly defined as a tragic event of great magnitude that requires the response of people outside the involved community. Disasters can be categorized as natural (e.g., massive flooding following a hurricane or an earthquake) or man-made (e.g., a toxic spill, war, or a terrorist event).

Chapter 5, Cultural Diversity

1. A nursing instructor has assigned a student to care for a client of Asian descent. The instructor reminds the student that personal space considerations vary among cultures. What personal space preferences are important for the student to consider when caring for this client?

A) People of Asian descent prefer some distance between themselves and others.

B) People of Asian descent commonly stand close to one another when talking.

C) People of Asian descent touch one another when sitting next to a familiar person.

D) People of Asian descent prefer direct eye contact when communicating.

Ans: A

Feedback:

Individuals of Asian descent are more comfortable with some distance between themselves and others. Direct eye contact may be considered impolite or aggressive within the Asian culture, and they may tend to avoid direct eye contact and avert their eyes while speaking with others.

2. When providing nursing care to an African American individual, which of the following cultural factors should the nurse consider?

A) Values and beliefs are often present oriented.

B) Families are usually patriarchal.

C) They possess weak religious affiliations.

D) Families are highly competitive.

Ans: A

Feedback:

Cultural factors that should be considered when providing care to the African American family include the recognition that the family is usually matriarchal, values and beliefs are present oriented, there is strong family unity and cooperation, and families are frequently highly religious and highly respect the African American clergy.

3. The nurse is obtaining a health history from a patient of Puerto Rican descent. Which of the following is most likely to be a health problem that has a cultural connection for this patient?

A) Lactose enzyme deficiency

B) Tuberculosis

C) Sickle cell anemia

D) Suicide

Ans: A

Feedback:

Common health problems that may affect the Puerto Rican population include lactose enzyme deficiency and parasitic diseases. Tuberculosis is a common health problem for the Native American population. Sickle cell anemia predominantly affects the African American population, and suicide is a common health problem for the Native American and white middle-class populations.

4. Despite the presence of a large number of elderly residents of Asian heritage, a long-term care facility has not integrated the Asian concepts of hot and cold into meal planning. Which of the following should the nurses at the facility recognize this as an example of?

A) Cultural blindness

B) Stereotyping

C) Cultural assimilation

D) Cultural imposition

Ans: A

Feedback:

Cultural blindness is characterized by ignoring cultural differences or considerations and proceeding as if they do not exist. This phenomenon may underlie the failure to incorporate cultural considerations into dietary choices. Stereotyping assumes homogeneity of members of other cultures. Cultural assimilation involves the replacement of values with those of a dominant culture. Cultural imposition presumes that everyone should conform to a majority belief system.

5. When providing care on an Indian reservation, the nurse has prioritized assessments for diabetes and fetal alcohol syndrome when working with residents of the reservation. How should this nurse's practice be best understood?

A) The nurse is correct in assessing for health problems that have a higher incidence and prevalence among this population.

B) The nurse is stereotyping American Indians as leading unhealthy lifestyles and abusing alcohol.

C) The nurse is performing cultural imposition of the majority American culture, and the accompanying beliefs around diabetes and alcohol use.

D) The nurse should seek specific permission from each client before proceeding with these assessments.

Ans: A

Feedback:

Because diabetes and fetal alcohol syndrome are known to have a higher incidence and prevalence among American Indians, Nurse K. is justified in reflecting this objective reality during health assessment. This action is rooted in epidemiology, not the inaccurate generalizations of stereotyping. Because the consequences of both problems are significant and objective, Nurse K. is not guilty of cultural imposition and specific permission for these assessments is not likely necessary.

6. A Mexican immigrant who migrated to the United States and lives in a Spanish-speaking community with other relatives is taken to the ER following a fall at work. He is admitted to the hospital for observation. The nurse is aware tht this client is at risk for:

A) Cultural assimilation

B) Cultural shock

C) Cultural imposition

D) Cultural blindness

Ans: B

Feedback:

Culture shock refers to the feelings a person experiences when placed in a different culture perceived as strange. Culture shock may result in psychological discomfort or disturbances, as the patterns of behavior a person found acceptable and effective in his or her own culture may not be adequate or even acceptable in the new one. The person may then feel foolish, fearful, incompetent, inadequate, or humiliated.

7. A nurse walks by a client's room and observes a Shaman performing a healing ritual for the client. The nurse then remarks to a coworker that the ritual is a waste of time and disruptive to the other clients on the floor. What feelings is this nurse displaying?

A) Culture conflict

B) Cultural blindness

C) Stereotyping

D) Cultural shock

Ans: A

Feedback:

Culture conflict occurs when people become aware of cultural differences, feel threatened, and respond by ridiculing the beliefs and traditions of others to make themselves feel more secure about their own values.Cultural blindness occurs when one ignores differences and proceeds as though they do not exist. Stereotyping is the assumption that all members of a culture, ethnic group, or race act alike. Culture shock refers to the feelings a person experiences when placed in a different culture that is perceived as strange.

8. A nurse is caring for a client from Taiwan who constantly requests pain medication. What should the nurse consider when assessing the client's pain?

A) Most people react to pain in the same way.

B) Pain in adults in less intense than pain in children.

C) The client has a low pain tolerance.

D) Pain is what the client says it is.

Ans: D

Feedback:

Pain is what the client says it is, and nursing care should always be individualized. The nurse respects the client's right to respond to pain in whatever manner is culturally and individually appropriate and never stereotypes a client's perceptions or responses to pain. Pain tolerance is subjective; again, the client's pain is what she says it is.

9. A father, mother, grandmother, and three school-aged children have immigrated to the United States from Thailand. Which member(s) of the family are likely to learn to speak English more rapidly?

A) Unemployed father

B) Stay-at-home mother

C) Grandmother

D) Children

Ans: D

Feedback:

When people from another part of the world move to the United States, they may speak their own language fluently but have difficulty speaking English. This is especially true for women, older adults, and those who are unemployed. Children usually assimilate more rapidly and learn the language more quickly because they go to school each day and make new friends in the dominant culture.

10. A 40-year-old nurse is taking a health history from a Hispanic man aged 20 years. The nurse notes that he looks down at the floor when he answers questions. What should the nurse understand about this behavior?

A) The client is embarrassed by the questions.

B) This is culturally appropriate behavior.

C) The client dislikes the nurse.

D) The client does not understand what is being asked.

Ans: B

Feedback:

Eye contact is one of the most culturally variable forms of communication. Although Americans emphasize eye contact while speaking, Hispanics look downward in deference to age, gender, social position, economic status, and authority.

11. An older adult woman of Chinese ancestry refuses to eat at the nursing home, stating, “I’m just not hungry.” What factors should the staff assess for this problem?

A) The woman does not like to eat with other residents of the home.

B) The woman is using this as a means of going home.

C) The food served may not be culturally appropriate.

D) The food served may violate religious beliefs.

Ans: C

Feedback:

Residents in long-term care settings often do not have much choice of foods. As a result, they may not be able to select cultural food preferences. When assessing the cause of decreased appetite in clients, the nurse should determine whether the problem may be related to culture.

12. All of the following are factors to consider when caring for clients with limited income. Which one is the **most** important?

A) Basic human needs may go unmet

B) Limited access to reliable transportation

C) Decreased access to health care services

D) Risk for increased incidence of disease

Ans: A

Feedback:

Poverty prevents many people from consistently meeting their basic human needs. Limited means of transportation, decreased access to health care services, and an increased incidence of disease are also influenced by limited income, but meeting one’s basic human needs is the most important factor.

13. The nurse is providing home care for a client who traditionally drinks herbal tea to treat an illness. How should the nurse respond to a request for the herbal tea?

A) We do not allow our clients to drink herbal tea.

B) Why in the world would you want to drink that stuff?

C) Let me check with the doctor to make sure it is okay to drink the tea with your medicines.

D) I have to fill out a lot of forms that you will have to sign before I can do that.

Ans: C

Feedback:

Herbs are a common method of treatment in many cultures. If a client traditionally drinks an herbal tea to alleviate symptoms of an illness, there is no reason why both the herbal tea and the prescribed medications cannot be used as long as the tea is safe to drink and does not interfere with, or exaggerate, the action of the medications. Asking why the

patient would want to drink “that stuff” is demeaning to the patient. Answer d is incorrect because there is no paperwork necessary.

14. A nurse in a large metropolitan city enjoys working in a health clinic that primarily serves Hispanic clients. What does this statement imply about the nurse?

A) The nurse’s knowledge and skills are not adequate to care for clients with acute illnesses.

B) The nurse respects and values providing culturally competent care.

C) The nurse is attempting to overcome cultural blindness.

D) This employment makes the nurse feel superior to a minority group of people.

Ans: B

Feedback:

The nurse who recognizes and respects cultural diversity has cultural sensitivity, avoids cultural imposition and ethnocentrism, and provides nursing care that accepts the significance of cultural factors in health and illness.

15. A nurse is providing care for a Cambodian client. The nurse says, “You have to get up and walk whether you want to or not.” What is this statement an example of?

A) Culture shock

B) Stereotyping

C) Cultural imposition

D) Cultural competence

Ans: C

Feedback:

Cultural imposition is the tendency for health care personnel to impose their beliefs, practices, and values on people of other cultures because they believe their ideas are superior. When health care professionals assume they have the right to make decisions for clients, the clients often respond by becoming passive, angry, or resistant to treatment.

16. A home health nurse is visiting a client 60 years of age. During the initial visit, the client’s husband answers all of the questions. What would the nurse assess based on this behavior?

A) The client does not want the nurse to visit.

B) The husband does not trust his wife to answer questions.

C) The cltient is not able to answer the questions.

D) The husband is the dominant member of the family.

Ans: D

Feedback:

To provide culturally competent care, the nurse must take into consideration the role of the family member who makes most decisions. To disregard this fact or to proceed with nursing care that is not approved by this person can result in conflict or disregard for what is being taught.

17. An Asian American male client is operated on for gallstones. On the postoperative night, the nurse finds that the client is not sleeping and is tossing and turning. When asked about analgesics, the client expresses that he does not have pain. What nursing action is most appropriate?

A) Believing that the client has no pain

B) Assessing for non-verbal expressions of pain

C) Inspecting the incision site for any abnormality

D) Asking the client if he is feeling hungry

Ans: B

Feedback:

The nurse should be aware that in Asian American culture, men tend to control their emotions and expressions of physical discomfort. Keeping this in mind, the nurse should assess the client for non-verbal expressions of pain. The nurse should not believe the client when he says that he does not have pain because, after surgery, pain is likely to occur. The nurse may inspect the incision site, but it is not an appropriate action. Asking the client if he is hungry may be irrelevant.

18. An Anglo American client reports to the primary health care facility with symptoms of fever, cough, and running nose. While interviewing the client, which of the following points should the nurse keep in mind?

A) Do not probe into emotional issues.

B) Do not ask very personal questions.

C) Sit at the other corner of the room.

D) Maintain eye contact while talking.

Ans: D

Feedback:

While interviewing an Anglo-American client, the nurse should maintain eye contact, because it indicates openness and sincerity. Anglo-Americans freely express positive and negative feelings; therefore, the nurse may probe into emotional issues. Anglo-American culture is an open culture, and members of this culture don't mind providing personal information. Also, Anglo-Americans are not threatened by closeness, so the nurse may not have to sit in another corner of the room.

19. A nurse is caring for a client after internal fixation of a compound fracture in the tibia. The nurse finds that the client has not had his dinner, seems restless, and is tossing on the bed. Keeping in mind that the client is Latino, what is the most appropriate response by the nurse?

A) Are you having pain in your leg?

B) Tell me what you are feeling.

C) Do you need pain medication?

D) Are you feeling all right?

Ans: B

Feedback:

The nurse should ask the client what he is feeling. Asking open-ended questions would encourage the client to verbalize his pain. Latino men may not demonstrate their feelings or readily discuss their symptoms because they may interpret doing so as being less than manly. Closed-ended questions like Are you having pain?; Do you need pain medication?; and Are you feeling all right? may block communication and the client may not express his feelings.

20. A client who has difficulty sleeping expresses to the nurse that watching television may help him relax and get sleep. The nurse disregards the client's concern and suggests drinking warm milk before going to bed. Which cultural characteristic is the nurse demonstrating?

A) Stereotype

B) Ethnocentrism

C) Racism

D) Relativity

Ans: B

Feedback:

The nurse disregarding the client's concern is an example of ethnocentrism. Ethnocentric people view one's own culture as the only correct standard by which to view people of other cultures. Stereotypes are preconceived and untested beliefs about people. Racism uses skin color as the primary indicator of social value. Understanding that cultures relate differently to the same given situation is called relativity.

21. A nurse engages in professional rituals as a means to standardize practice and ensure efficiency. In doing so, the nurse integrates understanding of which of the following as a characteristic?

A) Preconceived and untested belief about people

B) Viewing one's own culture as the only correct standard

C) Common and observable expressions of culture

D) Belief system held to varying degrees as absolute truth

Ans: C

Feedback:

Rituals are common and observable expressions of culture. A preconceived and untested belief about people is called a stereotype. Viewing one's own culture as the only correct standard is ethnocentrism. A belief system held to varying degrees as absolute truth is referred to as culture.

22. The client in a rehabilitation unit is having a difficult time adjusting to the scheduled activities on the unit, as well as being dependent on others for meals and medications. Which word best describes what the patient is experiencing?

A) Anxiety

B) Disparity

C) Resolution

D) Shock

Ans: D

Feedback:

The acute experience of not comprehending the culture in which one is situated is called culture shock. This is often experienced by a client who suddenly finds himself or herself in the subculture of a hospital or health care agency.

23. A nurse in the hospital is caring for a Native American male. What person is most important to include in the care of the client?

A) Family

B) Physician

C) Tribal medicine man

D) Physical therapy aide

Ans: C

Feedback:

Observance of rituals in times of stress and uncertainty helps to restore a sense of control, competence, and familiarity; to that extent, these rituals are a desirable adjunct to nursing care.

24. When a labor and delivery nurse tells a coworker that an Asian client probably did not want any pain medication because “Asian women typically are stoic,” the nurse is expressing a belief known as what?

A) Stigma

B) Ethnic slur

C) Bias

D) Stereotype

Ans: D

Feedback:

Stereotypes are preconceived and untested beliefs about people. Ethnic slur refers to a statement made about another according to their ethnicity; stigma refers to social disapproval; bias refers to an inability to view someone or something without being objective.

25. The nurse is caring for a Mexican American who is Catholic. The nurse wishes to learn more about the culture by consulting a key informant. Which of the following religious practitioners would be most knowledgeable about the beliefs held by individuals of Mexican ethnicity?

A) A church mother

B) A voodoo priest

C) A curandera

D) A peyote leader

Ans: C

Feedback:

For Mexican Americans who are Roman Catholic, the priest and the curandera (a secular folk healer) may be useful informants.

26. A nurse is caring for an elderly woman from a far eastern culture. How does the nurse demonstrate awareness of culturally competent care?

A) Maintaining eye contact at all times.

B) Trying to speak louder than usual.

C) Using touch when communicating.

D) Establishing effective communication.

Ans: D

Feedback:

Establishment of an environment of culturally competent care and respect begins with effective communication, which occurs not only through words, but also through body language and other cues, such as voice, tone, and loudness. Maintaining eye contact at all times is incorrect because not all cultures are comfortable with eye contact; speaking louder is incorrect because the issue is a communication problem, not a hearing problem; not all cultures are comfortable with touch so this would block communication.

27. Most nurses have been taught to maintain direct eye contact when communicating with clients. Some cultural groups would not value direct eye contact with the nurse. Which cultural group would consider the direct eye contact impolite?

A) Americans

B) British

C) Canadians

D) Native Americans

Ans: D

Feedback:

Eye contact is also a culturally determined behavior. Although most nurses have been taught to maintain eye contact when speaking with patients, some people from certain cultural backgrounds may interpret this behavior differently. For example, some Asians, Native Americans, Indo-Chinese, Arabs, and Appalachians may consider direct eye contact impolite or aggressive, and they may avert their eyes when talking with nurses and others whom they perceive to be in positions of authority.

28. The nurse is admitting a new client to the unit. The nurse notes that this client would need an alternate meal choice when the menu specified pork for a meal. What cultural group would require an alternative meal choice?

A) Christian

B) Protestant

C) Muslim

D) Mormon

Ans: C

Feedback:

Many Muslim people abstain from eating pork.

29. Personal space and distance is a cultural perspective that can impact nurse-client interactions. What is the best way for the nurse to interact physically with a client who has a different cultural perspective on space and distance?

A) Know the client's cultural personal space preferences.

B) Realize that sitting close to the client is an indication of warmth and caring.

C) Sit three to six feet away from the patient in an attempt to not offend.

D) Remember not to intrude into the personal space of the elderly.

Ans: A

Feedback:

When providing nursing care that involves physical contact, you should know the client's cultural personal space preferences. Sitting close to, or too far away from, the patient may be interpreted as offensive. Age is not necessarily a deciding factor in regards to a person's cultural practices.

30. A male nurse is preparing to take the vital signs of a female patient. Which ethnic group would consider this improper?

A) Native American

B) Arab Muslim

C) White

D) African American

Ans: B

Feedback:

The Islamic religion does not allow the use of health care professionals of the opposite gender unless it is impossible to locate one of the same gender. Native Americans, Caucasians, and African Americans do not necessarily share this sentiment.

31. The nurse is admitting a client from China to the medical-surgical unit with a diagnosis of cancer. While doing the client's assessments, the client speaks of her naturalistic beliefs related to health care and the importance of the yin/yang theory. Based on her cancer diagnoses, the idea that cancer is considered a cold illness in the culture, and her yin/yang beliefs, which meal will the patient most likely order for lunch?

A) Chicken noodle soup with crackers, fruit crisp, and hot tea

B) Turkey sandwich, small tossed salad, and iced tea

C) Chef's salad, bread, and water

D) Fruit smoothie and granola bar

Ans: A

Feedback:

In some Asian cultures, good health is thought to be achieved through the proper balance of yin (feminine, negative, dark, cold) and yang (masculine, positive, light, warm). Hot foods are eaten when a person has a cold illness, such as cancer, a headache, and stomach cramps. Based on this information, the patient would likely select chicken noodle soup with crackers, fruit crisp, and hot tea, as these are hot foods. The other options are cold foods and would more likely be eaten when a patient has a hot illness.

32. The focal point of nursing is the nurse–client interaction. What must nurses consider when conducting the necessary assessment of their clients and significant others?

A) Their health disparities

B) Their societal beliefs

C) The subgroup they belong to

D) Their own cultural orientation.

Ans: D

Feedback:

Because the nurse–client interaction is the focal point of nursing, nurses should consider their own cultural orientation when conducting assessments of patients and their families and friends. Although nursing as a whole is actively recruiting more diverse members, many nurses are members of, and have the same value systems as, the dominant middle-class structure in the United States.

33. When the South Asian client arrives 25 minutes late to her appointment at the clinic, the nurse recognizes this as a sign of which of the following?

A) Disrespect

B) Laziness

C) Respect

D) Superiority

Ans: C

Feedback:

In some South Asian cultures, being late is considered a sign of respect. It may be useful to note this in the client's file and take it into account when scheduling future appointments.

34. What is the term that describes the inability of a person to recognize his or her own values, beliefs, and practices as well as those of others, because of strong ethnocentric tendencies?

A) Acculturation

B) Cultural blindness

C) Cultural imposition

D) Stereotyping

Ans: B

Feedback:

Cultural blindness occurs when one ignores differences and proceeds as though they do not exist, resulting in bias and stereotyping. Acculturation is the process by which members of a culture adapt or learn how to take on the behaviors of another group. Cultural imposition is the tendency to impose one's cultural beliefs, values, and patterns of behavior on a person from a different culture. Stereotyping is when one assumes that all members of a culture, ethnic group, or race act alike.

35. The nurse caring for a Native American client plans care understanding that one belief of Native American healing practices is which of the following?

A) Modern life facilitates healing agents.

B) Healing takes time.

C) Balancing yin and yang is important.

D) Energy flows through meridians throughout the body.

Ans: B

Feedback:

Native American healing practices are grounded in their cultural views. One concept, identified in a study, is that healing takes time.

Chapter 6, Values, Ethics, and Advocacy

1. A nurse in a physician's office has noted on several occasions that one of the physicians frequently obtains controlled-drug prescription forms for prescription writing. The physician reports that his wife has chronic back pain and requires pain medication. One day the nurse enters the physician's office and sees him take a pill out of a bottle. The doctor mentions that he suffers from migraines and that his wife's pain medication alleviates the pain. What type of nurse-physician ethical situation is illustrated in this scenario?

A) Unprofessional, incompetent, unethical, or illegal physician practice

B) Disagreements about the proposed medical regimen

C) Conflicts regarding the scope of the nurse's role

D) Claims of loyalty

Ans: A

Feedback:

The physician is demonstrating unprofessional, incompetent, unethical, or illegal physician practice.

2. The client was diagnosed with diabetes three years ago, but has failed to integrate regular blood glucose monitoring or dietary modifications into his lifestyle. He has been admitted to the hospital for treatment of acute renal failure secondary to diabetic nephropathy, an event that has prompted the client to reassess his values. Which of the following actions most clearly demonstrates that this client is engaging in the step of prizing within his valuing process?

A) The client expresses pride that he now has the knowledge and skills to take control of his diabetes management.

B) The client states that he will now begin to check his blood glucose before each meal and at bedtime.

C) The client is now able to explain how his choices have contributed to his renal failure.

D) The client expresses remorse at how his failure to take make lifestyle changes has adversely affected his health.

Ans: A

Feedback:

Within the valuing process, expressions of pride and happiness are considered to be indications of prizing. Resolving to make changes is an aspect of choosing, while expressing insight about his role in his current diagnosis demonstrates that the client has the desire to re-examine his values.

3. The children of a female client 78 years of age with a recent diagnosis of early-stage Alzheimer's disease are attempting to convince their mother to move into an assisted living facility, a move to which the client is vehemently opposed. Both the client and her children have expressed to the nurse how they are entrenched in their position. Which of the following statements expresses a utilitarian approach to this dilemma?

A) The decision should be made in light of consequences.

B) The client's autonomy and independence are the priority considerations.

C) Benefits and burdens should be evenly distributed between the children and the client.

D) The client has a right to self-determination.

Ans: A

Feedback:

Utilitarianism is the theory of ethics that weighs rightness and wrongness according to consequences and outcomes for all those who are affected. Utilitarianism prioritizes these consequences and outcomes over principles such as autonomy and justice; principles that underlie the other statements addressing the patient's right to self-determination; and fair distribution of benefits and burdens.

4. A group of nurse researchers has proposed a study to examine the efficacy of a new wound care product. Which of the following aspects of the methodology demonstrates that the nurses are attempting to maintain the ethical principle of nonmaleficence?

A) The nurses are taking every reasonable measure to ensure that no participants experience impaired wound healing as a result of the study intervention.

B) The nurses have organized the study in such a way that the foreseeable risks and benefits are distributed as fairly as possible.

C) The nurses have given multiple opportunities for potential participants to ask questions, and have been following the informed consent process systematically.

D) The nurses have completed a literature review that suggests the new treatment may result in decreased wound healing time.

Ans: A

Feedback:

The principle of nonmaleficence dictates that nurses avoid causing harm. In this study, this may appear in the form of taking measures to ensure that the intervention will not cause more harm than good. The principle of justice addresses the distribution of risks and benefits, and the informed consent process demonstrates that autonomy is being protected. Preliminary indications of the therapeutic value of the intervention show a respect for the principle of beneficence.

5. A client with a diagnosis of colorectal cancer has been presented with her treatment options, but wishes to defer any decisions to her uncle, who acts in the role of a family patriarch within the client's culture. By which of the following is the client's right to self-determination best protected?

A) Respecting the client's desire to have the uncle make choices on her behalf

B) Revisiting the decision when the uncle is not present at the bedside

C) Teaching the client about her right to autonomy

D) Holding a family meeting and encouraging the client to speak on her own behalf

Ans: A

Feedback:

The right to self-determination (autonomy) means that it should never be forced on anyone. The client has the autonomous right to defer her decision-making to another individual if she freely chooses to do so.

6. A male client age 56 years is experiencing withdrawal from alcohol and is placing himself at risk for falls by repeatedly attempting to scale his bedrails. Benzodiazepines have failed to alleviate his agitation and the nurse is considering obtaining an order for physical restraints to ensure his safety. The nurse should recognize that this measure may constitute what?

A) Paternalism

B) Deception

C) Harm

D) Advocacy

Ans: A

Feedback:

Paternalism involves the violation of a client's autonomy in order to maximize good or minimize harm, a situation that requires careful consideration in light of ethical principles. Deception is unlikely to occur and the risk for harm is likely decreased by the use of restraints. Advocacy is the protection and support of another's rights.

7. A mother always thanks clerks at the grocery store. Her daughter age 6 years echoes her thank you. The child is demonstrating what mode of value transmission?

A) Modeling

B) Moralizing

C) Reward and punishment

D) Responsible choice

Ans: A

Feedback:

Through modeling, children learn of high or low value by observing parents, peers, and significant others. Modeling can thus lead to socially acceptable or unacceptable behaviors. Children whose caregivers use the moralizing mode of value transmission are taught a complete value system by parents or an institution (e.g., church or school) that allows little opportunity for them to weigh different values. Through rewarding and punishing, children are rewarded for demonstrating values held by parents and punished for demonstrating unacceptable values. Caregivers who follow the responsible-choice mode of value transmission encourage children to explore competing values and to weigh their consequences.

8. Which of the following modes of value transmission is most likely to lead to confusion and conflict?

A) Modeling

B) Moralizing

C) Laissez-faire

D) Responsible choice

Ans: C

Feedback:

Those who use the laissez-faire approach for value transmission leave children to explore values on their own (no one set of values is presented as best for all) and to develop a personal value system. This approach often involves little orno guidance and can lead to confusion and conflict.

9. A nurse in a women's health clinic values abstinence as the best method of birth control. However, she offers compassionate care to unmarried pregnant adolescents. What is the nurse demonstrating?

A) modeling of value transmission

B) conflict in values acceptance

C) nonjudgmental "value neutral" care

D) values conflict that may lead to stress

Ans: C

Feedback:

The nurse is demonstrating nonjudgmental "value neutral" care. This means she is respecting and accepting the individuality of patients, does not assume that her personal values are right, and does not judge the patients' values as right or wrong depending on their congruence with hers.

10. While at lunch, a nurse heard other nurses at a nearby table talking about a client they did not like. When they asked him what he thought, he politely refused to join in the conversation. What value was the nurse demonstrating?

A) The importance of food in meeting a basic human need

B) Basic respect for human dignity

C) Men do not gossip with women

D) A low value on collegiality and friendship

Ans: B

Feedback:

Nurses who feel uncomfortable gossiping with other nurses about patients realize that this behavior contradicts a basic respect for human dignity. This respect is a value that allows one to choose freely to believe in the worth and uniqueness of each individual.

11. A middle-aged man is having increasing difficulty breathing. He never exercises, eats fast food regularly, and smokes two packs of cigarettes a day. He tells the nurse practitioner that he wants to change the way he lives. What is one means of helping him change behaviors?

A) Ethical change strategy

B) Values neutrality choices

C) Values transmission

D) Values clarification

Ans: D

Feedback:

Values clarification is a process by which people come to understand their own values and value system. When nurses understand the values that motivate patients' decisions and behaviors, they can tap these values when teaching and counseling patients.

12. A nurse using the principle-based approach to client care seeks to avoid causing harm to clients in all situations. What is this principle known as?

A) Nonmaleficence

B) Justice

C) Fidelity

D) Autonomy

Ans: A

Feedback:

The principle-based approach to ethics combines elements of both utilitarian and deontologic theories and offers specific action guides for practice. The Beauchamp and Childress principle-based approach to bioethics (2001) identifies four key principles: autonomy (promote self-determination), nonmaleficence (avoid causing harm), beneficence (benefit the patient), and justice (act fairly).

13. A nurse provides client care within a philosophy of ethical decision making and professional expectations. What is the nurse using as a framework for practice?

A) Code of Ethics

B) Standards of Care

C) Definition of Nursing

D) Values Clarification

Ans: A

Feedback:

A professional code of ethics provides a framework for making ethical decisions and sets forth professional expectations. Codes of ethics inform both nurses and society of the primary goals and values of the profession.

14. A client nearing the end of life requests that he be given no food or fluids. The physician orders the insertion of a nasogastric tube to feed the client. What situation does this create for the nurse providing care?

A) Nurse must follow the physician's orders

B) An inability to provide care for the patient

C) An ethical dilemma about inconsistent courses of action

D) A barrier to establishing an effective nurse–patient relationship

Ans: C

Feedback:

In an ethical dilemma, two or more clear moral principles apply but support mutually inconsistent courses of action. In this case, the nurse must decide what to do based on ethical decision making and take action that can be justified ethically based on that process.

15. Two children need a kidney transplant. One is the child of a famous sports figure, whereas the other child comes from a low-income family. What ethically relevant consideration is important to the nurse as an advocate for these clients?

A) Balance between benefits and harms in patient care

B) Norms of family life

C) Considerations of power

D) Cost-effectiveness and allocation

Ans: D

Feedback:

The increasing awareness of how difficult it is to make valued and scarce health resources available to all in need has resulted in a new appreciation for the moral relevance of cost-effectiveness. Balance between benefits and harms in patient care relates to reasoning about the benefits or burdens of treatment and the related harms; in this scenario, both children's risk and benefits may be the same. Norms of family life relate to the ways a client's illness impacts family members and significant others; not enough information is provided to know how this ethical principle applies in this scenario. Considerations of power relates to abuse of power by clinicians; this scenario does not present information suggesting this is occurring.

16. A student nurse is working in the library on her plan of care for a clinical assignment. The client's name is written at the top of her plan. What ethical responsibility is the student violating?

A) Confidentiality

B) Accountability

C) Trust

D) Informed consent

Ans: A

Feedback:

The student is violating confidentiality. Confidentiality is violated when patients are identified by name on written documents available to those who are not directly responsible for their care.

17. A nurse is concerned about the practice of routinely ordering a battery of laboratory tests for clients who are admitted to the hospital from a long-term care facility. An appropriate source in handling this ethical dilemma would be which of the following?

A) The client's family

B) The admitting physician

C) The nurse in charge of the unit

D) The institutional ethics committee

Ans: D

Feedback:

Many health care institutions have developed ethics committees whose functions include education, policymaking, case review, and consultation. These committees are multidisciplinary and provide a forum where divergent views can be discussed without fear of repercussion.

18. A client, unsure of the need for surgery, asks the nurse, "What should I do?" What answer by the nurse is based on advocacy?

A) "If I were you, I sure would not have this surgical procedure."

B) "Gosh, I don't know what I would do if I were you."

C) "Tell me more about what makes you think you don't want surgery."

D) "Let me talk to your doctor and I will get back to you as soon as I can."

Ans: C

Feedback:

Nurses as advocates must realize that they do not make ethical decisions for their clients. Rather, they facilitate clients' decision-making by interpreting findings, informing cliients of various aspects to be considered, helping clients verbalize and organize their feelings, calling in others involved in the decision making, and helping clients assess all their options in relation to their beliefs.

19. A client who is scheduled to have surgery for a hernia the next day is anxious about the whole procedure. The nurse assures the client that surgery for hernias is very common and that the prognosis is very good. What skills of the nurse are reflected here?

A) Imaginal skills

B) Interpersonal skills

C) Instrumental skills

D) Systems skill

Ans: B

Feedback:

The scenario reflects the nurse's interpersonal skills. It shows how a person relates with others. The nurse shows imaginal skills when he or she envisions a plan for adapting and personalizing client care. Instrumental skills are associated with basic physical and intellectual competencies. Systems skills are those that help the nurse see the whole picture and how various parts relate.

20. A nurse is caring for a client who is a celebrity in the area. A person claiming he is a family member inquires about the medical details of the client. The nurse reveals the information but later comes to find out that the person was not a family member. The nurse has violated which of the following?

A) Veracity

B) Fidelity

C) Confidentiality

D) Autonomy

Ans: C

Feedback:

The nurse has violated the principle of confidentiality by revealing the client's personal medical information to a third person. Confidentiality is a professional duty and a legal obligation. What is documented in the client's record is accessible only to those providing care to that client. The nurse's action does not violate rules of veracity, fidelity, or autonomy. Fidelity means being faithful to one's commitments and promises. Veracity means telling the truth, which is essential to the integrity of the client-provider relationship. Autonomy involves a client making his or her own decisions.

21. A nursing instructor is teaching a class about ethical principles to a group of nursing students. The instructor determines that the teaching was successful when the students give which of the following as an example of nonmaleficence?

A) Protecting clients from a chemically impaired practitioner

B) Performing dressing changes to promote wound healing

C) Providing emotional support to clients who are anxious

D) Administering pain medications to a client in pain

Ans: A

Feedback:

Protecting clients from a chemically impaired practitioner is an appropriate example of nonmaleficence. Nonmaleficence means to avoid doing harm, to remove from harm, and to prevent harm. Performing dressing changes to promote wound healing, providing emotional support to clients who are anxious, and administering pain medications to a client in pain are examples of beneficence, which means doing or promoting good.

22. A dying client tells the nurse that he doesn't want to see his family because he doesn't want to cause them more sadness. Which action by the nurse is most appropriate?

A) Arrange a meeting between the family and the client.

B) Help the patient clarify his values.

C) Educate the patient on death and dying concepts.

D) Allow the patient time for quiet reflection.

Ans: B

Feedback:

Values clarification is a method of self-discovery by which people identify their personal values and value rankings. The client's value of family may be obscured because of his overwhelming need to protect his family.

23. A nurse is caring for a client who is a practicing Jehovah's Witness. The physician orders two units of packed cells based on his low hemoglobin and hematocrit levels. The nurse states to the surgeon that it is unethical to go against the patient's beliefs even though his blood counts are very low. What is the best description of the nurse's intentions?

A) Acting in the patient's best interest

B) Siding with the patient over the surgeon

C) Observing institutional policies

D) Being legally responsible

Ans: A

Feedback:

Nurses' ethical obligations include acting in the best interest of their clients, not only as individual practitioners, but also as members of the nursing profession, the health care team, and the community at large.

24. What is the function of the American Nurses Association's Code of Ethics for Nurses?

A) Serves to establish personal ethics for nurses

B) Delineates nurses' conduct and responsibilities

C) Serves as a guideline for all health care practice

D) Plays an important role in legal proceedings

Ans: B

Feedback:

The ANA recently revised the Code of Ethics for Nurses that delineates the conduct and responsibilities expected of all nurses in their nursing practices.

25. When a nurse refuses to compromise a client's right to privacy, even when the nurse is threatened, the nurse is expressing an ethical framework termed what?

A) Utilitarian

B) Deontologic

C) Justice

D) Nonmaleficence

Ans: B

Feedback:

Deontologic frameworks emphasize roles or responsibilities that one is morally obligated to fulfill.

26. A nurse is caring for a woman 28 years of age who has delivered a baby by Cesarean section. She describes her pain as a 9. The nurse medicates her for pain. This is an example of which of the following ethical frameworks?

A) Justice

B) Fidelity

C) Beneficence

D) Nonmaleficence

Ans: C

Feedback:

Beneficence means doing or promoting good. The treatment of the client's pain is the nurse's act of doing good.

27. A home care nurse visits a client who is confined to bed and is cared for by her daughter. The daughter is known to suffer from chemical dependence. The home is cluttered and unclean. During the assessment the nurse notes that the client is wet with urine and has dried feces on her buttocks, and demonstrates signs of dehydration. After caring for the client, the nurse contacts the physician and reports the incident to Adult Protective Services. This is an example of which ethical framework?

A) Justice

B) Autonomy

C) Nonmaleficence

D) Fidelity

Ans: C

Feedback:

The principle of nonmaleficence means to avoid doing harm, to remove harm, and to prevent harm. Autonomy means to respect the rights of clients or their surrogates to make healthcare decisions. Justice means to give each his or her due. Fidelity means to keep promises.

28. A woman age 83 years who has suffered a cerebrovascular accident and is unable to swallow refuses the insertion of a feeding tube. This is an example of what ethical principle?

A) Nonmaleficence

B) Veracity

C) Autonomy

D) Justice

Ans: C

Feedback:

Autonomy essentially means independence and the ability to be self-directed.

29. A nurse states to the client that she will keep her free of pain. However, her family wishes to try a treatment to prolong her life that may necessitate withholding pain medication. This factor will cause an ethical dilemma for the nurse in relation to which ethical principle?

A) Fidelity

B) Veracity

C) Justice

D) Autonomy

Ans: A

Feedback:

Fidelity means being faithful to one's commitments and promises.

30. Which of the following are examples of a nurse demonstrating the professional value of altruism? Select all that apply.

A) The nurse arranges for an interpreter for a client whose primary language is Spanish.

B) The nurse calls the physician of a client whose pain medication is not strong enough.

C) The nurse provides information for a client so he is capable of participating in planning his care.

D) The nurse reviews a client chart to determine who may be informed of the patient's condition.

E) The nurse documents client care accurately and honestly and reviews the entry to ensure there are no errors.

Ans: A, B

Feedback:

The altruistic nurse demonstrates understanding of cultures, beliefs, and perspectives of others; advocates for clients; and takes risks on behalf of clients and colleagues. The professional practice reflects autonomy when the nurse respects clients' rights to make decisions about their health care. Human dignity is reflected when the nurse values and respects all clients and colleagues by preserving their confidentiality. Integrity is reflected in professional practice when the nurse is honest and provides care based on an ethical framework that is accepted within the profession. Social justice is upholding moral, legal, and humanistic principles. One way to do this is by encouraging legislation and policy consistent with the advancement of nursing care and health care.

31. A nurse has a duty of nonmaleficence. Which of the following would be considered a contradiction to that duty?

A) Provide comfort measures for a terminally ill patient.

B) Assist the patient with ADLs.

C) Refuse to administer pain medication as ordered.

D) Provide all information related to procedures.

Ans: C

Feedback:

The duty not to inflict harm, as well as prevent and remove harm, is termed nonmaleficence. Providing comfort measures for a terminally ill patient, assisting a patient with ADLs and providing information related to procedures would not be considered a contradiction to the nurse's duty of nonmaleficence.

32. A nurse working in a long-term care facility has an elderly male client who is very confused. What ethical dilemma is posed when using restraints in a long-term care setting?

A) It limits personal safety.

B) It increases confusion.

C) It threatens autonomy.

D) It prevents self-directed care.

Ans: C

Feedback:

Because there are safety risks involved when using restraints on elderly confused clients, this is a common ethical problem in long-term care settings, as well as other health care settings. Restraints limit the individual's autonomy because they are perceived as imprisonment. Restraints should not limit personal safety. Often, restraints increase confusion, and they prevent self-directed care.

33. A home health nurse who performs a careful safety assessment of the home of a frail elderly patient to prevent harm to the patient is acting in accord with which of the following, a principle of bioethics?

A) Nonmaleficence

B) Advocacy

C) Morals

D) Values

Ans: A

Feedback:

Nonmaleficence is a principle of bioethics and is defined as the obligation to prevent harm. Advocacy, morals, and values are not principles of bioethics.

34. A nurse has had, on several occasions, the opportunity to share personal prescriptions with family members when they were in need of pain medication or antibiotics. Which set of rules should govern this moral decision?

A) Ethics

B) Administrative law

C) Common law

D) Civil law

Ans: A

Feedback:

Although all of the options may affect your decision, moral decisions are guided by ethics, which are internal set of principles and values that guide the behavior of a person. Sharing medications prescribed to you with other people, including family members, would be considered unethical. It is important to distinguish ethics from law, religion, custom, and institutional practices. For example, the fact that an action is legal or customary does not in itself make the action ethically or morally right.

35. An ethical conflict exists around a female client's expressed desire to have a neighbor make her treatment decisions. This neighbor is an individual who the client's children characterize as a predator. Place in the correct order the steps that the nurse should follow in resolving this ethical conflict.

1. Clearly identify the ethical problem

2. Apply ethical principles to the situation

3. Identify the different options

4. Gather relevant data about the situation

5. Make and evaluate a decision

A) 1, 2, 3, 4, 5

B) 4, 1, 3, 2, 5

C) 2, 3, 4, 1, 5

D) 1, 4, 3, 2, 5

Ans: B

Feedback:

The nursing process of assessment, diagnosis, planning, implementation, and evaluation can be applied to appropriately respond to many ethical dilemmas.

Chapter 7, Legal Dimensions of Nursing Practice

1. Which of the following aspects of nursing would be most likely defined by legislation at a state level?

A) The differences in the scope of practice between registered nurses (RNs) and licensed practical nurses (LPNs).

B) The criteria that a nurse must consider when delegating tasks to unlicensed care providers.

C) The criteria that clients must meet in order to qualify for Medicare or Medicaid.

D) The process that nurses must follow when handling and administering medications.

Ans: A

Feedback:

The scope of practice defines the parameters within which nurses provide care, and is established by state legislation, most commonly in the form of a Nurse Practice Act. The criteria and due process for delegation in the clinical setting is addressed by a state board of nursing. Qualification criteria for programs such as Medicare and Medicaid are established by federal legislation, while the process for safe and appropriate medication administration is defined and monitored by a state board of nursing.

2. During a clinical placement on a subacute, geriatric medicine unit, a student nurse fed a stroke client some beef broth, despite the fact that the client's diet was restricted to thickened fluids. As a result, the client aspirated and developed pneumonia. Which of the following statements underlies the student's potential liability in this situation?

A) The same standards of care that apply to a registered nurse apply to the student.

B) The student and the nursing instructor share liability for this lapse in care.

C) The patient's primary nurse is liable for failing to ensure that delegated care was appropriate.

D) The student's potential liability is likely negated by the insurance carried by the school of nursing.

Ans: A

Feedback:

Despite the fact that their knowledge and skills are still under development, nursing students are held to the same standards of care as registered nurses. Consequently, primary liability does not lie with the student's instructor or the patient's primary nurse. Insurance may be carried by the school of nursing, but this does not negate the student's legal responsibility to provide care at a high standard.

3. A nurse is arrested for possession of illegal drugs. What kind of law is involved with this type of activity?

A) Civil

B) Private

C) Public

D) Criminal

Ans: D

Feedback:

Criminal law concerns state and federal criminal statutes, which define criminal actions such as murder, manslaughter, criminal negligence, theft, and illegal possession of drugs. Civil law, also called private law, includes laws relating to contracts, ownership of property, and the practice of nursing, medicine, pharmacy, and dentistry. Public law is law in which the government is involved directly.

4. A lawyer quotes a precedent for punishment of a crime committed by the defendant in a trial. What is court-made law known as?

A) Public law

B) Statutory law

C) Common law

D) Administrative law

Ans: C

Feedback:

The government provides for a judiciary system, which is responsible for reconciling controversies. It interprets legislation at the local, state, and national levels as it has been applied in specific instances and makes decisions concerning law enforcement. A body of law known as common law has evolved from these accumulated judiciary decisions. Common law is thus court-made law, and most law involving malpractice is common law.

5. A client is suing a nurse for malpractice. What is the term for the person bringing suit?

A) Plaintiff

B) Defendant

C) Litigator

D) Witness

Ans: A

Feedback:

A lawsuit is a legal action in a court. Litigation is the process of bringing and trying a lawsuit. The person or government bringing suit against another is called the plaintiff. The one being accused of a crime or tort (defined later) is called the defendant. The defendant is presumed innocent until proved guilty of a crime or tort.

6. A nurse is providing client care in a hospital setting. Who has full legal responsibility and accountability for the nurse's actions?

A) The nurse

B) The head nurse

C) The physician

D) The hospital

Ans: A

Feedback:

In modern practice, nurses assess and diagnose clients and plan, implement, and evaluate nursing care. Full legal responsibility and accountability for these nursing actions rest with the nurse.

7. What type of law regulates the practice of nursing?

A) Common law

B) Public law

C) Civil law

D) Criminal law

Ans: C

Feedback:

Civil laws regulate the practice of nursing. A law is a standard or rule of conduct established and enforced by the government, chiefly to protect the rights of the public. Private law, also called civil law, regulates relationships among people and includes laws related to the practice of nursing.

8. What is the legal source of rules of conduct for nurses?

A) Agency policies and protocols

B) Constitution of the United States

C) American Nurses Association

D) Nurse Practice Acts

Ans: D

Feedback:

Nurse Practice Acts are examples of statutory law, enacted by a legislative body in keeping with both the federal constitution and the applicable state constitution. They are the primary source of rules of conduct for nurses. Standards of practice, which differ from rules of conduct, are made by agency policies and protocols and by the American Nurses Association.

9. A nurse moves from Ohio to Missouri. Where can a copy of the Nurse Practice Act in Missouri be obtained?

A) Ohio State Board of Nursing

B) Missouri State Board of Nursing

C) Federal government nursing guidelines

D) National League for Nursing

Ans: B

Feedback:

Each state has a Nurse Practice Act that protects the public by broadly defining the legal scope of nursing practice. A copy of the Nurse Practice Act for the state in which a nurse practices can be obtained from that state's board of nursing. Neither the federal government nor the National League for Nursing has copies of nurse practice acts.

10. Which of the following best describes voluntary standards?

A) Voluntary standards are guidelines for peer review, guided by the public's expectation of nursing.

B) Voluntary standards set requirements for licensure and nursing education.

C) Voluntary standards meet criteria for recognition, specified area of practice.

D) Voluntary standards determine violations for discipline and who may practice.

Ans: A

Feedback:

Voluntary standards are developed and implemented by the nursing profession itself. They are not mandatory but are used as guidelines for peer review. The organizations that set standards are guided by society's need for nursing and by the public's expectations of nursing.

11. Which of the following accreditations is a legal requirement for a school of nursing to exist?

A) National League for Nursing Accrediting Commission

B) American Association of Colleges of Nursing accreditation

C) State Board of Nursing accreditation

D) Educational institution accreditation

Ans: C

Feedback:

State laws are enacted to ensure that schools preparing nursing practitioners maintain minimum standards of education. This is legal accreditation. Accreditation by voluntary agencies is not required for a school to exist.

12. Which of the following is the most frequent reason for revocation or suspension of a nurse's license?

A) Fraud

B) Mental impairment

C) Alcohol or drug abuse

D) Criminal acts

Ans: C

Feedback:

A nurse's license may be suspended or revoked for fraud, deceptive practices, criminal acts, previous disciplinary action by other state boards, negligence, physical or mental impairments, or alcohol or drug abuse. The most frequent reason is alcohol or drug abuse.

13. A nurse does not assist with ambulation for a postoperative client on the first day after surgery. The client falls and fractures a hip. What charge might be brought against the nurse?

A) Assault

B) Battery

C) Fraud

D) Negligence

Ans: D

Feedback:

A tort is a civil wrong committed by a person against another person or his or her property. Negligence, an unintentional tort, occurs when a person fails to exercise reasonable care in the performance of his or her duties. In this situation, the nurse did not initiate proper precautions to prevent patient harm and is subject to the charge of negligence.

14.	A client refuses to have a pain medication administered by injection. A nurse says, “If you don’t let me give you the shot, I will get help to hold you down and give it.” With what crime might the nurse be charged?
A)	Assault
B)	Battery
C)	Negligence
D)	Defamation
Ans:	A
	Feedback:
	Assault and battery are intentional torts. Assault is a threat or attempt to make bodily contact with another person without that person’s consent. Threatening to forcibly administer an injection after the patient has refused it is assault. Battery is an assault that is carried out and includes willful, angry, and violent or negligent touching of another person’s body, clothes, or anything attached to or held by that other person. Negligence is defined as performing an act that a reasonably prudent person under similar circumstances would not do or, conversely, failing to perform an act that a reasonably prudent person under similar circumstances would do. Defamation is an intentional tort in which one party makes derogatory remarks about another that diminish the other party’s reputation.
15.	Two nurses are discussing a client’s condition in an elevator full of visitors. With what crime might the nurses be charged?
A)	Defamation of character
B)	Invasion of privacy
C)	Unintentional negligence
D)	Intentional negligence
Ans:	B
	Feedback:
	Certain acts by nurses could constitute invasion of privacy, including talking about patients in public areas, such as elevators. This violates federal law. In this case, the nurses would not be charged with defamation or negligence.
16.	A lawsuit has been brought against a nurse for malpractice. The client fell and suffered a skull fracture, resulting in a longer hospital stay and need for rehabilitation. What does the description of the client and his injuries represent as proof of malpractice?
A)	Damages
B)	Causation
C)	Duty
D)	Breach of duty
Ans:	A
	Feedback:
	Liability involves four elements: duty (obligation to use care and follow standards), breach of duty (failure to follow standards of care), causation (the failure to follow standards of care resulted in the injury), and damages (the actual harm or injury resulting to the patient).
17.	A nurse has been named as a defendant in a lawsuit. With whom should the nurse discuss the case?

A) Colleagues

B) Reporters

C) Plaintiff

D) Attorney

Ans: D

Feedback:

The nurse should only discuss the case with the attorney representing him or her and/or the institution. Recommendations for the nurse as defendant include not discussing the case with anyone at the employing agency (except the risk manager), the plaintiff, the plaintiff's lawyer, anyone testifying for the plaintiff, or reporters.

18. Which of the following is the nurse's best legal safeguard?

A) Collective bargaining

B) Written or implied contracts

C) Competent practice

D) Patient education

Ans: C

Feedback:

Competent practice is the nurse's most important and best legal safeguard. Each nurse is responsible for making sure his or her educational background and clinical experience are adequate to fulfill the nursing responsibilities described in the job description. Collective bargaining, written or implied contracts, and/or patient education do not provide the best legal safeguard.

19. A nurse has taken a telephone order from a physician for an emergency medication. The dose of the medication is abnormally high. What should the nurse do next?

A) Administer the medication based on the order

B) Question the order for the medication

C) Refuse to administer the medication

D) Document concerns about the order

Ans: B

Feedback:

The nurse should question any physician order that is ambiguous, contraindicated by normal practice (such as an abnormally high medication dose), or contraindicated by the client's present condition. The nurse should not administer the medication, refuse to administer the medication without contacting the physician, or document concerns about the order without doing anything further.

20. A client gets out of bed following hip surgery, falls, and re-injures her hip. The nurse caring for her knows that it is her duty to make sure an incident report is filed. Which of the following statements accurately describes the correct procedure for filing an incident report?

A) The physician in charge should fill out the report.

B) The names of the staff involved should not be included.

C) The reports are used for disciplinary action against the staff.

D) The report should contain all the variables related to the incident.

Ans: D

Feedback:

An incident report, also called a variance or occurrence report, is used by health care agencies to document the occurrence of anything out of the ordinary that results in, or has the potential to result in, harm to a patient, employee, or visitor. The nurse responsible for a potentially (or actually) harmful incident or who witnesses an injury is the one who fills out the incident form. This form should contain the complete name of the person or people involved and the names of all witnesses; a complete factual account of the incident; the date, time, and place of the incident; pertinent characteristics of the person or people involved (e.g., alert, ambulatory, asleep) and of any equipment or resources being used; and any other variables believed to be important to the incident. These reports are used for quality improvement and should not be used for disciplinary action against staff members.

21. An on-duty nurse discovers that her colleague is pilfering medicines. According to the Nurse Practice Acts, what should the nurse do?

A) Keep silent and overlook the incident

B) Inform the local police station

C) Discuss this incident with the colleague

D) Report the incident to the supervisor

Ans: D

Feedback:

According to the Nurse Practice Acts, the nurse should report the incident to the supervisor. Laws are enacted to regulate the practice of nursing and may be used to decide upon an appropriate action. Discussing the incident with a colleague may alarm the nurse who is pilfering medicines and she may become cautious. The nurse should not overlook the incident because pilfering of medicines is an offense. Calling local police may lead to undue interference.

22. A client who has undergone resection of the intestine is on a liquid diet with a nasogastric tube in place. He refuses the food tray with regular food that comes to his room and insists that a physician be called. The nurse insists that it is the right food and makes the client take it. The client develops complications and has to be re-operated upon. How is negligence determined in this situation?

A) The nurse did not call the physician when the client asked.

B) The nurse did not realize the importance of the tube.

C) The dietary department sent the wrong diet for the client.

D) The nurse insisted the patient have the solid food.

Ans: B

Feedback:

Negligence is defined as harm that occurs because the person did not act reasonably. In this case, the nurse did not realize that the client was on a nasogastric tube, and should consequently have been on liquid feeds after intestinal surgery; as a result, the patient developed complications. The acts of not calling the physician and insisting the patient have food do not amount to negligence. The dietary department sending the wrong food is unrelated to the nurse.

23. A home care nurse is caring for a quadriplegic client who needs regular position changes and back massages. A gentleman identifying himself as a family friend inquires if he can be of any help to the family. What should be the nurse's response be?

A) The nurse should ask the gentleman to talk to the family directly.

B) The nurse should invite the gentleman to learn the caring techniques.

C) The nurse should state that the family does not need any help.

D) The nurse should refer the gentleman to the local social worker.

Ans: A

Feedback:

The nurse should ask the gentleman to talk to the family directly. Revealing information about the client's care is a violation of the client's privacy. The nurse should not invite the gentleman for a learning session because it would be a breach of the client's right to privacy. Referring him to a social worker is not an appropriate choice.

24. A client is admitted with symptoms of psychosis. The nurse hurries to the client's room when she hears the client calling for help. She finds the client lying on the ground. The nurse assists the client back to the bed and performs a thorough assessment. The nurse informs the physician and completes the incident report. Which of the following statements should the nurse document in the incident report?

A) The client was trying to lower the side rails.

B) The client was found lying on the floor.

C) The client was trying to get out of the bed.

D) The client was not aware that he had fallen.

Ans: B

Feedback:

An incident report is a written account of an unusual, potentially injurious event involving a client, employee, or visitor. All of the details given in the incident report should be accurate and not assumed. Accurate and detailed documentation helps to prove that the nurse acted reasonably or appropriately in the circumstance. The nurse should document that the client was found lying on the floor. The other statements are assumptions and should not be included in the incident report.

25. A nurse fails to administer a medication that prevents seizures, and the client has a seizure. The nurse is in violation of the Nurse Practice Act. What type of law is the nurse in violation of?

A) Criminal

B) Federal

C) Civil

D) Supreme

Ans: C

Feedback:

Malpractice cases are generally the kind of civil cases that involve nurses.

26. A baccalaureate-prepared nurse is applying for a nurse practitioner position. The nurse is:

A) Well educated and can perform these duties

B) Able to practice as a nurse practitioner

C) Educated to practice only with pediatric patients

D) Practicing beyond his scope according to licensure

Ans: D

Feedback:

A nurse without an advanced practice license is not able to practice beyond his or her scope in accordance with the Nurse Practice Act.

27. When the nurse inserts an ordered urinary catheter into the client's urethra **after** the client has refused the procedure, and then the client suffers an injury, the client may sue the nurse for which type of tort?

A) Battery

B) Assault

C) Invasion of privacy

D) Dereliction of duty

Ans: A

Feedback:

Battery is the actual carrying out of such threat (unlawful touching of a person's body). A nurse may be sued for battery if he or she fails to obtain consent for a procedure.

28. A group of nurses working in a long-term care facility fails to keep the narcotic medications in a secure location. The nurses also fail to count the medications before and after each shift, as indicated by the institution's policies and procedures. These failures may result in what type of disciplinary action?

A) Action against the nurses' licenses

B) Action against the facility's state license

C) Action against the state regulating body

D) Action against the pharmacist's license

Ans: A

Feedback:

In institutions, most controlled substances must be kept secure and monitored closely in accordance with institutional and state regulations. Failure to do so may lead to disciplinary action against the nurse's license.

29. Which of the following statements accurately describes an aspect of the credentialing process used in nursing practice? Select all that apply.

A) Credentialing refers to the way in which professional competence is ensured and maintained.

B) Accreditation is the process by which the state determines that a person meets minimum requirements to practice nursing.

C) Certification grants recognition in a specified practice area to people who meet certain criteria.

D) Legal accreditation of a school preparing nursing personnel by the state Board of Nursing is voluntary.

E) Once earned, a license to practice is a property right and may not be revoked without due process.

Ans: A, C, E

Feedback:

Credentialing refers to the way in which professional competence is ensured and maintained. Licensure is the process by which a state determines that a candidate meets certain minimum requirements to practice in the profession and grants a license to do so. Certification is the process by which a person who has met certain criteria established by a nongovernmental association is granted recognition in a specified practice area. State accreditation is a legal requirement; legal accreditation of a school preparing nursing personnel by the state Board of Nursing should not be confused with voluntary accreditation. Once earned, a license to practice is a property right and may not be revoked without due process. This includes notice of an investigation, a fair and impartial hearing, and a proper decision based on substantial evidence. According to the National Council of State Boards of Nursing, a mutual recognition model of nurse licensure exists that allows a nurse to have one license in his or her state of residency, and to practice in other states (both physically and electronically) as well, subject to each state's practice law and regulation, unless otherwise restricted.

30. According to HIPPA regulations, which of the following is a client right regarding the client's medical record? Select all that apply.

A) To see the health record

B) To copy the health record

C) To make additions to the health record

D) To cross out sections of the health record

E) To restrict certain disclosures of the health record

Ans: A, B, E

Feedback:

According to HIPAA, clients have a right to see and copy their health record; to update their health record; to get a list of the disclosures a health care institution has made independent of disclosures made for the purposes of treatment, payment, and health care operations; to request a restriction on certain uses or disclosures; and to choose how to receive health information. The client may not make additions, cross out sections, or destroy the health record.

31. A nurse explains the informed consent form to a client who is scheduled for heart bypass surgery. Which of the following are elements of this consent form? Select all that apply.

A) Disclosure

B) Organ donation

C) DNR orders

D) Comprehension

E) Competence

Ans: A, D, E

Feedback:

Every person is granted freedom from bodily contact by another person, unless consent is granted. In all health care agencies, informed and voluntary consent is needed for admission (for routine treatment), for each specialized diagnostic procedure or medical or surgical treatment, and for any experimental treatments or procedures. Elements of informed consent include disclosure, comprehension, competence, and voluntariness.

32. Which of the following nursing actions would be considered a violation of HIPPA regulations? Select all that apply.

A) A nurse ambulates a client through a hospital hallway in a hospital gown that is open in the back.

B) A nurse shoves a confused, bedridden client into bed after he made several attempts to get up.

C) A nurse inadvertently administers the wrong dose of morphine to a client in the ICU.

D) A nurse uses a client's chart as a sample teaching case without changing the client's name.

E) A nurse reports the condition of a client to the client's employer.

Ans: A, D, E

Feedback:

HIPPA regulations exist to protect patient privacy. Answers A, D, and E are examples of violations of HIPPA. Shoving a patient is battery and inadvertently administering the wrong dose of a medicine is negligence. A person fraudulently misrepresenting himself or herself to obtain a license to practice nursing is considered fraud.

33. The nursing student asks the nurse for an example of a "never event." Which example provided by the nurse best answers the nursing student's question?

A) The client scheduled for a cholecystectomy has a total abdominal hysterectomy.

B) The client receives preoperative medication before signing the informed consent.

C) The client receives a medication and develops a rash on the trunk of the body, itching, and dyspnea.

D) The client fails to receive a regularly scheduled medication.

Ans: A

Feedback:

A "never event" is an extremely rare medical error that should never occur. The performance of the wrong surgery on a client is an example of a never event. The other examples are examples of incidents or variances, events that occur out of the ordinary that result in, or have the potential to result in, harm to a client, employee, or visitor.

34. The nurse reports a nursing colleague on the unit who is lethargic and verbally responding in a slow manner. What is this an example of?

A) Whistle-blowing

B) Collective bargaining

C) Delegating nursing care

D) Ensuring adequate staffing

Ans: A

Feedback:

Whistle-blowing is when the nurse reports unsafe practice environments. Impaired nurses threaten the safety of clients in the clinical setting, as does inadequate staffing. Nurses may delegate or assign tasks involved in the delivery of nursing care to individuals as long as the individual has sufficient knowledge and skill to perform the assigned task. Collective bargaining is a legal process in which representatives of organized employees negotiate with employers about work conditions.

35. The nurse is accused of malpractice by a client. List the order in which the steps of the litigation process will occur (use all options).

1) The basis for the claim is determined to be appropriate and timely with all elements of liability present.

2) All parties named as defendants (nurses, physicians, health care agency), as well as insurance companies and attorneys, work toward a fair settlement.

3) Trial takes place; both sides present their evidence and arguments.

4) The case is presented to a malpractice arbitration panel. The panel's decision is either accepted or rejected, in which case a complaint is filed in trial court.

5) Pretrial discovery activities occur: review of medical records and depositions of plaintiff, defendants, and witnesses.

6) The defendants contest allegations.

A) 2, 3, 4, 1, 5, 3

B) 1, 2, 4, 6, 5, 3

C) 1, 2, 3, 4, 5, 6

D) 2, 6, 5, 3, 1, 4

Ans: B

Feedback:

The steps involved in malpractice litigation are as follows: 1. The basis for the claim is determined to be appropriate and timely; all elements of liability are present (duty, breach of duty, causation, and serious damages). 2. All parties named as defendants (nurses, physicians, health care agency), as well as insurance companies and attorneys, work toward a fair settlement. 3. The case is presented to a malpractice arbitration panel. The panel's decision is either accepted or rejected, in which case a complaint is filed in trial court. 4. The defendants contest allegations (argue that there is no basis for alleging deviation from the appropriate standard of care or for proving causation and damages). 5. Pretrial discovery activities occur: review of medical records and depositions of plaintiff, defendants, and witnesses. 6. Trial takes place; both sides present their evidence and arguments. 7. Decision or verdict is reached by the judge and/or jury. 8. If the verdict is not accepted by both sides, it may be appealed to an appellate court.

Chapter 8, Communication

1. A group of nursing students is working together on a presentation for their clinical instructor. One student in the group participates by arguing and attempting to block each step of the process of this presentation. The student's behavior is causing frustration for the others and slowing their progress. Which of the following best describes the role this individual student is playing in relationship to the group dynamics?

A) Self-serving

B) Task-oriented

C) Maintenance

D) Group-building

Ans: A

Feedback:

The student's behavior is best described as self-serving. Self-serving roles advance the needs of individual members at the group's expense. Task-oriented roles focus on the work to be completed. Group-building or maintenance roles focus on the well-being of the people doing the work.

2. The nurse is caring for a client who speaks Chinese, and the nurse does not speak Chinese. An appropriate approach for communication with this client includes what?

A) Using a caring voice and repeating messages frequently

B) Speaking directly and loudly to the client

C) Avoiding the use of gesture or play-acting

D)	Writing messages for the client and offering him a dictionary for translation.
Ans:	A
	Feedback:
	Approaches to use when a client speaks a different language include speaking slowly and distinctly, and avoiding loud voices. Use a caring voice, keeping messages simple, and repeat messages frequently. The use of a language dictionary by the nurse is appropriate, but writing messages and asking the client to translate is not an appropriate approach. Gestures, pictures, and play-acting help the client understand.
3.	The daughter of an older adult female client has asked the nurse why a urine specimen was collected from her mother earlier that morning. How can the nurse best respond to the daughter's query?
A)	"We want to test your mother's urine to make sure she doesn't have a urinary tract infection."
B)	"Your mother's doctor ordered a urine C&S to rule out a UTI."

C) "We want to do everything we can to get your mother healthy again."

D) "Sometimes sick urine can make the whole person sick, and this might be causing her fever."

Ans: A

Feedback:

In order to communicate effectively, the nurse needs to avoid the use of jargon or abbreviations ("C&S") that are unfamiliar to those outside the health care system. At the same time, accuracy is important, and vague and "dumbed-down" answers ("we want to do everything we can," "sick urine") are inappropriate.

4. A nurse has drafted an SBAR communication before contacting the primary care provider of a client whose condition has worsened suddenly. How should the nurse best conclude this communication?

A) Ask the care provider to come and assess the client.

B) Provide the client's most recent vital signs.

C) Ask the care provider if he or she is familiar with this client.

D) Provide the most likely diagnosis of the problem.

Ans: A

Feedback:

The final phase of an SBAR communication involves making a recommendation. In the case of a client whose condition is worsening, this may entail recommending that the primary care provider come to assess the client. Asking the care provider if he or she is familiar with the client should be done early in the communication. Providing assessment data and possible diagnoses are addressed in the background and assessment sections of the tool.

5. The nurse has entered a client's room and observes that the client is hunched over and appears to be breathing rapidly. What type of question should the nurse first implement in this interaction?

A) A yes/no question

B) A directing question

C) An open-ended question

D) A reflective question

Ans: A

Feedback:

There are times when yes/no questions are appropriate. In this case, the nurse may want to ask, "Do you feel short of breath?" or something similar. Directing questions and reflective questions follow up on earlier communication. An open-ended question may elicit the necessary assessment data, but a yes/no question accomplishes this goal more directly.

6. The nurse has entered a client's room after receiving a morning report. The nurse rapidly assessed the client's airway, breathing, and circulation and greeted the client by saying "Good morning." The client has made no reciprocal response to the nurse. How should the nurse best respond to the client's silence?

A) The nurse should ask appropriate questions to understand the reasons for the client's silence.

B) The nurse should apologize for bothering the client, perform necessary assessments efficiently and leave the room.

C) The nurse should document the client's withdrawal and diminished mood in the nurse's notes.

D) The nurse should ask the client if he feels afraid or angry.

Ans: A

Feedback:

Silence can have many meanings, and the nurse should attempt to identify the meaning of the client's silence in a tactful manner. Directly asking if the client is angry or fearful is likely presumptuous and may harm rapport. The nurse should not make assumptions around the client's mood nor should the nurse cease to engage with the client.

7. A nurse touches a client's hand to indicate caring and support. What channel of communication is the nurse using?

A) Auditory

B) Visual

C) Olfactory

D) Kinesthetic

Ans: D

Feedback:

The nurse is using a kinesthetic channel of communication. The channel of communication is the medium the sender has selected to send the message. The channel might target any of the receiver's senses. The channels are auditory (spoken words and cues), visual (sight, observations, and perceptions), and kinesthetic (touch).

8. A nurse is educating a home care client on how to administer a topical medication. The client is watching television while the nurse is talking. What might be the result of this interaction?

A) The message will likely be misunderstood.

B) The stimulus for communication is unclear.

C) The receiver will accurately interpret the message.

D) The communication will be reciprocal.

Ans: A

Feedback:

Noise, which is a factor that distorts the quality of a message, can interfere with communication at any point in the process. If the client is watching television, it is likely that the message from the nurse will be misunderstood.

9. The family of a client in a burn unit asks the nurse for information. The nurse sits with the family and discusses their concerns. What type of communication is this?

A) Intrapersonal

B) Interpersonal

C) Organizational

D) Focused

Ans: B

Feedback:

Interpersonal communication occurs among two or more people with a goal to exchange messages. Nurses spend most of their day communicating with clients, family members, and health care team members.

10. Which of the following is an example of nonverbal communication?

A) A nurse says, “I am going to help you walk now.”

B) A nurse presents information to a group of clients.

C) A client’s face is contorted with pain.

D) A client asks the nurse for a pain shot.

Ans: C

Feedback:

Nonverbal communication is the transmission of information without the use of words. In this situation, the facial contortion is a nonverbal message of pain.

11. A nursing student caring for an unconscious client knows that communication is important even if the client does not respond. Which nonverbal action by the nursing student would communicate caring?

A) Making constant eye contact with the client

B) Waving to the client when entering the room

C) Sighing frequently while providing care

D) Holding the client’s hand while talking

Ans: D

Feedback:

Tactile sense is a form of nonverbal communication and is viewed as one of the most effective nonverbal ways to express feelings of comfort.

12. Which of the following statements is true of factors that influence communication?

A) Nurses provide the same information to all clients, regardless of age.

B) Men and women have similar communication styles.

C) Culture and lifestyle influence the communication process.

D) Distance from a client has little effect on a nurse’s message.

Ans: C

Feedback:

Culture and lifestyle do influence the communication process; understanding a client’s culture assists nurses in understanding nonverbal communication and enables the nurse to deliver accurate care.

13. A nurse is sitting near a client while conducting a health history. The client keeps edging away from the nurse. What might this mean in terms of personal space?

A) The nurse is outside the client’s personal space.

B) The nurse is in the client’s personal space.

C) The client does not like the nurse.

D) The client has concerns about the questions.

Ans: B

Feedback:

Each person has a sense of how much personal or private space is needed and what distance between individuals is optimum. It is best to take cues from the client; a client moving backward indicates discomfort with invasion of his or her personal space.

14. Why is communication important to the "assessing" step of the nursing process?

A) The major focus of assessing is to gather information.

B) Assessing is primarily focused on physical findings.

C) Assessing involves only nonverbal cues.

D) Written information is rarely used in assessment.

Ans: A

Feedback:

The major focus of assessment is to gather information using both verbal and nonverbal communication forms. Nurses use the written word, the spoken word, and one-to-one communication with clients. Effective communication techniques, as well as observational skills, are used extensively during assessment.

15. A nurse uses the SBAR method to hand off the communication to the health care team. Which of the following might be listed under the "B" of the acronym?

A) Vital signs

B) Mental status

C) Client request

D) Further testing

Ans: B

Feedback:

SBAR stands for Situation, Background, Assessment, and Recommendations, and provides a consistent method for hand-off communication that is clear, structured, and easy to use. Vital signs would fall under the category of situation; mental status: background; client request: assessment; further testing: recommendations.

16. What is the goal of the nurse in a helping relationship with a client?

A) To provide hands-on physical care

B) To ensure safety while caring for the client

C) To assist the client to identify and achieve goals

D) To facilitate the client's interactions with others

Ans: C

Feedback:

A helping relationship exists among people who provide and receive assistance in meeting human needs. When a nurse and a client are involved in a helping relationship, the nurse assists the client to identify and achieve goals that allow the client's human needs to be met.

17. What action by the nurse will facilitate the helping relationship during the orientation phase?

A) Providing assistance to meet activities of daily living

B) Introducing oneself to the client by name

C) Designing a specific teaching plan of care

D) Preparing for termination of the relationship

Ans: B

Feedback:

In the orientation phase of the helping relationship, the nurse and patient meet and learn to identify each other by name. It is especially important that the nurse introduce herself or himself to the patient during this phase.

18. Which of the nursing roles is primarily performed during the working phase of the helping relationship?

A) Educator and counselor

B) Provider of care

C) Leader and manager

D) Researcher

Ans: A

Feedback:

The nursing roles of educator and counselor are primarily performed during the working phase of the helping relationship. This is where the nurse's interpersonal skills are used to the fullest.

19. Which term describes a nurse who is sensitive to the client's feelings, but remains objective enough to help the client achieve positive outcomes?

A) Competent

B) Caring

C) Honest

D) Empathic

Ans: D

Feedback:

Empathy is identifying with the way another person feels. An empathic nurse is sensitive to the client's feelings and problems, but remains objective enough to help the client work to attain positive outcomes.

20. What is the primary focus of communication during the nurse–client relationship?

A) Time available to the nurse

B) Nursing activity to be performed

C) Client and client needs

D) Environment of the client

Ans: C

Feedback:

Communication in the nurse–client relationship should focus on the client and patient needs, not on the nurse or an activity in which the nurse is engaged.

21. Which of the following is an example of a closed-ended question or statement?

A) "How did that make you feel?"

B) "Did you take those drugs?"

C) "What medications do you take at home?"

D) "Describe the type of pain you have."

Ans: B

Feedback:

The closed-ended question or statement provides the receiver with limited choices of possible responses and might often be answered by one or two words, such as "yes" or "no." When not used appropriately, closed-ended questions are a barrier to effective communication.

22. A client tells the nurse that he is very worried about his surgery. Which of the following responses by the nurse is a cliché?

A) "Tell me what you are worried about."

B) "Have you spoken to your family about your concerns?"

C) "Do you want to cancel your surgery?"

D) "Don't worry, everything will be fine."

Ans: D

Feedback:

A cliché is a stereotypical, trite, or pat answer. Most health care clichés suggest there is no cause for concern, or they often offer false assurance. Their use tends to be interpreted as a lack of real interest in what has been said.

23. A nurse tells a client, "Aren't you going to get out of bed or are you just going to sleep all day and night?" This is an example of which of the following barriers to communication?

A) Using comments that give advice

B) Using judgmental or belittling language

C) Using leading questions

D) Using probing questions

Ans: B

Feedback:

Using judgmental comments tends to impose the nurse's standards on the client. In this case, the nurse judges the client as being lazy and the nurse's apparent hostility could end effective communication.

24. A nurse is caring for a client who is visually impaired. Which of the following is a recommended guideline for communication with this client?

A) Ease into the room without acknowledging presence until the client can be touched.

B) Speak in a louder tone of voice to make up for lack of visual cues.

C) Explain reason for touching client before doing so.

D) Keep communication simple and concrete.

Ans: C

Feedback:

For clients who are visually impaired, the nurse should acknowledge his or her presence in the client's room, identify self by name, speak in a normal tone of voice, explain the reason for touching the client before doing so, and indicate to the client when the conversation has ended and when leaving the room.

25. A client has been recently diagnosed with diabetes. He is seen in the emergency room every day with high blood sugar. The client apologizes to the nurse for bothering them every day, but he cannot give himself insulin injections. What should the nurse's response be?

A) "I myself cannot take insulin injections."

B) "Has someone taught you how to take them?"

C) "You should learn to take injections yourself."

D) "Ask the doctor to change the medications."

Ans: B

Feedback:

The nurse should assess whether the client has a knowledge deficit regarding self-injection. If there is a knowledge deficit, the nurse should educate the client in the correct method of taking insulin injections. Answer A is a negative reinforcement and is therefore inappropriate. Demanding that the client learn injection administration is also inappropriate. Answer D is inappropriate, because the nurse should not offer a change that cannot be carried out.

26. A nurse pays a house visit to a client who is on total parenteral nutrition. The client expresses that he misses enjoying food with his family. What is the most appropriate response by the nurse?

A) Tell me more about how it feels to eat with your family.

B) You can sit with your family at meal times, even though you don't eat.

C) In a few weeks you may be allowed to eat a little; you may enjoy then.

D) I know that you must be missing your favorite foods.

Ans: A

Feedback:

The nurse should help the client to verbalize his feelings and cope with aspects of illness and treatment. Asking open-ended questions is most appropriate as the nurse encourages the client to express his feelings. The other options block communication and are not appropriate. Telling the client that he can sit with his family but avoid eating does not consider the client's feelings. Informing the client that he will be able to eat food in a few weeks changes the subject and stops communication. Stating that the client is missing his favorite dishes devalues the client's feelings.

27. A nurse is caring for a client with myasthenia gravis. The client is having difficulty forming words and his tone is nasal. Which of the following is an effective communication strategy for this client?

A) Engage the client in a lengthy discussion to strengthen his voice.

B) Encourage the client to speak quickly while talking.

C) Repeat what the client has said to verify the meaning.

D) Nod continuously when the client is talking.

Ans: C

Feedback:

The client is having a problem forming words and has a nasal tone due to a nerve involvement that controls speech. For effective communication, the nurse should repeat and verify whatever the client says. The nurse should ask those questions which can be answered in a yes or no form. Lengthy discussions may tire the client. Encouraging the client to speak quickly is inappropriate. Nodding continuously when the client is talking would not facilitate an effective communication strategy.

28. The nurse has engaged the services of an interpreter when interviewing a client who speaks a language that the nurse does not understand. The interpreter is functioning in which role during the communication process?

A) Sender

B) Encoder

C) Receiver

D) Communication channel

Ans: D

Feedback:

The interpreter's role is that of a communication channel. A communication channel is the medium, the carrier of the message. The interpreter conveys the message sent by the client to the nurse. The client is the sender and the encoder of the message. The nurse is the receiver of the message.

29. A client comes to the clinic complaining of abdominal pain. Which first question would be most appropriate for the nurse to ask to facilitate the assessment?

A) "Do you have sharp, stabbing pain?"

B) "Is the pain associated with meals?"

C) "What activities exaggerate the pain?"

D) "Does the pain increase on palpation?"

Ans: C

Feedback:

"What activities exaggerate the pain?" is an open-ended question, because it gives the client an opportunity to express feelings and describe the pain. "Do you have sharp, stabbing pain?"; "Is the pain associated with meals?"; and "Does the pain increase on palpation?" are questions that can be answered with "Yes" or "No." These questions would be helpful later in the assessment to help focus on the client's statements.

30. When documenting client care, the nurse understands that the most important reason for correct and accurate documentation is which of the following?

A) Legal representation to care

B) Conveyance of information

C) Assisting in organization of care

D) Noting the client's response to interventions

Ans: B

Feedback:

Documentation of care in the client's record is most important for communicating with other health care team members that are involved in the care of the patient.

31. An older adult client who has had a colostomy for over 10 years states, "I won't need any teaching about colostomies. I understand how to change the bag and care for my colostomy, but I'm not sure how to best clean my stoma." What does this statement indicate?

A) An incongruent relationship

B) A confused relationship

C) A non-therapeutic relationship

D) An evaluative relationship

Ans: A

Feedback:

The client's two statements are incongruent with each other. This indicates the need for further education.

32. Which of the following statements accurately describes the relationship between therapeutic communication and the nursing process? Select all that apply.

A) Effective communication techniques, as well as observational skills, are used extensively during the assessment step.

B) Only the written word in the form of a medical record is used during the diagnosing step of the nursing process.

C) The implementing step requires communication among the client, nurse, and other team members to develop interventions and outcomes.

D) Verbal and nonverbal communication are used to educate, counsel, and support clients and their families during the implementation phase.

E) Nurses rely on the verbal and nonverbal cues they receive from their clients to evaluate whether client objectives have been achieved.

Ans: A, D, E

Feedback:

Effective communication techniques, as well as observational skills, are used extensively during the assessment phase, since the major focus of assessment is to gather information in both verbal and nonverbal communication forms. Following the formulation of the nursing diagnoses, the nurse communicates findings to other nursing professionals through the use of the written and spoken word. The planning step requires communication among the client, nurse, and other team members, as mutually agreed-upon outcomes are developed and interventions are determined. Verbal and nonverbal communication are employed to enhance basic caregiving measures and to educate, counsel, and support clients and their families during the implementation phase. Nurses often rely on the verbal and nonverbal cues they receive from their clients to verify whether client objectives have been achieved. Because one nurse cannot provide 24-hour coverage for clients, significant information must be passed on to others through nursing progress notes and care plans (documentation).

33. A nurse who is discharging a client is terminating the helping relationship. Which of the following actions might the nurse perform in this phase? Select all that apply.

A) Making formal introductions

B) Making a contract regarding the relationship

C) Providing assistance to achieve goals

D) Helping client perform activities of daily living

E) Examining goals of the relationship to determine their achievement

Ans: E

Feedback:

In the termination phase, the nurse examines with the client the goals of the helping relationship for indications of their attainment, or for evidence of progress toward them. If goals were not attained, the nurse should help the client establish a relationship with the new nurse. Answers A and B occur in the orientation phase, and answers C and D occur in the working phase.

34. A nurse tells a client that she will come back in 10 minutes to re-assess the client's pain. When the nurse returns in 10 minutes, which aspect of the therapeutic relationship is the nurse developing?

A) Empathy

B) Sympathy

C) Trust

D) Closure

Ans: C

Feedback:

When a nurse repeatedly upholds commitments made to a client, it fosters foundational trust within the therapeutic relationship. The other options may be part of the therapeutic relationship, but in this case the nurse's behavior will instill trust.

35. Which of the following should the nurse first consider when attempting to become culturally competent?

A) Personal cultural beliefs and prejudices

B) Understanding the client's response

C) Avoiding labeling clients

D) Treating the client with dignity

Ans: A

Feedback:

The first step toward cultural competence requires becoming aware of your own personal cultural beliefs and prejudices.

Chapter 9, Teaching and Counseling

1. A male client age 61 years has been admitted to a medical unit with a diagnosis of pancreatitis secondary to alcohol use. Which of the client's following statements suggests that nurses' education has resulted in affective learning?

A) "I'm starting to see how my lifestyle has caused me to end up here."

B) "I understand why they're not letting me eat anything for the time being."

C) "My intravenous drip will keep me from getting dehydrated right now."

D) "I can see how things could have been much worse if I hadn't gotten to the hospital when I did."

Ans: A

Feedback:

The client's understanding of his contribution to his problem demonstrates a shift in attitude and feelings that is characteristic of affective learning. Understanding the treatment, course, and prognosis of his illness are aspects of cognitive learning.

2. The nurse has been working with a client for several days during the client's recovery from a femoral head fracture. How should a nurse best evaluate whether client education regarding the prevention of falls in the home has been effective?

A) "What changes will you make around your house to reduce the chance of future falls?"

B) "Do you have any questions about the fall prevention measures that we've talked about?"

C) "In light of what we've talked about, why is it important that you remove the throw rugs in your house?"

D) "Do you think that the safety measures I taught you are clear and realistic?"

Ans: A

Feedback:

An open-ended question that requires the client to apply the information that has been taught is often the most accurate way to evaluate the effectiveness of client education. Yes/no questions are much less effective ("Do you have any questions?"; "Do you think that the safety measures I taught you are clear and realistic?"). Asking the client about the importance of preventing falls does not directly assess what the client will actually do to prevent falls.

3. A diabetes nurse educator is teaching a client, newly diagnosed with diabetes, about his disease process, diet, exercise, and medications. What is the goal of this education?

A) To help the client develop self-care abilities

B) To ensure the client will return for follow-up care

C) To facilitate complete recovery from the disease

D) To implement ordered teaching and counseling

Ans: A

Feedback:

The basic purpose of educating and counseling is to help clients and families develop the self-care abilities (knowledge, attitude, skills) needed to maintain and improve health.

4. A nurse refers a client with a new colostomy to a support group. This nurse is practicing which of the following aims of nursing?

A) Promoting health

B) Preventing illness

C) Restoring health

D) Facilitating coping

Ans: D

Feedback:

Not all clients fully recover from their illness or injury; many clients will need to learn to cope with permanent health alterations.

5. Which of the following is an essential component of the definition of learning?

A) Increases self-esteem

B) Decreases stress

C) Can be measured

D) Cannot be measured

Ans: C

Feedback:

Learning is the process by which a person acquires or increases knowledge, or changes behavior in a measurable way, as a result of an experience.

6. A nursing faculty member is teaching a class of second-degree students who have an average age of 32. What is important to remember when teaching adult learners?

A) A focus on the immediate application of new material

B) A need for support to reduce anxiety about new learning

C) Older students may feel inferior in terms of new learning

D) All students, regardless of age, learn the same

Ans: A

Feedback:

Adults need to be taught differently. Andragogy, the study of teaching adults, is based on several principles. One of those is that most adults' orientation to learning is that new material should be immediately applicable.

7. A nurse is designing a teaching program for individuals who have recently immigrated to the United States from Iraq. Which of the following considerations is necessary for culturally competent client teaching?

A) Use materials developed previously for U.S. citizens.

B) Use all visual materials when teaching content.

C) Use a lecture format to teach content with few questions.

D) Develop written materials in the client's native language.

Ans: D

Feedback:

With changes in society, nurses are faced with the challenge of teaching clients from different cultural and ethnic backgrounds. One of the strategies is to develop written materials in the native language of the client.

8. Which of the following strategies might a nurse use to increase compliance with education?

A) Include the client and family as partners.

B) Use short, simple sentences for all ages.

C) Provide verbal instruction at all times.

D) Maintain clear role as the authority.

Ans: A

Feedback:

Compliance is facilitated by including the client and family in the education–learning process. Other strategies include making sure instructions are understandable, using interactive education methods, and having a strong interpersonal relationship with clients and their families.

9. A young mother asks the nurse in a pediatric office for information about safety, diet, and immunizations for her baby. Which nursing diagnosis would be appropriate for this client?

A) Knowledge Deficit: Infant care

B) Impaired Health Maintenance

C) Readiness for Enhanced Parenting

D) Readiness for Enhanced Coping

Ans: C

Feedback:

A client who requests information is demonstrating motivation and readiness to learn. The appropriate nursing diagnosis would be Readiness for Enhanced Parenting.

10. Developing an education plan is comparable to what other nursing activity?

A) Documenting in the nurses notes

B) Formulating a nursing care plan

C) Performing a complex technical skill

D) Using a standardized form or format

Ans: B

Feedback:

Planning for learning involves the development of an education plan. Both education plans and nursing care plans follow the steps of the nursing process.

11. A student is developing an education plan for her assigned client. The student wants to educate the client on what symptoms to report after chemotherapy. What would the student need to do first?

A) Ask other students what should be included in content.

B) Ask the client what he or she wants to know.

C) Tell the instructor that this topic hasn't been covered yet.

D) Review information available in writing and on the Internet.

Ans: D

Feedback:

New nurses (and students) usually need to research the subject to be taught to determine what information exists on the topic. Books, journals, manuals, and Web-based sources may be used to find information.

12. A mother of a toddler wants to learn how to do CPR. What education strategy would be most effective in helping her learn?

A) Lecture

B) Discussion

C) Demonstration

D) Discovery

Ans: C

Feedback:

When a client wants to learn a specific skill, such as CPR, demonstration is an effective strategy. The client's learning can be evaluated by return demonstration. Lecture, discussion, and discovery are not as effective in teaching a skill.

13. A nurse instructs a client to tell her about the side effects of a medication. What learning domain is the nurse evaluating?

A) Affective

B) Cognitive

C) Psychomotor

D) Emotional

Ans: B

Feedback:

Cognitive learning involves storing and recalling new knowledge in the brain. Cognitive learning may be evaluated through oral questioning.

14. When is the best time to evaluate one's own teaching effectiveness?

A) During the education session

B) Immediately after an education session

C) 1 week after the education session

D) 1 month after the education session

Ans: B

Feedback:

It is best to evaluate one's own teaching effectiveness immediately after an education session by quickly reviewing how one feels the plan was implemented; noting both strengths and weaknesses helps plan for subsequent sessions.

15. A male client age 42 years recovering from a MI is having difficulty following the care plan to stop smoking and exercise. What is the nurse's best response to this client?

A) Praise him for trying.

B) Tell him that he will have another MI and it will be his own fault.

C) Tell him that his cigarettes will be taken away if he smokes again.

D) Ignore the behavior and recommend a behavior modification program.

Ans: D

Feedback:

Negative reinforcement (criticism or punishment) is generally ineffective; undesirable behavior is usually best ignored. Behavior modification programs that reward desired behaviors and ignore undesired behaviors might be best for this client.

16. What is the most critical element of documentation of education?

A) A summary of the education plan

B) The implementation of the education plan

C) the client's need for learning

D) Evidence that learning has occurred

Ans: D

Feedback:

Documentation of the education–learning process includes a summary of the learning need, the plan, the implementation of the plan, and the evaluation results. The evaluative statement is crucial and must show concrete evidence that demonstrates that learning has occurred. If the desired learning has not occurred, the notes should indicate how the problem was resolved. It is insufficient to document only what was taught; the charting must show evidence that the client or significant other has actually learned the material taught.

17. What word or phrase best describes an effective counselor?

A) Technically skilled

B) Knowledgeable

C) Practical

D) Caring

Ans: D

Feedback:

An effective counselor needs to be a caring individual with the interpersonal skills of warmth, friendliness, openness, and empathy.

18. An older adult client is very stressed about who will care for his pets while he is hospitalized for a fall that caused a fractured hip. What type of counseling would the nurse conduct?

A) None

B) Long-term

C) Short-term

D) Motivational

Ans: C

Feedback:

Short-term counseling focuses on an immediate problem or concern of the client or family. Even if it is a relatively minor concern, it needs immediate attention.

19. A nurse is using motivational interviewing to find out why a client refuses to participate in the recommended rehabilitation program. Which of the following is an example of using the skill of reflective listening to help motivate this client?

A) So, you feel that you are not ready to start a program this week…?

B) Why do you feel that you are not ready to start rehabilitation?

C) I understand that you are afraid to start rehabilitation; where do you see yourself in a week?

D) Remember we discussed what needs to be done to get you back on your feet…How do you feel about getting started?

Ans: A

Feedback:

Four skills have proved effective in motivational interviewing. These include: (answer A) reflective listening (restates the client's response back to him or her), (answer B) asking open questions (encourages discussion of the reason for making desired changes), (answer C) affirming (supports the client's efforts and encourages further exploration), and (answer D) summarizing (links and reinforces material that has been discussed).

20. At completion of the health education for a client, the nurse documents the details of the health education in the client's medical record. What can be determined by this documentation?

A) Proof of compliance with education standards

B) Client's response to the health education

C) Self-administration of medications

D) Dietary instructions for the client

Ans: A

Feedback:

The information about who was taught, what was taught, the education method, and the evidence of learning is the best proof of compliance with education standards. These are entered in the client's medical record. The client's response to the health education cannot be determined by this document. Self-administration of medications and dietary instructions for the client are not implied from who was taught, what was taught, the education method, and the evidence of learning.

21. A client 36 years of age is able to understand the health education when she is given the opportunity to put theeducation into practice. The nurse helps the client to self-administer the medication dosage before the client is discharged from the health care facility. Which domain correctly identifies the client's learning style?

A) Cognitive domain

B) Affective domain

C) Psychomotor domain

D) Interpersonal domain

Ans: C

Feedback:

The client's learning style falls into the psychomotor domain, which is a style of processing that focuses on learning by performing what has been learned. The cognitive domain is a style of processing information by listening or reading facts and descriptions. The affective domain is a style of processing, which appeals to a person's feelings, beliefs, or values. The interpersonal domain is a style of processing that focuses on learning through social relationships.

22. When caring for a client, the nurse gives day-to-day examples to explain certain points of the health education. The nurse also notes the client's concentration level and educates when the client is active. Which category does the client fall into?

A) Motivation

B) Attention and concentration

C) Learning readiness

D) Learning needs

Ans: B

Feedback:

The client's attention and concentration affect the duration, delivery, and education methods employed. It is helpful to observe the client and implement health education when he or she is most alert and comfortable. This also means involving the client in an active way by providing examples of day-to-day activities. Learning is optimal when a person has a purpose for acquiring new information. The client needs to be motivated to learn new things. Readiness refers to the client's physical and psychological well-being. The best education and learning take place when both are individualized. To be most efficient and personalized, the nurse must gather pertinent information from the client and determine the client's needs when learning.

23. A nurse notices that a toddler is constantly snatching toys from the hands of other preschool children at the health care facility, placing the toddler and other children at risk for injury. Which of the following would be a most effective method for teaching the toddler not to snatch toys?

A) Ask the children to play another game.

B) Tell the toddler that God punishes children who snatch.

C) Give the toddler another toy with which to play.

D) Enlist the aid of the toddler's parents in education.

Ans: D

Feedback:

The nurse should inform the toddler's parents as to his or her behavior. Since toddlers and preschoolers are accustomed to learning from and communicating with their parents, the parents are usually the most effective teachers. Children learn through play, so using dolls or toys as models can enhance learning. Giving another toy to the toddler or asking the children to play another game may not solve the problem, as the toddler would still want someone else's toys. Telling the toddler that God punishes children who snatch is not correct because the nurse is indirectly trying to scare and threaten the toddler.

24. To meet accreditation standards regarding client care, a health care facility must show evidence of what?

A) Employee satisfaction surveys

B) Financial accounts and statements

C) Documentation of indigent care

D) Client education documentation

Ans: D

Feedback:

The Joint Commission also has established standards for client education that health care agencies must meet to receive accreditation.

25. When providing client education it is essential for the nurse to incorporate what action so that learning can be optimized?

A) Have the clients read material after client education

B) Be sure that clients are formally engaged

C) Include educational strategies that encourage clients to be active participants

D) Administer tests to evaluate learning

Ans: C

Feedback:

The teaching–learning relationship is a dynamic, interactive process that involves active participation from the nurse and client.

26. The parents of an infant suffering from apnea need to be educated on the apnea monitor and cardiopulmonary resuscitation. What should the nurse assess first regarding the parents?

A) Educational levels

B) Home environment

C) Infant bonding

D) Baseline knowledge of these concepts

Ans: D

Feedback:

Before educating parents on the apnea monitor and cardiopulmonary resuscitation, the nurse should determine the parents' baseline knowledge so that the nurse knows where to begin. Educational level would be the next assessment in order to plan the appropriate teaching delivery method.

27. When the newly diagnosed, insulin-dependent diabetic client tells the nurse that he has never received instruction on the administration of injections, an appropriately stated nursing diagnosis for the client is what?

A) Self-care deficit related to lack of knowledge about injections

B) Knowledge deficit related to lack of knowledge about injections

C) Deficient knowledge of injection administration as verbalized by the client, related to the lack of instruction and experience

D) Ineffective health care maintenance related to diabetic instructions

Ans: C

Feedback:

Many factors can contribute to deficient knowledge, such as a lack of exposure, lack of recall, information misinterpretation, cognitive limitations, lack of interest in learning, and unfamiliarity with information resources.

28. A nurse is writing learning outcomes for a client recovering from severe burns. Which of the following verbs would be good choices to use when preparing outcomes related to learning how to change dressings? Select all that apply.

A) Assembles

B) Demonstrates

C) Gives examples

D) Identifies

E) Chooses

Ans: A, B

Feedback:

Changing dressings falls into the psychomotor domain. “Assembles” and “demonstrates” are appropriate verbs for outcomes. “Gives examples” and “identifies” are verbs best used for the cognitive domain. “Chooses” and “values” relate to the affective domain.

29. A nurse educating a new mother on how to bathe her infant uses the acronym TEACH to maximize the effectiveness of the education plan. Which of the following are guidelines based on this acronym? Select all that apply.

A) Tune out the individual client.

B) Edit client information.

C) Act on every teaching moment.

D) Always refer a client to counseling.

E) Clarify often.

Ans: B, C, E

Feedback:

To maximize the effectiveness of patient education, the nurse should use the acronym TEACH — T: tune into the client, E: edit client information, A: act on every teaching moment, C: clarify often, H: honor the client as a partner in the education process.

30. The National Patient Safety Foundation recently collaborated with the Partnership for Clear Health Communication (2007) to create awareness of the need for improved health literacy and developed the Ask Me 3 tool. Which of the following is an Ask Me 3 question? Select all that apply.

A) Who will be my health care provider?

B) What is my main problem?

C) What do I need to do?

D) Where will I get help?

E) Why is it important for me to do this?

Ans: B, C, E

Feedback:

Ask Me 3 questions are: What is my main problem? What do I need to do? Why is it important for me to do this?

31. According to Rosenstock, which of the following are health beliefs critical for client motivation? Select all that apply.

A) Clients view themselves as susceptible to the disease in question.

B) Clients view the disease as a serious threat.

C) Clients believe there are actions they can take to reduce the probability of contracting the disease.

D) Clients believe the threat of taking these actions is greater than the disease itself.

E) Patients view themselves as victims of the disease in question.

Ans: A, B, C

Feedback:

A client's health beliefs can have great influence on motivation. The health belief model identifies several health beliefs as critical for client motivation (Rosenstock, 1974). Motivation is enhanced when clients view themselves as susceptible to the disease in question; when clients view the disease as a serious threat; when clients believe there are actions they can take to reduce the probability of contracting the disease; when clients believe the threat of taking these actions is not as great as the disease itself.

32. A nurse is educating an elderly client with diabetes and his family members about the importance of a nutritious diet. The nurse knows that client education promotes which of the following purposes? Select all that apply.

A) Helps the nurse to restore optimal health in the client

B) Helps the client to cope with alterations in health status

C) Helps the nurse to be more aware of the client's health

D) Helps the nurse to diagnose the client's illness early

E) Helps the nurse to be well-informed about the client's care

Ans: A, B

Feedback:

Nurses are involved in client education to promote wellness (primary prevention), prevent or diagnose illness early (secondary prevention), restore optimal health and function if illness has occurred (tertiary prevention), and assist clients and families to cope with alterations in health status. Simply being knowledgeable about the client's health status and care is not enough. Nurses must know the education and learning process and know how best to include the client's family in the process.

33. A nurse in a neighborhood clinic is conducting educational sessions on weight loss. What aim of nursing is met by these educational programs?

A) Practicing advocacy

B) Preventing illness

C) Restoring health

D) Facilitating coping

E) Maintaining and promoting health

Ans: B, C, E

Feedback:

If this education is directed toward those who are healthy, weight loss information can help maintain health and prevent illness. If this education is used in those already ill (hypertension, diabetes), weight loss can restore health. The nurse is not practicing advocacy or facilitating coping by providing weight loss education.

34. What client characteristic is important to assess when using the health belief model as the framework for teaching?

A) Developmental level

B) Source of information

C) Motivation to learn

D) Family support

Ans: C

Feedback:

When assessing a client's learning readiness, it is important to consider his or her motivation. Motivation is influenced by an individual's health beliefs and plays a key role in the health belief model. Motivation encourages the client to adopt health promotion and disease prevention actions.

35. A nurse is working with an older adult client, educating the client on how to ambulate with the aid of a walker. The nurse notes that the client appears to lack the motivation to learn how to use device. The client states, "I'm just too old to learn." Which of the following would be most appropriate for the nurse to do to motivate this client?

A) Tell the client how to move the walker as he ambulates.

B) Explain how the walker supports the client's lower extremities

C) Fully discuss the rationale for using the walker.

D) Describe how the walker can improve the client's quality of life.

Ans: D

Feedback:

Motivating the older adult client can be done by showing the client how the new knowledge will improve his quality of life, regardless of how long that may be. It will also demonstrate how the new knowledge could improve the client's level of independence. Although demonstrating the use of the walker and explaining how the walker assists with ambulation (and the rationale for its use) can be used to educate the client, these actions would not promote motivation for the client to learn.

Chapter 10, Leading, Managing and Care Delegating

1. Which of the following nursing care tasks is acceptable for a graduate nurse to delegate to unlicensed assistive personnel (UAP)?

A) Assisting a client with ambulation

B) Evaluation of nursing care delivered to a client

C) Initial and ongoing assessments

D) Development of a client teaching plan

Ans: A

Feedback:

Tasks that should be performed by a registered nurse include initial and ongoing assessments, determining nursing diagnoses, plan of care, evaluation of client progress, evaluation of the nursing care delivered to the patient, supervision and education of nursing personnel, and client education. Tasks such as ambulation, assistance with meals and hygiene, and obtaining vital signs are acceptable tasks for a UAP to perform.

2. Nurses with varying levels of experience possess leadership skills. A graduate nurse walks out of the nurse manager's office after a meeting. The graduate nurse reflects on the positive and negative feedback that she received from the manager regarding her three months working on the unit. What nursing leadership skill is best illustrated by the graduate nurse in this scenario?

A) Self-evaluation skills

B) Communication skills

C) Problem-solving skills

D) Management skills

Ans: A

Feedback:

Self-evaluation skills incorporate the ability to assess honestly one's effectiveness, to accept both praise and criticism, and to direct personal professional growth. Communication skills demonstrate the ability to establish trusting interpersonal relationships with clients, peers, subordinates, and superiors to maximize goal achievement. Problem-solving skills include the ability to analyze all sides of a problem, to suspend judgment, to explore multiple options, and to work toward a creative solution. Management skills are the ability to direct others toward goal achievement.

3. What type of leadership can a graduate nurse working in a magnet hospital expect?

A) Democratic

B) Autocratic

C) Situational

D) Quantum

Ans: A

Feedback:

Working in a magnet hospital can maximize the potential of new graduates who prefer democratic leadership.

4. The nurse is having an exceptionally busy shift on an obstetrical unit. Which of the following tasks is the nurse justified in delegating to an unlicensed care provider?

A) Emptying a client's Foley catheter bag and reporting the volume to the nurse

B) Helping a first-time mother achieve a good latch when breast-feeding her infant

C) Assessing the size and quantity of clots that are in a client's bedpan and informing the nurse

D) Giving an anti-inflammatory to a client who is eight hours postdelivery

Ans: A

Feedback:

Emptying a Foley catheter bag and reporting the volume is within the scope of an unlicensed care provider. Assistance with breast-feeding, assessments, and medication administration are not tasks that should be delegating to anyone but an RN.

5. The nurse has just graduated with a Bachelor of Science in Nursing and is eager to find a mentor at this early stage in her career. Which of the following individuals is most likely to be an appropriate mentor for the nurse?

A) An experienced nurse who was a preceptor in a previous clinical placement

B) The nurse educator on the hospital unit where the novice nurse has been hired

C) A colleague who graduated with honors at the same time as the novice nurse.

D) The unit manager who the novice nurse.

Ans: A

Feedback:

A person who demonstrates positive qualities and who possesses more experience is often a good choice to be a nurse's mentor. A person in formal authority or oversight, such as the unit educator or manager, is a less ideal choice, and a peer is not normally an ideal choice of mentor.

6. A senior student has been elected president of the Student Nurses Association. Which of the following qualities is essential to being a nursing leader?

A) Physical stamina

B) Physical attractiveness

C) Flexibility

D) Independence

Ans: C

Feedback:

Flexibility is a must for all nurse leaders. The needs of clients, families, and the nursing team can change from minute to minute. Leaders of nursing organizations must also demonstrate the characteristics of a nursing leader.

7. Which type of skills is not needed for nursing leadership?

A) Communication skills

B) Technical skills

C) Problem-solving skills

D) Self-evaluation skills

Ans: B

Feedback:

The four basic types of skills needed for nursing leadership are communication, problem solving, management, and self-evaluation. Technical skills are important to other nursing roles, but are not leadership skills.

8. A nurse strives to establish trusting interpersonal relationships with clients, peers, subordinates, and superiors to facilitate goal achievement and personal growth of all participants. Which type of skills is this nurse demonstrating?

A) Communication skills

B) Problem-solving skills

C) Management skills

D) Self-evaluation skills

Ans: A

Feedback:

Communication skills involve the ability to establish trusting interpersonal relationships with clients, peers, subordinates, and superiors to maximize goal achievement and enhance the personal growth. Problem-solving skills refer to the ability to analyze all sides of a problem, to suspend judgment, to explore multiple options, and to work toward a creative solution. Management skills pertain to the ability to direct others toward goal achievement. Self-evaluation skills involve the ability to assess honestly one's effectiveness, to accept both praise and criticism, and to direct personal professional growth and development.

9. A nurse manager makes all of the decisions for staff activities. What type of leadership is demonstrated by this action?

A) Democratic

B) Self-governance

C) Laissez-faire

D) Autocratic

Ans: D

Feedback:

Autocratic leadership involves the leader assuming complete control over the decisions and activities of the group. An extremely autocratic leader might make all decisions for workers without considering their ideas or feelings.

10. What type of leader shares decisions and activities with group participants?

A) Democratic

B) Autocratic

C) Laissez-faire

D) Situational

Ans: A

Feedback:

Democratic leadership, also called participative leadership, is characterized by equality among the leader and other participants. Decisions and activities are shared.

11. A nurse leader is described as charismatic, motivational, and passionate. Communications are open and honest, and the nurse is willing to take risks. What type of leadership is the nurse practicing?

A) Democratic

B) Autocratic

C) Quantum

D) Transformational

Ans: D

Feedback:

Transformational leaders are often described as charismatic, challenging, and passionate about their vision. They communicate openly and honestly, show concern for others, and are willing to take risks.

12. A nurse is described as a "quantum leader." Which action characterizes this type of leadership?

A) A nurse conducts a blind survey to evaluate her leadership skills.

B) A nurse relinquishes power to a group deciding hospital policy.

C) A nurse makes policy decisions for coworkers without consulting them.

D) A nurse sticks to the "tried and true" methods when implementing client care.

Ans: A

Feedback:

Quantum leaders must have excellent communication skills, encourage personal critiques, and challenge current ways of thinking and doing. A nurse who relinquishes power to a group to make decisions is using laissez-faire leadership. A nurse making decisions for coworkers without considering their feelings is an autocratic leader.

13. When comparing team nursing with functional nursing, what characteristic is found?

A) Team nursing is very similar to functional nursing.

B) Team nursing focuses on individual client care.

C) Functional nursing has a stronger focus on the client.

D) Functional nursing is based on total client care.

Ans: B

Feedback:

In team nursing, a registered nurse and other caregivers provide care to a designated group of clients for a given shift. Team nursing modifies the depersonalized approach of functional nursing and focuses on individual client care.

14. A nurse believes in listening to clients and coworkers more than talking to them, allowing more personal control for all involved. This is a quality of which of the following managerial mindsets?

A) Reflective

B) Analytical

C) Worldly

D) Collaborative

Ans: D

Feedback:

The collaborative mindset involves listening more than talking, and allowing people to take initiative and control their own work. The reflective mindset allows managers to mentally digest experiences and reflect on them in a different way. The analytical mindset encourages introspection so that one can recognize biases and see things in a unique way. This facilitates a change in course and movement toward resolution of problems. The worldly mindset recognizes cultures and contexts or "seeing differently out to reflect differently in."

15. In which of the following conflict resolution strategies is the conflict rarely resolved?

A) Collaborating

B) Compromising

C) Competing

D) Smoothing

Ans: D

Feedback:

Smoothing is an effort to complement the other party and focus on agreement rather than disagreement, thus reducing the emotion in the conflict. The original conflict is rarely resolved with this technique.

16. In Lewin's classic theory of change, what happens during unfreezing?

A) Planning is conducted.

B) Change is initiated.

C) Change becomes operational.

D) The need for change is recognized.

Ans: D

Feedback:

In Lewin's change theory, during unfreezing the need for change is recognized. Unfreezing does not include planning, initiating, or operationalizing change.

17. Planned change is a purposeful, systematic effort to alter or bring about change. What occurs next after alternative solutions to a problem are determined and analyzed?

A) All of the alternative solutions are implemented.

B) A course of action is chosen from among the alternatives.

C) The effects of the change are evaluated.

D) The change is stabilized and established.

Ans: B

Feedback:

After determining and analyzing alternative solutions to a problem, select a course of action from the possible alternatives. It is best to avoid initiating too many courses of action and thereby dissipating resources and energy.

18. In general, how do most people view change?

A) By how it affects the cohesiveness of the group

B) By how much it will cost in time and resources

C) By how they are affected personally

D) By how it will affect others on the staff

Ans: C

Feedback:

In general, people view change in terms of how they are affected personally. Examples include threats to self-esteem, amount of work required, and effect on social relationships.

19. A nurse manager has encountered resistance to a planned change. What is one way the nurse can overcome the resistance?

A) Tell the staff that if they don't like it, they can quit.

B) Implement change rapidly and all at once.

C) Encourage open communication and feedback.

D) Let the staff know that the change is mandated.

Ans: C

Feedback:

Providing opportunities for open communication and feedback is one way to overcome resistance to change.

20. Which of the following statements accurately describes the use of power by change agents?

A) They know that power comes from one source—management.

B) When introducing change they do not enlist the support of key power players.

C) They are often accomplished professional women.

D) They do not recognize their own strengths and weaknesses.

Ans: C

Feedback:

Power,the ability to influence others to achieve a desired effect, has many sources. When introducing change, it is helpful to recognize and enlist the support of key power players who can then encourage others to become involved. Women are accomplished professionals and occupy powerful leadership positions in corporations, health care organizations, and political arenas. Nursing leaders recognize the strengths and limitations of their own power and encourage others to develop and use power constructively.

21. A nurse working on leadership skills should keep in mind which of the following accurate statements regarding leaders?

A) People are born leaders.

B) Leadership should be approached quickly.

C) Leaders develop leadership skills in undefined situations.

D) All nurse leaders began as inexperienced nurses.

Ans: D

Feedback:

Leadership should be approached like any other new role or skill: slowly and carefully. Nursing students and beginning nurses should be prepared with all of the necessary tools or skills before attempting the new role. Initially, nurses develop leadership skills in well-defined clinical situations. With each experience, growth occurs and leadership is strengthened. All nurse managers, nurse administrators, and nursing leaders also began as inexperienced nurses.

22. A student nurse has just graduated with a baccalaureate degree in nursing. What type of nursing leadership will this nurse be expected to provide?

A) Nursing care of the individual client

B) Demonstration of selected critical skills

C) Ability to be a follower rather than a leader

D) Nursing care of groups of clients

Ans: A

Feedback:

New graduates have leadership responsibilities when they begin nursing. Nursing leadership begins with nursing care of the individual client.

23. A nurse is considering the delegation of administering medications to an unskilled assistant. What is the first question the nurse must ask herself before doing so?

A) Has the assistant been trained to perform the task?

B) Have I evaluated the client's response to this task?

C) Is the delegated task permitted by law?

D) Is appropriate supervision available?

Ans: C

Feedback:

The first question the nurse should always consider before delegating a task is "Is the delegated task permitted by law?" In this case, it would not be, and the task (administering medications) would not be delegated.

24. The ANA, which is committed to monitoring the regulation, education, and use of NAPs, recommends adherence to which one of the following principles?

A) It is the nursing profession that determines the scope of nursing practice.

B) It is the RN who defines and supervises the education, training, and use of any unlicensed assistant roles.

C) It is the assigned NAP who is responsible and accountable for his or her nursing practice.

D) It is the purpose of the RN to work in a supportive role to the assistive personnel.

Ans: A

Feedback:

It is the nursing profession that determines the scope of nursing practice, and defines and supervises the education, training, and use of any unlicensed assistant roles involved in providing direct nursing care. It is the registered nurse who is responsible and accountable for nursing practice, and who supervises any assistant involved in providing direct client care. It is the purpose of assistive personnel to work in a supportive role to the registered nurse, carrying out tasks that enable the professional nurse to concentrate on caring for the client.

25. Which of the following is a characteristic of mentorship?

A) It is a paid position to orient new nurses to the workplace.

B) It involves membership in a professional organization.

C) It is a link to a protégé with common interests.

D) It is not encouraged in health care settings

Ans: C

Feedback:

Mentorship is a relationship in which an experienced individual (the mentor) advises and assists a less experienced individual (protégé). This is an effective way of easing a new nurse into leadership responsibilities. Mentors link with protégés by common interest and provide support, information, and network links. The relationship does not include financial reward. An alternative model is preceptorship. The preceptor (experienced nurse) is selected (and generally paid) to introduce an employee to new responsibilities through education and guidance.

26. A nurse manager has directed a registered nurse who is out of school for one year to become a member of the institution's policy and procedure committee. A goal in the nurse manager's delegation is to assist the nurse to what?

A) Be involved in the hospital

B) Be confident in employment

C) Grow in her profession

D) Understand the hospital setting

Ans: C

Feedback:

Delegation of activities to staff members will assist them to grow and become more committed to their organization.

27. Which of the following statements accurately describes recommended guidelines for overcoming resistance to change? Select all that apply.

A) Explain the proposed changes only to the managers of the people involved.

B) Whenever possible, use technical language to describe the changes.

C) List the advantages of the proposed change for members of the group.

D) Avoid relating the change to the group's existing beliefs and values.

E) If possible, introduce change gradually.

Ans: C, E

Feedback:

To overcome resistance to change, the nurse should explain the proposed change to all affected people in simple, concise language; list the advantages of the proposed change, both for the individual and for members of the group; relate the proposed change to the person's (or group's) existing beliefs and values; if possible, introduce change gradually; provide incentives for commitment to change such as money, status, time off, or a better working environment.

28. A nurse is attempting to change the method for documenting client care in a hospital setting. Which of the following should be considered before planning change? Select all that apply.

A) What is amenable to change?

B) How does the group function as a unit?

C) Is the group ready for change?

D) Are the changes major or minor?

E) How can I keep from changing again?

Ans: A, B, C, D

Feedback:

Before planning to make a change, a nurse manager should consider the following; What is amenable to change? Considering this question might reveal a behavior not amenable to change. How does the group function as a unit? Is the person or group ready for change and, if so, at what rate can that change be expected to be accepted? Are the changes major or minor? A series of small changes might be more easily accomplished than one large, dramatic change. Change is inevitable; a more appropriate question to ask is how often this change needs to be evaluated.

29. A head nurse assumes the leadership role when directing and supervising coworkers. Which of the following are attributes of a leader? Select all that apply.

A) Philosophical

B) Task-oriented

C) Charismatic

D) Dynamic

E) Intimidating

Ans: A, C, D

Feedback:

Leadership involves philosophy, perception, and judgment whereas management tasks are the core of the management role. Leaders need to be comfortable with themselves (i.e., have a positive self-image) and present themselves as role models for followers. Ideally, they also have a vision that energizes the group and brings forth the best efforts of members. Leaders may be charismatic, dynamic, enthusiastic, poised, confident, and self-directed.

30. The nurse is caring for a client who had a sudden episode of vomiting, which produced 900 mL of frank blood. The nurse directed and delegated to colleagues in order to notify the physician. She started intravenous fluids, and provided physical and emotional support for the client. Different situations call for different leadership styles. Which of the following leadership styles did the nurse display in this situation?

A) Democratic

B) Laissez-faire

C) Autocratic

D) Transformational

Ans: C

Feedback:

Autocratic leadership involves the leader assuming complete control. Democratic leadership displays a sense of equality among the leader and other participants. With laissez-faire leadership, the leader relinquishes power to the group. Transformational leaders create intellectually stimulating practice environments and challenge themselves and others to grow personally and professionally, and to learn.

31. The nurse is a manager on an orthopedic unit. The unit changed to a new computer documentation system three days ago. One of the night nurses has called in sick every shift since the new system started. The nursing manager is aware that this situation has to do with resistance to change. Which of the following are common reasons why people resist change? Choose all that apply.

A) Feel threatened

B) Fear increased responsibility

C) Lack of understanding

D) See no benefits to the change

E) Dislike hospital chief officer

Ans: A, B, C, D

Feedback:

The most common reasons people resist change are threat to self, lack of understanding, fear of increased responsibility, envisioning a lack of benefits to the change, and being unable to tolerate working in a state of flux. Dislike of the hospital CEO is not a common reason to resist change.

32. The nursing student is working to improve his time management. Which of the following would assist the nursing student in accomplishing his goal? Choose all that apply.

A) Identify priorities for the day.

B) Evaluate time management at the end of the day.

C) Establish a reasonable time line.

D) Plan to arrive right at start of shift.

E) Plan on his cohorts helping him

Ans: A, B, C

Feedback:

Establish goals and priorities for each day. The nurse should identify what needs to be accomplished each day, differentiating need to do from nice to do tasks. Then nurse should establish a time line so that it is clearly evident when he or she is falling behind schedule, in time to correct it. The nurse should evaluate success or failure and use the results to plan the next day ‘s time management. The nurse should plan to arrive at least 15 minutes or more before the start of shift so that he or she can be prepared to receive change of shift report. Then nurse should plan time to assist his cohorts instead of them helping him. The cohorts may be too busy to assist or may need assistance themselves.

33. During a staff meeting, the nurse is discussing new quantum leadership. The nurse explains that in this type of leadership change is viewed as which of the following?

A) Constant and predictable

B) Dynamic and constantly unfolding

C) Evolving very slowly

D) An entity needing planning

Ans: B

Feedback:

We are in a difficult transition period between the old and the new age. In the old age, change was viewed as an entity to be planned, carefully managed, and accepted. In the new quantum age, change is conceived as dynamic, ever-present, and continually unfolding.

34. Which of the following tasks could the nurse safely delegate to unlicensed assistive personnel?

A) An initial assessment of a client

B) Determination of a nursing diagnosis

C) Evaluation of client progress

D) Documentation of client’s I+O on a flow sheet

Ans: D

Feedback:

Nursing care or tasks that should never be delegated except to another RN include (Ayers & Montgomery, 2008) the following: the initial and ongoing nursing assessment of the client and his or her nursing care needs; the determination of the nursing diagnosis, nursing care plan, evaluation of the client’s progress in relation to care plan, and evaluation of the nursing care delivered to the client; the supervision and education of nursing personnel; client education that requires an assessment of the client and his or her education needs; and any other nursing intervention that requires professional nursing knowledge, judgment, and/or skill.

35. There is a perception in a long-term care facility that the older adult residents are experiencing falls more often than in the past. An audit of incident reports has confirmed this, and the nursing leadership has recognized the need to make changes to reduce the incidence of falls. How should the leaders proceed with this planned change? Place the following steps in the correct order.

1. Implement the change in nursing practice.

2. Choose a new protocol that is likely to reduce falls.

3. Take measures to ensure that nursing practice does not revert.

4. Determine and analyze different solutions to the problem.

5. Develop a plan for implementing the change.

A) 1, 2, 3, 4, 5

B) 1, 3, 2, 4, 5

C) 5, 1, 2,, 3, 4

D) 4, 2, 5, 1, 3

E) 3, 1, 4, 5, 2

Ans: D

Feedback:

The eight-step program of planned change is similar to the nursing process of assessment, diagnosis, planning, implementation, and evaluation. After this process, measures are taken to ensure that the change is stabilized and made permanent.

Chapter 11, The Health Care Delivery System

1. Which of the following clients is the most appropriate candidate for receiving outpatient care?

A) A client whose complaints of irregular bowel movements have necessitated a colonoscopy

B) A woman who has previously borne two children and is entering the second stage of labor

C) A man who is receiving treatment for sepsis after his blood cultures came back positive

D) A client with a history of depression who is currently expressing suicidal ideation

Ans: A

Feedback:

Outpatient services are appropriate for clients who are medically stable but who require diagnostic testing, such as a colonoscopy. Clients in active labor and clients who are actively septic or suicidal require close monitoring and frequent interventions, which can only be safely provided on an inpatient basis.

2. After many years of advanced practice nursing, a nurse has recently enrolled in a nurse practitioner program. This nurse has been attracted to the program by the potential to provide primary care for clients after graduation, an opportunity that is most likely to exist in which of the following settings?

A) A rural health ce

B) A long-term care facility

C) A university hospital

D) A community hospital

Ans: A

Feedback:

Many rural health centers employ few health care providers, and primary care is often provided by a nurse practitioner (NP). A nurse practitioner may provide care in a long-term care facility or hospital, but in these settings, the NP is less likely to be the provider of primary care to clients.

3. Which of the following phrases best describes hospitals today?

A) Focus on chronic illnesses

B) Focus on acute care needs

C) Primary care centers

D) Voluntary agencies

Ans: B

Feedback:

Hospitals have become acute care providers for people who are too ill to care for themselves at home, who are severely injured, who require surgery or complicated treatment, or who are having babies. Hospitals rarely focus on chronic illnesses, and they are not primary care centers. Hospitals are not classified as voluntary agencies.

4. A man is scheduled for hospital outpatient surgery. He tells the nurse, "I don't know what that word, *outpatient*, means." How would the nurse respond?

A) "It means you will have surgery in the hospital and stay for 2 days."

B) "It means the surgeon will come to your home to do the surgery."

C) "Why would you ask such a question? Don't worry about it."

D) "You will have surgery and go home that same day."

Ans: D

Feedback:

In addition to providing acute care, hospitals have many services for outpatients (those who require health care but do not need to stay in the facility). Clients who have outpatient surgery have the procedure, return to their hospital room for recovery, and then are discharged home on the same day.

5. A nurse in a walk-in health care setting provides technical services (e.g., administering medications), determines the priority of care needs, and provides client teaching on all aspects of care. Which of the following terms best describes this type of health care setting?

A) Hospital

B) Physician's office

C) Ambulatory center

D) Long-term care

Ans: C

Feedback:

Nurses in ambulatory care centers (walk-in clinics) provide technical services (e.g., administering medications), determine the priority of care needs, and provide teaching about all aspects of care. Nurses employed in hospitals have many roles, including manager of other members of the health care team providing client care, administrator, nurse practitioner, clinical nurse specialist, patient educator, in-service educator, and researcher. In physician's offices, advanced practice registered nurses (APRNs), nurse practitioners, midwives, or clinical nurse specialists work independently or collaboratively with physicians to make assessments and care for clients who require health maintenance or health promotion activities. Long-term care provides medical and nonmedical care for people with chronic illnesses or disabilities.

6. Nurses who are employed in home care have a variety of responsibilities. Which of the following is one of those responsibilities?

A) Provide all care and services

B) Maintain a clean home environment

C) Advise clients on financial matters

D) Collaborate with other care providers

Ans: D

Feedback:

Nurses who provide care in the home make assessments, provide physical care, administer medications, teach, and support family members. They also collaborate with other health care providers in providing care and services. Home care nurses do not provide all care and services, maintain a clean home environment, or advise clients on financial matters.

7. Which of the following is true of long-term care facilities?

A) They provide care only to older adults.

B) They provide care for homeless adults.

C) They provide care to people of any age.

D) They provide care only for people with dementia.

Ans: C

Feedback:

Long-term care facilities provide health care, and help with the activities of daily living, for people of any age who are physically or mentally unable to care for themselves independently. They do not provide care only to older adults or those with dementia, although they do care for those populations as well as others. They do not provide care to homeless persons.

8. A grade school is preparing a series of classes on the dangers of smoking. Who would be most likely to teach the classes?

A) A community health nurse

B) An outside consultant

C) A teacher

D) The school nurse

Ans: D

Feedback:

School nurses provide many different services, including maintaining immunization records, providing emergency care, administering prescribed medications, conducting routine screenings, conducting health assessments, and teaching for health promotion (e.g., the dangers of smoking). Although any of the other choices may provide teaching, it is the nurse who primarily provides health-related teaching.

9. An elderly woman has total care of her husband, who suffers from debilitative rheumatoid arthritis. The couple voices concern over the pain and stress associated with the condition. What type of care might the nurse suggest to help the couple?

A) Primary care

B) Respite care

C) Bereavement care

D) Palliative care

Ans: D

Feedback:

The goal of palliative care is relief from the symptoms, pain, and stress of a serious illness, and to improve the quality of life for both the client and the family. The main purpose of respite care is to give the primary caregiver some time away from the responsibilities of day-to-day care. Primary care is found in acute care settings and physicians' offices. Bereavement care is provided to families following the death of a family member.

10. What population do hospice nurses provide with care?

A) Those requiring care to improve health

B) Children with chronic illnesses

C) Dying persons and their loved ones

D) Older adults requiring long-term care

Ans: C

Feedback:

Hospice is a program of palliative and supportive services providing physical, psychological, social, and spiritual care for dying persons, their families, and other loved ones. Hospice nurses do not implement care to improve health, focus on children with chronic illnesses, or care for older adults in long-term care.

11. Who provides physicians with the authority to admit and provide care to clients requiring hospitalization?

A) The health care institution itself

B) Board of Healing Arts

C) American Medical Association

D) State Board of Nursing

Ans: A

Feedback:

Physicians are granted the authority to admit clients to a health care agency or institution, and to provide care in that setting by the health care agency or institution itself. They are licensed to practice medicine by a state medical board, not a state board of nursing or a board of healing arts.

12. After a stroke, a client is having difficulty swallowing. The nurse may make a referral to what member of the health care team?

A) Physical therapist

B) Speech therapist

C) Social worker

D) Respiratory therapist

Ans: B

Feedback:

In addition to providing services to improve oral communication, a speech therapist may also diagnose and treat swallowing problems in clients who have had a head injury or stroke. A physical therapist assists with musculoskeletal and neurological impairments, a social worker is educated to help clients with economic and social issues, and a respiratory therapist provides treatments to improve breathing.

13. Medicare uses a prospective payment plan based on diagnosis-related groups (DRGs). What are DRGs?

A) Locally supported health care financing, usually by donations

B) A public assistance program for low-income individuals

C) Predetermined payment for services based on medical diagnoses

D) A private insurance plan for subscribers who pay a copayment

Ans: C

Feedback:

Medicare, based on DRGs, pays a hospital a fixed amount that is predetermined by the medical diagnosis or specific treatment rather than by the actual cost of hospitalization and care. This plan was put into effect in an effort to control rising health care costs. It is not supported by donations; it is not a public assistance program or a private insurance plan.

14. A client has a private insurance policy that pays for most health care costs and services. Why is this plan called a third-party payer?

A) The insurance company pays all or most of the costs.

B) The family of the client is required to pay costs.

C) The client gets the bill and pays out-of-pocket costs.

D) Medicare and Medicaid will pay most of the costs.

Ans: A

Feedback:

Insurance for health care may be financed through private insurance, in which members pay a monthly premium. These plans are called third-party payers, because the insurance company pays all or most of the cost of care.

15. A person receiving health care insurance from his employer knows that he should check the approved list of contracted health care providers before seeking services, in order to receive them at a lower cost. What type of insurance is most likely involved?

A) Medicaid

B) Preferred provider organization

C) Health maintenance organization

D) Long-term care insurance

Ans: B

Feedback:

Preferred provider organizations (PPOs) allow a third-party payer (agencies that pay health care providers for services provided to individuals, such as a health insurance company) to contract with a group of health care providers to provide services at a lower fee in return for prompt payment and a guaranteed volume of clients and services. Although clients are encouraged to use specific providers, they may also seek care outside the panel without referral by paying additional out-of-pocket expenses.

16. What is the primary focus of health care today?

A) Care of acute illnesses

B) Care of chronic illnesses

C) Health promotion

D) Health restoration

Ans: C

Feedback:

In the past, health care focused on the treatment of illnesses rather than prevention through health promotion, because preventive strategies were not covered by health insurance. Health awareness and the desire to be involved in one's own health care have strongly influenced the delivery of health care services in our society.

17. What is one way in which nurses can help shape health care reform?

A) Do their job and do it well

B) Refuse to participate in organizations

C) Support legislation to improve care

D) Become a member of a support group

Ans: C

Feedback:

There are many ways in which nurses can help shape health care reform, including supporting legislation to improve care. Nurses are expected to do their job well. Refusing to participate in organizations and/or becoming a member of a support group will not help shape health care reform.

18. Which of the following health care insurance programs is most suitable for a client 68 years of age?

A) Medicaid

B) Medicare

C) Capitation

D) AmeriCare

Ans: B

Feedback:

Medicare is a federal program that finances health care costs of persons 65 years and older, permanently disabled workers of any age and their dependents, and those with

end-stage renal disease. The system is funded primarily through withholdings from an employed person's income. Capitation is a reimbursement strategy in managed care organizations. AmeriCare is a type of private insurance. Capitation and AmeriCare are not the preferred providers for the client, considering the client's old age. Medicaid is a federal program that is operated by the states, and each state decides who is eligible and the scope of health services offered. In Medicaid, eligibility may be decided by the state, which is not the case in Medicare.

19. Nurses who assist clients to deal holistically with their health care needs at the end of their lives work primarily in which health care delivery system?

A) Acute care

B) Primary care

C) Hospice

D) Rehabilitation

Ans: C

Feedback:

The opportunity to help people maintain their ability to remain at home and deal holistically with their health and family needs at the end of their lives is home health hospice care.

20. What is one of the most significant trends in health care today?

A) Increased length of hospital stays

B) Shift from hospitals to community-based care

C) Emphasis on disease management

D) Narrowing of the areas for nursing practice

Ans: B

Feedback:

The shift to community-based care is related to the public's desire to participate more actively in health care decisions, issues, and choices.

21. Long-term care is often needed for the elderly client. Select all the services that may be provided to the resident in a long-term care facility.

A) Assistance with activities of daily living

B) Immediate post-op care

C) Mental disability services

D) Nonmedical care for chronic illness

E) Day care meals and services

Ans: A, C, D

Feedback:

Acute/immediate post-op care is a specific need/care immediately following surgery/procedures and is completed at the facility. Day care meals and services are separate services and are not provided to residents in a long-term-care facility. All the others are part of what a long-term care facility provides.

22. The nurse working in the hospital understands the changes that have resulted in shorter hospital stays, with a focus on acute care needs of the client. Which of the following factors influence shorter hospital stays? Select all that apply.

A) Federal regulations for health care reimbursement policies.

B) Increased emphasis on preventive care.

C) Improvement in treatment of illness.

D) Patients realize that longer stays result in infections and other problems.

Ans: A, B, C

Feedback:

Shorter hospital stays direct the focus on the acute care needs of the client and have resulted from improved treatment of disease, increases in preventive care, and federal regulations and other health care reimbursement policies. Longer hospital stays are often the result of infection, as this factor is not related to shorter hospital stays.

23. Medicare reimburses in-hospital costs based on a set payment for a diagnostic related group (DRG). This means the hospital is reimbursed for a fixed amount based on the diagnosis and projected cost for care. As a result of this system the hospital can make a profit or a loss. Select the responses that describe when a profit for care of the client can be achieved.

A) All of the hospitalization charges are less than projected.

B) The client receives incompatible blood so the hospital does not get charged for it.

C) The client is discharged before the approved discharge date.

D) The nursing care results in the client reaching outcomes for recovery, without complication, after the projected timetable.

Ans: A, C

Feedback:

The hospital will make a profit when cost of hospitalization is less than the reimbursement assigned for the severity of illness and projected care costs. If the client is discharged earlier than projected the hospital keeps the total reimbursed. Incompatible blood is a preventable error, for which the hospital is not reimbursed. Reaching outcomes after the approved time results in additional cost to the hospital.

24. Hospice nurses provide care in a variety of settings, including clients' homes, long-term-care facilities, and hospice residences. After the client dies, what happens next?

A) The hospice services are provided to the families of the former residence clients only.

B) The hospice services continue for family and friends during the bereavement period, up to one month after the death.

C) The hospice nurse continues to care for the client's family for up to one year.

D) Nurses assist the family to work through their grief during the period of mourning.

Ans: C

Feedback:

After the death of the patient, the hospice nurse continues to care for the client's family during the bereavement period for up to one year. Nurses help the family to work through their loss.

25. One of the newest concepts in providing long-term care is called aging in place. What is the best description of this type of care?

A) Clients move to an independent living apartment or home, then have access to increasing health care services as needed, provided within the health care community where they live.

B) Clients move into the nursing home, and access more and more services as required in the same facility.

C) A long-term-care facility, associated with a hospital, that provides acute care services as needed so the client can return to long term care.

D) Clients are maintained in their own homes with home health care.

Ans: A

Feedback:

The best description of "aging in place" is the type of care where the client moves into an independent living space, and then has access to more services, such as assisted living and/or skilled care, that are part of the health care community in which they live.

26. Health care is constantly changing and becoming more complex. Select the answers that describe clients as health care consumers today. Select all that apply.

A) They often have health information obtained from the Internet.

B) They prefer to control the decisions made about their own health care.

C) Most are less concerned about health care costs as long as they receive good care.

D) They express concern regarding access to care and the quality of service.

E) They have helped develop clients' rights and cost-containment measures.

Ans: A, B, D, E

Feedback:

Health care consumers are increasingly more knowledgeable about health, and prefer to control the decisions about their care. They express concern about access to services, and the cost and quality of care. They question duplication of services, and are actively engaged. They have helped to develop client rights and cost-containment measures as protections for clients in health care settings. Today clients are surveyed regarding their experiences with doctors and nurses in hospitals.

27. The Public Health Service (PHS) is a federal agency of the U.S. Department of Health and Human Services. The professional nurse is aware that the services provided by the PHS include which of the following? Select all that apply.

A) Care to migrant workers

B) Care in federal prisons

C) Veterans Administration (VA) hospitals

D) Indian Health Services

Ans: A, B, D

Feedback:

The Public Health Services provides all of these services and others, except the Veterans Administration Hospitals. VA hospitals are supported by government-operated health care, not the PHS.

28. Health care costs are increasing as technology and related services increase. Patients interact with many health care providers, such as RNs, LPNs, physicians, physical therapists, medical technologists, radiation technologists, specialists, and others employed in health care. As a result of the complexity of care and multiple providers, health care is becoming fragmented. What are the major results of fragmented care?

A) Less confusion for clients regarding treatment.

B) Increased medication errors.

C) Clients receive more specialized care.

D) Lack of continuity of care.

Ans: B, C, D

Feedback:

Fragmented care increases health care costs and the number of providers/specialists seeing the client. A lack of continuity of care often results, increasing the client's confusion, and medication errors may increase. Although clients often receive specialized care and services, there may be conflicting care plans.

29. A nurse is making a visit to a client in the home. As a home health care nurse you may be expected to accomplish which of the following?

A) Complete an assessment on each visit.

B) Provide support to the client and family.

C) Administer treatments and medications.

D) Document actions regarding patient, activities, and progress.

E) Communicate and collaborate with other members of the health team.

Ans: A, B, C, D, E

Feedback:

All of the above. Home health care nurses may provide all of these activities in the home setting.

30. Nurses work with various members of the health team. The nurse understands that the role of the hospitalist is best described as:

A) the doctor who admits the patient, assumes the management of the patient's care, and maintains communication with the primary physician while the patient is hospitalized.

B) the physician who manages the patient's care in emergency and intensive care units only.

C) the doctor who notifies the primary physician that their patient has been admitted to the hospital, and transfers care to a the referral specialist.

D) the specialist who admits the patient to hospital, and returns care to the primary physician for all other referrals and services.

Ans: A

Feedback:

The hospitalist is a physician who provides care to the patient in the emergency room and after admission to the hospital. The hospitalist communicates with the patient's primary doctor, but manages the hospital care.

31.	A nurse has been hired to work as an occupational health nurse. In this position as a registered nurse, what will this nurse provide?
A)	Occupational therapy to schoolchildren.
B)	Education and safety programs in industrial settings.
C)	Assessment and motivation services to the unemployed.
D)	Activities to assist patients with ADLs in homeless shelters.
Ans:	B
	Feedback:
	Industrial settings is the best answer to define/describe occupational health nursing, which focuses on employee safety and health-promotion programs. The other options do not address health needs in an employment setting.
32.	In providing nursing care, it is most important to perform which of the following actions?
A)	Administration of prescribed medications
B)	Implementation of physician's orders
C)	Evaluation of client's responses
D)	Coordination of care with the health care team
Ans:	D
	Feedback:
	Nurses have moved from simply observing and giving prescribed medications to coordinating clinical information for the entire health care team.
33.	The U.S. system of health care is based on an ability to pay for care, which leaves millions of people uninsured or underinsured, with inadequate access to health care. Nurses are often presented with ethical dilemmas when caring for patients and families. Which of the following is an example of an ethical dilemma? Select all that apply.
A)	All clients are entitled to care, whether they can pay or not, because health care is a right.
B)	You may have to pay higher insurance premiums to cover the cost of care because you smoke.
C)	There are free clinics and health programs to serve the poor; they should receive health care there.
D)	Should the uninsured person, who cannot pay for health care, receive the same care and services as someone who works and pays for insurance?
Ans:	D
	Feedback:
	Only answer D suggests an ethical dilemma for which there is no easy answer. Answer A is an assumption that many have about health care. Answer B is a fact, as some health insurance programs charge more for those who smoke. Answer C is an opinion, as although there are some clinics for the poor, health care access is limited.
34.	A nurse is caring for clients at an ambulatory care facility. Which care intervention is least likely to be provided by the nurse in this setting?
A)	Patient education
B)	Treatment of minor trauma

C) Medication administration

D) Crisis management

Ans: D

Feedback:

Nurses in ambulatory care centers and clinics provide technical services (e.g., administering medications), determine the priority of care needs, and provide teaching about all aspects of care. The urgent care center is a special type of ambulatory care center that provides walk-in care for illnesses and minor trauma. Crisis management or intervention is typical of mental health centers and not of ambulatory care settings.

35. A nurse and a client are discussing managed care. The nurse explains that the managed care model was designed for which of the following reasons?

A) Increasing client satisfaction

B) Controlling costs while maintaining quality of care

C) Providing a distinct area of care

D) Providing an all-RN staff

Ans: B

Feedback:

Case management is used in such situations to ensure optimum, high-quality care in the most efficient and economic manner. It is done by controlling costs while maintaining quality of care.

Chapter 12, Collaborative Practice and Care Coordination Across Settings

1. A client asks a nurse, “How does ergotamine (Ergostat) relieve migraine headaches?” The nurse should respond that it:

A) dilates cerebral blood vessels.

B) constricts cerebral blood vessels.

C) decreases peripheral vascular resistance.

D) decreases the stimulation of baroreceptors.

Ans: B

Feedback:

Ergotamine relieves migraine headaches by constricting, not dilating, cerebral arterial vessels. The drug’s ability to prevent norepinephrine reuptake may add to this effect. The net result is decreased pulsatile blood flow through the cerebral vessels and symptom relief. Ergotamine doesn’t decrease peripheral vascular resistance or stimulation of baroreceptors.

2. What role will the nurse play in transferring a client to a long-term care facility?

A) Provide a verbal report to the nurse at the long-term care facility on the client, the hospital care, and the client’s current condition.

B) Assure that the client’s original chart accompanies the client.

C) Arrange for the client’s belongings to remain at the hospital until discharge from the long-term care facility.

D) Inform the client that transferring should be a stress-free situation.

Ans: A

Feedback:

The nurse at the hospital will provide a verbal report to the nurse at the long-term facility. The client's belongings will accompany the client to the long-term facility, and the nurse should assure that this occurs. The original chart will not accompany the client, but copies of the chart or sections of the chart may be sent based upon agency protocols. The nurse should also recognize and inform the client that while a transfer may be a welcome event, it also can be stressful.

3. The nurse recognizes that the goals established for a client's discharge are more likely to be accomplished when …

A) the client assists in developing the goals.

B) the physician develops the goals.

C) the nurse develops the goals.

D) the multidisciplinary team develops the goals.

Ans: A

Feedback:

If the client is involved in establishing the goals, it is more likely that the expected outcomes of the discharge plan will be met. The client may fail to follow the plan if the goals are not mutually agreed on, or are not based on a complete assessment of the client's needs.

4. Which of the following phrases best describes continuity of care?

A) Focusing on acute care in the hospital

B) Serving the needs of children

C) Facilitating transition between settings

D) Providing single-episode care services

Ans: C

Feedback:

Continuity of care is a process by which health care providers give appropriate uninterrupted care and facilitate the client's transition between different settings and levels of care. The other choices do not describe continuity of care.

5. Which of the following nursing diagnoses would be appropriate for almost all clients entering a health care setting?

A) Impaired Elimination

B) Dysfunctional Grieving

C) Fatigue

D) Anxiety

Ans: D

Feedback:

Entering and leaving a health care setting, as well as receiving care at home, are experiences that produce anxiety for both clients and family members. Most clients entering a health care setting do not have impaired elimination, dysfunctional grieving, or fatigue.

6. A nurse is admitting an older woman (Grace Staples) to a long-term care facility. How should the nurse address the woman?

A) "We will just call you Grace while you live here. Okay?"

B) "I know you have lots of grandchildren, Grandma."

C) "What name do you want us to use for you?"

D) "I think you will enjoy living here, Sweetie."

Ans: C

Feedback:

The nurse should communicate with the client as an individual so he or she can maintain his or her own identity. Ask clients how you should address them. Do not call older adults Grandma or Grandpa.

7. Which of the following is the major goal of ambulatory care facilities?

A) To save money by not paying hospital rates

B) To provide care to clients capable of self-care at home

C) To perform major surgery in a community setting

D) To perform tests prior to being admitted to the hospital

Ans: B

Feedback:

An individual may receive care in many different kinds of ambulatory facilities, including physician offices, clinics, hospital outpatient services, emergency rooms, and same-day surgery centers. The goal of these facilities is to provide health care services to patients who are able to provide self-care at home. Although this saves money on hospital bills, that is not the major goal of ambulatory facilities. Major surgery and pretesting for surgery are not usually done at these centers.

8. According to established standards, which health care provider should conduct a holistic assessment for all clients admitted to the hospital?

A) Physician

B) Admission clerk

C) Licensed practical nurse

D) Registered nurse

Ans: D

Feedback:

The Joint Commission has established standards for hospital admission. These standards include assessment of each client's need for nursing care by a registered nurse and biophysical, psychosocial, environmental, self-care, educational, and discharge planning factors. The admission health assessment is not the responsibility of the physician, licensed practical nurse, or admission clerk.

9. Which health care provider is responsible for ensuring the room is prepared for admission and that the client is welcomed?

A) Nursing assistant

B) Admitting room clerk

C) Social worker

D) Nurse

Ans: D

Feedback:

Although the nurse may delegate most of the activities necessary to prepare a room for an admission, it is the nurse's responsibility to ensure other personnel complete the activities and to welcome the client to the unit.

10. A client has suddenly become very ill, and a nurse is transferring him to the intensive care unit (ICU). How does the nurse provide information to ensure continuity of care?

A) By giving a verbal report to nurses in the ICU

B) By ensuring that the chart and all belongings are moved

C) By delegating a nursing assistant to provide information

D) By asking the family to provide the information

Ans: A

Feedback:

When a client is transferred to another unit, the nurse in the original unit gives a verbal report about the client to the nurse in the new area. Continuity of care is not ensured by moving the chart and belongings, delegating responsibility to a nursing assistant, or asking the family to provide information.

11. At what point during hospital-based care does planning for discharge begin?

A) Upon admission to the hospital

B) After the patient is settled in a room

C) Immediately before discharge

D) After leaving the hospital

Ans: A

Feedback:

Planning for discharge begins on admission to the hospital, when admission information about the client is collected and documented.

12. A nurse, preparing for a client's discharge after surgery, is teaching the client's wife to change the dressing. How can the nurse be certain the wife knows the procedure?

A) Tell the wife exactly how to do it.

B) Give the wife information about supplies.

C) Have the wife demonstrate the procedure.

D) Ask another nurse to reinforce teaching.

Ans: C

Feedback:

All steps of a procedure should be demonstrated, practiced, and provided in writing. The client or caregiver should then perform the procedure in the presence of the nurse to demonstrate understanding. Simply stating the information, providing information about supplies, or asking another nurse to reinforce teaching does not mean the caregiver knows the information.

13. What is required of a client who leaves the hospital against medical advice (AMA)?

A) Nothing. The hospital has no legal concerns.

B) Full reimbursement of any medical expenses

C) Providing contact phone numbers if needed

D) Signing a form releasing legal responsibility

Ans: D

Feedback:

A client is legally free to leave the hospital, but must sign a form that releases the physician and health care institution from any legal responsibility for his or her health status. The client's signature must be witnessed, and the form becomes part of the client's medical record.

14. A home health care agency providing care in a local community is supported by the United Way and local donations. What type of agency is this?

A) Voluntary

B) Public

C) Proprietary

D) Institution-based

Ans: A

Feedback:

Home care agencies differ in the way they are organized and administered. They may be official or public (operated by state or local governments and primarily financed by tax funds), voluntary or not-for-profit (supported by donations, endowments, charities, and insurance reimbursements), proprietary (for-profit organizations governed by individual owners or national corporations), or institution-based (operate under a parent organization, such as a hospital).

15. Why would a home health care agency choose to be certified by Medicare?

A) To remain open and offer services

B) To ensure that all available services can be provided

C) To receive reimbursement for Medicare-covered services

D) To be able to admit clients without a physician's order

Ans: C

Feedback:

There are two types of home health care agencies: those certified by Medicare and those that are not. An agency must be certified by Medicare in order to receive reimbursement for Medicare-covered services.

16. In addition to a physician's order, what is one of the eligibility requirements for Medicare-covered home health care?

A) The client must have transportation to the physician's office.

B) The family must be willing to meet health care needs.

C) The client must be essentially homebound.

D) The client must be able to leave the home unassisted.

Ans: C

Feedback:

To be eligible for Medicare-covered home health care services, the client must meet certain criteria. One is that the client must be homebound or normally unable to leave the home unassisted. The client may leave home for medical treatment or short, infrequent trips, but leaving the home must require considerable effort.

17. What is the goal of nurses who provide home health care?

A) Helping clients achieve maximum independence and health

B) Collaborating with other health care providers and services

C) Minimizing the manifestations of disease processes

D) Encouraging clients' dependence on family members

Ans: A

Feedback:

The essential components of home health care include the client, the family, and health care professionals from various disciplines. The goal of nursing care in the home is to help clients reach maximum independence and health. Although nurses collaborate with other health care providers, they do so to meet this goal. Home health care is not provided to minimize disease manifestations or to encourage clients' dependence on family members.

18. Which of the following health care professionals prescribes home care and certifies the plan of care for the client?

A) Social worker

B) Discharge nurse

C) Home healthcare nurse

D) Physician

Ans: D

Feedback:

The physician certifies the client has a health problem so that the client may receive home health care services. The physician also prescribes and certifies a plan of care for the client. The plan is not certified by a social worker, discharge nurse, or home health care nurse.

19. Although all of the following components are important, which two components of nursing care are identified by home health care nurses as *most* important when caring for clients in the home?

A) Computer knowledge, cultural diversity

B) Physical assessment, infection control

C) Communications, technical skills

D) Documentation, problem solving

Ans: B

Feedback:

Home health care nurses have identified the following areas of knowledge as most important: legal regulations, physical assessment, body mechanics, nursing diagnoses, and infection control.

20. A client is having problems with insurance reimbursement. The home health care nurse discusses the client's need for home health services with the insurance company. What role is the nurse demonstrating?

A) Direct care provider

B) Coordinator of services

C) Educator

D) Advocate

Ans: D

Feedback:

Patients often need help understanding the complex health care system, including handling insurance problems. Advocacy (the protection and support of another's rights) is an important role of the home health care nurse. By convincing the insurance company of the client's continued need for home care services, the nurse is acting as an advocate.

21. Which one of the following roles of the home health care nurse illustrates the role of coordinator of services?

A) Providing certification for home care

B) Providing direct physical care to the client

C) Providing information about community resources

D) Educating the client and caregiver about wound care

Ans: C

Feedback:

The home health care nurse is generally the coordinator of all other health care providers visiting the client. He or she is also responsible for coordinating community resources needed by the client. The nurse does not provide certification. Providing direct care is a part of the caregiver role, whereas educating about wound care is part of the educator role.

22. Which of the following is recommended to ensure safety for the home health care nurse?

A) Traveling with another nurse

B) Carrying a cell phone

C) Talking to family members

D) Refusing assignments

Ans: B

Feedback:

The nurse must evaluate the safety of the neighborhood before making the first home visit. Guidelines for safety of the nurse include carrying a cell phone programmed with emergency numbers. In most instances, it is not economically feasible to travel with another nurse. Talking to family members and refusing assignments do not ensure safety.

23. What must a nurse do before altering the arrangement of furniture in the home to facilitate care?

A) Nothing; the nurse may move the furniture if needed.

B) Document the need to move the furniture.

C) Tell the client that the furniture has to be moved.

D) Ask the client's permission to move the furniture.

Ans: D

Feedback:

The nurse may believe the furniture in the client's home needs to be rearranged to allow the use of equipment and to remove safety hazards, but the client should give permission before any changes are made. It is not necessary to document the need to move furniture.

24. What technique should the nurse use to implement infection control in the home?

A) Avoid touching any object in the home, including door knobs.

B) Practice hand hygiene when beginning and ending the home visit.

C) Wear gloves at all times when in the home or traveling in the car.

D) Take prescribed antibiotics on a regular basis on working days.

Ans: B

Feedback:

Of all the methods used to prevent infection, hand hygiene is the most important and is necessary before and after treating the client (i.e., when beginning and ending the home visit).

25. A client is diagnosed with mild dementia while in the hospital. In preparing for discharge, what should the nurse should discuss with the family?

A) Possible need for home care

B) Legal responsibility for the future

C) Need for transfer to a long-term care facility

D) Lack of free resources of care

Ans: A

Feedback:

The needs of the client should be considered when making discharge plans. Common risk factors associated with the need for home care include limited social, mental, or physical functioning. Legal issues, long-term care, and free resources are not indicated in this situation.

26. Which of the following are examples of nursing actions performed in the entry phase of the home visit? Select all that apply.

A) Developing rapport

B) Making assessments

C) Evaluating safety issues

D) Gathering supplies

E) Collecting client information

Ans: A, B

Feedback:

In the entry phase, the nurse develops rapport with the patient and family, makes assessments, determines nursing diagnoses, establishes desired outcomes (along with the client and family), plans and implements prescribed care, and provides education. In the pre-entry phase, the nurse evaluates safety issues, gathers supplies, and collects client information.

27. Which of the following interventions would be performed by the occupational therapist as a member of the home health care team? Select all that apply.

A) Evaluate the client's functional level.

B) Provide muscle-strengthening exercises.

C) Educate client and family about promoting self-care in ADLs.

D) Provide assistance with securing needed equipment.

E) Implement the plan of care designed by the nurse.

Ans: A, C

Feedback:

The occupational therapist evaluates the client's functional level, educates the client and family on promoting self-care in activities of daily living, assesses the home for safety, and provides adaptive equipment (as necessary). Muscle-strengthening exercises are provided by the physical therapist. Assistance with securing needed equipment is provided by the social worker. The home health aide implements the plan of care designed by the nurse, and the nurse researches the cost-effectiveness of the plan.

28. Which of the following roles of the nurse is most important in providing continuity of care to clients? Select all that apply.

A) Educator

B) Collaborator

C) Mentor

D) Advocate

E) Role model

Ans: A, B, D

Feedback:

To provide continuity of care, nurses must consider education and referrals in the care of any person admitted to any type of health care setting, and must also involve the client and family in a mutual planning process. The nurse must also collaborate with other members of the health care team in meeting the physical, psychological, sociocultural, and spiritual needs of the client and family, in all settings and at all levels of health or illness. Although it is important to be a mentor, role model, and researcher, these roles are not directly related to providing continuity of care.

29. The nurse is planning the discharge of a client who had surgery for a left hip replacement. The client is being discharged from the hospital to the home and requires a walker and high-rise toilet seat. Which type of home health care service does the client require?

A) Custodial services

B) Home medical services

C) High-technology pharmacology services

D) Hospice services

Ans: B

Feedback:

Home medical services provide durable medical equipment, such as walkers, canes, crutches, wheelchairs, high-rise toilet seats, commodes, beds, and oxygen. Custodial services include homemaking and housekeeping services, as well as companionship and live-in services. Hospice services provide pain management, physician services, spiritual support, respite care, and bereavement counseling. High-technology pharmacology services provide intravenous therapy, home uterine monitoring, ventilator management, and chemotherapy.

30. The nurse is identifying needs of the client and family during the initial home visit. Which question would be inappropriate for the nurse to ask?

A) Tell me what responsibilities each member of the family has.

B) "Can we get rid of some of this clutter in your home?

C) What do you believe is causing your illness?

D) What foods are important in your family life?

Ans: B

Feedback:

When identifying needs of the client and family the nurse needs to consider the culture of the family unit. Information regarding the responsibilities of each family member, cultural foods important to the family, and the family members' perceptions of what is causing the illness can assist the nurse in providing culturally sensitive care. The nurse also needs to assess the physical environment of the home. However, referring to the home as cluttered is a judgmental statement that will cause the family to become defensive and will prevent the development of a trusting relationship.

31. The Joint Commission is one agency that accredits health care institutions. The nurse understands that the Joint Commission has mandated the use of which national safety practice to protect clients admitted to a health care facility?

A) Nurses use the Rights checklist prior to administering medications.

B) Upon admission all clients sign advanced directives.

C) The use of a wristband for identification of the patient.

D) The use of standard precautions in the operating room.

Ans: C

Feedback:

The Joint Commission accredits health care organizations and has required that to maintain client safety the wristband with the identification number/bar-code, client's name, physician's name, and other important identifying information be worn by the client. It does not require clients to sign advanced directives, and does not regulate nursing practice regarding medications and standard precautions.

32. Nursing continues to recognize and participate in providing appropriate, uninterrupted care and facilitate clients' transitions between different settings and levels of care. What would be an example of this continuity of care?

A) The nurse collaborating with other members of the health care team

B) The nurse accompanying the physician on rounds

C) The nurse taking detailed notes on how each client wants to continue care

D) The nurse attending an appointment with the client in some place other than where the nurse works

Ans: A

Feedback:

Continuity of care is a process by which health care providers give appropriate, uninterrupted care and facilitate a client's transition between different settings and levels of care. To do this, the nurse must, along with other responsibilities, collaborate with other members of the health care team in meeting all the needs of each client. The other answers are incorrect because they are not examples of the idea of the continuity of care.

33. The models of nursing care delivery have been many and varied throughout the history of nursing. Which of the following best describes the idea of the continuity of care?

A) Money focused

B) Client focused

C) Primary nursing

D) Functional nursing

Ans: B

Feedback:

Community-based nursing practice, admission and discharge from a health care setting, transfer from one setting to another, and readiness for home health care all have to do with the continuity of care and are client-focused. In other words, they focus on a client's needs and the nurse's role in providing that continuity. The other answers are incorrect.

34. The wristband is an important safety component during the client's stay because it is one of two identifiers required by which group's national safety standards (2008) to accurately identify a client during such activities as giving medication, fluids, and blood?

A) The Joint Commission

B) NANDA

C) HIPAA

D) The Kardex

Ans: A

Feedback:

The wristband is an important safety component during the client's stay because it is one of two identifiers required by The Joint Commission's national safety standards (2008) to accurately identify a patient during such activities as giving medication, fluids, and blood.

35. The home health nurse receives a referral from the hospital for a client who needs a home visit. After reading the referral, what would be the first action the nurse should take?

A) Identify community services initially for the client

B) Obtain client information from the discharge planner

C) Call the client to obtain permission to visit

D) Schedule a home health aide to visit the client

Ans: B

Feedback:

After receiving a referral, the first step is to call the physician or discharge planner to collect as much information as possible about the client. After the nurse reviews the information, he or she can call the client to obtain permission and schedule the visit. The nurse may identify community services or the need for a home health aide after she assesses the client and the home environment during the first visit with the client.

Chapter 13, Blended Competencies

1. The nursing student uses evidence-based practice findings in the development of a care plan. This is an example of which type of nursing skill?

A) Cognitive skill

B) Technical skill

C) Interpersonal skill

D) Ethical/legal skill

Ans: A

Feedback:

The student is demonstrating the use of cognitive skills, which is characterized by identifying scientific rationales for the client's plan of care, selecting nursing interventions that are most likely to yield the desired outcomes, and using critical thinking to solve problems. Technical skills focus on manipulating equipment skillfully to produce a desired outcome. Interpersonal skills are used to establish and maintain a caring relationship. Ethically and legally skilled nurses conduct themselves in a manner consistent with their personal moral code and professional role responsibilities.

2. A nurse has come on day shift and is assessing the client's intravenous setup. The nurse notes that there is a mini-bag of the client's antibiotic hanging as a piggyback, but that the bag is still full. The nurse examines the patient's medication administration record (MAR) and concludes that the night nurse likely hung the antibiotic but failed to start the infusion. As a result, the antibiotic is three hours late and the nurse has consequently filled out an incident report. In doing so, the nurse has exhibited which of the following?

A) Ethical/legal skills

B) Technical skills

C) Interpersonal skills

D) Cognitive skills

Ans: A

Feedback:

Reporting problems and unacceptable practices is an aspect of ethical/legal skills. Technical skills enable the safe performance of kinesthetic tasks while interpersonal skills are the manifestations of caring. Cognitive skills encompass knowledge and critical thinking.

3. A client who has been admitted to the hospital for the treatment of a gastrointestinal bleed requires a transfusion of packed red blood cells. Which of the following aspects of the nurse's execution of this order demonstrates technical skill?

A) Starting a new, large-gauge intravenous site on the client, and priming the infusion tubing

B) Understanding the Rh system that underlies the client's blood type

C) Ensuring that informed consent has been obtained and properly filed in the client's chart

D) Explaining the process that will be involved in preparing and administering the transfusion

Ans: A

Feedback:

Performing tasks that require manual dexterity is a manifestation of technical skills. Explaining the transfusion process is largely dependent on interpersonal skills, while understanding the theory behind blood types is indicative of cognitive skills. Informed consent lies within the domain of legal/ethical skills.

4. In which of the following situations would the nurse be most justified in implementing trial-and-error problem solving?

A) The nurse is attempting to landmark an obese client's apical pulse.

B) The nurse is attempting to determine the range of motion of a client's hip joint following hip surgery.

C) The nurse is attempting to determine which PRN (as needed) analgesic to offer a client who is in pain.

D) The nurse is attempting to determine whether a poststroke client has a swallowing deficit.

Ans: A

Feedback:

Trial-and-error problem solving can be dangerous to the client. Testing range of motion by trial-and-error could result in dislocation; trial-and-error drug administration could result in over- or under-medicating; trial-and-error assessment of a potential swallowing deficit could result in aspiration. Each of these situations warrants more systematic problem solving. Trial-and-error landmarking of an anatomically difficult point, such as the apex of an obese client's heart, does not pose a threat to the client and a reasonable amount of "hunting" for the apical pulse may be necessary.

5. What nursing organization first legitimized the use of the nursing process?

A) National League for Nursing

B) American Nurses Association

C) International Council of Nursing

D) State Board of Nursing

Ans: B

Feedback:

Although the term "nursing process" was first used by Lydia Hall in 1955 and nursing theorists delineated specific steps in a process approach to nursing, use of the nursing process was legitimized in 1973, when the American Nurses Association's Congress for Nursing Practice developed Standards of Practice to guide nursing performance.

6. A client comes to the emergency department complaining of severe chest pain. The nurse asks the client questions and takes vital signs. Which step of the nursing process is the nurse demonstrating?

A) Assessing

B) Diagnosing

C) Planning

D) Implementing

Ans: A

Feedback:

Assessing is the step in which nurses assess the client to determine the need for nursing care. When assessing, the nurse systematically collects client data.

7. A nurse is examining a child two years of age. Based on her findings, she initiates a care plan for a potential problem with normal growth and development. Which step of the nursing process identifies actual and potential problems?

A) Assessing

B) Diagnosing

C) Planning

D) Implementing

Ans: B

Feedback:

After assessing the need for nursing care, the nurse clearly identifies client strengths, and actual and potential problems in diagnoses.

8. A home health nurse reviews the nursing care with the client and family and then mutually discusses the expected outcomes of the nursing care to be provided. Which step of the nursing process is the nurse illustrating?

A) Diagnosing

B) Planning

C) Implementing

D) Evaluating

Ans: B

Feedback:

During the planning step, the nurse identifies expected outcomes of the plan of care. The plan of care should be holistic and individualized, specify desired client goals and related outcomes, and identify the nursing interventions most likely to meet those expected outcomes.

9. Based on an established plan of care, a nurse turns a client every two hours. What part of the nursing process is the nurse using?

A) Assessing

B) Planning

C) Implementing

D) Evaluating

Ans: C

Feedback:

During the implementing step of the nursing process, the nurse carries out interventions that were developed during the planning step.

10. What name is given to standardized plans of care?

A) Critical pathways

B) Computer databases

C) Nursing problems

D) Care plan templates

Ans: A

Feedback:

Standardized care plans include critical pathways, which target desired outcomes for particular illnesses, procedures, or conditions along a timeline. Critical pathways are used in many health care settings.

11. Which of the following groups developed standard language to increase the visibility of nursing's contribution to client care by continuing to develop, refine, and classify phenomena of concern to nurses?

A) NANDA

B) NIC

C) NOC

D) HHCC (now CCC)

Ans: A

Feedback:

The North American Nursing Diagnosis Association (NANDA) International increased the visibility of nursing's contribution to client care by continuing to develop, refine, and classify phenomena of concern to nurses. The Nursing Interventions Classification (NIC) works to identify, label, validate, and classify actions nurses perform, including direct and indirect care interventions. The Nursing-Sensitive Outcomes Classification (NOC) identifies, validates, and classifies nursing-sensitive client outcomes and indicators to evaluate the validity and usefulness of the classification. Home Health Care Classification (HHCC, now known as Clinical Care Classification (CCC) system) provides a structure for documenting and classifying home health and ambulatory care.

12. Legally speaking, how would the nurse ensure that care was not negligent?

A) Verbally reporting assessments to the client's physician

B) Keeping private notes about the care given to each assigned client

C) Documenting the nursing actions in the client's record

D) Tape recording complete information for each oncoming shift

Ans: C

Feedback:

Legally speaking, a nursing action not documented in the client's record is a nursing action not performed. Unless the record contains written (not verbal, tape-recorded, or in private notes) documentation of care provided, the court would have no reason to accept a nurse's claim that the care was given.

13. A nurse interviews a pregnant teenager and documents her answers on the client record. At the same time, the nurse responds to the client's concerns and makes a referral for counseling and maternity care. This scenario is an example of which of the descriptors of the nursing process?

A) Systematic

B) Dynamic

C) Outcome oriented

D) Universally applicable

Ans: B

Feedback:

Although the nursing process is presented as an orderly progression of steps, in reality there is great interaction and overlapping among the five steps. No one step in the nursing process is a one-time phenomenon; each step flows into the next step. In some nursing situations, all five stages occur almost simultaneously.

14. An experienced ICU nurse is mentoring a student. The nurse tells the student, "I think something is going wrong with your client." What type of clinical decision making is the experienced nurse demonstrating?

A) Trial-and-error problem solving

B) Intuitive thinking

C) Scientific problem solving

D) Methodical reasoning

Ans: B

Feedback:

Nurses today acknowledge the role of intuitive thinking in clinical decision making. Many veteran nurses can describe situations in which an "inner prompting" led to a quick nursing intervention that saved a client's life. However, intuitive problem solving comes with years of practice and observation.

15. A nurse is caring for a client in the ER who was injured in a snowmobile accident. The nurse documents the following client data: uncontrollable shivering, weakness, pale and cold skin. Th nurse suspects the client is experiencing hypothermia. Upon further assessment, the nurse notes a heart rate of 53 BPM and core internal temperature of 90°F, which confirms the initial diagnosis. The nurse then devises a plan of care and continues to monitor the client to evaluate the outcomes. This nurse is using which of the following types of problem solving in her care of this client?

A) Trial-and-error

B) Scientific

C) Intuitive

D) Critical thinking

Ans: B

Feedback:

Scientific problem solving is a systematic, seven-step, problem-solving process that involves (1) problem identification, (2) data collection, (3) hypothesis formulation, (4) plan of action, (5) hypothesis testing, (6) interpretation of results, and (7) evaluation, resulting in conclusion or revision of the study. This method is used most correctly in a controlled laboratory setting but is closely related to the more general problem-solving processes commonly used by health care professionals as they work with clients, such as the nursing process.

16. Which of the following is one example of a client benefit of using the nursing process?

A) Greater personal satisfaction

B) Decreased reliance on the nursing staff

C) Continuity of care

D) Decreased incidence of medical errors

Ans: C

Feedback:

When used well, the nursing process achieves for the client scientifically based, holistic, individualized care; the opportunity to work collaboratively with nurses; and continuity of care.

17. What is a systematic way to form and shape one's thinking?

A) Critical thinking

B) Intuitive thinking

C) Trial-and-error

D) Interpersonal values

Ans: A

Feedback:

Critical thinking is defined as "a systematic way to form and shape one's thinking. It functions purposefully and exactingly. It is thought that is disciplined, comprehensive, based on intellectual standards, and, as a result, well-reasoned" (Paul, 1993, p. 20).

18. What step in the nursing process is most closely associated with cognitively skilled nurses?

A) Assessing

B) Planning

C) Implementing

D) Evaluating

Ans: B

Feedback:

Cognitively skilled nurses are critical thinkers and are able to select those nursing interventions that are most likely to yield the desired outcomes.

19. A nurse asks a multidisciplinary team to collaborate in developing the most appropriate plan of care to meet the needs of an adolescent with a severe head injury. Which of the blended skills essential to nursing practice is the nurse using?

A) Cognitive skills

B) Interpersonal skills

C) Technical skills

D) Ethical/legal skills

Ans: B

Feedback:

Interpersonally skilled nurses establish and maintain caring relationships that facilitate the achievement of valued goals, and simultaneously affirm the worth of those in the relationship. They are, among other things, able to work collaboratively with the health care team to reach valued goals.

20. A student is asked to perform a skill for which he is not prepared. When using the method of critical thinking, what would be the first step to resolve the situation?

A) Purpose of thinking

B) Adequacy of knowledge

C) Potential problems

D) Helpful resources

Ans: A

Feedback:

The student's first step when thinking critically about a situation is to identify the purpose or goal of the thinking. This helps to discipline thinking by directing all thoughts toward the goal.

21. Members of the staff on a hospital unit are critical of a client's family, who has different cultural beliefs about health and illness. A student assigned to the patient does not agree,based on her care of the client and family. What critical thinking attitude is the student demonstrating?

A) Being curious and persevering

B) Being creative

C) Demonstrating confidence

D) Thinking independently

Ans: D

Feedback:

Although all the attitudes listed are components of critical thinking, the student is thinking independently. Nurses who are independent thinkers are careful not to let the *status quo* or a persuasive individual control their thinking.

22. As a beginning student in nursing, what is essential to the mastery of technical skills, such as giving an injection?

A) Read the steps of the procedure before clinical assignments.

B) Even if you do not know how to give an injection, act as if you do.

C) Practice giving injections in the learning laboratory until you feel comfortable.

D) Tell your instructor that you don't think you can ever give an injection.

Ans: C

Feedback:

Before attempting to perform a technical skill with or on a patient, it is necessary for the nurse to practice that skill until he or she feels confident in doing it.

23. Which of the following interpersonal skills is essential to the practice of nursing?

A) Performing technical skills knowledgeably and safely

B) Maintaining emotional distance from clients and families

C) Keeping personal information among shared clients confidential

D) Promoting the dignity and respect of patients as people

Ans: D

Feedback:

Characteristics of interpersonal caring that are essential to the practice of nursing include promoting the dignity and respect of clients as people, the centrality of the caring relationship, and a mutual enrichment of both participants in the nurse–client relationship.

24. A client age 50 years reports to a primary care unit with an open wound due to a fall in the bathroom. Which of the following nursing actions represents caring skills?

A) The nurse cleans the wound and applies a dressing to it.

B) The nurse inspects and examines the wound for swelling.

C) The nurse tells the client to use caution while on slippery surfaces.

D) The nurse informs the client that the wound is small and will heal easily.

Ans: A

Feedback:

The nursing action of cleaning the wound and applying a dressing indicates caring skills. The nurse implements assessment skills while inspecting and examining the wound. The nurse counsels the client to use caution when walking on slippery surfaces. By informing the client about the wound's condition, the nurse uses comforting skills.

25. The nurse, after gathering data, analyzes the information to derive meaning. The nurse is involved in which phase of the nursing process?

A) Planning

B) Diagnosis

C) Implementation

D) Outcome identification

Ans: B

Feedback:

The diagnosis phase involves the analysis of information and deriving the meaning from the analysis. The planning phase involves preparing a care plan and directing the nursing staff in providing care. The implementation phase involves initiation, evaluation of response to the plan, record of nursing actions, and client response to actions. Outcome identification involves formulating and documenting measurable, realistic, client-focused goals.

26. After completing an assessment of a client, the nurse uses critical thinking and clinical reasoning to prioritize the client's problems. Which of the following would the nurse determine is the highest priority?

A) Severe bleeding from a wound

B) History of asthma

C) Diabetes

D) Lack of family support

Ans: A

Feedback:

The client's problem is considered to be of high priority if it is life threatening, requires more intervention time, and has serious consequences. The severe bleeding from a wound would be the highest priority. The client's history of asthma, diabetes, and lack of family support may be important but the bleeding is the priority.

27. When the nurse is administering Lasix 20 mg to a client in congestive heart failure, what phase of the nursing process does this represent?

A) Assessment

B) Planning

C) Implementation

D) Evaluation

Ans: C

Feedback:

Implementation refers to the action phase of the nursing process, in which nursing care is provided.

28. When the nurse assesses the client's blood sugar, what is the term for the type of skill the nurse is using?

A) Technical

B) Therapeutic

C) Interactional

D) Adaptive

Ans: A

Feedback:

Technical skills are used to carry out treatments and procedures.

29. Nurses apply critical thinking to clinical reasoning and judgment in their nursing practice every day. Which of the following are characteristics of this practice? Select all that apply.

A) It is guided by standards, policies and procedures, ethics codes, and laws.

B) It is based on principles of nursing process, problem solving, and the scientific method.

C) It carefully identifies the key problems, issues, and risks involved.

D) It is driven by the nurse's need to document competent, efficient care.

E) It calls for strategies that make the most of human potential.

Ans: A, B, C, E

Feedback:

Critical thinking is guided by standards, policies and procedures, ethics codes, and laws; is based on principles of nursing process, problem solving, and the scientific method; and carefully identifies the key problems, issues, and risks involved. It is driven by client, family, and community needs, as well as nurses' needs to give competent, efficient care (e.g., streamlining paperwork to free nurses for client care). It calls for strategies that make the most of human potential and compensate for problems created by human nature. It is constantly re-evaluating, self-correcting, and striving to improve.

30. Nurses make decisions in their practice every day. Which of the following are potential errors in this decision-making process? Select all that apply.

A) Placing emphasis on the last data received

B) Avoiding information contrary to one's opinion

C) Selecting alternatives to maintain status quo

D) Being predisposed to multiple solutions

E) Prioritizing problems in order of importance

Ans: B, C

Feedback:

Potential errors in decision making include bias: placing emphasis on the first data received, avoiding information contrary to one's opinion, selecting alternatives to maintain status quo, and being predisposed to a single solution. Failure to prioritize problems in order of importance is failure to consider the total situation. Failure to use appropriate resources is impatience. All these actions can lead to errors in decision making (Lipe & Beasley, 2004.)

31. Which of the following is an essential feature of professional nursing? Select all that apply.

A) Providing a caring relationship to facilitate health and healing

B) Attention to a range of human experiences and responses to health and illness

C) Use of objective data to negate the client's subjective experience

D) Use of judgment and critical thinking to form a medical diagnosis

E) Advancement of professional nursing knowledge through scholarly inquiry

Ans: A, B, E

Feedback:

As the role has changed, definitions of nursing have evolved to acknowledge the following essential features of professional nursing: (1) providing a caring relationship that facilitates health and healing, (2) attention to the range of human experiences and responses to health and illness within the physical and social environments, (3) integration of objective data with knowledge gained from an appreciation of the client's or group's subjective experience, (4) application of scientific knowledge to the processes of diagnosis and treatment through the use of judgment and critical thinking, (5) advancement of professional nursing knowledge through scholarly inquiry, and (6) influence on social and public policy to promote social justice.

32. Self-evaluation is a method that nurses use to promote their own development, and to grow in confidence in their nursing roles. This process is referred to as what?

A) Promoting the nurse's self-esteem.

B) Reflective practice.

C) Assessment of oneself.

D) Learning from mistakes.

Ans: B

Feedback:

Reflective practice is the use of self-evaluation by nurses committed to quality nursing practice. The others may be additional gains but are not descriptive of self-evaluation.

33. Nursing is a profession in a rapidly changing health care environment. What is the most important reason for the nurse to develop critical thinking and clinical reasoning?

A) To be able to employ the nursing process in client care.

B) The licensing examination requires nurses to be adept at critical thinking.

C) Because clients deserve experts who know how to care for them.

D) To provide quality care with nursing ability and knowledge.

Ans: D

Feedback:

The goal of all nursing is to meet the standard of quality care. Clinical reasoning and critical thinking may be applied in all of the answers but the most important goal in health care is to provide quality nursing care to clients.

34. The nurse is providing care for a pediatric client on night shift. At 0400, the nurse notes that the child has a high fever but does not have an order for an antipyretic. What nursing action represents a good example of teamwork and collaboration as defined by the Quality and Safety Education for Nurses (QSEN) competencies? The nurse:

A) calls the health care practitioner, reports her findings, and requests an order for an antipyretic.

B) gives the child a common over-the-counter antipyretic based on dosing recommendations and reports this to the oncoming nurse.

C) reports to the oncoming nurse at 0700 that the child has a fever so that when the healthcare provider comes in, she can obtain an order for an antipyretic.

D) requests that the child ‘s mother give the child something for the fever that she brought from home.

Ans: A

Feedback:

Teamwork and collaboration as defined by QSEN indicates the need to recognize practice boundaries at the same time as functioning within the inter-professional team to accomplish shared decision making. It is the nurses responsibility to report altered client status that may require collaborative interventions, irregardless of time of day. For the nurse to administer a medication, there must be a written order for the medication, and it is outside of the scope of practice to prescribe medications. Waiting to report the assessment to an oncoming nurse may delay client care and effect client outcomes. It would be inappropriate to require the mother take care of this with medications brought from home.

35. Which of the following group of terms best describes the nursing process?

A) nursing goals, medical terminology, linear

B) nurse-centered, single focus, blended skills

C) patient-centered, systematic, outcomes-oriented

D) family-centered, single point in time, intuitive

Ans: C

Feedback:

The nursing process is a patient-centered, systematic, outcomes-oriented method of caring that provides a framework for nursing practice. It is nursing practice in action.

Chapter 14, Assessing

1. Which of the following guidelines should a nursing instructor provide to nursing students who are now responsible for assessing their clients?

A) "Assessment data about the client should be collected continuously."

B) "Assess your client after receiving the nursing report and again before giving a report to the next shift of nurses."

C) "Assess your client at least hourly if the client's vital signs are unstable, and every two hours if the vital signs are stable."

D) "Assessment data should be collected prior to the physician rounding on the unit."

Ans: A

Feedback:

Data about the client are collected continuously because the client's health status can change quickly.

2. The nurse is using a systematic approach to the collection of assessment data. The nurse uses an assessment guide that uses a hierarchy of five life requirements universal to all persons. What model for organizing the assessment data is the nurse using?

A) Human Needs (Maslow) model

B) Functional Health Patterns model

C) Human Response Patterns model

D) Body System model

Ans: A

Feedback:

The nurse is following the Human Needs model based on Maslow's Hierarchy of Human Needs. The Functional Health Patterns model was developed by Gordon and is a framework that identifies 11 functional health patterns and organizes data according to these patterns. The Body System model is often used by the medical community, and it organizes data according to organ and tissue function in various body systems. The Human Response Pattern model focuses on a unitary person.

3.	A novice nurse collects data on a newly admitted client. Upon evaluation of this data, the nurse provides an erroneous interpretation. What is a corrective action for this interpretation?
A)	Encourage the novice nurse to independently observe the same situation with a peer, validate the data, and discuss the situation afterward.
B)	Encourage the novice nurse to develop his or her own tool for data collection.
C)	Encourage the novice nurse to collect and interpret the data for the client repeatedly, until the novice nurse arrives at the correct interpretation.
D)	Encourage the novice nurse to meet with the nurse manager to discuss the situation and seek mentoring for communication skills.
Ans:	A
	Feedback:
	The novice nurse can improve interpretation skills by independently observing the same situation with a peer, comparing notes afterward, and role-playing various validation techniques.
4.	When documenting subjective data, the nurse should do which of the following?
A)	Use the client's own words placed in quotation marks.
B)	Paraphrase the information stated by the client.
C)	Validate the information with the client's family prior to documentation.
D)	Record the information using nonspecific words.

Ans: A

Feedback:

Subjective data should be recorded using the client's own words, whenever possible. Quotation marks should be used around the client's statement. The tendency to use nonspecific terms that are subject to individual definition or interpretation should be avoided.

5. The nurse has entered a client's room to find the client diaphoretic (sweat-covered) and shivering, inferring that the client has a fever. How should the nurse best follow up this cue and inference?

A) Measure the client's oral temperature.

B) Ask a colleague for assistance.

C) Give the client a clean gown and warm blankets.

D) Obtain an order for blood cultures.

Ans: A

Feedback:

An inference must be followed by a validation process. In this case, the inference of fever is best validated or rejected by measuring the client's temperature. This should precede interventions such as blood work or even providing a warm blanket.

6. The nurse completes a health history and physical assessment on a client who has been admitted to the hospital for surgery. What is the purpose of this initial assessment?

A) To gather data about a specific and current health problem

B) To identify life-threatening problems that require immediate attention

C) To compare and contrast current health status to baseline data

D) To establish a database to identify problems and strengths

Ans: D

Feedback:

An initial assessment is performed shortly after the client is admitted to a health care agency or service. The purpose of the initial assessment is to establish a complete database for problem identification and care planning.

7. A client comes to her health care provider's office because she is having abdominal pain. She has been seen for this problem before. What type of assessment would the nurse do?

A) Initial assessment

B) Focused assessment

C) Emergency assessment

D) Time-lapsed assessment

Ans: B

Feedback:

A focused assessment is completed by the nurse to gather data about a specific problem that has already been identified. It is also used to identify new or overlooked problems.

8.	A nurse is assisting with lunch at a nursing home. Suddenly, one of the residents begins to choke and is unable to breathe. The nurse assesses the resident's ability to breathe and then begins CPR. Why did the nurse assess respiratory status?
A)	To identify a life-threatening problem
B)	To establish a database for medical care
C)	To practice respiratory assessment skills
D)	To facilitate the resident's ability to breathe
Ans:	A
	Feedback:
	When a life-threatening physiologic or psychological crisis occurs, the nurse performs an emergency assessment to identify life-threatening problems. Emergency assessments are not used to establish a database for medical care, practice assessment skills, or help a physiologic process (such as breathing).
9.	A nurse performs an assessment of a client in a long-term care facility and records baseline data. The nurse reassesses the client a month later and makes revisions in the plan of care. What type of assessment is the second assessment?
A)	Comprehensive
B)	Focused
C)	Time-lapsed
D)	Emergency
Ans:	C
	Feedback:
	The time-lapsed assessment is scheduled to compare a client's current status to baseline data obtained earlier. Most clients in residential settings and those receiving nursing care over longer periods of time, such as homebound clients with visiting nurses, are scheduled for periodic time-lapsed assessments to reassess health status and to make necessary revisions in the plan of care.
10.	Of the following information collected during a nursing assessment, which are subjective data?
A)	vomiting, pulse 96
B)	respirations 22, blood pressure 130/80
C)	nausea, abdominal pain
D)	pale skin, thick toenails
Ans:	C
	Feedback:
	Subjective data are information perceived only by the affected person. They cannot be perceived or verified by another person. Other terms for subjective data are symptoms or covert data.
11.	A nurse in the emergency department is completing an emergency assessment for a teenager just admitted from a car crash. Which of the following is objective data?
A)	"My leg hurts so bad. I can't stand it."
B)	"Appears anxious and frightened."

C) “I am so sick; I am about to throw up.”

D) “Unable to palpate femoral pulse in left leg.”

Ans: D

Feedback:

Objective data are observable and measurable data that can be seen, heard, or felt by someone other than the person experiencing them. Objective data observed by one person can be verified by another person observing the same client. Objective data are also called signs or overt data. The only objective data in this question would be that the nurse is unable to palpate a femoral pulse.

12. A nurse is collecting information from a client with dementia. The client’s daughter accompanies the client. Which of the following statements by the nurse would recognize the client’s value as an individual?

A) “Can you tell me how long your father has been this way?”

B) “Sarah, I have to go and read your father’s old charts before we talk.”

C) “Mr. Koeppe, tell me what you do to take care of yourself.”

D) “Mr. Koeppe, I know you can’t answer my questions, but it’s okay.”

Ans: C

Feedback:

Clients such as older adults with dementia, and their children, cannot be relied on to report accurately. However, they should be encouraged to respond to interview questions as best as they can. Bypassing the client communicates that the nurse does not have time or has doubts in the client’s ability to communicate.

13. A nurse is collecting data from a home care client. In addition to information about the client’s health status, what is another observation the nurse should make?

A) Number of rooms in the house

B) Safety of the immediate environment

C) Frequency of home visits to be made

D) Friendliness of the client and family

Ans: B

Feedback:

The nurse should also observe the safety of the immediate environment. Observation is the conscious and deliberate use of the five senses to gather data. Each time a client is observed, the nurse observes current responses, ability to provide self-care, the immediate environment, and the larger environment.

14. A nurse is preparing to conduct a health history for a client who is confined to bed. How should the nurse position herself?

A) Standing at the end of the bed

B) Standing at the side of the bed

C) Sitting at least six feet from the beside

D) sitting at a 45-degree angle to the bed

Ans: D

Feedback:

If the patient is in bed, placing a chair at a 45-degree angle is helpful in facilitating an easy exchange of information. If the nurse stands at the side or foot of the bed and physically looks down at the client, a superior–inferior relationship is communicated and can negatively affect the interview.

15. Which of the following questions or statements would be appropriate in eliciting further information when conducting a health history interview?

A) "Why didn't you go to the doctor when you began to have this pain?"

B) "Are you feeling better now than you did during the night?"

C) "Tell me more about what caused your pain."

D) "If I were you, I would not wait to get medical help next time."

Ans: C

Feedback:

Avoid questions that impede communication during the interview, including those that can be answered by yes or no, why or how questions, and giving advice.

16. Which of the following questions or statements would be an appropriate termination of the health history interview?

A) "Well, I can't think of anything else to ask you right now."

B) "Can you think of anything else you would like to tell me?"

C) "I wish you could have remembered more about your illness."

D) "Perhaps we can talk again sometime. Goodbye."

Ans: B

Feedback:

The successful interview is concluded carefully. After summarizing the data, it is helpful to ask the client if he or she has anything else to tell the nurse. This gives the client the chance to add data the nurse did not think to include.

17. A nurse is conducting a health history interview for a woman at an assisted-living facility. The woman says, "I have been so constipated lately." How should the nurse respond?

A) "Do you have a family history of chest problems?"

B) "Why don't you use a laxative every night?"

C) "Do you take anything to help your constipation?"

D) "Everyone who ages has bowel problems."

Ans: C

Feedback:

A possible cause of omission of pertinent data is failing to follow up on cues during data collection. The nurse should ask about what the client uses to self-treat her constipation in order to identify further important information. It is not correct to ignore the statement, ask "why" questions, or make assumptions.

18. A nurse who collected and organized data during a client history realizes that there is not enough information to plan interventions. Which of the following would be the best remedy to prevent this from happening in the future?

A) The nurse should practice interviewing strategies.

B) The nurse should modify data collection tool.

C) The nurse should determine specific purpose of data collection.

D) The nurse should update the database.

Ans: A

Feedback:

Strong interviewing skills are needed to obtain the necessary patient data. A common cause of data omission is the nurse's failure to know what information is wanted or not following up on client cues. The nurse only needs to modify the data collection tool if the database is inappropriately organized. If irrelevant or duplicate data is collected, the nurse should determine specific purpose of data collection. Data collection should be ongoing. If the nurse notices that data collection stopped after the initial assessment data were collected, the nurse should update the database.

19. What is the primary purpose of validation as a part of assessment?

A) To identify data to be validated

B) To establish an effective nurse–client communication

C) To maintain effective relationships with coworkers

D) To plan appropriate nursing care

Ans: D

Feedback:

Validation is the act of confirming or verifying to plan appropriate nursing care. Validation is an important part of assessment because invalid information can lead to inappropriate nursing care. Validation does not identify data to be validated, nor does it establish effective nurse–client communication or relationships with coworkers.

20. A client is being prepared for cardiac catheterization. The nurse performs an initial assessment and records the vital signs. Which of the following data collected can be classified as subjective data?

A) Blood pressure

B) Nausea

C) Heart rate

D) Respiratory rate

Ans: B

Feedback:

Subjective data are those which the client can feel and describe. Nausea is subjective data, as it can only be described and not measured. Blood pressure, heart rate, and respiratory rate are measurable factors and are therefore objective data.

21. A client is brought to the emergency department in an unconscious condition. The client's wife hands over the previous medical files and points out that the client had suddenly fallen unconscious after trying to get out of bed. Which of the following is a primary source of information?

A) Client'swife

B) Medical documents

C) Test results

D) Assessment data

Ans: A

Feedback:

In this case, the primary source of information is the client's wife, as she can provide a detailed description of the incident as well as provide the medical history of the client. The medical files, test results, and assessment data are secondary sources of information.

22. The nurse is performing an assessment of a client who has a small wound on the knee, collecting cues about the client's health status. Which of the following would the nurse identify as a subjective cue?

A) Sharp pain in the knee

B) Small bloody drainage on dressing

C) Temperature of 102 degrees F

D) Pulse rate of 90 beats per minute

Ans: A

Feedback:

Sharp pain in the knee is an example of a subjective cue. Subjective cues are imperceptible, immeasurable, and abstract. Small bloody drainage on dressing, a temperature of 102 degrees F, and a pulse rate of 90 beats per minute are examples of objective cues.

23. A nurse caring for a client admitted to the intensive care unit with a stroke assesses the client's vital signs, pupils, and orientation every few minutes. The nurse is performing which type of assessment?

A) Initial assessment

B) Focused assessment

C) Time-lapsed reassessment

D) Emergency assessment

Ans: B

Feedback:

The nurse is performing a focused assessment to determine whether the problem still exists, and whether the status of the problem has changed. An initial or admission assessment is the initial identification of normal function, functional status, and collection of data concerning actual or potential dysfunction. Time-lapsed reassessment is performed after the initial assessment when substantial periods of time have elapsed between assessments. An emergency assessment is performed any time a physiologic, psychological, or emotional crisis occurs.

24. When the nurse inspects a postoperative incision site for infection, which one of the following types of assessments is being performed?

A) Complete

B) Focused

C) General

D) Time-lapse

Ans: B

Feedback:

In focused assessments, the nurse determines whether the problem still exists and whether the status of the problem has changed.

25. An unconscious patient is brought to the emergency department. Which of the following assessments should be implemented first?

A) The client's airway should be assessed.

B) The nurse should determine the reason for admission.

C) The nurse should review the client's medications.

D) The client's past medical history is assessed.

Ans: A

Feedback:

Emergency assessment takes place in life-threatening situations in which the preservation of life is the top priority. Often, the client's difficulty involves airway, breathing, and circulatory problems.

26. The nurse observes the client as he walks into the room. What information will this provide the nurse?

A) Information regarding the client's gait

B) Information regarding the client's personality

C) Information regarding the client's psychosocial status

D) Information on the rate of recovery from surgery

Ans: A

Feedback:

Observation includes looking, watching, examining, scrutinizing, surveying, scanning, and appraising.

27. After assessment of a client in an ambulatory clinic, the nurse records the data on the computer. The nurse recognizes which of the following as objective data?

A) Auscultation of the lungs

B) Complaint of nausea

C) Sensation of burning in her epigastric area

D) Belief that demons are in her stomach

Ans: A

Feedback:

Objective data include techniques of inspection, palpation, percussion, and auscultation. Symptoms, values, perceptions, feelings, beliefs, attitudes, and sensations are sources of subjective data.

28. A nurse performing triage in an emergency room makes assessments of clients using critical thinking skills. Which of the following are critical thinking activities linked to assessment? Select all that apply.

A) Carrying out a physician's order to intubate a client

B) Educating a novice nurse on the principles of triage

C) Using the nursing process to diagnose a blocked airway

D) Interviewing privately a client suspected of being a victim of abuse

E) Checking with the family about the data supplied by a client suffering from dementia

Ans: C, D, E

Feedback:

Since the entire nursing process rests on the initial and ongoing assessment of the client, it is imperative to use excellent critical thinking skills when gathering, validating, analyzing, and communicating data. The nurse using critical thinking skills assesses information systematically using the nursing process, detects biases, makes judgments about the significance of data, and identifies assumptions and inconsistencies. Carrying out physician's orders and educating a novice nurse involve the implementation stage of the nursing process.

29. Which of the following data regarding a client with a diagnosis of colon cancer are subjective? Select all that apply.

A) The client's chemotherapy causes him nausea and loss of appetite.

B) The client became teary when his daughter from out of state came to the bedside.

C) The client's ileostomy put out 125 mL of effluent in the past four hours.

D) The patient is unwilling to manipulate or empty his ostomy bag.

E) The patient has been experiencing fatigue in recent weeks.

Ans: A, E

Feedback:

Reports of nausea, anorexia, and fatigue are subjective data that depend on the client's self-report. Weeping, ostomy output, and an inability to perform a kinesthetic task are observable assessment findings that would be characterized as objective.

30. Which of the following examples of client data needs to be validated? Select all that apply.

A) A client has trouble reading an informed consent, but states he does not need glasses.

B) An elderly client explains that the black and blue marks on his arms and legs are due to a fall.

C) A nurse examining a client with a respiratory infection documents fever and chills.

D) A client in a nursing home states that she is unable to eat the food being served.

E) A pregnant client is experiencing contractions that are two minutes apart.

Ans: A, B

Feedback:

Because validation of all data is neither possible nor necessary, nurses need to decide which items need verification. For example, data need to be verified when there are discrepancies: A patient tells the nurse he is fine and has no concerns, but the nurse notes that he demonstrates tense body musculature and seems curt in his responses. When there is a discrepancy between what the person is saying and what the nurse is observing, validation is necessary to determine accuracy. Data also need verification when they lack objectivity.

31. Which of the following are examples of common factors in a client that may influence assessment priorities? Select all that apply.

A) Diet and exercise program

B) Standing in the community

C) Ability to pay for services

D) Developmental stage

E) Need for nursing

Ans: A, D, E

Feedback:

The purpose for which the assessment is being performed offers the best guideline about what type and how much data to collect. Assessment priorities are influenced by the client's health orientation, developmental stage, culture, and need for nursing. After the comprehensive nursing assessment has been completed, client health problems dictate assessment priorities for future nurse–client interactions.

32. The nurse is conducting a nursing history of a client with a respiratory rate of 30, audible wheezing, and nasal flaring. During the interview, the client denies problems with breathing. What action should the nurse take next?

A) Clarify discrepancies of assessment data with the client.

B) Validate client data with members of the health care team.

C) Document all data collected in the nursing history and physical examination.

D) Seek input from family members regarding the client's breathing at home.

Ans: A

Feedback:

First, the nurse needs to validate the data with the client, who is the primary source. The nurse can validate data with the health care provider but consulting with the client is the best option. The client must give permission for family members to participate in the health history. Ultimately, the nurse documents all assessment data, both from the history and the physical exam.

33. The nurse is reviewing information about a client and notes the following documentation Client is confused. The nurse recognizes this information is an example of what?

A) Subjective data

B) A data cue

C) An inference

D) Primary data

Ans: C

Feedback:

Making a judgment that the client is confused is an inference. An inference must be validated with subjective and/or objective data cues. Sources of data cues can be primary or secondary.

34. While bathing the client, the nurse observes the client grimacing. The nurse asks if the client is experiencing pain. The client nods yes and refuses to continue the bath. The nurse removes the wash basin, makes the client comfortable, and documents the event in the client's chart. Which of the following actions clearly demonstrates assessing?

A) The nurse bathing the client

B) The nurse documenting the incident

C) The nurse asking if the client is having pain

D) The nurse removing the wash basin

Ans: C

Feedback:

The nurse asking if the client is having pain clearly demonstrates assessing. Bathing the client and removing the wash basin demonstrate implementation. Documentation is part of every step of nursing process.

35. The nurse has entered a client's room to find the client diaphoretic (sweat-covered) and shivering, inferring that the client has a fever. How should the nurse best follow up this cue and inference?

A) Measure the client's oral temperature.

B) Ask a colleague for assistance.

C) Give the client a clean gown and warm blankets.

D) Obtain an order for blood cultures

Ans: A

Feedback:

An inference must be followed by a validation process. In this case, the inference of fever is best validated or rejected by measuring the client's temperature. This should precede interventions such as blood work or even providing a warm blanket.

Chapter 15, Diagnosing

1. Which of the following is a correct guideline to follow when composing a nursing diagnosis statement?

A) Place defining characteristics after the etiology and link them by the phrase "as evidenced by."

B) Phrase the nursing diagnosis as a client need.

C) Place the etiology prior to the client problem and linked by the phrase "related to."

D) Incorporate subjective and judgmental terminology.

Ans: A

Feedback:

Defining characteristics should follow the etiology and be linked by the phrase "as evidenced by" when included in the nursing diagnosis. The nursing diagnosis should be phrased as a client problem or alteration in health state, rather than as a client need. The client problem precedes the etiology and is linked by the phrase "related to." Avoid using judgmental language and write in legally advisable terms.

2. In planning the care for a client who has pneumonia, the nurse collects data and develops nursing diagnoses. Which of the following is an example of a properly developed nursing diagnosis?

A) Ineffective airway clearance as evidenced by inability to clear secretions

B) Ineffective health maintenance as evidenced by unhealthy habits

C) Ineffective breathing pattern related to pneumonia

D) Ineffective therapeutic regimen management due to smoking

Ans: A

Feedback:

The appropriately written nursing diagnosis is “ineffective airway clearance related to inability to clear secretions.” “Ineffective health maintenance related to unhealthy habits” is incorrect because it shows value judgments by the nurse. “Ineffective breathing pattern related to pneumonia” is incorrectly written because it includes a medical diagnosis. “Ineffective therapeutic regimen management due to smoking” is incorrect because the clause “due to” implies a direct cause-and-effect relationship.

3. The nurse has identified a number of risk nursing diagnoses in the care of an adolescent who has been admitted to the hospital for treatment of an eating disorder. These risk diagnoses indicate which of the following?

A) The client is more vulnerable to certain problems than other individuals would be.

B) The diagnoses present significant risks for the development of medical diagnoses.

C) The data necessary to make a definitive nursing diagnosis is absent.

D) The diagnosis has yet to be confirmed by another practitioner.

Ans: A

Feedback:

Risk nursing diagnoses are clinical judgments that an individual, family, or community is more vulnerable to develop the problem than others in the same or similar situation. They do not denote a particular link to medical diagnoses nor do they require independent confirmation. Missing data is associated with possible nursing diagnoses.

4. A client with a new colostomy often becomes short and sarcastic when nurses attempt to teach him about the management of his new appliance. The nurse has consequently documented “Noncompliance related hostility” on the client’s chart. What mistake has the nurse made when choosing and documenting this nursing diagnosis?

A) Presuming to know the factors contributing to the problem

B) Identifying a problem that cannot be changed

C) Identifying a problem without corroborating evidence in the statement

D) Neglecting to identify potential complications related to the problem

Ans: A

Feedback:

Multiple factors may underlie the client’s response to education in a complex and emotionally charged situation, such as receiving a new ostomy. As a result, it is likely presumptuous to ascribe the client’s response to hostility. The problem is likely modifiable with a correct approach; the evidence underlying a nursing diagnosis is not normally explicit in the statement itself. The existence of potential complications is not central to the psychosocial nature of this client’s situation.

5. The nurse has drafted a nursing diagnosis of Imbalanced Nutrition: More Than Body Requirements in the care of moderately obese client. How should the nurse proceed after writing this diagnosis?

A) Validate the nursing diagnosis

B) Identify potential complications

C) Cross-reference the nursing diagnosis with medical diagnoses

D) Modify interventions based on the diagnosis

Ans: A

Feedback:

After writing a nursing diagnosis, it is important to verify and validate the diagnosis. This action should precede the modification of the client's care. Nursing diagnoses do not always correlate with medical diagnoses and not every nursing diagnosis is accompanied by potential complications.

6. Which of the following provides the nurse with the most reliable basis on which to choose a nursing diagnosis?

A) A cluster of several significant cues of data that suggest a particular health problem

B) A single, definitive cue that is closely associated with a common diagnosis

C) A cue that can be verified by objective, medical data

D) A group of related nursing diagnoses that exist within the same NANDA-approved domain

Ans: A

Feedback:

A data cluster is a grouping of client data or cues that points to the existence of a client health problem. Nursing diagnoses should always be derived from clusters of significant data rather than from a single cue. Medical corroboration is not always possible or necessary. The presence of multiple nursing diagnoses within one domain does not necessarily validate further diagnoses in that same domain.

7. In addition to identifying responses to actual or potential health problems, what is another purpose of the diagnosing step in the nursing process?

A) To collect information about subjective and objective data

B) To correlate nursing and medical diagnostic criteria

C) To identify etiologies of health problems

D) To evaluate mutually developed expected outcomes

Ans: C

Feedback:

The purpose of diagnosing, the second step in the nursing process, is to identify how an individual, a group, or a community responds to actual or potential health and life processes; to identify etiologies (factors that contribute to or cause health problems); and to identify resources or strengths that the individual, group, or community can draw on to prevent or resolve problems.

8. Which of the following client care concerns is clearly a nursing responsibility?

A) Prescribing medications

B) Monitoring health status changes

C) Ordering diagnostic examinations

D) Performing surgical procedures

Ans: B

Feedback:

Monitoring for health status changes is clearly a nursing responsibility. The other options are medical responsibilities, although in some instances an advanced practice nurse practitioner may be responsible for A and C.

9.	After completing assessments, a nurse uses the data collected to identify appropriate nursing diagnoses for a client. For what are the nursing diagnoses used?
A)	Selecting nursing interventions to meet expected outcomes
B)	Establishing a database of information for future comparison
C)	Mutually establishing desired outcomes of the plan of care
D)	Evaluating the effectiveness of the established plan of care
Ans:	A
	Feedback:
	The nurse formulates, validates, and lists nursing diagnoses for each client. Nursing diagnoses provide the basis for selecting nursing interventions that will achieve valued client outcomes for which the nurse is responsible.
10.	Which of the following statements accurately describes the legal responsibility of the nurse making a diagnosis for a client?
A)	The nurse may make a diagnosis, but the physician is responsible for making sure it is appropriate for the client.
B)	The nurse practitioner is responsible for making all nursing diagnoses and determining if they are appropriate for the client.
C)	The nurse must decide if he or she is qualified to make a nursing diagnosis and will accept responsibility for treating it.
D)	The health care facility directs the nursing diagnosis in order to receive payment for services performed.
Ans:	C
	Feedback:
	The term diagnosis means there is a problem requiring qualified treatment. The nurse must decide if he or she is qualified to make the diagnosis and will be able to treat it. If not, the nurse must refer the client to a qualified person for treatment.
11.	A student is reviewing a client's chart before giving care. She notes the following diagnoses in the contents of the chart: "appendicitis" and "acute pain." Which of the diagnoses is a medical diagnosis?
A)	Neither appendicitis nor acute pain
B)	Both appendicitis and acute pain
C)	Appendicitis
D)	Acute pain
Ans:	C
	Feedback:
	Medical diagnoses identify diseases (in this case, appendicitis). Nursing diagnoses describe problems treated by the nurse within the scope of independent nursing practice.
12.	A nurse develops a plan of care to meet the needs of a client who has had a large loss of blood after a snowmobile crash. Intravenous fluids and blood are administered and the nurse monitors the client's physiologic response. This action is known as a:
A)	medical diagnosis.
B)	nursing diagnosis.

C) collaborative problem.

D) goal for care.

Ans: C

Feedback:

Collaborative problems are certain physiologic complications that nurses monitor to detect onset or changes in status. Nurses manage collaborative problems by using physician-prescribed and nursing-prescribed interventions to minimize the complications of the event.

13. A nurse is reviewing the health history and physical assessment findings for a client who is having respiratory problems. Of the following data collected, what data from the health history would be a cue to a nursing diagnosis for this problem?

A) "I often have diarrhea after I eat spicy foods."

B) "My skin is so dry I just can't keep from scratching."

C) "I get out of breath when I walk a few steps."

D) "I just feel so bad about myself these days."

Ans: C

Feedback:

Most experienced nurses begin the work of interpreting and analyzing data while they are still collecting it. The term *cue* is often used to denote significant data, which "raises a red flag" to look for patterns or clusters of data that signal a nursing diagnosis. In this instance, the client's statement of getting out of breath when walking would be a cue to assess other subjective and objective data related to the respiratory system.

14. What is the focus of a diagnostic statement for a collaborative problem?

A) The client problem

B) The potential complication

C) The nursing diagnosis

D) The medical diagnosis

Ans: B

Feedback:

To write a diagnostic statement for a collaborative problem, the nurse should focus on the potential complications of the problem and use "PC" (for potential complication), followed by a colon, and list the complications that might occur. For clarity, the nurse should link the potential complications and the collaborative problem by using "related to."

15. Successful implementation of each step of the nursing process requires high-level skills in critical thinking. Which of the following statements accurately describe a guideline for using this process?

A) Trust clinical judgment and experience over asking for help.

B) Respect clinical intuition, but never allow it to determine a diagnosis.

C) Recognize personal biases as a strength in formulating diagnoses.

D) Keep an open mind and trust your intuition when formulating diagnoses.

Ans: D

Feedback:

To correctly diagnose health problems, the nurse must be familiar with nursing diagnoses and other health problems; read professional literature and keep reference guides handy; trust clinical experience and judgment but be willing to ask for help when the situation demands more than his or her qualifications and experience can provide; respect clinical intuitions, but before writing a diagnosis without evidence, increase the frequency of observations and continue to search for clues to verify intuition. The nurse must also recognize personal biases and keep an open mind.

16. A nurse observes a new mother tenderly holding and softly talking to her baby. What does this observation tell the nurse about the baby's strengths?

A) Nothing; this observation is not important.

B) The mother is just behaving as all mothers do.

C) A baby is not capable of having strengths.

D) Nurturing is a strength for developing infants.

Ans: D

Feedback:

A strength, as assessed by the nurse during data interpretation and analysis, contributes to a client's level of wellness. In this case, the obvious love of the mother for her baby indicates a significant strength in the normal growth and development of the baby.

17. A nurse completes a health history and physical assessment for an adolescent before he begins football practice. Based on findings, the nurse recommends reinforcing good health habits. What conclusion did the nurse reach after interpreting and analyzing the data?

A) No problem

B) Possible problem

C) Actual problem

D) Clinical problem

Ans: A

Feedback:

The nurse reaches one of four basic conclusions after interpreting and analyzing the client data. Different nursing responses are possible for each conclusion. In this case, the nurse would most likely conclude there was no problem and reinforce the client's health habits.

18. A nurse caring for an older adult client in a long-term care facility notices that the bedding is wet when the client gets up in the morning. The nurse collects more data to form a conclusion. What type of problem is involved in this scenario?

A) No problem

B) Possible problem

C) Actual problem

D) Clinical problem

Ans: B

Feedback:

The nurse reaches one of four basic conclusions after interpreting and analyzing the client data: no problem, possible problem, actual or potential problem, or clinical problem. When dealing with a possible problem, the nurse must collect more data to confirm or disprove a suspected problem.

19. A nurse is formulating a nursing diagnosis for a client with a respiratory disease. Which of the following would be correct?

A) "needs nasal oxygen to improve breathing"

B) "cough related to ineffective airway clearance"

C) "ineffective airway clearance related to thick mucus"

D) "refuses to cough and expectorate thick mucus"

Ans: C

Feedback:

It is important to use guidelines to formulate correctly written nursing diagnoses. The nurse would not use client needs, put defining characteristics before the diagnoses, or judge the willingness of the client to cough.

20. A nurse writes the following nursing diagnosis for a client with Alzheimer's disease: Disturbed Thought Processes related to Alzheimer's disease as evidenced by incoherent language. Which part of this diagnosis is considered the problem statement?

A) disturbed thought processes

B) related to

C) Alzheimer's disease

D) incoherent language

Ans: A

Feedback:

The purpose of the problem statement is to describe the health state or health problem of the client as clearly and concisely as possible. Because this section of the nursing diagnosis identifies what is unhealthy about the client and what the client would like to change in his or her health status, it suggests client outcomes. NANDA recommends the use of quantifiers or descriptors to limit or specify the meaning of a problem statement. Disturbed thought processes is a NANDA-approved descriptor for this client problem. The etiology identifies the physiologic, psychological, sociologic, spiritual, and environmental factors believed to be related to the problem as either a cause or a contributing factor, and in this case is Alzheimer's disease. Incoherent language is considered a defining characteristic or subjective/objective data signaling the existence of an actual or potential health problem.

21. A nurse is formulating a diagnosis for a client who is reliving a brutal mugging that took place several months ago. The client is crying uncontrollably and states that he "can't live with this fear." Which of the following diagnoses for this client is correctly written?

A) Post-trauma syndrome related to being attacked

B) Psychological overreaction related to being attacked

C) Needs assistance coping with attack

D) Mental distress related to being attacked

Ans: A

Feedback:

Post-trauma syndrome is a NANDA-approved problem statement and being attacked is the correct etiology. Overreaction and mental distress implies a value judgment by the nurse. Needs assistance addresses the need of the client.

22. Of the following types of nursing diagnoses, which one is validated by the presence of major defining characteristics?

A) Risk nursing diagnosis

B) Actual nursing diagnosis

C) Possible nursing diagnosis

D) Wellness diagnosis

Ans: B

Feedback:

Actual nursing diagnoses represent problems that have been validated by the presence of major defining characteristics. An actual nursing diagnosis has four components: label, definition, defining characteristics, and related factors.

23. A nursing diagnosis is written as Disturbed Self-Esteem related to presence of large scar over left side of face. What does the phrase "Disturbed Self-Esteem" identify?

A) The expected outcome of the plan of care

B) A cue to determining a health problem

C) The major defining characteristic of a health problem

D) The health state or problem of the client

Ans: D

Feedback:

The problem, a part of a nursing diagnosis, describes the health state or health problem of the client as clearly and concisely as possible. It identifies what is unhealthy about the client and what the client would like to change. It also suggests client outcomes but is not an outcomes statement.

24. In the nursing diagnosis Disturbed Self-Esteem related to presence of large scar over left side of face, what part of the nursing diagnosis is "presence of large scar over left side of face"?

A) Etiology

B) Problem

C) Defining characteristics

D) Client need

Ans: A

Feedback:

The etiology identifies the physiologic, psychological, sociologic, spiritual, and environmental factors believed to be related to the problem as either a cause or a contributing factor. The etiology directs nursing interventions.

25. A student identifies Fatigue as a health problem and nursing diagnosis for a client receiving home care for treatment of metastatic cancer. What statement or question would be best to validate this client problem?

A) "I have assessed you and find you are fatigued."

B) "I analyzed and interpreted your information as fatigue."

C) "Why are you so tired all the time?"

D) "I think fatigue is a problem for you. Do you agree?"

Ans: D

Feedback:

After a tentative nursing diagnosis is made, it should be validated. Clients who are able to participate in decision making should be encouraged to validate the diagnosis.

26. Of all the benefits of using nursing diagnoses, which one is probably the most important to nurses?

A) Defining the domain of nursing practice

B) Informing patients of their care

C) Improving communication among nurses

D) Structuring curricular content

Ans: C

Feedback:

Although all the choices are correct, improved communication among nurses and other health care professionals is probably the most important benefit that accurate, up-to-date nursing diagnoses offer nurses.

27. According to Maslow's hierarchy of needs, which nursing diagnosis has the lowest priority for a client admitted to the intensive care unit with a diagnosis of congestive heart failure?

A) Ineffective airway clearance

B) Ineffective coping

C) Impaired urinary elimination

D) Risk for body image disturbance

Ans: D

Feedback:

Risk for disturbed body image is the least priority among all the nursing diagnoses mentioned, according to the Maslow's hierarchy. Body image disturbance is not vital for life. Secondly, it is a potential diagnosis, not an actual diagnosis. The other options could be an actual diagnosis present in the client. Ineffective airway clearance is the most important diagnosis because it is vital to life. Impaired urinary elimination is the next most important diagnosis because it is a physiological need. Ineffective coping is a social need, followed by the least important diagnosis of disturbed body image.

28. A client has an external fixation device on his leg due to a compound fracture. The client says that the device and swelling makes his leg look ugly. Which nursing diagnosis should the nurse document in his care plan based on the client's concern?

A) Impaired physical mobility

B) Disturbed body image

C) Risk for infection

D) Risk for social isolation

Ans: B

Feedback:

The diagnosis of disturbed body image is appropriate for the client because he is worried about the appearance of his legs due to swelling and the external fixation device. There is no mention about impaired physical mobility or risk for social isolation in the client's concern. There may be a risk of infection, but the client does not mention it.

29. A client who has to undergo a parathyroidectomy is worried that he may have to wear a scarf around his neck after surgery. What nursing diagnosis should the nurse document in the care plan?

A) Risk for impaired physical mobility due to surgery

B) Ineffective denial related to poor coping mechanisms

C) Disturbed body image related to the incision scar

D) Risk of injury related to surgical outcomes

Ans: C

Feedback:

The client is concerned about the surgery scar on his neck, which would disturb his body image; therefore, the appropriate diagnosis should be disturbed body image related to the incision scar. Risk for impaired physical mobility may be present after surgery, but is not related to the concerns expressed by the client. Likewise, ineffective denial related to poor coping mechanisms, and injury related to surgical outcomes are also not related to the client's concern.

30. A nurse who is caring for an unresponsive client formulates the nursing diagnosis, "Risk for Aspiration related to reduced level of consciousness." The nurse documents this nursing diagnosis as correct based on the understanding that which of the following is a characteristic of this type of diagnosis?

A) Is written as a two-part statement

B) Describes human response to a health problem

C) Describes potential for enhancement to a higher state

D) Made when not enough evidence supports the problem

Ans: A

Feedback:

The risk diagnoses are written as two-part statements because they do not include defining characteristics. An actual nursing diagnosis describes human response to a health problem. Wellness diagnoses describe potential for enhancement to a higher state. A possible nursing diagnosis is made when not enough evidence supports the problem.

31. After assessing a client, the nurse formulates several nursing diagnoses. Which of the following would the nurse identify as an actual nursing diagnosis?

A) Impaired urinary elimination

B) Readiness for enhanced sleep

C) Risk for infection

D) Possible impaired adjustment

Ans: A

Feedback:

Impaired urinary elimination is an actual nursing diagnosis because it describes a human response to a health problem that is being manifested. Readiness for enhanced sleep is a wellness diagnosis. Risk for infection is a risk diagnosis, and possible impaired adjustment is a possible nursing diagnosis.

32. What is the nurse accountable for, according to the state nurse practice act?

A) Continuing education

B) Nursing diagnoses

C) Prescribing medications

D) Mentoring other nurses

Ans: B

Feedback:

State nurse practice acts have included diagnosis as part of the domain of nursing practice for which nurses are held accountable.

33. A client is experiencing shortness of breath, lethargy, and cyanosis. These three cues provide organization or …

A) Categorizing

B) Diagnosing

C) Grouping

D) Clustering

Ans: D

Feedback:

Cue clustering brings together cues that if viewed separately would not convey the same meaning.

34. The nurse is providing care for a client who experienced an ischemic stroke five days ago. Which of the following diagnoses would the nurse be justified in identifying and documenting in the care of this client? Select all that apply.

A) Dysphagia

B) Bowel Incontinence

C) Impaired Swallowing

D) Impaired Physical Mobility

E) Risk for Hemiparesis

Ans: B, C, D

Feedback:

Bowel Incontinence, Impaired Swallowing, and Impaired Physical Mobility are all health problems that can be independently prevented or resolved by nursing practice. Dysphagia and hemiparesis are medical diagnoses.

35. Which of the following reflects the diagnosis phase?

A) The nurse identifies that the client does not tolerate activity.

B) The nurse performs wound care using sterile technique.

C) The nurse sets a tolerable pain rating with the client.

D) The nurse documents the client's response to pain medication.

Ans: A

Feedback:

Recognition of a client health problem that can be prevented or resolved by independent nursing intervention, such as activity intolerance, is the focus of diagnosing. Performing wound care is an example of implementation. Setting a tolerable pain rating with the client is an example of planning. Documenting the client's response to pain medication is an example of evaluation.

Chapter 16, Outcome Identification and Planning

1. The nurse develops long-term and short-term outcomes for a client admitted with asthma. Which of the following is an example of a long-term goal?

A) Client returns home verbalizing an understanding of contributing factors, medications, and signs and symptoms of an asthma attack.

B) By day 3 of hospitalization, the client verbalizes knowledge of factors that exacerbate the symptoms of asthma.

C) Within one hour of a nebulizer treatment, adventitious breath sounds and cough are decreased.

D) Within 72 hours of admission, the client's respiratory rate returns to normal and retractions disappear.

Ans: A

Feedback:

An example of a long-term outcome is "Patient returns home verbalizing an understanding of contributing factors, medications, and signs and symptoms of an asthma attack." The other three examples are short-term outcomes that focus on short-term goals related to the period of time during hospitalization.

2. Nurses make common errors in the identification and development of outcomes. Which of the following is a common error made when writing client outcomes?

A) The nurse expresses the client outcome as a nursing intervention.

B) The nurse develops measurable outcomes using verbs that are observable.

C) The nurse develops a target time when the client is expected to achieve that outcome.

D) The outcome should include a subject, verb, conditions, performance criteria, and target time.

Ans: A

Feedback:

A common error made when writing client outcomes includes the nurse expressing the client outcome as a nursing intervention. The other mentioned criteria for writing client outcomes are correct.

3. Increasingly, health care institutions are implementing computerized plans of nursing care. A benefit of using computerized plans includes which of the following?

A) Reduction in the time spent on care planning

B) Increased autonomy related to the nursing care planning process

C) Enhanced individualization of a care plan

D) Increased nursing expertise in care planning

Ans: A

Feedback:

The benefits of using computerized plans include ready access to a large knowledge base; improved record keeping, with resultant improvement in audits and quality assurance; documentation by all members of the health care team; and reduced time spent on paperwork. Research cautions that computerized systems for client care planning contribute to loss of autonomy, loss of individualization of care, and loss of nursing expertise.

4. The nurse is planning the care of a male client who is receiving treatment for acute renal failure and who has begun dialysis three times weekly. The nurse has identified the following outcome: "Client will demonstrate the appropriate care of his arteriovenous fistula." This outcome is classified as which of the following?

A) Psychomotor

B) Affective

C) Cognitive

D) Holistic

Ans: A

Feedback:

Psychomotor outcomes describe the client's achievement of new skills, such as the safe and aseptic care of a new fistula. Cognitive outcomes are focused on knowledge and effective outcomes address values, beliefs, and attitudes. Outcomes are not classified as holistic.

5. The nurse is caring for a client who has been newly diagnosed with diabetes. One of the outcomes the nurse read on the client's plan of care this morning was: "Client will demonstrate correct technique for self-injecting insulin." The client required insulin prior to his lunch and successfully drew up and administered his insulin while the nurse observed. How should the nurse follow up this observation?

A) Record an evaluative statement in the client's plan of care.

B) Remove the outcome from the client's care plan.

C) Ask the nurse who wrote the plan of care to document this development.

D) Reassess the client's psychomotor skills at dinner time.

Ans: A

Feedback:

The client has successfully met this outcome, and the nurse should note the time and date that it was achieved in the client's plan of care. The outcome should not be removed from the plan of care and it is unnecessary to have the original author of the plan update it. Further observation may or may not be necessary at dinner time, but an evaluative statement should nonetheless be recorded at the present time.

6. A male client is scheduled to be fitted with a prosthesis following the loss of his nondominant hand in a farm accident several weeks earlier. Nurses have documented the following outcome during this stage of his care: "After attending an educational session, client will demonstrate correct technique for applying his prosthesis." Which of this client's following statements would signal a need to amend this outcome?

A) "I'm not interested one bit in wearing an artificial hand."

B) "I'm worried that I'm going to get some really strange looks when I wear this thing."

C) “I don’t have a clue how this thing goes on and comes off.”

D) “I don’t understand the technology that’s used in this artificial hand.”

Ans: A

Feedback:

It is imperative that interventions and outcomes be valued by the client. The client’s resistance to using a prosthesis likely invalidates the outcome that addresses his technique for its use. The other statements express cognitive and affective learning needs that would need to be addressed, but none of those precludes his eventual mastery of the prosthesis.

7. What is the primary purpose of the outcome identification and planning step of the nursing process?

A) To collect and analyze data to establish a database

B) To interpret and analyze data so as to identify health problems

C) To write appropriate client-centered nursing diagnoses

D) To design a plan of care for and with the client

Ans: D

Feedback:

The primary purpose of outcome identification and planning is to design a plan of care for (and with) the client that, once implemented, results in the prevention, reduction, or resolution of client health problems and the attainment of the client’s health expectations, as identified in the client outcomes.

8. Critical thinking is an essential component in all phases of the nursing process. What question might be used to facilitate critical thinking during outcome identification and planning?

A) “How do I best cluster these data and cues to identify problems?”

B) “What problems require my immediate attention or that of the team?”

C) “What major defining characteristics are present for a nursing diagnosis?”

D) “How do I document care accurately and legally?”

Ans: B

Feedback:

Questions to facilitate critical thinking during outcome identification and planning include those related to setting priorities, such as “Which problems require my immediate attention or that of the team?” and “Which problems are most important to the client?”

9. A nurse is discharging a client from the hospital. When should discharge planning be initiated?

A) At the time of discharge from an acute health care setting

B) At the time of admission to an acute health care setting

C) Before admission to an acute health care setting

D) When the client is at home after acute care

Ans: B

Feedback:

Discharge planning is best carried out by the nurse who worked most closely with the client and family. In acute care settings, comprehensive discharge planning begins when the client is admitted for treatment.

10. The nursing diagnosis Impaired Gas Exchange, prioritized by Maslow's hierarchy of basic human needs, is appropriate for what level of needs?

A) Physiologic

B) Safety

C) Love and belonging

D) Self-actualization

Ans: A

Feedback:

Because basic human needs must be met before a person can focus on higher-level needs, client needs may be prioritized according to Maslow's hierarchy. Physiologic needs, including the need for oxygen, are the most basic and have the highest priority.

11. A resident of a long-term care facility refuses to eat until she has had her hair combed and her make-up applied. In this case, what client need should have priority?

A) The need to have nutrition

B) The need to feel good about oneself

C) The need to live in a safe environment

D) The need for love from others

Ans: B

Feedback:

When setting priorities, it is best to first meet the needs that the client believes are most important. In this situation, the woman is not refusing food altogether; rather, she wants to feel good about herself (self-esteem) when she does eat.

12. During outcome identification and planning, from what part of the nursing diagnoses are outcomes derived?

A) The defining characteristics

B) The related factors

C) The problem statement

D) The database

Ans: C

Feedback:

Outcomes are derived from the problem statement of the nursing diagnosis. For each nursing diagnosis, at least one outcome should be written that, if achieved, demonstrates a direct resolution of the problem statement.

13. A nurse is developing outcomes for a specific problem statement. What is one of the most important considerations the nurse should have?

A) The written outcomes are designed to meet nursing goals

B) To encourage the client and family to be involved

C) To discourage additions by other healthcare providers

D) Why the nurse believes the outcome is important

Ans: B

Feedback:

One of the most important considerations in writing outcomes is to encourage the client and family to be involved in goal development as their abilities and interest permit. The more involved they are, the greater the probability the goals will be achieved.

14. Which of the following outcomes is correctly written?

A) Abdominal incision will show no signs of infection.

B) On discharge, client will be free of infection.

C) On discharge, client will be able to list five symptoms of infection.

D) During home care, nurse will not observe symptoms of infection.

Ans: C

Feedback:

To be measurable, outcomes should have a subject (client or part of the client), verb (action to be performed), conditions (not always included), performance criteria (observable, measurable), and target time (to achieve the outcome).

15. Which of the following illustrates a common error when writing client outcomes?

A) Client will drink 100 mL of fluid every 2 hours from 6 a.m. to 9 p.m.

B) Client will demonstrate correct sequence of exercises by next office visit.

C) Client will be less anxious and fearful before and after surgery.

D) On discharge, client will list five symptoms of infection to report.

Ans: C

Feedback:

Common errors when writing client outcomes include expressing the outcome as a nursing intervention, using verbs that are not observable and measurable (as is done here), and writing vague outcomes (also done here).

16. Which of the following groups of terms best describes a nurse-initiated intervention?

A) Dependent, physician-ordered, recovery

B) Autonomous, clinical judgment, client outcomes

C) Medical diagnosis, medication administration

D) Other health care providers, skill acquisition

Ans: B

Feedback:

A nursing intervention is any treatment, based on clinical judgment and knowledge, that a nurse performs to enhance client outcomes. Nurse-initiated interventions are autonomous (independently performed).

17. What part of the nursing diagnosis statement suggests the nursing interventions to be included in the plan of care?

A) Problem statement

B) Defining characteristics

C) Etiology of the problem

D) Outcomes criteria

Ans: C

Feedback:

In contrast to the client goals, which are suggested by the problem statement of the diagnosis, it is the cause of the problem (etiology) that suggests the nursing interventions. Effective nurses select nursing interventions that specifically address factors that cause, or contribute to, the client's problem.

18. What name is given to tools that are used to communicate a standardized interdisciplinary plan of care for clients within a case management health care delivery system?

A) Kardex care plans

B) Computerized plans of care

C) Clinical pathways

D) Student care plans

Ans: C

Feedback:

Clinical pathways (critical pathways, CareMaps) are tools used to communicate the standardized interdisciplinary plan of care for clients. The emphasis in case management is on clearly stating expected client outcomes and the specific times targeted to achieve these outcomes.

19. A nurse has developed a plan of care with nursing interventions designed to meet specific client outcomes. The outcomes are not met by the time specified in the plan. What should the nurse do now in terms of evaluation?

A) Continue to follow the written plan of care.

B) Make recommendations for revising the plan of care.

C) Ask another health care professional to design a plan of care.

D) State "goal will be met at a later date."

Ans: B

Feedback:

Client outcomes are meaningless unless the nurse evaluates the client's progress toward their achievement. If the plan is not achieved (not met), recommendations for revising the plan of care are included in the evaluative statement.

20. Which of the following types of care plans is most likely to enable the nurse to take a holistic view of the client's situation?

A) Kardex

B) Case management

C) Critical pathways

D) Concept map care plan

Ans: D

Feedback:

A concept map care plan is a diagram of client problems and interventions. The nurse's ideas about client problems and treatments are the "concepts" that are diagrammed. These maps are used to organize client data, analyze relationships in the data, and enable the nurse to take a holistic view of the client's situation (Schuster, 2002).

21. Which of the following is an example of a well-stated nursing intervention?

A) Client will drink 100 mL of water every 2 hours while awake.

B) Offer client 100 mL of water every 2 hours while awake.

C) Offer client water when he complains of thirst.

D) Client will continue to increase oral intake when awake.

Ans: B

Feedback:

Nursing interventions describe in writing the specific nursing care to be implemented for the client. They include information that answers the questions who, what, where, when, and how.

22. What common problem is related to outcome identification and planning?

A) Failing to involve the client in the planning process

B) Collecting sufficient data to establish a database

C) Stating specific and measurable outcomes based on nursing diagnoses

D) Writing nursing orders that are clear and resolve the problem

Ans: A

Feedback:

One of the most important considerations in outcome achievement is to encourage the client and family to be as involved in goal development as their abilities and interest permit. The more involved they are, the greater the probability that the outcomes will be achieved.

23. A nurse is assigned to care for a client diagnosed with asthma who has just been admitted to the health care facility. The nurse determines the client's priorities for care using which of the following?

A) Assessment skills

B) Nursing books

C) Client's records

D) Supervisor's advice

Ans: A

Feedback:

The nurse should use assessment skills to determine the priority of nursing care for the client. Books on nursing can give only the theoretical aspect of nursing care. Client's records reveal information about the client's condition but do not convey the client's needs. Advice from supervisors can be taken if confronted with a problem.

24. A client is scheduled for surgery for an abdominal hysterectomy. During the preoperative assessment, the client states, "I am very nervous and scared to have surgery." What client outcome is the priority?

A) Evaluate the need for antibiotics.

B) Resolve the client's anxiety.

C) Provide preoperative education.

D) Prepare the client for surgery.

Ans: B

Feedback:

A priority is something that takes precedence in position, deemed the most important among several items. The client's preparation for surgery is important, but to have a successful outcome, the nurse must address the psychosocial issues related to anxiety.

25. Which of the following client outcomes best describes the parameters for achieving the outcome?

A) The client will eat a well-balanced diet.

B) The client will consume a 2,400-calorie diet, with three meals and two snacks, starting tomorrow.

C) The client will cleanse his wound with soap and water and apply a dry sterile dressing.

D) The client will be without pain in 24 hours.

Ans: B

Feedback:

The client will consume a 2,400-calorie diet, with three meals and two snacks, starting tomorrow possesses all parameters for achieving the outcome.

26. Nurses identifying outcomes and related nursing interventions must refer to the standards and agency policies for setting priorities, identifying and recording expected client outcomes, selecting evidence-based nursing interventions, and recording the plan of care. Which of the following are recognized standards? Select all that apply.

A) Professional physicians' organizations

B) State Nurse Practice Acts

C) The Joint Commission

D) The Agency for Health Care Research and Quality

E) The Patient Health Partnership

Ans: B, C, D

Feedback:

To plan health care correctly, the nurse must be familiar with standards and agency policies for setting priorities, identifying and recording expected client outcomes, selecting evidence-based nursing interventions, and recording the plan of care. These standards include the law, national practice standards, specialty professional nursing organizations, The Joint Commission, the Agency for Health Care Research and Quality, and employers.

27. In which of the following clients has the order of priorities for nursing diagnoses changed? Select all that apply.

A) A client in a long-term care facility who had a stroke

B) A client who is recovering from a broken leg

C) A client who insists on using the bathroom instead of a bedpan

D) A client who appears confused after taking pain medication

E) A pregnant client whose contractions are progressing as anticipated

Ans: A, C, D

Feedback:

The work of setting priorities demands careful critical thinking. When planning nursing care, the nurse should consider the following: Have changes in the client's health status influenced the priority of nursing diagnoses? Have changes in the way the client is responding to health and illness (or the plan of care) affected those nursing diagnoses that can be realistically addressed? Are there relationships among diagnoses that require that one be worked on before another can be resolved? Do several client problems need to be dealt with together.

28. Which of the following statements accurately describes the impact on nursing of using NIC/NOC standardized languages? Select all that apply.

A) They demonstrate the impact that nurses have on the system of health care delivery.

B) They standardize and define the knowledge base for nursing curricula and practice.

C) They limit the number of appropriate nursing interventions to be selected.

D) They hinder the teaching of clinical decision making to novice nurses.

E) They enable researchers to examine the effectiveness and cost of nursing care.

Ans: A, B, E

Feedback:

Using NIC/NOC standardized language demonstrates the impact that nurses have on the system of health care delivery; standardizes and defines the knowledge base for nursing curricula and practice; facilitates the selection of appropriate nursing interventions; facilitates the teaching of clinical decision making to novice nurses; enables researchers to examine the effectiveness and cost of nursing care; assists educators to develop curricula that better articulate with clinical practice; assists administrators in planning more effectively for staff and equipment needs; promotes the development and use of nursing information systems; and communicates the nature of nursing to the public.

29. Which of the following is a correctly written client goal? Select all that apply.

A) The client will identify five low-sodium foods by October 9.

B) The client will know the signs and symptoms of infection.

C) The client will rate pain as a 3 or less on a 10-point scale by 5 pm today.

D) The client will understand the side effects of digoxin (Lanoxin).

E) The client will eat at least 75% of all meals by May 5.

Ans: A, C, E

Feedback:

Outcomes are client-centered, use action verbs, identify measurable criteria, and include a time frame as to when the outcome should be achieved. A correctly written outcome will identify who (the client) will do what (eat), how well (75%) under what circumstances (not always included), and by when (May 5). Understand and know are vague and are not action-oriented.

30. Which intervention does the nurse recognize as a collaborative intervention?

A) Teach the client how to walk with a three-point crutch gait.

B) Administer spironolactone (Aldactone).

C) Perform tracheostomy care every eight hours.

D) Straight catheterize every six hours.

Ans: A

Feedback:

Collaborative interventions are treatments initiated by other providers, such as pharmacists, respiratory therapists, physical therapists, and other members of the health care team. Teaching the client how to walk with crutches would be a collaborative intervention. Administering medications, performing tracheostomy care, and catheterizing a client require a physician's order and are physician-initiated interventions.

31. Which of the following is a correctly written client goal?

A) The client will eliminate a soft formed stool.

B) The client understands what foods are low in sodium.

C) The client will ambulate 10 feet with a walker by October 12.

D) The client correctly self-administers the morning dose of insulin.

Ans: C

Feedback:

Outcomes are client-centered, use action verbs, identify measureable criteria, and include a time frame as to when the outcome should be achieved. A correctly written outcome will identify who (the client) will do what (ambulate), how well (10 feet), under what circumstances (with a walker), and by when (October 12). Understand is vague and not action-oriented. The outcomes regarding eliminating a stool and self-administering insulin are missing the time frame.

32. The nursing student asks the nurse about nurse-initiated and physician-initiated interventions. Which of the following is a physician-initiated intervention?

A) Teach client how to transfer from bed to chair and chair to bed.

B) Administer oxygen 4 L/min per nasal cannula.

C) Assist the client with coughing and deep breathing every hour.

D) Monitor intake and output every 2 hours.

Ans: B

Feedback:

A physician-initiated intervention is an intervention initiated by a physician in response to a medical diagnosis but carried out by a nurse in response to a physician's order. A physician's order is required for the nurse to administer drugs, such as oxygen. A nurse-initiated intervention is an autonomous action based on scientific rationale that a nurse executes to benefit the client in a predictable way related to the nursing diagnosis and expected outcomes. Nursing-initiated interventions, such as teaching client how to transfer, assisting with coughing and deep breathing, and monitoring intake and output do not require a physician's order.

33. The nurse formulates the following client outcome: Client will correctly draw up morning dose of insulin and identify four signs and symptoms of hypoglycemia by September 7. Which error has the nurse made?

A) Expressed the client outcomes as a nursing intervention

B) Wrote vague outcomes that will confuse other nurses

C) Included more than one client behavior in the outcome

D) Used verbs that are not observable and measurable

Ans: C

Feedback:

Two client behaviors have been included in the outcome statement: drawing up insulin and identifying four signs and symptoms.

34. Which of the following is not appropriate in writing client-centered measurable outcomes?

A) The client or a part of the client

B) A flexible time frame

C) Observable, measurable terms

D) The action the client will perform

Ans: B

Feedback:

In writing client-centered measurable outcomes, a target time is required. This target time specifies when the client is expected to be able to achieve the outcome. The other options given (the client or part of the client; observable and measurable terms; the action the patient will perform) are all part of client-centered measurable outcomes.

35. While developing the plan of care for a new client on the unit the nurse must identify expected outcomes that are appropriate for the new client. What is a resource for identifying these appropriate outcomes?

A) Community Specific Outcomes Classification (CSO)

B) The Nursing-Sensitive Outcomes Classification (NOC)

C) State Specific Nursing Outcomes Classification (SSNOC)

D) Department of Health and Human Resources Outcomes Classification (HHROC)

Ans: B

Feedback:

Resources for identifying appropriate expected outcomes include the Nursing-Sensitive Outcomes Classification (NOC) (Chart 3-6) and standard outcome criteria established by health care agencies for people with specific health problems. The other options are incorrect because they do not exist.

Chapter 17, Implementing

1. A client being prepared for discharge to his home will require several interventions in the home environment. The nurse informs the discharge planning team, consisting of a home health care nurse, physical therapist, and speech therapist, of the client's discharge needs. This interaction is an example of which professional nursing relationship?

A) Nurse-health care team

B) Nurse-patient

C) Nurse-patient-family

D) Nurse-nurse

Ans: A

Feedback:

A nurse-health care team professional relationship occurs when the nurse coordinates the input of the multidisciplinary team into a comprehensive plan of care. The nurse may also serve as a liaison between the client and family and the health care team, as necessary.

2. A graduate nurse recently attended a conference on acute coronary syndrome. In preparing a plan of care for a client admitted with acute coronary syndrome, the nurse considers the information she learned at the conference. Which nursing variable is the nurse utilizing in the development of the plan of care?

A) Research findings

B) Resources

C) Current standards of care

D) Ethical and legal guides to practice

Ans: A

Feedback:

Nurses concerned about improving the quality of nursing care use research findings to enhance their nursing practice. Reading professional journals and attending continuing education workshops and conferences are excellent ways to learn about new nursing strategies that have proved effective.

3. The American Nurses Association recommends adherence to defined principles when delegating care tasks to unlicensed assistive personnel. According to these principles, who is responsible and accountable for nursing practice?

A) The registered nurse

B) The American Nurses Association

C) The nurse manager

D) The unit's medical director

Ans: A

Feedback:

It is the registered nurse who is responsible and accountable for nursing practice.

4. An older adult client is receiving care on a rehabilitative medicine unit during her recovery from a stroke. She complains that the physical therapist, occupational therapist, neurologist, primary care physician, and speech language pathologist "don't seem to be on the same page" and that "everyone has their own plan for me." How can the nurse best respond to the client's frustration?

A) Facilitate communication between the different professionals and attempt to coordinate care.

B) Educate the client about the unique scope and focus of each member of the healthvcare team.

C) Modify the client's plan of care to better reflect the commonalities between the different disciplines.

D) Arrange for each professional to perform bedside assessments and interventions simultaneously rather than individually.

Ans: A

Feedback:

Nurses play a pivotal role in the coordination of care and often need to facilitate communication between members of different disciplines. Educating the client about the role of each professional may be useful, but it does not achieve coordination of care. Similarly, amending the client's plan of care will not create unity and collaboration. It is unrealistic to expect each member of the care team to always visit simultaneously.

5. A male client 30 years of age is postoperative day 2 following a nephrectomy (kidney removal) but has not yet mobilized or dangled at the bedside. Which of the following is the nurse's best intervention in this client's care?

A) Educate the client about the benefits of early mobilization and offer to assist him.

B) Respect the client's wishes to remain in his bed and ask him when he would like to begin mobilizing.

C) Show the client the expected outcomes on his clinical pathway that relate to mobilization.

D) Document the client's noncompliance and reiterate the consequences of delaying mobilization.

Ans: A

Feedback:

Educating the client about the benefits of mobilizing, and offering to assist combines teaching with the promotion of self-care. It is likely premature to label the client as noncompliant, and showing him the expected outcomes on his clinical pathway is unlikely to motivate him if he is reluctant. It is appropriate for the nurse to educate and encourage the client rather than simply accepting his refusal and providing no other interventions.

6. Many of the homeless clients who are supposed to receive care for HIV/AIDS miss their appointments at a clinic because it is located in a high-rise building on a university campus. Several of the clients state that the clinic is difficult to find and in an intimidating environment. This demonstrates that which of the following variables influencing outcome achievement is being inadequately addressed?

A) Psychosocial background of clients

B) Developmental stage of clients

C) Ethical and legal considerations

D) Resources

Ans: A

Feedback:

Requiring clients to attend a clinic that is difficult to access, and located in a daunting environment, shows a lack of consideration for clients' psychosocial backgrounds. Resources, development, and ethics are not central to this lapse in care.

7. A female client 89 years of age has been admitted to the hospital with a diagnosis of failure to thrive. She has become constipated in recent days, in spite of maintaining a high fluid intake and taking oral stool softeners. She admits to her nurse that the problem is rooted in the fact that she feels mortified to attempt a bowel movement on a commode at her bedside where staff and other clients can hear her. The nurse should respond by modifying which of the following resources?

A) Environment

B) Personnel

C) Equipment

D) Patient and visitors

Ans: A

Feedback:

Providing an environment for the client that is more conducive to privacy and, ultimately, to her elimination needs is necessary in this case. The equipment itself (i.e., the commode) is not the problem, but rather its proximity to others. The staff and the client herself are not central to the client's new problem.

8. What is the unique focus of nursing implementation?

A) Client response to health and illness

B) Client response to nursing diagnosis

C) Client compliance with treatment regimen

D) Client interview and physical assessment

Ans: A

Feedback:

In all nurse–client interactions, the nurse is concerned with the client's response to health and illness and the nurse's ability to meet basic human needs. Whereas other health care professionals focus on selected aspects of the client's treatment regimen, nurses are concerned with how the client is responding to the plan of care in general.

9. The researchers developing classifications for interventions are also committed to developing a classification of which of the following?

A) Diagnoses

B) Outcomes

C) Goals

D) Data clusters

Ans: B

Feedback:

The researchers involved in the development of NICs are also committed to developing a classification of client outcomes for nursing interventions, called Nursing Outcomes Classifications (NOCs). This research aims to identify, label, validate, and classify nursing-sensitive client outcomes and indicators, evaluate the validity and usefulness of the classification in clinical field-testing, and define and test measurement procedures for the outcomes and indicators.

10. What activity is carried out during the implementing step of the nursing process?

A) Assessments are made to identify human responses to health problems.

B) Mutual goals are established and desired client outcomes are determined.

C) Planned nursing actions (interventions) are carried out.

D) Desired outcomes are evaluated and, if necessary, the plan is modified.

Ans: C

Feedback:

During the implementing step of the nursing process, nursing actions (interventions) planned during the planning step are carried out.

11. What role of the nurse is crucial to the prevention of fragmentation of care?

A) Advocate

B) Educator

C) Counselor

D) Coordinator

Ans: C

Feedback:

One of nursing's major contributions to the health care team is the role of coordinator. Care can easily become fragmented when clients are seen by numerous specialists—each interested in a different aspect of the client. It is important for the nurse to make rounds with other health care professionals and to read the results of consultations that clients have had with specialists. They can then interpret the specialists' findings for clients and family members, prepare clients to participate maximally in the plan of care before and after discharge, and serve as a liaison among the members of the health care team.

12. A nurse is changing a sterile pressure ulcer dressing based on an established protocol. What does this mean?

A) The nurse is using critical thinking to implement the dressing change.

B) The client has specified how the dressing should be changed.

C) Written plans are developed that specify nursing activities for this skill.

D) The physician verbally requested specific steps of the dressing change.

Ans: C

Feedback:

Protocols (written plans that detail the nursing activities to be executed in specific situations) are nurse-initiated interventions. They expand the scope of nursing practice in certain clearly defined situations.

13. A client who was previously awake and alert suddenly becomes unconscious. The nursing plan of care includes an order to increase oral intake. Why would the nurse review the plan of care?

A) To implement evidence-based practice

B) To ensure the order follows hospital policy

C) To be sure interventions are individualized

D) To be sure the intervention is safe

Ans: D

Feedback:

Nurses reassess the client and review the plan of care before initiating any nursing intervention. This is done to make sure that the plan of care is still responsive to the client's needs, and is safe for the particular client. In this case, the nurse would not give oral fluids to an unconscious client.

14. A nurse is preparing to insert an intravenous line and begin administering intravenous fluids. The client has visitors in the room. What should the nurse do?

A) Ask the visitors to leave the room.

B) Ask the client if visitors should remain in the room.

C) Tell the client to ask the visitors to leave the room.

D) Wait until the visitors leave to begin the procedure.

Ans: B

Feedback:

If visitors are in the client's room, check with the client to see whether she or he wants the visitors to stay during the procedure.

15. A student is ambulating a client for the first time after surgery. What would the student do to anticipate and plan for an unexpected outcome?

A) Take the client's vital signs after ambulation.

B) Ask the client's wife to assist with ambulation.

C) Delay ambulation until the following shift.

D) Ask another student to help with ambulation.

Ans: D

Feedback:

Unexpected outcomes do occur, such as the risk of a fall for the postoperative client who is ambulated for the first time. In anticipation, the student caregiver could ask another student to help ambulate the client, thus decreasing this risk.

16. The staff in a long-term care facility often plays loud rock music on the radio and designs children's games as exercise. What is the staff doing in this situation?

A) Considering the hearing level of older adults

B) Failing to consider visual deficits that occur with aging

C) Ignoring the developmental needs of older adults

D) Meeting needs for sensory input and exercise

Ans: C

Feedback:

Nurses must be careful not to let stereotypes about developmental stages and tasks influence client care. Playing loud rock music and designing children's games ignore the older adults' needs and is demeaning.

17. A nurse administers a medication for pain but forgets to document it in the client's medical record. Legally, what does this mean?

A) Nothing, the nurse's honesty will not be questioned.

B) The nurse can add the documentation after the client goes home.

C) The physician will verify that the nurse carried out the order.

D) In the eyes of the law, if it is not documented, it was not done.

Ans: D

Feedback:

Nurses must carefully document each intervention. The legal truth is "if it wasn't documented, it wasn't done."

18. A nurse delegates a specific intervention to a UAP. What implications does this have for the nurse?

A) The UAP is responsible and accountable for his or her own actions.

B) Nurses do not have authority to delegate interventions.

C) The nurse transfers responsibility but is accountable for the outcome.

D) The UAP can function in an independent role for all interventions.

Ans: C

Feedback:

UAPs are trained to function in an assistive role to the RN in client activities as delegated and supervised by the RN. Delegation is the transfer of responsibility of an activity to another individual while retaining accountability for the outcome.

19. A nurse on duty finds that a client is anxious about the results of laboratory testing. Which intervention by the nurse reflects a supportive intervention?

A) Sitting with the client to encourage her to talk

B) Telling the laboratory technician to speed up the results

C) Calling the physician for an order for an anxiolytic

D) Educating the client about reducing risk factors

Ans: A

Feedback:

Supportive interventions include recognizing the need for encouragement, unconditional acceptance of behaviors, and the positive effects of being present for clients during stress or crisis. To support the anxious client, the nurse should sit with her and encourage her to talk. Telling the laboratory technician to speed up the results, or calling the physician and taking orders for anxiolytics are inappropriate supportive interventions. Educating the client about reducing risk factors is an educational intervention.

20. Educating clients on their diabetic regimen of administering insulin is the implementation of which skill?

A) Intrinsic

B) Technical

C) Interpersonal

D) Visual

Ans: B

Feedback:

The administration of insulin is a technical skill. Technical competence means being able to use equipment, machines, and supplies in a particular specialty.

21. A registered nurse who provides care in a subacute setting is responsible for overseeing and delegating to unlicensed assistive personnel (UAP). Which of the following principles should the nurse follow when delegating to UAP? Select all that apply.

A) Ensure that UAPs closely follow the nursing process when providing care.

B) Audit the client documentation that UAPs record after they perform interventions.

C) Take frequent mini-reports from UAPs to ensure changes in client status are identified.

D) Know what clinical cues the UAP should be alert for and why.

E) Make frequent walking rounds to assess clients.

Ans: C, D, E

Feedback:

The nurse must take careful action to ensure that delegation results in safe and competent client care. This necessitates such measures as taking frequent mini-reports, identifying the clinical cues that UAPs should be aware of, and performing rounds often. UAPs are not normally educated to follow the nursing process nor to perform documentation.

22. Which of the following statements accurately describes a recommended guideline for implementation? Select all that apply.

A) When implementing nursing care, remember to act independently, regardless of the wishes of the client/family.

B) Before implementing any nursing action, reassess the client to determine whether the action is still needed.

C) Assume that the nursing intervention selected is the best of all possible alternatives.

D) Consult colleagues and the nursing and related literature to see if other approaches might be more successful.

E) Reduce your repertoire of skilled nursing interventions to ensure a greater likelihood of success.

Ans: B, D

Feedback:

When implementing nursing care, the nurse should act in partnership with the client/family and reassess the client to determine if the nursing action is still needed. The nurse should always question that the nursing intervention selected is the best of all possible alternatives. The nurse should consult colleagues and related nursing literature to see if other approaches might be more successful. The nurse should develop a repertoire of skilled nursing interventions, and check to make sure that the ones selected are consistent with standards of care and within legal/ethical guidelines to practice.

23. Which example reflects client variables that influence outcome achievement? Select all that apply.

A) The client was born with cystic fibrosis.

B) The nurse works at a hospital in a diverse community.

C) Nursing interventions are consistent with standards of care.

D) The client is a college graduate and is employed.

E) The client engages in activities associated with Ramadan.

Ans: A, D, E

Feedback:

Important client variables that influence outcome achievement include the physical health of the client, level of education attained, and cultural practices that impact life and health practices. Nurse variables, such as working in a diverse community, and standards of practice also influence client outcome achievement.

24. The nurse is trying to determine factors influencing a client who is not following the plan of care. Which client statement identifies a potential factor interfering with following the plan of care? Select all that apply.

A) I don’t drive so I was unable to fill my prescription.

B) I consult the list of low sodium foods when preparing meals.

C) My social security check does not come until next week.

D) I dropped the strips for my finger-stick blood glucose testing in the bath water.

E) "My daughter helps me with my range of motion exercises every morning and afternoon."

Ans: A, C, D

Feedback:

Common factors that contribute to a client not following the plan of care include inability to afford treatment (social security check) and limited access to treatment (doesn't drive; damaged testing strips).

25. The nurse is caring for a client with a diagnosis of end-stage renal disease. The client has expressed the desire to be kept comfortable and to not continue further treatment. The daughter arrives from out of town and is demanding to have further testing done to determine the best treatment option for the client. What is the best action for the nurse to take at this time?

A) Explain to the daughter the wishes of the client.

B) Arrange a meeting between the physician and daughter.

C) Contact the imaging center to schedule the testing.

D) Persuade the client to agree to the daughter's request.

Ans: A

Feedback:

The priority is for the nurse to explain to the daughter the wishes of the client and support the client's decision. As an advocate, the nurse implements actions to protect the rights of the client. The other options do not support the client's decision.

26. Which is a responsibility of the nurse in the nurse-client-family team relationship?

A) Provide creative leadership to make the nursing unit a satisfying and challenging place to work.

B) Support the nursing care given by other nursing and non-nursing personnel.

C) Educate the family to be informed and assertive consumers of health care.

D) Coordinate the inputs of the multidisciplinary team into a comprehensive plan of care.

Ans: C

Feedback:

Educating the family to be informed and assertive consumers of health care is a role responsibility in the nurse-client-family relationship. Responsibilities of the nurse in the nurse-health care team relationship include coordinating the inputs of the multidisciplinary team into a comprehensive plan of care. In the nurse-nurse relationship, the nurse provides creative leadership to make the nursing unit a satisfying and challenging place to work, and supports the nursing care given by other nursing personnel.

27. The nurse is caring for a client with a diagnosis of colon disease. The client has expressed to various members of the health care team the desire to be kept comfortable and to not continue further treatment. The client asks the nurse to be present when the client discusses the decision with other family members. In which professional nursing relationship is the nurse participating?

A) Nurse-client

B) Nurse-nurse

C) Nurse-client-family

D) Nurse-health care team

Ans: C

Feedback:

The nurse is fulfilling role responsibilities of the nurse-client-family relationship when being present for a discussion of the matter by the client and family.

28. The nurse is delegating to the unlicensed assistive personnel (UAP). What is the best instruction by the nurse?

A) Notify me right away if the client's systolic blood pressure is 170 or greater.

B) Let me know if the client's blood pressure becomes elevated.

C) If the client's blood pressure falls outside normal limits, come get me.

D) I need to know if the client's blood pressure changes from his normal baseline.

Ans: A

Feedback:

When delegating tasks, it is essential for the nurse to give clear instructions to the person to whom the task is being delegated. The statement, which includes specific parameters for the systolic blood pressure, clearly identifies what the UAP should be alerted to and the subsequent action to take. The other three options are vague and do not provide adequate direction for the UAP.

29. The nursing student is caring for a Native American client who is admitted for deep vein thrombosis. The nursing student speaks with a nurse regarding the client's lack of eye contact with the student. The nurse responds that Native Americans view eye contact as an invasion of privacy. Which error did the nursing student make?

A) Failure to act in partnership with the client.

B) Failure to approach the client caringly.

C) Failure to seek the client's input in the plan of care.

D) Failure to provide culturally sensitive care.

Ans: D

Feedback:

The nursing student failed to provide culturally sensitive care by expecting the client to engage in eye contact. There is no information to suggest the nursing student failed to act in partnership with the client, approach the client caringly, or seek the client's input in the plan of care.

30. The nurse is preparing to implement plans of care with several clients. Which action would be inappropriate for the nurse to perform?

A) Ask the English-as-a-Second-Language (ESOL) client to state in his or her own words what it means to be NPO.

B) Seek input from the family of how the client with aphasia normally communicates at home.

C) Respond to the postoperative client's question that baths are given only in the morning.

D) Request that family members provide ethnic/cultural foods of the African client's liking.

Ans: C

Feedback:

Guidelines for implementing indicate that the nurse implements care that is culturally sensitive and individualized for the client. The nurse forms a partnership with the client and family when implementing care. The response by the nurse indicating a set time for baths is not reflective of being open to individualizing client care. The other options are consistent with the guidelines for implementing.

31. Nursing students need to learn to nurse themselves in order to prepare to be professional nurses. Which activities would fail to prepare nursing students for the delivery of nursing care?

A) Time management, communication, and establishing a support system.

B) Establishing a support system, a sense of humor, and self-awareness.

C) Self-awareness, preparation for crisis, and stress management.

D) A sense of humor, anticipation of loss, and developing negative body image.

Ans: D

Feedback:

Activities that would prepare nursing students for the delivery of nursing care include time management, communication, establishing a support system, self-awareness, stress management, a sense of humor, and preparation for crisis and loss. Negative body image is not desired.

32. The nurse is assessing a client with a diagnosis of hypertension. The client's blood pressure is 178/88, an increase from 134/78 at the previous clinic visit. The nurse asks the client what has changed from the previous visit. Which client statement identifies a potential factor interfering with the plan of care?

A) My husband has been ill and I don't have anyone to help me care for him.

B) I have learned to prepare foods differently so they are low in fat.

C) My neighbor walks with me around the neighborhood every morning.

D) I have been taking my hydrochlorothiazide (HydroDIURIL) every day.

Ans: A

Feedback:

Common factors that contribute to a client not following the plan of care include lack of family support, inability to afford treatment, limited access to treatment, and adverse physical or emotional effects of treatment. The burden of caring for her husband may be placing stress on the client, and causing her blood pressure to be elevated despite engaging in health promotion and blood pressure-lowering activities.

33. The nurse overhears two nursing students talking about nursing interventions. Which statement by one of the nursing students indicates further education is required?

A) Nursing interventions must be consistent with standards of care and research findings.

B) Nursing interventions must be culturally sensitive and individualized for the client.

C) Nursing interventions must be compatible with other therapies planned for the client.

D) Nursing interventions must be approved by other members of the health care team.

Ans: D

Feedback:

Nursing interventions should be based on the etiology in the nursing diagnosis, be compatible with other planned therapies, be consistent with standards of care and research, and individualized for the client. Nursing interventions can

be independent, dependent, and interdependent. Independent nursing interventions are nurse-initiated interventions directed at the etiology of the client problem; they do not require approval from other members of the health care team.

34. Each time a nurse administers an insulin injection to a client with diabetes, she tells the client what she is doing and demonstrates each step of preparing and giving the injection. What is the nurse promoting in the client?

A) Self-care

B) Dependence

C) Competence

D) Discipline

Ans: A

Feedback:

The plan of nursing care should include specific instructions for education/learning needs of the client to promote self-care and independence. Competency pertains to the nurse's ability (knowledge, skills, and attitudes) to provide safe and effective care. The nurse's role includes education, counseling, and advocating, but not providing discipline to clients.

35. What characteristic of a competent nurse practitioner enables nurses to be role models for clients?

A) Sense of humor

B) Writing ability

C) Organizational skills

D) Good personal health

Ans: D

Feedback:

Good personal health enables nurses not only to practice more efficiently, but also to be a health model for clients and their families. Nurses can help clients to imitate good health behaviors, and eventually integrate them into their daily life through the process of identification.

Chapter 18, Evaluating

1. Upon evaluation of the client's plan of care, the nurse determines that the expected outcomes have been achieved. Based upon this response, the nurse will do what?

A) Terminate the plan of care.

B) Modify the plan of care.

C) Continue the plan of care.

D) Re-evaluate the plan of care.

Ans: A

Feedback:

The nurse will terminate the plan of care when each expected outcome has been achieved. Modifying the plan of care is necessary if there are difficulties in achieving the outcomes. Re-evaluating each step of the nursing process is a step in the modification of a plan of care. Continuing the plan of care occurs if more time is needed to achieve the outcomes.

2. Nursing care and client outcomes may be evaluated by use of a retrospective evaluation process. Which of the following is an example of a retrospective evaluation process?

A) Postdischarge questionnaire.

B) Direct observation of nursing care.

C) Client interview during hospitalization.

D) Review of client's chart during hospitalization.

Ans: A

Feedback:

Retrospective evaluation may use postdischarge questionnaires and client interviews, or chart reviews after the client has been discharged. Concurrent evaluation occurs while the client is receiving care and may include the following: direct observation of nursing care and client interviews; and direct observation of chart reviews during hospitalization.

3. An older adult client has lost significant muscle mass during her recovery from a systemic infection. As a result, she has not yet met the outcomes for mobility and activities of daily living that are specified in her nursing plan of care. How should her nurses best respond to this situation?

A) Continue the plan of care with the aim of helping the client achieve the outcomes.

B) Terminate the plan of care since it does not accurately reflect the client's abilities.

C) Modify the plan of care to better reflect the client's current functional ability.

D) Replace the client's individualized plan of care with a clinical pathway.

Ans: A

Feedback:

Nurses regularly evaluate clients' progression toward the achievement of outcomes that are specified in plans of care. When clients need more time to achieve desired outcomes, it is appropriate to continue with the existing plan of care. It is not necessary to terminate the plan of care and modification may be premature. Abandoning the plan and replacing it with a clinical pathway is counterproductive to the continuity of care.

4. The nurse has responded to a client's request to view her medical chart by arranging a meeting between the client, the clinical nurse leader, and her primary care physician. The nurse is exemplifying which of the following characteristics of quality health care?

A) Information

B) Science

C) Cooperation

D) Individualization

Ans: A

Feedback:

The Institute of Medicine's Committee on Quality Health Care in America has identified aspects of care that clients can reasonably expect. One of these expectations is information, which is manifested by allowing clients access to their medical records. Other characteristics that clients can expect are knowledge-based care (science), coordination between professionals (cooperation), and respect for client choices and preferences (individualization).

5. Nurses have identified the following outcome in the care of a client who is recovering from a stroke: "Client will ambulate 100 feet without the use of mobility aids by 12/12/2011." Several nurses have evaluated the client's

progression towards this outcome at various points during her care. Which of the following evaluative statements is most appropriate?

A) "12/12/2011 – Outcome partially met. Patient ambulated 75 feet without the use of mobility aids"

B) "12/12/2011 – Outcome unmet. Patient's ambulation remains inadequate."

C) "12/10/2011 Outcome met, but with the use of a quad cane to assist ambulation."

D) "12/14/2011 Outcome met."

Ans: A

Feedback:

An evaluative statement should include both the decision about how well the outcome was met along with data that support this decision. Characterizing the client's ambulation as "inadequate" is not sufficiently precise. Stating that this outcome was met with the use of a cane contradicts the original terms of the outcome.

6. The nurse witnessed a more senior nurse make six unsuccessful attempts at starting an intravenous (IV) line on a client. The senior nurse persisted, stating, "I refuse to admit defeat." This resulted in unnecessary pain for the client. How should the first nurse best respond to this colleague's incompetent practice?

A) Report the nurse's practice and have the nurse manager address the matter.

B) Encourage the nurse to attend an in-service on IV starts.

C) Reassure the nurse that this is a difficult skill and give her feedback on her performance.

D) Document an unmet outcome in the client's plan of care.

Ans: A

Feedback:

According to the study *Silence Kills: The Seven Crucial Conversations for Healthcare* (Maxfield, Grenny, Patterson, McMillan, & Switzler, 2005), an appropriate response to incompetence is to report the matter and enlist the manager to conduct follow-up. Reassuring the nurse and encouraging education are not sufficient responses to incompetence. This action does not constitute an unmet outcome on the part of the client.

7. The manager of a medical unit regularly reviews the incident reports that result from errors and near misses that occur on the unit. How should the manager best respond to these incident reports?

A) Use them to inform improvements and education on the unit.

B) Use them to identify deficient workers for removal or demotion.

C) Cross-reference them with client satisfaction reports from the unit.

D) Use them to identify individuals who would benefit from probationary measures.

Ans: A

Feedback:

It is most beneficial for the manager to frame incident reports as sources of improvement, which can improve both client care and the work environment. Punitive follow-up by demotion, probation, or removal is likely to create reluctance among staff to complete incident reports. Cross-referencing incident reports with client satisfaction reports is unlikely to result in substantial improvements to the unit's care and culture.

8. What cognitive processes must the nurse use to measure client achievement of outcomes during evaluation?

A) Intuitive thinking

B) Critical thinking

C) Traditional knowing

D) Rote memory

Ans: B

Feedback:

Each element of evaluation requires the nurse to use critical thinking about how best to evaluate the client's progress toward valued outcomes.

9. A nurse is evaluating the outcomes of a plan of care to teach an obese client about the calorie content of foods. What type of outcome is this?

A) Psychomotor

B) Affective

C) Physiologic

D) Cognitive

Ans: D

Feedback:

Cognitive goals involve increasing client knowledge. These goals may be evaluated by asking clients to repeat information or to apply new knowledge in their everyday lives.

10. A nurse is educating a client on how to administer insulin, with the expected outcome that the client will be able to self-administer the insulin injection. How would this outcome be evaluated?

A) Asking the client to verbally repeat the steps of the injection

B) Asking the client to demonstrate self-injection of insulin

C) Asking family members how much trouble the client is having with injections

D) Asking the client how comfortable he or she is with injections

Ans: B

Feedback:

Psychomotor outcomes describe the client's achievement of new skills and are evaluated by asking the client to demonstrate the new skill.

11. A nurse in a community health center has been having regular meetings with a woman who wants to stop smoking. Which of the following outcome decision options would the nurse document if the woman has not smoked for three months?

A) Outcome met

B) Outcome partially met

C) Outcome not met

D) Outcome inappropriate

Ans: A

Feedback:

After data have been collected and interpreted to determine client outcome achievement, the nurse makes and documents a judgment summarizing the findings. The three decision options are met, partially met, and not met. In this case, the nurse's judgment is that the client has met the expected outcome of smoking cessation.

12. A nurse is interested in improving client care on the unit through performance improvement. What is the first step in this process?

A) Discover the problem.

B) Plan a strategy.

C) Implement a change.

D) Assess the change.

Ans: A

Feedback:

Each nurse must decide how to respond when he or she perceives that client care is being compromised. The four steps listed are all components of the process of performance improvement, with discovering the problem being the first step.

13. A nurse forgets to raise the bed railings of a client who is confused after taking pain medications. The client attempts to get out of bed, and suffers a minor fall. The nurse asks a colleague who witnessed the fall not to mention it to anyone because the client only had minor bruises. What would be the appropriate action of the colleague?

A) No other steps need to be taken, since the client was not seriously injured.

B) The colleague should inform the nurse that a full report of the incident needs to be made.

C) The colleague should monitor the client closely for any adverse effects of the fall.

D) The colleague should report the incident in a peer review of the nurse.

Ans: B

Feedback:

The colleague should tell the nurse that a full report needs to be made. If appropriate, the colleague could help the nurse identify what contributed to her not raising the bed railings in an effort to prevent it from happening in the future.

14. A nurse is evaluating and revising a plan of care for a client with cardiac catheterization. Which of the following actions should the nurse perform before revising a plan of care?

A) Discuss any lack of progress with the client.

B) Collect information on abnormal functions.

C) Identify the client's health-related problems.

D) Select appropriate nursing interventions.

Ans: A

Feedback:

The nurse should discuss any lack of progress with the client so that both the client and the nurse can speculate on what activities need to be discontinued, added, or changed. Collecting information on abnormal functions and risk factors is done during the assessment. Identification of the client's health-related problems is done during diagnosis. Nurses select appropriate nursing interventions and document the plan of care in the planning stage of the nursing process, not during evaluation.

15. When a charge nurse evaluates the need for additional staff nurses and additional monitoring equipment to meet the client's needs, the charge nurse is performing an evaluation termed …

A) process evaluation

B) structure evaluation

C) outcome evaluation

D) summary evaluation

Ans: B

Feedback:

Structure evaluation focuses on the attributes of the setting or surroundings where health care is provided.

16. When a nursing supervisor evaluates the staff nurse's performance with a group of clients to whom the staff nurse has provided nursing care, the supervisor is performing which type of evaluation?

A) Outcome evaluation

B) Summary evaluation

C) Structure evaluation

D) Process evaluation

Ans: D

Feedback:

Process evaluation focuses on the nurse's performance and whether the nursing care provided was appropriate and competent.

17. A nurse working in a hospital setting discovers problems with the delivery of nursing care on the pediatric unit. Which of the following suggestions from the Institute of Medicine's Committee on Quality of Health Care in America (Kohn, Corrigan, & Donaldson, 2000) could help redesign and improve care? Select all that apply.

A) Base care on continuous healing relationships.

B) Customize care based on available resources.

C) Keep the nurse as the source of control.

D) Share knowledge and allow for free flow of information.

E) Practice evidence-based decision making.

Ans: A, D, E

Feedback:

The Institute of Medicine's Committee on Quality of Health Care in America (Kohn, Corrigan, & Donaldson, 2000) suggests 10 new rules to redesign and improve care: (1) care based on continuous healing relationships, (2) customization based on client needs and values, (3) the client as the source of control, (4) shared knowledge and the free flow of information, (5) evidence-based decision making, (6) safety as a system property, (7) the need for transparency, (8) anticipation of needs, (9) continuous decrease in waste, and (10) cooperation among clinicians.

18. A nurse is counseling a novice nurse who gives 150% effort at all times and is becoming frustrated with a health care system that provides substandard care to clients. Which of the following advice would be appropriate in this situation? Select all that apply.

A) Tell the new nurse to help other nurses perform their jobs, thus ensuring quality client care is being delivered.

B) Encourage the new nurse to leave her problems at work behind, instead of rehashing them at home.

C) After establishing a reputation for delivering quality nursing care, have her seek creative solutions for nursing problems.

D) Tell her to view nursing care concerns as challenges rather than overwhelming obstacles, and seek help for solutions.

E) State that if resources do not permit quality care, it is not the role of the new nurse to explore change strategies within the institution.

Ans: B, C, D

Feedback:

The following items are good advice for nurses experiencing burnout: Learn to give quality care during designated work period; leave on time; avoid the temptation to do the work of others; and leave work concerns at work. After establishing a reputation for delivering quality nursing care, seek creative solutions for nursing problems (strategies to increase nursing resources, motivation, morale) and try them — hopefully with a support network. View concerns as challenges rather than overwhelming obstacles. Develop a realistic sense of how much nursing care (and of what quality) can be delivered with existing resources. If resources do not permit quality care, explore change strategies within the institution. If administration is not supportive, explore other practice settings.

19. Which activity does the nurse perform during the evaluating stage? Select all that apply.

A) Validates with the client the problem of constipation.

B) Collects data to determine the number of catheter-associated infections on the nursing unit.

C) Increases the frequency of repositioning from every two hours to every one hour.

D) Sets a goal of ambulating from bed to room door and back to bed.

E) Identifies smoking and sedentary lifestyle as risk factors for hypertension.

Ans: B, C

Feedback:

During the evaluation stage, the nurse modifies the plan of care if desired outcomes are not achieved (increased frequency of repositioning) and collects data, such as number of infections, to monitor quality and effectiveness of nursing practice. During the diagnosis stage, the nurse identifies factors contributing to the client's health problem, such as smoking and sedentary lifestyle, and validates the identified health problems (such as constipation) with the clients. The nurse establishes plan priorities and sets goals with the client and family during the outcome identification and planning.

20. Which activity does the nurse engage in during evaluation? Select all that apply.

A) Collect data to determine whether desired outcomes are met.

B) Assess the effectiveness of planned strategies.

C) Adjust the time frame to achieve the desired outcomes.

D) Involve the client and family in formulating desired outcomes.

E) Initiate activities to achieve the desired outcomes.

Ans: A, B, C

Feedback:

The nurse establishes desired outcomes with the client and family during the outcome identification and planning stage. The nurse initiates activities to achieve the desired outcomes during the implementation stage. During the evaluation stage, the nurse collects data to determine whether desired outcomes are met, assesses the effectiveness of planned strategies, and adjusts the time frame to achieve the desired outcomes.

21. Which client outcome is a physiologic outcome? Select all that apply.

A) The client's HA1c is 7.4%.

B) The client's blood pressure is 118/74.

C) The client rates his or her pain rating as 6.

D) The client self-administers insulin subcutaneously.

E) The client describes manifestations of wound infection.

Ans: A, B, C

Feedback:

Physiologic outcomes are physical changes in the client, such as pain ratings and blood pressure and HA1c measurements. Psychomotor outcomes describe the client's achievement of new skills, such as insulin administration. Cognitive outcomes demonstrate gains in client knowledge, such as manifestations of infection.

22. Which activity is a possible solution for inadequate nursing staffing?

A) Identify the kind and amount of nursing services required.

B) Learn to give quality care during designated work period.

C) Use a team conference to develop a consistent plan of care.

D) Educate the client to become an assertive health care consumer.

Ans: A

Feedback:

A possible solution for inadequate staffing is to identify the kind and amount of nursing services required. Using a team conference to develop a consistent plan of care is a possible solution for the client who refused to cooperate with the therapeutic regimen. Educating the client to become an assertive health care consumer is a possible solution for the client who quietly accepts whatever care is delivered or not delivered. A possible solution for the nurse who is a candidate for burnout is to learn to give quality care during the designated work period.

23. The nurse assesses urine output following administration of a diuretic. Which step of the nursing process does this nursing action reflect?

A) Assessment

B) Outcome identification

C) Implementation

D) Evaluation

Ans: D

Feedback:

Assessing the client's response to a diuretic medication is an example of evaluation. During assessment, the nurse collects and synthesizes data to identify patterns. The nurse establishes desired outcomes with the client and family

during the outcome identification and planning stage. The nurse initiates activities to achieve the desired outcomes during the implementation stage.

24. The nurse participates in a quality assurance program. Data from the previous year indicates a 2% reduction in the number of repeat admissions for clients who underwent hip replacement surgery. The nurse recognizes this is which type of evaluation?

A) Design evaluation

B) Process evaluation

C) Outcome evaluation

D) Structure evaluation

Ans: C

Feedback:

Quality assurance programs focus on three types of evaluation: structure, process, and outcome. Outcome evaluation focuses on measurable changes in the health status of clients, such as a 2% reduction in the number of repeat admissions for clients who underwent hip replacement surgery. Structure evaluation focuses on the environment in which care is provided, whereas process evaluation focuses on the nature and sequence of activities carried out by implementing the nursing process. There is no design evaluation.

25. The nurse participates in a quality assurance program and reviews evaluation data for the previous month. Which of the following does the nurse recognize as an example of process evaluation?

A) A 10% reduction in the number of ventilator-associated pneumonia

B) A 5% increase in the number of nosocomial catheter-related urinary tract infections

C) 40% of all client rooms in the facility are private and equipped with a computer

D) A nursing care plan was developed within the eight hours of admission for 97% of all admissions.

Ans: D

Feedback:

Process evaluation focuses on the nature and sequence of activities carried out by nurses implementing the nursing process, such as the timing of nursing care plan creation. Quality assurance programs focus on three types of evaluation: structure, process, and outcome. Outcome evaluation focuses on measurable changes in the health status of clients, such as the number of ventilator-associated pneumonia and nosocomial catheter-related urinary tract infections. Structure evaluation focuses on the environment in which care is provided, such as the number of private rooms equipped with a computer.

26. The client's expected outcome is The client will maintain skin integrity by discharge. Which of the following measures is best in evaluating the outcome?

A) The client's ability to reposition self in bed.

B) Pressure-relieving mattress on the bed.

C) Percent intake of a diet high in protein.

D) Condition of the skin over bony prominences.

Ans: D

Feedback:

During evaluation, the nurse collects data and makes a judgment summarizing the findings. In making a decision about how well the outcome was met, the nurse examines client data or behaviors that validate *whether* the outcome is met. The condition of the skin, especially over bony prominences, provides the best measure of whether skin integrity has been maintained.

27. An expected client outcome is, The client will remain free of infection by discharge. When evaluating the client's progress, the nurse notes the client's vital signs are within normal limits, the white blood cell count is 12,000, and the client's abdominal wound has a half-inch gap at the lower end with yellow-green discharge. Which statement would be an appropriate evaluation statement?

A) Goal partially met; client identified fever and presence of wound discharge.

B) Client understands the signs and symptoms of infection.

C) Goal partially met; client able to perform activities of daily living.

D) Goal not met; white blood cell count elevated, presence of yellow-green discharge from wound.

Ans: D

Feedback:

During evaluation, the nurse collects data and makes a judgment summarizing the findings. In making a decision about how well the outcome was met, the nurse has three options: met, partially met, or not met. An elevated white blood cell count and the presence of yellow-green wound discharge are clinical manifestations consistent with an infectious process, so the outcome has not been met.

28. The nurse is caring for a client who is experiencing an asthma attack. Ten minutes after administering an inhaled bronchodilator to the client, the nurse returns to ask if the client's breathing is easier. The nurse is engaging in which phase of the nursing process?

A) Assessment

B) Diagnosing

C) Planning

D) Implementing

E) Evaluating

Ans: E

Feedback:

The nurse is collecting evaluative data to determine whether or not the client is achieving the therapeutic response to the bronchodilator.

29. The nurse is preparing to mail a client satisfaction questionnaire to a client who was discharged from the hospital four days ago. Which type of evaluation is the nurse conducting?

A) Retrospective evaluation

B) Peer review

C) Nursing audit

D) Concurrent evaluation

Ans: A

Feedback:

A retrospective audit uses post-discharge questionnaires to collect data. A nursing audit is a method of evaluating nursing care that involves reviewing client records to assess the outcomes of nursing care (or the process by which these outcomes were achieved). Concurrent evaluation involves direct observations of nursing care, client interviews, and chart review to determine whether the specified evaluative criteria are met. Peer review involves the evaluation of one staff member by another staff member on the same level in the hierarchy of the organization. This is done for the purpose of professional performance improvement.

30. The nurse is caring for the client with pneumonia. An expected client outcome is, The client will maintain adequate oxygenation by discharge. Which outcome criterion indicates the goal is met?

A) Client taking antibiotic as ordered.

B) Client identifies signs and symptoms of recurrence of infection.

C) Client coughing and deep breathing every one hour.

D) Client no longer requires oxygen.

Ans: D

Feedback:

The client who is maintaining adequate oxygenation would not require oxygen. The client could be able to do the other three options and still have problems with oxygenation.

31. The client reports participating in water aerobics for 60 minutes three times each week. This is an example of what type of outcome?

A) Affective outcome

B) Psychomotor outcome

C) Physiologic outcome

D) Cognitive outcome

Ans: A

Feedback:

An affective outcome involves changes in the client's values, beliefs, and attitude, such as participating in water aerobics. Cognitive outcomes demonstrate increases in client knowledge. Physiologic outcomes are physical changes in the client. Psychomotor outcomes describe the client's achievement of new skills.

32. The client's pulse oximetry reading is 97% on room air 30 minutes after removal of a nasal cannula. This is an example of what type of outcome?

A) Affective outcome

B) Psychomotor outcome

C) Physiologic outcome

D) Cognitive outcome

Ans: C

Feedback:

Physiologic outcomes are physical changes in the client, such as pulse oximetry. An affective outcome involves changes in the client's values, beliefs, and attitude. Cognitive outcomes demonstrate increases in client knowledge. Psychomotor outcomes describe the client's achievement of new skills.

33. The nurse is giving a shift report to the oncoming nurse who will be caring for a client with a portacath access device. The oncoming nurse states, I have never taken care of a client with a portacath. Would you give me the basics, so I know what to do? Which standard for establishing and sustaining healthy work environments is the oncoming nurse breaching?

A) Appropriate staffing

B) Effective decision making

C) True collaboration

D) Skilled communication

Ans: A

Feedback:

Appropriate staffing ensures that client needs are effectively matched with nurse competencies. In this scenario, the nurse is ill-prepared to care for the client. The nurse needs structured training to learn about the nursing care of portacaths. Skilled communication requires health team members to communicate in a respectful, non-intimidating manner with colleagues. True collaboration involves skilled communication, mutual respect, shared responsibility, and decision making among nurses, and between nurses and other health team members. Effective decision making ensures nurses are valued and active partners in making policy, directing and evaluating clinical care, and leading organizational operations.

34. The correct sequence of steps for performance improvement is:

1. Discover a problem.

2. Plan a strategy using indicators.

3. Implement a change.

4. Assess the change.

A) 1, 2, 3, 4

B) 1, 4, 2, 3

C) 4, 1, 2, 3

D) 1, 2, 4, 3

E) 1, 3, 2, 4

Ans: A

Feedback:

The correct sequence of steps for performance improvement is (1) discover a problem; (2) plan a strategy using indicators; (3) implement a change; and (4) assess the change; if the change is not met, plan a new strategy.

Chapter 19, Documenting, Reporting, Conferring

1. A client's diagnosis of pneumonia requires treatment with antibiotics. The corresponding order in the client's chart should be written as …

A) Avelox (moxifloxacin) 400 mg daily

B) Avelox (moxifloxacin) 400 mg Q.D.

C) Avelox (moxifloxacin) 400 mg qd

D) Avelox (moxifloxacin) 400 mg OD

Ans: A

Feedback:

Among the JCAHO's list of "do not use" abbreviations are Q.D., qd, and OD when denoting a once-per-day drug administration. Because of the potential for misinterpretation and consequent drug errors, the JCAHO recommends writing "daily" in the order.

2. The nurses who provide care in a large, long-term care facility utilize charting by exception (CBE) as the preferred method of documentation. This documentation method may have which of the following drawbacks?

A) Vulnerability to legal liability since nurse's safe, routine care is not recorded

B) Increased workload for nurses in order to complete necessary documentation

C) Failure to identify and record client problems and associated interventions

D) Significant differences in the charting between nurses due to lack of standardization

Ans: A

Feedback:

A significant drawback to charting by exception is its limited usefulness when trying to prove high-quality safe care in response to a negligence claim made against nursing. CBE is generally less time-consuming than alternate methods of documentation, and both standardization of charting and identification of client-specific problems are possible within this documentation framework.

3. The nurse managers of a home health care office wish to maximize nurses' freedom to characterize and record client conditions and situations in the nurses' own terms. Which of the following documentation formats is most likely to promote this goal?

A) Narrative notes

B) SOAP notes

C) Focus charting

D) Charting by exception

Ans: A

Feedback:

One of the advantages of a narrative notes model of documentation is that it allows nurses to describe clinical encounters in their own terms, as they understand them. Other documentation formats, such as SOAP notes, focus charting, and charting by exception, are more rigidly delineated and allow nurses less latitude in their documentation.

4. A hospital utilizes the SOAP method of charting. Within this model, which of the nurse's following statements would appear at the beginning of a charting entry?

A) "Client complaining of abdominal pain rated at 8/10."

B) "Client is guarding her abdomen and occasionally moaning."

C) “Client has a history of recent abdominal pain.”

D) “2 mg Dilaudid PO administered with good effect”

Ans: A

Feedback:

The SOAP method of charting (Subjective data, Objective data, Assessment, Plan) begins with the information provided by the client, such as a complaint of pain. The nurse’s objective observations and assessments follow, with interventions, actions, and plans later in the charting entry.

5. What is the nurse’s best defense if a client alleges nursing negligence?

A) Testimony of other nurses

B) Testimony of expert witnesses

C) Client’s record

D) Client’s family

Ans: C

Feedback:

The client record is the only permanent legal document that details the nurse’s interactions with the client. It is the best defense if a client or client surrogate alleges nursing negligence.

6. A nurse is documenting the intensity of a client’s pain. What would be the most accurate entry?

A) “Client complaining of severe pain.”

B) “Client appears to be in a lot of pain and is crying.”

C) “Client states has pain; walking in hall with ease.”

D) “Client states pain is a 9 on a scale of 1 to 10.”

Ans: D

Feedback:

Information should be documented in a complete, accurate, relevant, and factual manner. Avoid interpretations of behavior, generalizations, and words such as “good.”

7. Which of the following data entries follows the recommended guidelines for documenting data?

A) “Client is overwhelmed by the diagnosis of pancreatic cancer.”

B) “Client’s kidneys are producing sufficient amount of measured urine.”

C) “Following oxygen administration, vital signs returned to baseline.”

D) “Client complained about the quality of the nursing care provided on previous shift.”

Ans: C

Feedback:

The nurse should record client findings (observations of behavior) rather than an interpretation of these findings, and avoid words such as “good,” “average,” “normal,” or “sufficient,” which may mean different things to different readers.

The nurse should also avoid generalizations such as “seems comfortable today.” The nurse should avoid the use of stereotypes or derogatory terms when charting, and should chart in a legally prudent manner.

8. Alice Jones, a registered nurse, is documenting assessments at the beginning of her shift. How should she sign the entry?

A) Alice J, RN

B) A. Jones, RN

C) Alice Jones

D) AJRN

Ans: B

Feedback:

Each entry is signed with the first initial, last name, and title. In this case, A. Jones, RN, is correct.

9. A student has reviewed a client’s chart before beginning assigned care. Which of the following actions violates client confidentiality?

A) Writing the client’s name on the student care plan

B) Providing the instructor with plans for care

C) Discussing the medications with a unit nurse

D) Providing information to the physician about laboratory data

Ans: A

Feedback:

Students using client records are bound professionally and ethically to keep in strict confidence all the information they learn from those records. The student may discuss care with the instructor, medications with a staff nurse, and laboratory data with the physician. The student should not use actual client names or other identifiers in written assignments or oral reports.

10. A physician’s order reads “up ad lib.” What does this mean in terms of client activity?

A) May walk twice a day

B) May be up as desired

C) May only go to the bathroom

D) Must remain on bed rest

Ans: B

Feedback:

The abbreviation “up ad lib” means the client may be up as desired.

11. In what type of documentation method would a nurse document narrative notes in a nursing section?

A) Problem-oriented medical record

B) Source-oriented record

C) PIE charting system

D) Focus charting

Ans: B

Feedback:

A source-oriented record is one in which each health care group keeps data on its own separate form (e.g., physicians, nurses, and laboratory). Progress notes written by nurses using this method are narrative notes.

12. Which one of the following methods of documentation is organized around client diagnoses rather than around patient information?

A) Problem-oriented medical record (POMR)

B) Source-oriented record

C) PIE charting system

D) focus charting

Ans: A

Feedback:

The POMR is organized around a client's problems rather than around sources of information. With POMRs, all health care professionals record information on the same forms. The advantages of this type of record are that the entire health care team works together in identifying a master list of client problems and contributes collaboratively to the plan of care.

13. A nurse organizes client data using the SOAP format. Which of the following would be recorded under "S" of this acronym?

A) Client complaints of pain

B) Client history

C) Client's chief complaint

D) Client interventions

Ans: A

Feedback:

The SOAP format (subjective data, objective data, Assessment [the caregiver's judgment about the situation], plan) is used to organize data entries in the progress notes of the POMR. A client complaint of pain is subjective data (S).

14. Which of the following methods of documenting client data is least likely to hold up in court if a case of negligence is brought against a nurse?

A) Problem-oriented medical record

B) Charting by exception

C) PIE charting system

D) Focus charting

Ans: B

Feedback:

Charting by exception is a shorthand documentation method that makes use of well-defined standards of practice; only significant findings or "exceptions" to these standards are documented in narrative notes. A significant drawback to charting by exception is its limited usefulness when trying to prove high-quality safe care in response to a negligence claim made against nursing.

15. A nurse has access to computerized standardized plans of care. After printing one for a client, what must be done next?

A) Date it and put it in the client's record.

B) Sign it and put it in the Kardex.

C) Individualize it to the specific client.

D) Use it as printed, based on common needs.

Ans: C

Feedback:

Standardized care plans that identify common problems and needs with relation to select client cohorts may be used. Unless such care plans are individualized to a specific client, however, they may not address individual client needs.

16. What part of the client's record is commonly used to document specific client variables, such as vital signs?

A) Progress notes

B) Nursing notes

C) Critical paths

D) Graphic record

Ans: D

Feedback:

The graphic record is a form used to document specific client variables such as vital signs, weight, intake and output, and bowel movements.

17. A nurse is documenting information about a client in a long-term care facility. What is used in a Medicare-certified facility as a comprehensive assessment and as the foundation for the Resident Assessment Instrument (RAI)?

A) PIE system

B) Minimum data set

C) OASIS

D) Charting by exception

Ans: B

Feedback:

Long-term care documentation is specified by the RAI with the minimum data set forming the foundation for the assessment. This is required in all facilities certified to participate in Medicare or Medicaid. OASIS is used in the home health care industry.

18. What is the primary purpose of an incident report?

A) Means of identifying risks

B) Basis for staff evaluation

C) Basis for disciplinary action

D) Format for audiotaped report

Ans: A

Feedback:

An incident report, also termed a variance or occurrence report, is a tool used by health care agencies to document the occurrence of anything out of the ordinary that results in, or has the potential to result in, harm to a client, employee, or visitor. Incident reports should not be used for disciplinary action against staff members.

19. A group of nurses visits selected clients individually at the beginning of each shift. What are these procedures called?

A) Nursing care conferences

B) Staff visits

C) Interdisciplinary referrals

D) Nursing care rounds

Ans: D

Feedback:

Nursing care rounds are procedures in which a group of nurses visits select clients individually at each client's bedside. The primary purposes are to gather information to help plan and evaluate nursing care and to provide the client with an opportunity to discuss care.

20. A nurse uses informatics to plan nursing care for a client. Which three terms best describes this science as it is applied to nursing?

A) Data, information, knowledge

B) Process, documentation, analysis

C) Research, controls, variables

D) Hypothesis, nursing, practice

Ans: A

Feedback:

According to the ANA Scope and Standards of Nursing Informatics Practice, nursing informatics is a specialty that integrates nursing science, computer science, and information science to manage and communicate data, information, and knowledge in nursing practice. Nursing informatics facilitates the integration of data, information, and knowledge to support clients, nurses, and other providers in their decision making in all roles and settings. This support is accomplished through the use of information structures, information processes, and information technology (ANA, 2001, p. vii).

21. A client complains to the nurse-in-charge about another nurse on night shift. The client says that he kept calling the nurse but she never responded. Further, when he questioned the nurse, she said that she had other patients to take care of. The nurse-in-charge is aware that the client can be very demanding. What is an appropriate response for the nurse?

A) "I am sorry that you had to suffer this way. The nurse on night duty should be fired."

B) "It's hard to be in bed and ask for help. You ring for a nurse who never seems to help."

C) "You seem to be impatient. The nurses work very hard and they do whatever they can."

D) "I can see that you are angry. What the nurse did is wrong, and it won't happen again."

Ans: B

Feedback:

The nurse should empathize with the client to perceive how the client is feeling. The nurse shares his or her perception with the client, which makes him comfortable to share his anxieties, fear, and concerns. The first response conveys pity on the client, which is inappropriate. In the third response, the nurse is taking the side of the nursing staff and the client may not like it. The fourth response is nontherapeutic.

22. A nurse at a health care facility has just reported for duty. Which of the following should the nurse do to ensure maximum efficiency of change-of-shift reports?

A) Pay courtesy calls to staff members before attending the meeting.

B) Wait for the physicians to arrive before exchanging notes.

C) Avoid asking questions related to the medical record.

D) Come prepared with material required to take notes.

Ans: D

Feedback:

The nurse should come prepared with material required to take notes during the change-of-shift reports. The nurse should not delay the meeting for change-of-shift report by paying courtesy calls to staff members before attending the meeting. Change-of-shift reports are not conducted in the presence of physicians, thus the nurse does not need to wait for the physicians to arrive before exchanging notes. The nurse should ask questions related to the medical record if any information is unclear.

23. A nurse is manually documenting information related to a client's condition. When documenting this information, the nurse makes an error on the manual record sheet. Which is the best technique for recording the error made in documentation?

A) Erase the incorrect statement and write the correct one.

B) Cross out the wrong statement in a way that is not readable.

C) Use correction fluid to obliterate what has been written.

D) Cross out the incorrect statement with a single line.

Ans: D

Feedback:

When recording an error in documentation, the nurse should always cross out the incorrect statement with a single line so that it remains readable, add the date, initial, and then document the correct information. The nurse should not erase the incorrect statement and replace it with the correct one, nor cross out the wrong statement in a way that makes the statement unreadable, nor use correction fluid to obliterate what has been written. These methods render the medical record a poor legal defense.

24. A nurse caring for a client who is being treated by three physicians uses the source-oriented format for documentation. What are the benefits of using this format of documentation?

A) Information is documented in separate forms by each health care personnel.

B) It is a unified, cooperative approach for resolving the client's problems.

C) It is organized at one location according to the client's health problems.

D) It is compiled to facilitate communication among health care professionals.

Ans: A

Feedback:

Source-oriented documentation is a record organized according to the source of documented information. This type of record contains separate forms on which health care personnel make written entries about their own specific activities in relation to the client's care. The problem-oriented method of recording demonstrates a unified, cooperative approach to resolving the client's problems. Source-oriented records are organized at numerous locations; there is not one location for information. The problem-oriented record is compiled to facilitate communication among health care professionals.

25. A newly hired nurse is participating in the orientation program for the health care facility. Part of the orientation focuses on the use of the SOAP (subjective, objective, assessment, and plan) method for documentation, which the facility uses. The nurse demonstrates understanding of this method by identifying which of the following as the first step?

A) Plan of care

B) Data, action, and response

C) Problem selected

D) Nursing activities during a shift

Ans: C

Feedback:

The SOAP method begins by selecting a problem from a list. PIE (problems, interventions, and evaluation) notes incorporate the plan of care into the progress notes. Focus DAR notes organizes entries by data, action, and response. The narrative notes are used to record relevant client and nursing activities throughout a shift.

26. A nurse is documenting client information using PIE charting. Which information would the nurse expect to document?

A) Client assessment

B) Intervention carried out

C) Written plan of care

D) Multidisciplinary interventions

Ans: B

Feedback:

In the PIE notes, the nurse documents the problem, intervention and evaluation. Thus the nurse would document the intervention carried out. Client assessment is not a part of the PIE notes, because this information is recorded on flow sheets for each shift. Although the PIE system uses a nursing plan-of-care format, there is no written plan of care. The PIE system is not multidisciplinary; it provides a documentation system for nursing only.

27. What activity in charting will assist most in the avoidance of errors?

A) Objectivity

B) Organization

C) Legibility

D) Timeliness

Ans: D

Feedback:

Documentation in a timely manner can help avoid errors.

28. A nurse in a nursing home is writing a note that addresses the care a resident has received during the day and the resident's response to care. What type of note does this represent?

A) PIE note

B) Flow sheet

C) Narrative note

D) SOAP note

Ans: C

Feedback:

A narrative note in a skilled nursing facility might include the type of morning care, nutritional intake, client activity pattern, and comfort measures provided, along with the client's response.

29. Which of the following abbreviations is on the list of the Joint Commission do not use abbreviations? Select all that apply.

A) U (unit)

B) QD (daily)

C) NPO (nothing per os)

D) mL (milliliters)

E) > (greater than)

Ans: A, B, E

Feedback:

The words "unit", "daily", "greater than" and "less than" should be spelled out. NPO, mL, and mcg are acceptable abbreviations.

30. Which of the following are examples of incidental disclosures of client health information that are permitted? Select all that apply.

A) A nurse working in a physician's office puts out a sign-in sheet for incoming clients.

B) Two nurses are overheard talking about a client through the door of an empty client room.

C) A nurse places a client chart in a holder on the examining room door with the name facing out.

D) A nurse leaves an x-ray on a light board in the hallway that leads to the examining rooms.

E) A nurse calls out the name of a client who is seated in the waiting room.

Ans: A, B, E

Feedback:

Permitted incidental disclosures of PHI include using sign-in sheets without the reason for visit; the possibility of a conversation being overheard if measures are taken to be private; placing a client chart on the door with the face pages facing inward; placing an x-ray on a light board as long as it is not unattended; calling the name of a waiting patient; and leaving appointment reminders on answering machines (provided only a minimal amount of information is given).

31. Which of the following are examples of breaches of client confidentiality? Select all that apply.

A) A nurse discusses a client with a coworker in the elevator.

B) A nurse shares her computer password with a relative of a client.

C) A nurse checks the medical record of a client to see who should be called in an emergency.

D) A nurse updates the employer of a client regarding the client's return to work.

E) A nurse uses a computer to document a client's response to pain medication.

Ans: A, B, D

Feedback:

Nurses may use computers to document client data as long as they are not in a public area, and as long as the computer is shut down following the entries. A nurse can also check the medical record for a relative to call in case of an emergency. All the other examples are violations of client confidentiality.

32. In which of the following cases should a progress note be written? Select all that apply.

A) For any nurse–client interaction

B) When admitting a client

C) When receiving a client postoperatively

D) When assisting a client with ADLs

E) When a procedure is performed

Ans: B, C, E

Feedback:

A progress note should be written in the following instances: upon admission, transfer to another unit, and discharge; when a procedure is performed; upon receiving a client postoperatively or postprocedure; upon communicating with physicians regarding critical client information (e.g., abnormal lab value result); or for any change in client status.

33. A nurse realizes that the dosage of the medication administered to the client has been entered incorrectly into the client records. Which of the following would be most appropriate for the nurse to do?

A) Completely erase or delete the erroneous entry if possible.

B) Use a highlighter to mark the incorrect entry and place initials next to it.

C) Strike out the entry with a single line, place initials next to it, and write the correct entry.

D) Black out the erroneous entry with a dark pen or marker.

Ans: C

Feedback:

The nurse should strike out the erroneous entry with a single line and place initials over it. When an error occurs, erasure or use of correction fluid is not permissible. Use of highlighters is not allowed and can draw attention to the erroneous documentation.

34. The nurse notes that the blood glucose level of a client has increased and is planning to notify the health care provider by telephone. Which of the following techniques would be most appropriate for the nurse to use when communicating with the health care provider?

A) ISBAR

B) EMAR

C) SOAP

D) CBE

Ans: A

Feedback:

The nurse should use ISBAR to communicate verbally to the health care provider. Identify/Introduction, Situation, Background, Assessment, and Recommendation (ISBAR) is the communication tool to provide critical client information to the health care provider. EMAR is Electronic Medication Administration Record, which documents medication administration. SOAP is Subjective, Objective, Assessment, and Plan, which is a progress note that relates to only one health problem. CBE is Charting by Exception and permits the nurse to document only those findings that fall outside the standard of care and norms that have been developed by the institution.

35. The nurse is reviewing a client's chart. When reading the history, physical, and physician progress notes, the nurse anticipates finding which of the following?

A) The physician's assessment and treatment

B) Results of laboratory and diagnostic studies

C) Nursing documentation and plan of care

D) Information from other members of the health care team

Ans: A

Feedback:

The medical history, physical examination, and progress notes record the findings of physicians as they assess and treat the client. They focus on identifying pathologic conditions and their causes, as well as determining the medical regimen for treatment.

36. The nurse should utilize ISBARR communication (Introduction, Situation, Background, Assessment, Recommendation, Read Back) during which of the following clinical situations?

A) When communicating a client's change in condition to the client's physician

B) When providing a change-of-shift report to a colleague

C) When documenting the care that was provided to a client whose condition recently deteriorated

D) When reporting to a client's family member or significant other

Ans: A

Feedback:

ISBARR communication is an increasingly common tool for interdisciplinary communication. It is not typically used during change-of-shift report nor when communicating with family members. ISBARR is considered a framework for communication rather than a format for documentation.

Chapter 20, Informatics

1. In informatics, raw, unprocessed numbers, symbols, or words that have no meaning by themselves are called which of the following?

1)Information

2)Data

3)Knowledge

4)Wisdom

ANS: 2

Data are raw, unprocessed i

processed into a meaningful, structured form. Knowledge is formed when data are grouped, creating meaningful information and relationships, which are then added to other structured information. Wisdom is the appropriate use of knowledge in managing or solving human problems.

=

____ 2. Which informatics concept concerns the appropriate use of knowledge in managing or solving human problems?

1)Wisdom

2)Data

3)Knowledge

4)Information

ANS: 1

Wisdom is the appropriate use of knowledge in managing or solving human problems. Data are raw, unprocessed numbers, symbols, or words that have no meaning by themselves. Information consists of groupings of data processed into a meaningful, structured form. Knowledge is formed when data are grouped, creating meaningful information and relationships, which are then added to other structured information.

____ 3. Computers are important for evidence-based practice because:

1)They are available in all healthcare institutions.

2)Extra training is not required for information retrieval.

3)Information can be accessed and managed more efficiently.

4)All of the best evidence is located on a computer.

ANS: 3

To incorporate the current, *best* evidence in your nursing practice, you must be able to locate the evidence, evaluate its quality and relevance to the problem, and apply the solution to clinical care. Computers are useful for data access, management, storage, and retrieval when conducting research or reviewing research findings. Specialized software aids in statistical analysis of research data. Computers are not available to all personnel in all healthcare institutions nor can the entirety of best evidence be found electronically. Training and experience are required to learn how to use a computer as well as how to conduct a literature search.

____ 4. You are a preceptor for a new nursing employee at the local hospital. She needs to access a patients electronic health record (EHR) to retrieve laboratory results; however, the newly hired nurse has not yet received a computer password. What action should you take?

1)Give her your password to use until she obtains her own password.

2)Log on and remain with her while she views the record.

3)Notify your supervisor that the new employee needs a password.

4)Inform her that she will not receive a password until her orientation is complete.

ANS: 3

Never share your password with another person or log on to a computer to allow another access to information. Instead, notify your supervisor that the new employee needs a password. In most hospitals, nurses are given a password during their orientation.

____ 5. Review the following: 38 years old; growth in height to 52; female gender; weight gain of 15 pounds. This list can be referred to as which of the following?

1)Information

2)Knowledge

3)Data

4)Patient record

ANS: 1

The segments are grouped into a meaningful, structured form and are considered together as information. However, 38, 52, female, 15 standing alone would be examples of raw, unprocessed numbers, symbols, or words that have no meaning by themselves and therefore would be data.

____ 6. CINAHL is a(n):

1)Popular periodical.

2)Internet site.

3)Scholarly journal.

4)Literature database

ANS: 4

CINAHL, *The Cumulative Index of Nursing and Allied Health Literature,* is a literature database covering nursing, allied health, biomedical, and consumer health journal articles. CINAHL may be accessed by the Internet or in hard copy in most libraries.

____ 7. A nurse is entering a pharmacy request for patient medication in the patients electronic health record (EHR) while seated at a computer in the nursing station. A physician approaches her and asks her to access another patients EHR so that he can look at the patients laboratory report. Which of the following is the best action for the nurse to take?

1)Access the lab report for the physician.

2)Log off the computer before proceeding.

3)Quickly finish the pharmacy requisition before the physician logs on.

4)Allow the physician to access the laboratory report without logging out.

ANS: 2

The nurse should log off the computer and then allow the physician to log on under his own password. Accessing information that is not relevant to the care that the nurse is providing is a HIPAA violation. Rushing to complete a pharmacy request for patient medication is a situation of risk for medication error. The nurse should never hurriedly order or administer medication because that is when errors are more likely to occur. The nurse should never allow anyone to use her password to access information.

____ 8. What is (are) the primary benefit(s) of computer physician order entry (CPOE)?

1)Increased privacy

2)Improved access to patient data

3)Cost savings

4)Reduced medication errors

ANS: 4

Computer physician order entry (CPOE) is technology that allows healthcare providers to enter orders into a computerized prescribing system instead of handwriting them. Orders are integrated with patient information, including allergy history and laboratory and other prescription data. The new order is then automatically checked for potential errors or problems. This reduces prescription errors resulting from illegible penmanship. It can detect dosing errors by flagging medication dilution or dosages that fall outside normal dosing standards. The system warns about the possibility of a drug interaction, allergy, or incorrect dose. As some drug names sound like other drugs, CPOE can alert prescribers and potentially avoid a drug error that could be serious or fatal. Although the efficiencies of the CPOE reduce costs, it is not the primary benefit of the system. Likewise, orders entered into the computer are more conveniently accessed by nurses and pharmacists, but the most important benefit of CPOE is to reduce errors.

Multiple Response

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

____ 1. Which of the following are main functions of a computer? Choose all that apply.

1)Process

2)Storage

3)Memory

4)Output

ANS: 1, 2, 4

____ 2. Which of the following aspects of a computer determine its power? Choose all that apply.

1)User friendliness

2)Speed of operations

3)Accessibility for the user

4)Data storage capacity

ANS: 2, 4

The power of a computer is determined by its speed, accuracy, reliability, and data storage and processing capabilities. Although ease of use and accessibility are important features for users, these factors do not determine the power of a computer.

____ 3. Which of the following health information is protected in the electronic health record? Choose all that apply.

1)Social Security number

2)Insurance information

3)Physicians name

4)Laboratory results

ANS: 1, 2, 4

A patients **protected health information** includes any individually identifiable health information; current, past, or potential physical or mental conditions; and any

____ 4. The nurse is preparing to pass the 0900 medications prescribed for her patients. She removes the medications from the automated dispensing unit. When scanning the medication, an alert notifies the nurse that the patient is allergic to this medication. What action should the nurse take? Choose all that apply.

1)Override the alert and administer the medication.

2)Confirm the patients allergies and type of reaction.

3)Notify the prescriber of the patient medication allergy.

4)Be sure an antidote is available at the patients bedside.

ANS: 2, 3

Alerts are configured to notify the nurse of potential adverse effects before the patient receives the medication. Sometimes patients state they are allergic to a medication when, in reality, they may only have experienced a side effect. The physician or pharmacist can be instrumental in discerning if the patients reaction was a true allergy. The physician should always be notified before administering medications when an allergy error has been received. Although an antidote to a medication could be useful in the event of a harmful effect, the medication in the situation should not be given, and therefore, the antidote would not be necessary.

Completion

Complete each statement.

1._____ is the managing and processing of information necessary to make decisions.

ANS: Informatics

2._____ is the use of telecommunication to send healthcare information between patients and professionals at different locations.

ANS: Telehealth

3.Facebook, MySpace, and LinkedIn are examples of _____ tools.

ANS: social networking

4._____ such as NIC, NOC, NANDA-I, and PNDS can be used to describe the unique nursing contributions to patient care.

ANS: Standardized nursing languages

Standardized nursing languages communicate health information, promote evidence-based practice using health records, decrease medical error, and protect patient privacy and confidentiality. However, no single nursing language currently describes all of the aspects of nursings contribution to care. Use of standardized terminology helps to match like terms within the electronic medical record.

Chapter 21, Developing Concepts

1. A child demonstrates increasing language skills and an understanding of symbols. Creative play and the use of imagination is an important activity in the child's life. Based upon these characteristics and according to Jean Piaget's theory, what stage of cognitive development is the child demonstrating?

A) Preoperational stage

B) Sensorimotor stage

C) Concrete operational stage

D) Formal operational stage

Ans: A

Feedback:

The preoperational stage (ages 2 to 7 years) is characterized by the beginning use of symbols, through increased language skills and pictures. Play activities during this time help the child understand life events and relationships. The sensorimotor stage (birth to 24 months) is marked by stages that begin with the demonstration of basic reflexes through beginning development in reasoning skills. The concrete operational stage (ages 7 to 11 years) is characterized by the development of logical thinking, an understanding of reversibility, relations to numbers, and the loss of egocentricity. The formal operational stage (age 11 years and older) is characterized by the use of abstract thinking and deductive reasoning.

2. A female client age 35 years explains to the community health nurse that her primary focus daily is the care of her family, her job, and her volunteer activities at her church. The client verbalizes contentment with her various roles and the balancing of these roles. According to the theory on "individual life structure" developed by Daniel Levinson and associates, this client is demonstrating characteristics associated with what phase of adulthood?

A) Settling down

B) Early adult transition

C) Entering the adult world

D) Midlife transition

Ans: A

Feedback:

In the settling-down phase (age 30-40), the adult invests energy into the areas of life that are most important, such as family, work, and community. The years of the middle to late 20s (age 22-28) are a time to build on previous decisions and choices, and to try different careers and lifestyles. It is defined as the phase of "entering the adult world." During early adult transition, the major concerns of the young adult (age 18-22) are to break away from the parents, to make initial career choices, and to establish intimate relationships. Midlife transition (age 40-45) involves a reappraisal of one's goals and values.

3. A child who attends church with his parents imitates religious gesture but does not have an understanding of these religious behaviors. The child also asks his parents, "How do you know God exists? Have you ever seen him?" This child is described as having characteristics associated with which stage of faith development as defined by Fowler?

A) Intuitive–Projective Faith

B) Mystical–Literal Faith

C) Synthetic–Conventional Faith

D) Individuative–Reflective Faith

Ans: A

Feedback:

The child is demonstrating characteristics of the stage of Intuitive–Projective Faith. During this stage, the child takes on parental attitudes toward religious or moral beliefs without an understanding of them. During the Mystical–Literal Faith stage, the child accepts the existence of a deity. Synthetic–Conventional Faith is the characteristic stage for many adolescents when they begin to question life-guiding values or religious practices in an attempt to stabilize their own

identity. The Individuative–Reflective Faith stage often occurs during the older adolescent and young adult years, as individuals become responsible for their own commitments, beliefs, and attitudes.

4. After a child plays in the yard, his mother asks him to pick up his toys and put them in the toy bin in the garage. Knowing that he does not want to spend time in his room as a punishment, the child follows his mother's directions. What stage of moral development, according to Kohlberg, is this child demonstrating?

A) Preconventional level: stage 1

B) Preconventional level: stage 2

C) Conventional level: stage 1

D) Conventional level: stage 2

Ans: A

Feedback:

The preconventional level is based on external control as the child learns to conform to rules imposed by authority figures. At stage 1 (punishment and obedience orientation), the motivation for choices of action is fear of physical consequences of authority's disapproval. At stage 2 (instrumental relativist orientation), the thought of receiving a reward overcomes fear of punishment, so actions that satisfy this desire are selected. The conventional level involves identifying with significant others and conforming to their expectations.

5. A boy age 4 years is constantly seeking out and exploring new experiences, and repeatedly asking his parents why-type questions. The boy's behavior suggests that he is successfully navigating an important developmental task within the developmental theory of:

A) Erikson

B) Freud

C) Kohlberg

D) Fowler

Ans: A

Feedback:

Erikson characterized development as a series of crises. The preschooler typically must choose between initiative (seeking new experiences and learning) and guilt. Freud focuses on psychosexuality while Kohlberg prioritizes moral development. Fowler explains development through the lens of faith.

6. Which of the following developmental tasks is an important component of middle adulthood within Havighurst's theory of psychosocial development?

A) Accepting and adjusting to physical changes

B) Adjusting to reduced income

C) Adjusting to decreasing health

D) Learning to live with a marriage partner

Ans: A

Feedback:

Havighurst identifies the acceptance and adjustment to physical changes as a task associated with middle adulthood. Adjusting to declining health and reduced income are associated with later maturity, while learning to live with a marriage partner is a developmental task of young adulthood.

7.	A nurse provides care in a women's health clinic that is located in an inner city neighborhood. Which of the following theorists' work applies most directly to this nurse's client population?
A)	Gilligan
B)	Kohlberg
C)	Gould
D)	Fowler
Ans:	A
	Feedback:
	Carol Gilligan's work specifically addresses the moral development of women, proposing an ethic of care that develops through three levels during women's lives. Kohlberg, Gould, and Fowler do not differentiate between the developmental considerations of males and females.
8.	Which of the following nurses is most likely to care for clients who are trying to resolve identity versus role confusion?
A)	A nurse who provides care in a large junior high school
B)	A pediatric nurse
C)	A nurse who works in a long-term care facility
D)	An occupation health nurse based at a lumber mill
Ans:	A
	Feedback:
	According to Erikson, the crisis of identity versus role confusion is characteristic of adolescence. Consequently, a nurse who provides care in a junior high school is likely to see frequent manifestations of this crisis. Early childhood, middle adulthood, and late adulthood are not typical life stages for the resolution of this crisis.
9.	A child gains weight and becomes taller each year. What is this process called?
A)	Development
B)	Orderly change
C)	Progression
D)	Growth
Ans:	D
	Feedback:
	Growth is an increase in body size or changes in body cell structure, function, and complexity. Development is an orderly pattern of changes in structure, thoughts, feelings, or behaviors resulting from maturation, experiences, and learning.
10.	All humans learn from both formal and informal experiences. What orderly pattern of changes results in part from learning?
A)	Development
B)	Growth
C)	Maturity

D) Aging

Ans: A

Feedback:

Development is an orderly pattern of changes in structure, thoughts, feelings, or behaviors resulting from maturation, experiences, and learning. It is a dynamic and continuous process as one proceeds through life, characterized by a series of ascents, plateaus, and declines. Growth is an increase in body size or changes in body cell structure, function, and complexity.

11. As the fetus develops, certain growth and development trends are regular and predictable. The first trend is cephalocaudal growth. What does this mean?

A) Legs and feet develop first.

B) Both sides of the body develop equally.

C) Head and brain develop first.

D) Gross motor skills are learned last.

Ans: C

Feedback:

Cephalocaudal (proceeding from the head to the tail) development is the first trend, followed by proximodistal (progressing from gross motor to fine motor movements), and finally by symmetric (both sides of the body developing equally).

12. Many different factors affect growth and development. For example, why does one child have blonde hair and blue eyes while another child has brown hair and green eyes?

A) Childhood illnesses

B) Genetic inheritance

C) Prenatal influences

D) Maternal nutrition

Ans: B

Feedback:

At conception, every human receives an equal number of chromosomes from each parent. Physical characteristics, such as height, bone size, and eye and hair color, are inherited from our family of origin.

13. According to Erikson, normal adolescent behavior includes trying on new roles and possibly even rebelling. What is the purpose of this behavior in adolescents?

A) To establish a sense of security

B) To establish a sense of identity

C) To gain autonomy

D) To avoid inferiority

Ans: B

Feedback:

	According to Erikson, the developmental task for adolescents is identity versus role confusion. Trying on new roles and even rebelling are normal behaviors as the adolescent acquires a sense of self and decides what direction to take in life. The other choices are not appropriate for adolescents.
14.	A school-aged child always follows the rules and obeys traffic lights when crossing the street. Based on Kohlberg's theory, what type of development is being demonstrated?
A)	Cognitive
B)	Intellectual
C)	Moral
D)	Psychosocial
Ans:	C
	Feedback:
	Kohlberg's theory of moral development includes the stages through which individuals move. School-aged children obey rules and regulations established by society and enforced by authority figures.
15.	In contrast to Kohlberg, Gilligan developed a theory of moral development specifically for women. What is the central theme of Gilligan's theory?
A)	Response and care
B)	Rights and justice
C)	Adult transformation
D)	Individual life structure
Ans:	A
	Feedback:
	Gilligan's theory, developed to explain the female viewpoint of morality as different from that of Kohlberg, views females as developing a morality of response and care and males as developing a morality of justice, rights, and obligation.
16.	A child 7 years of age attending a Roman Catholic Mass with his parents stands and holds his hymnal to sing the opening song. According to Fowler, what stage of development is this child experiencing?
A)	Undifferentiated faith
B)	intuitive–projective faith
C)	mythical–literal faith
D)	synthetic–conventional faith
Ans:	B
	Feedback:
	Intuitive–projective faith is most typical of the 3- to 7-year-old child. Children imitate religious gestures and behaviors of others, primarily their parents. They take on their parents' attitudes toward religious or moral beliefs without a thorough understanding of them. Imagination in this stage leads to long-lived images and feelings that they must question and reintegrate in later stages.
17.	A child 2 years of age is hospitalized for a surgical procedure. Although previously all fluids were taken from a cup, the toddler wants a bottle to suck on. The nurse recognizes this behavior as what?

A) Totally unacceptable

B) Proof that the child is sick

C) Normal regression

D) Abnormal behavior

Ans: C

Feedback:

Based on the principles and theories of growth and development, the nurse recognizes possible regression during difficult periods or times of crisis, accepting and supporting a return to a forward progression in development. It is acceptable, normal behavior for the hospitalized toddler.

18. Which developmental theory suggests success in achieving developmental tasks during later stages of life?

A) Kohlberg's theory

B) Piaget's theory

C) Havighurst's theory

D) Kubler-Ross' theory

Ans: C

Feedback:

Havighurst's theory of development suggests that success in achieving developmental tasks leads to success with tasks in later stages of life.

19. Which of the following actions would generally take place in the settling down stage of Daniel Levinson's Individual Life Structure theory? Select all that apply.

A) Breaking away from the family

B) Making initial career choices

C) Trying new lifestyles

D) Striving to gain respect

E) Investing in family

Ans: D, E

Feedback:

In the settling-down phase (age 30–40), the adult invests energy into the areas of life that are most personally important. The areas of investment are primarily family, work, and community. The individual strives to gain respect, status, and a sense of authority. Breaking away from family occurs in the early adult transition. Making initial career choices and trying new lifestyles occurs in the entering-the-adult-world stage. Maximizing self-approval occurs in the pay-off years.

20. Which of the following statements accurately describes factors that may affect an individual's growth and development? Select all that apply.

A) Physical characteristics such as height, bone size, eye color, and hair color are inherited from the family of origin.

B) Fetal development can be altered by maternal age, inadequate maternal nutrition or substance abuse.

C) Abuse of alcohol and drugs is more prevalent in teenagers who have poor family relationships, low self-esteem, and poor social skills.

D) Infants who are malnourished in utero develop fewer brain cells than infants who have had adequate prenatal nutrition.

E) Environmental factors such as poverty and violence do not have a direct effect on growth and development.

Ans: A, B, C, D

Feedback:

Physical characteristics, such as height, bone size, eye color and hair color, are inherited from our family of origin. Fetal development can be altered by maternal age (with risk greater in those under age 15 and over age 35), substance abuse, inadequate prenatal care, inadequate maternal nutrition, and maternal substance abuse. Abuse of alcohol and drugs is more prevalent in teenagers who have poor family relationships, low self-esteem, and poor social skills. Infants who are malnourished in utero develop fewer brain cells than infants who have had adequate prenatal nutrition. Environmental factors that might alter development include poverty and violence. The effect of each can occur independently, but they are more likely to be interrelated. Prenatal, individual, and caregiver factors influence development in many ways.

21. The nurse is seeing a pregnant woman 25 years of age. The woman's partner is very caring and loving, but has decided that he does not want to be a father, and so has left the relationship. The woman is determined to raise her child alone and says, "I will never let myself be hurt like that again." According to Gilligan's theory, on which level is this woman?

A) Level 1: Selfishness

B) Level 2: Undifferentiated Faith

C) Level 3: Goodness

D) Level 4: Nonviolence

Ans: A

Feedback:

Level 1 of Gilligan's theory says that relationships are often disappointing, and as a result, a woman might isolate herself to avoid getting hurt. Undifferentiated faith is part of Fowler's theory, not Gilligan's. Goodness is Level 2 of Gilligan's theory and says that acceptance by others is very important. Nonviolence is Gilligan's Level 3, and it says that nonviolence has to do with all judgments and decisions.

22. The nurse is caring for a woman 55 years of age who has been admitted for a hernia repair. The nurse is doing an initial nursing assessment and considers developmental theories. Where would the nurse place the client according to the theory of Daniel Levinson and associates?

A) The pay-off years

B) Later maturity

C) Generativity versus stagnation

D) Postconventional level

Ans: A

Feedback:

Levinson and associates describe the pay-off years as the years from 45 to 65. They are a time of maximum self-direction and self-approval. Physical and mental changes increase an awareness of one's aging and mortality. The postconventional level is a stage described by Lawrence Kohlberg. Later maturity is a stage described by Robert Havighurst. Generativity versus stagnation is appropriate for this client's age, but is a theory stage of Erik Erikson.

23. A mother brings her toddler, age 20 months, to the clinic today for immunizations. She talks about trying to initiate toilet training a few weeks ago, but her son wasn't interested. She decided to put it off for awhile. She told her son he was a good boy and they would try again another time. According to Erik Erikson's theory, what is the likely outcome for Matt's developmental stage?

A) Autonomy

B) Identity

C) Intimacy

D) Initiative

Ans: A

Feedback:

Autonomy versus shame and doubt implies that if the caregivers are overprotective or have expectations that are too high, shame and doubt, as well as feelings of inadequacy, might develop in the child. The mother has a good attitude towards toilet training and from that, her son will develop his autonomy. Initiative has to do with Erikson's theory about preschool-aged children. Identify is related to adolescence, and intimacy is about young adulthood.

24. A nursing student is assisting the school nurse with a middle school health fair. The student does height and weight assessments on the students. As the nursing student assess them, the student observes that the students are able to use deductive reasoning and think in abstract ways. According to Piaget, in what development stage are they?

A) Genital

B) Identity versus role confusion

C) Formal operational

D) Gender role acceptance

Ans: C

Feedback:

Piaget owns the formal operational theory stage that is characterized by the use of abstract thinking and deductive reasoning. Freud's theory of the genital stage indicates sexual interest can be expressed in overt sexual relationships. Sexual pressures and conflicts typically cause turmoil as the adolescent makes adjustments in relationships. Identity versus role confusion is Erikson's stage for adolescents. The stage of gender role acceptance belongs to Havighurst.

25. The emergency department nurse is caring for an infant age 2 months who was brought in by a hired caregiver. The infant is underweight and looks uncared for. The caregiver reports that the mother of the infant is unreliable and may be using drugs; the infant is often unclean and hungry when dropped off at the caregiver's home. The infant has diaper rash and a weak cry. If this situation is not remedied, what will this infant have difficulty achieving, according to Erikson's developmental theory?

A) Trust

B) Autonomy

C) Initiative

D) Identity

Ans: A

Feedback:

The infant learns to rely on caregivers to meet basic needs of warmth, food, and comfort. This is how the infant learns to form trust in others. Mistrust is the result of inconsistent, inadequate, or unsafe care. The other choices are later stages of Erikson's developmental theory.

26. The nurse is working in the newborn nursery and observes neonates in various states of health and wellness. The nurse is aware that which of the following factors can affect fetal development? Choose all that apply.

A) Age of mother

B) Prenatal nutrition

C) Substance abuse by mother

D) Congenital vision deficit

E) Poor neonatal nutrition

Ans: A, B, C

Feedback:

Fetal development can be altered by maternal age (with risk greater in those under age 15 or over age 35), substance abuse, inadequate prenatal care, inadequate maternal nutrition, and maternal substance abuse. Congenital abnormalities and poor neonatal nutrition do not affect fetal development.

27. The nurse is educating a high school health and fitness class about substance abuse. One of the group members asks what happens if a pregnant woman is using drugs. The nurse's best replies include which of the following? Choose all that apply.

A) Low birth weight

B) Premature births

C) Regular prenatal care

D) Congenital anomalies

E) Risk of poor nutrition

Ans: A, B, D, E

Feedback:

Substance abuse by a pregnant woman increases the risk for congenital anomalies, low birth weight, and prematurity in her developing fetus. Someone who is using drugs is less likely to eat a nutritious diet and have regular prenatal care.

28. A nursing student is observing in a pediatric clinic. A grandmother brings an infant age 2 months to be seen. The infant has failed to gain the expected amount of weight and looks unwell. The nursing student wonders if this may be a failure to thrive baby. Which one of the following has been linked to failure to thrive babies?

A) Nutritional deprivation

B) Working mothers

C) Use of day care centers

D) Premature births

Ans: A

Feedback:

Failure to thrive, a condition of early infancy, has been linked to both nutritional and emotional deprivation. This list is not all inclusive. Use of day care centers by working mothers has not been noted as a factor contributing to failure to thrive, nor have premature births.

29. A nurse is caring for a child age 13 months who was admitted to the pediatric unit with a new diagnosis of asthma. The mother tells mentions how frustrated she gets because the baby puts everything in her mouth, even things that are not clean. The nurse knows that according to Freud's theory of growth and development, which of the following explains this behavior?

A) Lessens teething pain

B) Major source of gratification

C) Sucking is a basic reflex

D) Assists in gaining confidence

Ans: B

Feedback:

According to Freud, during the oral stage, the infant uses his or her mouth as the major source of gratification and exploration. Pleasure is experienced from eating, biting, chewing, and sucking. This provides the infant with security. Chewing on things probably does lessen teething pain and sucking is a basic reflex, but neither of these things are part of Freud's theory. Putting things in the mouth is not connected with gaining confidence.

30. The nursing student is visiting a middle school with an assignment to observe and visit with students while walking around with the school nurse. Then nursing student is interested to learn that some students seem to be rebelling against authority figures like teachers and parents. The nursing student recalls that, according to Erikson's theory, this is not abnormal behavior. To which stage of Erikson's theory does this behavior belong?

A) Identity versus role confusion

B) Industry versus inferiority

C) Initiative versus guilt

D) Autonomy versus shame

Ans: A

Feedback:

Trying on roles and even rebellion are considered normal behaviors as the adolescent acquires a sense of self and decides what direction will be taken in life. Role confusion occurs when the adolescent is unable to establish identity and a sense of direction. The other choices are different stages of Erikson's theory.

31. A nursing student is visiting a third-grade class to observe growth and development in action and does assessments on the children. They are learning to think logically and to classify and relate objects and ideas. According to Erikson, in what developmental stage are they?

A) Industry versus inferiority

B) Latency

C) Acceptance of deity

D) Concrete operational

Ans: A

Feedback:

Third graders are in Erikson's industry versus inferiority stage. Focusing on the end result of achievements, the school-aged child gains pleasure from finishing projects and receiving recognition for accomplishments. Concrete operational is Piaget's theory for school-aged children. Latency is Freud's theory. Acceptance of a deity is a developmental theory belonging to Fowler.

32. The nurse is caring for a an infant age 11 months. The infant's mother tells states that when she asked the doctor about starting to toilet train her child, the doctor talked about cephalocaudal development. The mother then asks for an explanation of this term. Which of the following about cephalocaudal development is the nurse's best reply?

A) Proceeds from brain down to feet

B) Both sides of the body develop equally

C) Brain must fully develop before toilet training

D) Gross control to fine control

Ans: A

Feedback:

Cephalocaudal (proceeding from head to tail) development is the first trend, with the head and brain developing first, followed by the trunk, legs, and feet. The second trend is proximodistal development, which means that growth progresses from gross motor movements (such as learning to lift one's head) to fine motor movements (such as learning to pick up a toy with the fingers). The last trend is symmetric development of the body, with both sides of the body developing equally.

33. Then nurse is caring for single, professional woman age 29 years, who was admitted with a severe gall bladder attack. The nurse visits with her and performs an assessment. The client is not married and fears a committed relationship because of a bad experience some years ago. The nurse knows that, according to Erikson's developmental theory, Judith is in danger of which of the following?

A) Isolation

B) Inferiority

C) Role confusion

D) Stagnation

Ans: A

Feedback:

Erikson's theory of young adulthood relates to finding one's life partner and sharing intimacy. The tasks for the young adult are to unite self-identity with identities of friends and to make commitments to others. Fear of such commitments results in isolation and loneliness. Role confusion, inferiority, and stagnation are related to Erikson's other age groups.

34. The nurse is working on the pediatric unit today and caring for a girl age 8 months who is admitted with a respiratory infection. As the nurse assesses her, the mother notes that she thinks her daughter is ready to walk. The nurse explains cephalocaudal development to her and why walking may take a little longer to happen. The nurse also provides some information about appropriate expectations. Place the following developmental abilities in order according to cephalocaudal progression.

1. Roll over

2. Sit up alone

3. Crawl

4. Walk

5. Run

6. Skip

A) 1, 2, 4, 6, 3, 5

B) 1, 3, 2, 4, 5, 6

C) 1, 2, 3, 4, 5, 6

D) 1, 2, 4, 3, 6, 5

E) 2, 1, 3, 4, 5, 6

Ans: C

Feedback:

Growth and development follow regular and predictable trends. Cephalocaudal (proceeding from head to tail) development is the first trend, with the head and brain developing first, followed by the trunk, legs, and feet.

The nurse is working on the pediatric unit today and caring for an infant age 3 months who is admitted with a respiratory infection. As the nurse assesses her, the mother tells states that she thinks the baby is ready to feed herself. The nurse explains proximodistal development to the mother and why self-feeding may take a little longer to happen. The nurse provides some information about appropriate expectations. Place the following developmental abilities in order according to proximodistal progression.

1. Waving arms

2. Lifting head

3. Holding a spoon

35. 4. Picking up a grain of rice

A) 1, 2, 3, 4

B) 2, 1, 3, 4

C) 3, 1, 2, 4

D) 2, 3, 1, 4

Ans: B

Feedback:

Proximodistal development means that growth progresses from gross motor movements (such as learning to lift one's head) to fine motor movements (such as learning to pick up a toy with the fingers).

Chapter 22, Conception Through Young Adult

1. A nurse is teaching a young woman about healthy behaviors during the embryonic stage of pregnancy. Which of the following should the nurse emphasize to prevent congenital anomalies?

A) Adequate intake of food and fluids

B) Importance of rest and sleep

C) Avoid alcohol and nicotine

D) Progression of stages during delivery

Ans: C

Feedback:

The embryonic stage of prenatal development occurs from the fourth to the eighth week of pregnancy. Because this is a period of rapid growth and change, the fetus is especially vulnerable to any factor that might cause congenital anomalies, such as maternal use of alcohol and nicotine. Although the other choices are appropriate in educating the pregnant woman, they do not prevent congenital anomalies.

2. A nurse is teaching a pregnant woman about nutritional needs. Which of the following nutritional deficiencies during pregnancy might result in neural tube defects in the developing fetus?

A) Vitamin D

B) Iodine

C) Calcium

D) Folic acid

Ans: D

Feedback:

During pregnancy, maternal nutrition is essential for normal fetal growth and development. Folic acid deficiencies might result in neural tube defects in the infant.

3. At birth, the neonate must adapt to extrauterine life through several significant physiologic adjustments. Which of the following is the most important adjustment that occurs?

A) Body temperature responds to the environment

B) Reflexes develop

C) Stool and urine are eliminated

D) Breathing begins

Ans: D

Feedback:

At birth, the neonate must adapt to extrauterine life through several significant physiologic adjustments. The most important occur in the respiratory and circulatory systems as the neonate begins breathing and becomes independent of the umbilical cord.

4. A nurse documents the following data upon assessment of a neonate: heart rate 89 BPM, slow respiratory effort, flaccid muscle tone, weak cry, and pale skin tone. What would be the Apgar score for this neonate?

A) 2

B) 3

C) 4

D) 5

Ans: B

Feedback:

The neonate is assessed immediately after birth. Of several existing measurement scales, the Apgar rating scale is the most commonly used. This scale is used to assess neonates 1 minute and 5 minutes after birth. This baby would receive 1 point for slow heartbeat, 1 point for slow respiratory effort, and 1 point for weak cry. Flaccid muscle tone and pale skin tone are both 0 points.

5. A nurse is teaching a group of parents about the dangers of Sudden Infant Death Syndrome (SIDS). The nurse recommends that parents place their children on a firm surface laying on their:

A) left side.

B) right side.

C) abdomen.

D) back.

Ans: D

Feedback:

Because sleep habits have been implicated with SIDS, it is recommended that healthy infants up to the age of 6 months sleep on their back (rather than the stomach) on a firm surface in a safety-approved crib. Placing infants in a side-lying position is not recommended because babies who sleep on their sides are more likely to roll onto their abdomen.

6. A nurse is observing a group of toddlers at play. What behavior illustrates normal physiologic development in children of this age?

A) Attempting to feed self

B) Using fingers to pick up small objects

C) Throwing and catching a ball

D) Understanding the feelings of others

Ans: B

Feedback:

Toddlers, aged 1 to 3, can pick up small objects with their fingers. The other responses are characteristic of other stages of physiologic development: Infants attempt to feed themselves; preschoolers can throw and catch balls; school-aged children understand the feelings of others (cognitive, not physiologic, development).

7. A nurse watches as a child continuously tells her mother “no!” to each comment the mother makes. The nurse knows that this behavior, termed negativism, is characteristic of which of the following developmental groups?

A) Toddler

B) Preschooler

C) School-aged child

D) Adolescent

Ans: A

Feedback:

Negativism (characteristically expressed by saying no) and outbursts of temper result from the toddler's efforts at control over the environment.

8. A preschooler is in Kohlberg's preconventional phase of moral reasoning. What is the focus of the phase?

A) To learn sex differences and modesty

B) A sexual desire for the opposite sex

C) Obeying rules to avoid punishment

D) Literal concept of God as a male human

Ans: C

Feedback:

The focus of the preschooler, based on Kohlberg's theory, is on obeying rules to avoid punishment and receive a reward. Although the other responses are characteristic developments of the preschooler, they are not components of moral development.

9. Which of the following sets of terms best characterizes the school-aged child?

A) Reflexes, alert state, temperament

B) Negativism, regression, anal stage

C) Preoperational, asking "why," fears

D) Doing, succeeding, accomplishing

Ans: D

Feedback:

The school-aged child is in the industry-versus-inferiority stage of Erikson's theory, with a focus on learning useful skills and developing positive self-esteem. The emphasis is on doing, succeeding, and accomplishing.

10. What social group prepares the school-aged child to get along in the larger world and teaches appropriate sex role behavior?

A) Parents

B) Peers

C) Siblings

D) Grandparents

Ans: B

Feedback:

Peer groups in middle childhood help prepare the child for getting along in the larger world and teach appropriate sex role behavior. They also act as transition models for the child in leaving the caregiver influence and moving toward adult independence.

11. A student nurse reading a client's chart notes that the physician has documented an adolescent as prepubescent. What does the term prepubescent mean?

A) Adult secondary sex characteristics are present

B) Ova and sperm are produced by the reproductive organs

C) Reproductive organs do not yet produce ova and sperm

D) Active sexual behavior has been initiated

Ans: C

Feedback:

Puberty can be divided into three stages. In the first stage—prepubescence—secondary sex characteristics begin to develop but the reproductive organs do not yet function.

12. A college student 20 years of age is preparing for a career as a teacher. What need initially influences the decision to establish a career?

A) Overcoming low self-esteem

B) Becoming independent of one's family

C) Establishing one's own moral philosophy

D) Demonstrating industry and spirituality

Ans: B

Feedback:

A major psychosocial developmental requirement for the young adult is choosing a vocation. The decision to enter the world of work is strongly influenced initially by the need to become independent of one's family and to be self-sufficient.

13. A nurse is teaching a young couple about the normal changes during pregnancy. What should be included in the teaching sessions about the expectant father's role?

A) Nothing, the mother's preparation is more important.

B) In a traditional family, the mother is responsible for child care.

C) The importance of feeling pride as a future parent.

D) The provision of support in meeting maternal needs.

Ans: D

Feedback:

During pregnancy, the expectant father needs to learn the normal physiologic and psychological changes of pregnancy, explore his feelings about the developing infant and birth, and accept his supportive role in meeting maternal needs.

14. What is the primary risk to the developing fetus during pregnancy if there is cocaine use by the mother?

A) Decreased fetal circulation and oxygenation

B) Increased maternal weight gain and edema

C) Neural tube defects and low birth weight

D) Respiratory difficulties and excess mucus

Ans: A

Feedback:

The maternal use of cocaine during pregnancy brings about abrupt changes in the mother's blood pressure, resulting in decreased fetal blood flow and oxygenation.

15. A nurse is educating the parents of an infant about possible health problems during infancy. Which of the following health problems during infancy is most serious?

A) Colic

B) Seborrheic dermatitis

C) Failure to thrive

D) SIDS

Ans: D

Feedback:

SIDS (sudden infant death syndrome) is the sudden death of an infant under the age of 1 year, unexpected in light of the infant's history, in which a postmortem examination fails to reveal a cause of death. It is the leading cause of death in infants aged 1 week to 1 year.

16. A nurse is explaining ADHD to a community parents group. What characteristics of this disorder are exhibited by an affected child?

A) Daydreams, math difficulties, speech problems

B) Inattention, impulsiveness, hyperactivity

C) Enuresis, shyness, scoliosis

D) Separation anxiety, reading difficulties, boredom

Ans: B

Feedback:

ADHD is a developmentally inappropriate degree of inattention, impulsiveness, and hyperactivity. To be diagnosed, the child must have manifested symptoms before the age of 7 years, and the symptoms must be present in at least two settings.

17. An adolescent client tells the nurse, "I just don't want to live anymore." What should the nurse do next?

A) Document the adolescent's statement in the client record.

B) Sit down and discuss all the reasons there are for living.

C) Make an immediate referral to a suicide-prevention professional.

D) Laughingly, teach the adolescent about making scary statements.

Ans: C

Feedback:

Suicide is the third leading cause of death in adolescents and young adults. Verbal or nonverbal indicators of suicide should not be ignored; rather, an immediate referral should be made to a professional trained in suicide prevention.

18. A mother of three children under the age of 4 tells the nurse, "I don't understand why my children are so hard to toilet train before they are 2." How should the nurse respond?

A) "Bladder control during the day usually occurs by ages 2.5 to 3 years."

B) "Do you think you are doing something wrong? They should be trained."

C) "I don't know. I will have to talk to your doctor, and I will let you know."

D) "I had that same problem. You just have to try harder."

Ans: A

Feedback:

Toddlers between the ages of 2.5 and 3 years usually have bladder control during the day and sometimes at night.

19. A nurse is teaching a group of expectant parents about infant safety. Which of the following is mandated by the law to promote infant safety?

A) Lowering temperatures on hot water heaters

B) Covering electrical outlets with safety prongs

C) Removing all cords from mini-blinds and drapes

D) Using special car safety seats and restraints

Ans: D

Feedback:

Preventive measures against safety hazards must be taught to new parents. The law mandates the use of special car safety seats and restraints for infants. The other choices are important safety considerations, but they are not mandated by law.

20. A student nurse is assigned to care for a preschool child who is scheduled for surgery. How can the student decrease the child's fears about the surgery?

A) Explain that nothing is going to hurt and that it will soon be over.

B) Be honest about pain and use words the child can understand.

C) Ask the child's parents to pretend that nothing is going to be done.

D) Ignore the child's fears and focus on teaching the parents.

Ans: B

Feedback:

Preschool-aged children who are scheduled for surgery or hospitalization have many fears. The nurse can help decrease fears by explaining procedures in language the child can understand and by being honest about how much pain a procedure will cause. The other choices would not be honest nor help the child.

21. Which of the following would be an appropriate topic for a nurse to present at an elementary school PTA meeting?

A) Prevention of congenital anomalies

B) Dangers of smoking and drinking during pregnancy

C) Importance of bonding and attachment

D) Commonality of communicable diseases

Ans: D

Feedback:

With increased interactions with other children in school, communicable conditions, such as scabies, impetigo, and head lice, are more prevalent. The other choices are not appropriate educational topics for parents of elementary school children.

22. A young adult tells the nurse that he has been sexually active with his girlfriend. What teaching is most important for this individual?

A) Proper hygiene

B) Condom use

C) Relationships

D) Stress

Ans: B

Feedback:

Adolescents and young adults who engage in unprotected sexual intercourse are at a higher risk for contracting sexually transmitted diseases (and their complications) than are adults. All STDs, especially AIDS, pose serious health threats.

23. A school nurse is concerned about the almost skeletal appearance of one of the high school students. Although all of the following nutritional problems can occur in adolescents, which one is most often associated with a negative self-concept?

A) Eating fast foods

B) Obesity

C) Fad dieting

D) Anorexia nervosa

Ans: D

Feedback:

Fad diets, eating fast foods, and obesity are common nutritional problems in adolescents. However, the most common severe eating disorders are anorexia nervosa and bulimia, which almost always involve a negative self-concept.

24. An girl age 18 years has chosen not to attend a party in which alcohol will be consumed. Which value system is she most likely adhering to?

A) Role modeling

B) Intimacy versus isolation

C) Law-and-order orientation

D) Autonomy versus shame and doubt

Ans: C

Feedback:

Adolescents have a high level of moral judgment, with a law-and-order orientation.

25. A woman is visiting the office and is in her third trimester of pregnancy. She asks the nurse about the development that is occurring at this stage of pregnancy. Which is accurate to tell her about the fetus?

A) The lungs are mature.

B) The fetus is 11 to 14 inches.

C) The arms and legs are reflexive.

D) The head circumference is 34 cm.

Ans: A

Feedback:

In the third trimester, the lungs are mature.

26. The nursing student is assessing a neonate who has been brought to the clinic for a well-baby visit. Which of the following would the nursing student expect as normal development for a neonate?

A) Reaching for objects

B) Staring at objects

C) Kicking at objects

D) Selecting specific objects

Ans: B

Feedback:

Neonates stare at objects, but are not capable of reaching, kicking or selecting objects at this phase of development.

27. The nurse is educating the mother of an infant age 4 months on safety concepts in child rearing. Which of the following statements by the mother suggests that she may require some repetition and reinforcement of the information?

A) I must keep small objects out of the baby's reach.

B) The baby will sleep in her crib, not with me and my husband."

C) I must keep appointments for the baby's immunizations.

D) The baby can sleep on her stomach during naps.

Ans: D

Feedback:

Because sleep habits have been implicated with SIDS, it is recommended that healthy infants up to the age of 6 months sleep on their back (rather than the stomach) on a firm surface in a safety-approved crib. There is a schedule that includes recommendations for infant immunizations from the Advisory Committee on Immunization Practices. Because infants put small objects in their mouths, choking is a risk. Accidental deaths occur most commonly when infants sharea bed with parents (cosleeping) and are inadvertently wedged beneath another person, trapped in a dangerous position, such as between the bed and the wall, or suffocated by bedding.

28. The nurse is visiting with the mother of a child age 20 months. The mother reports concern about the frequency of the toddler's loud outbursts of temper and saying no. The nurse recalls Erikson's theory about negativism and tells the mother which of the following?

A) This is normal, and this is how your child tries to exert control over his environment.

B) This is unacceptable and you must provide appropriate discipline.

C) This has to do with regression and is a response to stress.

D) This is normal and has to do with learning right from wrong.

Ans: A

Feedback:

Negativism (characteristically expressed by saying no) and outbursts of temper result from the toddler's efforts at control over the environment. Because this is normal, severe discipline is not warranted. Regression, or behavior that is more characteristic of a younger age, can occur at any time in response to stressful circumstances. Learning right from wrong is one of the tasks in Havighurst's theory.

29. The nurse is providing education on child growth and development to a group of parents at a public health clinic. In answer to a question about childhood enuresis, the nurse verifies that this can be a significant issue to the child and the parents. The nurse should be sure to inform the group that this condition is which of the following?

A) A benign and self-limiting disorder

B) Increasing in incidence in the United States

C) Of significant concern to pediatricians

D) Due to a lack of physical activity

Ans: A

Feedback:

Enuresis is diagnosed when a child is at least 5 years of age and is still having involuntary urination, usually at night. Although this problem is significant to the child and his or her parents, it is defined as a benign and self-limiting disorder, usually ending between 6 and 8 years of age. There is no research indicating that the incidence is increasing in the United States or that it is caused by lack of physical activity.

30. The nurse is providing education on childhood safety to a group of parents. In response to a question, the nurse relates that the major causes of death in toddlers include which of the following? Choose all that apply.

A) Infections

B) Childhood diseases

C) Drowning

D) Motor vehicle crashes

E) Accidents

Ans: C, D, E

Feedback:

Accidents, such as motor vehicle crashes, poisonings, burns, drowning, choking and aspirations, and falls are the major cause of death in toddlers. Childhood diseases are not a factor due to current immunization protection. Most infections are treatable with antibiotics.

31. The nurse provides prenatal education to a group of pregnant teenagers. One of the group members asks the nurse to talk about the possible complications for a newborn. An accurate statement about neonatal complications would be which of the following?

A) Respiratory difficulties

B) Physiologic jaundice

C) Caput succedaneum

D) Subconjunctival hemorrhage

Ans: A

Feedback:

Respiratory difficulties can occur and be life-threatening to the neonate. Birth traumas that cause temporary symptoms are of concern because the parents need to be reassured that the symptoms will disappear. Examples include caput succedaneum (localized edema of the scalp), molding (elongation of the skull as the baby passes through the birth canal), and subconjunctival hemorrhage. The nonthreatening nature of physiologic jaundice, which commonly occurs in the neonate's first days, should also be explained to the parents.

32. The nurse is providing prenatal education for a group of young pregnant women. One woman asks about the advantages of breastfeeding her infant. Which of the following would the nurse include in answer to this question? Choose all that apply.

A) Has high lactose and low protein content

B) Permanent immunity from certain infections

C) Acidic environment which inhibits bacterial growth

D) Contains antibodies, immunoglobulins, and leukocytes

E) Alkaline environment which inhibits microbe growth

Ans: A, C, D

Feedback:

The neonate inherits a transient immunity from infections as a result of immunoglobulins that cross the placenta. Breastfeeding provides further protection against bacterial and viral infections through antibodies, immunoglobulins, and leukocytes in breast milk. The high lactose content in breast milk, combined with limited protein, promotes an acid environment that is unsuitable for bacterial growth.

33. The nurse is educating a Young Childcare class and one of the parents asks what kinds of actions on his part may increase safety for his 14-month-old daughter during the next 2 years. Which of the following responses would be appropriate? Choose all that apply.

A) Keep medications locked away

B) Keep plastic bags out of reach

C) Use approved car seats

D) Teach to chew small food well

E) Do not swing by arms or legs

Ans: A, B, C, E

Feedback:

Accidents are a leading cause of injuries and death in toddlers. Toddlers are curious about medications and may swallow them if allowed. They may asphyxiate themselves if allowed to play with plastic bags. Approved car seats will keep them safe in case of a motor vehicle accident. Swinging by extremities may cause dislocation of joints. Toddlers should not be allowed access to small-sized foods, such as grapes, olives, or carrot rounds. Small, hard foods should never be allowed.

34. A school nurse often observes adolescents challenging the decision making of their parents and teachers. Which of these developmental theorists relates this as an expected occurrence?

A) Piaget

B) Freud

C) Havighurst

D) Erikson

Ans: A

Feedback:

According to Piaget, challenging the decision making of adults is common in adolescence.

35. A nurse is teaching the care of the newborn class and one of the members makes a comment about keeping the baby too warm. She says, My mother always said to go by how I feel; if I'm cold, the baby needs more clothing and if I'm too warm, so is the baby." Which of the following is the nurse's best response?

A) That is correct; you should go by how warm you are feeling.

B) Always keep the baby bundled up to keep warm.

C) The baby's temperature responds quickly to the environmental temperature.

D) If the baby shivers, add more layers of clothing.

Ans: C

Feedback:

The newborn is unable to regulate its body temperature, so it takes on the temperature of the environment. The mother cannot go by how she feels because hormonal changes after childbirth may affect her temperature. Always keeping the baby bundled will probably cause overheating in some cases. The newborn is unable to produce heat by shivering.

Chapter 23, The Aging Adult

1. A client age 71 years has recently integrated large amounts of blueberry and pomegranate juice into her diet, touting their antioxidant properties that mitigate the effects of separated high-energy electrons. The client's actions reflect which of the following theories of aging?

A) Free radical theory

B) Genetic theory

C) Cross-linkage theory

D) Immunity theory

Ans: A

Feedback:

Free radicals, formed during cellular metabolism, are molecules with separated high-energy electrons, which can have adverse effects on adjacent molecules. Antioxidants are purported to mitigate the effects of these free radicals. Neither the genetic theory, immunity theory, nor cross-linkage theory of aging directly addresses the potentially harmful effects of free radicals.

2. The staff at a long-term care facility have made minimal effort to secure a shared room for a couple in their late 80s, who have been married for several decades. The manager states, "I'm sure that bedroom activity is the last thing on their mind these days." How should the nurse best respond to the manager's characterization of sexuality in older adults?

A) "They might not be as active as in years past, but sexuality is still important for older people."

B) "It's actually a myth that older adults have sex less often than younger adults."

C) "There's no reason that we should assume they're less interested than when they first got married."

D) "Their sexual activity has probably stopped by now, but they still need companionship."

Ans: A

Feedback:

Although sexual activity may be less frequent, the ability to perform and enjoy sexual activity lasts well into the 90s in healthy older adults. However, it is unlikely that interest remains at the same level as when the couple was first married.

3. Which of the following assessment findings of a male client age 77 years should signal the nurse to a potentially pathologic finding, rather than a normal age-related change?

A) The client is oriented to person and place but is unsure of the month.

B) The client states that his urine stream is less strong than in the past.

C) The client claims to hear high-pitched sounds less clearly than earlier in life.

D) The client's gait is slow and his posture appears stooped.

Ans: A

Feedback:

Age-related physiologic changes include a weakening of bladder emptying, presbycusis, and a slow gait that may be accompanied by stooped posture. Disorientation to time, however, should always prompt the nurse to perform further assessment and should never be considered a normal accompaniment to the aging process.

4. A home health care nurse has observed that a client 80 years of age, who has multiple chronic health problems, takes a total of 19 medications on either a scheduled or PRN (as needed) basis. How should the nurse address this client's risk of harm from polypharmacy?

A) Ensure that the client's care is coordinated and encourage the primary care provider to review her medication regimen.

B) Recommend holistic and herbal remedies to replace some of the medications.

C) Contact the client's local pharmacy to discuss possible changes to her medication regimen.

D) Encourage the client to reduce her medication load by withholding some medications when she is asymptomatic.

Ans: A

Feedback:

Polypharmacy can sometimes be addressed by conducting a thorough and coordinated review of a client's medication regimen. It would be inappropriate and unsafe for the nurse to arbitrarily withhold some medications or to encourage the client to do so. The client's local pharmacist is not normally able to make independent changes to the client's medication regimen.

5. According to the free radical theory of aging, what substance is affected by aging and causes damage?

A) Carbohydrates

B) Proteins

C) Water

D) Lipids

Ans: D

Feedback:

Free radicals, formed during cellular metabolism, have adverse effects on adjacent molecules. Lipids (found in cell membranes, proteins, and cell organelles) are affected. Over time, irreversible damage results from the accumulated effects of this damage. Carbohydrates, proteins, and water are not affected in this way.

6. Which aging theory describes a chemical reaction that produces damage to the DNA and cell death?

A) Genetic theory

B) Immunity theory

C) Cross-linkage theory

D) Free radical theory

Ans: C

Feedback:

Cross-linkage is a chemical reaction that produces damage to the DNA and cell death. As one ages, cross-links accumulate, leading to essential molecules in the cell that bind together and interfere with normal cell function.

7. According to Erikson, the middle adult is in a period of generativity versus stagnation. What happens if developmental tasks are not achieved?

A) Physical changes are denied

B) Health needs become a major concern

C) Motivation to learn is decreased

D) Awareness of own mortality increases

Ans: B

Feedback:

According to Erikson, if the middle adult does not achieve the tasks of generativity, stagnation results. Adults who do not achieve the tasks of establishing and guiding the next generation, accepting middle-age changes, adjusting to the needs of aging parents, and re-evaluating goals and accomplishments tend to focus on themselves and become overly concerned with their own physical and emotional health needs.

8. A middle adult client requests visits by the hospital chaplain and reads the Bible each day while hospitalized for treatment of heart problems. What is the individual illustrating?

A) Midlife transition

B) Support of the rights of others

C) Fear for the future

D) Trust in spiritual strength

Ans: D

Feedback:

The middle adult, according to Fowler's theory of spiritual development, is less rigid in his or her beliefs and has increased faith in a supreme being, as well as trust in spiritual strength.

9. While conducting a health assessment with an older adult, the nurse notices it takes the person longer to answer questions than is usual with younger clients. What should the nurse do?

A) Stop asking questions so as not to confuse the client.

B) Slow the pace and allow extra time for answers.

C) Realize that the client has some dementia.

D) Ask a family member to answer the questions.

Ans: B

Feedback:

Cognition does not change appreciably with aging. It is normal for the older adult to take longer to respond and react. The nurse should slow the pace of care and allow older clients extra time to answer questions or complete activities.

10. A nurse says to an older adult who is being cared for at home, "Tell me what your life was like when you were first married." What does this statement encourage the client to do?

A) Explain why he or she has certain emotions

B) Become more introspective and self-focused

C) Practice life review or reminiscence

D) Look backward with regret for undone tasks

Ans: C

Feedback:

Older adults search for emotional integration and acceptance of the past and present. They often like to tell stories of past events in life to reminisce, and to restructure life experiences to facilitate achieving ego integrity. This phenomenon, called life review or reminiscence, has been identified worldwide. In a sense, this is a way for an older adult torelive and restructure life experiences and is part of achieving ego integrity. Nurses can also use reminiscence as a therapy to facilitate adaptation to present circumstances.

11. An older adult, newly widowed, has been unable to adjust to her change in roles or form new relationships. What is this experience called?

A) Social isolation

B) Social ineptness

C) Ineffective coping

D) Negativism of aging

Ans: A

Feedback:

If an older adult cannot adjust to changes in social roles and form new relationships, social isolation can become a problem. Social isolation is a sense of being alone and lonely as a result of having fewer meaningful relationships. Social isolation is a sense of being alone and lonely as a result of having fewer meaningful relationships. It may occur because of declining health or income, transportation problems, or ageism. Whatever the cause, prolonged social isolation has been associated with declining health and higher mortality rates.

12. What is one reason for the "middle-aged spread" often seen in middle adults?

A) Changes in hormones

B) Loss of satisfactory roles

C) Decreased physical activity

D) Satisfaction with one's life

Ans: C

Feedback:

Middle-aged adults tend to maintain previous eating patterns and caloric intake while being less physically active. This trend can result in obesity and atherosclerosis, increasing the risk for high blood pressure, coronary artery disease, renal failure, and diabetes.

13. A nurse educates adults in preventive measures to avoid problems of middle adult years. Which of the following are the major health problems during the middle adult years?

A) Cardiovascular disease, cancer

B) Upper respiratory infections, fractures

C) Communicable diseases, dementia

D) Sexually transmitted diseases, drug abuse

Ans: A

Feedback:

The major health problems of the middle adult years are cardiovascular and pulmonary diseases, cancer, rheumatoid arthritis, diabetes, obesity, alcoholism, and depression. The risk for these health problems often depends on a combination of lifestyle factors and aging.

14. Which of the following statements is true for nursing care of older adults?

A) Most older adults are unable to care for themselves independently.

B) Most older adults are functional, benefiting from health-oriented interventions.

C) Fewer older adults will require nursing care during the 21st century.

D) Interventions for older adults are no different from those for young adults.

Ans: B

Feedback:

As the number of older adults increases, nurses will spend more time providing care for this population. Most older adults are not impaired but remain functional in the community, thereby benefiting from health-oriented nursing interventions.

15. A nurse is developing a plan of care for an older adult with chronic heart disease. Which of the following factors must be considered?

A) Family members do not need to be as involved in the care of the older adult.

B) Almost 100% of all older adults have limitations from multiple chronic illnesses.

C) Older adults do not want to maintain their health and independence.

D) Medications, hospitalizations, and medical supplies increase economic difficulties.

Ans: D

Feedback:

Family members must learn to cope with needs of the chronically ill older adult. About 50% of older adults have limitations from one or more chronic illnesses. Most older adults want to remain healthy and independent. Economic difficulties are a major concern.

16. A woman aged 88 years who lives alone has deficits in vision and hearing, although these deficits are corrected by glasses and hearing aids. Her blood pressure medicine is making her dizzy. What response to these health problems would the home health nurse identify?

A) Risk for decreased social interaction

B) Altered consciousness

C) Risk for accidental injury

D) Risk for impaired judgment

Ans: C

Feedback:

The older adult is at increased risk for accidental injury because of changes in vision and hearing, loss of muscle mass and strength, slower reflexes and reaction time, and decreased sensory ability. The effects of chronic illness and medications may also make the older adult more prone to accidents.

17. The daughter of an older adult calls the nurse practitioner to report that her mother is becoming very confused after dark. What is this type of confusion named?

A) Night-time confusion

B) Sundowning syndrome

C) Alzheimer's disease

D) Cognitive dysfunction

Ans: B

Feedback:

Sometimes confusion and depression in an older adult are mistaken for true dementia. A type of confusion called sundowning syndrome sometimes occurs, in which the older adult habitually becomes confused after dark.

18. During a health assessment, a woman age 49 years tells the nurse that she is "just so tired and has been having mood swings and hot flashes." Based on this information, the nurse would conduct a more thorough history and assessment of what body system?

A) Reproductive

B) Cardiovascular

C) Respiratory

D) Cranial nerves

Ans: A

Feedback:

Women between the ages of 40 and 55 experience menopause, with a gradual decrease in ovarian function and subsequent depletion of estrogen and progesterone. Menstrual periods stop abruptly or gradually, and many women experience hot flashes, mood swings, and fatigue. The nurse would focus on assessing the reproductive system.

19. While caring for an older adult male, the nurse observes that his skin is dry and wrinkled, his hair is gray, and he needs glasses to read. Based on these observations, what would the nurse conclude?

A) These are normal physiologic changes of aging.

B) The observations are not typically found in older adults.

C) These are abnormal observations and must be reported.

D) Extra education will be necessary to prevent complications.

Ans: A

Feedback:

Dry wrinkled skin, gray hair, and needing glasses to read are all commonly occurring and normal physiologic changes of aging. They are not abnormal and do not lead to complications.

20. A teenager states, “Old people are different. They don’t need the same things that young people do.” What is this statement an example of?

A) Racism

B) Ageism

C) Indifference

D) Knowledge

Ans: B

Feedback:

Ageism is a form of prejudice, like racism, in that older adults are stereotyped by characteristics found in only a few members of their age group. In ageism, older adults are viewed as different and without the same desires, needs, and concerns as others.

21. Which of the following statements is true of the older adult population?

A) Old age begins at 65 years of age.

B) Most older adults live in nursing homes.

C) Older adults are not interested in sex.

D) Incontinence is not a part of aging.

Ans: D

Feedback:

Although a common myth of aging is that bladder problems are common, in actuality incontinence is not a normal part of aging and should warrant medical attention.

22. A nurse is educating a group of middle adults about health promotion. What statement by one of the participants indicates the need for additional education?

A) “I will make exercise a part of my daily activities.”

B) “I should eat a diet high in fats but low in fiber.”

C) “I will begin a smoking cessation program this week.”

D) "I only have one glass of wine a day with dinner."

Ans: B

Feedback:

Health promotion activities for the middle adult include a diet low in fat and cholesterol that includes fruits, vegetables, and fiber; regular daily exercise; drinking alcohol in moderation; and no smoking.

23. In general, what is the focus of care for nurses who work with older adults?

A) Providing all necessary physical care

B) Referring clients for needed emotional support

C) Establishing goals and expected outcomes for the client

D) Assisting clients to function as independently as possible

Ans: D

Feedback:

The focus of nursing care is to assist older adults to function as independently as possible, and to support their individual strengths.

24. A nurse is providing care to an older adult at home after major abdominal surgery. Which of the following nursing diagnoses would most likely be appropriate?

A) Adult Failure to Thrive

B) Anticipatory Grieving

C) Impaired Memory

D) Risk for Infection

Ans: D

Feedback:

The older adult heals more slowly and may have decreased immune function. Combined with dry skin that has decreased elasticity, these factors increase the risk for infection from the abdominal incision.

25. A nurse documents the following assessment on an older adult client's chart: "dry, thin skin." Which of the following nursing diagnoses would be appropriate for this client?

A) Risk for falls

B) Risk for imbalanced body temperature

C) Risk for infection

D) Risk for sedentary lifestyle

Ans: C

Feedback:

The dry, thin skin of elderly clients is prone to infection.

26. An older adult lives in a facility that provides, housing, group meals, personal care and support, social activities, and minimal health care services. What type of facility does this describe?

A) Nursing home

B) Assisted living

C) Accessory apartment

D) Home modification

Ans: B

Feedback:

Various types of housing options exist for older adults. Assisted-living facilities generally provide housing, group meals, personal care and support services, and social activities in a social setting, and there may be some health care provided. Nursing homes provide skilled nursing care and/or long-term care, including meals, personal care, and medical care. An accessory apartment is a separate apartment constructed in part of an existing house, such as a basement or attic. Home modification allows older adults to stay in their own homes by making changes to the home.

27. A nurse who provides care in a long-term care facility recognizes the need to promote health rather than solely treating illness. Which of the following measures should the nurse encourage among the older adult resident population of the facility? Select all that apply.

A) Encourage frequent naps in order to ensure adequate sleep and rest.

B) Encourage residents to take dietary supplements when safe.

C) Conduct activities at a slower pace and allow residents time to respond.

D) Encourage residents to engage in the present rather than perform reminiscence.

E) Promote self-care and only assist residents when it is necessary.

Ans: B, C, E

Feedback:

Dietary supplements are appropriate and conducive to health, provided safety has been considered. It is appropriate to conduct activities at a somewhat slower pace with older adults, since a mild slowing of cognitive and neurological function is a recognized phenomenon that is considered normal. Self-care should be fostered and assistance provided when necessary. Frequent naps are counterproductive to healthy sleeping and waking cycles. Reminiscence is a healthy and important process and it does not preclude engagement with the present.

28. Which of the following are physical changes that occur in middle adulthood? Select all that apply.

A) Body fat is redistributed.

B) The skin is more elastic.

C) Cardiac output begins to increase.

D) Muscle mass gradually decreases.

E) There is a loss of calcium from bones.

Ans: A, D, E

Feedback:

In middle adulthood, fatty tissue is redistributed; men tend to develop abdominal fat, women thicken through the middle, and the skin is drier. Also, cardiac output begins to decrease; muscle mass, strength, and agility gradually decrease; there is a loss of calcium from bones, especially in perimenopausal women; and hormone production decreases, resulting in menopause or andropause.

29. While providing hygiene care to a confused older adult client diagnosed with Alzheimer's disease, the nures is called to the nursing station. To ensure patient safety the nurse must do what?

A) Ask a family member to stay with him.

B) Cover him with a blanket for warmth.

C) Reattach the restraints.

D) Put side rails up before leaving the client.

Ans: D

Feedback:

The issue is safety of a confused client, so the side rails must be up. It is not the family's responsibility to maintain his safety, a blanket is not for safety, and restraints are not routinely used.

30. The nurse is assigned to a 52-year-old male patient. He is talkative and usually friendly when the nurse enters his room. Today, however, he is standing at the mirror and says: I lost my job because the company downsized, there isn't anything I can do. As his caregiver, the nurse recognizes this expression of concern is related to which of the following?

A) He assumes the termination is his fault.

B) Dissatisfaction with changes in his appearance and energy levels.

C) His career goals and retirement plans are compromised.

D) He is in an androgenic crisis.

Ans: C

Feedback:

The loss of his employment is a major change that disrupts his life-long goals. The middle adult is becoming aware of physical changes and limited time to live. This situation is not a hormonal crisis, and although the patient may feel the job loss is his fault, that is not what he expressed.

31. Dementia is a disorder that progresses over several years, with increasing confusion, forgetting family, and disorientation in familiar surroundings. A common problem with dementia patients is sundowning syndrome, which is described as …

A) a behavior change at sunset as the client becomes more fatigued, listless, and disoriented.

B) occasional onset of marked confusion, wandering and feeling lost during the afternoon, before sunset.

C) habitual agitation, restlessness, and confusion that occurs after dark.

D) increasing sleeplessness at night because the patient cat-naps during the day.

Ans: C

Feedback:

Sundowning syndrome is described as a common problem in clients with dementia, in which the older adult client habitually becomes confused, restless, and agitated after dark.

32. Eighty percent of older adults have one chronic illness, and 60% have at least two. The older adult's ability to adapt determines:

A) whether they are ill or healthy.

B) degree of loss of the physiologic reserve of the various organ systems

C) that not wanting to change makes them more determined.

D) how quickly they become overwhelmed with the stress of it all.

Ans: A

Feedback:

There is growing evidence that aging is not synonymous with loss of function or disability. Although coping with chronic illness is common for the older adult, the ability to adapt determines whether they are ill or healthy.

33. One of the adverse events that Medicare will no longer reimburse the hospital for is an in-hospital fall. Fall prevention is a major part of nursing and risk management. In order to reduce the risk of falling, the nurse must:

A) ensure that the patient wears his prescription glasses when up.

B) post signs to alert staff to the patient at high risk for falls.

C) always assist every patient with ambulation.

D) assess the patient's fatigue level.

E) monitor gait and balance.

Ans: A, B, D, E

Feedback:

Fall prevention need only apply to patients at risk. It is not realistic to expect that every patient would always need assistance to ambulate.

34. The home health nurse is making an initial home visit to a male widow age 76 years. During the assessment the nurse finds that the client is taking multiple medications. The client states that he has also been taking some herbal remedies. What should the nurse be sure to include in the client education?

A) Herbal remedies are holistic.

B) Herbal remedies are often cheaper than prescribed medicine.

C) The importance of avoiding herbal remedies

D) The need to inform his physician and pharmacist about the herbal remedies

Ans: D

Feedback:

Herbal remedies combined with prescribed medications can lead to interactions that may be toxic. Clients should notify the physician and pharmacist of any herbal remedies they are using. Option A is incorrect even though herbal remedies are considered holistic; this is not something that is necessary to include in the client education. Option B is incorrect; herbal remedies may be cheaper than prescribed medicine but this is still not something that is necessary to include in the client education. Option C is incorrect because for most people it is not necessary to avoid herbal remedies.

35. According to Havighurst, which of the following are developmental tasks of middle adulthood? Select all that apply.

A) Accept and adjust to physical changes.

B) Maintain a satisfactory occupation.

C) Assist children to become responsible adults.

D) Maintain social contacts and relationships.

E) Relate to one’s spouse or partner as a person.

Ans: A, B, C, E

Feedback:

The developmental tasks of the middle adult described by Havighurst (1972) are learned behaviors arising from maturation, personal motives and values, and civic responsibility. To successfully master this developmental stage, the middle adult must accept and adjust to physical changes, maintain a satisfactory occupation, assist children to become responsible adults, adjust to aging parents, and relate to one’s spouse or partner as a person. Maintaining social contacts and relationships, as well as being flexible and adapting to age-related roles, is a task of older adulthood.

Chapter 24, Asepsis and Infection Control

1. The nurse is aware that an antiviral medication is most effective when given during which phase of the infectious process?

A) Prodromal stage

B) Incubation period

C) Full stage of illness

D) Convalescent period

Ans: A

Feedback:

When given during the prodromal stage of certain viruses, antiviral medications can shorten the full stage of the illness.

2. Which of the following most accurately defines an infection?

A) An illness resulting from living in an unclean environment

B) The result of lack of knowledge about food preparation

C) A disease resulting from pathogens in or on the body

D) An acute or chronic illness resulting from traumatic injury

Ans: C

Feedback:

An infection is a disease state that results from the presence of pathogens (disease-producing microorganisms) in or on the body.

3. A client who has had abdominal surgery develops an infection in the wound while still hospitalized. Which of the following agents is most likely the cause of the infection?

A) Virus

B) Bacteria

C) Fungi

D) Spores

Ans: B

Feedback:

Some of the more prevalent agents that cause infection are bacteria, viruses, and fungi. Bacteria are the most significant and most commonly observed infection-causing agents in health care institutions.

4. A nurse caring for a client who has gas gangrene knows that this infection originated in which of the following reservoirs?

A) Other people

B) Food

C) Soil

D) Animals

Ans: C

Feedback:

The soil can act as a reservoir; the organisms that cause gas gangrene and tetanus are examples of pathogens whose reservoir is soil. Nurses can serve as reservoirs and inadvertently transfer pathogenic organisms to clients. For example, a nurse with artificial nails may harbor a large number and variety of microbes under the nails. Undercooked ground beef, tomatoes, and bagged spinach are reservoirs that have been identified as responsible for recent outbreaks of *E. coli* infections. The rabies virus is an example of a pathogen whose reservoir is various animals, notably dogs, squirrels, bats, and raccoons.

5. A client with an upper respiratory infection (common cold) tells the nurse, "I am so angry with the nurse practitioner because he would not give me any antibiotics." What would be the most accurate response by the nurse?

A) "Antibiotics have no effect on viruses."

B) "Let me talk to him and see what we can do."

C) "Why do you think you need an antibiotic?"

D) "I know what you mean; you need an antibiotic."

Ans: A

Feedback:

Viruses are the smallest of all microorganisms. Viruses, including the common cold and AIDS, cause many infections. Antibiotics have no effect on viruses.

6. A woman tests positive for the human immunodeficiency virus antibody but has no symptoms. She is considered a carrier. What component of the infection cycle does the woman illustrate?

A) A reservoir

B) An infectious agent

C) A portal of exit

D) A portal of entry

Ans: A

Feedback:

Humans may act as reservoirs for an infectious agent and not exhibit any manifestations of the disease. They are considered carriers and can transmit the disease. In this case, the woman is the reservoir for the HIV virus.

7. A man on an airplane is sitting by a woman who is coughing and sneezing. If she has an infection, what is the most likely means of transmission from the woman to the man?

A) Direct contact

B) Indirect contact

C) Vectors

D) Airborne route

Ans: D

Feedback:

An organism may be transmitted from its reservoir by various means or routes. Microorganisms can be spread through the airborne route when an infected host coughs, sneezes, or talks or when the organism becomes attached to dust particles.

8. A nurse is caring for an adolescent who is diagnosed with mononucleosis, commonly called “the kissing disease.” The nurse explains that the organisms causing this disease were transmitted by:

A) direct contact.

B) indirect contact.

C) airborne route.

D) vectors.

Ans: A

Feedback:

Organisms can enter the body by way of the contact route, either directly or indirectly. Direct contact involves proximity between the susceptible host and an infected person or a carrier, such as through touching, kissing, or sexual intercourse. Mononucleosis can be spread through direct contact with saliva, mucus from the nose and throat, and sometimes tears.

9. Of all possible nursing interventions to break the chain of infection, which is the most effective?

A) Administering medications

B) Providing good skin care

C) Practicing hand hygiene

D) Wearing gloves at all times

Ans: C

Feedback:

Practicing hand hygiene is the most effective way to help prevent the spread of organisms. Nurses need to focus on this simple procedure that can interrupt the cycle of infection.

10. A nurse is educating a rural community group on how to avoid contracting West Nile virus by using approved insect repellant and wearing proper coverings when outdoors. By what means is the pathogen involved in West Nile virus transmitted?

A) Direct contact

B) Indirect contact

C) Airborne route

D) Vectors

Ans: D

Feedback:

Vectors, such as mosquitoes, ticks, and lice, are nonhuman carriers that transmit organisms from one host to another, that is, by injecting salivary fluid when a human bite occurs.

11. Which of the following questions asked by the nurse when taking a client's health history would collect data about infection control?

A) Tell me what you eat in each 24-hour period.

B) Do you sleep well and wake up feeling healthy?

C) What were the causes of death for your family members?

D) When did you complete your immunizations?

Ans: D

Feedback:

The nurse's role in infection control includes early detection and surveillance. When taking a health history, the nurse asks about immunization status and previous/recurring infections. The other questions are appropriate in a health history, but are not specific to infections.

12. A college-aged student has influenza. At what stage of the infection is the student most infectious?

A) Incubation period

B) Prodromal stage

C) Full stage of illness

D) Convalescent period

Ans: B

Feedback:

A person is most infectious during the prodromal stage. Early signs and symptoms of disease are present, but these are often vague and nonspecific. During this phase, the person often does not realize that he or she is contagious. As a result, the infection spreads.

13. Which of the following is an example of the body's defense against infection?

A) Racial characteristics

B) Body shape and size

C) Immune response

D) Level of susceptibility

Ans: C

Feedback:

The body has various defenses against infection, including normal flora and the inflammatory response. One of the most effective is the immune response, which involves specific reactions in the body as it responds to an invading foreign protein, such as bacteria. The foreign material is called an antigen, and the body commonly responds by producing an antibody. Race, body size and shape, and level of susceptibility do not affect defense against infection.

14. A nurse has seen several clients at a community health center. Which of the clients would be most at risk for developing an infection?

A) An older adult with several chronic illnesses

B) An infant who has just received first immunizations

C) An adolescent who had a basketball physical

D) A middle-aged adult with joint pain and stiffness

Ans: A

Feedback:

Many factors affect the risk for infection, including age, sex, race, and heredity. Neonates and older adults, especially those who have preexisting illnesses, appear to be more vulnerable to infection.

15. A client comes to the emergency department with major burns over 40% of his body. Although all of the following are true, which one would provide the rationale for a nursing diagnosis of Risk for Infection?

A) Stress may adversely affect normal defense mechanisms.

B) White blood cells provide resistance to certain pathogens.

C) Intact skin and mucous membranes protect against microbial invasion.

D) Age, race, sex, and hereditary factors influence susceptibility to infection.

Ans: C

Feedback:

Intact skin and mucous membranes provide resistance to certain pathogens. A major burn of 40% of the body provides multiple portals of entry for pathogens.

16. A nurse is educating adolescents on how to prevent infections. What statement by one of the adolescents indicates that more education is needed?

A) "I will wash my hands before and after going to the bathroom."

B) "I don't wear a condom when I have sex, but I know my partners."

C) "I always eat fruits and vegetables, and I sleep eight hours a night."

D) "When I have an infection, I rest and take my medications."

Ans: B

Feedback:

Sensible nutrition, adequate rest and exercise, and good personal hygiene habits can help maintain optimum body function and immune response. Unsafe sex practices are potentially dangerous and provide an opportunity for pathogens to enter a host and cause an infection.

17. A female client is on isolation because she acquired a methicillin-resistant *S. aureus* (MRSA) infection after hospitalization for hip replacement surgery. What name is given to this type of infection?

A) Nosocomial

B) Viral

C) Iatrogenic

D) Antimicrobial

Ans: A

Feedback:

For various reasons and sometimes despite best efforts, certain clients in health agencies develop infections that were not noted to be present on admission. The term *nosocomial infection* is used to describe a hospital-acquired infection.

18. The following procedures have been ordered and implemented for a hospitalized client. Which procedure carries the greatest risk for a nosocomial infection?

A) Enema

B) Intramuscular injections

C) Heat lamp

D) Urinary catheterization

Ans: D

Feedback:

Most nosocomial infections are caused by bacteria. Urinary tract infections, pneumonia, and bloodstream infections are the three most common nosocomial infections, most of which can be traced to an invasive device (e.g., a urinary catheter).

19. A nursing home recently has had a significant number of nosocomial infections. Which of the following measures might be instituted to decrease this trend?

A) Mandating antibiotics for all nursing home residents

B) Have written, infection-prevention practices for all employees

C) Requiring all employees to have monthly screenings for skin flora

D) Restricting visitors and community activities for residents

Ans: B

Feedback:

Health care agencies, including hospitals and nursing homes, have found several measures to be successful in reducing the incidence of nosocomial infections. One of these measures is having written, infection-prevention practices for all personnel. Adherence to hand hygiene recommendations and infection-control precaution techniques can prevent many nosocomial infections.

20. What are the recommended cleansing agents for hand hygiene in any setting when the risk of infection is high?

A) Liquid or bar hand soap

B) Cold water

C) Hot water

D) Antimicrobial products

Ans: D

Feedback:

Using handwashing products that contain an antimicrobial or antibacterial ingredient is recommended in any setting where the risk of infection is high. When present in certain concentrations, these agents can kill bacteria or suppress their growth.

21. A nurse has completed morning care for a client. There is no visible soiling on her hands. What type of technique is recommended by the CDC for hand hygiene?

A) Do not wash hands, apply clean gloves.

B) Wash hands with soap and water.

C) Clean hands with an alcohol-based handrub.

D) Wash hands with soap and water, follow with handrub.

Ans: C

Feedback:

The CDC recommends that a health care worker whose hands are visibly soiled or contaminated with blood or body fluids wash the hands with soap and water. If the hands are not visibly soiled, an alcohol-based handrub can be used.

22. Which statement is true of health care personnel and good hand hygiene?

A) Hand hygiene is carefully followed.

B) Compliance is difficult to achieve.

C) Only nurses need to practice hand hygiene.

D) Wearing gloves reduces the need for hand hygiene.

Ans: B

Feedback:

Even though health care personnel know the importance of good hand hygiene, most studies report that compliance with this simple preventive measure is difficult to achieve. Despite intensive educational efforts, good hand hygiene is practiced infrequently.

23. A nurse is caring for a client with a serious bacterial infection. The client is dehydrated. Knowledge of the physical effects of the infection would support which of the following nursing diagnoses?

A) High Risk for Infection

B) Excess Fluid Volume

C) Risk for Imbalanced Body Temperature

D) Risk for Latex Allergy Response

Ans: C

Feedback:

The response of the body to an infectious process (fever), as well as dehydration, would support the nursing diagnosis of Risk for Imbalanced Body Temperature for this client.

24. What is the correct rationale for using body substance precautions?

A) The risk of transmitting HIV in sputum and urine is nonexistent.

B) Disease-specific isolation procedures are adequate protection.

C) Only actively infected clients are considered contagious.

D) All body substances are considered potentially infectious.

Ans: D

Feedback:

Body substance precautions are an extension of universal precautions. These precautions consider all body substances potentially infectious, regardless of a person's diagnosis. The consistent use of barriers whenever health care personnel have contact with moist body substances, mucous membranes, and nonintact skin is highly recommended.

25. The latest CDC guidelines designate standard precautions for all substances except which of the following?

A) Urine

B) Blood

C) Sweat

D) Vomitus

Ans: C

Feedback:

Current CDC guidelines define standard precautions as those used in the care of all hospitalized individuals, regardless of their diagnosis or possible infection status. They apply to blood, all body secretions and excretions (except sweat), nonintact skin, and mucous membranes.

26. A student nurse is performing a urinary catheterization for the first time and inadvertently contaminates the catheter by touching the bed linens. What should the nurse do to maintain surgical asepsis for this procedure?

A) Nothing, because the client is on antibiotics.

B) Complete the procedure and then report what happened.

C) Apologize to the client and complete the procedure.

D) Gather new sterile supplies and start over.

Ans: D

Feedback:

When following surgical asepsis, areas are considered contaminated if they are touched by any object that is also not sterile. One of the most important aspects of medical and surgical asepsis is that the effectiveness of both depends on faithful and conscientious practice by those carrying them out.

27. A nurse is performing a sterile dressing change. If new sterile items or supplies are needed, how can they be added to the sterile field?

A) With sterile forceps or hands wearing sterile gloves

B) By carefully handling them with clean hands

C) With clean forceps that touch only the outermost part of the item

D) By clean hands wearing clean latex gloves

Ans: A

Feedback:

Once a sterile field is established, objects on a field may only be handled by using sterile forceps or with hands wearing sterile gloves. The other choices would contaminate the sterile field.

28. A nurse is positioning a sterile drape to extend the working area when performing a urinary catheterization. Which of the following is an appropriate technique for this procedure?

A) Use sterile gloves to handle the entire drape surface.

B) Fold the lower edges of the drape over the sterile-gloved hands.

C) Touch only the outer two inches of the drape when not wearing sterile gloves.

D) When reaching over the drape do not allow clothing to touch the drape.

Ans: A

Feedback:

Using sterile gloves allows the nurse to handle the entire drape surface. The nurse should fold the lower edges of the drape over the sterile-gloved hands for protection when positioning. When not wearing sterile gloves, the nurse should touch only the outer one inch (2.5 cm) of the drape, and the nurse should not reach over the drape because this would contaminate a sterile area.

29. What are the general nursing care guidelines that the nurse should follow when caring for clients in a health care facility?

A) Avoid physical contact with the infected client.

B) Avoid jewelry with prongs or protruding stones.

C) Isolate the client and keep the room door closed.

D) Shake linens properly when changing the beds.

Ans: B

Feedback:

The nurse should avoid wearing artificial nails, colored nail polish, and jewelry with prongs or protruding stones to avoid the spread of pathogens. The nurse should avoid physical contact with the infected client only when the disease is known to be transmitted through physical contact. The nurse can practice isolation of the client if instructed by the physician, but need not keep the room door closed. The nurse should avoid shaking linens when changing the beds because this causes spread of dust and pathogens.

30. A nurse is required to clean the open wounds of a client who has been involved in an automobile accident. What intervention would the nurse need to perform when cleaning open wounds to protect himself from infection?

A) Wash hands with alcohol-based hand wash.

B) Wear a pair of sterile latex gloves.

C) Use sterilizing acid to clean the injury.

D) Use sterile solutions such as normal saline.

Ans: B

Feedback:

In order to protect themselves from infections when dealing with open wounds, nurses should wear sterile latex gloves when cleaning the open wounds of a client. Latex gloves allow the nurse to handle sterile equipment and supplies without contaminating them during the treatment, and the gloves also protect the nurse from the infection caused by the injury. Though washing hands with an alcohol-based hand wash helps kill the microorganisms, it will not protect the nurse from being infected during the cleaning of the wound. Sterilizing acid is used to sterilize heat-sensitive instruments. Sterilizing solutions such as normal saline are used to avoid contamination.

31. A nurse is changing the bed linen of a client admitted to the health care facility. Which of the following isolation precautions should the nurse follow?

A) Standard precautions

B) Droplet precautions

C) Contact precautions

D) Airborne precautions

Ans: A

Feedback:

Health care personnel follow standard precautions whenever there is the potential for contact with the following: blood; body fluids except sweat, regardless of whether they contain visible blood; non-intact skin; and mucous membranes. Standard precautions are measures for reducing the risk of microorganism transmission from both recognized and unrecognized sources of infection. The other three precautions are transmission-based precautions, which are measures for controlling the spread of infectious agents from clients known to be, or suspected of being, infected with highly transmissible or epidemiologically important pathogens.

32. Which of the following are characteristics of the stage of infection known as full stage of illness? Select all that apply.

A) It is the interval between the pathogen's invasion of the body and the appearance of symptoms of infection.

B) Specific signs and symptoms are present.

C) The organisms are growing and multiplying.

D) The signs and symptoms disappear, and the person returns to a healthy state.

E) Early signs and symptoms of disease are present, but these are often vague and nonspecific.

Ans: B, C

Feedback:

The incubation period is the interval between the pathogen's invasion of the body and the appearance of symptoms of infection. During this stage, the organisms are growing and multiplying. The presence of specific signs and symptoms indicates the full stage of illness, and the type of infection determines the length of the illness and the severity of the

manifestations. The convalescent period is the recovery period from the infection; the signs and symptoms disappear, and the person returns to a healthy state. A person is most infectious during the prodromal stage, in which early signs and symptoms of disease are present, but are often vague and nonspecific (ranging from fatigue and malaise to a low-grade fever).

33. Which of the following statements about glove use and hand hygiene is true?

A) Artificial fingernails should not be worn by staff involved in direct client care.

B) Nonsterile gloves can be decontaminated with alcohol-based hand rub, but must be changed between clients.

C) Use of alcohol-based hand rubs is appropriate after using the restroom.

D) The use of sterile gloves reduces the need for hand hygiene.

Ans: A

Feedback:

The CDC Guideline for Hand Hygiene in Health-Care Settings (2002) specifies that health care personnel involved in patient care should not wear artificial nails because they are more likely to be associated with higher bacterial counts.

34. An experienced nurse is teaching a student nurse the proper use of hand hygiene. Which of the following is an accurate guideline that should be discussed?

A) The use of gloves eliminates the need for hand hygiene.

B) The use of hand hygiene eliminates the need for gloves.

C) Hand hygiene must be performed after contact with inanimate objects near the client.

D) Hand lotions should not be used after hand hygiene.

Ans: C

Feedback:

Hand hygiene must be performed when moving from a contaminated body site to a clean body site during client care, and after contact with inanimate objects near the client. Using gloves does not eliminate the need for hand hygiene and, in some cases, gloves must still be used after hand hygiene. Lotions may be used to prevent irritation.

35. What is the minimal amount of time that a nurse should scrub hands that are not visibly soiled for effective hand hygiene?

A) 20 seconds

B) 30 seconds

C) 1 minute

D) 5 minutes

Ans: A

Feedback:

Effective handwashing requires at least a 20-second scrub with plain soap or disinfectant and warm water. Hands that are visibly soiled need a longer scrub.

Chapter 25, Vital Signs

1. Upon auscultation of a client's heart rate, the nurse notes the rate to have an irregular pattern of 72 beats/minute. The nurse notifies the physician because the client is exhibiting signs of which of the following?

A) A dysrhythmia

B) Tachycardia

C) Bradycardia

D) Hypertension

Ans: A

Feedback:

An irregular pattern of heartbeats is called a dysrhythmia. Tachycardia is an increased heart rate of 100 to 180 beats/minute. Bradycardia is a pulse rate below 60 beats/minute. The normal pulse rate ranges from 60 to 100 beats per minute. Hypertension is a blood pressure that is above normal for a sustained period.

2. The nurse notes a difference in systolic blood pressure readings between the client's arms. How will the nurse approach subsequent readings based upon this difference in blood pressures?

A) The nurse will use the arm with the highest reading.

B) The nurse will use the arm with the lowest reading.

C) The nurse will average the two blood pressures and document this average.

D) The nurse will obtain a blood pressure on the client's leg.

Ans: A

Feedback:

An initial nursing assessment should include blood pressure assessments on both arms. It is normal to have a 5- to 10-mm Hg difference in the systolic reading between arms. Use the arm with the higher reading for subsequent pressures.

3. An male client 86 years of age with a diagnosis of vascular dementia and cardiomyopathy is exhibiting signs and symptoms of pneumonia. The nurse has attempted to assess his temperature using an oral thermometer, but the client is unable to follow directions to close his mouth and secure the thermometer sublingually. Additionally, he repeatedly withdraws his head when the nurse attempts to use a tympanic thermometer. How should the nurse proceed with this assessment?

A) Assess the client's temperature by axilla.

B) Assess the client's skin tone and the presence or absence of sweating to determine whether the client is febrile.

C) Use a disposable mercury thermometer to take the client's temperature.

D) Take the client's temperature rectally.

Ans: A

Feedback:

The axillary site is an accurate and acceptable alternative when other sites are impractical or contraindicated. Rectal temperatures are contraindicated in cardiac clients; mercury thermometers are not commonly used. It is unacceptable for the nurse to rely solely on subjective assessments to determine whether the client is febrile.

4. When assessing a client's vital signs, a nursing student has explained each of her next actions prior to assessing the client's temperature, pulse, and blood pressure. However, the nurse has not announced her intention to assess the client's respiratory rate prior to measuring it. Which of the following is a plausible rationale for the nurse's decision?

A) Respirations have both autonomic and voluntary control.

B) The nurse likely assessed the client's respiratory rate simultaneous to heart rate.

C) Temperature, pulse, and blood pressure are more volatile than respiratory rate.

D) Tachypnea is an expected finding among hospitalized individuals.

Ans: A

Feedback:

Because respiratory rate is under both autonomic and voluntary control, making the client conscious of his or her respiratory rate prior to assessment has the potential to affect that accuracy of the assessment. It is not possible to simultaneously assess pulse and respirations. Temperature, pulse, and blood pressure are not necessarily more volatile than respiratory rate. Tachypnea is not an expected finding.

5. Which of the following clients should the nurse monitor vital signs every four hours?

A) A client in a critical care unit

B) A client hospitalized for high blood pressure

C) a resident in a long-term care facility

D) a long-term care resident on Medicare A

Ans: B

Feedback:

Vital signs are assessed at least every four hours in hospitalized clients with elevated temperatures, with high or low blood pressures, with changes in pulse rate or rhythm, or with respiratory difficulty. In critical care settings, technologically advanced devices are used to continually monitor clients' vital signs. Regulations require monthly vital sign measurements in long-term care residents, but if the resident is classified as Medicare A (meaning discharged from the hospital and Medicare is paying for the stay to receive skilled nursing care) vital signs are taken daily.

6. Which is the primary source of heat in the body?

A) Hormones

B) Metabolism

C) Blood circulation

D) Muscles

Ans: B

Feedback:

The primary source of heat in the body is metabolism, with heat produced as a byproduct of metabolic activities that generate energy for cellular functions. Various mechanisms increase body metabolism, including hormones and exercise.

7. A nurse places a fan in the room of a client who is overheated. This is an example of heat loss related to which of the following mechanisms of heat transfer?

A) Evaporation

B) Radiation

C) Conduction

D) Convection

Ans: D

Feedback:

Convection is the dissemination of heat by motion between areas of unequal density, as occurs with a fan blowing over a warm body. Evaporation is the conversion of a liquid to a vapor. Radiation is the diffusion or dissemination of heat by electromagnetic waves. Conduction is the transfer of heat to another object during direct contact.

8. Which of the following is an average normal temperature in Centigrade for a healthy adult?

A) oral: 37.0°C

B) rectal: 36.5°C

C) axillary: 37.5°C

D) tympanic: 34.4°C

Ans: A

Feedback:

The normal range for an oral temperature is 37.0°C, a rectal temperature is 37.5°C, an axillary temperature is 36.5°C, and a tympanic temperature is 37.5°C.

9. What anatomic site regulates the pulse rate and force?

A) Thermoregulatory center

B) Cardiac sinoatrial node

C) Cardiac atria and valves

D) Peripheral chemoreceptors

Ans: B

Feedback:

The pulse is regulated by the autonomic nervous system through the cardiac sinoatrial node. The other anatomic sites may affect, but do not regulate, the pulse rate and force.

10. A client is constipated and trying to have a bowel movement. How does holding the breath and pushing down (the Valsalva maneuver) affect the pulse?

A) Left ventricle pumps more forcefully; pulse is stronger

B) Stimulates the vagus nerve to increase the rate

C) Stimulates the vagus nerve to decrease the rate

D) Right ventricle is less efficient; pulse is thready

Ans: C

Feedback:

Parasympathetic stimulation via the vagus nerve decreases the heart rate. The Valsalva maneuver stimulates the vagus nerve, resulting in a slower pulse rate.

11.	The arterial blood gases for a client in shock demonstrate increased carbon dioxide and decreased oxygen. What type of respirations would the nurse expect to assess based on these findings?
A)	Absent and infrequent
B)	Shallow and slow
C)	Rapid and deep
D)	Noisy and difficult
Ans:	C
	Feedback:
	Any condition causing an increase in carbon dioxide and a decrease in oxygen in the blood tends to increase the rate and depth of respirations. An increase in carbon dioxide is the most powerful respiratory stimulant.
12.	A student is reading the medical record of an assigned client and notes the client has been afebrile for the past 12 hours. What does the term “afebrile” indicate?
A)	Normal body temperature
B)	Decreased body temperature
C)	Increased body temperature
D)	Fluctuating body temperature
Ans:	A
	Feedback:
	A person with normal body temperature is referred to as afebrile.
13.	A nurse is assessing a client who has a fever, has an infection of a flank incision, and is in severe pain. What type of pulse rate would be likely?
A)	Bradycardia
B)	Tachycardia
C)	Dysrhythmia
D)	Bigeminal
Ans:	B
	Feedback:
	The pulse rate increases (tachycardia) and decreases in response to a variety of physiologic mechanisms. Tachycardia is a response to an elevated body temperature and pain.
14.	A nurse is conducting a health history for a client with a chronic respiratory problem. What question might the nurse ask to assess for orthopnea?
A)	“Do you have problems breathing when you walk up stairs?”
B)	“Does your medication help you breathe better?”
C)	“How many pillows do you sleep on at night to breathe better?”
D)	“Tell me about your breathing difficulties since you stopped smoking.”

Ans: C

Feedback:

People with difficulty breathing can often breathe more easily in an upright position, a condition known as orthopnea. While sitting or standing, gravity lowers organs in the abdominal cavity away from the diaphragm, giving more room for the lungs to expand. People with orthopnea characteristically use many pillows during sleep to accomplish this.

15. What population is at greatest risk for hypertension?

A) Hispanic

B) White

C) Asian

D) African American

Ans: D

Feedback:

Race is a factor in hypertension, a disorder characterized by high blood pressure. It is more prevalent and more severe in African American men and women.

16. A middle-aged, overweight adult man has had hypertension for 15 years. What pathologic event is he most at risk for?

A) Stroke

B) Anemia

C) Cancer

D) Infection

Ans: A

Feedback:

Hypertension is the most important risk factor associated with stroke.

17. A nurse educator is teaching a client about a healthy diet. What information would be included to reduce the risk of hypertension?

A) "Eat a diet high in fruits and vegetables."

B) "Remember to drink eight to 10 glasses of water a day."

C) "It is important to have increased fats in your diet."

D) "Put away the salt shaker and eat low-salt foods."

Ans: D

Feedback:

High salt intake is a high risk factor for the development of hypertension.

18. A nurse is caring for a client who is ambulating for the first time after surgery. Upon standing, the client complains of dizziness and faintness. The client's blood pressure is 90/50. What is the name for this condition?

A) Orthostatic hypotension

B) Orthostatic hypertension

C) Ambulatory bradycardia

D) Ambulatory tachycardia

Ans: A

Feedback:

Orthostatic hypotension (postural hypotension) is a low blood pressure associated with weakness or fainting when one rises to an erect position (from supine to sitting, supine to standing, or sitting to standing). It is the result of peripheral vasodilation without a compensatory rise in cardiac output.

19. What site for taking body temperature with a glass thermometer is contraindicated in clients who are unconscious?

A) Rectal

B) Tympanic

C) Oral

D) Axillary

Ans: C

Feedback:

Assessing an oral temperature with a glass thermometer is contraindicated in unconscious, irrational, or seizure-prone adults, as well as in infants and young children. This is due to the danger of breaking the thermometer in the mouth.

20. A nurse is taking a client's temperature and wants the most accurate measurement, based on core body temperature. What site should be used?

A) Rectal

B) Oral

C) Axillary

D) Forehead

Ans: A

Feedback:

Heat is generated by metabolic processes in the core tissues of the body, transferred to the skin surface by the circulating blood, and then dissipated to the environment. Core body temperatures may be measured at rectal or tympanic sites.

21. A hospital unit has a policy that rectal temperatures may not be taken on clients who have had cardiac surgery. What rationale supports this policy?

A) It is an embarrassing and painful assessment.

B) Thermometer insertion stimulates the vagus nerve.

C) It is less expensive to take oral temperatures.

D) It is to avoid perforating the wall of the rectum.

Ans: B

Feedback:

Because inserting the thermometer into the rectum can slow the heart rate by stimulating the vagus nerve, assessing a rectal temperature may not be allowed for clients after cardiac surgery.

22. As adults age, the walls of their arterioles become less elastic, increasing resistance and decreasing compliance. How does this affect the blood pressure?

A) The blood pressure does not change.

B) The blood pressure is erratic.

C) The blood pressure decreases.

D) The blood pressure increases.

Ans: D

Feedback:

The elasticity and resistance of the walls of the arterioles help to maintain normal blood pressure. With aging, the walls of arterioles become less elastic, which interferes with their ability to stretch and dilate, contributing to a rising pressure within the vascular system. This is reflected in an increased blood pressure.

23. Two nurses collaborate in assessing an apical-radial pulse on a client. The pulse deficit is 16 beats/minute. What does this indicate?

A) The radial pulse is more rapid than the apical pulse.

B) This is a normal finding and should be ignored.

C) The client's arteries are very compliant.

D) Not all of the heartbeats are reaching the periphery.

Ans: D

Feedback:

A difference between the apical and radial pulse rates is the pulse deficit, and signals that all of the heartbeats are not reaching the peripheral arteries or are too weak to be palpated.

24. A nurse is assessing the blood pressure on an obese woman. What error might occur if the cuff used is too narrow?

A) Reading is erroneously high

B) Reading is erroneously low

C) Pressure on the cuff with be painful

D) It will be difficult to pump up the bladder

Ans: A

Feedback:

The bladder of the cuff should enclose at least two-thirds of the adult limb. If the cuff is too narrow, the reading could be erroneously high because the pressure is not being transmitted evenly to the artery.

25. Various sounds are heard when assessing a blood pressure. What does the first sound heard through the stethoscope represent?

A) Systolic pressure

B) Diastolic pressure

C) Auscultatory gap

D) Pulse pressure

Ans: A

Feedback:

The first sound heard through the stethoscope, which is the onset of phase I of Korotkoff sounds, represents the systolic pressure.

26. An adult client is assessed as having an apical pulse of 140. How would the nurse document this finding?

A) Bradycardia

B) Tachycardia

C) Dysrhythmia

D) Normal pulse

Ans: B

Feedback:

Tachycardia is a rapid pulse (heart) rate. An adult has tachycardia when the pulse rate is 100 to 180 beats/min. Thenurse would document a rate of 140 as tachycardia. Bradycardia is a slower than normal pulse rate. Dysrhythmia is an irregular pulse rate.

27. A client in a physician's office has a single blood pressure (BP) reading of 150/92. Should the client be taught about hypertension?

A) It depends on the time of day the BP was taken.

B) It depends on whether the client is male or female.

C) No, a single BP reading should not be used.

D) Yes, this reading is high enough to be significant.

Ans: C

Feedback:

The American Heart Association recommends that blood pressure readings be averaged on two or more subsequent occasions before diagnosing hypertension.

28. All of the following clients have a body temperature of 38°C (100.4°F). About which client would a nurse be most concerned?

A) An older adult

B) A pregnant adolescent

C) A junior high football player

D) An infant 2 months of age

Ans: D

Feedback:

A mild elevation in body temperature, as is given here, might indicate a serious infection in infants younger than 3 months of age, who do not have well-developed temperature control mechanisms.

29. A home health care nurse notices that his assigned client uses a mercury thermometer. He asks the nurse what to do if it breaks. Which of the following is **not** correct?

A) "Just flush the glass and mercury down the toilet."

B) "Do not vacuum the area where it breaks."

C) "Open the windows and close off the room for an hour."

D) "Throw away any clothing exposed to the mercury."

Ans: A

Feedback:

Mercury should never be flushed down the toilet. Mercury is not only hazardous to people but it also pollutes the environment, especially if it gets into water. The other responses are correct.

30. A nurse is caring for a middle-aged client who looks worried and flares his nostrils when breathing. The client complains of difficulty in breathing, even when he walks to the bathroom. Which of the following breathing disorders is most appropriate to describe the client's condition?

A) Hyperventilation

B) Hypoventilation

C) Dyspnea

D) Apnea

Ans: C

Feedback:

Clients with dyspnea usually appear anxious and worried. The nostrils flare as they fight to fill the lungs with air. Dyspnea is almost always accompanied by a rapid respiratory rate because clients work to improve the efficiency of their breathing. The client's condition cannot be termed hyperventilation, hypoventilation, or apnea. Hyperventilation and hypoventilation affect the volume of air entering and leaving the lungs. Apnea is total absence of breathing, which is life-threatening if it lasts more than four to six minutes.

31. A nurse needs to measure the pulse of a client admitted to the health care facility. Which site would the nurse most likely use?

A) Femoral

B) Temporal

C) Pedal

D) Radial

Ans: D

Feedback:

The radial artery is the site most commonly assessed in a clinical setting. The radial pulse is palpated on the thumb side of the inner aspect of the wrist. Deep palpation is required to detect the femoral pulse beneath the subcutaneous tissue, in the anterior medial aspect of the thigh, just below the inguinal ligament, about halfway between the anterior superior iliac spine and the symphysis pubis. The pulsation of the temporal artery is palpated in front of the upper part of the ear;

however, it is not the site most commonly assessed in the clinical setting. The pedal pulse or dorsalis pedis pulse can be felt on the dorsal aspect of the foot; however, the dorsalis pedis pulse may be congenitally absent in some clients.

32. A nurse palpates the pulse of a client and documents the following: 6/6/12 pulse 85 and regular, 3+, and equal in radial, popliteal, and dorsalis pedis. What does the number 3+ represent?

A) Pulse rate

B) Pulse quality (amplitude)

C) Pulse rhythm

D) Pulse deficit

Ans: B

Feedback:

Pulse quality/amplitude describes the quality of the pulse in terms of its fullness, ranging from absent (0) to bounding (4+). Pulse rates are measured in beats per minute. Pulse rhythm is the pattern of the pulsations and the pauses between them. The pulse deficit is the difference between the apical and radial pulse rates.

33. A nurse has an order to take the core temperature of a client. At which of the following sites would a core body temperature be measured?

A) Rectal

B) Oral

C) Skin surface

D) Axillary

Ans: A

Feedback:

Core temperatures are measured by nurses rectally. Surface body temperatures are measured at oral (sublingual), axillary, and skin surface sites.

34. The nurse at the beginning of the shift plans to see which client first, based on the following vital signs?

A) The client age 2 years whose respiratory rate is 16 breaths/minute

B) The newborn whose axillary temperature is 98.2 ºF (36.8 ºC)

C) The client age 7 years whose pulse is 120 beats/minute

D) The client age 10 years whose blood pressure is 102/62 mmHg

Ans: A

Feedback:

Normal respiratory rate for a child 1 to 3 years of age is 20 to 40 breaths/minute. Therefore, the nurse should assess the 2-year-old with a respiratory rate of 16 first, as the other clients' vital signs are within normal limits.

35. A nurse walks into a client's room and finds him having difficulty breathing and complaining of chest pain. He has bradycardia and hypotension. What should the nurse do next?

A) Take vital signs again in 15 to 30 minutes.

B) Document the data and report it later.

C) Ask the client if he is anxious or afraid.

D) Report findings to the physician immediately.

Ans: D

Feedback:

The nurse should immediately report bradycardia associated with difficult breathing, changes in level of consciousness, hypotension, ECG changes, and angina (chest pain). Emergency treatment is by administering atropine intravenously to block vagal stimulation and restore normal heart rate.

Chapter 26, Health Assessment

1. Upon entering the client's room at the beginning of a shift and throughout the shift, the nurse assesses the client. The nurse considers the client's plan of care and response to nursing interventions during the assessments. What type of assessment is the nurse performing?

A) Ongoing partial assessment

B) Comprehensive assessment

C) Focused assessment

D) Emergency assessment

Ans: A

Feedback:

An ongoing partial assessment is conducted at regular intervals during care of the client and concentrates on identified health problems and the effectiveness of interventions. A comprehensive assessment includes a health history and complete physical examination and is usually conducted when a client first enters a health care setting. A focused assessment is conducted to assess a specific problem. An emergency assessment is a type of rapid focused assessment conducted to determine a potentially fatal situation.

2. An older adult asks the nurse about the appearance of flat brown age spots on the hands. After examining the client's hands, the nurse recognizes these skin characteristics as a common skin variation in the older adult and documents the variations as which of the following?

A) Senile lentigines

B) Lanugo

C) Senile keratosis

D) Cherry angiomas

Ans: A

Feedback:

Senile lentigines are flat, brown age spots, senile keratosis are raised, dark areas, and cherry angiomas are small, round red spots. All are common skin variations in the older adult. Lanugo is a fine downy hair that appears on the newborn for the first two weeks of life.

3. The nurse is performing an assessment on an infant. Which finding is considered an abnormal cardiovascular assessment that should be documented and reported to the physician?

A) Decreased heart rate

B) Visible pulsation through a thin chest wall

C) Sinus dysrhythmia that increases with inspiration and decreases with expiration

D) Presence of an S heart sound

Ans: A

Feedback:

Infants and children should have a more rapid heart rate, instead of a decreased heart rate, until about age 8 years. Common cardiovascular findings include visible pulsation if the chest wall is thin, sinus dysrhythmia (the rate increases with inspiration and decreases with expiration), and the presence of an S heart sound.

4. The nurse is conducting an assessment on the integumentary system of a client age 74 years. Which of the following findings should the nurse document as an anomaly that may warrant follow-up?

A) The client states that a mole on his forehead has become larger in recent months.

B) Decreased skin turgor is evident when the skin is folded and then released.

C) Small, round, red spots are present on the client's forearms bilaterally.

D) There are some raised, brown areas on the backs of the client's hands.

Ans: A

Feedback:

Changes in the size or appearance of a mole always require further assessment and follow-up due to their association with skin cancer. Decreased skin turgor is an expected finding in older adults, as are diffuse red spots (cherry angioma) and raised, dark areas (senile lentigines).

5. As a component of a head to toe assessment, the nurse is preparing to assess convergence of the client's eyes. How should the nurse conduct this assessment?

A) Ask the client to follow her finger as she slowly moves it towards the client's nose.

B) Ask the client to look ahead while slowly bringing a pen light in from the side and to the client's pupil.

C) Ask the client to hold his head stationary while following a pencil from left to right.

D) Ask the client to read a Snellen chart from a distance of 20 feet.

Ans: A

Feedback:

Eye convergence is assessed by holding your finger 6″ to 8″ from the patient's nose and asking the patient to follow it as it moves closer. A pen light is used to assess pupillary reaction. Visual acuity is assessed with the use of a Snellen chart. Following a pencil from side to side is a test for extraocular movements.

6. A nurse is conducting a health assessment. How will the information collected from the client be used?

A) As a basis for the nursing process

B) To illustrate nursing competence

C) To facilitate nurse–client caring

D) As one component of medical care

Ans: A

Feedback:

Health assessment is an integral component of nursing care and is the basis of the nursing process. Health assessments by nurses are used to plan, implement, and evaluate education and care. Nursing assessment is different from other types of health care provider assessments, as it is a holistic collection of information about a client's level of health.

7. A home health nurse is visiting a client who recently was hospitalized for repair of a fractured hip. The client tells the nurse, "I have had a lot of pain in my abdomen." What type of assessment would the nurse conduct?

A) Comprehensive

B) Ongoing partial

C) Focused

D) Emergency

Ans: C

Feedback:

A focused assessment is conducted to assess a specific problem. In this case, the nurse would ask the client about urinary frequency, bowel movements, and diet, and then take vital signs and assess the abdomen. Comprehensive assessments include a detailed health history and physical assessment. Ongoing partial assessments are conducted at regular intervals, and emergency assessments are carried out in emergency situations (such as prior to CPR).

8. An adolescent comes to a community health clinic with complaints of vaginal itching and discharge. She believes it is from having sex with her boyfriend. Which response should the nurse use during the health history to elicit information?

A) "Tell me about the sexual activity with your boyfriend."

B) "Why did you ever have sex with someone you don't know?"

C) "You are old enough to know to use condoms."

D) "I don't understand how you could be so careless."

Ans: A

Feedback:

The health history is used to collect subjective data about the client's health status. Nurses use therapeutic communication skills, including open-ended statements and questions that are not threatening or negative, to establish an effective nurse–client relationship that facilitates communication.

9. A nurse is preparing a client for a physical assessment. The client appears anxious about the assessment. Which statement by the nurse would be most appropriate?

A) "This is nothing to worry about. I won't hurt you."

B) "Some of the examination may be painful, but I will be gentle."

C) "Let me tell you what I will be doing. It should not be painful."

D) "I have to do this, so just relax and it won't last long."

Ans: C

Feedback:

The client may be anxious for many reasons. Tell the client that the assessments should not be painful. Explaining the assessment in general terms can help decrease the client's embarrassment, fear of possible abnormal physical findings, or fear of "failing" a test.

10. What would a nurse ensure before beginning a health assessment?

A) That the time needed for the assessment fits into the nurse's work schedule

B) That the room is private, quiet, warm, and has adequate light

C) That family members are present to answer specific questions

D) That there is a written physician's order for the assessment

Ans: B

Feedback:

The nurse and client should agree on a time for the assessment. The room (or area) should be private, quiet, and warm enough to prevent chilling, and it should have adequate lighting, either by sunlight or overhead fixtures. Family members may remain, especially if they are needed to explain activities to the client. A nursing assessment does not require a physician's order.

11. A nurse working in a clinic is planning to conduct vision screenings for a group of low-income women. What equipment would be needed to test vision?

A) Snellen chart

B) Stethoscope

C) Ophthalmoscope

D) Otoscope

Ans: A

Feedback:

A Snellen chart is used as a screening test for distant vision. It consists of characters in 11 lines of different-sized type, with the largest characters at the top of the chart and the smallest characters at the bottom. Vision is recorded as a score; for example, 20/20 is normal vision. A stethoscope is used to auscultate body sounds. An ophthalmoscope is used to assess the inner eye. An otoscope is used to inspect the nasal passages.

12. When using assessment equipment that will touch the client, what should the nurse do before conducting the assessment?

A) Describe the equipment and how it works.

B) Show pictures of functions of the equipment.

C) Draw pictures of the anatomy to be assessed.

D) Warm the equipment with hands or warm water.

Ans: D

Feedback:

Equipment that will touch the client during a physical examination should be warmed by the examiner's hands or warm water before use.

13. A school nurse is preparing to test the auditory function of grade school students. What equipment will be needed for this examination?

A) Tuning fork

B) Percussion hammer

C) Speculum

D) Ophthalmoscope

Ans: A

Feedback:

A tuning fork is a two-pronged metal instrument used to test auditory function and vibratory perception. The fork is activated to vibrate by holding the base and gently tapping the prongs against the palm of the examiner's hand. Once vibrating, the fork is held at the base to avoid diminishing the vibration.

14. A nurse is preparing to examine the breasts of a client. In what position should the nurse place the client?

A) Prone

B) Standing

C) Dorsal recumbent

D) Lithotomy

Ans: C

Feedback:

The dorsal recumbent position is used to assess the head, neck, anterior thorax, lungs, heart, breasts, extremities, and peripheral pulses. The prone position is used to assess the hip joint and posterior thorax. The standing position is used to assess posture, balance, and gait. The lithotomy position is used to assess female genitalia and rectum.

15. A nurse is using inspection as an assessment technique. What does the nurse use during inspection?

A) Equipment such as a stethoscope

B) Both hands to produce sounds

C) Light palpation to detect surfaces

D) Senses of vision, hearing, smell

Ans: D

Feedback:

Inspection is the process of performing deliberate, purposeful observations. The nurse observes visually but also uses hearing and smell to gather data throughout the assessment. A stethoscope is used for auscultation, and the hands are used to percuss and palpate.

16. Which of the following can a nurse assess by palpation?

A) Heart sounds, lung sounds, blood pressure

B) Temperature, turgor, moisture

C) Vision, hearing, cranial nerves

D) Tissue density, gait, reflexes

Ans: B

Feedback:

Palpation is an assessment technique that uses the sense of touch. The hands and fingers can assess temperature, turgor, texture, moisture, vibrations, and shape.

17. When auscultating a client's abdomen, a nurse notes gurgling sounds. What characteristic of sound would the nurse document?

A) Resonance

B) Turgor

C) Quality

D) Texture

Ans: C

Feedback:

Auscultation is the act of listening with a stethoscope to sounds produced within the body. Four characteristics are assessed and documented: pitch (high to low), loudness (soft to loud), quality (gurgling or swishing), and duration (short, medium, long). Resonance is measured with percussion. Turgor and texture are assessed with palpation.

18. A nurse is performing a general survey of a client admitted to the hospital. Which of the following actions is an element of this procedure?

A) Taking vital signs

B) Palpating the integument

C) Identifying risk factors for altered health

D) Assessing the head and neck

Ans: A

Feedback:

The general survey is the first component of the physical assessment. It includes observing the client's overall appearance and behavior, taking vital signs, and measuring height and weight. Information from the general survey provides clues to the client's overall health. Palpating the integument and assessing the head and neck are part of the physical assessment. Identifying risk factors for altered health occurs in the health history.

19. When inspecting the skin of a client, the nurse notes a bluish tinge to the skin. What condition would the nurse document?

A) Jaundice

B) Cyanosis

C) Erythema

D) Pallor

Ans: B

Feedback:

Cyanosis is a bluish or grayish discoloration of the skin in response to inadequate oxygenation. Jaundice is a yellow color of the skin resulting from liver and gallbladder disease, some types of anemia, and excessive hemolysis. Erythema is redness of the skin associated with sunburn, inflammation, fever, trauma, and allergic reactions. Pallor is paleness of the skin, which often results from a decrease in the amount of circulating blood

or hemoglobin, causing inadequate oxygenation of the body tissues.

20. The nurse palpating the skin of a client documents a firm 1.5 cm mass on the lower right leg. What type of skin lesion does this describe?

A) Macule

B) Wheal

C) Vesicle

D) Nodule

Ans: D

Feedback:

A nodule is a mass 0.5 cm to 2 cm that is firmer than a papule. A macule is a lesion that is 1 cm or smaller. A wheal is an irregular, superficial area of localized skin edema. A vesicle is a 1 cm or less lesion filled with serous fluid.

21. A nurse assesses a client's eyes by testing the cardinal fields of vision for coordination and alignment. What eye characteristic is being assessed by this process?

A) Visual acuity

B) Extraocular movements

C) Peripheral vision

D) Existence of cataracts

Ans: B

Feedback:

The nurse tests for extraocular movements by assessing the cardinal fields of vision for coordination and alignment. Normally both eyes move together, are coordinated, and are parallel. Visual acuity is assessed with the Snellen chart. Tests for peripheral vision (or visual fields) are used to assess retinal function and optic nerve function. Full peripheral vision is normal. Cataracts are noted by inspection (cloudiness of the lens).

22. While conducting a physical examination of the thorax, a nurse notes and documents breath sounds as moderate "blowing" sounds with equal inspiration and expiration. What type of breath sounds are these?

A) Bronchial

B) Bronchovesicular

C) Vesicular

D) Adventitious

Ans: B

Feedback:

Bronchial breath sounds are high pitched, with expiration longer than inspiration. Bronchovesicular sounds are moderate "blowing" sounds with equal inspiration and expiration. Vesicular sounds are soft and low-pitched, with longer inspiration than expiration. Adventitious sounds are not normally heard in the lungs.

23. A nurse is conducting a health assessment for an African American client. What should the nurse consider in terms of cultural sensitivity?

A) All individuals, regardless of culture, have the same anatomy and physiology.

B) Asking specific questions about race during the health history

C) Cultural risk factors for alterations in health and normal racial variations

D) Differences in emotional, social, and spiritual basic human needs

Ans: C

Feedback:

The person's culture does not affect how a health assessment is conducted, but it is an integral component of nurse–client interactions. Nurses should know risk factors for alterations in health based on racial inheritance, as well as normal variations that occur among races.

24. When conducting a physical assessment, what should the nurse assess and document about size and shape of body parts?

A) Actual measurements in centimeters

B) Symmetry (comparison of bilateral body parts)

C) Indications of general health status

D) Vital signs of all extremities (arms and legs)

Ans: B

Feedback:

When conducting a physical assessment, the nurse assesses and compares all bilateral body parts. The symmetry of parts of the body (such as the skull) and the extremities (arms and legs) is an important assessment to document.

25. While assessing breath sounds, a nurse hears crackles. What causes these abnormal sounds?

A) Air in the lungs

B) A narrowing of the upper airway

C) Narrowed small air passages

D) Moisture in air passages

Ans: D

Feedback:

Crackles are fine-to-coarse crackling sounds made as air moves through wet secretions. They are described as "fine" when air passes through moisture in small air passages, and as "coarse" when air passes through moisture in the bronchioles, bronchi, and trachea. A wheeze is produced by narrowed air passages. The lungs normally contain air.

26. When assessing the abdomen, which assessment technique is used last?

A) Inspection

B) Auscultation

C) Percussion

D) Palpation

Ans: D

Feedback:

The sequence of techniques used to assess the abdomen is inspection, auscultation, percussion, and palpation. Percussion and palpation stimulate bowel sounds and thus are done after auscultation of the abdomen.

27. What is one purpose of documentation of the health assessment?

A) To identify the nurse's role in health care

B) To identify actual and potential health problems

C) To expand nursing knowledge and skills

D) To provide a basis for evidence-based nursing

Ans: B

Feedback:

The nurse organizes and documents assessment data to identify actual and potential health problems, to make nursing diagnoses, to plan appropriate care, and to evaluate the client's response to treatment.

28. An African American client with jaundice has been admitted to the health care facility. Which of the following body areas is the best place to assess jaundice?

A) Sclera

B) Nailbeds

C) Lips

D) Palm

Ans: A

Feedback:

In African American clients, the sclera is the best place to assess the yellowish discoloration of jaundice. Jaundice assessment cannot be done on the nailbeds, lips, or palm due to hyperpigmentation.

29. A nurse is assessing the spine of a client with kyphosis. Which of the following would the nurse expect to observe about the client's posture?

A) The shoulder and upper back curves forward

B) The lumbar region tends to curve inward

C) The sacral region tends to turn outward

D) A portion of the spine is curved to the side laterally

Ans: A

Feedback:

In kyphosis, the shoulder and upper back tend to curve forward. In lordosis, the lumbar region curves inward and the sacral region curves outward. Scoliosis is a curvature of a portion of the spine to the side, laterally.

30. During a nurse's visit to the client's home, the client states, "I have pain in my right knee." The nurse assesses the client's right knee. What kind of assessment is this?

A) Focused assessment

B) Spiritual assessment

C) Social assessment

D) Comprehensive assessment

Ans: A

Feedback:

Often, nurses must select the most important interviewing questions or assessment techniques to use, and perform a focused health assessment based on the client's problem.

31. Which framework is used during the focused assessment?

A) Functional health assessment

B) Head-to-toe framework

C) Conceptual framework

D) Body systems framework

Ans: D

Feedback:

Body systems approach is used during the focused assessment of an acutely or critically ill client to determine function of a particular body system.

32. The nurse is preparing to assess a client's cranial nerves. Which of the following techniques should you use to assess cranial nerve III?

A) Shine a bright light in the client's eye and observe for bilateral pupillary response.

B) Ask the client to close the eyes, occlude a nostril, then identify the smell of different substances.

C) Determine visual acuity using a Snellen chart

D) Occlude the patient's right ear, whisper a word into the left ear, and ask the patient to repeat it.

Ans: A

Feedback:

This technique is used to assess CN VIII (Acoustic).

33. How would a nurse assess a client for pupillary accommodation?

A) Using an ophthalmoscope, check the red reflex.

B) Ask the client to focus on a finger and move the client's eyes through the six cardinal positions of gaze.

C) Ask the client to focus on an object as it is brought closer to the nose.

D) Ask the client to read the smallest possible line of letters on the Snellen chart.

Ans: C

Feedback:

The normal pupillary response is constriction, and convergence when focusing on a near object. Presence of the red reflex indicates that the cornea, anterior chamber, and lens are free of opacity and clouding. Answer B evaluates the function of each of the eye muscles and cranial nerves. The Snellen chart tests visual acuity.

34. During an assessment of the cranial nerves, the nurse asks the client to smile, frown, wrinkle the forehead, and puff out the cheeks. What nerve is being tested by this action?

A) Cranial nerve I

B) Cranial nerves II and III

C) Cranial nerve VII

D) Cranial nerve VIII

Ans: C

Feedback:

Cranial nerve VII is the facial nerve tested by smiling, frowning, wrinkling the forehead, and puffing out the cheeks. CNI is the olfactory nerve, CNII and III are the optic and oculomotor nerves, and CNVIII is the acoustic nerve.

35. The nurse preparing to perform an abdominal assessment on a client places the client in which of the following positions?

A) Supine

B) Sims

C) Prone

D) Lithotomy

Ans: A

Feedback:

The nurse should place the client in the supine position when performing an abdominal assessment.

Chapter 27, Safety, Security, and Emergency Preparedness

1. The clinical nurse educator at a long-term care facility is responsible for organizing and carrying out staff education sessions. Which of the following topics for staff education is most likely to benefit the greatest number of residents?

A) Educating nurses on how to prevent falls

B) Reviewing safe medication administration

C) Educating nurses on how to prevent wandering by confused residents

D) Reviewing resuscitation for cardiac and respiratory arrest

Ans: A

Feedback:

Falls remain the leading cause of death among older adult Americans. Education that aims to reduce the incidence of falls is likely to be of more benefit than measures that address medication administration, prevention of wandering, or resuscitation procedures, even though such topics may be of importance.

2. Which of the following measures should nurses implement in a hospital setting in order to identify intimate partner violence (IPV)?

A) Routine screening of newly admitted clients

B) Focused physical assessment for IPV for all new clients

C) Involvement of a social worker in the admission assessment of all new female clients

D) Review of the definition and legal repercussions of IPV with all new female clients

Ans: A

Feedback:

Practices related to the identification of IPV vary, but it is generally agreed that a simple screening tool can be an effective strategy. A focused physical assessment and the involvement of social work are not warranted for all clients. A review of the definition and repercussions of IPV is likely not as effective as a simple and direct screening tool.

3. A nurse is admitting a client to a geriatric medicine unit following the client's recent diagnosis of acute renal failure. Which of the following nursing actions is most likely to reduce the client's chance of experiencing a fall while on the unit?

A) Orient the client to the room and environment thoroughly upon admission.

B) Provide the client with a bedpan to reduce the need to transfer to a commode or washroom.

C) Administer pain medications sparingly in order to minimize cognitive or musculoskeletal side effects.

D) Place the client in a shared room with a client who is stable and oriented.

Ans: A

Feedback:

A person who is familiar with his or her surroundings is less likely to experience an accidental injury. As part of the hospital admission routine, it is important to orient the client to the safety features and equipment in the room. A bedpan should not be used for the sole reason of reducing the risk of falls, and pain medication should be provided in doses sufficient to treat the client's pain. A client should never be charged with supervising the safety of another client.

4. Which of the following clients is most likely to face an increased risk of falls due to his or her medication regimen?

A) A female client age 77 years who has received a benzodiazepine to minimize her anxiety

B) A male client age 79 years whose recent high blood pressure has required a PRN dose of an angiotensin-converting enzyme (ACE) inhibitor

C) A woman age 81 years who has required a blood transfusion to treat a gastrointestinal bleed

D) A man 90 years of age whose venous ulcer has required the administration of intravenous antibiotics

Ans: A

Feedback:

While all drugs carry some risk of adverse effects, the use of benzodiazepines and antiepileptics are more predicative of falls than are other drug families.

5. A girl age 4 years has been admitted to the emergency department after accidently ingesting a cleaning product. Which of the following treatments is most likely appropriate in the immediate treatment of the girl's poisoning?

A) Administration of activated charcoal

B) Inducing vomiting

C) Gastric lavage

D) Intravenous rehydration

Ans: A

Feedback:

Activated charcoal is the most common treatment for many poisonings and is more effective and safe than induced vomiting or gastric lavage. Rehydration is likely necessary, but this does not actively treat the girl's poisoning.

6. In light of the failure of alternatives, a nurse has been forced to physically restrain an agitated client. Which of the following actions should the nurse perform when applying and maintaining the restraints?

A) Tie the client's hand restraint to the bed frame rather than the side rail.

B) Obtain a physician's order for the restraints within 24 hours.

C) Ensure the client is under continuous surveillance while restrained.

D) Choose a restraint device that best minimizes the client's mobility.

Ans: A

Feedback:

Restraints should be tied to the frame of the bed rather than to the side rails. A physician's order is needed for restraints, except in emergencies when an order must be obtained within one hour of application. Frequent assessment of the client is needed, but continuous surveillance is not necessarily required. The least restrictive type of device that allows the greatest mobility, while still ensuring safety, is chosen.

7. A client is very anxious and states, "I am so stressed." Why do these factors affect the client's safety?

A) Stress increases retention of information

B) Stress affects interpersonal relationships

C) Stress increases concern about hazards

D) Stress tends to narrow the attention span

Ans: D

Feedback:

Stressful situations tend to narrow a person's attention span and make him or her more prone to accidents. Stress does not increase retention of information or concern about hazards. Although stress may affect interpersonal relationships, that is not the same as safety.

8. A client with diabetes has impaired sensation in her lower extremities. What education would be necessary to reduce her risk of injury?

A) "Always test the temperature of bath water before stepping in."

B) "Take your insulin twice a day as we have discussed."

C) "Remember to follow your diet so you lose weight this month."

D) "Rub lotion on the skin of your legs and feet twice a day."

Ans: A

Feedback:

Alterations in sensory perception can have a serious effect on safety. A client whose tactile sense is impaired may not perceive temperature extremes that are a threat to safety. Although all the other statements may be necessary, they do not promote safety.

9. Which of the following people has the greatest risk for accidental injury?

A) An infant just learning to crawl

B) An older adult who walks two miles a day

C) An athlete who exercises on a regular basis

D) A worker who operates industrial machines

Ans: D

Feedback:

Certain occupations, lifestyles, and environments place people in more hazardous situations. A worker who operates industrial machines is at greater risk for accidental injury as well as for hearing loss.

10. What age group is most vulnerable to toxic fumes or asphyxiation?

A) Young children

B) Adolescents

C) Toung adults

D) Middle adults

Ans: A

Feedback:

Most exposure to toxic fumes, such as carbon monoxide, occurs in the home. Young children and older adults are more vulnerable to toxic fumes. Suffocation, or asphyxiation, can occur at any age, but the incidence is greater in children.

11. What safety device for children is mandated by law in all 50 states?

A) Bumper pads in baby cribs

B) Infant car seats and carriers

C) Automatic hot water heater controls

D) Parental controls for Internet access

Ans: B

Feedback:

All 50 states mandate the use of infant car seats and carriers when transporting a child in a motor vehicle.

12. An emergency room nurse is assessing a toddler with multiple bruises and burns. The nurse suspects the toddler has been abused. What is legally required of the nurse?

A) Nothing; the nurse has no control over the toddler's home.

B) Refer the caregivers of the toddler to a home health nurse.

C) Verbally confront the caregivers about the suspicions.

D) Report suspicions about the abuse to proper authorities.

Ans: D

Feedback:

Nurses are both legally and ethically obligated to report abuse, either suspected or confirmed. In many states, the failure to report actual or suspected abuse is a crime. The role of the nurse does not include confrontation.

13. A grade school nurse is addressing parents at a PTA meeting regarding car safety. Which of the following is a recommended safety guideline for this age group?

A) All school-age children need to be secured in safety seats.

B) Booster seats should be used for children until they are 4 feet 9 inches tall or at least 8 years of age.

C) Children under 8 years old should ride in the back seat.

D) All school-age children need to be secured in lap seat belts.

Ans: B

Feedback:

All school-age children need to be secured in safety seats, belt-positioning booster seats, or shoulder lap belts for their size. The National Highway Traffic Safety Administration recommends booster seats for children until they are 4 feet 9 inches tall or at least 8 years of age, and all children 12 and under should ride in the back seat to eliminate the risk of injury from airbag deployment (National Highway Traffic Safety Administration [NHTSA], 2008).

14. An adolescent has recently had a ring inserted into her navel. Which of the following is the greatest risk facing the adolescent as a result of this activity?

A) A scar over the navel

B) A local and/or systemic infection

C) A greater acceptance by peers

D) A strained relationship with parents

Ans: B

Feedback:

Body piercing is a quick procedure that does not require anesthesia, but the risk for infection is great. This risk includes local infection, hepatitis B virus, and HIV.

15. Nurses provide many interventions to prevent falls in health care settings. Which of the following would be an appropriate intervention to prevent falls?

A) Keep bed in the high position.

B) Keep side rails up at all times.

C) Apply restraints to all confused clients.

D) Lock wheels on beds and wheelchairs.

Ans: D

Feedback:

Locking wheels on beds and wheelchairs prevents them from rolling and precipitating a fall. Beds should be kept in low positions with the side rails down in most situations; restraints should be applied only as a last resort.

16. A nurse makes a medication error and fills out an incident report. What will the nurse do with the incident report once it is filled out?

A) Place it in the client's medical record.

B) Take it home and keep it locked up.

C) Maintain it according to agency policy.

D) Include it with documentation of the error.

Ans: C

Feedback:

An accident in a health care agency requires filling out an incident report, a confidential document that objectively describes the circumstances of the accident. The incident report is not a part of the medical record and should not be mentioned in the documentation. The report is maintained by the agency.

17. In what situation would the use of side rails not be considered a restraint?

A) The nurse keeps them raised at all times.

B) The institution's policies mandate using side rails.

C) A visitor requests their use.

D) A client requests they be up at night.

Ans: D

Feedback:

It is now recognized that side rails can pose serious risks for some clients. However, side rails are not considered restraints if the client requests they be put up at night to increase feelings of security while asleep. Agency policies help nurses determine when to apply restraints and what type to use.

18. *Bioterrorism* has become a commonly used term. What is the definition of bioterrorism?

A) A verbal threat by those wishing to harm specific individuals

B) A written threat calculated to produce terror in a family

C) The deliberate spread of pathogens into a community

D) A worldwide plan to produce illness and injury

Ans: C

Feedback:

Bioterrorism involves the deliberate spread of pathogenic organisms into a community.

19. A client arrives at the emergency department with nausea, hematemesis, fever, abdominal pain, and severe diarrhea. There is a suspicion the client has been exposed to the anthrax bacillus. What category of medications will be administered?

A) Antimicrobials

B) Narcotics

C) Antihistamines

D) Antacids

Ans: A

Feedback:

Anthrax is a potentially fatal bacterial infection. The recommended treatment for exposure to, as well as symptoms of, an anthrax infection is with rapid administration of antimicrobial therapy. Narcotics are administered to manage pain. Antihistamines are prescribed to manage allergy conditions. Antacids are prescribed to manage gastrointestinal disorders.

20. What statement by a client would indicate that a nurse had successfully implemented a educating/learning strategy to prevent injury in the home?

A) "I will turn off the outside lights and lock the doors every night."

B) "Do you think it would be best for me to buy a gun?"

C) "I am going to remove all those throw rugs on the floor."

D) "Well, I always let the boys play in the bathtub; they love it."

Ans: C

Feedback:

Nurses must evaluate the effectiveness of their interventions to promote safety and prevent injury. If the expected client outcomes have been met and evaluative criteria satisfied, the client should be able to correctly identify real and potential unsafe environmental situations, and implement safety measures in the environment.

21. A nurse is caring for a stable toddler diagnosed with accidental poisoning, due to the ingestion of cleaning solution. What must be included in educating parents about how to protect a toddler from accidental poisoning?

A) Closely monitor the toddler's activity.

B) Label poisonous solutions.

C) Keep cleaning solutions locked up.

D) Do not leave the toddler alone.

Ans: C

Feedback:

The parents should keep cleaning solutions locked up to protect the toddler from accidental poisoning. Accidental poisonings usually occur among toddlers and commonly involve substances located in bathrooms or kitchens. Labeling poisonous substances may not help as toddlers are unable to read. Not leaving the child alone and closely monitoring the child are important, but not feasible all the time.

22. When educating parents of preschoolers, what is most important to include in your presentation?

A) Use wrist guards with rollerblades

B) Teach preschoolers to tread water

C) Keep chemicals in a locked cabinet

D) Strict discipline with potty training

Ans: C

Feedback:

Increasing mobility, lack of life experience and judgment, and immature musculoskeletal and neurologic systems lead to potentially hazardous encounters for toddlers and preschoolers.

23.	The facility risk management team is preparing an in-service to nursing staff members. The presentation will highlight risk factor increase related directly to the type of clientele on a nursing unit. The presenter will correctly explain that which of the following risks is increased for female nurses who work on an oncology care unit?
A)	Back injuries
B)	Bloodborne pathogens
C)	Adverse reproduction
D)	Neurologic disorders
Ans:	C
	Feedback:
	Common risks in health care facilities are exposure to bloodborne pathogens from stick injuries via used needles, back injuries caused by heavy lifting, and potential adverse reproductive outcomes as a result of overexposure to antineoplastic medications. On oncology divisions, the nurse is continually exposed to antineoplastic agents.
24.	The nurse is caring for a client who has prescribed extremity restraints. The nurse is required to document which of the following?
A)	Alternative measures attempted before applying the restraints
B)	A verbal order for renewal of the restraints every 48 hours
C)	Detailed description of the restraint application process
D)	Type of personal protective equipment (PPE) used by the nurse during restraint application
Ans:	A
	Feedback:
	This is not typically documented.
25.	A nurse enters a client's room and finds that the client has fallen on her way to the bathroom. Which of the following is a prudent nursing intervention for this client?
A)	Briefly leave the client in order to call the primary physician to assess the client's condition.
B)	Order x-rays or CT scans for the client, as needed.
C)	Document the incident, assessment, and interventions in the client's medical record.
D)	Do not file an event report unless the client is seriously injured in the fall.
Ans:	C
	Feedback:
	The nurse is responsible for documenting the incident in the client's record. Assess the patient immediately and provide appropriate care and interventions based on client status, and ensure prompt follow-through for any physician orders for diagnostic tests. An event report should be filed in the case of a fall, as per facility policy.
26.	A doctor orders restraints for an older adult client who is disoriented from the pain medication she is taking. Which of the following is an appropriate guideline for applying these restraints?
A)	Chemical restraints should be tried before using physical restraints.
B)	The restraints can be ordered by the nursing supervisor in emergency situations.

C) The client's vital signs must be assessed every hour.

D) Adults must be reassessed within 4 hours; children age 9 to 17 years within two hours; and children under 9 years within one hour.

Ans: D

Feedback:

Client with restraints must be monitored and reassessed as described in answer D. Restraints must be ordered by a physician, and client vital signs must be assessed every two hours.

27. A physician orders restraints for a confused client who is at risk for injury by pulling out tubes necessary to sustain her life. Which of the following statements describes an accurate action to take when applying these restraints?

A) Apply restraints to the hands or wrists, never to the ankles.

B) Ensure that two fingers can be inserted between the restraint and the client's extremity.

C) Use a quick-release knot to tie the restraint to the side rail.

D) Remove the restraint at least every four hours, or according to agency policy.

Ans: B

Feedback:

Restraints should be sufficiently loose for two fingers to be inserted between the restraint and the extremity. Restraints can be placed on ankles; quick-release knots should be tied to the bed frame, not the side rail. Restraints should be removed every two hours.

28. Which of the following populations, based on their development stage, would benefit from strategies to prevent falls? Select all that apply.

A) Newborns

B) Toddlers

C) Adolescents

D) Adults

E) Older Adults

Ans: A, B, E

Feedback:

Educate parents never to leave newborns alone on a changing table, and also teach parents of toddlers to childproof the home. Parents of preschoolers should make sure their children wear proper safety equipment when riding bicycles or scooters. Adolescents and adults are not at high risk for falls. Older adults, however, are at risk for falls due to the effects of aging on the body systems.

29. After a client falls out of bed, the nurse completes which of the following?

A) Safety event report (incident report)

B) Telephone call to hospital's attorney

C) Progress note stating event report was completed

D) Malpractice report

Ans: A

Feedback:

An accident or incident that compromises safety in a health care agency requires the completion of a safety event report. This is a confidential document, formerly referred to as an incident report. The safety event report is not a part of the medical record and should not be mentioned in the documentation.

30. The nurse knows that a health care facility should determine its disaster-preparedness plan for delivering care in the event of an emergency or disaster?

A) As soon as the disaster is announced publicly

B) When officially informed that a disaster has occurred

C) After the first disaster has been experienced

D) In advance of a possible emergency or disaster

Ans: D

Feedback:

Each health care facility should determine in advance how to deliver care, if an emergency or disaster occurs. This involves collaboration with internal committees and external agencies.

31. A nurse is assessing a client who recently had a stroke. What is one area of assessment necessary to promote safety?

A) Neuromuscular

B) Respiratory

C) Gastrointestinal

D) Genitourinary

Ans: A

Feedback:

Anything that affects a patient's health state potentially can affect the safety of the environment. For example, a nurse who is assessing a patient with a recent stroke would assess neuromuscular impairment to prevent falls.

32. A nurse specializes in caring for victims of domestic violence. Which of the following statements accurately describes domestic violence in the United States? (Select all that apply.)

A) Studies indicate that each year, more than 12 million adults in the United States are victims of intimate partner violence.

B) Intimate partner violence is domestic violence or battering between two people in a close relationship.

C) Many men who batter their spouses also batter their children.

D) There is no evidence linking childhood sexual abuse to adult physical symptoms or substance abuse.

E) Domestic violence is not seen in a cycle.

Ans: A, B, C

Feedback:

Studies indicate that each year, more than 12 million adults in the United States are victims of intimate partner violence. Intimate partner violence is domestic violence or battering between two people in a close relationship. Many men who batter their spouses also batter their children. Recent evidence suggests a relationship between childhood sexual abuse

and certain physical symptoms in adulthood, such as gastrointestinal symptoms, eating disorders, and substance abuse. The nurse may be involved directly in health education and counseling measures, or may suggest other resources to the family as additional support for safety, well-being and to interrupt the cycle of violence.

33. Prior to inserting a nasogastric tube, the nurse correctly verifies the client's identity through which of the following methods?

A) Ask the client: "Is your name___?"

B) Check the client's identification bracelet.

C) Verify the client's room number.

D) Call the client by his or her first name.

Ans: B

Feedback:

The Joint Commission's National Patient Safety Goals include improving the accuracy of client identification. The nurse should check the client's identification bracelet to verify the client's identity.

34. Which of the following nursing diagnoses would be appropriate for teaching interventions for a single mother who leaves her toddler unattended in the bathtub?

A) Noncompliance

B) Risk for Suffocation

C) Risk for Falls

D) Risk for Imbalanced Body Temperature

Ans: B

Feedback:

Death from drowning occurs from suffocation. Nearly half of all drowning victims are children under the age of 5. Most drowning deaths in young children occur because of inadequate supervision of a bathtub or pool.

35. The nurse conducting a community emergency preparedness education class includes which of the following as an example of a natural disaster?

A) Toxic spill

B) Earthquake

C) War

D) Terrorist event

Ans: B

Feedback:

A disaster is broadly defined as a tragic event of great magnitude that requires the response of people outside the involved community. Disasters can be categorized as natural (e.g., massive flooding following a hurricane or an earthquake) or man-made (e.g., a toxic spill, war, or a terrorist event).

Chapter 28, Complementary and Integrative Health

1. A nurse is using a technique that involves the five senses to visualize recovering from an upcoming surgical procedure. What type of technique is the nurse teaching the client to use?

A) Guided imagery

B) Yoga

C) Prayer

D) Aromatherapy

Ans: A

Feedback:

Guided imagery involves using five senses to imagine an event or body process unfolding according to plan. Yoga is the practice of physical postures that promotes strength and flexibility. Prayer does not involve the five senses and is difficult to measure. Aromatherapy is the use of essential oils of plants to treat symptoms.

2. Why is it important to obtain information from a client related to the use of herbal supplements during a nursing assessment?

A) Some herbs or supplements may interact with a client's prescribed medications.

B) Nurses have special knowledge related to the use of herbs and supplements.

C) Some herbs or supplements require a special diet.

D) The herb or supplement may need to be acquired from another country.

Ans: A

Feedback:

Some herbs and supplements may interact with prescribed medications, so the nurse needs to document the herbs or supplements that the client reports taking. Extensive specialized training is required before a nurse can be competent to advise clients on the use of herbs and supplements.

3. A Native American client informs the nurse that she practices shamanism. The nurse is aware that shamanism is best described as which of the following?

A) Use of general healing techniques that involve plants, herbs, animals, ritual, ceremony, and purification by a medicine man or woman

B) A system of postures, exercises, breathing techniques, and visualization that regulate balance

C) The placement of thin, short, sterile needles at centers of nerve and vascular tissue along a meridian

D) Adjustment of the spine to accomplish proper alignment and to release pressure on a nerve

Ans: A

Feedback:

Shamanism is the use of general healing techniques that involve plants, herbs, animals, ritual, ceremony, and purification by a medicine man or woman. Qi gong is a system of postures, exercises, breathing techniques, and visualization that regulate balance. Acupuncture is the placement of thin, short, sterile needles at centers of nerve and

vascular tissue along a meridian. Chiropractic medicine is the adjustment of the spine to accomplish proper alignment and to release pressure on a nerve.

4. Which of the following considerations should a nurse prioritize surrounding the use of herbs and supplements by a client?

A) Potential interactions with drugs

B) The client's cultural background and beliefs

C) The client's previous use of herbal supplements

D) Pharmacological alternatives to herbs and supplements

Ans: A

Feedback:

Safety is paramount when herbs and supplements are being considered. One of the most salient safety considerations surrounds the potential for drug interactions. This consideration supersedes a client's culture and previous use of herbs. It is beyond most nurses' scope of practice to recommend pharmacological alternatives to an herb or supplement.

5. A nurse practices holistic client care. Which of the following is a guiding principle of this practice?

A) Holism is focused on reductionism.

B) All living organisms exist independently.

C) The body is the sum of its parts.

D) The body is a unified, dynamic whole.

Ans: D

Feedback:

Holism is a theory and philosophy that focuses on connections and interactions between parts of the whole. In contrast, the prevailing scientific approach has focused on reductionism, the goal of which is to reduce all phenomena to the smallest possible atom, particle, or interaction and make the body the sum of its parts.

6. A young mother experiences nausea and diarrhea when stressed. What mind–body messenger is believed to be responsible for these responses?

A) Reproductive hormones

B) White blood cells

C) Neuropeptides

D) Pancreatic insulin

Ans: C

Feedback:

The scientific field of psychoneuroimmunology studies neurochemicals, such as neuropeptides, that are believed to be the messenger molecules that connect the body and mind. Many neuropeptide receptor sites lie along the gastrointestinal tract; as a result, people can experience a large variety of gastrointestinal symptoms in response to emotional situations.

7. A client with rheumatoid arthritis complains of soreness in his joints. Which of the following homeopathic remedies might the nurse recommend for this client?

A) Arnica

B) Calendula

C) Nux vomica

D) Ignatia

Ans: A

Feedback:

Arnica is a topical cream or oral pellets used for muscle soreness or bruising, joint sprains, or strains. Calendula is an ointment applied to cuts, scrapes, burns, sores, and nonfungal eruptions. Nux vomica is a remedy for stress, overwork, impatience, and irritability. Ignatia is a remedy taken immediately following grief or loss and extreme sadness.

8. A nurse uses Therapeutic Touch to decrease a postoperative client's nausea. Which of the following is a principle of this CAT modality?

A) A human being is a closed energy system.

B) A human being is bilaterally asymmetric.

C) Illness is an imbalance in a person's energy field.

D) Humans do not have the ability to transform.

Ans: C

Feedback:

Therapeutic Touch, the use of the hands on or near the body with the intent to help or heal, is based on four principles. One of the principles is that illness is an imbalance in a person's energy field. Humans are open energy systems, are not bilaterally asymmetric, and have the ability to transform.

9. What is the ultimate goal of increasing the parasympathetic system influence on the body through relaxation or meditation?

A) Stimulate improved gastrointestinal function

B) Increase cardiac output and blood pressure

C) Facilitate respiratory function and cough

D) Reduce the effects of stress on the body

Ans: D

Feedback:

Sympathetic system dominance is characterized by increased epinephrine levels in the body, contributing to such stress-related conditions as hypertension, tachycardia, and increased respiratory rate. Parasympathetic dominance has opposite effects, reducing the effects of stress and stress-related illnesses on the body.

10. A nurse who is a traditional Chinese medicine practitioner is providing home care to a client who also uses traditional Chinese medicine for health care. What specific assessments would the nurse make?

A) Tongue and pulses

B) Abdominal muscles and respirations

C) Muscle tone and cranial nerves

D) Vision and hearing

Ans: A

Feedback:

The goal of the TCM diagnostic process when assessing a client who practices traditional Chinese medicine is to arrive at the pattern of disharmony that is being manifested. The nurse would obtain a holistic health history and assess particular parts of the client's body, such as the tongue and pulses.

11. A client interested in acupuncture asks a nurse, "Just exactly what does it do?" What would the nurse explain?

A) "Acupuncture is based on a philosophy of laying on of hands."

B) "I don't think it does anything, so I don't know anything about it."

C) "It uses a manual process of adjusting the spine."

D) "It changes the flow of energy and helps healing."

Ans: D

Feedback:

Acupuncture is based on a belief in energy circuits that nourish and supply all cells and organs of the body. By placing needles at particular acupoints, the flow of energy is either increased or decreased, contributing to healing.

12. A nurse is teaching a client about the proper use of herbs and supplements. Which statement should be included?

A) "Look on the Internet for the products you want to try."

B) "The federal government regulates supplements."

C) "It doesn't matter how much you take."

D) "The product may take a longer time to be effective."

Ans: D

Feedback:

Information about the use of herbs and supplements includes the following: they should come from a reliable source; are not regulated; can be toxic in higher-than-recommended doses; and may take longer to produce a therapeutic effect than allopathic preparations.

13. Which essential oil can be used during aromatherapy to treat nausea?

A) Lavender

B) Garlic

C) Parsley

D) Peppermint

Ans: D

Feedback:

Essential oils commonly used in a health care setting to treat nausea include ginger and peppermint. Garlic, lavender, and parsley are not used to treat nausea.

14. A nurse is conducting a health history and asks the client about use of complementary and alternative therapies (CAT) to treat her chronic headaches. What response would require further questions?

A) “I practice meditation.”

B) “I use relaxation to help me go to sleep.”

C) “Each week, I have a total body massage.”

D) “I take herbs to treat my headaches.”

Ans: D

Feedback:

Alternative therapies, such as herbs, are used most frequently for chronic conditions such as depression or headaches. However, certain herbs may interact with each other or with prescribed medications, causing negative effects. Forthis reason, the nurse must ask further questions about the type of herb as well as the frequency of use.

15. What philosophy underlies the use of CAT?

A) The mind, body, and spirit function as a unified whole.

B) The mind and the body are separate and distinct.

C) Parts of an organism rarely interact or change.

D) Traditional medicine is most effective for chronic illnesses.

Ans: A

Feedback:

A holistic philosophy underlies much of CAT. People have a mind, body, and spirit that are connected and function as a unified whole. A change in any part of the organism will be reflected in other parts.

16. A nurse practitioner uses integrative care in his practice. What does this mean?

A) He uses allopathic medicine to treat all clients.

B) He uses both allopathic medicine and CAT.

C) The nurse uses CAT, a physician-prescribed medication.

D) The nurse provides care for clients of all age groups.

Ans: B

Feedback:

A health care provider who uses integrative care uses some combination of allopathic medicine and CAT. Integrative care does not mean using allopathic medicine to treat clients of all age groups; CAT is not a physician-prescribed medication.

17. A nurse is practicing imagery to relieve stress. What might accompany the imagery to even further promote relaxation?

A) Bright lighting

B) Bodywork techniques

C) Talking on the phone

D) Listening to music

Ans: D

Feedback:

Music has demonstrated effectiveness in reducing pain, decreasing anxiety, promoting relaxation, and distracting from unpleasant sensations. The other choices are not appropriate for promoting relaxation.

18. A trained nurse uses the technique of "Rolfing" to break up tension in client body structures. What type of CAT is being used by this nurse?

A) Therapeutic Touch

B) Therapeutic massage

C) Acupuncture

D) Healing touch

Ans: B

Feedback:

Therapeutic massage consists of an assortment of techniques that involve manipulation of soft tissues of the body through pressure and movement, as well as a variety of techniques such as Rolfing, shiatsu, Feldenkrais, Alexander, myofascial release, and others. The goal is to break up tension held in body structures, promote communication between mind–body structures, promote detoxification, and generally improve body functioning.

19. A client is very anxious before an invasive procedure. What CAM therapy would be most helpful to assist in decreasing anxiety?

A) Meditation

B) Chinese medicine

C) Acupuncture

D) Herbs

Ans: A

Feedback:

Meditation is a way to tune and train the mind, leading to greater efficiency in everyday life. This will be most helpful in assisting this client to decrease the stress level. Chinese medicine has a very broad base and includes meditation, acupuncture, and herbs.

20. A client inquires about the use of herbal therapy. Which statement by the nurse is most accurate?

A) "All herbs are equal in purity, so purchase the cheapest brand."

B) "Herbs can have side effects and can interact with prescription medications."

C) "Be sure to pay attention to the packaging's therapeutic and prevention information."

D) "It is best if you select a licensed herbalist as a practitioner."

Ans: B

Feedback:

It is important for clients to understand that herbs can have side effects and can interact with prescription medications. Standardization of the herb's constituents is useful, but also limited because not all the compounds or the required levels are known. Thus, the purity and dosage contents may not be equal between herbs. Herbal products cannot make therapeutic and prevention claims. There is no current licensing body for herbalists.

21. Which of the following populations are more inclined to use CAT? Select all that apply.

A) Women

B) Adults aged 20 to 30

C) People living in the east

D) Former smokers

E) Adults who are poor

Ans: A, D

Feedback:

The 2007 survey found that in the United States, approximately 38% of adults (about 4 in 10) and approximately 12% of children (about 1 in 9) were using some form of CAT in the 12 months before the survey. Consistent with results from the 2002 NHIS, in 2007, CAT use was more prevalent among women, adults age 30 to 69, adults with higher levels of education, adults who were not poor, adults living in the West, former smokers, and adults who were hospitalized in the last year.

22. The client is postoperative. The nurse is practicing healing touch with the client. Which of the following would the nurse evaluate as an expected outcome of healing touch?

A) The wound is not approximated three days following surgery.

B) The client reports pain as a "6" on a 0 to 10 pain scale.

C) The client states that his anxiety following surgery has decreased.

D) The client's temperature has remained at or below 100.4ºF

Ans: C

Feedback:

Healing touch may reduce the client's anxiety, stimulate wound healing, relieve pain, and promote health. The wound not being approximated, pain level of "6", and temperature of 100.4ºF are not expected outcomes of healing touch.

23. The nurse is providing information about warfarin (Coumadin) to a client who takes herbal products. The nurse states, "Some herbs interfere with the effectiveness of warfarin. Do you take …

A) echinacea?"

B) goldenseal?"

C) ginkgo biloba?"

D) tumeric?"

Ans: C

Feedback:

Ginkgo biloba is an herb that affects platelet function. As a result, it should not be used with warfarin.

24. A client is taking ginkgo to improve her memory. In the education plan regarding this herb, the nurse should include which of the following?

A) It may raise blood pressure.

B) Avoid this herb if allergic to plants.

C) There is a possible sensitivity to light.

D) Use caution if taking aspirin.

Ans: D

Feedback:

Clients should be advised to use caution if taking aspirin in conjunction with ginkgo. Ginseng may raise blood pressure. Avoid echinacea if allergic to plants in the daisy family. Taking St. John's wort may cause sensitivity to light.

25. Which of the following is a theory and philosophy that focuses on connections and interactions between parts of the whole?

A) Complementary therapies

B) Allopathic medicine

C) Integrative care

D) Holism

Ans: D

Feedback:

Holism is a theory and philosophy that focuses on connections and interactions between parts of the whole. Complementary therapies can be used with traditional medical interventions and complement them. Allopathic medicine is also known as biomedicine. Integrative care uses a combination of allopathic medicine and complementary and alternative therapies.

26. The imbalance of which of the following can by the result of stress, lifestyle, and improper diet?

A) Doshas

B) Qi

C) Chakras

D) Aura

Ans: A

Feedback:

Imbalance of the doshas can be caused by a number of factors, including stress, lifestyle, and improper diet. Qi represents an invisible flow of energy that circulates through plants, animals, and people. Chakras are concentrated areas of energy. An aura consists of at least seven layers of energy that surround the body.

27. Which of the following would be the least consistent as a reason for the use of complementary and alternative medicine (CAM)?

A) Increasing numbers of acute conditions

B) Dissatisfaction with conventional medicine

C) Difficulty meeting rising health care costs

D) Growth of culturally diverse groups

Ans: A

Feedback:

There are increasing numbers of people with chronic, incurable conditions. Reasons to use CAM include dissatisfaction with conventional medicine, difficulty meeting rising health care costs, and a growth of culturally diverse groups.

28. There are four primary scientific principles for therapeutic touch. Which of the following is not one of these principles?

A) A human being is bilaterally symmetrical.

B) A human being is an open energy system.

C) Distractions of modern life interfere with healing agents.

D) Illness is an imbalance in an individual's energy field.

Ans: C

Feedback:

The four primary scientific principles of therapeutic touch are as follows: A human being is bilaterally symmetrical. A human being is an open energy system. Illness is an imbalance in an individual's energy field. Human beings have natural abilities to transform and transcend their conditions of living. The idea that distractions of modern life interfere with healing agents is a Native American belief and is not related to therapeutic touch.

29. Which of the following is considered a holistic approach to food choices?

A) The carbonation in soft drinks is beneficial to health.

B) Vegetarian diets should be avoided because they limit options.

C) Avoid eating foods with preservatives.

D) Increase intake of natural sugar.

Ans: C

Feedback:

A holistic approach to food includes avoiding eating foods with preservatives and reducing or eliminating the amount of soft drinks consumed. It also recommends a vegetarian diet and reducing intake of refined and natural sugars.

30. A client informs a nurse practitioner that she takes the herb St. John's wort for symptoms of depression. The nurse recognizes herbal therapy as belonging to which complementary and alternative therapy (CAT) domain?

A) Biologically based practices

B) Energy medicine

C) Mind-body medicine

D) Manipulative practices

Ans: A

Feedback:

Biologically based practices include the use of herbs, animal-derived extracts, vitamins, minerals, fatty acids, proteins, prebiotics and probiotics, whole diets, and functional foods. Energy medicine involves the use of energy fields, such as magnetic fields or biofields. Mind-body medicine uses techniques to enhance the mind's ability to affect bodily function and symptoms. Manipulative practices work with structures and systems of the body.

31. The nurse is slightly overweight and decides to take a holistic approach to losing weight. The nurse does which of the following? Select all that apply.

A) Eliminates cola drinks

B) Decreases refined sugar

C) Avoids foods with preservatives

D) Adopts a vegatarian diet

E) Substitutes aspartame for sugar

Ans: A, B, C, D

Feedback:

Holistic approaches to food choices include eliminating cola drinks, reducing refined sugar, and adopting a primarily vegetarian diet. Substituting aspartame for sugar is not an example of a holistic approach to food choices.

32. A woman age 35 years with a chronic disorder tells her nurse that she would be interested in finding out about complementary therapies that are available. What would be the nurse's best response to this client?

A) "It is best to stick with allopathic medicine.

B) Complementary therapies are not available for your condition.

C) Complementary therapies are not covered by your insurance plan.

D) Complementary therapies are being used as an 'answer' to the problem of chronic illness.

Ans: D

Feedback:

Allopathic medical care is particularly effective when aggressive treatment is needed in emergency or acute situations. However, allopathic medical care has not been totally effective in dealing with chronic illness, a persistent problem. Increasingly, complementary and alternative therapies are being used as an answer to the problem of chronic illness.

33. Which of the following complementary and alternative therapies is based on the "Law of Minimal Dose"?

A) Homeopathy

B) Traditional Chinese

C) qi Gong

D) Ayurveda

Ans: A

Feedback:

Samuel Hahnemann, a German physician, developed homeopathy approximately 200 years ago. The allopathic approach to dealing with illness is frequently to suppress symptoms; for example, acetaminophen can be given to reduce a fever. In contrast, homeopaths believe that when symptoms are suppressed in this manner, the condition goes deeper into the body, making it ultimately more difficult to cure. Supporters of homeopathy point to two unconventional theories: – "Like cures like"—the notion that a disease can be cured by a substance that produces similar symptoms in healthy people. – "Law of minimum dose"—the notion that the lower the dose of the medication, the greater its effectiveness. Many homeopathic remedies are so diluted that no molecules of the original substance remain.

34. A nurse is teaching a client about holistic approaches to food choices. Which of the following would the nurse recommend?

A) Consume more dairy products.

B) Use artificial sweeteners instead of sugar.

C) Drink diet sodas instead of regular sodas.

D) Reduce refined sugar intake.

Ans: D

Feedback:

Some recommendations include reducing the amount of processed foods; reducing/eliminating soft drinks (colas); reducing intake of refined and natural sugars; reducing intake of artificial sweeteners, including aspartame; eating organically grown foods; reducing intake of dairy products; and being aware of genetically engineered, radiated food.

35. The nurse caring for a Native American client plans care understanding that one belief of Native American healing practices is which of the following?

A) Modern life facilitates healing agents.

B) Healing takes time.

C) Balancing yin and yang is important.

D) Energy flows through meridians throughout the body.

Ans: B

Feedback:

Native American healing practices are grounded in their cultural views. One concept, identified in a study, is that healing takes time.

Chapter 29, Medications

1. The nurse is preparing to administer a medication via a nasogastric tube. What guideline is appropriate for the nurse to follow when administering a drug via this route?

A) Flush the tube with water between each drug administered.

B) Position the client supine prior to administering the drug.

C) Administer the medication at a cold temperature.

D) If connected to suction, do not reconnect to suction for five minutes after drug administration.

Ans: A

Feedback:

Guidelines to consider when administering a drug via nasogastric tube include positioning the client with the head of the bed elevated, administering the medication at room temperature for the client's comfort, flushing the tube with water between each drug administered, and avoiding the use of suction for 20 to 30 minutes after the drug is administered.

2. The medical chart of a newly admitted client notes a penicillin allergy, yet the physician has just written an order for an antibiotic in the same drug family after reviewing the client's wound culture and sensitivity. How should the nurse respond to this situation?

A) Withhold the medication until the potential drug allergy has been addressed by the care team.

B) Administer the medication and increase the frequency of assessments in the hours that follow.

C) Substitute an antibiotic with similar action, but which is from a different drug family.

D) Discuss the severity, signs and symptoms of the drug allergy with the client in order to ascertain the risks of administration.

Ans: A

Feedback:

Client safety is paramount, and the nurse has a responsibility to ensure that a potential threat of harm is identified and dealt with promptly. It is beyond the nurse's scope of practice to independently substitute another drug, and it would be unsafe to administer the drug in light of this revelation. The nurse would not administer the drug even if the client stated that his or her allergy is mild.

3. Which of the following clients receives a drug that requires parenteral route?

A) A woman who has been ordered intravenous antibiotics

B) A woman who takes a diuretic pill each morning

C) A man with emphysema who uses nebulized bronchodilators

D) A man who has an antifungal ointment applied to his skin rash daily

Ans: A

Feedback:

The parenteral route includes such methods as intravenous administration and injections. Pills are given by an oral route and a nebulizer is administered by the pulmonary route. An ointment is a topical medication.

4. A physician has ordered peak and trough levels of a medication. When would the nurse schedule the trough level specimen?

A) Before administering the first dose

B) Immediately after the first dose

C) 30 minutes before the next dose

D) 24 hours after the last dose

Ans: C

Feedback:

The trough level is the point when the drug is at its lowest concentration, and the specimen is usually drawn in the 30-minute interval before the next dose. The peak level, in contrast, is the highest plasma concentration of the drug.

5. A client taking insulin has his levels adjusted to ensure that the concentration of drug in the blood serum produces the desired effect without causing toxicity. What is the term for this desired effect?

A) Peak level

B) Trough level

C) Half-life

D) Therapeutic range

Ans: D

Feedback:

A drug's therapeutic range is the concentration of drug in the blood serum that produces the desired effect without causing toxicity. The peak level, or highest plasma concentration, of the drug should be measured when absorption is complete. The peak level may be affected by factors that affect drug absorption as well as the route of administration. The trough level is the point when the drug is at its lowest concentration, and this specimen is usually drawn in the 30-minute interval before the next dose. A drug's half-life is the amount of time it takes for 50% of the blood concentration of a drug to be eliminated from the body.

6. A client who is taking an oral narcotic for pain relief tells the nurse he is constipated. What is this common response to narcotics called?

A) Therapeutic effect

B) Adverse effect

C) Toxic effect

D) Idiosyncratic effect

Ans: B

Feedback:

Although therapeutic effect is the desired outcome of medication administration, sometimes adverse effects occur. Adverse effects (such as constipation from narcotics) often are predictable and can usually be tolerated. Toxic effects (toxicities) are specific groups of symptoms related to drug therapy that carry risk for permanent damage or death. An idiosyncratic effect(sometimes called paradoxical effect) is any unusual or peculiar response to a drug that may manifest itself by over-response, under-response, or even the opposite of the expected response.

7. A nurse is conducting an interview for a health history. In addition to asking the client about medications being taken, what else should be asked to assess the risk for drug interactions?

A) The effects of prescribed medications

B) Type and amount of foods eaten

C) Daily amount of intake and output

D) Use of herbal supplements

Ans: D

Feedback:

Herbal remedies can interact with prescribed medications. When asking a client if he or she is taking any medications, the nurse should specifically ask if herbal supplements are also being used.

8. A nurse is converting the dosage of a medication to a different unit in the metric system. The medication label specifies the drug as being 0.5 g per tablet. The order is for 500 mg. How many tablets will the nurse give?

A) 1

B) 2

C) 5

D) 10

Ans: A

Feedback:

To convert in the metric system from a smaller unit to a larger unit, move the decimal point three places to the right. As 0.5 g = 500 mg, the nurse would administer one tablet.

9.	A physician has ordered that a medication be given “stat” for a client who is having an anaphylactic drug reaction. At what time would the nurse administer the medication?
A)	At the next scheduled medication time
B)	Immediately after the order is noted
C)	Not until verifying it with the client
D)	Whenever the client asks for it
Ans:	B
	Feedback:
	A stat order is a single order, and it is carried out immediately. This is a legal order. The nurse would not wait until the next scheduled medication time or verify the order with the client. With a p.r.n. order, the client receives medication when it is requested or required.
10.	What does the nurse do to verify an order for a medication listed on a medication administration record (MAR)?
A)	Compare it with the original physician’s order.
B)	Ask another nurse what the drug is.
C)	Look up the drug in a textbook.
D)	Call the pharmacist for verification.
Ans:	A
	Feedback:
	In many institutions, the medication order is copied onto the client’s medication record. The nurse is responsible for checking that the medication order was transcribed correctly by comparing it with the original physician’s order.
11.	A nurse is administering a medication that is formulated as enteric-coated tablets. What is the rationale for not crushing or chewing enteric-coated tablets?
A)	To prevent absorption in the mouth
B)	To prevent absorption in the esophagus
C)	To facilitate absorption in the stomach
D)	To prevent gastric irritation
Ans:	D
	Feedback:
	Enteric-coated tablets are covered with a hard surface to impede absorption until the tablet has left the stomach. Enteric-coated tablets should not be chewed or crushed because the active ingredient of the drug is irritating to the gastric mucosa.
12.	A nurse is administering a liquid medication to an infant. Where will the nurse place the medication to prevent aspiration?
A)	Between the gum and the cheek
B)	In front of the teeth and gums
C)	On the front of the tongue

D) Under the tongue

Ans: A

Feedback:

A dropper is used to give infants or very young children liquid medications while holding them in a sitting or semisitting position. The medication is placed between the gum and the cheek to prevent aspiration.

13. A nurse is teaching an older adult at home about taking newly prescribed medications. Which information would be included?

A) "You can identify your medications by their color."

B) "I have written the names of your drugs with times to take them."

C) "You won't forget a medication if you count them every day."

D) "Don't worry if the label comes off; just look at the shapes."

Ans: B

Feedback:

Teach clients the names of drugs rather than distinguishing drugs by color. Manufacturers may vary the color of generic drugs, and the visual changes associated with aging may make it more difficult to identify medications by color. Medications should not be identified by counting or by shapes.

14. A student nurse is administering medications through a nasogastric tube connected to continuous suction. How will the student do this accurately?

A) Briefly disconnect tubing from the suction to administer medications, then reconnect.

B) Realize this can't be done, and document information.

C) Disconnect tubing from the suction before giving drugs, and clamp tubing for 20 to 30 minutes.

D) Leave the suction alone and give medications orally or rectally.

Ans: C

Feedback:

To administer medications to clients with a nasogastric tube connected to continuous suction, disconnect the tubing from the suction, administer the medications one at a time, and then clamp the tubing for 20 to 30 minutes after administration to allow absorption.

15. What would a nurse instruct a client to do after administration of a sublingual medication?

A) "Take a big drink of water and swallow the pill."

B) "Try not to swallow while the pill dissolves."

C) "Swallow frequently to get the best benefit."

D) "Chew the pill so it will dissolve faster."

Ans: B

Feedback:

Sublingual and buccal medications should not be swallowed, but rather held in place so that complete absorption takes place.

16. A nurse is administering an intramuscular injection of a viscous medication using the appropriate-gauge needle. What does the nurse need to know about needle gauges?

A) All needles for parenteral injection are the same gauge.

B) The gauge will depend on the length of the needle.

C) Ask the client what size needle is preferred.

D) Gauges range from 18 to 30, with 18 being the largest.

Ans: D

Feedback:

The gauge is determined by the diameter of the needle and ranges from 18 to 30. As the diameter of the needle increases, the gauge number decreases (an 18-gauge needle is, therefore, larger than a 30-gauge needle). A viscous medication requires a larger-gauge needle for injection.

17. A nurse has administered an intramuscular injection. What will the nurse do with the syringe and needle?

A) Recap the needle; place it in a puncture-resistant container.

B) Do not recap the needle; place it in a puncture-resistant container.

C) Break off the needle, place it in the barrel, and throw it in the trash.

D) Take off the needle and throw the syringe in the client's trash can.

Ans: B

Feedback:

After use, needles and syringes are placed in a puncture-resistant container without being recapped. This prevents needlestick injuries, because most occur during recapping.

18. A clinic nurse is preparing for a tuberculosis screening. Knowing the injections will be administered intradermally, what size needles and syringes will the nurse prepare?

A) 10-mL syringe, 3-inch 18-gauge needle

B) 5-mL syringe, 2-inch 20-gauge needle

C) Insulin syringe, 1-inch 16-gauge needle

D) Tuberculin syringe, 1/2-inch 26-gauge needle

Ans: D

Feedback:

Equipment used for an intradermal injection includes a tuberculin syringe calibrated in tenths and hundredths of a milliliter. A quarter-inch to half-inch 26- or 27-gauge needle is used.

19. A nurse is caring for a client in the nursing unit when the physician, during the rounds, prescribes a medication for the client. What appropriate action should the nurse take to ensure the accuracy of the verbal medication order?

A) Ask the physician to repeat the dosage.

B) Ask the physician to spell out the medication name.

C) Ask a second nurse to listen for accuracy.

D) Ask the physician to write out the order.

Ans: D

Feedback:

To maintain the accuracy of a verbal order, the nurse should tactfully ask the physician for a written order. When obtaining phone orders, it is important to repeat the dosages of medications and to spell medication names for confirmation of accuracy. Some nurses may ask a second nurse to listen to a telephone order on an extension.

20. A nurse at the health care facility is preparing the medication dosage for a client. Why should the nurse read and compare the label on the medication with the MAR at least three times (before, during, and after) while preparing the medication for administration?

A) Ensures that the right medication is given at the right time by the right route

B) Complies with the medical order and ensures that the right dose is given

C) Ensures that the medication has been administered to the right client

D) Demonstrates timely administration and compliance with the medical order

Ans: A

Feedback:

When preparing the medications for administration, the nurse reads and compares the label on the medication with the MAR at least three times. This is to ensure that the right medication is given at the correct time, and by the correct route. The nurse calculates the doses to comply with the medical order and ensure that the right dose is given. Before administration, the nurse identifies the client by checking the wristband or asking the client's name. This is to ensure that the medication is given to the right person. The nurse should plan to administer the medications within 30 to 60 minutes of their scheduled time, which demonstrates timely administration and compliance with the medical order.

21. A client with allergy has been advised to have an allergy test. The nurse needs to administer an injection to the client for allergy testing. Which of the following injection routes is most suitable for allergy testing?

A) Subcutaneous

B) Intramuscular

C) Intradermal

D) Intravenous

Ans: C

Feedback:

Intradermal injection routes are commonly used for tuberculin tests and allergy testing because they are administered between the layers of the skin. A subcutaneous injection is not suitable because it is administered more deeply than an intradermal injection; whereas, an intramuscular injection is administered in one muscle or muscle group. Intravenous injection is also not suitable because it is instilled into veins.

22. A nurse needs to administer an intradermal tuberculin skin test injection to a client. Which of the following is the most suitable angle when administering an intradermal injection?

A) 180-degree angle

B) 90-degree angle

C) 45-degree angle

D) 10-degree angle

Ans: D

Feedback:

When administering an intradermal injection, the nurse should hold the syringe almost parallel to the skin at a 10-degree angle with the bevel pointing upward. This facilitates delivering the medication between the layers of the skin and advances the needle to the desired depth. A nurse administers a subcutaneous injection at a 45-degree angle or a 90-degree angle to reach the subcutaneous level of tissue, depending on the length of the needle. The nurse will not be able to insert the injection if it is held at a 180-degree angle.

23. A nurse needs to administer a prescribed dose of a narcotic medication to a client with acute neck pain. Which of the following precautions should the nurse take when storing narcotic medications?

A) In a double-locked drawer

B) In a single container

C) In a self-contained packet

D) In disguised containers

Ans: A

Feedback:

The nurse should place narcotic drugs in a double-locked drawer. Narcotics are controlled substances, meaning that federal laws regulate their possession and administration. Health care facilities keep narcotics in a double-locked drawer, box, or room on the nursing unit. A narcotic drug may not be placed in a single container, self-contained packet, or in disguised containers.

24. A nurse at a health care facility administers a prescribed drug to a client and does not record doing so in the medical administration record. The nurse who comes during the next shift, assuming that the medication has not been administered, administers the same drug to the client again. The nurse on the previous shift calls to inform the health care facility that the administration of the drug to this client in the earlier shift was not recorded. What should the nurse on duty do immediately upon detection of the medication error?

A) Report the incident to the physician.

B) Report the incident to the supervising nurse.

C) Check the client's condition.

D) Fill in the accident report sheet.

Ans: C

Feedback:

On detection of the medication error, the nurse should immediately check the client's condition. When medication errors occur, nurses have an ethical and legal responsibility to report them to maintain the client's safety. As soon as the nurse recognizes an error, he or she should check the client's condition and report the mistake to the prescriber and supervising nurse immediately. Health care agencies have a form for reporting medication errors called an incident sheet or accident sheet.

25. A client with dry skin has been prescribed inunction. Which of the following should the nurse do to promote absorption of the ointment?

A) Shaking the contents of the ointment

B) Applying inunction with a cotton ball

C) Rubbing the ointment into the skin

D) Warming the inunction before application

Ans: C

Feedback:

In order to promote absorption, the nurse should rub the ointment into the client's skin. Shaking the contents would mix the contents uniformly, whereas applying the with a cotton ball would distribute the substance over a wide area. Warming the ointment before application would provide comfort.

26. A nurse at a health care facility has to instill ear drops in a client. The nurse knows that which of the following techniques varies for an adult and child client?

A) Manipulation of the client's ear to straighten the auditory canal

B) Dilution of the medication drops before instilling in the client's ear

C) Position in which the client remains until medication reaches the eardrum

D) Amount of time before instilling medication in the client's opposite ear

Ans: A

Feedback:

The nurse should be aware that the method of manipulation of the client's ear to straighten the auditory canal varies between an adult and child. In a young client, the nurse pulls the ear down; in an adult client, the nurse pulls the ear up and back. The medication is not diluted; the number of medication drops instilled is as per the physician's prescription, and does not depend on the client's age. The position in which the client remains until the medication reaches the eardrum, and the amount of time before instilling medication in the client's opposite ear, does not differ with the age of the client.

27. A nurse is showing an older adult client the correct method of self-administering an insulin injection at home. Which of the following points should the nurse tell the client in order to avoid lipoatrophy and lipohypertrophy?

A) Change the needle daily with each injection.

B) Rotate the site with each injection.

C) Apply local anesthetic to the injection site.

D) Massage the injection site for 10 minutes.

Ans: B

Feedback:

The nurse should tell the client to rotate the injection site each time an insulin injection is administered to prevent lipoatrophy and lipohypertrophy. In case of an insulin injection, the needle need not be changed daily but rather after a specific period specified by the manufacturer on the injection. Local anesthetic need not be applied to the injection site when administering insulin as the needle used causes very little discomfort. There is also no need to massage the injection site when insulin is administered. Massaging is contraindicated when heparin is administered, because this can increase the tendency for local bleeding.

28. A nurse should read the instructions stated on a vial container before reconstituting it and administering it to a client. Which of the following instructions are stated on the label of a vial container?

A) Type of needle to be used for withdrawal

B) Directions for administering the drug

C) Best site for administering the drug

D) Amount of diluent to be added

Ans: D

Feedback:

When reconstitution is necessary, the drug label lists instructions such as the amount of diluent to be added and the type of diluent to be used, but not the type of needle. The label states the dosage per volume after reconstitution, not the best site for administering the drug after the reconstitution. It also states the directions for storing the drug, not the directions for administering the drug to a client.

29. A nurse is bunching the tissue of a client when administering a subcutaneous injection to that client. The nurse knows that which of the following is the reason for bunching when injecting subcutaneously?

A) To prevent needle-stick injuries

B) To ensure the accuracy of landmarking

C) To facilitate blood circulation at injection site

D) To avoid instilling medication within the muscle

Ans: D

Feedback:

Nurses bunch tissue between the thumb and fingers before administering the injection to avoid instilling medication within the muscle. Bunching does not prevent needle-stick injuries, it does not facilitate blood circulation at the injection site, nor does it ensure the accuracy of landmarking.

30. A client diagnosed with anemia is receiving a blood transfusion. The client develops urticaria accompanied by wheezing and dyspnea not long after the transfusion starts. The nurse interprets this as indicative of which of the following?

A) Allergic reaction

B) Side effect

C) Toxicity

D) Antagonism

Ans: A

Feedback:

With urticaria, hives, wheezing, and dyspnea are the symptoms of severe allergic reaction, which is due to an anaphylactic reaction. Minor adverse effects are called side effects. Many side effects are essentially harmless and can be ignored. Toxicity results from overdosage or buildup of medication in the blood due to impaired metabolism and excretion. Antagonism is a drug interaction by which drug effects decrease.

31. Which medication system allows for client independence?

A) Unit dose system

B) Self-administered medication system

C) Automated medication-dispensing system

D) Bar Code Medication Administration

Ans: B

Feedback:

The self-administered system allows the client independence and responsibility. It also allows nursing supervision, education, and evaluation for client compliance and safety medication management prior to facility discharge.

32. A physician writes an order for ampicillin 1 gram every 6 hours for a client. What is missing in this order?

A) Time

B) Amount

C) Route

D) Frequency

Ans: C

Feedback:

The medication order does not identify a route.

33. What is the name of the process by which a drug moves through the body and is eventually eliminated?

A) Pharmacology

B) Pharmacotherapeutics

C) Pharmacokinetics

D) Pharmacodynamics

Ans: C

Feedback:

Pharmacokinetics is the process by which a drug moves through the body and is eventually eliminated.

34. Medications administered that are renal toxic should have frequent assessments of which blood values?

A) AST and ALT

B) BUN and creatinine

C) WBC and platelets

D) RBC and differential

Ans: B

Feedback:

If medications are known to cause kidney dysfunction, kidney function tests (serum creatinine, blood urea nitrogen) should be frequent.

35. The “Rights of Medication Administration” help to ensure accuracy when administering medications. Which of the following represent these five rights? Select all that apply.

A) Medication

B) Client

C) Prescribing physician

D) Pharmacy

E) Dosage

F) Route

Ans: A, B, E, F

Feedback:

To prevent medication errors, always ensure that the: (1) Right medication is given to the (2) right client in the (3) right dosage through the (4) right route at the (5) right time.

Chapter 30, Perioperative Nursing

1. The nurse is preparing to send a client to the operating room for an exploratory laparoscopy. The nurse recognizes that there is no informed consent for the procedure on the client's chart. The nurse informs the physician who is performing the procedure. The physician asks the nurse to obtain the informed consent signature from the client. What is the nurse's best action to the physician's request?

A) Inform the physician that it is his or her responsibility to obtain the signature.

B) Obtain the signature and ask another nurse to cosign the signature.

C) Inform the physician that the nurse manager will need to obtain the signature.

D) Call the house officer to obtain the signature.

Ans: A

Feedback:

The responsibility for securing informed consent from the client lies with the person who will perform the procedure. The nurse's best action is to inform the physician that it is his or her responsibility to obtain the signature.

2. Upon assessment, a client reports that he drinks five to six bottles of beer every evening after work. Based upon this information, the nurse is aware that the client may require which of the following?

A) Larger doses of anesthetic agents and larger doses of postoperative analgesics

B) Larger doses of anesthetic agents and lower doses of postoperative analgesics

C) Lower doses of anesthetic agents and lower doses of postoperative analgesics

D) Lower doses of anesthetic agents and larger doses of postoperative analgesics

Ans: A

Feedback:

Clients with a large habitual intake of alcohol require larger doses of anesthetic agents and postoperative analgesics, increasing the risk for drug-related complications.

3. The telemetry unit nurse is reviewing laboratory results for a client who is scheduled for an operative procedure later in the day. The nurse notes on the laboratory report that the client has a serum potassium level of 6.5 mEq/L, indicative of hyperkalemia. The nurse informs the physician of this laboratory result because the nurse recognizes hyperkalemia increases the client's operative risk for which of the following?

A) Cardiac problems

B) Infection

C) Bleeding and anemia

D) Fluid imbalances

Ans: A

Feedback:

Hyperkalemia or hypokalemia increases the client's risk for cardiac problems. A decrease in the hematocrit and hemoglobin level may indicate the presence of anemia or bleeding. An elevated white blood cell count occurs in the presence of infection. Abnormal urine constituents may indicate infection or fluid imbalances.

4. The nurse is providing education to a client regarding pain control after surgery. What time does the nurse inform the client is the best time to request pain medication?

A) Before the pain becomes severe

B) When the client experiences a pain rating of "10" on a 1-to-10 pain scale

C) When there is no pain, but it is time for the medication to be administered

D) After the pain becomes severe and relaxation techniques have failed

Ans: A

Feedback:

If a pain medication is ordered p.r.n., the client should be instructed to ask for the medication before the pain becomes severe.

5. A client returning to the floor after orthopedic surgery is complaining of nausea. The nurse is aware that an appropriate intervention is to do which of the following?

A) Avoid strong smelling foods.

B) Provide clear liquids with a straw.

C) Avoid oral hygiene until the nausea subsides.

D) Hold all medications.

Ans: A

Feedback:

Nursing care for a xlient with nausea includes avoiding strong smelling foods, providing oral hygiene, administering prescribed medications (especially medications ordered for nausea and vomiting), and avoiding use of a straw.

6. In order to prevent the possibility of venous stasis, a nurse is teaching a surgical client how to perform leg exercises. Which of the client's following statements indicates a sound understanding of leg exercises?

A) "I'll practice these now and try to start them as soon as I can after my surgery."

B) "I'll try to do these lying on my stomach so that I can bend my knees more fully."

C) "I'll make sure to do these, as long as my doctor doesn't tell me to stay on bed rest after my operation."

D) "I'm pretty sure my stomach muscles are strong enough to lift both of my legs off the bed at the same time."

Ans: A

Feedback:

Leg exercises should be begun as soon as possible after surgery, unless contraindications exist. Bed rest does not preclude the performance of leg exercises and the legs should be lifted individually, not simultaneously. The client should perform leg exercises in a semi-Fowler's, not prone, position.

7. A female client is scheduled for liposuction surgery to reduce her weight. Based on urgency, how is this surgery classified?

A) Urgent

B) Elective

C) Emergency

D) Emergent

Ans: B

Feedback:

A liposuction procedure is classified as elective surgery, in which the procedure is preplanned and based on the client's choice. Other classifications are urgent (surgery is necessary for the client's health but not an emergency) and emergency (the surgery must be done immediately to preserve life, body part, or body function).

8. A client scheduled for major surgery will receive general anesthesia. Why is inhalation anesthesia often used to provide the desired actions?

A) Rapid excretion and reversal of effects

B) Safe administration in the client's own room

C) Involves only the respiratory system and skin

D) Slow onset of action and maintains reflexes

Ans: A

Feedback:

General anesthesia involves the administration of drugs by inhalation and intravenous routes to produce central nervous system depression. Inhalation anesthesia is often used because it has the advantage of rapid excretion and reversal of effects.

9. A nurse is educating a client about regional anesthesia. Which of the following statements is accurate about this type of anesthesia?

A) "You will be asleep and won't be aware of the procedure."

B) "You will be asleep but may feel some pain during the procedure."

C) "You will be awake but will not be aware of the procedure."

D) "You will be awake and will not have sensation of the procedure."

Ans: D

Feedback:

Regional anesthesia occurs when an anesthetic agent is injected near a nerve or nerve pathway in or around the operative site, inhibiting the transmission of sensory stimuli to central nervous system receptors. The client remains awake but loses sensation in a specific area or region of the body.

10. A nurse has been asked to ensure informed consent for a surgical procedure. What might be a role of the nurse?

A) Securing informed consent from the client

B) Signing the consent form as a witness

C) Ensuring the client does not refuse treatment

D) Refusing to participate based on legal guidelines

Ans: B

Feedback:

The responsibility for securing informed consent from the client lies with the person who will perform the procedure, usually the physician. The nurse may sign as a witness, signifying that the client signed the consent form without coercion, and was alert and aware of the act.

11. A client, scheduled for open-heart surgery, tells the nurse he does not want to be "saved" if he dies during surgery. What should the nurse do next?

A) Discuss with and document the wishes of the client and family

B) Administer the ordered oral and intravenous preoperative medications

C) Notify the physician after completion of the surgical procedure

D) Verbally report the client's wishes to the operating room supervisor

Ans: A

Feedback:

Advance directives allow the client to specify instructions for health care treatment if unable to communicate these wishes during or after surgery. It is important for the nurse to discuss and document exact do not resuscitate(DNR) wishes of the client and family before surgery.

12. An operating room nurse is preparing for a surgical procedure on an infant. The nurse's perioperative care is based on what physiologic factor that puts infants at greater risk from surgery than adults?

A) Increased vascular rigidity

B) Diminished chest expansion

C) Lower total blood volume

D) Decreased peripheral circulation

Ans: C

Feedback:

Infants are at a greater risk from surgery as a result of various physiologic factors. A major factor is that the infant has a lower total blood volume, making even a small loss of blood a serious consideration because of the risk for dehydration and the inability to respond to the need for increased oxygen during surgery.

13. After conducting a preoperative health assessment, the nurse documents that the client has physical assessments supporting the medical diagnosis of emphysema. Based on this finding, what postoperative interventions would be included on the plan of care?

A) Perform sterile dressing changes each morning.

B) Administer pain medications as needed.

C) Conduct a head-to-toe assessment each shift.

D) Monitor respirations and breath sounds.

Ans: D

Feedback:

Respiratory disorders, including emphysema, increase the risk for respiratory depression from anesthesia as well as postoperative pneumonia and atelectasis.

14. A preoperative assessment finds a client to be 75 pounds overweight. The client is to have abdominal surgery. What nursing diagnosis would be appropriate based on the client's weight?

A) Risk for Aspiration

B) Risk for Imbalanced Body Temperature

C) Risk for Infection

D) Risk for Falls

Ans: C

Feedback:

Fatty tissue in obese clients has a poor blood supply and, therefore, has less resistance to infections. Postoperative complications of delayed wound healing, wound infection, and disruption of the wound are more common in obese clients.

15. Which of the following interventions is of major importance during preoperative education?

A) Performing skills necessary for gastrointestinal preparation

B) Encouraging the client to identify and verbalize fears

C) Discussing the site and extent of the surgical incision

D) Telling the client not to worry or be afraid of surgery

Ans: B

Feedback:

A surgical procedure causes anxiety and fear. The nurse should encourage the client to identify and verbalize fears; often simply talking about fears helps to diminish their magnitude.

16. A nurse is reviewing results of preoperative screening tests and notes the client's potassium level is dangerously low. What should the nurse do next?

A) Nothing; potassium levels have no influence on surgical outcome.

B) Include the information in the postoperative end of shift report.

C) Document the data and notify the physician who will do the surgery.

D) Ask the client and family members why the potassium is low.

Ans: C

Feedback:

Either high or low levels of potassium put the surgical client at increased risk for cardiac problems during and after surgery. The nurse's role includes recording the data in the client's record and reporting abnormal findings.

17. A nurse is educating a surgical client on postoperative p.r.n. pain control. Which of the following should be included?

A) "We will bring you pain medications; you don't need to ask."

B) "Even if you have pain, you may get addicted to the drugs."

C) "You won't have much pain so just tough it out."

D) "You need to ask for the medication before the pain becomes severe."

Ans: D

Feedback:

If medication for pain is ordered p.r.n., there is a time restriction between doses. The client needs to ask for the medication and should do so before the pain becomes severe.

18. A nurse is educating a preoperative client on how to cough effectively. What can the nurse tell the client to do to facilitate coughing?

A) "Hold a pillow or folded bath blanket over the incision."

B) "Get up and walk before you try to cough."

C) "It would be best if you do not cough until you feel better."

D) "When you cough, cover your nose and mouth with a tissue."

Ans: A

Feedback:

Because postoperative coughing is often painful, the client should be taught how to splint the incision by supporting it with a pillow or folded bath blanket.

19. A cleansing enema is ordered for a client who is scheduled to have colon surgery. What is the rationale for this procedure?

A) Surgical clients routinely are given a cleansing enema.

B) Cleansing enemas are given before surgery at the client's request.

C) There will be less flatus and discomfort postoperatively.

D) Peristalsis does not return for 24 to 48 hours after surgery.

Ans: D

Feedback:

If the client is scheduled for gastrointestinal tract surgery, a cleansing enema is usually ordered. Peristalsis does not return for 24 to 48 hours after the bowel is handled, so preoperative cleansing helps decrease postoperative constipation.

20. A nurse working in a PACU is responsible for conducting assessments on immediate postoperative clients. What is the purpose of these assessments?

A) To determine the length of time to recover from anesthesia

B) To use intraoperative data as a basis for comparison

C) To focus on cardiovascular data and findings

D) To prevent complications from anesthesia and surgery

Ans: D

Feedback:

Immediate postoperative care in the PACU involves assessing the postoperative client with emphasis on preventing complications from the surgery.

21. A nurse is providing ongoing postoperative care to a client who has had knee surgery. The nurse assesses the dressing and finds it saturated with blood. The client is restless and has a rapid pulse. What should the nurse do next?

A) Document the data and apply a new dressing.

B) Apply a pressure dressing and report findings.

C) Reassure the family that this is a common problem.

D) Make assessments every 15 minutes for four hours.

Ans: B

Feedback:

Hemorrhage is an excessive internal or external loss of blood. Common indications of hemorrhage include a rapid, thready pulse. If bleeding occurs, the nurse should apply a pressure dressing to the site, report findings to the physician, and be prepared to return the client to the operating room if bleeding cannot be stopped or is massive.

22. A postoperative home care client has developed thrombophlebitis in her right leg. What category of medications will probably be prescribed for this cardiovascular complication?

A) Anticoagulants

B) Antibiotics

C) Antihistamines

D) Antigens

Ans: A

Feedback:

Thrombophlebitis is an inflammation of a vein associated with thrombus formation. Thrombophlebitis from venous stasis is most commonly seen in the legs of postoperative clients. Nursing interventions include administering ordered medications, most often anticoagulants.

23. A student is assessing a postoperative client who has developed pneumonia. The plan of care includes positioning the client in the Fowler's or semi-Fowler's position. What is the rationale for this position?

A) It increases blood flow to the heart.

B) The client will be more comfortable and have less pain.

C) It facilitates nursing assessments of skin color and temperature.

D) It promotes full aeration of the lungs.

Ans: D

Feedback:

Pneumonia may occur in the postoperative client from aspiration, immobilization, depressed cough reflex, infection, increased secretions from anesthesia, or dehydration. Nursing interventions include positioning the client in the Fowler or semi-Fowler position to promote full aeration of the lungs.

24. A young woman has been in an automobile crash that resulted in an amputation of her left lower leg. She verbalizes grief and loss. What knowledge by the nurse is used to provide interventions to help the client cope?

A) The client should be grateful to be alive.

B) This is a normal, appropriate response.

C) This is an abnormal, inappropriate response.

D) Tissue healing will help the client adapt.

Ans: B

Feedback:

Many surgical clients have the same reaction to loss of a body part as they would to a death. A surgical client's grief is a normal, appropriate response. The nurse must be aware of the client's needs and provide interventions to meet those needs in coping with change.

25. A nurse in an outpatient surgical center is teaching a client about what will be necessary for discharge to home. What information should the nurse include about transportation?

A) The client is not allowed to drive a car home.

B) If the client is not dizzy, driving a car is allowed.

C) Only adults over the age of 25 may drive home.

D) None; this is not necessary information.

Ans: A

Feedback:

After outpatient surgery, clients may go home when they are no longer dizzy or drowsy, have stable vital signs, and have voided. Clients are not allowed to drive a car home.

26. Which of the following interventions are recommended guidelines for meeting client postoperative elimination needs?

A) Assess abdominal distention, especially if bowel sounds are audible or are low pitched.

B) Assess for the return of peristalsis by auscultating bowel sounds every four hours when the client is awake.

C) Encourage food and fluid intake when ordered, especially dairy products and low-fiber foods.

D) Assess for bladder distention by Palpating below the symphysis pubis if the client has not voided within eight hours after surgery.

Ans: B

Feedback:

Assess for the return of peristalsis by auscultating bowel sounds every four hours when the client is awake. Assess abdominal distention, especially if bowel sounds are inaudible or are high pitched. Encourage food and fluid intake when ordered, especially fruit juices and high-fiber foods. Assess for bladder distention by palpating *above* the symphysis pubis if the client has not voided within eight hours after surgery.

27. A nurse is assisting a postoperative client with deep-breathing exercises. Which of the following is an accurate step for this procedure?

A) Place the client in prone position, with the neck and shoulders supported.

B) Ask the client to place the hands over the stomach, so he or she can feel the chest rise as the lungs expand.

C) Ask the client to exhale rapidly and completely, and inhale through the nose rapidly and completely.

D) Ask the client to hold his or her breath for three to five seconds and mentally count “one, one thousand, two, one thousand” and so forth.

Ans: D

Feedback:

The nurse should place the client in semi-Fowler’s position, with the neck and shoulders supported, and ask the client to place the hands over the rib cage, so he or she can feel the chest rise as the lungs expand. Then, ask the patient to exhale gently and completely, inhale through the nose gently and completely, hold his or her breath for three to five seconds, and mentally count “one, one thousand, two, one thousand” etc., then exhale as completely as possible through the mouth with lips pursed (as if whistling).

28. A client with abdominal incisions experiences excruciating pain when he tries to cough. What should the nurse do to reduce the client’s discomfort when coughing?

A) Administer prescribed pain medication just before coughing.

B) Ask the client to drink plenty of water before coughing.

C) Ask the client to lie in a lateral position when coughing.

D) Administer prescribed pain medication 30 minutes before deliberately attempting to cough.

Ans: D

Feedback:

Coughing is painful for clients with abdominal or chest incisions. Administering pain medication approximately 30 minutes before coughing, or splinting the incision when coughing, can reduce discomfort. Making the client lie in a lateral position or asking the client to drink plenty of water is not helpful because it will make breathing and coughing even more difficult for the client.

29. A physician has ordered a nurse to administer conscious sedation to a client. Which of the following is possible after administering conscious sedation to a client?

A) Client can respond verbally despite physical immobility.

B) Client can tolerate long therapeutic surgical procedures.

C) Client is relaxed, emotionally comfortable, and conscious.

D) Client’s consciousness level can be monitored by equipment.

Ans: C

Feedback:

Conscious sedation refers to a state in which the client is sedated in a state of relaxation and emotional comfort, but is not unconscious. The client is free of pain, fear, and anxiety and can tolerate unpleasant diagnostic and short therapeutic surgical procedures, such as an endoscopy or bone marrow aspiration. The client can respond verbally and physically. However, no equipment can replace a nurse’s careful observations for monitoring clients.

30. A nurse is taking care of a client during the immediate post-operative period. Which of the following duties performed during the immediate post-operative period is most important?

A) Ensure the safe recovery of surgical clients.

B) Monitor the client for complications.

C) Prepare a room for the client’s return.

D) Assess the client's health constantly.

Ans: B

Feedback:

The immediate post-operative period refers to the first 24 hours after surgery. During this time, the nurse monitors the client for complications as he or she recovers from anesthesia. Once the client is stable, the nurse prepares a room for the client's return and assesses the client to prevent or minimize potential complications. The nurse ensures the safe recovery of the client after the client has stabilized.

31. A nurse is caring for a client who is scheduled to undergo a breast biopsy. Which of the following major tasks does the nurse perform immediately during the pre-operative period?

A) Obtain a signature on the consent form.

B) Review the surgical checklist.

C) Conduct a nursing assessment.

D) Reduce the dosage of toxic drugs.

Ans: C

Feedback:

During the immediate pre-operative period, the nurse conducts a nursing assessment. Nurses obtain the signature of the client, nearest blood relative, or someone with durable power of attorney before the administration of any pre-operative sedatives. They also administer medications as ordered by the physician regardless of their toxicity. They assist the client with psychosocial preparation and complete the surgical checklist, which is reviewed by the operating room personnel.

32. A nurse is assisting a physician during a cesarean section for a client. The client is administered epidural anesthesia. Which of the following is an advantage of epidural anesthesia?

A) It counteracts the effects of conscious sedation.

B) It decreases the risk of gastrointestinal complications.

C) It prevents clients from remembering the initial recovery period.

D) It acts on the central nervous system to produce loss of sensation.

Ans: B

Feedback:

Epidural anesthesia is a regional anesthesia administered to a client before surgery; it decreases the risk of gastrointestinal complications in clients. Reversal drugs are medications that counteract the effects of those used for conscious sedation. General anesthesia acts on the central nervous system to produce loss of sensation; it prevents clients from remembering their initial recovery period.

33. Which of the following nursing interventions occurs in the postoperative phase of the surgical experience?

A) Airway/oxygen therapy/pulse oximetry

B) Teaching deep breathing exercises

C) Reviewing the meaning of p.r.n. orders for pain medications

D) Putting in IV lines and administering fluids

Ans: A

Feedback:

Airway/oxygen therapy/pulse oximetry occur in the postanesthesia unit in the postoperative phase. Teaching deep-breathing exercises and reviewing the meaning of p.r.n. orders for medications occur in the preoperative phase. Putting in IV lines and administering fluids occurs in the intraoperative phase.

34. Which statement accurately represents a recommended guideline when providing postoperative care for the following clients?

A) Force fluids for an adult client who has a urine output of less that 30 mL per hour.

B) If client is febrile within 12 hours of surgery, notify the physician immediately.

C) If the dressing was clean but now has a large amount of fresh blood, remove the dressing and reapply it.

D) If vital signs are progressively increasing or decreasing from baseline, notify the physician of possible internal bleeding.

Ans: D

Feedback:

A continued decrease in blood pressure or an increase in heart rate could indicate internal bleeding, and the physician should be notified. If an adult client has a urine output of less than 30 mL per hour, the physician should be notified, unless this is expected. If the client is febrile within 12 hours of surgery, the nurse should assist the client with coughing and deep-breathing exercises. When large amounts of fresh blood are present, the dressing should be reinforced with more bandages and the physician notified.

35. A diabetic client is undergoing surgery to amputate a gangrenous foot. This procedure would be considered which of the following categories of surgery based on purpose?

A) Diagnostic

B) Ablative

C) Palliative

D) Reconstructive

Ans: B

Feedback:

Ablative surgery is performed to remove a diseased body part. Diagnostic surgery is performed to make or confirm a diagnosis. Palliative surgery involves relieving or reducing intensity of an illness. Reconstructive surgery restores function to traumatized or malfunctioning tissue.

Chapter 31, Hygiene

1. Which client is most likely to require hospitalization related to problems associated with the feet?

A) A client with peripheral vascular disease

B) A client with osteoporosis

C) A client with asthma

D) A client with diabetes insipidus

Ans: A

Feedback:

Foot problems, particularly common in people with diabetes and peripheral vascular disease, often require hospitalization.

2. The nurse assists the client to the bathroom sink to perform morning care. The nurse observes the client wash his face, arms, abdomen, and legs. The nurse washes the client's back and rectal area and applies soap to the back. The client brushes his teeth and ambulates to a chair in his room with assistance. How will the nurse describe the morning care on the client's chart?

A) Partial care

B) As-needed care

C) Self-care

D) Complete care

Ans: A

Feedback:

Morning care is categorized as self-care, partial care, or complete care. Clients identified as partial care most often receive morning care at the bedside, or seated near the sink in the bathroom. They usually require assistance with body areas that are difficult to reach. Clients identified as self-care are capable of managing their personal hygiene independently once oriented to the bathroom. Clients identified as complete care require nursing assistance with all aspects of personal hygiene. In additional to scheduled care, the nurse will offer care as needed.

3. Upon review of the client's orders, the nurse notes that the client was recently started on an anticoagulant. What is an appropriate consideration when assisting the client with morning hygiene?

A) Provide the client with an electric shaver.

B) Provide the client with a firm bristled toothbrush.

C) Do not allow the client to shower.

D) Avoid massaging the client's back with lotion.

Ans: A

Feedback:

Electric shavers are recommended when a client is receiving anticoagulant therapy. In addition, the nurse should not provide a firm-bristled toothbrush because the client is more prone to bleeding, and the firm bristles may lead to bleeding. The client should be allowed to shower, unless there are other contraindications. A back massage will provide an ideal time to perform a skin assessment for bruising or breakdown.

4. The nurse and nursing aid are providing perineal care for an incontinent client. What information is important for the nurse to consider when providing perineal care?

A) Apply moisture barriers to the skin of the perineal area.

B) Provide excessive hydration to the skin of the perineal area.

C) Wash the perineal area frequently with soap and water.

D) Aggressively cleanse the perineal area with a washcloth or towel.

Ans: A

Feedback:

Care to the perineal area for an incontinent client includes the use of moisture barriers, skin cleansers, and moisturizers and the avoidance of soap or friction. Measures should be followed to reduce overhydration because this will increase the risk for perineal damage and skin breakdown.

5. The nurse has completed an assessment of a client's typical hygiene practices. How should the nurse best document the findings of this assessment in the client's chart?

A) "Client normally bathes and washes her hair every other day; applies moisturizer to dry areas on her elbows and forearms."

B) "Client prioritizes personal hygiene in her daily routines and is proactive with skin care."

C) "Client bathes more often than necessary and consequently experiences dry skin."

D) "Client's level of personal hygiene is acceptable and age-appropriate."

Ans: A

Feedback:

When documenting the nursing history, it is best to be specific, clearly describing the client's typical hygiene practices and any complaints. Judgments regarding cause and effect are likely premature in this context and may be inaccurate.

6. An older adult resident of a long-term care facility has recurring problems with dry skin. Which of the following strategies should the nursing staff utilize in order to help meet the resident's hygiene needs while preventing skin dryness?

A) Use a nonsoap cleaning agent.

B) Use organic soap and shampoo.

C) Bathe the client more often, but without using soap or shampoo.

D) Provide the client with bed baths rather than tub baths.

Ans: A

Feedback:

Soap cleans the skin, but while it removes dirt from the surface, it affects the lipids that are present on the skin, and the skin pH. This contributes to drier skin, damaging the barrier function of the skin. The substitution of a nonsoap, emollient cleaning agent is an easy way to prevent drying and damage to the skin. An organic soap is not necessarily less drying to the skin. It would be inappropriate to forego the use of any cleaning products whatsoever. Providing a bed bath rather than a tub bath will not necessarily minimize dry skin.

7. A nurse is preparing to provide foot care to a client who has decreased mobility. Which of the following techniques should the nurse employ when providing this care?

A) Use an antifungal powder on the client's feet if necessary.

B) Carefully remove any corns or calluses that are present.

C) Soak the client's feet for 15 to 20 minutes prior to cleansing.

D) Avoid using soaps or commercial cleansers whenever possible.

Ans: A

Feedback:

Antifungal foot powders may be used when indicated, and it is appropriate to use soap and/or cleansers when providing foot care. Corns and calluses should not be removed, and the nurse should avoid soaking the client's feet.

8. Which of the following factors does **not** affect personal hygiene practices?

A) Culture

B) Income level

C) Health state

D) Gender

Ans: D

Feedback:

Personal hygiene practices vary widely among individuals and are affected by culture, socioeconomic status, spiritual practices, developmental level, health state, and personal preferences.

9. A homeless person uses the soap and towels in a public restroom to wash up. This is an example of which type of factor affecting personal hygiene practices?

A) Socioeconomic class

B) Culture

C) Developmental level

D) Health state

Ans: A

Feedback:

A person's socioeconomic class and financial resources often define the hygiene options available to him or her. Access to assistive services, such as shelters, may be limited for some clients. For example, homeless people, who often carry all their belongings in a car or shopping cart, may welcome the warm running water and soap available in roadside or public restrooms.

10. Which clent would be at greatest risk for injury to the skin and mucous membranes?

A) Infant 10 days old with no health problems

B) adolescent 17 years of age with asthma

C) Man 44 years of age with hemorrhoids

D) Man 77 years of age with diabetes

Ans: D

Feedback:

Resistance to injury of the skin and mucous membranes varies among people. Factors influencing resistance include the person's age, the amount of underlying tissue, and illness conditions. In this question, the older man with diabetes would be most at risk.

11. A nurse is conducting a health history for a client with a skin problem. What question or statement would be most useful in eliciting information about personal hygiene?

A) "Perhaps you don't recognize your bad body odor."

B) "You must eat a lot of greasy foods to have this acne."

C) "Tell me about what you do to take care of your skin."

D) "Why do you only take a bath once a week?"

Ans: C

Feedback:

When skin problems are present, the nurse asks the client about usual personal hygiene practices and documents the client's responses. The questions should be open-ended and nonthreatening.

12. Which client would be most at risk for alterations in oral health?

A) Infant who is breast-fed

B) Man with a nasogastric tube

C) Woman who is pregnant

D) Healthy young adult

Ans: B

Feedback:

A variety of illnesses and habits may increase the risk for oral health problems, including poor nutrition, treatment with chemotherapy, those who are NPO, and those who have nasogastric tubes or oral airways in place.

13. A student has been assigned to provide hygiene care to four clients. Which one would require special consideration for perineal care?

A) Middle-aged man with a nasogastric tube

B) Young adult man who has had a hernia repair

C) Young woman who has had cosmetic surgery

D) Middle-age woman with a Foley catheter

Ans: D

Feedback:

The dark, warm, moist perineal and vaginal areas favor bacterial growth. Variables known to create a need for special care include an indwelling Foley catheter. The client who cannot clean the perineal area needs the nurse's assistance for personal hygiene.

14. While conducting an oral assessment, a nurse notices the client's gums are red and swollen, some teeth are loose, and blood and pus can be expressed when the gums are palpated. What condition do these symptoms indicate?

A) Periodontitis

B) Plaque

C) Halitosis

D) Caries

Ans: A

Feedback:

Periodontitis is a marked inflammation of the gums that also involves degeneration of the dental periosteum (tissues) and bone. Symptoms include bleeding gums; swollen, red, painful gum tissues; receding gumlines with the formation of pockets between the teeth and gums; pus that appears when gums are pressed; and loose teeth.

15. A school nurse is assessing children in the third grade for pediculosis capitis. What assessments should be made?

A) The pubic area for growth of hair

B) The head for nits on hair shafts

C) The nails for evidence of cleanliness

D) The body for evidence of abuse

Ans: B

Feedback:

Infestation with lice is called pediculosis. Pediculosis capitis infests the hair and scalp. Lice lay eggs, called nits, on the hair shafts. Nits are white or light gray and look like dandruff, but cannot be brushed or shaken off the hair.

16. A student has been assigned to provide morning care to a client. The plan of care includes the information that the client requires partial care. What will the student do?

A) Provide total physical hygiene, including perineal care.

B) Provide total physical hygiene, excluding hair care.

C) Provide supplies and orient to the bathroom.

D) Provide supplies and assist with hard-to-reach areas.

Ans: D

Feedback:

Morning care is often identified as either self-care, partial care, or complete care. Clients requiring partial morning care most often receive care at the bedside or seated near the sink in the bathroom. They usually require assistance with body areas that are difficult to reach.

17. Before a long-term care resident goes to sleep at night, his dentures are placed in a denture cup with clean water. What rationale supports placing dentures in water?

A) None; they should be placed in saline

B) To increase comfort when replaced in the mouth

C) To prevent drying and warping of plastic

D) To ensure the dentures are not thrown away

Ans: C

Feedback:

If a client removes dentures while sleeping, they should be stored in water in a disposable denture cup to prevent drying and warping of plastic materials.

18. A nurse is providing oral care to a client with dentures. What action would the nurse do first?

A) Assess the mouth and gums.

B) Don gloves.

C) Wash the client's face.

D) Apply lubricant.

Ans: B

Feedback:

When providing oral care and denture care, the nurse would be exposed to body fluids. The nurse should always don gloves if exposure to body fluids will occur.

19. The mother of a child 2 years of age tells the nurse she always cleans the child's ears with a hairpin. What would the nurse tell the mother?

A) "That's not good. Use a Q-tip or your finger instead."

B) "You really like to keep your child clean. Good for you!"

C) "That is dangerous; you might puncture the eardrum."

D) "Show me exactly how you use the hairpin."

Ans: C

Feedback:

Little intervention is needed for routine hygiene of the ear. Using bobby pins, hairpins, paper clips, or fingernails to remove wax from the ear is extremely dangerous because these may injure or puncture the eardrum.

20. A nurse is providing perineal care to a female client. In which direction would the nurse move the washcloth?

A) From the pubic area toward the anal area

B) From the anal area to the pubic area

C) From side to side within the labia

D) The direction does not make any difference

Ans: A

Feedback:

Always proceed from the least contaminated area to the most contaminated area. For a female client, spread the labia and move the washcloth from the pubic area toward the anal area to prevent carrying organisms from the anal area back over to the genital area.

21. A female client in a reproductive health clinic tells the nurse practitioner that she douches every day. Should the nurse tell the client to continue this practice?

A) Yes, this helps prevent vaginal odor.

B) Yes, this decreases vaginal secretions.

C) No, douching removes normal bacteria.

D) No, douching may increase secretions.

Ans: C

Feedback:

In normal healthy women, daily douching is believed to be unnecessary because it removes normal bacterial flora from the vagina. Douching has been linked to bacterial vaginosis, pelvic inflammatory disease, higher rates of HIV transmission, tubal pregnancies, chlamydial infection, and cervical cancer.

22. An older adult client with Parkinson's disease is unable to take care of himself. The client frequently soils his bed and is unable to clean himself independently. How should the nurse in this case ensure the client's perineal care?

A) Cleanse to remove secretions from less-soiled to more-soiled areas.

B) Cleanse using a cotton cloth and warm water.

C) Use tissue rolls to clean the client's perineal area.

D) Provide the client with a bed pan or a jar to collect the urine.

Ans: A

Feedback:

To ensure proper perineal care, the nurse should cleanse to remove secretions and excretions from less-soiled to more-soiled areas. The nurse must also prevent direct contact with and any secretions or excretions by wearing clean gloves. The nurse should not use cotton cloth or tissues to clean the perineal area because that might lead to skin impairment. Older adult clients have sensitive skin, which may be easily impaired when cleaning. Because the client cannot do anything independently, providing him with a bed pan or a jar will not help.

23. A nurse is assessing a client during a health care camp. The nurse observes that the client has poor hygiene and an itchy, infected scalp. Which of the following should the nurse ask the client to do?

A) Wash hair daily

B) Use dry shampoo

C) Use oil-based shampoo

D) Use anti-lice shampoo

Ans: A

Feedback:

The client with a scalp infection should be advised to shampoo her hair daily with a mild shampoo. For occasional use, the nurse will use dry shampoos, which are applied to the hair as a powder. Other options include aerosol spray or foam. Anti-lice shampoos or oil-based shampoos are not used for fear of aggravating the infection.

24. A nurse is brushing the hair of a client admitted to the health care facility following a fracture in the hand. The nurse implements this action based on the understanding that brushing the hair achieves which of the following?

A) Facilitates oil distribution

B) Cleans hair and scalp

C) Removes excess oil

D) Cleans the hair of dirt

Ans: A

Feedback:

Brushing the hair facilitates oil distribution along the hair shaft more effectively than combing, as well as massages the scalp and stimulates circulation. Shampooing cleans the hair and scalp, helps get rid of excess oil, and cleans the hair of dirt. It provides a relaxing, soothing experience for the client.

25. On the first postoperative day, the client is assisted to the bathroom. It is important for the nurse to do what?

A) Allow the client privacy

B) Assess the client's safety

C) Assess the client's pain

D) Allow sufficient time

Ans: B

Feedback:

Toileting often is associated with falls; the nurse must ensure the client's safety.

26. A client age 78 years with diabetes needs to have his toenails trimmed. It is important for the nurse to do what?

A) Remove ingrown toenails

B) Cut the nail straight across

C) Protect the foot from blisters

D) Soak the foot in witch hazel

Ans: B

Feedback:

The feet of older adults require special attention, because foot problems may relate to reduced peripheral blood flow. Poor circulation makes the feet more vulnerable to infection and skin breakdown, particularly after trauma. By cutting the nail straight across, the nurse can protect the toes from trauma.

27. What type of bath is preferred to decrease the inflammation after rectal surgery?

A) Bed bath

B) Tub bath

C) Whirlpool bath

D) Sitz bath

Ans: D

Feedback:

A sitz bath can be helpful in soaking a client's pelvic area in warm water to decrease inflammation after childbirth or rectal surgery, or to decrease inflammation of hemorrhoids.

28. Which of the following clients ia at an increased risk for oral problems? Select all that apply.

A) Comatose client

B) Confused client

C) Depressed client

D) Client undergoing chemotherapy

E) Hypertensive client

Ans: A, B, C, D

Feedback:

Clients at increased risk for oral problems include those who are seriously ill, comatose, dehydrated, confused, depressed, or paralyzed. Clients who are mouth breathers, those who can have no oral intake of nutrition or fluids, those with nasogastric tubes or oral airways in place, and those who have had oral surgery are also at increased risk. Variables known to cause oral problems include deficient self-care abilities, poor nutrition or excessive intake of refined sugars, family history of periodontal disease, or ingestion of chemotherapeutic agents that produce oral lesions.

29. What care should the nurse take when providing foot care for a client with peripheral vascular disease? Select all that apply.

A) Use an emery board to file toe nail edges

B) Cut the toenails short

C) Cut the nail in one piece

D) Avoid cutting into calluses

E) Cut the nails straight across

Ans: A, D, E

Feedback:

The nurse caring for the client with peripheral vascular disease should use an emery board to file nail edges. These clients may have thick distorted nails that may be difficult to cut, but can be safely filed. The nurse should avoid cutting the nails too short or cutting into calluses to prevent trauma. The nurse should cut the nails straight across if possible, and cut in a few small pieces rather than one piece to prevent injury or skin breakdown.

30. The nurse is planning to bathe a client who has thigh-high antiembolism stockings in place. Which of the following actions is correct?

A) Remove the antiembolism stockings during the bath.

B) Leave the antiembolism stockings in place, but be sure to remove all wrinkles.

C) Fold the antiembolism stockings half-way down to allow assessment of the popliteal pulse.

D) Leave the antiembolism stockings in place and spot-clean any soiled areas on the stockings.

Ans: A

Feedback:

Antiembolism stockings should be removed periodically to allow for assessment.

31. The nurse is preparing to perform perineal care on an uncircumcised adult male client who was incontinent of stool. The client's entire perineal area is heavily soiled. Which of the following techniques for cleaning the penis is correct?

A) Retract the foreskin while washing the penis; then, immediately pull the foreskin back into place.

B) Retract the foreskin while washing the penis, allow 10 to 15 minutes for the glans penis to dry; then, replace the foreskin in its original position.

C) Avoid retraction of the foreskin because injury and scarring could occur.

D) Soak the end of the penis in warm water before cleaning the shaft of the penis.

Ans: A

Feedback:

Failing to pull the foreskin back into place may cause tissue damage to the penis.

32. The nurse has completed bed bath on a client who is obese. The client asks you to sprinkle baby powder in the perineal area. Which of the following actions is correct?

A) Inform the client that baby powder is not used because it may become a medium for bacterial growth.

B) Carefully apply baby powder to skin folds only.

C) Pour a small amount of powder into the hand and gently pat the perineal area while avoiding aerosolization of the powder.

D) Apply a generous amount of baby powder to all areas where skin touches skin.

Ans: A

Feedback:

Failing to pull the foreskin back into place may cause tissue damage to the penis.

33. Which of the following is a correct guideline to follow when providing a bed bath for a client?

A) When cleaning the eye, move the washcloth from the outer to the inner aspect of the eye.

B) Fold the washcloth like a mitt on your hand so that there are no loose ends.

C) Clean the perineal area before cleaning the gluteal area.

D) Change the bath water after washing each body part.

Ans: B

Feedback:

Fold the washcloth like a mitt on your hand so that there are no loose ends. Moving from the inner to the outer aspect of the eye prevents carrying debris toward the nasolacrimal duct. The gluteal area should be cleaned first and the bath water and towels should be changed before cleaning the perineal area. It is not necessary to change the bath water after washing every body part.

34. A nurse is assisting a client to shave his beard. Which of the following statements accurately describes a recommended step in this process?

A) Cover the client with a blanket.

B) Fill a basin with cool water.

C) Apply cream to area to be shaved in a layer about $^1/_2$-inch thick.

D) Shave against the direction of hair growth in upward, short strokes

Ans: C

Feedback:

Steps in the procedure include: Cover patient's chest with a towel or waterproof pad. Fill bath basin with warm (43ºC to 46ºC [110ºF to 115ºF]) water. Put on gloves. Moisten the area to be shaved with a washcloth. Dispense shaving cream into palm of hand. Apply cream to area to be shaved in a layer about $^1/_2$-inch thick. With one hand, pull the skin taut at the area to be shaved. Using a smooth stroke, begin shaving. *If shaving the face,* shave with the direction of hair growth in downward, short strokes. *If shaving a leg,* shave against the hair in upward, short strokes. *If shaving an underarm,* pull skin taut and use short, upward strokes.

35. A client is admitted to the health care facility with a diagnosis of pediculosis capitis. Which of the following would the nurse expect to find in the client?

A) Diffuse scaling of the epidermis

B) Itching and flaking of whitish scales

C) Premature loss of hair

D) Inflammation related to bites along the hairline

Ans: D

Feedback:

The nurse would find inflamed bites along the hairline in the client with pediculosis infestation. Diffuse scaling of the epidermis with itching and flaking of whitish scales is seen in clients who have dandruff. Hair loss is not a manifestation of pediculosis capitis.

Chapter 32, Skin Integrity and Wound Care

1. Upon assessment of a client's wound, the nurse notes the formation of granulation tissue. The tissue easily bleeds when the nurse performs wound care. What is the phase of wound healing characterized by the nurse's assessment?

A) Proliferation phase

B) Hemostasis

C) Inflammatory phase

D) Maturation phase

Ans: A

Feedback:

The proliferation phase is characterized by the formation of granulation tissue (highly vascular, red tissue that bleeds easily). During the proliferation phase, new tissue is built to fill the wound space. Hemostasis involves the constriction of blood vessels and the beginning of blood clotting immediately after the initial injury. The inflammatory phase lasts about four to six days, and white blood cells and macrophages move to the wound. The maturation phase is the final phase of wound healing and involves remodeling of collagen that was haphazardly deposited in the wound; in addition, a scar forms.

2. Upon responding to the client's call bell, the nurse discovers the client's wound has dehisced. Initial nursing management includes calling the physician and doing which of the following?

A) Covering the wound area with sterile towels moistened with sterile 0.9% saline

B) Closing the wound area with Steri-Strips

C) Pouring sterile hydrogen peroxide into the abdominal cavity and packing with gauze

D) Holding the wound together until the physician arrives

Ans: A

Feedback:

If dehiscence occurs, cover the wound area with sterile towels moistened with sterile 0.9% saline. The client should also be placed in the low Fowler's position, and the exposed abdominal contents should be covered as previously discussed. Notify the physician immediately because this is a medical emergency. Do not leave the client alone.

3. The wound care clinical nurse specialist has been consulted to evaluate a wound on the leg of a client with diabetes. The wound care nurse determines that damage has occurred to the subcutaneous tissues; how would she document this wound?

A) Stage I pressure ulcer

B) Stage II pressure ulcer

C) Stage III pressure ulcer

D) Stage IV pressure ulcer

Ans: C

Feedback:

Damage to the subcutaneous tissue indicates a stage III ulcer. Extensive destruction associated with full-thickness skin loss is categorized as a stage IV pressure ulcer. A stage I ulcer is a defined area of persistent redness in lightly pigmented skin and a persistent red, blue, or purple hue in darker pigmented skin. A stage II pressure ulcer is superficial and may present as a blister or abrasion.

4. When measuring the size, depth, and wound tunneling of a client's stage IV pressure ulcer, what action should the nurse perform first?

A) Perform hand hygiene.

B) Insert a swab into the wound at 90 degrees.

C) Measure the width of the wound with a disposable ruler.

D) Assess the condition of the visible wound bed.

Ans: A

Feedback:

Hand hygiene should precede any wound assessment or wound treatment.

5. The nurse would recognize which of these devices as an open drainage system?

A) Penrose drain

B) Jackson-Pratt drain

C) Hemovac

D) Negative pressure dressing

Ans: A

Feedback:

A Penrose drain is an open system that lacks a collection device. Jackson-Pratt drains, Hemovacs, and negative pressure dressings all utilize a suction device or collection reservoir and are considered to be closed systems.

6. Which is an example of a closed wound?

A) Abrasion

B) Ecchymosis

C) Incision

D) Puncture wound

Ans: B

Feedback:

A closed wound results from a blow, force, or strain caused by trauma (such as a fall, an assault, or a motor vehicle crash). The skin surface is not broken, but soft tissue is damaged, and internal injury and hemorrhage may occur. Examples include ecchymosis and hematomas. An open wound occurs from intentional or unintentional trauma. The skin surface is broken, providing a portal of entry for microorganisms. Bleeding, tissue damage, and increased risk for infection and delayed healing may accompany open wounds. Examples include incisions and abrasions.

7. What are the two major processes involved in the inflammatory phase of wound healing?

A) Bleeding is stimulated, epithelial cells are deposited

B) Granulation tissue is formed, collagen is deposited

C) Collagen is remodeled, avascular scar forms

D) Blood clotting is initiated, WBCs move into the wound

Ans: D

Feedback:

The inflammatory phase of wound healing begins at the time of injury and prepares the wound for healing. The two major physiologic activities are blood clotting (hemostasis) and the vascular and cellular phase of inflammation.

8. A nurse is caring for a client who is two days postoperative after abdominal surgery. What nursing intervention would be important to promote wound healing at this time?

A) Administer pain medications on a p.r.n. and regular basis.

B) Assist in moving to prevent strain on the suture line.

C) Tell the client that a mild fever is a normal response.

D) If a scar forms over a joint, it may limit movement.

Ans: B

Feedback:

The proliferative phase of wound healing begins within two to three days of the injury. Collagen synthesis and accumulation continue, peaking in five to seven days. During this time, adequate nutrition, oxygenation, and prevention of strain on the suture line are important client care considerations.

9. A home health nurse has a caseload of several postoperative clients. Which one would be most likely to require a longer period of care?

A) An infant

B) A young adult

C) A middle adult

D) An older adult

Ans: D

Feedback:

An older adult heals more slowly than do children and adults as a result of physiologic changes of aging, resulting in diminished fibroblastic activity and circulation. Older adults are also more likely to have one or more chronic illnesses, with pathologic changes that impede the healing process.

10. A nurse is educating a postoperative client on essential nutrition for healing. What statement by the client would indicate a need for more information?

A) "I will drink a lot of orange juice and drink milk, too."

B) "I will take the zinc supplement the doctor recommended."

C) "I will restrict my diet to fats and carbohydrates."

D) "I will drink 8 to 10 glasses of water every day."

Ans: C

Feedback:

Wound healing requires adequate proteins, carbohydrates, fats, vitamins, and minerals. Calories and proteins are necessary to rebuild cells and tissues. Vitamins C and D, zinc, and adequate fluids are also necessary for wound healing.

11. What nursing diagnosis would be a priority for a client who has a large wound from colon surgery, is obese, and is taking corticosteroid medications?

A) Self-care Deficit

B) Risk for Imbalanced Nutrition

C) Anxiety

D) Risk for Infection

Ans: D

Feedback:

Clients who are taking corticosteroid medications are at high risk for delayed healing and wound complications such as infections, because corticosteroids decrease the inflammatory process that may in turn delay healing.

12. A nurse working in long-term care is assessing residents at risk for the development of a decubitus ulcer. Which one would be most at risk?

A) A client 83 years of age who is mobile

B) A client 92 years of age who uses a walker

C) A client 75 years of age who uses a cane

D) A client 86 years of age who is bedfast

Ans: D

Feedback:

Most pressure ulcers occur in older adults as a result of a combination of factors, including aging skin, chronic illness, immobility, malnutrition, fecal and urinary incontinence, and altered level of consciousness. The bedfast resident would be most at risk in this situation.

13. What intervention should be included on a plan of care to prevent pressure ulcer development in health care settings?

A) Change position at least once each shift.

B) Implement a turning schedule every two hours.

C) Use ring cushions for heels and elbows.

D) Do not turn; use pressure-relieving support surface.

Ans: B

Feedback:

To protect clients at risk from the adverse effects of pressure, implement turning using an every-2-hour schedule in the health care setting. More frequent position changes may be necessary. Never use ring cushions or "donuts."

14. A nurse is assessing a client with a stage IV pressure ulcer. What assessment of the ulcer would be expected?

A) Full-thickness skin loss

B) Skin pallor

C) Blister formation

D) Eschar formation

Ans: A

Feedback:

A stage IV pressure ulcer is characterized by the extensive destruction associated with full-thickness skin loss.

15. During a dressing change, the nurse assesses protrusion of intestines through an opened wound. What would the nurse do after covering the wound with towels moistened with sterile 0.9% sodium chloride solution?

A) Document the assessments and intervention.

B) Reinforce the dressing with additional layers.

C) Administer pain medications intramuscularly.

D) Notify the physician and prepare for surgery.

Ans: D

Feedback:

Protrusion of the intestines through an opened wound indicates evisceration. After covering the wound with towels soaked in sterile normal saline, the nurse should immediately notify the physician. Immediate surgical repair is required.

16. A nurse assessing a client's wound documents the finding of purulent drainage. What is the composition of this type of drainage?

A) Clear, watery blood

B) Large numbers of red blood cells

C) Mixture of serum and red blood cells

D) White blood cells, debris, bacteria

Ans: D

Feedback:

Purulent drainage is made up of white blood cells, liquefied dead tissue debris, and both dead and live bacteria. Purulent drainage is thick, often has a musty or foul odor, and varies in color (such as dark yellow or green), depending on the causative organism. Serous drainage is composed primarily of the clear, serous portion of the blood and from serous membranes. Serous drainage is clear and watery. Sanguineous drainage consists of large numbers of red blood cells and looks like blood. Bright-red sanguineous drainage is indicative of fresh bleeding, whereas darker drainage indicates older bleeding. Serosanguineous drainage is a mixture of serum and red blood cells. It is light pink to

blood tinged.

17. The plan of care for a postoperative client specifies that sterile 0.9% sodium chloride solution be used to clean the wound. What should the nurse do after reading this information?

A) Question the physician about the accuracy of this agent.

B) Refuse to use 0.9% normal saline on a wound.

C) Document the rationale for not changing the dressing.

D) Continue with the dressing change as planned.

Ans: D

Feedback:

Although various antiseptic cleaning agents could be used to clean a wound, sterile 0.9% normal saline is usually the agent of choice. Other agents may be caustic to skin and tissues.

18. A young man who has had a traumatic mid-thigh amputation of his right leg refuses to look at the wound during dressing changes. Which response by the nurse is appropriate?

A) "Oh, for gosh sakes…it doesn't look that bad!"

B) "I understand, but you are going to have to look someday."

C) "I respect your wish not to look at it right now."

D) "You won't be able to go home until you look at it."

Ans: C

Feedback:

The sight of the wound may disturb a client. If the wound involves a change in normal body functions or appearance, the pclient may not want to look at the wound. With patience and emotional support, clients learn to cope with and adapt to their wounds in time.

19. A nurse is teaching a client on home care about how to apply hot packs to an infected leg ulcer. What statement by the client indicates the need for further education?

A) "I understand the rebound effect of heat."

B) "I will put the heat packs only on the sore on my leg."

C) "I will only leave the heat packs on for 20 minutes."

D) "I will leave the heat packs on for an hour."

Ans: D

Feedback:

Initially, temperature receptors in the skin are strongly stimulated. This response decreases rapidly for the first few seconds after being stimulated and more slowly for the next 30 minutes as the receptors adapt to the temperature. Be sure to tell clients that increasing the temperature or lengthening the time of application can seriously damage tissues.

20. Of the many topics that may be taught to clients or caregivers about home wound care, which one is the most significant in preventing wound infections?

A) Taking medications as prescribed

B) Proper intake of food and fluids

C) Thorough hand hygiene

D) Adequate sleep and rest

Ans: C

Feedback:

The single most important information on which to educate clients and caregivers about home wound care is the importance of thorough hand hygiene to prevent wound infections.

21. Which of the following is a recommended guideline nurses follow when using an electric heating pad on a client?

A) Secure the heating pad to the client's clothing with safety pins.

B) Place a heavy towel or blanket over the heating pad to maximize heat effects.

C) Use a heating pad with a selector switch that can be turned up by the client if needed.

D) Place a heating pad anteriorly or laterally to, not under, the body part.

Ans: D

Feedback:

Guidelines include: Place a heating pad anteriorly or laterally to, not under, the body part. If the heating pad is between the client and the mattress, heat dissipation may be inadequate, leading to burning of the client or the bed linens. Avoid using pins to secure a heating pad because there is a danger of electric shock if a pin touches a wire. Do not cover the heating pad with anything that might be heavy; heat may accumulate and burn the client when it cannot dissipate normally from the pad. Use a heating pad with a selector switch that cannot be turned up beyond a safe temperature.

22. A nurse caring for a female client notes a number of laceration wounds around the cervix of the uterus due to childbirth. How could the nurse describe the laceration wound in the client's medical record?

A) A clean separation of skin and tissue with a smooth, even edge

B) A separation of skin and tissue in which the edges are torn and irregular

C) A wound in which the surface layers of skin are scraped away

D) A shallow crater in which skin or mucous membrane is missing

Ans: B

Feedback:

A laceration wound can be described as a separation of skin and tissue in which the edges are torn and irregular. An incision wound is described as a clean separation of skin and tissue with a smooth, even edge. An abrasion is a wound in which the surface layers of skin are scraped away. Ulceration is a shallow crater in which skin or mucous membrane is missing.

23. A nurse caring for a post-operative client observes the drainage in the client's closed wound drainage system. The drainage is thin with a pale pink-yellow color. The nurse documents the drainage as which of the following?

A) Serous

B) Sanguineous

C) Serosanguineous

D) Purulent

Ans: C

Feedback:

The nurse should document the drainage as serosanguineous, which is pale pink-yellow, thin, and contains plasma and red cells. Serous drainage is pale yellow and watery, like the fluid from a blister. Sanguineous drainage is bloody, as from an acute laceration. Purulent drainage contains white cells and microorganisms and occurs when infection is present. It is thick and opaque and can vary from pale yellow to green or tan, depending on the offending organism.

24. An older adult client has edema of the right lower extremity with redness and clear drainage. This is most likely related to what?

A) Beta-hemolytic streptococcus

B) Age

C) Venous insufficiency

D) Hemangioma

Ans: C

Feedback:

Leg and foot ulcers occur from various causes, but the most common are ulcers secondary to venous insufficiency, arterial insufficiency, and neuropathy.

25. Which of the following clients would be considered at risk for skin alterations? Select all that apply.

A) A teenager with multiple body piercings

B) A homosexual in a monogamous relationship

C) A client receiving radiation therapy

D) A client undergoing cardiac monitoring

E) A client with diabetes

Ans: A, C, E

Feedback:

Body piercings, radiation therapy, and diabetes place clients at risk for skin alterations. Having a homosexual relationship with multiple partners would also place a client at risk for HIV and skin alterations. Cardiac monitoring and respiratory disorders are not risk factors.

26. A nurse is applying cold therapy to a client with a contusion of the arm. Which of the following is an effect of cold therapy? Select all that apply.

A) Constricts peripheral blood vessels

B) Reduces muscle spasms

C) Increases blood flow to tissues

D) Increases the local release of pain-producing substances

E) Reduces the formation of edema and inflammation

Ans: A, B, E

Feedback:

The local application of cold constricts peripheral blood vessels, reduces muscle spasms, and promotes comfort. Cold reduces blood flow to tissues and decreases the local release of pain-producing substances such as histamine, serotonin, and bradykinin. This action in turn reduces the formation of edema and inflammation. Decreased metabolic needs and capillary permeability, combined with increased coagulation of blood at the wound site, facilitate the control of bleeding and reduce edema formation. Cold also reduces muscle spasms, alters tissue sensitivity (producing numbness), and promotes comfort by slowing the transmission of pain stimuli.

27. Which of the following are functions of the skin? Select all that apply.

A) Protection

B) Temperature regulation

C) Sensation

D) Vitamin C production

E) Immunological

Ans: A, B, C, E

Feedback:

The skin provides multiple functions: protection, temperature regulation, psychosocial, sensation, vitamin D production, immunological, absorption, and elimination.

28. While performing a bed bath, the nurse notes an area of tissue injury on the client's sacral area. The wound presents as a shallow open ulcer with a red-pink wound bed and partial thickness loss of dermis. Which of the following is the correct name of this wound?

A) Stage II pressure ulcer

B) Stage I pressure ulcer

C) Stage III pressure ulcer

D) Stage IV pressure ulcer

Ans: A

Feedback:

Stage I is defined as intact skin with a localized area of nonblanchable redness, usually over a bony prominence. Stage II is defined as partial thickness loss of dermis presenting as a shallow open ulcer with a red-pink wound bed. Stage III is defined as full-thickness loss without exposed bone, tendon, or muscle. Stage IV is defined as full-thickness tissue loss with exposed bone, tendon, and muscle.

29. A nurse is treating the pressure ulcer of an African American client. How would the nurse assess for deep tissue injury in this client?

A) Upon inspection the nurse would notice a purple or maroon localized area of discolored, intact skin.

B) Upon inspection, the nurse would see a blood-filled blister due to damage of underlying soft tissue from pressure and/or shear.

C) Upon palpation, the nurse determines that the area preceded by deep tissue injury is painful, firm, boggy, warmer or cooler as compared with adjacent tissue.

D) Upon inspection the nurse notes partial thickness loss of dermis presenting as a shallow open ulcer with a red-pink wound bed, without slough.

Ans: C

Feedback:

Deep tissue injury may be difficult to detect in individuals with dark skin tones. The area may be preceded by tissue that is painful, firm, boggy, warmer or cooler as compared with adjacent tissue. Evolution may include a thin blister over a dark wound bed. The wound may further evolve and become covered by a thin eschar. Evolution may be rapid, exposing additional layers of tissue even with optimal treatment.

30. A nurse inspecting a client's pressure ulcer documents the following: full-thickness tissue loss; visible subcutaneous fat; bone, tendon, and muscle are not exposed. This pressure ulcer is categorized to be at which of the following stages?

A) Stage I

B) Stage II

C) Stage III

D) Stage IV

Ans: C

Feedback:

In stage III there is full-thickness tissue loss; subcutaneous fat may be visible, but bone, tendon, or muscle are not exposed. In stage I there is intact skin with nonblanchable redness of a localized area, usually over a bony prominence. In stage II there is partial thickness loss of dermis presenting as a shallow open ulcer with a red-pink wound bed, without slough. In stage IV, there is full-thickness tissue loss with exposed bone, tendon, or muscle.

31. Which of the following is an accurate step when applying a saline-moistened dressing on a client's wound?

A) Do not use irrigation to clean the wound before changing the dressing.

B) Hold the fine-mesh gauze over the basin and pour the ordered solution over the mesh to saturate it.

C) Exert light pressure to pack the wound tightly with moistened dressing.

D) Apply several dry, sterile gauze pads over the wet gauze and place the ABD pad over the gauze.

Ans: D

Feedback:

Answer D is the correct step in the procedure. The wound should be cleaned, if needed, using sterile forceps. Irrigation may be used as ordered or required. The wound should be cleaned from the top to the bottom, and from the center to the outside. The fine-mesh gauze should be placed into the basin and the ordered solution poured over the mesh to saturate it. The dressing should be gently and loosely packed inside the wound.

32. A physician orders a dressing to cover a wound that is shallow with minimal drainage. What would be the best type of dressing for this wound?

A) Saline-moistened dressing

B) Dressing secured with Montgomery straps

C) Hydrocolloid dressing

D) Foam dressing

Ans: C

Feedback:

Hydrocolloid dressings are used for wounds that are shallow to moderate depth with minimal drainage. Saline-moistened dressing is often used with chronic wounds and pressure wounds. Montgomery straps are recommended to secure

dressings on wounds that require frequent dressing changes, such as wounds with increased drainage. Foam dressings are recommended for chronic wounds.

33. Which of the following is an indication for the use of negative pressure wound therapy?

A) Bone infections

B) Malignant wounds

C) Wounds with fistulas to body cavities

D) Pressure ulcers

Ans: D

Feedback:

Negative pressure wound therapy (NPWT) is used to treat a variety of acute or chronic wounds, wounds with heavy drainage, wounds failing to heal, or wounds healing slowly. Examples of such wounds include pressure ulcers; arterial, venous, and diabetic ulcers; dehisced surgical wounds; infected wounds; skin graft sites; and burns. NPWT is not considered for use in the presence of active bleeding; wounds with exposed blood vessels, organs, or nerves; malignancy in wound tissue; presence of dry/necrotic tissue; or with fistulas of unknown origin (Hess, 2008; Preston, 2008; Thompson, 2008).

34. A student has been assigned to provide morning care to a client. The plan of care includes the information that the client requires partial care. What will the student do?

A) Provide total physical hygiene, including perineal care.

B) Provide total physical hygiene, excluding hair care.

C) Provide supplies and orient to the bathroom.

D) Provide supplies and assist with hard-to-reach areas.

Ans: D

Feedback:

Morning care is often identified as either self-care, partial care, or complete care. Clients requiring partial morning care most often receive care at the bedside or seated near the sink in the bathroom. They usually require assistance with body areas that are difficult to reach.

Chapter 33, Activity

1. A staff development nurse is discussing techniques to prevent back injury with a group of nursing assistants. The nurse informs the group that back stress and injury can be prevented by doing which of the following?

A) Spreading feet shoulder-width apart to broaden the base of support

B) Using the strength of the back muscles during strenuous activities

C) Holding the object that you are lifting or moving away from the body

D) Pulling equipment, rather than pushing it, when possible

Ans: A

Feedback:

Techniques that prevent back stress and injury include spreading the feet shoulder-width apart to broaden the base of support; pushing equipment, rather than pulling, whenever possible; holding the object you are lifting or moving close to

the body; and using the longest and strongest muscles of the arms and legs to provide power, since the muscles of the back are less strong and more easily injured.

2. While receiving a report, the nurse learns that a client has paraplegia. The nurse will plan care for this client based upon the understanding that the client has which of the following?

A) Paralysis of the legs

B) Weakness affecting one-half of the body

C) Paralysis affecting one-half of the body

D) Paralysis of the legs and arms

Ans: A

Feedback:

Paraplegia is paralysis of the legs, and quadriplegia is paralysis of the arms and legs. Hemiparesis refers to weakness of one half of the body, and hemiplegia is paralysis of one half of the body.

3. The physician's admitting orders indicate that the client is to be placed in a Fowler's position. Upon positioning this client, how much will the nurse elevate the head of the bed?

A) 45 to 60 degrees

B) 15 to 20 degrees

C) 30 degrees

D) 90 degrees

Ans: A

Feedback:

In the Fowler's position, the head of the bed is elevated 45 to 60 degrees. Low-Fowler's or semi-Fowler's is positioning of the head of the bed to only 30 degrees. In the high-Fowler's position, the head of the bed is elevated 90 degrees.

4. A client 80 years of age experienced dysphagia (impaired swallowing) in the weeks following a recent stroke, but his care team wishes to now begin introducing minced and pureed food. How should the nurse best position the client?

A) Fowler's

B) Low-Fowler's

C) Protective supine

D) Semi-Fowler's

Ans: A

Feedback:

Fowler's position optimizes cardiac function and respiratory function in addition to being the best position for eating. The client's risk of aspiration would be extreme in a supine position. Low-Fowler's and semi-Fowler's are synonymous, and this position does not aid swallowing as much as a high-Fowler's position.

5. An obstetrical nurse is preparing to help a client up from her bed and to the bathroom three hours after the woman delivered her baby. Which of the following actions should the nurse perform first?

A) Explain to the client how the nurse will assist her.

B) Position a walker in front of the client to provide stability.

C) Enlist the assistance of another nurse or the physiotherapist.

D) Have the client stand for 30 seconds prior to walking.

Ans: A

Feedback:

Any effort to assist a client with mobilization should be preceded by thoroughly explaining the procedure; this optimizes the client's participation and lessens the potential for falls and injuries. The client is unlikely to require a walker or the assistance of multiple care providers, but even if she did, an explanation should still be provided first. It is not necessary to have the client stand for an extended period before ambulating.

6. A client 86 years of age with a diagnosis of late-stage Alzheimer's disease requires full assistance with transfers to and from his bed. Which of the following nursing actions is most likely to promote safe handling of this client?

A) Provide to the client brief, clear instructions that are phrased positively.

B) Post written instructions at the client's bedside to supplement spoken instructions.

C) Ask for the client's input on the timing and technique for transfers.

D) Ask for the client's feedback frequently during transfers.

Ans: A

Feedback:

When handling clients who have dementia, clear, short instructions are most effective. These instructions should be phrased positively ("stand up" rather than "don't sit down"). For a client with an advanced state of dementia, asking for feedback during transfers, and input on planning transfers is likely to be ineffective and may be frustrating for both the client and the nurse.

7. A nurse is providing care for a client who has been newly admitted to the long-term care facility. What is the primary criterion for the nurse's decision whether to use a mechanized assistive device for transferring the client?

A) The client's ability to assist

B) The client's body weight

C) The client's cognitive status

D) The client's age

Ans: A

Feedback:

The nurse assesses several parameters when choosing whether to use a mechanized assistive device for a client transfer. The most important consideration, however, is the client's ability to safely assist with his or her transfer.

8. What function of the skeletal system is essential to proper function of all other cells and tissues?

A) Supporting soft tissues of the body

B) Protecting delicate body structures

C) Providing storage area for fats

D) Producing blood cells

Ans: D

Feedback:

The production of blood cells (hematopoiesis) is the function of the skeletal system that is essential to all other cells and tissues of the body working properly.

9. A nurse is assessing the activity level of an infant age 5 months. What normal findings would be assessed?

A) Ability to sit and head control

B) Ability to pick up small objects

C) Progress toward running and jumping

D) Progress toward unassisted walking

Ans: A

Feedback:

At 5 months of age, the infant usually has achieved head control and is able to sit alone. Individual variations in activity patterns and neuromuscular development should be expected.

10. Which postural deformity might be assessed in a teenager?

A) Kyphosis

B) Rickets

C) Osteoporosis

D) Scoliosis

Ans: D

Feedback:

Scoliosis, a lateral curvature of the spine, would most likely be assessed in a teenager. Kyphosis and osteoporosis are seen in older adults. Rickets is seen in children.

11. A nurse is teaching an older woman how to move and lift her disabled husband. The woman has osteoarthritis of the hips and knees. What is the goal of the nurse's education plan?

A) Minimize stress on the wife's joints

B) Povide exercise for the husband

C) Increase socialization with neighbors

D) Maintain self-esteem of the wife

Ans: A

Feedback:

Older adults often have osteoarthritis, a noninflammatory progressive disorder of the moveable joints, particularly weight-bearing joints. Teaching clients to minimize stress on the joints to prevent possible injury and reduce pain is important.

12. Why is it important for the nurse to teach and role model proper body mechanics?

A) To ensure knowledgeable client care

B) To promote health and prevent illness

C) To prevent unnecessary insurance claims

D) To demonstrate knowledge and skills

Ans: B

Feedback:

The correct use of body mechanics is a part of health promotion and illness prevention. The nurse has a major responsibility to teach good body mechanics, both directly and indirectly, by example.

13. A nurse is placing a client in Fowler's position. What should she teach the family about this position?

A) "Use at least two big pillows to support the head."

B) "Cross the arms over the client's abdomen."

C) "Do not raise the knees with the knee gatch."

D) "Keep the hands lower than the rest of the body."

Ans: C

Feedback:

When positioning the client in Fowler's position, allow the head to rest against the mattress or use only a small pillow. Support the forearms on pillows, with the hand slightly elevated above the forearm. Do not use the knee gatch to raise the knees.

14. While performing a physical examination on a client, the nurse observes that the client has scoliosis based on which of the following?

A) Lateral deviation of the thoracic spine

B) Concave curvature of the cervical spine

C) Convex curvature of the thoracic spine

D) Concave curvature of the lumbar spine

Ans: A

Feedback:

Scoliosis is the lateral deviation of the thoracic spine. Concave curvature of the cervical spine, convex curvature of the thoracic spine, and concave curvature of the lumbar spine are the characteristics of a normal spinal alignment.

15. A nurse is caring for a frail older adult client with chronic obstructive pulmonary disease. The client always remains in a sitting position to help him breathe more easily. Based on the understanding that prolonged sitting may put pressure on bony prominences, the nurse frequently assesses which area of this client?

A) Back of the skull

B) Elbows

C) Sacrum

D) Heels

Ans: C

Feedback:

The sacrum bears the greatest pressure during a sitting position. The back of the skull, elbows, and heels bear pressure in a supine position.

16. A young adult woman has had orthopedic surgery on her right knee. The first time she gets out of bed, she describes weakness, dizziness, and feeling faint. The nurse correctly recognizes that which of the following conditions is likely affecting the client?

A) Thrombophlebitis

B) Anemia

C) Orthostatic hypotension

D) Bradycardia

Ans: C

Feedback:

Orthostatic hypotension refers to a reduction in blood pressure with position changes from lying to sitting or standing. Blood pooling in the legs increases, thus increasing the postural hypotension. Thrombophlebiits refers to an inflammation of a the veins; it manifests with redness and swelling. Anemia refers to a reduction in hemoglobin. This may present with feelings of weakness. Bradycardia refers to a reduced heart rate.

17. Which of the following activities is normally acquired in the toddler years? Select all that apply.

A) Rolling over

B) Pulling to a standing position

C) Walking

D) Running

E) Jumping

Ans: C, D, E

Feedback:

In the toddler, gross and fine motor development continue rapidly; by 15 months, most can walk unassisted, run, and jump. Rolling over and pulling to a standing position are accomplished by the infant.

18. The nurse cares for a newly admitted client who will soon need to be taken to the radiology department for a CT scan. The client has a Body Mass Index (BMI) of 52. Which of the following strategies to transport the client is most appropriate?

A) Obtain a mechanical lateral transfer device to move the client onto a stretcher.

B) Enlist the aid of two other staff members and pull the client across the bed and onto a stretcher.

C) Position a friction-reducing sheet under the client before attempting the transfer.

D) Transport the client to the radiology department in the hospital bed.

Ans: A

Feedback:

The combined weight of the bed and client will be difficult to move safely. Additionally, this strategy does not address the need to transfer the client onto, and off of, equipment in the radiology department.

19. The nurse is caring for a client who has been on bed rest. The primary care provider has just written a new order for the client to sit in the chair three times a day. Which of the following actions will be most effective to transfer the client safely into the chair?

A) Have the client sit on the side of the bed for several minutes before moving to the chair.

B) Infuse an intravenous fluid bolus 15 minutes before transferring the client into the chair.

C) Position a friction-reducing sheet under the client.

D) Obtain a quad cane for the client to use as a transfer aid.

Ans: A

Feedback:

Having the client sit at the side of the bed minimizes the risk for blood pressure changes (orthostatic hypotension) that can occur with position change.

20. The nurse is helping a client walk in the hallway when the client suddenly reaches for the handrail and states, "I feel so weak. I think I am going to pass out." Which of the following initial actions by the nurse is appropriate?

A) Firmly grasp the client's gait belt.

B) Support the client's body against yours and gently slide the client onto the floor.

C) Ask the client to lean against the wall while you obtain a wheelchair.

D) Apply oxygen and wait several minutes for the weakness to pass.

E) Ask the patient, "When was the last time you ate?"

Ans: B

Feedback:

Assessing for the potential causes of the weakness should occur after the client's safety is assured.

21. Once applied, antiembolism stockings should not be removed until the primary care provider writes an order to discontinue them.

A) True

B) False

Ans: B

Feedback:

Antiembolism stockings may be removed (for example, during morning care to inspect the legs) without the primary care provider writing an order to discontinue them.

22. A nurse uses proper body mechanics to move a client up in bed. Which of the following is a guideline for using these techniques properly?

A) Face the direction of movement.

B) Twist body at the waist when lifting.

C) Keep body weight higher than center of gravity.

D) Keep feet together to provide a base of support.

Ans: A

Feedback:

When using body mechanics, the nurse should face the direction of movement and avoid twisting the body. Maintaining balance involves keeping the spine in vertical alignment, body weight close to the center of gravity, and feet spread for a broad base of support.

23. Which of the following clients would be an appropriate candidate to move by using a powered stand-assist device?

A) A comatose client who is being taken for x-rays

B) An alert client after knee replacement surgery who is being assisted to ambulate

C) An obese client who has Alzheimer's disease and is being escorted to the shower room

D) A car accident victim with fractures in both legs who is being moved to another room

Ans: B

Feedback:

Powered stand-assist devices can be used with clients with weight-bearing ability on at least one leg, who can follow directions, and who are cooperative. Clients who are unable to bear partial weight, full weight or who are uncooperative should be transferred using a full body sling lift.

24. A nurse is ambulating a client who catches her foot on the bed frame and begins to fall. Which of the following is an accurate step to prevent or minimize damage from this fall?

A) The nurse should place his or her feet close together with one foot in front of the other.

B) The nurse should rock his or her pelvis out on the opposite side of the client.

C) The nurse should grasp the gait belt and pull the client's body backward away from his or her body.

D) The nurse should gently slide the client down his or her body to the floor.

Ans: D

Feedback:

The nurse should place feet wide apart, with one foot in front and rock pelvis out on the side nearest the client. The nurse should grasp the gait belt and support the client by pulling his or her weight backward against his or her body, and then gently sliding the client down his or her body to the floor, protecting the client's head.

25. The nurse is preparing to move a client from bed into a wheelchair to eat lunch. What client data would the nurse check to see if the assistance of another nurse is needed?

A) Client restrictions

B) Client age

C) Client food preferences

D) Client restraints

Ans: A

Feedback:

When attempting to move a client, the nurse would first check the client's chart to see if the client has any physical limitations or restrictions. The nurse would also evaluate the client's condition and determine whether or not the client can help with positioning or understand directions. Lastly, the nurse would evaluate the client's body weight and his or

her own strength. Age and food preferences would not affect movement. Clients with restraints still need to be moved and repositioned.

26. A nurse is repositioning a client who has physical limitations due to recent back surgery. How often would the nurse turn the client in bed?

A) Every hour

B) Every two hours

C) Every four hours

D) Every shift

Ans: B

Feedback:

The nurse would turn the client in bed every two hours to avoid complications due to inactivity. The nurse would also include this activity in the client plan of care.

27. The nurse is preparing a client to be turned in bed. In what position would the nurse place the client to begin this procedure?

A) Sitting up

B) Lying prone

C) Lying flat

D) Lying flat with feet raised slightly

Ans: C

Feedback:

The nurse would position the bed so that the client is lying flat on his/her back and then raise the bed to a comfortable working height. This facilitates moving the client to the side in order to perform the turn in bed.

28. The nurse is preparing to move a patient up in bed with the assistance of another nurse. In what position would the nurse place the patient, if tolerated?

A) Reverse Trendelenburg

B) Supine

C) Sitting

D) Semi-Fowler’s

Ans: B

Feedback:

The nurse would adjust the head of the bed to a flat position or slight Trendelenburg, as low as the patient can tolerate. Flat positioning helps to decrease the gravitational pull of the upper body.

29. When moving a client up in bed, the nurse asks the client to fold the arms across the chest and lift the head with the chin on the chest. What is the rationale for placing the client in this position?

A) To prevent hyperextension of the neck

B) To prevent pressure on the arms

C) To lower the client's center of gravity

D) To decrease the effort needed to move the client

Ans: A

Feedback:

The nurse would ask the client to fold the arms across the chest and lift the head with the chin on the chest. Positioning in this manner provides assistance, reduces friction, and prevents hyperextension of the neck.

30. When transferring a client from bed to a stretcher, the nurses working together turn the client to position a transfer board partially underneath the patient. What is the rationale for using a transfer board in this procedure?

A) To lift the client off the bed.

B) To slide the board with the client onto the stretcher.

C) To reduce friction as the client is pulled laterally onto the stretcher.

D) To protect the client's head from hitting the headboard.

Ans: C

Feedback:

The transfer board or other lateral-assist device reduces friction, easing work load to move the client. It is positioned partially under the client, across the space between the bed and stretcher.

31. When assisting a client from the bed into a wheelchair, the nurse assesses the client standing up and notices the client is weak and unsteady. What would be the recommended nursing intervention in this situation?

A) Allow the client to keep standing for several minutes until balance returns.

B) Use the call bell to summon the assistance of another nurse.

C) Return the client to the bed.

D) Place the client into the wheelchair.

Ans: C

Feedback:

Once the client is standing, the nurse would assess the patient's balance and leg strength. If the client is weak or unsteady, the nurse would return the client to the bed.

32. Student nurses are turning a client in bed. In order to move the client to the edge of the bed, which positioning instruction is best to give the client when using the friction-reducing sheet?

A) Cross the arms across the chest and keep the legs straight.

B) Cross the arms across the chest and cross the legs.

C) Keep the arms at the sides and the legs crossed.

D) Keep the arms folded loosely at the abdomen and the legs straight.

Ans: B

Feedback:

The nurse would ask the client to cross the arms across the chest, and cross the legs. This facilitates the turning motion and protects the client's arms during the move. Or, if the client is able, the nurse may ask the client to assist by grasping the bed rail on the side toward which the client is turning.

33. A nurse is assisting in the transfer of a client to a stretcher. The client has casts on both legs. What is the nurse's best choice of transfer equipment for this client who cannot bear weight on either leg?

A) Powered-stand assist

B) Transfer chair

C) Repositioning lift

D) Gait belt

Ans: B

Feedback:

Chairs that can convert into stretchers are available. These are useful with clients who have no weight-bearing capacity, cannot follow directions, and/or cannot cooperate. The back of the chair bends back and the leg supports elevate to form a stretcher configuration, eliminating the need for lifting the client. Powered-stand assist devices and repositioning devices require the client to have weight-bearing capacity in one leg. Gait belts are used to assist clients to ambulate safely.

34. While being measured for anti-embolism stockings, the client asks the nurse why they are necessary. What would be the nurses's best response?

A) They promote venous blood return to the heart.

B) They eliminate peripheral edema.

C) They provide a nonslip foot surface to help prevent falls.

D) They reduce the risk for impaired skin integrity.

Ans: A

Feedback:

Anti-embolism stockings are used to promote venous blood return to the heart and help in preventing blood clots. They often do help with edema in the legs, but they do not eliminate edema (nor is this their main goal). They do not provide a nonslip foot surface. If applied incorrectly they can increase the risk for impaired skin integrity.

35. The nurse and an assistant are preparing to move a client up in bed. Arrange the following steps in the correct order.

1. Adjust the head of the bed to a flat position.

2. Place a friction-reducing sheet under the client.

3. Ask the client to bend legs and place the chin on the chest.

4. Position the assistant on the side opposite you.

5. Remove all pillows from under the client.

6. Grasp the sheet and move the client on the count of 3.

A) 3, 1, 2, 4, 5, 6

B) 1, 2, 4, 3, 5, 6

C) 1, 5, 4, 2, 3, 6

D) 3, 2, 1, 4, 6, 5

E) 1, 3, 2, 4, 5, 6

Ans: C

Feedback:

This is the correct order for a nurse and an assistant who are preparing to move a client up in bed.

Chapter 34, Rest and Sleep

1. Which natural chemical does the body produce at night to decrease wakefulness and promote sleep?

A) Melatonin

B) Serotonin

C) Endorphins

D) Dopamine

Ans: A

Feedback:

Melatonin is a natural chemical produced at night that decreases wakefulness and promotes sleep.

2. A client reports that her naps after lunch often stretch to three hours in length and that she has great difficulty rousing herself after a nap. This condition is best termed as which of the following?

A) Hypersomnia

B) Insomnia

C) Parasomnia

D) Sleep apnea

Ans: A

Feedback:

Hypersomnia is a condition characterized by excessive sleep, particularly during the day. Insomnia is characterized by difficulty falling asleep, intermittent sleep, or early awakening from sleep. Parasomnias are patterns of waking behavior that appear during sleep. Sleep apnea is a condition in which a person experiences the absence of breathing, or diminished breathing efforts, during sleep (between snoring intervals).

3. A client in his 40s has asked the nurse how much sleep he should be getting in order to maximize his health and well-being. How should the nurse respond?

A) "Most adults need between seven and nine hours, but everyone is different."

B) "It's important to get a minimum of eight hours sleep each night."

C) "More sleep equals better health, so the more sleep you can fit into your schedule, the better."

D) "Sleep needs depend a lot on age, and at your age, six to seven hours usually suffice."

Ans: A

Feedback:

Sleep needs and routines are highly individual, but most adults require between seven and nine hours of sleep.

4. Which of the following clients likely faces a risk for the nursing diagnosis of Disturbed Sleep Pattern: Difficulty Remaining Asleep?

A) A client who receives IV antibiotics every three hours

B) A client whose opioid analgesics result in central nervous system depression

C) A client who is receiving corticosteroids that make her feel restless and agitated

D) A client whose physical therapy has been scheduled in the late evening

Ans: A

Feedback:

A client who requires medications throughout the night is likely to experience the frequent awakenings associated with Disturbed Sleep Pattern: Difficulty Remaining Asleep. Drowsiness or agitation as a result of medications may affect sleep, but are less likely to result in mid-sleep awakenings. A client who performs physical activity prior to bedtime may have difficulty falling asleep.

5. Which group of terms best describes sleep?

A) Decreased state of activity, refreshed

B) Altered consciousness, relative inactivity

C) Comatose, immobility

D) Alert, responsive

Ans: B

Feedback:

Sleep is a state of rest accompanied by altered consciousness and relative inactivity. Rest is a condition in which the body is in a decreased state of activity.

6. An individual awakens from a sound sleep in the middle of the night because of abdominal pain. Why does this happen?

A) Stimuli from peripheral organs to the RAS

B) Stimuli to the wake center in the cerebral cortex

C) Messages from chemoreceptors to the brain

D) Messages from baroreceptors to the spinal cord

Ans: A

Feedback:

The reticular activating system (RAS) facilitates reflex and voluntary movements as well as cortical activities related to a state of alertness. Wakefulness occurs when the RAS experiences stimuli (including pain) from peripheral organs and cells.

7. A nurse is caring for a client who is sleeping for abnormally long periods of time. This condition may be caused by injury to which of the following body structures?

A) Spinal cord

B) Pancreas

C) Hypothalamus

D) Thyroid

Ans: C

Feedback:

The hypothalamus has control centers for several involuntary activities of the body, one of which concerns sleeping and waking. Injury to the hypothalamus may cause a person to sleep for abnormally long periods.

8. What name is given to the rhythmic biologic clock that exists in humans?

A) Sleep-wake cycle

B) Alert-unaware process

C) Circadian rhythm

D) Yo-yo theory

Ans: C

Feedback:

Rhythmic biologic clocks are known to exist in plants, animals, and humans. Circadian rhythms complete a full cycle every 24 hours and in humans affect heart rate, blood pressure, body temperature, hormone secretions, and metabolism, as well as performance and mood.

9. A nurse working the night shift assesses a client's vital signs at 4 a.m. (0340). What would be the expected findings, based on knowledge of NREM sleep?

A) Decreased TPR and BP

B) Increased TPR and BP

C) No change from daytime readings

D) Highly individualized, cannot predict

Ans: A

Feedback:

Throughout the stages of NREM sleep, the parasympathetic nervous system dominates; decreases in temperature, pulse, respirations, and blood pressure occur.

10. A nurse educates a young couple on putting their newborn on his back to sleep. What is the rationale for this information?

A) Prone position increases the risk for sudden infant death syndrome.

B) Prone position decreases the risk for sudden infant death syndrome.

C) Supine position may alter the size and shape of the infant's head.

D) Supine position makes changing diapers and feeding difficult.

Ans: A

Feedback:

Newborns sleep an average of 16 out of every 24 hours. It is important to teach parents to position an infant on the back. Sleeping in the prone position increases the risk for sudden infant death syndrome (SIDS).

11. Based on the circadian cycle, the body prepares for sleep at night by decreasing the body temperature and releasing which chemical?

A) Neonephrine

B) Seratonin

C) Melatonin

D) Dopamine

Ans: C

Feedback:

Based on the circadian cycle, the body prepares for sleep at night by decreasing the body temperature and releasing melatonin (a natural chemical produced at night that decreases wakefulness and promotes sleep).

12. A middle-age adult man has just started an exercise program. What would the nurse teach him about timing of exercise and sleep?

A) Exercising immediately before bedtime enhances ability to sleep

B) Exercising within two hours of bedtime can hinder ability to sleep

C) The time of day does not matter; exercise facilitates sleep

D) The fatigue from exercise may be a hindrance to sleep

Ans: B

Feedback:

Moderate exercise is a healthy way to promote sleep, but exercise that occurs within a two-hour interval before normal bedtime can hinder sleep.

13. Which medication is least likely to affect sleep quality?

A) Diuretic

B) Steroid

C) Antidepressant

D) Ambien

Ans: D

Feedback:

Sleep quality is influenced by drugs. Drugs that decrease sleep include diuretics, steroids, and antidepressants. Ambien and chloral hydrate appear to influence the quality of sleep least and promote normal sleep.

14. Which individual is likely to require more hours of sleep?

A) a person 75 years of age

B) a person 43 years of age

C) a person 25 years of age

D) a person 15 years of age

Ans: D

Feedback:

Despite individual variations, growing children, especially adolescents who are in a tremendous growth period, require from 10 to 14 hours of sleep per night. This is in comparison with the accepted standard for adults, which is 8 hours. Older adults often require less sleep.

15. A client's bed partner reports the client often has irregular snoring and silence followed by a snort. Does this warrant further assessment?

A) No, snoring has varied patterns

B) No, this is a description of normal snoring

C) Yes, this is an indicator of obstructive apnea

D) Yes, the bed partner is unable to sleep at night

Ans: C

Feedback:

Snoring is caused by an obstruction to airflow through the nose and mouth. When snoring changes from the characteristic sawing wood sound to a more irregular silence followed by a snort, this indicates obstructive apnea.

16. Which of the following is the most common sleep disorder?

A) Hypersomnia

B) Parasomnia

C) Insomnia

D) Dyssomnia

Ans: C

Feedback:

Insomnia is characterized by difficulty falling asleep, intermittent sleep, or early awakening from sleep. It is the most common of all sleep disorders.

17. A client who has a sleep disorder is trying stimulus control to improve amount and quality of sleep. What is recommended in this type of therapy?

A) Use the bedroom for sleep and sex only.

B) Use the bedroom for reading and eating.

C) Go to bed at the same time every night.

D) Sleep alone with minimal coverings.

Ans: A

Feedback:

Stimulus control involves using the bedroom for sleep and sex only. If not asleep within 15 to 20 minutes, the person should leave the room and return only when he or she feels sleepy. Getting up at the same time every day is also recommended.

18. A client is diagnosed with narcolepsy. Which of the following is a characteristic of this disorder?

A) Waking during sleep

B) Restless leg syndrome

C) Uncontrollable desire to sleep

D) Decrease in the amount or quality of sleep

Ans: C

Feedback:

Narcolepsy is a condition characterized by an uncontrollable desire to sleep. Narcolepsy is considered a neurologic disorder.

19. A client with a sleep disorder experiences cataplexy. Which is a feature of this condition?

A) Irresistible urge to sleep, regardless of the type of activity in which the client is engaged

B) Sudden loss of motor tone that may cause the person to fall asleep; usually experienced during a period of strong emotion

C) Nightmare or vivid hallucinations experienced during sleep time

D) Skeletal paralysis that occurs during the transition from wakefulness to sleep

Ans: B

Feedback:

Cataplexy is the sudden loss of motor tone that may cause the person to fall asleep; this is usually experienced during a period of strong emotion. Sleep attacks are irresistible urges to sleep, regardless of the type of activity in which the client is engaged. Hypnagogic hallucinations involve nightmares or vivid hallucinations. In sleep-onset REM periods, during a sleep attack, the person moves directly into REM sleep. Sleep paralysis is skeletal paralysis that occurs during the transition from wakefulness to sleep.

20. What is the rationale for using CPAP to treat sleep apnea?

A) Positive air pressure holds the airway open.

B) Negative air pressure holds the airway closed.

C) Delivery of oxygen facilitates respiratory effort.

D) Alternating waves of air stimulate breathing.

Ans: A

Feedback:

Continuous positive airway pressure (CPAP) is used to treat sleep apnea. The device, worn at night, delivers positive air pressure through a facemask to hold the airway open.

21. The parents of a boy 10 years of age are worried about his sleepwalking (somnambulism). What topic should the nurse discuss with the parents?

A) Sleep deprivation

B) Privacy

C) Schoolwork

D) Safety

Ans: D

Feedback:

Somnambulism (sleepwalking) is a parasomnia, a pattern of waking behaviour that appears during sleep. It is more commonly seen in children and is commonly outgrown before adulthood. Safety and prevention of injury are paramount concerns.

22. What independent nursing action can be used to facilitate sleep in hospitalized clients who are on bedrest?

A) Administering prescribed sleep medications

B) Changing the bed with fresh linens

C) Encouraging naps during the daytime

D) Giving a back massage

Ans: D

Feedback:

Simple interventions, such as offering a back massage, can promote comfort and sleep in hospitalized clients on bedrest.

23. A sedative-hypnotic has been prescribed to help a client sleep. What should the nurse teach the client about this medication?

A) It should be taken every night for several months

B) It is useful for sleep but is better taken with alcohol

C) It loses its effectiveness after one or two weeks

D) It should be taken in the morning for long-term effects

Ans: C

Feedback:

Although most sedative-hypnotics provide several nights of excellent sleep, the medication often loses its effect after one or two weeks. Caution the client not to increase the dose or take the drug with alcohol to try to increase effect.

24. What is the most common method for ordering sleep medications?

A) Stat

B) p.r.n

C) Single order

D) Daily dose

Ans: B

Feedback:

Sleep medications are often ordered on a p.r.n. (as needed) basis. These medications should be administered only when indicated, and always with the full knowledge of their limitations.

25. What condition have studies confirmed occurs when adults and children do not get recommended hours of sleep at night?

A) Obesity

B) Anxiety

C) Diabetes

D) Hypertension

Ans: A

Feedback:

The fact that children and adults are getting less sleep has been implicated as a contributing factor to the obesity epidemic in the United States (CDC, 2008, Goldsmith, 2007). Various studies confirm that adults and children who slept less than their recommended hours per night were more likely to be overweight. This sleep-weight link is possibly related to two hormones: leptin and ghrelin. Leptin signals the brain to stop eating, whereas ghrelin promotes continued eating. Research suggests that sleep deprivation lowers leptin levels and elevates ghrelin levels, thus increasing one's appetite.

26. Which drug normalizes sleep cycles by enabling the body's supply of melatonin to naturally promote sleep?

A) Flurazepam (Dalmane)

B) Temazepam (Restoril)

C) Eszopiclone (Lunesta)

D) Ramelteon (Rozerem)

Ans: D

Feedback:

The most recently approved sleep medication is Ramelteon (Rozerem). This drug is classified as a melatonin receptor agonist and it normalizes sleep cycles by enabling the body's supply of melatonin to naturally promote sleep (Goldsmith, 2007).

27. Which expected outcome demonstrates the effectiveness of a plan of care to promote rest and sleep?

A) Verbalizes inability to sleep without medications

B) Continues to read in bed for hours each night

C) Identifies factors that interfere with normal sleep pattern

D) Reports minimal improvement in quality of rest and sleep

Ans: C

Feedback:

The nurse evaluates the effectiveness of the plan of care to promote rest and sleep by evaluating if the client has met the expected outcomes of the plan. If the client is able to identify factors that interfere with normal sleep patterns, this illustrates achievement of one expected outcome.

28. A nurse is caring for a client who has been diagnosed with insomnia. What nursing intervention would help the nurse relieve the client's condition?

A) Maintain a calm and quiet environment free from noise.

B) Administer sedatives as prescribed by the physician.

C) Motivate the client to sleep because it may affect his health.

D) Engage the client in some diversional activities.

Ans: A

Feedback:

Maintaining a calm and quiet environment is the most appropriate nursing activity to relieve insomnia. Motivating the client to sleep by telling him that it may affect his health may cause anxiety in the client. Engaging the client in diversional activities at bedtime may increase sleeplessness. Sedatives can be administered as prescribed, but they should be used as last resort. These activities may not relieve insomnia in the client.

29. A nurse is caring for a client diagnosed with sleep apnea. What should the nurse do in order to promote sleep in the client?

A) Encourage the client to lose weight.

B) Avoid sedatives for sleeping.

C) Encourage deep breathing exercises.

D) Provide good ventilation in the room.

Ans: B

Feedback:

The nurse should avoid sedatives in the client because sedatives may depress respiration. The client with sleep apnea already has decreased ventilation and low blood oxygenation; the condition may become worse if the respiration is further depressed by sedatives. Losing weight is a long-term measure and is not applicable in this case. Encouraging deep breathing exercises and providing good ventilation may help the client,

but they are secondary measures.

30. A nurse is caring for a client who complains about sleep apnea. Which of the following delivery devices should the nurse use to administer oxygen to this client?

A) Nasal catheter

B) Oxygen tent

C) Transtracheal oxygen

D) CPAP mask

Ans: D

Feedback:

The nurse should use a CPAP mask for a client with complaints of sleep apnea. A CPAP mask maintains positive pressure within the airway throughout the respiratory cycle. Clients generally wear this type of mask at night to maintain oxygenation when they experience sleep apnea. A nasal catheter is a tube for delivering oxygen that is inserted through the nose into the posterior nasal pharynx. It is used for clients who tend to breathe through the mouth or experience claustrophobia when a mask covers their face. An oxygen tent is a clear plastic enclosure that provides cooled, humidified oxygen, which is used for active toddlers. Transtracheal oxygen is a hollow tube inserted within the trachea to deliver oxygen to clients who require long-term oxygen therapy.

31. Which of the following guidelines does the nurse apply to discussion of sleep patterns with older adult clients?

A) Circadian rhythms become more prominent as clients age.

B) The amount of stage 4 sleep increases as clients age.

C) Total sleep time decreases as the clients age.

D) Older clients fall asleep more quickly than younger ones.

Ans: C

Feedback:

As people age, the amount of stage 4 sleep decreases significantly. Sleeping patterns may become polyphasic, with a shorter nocturnal period plus daytime naps.

32. A client has sought care because of insomnia that has been increasing in severity and frequency in recent months. What questions should the nurse include in an assessment of this client's health problem? Select all that apply.

A) "Do you have a family history of sleep disturbances?"

B) "Do you smoke?"

C) "What medications are you currently taking?"

D) "Do you have a consistent routine around getting ready for bed and going to bed?"

E) "How would you characterize your mood lately?"

Ans: B, C, D, E

Feedback:

Sleep is a multifaceted phenomenon that is affected by many variables. Among these are cigarette smoking, medications, sleep routines, and mood; the nurse should assess each of these areas. Sleep problems do not normally have a genetic basis.

33. A new mother is discussing her 6-month-old infant's sleep habits and expresses concern about the infant obtaining too much sleep. The mother reports the infant's circadian cycle as:

Time period	Activity
0600-0900	awake
0900-1100	sleep
1100-1300	awake
1300-1600	sleep
1600-1900	awake
1900-2200	sleep

2200-2400	awake
2400-0600	sleep

The best statement by the nurse is:

A) "Your infant requires more time asleep during the day hours."

B) "You need to awaken your infant during the 2400 to 0600 time period."

C) "Your infant is obtaining the average hours of sleep per day for an infant."

D) "Your infant is actually obtaining too little sleep for one day."

Ans: C

Feedback:

Infants usually require 14 to 20 hours of sleep per day. This infant is obtaining 14 hours of sleep each day.

34. The nurse manager in an acute care facility has received client evaluations in which the clients have complained about excessive noise that interfered with their rest. The nurse manager and nursing staff plan to do the following. Which activity will most assist clients in obtaining rest?

A) Post signs for quiet and turn down hall lights during formal quiet times.

B) Ensure clients are offered prescribed sleeping medications at bedtime.

C) Provide a small carbohydrate snack or juice prior to hours of sleep.

D) Adjust the temperature of the room to 74 degrees and provide a blanket.

Ans: A

Feedback:

All of the options may be helpful in promoting rest. However, the client complaints are about excessive noise, and posting signs for quiet and turning down hall lights during formal quiet times is the only option that directly addresses noise. Also, some clients cannot rest if the room temperature is not to their liking. The room temperature needs to be adjusted to client preference.

35. The client is a male who states his wife complains that his snoring awakens her at night. The spouse is present. To obtain further data, the nurse asks the spouse what?

A) "How loud is his snoring?"

B) "Is there silence after snoring which then is followed with a snort?"

C) "How long does he snore each night?"

D) "How often are you awakened at night due to his loud snoring?"

Ans: B

Feedback:

Snoring that is followed by silence and then a snort may be a sign of obstructive apnea. Snoring is not considered a sleeping disorder and is often more disturbing to the sleep partner.

Chapter 35, Comfort and Pain Management

1. A cyclist reports to the nurse that he is experiencing pain in the tendons and ligaments of his left leg, and the pain is worse with ambulation. The nurse will document this type of pain as which of the following?

A) Somatic pain

B) Cutaneous pain

C) Visceral pain

D) Phantom pain

Ans: A

Feedback:

Somatic pain is diffuse or scattered pain, and it originates in tendons, ligaments, bones, blood vessels, and nerves. Cutaneous pain usually involves the skin or subcutaneous tissues. Visceral pain is poorly localized and originates in body organs. Phantom pain occurs in an amputated leg for which receptors and nerves are clearly absent, but the pain is a real experience for the client.

2. Which statement accurately describes pain experienced by the older adult?

A) Boredom and depression may affect an older person's perception of pain.

B) Residents in long-term care facilities have a minimal level of pain.

C) The older client has decreased sensitivity to pain.

D) A heightened pain tolerance occurs in the older adult.

Ans: A

Feedback:

Boredom, loneliness, and depression may affect an older person's perception and report of pain. One myth held by many to be true is that older clients have a decreased sensitivity to pain and therefore a heightened pain tolerance. Numerous older adult clients residing in long-term care facilities have significant pain that negatively affects their quality of life.

3. Pet therapy is commonly used in long-term facilities for distraction. If a client is experiencing pain and the pain is temporarily decreased while petting a visiting dog or cat, this is an example of which type of distraction technique?

A) Tactile kinesthetic distraction

B) Visual distraction

C) Auditory distraction

D) Project distraction

Ans: A

Feedback:

Examples of tactile kinesthetic distraction include holding or stroking a loved one, pet, or toy; rocking; and slow rhythmic breathing. Project distraction includes playing a challenging game or performing meaningful work. Visual distraction can be accomplished through reading or watching television. Auditory distraction may occur when one listens to music.

4. Of the following individuals, who can best determine the experience of pain?

A) The person who has the pain

B) The person's immediate family

C) The nurse caring for the client

D) The physician diagnosing the cause

Ans: A

Feedback:

According to McCaffery, an expert on pain, "Pain is whatever the experiencing person says it is, existing whenever he (or she) says it does." The only one who can be a real authority on whether and how a person experiences pain is that individual.

5. A client who has breast cancer is said to be in remission. What does this term signify?

A) The client is experiencing symptoms of the disease.

B) The client has end-stage cancer.

C) The client is experiencing unremitting pain.

D) The disease is present but the client is not experiencing symptoms.

Ans: D

Feedback:

Commonly, people with chronic pain experience periods of remission (when the disease is present but the person does not experience symptoms) or exacerbation (the symptoms reappear).

6. Which of the following clients would be classified as having chronic pain?

A) A client with rheumatoid arthritis

B) A client with pneumonia

C) A client with controlled hypertension

D) A client with the flu

Ans: A

Feedback:

Chronic pain is pain that may be limited, intermittent, or persistent but that lasts beyond the normal healing period. Acute pain is generally rapid in onset and varies in intensity from mild to severe. After its underlying cause is resolved, acute pain disappears. It should end once healing occurs.

7. A client has a severe abdominal injury with damage to the liver and colon from a motorcycle crash. What type of pain will predominate?

A) Psychogenic pain

B) Neuropathic pain

C) Cutaneous pain

D) Visceral pain

Ans: D

Feedback:

Visceral pain is poorly localized and originates in body organs in the thorax, cranium, and abdomen. The pain occurs as organs stretch abnormally and become distended, ischemic, or inflamed.

8. A client in the emergency department is diagnosed with a myocardial infarction (heart attack). The client describes pain in his left arm and shoulder. What name is given to this type of pain?

A) Cutaneous pain

B) Referred pain

C) Allodynia

D) Nociceptive

Ans: B

Feedback:

Referred pain is pain that is perceived in an area distant from the point of origin. Pain associated with a myocardial infarction is frequently referred to the neck, shoulder, or arm.

9. Why is acute pain said to be protective in nature?

A) It warns an individual of tissue damage or disease.

B) It enables the person to increase personal strength.

C) As a subjective experience, it serves no purpose.

D) As an objective experience, it aids diagnosis.

Ans: A

Feedback:

Pain is a subjective experience. Acute pain, lasting from a few minutes to less than six months, warns an individual of tissue damage or organic disease. After its underlying cause is resolved, acute pain disappears.

10. A client tells the nurse that she is experiencing stabbing pain in her mouth, gums, teeth, and chin following brushing her teeth. These are symptoms of which of the following pain syndromes?

A) Complex regional pain syndrome

B) Postherpetic neuralgia

C) Trigeminal neuralgia

D) Diabetic neuropathy

Ans: C

Feedback:

A symptom of trigeminal neuralgia is paroxysms of lightning-like stabs of in tense pain in the distribution of one or more divisions of the trigeminal nerve, the fifth cranial nerve. Pain is usually experienced in the mouth, gums, lips, nose, cheek, chin, and surface of the head and may be triggered by everyday activities like talking, eating, shaving, or brushing one's teeth.

11. A nurse implements a back massage as an intervention to relieve pain. What theory is the motivation for this intervention?

A) Gate control theory

B) Neuromodulation

C) Large/small fiber theory

D) Prostaglandin stimulation

Ans: A

Feedback:

The gate control theory of pain describes the transmission of painful stimuli. Nursing interventions, such as massage or a warm compress to a painful lower back, stimulate large nerve fibers to close the gate, thus blocking nerve impulses from that area.

12. A client has been taught relaxation exercises before beginning a painful procedure. What chemicals are believed to be released in the body during relaxation to relieve pain?

A) Narcotics

B) Sedatives

C) A-delta fibers

D) Endorphins

Ans: D

Feedback:

Endorphins, which are opioid neuromodulators, are produced at neural synapses at various points in the CNS pathway. They have prolonged analgesic effects and produce euphoria. It is suggested that they may be released when measures such as skin stimulation and relaxation techniques are used.

13. How may a nurse demonstrate cultural competence when responding to clients in pain?

A) Treat every client exactly the same, regardless of culture.

B) Be knowledgeable and skilled in medication administration.

C) Know the action and side effects of all pain medications.

D) Avoid stereotyping responses to pain by clients.

Ans: D

Feedback:

Culture influences an individual's response to pain. It is particularly important to avoid stereotyping responses to pain because the nurse frequently encounters clients who are in pain or anticipating it will develop. A form of pain expression that is frowned upon in one culture may be desirable in another cultural group.

14. Which client would be most likely to have decreased anxiety about, and response to, pain as a result of past experiences?

A) One who had pain but got adequate relief

B) One who had pain but did not get relief

C) One who has had chronic pain for years

D) One who has had multiple pain experiences

Ans: A

Feedback:

An individual's experience of pain in the past, and the qualities of that experience, profoundly affect new pain experiences. Some clients have experienced severe acute or chronic pain in the past but received immediate and adequate pain relief. These clients are generally unafraid of pain and initiate appropriate requests for assistance.

15. Which misconception is common in clients in pain?

A) "I will get addicted to pain medications."

B) "I need to ask for pain medications."

C) "The nurses are here to help relieve the pain."

D) "I do not have to fight the pain without help."

Ans: A

Feedback:

Many misconceptions interfere with the client's ability to communicate pain. A common misconception is that "if I ask for something for pain, I may become addicted to the medication."

16. What is the term used to describe a pharmaceutical agent that relieves pain?

A) Antacid

B) Antihistamine

C) Analgesic

D) Antibiotic

Ans: C

Feedback:

An analgesic is a pharmaceutical agent that relieves pain. Analgesics reduce the perception of pain and alter responses to discomfort.

17. A client with cancer pain is taking morphine for pain relief. Knowing constipation is a common side effect, what would the nurse recommend to the client?

A) "Only take morphine when you have the most severe pain."

B) "Increase fluids and high-fiber foods, and use a mild laxative."

C) "Administer an enema to yourself every third day."

D) "Constipation is nothing to worry about; take your medicine."

Ans: B

Feedback:

The most common side effects associated with opioids (e.g., morphine) are sedation, nausea, and constipation. If constipation persists, it usually responds to treatment with increased fluids and fiber, and use of a mild laxative.

18. Which client would benefit from a p.r.n. drug regimen?

A) One who had thoracic surgery 12 hours ago

B) One who had thoracic surgery four days ago

C) One who has intractable pain

D) One who has chronic pain

Ans: B

Feedback:

A p.r.n. drug regimen has not proven effective for people experiencing acute pain, such as in the early postoperative period. It is not adequate for clients with intractable or chronic pain. However, later in the postoperative period, it may be acceptable to relieve occasional pain episodes.

19. A nurse is teaching an alert client how to use a PCA system in the home. How will she explain to the client what he must do to self-manage pain?

A) "You don't have to do anything. The machine does it all."

B) "I will teach your family what they need to do."

C) "When you push the button, you will get the medicine."

D) "The medicine is going into your body all the time."

Ans: C

Feedback:

When the sensation of pain occurs, the client pushes a button that activates the PCA device to deliver a small preset bolus dose of the analgesic. A lockout interval (usually 5 to 10 minutes) prevents reactivation of the pump and administration of another dose during that period of time. Other safeguards also limit the possibility of overmedication.

20. A middle-age client is complaining of acute joint pain to a nurse who is assessing the client's pain in a clinic. Which of the following questions related to pain assessment should the nurse ask the client?

A) Does your diet include red meat and poultry products?

B) Does your pain level change after taking medications?

C) Are your family members aware of your pain?

D) Have you thought of the effects of your condition on your family?

Ans: B

Feedback:

The nurse should ask direct and specific questions about the nature of the pain and whether it changes with medication, as this helps the nurse to quickly gather objective data about the client's pain. The nurse should avoid asking irrelevant and closed-ended questions, such as whether the client's diet includes red meat and poultry products, or whether the client has thought about the effects of his condition on his family. These types of questions do not add any value to pain assessment, but could make the client feel more depressed and uncomfortable.

21. A client having acute pain tells the nurse that her pain has gradually reduced, but that she fears it could recur and become chronic. What is a characteristic of chronic pain?

A) Chronic pain will lead to psychological imbalance.

B) Chronic pain has far-reaching effects on the client.

C) Chronic pain can be severe in its initial stages.

D) Chronic pain eases with healing and eventually disappears.

Ans: B

Feedback:

Chronic pain has far-reaching effects on the client because the discomfort lasts longer than six months. Chronic pain is not as severe in the initial stage as acute pain, but does not disappear eventually with pain medication. Chronic pain need not always lead to psychological imbalance.

22. A nurse is assessing a client with arthritis. Which of the following should the nurse consider in the initial assessment of the client?

A) Blood group

B) Anxiety level

C) Pain level

D) Glucose level

Ans: C

Feedback:

The nurse should first assess the client's pain level since the client has arthritis. Anxiety level, blood group, and glucose level are not vital signs which will help the nurse assess the client's pain during the initial assessment.

23. A nurse is caring for a client with acute back pain. When should the nurse assess the client's pain?

A) Six hours after administering a prescribed analgesic

B) After the client is discharged from the health care facility

C) Once per day when the pain is a potential problem

D) Whenever the vital signs are measured and documented

Ans: D

Feedback:

The nurse should assess the client's pain whenever the nurse measures and documents vital signs. When administering a prescribed analgesic, the nurse should assess pain before implementing a pain-management intervention, and again 30 minutes later. The nurse should assess the client's pain when the client is admitted to, not discharged from, the health care facility. Similarly, the nurse should assess pain once per shift when pain is an actual or potential problem.

24. A client has an order for a narcotic analgesic every three to four hours and he received his last dose three hours earlier. Which of the following actions is most appropriate for the nurse to take in response to the client's request for pain medication on his first postoperative day?

A) Provide the client with pain medication

B) Tell the client that the pain cannot be severe

C) Document and ask the client to wait one hour

D) Contact the physician for a change in medication

Ans: A

Feedback:

Inadequate or poor pain assessment is a leading factor in poor pain control, because the health care professional may not know a client has pain. The nurse must provide the next dose of pain medication.

25. Besides controlling pain of the post-abdominal surgery client with narcotics, the nurse suggests to the client that he …

A) focus on pain relief

B) use distraction

C) describe the pain

D) think about the next dose

Ans: B

Feedback:

Distraction is useful when clients are undergoing brief periods of sharp, intense pain, such as dressing changes, wound débridement, biopsy, or incident pain from shifting positions.

26. The Joint Commission supports the client's right to pain management, and published standards for assessment and management of pain in hospitals, ambulatory care settings, and home care settings (Joint Commission, 2008b). Which of the following are recommended guidelines for pain management? Select all that apply.

A) Teach all clients to use a pain rating scale.

B) Determine a pain-rating goal with each client.

C) Use pharmacologic pain relief measures first.

D) Manipulate factors that affect the pain experience.

E) Keep the primary care provider in charge of all pain relief measures.

Ans: A, B, D

Feedback:

The Joint Commission recommendations include teaching all clients to use a pain-rating scale and determining a pain-rating goal with each client. Nursing interventions to achieve this goal include establishing a trusting nurse–patient relationship; manipulating factors that affect the pain experience; initiating nonpharmacologic pain relief measures; managing pharmacologic interventions; reviewing additional pain control measures; ensuring ethical and legal responsibility to relieve pain; and educating the client about pain.

27. The nurse talks with a client who states, "My primary care provider wants me to try a TENS unit for my pain. How can electricity decrease my pain?" Which of the following responses is most appropriate?

A) "The mild electrical impulses block the pain signal before it can reach the brain."

B) "The electrode patches generate heat and decrease muscle tension."

C) "The machine tricks the mind into believing the pain does not exist."

D) "The electricity produces numbness and alters tissue sensitivity."

Ans: A

Feedback:

This statement explains the use of cold therapy for pain.

28. The nurse is caring for a client who is receiving morphine via a patient-controlled analgesia (PCA) pump. The nurse notes that the client's respiratory rate is 10 breaths per minute. The client is somnolent, with minimal response to physical stimulation. The nurse should prepare to administer which of the following medications?

A) Intravenous naloxone (Narcan)

B) Intravenous flumazenil (Romazicon)

C) Oral modafinil (Provigil)

D) Nebulized albuterol (Proventil)

Ans: A

Feedback:

Albuterol is a bronchodilator and not appropriate for this clinical situation.

29. The nurse has just completed programming of a patient-controlled analgesia (PCA) pump using prescribed parameters. Which of the following actions should you take next?

A) Verify the settings with another nurse.

B) Document implementation of the PCA on the client's chart.

C) Attach the PCA pump tubing to the client's intravenous access device.

D) Check the pump's electrical cords for cracks, splits, or fraying.

Ans: A

Feedback:

This action should be performed before programming is initiated.

30. A nurse is ordered to apply a transcutaneous electrical nerve stimulation (TENS) unit to a client recovering from abdominal surgery. Which of the following is a consideration when using this device?

A) TENS is an invasive technique for providing pain relief.

B) TENS involves the electrical stimulation of large-diameter fibers to inhibit the transmission of painful impulses carried over small-diameter fibers.

C) TENS is most beneficial when used to treat pain that is generalized.

D) A TENS unit is applied intermittently throughout the day and should not be worn for extended periods of time.

Ans: B

Feedback:

Transcutaneous electrical nerve stimulation (TENS) is a noninvasive technique for providing pain relief that involves the electrical stimulation of large-diameter fibers to inhibit the transmission of painful impulses carried over small-diameter fibers. It is most beneficial when the pain is localized and the unit can be worn for extended periods of time.

31. A nurse is assessing the vital signs of a client who is moaning due to the acute onset of pain. What would be the expected objective findings?

A) Decreased pulse and respirations

B) Increased pulse and blood pressure

C) Increased temperature

D) No change from client's norms

Ans: B

Feedback:

A client who is in acute pain will most often also have an increased pulse and blood pressure.

32. A nurse is assessing a mentally challenged, adult client who is in pain after a fall. Which of the following scales should the nurse use to assess the client's pain?

A) Pain Assessment in Advanced Dementia (PAINAD)

B) Wong-Baker Faces scale

C) Linear Scale

D) Numeric Scale

Ans: A

Feedback:

The nurse should use the Pain Assessment in Advanced Dementia (PAINAD) scale, which was developed for cognitively impaired clients. The Wong-Baker FACES scale is best for children and clients who are culturally diverse. Nurses generally use a numeric scale, a word scale, or a linear scale to quantify the pain intensity of adult clients who can express their pain intensity in words, numbers, or linear fashion with the help of the respective scales.

33. The nurse is caring for a client with terminal bone cancer. The client states, My pain is getting worse and worse, and the morphine doesn't help anymore. The nurse determines the client's pain is which of the following?

A) Acute

B) Chronic malignant

C) Diffuse

D) Intractable

Ans: D

Feedback:

Chronic malignant pain is acute pain episodes, persistent chronic pain, or both, associated with a progressive malignant-type process.

34. A nurse asks a client to rate his pain on a scale of 0 to 10, with 0 being no pain and 10 being worst pain. What characteristic of pain is the nurse assessing?

A) Duration

B) Location

C) Chronology

D) Intensity

Ans: D

Feedback:

When a nurse asks a client to rate his pain on a scale of 0 to 10, the intensity of the pain is being assessed. Duration is how long the pain has lasted, and location is the site of the pain.

35. A mother calls the nurse practitioner to say, “I don’t know what is wrong with my baby. He cried all night and kept pulling at his ear.” How would the nurse respond?

A) “Oh, he probably was just hungry and wet. Did you feed him?”

B) “Babies at that age cry at night. Think nothing of it.”

C) “That means his ear hurt. Bring him in to be checked.”

D) “That probably means he had a tummy ache. How is he now?”

Ans: C

Feedback:

Pain is frustrating for children because they are unable to understand the concept and cause of pain, and may have difficulty describing it. Crying and touching/grabbing the painful body part are observations that may indicate pain in a child.

Chapter 36, Nutrition

1. A dietitian is providing an in-service for the nurses on a medical-surgical unit. During the in-service, she informs the group that there are six classes of nutrients, and three supply the body with energy. What are the three sources of energy?

A) Carbohydrates, protein, and lipids

B) Vitamins, minerals, and water

C) Carbohydrates, protein, and water

D) Lipids, vitamins, and minerals

Ans: A

Feedback:

Of the six classes of nutrients, three supply energy (carbohydrates, protein, and lipids), and three are needed to regulate body processes (vitamins, minerals, and water).

2. In planning to meet the nutritional needs of a critically ill client in the intensive care unit, which factor will increase the client’s basal metabolic rate?

A) Infection

B) Advanced age

C) Prolonged fasting

D) Long periods of sleep

Ans: A

Feedback:

Factors that increase a person’s basal metabolic rate (BMR) include growth, infections, fever, emotional tension, extreme environmental temperatures, and elevated levels of certain hormones (epinephrine and thyroid hormones). Aging, prolonged fasting, and sleep all decrease BMR.

3. A client is interested in losing 15 pounds, and she informs the nurse she is counting her calorie intake each day. The client has a goal of losing one pound a week until she reaches her goal. The client asks the nurse how many calories she should decrease daily to lose a pound a week. What is the nurse’s best response?

A) 500 calories/day

B) 200 calories/day

C) 300 calories/day

D) 400 calories/day

Ans: A

Feedback:

To lose 1 pound (0.45 kg) in a week, daily calorie intake should be decreased by 500 calories a day. One pound of body fat equals about 3,500 calories; 3,500 calories divided by 7 days = 500 calories/day.

4. The nurse caring for a client for several days has assessed that he has been eating poorly during his hospitalization. Which nursing measure should the nurse implement to assist the client in improving his nutritional intake?

A) Encourage his daughter to prepare food at home and bring it to the client.

B) Serve large meals and encourage the client to eat as much as possible.

C) Provide distractions while the client is fed so that he will eat more.

D) Provide bland meals.

Ans: A

Feedback:

The nurse should solicit food preferences and encourage favorite foods from home, when possible. Be sure the foods look attractive and the eating area is free of odors, clutter, and distractions during mealtime. Provide small, frequent meals to avoid overwhelming the client with large amounts of food.

5. Which of the following nutritional guidelines should a nurse provide to a client who is entering the second trimester of her pregnancy?

A) "You'll need to eat more calories and to make sure you eat a balanced diet high in nutrients."

B) "Try to eat your normal number of calories, but aim to eat a diet that's higher in fruits and vegetables."

C) "The more food energy you consume, the greater the chances that you will have a healthy pregnancy."

D) "Maintain your regular calorie intake, but take some supplements and emphasize organic foods."

Ans: A

Feedback:

Nutrient needs during pregnancy increase to support growth and maintain maternal homeostasis, particularly during the second and third trimesters. During the last two trimesters, women of normal weight need approximately 300 extra calories per day. Key nutrient needs include protein, calories, iron, folic acid, calcium, and iodine. It would be inaccurate to encourage the client to maximize calorie intake.

6. The nurse is testing the blood glucose levels of a client with a history of diabetes. The nurse has performed hand hygiene, checked the order, informed the client and turned on the monitor. After removing a test strip from the vial, the nurse should do which of the following?

A) Confirm that the strip and the meter share the same code.

B) Massage the client's finger toward the selected puncture site.

C) Cleanse the client's finger with alcohol.

D) Pierce the client's skin with the lancet.

Ans: A

Feedback:

It is important to confirm that the code on the strip and the meter match. This should precede massaging and cleansing the client's finger or piercing his/her skin.

7. A client is discussing weight loss with a nurse. The patient says, "I will not eat for two weeks, then I will lose at least 10 pounds." What should the nurse tell the client?

A) "What a good idea. Go ahead. That will jump start your weight loss!"

B) "Many people find that to be an ideal way to lose weight quickly and easily."

C) "That will increase your metabolic rate and help you lose weight."

D) "That will decrease your metabolic rate and make weight loss more difficult."

Ans: D

Feedback:

Most nutritionists agree that fasting or following a very low-calorie diet defeats a weight-loss plan because the body interprets this eating pattern as starvation, and compensates by slowing down the basal metabolic rate, making it even more difficult to lose weight.

8. Which client will have an increased metabolic rate and require nutritional interventions?

A) A healthy young adult who works in an office

B) A retired person living in a temperate climate

C) A person with a serious infection and fever

D) An older, sedentary adult with painful joints

Ans: C

Feedback:

Factors that increase metabolic rate include growth, infections, fever, emotional tension, extreme environmental temperatures, and elevated levels of some hormones. Aging, prolonged fasting, and sleep decrease metabolic rate.

9. A nurse is helping a client design a weight-loss diet. To lose one pound of fat (3,500 calories) per week, how many calories should be decreased each day?

A) 100

B) 250

C) 500

D) 1,000

Ans: C

Feedback:

One pound of body fat equals about 3,500 calories. To gain or lose one pound in a week, daily calorie intake should be reduced by 500 calories per day (3,500 calories divided by 7 = 500 calories per day).

10.	A hospitalized client has been NPO with only intravenous fluid intake for a prolonged period. What assessments might indicate protein-calorie malnutrition?
A)	Fever, joint pain, dehydration
B)	Poor wound healing, apathy, edema
C)	Sleep disturbances, anger, increased output
D)	Weight gain, visual deficits, erythema of skin
Ans:	B
	Feedback:
	The stress of illness, surgery, or prolonged periods of time on simple intravenous therapy without oral intake places hospitalized clients at risk for developing protein-calorie malnutrition. This can result in weakness, poor wound healing, mental apathy, and edema.
11.	How often would a nurse recommend a client eat or drink a source of vitamin C?
A)	Once a week
B)	Once a month
C)	Three times a week
D)	Every day
Ans:	D
	Feedback:
	Vitamin C, a water-soluble vitamin, is usually not stored in the body. Deficiency symptoms are apt to develop quickly when intake is inadequate; a daily intake is recommended.
12.	While reviewing an adult client's chart, a nurse notes average daily intake of fluids as 2,000 mL/day. What will the nurse do based on this information?
A)	Change the plan of care to include forcing fluids.
B)	Ask the client to drink more water during the day.
C)	Post a sign limiting fluids to 1,000 mL every 24 hours.
D)	Continue with care; this is a normal fluid intake.
Ans:	D
	Feedback:
	Water intake averages 2,000 to 2,500 mL/day for adults. The nurse would continue with care, because the client has a normal fluid intake.
13.	A nurse has documented that a client has anorexia. What does this term mean?
A)	Eating more than daily requirements
B)	Lack of appetite
C)	Vitamin C deficiency
D)	Fluid deficit

Ans: B

Feedback:

Anorexia is lack of appetite. It may be related to multiple factors, including diseases, psychosocial causes, impaired ability to chew and taste, or inadequate income.

14. A nurse is discussing infant care with a woman who just had a baby girl. What type of nutrition would the nurse recommend for the infant?

A) Solid foods after the first month

B) No solid foods until age 1 year

C) Bottle feeding with cow's milk

D) Breast-feeding or formula with iron

Ans: D

Feedback:

Nutritional needs per unit of weight are greater in infants than at any other time in the life cycle. Breast-feeding or a commercial formula with iron is recommended as the major source of nutrition for the first 6 to 12 months of life. Cow's milk is not recommended for infants under 1 year. Solid foods are usually not introduced until 6 months.

15. What information do anthropometric measurements provide in adults?

A) Indirect measure of protein and fat stores

B) Direct measure of degree of obesity

C) Indication of degree of growth rate

D) Reflection of social interaction with others

Ans: A

Feedback:

Anthropometric measurements are used to determine body dimensions. In children, they are used to assess growth rate; in adults, they give indirect measurements of body protein and fat stores.

16. What independent nursing intervention can be implemented to stimulate appetite?

A) Administer prescribed medications.

B) Recommend dietary supplements.

C) Encourage or provide oral care.

D) Assess manifestations of malnutrition.

Ans: C

Feedback:

There are many methods of stimulating appetite in a client to prevent malnutrition. One independent nursing intervention that is useful is to encourage or provide oral care.

17. A nurse is feeding a client. Which of the following statements would help a person maintain dignity while being fed?

A) "I am going to feed you your cereal first, and then your eggs."

B) "I wish I had more time so I could feed you all of your meal."

C) "I know you don't like me to feed you, but you need to eat."

D) "What part of your dinner would you like to eat first?"

Ans: D

Feedback:

The loss of independence that comes with the inability to self-feed can be a severe blow to a person's self-esteem. Asking the person his or her preference regarding the order of items eaten can help maintain dignity while being fed.

18. A client has been prescribed a clear liquid diet. What food or fluids will be served?

A) Milk, frozen dessert, egg substitutes

B) High-calorie, high-protein supplements

C) Hot cereals, ice cream, chocolate milk

D) Jell-O, carbonated beverages, apple juice

Ans: D

Feedback:

Clear liquid diets contain only foods that are clear liquids at room or body temperature. Included are gelatin, fat-free broth, bouillon, ice pops, clear juices, carbonated beverages, regular and decaffeinated coffee, and tea. A full liquid diet includes all fluids and foods that become liquid at room temperature. This would include ice cream, chocolate milk, and liquid dietary supplements.

19. What is the route of administration for TPN?

A) Oral

B) Subcutaneous

C) Intramuscular

D) Intravenous

Ans: D

Feedback:

TPN meets the client's nutritional needs by way of nutrient-filled solutions administered intravenously through a central line, usually the subclavian or internal jugular veins.

20. A nurse is caring for a client with a history of cardiac and vascular disease. Which of the following fats should the nurse allow in the client's diet for his condition?

A) Unsaturated fats

B) Trans fats

C) Saturated fats

D) Hydrogenated fats

Ans: A

Feedback:

Unsaturated fat is a healthier form of fat than saturated fat, because it contains less hydrogen, and therefore can be included in the client's diet. Saturated fats are lipids that contain as much hydrogen as their molecular structure can hold, and are generally solid. Most saturated fats are found in animal sources, such as the marbled fat in meat. Saturated fats are responsible for cardiac and vascular diseases. Trans fats are unsaturated fats that have been hydrogenated, a process in which hydrogen is added to the fat. Consumption of trans fats, saturated fats, and hydrogenated fats increases the risk of coronary heart disease.

21. A client visits a health care facility with complaints of loss of appetite following a prolonged illness. How should the nurse document the client's condition?

A) Emaciation

B) Cachexia

C) Anorexia

D) Nausea

Ans: C

Feedback:

The nurse should document the loss of appetite following prolonged illness as anorexia. Emaciation is excessive leanness. Cachexia is the general wasting away of body tissue. Nausea usually precedes vomiting and is associated with gastrointestinal sensations.

22. A nurse is caring for a client with excessive abdominal fat. Which of the following is a risk associated with excessive abdominal fat about which the nurse should inform the client?

A) Emaciation

B) Cachexia

C) Cardiovascular disease

D) Anorexia

Ans: C

Feedback:

Excess abdominal fat may lead to cardiovascular disease, hypertension, and diabetes. Anorexia is the loss of appetite. Emaciation is characterized by excessive leanness. Cachexia is the general wasting away of body tissue.

23. A nurse is caring for a young adult female client who has a folic acid defiency. When teaching the client about this condition, the nurse would include a discussion about the client's increased risk for which of the following?

A) Neural tube deficits in the fetus

B) Inadequate absorption of calcium and phosphorus

C) Hemolysis of red blood cells

D) Impaired neuromuscular functioning

Ans: A

Feedback:

Folic acid deficiency in pregnant women can lead to neural tube deficits like spina bifida in the fetus. Because fetal neural development begins so early in pregnancy, women in their childbearing years must have adequate folic acid intake. Deficiency in vitamin D intake leads to inadequate absorption of calcium and phosphorus, and a deficiency of

mineralization in bones and teeth. Increased hemolysis of red blood cells, poor reflexes, impaired neuromuscular functioning, and anemias are signs of vitamin E deficiency, not folic acid deficiency.

24. To promote health of the fetus, the nurse should instruct the woman in the first trimester of pregnancy to do which of the following?

A) Eliminate high-fiber foods

B) Eat foods high in folic acid

C) Consume saturated fats

D) Consume milk products in the last trimester

Ans: B

Feedback:

Folic acid deficiency in pregnant women can lead to neural tube deficits in the fetus. Women during pregnancy may experience constipation. Increased fiber intake is recommended. Saturated fats are to be eaten only in moderation. Milk products are important during the entire pregnancy.

25. A nurse researching a diet for a client with diabetes includes foods that supply energy to the body. Which of the following are classes of nutrients that supply this energy? Select all that apply.

A) Vitamins

B) Proteins

C) Fats

D) Minerals

E) Carbohydrates

Ans: B, C, E

Feedback:

Of the six classes of nutrients, three supply energy (carbohydrates, proteins, lipids [fats]) and three are needed to regulate body processes (vitamins, minerals, water).

26. Which of the following factors increase BMR? Select all that apply.

A) Growth

B) Infections

C) Fever

D) Emotional tension

E) Aging

Ans: A, B, C, D

Feedback:

Factors that increase BMR include growth, infections, fever, emotional tension, extreme environmental temperatures, and elevated levels of certain hormones, especially epinephrine and thyroid hormones. Aging, prolonged fasting, and sleep all decrease BMR.

27. Which of the following are signs and symptoms of poor nutritional status?

A) Flaky facial skin, facial edema, pale skin color

B) Tongue is a deep red in color with surface papillae present.

C) Firm, pink nailbeds

D) Firm hair that is resistant to plucking

Ans: A

Feedback:

Healthy skin is uniform in color and not swollen.

28. Which of the following laboratory results indicates the presence of malnutrition?

A) Serum albumin 2.8 g/dL

B) Hemoglobin (Hgb) 11.3 g/dL

C) Creatinine 1.9 mg/dL

D) Hematocrit (Hct) 56%

Ans: A

Feedback:

Increased Hct indicates dehydration.

29. A nutritionist helps to plan a diet for a client with diabetes. Which of the following foods is a carbohydrate that should be included to help improve glucose tolerance?

A) Milk

B) Eggs

C) Oatmeal

D) Nuts

Ans: C

Feedback:

Oatmeal is a water-soluble carbohydrate that helps improve glucose tolerance in diabetics. Milk, eggs, and nuts are proteins.

30. A nurse calculates the BMI of a client during a general survey as 26. Under which of the following categories would this client fall?

A) Underweight

B) Normal

C) Overweight

D) Obesity Class I

Ans: C

Feedback:

BMI values are: Underweight <18.5; normal 18.5 to 24.9; overweight 25.0 to 29.9; obesity class I 30.0 to 34.9; obesity class II 35.0 to 39.9; and extreme obesity 40.0+.

31. A nurse is caring for a client with complaints of chest pain. Which of the following test results would indicate whether the client is at risk for cardiac disease?

A) Test results of levels of unsaturated fats

B) Test results for dyslipidemia

C) Test results of levels of balanced proteins

D) Test results of levels of calories in each food intake

Ans: B

Feedback:

Health care providers test for dyslipidemia to assess clients' risks for cardiovascular disease. Measuring levels of protein, calories, or unsaturated fats will not help to assess if a client is at risk for cardiac and vascular disease.

32. For which of the following clients should the nurse anticipate the need for a pureed diet?

A) A man whose stroke has resulted in difficulty swallowing

B) A woman who has required gallbladder surgery

C) A man with dementia who is unable to follow instructions

D) An obese woman after bariatric surgery

Ans: A

Feedback:

Pureed diets are indicated for clients who have significant problems chewing and/or swallowing. Surgery and confusion are not indications for this change in the texture and consistency of food.

33. A nurse performing a nutritional assessment determines that the BMI of a 5'11" (1.8 meters) male client who weighs 81 kilograms is which of the following?

A) 25.1

B) 18.5

C) 20.3

D) 28.6

Ans: A

Feedback:

The formula for calculating BMI is (body weight in kilograms) divided by (body height in meters squared). (weight in kg) (height in meters) * (height in meters)

34. Most nutritionists recommend increasing fiber in the diet. In addition to other benefits, how does fiber affect cholesterol?

A) Increases fecal excretion of cholesterol

B) Decreases fecal excretion of cholesterol

C) Facilitates intake and use of trans fat

D) Raises blood cholesterol levels

Ans: A

Feedback:

To help lower serum cholesterol levels, researchers recommend limiting cholesterol intake, eating less total fat, eating more unsaturated fat, and increasing fiber intake. Fiber increases fecal excretion of cholesterol.

The nurse prepares to administer an intermittent feeding to a client who has a nasogastric feeding tube. Arrange the following steps in the correct order

1. Verify correct tube placement.

2. Position client with head of bed elevated 30 to 45° degrees

3. Aspirate all gastric contents.

4. Flush tube with 30 mL water.

5. Verify that residual volume is less than 400 mL.

35. 6. Administer feeding.

A) 1, 2, 3, 4, 5, 6

B) 2, 1, 3, 5, 4, 6

C) 2, 3, 1, 4, 6, 5

D) 1, 3, 2, 4, 5, 6

E) 1, 4, 2, 3, 5, 6

Ans: B

Feedback:

The correct order for administering an intermittent feed to a client who has a nasogastric feeding tube is (1) Position client with head of bed elevated 30 to 45° degrees; (2) Verify correct tube placement; (3) Aspirate all gastric contents; (4) Verify that residual volume is less than 400 mL; (5) Flush tube with 30 mL water; and (6) Administer feeding.

Chapter 37, Urinary Elimination

1. During a visit to the pediatrician's office, a parent inquires about toilet training her daughter age 2 years. The nurse informs the mother that one factor in determining toilet-training readiness is when …

A) the child can recognize bladder fullness.

B) the child can hold the urine for four to five hours.

C) The child cannot control urination until seated on the toilet.

D) The child ignores the desire to void.

Ans: A

Feedback:

Toilet training usually begins around ages 2 or 3 years. Toilet training should not begin until the child is able to hold urine for two hours, recognize the feeling of bladder fullness, communicate the need to void, and control urination until seated on the toilet.

2. A client with urine retention related to a complete prostatic obstruction requires a urinary catheter to drain the bladder. Which type of catheter is most appropriate for a client that has an obstructed urethra?

A) Suprapubic catheter

B) Indwelling urethral catheter

C) Intermittent urethral catheter

D) Straight catheter

Ans: A

Feedback:

A suprapubic catheter is used for long-term continuous drainage and is inserted through a small incision above the pubic area. Suprapubic bladder drainage diverts urine from the urethra when injury, stricture, prostatic obstruction, or abdominal surgery has compromised the flow of urine through the urethra.

3. A patient has developed edema in her lower legs and feet, prompting her physician to prescribe furosemide (Lasix), a diuretic medication. After the client has begun this new medication, what should the nurse anticipate?

A) Increased output of dilute urine

B) Increased urine concentration

C) A risk of urinary tract infections

D) Transient incontinence and increased urine production

Ans: A

Feedback:

Diuretics result in moderate to severe increases in the production of dilute urine. Concentration will decrease, not increase, and there is no accompanying risk of urinary tract infections. For some clients, this sudden increase in urine output may precipitate transient incontinence, but this remains an abnormal finding.

4. A nurse is preparing to catheterize a female client. What will the nurse consider when comparing the anatomy of the female urethra with that of the male urethra?

A) Has different innervation

B) No connection with bladder

C) Shorter in length

D) Longer in length

Ans: C

Feedback:

The anatomy of the urethra differs in males and females. The male urethra is about $5^1/_2$ to $6^1/_4$ inches (13.7 to 16.2 cm) long. The female urethra is about $1^1/_2$ to $2^1/_2$ inches (3.7 to 6.2 cm) long. This difference is important in terms of catheterization and risk for infection.

5. Which of the following describes the term micturition?

A) Emptying the bladder

B) Catheterizing the bladder

C) Collecting a urine specimen

D) Experiencing total incontinence

Ans: A

Feedback:

The process of emptying the bladder is known as urination, micturition, or voiding.

6. A nurse working in a community pediatric clinic explains the process of toilet training to mothers of toddlers. Which is a recommended guideline for initiating this training?

A) The child should be able to hold urine for four hours.

B) The child should be between 18 and 24 months old.

C) The child should be able to communicate the need to void.

D) The child does not need the desire to gain control of voiding.

Ans: C

Feedback:

Voluntary control of the urethral sphincters occurs between 18 and 24 months of age. However, many other factors are required to achieve conscious control of bladder function, and toilet training usually begins at about 2 to 3 years of age. Toilet training should not begin until the child is able to hold urine for two hours, recognize the feeling of bladder fullness, communicate the need to void, and control urination until seated on the toilet. The child's desire to gain control is also important.

7. A nurse is caring for older adult clients in an assisted-living facility. Which effect of aging should the nurse consider when performing a urinary assessment?

A) The diminished ability of the kidneys to concentrate urine may result in urinary tract infection.

B) Increased bladder muscle tone may reduce the capacity of the bladder to hold urine, resulting in frequency.

C) Decreased bladder contractility may lead to urine retention and stasis, which increase the likelihood of urinary tract infection.

D) Neuromuscular problems may result in the client finding urinary control too much trouble, resulting in incontinence.

Ans: C

Feedback:

Decreased bladder contractility may lead to urine retention and stasis, which increase the likelihood of urinary tract infection. The diminished ability of the kidneys to concentrate urine may result in nocturia (urination during the night). Decreased bladder muscle tone may reduce the capacity of the bladder to hold urine, resulting in increased frequency of urination. Neuromuscular problems, degenerative joint problems, alterations in thought processes, and weakness may interfere with voluntary control and the ability to reach a toilet in time. Individuals who view themselves as old, powerless, and neglected may cease to value voluntary control over urination, and simply find toileting too much bother no matter what the setting. Incontinence may be the result.

8. A nurse is assessing the urine output of a client with Parkinson's disease who is on levodopa. Which of the following is a common finding for a client on this medication?

A) The urine may be brown or black.

B) The urine may be blood-tinged.

C) The urine may be green or blue-green.

D) The urine may be orange or orange-red.

Ans: A

Feedback:

Levodopa (l-dopa), an antiparkinson drug, and injectable iron compounds can lead to brown or black urine. Anticoagulants may cause hematuria (blood in the urine), leading to a pink or red color. Diuretics can lighten the color of urine to pale yellow. Phenazopyridine (Pyridium), a urinary tract analgesic, can cause orange or orange-red urine.

9. A client tells the nurse, “Every time I sneeze, I wet my pants.” What is this type of involuntary escape of urine called?

A) Urinary incontinence

B) Urinary incompetence

C) Normal micturition

D) Uncontrolled voiding

Ans: A

Feedback:

The process of emptying the bladder is termed micturition, voiding, or urination. Sometimes increased abdominal pressure, such as occurs when sneezing or coughing, forces an involuntary escape of urine, especially in women because the urethra is shorter. Any involuntary loss of urine that causes such a problem is referred to as urinary incontinence.

10. During a health history interview, a male client tells the nurse that he does not feel that he completely empties his bladder when he voids. He has been diagnosed with an enlarged prostate. What is the name of this symptom?

A) Urinary incontinence

B) Urinary retention

C) Involuntary voiding

D) Urinary frequency

Ans: B

Feedback:

Urinary retention occurs when urine is produced normally but is not excreted completely from the bladder. Factors associated with urinary retention include medications, an enlarged prostate, or vaginal prolapse. Incontinence is involuntary loss of urine from the bladder. Retention is an accumulation of urine in the bladder. Frequency is voiding more often than usual.

11. A nurse is assessing the urine on a newborn’s diaper. What would be a normal assessment finding?

A) Scanty to no urine

B) Highly concentrated urine

C) Light in color and odorless

D) Dark in color and odorous

Ans: C

Feedback:

Infants are born with little ability to concentrate urine. An infant's urine is usually very light in color and without odor until about 6 weeks of age, when the nephrons are able to control reabsorption of fluids and effectively concentrate urine. Infants do not normally have scanty, highly concentrated, or dark and odorous urine.

12. An older woman who is a resident of a long-term care facility has to get up and void several times during the night. This can be the result of what physiologic change with normal aging?

A) Diminished kidney ability to concentrate urine

B) Increased bladder muscle tone causing urinary frequency

C) Increased bladder contractility causing urinary stasis

D) Decreased intake of fluids during daytime hours

Ans: A

Feedback:

Physiologic changes that accompany normal aging may affect urination in older adults. These changes include the diminished ability to concentrate urine that may result in nocturia (voiding during the night). Aging does not result in increased bladder muscle tone or increased bladder contractility. A decrease in fluid intake would not result in nocturia.

13. After surgery, a postoperative client has not voided for eight hours. Where would the nurse assess the bladder for distention?

A) Between the symphysis pubis and the umbilicus

B) Over the costovertebral region of the flank

C) In the left lower quadrant of the abdomen

D) Between ribs 11 and 12 and the umbilicus

Ans: A

Feedback:

When the bladder is distended with urine, it rises above the symphysis pubis and may reach to just below the umbilicus. The other choices are anatomically incorrect for assessing a distended bladder.

14. A nurse is delegating the collection of urinary output to an assistant. What should the nurse tell the assistant to do while measuring the urine?

A) Compare the amount of output with intake.

B) Use a clean measuring cup for each voiding.

C) Tell the client to wash the urethra before voiding.

D) Wear gloves when handling a client's urine.

Ans: D

Feedback:

Gloves are required when handling urine to prevent exposure to pathogenic microorganisms or blood that may be present in the urine. In addition, goggles are also worn if there is a concern of urine splashing.

15. A nurse has instructed a client at the clinic about collecting a specimen for a routine urinalysis. The client makes the following statements. Which one indicates a need for more teaching?

A) "I need to tell you that I am having my menstrual period."

B) "I will void into the specimen bottle you gave me."

C) "I will keep the toilet paper in the specimen."

D) "I will be sure that no stool is included in my urine."

Ans: C

Feedback:

Urine for a routine urinalysis does not have to be sterile. Ask the client to void into a clean receptacle and avoid contamination with stool. Note on the request form if a woman is having her menstrual period. Instruct clients not to put toilet paper into the urine because this makes analysis more difficult.

16. A student is collecting a sterile urine specimen from an indwelling catheter. How will the student correctly obtain the specimen?

A) Pour urine from the collecting bag.

B) Remove the catheter and ask the client to void.

C) Aspirate urine from the collecting bag.

D) Aspirate urine from the collection port.

Ans: D

Feedback:

When it is necessary to collect a urine specimen from a client with an indwelling catheter, it should always be obtained from the catheter itself using the special collection port.

17. A nurse is initiating a 24-hour urine collection for a client at home. What will be the first thing the nurse will ask the client to do at the beginning of the specimen collection?

A) Void and discard the urine.

B) Begin the collection at a specific time.

C) Add the first voiding to the specimen.

D) Keep the urine warm during collection.

Ans: A

Feedback:

The collection is initiated at a specific time, but the client is asked to void at that time and discard the urine from the first voiding. In most instances, a preservative is added to the collection bottle, or the collected urine is kept cold through refrigeration or putting it on ice.

18. An older adult woman has constant dribbling of urine. The associated discomfort, odor, and embarrassment may support which of the following nursing diagnoses?

A) Social Isolation

B) Impaired Adjustment

C) Defensive Coping

D) Impaired Memory

Ans: A

Feedback:

Urinary incontinence is a special problem for older adults who may have decreasing control over micturition, or find it more difficult to reach the toilet in time. The discomfort, odor, and embarrassment of urine-soaked clothing can greatly diminish a person's self-concept, causing him or her to feel like a social outcast.

19. A male client who has had outpatient surgery is unable to void while lying supine. What can the nurse do to facilitate his voiding?

A) Assist him to a standing position.

B) Tell him he has to void to be discharged.

C) Pour cold water over his genitalia.

D) Ask his wife to assist with the urinal.

Ans: A

Feedback:

Helping clients assume their usual voiding positions may be all that is necessary to resolve an inability to void. If male clients cannot void lying down, encourage them to void while standing at the bedside unless this is contraindicated.

20. A nurse is educating a client on the amount of water to drink each day. What is the recommended daily fluid intake for adults?

A) 1 to 2 (4-oz) glasses per day

B) 5 to 6 (6-oz) glasses per day

C) 8 to 10 (8-oz) glasses per day

D) 16 to 20 (12-oz) glasses per day

Ans: C

Feedback:

Adults with no disease-related fluid restrictions should drink 2,000 to 2,400 mL (8 to 10 8-oz glasses) of fluid daily. Monitor fluid intake for those that are high in caffeine, sodium, and sugar.

21. A nurse is carrying out an order to remove an indwelling catheter. What is the first step of this skill?

A) Deflate the balloon by aspirating the fluid.

B) Ask the client to take several deep breaths.

C) Tell the client burning may initially occur.

D) Wash hands and put on gloves.

Ans: D

Feedback:

Although all the steps listed are correct, the first step of any skill involving body fluids is to wash hands and don gloves.

22. A nurse has catheterized a client to obtain urine for measuring postvoid residual (PVR) amount. The nurse obtains 40 mL of urine. What should the nurse do next?

A) Report this abnormal finding to the physician.

B) Perform another catheterization to verify the amount.

C) Document this normal finding for postvoid residual.

D) Palpate the abdomen for a distended bladder.

Ans: C

Feedback:

A postvoid residual (PVR) urine measures the amount of urine remaining in the bladder after voiding. It can be measured by catheterization or a bladder scan. A PVR of less than 50 mL indicates adequate bladder emptying. The nurse would document this normal finding for PVR.

23. A nurse is inserting an indwelling urethral catheter. What type of supplies will the nurse need for this procedure?

A) A clean catheter and rubber gloves

B) A sterile catheterization kit or tray

C) Solutions to sterilize the urethra

D) Solutions to sterilize the vagina

Ans: B

Feedback:

The bladder is a sterile environment. The urethra and vagina cannot be sterilized. The equipment used for catheterization is usually prepackaged in a sterile disposable kit or tray.

24. A client has been taught how to do Kegel exercises. What statement by the client indicates a need for further information?

A) "I understand these will help me control stress incontinence."

B) "I know this is also called pelvic floor muscle training."

C) "I will do these 30 to 80 times a day for two months."

D) "I will contract the muscles in my abdomen and thighs."

Ans: D

Feedback:

Kegel exercises, or pelvic floor muscle training, are used to tone and strengthen the muscles that support the bladder. They can improve voluntary control of urination and thus improve or eliminate stress incontinence. The muscles to contract are the same ones used to stop urination midstream or control defecation. The client should not contract the muscles of the abdomen, inner thigh, or buttocks while doing Kegel exercises.

25. A man with urinary incontinence tells the nurse he wears adult diapers for protection. What risks should the nurse discuss with this client?

A) Public embarrassment

B) Skin breakdown and UTI

C) Inability to control urine

D) Odor and leakage

Ans: B

Feedback:

Clients frequently turn to absorbent products for protection when they are incontinent of urine and if they have not had this condition properly diagnosed and treated. When used improperly, such products may cause skin breakdown and place the client at risk for a UTI.

26. A school nurse is educating a class of middle-school girls on how to promote urinary system health. Which of the following statements by one of the girls indicates a need for more information?

A) "I will take showers rather than baths."

B) "I will wear underpants with cotton crotches."

C) "I will tell my parents if I have burning or pain."

D) "I will wipe back to front after going to the toilet."

Ans: D

Feedback:

Teaching about measures to promote urinary system health is a major nursing responsibility. Measures include drying the perineal area after urination or defecation from the front to the back (or from urethra to rectum).

27. A client is taking diuretics. What should the nurse teach the client about his urine?

A) Urinary output will be decreased.

B) Urinary output will be increased.

C) Urine will be a pale yellow color.

D) Urine may be brown or black.

Ans: C

Feedback:

Certain drugs cause the urine to change color. Diuretics can lighten the color of urine to pale yellow. The nurse should inform the client about this side effect of the medication.

28. A nurse is preparing a client for an invasive diagnostic procedure of the urinary system. What statement by the nurse would help reduce the client's anxiety?

A) "We do these procedures every day, so you don't need to worry."

B) "I have had this done to me, and it only hurt for a little while."

C) "Why are you so worried? Do you think you have a tumor?"

D) "Let me explain to you what they do during this procedure."

Ans: D

Feedback:

Various diagnostic procedures, typically performed in a hospital operating room or outpatient facility, are used to study the urinary system. Nurses are responsible for preparing the client and giving aftercare. Explaining the procedure helps reduce the client's anxiety.

29. A nurse is caring for a client who is being treated for bladder infection. The client complains to the nurse that he has been having difficulty voiding and feels uncomfortable. How should the nurse document the client's condition?

A) Anuria

B) Oliguria

C) Polyuria

D) Dysuria

Ans: D

Feedback:

The nurse could document the client's condition as dysuria, which is difficulty or discomfort when voiding. Dysuria is a common symptom of trauma to the urethra or bladder infection. Anuria means absence of urine or a volume of 100 mL or less in 24 hours. Oliguria indicates inadequate elimination of urine. Polyuria is the term used to indicate greater than normal urinary volume, and may accompany minor dietary variations.

30. A nurse uses a catheter to collect a sterile urine specimen from a client at a health care facility. If a catheter is required temporarily, which type of catheter should the nurse use?

A) Condom catheter

B) Urinary bag

C) Straight catheter

D) Retention catheter

Ans: C

Feedback:

The nurse should use a straight catheter to collect a sterile urine specimen from the client. A straight catheter is a urine drainage tube inserted but not left in place. It drains urine temporarily or provides a sterile urine specimen. Condom catheters are helpful for clients with urinary incontinence receiving care at home, because they are easy to apply. A urinary bag is more often used to collect urine specimens from infants. A retention catheter, also called an indwelling catheter, is left in place for a period of time.

31. A client with a urinary tract infection is to be discharged from the health care facility. After teaching the client about measures to prevent urinary tract infections, the nurse determines that the education was successful when the client states which of the following?

A) "I should take frequent bubble baths."

B) "I need to void after sexual intercourse."

C) "I should wipe from back to front after going to the bathroom."

D) "I need to wear pants that are snug fitting."

Ans: B

Feedback:

The client's statement about voiding after sexual intercourse to prevent urinary tract infection is accurate. Taking frequent bubble baths, wiping the perineum from back to front, and wearing snug fitting pants increases the risk of urinary tract infection. The client should avoid taking frequent bubble baths, using harsh soaps, and wearing tight-fitting pants because they can irritate the urethra. The client also should always wipe from front to back after urinary or fecal elimination.

32. A client is admitted to the health care facility with complaints of pain on urination that is secondary to a urinary tract infection (UTI). The nurse documents this finding as which of the following?

A) Polyuria

B) Dysuria

C) Nocturia

D) Hematuria

Ans: B

Feedback:

Dysuria means painful voiding. Pain is often associated with UTIs and is felt as a burning sensation duringurination. Polyuria is the formation and excretion of excessive amounts of urine in the absence of a concurrent increase in fluid intake. Voiding during normal sleeping hours is called nocturia. Hematuria refers to blood in the urine.

33. What is the micturition reflex?

A) The process of filtration beginning with the glomerulus

B) The act of bladder contraction and perceived need to void

C) The reabsorption of the substances the body wants to retain

D) The secretion of electrolytes that are harmful to the body

Ans: B

Feedback:

Several words are used to describe the process of excreting urine from the body, including urination, voiding, and micturition.

34. A nurse is using a bladder scanner to assess the bladder volume of a client with urinary frequency. In which of the following positions would the nurse place the client?

A) Supine

B) Sims’

C) High Fowler’s

D) Dorsal recumbent

Ans: A

Feedback:

Portable bladder ultrasound devices are accurate, reliable, and noninvasive devices used to assess bladder volume. Results are most accurate when the client is in the supine position during the scanning.

35. The home health nurse is caring for an older adult woman living alone at home who is incontinent of urine and changes her adult diaper daily. Which of the following nursing diagnoses is the most appropriate for this client?

A) Risk for activity intolerance

B) Risk for impaired skin integrity

C) Risk for infection

D) Risk for falls

Ans: B

Feedback:

A client who is incontinent, utilizes adult diapers, and only changes them daily is at Risk for Impaired Skin Integrity in the genital and perineal area.

Chapter 38, Bowel Elimination

1. The nursing instructor informs a student nurse that a client she is caring for has a chronic neurologic condition that decreases the client's peristalsis. What nursing diagnosis is the most likely risk for this client?

A) Constipation

B) Diarrhea

C) Deficient fluid volume

D) Excessive fluid volume

Ans: A

Feedback:

Peristalsis is defined as the contractions of the circular and longitudinal muscles of the intestine. Decreased peristalsis will result in constipation because the movement of the fecal mass will occur at a slower rate and more fluid will be absorbed in the colon.

2. During defecation, the client experiences decreased cardiac output related to the Valsalva maneuver. After the Valsalva maneuver, the nurse assesses the client's vital signs and expects to observe which of the following?

A) An increase in the client's blood pressure

B) A decrease in the client's blood pressure

C) An increase in the client's respiratory rate

D) A decrease in the client's respiratory rate

Ans: A

Feedback:

When an individual bears down to defecate, the increased pressures in the abdominal and thoracic cavities result in a decreased blood flow and a temporary decrease in cardiac output. Once the bearing down ceases, the pressure is lessened, and a larger than normal amount of blood returns to the heart; this act elevates the client's blood pressure.

3. While caring for an infant who is breast-fed, the nurse assesses the characteristics of the stools. What stool characteristics are expected in breast-fed infants?

A) Golden yellow and loose

B) Dark brown and firm

C) Yellow-brown and pasty

D) Green and mucusy

Ans: A

Feedback:

Breast-fed infants have more frequent stools, and the stools are yellow to golden, loose, and usually have little odor. With formula or cow's milk feedings, infants' stools vary from yellow to brown and are pasty in consistency.

4. Which type of stool would the nurse assess in a client with an illness that causes the stool to pass through the large intestine quickly?

A) Hard, formed

B) Black, tarry

C) Soft, watery

D) Dry, odorous

Ans: C

Feedback:

About 800 to 1,000 mL of liquid is absorbed daily by the large intestine. When absorption does not occur properly, such as when the waste products pass through the large intestine rapidly, the stool is soft and watery.

5. A nurse is assessing the stools of a breastfed baby. What is the appearance of normal stools for this baby?

A) Yellow, loose, odorless

B) Brown, paste-like, some odor

C) Brown, formed, strong odor

D) Black, semiformed, no odor

Ans: A

Feedback:

Breast-fed babies have more frequent stools, and the stools are yellow to golden and loose, usually with little odor. Breast-fed babies can normally have 2 to 10 stools per day.

6. A hospitalized toddler, previously bowel trained, has been having incontinent stools. What would the nurse tell the parents about this behavior?

A) "When he does this, scold him and he will quit."

B) "I don't understand why this child is losing control."

C) "This is normal when a child this age is hospitalized."

D) "I will have to call the doctor and report this behavior."

Ans: C

Feedback:

Discourage the use of punishment or shame for elimination accidents. Toddlers who are toilet trained often regress and experience soiling when hospitalized, and scolding or acting disgusted only reinforces the behavior.

7. A client is having difficulty having a bowel movement on the bedpan. What is the physiologic reason for this problem?

A) It is painful to sit on a bedpan.

B) The position does not facilitate downward pressure.

C) The position encourages the Valsalva maneuver.

D) The cause is unknown and requires further study.

Ans: B

Feedback:

Most people assume the squatting or slightly forward-sitting position with the thighs flexed to defecate. These positions result in increased pressure on the abdomen and downward pressure on the rectum to facilitate defecation. Obtaining the same results when seated on a bedpan is difficult.

8. The following foods are a part of a client's daily diet: high-fiber cereals, fruits, vegetables, 2,500 mL of fluids. What would the nurse tell the client to change?

A) Decrease high-fiber foods

B) Decrease amount of fluids

C) Omit fruits if eating vegetables

D) Nothing; this is a good diet

Ans: D

Feedback:

A high-fiber diet and a daily fluid intake of 2,500 to 3,000 mL of fluids facilitate bowel elimination. Intake of the foods described makes the feces more bulky, so they move through the intestine more quickly. The stool is softer and the time to absorb toxins is decreased (toxins are believed to have a role in the development of colon cancer).

9. A young woman comes to the emergency department with severe abdominal cramping and frequent bloody stools. Food poisoning is suspected. What diagnostic test would be used to confirm this diagnosis?

A) Routine urinalysis

B) Chest x-ray

C) Stool sample

D) Sputum sample

Ans: C

Feedback:

Outbreaks of food poisoning can result in severe gastrointestinal symptoms. Severe abdominal cramping followed by watery or bloody diarrhea may signal a microbial infection, which can be confirmed by a stool sample.

10. A nurse is conducting an abdominal assessment. What is the rationale for palpating the abdomen last in the sequence when conducting an abdominal assessment?

A) It is the most painful assessment method

B) It is the most embarrassing assessment method

C) To allow time for the examiner's hands to warm

D) It disturbs normal peristalsis and bowel motility

Ans: D

Feedback:

The sequence for abdominal assessment is inspection, auscultation, percussion, and palpation. Inspection and auscultation are performed before palpation because palpation may disturb normal peristalsis and bowel motility.

11. What are two essential techniques when collecting a stool specimen?

A) Hand hygiene and wearing gloves

B) Following policies and selecting containers

C) Wearing goggles and an isolation gown

D) Using a no-touch method and toilet paper

Ans: A

Feedback:

Use of medical aseptic techniques when collecting a stool specimen is imperative. Hand hygiene, before and after wearing rubber gloves, is essential.

12. What is occult blood?

A) Bright red visible blood

B) Dark black visible blood

C) Blood that contains mucus

D) Blood that cannot be seen

Ans: D

Feedback:

Occult blood in the stool is blood that is hidden in the specimen or cannot be seen on gross examination. It can be detected with simple screening tests, such as a Hematest.

13. A nurse is scheduling diagnostic studies for client. Which test would be performed first?

A) Fecal occult blood test

B) Barium study

C) Endoscopic exam

D) Upper gastrointestinal series

Ans: A

Feedback:

Nurses are commonly involved in scheduling diagnostic studies when a client is to undergo multiple studies. They should follow a logical sequence when more than one test is required for accurate diagnosis; that is, fecal occult blood tests to detect gastrointestinal bleeding; barium studies to visualize gastrointestinal structures and reveal any inflammation, ulcers, tumors, strictures, or other lesions; and endoscopic examinations to visualize an abnormality, locate a source of bleeding, and if necessary, provide biopsy tissue samples.

14. A client has had frequent watery stools (diarrhea) for an extended period of time. The client also has decreased skin turgor and dark urine. Based on these data, which nursing diagnosis would be appropriate?

A) Imbalanced Nutrition: Less than Body Requirements

B) Deficient Fluid Volume

C) Impaired Tissue Integrity

D) Impaired Urinary Elimination

Ans: B

Feedback:

Bowel elimination problems may also affect other areas of human functioning. For example, excessive diarrhea causes loss of body fluid, with resulting decreased skin turgor and concentrated urine. Deficient Fluid Volume is an appropriate nursing diagnosis based on the data.

15. An infant has had diarrhea for several days. What assessments will the nurse make to identify risks from the diarrhea?

A) Heart tones

B) Lung sounds

C) Skin turgor

D) Activity level

Ans: C

Feedback:

When infants and children become ill, they lose most fluids from their extracellular compartment, which quickly leads to dehydration. The nurse would assess skin turgor to identify this problem.

16. A client tells the nurse that he takes laxatives every day but is still constipated. The nurse's response is based on:

A) Habitual laxative use is the most common cause of chronic constipation.

B) If laxatives are not effective, the client should begin to use enemas.

C) A laxative that works by a different method should be used.

D) Chronic constipation is nothing to be concerned about.

Ans: A

Feedback:

Occasional use of laxatives is not harmful for most people, but they should not become dependent on them. Although many people do take laxatives because they believe they are constipated, most are unaware that habitual use of laxatives is the most common cause of chronic constipation.

17. A client who has been on a medication that caused diarrhea is now off the medication. What could the nurse suggest to promote the return of normal flora?

A) Stool-softening laxatives, such as Colace

B) Increasing fluid intake to 3,000 mL/day

C) Drinking fluids with a high sugar content

D) Eating fermented products, such as yogurt

Ans: D

Feedback:

Some medications, such as antibiotics, may destroy normal intestinal flora and cause diarrhea. To promote the return of normal flora, the nurse can recommend an intake of fermented dairy products, such as buttermilk or yogurt.

18. A client is on bedrest, and an enema has been ordered. In what position should the nurse position the client?

A) Fowler's

B) Sims'

C) Prone

D) Sitting

Ans: B

Feedback:

A reclining position on the left side (Sims' position) is recommended. The head may be slightly elevated, but Fowler's position should be avoided because the solution will remain in the rectum and expulsion will occur rapidly, resulting in minimal cleansing.

19. Which is an expected outcome for a client undergoing a bowel training program?

A) Have a soft, formed stool at regular intervals without a laxative.

B) Continue to use laxatives, but use one less irritating to the rectum.

C) Use oil-retention enemas on a regular basis for elimination.

D) Have a formed stool at least twice a day for two weeks.

Ans: A

Feedback:

Clients who have chronic constipation and impaction, and those who are incontinent of stool, may benefit from a bowel training program. The purpose of this program is to manipulate factors within the client's control (such as exercise or fluid intake) to produce the elimination of a soft, formed stool at regular intervals without a laxative.

20. A client tells the nurse, "I increased my fiber, but I am very constipated." What further information does the nurse need to tell the client?

A) "Just give it a few more days and you should be fine."

B) "Well, that shouldn't happen. Let me recommend a good laxative for you."

C) "When you increase fiber in your diet, you also need to increase liquids."

D) "I will tell the doctor you are having problems; maybe he can help."

Ans: C

Feedback:

A combination of high-fiber foods, 8 to 10 glasses of water a day, and exercise has been shown to be as effective as medications in controlling constipation. Caution the client to avoid increasing fiber intake without drinking enough fluids because this can lead to a bowel obstruction.

21. A nurse is documenting the appearance of feces from a client with a permanent ileostomy. Which of the following would she document?

A) "Ileostomy bag half filled with liquid feces."

B) "Ileostomy bag half filled with hard, formed feces."

C) "Colostomy bag intact without feces."

D) "Colostomy bag filled with flatus and feces."

Ans: A

Feedback:

The client with an ileostomy (temporary or permanent) has an opening into the small intestine. Because feces do not reach the large intestine, water is not absorbed, and the feces will be liquid.

22. A nurse is assessing the stoma of a client with an ostomy. What would the nurse assess in a normal, healthy stoma?

A) Pallor

B) Purple-blue

C) Irritation and bleeding

D) Dark red and moist

Ans: D

Feedback:

The ostomy stoma should be dark pink to red and moist. Abnormal findings include paleness (possible anemia), purple-blue color (possible ischemia), or bleeding.

23. A nurse is caring for a client who is postoperative Day 1 for a temporary colostomy. The nurse assesses no feces in the collection bag. What should the nurse do next?

A) Notify the physician immediately.

B) Ask another nurse to check her findings.

C) Nothing; this is normal.

D) Recheck the bag in two hours.

Ans: C

Feedback:

Typically, a colostomy does not produce drainage or feces until normal peristalsis returns after surgery, usually within two to five days.

24. A nurse is providing discharge instructions for a client with a new colostomy. Which of the following is a recommended guideline for long-term ostomy care?

A) During the first six to eight weeks after surgery, eat foods high in fiber.

B) Drink at least two quarts of fluids, preferably water, daily.

C) Use enteric-coated or sustained-release medications if needed.

D) Use a mild laxative if needed.

Ans: B

Feedback:

During the first six to eight weeks after surgery, the nurse should encourage the client with an ostomy to avoid foods high in fiber (e.g., foods with skins, seeds, and shells) as well as any other foods that cause diarrhea or excessive flatus. By gradually adding new foods, the ostomy client can progress to a normal diet. The nurse should urge clients to drink at least two quarts of fluids, preferably water, daily. The use of liquid, chewable, or injectable forms rather than long-acting, enteric-coated, or sustained-release medications is recommended. Laxatives and enemas are dangerous because they may cause severe fluid and electrolyte imbalance.

25. A nurse is assessing a client with constipation and severe rectal pain. Which of the following actions should the nurse perform to determine the presence of fecal impaction?

A) Inserted a lubricated, gloved finger into the rectum.

B) Obtain a sharp intestinal x-ray.

C) Insert a lubricated rectal tube into the rectum.

D) Administer an oil retention enema into the rectum.

Ans: A

Feedback:

The nurse should insert a lubricated, gloved finger into the rectum to determine the presence of fecal impaction. Fecal impaction occurs when a large, hardened mass of stool interferes with defecation. Obtaining a sharp intestinal x-ray is not a good idea because the barium retained in the intestine causes fecal impaction. Insertion of a rectal tube and administration of an oil retention enema are measures used to remove hardened stool,

not assess it.

26. The nurse is assessing a client with abdominal complaints. The nurse performs deep palpation of the abdomen for which reason?

A) Detect abdominal masses

B) Determine abdominal firmness

C) Assess softness of abdominal muscles

D) Assess degree of abdominal distention

Ans: A

Feedback:

The purpose of the deep palpation is to detect abdominal masses. Light palpation of the abdomen helps to determine the firmness or softness of the abdominal muscles and the degree of abdominal distention.

27. A nurse is providing care to a client who has undergone a colonoscopy. Which of the following would be most appropriate for the nurse to do after the procedure?

A) Avoid giving solid food

B) Administer a laxative to the client

C) Monitor for rectal bleeding

D) Limit oral fluid intake

Ans: C

Feedback:

The nurse should monitor the client for rectal bleeding after a colonoscopy. The nurse should provide rest and offer food and fluids as allowed. The evening before the procedure, solid foods are avoided and liquids are encouraged. Laxatives are also given before the procedure.

28. During a home visit, the nurse learns that the client ensures a daily bowel movement with the help of laxatives. The client feels that deviation from a bowel movement every day is unhealthy. Which nursing diagnosis would the nurse most likely identify?

A) Constipation

B) Perceived constipation

C) Risk of constipation

D) Bowel incontinence

Ans: B

Feedback:

The most appropriate nursing diagnosis for the client is perceived constipation, because the client has made a self-diagnosis of constipation and ensures a daily bowel movement through the abuse of laxatives. Constipation may be diagnosed in a client if there is a decrease in the normal frequency of defecation accompanied by a difficult or incomplete passage of stool (and/or passage of excessively hard, dry stool). Risk of constipation can be diagnosed if a client exhibits factors that predispose him or her for developing constipation. Bowel incontinence would be indicated if the client was experiencing an involuntary passage of stool.

29. A young woman has just consumed a serving of ice cream pie and develops severe cramping and diarrhea. The school nurse suspects the woman is …

A) Allergic to sugar

B) Lactose intolerant

C) Experiencing infectious diarrhea

D) Deficient in fiber

Ans: B

Feedback:

Many people have difficulty digesting lactose (the sugar contained in milk products). The breakdown of lactose into its component sugars, glucose and galactose, requires a sufficient quantity of the enzyme lactase in the small intestine. If a person is lactose-deficient, alterations of bowel elimination, including formation of gas, abdominal cramping, and diarrhea, can occur after ingestion of milk products.

30. A nurse assesses the abdomen of a client before and after administering a small-volume cleansing enema. What condition would be an expected finding?

A) Increased bowel sounds

B) Abdominal tenderness

C) Areas of distention

D) Muscular resistance

Ans: A

Feedback:

The goal of a cleansing enema is to increase peristalsis, which should increase bowel sounds.

31. A physician orders a retention enema for a client to destroy intestinal parasites. Which of the following enemas would be indicated for this client?

A) Oil retention enema

B) Carminative enema

C) Anthelmintic enema

D) Nutritive enema

Ans: C

Feedback:

Anthelmintic enemas are administered to destroy intestinal parasites. Oil retention enemas help to lubricate the stool and intestinal mucosa, making defecation easier. Carminative enemas help to expel flatus from the rectum and relieve distention. Nutritive enemas are administered to replenish fluids and nutrition rectally.

32. A nurse is ordered to perform digital removal of stool on a client with stool impaction. Which of the following is an appropriate step in this procedure?

A) Position the client in supine position as dictated by client comfort and condition.

B) Insert generously lubricated finger gently into the anal canal, pointing away from the umbilicus.

C) Gently work the finger around and into the hardened mass to break it up and then remove pieces of it.

D) Instruct the client not to bear down while extracting feces to prevent vagal response.

Ans: C

Feedback:

For digital removal of stool: Position the client on the left side (Sims' position), as dictated by client comfort and condition. Generously lubricate index finger with water-soluble lubricant and insert finger gently into anal canal, pointing toward the umbilicus. Gently work the finger around and into the hardened mass to break it up and then remove pieces of it. Instruct the client to bear down, if possible, while extracting feces, which will ease in removal.

33. A nurse assessing a client with an ostomy appliance documents the condition "prolapse" in the client chart and notifies the physician. Which of the following statements describes this condition?

A) The peristomal skin is excoriated or irritated because the appliance is cut too large.

B) The system has leaks or poor adhesion leading to noticeable odor.

C) The bag continues to come loose and become inverted.

D) The stoma is protruding into the bag and may become twisted.

Ans: D

Feedback:

During prolapse, the stoma is protruding into the bag. The nurse should have the client rest for 30 minutes and, if stoma is not back to normal size within that time, notify the physician. If stoma stays prolapsed, it may twist, resulting in impaired circulation to the stoma.

34. A nurse is following a physician's order to irrigate the NG tube of a client. Which of the following is a recommended guideline in this procedure?

A) Assist client to 30- to 45-degree position, unless this is contraindicated.

B) Draw up 60 mL of saline solution (or amount indicated in the order or policy) into syringe.

C) If Salem sump or double-lumen tube is used, make sure that syringe tip is placed in the blue air vent.

D) If unable to irrigate the tube, reposition client and attempt irrigation again; inject 20 to 30 mL of air and aspirate again.

Ans: A

Feedback:

To irrigate an NG tube, assist the client to 30- to 45-degree position, unless this is contraindicated. Pour the irrigating solution into the container and draw up 30 mL of saline solution (or amount indicated in the order or policy) into syringe. If Salem sump or double-lumen tube is used, make sure that syringe tip is placed in the drainage port and not in the blue air vent. If unable to irrigate the tube, reposition the client and attempt irrigation again. Inject 10 to 20 mL of air and aspirate again.

Then nurse is preparing to apply a fecal incontinence pouch. Arrange the following steps in the correct order.

1. Cleanse entire perianal area and pat dry.

2. Apply skin protectant and allow it to dry.

3. Separate buttocks and apply the pouch to the anal area.

4. Attach the pouch to a urinary drainage bag.

35. 5. Hang the drainage bag below the patient.

A) 2, 3, 4, 5, 1

B) 3, 4, 5, 1, 2

C) 1, 2, 3, 4, 5

D) 5, 4, 3, 2, 1

Ans: C

Feedback:

A nurse would not be able to determine if the entire intestinal tract is clear

Chapter 39, Oxygenation and Perfusion

1. The nurse caring for a client with emphysema has determined that a priority nursing diagnosis for this client is "Imbalanced Nutrition: Less Than Body Requirements related to difficulty breathing while eating." Based upon this diagnosis, which of the following is an appropriate nursing intervention to include in the client's care plan?

A) Provide six small meals daily.

B) Provide three large meals daily.

C) Encourage the client to eat immediately before breathing treatments.

D) Encourage the client to alternate eating and using a nebulizer during meal time.

Ans: A

Feedback:

The nurse should consider providing six small meals distributed over the course of the day instead of three large meals. Meals should be eaten one to two hours after breathing treatments and exercises.

2. The nurse is developing a plan of care for a client admitted with pneumonia. The nurse has determined that a priority nursing diagnosis for this client is "Ineffective Airway Clearance related to copious and tenacious secretions." Based upon this nursing diagnosis, what is an appropriate nursing intervention to include in the client's care plan?

A) Encouraging the client to consume two to three quarts of clear fluids daily

B) Creating an environment that is likely to reduce anxiety

C) Positioning the client supine

D) Encouraging the client to decrease the number of cigarettes smoked daily

Ans: A

Feedback:

Clients can help keep their secretions thin by drinking two to three quarts (1.9 L to 2.9 L) of clear fluids daily. Although it is important to create an environment that is likely to reduce a client's anxiety, doing so will not assist in promoting airway clearance. The nurse should not encourage the client to decrease the number of cigarettes smoked daily, but should encourage the client to stop smoking. Proper positioning to ease respirations includes placing the client in a high-Fowler's position.

3. While the nurse is providing morning hygiene for a client who has a chest tube, the client has rolled over quickly and the chest tube has become disconnected from the drainage unit. How should the nurse first respond to this event?

A) Submerge the end of the tube in sterile water.

B) Clamp the tube near the end and also near the insertion point.

C) Place the end of the tube on a sterile surface and seek help promptly.

D) Clean the end of the tube with an alcohol swab and reconnect it to the drainage unit.

Ans: A

Feedback:

If a chest tube becomes disconnected from the drainage unit, the nurse should submerge the end of the tube in a bottle of sterile water, thus preventing a pneumothorax but still allowing air to escape.

4. A client has had a head injury affecting the brain stem. What is located in the brain stem that may affect respiratory function?

A) Chemoreceptors

B) Stretch receptors

C) Respiratory center

D) Oxygen center

Ans: C

Feedback:

The medulla in the brain stem, immediately above the spinal cord, is the respiratory center. Stretch receptors are located in muscles. Chemoreceptors that affect respirations are located in the aortic arch and the carotid bodies.

5. Which of the following diseases may result in decreased lung compliance?

A) Emphysema

B) Appendicitis

C) Acne

D) Chronic diarrhea

Ans: A

Feedback:

Lung compliance refers to the stretchability of the lungs, or the ease with which lungs can be inflated. Emphysema, a chronic lung disease, and the normal changes associated with aging are examples of conditions that result in decreased elasticity of lung tissue, which in turn decreases lung compliance.

6. A nurse is caring for a client with pneumonia. The client's oxygen saturation is below normal. What abnormal respiratory process does this demonstrate?

A) changes in the alveolar-capillary membrane and diffusion

B) alterations in the structures of the ribs and diaphragm

C) rapid decreases in atmospheric and intrapulmonic pressures

D) lower-than-normal concentrations of environmental oxygen

Ans: A

Feedback:

Any change in the surface area of the lungs hinders diffusion of gas exchange. Any disease or condition that results in changes in the alveolar-capillary membrane, such as pneumonia or pulmonary edema, makes diffusion more difficult, assessed by decreased oxygen saturation measurement.

7. In what age group would a nurse expect to assess the most rapid respiratory rate?

A) Older adults

B) Middle adults

C) Adolescents

D) Infants

Ans: D

Feedback:

The normal infant's chest is small and the airways are short. There are fewer and smaller alveoli in infants. As a result, the respiratory rate is more rapid in infants than any other age group.

8. A father of a preschool-age child tells the nurse that his child "has had a constant cold since going to daycare." How would the nurse respond?

A) "Your child must have a health problem that needs medical care."

B) "Children in daycare have more exposure to colds."

C) "Are you washing your hands before you touch the child?"

D) "Be sure and have your child wear a protective mask at school."

Ans: B

Feedback:

The preschool-age child's eustachian tubes, bronchi, and bronchioles are elongated and less angular. Thus, the average number of routine colds and infections increases when the child enters daycare or school and is exposed more frequently to pathogens.

9. A woman 90 years of age has been in an automobile crash and sustained four fractured ribs on the left side of her thorax. Based on her age and the injury, she is at risk for what complication?

A) Pneumonia

B) Altered thought processes

C) Urinary incontinence

D) Viral influenza

Ans: A

Feedback:

The normal changes in the respiratory system associated with aging (such as rigidity of tissues and airways and decreased movement of the diaphragm) coupled with fractured ribs would increase the risk of pneumonia in an older adult.

10. Which individual is at greater risk for respiratory illnesses from environmental causes?

A) A farmer on a large farm

B) A factory worker in a large city

C) A woman living in a small town

D) A child living in a rural area

Ans: B

Feedback:

Researchers have demonstrated a high correlation between air pollution and lung diseases, including cancer. Air pollution puts people with certain occupations, and those who live in large cities, at a greater risk for these diseases.

11. A nurse is beginning to conduct a health history for a client with respiratory problems. He notes that the client is having respiratory distress. What would the nurse do next?

A) Continue with the health history, but more slowly.

B) Ask questions of the family instead of the client.

C) Conduct the interview later and let the client rest.

D) Initiate interventions to help relieve the symptoms.

Ans: D

Feedback:

Before beginning the interview for a health history, the nurse should ascertain that the client is not in acute distress. If the client is experiencing any respiratory distress, the nurse immediately initiates interventions to help relieve symptoms.

12. An emergency room nurse is auscultating the chest of a child who is having an asthmatic attack. Auscultation reveals the presence of wheezes. During what part of respirations do wheezes occur?

A) Inspiration and expiration

B) Only on inspiration

C) Only on expiration

D) When coughing

Ans: A

Feedback:

Wheezes are continuous sounds heard on expiration and sometimes on inspiration. They originate as air passes through airways constricted by swelling (as in asthma), secretions, or tumors.

13. A client is experiencing hypoxia. Which of the following nursing diagnoses would be appropriate?

A) Anxiety

B) Nausea

C) Pain

D) Hypothermia

Ans: A

Feedback:

Clients who are hypoxic commonly experience anxiety and restlessness related to feelings of suffocation.

14. A nurse is caring for a toddler who is having an acute asthmatic attack with copious mucus and difficulty breathing. The child's skin is cyanotic, respirations are labored and rapid, and pulse is rapid. What nursing diagnosis would have priority for care of this child?

A) Anxiety

B) Ineffective Airway Clearance

C) Excess Fluid Volume

D) Disturbed Sensory Perception

Ans: B

Feedback:

The nursing diagnosis Ineffective Airway Clearance indicates the child is unable to clear secretions or obstructions from the respiratory tract to maintain a clear airway. Although the child is anxious, this is not the priority of care. The other two diagnoses are not supported by the data.

15. What information would a home care nurse provide to a client who is measuring peak expiratory flow rate at home?

A) "Although the test is uncomfortable, it is not painful."

B) "You will be asked to forcefully exhale into a mouthpiece."

C) "The test is used to determine how much air you inhale."

D) "You will do this each morning while still lying in bed."

Ans: B

Feedback:

Peak expiratory flow rate (PEFR) refers to the volume of air that can be forcibly exhaled. While sitting or standing, the client takes a deep breath and forcibly exhales through a mouthpiece. The client does this three times, and the highest number is recorded. Clients commonly measure PEFR at home to monitor airflow when they have conditions such as asthma.

16. What does pulse oximetry measure?

A) Cardiac output

B) Peripheral blood flow

C) Arterial oxygen saturation

D) Venous oxygen saturation

Ans: C

Feedback:

Pulse oximetry is a noninvasive technique that measures the oxygen saturation of arterial blood. The normal range is 95% to 100%. It does not measure cardiac output, peripheral blood flow, or venous oxygen saturation.

17. Of all factors, what is the most important risk factor in pulmonary disease?

A) Air pollution from vehicles

B) Dangerous chemicals in the workplace

C) Active and passive cigarette smoke

D) Loss of the ozone layer of the atmosphere

Ans: C

Feedback:

The effects of both active and passive cigarette smoke increase airway resistance, reduce ciliary action, increase mucus production, and thicken alveolar-capillary membranes and bronchial walls. Cigarette smoke is the most important risk factor in pulmonary disease.

18. A nurse is caring for a client who suddenly begins to have respiratory difficulty. In what position would the nurse place the client to facilitate respirations?

A) Supine

B) Prone

C) High-Fowler's

D) Dorsal recumbent

Ans: C

Feedback:

During inspiration, the diaphragm contracts and descends, lengthening the thoracic cavity. This movement isfacilitated by a high-Fowler's position in which the abdominal contents move downward, providing more room for the descent of the diaphragm and greater lung expansion.

19. A nurse is educating a preoperative client on how to effectively deep breathe. Which of the following would be included?

A) "Make each breath deep enough to move the bottom ribs."

B) "Breathe through the mouth when you inhale and exhale."

C) "Breathe in through the mouth and out through the nose."

D) "Practice deep breathing at least once each week."

Ans: A

Feedback:

Instruct the client to make each breath deep enough to move the bottom ribs. Start with deep breaths by inhaling through the nose and exhaling through the mouth. Deep breathing should be done hourly when awake, or four times a day.

20. A nurse is educating a home care client on how to do pursed-lip breathing. What is the therapeutic effect of this procedure?

A) Using upper chest muscles more effectively

B) Replacing the use of incentive spirometry

C) Reducing the need for p.r.n. pain medications

D) Prolonging expiration to reduce airway resistance

Ans: D

Feedback:

Pursed-lip breathing can help clients with dyspnea and feelings of panic gain control of their respirations. This exercise trains the muscles to prolong expiration, increasing airway pressure during expiration, and reducing the amount of airway trapping and resistance.

21. A nurse is explaining a chest tube to family members who do not understand where it is placed. What would the nurse tell them?

A) "It is inserted into the space between the lining of the lungs and the ribs."

B) "I don't exactly know, but I will make sure the doctor comes to explain."

C) "It is inserted directly into the lung itself, connecting to a lung airway."

D) "It is inserted into the peritoneal space and drains into the lungs."

Ans: A

Feedback:

A chest tube is a firm plastic tube with drainage holes in the proximal end that is inserted into the pleural space, thus allowing compressed lung tissue to re-expand.

22. What prevents air from re-entering the pleural space when chest tubes are inserted?

A) The location of the tube insertion

B) The sutures that hold in the tube

C) A closed water-seal drainage system

D) Respiratory inspiration and expiration

Ans: C

Feedback:

After insertion, the chest tube is secured with a suture and tape, covered with an airtight dressing, and usually attached to a closed water-seal drainage system that prevents air from reentering the pleural space.

23. A nurse is educating a client who has congested lungs how to keep secretions thin, and more easily coughed up and expectorated. What would be one self-care measure to teach?

A) Limit oral intake of fluids to less than 500 mL per day.

B) Increase oral intake of fluids to two to three quarts per day.

C) Maintain bed rest for at least three days.

D) Take warm baths every night for a week.

Ans: B

Feedback:

Clients can keep their secretions thin by drinking two to three quarts (1.9 L to 2.9 L) of clear fluids daily. Fluid intake should be increased to the maximum the client's health state can tolerate.

24. What category of medications may be administered by nebulizer or metered-dose inhaler to open narrowed airways?

A) Bronchoconstrictors

B) Antihistamines

C) Narcotics

D) Bronchodilators

Ans: D

Feedback:

A nebulizer is used to adminster medications in the form of an inhaled mist. Bronchodilators are medications that may be administered by nebulizer or metered-dose inhaler to open narrowed airways. Antihistamines are not administeredvia nebulizer; they are prescribed to manage allergy-related symptoms. Narcotics are not administered via nebulizer; they are used to manage complaints of pain.

25. A physician prescribes the use of water-seal chest tube drainage for a client at a health care facility. What should the nurse ensure when using the water-seal chest tube drainage?

A) Filters need to be cleaned regularly to avoid unpleasant taste or smell.

B) The chest tube should not be separated from the drainage system unless clamped.

C) A nasal cannula should be used to administer oxygen when cleaning the opening.

D) A secondary source of oxygen should be available in case of power failure.

Ans: B

Feedback:

When using water-seal chest tube drainage, the nurse should never separate the chest tube from the drainage system unless clamped. Even then, the tube should be clamped only briefly. When using an oxygen concentrator as a source of oxygen, the nurse should clean the filter regularly to avoid an unpleasant taste or smell. A secondary source of oxygen should also be available in case of a power failure. When cleaning a transtracheal catheter, oxygen needs to be administered with a nasal cannula.

26. A nurse uses a nasal cannula to deliver oxygen to a client who is extremely hypoxic and has been diagnosed with chronic lung disease. What is the most important thing to remember when using a nasal cannula?

A) It can cause the nasal mucosa to dry in case of high flow.

B) It can cause anxiety in clients who are claustrophobic.

C) It can create a risk of suffocation.

D) It can result in an inconsistent amount of oxygen.

Ans: A

Feedback:

When using a nasal cannula to deliver oxygen to a client, the nurse should remember that the nasal cannula can cause the nasal mucosa to dry in case of high oxygen flow. A simple mask can cause anxiety in clients who are claustrophobic. Clients using a partial rebreather mask are at risk of suffocation. A face tent may deliver an inconsistent amount of oxygen, depending on environmental loss.

27. A nurse is conducting a health promotion program for adolescents to educate them about the hazards of smoking. When describing the effects on the respiratory system, which of the following would the nurse most likely include?

A) Decreased production of mucus

B) Inhibition of mucus removal

C) Increase in the mucous escalator

D) Inhibition of bacterial colonization

Ans: B

Feedback:

Smoking inhibits mucus removal. By producing more mucus and by slowing the mucous escalator, smoking inhibits mucus removal and can cause airway blockage, promoting bacterial colonization and infection.

28. The nurse is caring for a postoperative adult client who has developed pneumonia. The nurse should assess the client frequently for symptoms of

A) Atelectasis

B) Bronchospasm

C) Croup

D) Epiglottitis

Ans: A

Feedback:

Stiffer lungs tend to collapse and their alveoli also collapse. This condition is called atelectasis.

29. The home care nurse visits a client who has dyspnea. The nurse notes the client has pitting edema in his feet and ankles. What additional assessment would the nurse expect to observe?

A) Crackles in the lower lobes

B) Inspiratory stridor

C) Expiratory stridor

D) Wheezing in the upper lobes

Ans: A

Feedback:

People with chronic congestive heart failure often experience shortness of breath because of excess fluid in the lungs and low oxygen levels. Stridor is associated with respiratory infections such as croup. Wheezing may be heard in individuals who use tobacco products.

30. A nurse is caring for an older adult client who is to be discharged from the health care facility. The client has been prescribed the use of a liquid oxygen unit at home to continue with oxygen therapy. What should the nurse tell the client regarding the potential problems of using a liquid oxygen unit? Select all that apply.

A) Liquid oxygen may leak during warm weather.

B) The unit may give off a bad smell if not cleaned regularly.

C) The unit's outlet may become occluded because of frozen moisture.

D) Portable liquid oxygen is more expensive.

E) The unit may require a secondary source of oxygen.

Ans: A, C, D

Feedback:

The nurse should inform the client who has been prescribed the use of a liquid oxygen unit that the unit may leak during warm weather; frozen moisture may occlude the outlet; and the unit is more expensive when compared with other portable sources of oxygen. Emission of a bad smell if filters are not cleaned, increase in the electric bill, and requirement of a secondary source of oxygen in case of failure are disadvantages of using an oxygen concentrator and are not related to the use of a liquid oxygen unit.

31. A nurse is educating a postoperative client on how to use an incentive spirometer. Which of the following is an accurate step that should be included in the teaching plan?

A) Instruct the client to inhale normally and then place the lips securely around the mouthpiece.

B) Instruct the client to inhale slowly and as deeply as possible through the mouthpiece, without using the nose.

C) When the client cannot inhale anymore, the patient should hold his or her breath and count to 10.

D) Encourage the client to perform incentive spirometry two to three times every one to two hours, if possible.

Ans: B

Feedback:

The client using an incentive spirometer should exhale normally and place the lips around the mouthpiece. He or she should inhale slowly and deeply without using the nose, and when the client cannot inhale anymore, hold the breath and count to 3 before exhaling normally. This should be performed 5 to 10 times every one to two hours, if possible.

32. A nurse is delivering oxygen to a client via an oxygen mask. Which of the following is a recommended guideline for this procedure?

A) Adjust the mask so it fits tightly around the face.

B) For a mask with a reservoir, fill the reservoir half-full of oxygen.

C) Remove the mask and dry the skin every two to three hours if the oxygen is running continuously.

D) If the client is experiencing redness around the mask, remove and apply powder to the mask.

Ans: C

Feedback:

To apply an oxygen mask, position the facemask over the client's nose and mouth and adjust the elastic strap so that the mask fits snugly, but comfortably, on the face. For a mask with a reservoir, be sure to allow oxygen to fill the bag before proceeding to the next step. Remove the mask and dry the skin every two to three hours if the oxygen is running continuously; do not use powder around the mask.

33. A physician is choosing a chest drainage system for a client who is ambulating daily. Which of the following systems would be the best choice for this client?

A) Traditional water seal

B) Wet suction

C) Dry suction water seal

D) Dry suction/one-way valve system

Ans: D

Feedback:

The dry suction or one-way valve system works even if knocked over, making it ideal for clients who are ambulatory.

34. A client visits the health care facility for a scheduled physical assessment. What should the nurse do when physically assessing the quality of the client's oxygenation? Select all that apply.

A) Monitor the client's respiratory rate.

B) Note the amount of oxygen administered.

C) Check the symmetry of the client's chest.

D) Observe the breathing pattern and effort.

E) Check the devices used to deliver oxygen.

Ans: A, C, D

Feedback:

When physically assessing the quality of the client's oxygenation, the nurse should monitor the client's respiratory rate, check the symmetry of the client's chest, and observe the breathing pattern and effort of the client. The nurse should also auscultate for lung sounds. Additional assessments include recording the heart rate and blood pressure, determining the client's level of consciousness, and observing the color of the skin, mucous membranes, lips, and nailbeds. However, the nurse does not note the amount of oxygen administered to the client, or check the device that is used to deliver oxygen to the client during the physical assessment.

35. A nurse assesses the vital signs of a healthy newborn infant. What respiratory rate could be expected based on the developmental level of this client?

A) 15 to 25 breaths/minute

B) 16 to 20 breaths/minute

C) 20 to 44 breaths/minute

D) 30 to 55 breaths/minute

Ans: D

Feedback:

The normal range for an infant's breath per minute is 30 to 60.

Chapter 40, Fluid, Electrolyte, and Acid-Base Balance

1. Which body fluid is the fluid within the cells, constituting about 70% of the total body water?

A) Extracellular fluid (ECF)

B) Intracellular fluid (ICF)

C) Intravascular fluid

D) Interstitial fluid

Ans: B

Feedback:

Intracellular fluid is the fluid within the cells, constituting about 70% of total body fluid. Extracellular fluid is all flu outside the cells and includes intravascular and interstitial fluids.

2. Based on knowledge of total body fluids, a nurse is especially watchful for a fluid volume deficit in an infant. Why would the nurse do this?

A) Infants have less total body fluid and ECF than adults.

B) Infants have more total body fluid and ECF than adults.

C) Infants drink less fluid than adults.

D) Infants lose more fluids through output than adults.

Ans: B

Feedback:

An infant has considerably more total body fluid and ECF than an adult does. Because ECF is more easily lost from body than ICF, infants are more prone to fluid volume deficits.

3. What is the average adult fluid intake and loss in each 24 hours?

A) 500 to 1,000 mL

B) 1,000 to 1,500 mL

C) 1,500 to 2,000 mL

D) 1,500 to 3500 mL

Ans: D

Feedback:

The desirable amount of fluid intake and loss in adults ranges from 1,500 to 3,500 mL each 24 hours, with most people averaging 2,500 to 2,600 mL per day.

4. A nurse monitoring the intake and output of fluids for a client with severe diarrhea knows that normally how much body fluid is lost via the gastrointestinal tract?

A) 300 mL

B) 1,000 mL

C) 1,300 mL

D) 2,600 mL

Ans: A

Feedback:

Generally, fluid intake averages 2,600 mL per day, with approximately 1,300 mL coming from ingested water, 1,000 mL coming from ingested food, and 300 mL from metabolic oxidation.

5. A nurse reads the laboratory report and notes that the client has hyponatremia. What physical assessment should be made?

A) Observe skin color and texture.

B) Auscultate bowel sounds.

C) Percuss lung density.

D) Monitor for GI symptoms.

Ans: D

Feedback:

Hyponatremia is an ECF sodium deficit, resulting in osmotic pressure changes as ECF moves into the cells. When this occurs, anorexia, nausea, and vomiting may occur; the nurse should monitor for these symptoms. Skin color and texture, bowel sounds, and lung density are not affected with hypernatremia.

6. A home care client reports weakness and leg cramps. Per order, the nurse draws blood and requests a potassium level. What is the rationale for this request?

A) The nurse is concerned that the client's diet has caused sodium loss.

B) The nurse recognizes these symptoms of hypokalemia.

C) The client is actively seeking increased attention.

D) The client had bananas and orange juice for breakfast.

Ans: B

Feedback:

Hypokalemia is a potassium deficit in the ECF. When the ECF potassium falls, potassium moves out of the cells, creating an intracellular potassium deficiency. Typical symptoms include muscle weakness and leg cramps.

7. A client's $PaCO_2$ is abnormal on an ABG report. Which of is the most likely be the medical diagnosis?

A) Rheumatoid arthritis

B) Sexually transmitted infection

C) Chronic obstructive pulmonary disease

D) Infection of the bladder and ureters

Ans: C

Feedback:

Arterial blood gases are laboratory tests used to assess and treat acid–base disorders. $PaCO_2$ is the abbreviation for the partial pressure of carbon dioxide. The $PaCO_2$ is influenced almost entirely by respiratory activity, with a disease such as chronic obstructive pulmonary disease resulting in abnormal results.

8. Which question about fluid balance would be appropriate when conducting a health history for a client?

A) "Describe your usual urination habits."

B) "Describe your problems with constipation."

C) "How did you feel when your calcium was low?"

D) "Do you eat fruits and vegetables each day?"

Ans: A

Feedback:

Questions and leading statements about fluid balance are part of a comprehensive health history. The usual urinary output is one factor to consider in fluid balance.

9. A client is taking a diuretic that increases her urinary output. What would be an appropriate nursing diagnosis on which to base an educational plan?

A) Impaired Skin Integrity

B) Risk for Deficient Fluid Volume

C) Impaired Urinary Elimination

D) Urinary Retention

Ans: B

Feedback:

An appropriate nursing diagnosis for a client taking a diuretic that increases urinary output would be Risk for Deficient Fluid Volume. The nurse would educate the client on the symptoms of dehydration, how to increase fluid intake, and the need to maintain a record of daily weights.

10. A nurse measures a client's 24-hour fluid intake and documents the findings. To be an accurate indicator of fluid status, what must the nurse also do with the information?

A) Compare the client's intake with the normal range of adult fluid intake.

B) Report the exact milliliter of intake to the physician's office nurse.

C) Compare the total intake and output of fluids for the 24 hours.

D) Ensure that the information is included in the verbal end-of-shift report.

Ans: C

Feedback:

The nurse must pay attention to certain parameters when assessing a client's fluid status. This means comparing the total intake and output of fluids for a given period of time.

11. A physician writes an order to "force fluids." What will be the first action the nurse will take in implementing this order?

A) Explain to the client why this is needed.

B) Tell the client and family to increase oral intake.

C) Decide how much fluid to increase each eight hours.

D) Divide the intake so the largest amount is at night.

Ans: A

Feedback:

Several techniques are recommended to help the client drink greater than average amounts of fluids. Begin by explaining to the client in understandable terms the rationale for the increased fluids and the specific goal of taking the daily amount of fluids prescribed.

12. A client has an order to restrict fluids. What is one comfort measure nurses can implement for this client to alleviate a common problem?

A) Back rubs

B) Chewing gum

C) Hair care

D) Oral hygiene

Ans: D

Feedback:

Clients with restrictions on fluid intake often complain of thirst or a dry mouth. Provide oral hygiene at regular intervals. Offering hard candy or gum is no longer recommended.

13. A nurse is administering a potassium supplement to a client. What will the nurse do to disguise the taste and decrease gastric irritation?

A) Dilute it

B) Give it after meals

C) Mix it with food

D) Freeze it

Ans: A

Feedback:

Nurses must accurately administer supplements, following manufacturer's guidelines. Potassium supplements should be diluted to disguise the unpleasant taste and decrease gastric irritation.

14. A student is learning how to administer intravenous fluids, including accessing a vein. Although all of the following may occur, which is the most potentially harmful risk posed for the client when accessing the vein?

A) Discomfort

B) Pain

C) Minor bleeding

D) Infection

Ans: D

Feedback:

Accessing a vein increases the risk for infection. Sterile technique must be used when puncturing the vein.

15. Which location might the nurse use to assess the condition of an insertion site for a central venous access device?

A) Below the sternum

B) Over the fourth intercostal space

C) Over the jugular vein

D) The back of the hand

Ans: C

Feedback:

Central venous access devices are usually introduced into the subclavian or jugular vein and passed to the superior vena cava, just above the atrium. The nurse would assess the insertion site over the jugular vein in this question.

16. A specially trained nurse has inserted a PICC line. What would be done next?

A) Start administration of prescribed fluids.

B) Explain the procedure to the client and family.

C) Place the client on restricted oral fluids.

D) Send the client to the radiology department.

Ans: D

Feedback:

Radiographic verification of proper placement is always required before using a PICC line.

17. Cross-matching of blood is ordered for a client before major surgery. What does this process do?

A) Determines compatibility between blood specimens

B) Determines a person's blood type

C) Predicts the amount of needed blood replacement

D) Specifies the donor and the recipient of the blood

Ans: A

Feedback:

Before anyblood can be given to a client, it must be determined that the blood of the donor is compatible with that of the client. The process of determining compatibility between blood specimens is cross-matching. The examination to determine a person's blood type is called typing.

18. A client asks a nurse if it is possible to contract a disease by donating blood. How would the nurse respond?

A) "There is only a very small chance; I know you will be safe."

B) "Although hepatitis is possible, AIDS is not."

C) "If I were you, I would request special handling of my blood."

D) "There is no way you can contract a disease by giving blood."

Ans: D

Feedback:

Blood donors are carefully assessed and screened. There is no way that donors can contract any disease by giving blood.

19. A client scheduled for surgery has arranged for an autologous transfusion. What type of blood transfusion is this?

A) The client's family members have been donors.

B) The client donates his or her own blood.

C) The client's blood has been rendered sterile.

D) The client will only need fluids, not blood.

Ans: B

Feedback:

Some patients who know in advance that they will need blood can donate their own blood for transfusion. This is called autologous transfusion or autotransfusion.

20. A client is having a blood transfusion, but the fluid is dripping very slowly. The blood has been infusing for more than four hours. What should the nurse do next?

A) Continue with the transfusion and document the drip rate.

B) Report to the next shift the amount of blood left to infuse.

C) Take and record vital signs more often.

D) Discontinue the blood transfusion.

Ans: D

Feedback:

Blood that has been transfusing for more than four hours must be discontinued to prevent the risk of bacterial contamination.

21. Which client would be the most likely candidate for the administration of total parenteral nutrition?

A) A client with severe pancreatitis

B) A client with a myocardial infarction

C) A client with hepatitis B

D) A client with mild malnutrition

Ans: A

Feedback:

Total parenteral nutrition (TPN) is a highly concentrated nutrient solution consisting of dextrose, amino acids, and select electrolytes, vitamins, minerals, and trace elements that must be infused through a central vein because of its hypertonic nature. TPN frequently is given to clients with severe inflammatory bowel disease, severe pancreatitis, or acquired immunodeficiency syndrome (AIDS), who are unable to meet their nutritional needs through the oral or enteral routes.

22. A nurse is initiating a peripheral venous access IV infusion ordered for a client presurgically. In what position would the nurse place the client to perform this skill?

A) High-Fowler's

B) Low-Fowler's

C) Sims'

D) Dorsal recumbent

Ans: B

Feedback:

The low-Fowler's position permits either arm to be used and allows for good body alignment.

23. A client with dehydration is being administered IV fluids. During her rounds, the nurse noticed that the skin immediately surrounding the IV site was reddish in color and showing signs of inflammation. The nurse recognizes that what phenomenon is likely responsible?

A) Phlebitis

B) Thrombus formation

C) Pulmonary embolus

D) Air embolism

Ans: A

Feedback:

The nurse should record that the client has phlebitis, which is an inflammation of the vein. Thrombus formation is a situation in which there is a stationary blood clot. Pulmonary embolus is a situation in which the blood clot travels to the lung. Air embolism is a bubble of air traveling within the vascular system.

24. A nurse is caring for a client with phlebitis. The nurse notices that the client's forearm, which has the tubing, has become red and slightly warm. Which of the following actions should the nurse perform to avoid further complications and provide relief to the client?

A) Administer oxygen.

B) Call for help.

C) Discontinue the IV promptly.

D) Elevate the affected arm.

Ans: C

Feedback:

When there is phlebitis, the nurse should discontinue the IV promptly and apply warm compresses to the affected site to provide immediate relief to the client. The nurse elevates the client's affected arm when there is infiltration. When there is pulmonary embolus, the nurse should call for help and administer oxygen.

25. A client has a physician's order for NPO (nothing by mouth) following abdominal surgery to repair a bowel obstruction. The client has a nasogastric tube inserted to low intermittent suction. The client requires intravenous therapy for what purpose?

A) Replace fluid and electrolytes

B) Administer blood products

C) Provide protein supplements

D) Treat the client's infection

Ans: A

Feedback:

The therapeutic goal may be maintenance, replacement, treatment, diagnosis, monitoring, palliation, or a combination. This client requires intravenous fluids for replacement of those lost due to the NPO order, and the loss of fluid and electrolytes due to the nasogastric suctioning.

26. Which client will have more adipose tissue and less fluid?

A) A woman

B) A man

C) An infant

D) A child

Ans: A

Feedback:

Women have a lower fluid content because they have more adipose tissue then men.

27. Which of the following individuals with diarrhea for three days is more likely to suffer from fluid and electrolyte imbalance?

A) Infant

B) School-age child

C) Adolescent

D) Young adult

Ans: A

Feedback:

The very young child and older adults are at greatest risk for fluid or electrolyte imbalances.

28. Which of the following statements is an appropriate nursing diagnosis for an client 80 years of age diagnosed with congestive heart failure, with symptoms of edema, orthopnea, and confusion?

A) Extracellular volume excess related to heart failure, as evidenced by edema and orthopnea

B) Congestive heart failure related to edema

C) Fluid volume excess related to loss of sodium and potassium

D) Fluid volume deficit related to congestive heart failure, as evidenced by shortness of breath

Ans: A

Feedback:

Extracellular volume excess is the state in which a person experiences an excess of vascular and interstitial fluid.

29. A nurse is caring for a client with dehydration. Which of the following signs is observed in a client with dehydration? Select all that apply.

A) Decreased skin turgor over sternum

B) Decreased blood pressure

C) Low urine output

D) Increased pulse rate

E) Increased respiratory rate

Ans: A, B, C

Feedback:

The nurse should note decreased skin turgor, decreased blood pressure, and low urine output in a client with dehydration. The client's pulse and respiratory rate would decrease, instead of increase, with dehydration.

30. A nurse assessing the IV site of a client observes swelling and pallor around the site, and notes a significant decrease in the flow rate. The client complains of coldness around the infusion site. What IV complication does this describe?

A) Infiltration

B) Sepsis

C) Thrombus

D) Speed shock

Ans: A

Feedback:

Infiltration is the escape of fluid into the subcutaneous tissue due to a dislodged needle that has penetrated a vessel wall. Signs and symptoms include swelling, pallor, coldness, or pain around the infusion site, and significant decrease in the flow rate. The signs of sepsis include red and tender insertion site, fever, malaise, and other vital sign changes. The symptoms of thrombus are local, acute tenderness; redness, warmth, and slight edema of the vein above the insertion site. The signs of speed shock are pounding headache, fainting, rapid pulse rate, apprehension, chills, back pains, and dyspnea.

31. A nursing responsibility in managing IV therapy is to monitor the fluid infusions and to replace the fluid containers as needed. Which of the following is an accurate guideline for IV management that the nurse should consider?

A) The nurse should use new tubing when attaching additional IV solutions.

B) As one bag is infusing, the nurse should prepare the next bag so it is ready for a change when less than 10 mL of fluid remains in the original container.

C) It is the responsibility of the nurse to provide ongoing verification of the IV solution and the infusion rate with the physician's order.

D) Generally, the nurse should change the administration sets of simple IV solutions every 24 hours.

Ans: C

Feedback:

The nurse's ongoing verification of the IV solution and the infusion rate with the physician's order is essential. If more than one IV solution or medication is ordered, the nurse should make sure the additional IV solution can be attached to the existing tubing. As one bag is infusing, the nurse should prepare the next bag so it is ready for a change when less than 50 mL of fluid remains in the original container. Every 72 hours is recommended for changing the administration sets of simple IV solutions.

32. A nurse is changing a peripheral venous access dressing for a client. Which of the following is a recommended step in this procedure?

A) Observe clean technique to minimize the possibility of contamination.

B) Cleanse site thoroughly with sterile saline, or according to facility policy.

C) Apply chlorhexidine using a back and forth friction scrub for at least 30 seconds.

D) Wipe or blot the site dry and allow to dry completely before covering.

Ans: C

Feedback:

The nurse should do the following: observe meticulous aseptic technique to minimize the possibility of contamination; cleanse site with an antiseptic solution, such as chlorhexidine, or according to facility policy; press applicator against the skin and apply chlorhexidine using a back and forth friction scrub for at least 30 seconds. The nurse should not wipe or blot, and should allow to dry completely before reapplying dressing.

33. A nurse flushing a capped, peripheral venous access device finds that the IV does not flush easily. What is the appropriate intervention in this situation?

A) If infiltration or phlebitis is present, apply a sterile dressing to the site.

B) Aspirate and attempt to flush the line again.

C) If resistance remains after aspirating and flushing, forcefully flush the line.

D) If catheter has pulled out a short distance, push back in and flush line again.

Ans: B

Feedback:

If the IV does not flush easily, assess the insertion site. Infiltration and/or phlebitis may be present. If present, remove and restart in another location. In addition, the catheter may be blocked or clotted due to a kinked catheter at the insertion site. Aspirate and attempt to flush again. If resistance remains, do not force. Forceful flushing can dislodge a

clot at the end of the catheter. Remove and restart in another location. If assessment reveals the catheter has pulled out a short distance, do not reinsert it; it is no longer sterile. Remove and restart in another location.

34. A nurse inadvertently partially dislodges a PICC line when changing the dressing. What would be the appropriate intervention in this situation?

A) Swab the line with sterile saline and gently reinsert the line.

B) Sedate the client, remove the PICC line, and then notify the physician.

C) Set up a sonogram for the client to determine the end point of the line.

D) Reapply the dressing and notify the physician for further instructions.

Ans: D

Feedback:

When a PICC line is not all the way out, the nurse should notify the physician. The physician will most likely order a chest x-ray to determine where the end of the PICC line is. A dressing should be reapplied before the chest x-ray, to prevent further dislodgement.

35. The client is admitted to the nurse's unit with a diagnosis of heart failure. His heart is not pumping effectively, which is resulting in edema and coarse crackles in his lungs. The term for this condition is which of the following?

A) Fluid volume deficit

B) Myocardial Infarction

C) Fluid volume excess

D) Atelectasis

Ans: C

Feedback:

A common cause of fluid volume excess is failure of the heart to function as a pump, resulting in accumulation of fluid in the lungs and dependent parts of the body. Fluid volume deficit does not manifest itself as edema and abnormal lung sounds, but results in poor skin turgor, sunken eyes, and dry mucous membranes. Atelectasis is a collapse of the lung and does not have to do with fluid abnormalities. Myocardial infarction results from a blocked coronary artery and may result in heart failure, but is not a term for fluid volume excess.

Chapter 41, Self-Concept

1. Which term best describes an individual's self-concept?

A) Self-esteem

B) Self-actualization

C) Self-realization

D) Self-image

Ans: D

Feedback:

One's self-concept is synonymous with one's self-image. Self-esteem and self-actualization are components of self-concept.

2. A young woman client admits to a nurse that she cannot control her jealousy when she and her partner are out together and states, “It’s like we’re back in high school again.” This is an example of which identity disorder?

A) Self-actualization

B) Identity diffusion

C) Depersonalization

D) Lack of self-esteem

Ans: B

Feedback:

Identity diffusion is the failure to integrate various childhood identifications into a harmonious adult psychosocial identity, which can lead to disruptions in relationships and problems of intimacy. The need for self-actualization is the need to reach one’s potential through full development of one’s unique capability. Depersonalization is the subjective experience of the partial or total disruption of one’s ego, and the disintegration and disorganization of one’s self-concept (Stuart & Laraia, 2005). The need for self-esteem is the need to feel good about oneself and to believe that others hold one in high regard.

3. The wife of an older adult man has recently died. The couple was married for 32 years. What part of the man’s self-concept may be influenced by this loss?

A) Ideal self

B) Global self

C) Body image

D) False self

Ans: B

Feedback:

Global self is the term used to describe the composite of all the basic facts, qualities, traits, images, and feelings one holds about oneself. Some conditions associated with alterations in the global self include developmental changes, life crisis, illness, and loss.

4. A teenager describes herself as “tall, attractive, female, student, intelligent.” What part of her self-concept is she describing?

A) Self-expectations

B) Self-esteem

C) Self-knowledge

D) Self-evaluation

Ans: C

Feedback:

As a component of global self-concept, self-knowledge is used to describe the composite of all the basic facts, qualities, traits, images, and feelings one holds about oneself.

5. As a child grows, he unconsciously develops a component of self-concept based on the image of role models. What part of the self-concept does this describe?

A) False self

B) Evolving self

C) Self-knowledge

D) Self-expectations

E) `

Ans: D

Feedback:

Expectations for the self arise from various sources. The ideal self makes up the self one wants to be, and develops unconsciously early in childhood based on images of role models such as parents, caregivers, and public figures.

6. What is the name given to the evaluative and affective component of the self-concept?

A) Ideal self

B) Body image

C) Self-esteem

D) Self-knowledge

Ans: C

Feedback:

Self-esteem is the evaluative and affective component of the self-concept, sometimes termed self-respect, self-approval, or self-worth.

7. A nurse working with clients in a health care facility influences them to make healthy lifestyle choices. According to Coopersmith, which base of self-esteem for the nurse does this example represent?

A) Power

B) Significance

C) Competence

D) Virtue

Ans: A

Feedback:

Coopersmith (1967) identified the four bases of self-esteem as (1) significance—the way a person feels he or she is loved and approved of by the people important to that person; (2) competence—the way tasks that are considered important are performed; (3) virtue—the attainment of moral–ethical standards; and (4) power—the extent to which a person influences his or her own life, and others' lives.

8. A child learns to feel secure within the bonds of his immediate family by interacting with his caretakers. What is the term for this process?

A) Self-reflection

B) Adaptation

C) Attachment

D) Globalization

Ans: C

Feedback:

Bowlby (1969) developed attachment theory, which describes modes by which a young child develops and maintains feelings about the self, as well as values and beliefs about the world. Attachment is a process by which the child maintains security via an interpersonal bond with close caregivers, most notably parents. Through a learning process based on the child's perception of the caregiver's thoughts and reactions toward him or her, the child forms a sense of self as secure or insecure, calm or anxious, likable or not.

9. An infant learns that the physical self is different from the environment. What term is used to describe this stage of self-concept?

A) Self-awareness

B) Self-recognition

C) Self-definition

D) Self-concept

Ans: A

Feedback:

The stages in the development of the self include self-awareness (infancy), self-recognition (18 months), self-definition (3 years), and self-concept (6 to 7 years).

10. Who or what plays the most influential role in the internalization of self-concept in children?

A) Peers

B) Parents

C) School

D) Church

Ans: B

Feedback:

While forming the self-concept, the child internalizes other people's attitudes toward self. This internalization forms the foundation of self-concept. Parents or other direct caregivers play the most influential role; peers play the second most influential role.

11. An adolescent rapidly develops secondary sex characteristics and body changes. What should the nurse assess to determine how these changes might affect the adolescent's self-concept?

A) Expectations of the parents

B) Developmental environment

C) Meaningful use of time

D) Understanding of changes

Ans: D

Feedback:

An adolescent rapidly develops secondary sex characteristics and body changes that may affect self-concept. The nurse should assess the adolescent's knowledge of, and understanding of, body changes.

12. In which age group do interpersonal losses play a role in disturbances in self-concept?

A) Child

B) Teenager

C) Adult

D) Older adult

Ans: D

Feedback:

The many losses associated with aging (e.g., diminished strength and physical health, interpersonal losses, retirement, shrinking income) make older adults especially vulnerable to disturbances in self-concept, particularly chronic, low self-esteem.

13. The children of immigrants may have different values and practices than do their parents, causing them to abandon their parents' cultural beliefs. What is this called?

A) Cultural expectations

B) Cultural competence

C) Cultural dissonance

D) Cultural modernization

Ans: C

Feedback:

Children of immigrants whose values and practices of their culture or origin vary from the culture of adoption may face cultural dissonance. Conflict between parents and children, as well as cultural confusion, may occur.

14. Which statement is an example of the effect of aging, illness, or trauma on self-concept?

A) Society values the wisdom of aging

B) Society devalues aging and chronic illness

C) Few people take a healthy body for granted

D) Most people accept the inevitability of illness

Ans: B

Feedback:

Many people take a healthy body for granted. Society encourages a denial of the eventuality of aging and chronic illness. Society emphasizes and rewards youth, health, and physical attractiveness while devaluing aging, chronic illness, and less-than-perfect physical attractiveness.

15. During an assessment of a client's self-esteem, a man age 45 years tells the nurse that he lost his job due to downsizing and has been unemployed for six months. What would be the appropriate response from the nurse?

A) "You shouldn't feel bad about losing a job; it happens to everyone."

B) "Do you need your job to support a family?"

C) "How has losing your job affected your life and the lives of your significant others?"

D) "There are more important things in life to worry about other than losing a job."

Ans: C

Feedback:

Life stressors or crises (e.g., marriage, divorce, acute or chronic illness, an exam, a new job or job loss, a gray hair, a fire) might call forth a personal response and mobilize an individual's talents, resulting in good feelings about oneself. It also may result in emotional paralysis with diminished self-concept. People vary greatly in their perception of what constitutes a crisis or stressor, as well as the degree to which such experiences might disrupt or diminish self-concept. The nurse should investigate the client's feelings about losing his job by asking open-ended questions, and by not being judgmental or minimalizing the client's feelings.

16. What might a nurse ask during a health history to assess personal identity?

A) "Tell me how your illness has affected you in your job."

B) "Tell me what you do for fun and what you do for work."

C) "How do you believe others see you? Why do you believe that?"

D) "How would you describe yourself to others?"

Ans: D

Feedback:

When assessing self-concept, the information needed first is the client's description of self. Personal identity describes an individual's conscious sense of who he or she is. It can be assessed by asking, for example, "How would you describe yourself to others?"

17. During a self-esteem assessment of a young woman undergoing a complicated divorce, a nurse states: "Tell me something about the moral–ethical principles that govern your life." What aspect of self-esteem is the nurse assessing?

A) Significance

B) Virtue

C) Power

D) Competence

Ans: B

Feedback:

Virtue is the ability to live according to one's moral–ethical standards. Significance involves nurturing relationships in which needs for love and worth are mutually met. The ability to accomplish what is desired is power. The ability to assume role-related responsibilities with confidence is competence.

18. Which strategy can be used to help clients overcome powerlessness?

A) Encourage clients to identify their weaknesses.

B) Encourage clients to identify their strengths.

C) Provide advice on how to handle problems.

D) Set goals and make decisions for the client.

Ans: B

Feedback:

When confronted with a major stressor, many people forget they have histories of successful coping and numerous personal strengths. Nurses frequently fall into the trap of doing for clients, rather than helping those who are experiencing powerlessness identify personal strengths.

19. A nurse always addresses clients by the preferred name when entering a client's home or room. What is the nurse facilitating by this action?

A) A sense of self and worth

B) Reorientation to who they are

C) Personal strengths

D) Negative self-concept

Ans: A

Feedback:

Clients who are acutely ill are often separated from their personal strengths, but also from real sense of self. One action by the nurse that will help clients maintain a sense of self and worth is by addressing the client by preferred name when entering the home or room.

20. A nurse caring for critically ill clients uses interventions to help clients maintain a sense of self. Which of the following are recommended interventions?

A) Disregard the client's status.

B) Do not use touch out of respect for the client's privacy.

C) Converse with the client about his or her life experience.

D) Do not acknowledge or allow expression of negative feelings.

Ans: C

Feedback:

The nurse should converse with the client about his or her life experience; acknowledge the client's status, roles, and individuality; use looks, speech, and judicious touch to communicate worth; acknowledge and allow expression of negative feelings.

21. A nurse who works on the pediatric unit wants to help a child cope with the loss of a leg in a hunting accident. What would the nurse implement to help the child express feelings?

A) Support from other family members

B) Television cartoons

C) Story books

D) Dolls or animals

Ans: D

Feedback:

Nurses can use play therapy with children to help them describe their feelings and work through their grief using the nonthreatening medium of dolls and animals.

22. A school nurse is teaching parents how to build self-esteem in their children. Which is a recommended strategy?

A) Use praise and compliments judiciously

B) Wait for your child to initiate conversation

C) Focus on remedying the child's negative qualities

D) Give your child many opportunities to display abilities

Ans: D

Feedback:

To reinforce the positive qualities, (1) notice examples of ability in many different circumstances and point this out to the child, (2) find occasion to frequently and honestly praise the child, and (3) give the child an opportunity to show ability frequently.

23. While interviewing a compulsive gambler 45 years of age, the woman blames her loss of job, estrangement from spouse, and lack of friends on destiny. The nurse interprets this information as indicative of which aspect of altered self-concept?

A) Self-care deficit

B) Self-destructive behavior

C) Behavioral changes

D) Anxiety and depression

Ans: B

Feedback:

Self-destructive behaviors are addictive, giving immediate gratification only. The client is bound to gambling because of the temporary gratification it provides. She is unable to see the cause-and-effect relationship between her addiction and her current situation due to her self-concept dysfunction. Self-care deficit may manifest as disregard for special diet restriction, refusal to take medication, or missing follow-up appointments. Behavioral changes indicating self-concept dysfunction include lack of interest in activities, inability to make decisions, withdrawal from social situations, isolation, refusal to look in the mirror, refusal to look at an affected body part or discuss a limitation, avoidance of responsibility, show of hostility toward others, refusal to make eye contact, and negative verbalizations about self. Anxiety and depression are psychological manifestations of self-concept dysfunction.

24. A client states, "I am not smart enough to learn how to take care of my mother, and I just don't think I can do it." This is an example of …

A) Self-perception

B) Self-knowledge

C) Self-expectation

D) Social self

Ans: B

Feedback:

Self-knowledge or self-awareness involves the basic understanding of oneself, a cognitive perception. It is consciousness of one's abilities: cognitive, affective, and physical. Self-concept is the way a person thinks about himself or herself. Self-perception is how a person explains behavior based on self-observation.

25. A nurse visits a diabetic client age 60 years in his home after the client's above-the-knee amputation of his left leg. The client appears disheveled and with poor hygiene. He also avoids making eye contact with the nurse. Which of the following is likely to occur as a result of the client's reduced self-esteem?

A) Lethargy

B) Withdrawal

C) Self-care deficit

D) Lack of interest

Ans: C

Feedback:

Physical changes such as decreased strength, skin turgor, and sensory acuity affect body image in later life. Because of the valuation of youth in the media and popular culture, some older people experience lowered self-esteem with the changed body image.

26. The nurse promotes the self-concept of the parents of an infant age 6 months admitted to the hospital with a fever and dehydration by doing what?

A) Telling the parents that the infant's condition was not their fault

B) Allowing the parents to participate in the infant's care

C) Encouraging the parents to visit the infant every other day

D) Educating the parents on health-maintenance behaviors

Ans: B

Feedback:

When a person suffers from an illness or exhibits a self-concept dysfunction, family members may also be affected. Family members may need to assist the individual to perform activities of daily living, or may have to change the living situation with the use of adaptive equipment or other assistive devices.

27. To obtain subjective data about a burn client's self-concept, the nurse should do what?

A) Ask the client how she would describe herself.

B) Observe the client's interactions with others.

C) Document the client's lack of eye contact.

D) Note how the client conceals her wound.

Ans: A

Feedback:

Gordon (1997) suggests asking clients how they would describe themselves in the assessment of self-concept.

28. A female client, prominent in the local media, has had surgery for a colostomy. The client avoids looking at the colostomy and refuses visitors. Identify the most appropriate nursing diagnosis.

A) Altered self-esteem related to colostomy and poor self-image

B) Disturbed body image related to colostomy as evidenced by avoidance of colostomy

C) Fear of rejection by others related to colostomy and altered self-image

D) Altered role performance related to inability to cope with visitors

Ans: B

Feedback:

Disturbed body image possesses the clinical cues of behaviors of avoidance, monitoring, or acknowledgement of one's body.

29. The nurse is caring for a girl 13 years of age, who is admitted after taking some of her mother's sleeping pills. She is withdrawn and declines to eat or engage in conversation, except to say she doesn't like herself. The nurse is aware that potential causes of poor self-concept at this age can be related to which of the following? Choose all that apply.

A) Inability to accept bodily changes

B) Identify confusion

C) Failure to accept role responsibility

D) Failure to develop meaningful goals

E) Inability to resolve child versus adult roles

Ans: A, B, E

Feedback:

The adolescent can develop a poor self-concept related to bodily changes, the pull between adult and childhood roles, and identity confusion. The adult can have poor self-concept related to failure to accept role responsibilities, such as parenting or failure to develop meaningful goals, and therefore just drifting through life.

30. The nurse is caring for a man client, age 47 years, who suffers from myasthenia gravis. He has periods of great weakness and is unable to do the things for his family that he would like to. He tells the nurse that he is not worth much these days. Knowing that sometimes clients focus on things they cannot do, which of the following statements by the nurse might be helpful?

A) I'm sure that things will be better soon.

B) Some days are like that.

C) Does your family pitch in and help you?

D) What are some of the things you do well?

Ans: D

Feedback:

Many clients focus naturally on their deficiencies; asking pointed questions about personal strengths can help a client identify positive factors. Telling this client that things will be better soon is untruthful; his disease is not curable. Asking if his family is helpful will make him feel even more worthless. Saying, Some days are like that tells the client that you agree with his opinion that he is worthless.

31. The nurse cares for a successful chemical engineer, age 29 years, who is admitted with a respiratory infection. The client reports feeling more stress than ever since a job promotion six months ago and asks, Why would something so positive and wonderful cause so much stress for me? Which is an appropriate response by the nurse? Select all that apply.

A) All major life events can cause stress for us.

B) People vary greatly in their perception of what constitutes a crisis or stressor.

C) Your job promotion probably has nothing to do with the stress you feel.

D) Positive life events do not cause stress or illness.

E) Even positive life events can affect us in negative ways.

Ans: A, B, E

Feedback:

People vary greatly in their perception of what constitutes a crisis or stressor, as well as the degree to which such experiences might disrupt or diminish self-concept. Major stressors place anyone at relative risk for maladaptive responses such as withdrawal, isolation, depression, extreme anxiety, substance abuse, or exacerbation of physical illness. It is true that even positive events, such as marriage, a new baby, or a job promotion can place us at risk for great stress and all that goes with us. The client's promotion probably has a great deal to do with her stress level.

32. The nurse is caring for a female client 64 years of age who is admitted for knee replacement. As the nurse performs the shift assessment, the client comments, I wouldn't mind getting old if it were not for the physical losses, like the wrinkles, all the drooping, and the wearing out of everything. People like to be around youthful, beautiful men and women; I feel so unattractive. Is the client correct about how society views older people? In general, which of the following does society emphasize and reward? Choose all that apply.

A) Wisdom for sharing

B) Youthfulness

C) Mentoring the inexperienced

D) Health and fitness

E) Physical attractiveness

Ans: B, D, E

Feedback:

Society encourages a kind of denial of the eventuality of aging, chronic illness, and the necessity to integrate crisis and change throughout each person's lifetime. Society emphasizes and rewards youth, health, and narrow norms for physical attractiveness while devaluing seniors, those with chronic illness, and those whose appearance does not correspond to movie-star standards. Wisdom with the ability to mentor the inexperienced is important, but not as valued by society as physical attractiveness.

33. The nurse is attending a nursing conference about enhancing self-concept in relation to professional nursing practice. As the nurse is waiting for the first speaker to begin, she tries to recall what she knows and has read about this subject. Which of the following would be good for the nurse to keep in mind to enhance her self-concept as a professional nurse?

A) Don't worry about team esteem until your own is good.

B) Avoid your weaknesses until they become strengths.

C) Remember past errors so you do not repeat them.

D) You don't have to know everything to be a good nurse.

Ans: D

Feedback:

Dispel the myth that it is necessary to know all there is to know about nursing to be a good nurse. At no one point in time does any nurse ever have it all together. Take errors seriously but do not dwell on them; accentuate the positive. Do not avoid your weaknesses until they become stronger; they won't improve without hard work on your part. Work to develop team self-esteem. A basic interpersonal principle that seems to work well in practice is to offer to others what you want yourself.

34. The nurse is assessing his client's self-concept. The client is status post–myocardial infarction and is due to be discharged tomorrow. Which of the following focuses will give the nurse the most information about the client's self-concept? Choose all that apply.

A) Body image

B) Gender identity

C) Self-esteem

D) Role performance

E) Sexual orientation

Ans: A, C, D

Feedback:

The nurse assessing self-concept focuses on the client's personal identity, body image, self-esteem, and role performance. Sexual orientation and gender identity do not always provide information about self-concept.

35. A young woman has been in an automobile crash and sustained a laceration across the left side of her face, resulting in a large scar. What nursing diagnosis would be appropriate for this disfigurement?

A) Anxiety

B) Disturbed Body Image

C) Deficient Knowledge

D) Impaired Memory

Ans: B

Feedback:

Body image is the subjective view a person has about his or her physical appearance. Disturbances in body image occur with any alteration in bodily appearance, structure, or function.

Chapter 42, Stress and Adaptation

1. Which of the following responses to stressors results from the activation of the local adaptation syndrome?

A) A girl quickly withdraws her hand from a stream of hot tap water.

B) A woman's impending job interview has prompted the activation of her fight-or-flight response.

C) A man is experiencing moderate anxiety before meeting with an important client.

D) A man has a sudden urge for a bowel movement before undergoing thoracentesis.

Ans: A

Feedback:

The reflex pain response is a response to physiological stress that is a component of the local adaptation syndrome. Psychological anxiety and the activation of the fight-or-flight response are not considered to be manifestations of the local adaptation syndrome.

2. Which of the following best describes stress?

A) A response to changes in the normal balanced state

B) A perception that something is threatening

C) A response to internal environment for homeostasis

D) A localized response of a tissue or organ to a stressor

Ans: A

Feedback:

Stress is a condition in which the human system responds to changes in its normal balanced state. Stress results from a change in the environment that is perceived as a challenge, a threat, or a danger, and can have both positive and negative effects.

3. Cold temperatures and loud noises are stressors to one person but not another. Why does this occur?

A) Although the perception is the same, the response is individualized.

B) Both individuals will respond the same, depending on the situation.

C) The perception and effects of stressors are highly individualized.

D) The internal environment of one person is more selective.

Ans: C

Feedback:

A stressor is anything that is perceived as challenging, threatening, or demanding. Stressors may be internal or external. The perception and effects of the stressors are highly individualized.

4. What is the term for the change that takes place in response to a stressor?

A) Rehabilitation

B) Adaptation

C) Positive movement

D) Negative movement

Ans: B

Feedback:

When a person is in a threatening situation, immediate and often involuntary responses occur. The change that takes place in response to a stressor is adaptation.

5. A client responds to bad news regarding test results by crying uncontrollably. What is the term for this response to a stressor?

A) Adaptation

B) Homeostasis

C) Coping mechanism

D) Defense mechanism

Ans: C

Feedback:

When a person is in a threatening situation, immediate responses occur. Those responses, which are often involuntary, are called coping responses. The change that takes place as a result of the response to a stressor is adaptation.

6. Various physiologic mechanisms within the body respond to internal changes to maintain relative constancy in the internal environment. The state that results is called what?

A) Nirvana

B) Homeostasis

C) Fight-or-flight response

D) Anxiety

Ans: B

Feedback:

To maintain health, the body's internal environment must remain in a balanced state. Various physiologic mechanisms within the body respond to internal changes to maintain relative constancy in the internal environment, which is called homeostasis.

7. A student is preparing for her first client care assignment. She wakes up at 4 AM with a pounding pulse and diarrhea. What type of adaptive response to stress is she experiencing?

A) General adaptation syndrome

B) Mind–body interaction

C) Local adaptation syndrome

D) Coping or defense mechanism

Ans: B

Feedback:

The student's response to stress exemplifies the mind–body interaction and illustrates a link between psychological stressors and the physiologic stress response. A person perceives a threat on an emotional level as though it is a physiologic threat, and the body prepares itself for the fight-or-flight response.

8. A client with an inflamed appendix is feeling pain in the stomach area. What is the term for this body response to stress?

A) Local adaptation syndrome

B) General adaptation syndrome

C) Physiological homeostasis

D) Fight-or-flight response

Ans: A

Feedback:

The local adaptation syndrome is a localized response of the body to stress. It involves only a specific body part (such as a tissue or organ) instead of the whole body. The stress precipitating the LAS may be traumatic or pathologic.

9. What phase of the general adaptation syndrome is a client in when he uses all of his adaptive mechanisms for dealing with stress, leaving no defense against the distress?

A) Alarm reaction stage

B) Fight-or-flight stage

C) Stage of resistance

D) Stage of exhaustion

Ans: D

Feedback:

Exhaustion results when the adaptive mechanisms are exhausted. Without defense against the stressor, the body may either rest and mobilize its defenses to return to normal, or reach total exhaustion and die.

10. A client who is being seen at a physician's office states that he has "bad headaches all the time." Diagnostic tests are normal. What is this type of response to stress called?

A) Psychosomatic disorder

B) Acute illness

C) Chronic illness

D) Pretend disorder

Ans: A

Feedback:

Each person reacts to stress in his or her own way. With prolonged stress, some may develop diarrhea, others headaches. Such illnesses are real and are called psychosomatic disorders because the physiologic alterations are thought to be at least partially caused by psychological influences.

11. An individual steps into a tub of very hot water and immediately jumps out again. What mechanism caused this response?

A) Inflammatory response

B) Reflex pain response

C) General adaptation syndrome

D) Fight-or-flight response

Ans: B

Feedback:

The reflex pain response is a rapid and automatic response of the central nervous system to pain that serves as a protective mechanism to prevent injury.

12. If a nurse assessed the vital signs of a person who was in the initial alarm reaction stage (shock phase) of the GAS, what would be the expected findings?

A) Slow, deep breathing

B) Fatigue and lethargy

C) Hypotension

D) Hypertension

Ans: D

Feedback:

The alarm reaction is initiated when a person perceives a specific stressor and various defense mechanisms are activated. The initial or shock phase is characterized by increased energy, oxygen intake, cardiac output, blood pressure, and mental alertness.

13. Which of the following group of terms best describes anxiety?

A) Cognitive, known threat, depression

B) Cognitive, visible threat, anger

C) Known source, prolonged, solely physical

D) Unknown cause, emotional, apprehensive

Ans: D

Feedback:

The most common human response to stress is anxiety. Anxiety is a vague, uneasy feeling of discomfort or dread,an emotional response to a threat. The source is often nonspecific or unknown. It is a feeling of apprehension caused by anticipating a danger.

14. A nurse is preparing to educate a client about care at home. On entering the room, she finds the client pacing around the room, hyperventilating, and complaining of nausea. Based on these manifestations of severe anxiety, what would the nurse do?

A) Provide both verbal and written information to the client.

B) Ignore the client and teach the family the information.

C) Modify the education plan to the client's anxiety level.

D) Postpone implementation of the education plan.

Ans: D

Feedback:

Severe anxiety creates a very narrow focus on specific detail, causing all behavior to be geared toward getting relief. Manifestations include increased motor activity, nausea, and hyperventilation. The person has impaired learning ability. Education should be postponed and help to reduce the anxiety should be provided.

15. A woman who was assaulted in the street is brought to the emergency room for observation. A nurse documents that the woman has difficulty communicating verbally, is agitated, and complains of chest pain and a sense of impending doom. What type of anxiety is this client experiencing?

A) Mild anxiety

B) Moderate anxiety

C) Severe anxiety

D) Panic

Ans: D

Feedback:

Panic causes the person to lose control and experience dread and terror. The resulting disorganized state is characterized by increased physical activity, distorted perception of events, and loss of rational thought. Panic is manifested by difficulty communicating verbally, agitation, trembling, poor motor control, sensory changes, sweating, tachycardia, hyperventilation, dyspnea, palpitations, a choking sensation, and sensations of chest pain or pressure.

16. A man has noticed bright red blood in his bowel movements for over a month. He says to himself, "Oh, it's just my hemorrhoids." What defense mechanism is the man using?

A) Rationalization

B) Repression

C) Denial

D) Compensation

Ans: C

Feedback:

When using denial as a defense mechanism, an individual is refusing to acknowledge the presence of a condition that is disturbing.

17. Which of the following illnesses has been associated with long-term stress?

A) Bacterial infections

B) Cardiovascular disease

C) Renal disease

D) Fractures

Ans: B

Feedback:

Long-term stress affects physical status, increasing the risk for disease or injury. High levels of stress are associated with cardiovascular disease, gastrointestinal disorders, and cancer. These diseases are the result of a combination of factors, including the GAS, eating patterns, lifestyle, and coping mechanisms.

18. The wife of a client on hospice at home is diagnosed with "caregiver burden." Which of the following best describes this syndrome?

A) Prolonged stress from caring for a family member at home

B) Inability to provide competent care for a family member

C) Insufficient funds to pay for medical care of a family member

D) Effect of the illness causing stress in siblings

Ans: A

Feedback:

Caring for a family member at home for long periods can cause prolonged stress. Called *caregiver burden*, this stress response includes chronic fatigue, sleep problems, and an increased incidence of stress-related illnesses, such as high blood pressure and heart disease.

19. A friend has lost her job and is becoming increasingly anxious to the point of crisis. What type of crisis is she experiencing?

A) Adventitious

B) Maturational

C) Situational

D) Emotional

Ans: C

Feedback:

Crises may be maturational, situational, or adventitious. Situational crises occur when a life event, such as the loss of a job, disrupts a person's psychological equilibrium.

20. Which of the following is an example of developmental stress?

A) A newborn who needs to be fed by bottle

B) A school-age child learning to read

C) A teenager learning to drive a car

D) A middle adult accepting signs of aging

Ans: D

Feedback:

Developmental stress occurs as a person progresses through the normal stages of growth and development, from birth to old age. Within each stage, certain tasks must be achieved to resolve the crisis and reduce the stress. The middle adult has the developmental task of accepting physical signs of aging.

21. Of the following physiologic stressors, which one is a physical agent?

A) Heat

B) Drugs

C) Bacteria

D) Hypoxia

Ans: A

Feedback:

Physiologic stressors have both a specific effect (altered body structure and function) and a general effect (stress response). Heat is a physical agent that is a physiologic stressor.

22. Which area of nursing experiences the highest levels of stress in the work setting?

A) Obstetric nurses

B) Pediatric nurses

C) New graduates

D) Aging nurses

Ans: C

Feedback:

Nursing involves activities and interpersonal relationships that are often stressful. The stress is even greater for two groups of nurses: new graduates and nurses who work in intensive care and emergency care.

23. Which of the following questions would be helpful in eliciting data about the effects of stress during a health history?

A) "Why are you having so much difficulty breathing at night?"

B) "Why do you think smoking and drinking will calm you?"

C) "Do you often drink too much and have hangovers?"

D) "How does your body feel when you are upset?"

Ans: D

Feedback:

Stress causes many physiologic manifestations and emotional responses. The question "How does your body feel when you are upset" is nonjudgmental and nonthreatening, and encourages the client to talk about the symptoms he or she has experienced.

24. Which diagnoses would be written for stress as the cause of the problem?

A) Anxiety related to conflicts about values and goals in life

B) Caregiver Role Strain related to long-term stress of care for a parent with Alzheimer's disease

C) Spiritual Distress related to inability to accept diagnosis of terminal illness

D) Hopelessness related to presence of disabling physical injuries

Ans: A

Feedback:

Assessment data may reveal stress to be the problem as seen in answer A, or the etiology of a problem as seen in answers B, C, and D.

25. A nurse is educating a client about the benefits of exercise in reducing stress. How often would the nurse recommend the client exercise?

A) Two hours every day

B) One hour once a week

C) 30 to 45 minutes, most days of the week

D) 60 to 75 minutes, four to five times a week

Ans: C

Feedback:

General health guidelines recommend that an exercise program consist of 30 to 45 minutes of moderate activity most days of the week. Exercise improves one's general sense of well-being, relieves tension, and enables one to cope better with day-to-day stressors.

26. A nurse teaches a client deep-breathing exercises to help control his anxiety. This is considered what type of stress management technique?

A) Meditation

B) Relaxation

C) Anticipatory guidance

D) Guided imagery

Ans: B

Feedback:

Two helpful relaxation activities, to be practiced three or four times at each session, are deep breathing and progressive muscle relaxation. A person practicing meditation sits comfortably with closed eyes, relaxes the major muscle groups, and repeats the selected word silently with each exhalation. Anticipatory guidance focuses on psychologically preparing a person for an unfamiliar or painful event. In guided imagery, a person creates a mental image, concentrates on the image, and becomes less responsive to stimuli (including pain).

27. A client has been brought to the health care facility with accident-related injuries. During the initial interview, the client becomes agitated, upset and is unable to answer any more of the nurse's questions. What does the nurse conclude about the condition of the client?

A) The client's mind is preparing for a fight-or-flight response as he relates the incident.

B) The client's mind is numb, and he is not able to react to further questions from the nurse.

C) The brain is receiving less oxygen with each passing minute, which does not allow him to speak.

D) The brain is sending chemicals to the bloodstream that make the client afraid of the questions.

Ans: A

Feedback:

The client is currently in the alarm stage, where the stimulating neurotransmitters and neurohormones are released, which prepare the client for a fight-or-flight response. The brain, at this time, receives more oxygen to sharpen the senses and coordination. The brain also sends more chemicals to the bloodstream, which helps the client to keep alert for an extended period of time.

28. A client age 35 years is stressed because he is having problems with his superiors at work. The client says that he had an argument with his superiors about his salary. He has become very anxious and has started consuming large amounts of caffeine very frequently. He also suffers from insomnia and gets angry quickly. Which of the following techniques should the nurse suggest to help the client?

A) Non-therapeutic coping strategy

B) Negative coping strategy

C) Therapeutic coping strategy

D) Sensory manipulation strategy

Ans: C

Feedback:

Therapeutic coping strategies usually help the person to acquire insight, gain confidence to confront reality, and develop emotional maturity. Maladaption results when people use non-therapeutic coping strategies such as mind- and mood-altering substances, hostility and aggression, excessive sleep, avoidance of conflict, and abandonment of social activities. Sensory manipulation involves altering moods, feelings, and physiologic responses by stimulating pleasure centers in the brain using sensory stimuli. Negative coping strategies may provide immediate temporary relief from a stressor, but they eventually cause problems.

29. When discussing his problem, a client tells the nurse that he is always doing small, petty jobs for everyone and he is not happy about it. Because of this, he is feeling stressed and has been getting into fights with his wife. What should the nurse suggest to help the client overcome this problem?

A) Change jobs.

B) Avoid people who dump tasks on him.

C) Take control of the situation.

D) Avoid doing petty jobs.

Ans: C

Feedback:

A behavioral technique for modifying stress is to take control rather than become immobilized. This is also known as alternative behavior. Another behavioral approach to reduce stress is to sometimes say "no," in order to avoid becoming overwhelmed and more stressed. Changing jobs, avoiding the person, or avoiding the petty jobs would not help.

30. Which of the following statements, made by a senior citizen who has taken a class on stress reduction, would indicate to the nurse the need for further instruction?

A) Adults draw on coping skills learned throughout life.

B) Family members can be supportive during stress.

C) Stress may be positive or negative.

D) As one grows older, their stress decreases.

Ans: D

Feedback:

As a person ages, stress does not decrease; in fact, some people experience increased stressors associated with commonly encountered circumstances, such as experiencing empty-nest syndrome or dealing with the death of family and friends.

31. Which of the following body systems are the primary controllers of homeostatic mechanisms? Select all that apply.

A) Autonomic nervous system

B) Endocrine system

C) Respiratory system

D) Cardiovascular system

E) Gastrointestinal system

Ans: A, B

Feedback:

The autonomic nervous system and the endocrine system primarily control homeostatic mechanisms. Involved to a lesser degree are the respiratory, cardiovascular, gastrointestinal, and renal systems.

32. The client is under immediate stress. The nurse assesses which sign as an effect of the sympathetic system?

A) Blood sugar of 65 mg/dL

B) Heart rate of 102 beats/minute

C) Increased bowel sounds

D) Cool, clammy skin

Ans: B

Feedback:

When stressed, the client's sympathetic system is activated, which causes an increase in heart rate. The sympathetic system also stimulates release of glycogen, which increases blood glucose levels and dilates skeletal muscle blood vessels. This would most likely cause warm skin. The parasympathetic system, which functions under normal conditions and at rest, stimulates secretion of digestive juices and the smooth muscle of the digestive tract, thus leading to increased peristalsis.

33. The client is a child age 5 years hospitalized for a surgical procedure. The client is bedwetting. The parents report this is a new behavior and their child is toilet trained. The nurse assesses the client is exhibiting the defense mechanism of …

A) compensation.

B) displacement.

C) reaction formation.

D) regression.

Ans: D

Feedback:

Regression is a maladaptive behavior in which the client returns to an earlier method of behaving, as seen in the child who is now bedwetting. Compensation is overcoming a perceived weakness by emphasizing a more desirable trait. Displacement is transferring an emotional reaction from one object or person to another. Reaction formation is exhibiting behaviors that are the opposite of what the client would really like to do.

34. The client is a single parent being seen at an employee wellness clinic. The client tells the nurse he has three school-age children who participate in various activities. He states, "Every night, I am taking them to soccer practice, football practice, Girl Scouts. I have to fix dinner and then go over homework. I have no time for myself. I am so tired." The client exhibits tremors of his hands. Blood pressure is 140/88 mm Hg, heart rate is 98 beats/minute, and respirations are 30 breaths/minute. Data best supports which of the following nursing diagnoses?

A) Stress Overload related to single parenting

B) Defensive Coping related to inability to appraise stressors

C) Hopelessness related to multiple responsibilities

D) Disturbed Sleep Pattern related to anxiety

Ans: A

Feedback:

The client is stating his stressors and a reaction to the stressor when he states, “I am so tired.” This would support Stress Overload. Defensive Coping would be not appropriate as he can state stressors in his life. He does not express Hopelessness in his statement to the nurse. The nurse needs more data, such as difficulty falling asleep and interrupted sleep, to support Disturbed Sleep Pattern.

35. The nurse walks into the client’s room and finds her sobbing uncontrollably. When the nurse asks what the problem is, the client responds I am so scared. I have never known anyone who goes into a hospital and comes out alive. On this client’s care plan the nurse notes a nursing diagnosis of Ineffective coping related to stress. What is the best outcome you can expect for this client?

A) Client will adapt relaxation techniques to reduce stress.

B) Client will be stress free.

C) Client will avoid stressful situations.

D) Client will start anti-anxiety agent.

Ans: A

Feedback:

Stress management is directed toward reducing and controlling stress and improving coping. The outcome for this diagnosis is that the client needs to adopt coping mechanisms that are effective for dealing with stress, such as relaxation techniques. The other options are incorrect because it is unrealistic to expect a client to be stress free; avoiding stressful situations and starting an anti-anxiety agent are not the best answers as outcomes for ineffective coping.

Chapter 43, Loss, Grief, and Dying

1. As decisions related to health care become increasingly complex, nurses need to be familiar with concepts related to advance directives. Which statement regarding advance directives is correct?

A) Hospitals are legally required to inform clients about advance directives.

B) The status of advance directives remains consistent from state to state.

C) Advance directives should be developed with the assistance of a physician or nurse.

D) Nurses can be appointed a surrogate decision maker by the client.

Ans: A

Feedback:

The Patient Self-Determination Act of 1990 requires all hospitals to inform their clients about advance directives. Th status of advance directives varies from state to state. Clients appoint a family member or close friend as a surrogate decision maker, not a nurse or health care professional. Advance directives are developed by the client; nurses and physicians may play a role in providing education related to advance directives, but their role is not essential.

2. A woman has had a breast removed to treat cancer. What type of loss will she most likely experience?

A) Actual loss

B) Perceived loss

C) Maturational loss

D) Anticipatory loss

Ans: A

Feedback:

Loss occurs when a valued person, object, or situation is changed or made inaccessible so that its value is diminished or removed. Actual loss can be recognized by others as well as by the person sustaining the loss.

3. Which of the following is an example of a perceived loss?

A) A client mourns the loss of his amputated leg.

B) A client grieves for the loss of his wife to cancer.

C) An older client grieves for the loss of his independence.

D) A client grieves for the loss of his job.

Ans: C

Feedback:

Perceived loss, such asloss of youth, of financial independence, and of a valued environment, is experienced by the person but is intangible to others. Answers A, B, and D are actual loss and can be recognized by others as well as by the person sustaining the loss; for example, loss of a limb, of a child, of a valued object such as money, and of a job.

4. A man is diagnosed with terminal kidney failure. His wife demonstrates loss and grief behaviors. What type of loss is the wife experiencing?

A) Maturational loss

B) Anticipatory loss

C) Dysfunctional grieving

D) Bereavement

Ans: B

Feedback:

Anticipatory loss occurs when a person displays loss and grief behaviors for a loss that has yet to take place. It is often seen in the families of clients with serious or life-threatening illnesses, and serves to lessen the effect of the actual loss of a family member.

5. Which one of the following statements accurately describes the process known as grief reaction?

A) Reactions to grief and dying are different.

B) Reactions to grief are similar for all people.

C) Reactions to grief follow all stages of the grieving process.

D) Reactions to grief may differ from client to family.

Ans: D

Feedback:

Reactions to grief and dying are similar. The stages of these reactions overlap and vary among individuals. One person may skip a reaction stage, whereas another may repeat an earlier stage. Each person is different, and clients and family members may be at different reaction stages. More important than the actual stages of any given grief reaction is the idea that grief is a process that varies from person to person.

6. Which of the following statements is typical of the first stage of grieving described by Engel?

A) "No, not me."

B) "Why me?"

C) "My husband was the best man in the world."

D) "The funeral service helped me survive."

Ans: A

Feedback:

According to Engel, the first stage of grief is shock and disbelief. In this initial stage, the surviving family members often refuse to accept the fact of the loss, followed by a stunned or numb response of "No, not me."

7. The husband of a client who died of breast cancer is still grieving for his wife two years later. What type of grief is he experiencing?

A) Unresolved

B) Situational

C) Inhibited

D) Maturational

Ans: A

Feedback:

Unresolved grief is abnormal or distorted; it may be either unresolved or inhibited. In unresolved grief, a person may have trouble expressing feelings of loss or may deny them; unresolved grief also describes a state of bereavement that extends over a lengthy period. With inhibited grief, a person suppresses feelings of grief and may instead manifest somatic (body) symptoms, such as abdominal pain or heart palpitations.

8. According to the Harvard University Medical School committee, what function must be irreversibly lost to define death?

A) Respiratory functions

B) Reflexes

C) Consciousness

D) Brain function

Ans: D

Feedback:

A Harvard University Medical School committee added that the nonreversible loss of brain function, accompanied by the more traditional signs, should be the definitive definition of death.

9. A nurse assesses a terminally ill patient with a DNR order, with findings of decreased blood pressure, urinary and bowel incontinence, loss of reflexes, and Cheyne-Stokes respirations. Based on these findings, the nurse recognizes which of the following?

A) These are signs of impending death.

B) These signs do not indicate any abnormality.

C) The client requires immediate resuscitation.

D) The client's family should be asked to leave.

Ans: A

Feedback:

The clinical signs of impending or approaching death include decreased blood pressure, urinary and/or bowel incontinence, loss of reflexes, and Cheyne-Stokes respirations.

10. Kübler-Ross defines five stages of psychosocial responses to dying and death. Which of the following statements is characteristic of the bargaining stage?

A) "The doctors must have made a mistake."

B) "Why did this happen to me? I always exercised."

C) "Just let me live to see my grandson born."

D) "I've had a good life and I can die in peace."

Ans: C

Feedback:

In the bargaining stage of the psychosocial responses to dying and death, the client tries to bargain for more time to live. It is important to meet wishes for putting personal affairs in order and fulfilling last wishes during this time, if possible, because bargaining helps clients move into later stages of dying.

11. A client is diagnosed with a terminal illness. Who is usually responsible for deciding what, when, and how the client should be told?

A) Family

B) Clergy

C) Nurse

D) Physician

Ans: D

Feedback:

In the case of a terminal illness in which death is expected within a limited space of time, the physician is usually responsible for deciding what, when, and how the client should be told. The nurse, along with members of the clergy and other health care professionals, may be involved with these decisions and in discussing the client's condition with him or her.

12. A nurse providing palliative care for a dying man and his family knows that the goal of palliative care is what?

A) To aggressively treat the disease.

B) To provide care for the dying in the home.

C) To aggressively treat the symptoms of the disease.

D) To support the family of the dying client.

Ans: C

Feedback:

Palliative care means taking care of the whole person—body, mind, and spirit, heart and soul. It views dying as something natural and personal. The goal of palliative care is to give clients with life-threatening illnesses the best quality of life they can have by the aggressive management of symptoms. Hospice care is care provided for people with limited life expectancy, often in the home. While hospice care focuses on the needs of the dying, palliative care is appropriate across the spectrum of disease and illness.

13. A client asks a nurse to explain a living will. What is the nurse's best answer?

A) It specifies who will inherit the client's estate.

B) It determines an individual's quality of life.

C) It lists specific instructions for health care provisions.

D) It identifies a trusted person to make health care decisions.

Ans: C

Feedback:

A living will is a type of written advance directive that provides specific instructions about the kinds of health care that should be provided or foregone in particular situations.

14. A dying client states in writing ahead of time what her choices would be for health care should certain circumstances develop. What is the term for this document?

A) Living will

B) Advance directives

C) Durable power of attorney

D) Comfort measures only

Ans: B

Feedback:

Two kinds of written advance directives can minimize difficulties by allowing individuals to state in advance what their choices would be for health care, should certain circumstances develop. Living wills provide specific instructions about the kinds of health care that should be provided or foregone in particular situations. A durable power of attorney for health care appoints an agent the person trusts to make decisions in the event of subsequent incapacity. Comfort measures only indicate that the goal of treatment is a comfortable, dignified death, and that further life-sustaining measures are no longer indicated.

15. A dying client and family have requested that no attempts be made to resuscitate the client in the event of death. A doctor has written a DNR order. What is the nurse's responsibility if the client dies?

A) Follow his or her own conscience and perform CPR.

B) Make no attempt to resuscitate the client.

C) Follow a verbal physician's order for a slow code.

D) If the client is at home, call 911 and begin CPR.

Ans: B

Feedback:

A do not resuscitate (DNR) order means that no attempts are to be made to resuscitate a client who stops breathing or whose heart stops beating. The physician must write an order for this if the client or surrogate has expressed a wish that there be no attempts to resuscitate.

16. A terminally ill client, in severe pain, asks a nurse to help her die. What must the nurse consider morally, ethically, and professionally before answering the client?

A) ANA Code for Nurses, ethical and professional standards

B) Own personal moral and ethical values and standards

C) Hospital or agency procedures and protocols

D) Medical Code of Ethics, belief in active euthanasia

Ans: A

Feedback:

The ANA Code of Ethics, the ethical traditions and goals of the nursing profession, and nursing's covenant with society, all affirm that it is a violation for nurses to participate in assisting in a suicide and active euthanasia (assisting a client to die).

17. Which of the following persons is responsible for handling and filing a death certificate with proper authorities?

A) Mortician

B) Physician

C) Nurse

D) Hospital administrator

Ans: A

Feedback:

U.S. law requires that a death certificate be prepared for each person who dies. The law specifies what information needs to be supplied. Death certificates are sent to local health departments, which compile many statistics from the information. The mortician assumes responsibility for handling and filing the death certificate with proper authorities. A physician's signature is required on the certificate, as well as that of the pathologist, the coroner, and others in special cases. The nurse's responsibility is to ensure that the physician has signed a death certificate.

18. Although all of the following are factors that affect grief, which one is most likely to influence a person's expression of grief?

A) Socioeconomic factors

B) Cultural influences

C) Religious influences

D) Cause of death

Ans: B

Feedback:

Both the physical and emotional manifestations of grief may be culturally influenced. Culture also influences a person's expression of grief.

19. A dying client is undergoing terminal weaning. What is the purpose of this intervention?

A) To manage the symptoms of the illness

B) To prepare for resuscitation of the client

C) To initiate life-sustaining measures for the client

D) To gradually withdraw mechanical ventilation

Ans: D

Feedback:

Terminal weaning is the gradual withdrawal of mechanical ventilation from a client with a terminal illness or an irreversible condition with a poor prognosis.

20. A nurse is developing a plan of care for a dying client. Which of the following physiologic basic human needs should be addressed?

A) Personal hygiene

B) Rsk for infection

C) Family support

D) Spirituality

Ans: A

Feedback:

Physiologic care of the dying client involves meeting physical needs such as personal hygiene, pain control, nutritional and fluid needs, movement, elimination, and respiratory care.

21. While caring for a client near end of life, a student talks to her. Another student asks why she is talking to someone who is dying. Which response would be accurate?

A) “It makes me feel better to talk to my clients.”

B) “I do this so I won’t be so afraid the client will die.”

C) “I believe the client can hear me as long as she is alive.”

D) “I don’t know; the nurse in charge of the client told me to.”

Ans: C

Feedback:

The sense of hearing is believed to be the last sense to leave the body, with many clients able to hear almost to the moment of death. The nurse should explain to the client the nursing care being given and the noises in the unit.

22. A hospice nurse is providing emotional care and support for a family who lost a son. The care will be provided based on what knowledge?

A) All members of the family will react to loss in the same way.

B) Grief is an abnormal physical reaction to a loss.

C) Stages of grief reactions may overlap and are individualized.

D) Bereavement is a normal process, requiring little intervention.

Ans: C

Feedback:

Although reactions to grief and dying are similar, the stages of grief reactions overlap and vary among individuals. Each person is different, and family members may be at different reaction stages.

23. Family members of a dying client are in the room with their loved one. As the client nears death, what should the nurse tell the family?

A) "Please leave the room now. It is time to let go."

B) "Only one family member at a time can stay in the room."

C) "Please stay with your loved one and talk to him."

D) "I will have to get an order for you to stay now."

Ans: C

Feedback:

A fear of having to face death alone is a primary concern of dying patients. The presence of family members in the room should be encouraged and reminiscences should be shared.

24. A nurse is providing postmortem care. Which of the following nursing actions is a legal responsibility?

A) Placing the body in normal anatomic position

B) Removing tubes and soiled dressings

C) Washing the body to remove blood and excretions

D) Placing ID tags on the shroud and ankle

Ans: D

Feedback:

Although the nurse may place the body in a normal anatomic position and remove tubes and soiled dressings, the only legal action is placing ID tags on the shroud and ankle. The body is not usually washed by the nurse, as different cultures and religions have specific guidelines concerning cleansing the body.

25. A young client died following a cardiac arrest. The nurse caring for the client and the family notes that some members of the family refuse to accept that the client has died. What stage of grief is the family experiencing?

A) Shock and disbelief

B) Developing awareness

C) Restitution period

D) Idealization

Ans: A

Feedback:

The family members are in the "shock and disbelief" stage of grief, as they refuse to accept that a loved one has died. In the stage of developing awareness, the grieving person develops physical and emotional responses, such as feeling sick, sad, empty, or angry. In the idealization stage, the grieving person exaggerates the good qualities of the deceased.

26. A nurse is caring for a young client who is dying of renal failure. What should the nurse do when caring for the dying client's family members?

A) Inform the family that the client may soon be out of danger

B) Request the family members not to talk about death to the client

C) Inform the family members that it is time to bid farewell to the client

D) Provide respite care to the client's family members

Ans: C

Feedback:

The nurse should ask the family members to meet the client so that they can have a chance to say a final goodbye. The nurse should not provide any false hope to the client's family by telling them that the client may soon be out of danger. The nurse should not ask the client's family members to avoid talking about death, because the client would want to know that he or she is loved and will be missed by the family. Respite care is usually provided when the client is resting or out of danger.

27. A nurse is caring for a young client with acute renal failure who is dying. What care should the nurse take when helping dying clients to cope?

A) Avoid discussing death with the client.

B) Ask the client's family not to disturb the client.

C) Avoid informing the client of his or her actual health status.

D) Provide opportunities for the client to express his or her feelings freely.

Ans: D

Feedback:

The nurse should provide opportunities for the client to express his or her feelings freely, as it demonstrates attention to meeting individual needs. The nurse should not avoid discussing death with the client, nor ask the client's family not to disturb him or her. The nurse should inform the client of his or her actual health status if he or she wishes to know, as the Dying Person's Bill of Rights states that the client has a right to have his or her questions answered honestly.

28. A middle-age woman is mentally preparing for the death of her mother. What is the term for this mental preparation?

A) Grieving

B) Anticipatory grieving

C) Bereavement

D) Loss

Ans: B

Feedback:

Anticipatory grief is the characteristic pattern of psychological and physiologic responses a person makes to the impending loss (real or imagined) of a significant person, object, belief, or relationship.

29. An appropriate nursing diagnosis for the family of a client dying of cancer, whose members have expressed sorrow over the forthcoming loss, would be …

A) Anticipatory grieving related to loss of family member, as evidenced by sorrow

B) Dysfunctional grieving related to the loss of family member, as manifested by behaviors indicating anxiety

C) Potential for grieving related to loss of family member and sorrow

D) Dysfunctional grieving related to future loss of family member, manifested by family's developmental regression

Ans: A

Feedback:

Anticipatory grieving comprises the intellectual and emotional responses and behaviors by which individuals, families, and communities work through the process of modifying self-concept based on the perception of loss.

30. For which persons are death certificates necessary? Select all that apply.

A) Death from an infectious disease

B) Death in an institutional setting

C) Unexpected death

D) Murder victims

E) Death before age 65 years

Ans: A, B, C, D, E

Feedback:

U.S. law requires death certificates for all clients who die.

31. The client is newly diagnosed as having a terminal disease and asks, "I'm going to die soon, aren't I?" What are the most appropriate statements by the nurse? Select all that apply.

A) "You should ask your health care provider that question."

B) "What have you been told by your health care provider?"

C) "How do you feel about that?"

D) "This is something I am not comfortable discussing."

E) "No, you are not actively dying."

Ans: B, C

Feedback:

The questions "What have you been told?" and "How do you feel about that?" encourage the client to discuss what he does know and his feelings. The nurse needs to be comfortable about discussing issues related to dying with the client. Referring the question to the health care provider is considered passing the buck. The statement, "No, you are not actively dying" is closing the conversation and lying to the client.

32. A terminally ill client states to the nurse, "My situation is hopeless; I have no control over anything." The nurse implements which of the following interventions to enable hope for the client?

A) State to the client, "We have explored all treatment options."

B) Encourage the client to discuss his feelings.

C) Sit in a chair next to the client.

D) Hold the client's hand.

E) Withhold information about disease progression.

Ans: B, C, D

Feedback:

Measures to establish rapport with the client (e.g., providing time and physical contact by sitting in a chair next to the client; holding the client's hand) should be utilized. The client should be encouraged to express his feelings. The nurse avoids language that would extinguish hope as in the statement, "We have explored all treatment options." The nurse should provide information about the progress of the disease.

33. The nurse is giving palliative care to a client with a diagnosis of COPD. What is the goal of palliative care?

A) Improve the client's and family's quality of life.

B) Support aggressive treatment for cure.

C) Provide physical support for the client.

D) The client may develop a separate plan with each discipline of the health care team.

Ans: A

Feedback:

The goal of palliative care is to improve the client's and the family's quality of life. The support should include the patient's physical, emotional, and spiritual well-being. Each discipline should contribute to a single care plan that addresses the needs of the client and family. Options B, C and D are incorrect; the goal of palliative care is not aggressive support for curing the client. Providing physical support for the client is also not the goal of palliative care. Separate plans of care developed by the client with each discipline of the health care team are not the goal of palliative care.

34. Palliative care is a structured system for care delivery that has what as its aim?

A) To give traditional medical care

B) To prevent and relieve suffering

C) To bridge between curative care and hospice care

D) To provide care while there is still hope

Ans: B

Feedback:

Palliative care, which is conceptually broader than hospice care, is both an approach to care and a structured system for care delivery that aims to…prevent and relieve suffering and to support the best possible quality of life for clients and their families, regardless of the stage of the disease or the need for other therapies. Palliative care goes beyond giving traditional medical care, which makes option A incorrect. Palliative care is considered a bridge not exclusively limited to hospice care, which makes option C incorrect. Option D is incorrect; hope is something clients and families have even while the client is actively dying.

35. A dying client is crying. She states, Why me, Lord?" and "I can't pray." What would be an appropriate nursing diagnosis based on this data?

A) Psycho-spiritual distress

B) Low self esteem

C) Ineffective coping

D) Knowledge deficit related to praying

Ans: A

Feedback:

Spiritual needs must be included in the plan of care for the dying client. Verbal cues to psycho-spiritual distress include inability to pray and lack of inability to forgive one's self.

Chapter 44, Sensory Functioning

1. The nurse is assessing a client's gustatory function. What approach by the nurse will assist in assessing this sensation

A) "Tell me if the taste on your tongue is sweet, sour, bitter, or salty."

B) "Repeat the words that I speak softly to you."

C) "Please read this paragraph to me."

D) "Close your eyes and tell me what you smell."

Ans: A

Feedback:

Gustatory sensations equate to taste. Repeating words assesses auditory function. Reading a paragraph assesses visua disturbances. Smelling assesses for olfactory disturbances.

2. What term is used to describe the sense, usually at a subconscious level, of the movements and position of the body (especially its limbs) independent of vision?

A) Stereognosis

B) Visceral

C) Proprioception

D) Sensory perception

Ans: C

Feedback:

Proprioception describes the sense, usually at a subconscious level, of the movements and position of the body (especially its limbs) independent of vision. Stereognosis is the perception of the solidity, size, shape, and texture of body parts. Visceral refers to inner organs and reception. Sensory perception is the conscious process of selecting, organizing, and interpreting data from the senses into meaningful information.

3. A client says, "What is that awful smell?" What sense is being used?

A) Olfactory

B) Gustatory

C) Tactile

D) Auditory

Ans: A

Feedback:

The senses by which a person maintains contact with the external environment are vision (visual), hearing (auditory), smell (olfactory), taste (gustatory), and touch (tactile).

4. Which of the following best describes a stimulus?

A) A sense organ that receives a message and converts it into a nerve impulse

B) Conduction along a nerve pathway from the receptor to the brain

C) Reception and translation of an impulse into a sensation

D) An act or agent that initiates a response by the nervous system

Ans: D

Feedback:

For a person to receive the necessary data to experience the world, there must first be a stimulus. A stimulus is an agent, act, or other influence capable of initiating a response by the nervous system.

5. After assessing a client, a nurse documents the state of awareness as confused. What part of the brain controls awareness?

A) Cranial nerves

B) Reticular activating system

C) Hypothalamus

D) Medulla

Ans: B

Feedback:

To receive stimuli and respond appropriately, the brain must be alert or aroused. The reticular activating system (RAS) mediates arousal.

6. How would a nurse document the condition in which a client has a normal state of awareness?

A) “Aware of self and environment, responsive, well-oriented.”

B) “Easily distracted, alternates between drowsiness and excitability.”

C) “Disoriented, restless, agitated, hallucinating.”

D) “Can’t be aroused and does not respond to stimuli.”

Ans: A

Feedback:

A normal state of awareness is one in which there is awareness of self and the external environment, including being well-oriented and responsive.

7. A nurse documents the following on a client chart: “client manifests difficulties with spatial orientation, memory language, and changes in personality.” What state of arousal/awareness does this describe?

A) Delirium

B) Dementia

C) Confusion

D) Locked-in syndrome

Ans: A

Feedback:

Difficulties with spatial orientation, memory, language, and changes in personality occur with delirium. Disorientation, restlessness, confusion, hallucinations, and agitation, alternating with other conscious states, occurs with dementia. In confusion, the client manifests reduced awareness, is easily distracted, easily startled by sensory stimuli, and alternates between drowsiness and excitability. In locked-in syndrome, the client displays full consciousness, sleep–wake cycles are present, and auditory and visual function and emotions are preserved.

8. Which of the following hospital units is more likely to cause severe sensory alterations?

A) General unit

B) Short-stay surgery

C) Eye clinic

D) Intensive care

Ans: D

Feedback:

Severe sensory alterations can occur when a client is admitted to a health care agency, especially in certain areas such as intensive care units (termed intensive care unit [ICU] psychosis).

9. In which of the following health care settings is a client more likely to be at risk for sensory deprivation?

A) Hospital newborn nursery

B) Community health center

C) Emergency department

D) Long-term care

Ans: D

Feedback:

Sensory deprivation occurs when a client experiences decreased sensory input or input that is monotonous, unpatterned, or meaningless. In this question, clients in long-term care would be most at risk for sensory deprivation.

10. What type of cognitive responses might a nurse assess in a client with sensory deprivation?

A) Uncoordinated movements, altered sense of smell

B) Decreased attention span, difficulty problem solving

C) Apathy, depression

D) Rapid mood changes, anxiety

Ans: B

Feedback:

Cognitive responses to sensory deprivation include an inability to control thoughts, decreased attention span, and difficulty with memory, problem solving, and task performance.

11. A client admitted to the hospital for major surgery is at risk for what type of sensory alteration?

A) Sensory deprivation

B) Sensory deficits

C) Sensory overload

D) Sensory stimulation

Ans: C

Feedback:

Sensory overload is the condition that results when a person experiences so much sensory stimuli that the brain is unable to either respond meaningfully or ignore the stimuli. In some clients, especially those coming from a quiet environment with unvarying stimuli, the experience of being hospitalized results in sensory overload.

12. What intervention is recommended to reduce sensory stimulation for infants in the neonatal ICU?

A) Use bright lights

B) Use limited light

C) Play loud music

D) Avoid touch

Ans: B

Feedback:

Research has found that the neonatal ICU is a source of inappropriate sensory stimulation. To facilitate developmentally supportive care, it is recommended that medically fragile infants have limited light, visual, and vestibular stimulation to simulate being in the womb.

13. A client tells his nurse that he has difficulty hearing related to working in a loud factory setting for 15 years. What is the term for this condition?

A) Sensory deficit

B) Sensory deprivation

C) Sensory overload

D) Sensory stimulation

Ans: A

Feedback:

Impaired or absent functioning in one or more senses is termed sensory deficit.

14. A nurse assesses a mother who rocks and cuddles her newborn son. What sense is the mother stimulating?

A) Auditory

B) Kinesthetic

C) Visual

D) Gustatory

Ans: B

Feedback:

Different types of sensory stimulation are needed for growth as sensory receptors, organs, and the nervous system mature. Appropriate stimulation includes soothing, holding, rocking and changes of position (tactile and kinesthetic sensations), singing and being talked to (auditory sensations), and changing patterns of light and shade, such as through the use of mobiles and bright objects (visual sensations).

15. Is it important for a nurse to consider a client's culture when providing physical care?

A) Yes, culture dictates the amount of sensory stimulation considered normal.

B) Yes, the nurse's culture and the client's culture are often different.

C) No, the nurse must provide needed physical care to all clients.

D) No, the nurse is not required to consider culture when providing care.

Ans: A

Feedback:

An individual's culture may dictate the amount of sensory stimulation considered normal. Ethnicity, religion, income, and subgroup norms within a culture all influence the amount of sensory stimulation sought by an individual and considered normal.

16. A nurse is assessing a client on the first day after major abdominal surgery. Which of the following internal stimuli would be increased and affect client responses?

A) Lights and noise

B) Visitors and caregivers

C) Intravenous lines, pain

D) Ambulating, coughing

Ans: C

Feedback:

When assessing a client at risk for increased sensory stimulation, it is important to consider both internal and external stimuli that may cause sensory overload. Invasive treatments, such as intravenous lines, and pain are internal stimuli.

17. A nurse assessing older adults in a long-term care facility is aware that which of the following may result in sensory alterations for these clients?

A) Constipation

B) Anorexia

C) Dry skin

D) Presbyopia

Ans: D

Feedback:

The senses of vision, hearing, and touch decline with aging. Common sensory problems include presbyopia, a condition of aging in which decreased elasticity of the lens of the eye hinders accommodation to close vision.

18. A client has an abrupt onset of a cluster of global changes in attention, cognition, and level of consciousness. What would be the most appropriate nursing diagnosis?

A) Acute Confusion

B) Chronic Confusion

C) Impaired Memory

D) Disturbed Sensory Perception

Ans: A

Feedback:

The nursing diagnosis Acute Confusion is most appropriate. The definition of this diagnosis is "the abrupt onset of a cluster of global, transient changes and disturbances in attention, cognition, psychomotor activity, level of consciousness, or sleep–wake cycles."

19. A home care client has both visual and hearing deficits. Although all of the following are important, what would be a high priority concern when planning and implementing care?

A) Nutrition

B) Comfort

C) Safety

D) Communication

Ans: C

Feedback:

Safety is always a special concern for clients with sensory alterations. The nurse must ensure that the client's environment is as free of danger as possible, and assist the client in developing new self-care behaviors to compensate for sensory impairments.

20. A nurse asks the mother of a hospitalized client age 2 years to bring in his favorite blanket or stuffed animal. What sense is the nurse trying to stimulate with this intervention?

A) Gustatory

B) Visual

C) Tactile

D) Auditory

Ans: C

Feedback:

The different texture of the blanket/stuffed animal stimulates the tactile sense (sense of touch).

21. Which of the following nonpharmacologic, independent nursing interventions may be used to promote relaxation without also causing sensory overload?

A) Talking with the client

B) Playing music the client chooses

C) Watching talk shows the nurse chooses

D) Watching television reality shows that visitors choose

Ans: B

Feedback:

Music therapy has been found to be beneficial in reducing the stress response and promoting nonpharmacologic induced relaxation. It is important to choose music the client prefers.

22. A community health nurse is conducting a seminar on vision self-care. What might be one topic included in the education plan?

A) Wear sunglasses when working outside.

B) Close the eyes when working with chemicals.

C) Use over-the-counter eye drops when necessary.

D) When using aerosol sprays, spray toward self.

Ans: A

Feedback:

One suggestion for teaching self-care behaviors related to maintaining vision and preventing blindness is to wear sunglasses when working outdoors. This will help avoid damage from ultraviolet rays.

23. A nurse is educating a lawn-care worker on the risk of hearing loss. What might be recommended?

A) "Listen to loud music with earphones while mowing."

B) "Just ignore the noise; you are too young for damage."

C) "Wear earplugs while using lawn equipment."

D) "Clean your ears with cotton-tipped applicators daily."

Ans: C

Feedback:

Health education for reducing the risk of hearing loss, which may begin at any age, includes wearing earplugs when using loud equipment.

24. A nurse is making a home care visit to a client with a hearing deficit. What can she do to facilitate communication with the client?

A) Ask for permission to turn off the television set during the visit.

B) Talk in a loud tone of voice at all times during the visit.

C) Use written communication rather than verbal communication.

D) Reduce the time spent with the client to decrease frustration.

Ans: A

Feedback:

One way in which communication with a client with a hearing deficit can be facilitated is to decrease background noises (as from a television).

25. A nurse is caring for a person who is delusional. What is important for the nurse to do while communicating with the client?

A) Touch the client gently while talking.

B) Avoid arguing about erroneous statements.

C) Reinforce reality for delusional statements.

D) Maintain eye contact at all times.

Ans: C

Feedback:

Nursing interventions to be used when communicating with a confused client include reinforcing reality if the client is delusional.

26. A nurse is caring for a client who is unconscious. Which of the following is a recommended guideline for communication with this client?

A) Do not assume the person can hear you.

B) Keep environmental noise level high to stimulate the client.

C) Be careful what is said in front of the client as he or she might hear you.

D) Touch the person before speaking to them.

Ans: C

Feedback:

The following are recommended guidelines when communicating with a client who is unconscious: be careful what is said in front of the client as he or she might hear you, assume the person can hear you, keep environmental noise level low, and speak to the person before touching him or her.

27. During a client assessment, the nurse has the client close his eyes. She then places her finger on his right thigh. She asks the client where he is being touched and he answers “my right thigh.” This is an example of which sense?

A) Auditory

B) Visual

C) Kinesthetic

D) Olfactory

Ans: C

Feedback:

The kinesthetic sense influences the awareness of placement and action of body parts.

28. When a new mother asks the nurse whether her newborn infant can see her, the best response by the nurse is to tell the mother that her infant …

A) cannot see for 2 weeks of age

B) can differentiate objects only

C) can differentiate colors only

D) can see light and dark patterns

Ans: D

Feedback:

Newborns see only gross patterns of light and dark or bright colors. As they grow, vision becomes more discriminating.

29. A client in the intensive care unit will experience less sensory overload in which of the following situations?

A) If a clock displays date, time, AM/PM

B) If the nurse silences the alarms

C) If the nurse provides touch every hour

D) If the family visits at all times

Ans: A

Feedback:

Disorientation can occur when expected day/night differences in levels of general activity are lost. To reduce such disorientation, provide a clock displaying a clear distinction of AM/PM time, day, and date. Silencing the alarms could compromise the client's care.

30. A client with hearing loss gets very frustrated trying to carry on conversations with friends. Which type of stressor is the client experiencing?

A) Physical

B) Psychological

C) Sensory deficits

D) Sociocultural

Ans: C

Feedback:

Sensory deficits in vision and hearing interfere with one's ability to interact with other people and with the environment.

31. Which of the following are conditions that must be met for a person to receive the necessary data to experience the world? Select all that apply.

A) A stimulus must be present.

B) A receptor or sense organ must receive the stimulus and convert it to a nerve impulse.

C) The nerve impulse must be conducted along a nervous pathway from the receptor or sense organ to the brain.

D) The stimulus must be recognized by the cardiovascular system and sent to the brain.

E) The person must physically and mentally recognize the stimulus and accept or reject it in the brain.

F) A particular area in the brain must receive and translate the impulse into a sensation.

Ans: A, B, C, F

Feedback:

For a person to receive the necessary data to experience the world, four conditions must be met: (1) a stimulus—an agent, act, or other influence capable of initiating a response by the nervous system—must be present. (2) A receptor or sense organ must receive the stimulus and convert it to a nerve impulse. (3) The nerve impulse must be conducted along a nervous pathway from the receptor or sense organ to the brain. (4) A particular area in the brain must receive and translate the impulse into a sensation.

32. The nurse is caring for a client who suffered a stroke three days ago, and is assessing the client's state of arousal. The nurse knows that the part of the body responsible for a person being alert or aroused is which of the following?

A) Reticular activating system

B) Renin-angiotensin-aldosterone system

C) Cranial nerves

D) Adrenal glands

Ans: A

Feedback:

The reticular activating system (RAS) mediates arousal. The adrenal glands are endocrine glands that have many functions, but do not control arousal or alertness. The renin-angiotensin-aldosterone system has to do with fluid balance and blood pressure. The cranial nerves have a role in many of the body's abilities, but not arousal.

33. During the neurological assessment, the nurse asks the client if she has any problems with her sense of smell. The client relates that she lives near a factory that emits an obnoxious odor, but that she no longer notices the smell. The nurse tells Joan that this phenomenon is normal and is called which of the following?

A) Tolerance

B) Adaptation

C) Acceptance

D) Adjustment

Ans: B

Feedback:

The body quickly adapts to constant stimuli. In addition, the repeated stimulus of a continuing noise, such as city traffic, or a noxious odor eventually goes unnoticed. This phenomenon is termed "adaptation".

34. The nurse is caring for client 82 years of age who is struggling to adapt to hearing loss as he ages. The nurse performs which of the following interventions to assist the client in adapting to this sensory deficit? Choose all that apply.

A) Make sure he wears his hearing aid.

B) Speak in a lower tone of voice.

C) Speak so he can observe your lip movement.

D) Keep his environment clear of clutter.

E) Orient to person, place, and time frequently

Ans: A, B, C

Feedback:

Speaking in low tones and making sure he can see your lip movement will assist the client in hearing and understanding better, as will wearing his hearing aid. Keeping his room free of clutter is nice, but will not assist his hearing. Reorienting will not help to improve the client's hearing.

35. The nurse is working in a clinic and sees a resident of a long-term-care facility, age 82 years, who has come in to be checked by her physician. The caregiver, who accompanies her, reports that the client has been displaying the following: drowsiness, excessive sleeping, decreased attention span, irritability, and signs of depression. The client's daughter and family, who usually visit her, moved away from the area six weeks ago due to the husband's job. You suspect which of the following problems?

A) Sensory deprivation

B) Disturbed sensory perception

C) Residential psychosis

D) Locked-in syndrome

Ans: A

Feedback:

Sensory deprivation results when a person experiences decreased sensory input or input that is monotonous, unpatterned, or meaningless. A client confined to bed rest may receive many fewer stimuli, whereas one undergoing multiple diagnostic tests may receive a greater-than-normal level of sensory input. These and other typical experiences are likely to result in disturbed sensory perceptions experienced by the client. Locked-in syndrome is a state of full consciousness; sleep–wake cycles are present; quadriplegic, auditory and visual function are preserved; emotion is preserved. Residential psychosis is not a real condition.

Chapter 45, Sexuality

1. A woman tells a nurse, "My husband wants to have sex when I have my period. Is that safe?" What is an appropriate answer?

A) "No, the flow of blood could be slowed down."

B) "No, it will tend to make your cramps worse."

C) "Yes, but be sure to douche after sex."

D) "Yes, there is no reason not to have sex then."

Ans: D

Feedback:

There is no scientific rationale to support abstinence from sexual activity during menses. Sexual activity during mens may be more pleasurable and may reduce or relieve cramping.

2. A male client age 15 years is experiencing nocturnal emissions. What nursing intervention would be appropriate for client?

A) Ask the parents to consult with a specialist.

B) Tell the client to limit physical activity in the evening.

C) Ask the primary care provider to perform a physical examination.

D) No intervention is necessary as this is a normal phenomenon.

Ans: D

Feedback:

Many males, particularly adolescent boys, may experience a phenomenon known as a nocturnal emission, or "wet dream." These ejaculatory episodes occur during sleep without physical stimulation. They are perfectly normal and do not represent any sort of deviation.

3. In which of the phases of the sexual response cycle may secretions from Cowper's glands appear at the glans of the penis?

A) Excitement

B) Plateau

C) Orgasm

D) Resolution

Ans: B

Feedback:

In the male, secretions from Cowper's glands may appear at the glans of the penis during the plateau phase.

4. A male client tells the nurse that he does not understand why he feels the way he does when he is sexually excited. What would the nurse teach the client?

A) "I don't know, but I will ask my boyfriend if he can describe his feelings to me."

B) "The sexual response cycle includes excitement, plateau, orgasm, and resolution."

C) "That is something that just happens and nobody knows why."

D) "Isn't sex wonderful? I think it has different parts to the experience."

Ans: B

Feedback:

The sexual response cycle is a total body response with many physiologic changes throughout the body. The cycle has four phases: excitement, plateau, orgasm, and resolution.

5. A woman age 70 years tells the nurse that she is still sexually active. How would the nurse respond?

A) "You are too old for that kind of behavior."

B) "Tell me what you enjoy the most."

C) "You can be sexually active as long as you want to be."

D) "There comes a time in life when this is no longer important."

Ans: C

Feedback:

Sexual activity does not need to be hindered by age. Couples (or individuals) may continue intimate relationships for as long as they desire.

6. A young woman has been diagnosed with human papilloma virus (HPV). As a result, she will be at increased risk for which of the following?

A) Infertility

B) Genital warts

C) Vaginal bleeding

D) Cervical cancer

Ans: D

Feedback:

Infection with human papillomavirus (HPV), a sexually transmitted infection, increases a woman's risk for cervical cancer.

7. A nurse is educating a student nurse on how STIs affect the health of their clients. Which of the following statements accurately describes an effect of an STI?

A) STIs are most common in young to middle adulthood populations.

B) The incidence of STIs is decreasing due to health promotion efforts.

C) Most of the time STIs cause no symptoms, especially in women.

D) Health problems caused by STIs are more severe and frequent in men.

Ans: C

Feedback:

Most of the time, STIs cause no symptoms, particularly in women. STIs affect men and women of all backgrounds and economic levels; they are most prevalent among teenagers and young adults. The incidence of STIs is rising, in part because in the last few decades, young people have become sexually active earlier yet are marrying later. Health problems caused by STIs tend to be more severe and more frequent for women than for men, in part because the frequency of asymptomatic infection means that many women do not seek care until serious problems have developed.

8. What term is used to describe painful intercourse?

A) Dyspareunia

B) Dysmenorrhea

C) Impotence

D) Vulvodynia

Ans: A

Feedback:

Dyspareunia is painful intercourse. Dysmenorrhea is pain with menstruation. Impotence is erectile failure. Vulvodynia is vulvar pain.

9. An adolescent male tells the nurse that he is afraid his penis will be damaged because he masturbates every day. The nurse's response is based on what knowledge?

A) Masturbation is not a normal activity.

B) Only adult men masturbate.

C) Masturbation may delay puberty.

D) Self-stimulation is a normal activity.

Ans: D

Feedback:

Masturbation is a technique of sexual expression in which an individual practices self-stimulation. People masturbate regardless of age, sex, or marital status. It is a normal activity.

10. A heterosexual couple enjoys both anal and vaginal intercourse. What may result from these sexual activities?

A) Feelings of guilt and shame

B) Vaginal infections

C) Damage to the vagina

D) Penile infections

Ans: B

Feedback:

Once the penis is placed in the rectum, it should not be introduced into the vagina without thorough cleansing because microorganisms present in the rectum may cause vaginal infections.

11. While answering questions posed by a nurse during a health history, a young woman says, “Before my period I get headaches, am moody, and my breasts hurt.” What is the client experiencing?

A) Perimenopause

B) Menarche

C) PMS

D) Menses

Ans: C

Feedback:

Menstrual cycle–related distress, commonly called premenstrual (tension) syndrome (PMS), occurs in 50% to 90% of the female population. It is characterized by irritability, emotional tension, anxiety, mood changes, headache, breast tenderness, and water retention.

12. What are the primary nursing considerations when assisting with, or conducting, a physical assessment of the genitalia?

A) Ensuring sterility of all equipment and supplies

B) Respecting the client’s privacy and modesty

C) Providing a means for cleansing the area

D) Leaving the room during the assessment

Ans: B

Feedback:

When assisting with, or conducting, a physical assessment of the genitalia, keep the client comfortable and respect his or her privacy and modesty.

13. What is the most significant difficulty regarding sexuality faced by people taking medications for hypertension?

A) Medications result in increased desire for sex.

B) Medications change sexual functioning.

C) Clients experience a growth of body hair.

D) Clients experience increased body odors.

Ans: B

Feedback:

The most significant difficulty a person with hypertension faces regarding sexuality is that the medication used to control the disease frequently causes a change in sexual functioning. Impotence is a common response in men.

14. What do most nursing interventions pertaining to sexuality involve?

A) Teaching to promote sexual health

B) Examinations to identify sexually transmitted infections

C) Advocacy for those with sexual dysfunctions

D) Maintaining confidentiality and privacy

Ans: A

Feedback:

Most nursing interventions pertaining to a client's sexuality involve education to promote sexual health. Major goals of education are a change in knowledge, a change in client attitude, or a change in behavior.

15. A woman is using Depo-Provera as a method of birth control. What common side effect should the nurse explain to the client?

A) Constipation

B) Nausea

C) Irregular bleeding

D) Pregnancy

Ans: C

Feedback:

Depo-Provera is a progestin-only hormonal birth control system. One injection can prevent pregnancy for 12 weeks and is 99.7% effective. Irregular bleeding is the most common side effect.

16. A nurse is explaining the use of an IUD to a female client interested in obtaining contraception. Which of the following statements regarding the IUD is correct?

A) The intrauterine device (IUD) is an object that is placed by the client within the uterus to prevent implantation of a fertilized ovum.

B) IUDs are small devices made of flexible plastic that provide irreversible birth control.

C) IUDs do not prevent fertilization of the egg.

D) IUDs seem to affect the way the sperm or egg moves.

Ans: D

Feedback:

IUDs seem to affect the way the sperm or egg moves. IUDs are small devices made of flexible plastic that provide reversible birth control. The intrauterine device (IUD) is an object that is placed by a physician or nurse practitioner within the uterus to prevent implantation of a fertilized ovum. IUDs usually prevent fertilization of the egg, but the precise mechanism by which it works is unknown.

17. A nurse is counseling a female victim of sexual assault. Which of the following statements accurately describes the increased risks for this client?

A) The client is three times more likely to suffer from depression.

B) The client is 10 times more likely to suffer from post-traumatic stress disorder.

C) The client is 20 times more likely to abuse alcohol and 26 times more likely to abuse drugs.

D) The client is 20 times more likely to contemplate suicide.

Ans: A

Feedback:

Victims of sexual assault are 3 times more likely to suffer from depression, 6 times more likely to suffer from post-traumatic stress disorder, 13 times more likely to abuse alcohol, 26 times more likely to abuse drugs, and 4 times more likely to contemplate suicide.

18. A nurse is responding to sexual harassment from a client at work. Which of the following is a recommended guideline for dealing with this behavior?

A) If confronted by management, deny any feelings about being harassed.

B) Do not confront the person harassing you in person.

C) Set and enforce limits to the behavior and maintain boundaries.

D) Document the incident but do not report it to the supervisor unless harassment continues.

Ans: C

Feedback:

The following assertive response is recommended and supports the nurse in maintaining his or her self-respect; it encourages the client to accept responsibility for his or her behavior. Be self-aware: Do not deny feelings about being harassed. Confront: Provide feedback to the client in a nonthreatening way and clearly state what behavior is or is not acceptable. Set limits: Define clear and reasonable consequences that will be enforced if the behavior continues. Enforce the stated limits: Maintain boundaries. Report: Document the incident and submit to the supervisor.

19. A woman complains of pain with intercourse. What client medications should the nurse check for that contribute to dyspareunia?

A) Antihistamines

B) Calcium supplements

C) Antibiotics

D) Antihypertensives

Ans: A

Feedback:

Common causes of dyspareunia are organic problems, including inadequate lubrication at the vaginal opening or within the vaginal walls. Medications that cause dyspareunia include antihistamines, certain tranquilizers, marijuana, and alcohol.

20. After instructing the male client on the performance of a testicular examination, the nurse instructs the client to perform the examination how often?

A) Monthly

B) Weekly

C) Bi-monthly

D) Bi-yearly

Ans: A

Feedback:

The client should perform a testicular examination monthly.

21. The client suffered a myocardial infarction (MI) and has shared with the nurse that he is reluctant to resume sexual activity. He is worried about having another MI. The nurse discusses various methods of sexual expression and points out that the most important body area for sexual arousal and stimulation is which of the following?

A) Breasts

B) Skin

C) Brain

D) Genitalia

Ans: C

Feedback:

The human body contains many erogenous zones, areas that when stimulated cause sexual arousal and desire. These include the genitalia, the skin, and the breasts, but the most important body area for sexual arousal and stimulation is the brain.

22. The nurse is providing sexual education to a group of teenagers. One of the class members reports feeling sexually aroused when her boyfriend strokes her arms. The nurse points out that the human body has many erogenous zones, the largest being which of the following?

A) Skin

B) Brain

C) Genitalia

D) Breasts

Ans: A

Feedback:

The human body contains many erogenous zones, areas that when stimulated cause sexual arousal and desire. These include the genitalia, the brain, and the breasts, but the largest erogenous zone is the skin.

23. The clinic nurse sees the client today and asks about his chief complaint. The client describes to the nurse his inability to attain an erection. Which of the following would be a priority for the nurse to assess? Choose all that apply.

A) Medication history

B) Specifics about sexual problem

C) Sleep history

D) Physical activity history

E) History of diabetes

Ans: A, B, E

Feedback:

Assessment priorities for erectile dysfunction should include history of hypertension, current medications, diabetes, and specifics about the erectile problem. Physical activity should not adversely affect ability to attain an erection. Unless the client is severely sleep deprived, this also should not affect erectile ability.

24. During a class for 5th- and 6th-grade girls about menstruation, one student comments that she has heard that girls smell bad during their menses. Other students chime in saying they have heard the same thing and ask how to prevent odors. The nurse correctly answers with which of the following solutions?

A) Stay at home during heaviest flow

B) Use deodorizing pads and tampons

C) Utilize good hygiene and regular bathing

D) Change pads or tampons at least daily

Ans: C

Feedback:

Deodorized pads and tampons do little to minimize odor and can cause chemical irritation to the vulva and vagina. Good hygiene and regular bathing are much more effective during menses to prevent odor. Pads and tampons should be changed frequently to prevent odor and irritation from wetness, usually every few hours.

25. The nurse is caring for a female 29 years of age who is admitted with chronic pain secondary to rheumatoid arthritis. She confides in the nurse that she would like to be able to have sex with her husband but it just hurts too much. The nurse's best response is which of the following?

A) After a time that sort of thing doesn't matter.

B) Is your husband willing to forgo sex?

C) It may be time to put that behind you.

D) Modified positions may be possible.

Ans: D

Feedback:

The desire for human warmth and contact does not cease because of pain. Altered or modified positions for coitus are sometimes necessary, and discussing these with clients can be an important part of implementing the nursing process. The nurse should not discourage the client from wanting to enjoy sex, but should explore ways to help her.

26. A boy age 13 years visits the school nurse's office and asks to speak privately with her. He looks very upset and embarrassed and struggles to make eye contact with the nurse. After some stuttered stops and starts, he finally asks about masturbating and if the things he has heard about it are true. The nurse provides correct education and information for the young man about masturbation by telling him which of the following? Choose all that apply.

A) It is a technique of self-stimulation

B) People do it regardless of age or gender

C) Masturbation can lead to blindness

D) Masturbation is not dirty or wrong

E) Masturbation can decrease intelligence

Ans: A, B, D

Feedback:

Masturbation is a technique of sexual expression in which an individual practices self-stimulation. It is a way for a person to learn what he or she prefers during stimulation and what feels good. People masturbate regardless of sex, age, or marital status. Masturbation is not dirty and will not lead to blindness or insanity.

27. The nurse is caring for a female age 45 years who discloses during the admission nursing history that she is no longer able to enjoy sex with her husband because it causes too much pain in her vagina. The nurse includes which of the following nursing diagnoses in the client's care plan related to this information?

A) Sexual Dysfunction: Dyspareunia

B) Altered Sexuality Patterns: Change in sexual expression

C) Altered Sexuality Patterns: Loss of desire

D) Altered Sexuality Patterns: Change in positioning

Ans: A

Feedback:

"Sexual Dysfunction: Dyspareunia" is the correct choice because "dyspareunia" means painful intercourse. "Altered Sexuality Patterns: Change in sexual expression" is more about not being able to do what is usual for a particular person or client. The client has no loss of desire, but cannot enjoy sex because of pain. The problem is not about positioning, but about vaginal pain with intercourse.

28. A new client has come to the clinic wanting a method of birth control. The client asks about a diaphragm. What would the nurse teach this client about a diaphragm?

A) One size fits all females.

B) The diaphragm must be used during each episode of sexual activity.

C) A diaphragm's effectiveness does not require spermicidal jelly.

D) The diaphragm may be removed an hour following intercourse.

Ans: B

Feedback:

The diaphragm must be used during each episode of sexual activity. It must be left in six hours after intercourse and should be used with spermicidal jelly. There are different sizes of diaphragms, and the client needs to be fitted by the health care practitioner.

29. The nursing instructor is talking with the junior nursing class about male reproductive issues. The instructor tells the students that the causes of erectile dysfunction include which of the following? Select all that apply.

A) Alcoholism

B) Spinal cord trauma

C) Tadalafil

D) Phosphodiesterase-5 inhibitors

E) Diabetes

Ans: A, B, E

Feedback:

Causes include cardiovascular disease, endocrine disease (diabetes, pituitary tumors, testosterone deficiency, hyperthyroidism, and hypothyroidism), alcoholism, chronic renal failure, genitourinary conditions (radical pelvic surgery), hematologic conditions (Hodgkin lymphoma, leukemia), neurologic disorders (neuropathies, parkinsonism, spinal cord injury, multiple sclerosis), trauma to the pelvic or genital area, alcohol, smoking, medications, and drug abuse. Phosphodiesterase-5 inhibitors, which include Tadalafil, are used to treat erectile dysfunction; they don't cause it.

30. The nurse is conducting a class on human sexual response. The participants have understood the education when they identify that, during the excitement phase of the sexual response, the man may experience what?

A) Nipple erection

B) Hypotension

C) Bradycardia

D) Decreased blood flow to genitals

Ans: A

Feedback:

Some of the physiologic changes include an increase in heart rate and blood pressure, and the appearance of a pink to red flush to the skin. The first obvious sign of arousal in the man is an erection of the penis caused by increased pelvic congestion of blood. The scrotum noticeably elevates, thickens, and enlarges. The skin of the penis and scrotum turns a deep reddish-purple in response to congestion and arousal. Male nipples may also harden and become erect.

31. Which of the following questions or statements would be most useful for the nurse to make when eliciting information about a client's sexual history?

A) "We need to talk about this."

B) Why did you have unprotected sex?

C) "How would you describe the problem?

D) I need to know sex partners' numbers."

Ans: C

Feedback:

A helpful way to elicit information about a client's sexual history is to ask, How would you describe the problem?

32. The nurse conducting a class on human sexuality includes which of the following about gender identity?

A) It is opposite of biologic gender.

B) It may be the same as or different from biologic gender.

C) It is determined by male (XY) or female (XX) chromosomes.

D) It is determined by physical characteristics.

Ans: B

Feedback:

Gender sex denotes chromosomal sexual development. Gender identity is the inner sense one has of being male or female, which may be the same or different from biologic gender.

33. When conducting a class on sexuality with teenagers, the nurse includes that sexuality is which of the following?

A) External appearance of one's genitalia as male or female

B) Male or female internal organ structure and function

C) How one experiences maleness or femaleness physically, emotionally, and mentally

D) The pleasure experienced during sexual activity

Ans: C

Feedback:

A critical component of human identity and well-being, sexuality involves how a person exhibits and experiences maleness or femaleness physically, emotionally, and mentally. Sexuality is defined not only by a person's genitalia and hormones, but also by attitudes and feelings.

34. Parents of an infant express concern because the infant is touching his genitals. What should the nurse teach the parents?

A) Self-manipulation of genitals is normal behavior in an infant.

B) Have the child wear clothes that prohibit touching.

C) If this bad behavior continues, seek counseling.

D) Make him have time out every time it happens.

Ans: A

Feedback:

Infants touch their genitals. This is normal behavior for a toddler. Punishment of genital fondling may lead to guilt and shame regarding sexual behavior later in life.

35. Which of the following occurs in the male during the resolution phase of the sexual response cycle?

A) The penis becomes erect due to increased pelvic congestion of blood.

B) Involuntary spasmodic contractions occur in the penis.

C) The male orgasm occurs usually with ejaculation of semen from the penis.

D) The male experiences a period during which he is incapable of sexual response.

Ans: D

Feedback:

The resolution phase is characterized by a return to normal body functioning present before the excitement phase. The man experiences a period during which he is incapable of sexual response, called the refractory period. The length of the refractory period is individual; it might be a few minutes or even days before the man's body responds readily to continued sexual stimulation.

Chapter 46, Spirituality

1. Which of the following group of terms best defines spiritual distress?

A) Spirituality, religion

B) Alienation, despair

C) Faith, prayer

D) Forgiveness, purpose

Ans: B

Feedback:

Terms that define spiritual distress include spiritual pain, alienation, anxiety, guilt, anger, loss, and despair.

2. What spiritual need is believed to underlie all religious traditions and is common to all people?

A) Love and relatedness

B) Physical hygiene

C) Religious education

D) Church services

Ans: A

Feedback:

According to Shelly and Fish (1988), there are three spiritual needs underlying all religious traditions and common t people: (1) the needs for meaning and purpose, (2) love and relatedness, and (3) forgiveness.

3. Nurses provide care to meet needs in all the human dimensions. What is one intervention nurses can implement to m spiritual needs?

A) Refer all questions to a spiritual advisor.

B) Remind clients that nurses are not ministers.

C) Avoid any discussion of religion or spirituality.

D) Offer a compassionate presence.

Ans: D

Feedback:

Although nurses may differ in their beliefs about how involved they should become in meeting spiritual needs, it is impossible to ignore the spiritual dimensions of health. Nurses can assist clients to meet spiritual needs through a variety of interventions, including offering a compassionate presence.

4. A client expresses confidence in his traditional healer to relieve symptoms of an illness. What is the client demonstrating?

A) Hope

B) Spirituality

C) Faith

D) Charity

Ans: C

Feedback:

Faith generally refers to a confident belief in something for which there is no proof or material evidence. It can involve a person, idea, or thing and is usually followed by action related to the ideals and values of the belief. A client who has faith in a health care provider is more likely to follow the plan of care, and experience benefits.

5. A client tells the nurse, "I am an atheist. I do not believe in God." What would be an appropriate response by the nurse?

A) "Well, I believe in God and you should, too."

B) "I respect what you choose to believe in."

C) "How can you deny the existence of God?"

D) "What makes you think you are an atheist?"

Ans: B

Feedback:

An atheist is a person who denies the existence of God, guided by philosophies of living that do not include a religious faith. The atheist deserves respect for what he or she chooses to believe.

6. A client states that his life has meaning and purpose, he feels loved, and has experienced forgiveness in his life. What is the term that describes this state of spirituality?

A) Spiritual belief

B) Spiritual alienation

C) Spiritual health

D) Spiritual bliss

Ans: C

Feedback:

Defined most simply, spiritual health or well-being is the condition that exists when the universal spiritual needs for meaning and purpose, love and belonging, and forgiveness are met.

7. What factor is necessary to express and experience spirituality?

A) Quiet time in isolation from others

B) Membership in an organized religion

C) Long-term suffering and pain

D) Connectedness with other people

Ans: D

Feedback:

People express and experience spirituality through love and connectedness with other people. Love develops from the basic human need to love and be loved and is necessary to spiritual wholeness.

8. While reviewing the chart for an assigned client before beginning care, a student notes that the client does not belong to a specific religion. Based on this information, what should the student interpret about the client?

A) A person may be deeply spiritual but not profess a religion.

B) Belonging to an organized religion is essential to spirituality.

C) The student will not have to consider the spiritual dimension.

D) The client should be referred for spiritual counseling.

Ans: A

Feedback:

Religion refers to an organized system of beliefs about a higher power. A nurse should not interpret the fact that a client does not belong to an organized religion to mean the client has no spiritual needs; a person may be deeply spiritual yet not profess a religion.

9. Which of the following health care practices may be influenced by a young woman's religion?

A) Yearly mammograms

B) Annual physicals

C) Birth-control measures

D) Health assessments

Ans: C

Feedback:

Certain practices associated with health care may have religious significance for a client. For example, acceptable birth-control measures are determined by some religious faiths.

10. How can religious, life-affirming influences be compared with basic human needs?

A) Life-affirming influences encourage self-actualization.

B) Life-affirming influences enhance life.

C) Life-affirming influences meet basic physiologic needs.

D) Life-affirming influences cultivate wisdom.

Ans: A

Feedback:

Religious influences may be life affirming or life denying. Life-affirming influences encourage self-actualization, the highest level of basic human needs.

11. Some religious beliefs may conflict with prevalent health care practices. For example, what type of treatment is prohibited by the doctrine of Jehovah's Witnesses?

A) Using narcotics to treat pain

B) Administering blood transfusions

C) Minor surgical procedures

D) Diagnostic x-ray examinations

Ans: B

Feedback:

Sometimes religious beliefs conflict with prevalent health care practices. For example, the doctrine of Jehovah's Witnesses prohibits blood transfusions.

12. Each of the major religions has several characteristics in common. What is one of those characteristics?

A) Ministers are addressed as "Reverend."

B) An ethical code defines right and wrong.

C) Communion is delivered the same way.

D) Men and women are viewed as equals.

Ans: B

Feedback:

Each of the major religious groups has several characteristics in common. One of those characteristics is an ethical code that defines right and wrong.

13. A nurse fills the following roles in the community: health educator, personal health counselor, referral agent, trainer of volunteers, developer of support groups, integrator of faith and health, and health advocate. What is the term for this type of nurse?

A) Parish nurse

B) Religious nurse

C) Visiting nurse

D) Home health nurse

Ans: A

Feedback:

Parish nurses are not "visiting nurses" or "home health nurses" who provide direct bedside care. The key roles of the parish nurse are health educator, personal health counselor, referral agent, trainer of volunteers, developer of support groups, integrator of faith and health, and health advocate.

14. A nurse is caring for a hospitalized child. What would the nurse consider to meet the spiritual needs of the child?

A) Nothing; children do not have a spiritual self.

B) Complete information from the child's parents.

C) Only terminally ill children believe in God.

D) Children have definite perceptions of God.

Ans: D

Feedback:

Heller studied spirituality in children. In his study of 40 children between the ages of 4 and 12 years, he found that the children had definite perceptions of God.

15. The parents of an infant are members of a faith-healing group. They refuse to give the baby antibiotics for meningitis. What does the American Academy of Pediatrics recommend for cases such as this?

A) Respect for the parents' wishes, even if the baby dies

B) Exemption from child abuse charges

C) Application of child abuse and neglect statutes

D) Refusal to treat the child no matter how ill

Ans: C

Feedback:

Various faith-healing groups are asking for protection (under the veil of religious freedom) of their right to make decisions about medical care, even if those decisions result in the death of a family member, including a child. The American Academy of Pediatrics is urging that all child abuse, neglect, and medical neglect statutes be applied without potential or actual exemption for religious beliefs.

16. A nurse is using Anandarajah and Hight's (2001) HOPE acronym to assess a client's spirituality and religious beliefs. Which of the following is a component of this acronym?

A) H = heaven

B) O = openness

C) P = personal spirituality

D) E = eternity

Ans: C

Feedback:

One simple guide is Anandarajah and Hight's (2001) HOPE acronym:

H—Sources of **h**ope, meaning, comfort, strength, peace, love, and connection; **O—O**rganized religion; **P—P**ersonal spirituality and practice; **E—E**ffects on medical care and end-of-life issue.

17. A client scheduled for complex heart surgery has been reading the Bible for hours each day, cries often, and is not sleeping well. What might these observations cue the nurse about the client?

A) These behaviors are expected before major surgery.

B) These behaviors are signs of spiritual distress.

C) Family members live far away and the client is lonely.

D) The client is naturally emotional and reactive.

Ans: B

Feedback:

Many clients find it difficult to talk about their spiritual beliefs and problems but may have behavioral indicators of spiritual distress. Significant behavioral observations include sudden changes in spiritual practices, mood changes, sudden interest in spiritual matters, and disturbed sleep.

18. A client verbalizes to a mental health counselor that his life is meaningless since his wife divorced him and that he no longer wants to live. What nursing diagnosis, resulting from his spiritual distress, would be appropriate?

A) Sexual Dysfunction

B) Fear

C) Powerlessness

D) Risk for Self-Directed Violence

Ans: D

Feedback:

Spiritual distress may affect other areas of human functioning. Spiritual distress may be the etiology of the nursing diagnosis "Risk for Self-Directed Violence" related to feelings that life is meaningless.

19. A nurse is caring for a hospitalized client. What intervention can the nurse use to help the client continue normal spiritual practices?

A) Discuss the nurse's own religious beliefs with the client.

B) Tell the client that spiritual practices can be resumed later.

C) Request dietary consultation for the client's dietary restrictions.

D) Request medication from the physician to calm the client.

Ans: C

Feedback:

It is a responsibility of the nurse to help the client in an unfamiliar environment continue normal spiritual practices. One intervention that can facilitate the practice of religion is to attempt to meet the client's dietary restrictions.

20. Which of the following statements by a nurse would nurture spirituality by promoting love and relatedness?

A) "I know you are angry about your diagnosis."

B) "Tell me about what you do in your job."

C) "Tell me about how you get along with others."

D) "How often do you read the Bible each day?"

Ans: C

Feedback:

The nurse can help the client nurture his or her own spirituality by promoting meaning and purpose, love and relatedness, and forgiveness. To promote love and relatedness, encourage the client to talk about relationships with others and to identify the origin of negative beliefs about people.

21. What statement or question is useful for a nurse if a client asks the nurse to pray with him or her?

A) "I'm sorry, I am just too busy."

B) "How would you like us to pray?"

C) "You will have to talk to your minister."

D) "Why would you want me to do that?"

Ans: B

Feedback:

Clients accustomed to regular periods of prayer but who feel too ill to pray may ask the nurse to pray with them. Because there are many forms of prayer, the nurse can take the lead by asking "How would you like us to pray?"

22. A nurse is preparing a client's room to accommodate a visit from a spiritual counselor. Which of the following is a recommended practice?

A) Dim or turn off the lights.

B) Place a candle on the bedside table.

C) Remove any unnecessary equipment.

D) Place a cross on the bedside table.

Ans: C

Feedback:

Preparations of the client's room for the visit may vary, but the following are generally recommended practices: the room should be orderly and free of unnecessary equipment and items; there should be a seat for the religious counselor at the bedside or near the client so that both can be comfortable; the bedside table should be free of items and covered with a clean, white cover if a sacrament is to be administered; and the bed curtains should be drawn for privacy if the client can't be moved to a more private setting.

23. A client tells a nurse that he does not think he can have the recommended heart surgery because transfusions are against his religion. What is the best response of the nurse in this situation?

A) Tell the client that the surgery is necessary to keep him alive and is the only choice.

B) Obtain all the information needed for the client to make an informed decision.

C) Prepare the client for a visit from his spiritual advisor.

D) Have the client sign a form stating his refusal of the treatment.

Ans: B

Feedback:

The nurse's role is to assist the client in obtaining the information needed to make an informed decision and to support the client's decision making. Because what the nurse says, and the way it is said, may powerfully influence the client's decision, it is important to maintain objectivity. Conflicts that resist resolution may be referred to an ethics committee or consult team.

24. Which of the following religious groups believe in divine healing through the “laying on of hands?”

A) Judaism

B) Mormons

C) Buddhism

D) Christian Scientist

Ans: B

Feedback:

Devout Mormon adherents believe in divine healing through the “laying on of hands,” though many do not prohibit medical therapy. The Church maintains an extensive and well-funded welfare system, including financial support for the sick.

25. A nurse has developed a plan of care to meet the needs of a client with the nursing diagnosis of Spiritual Distress. What would be an expected outcome?

A) Identify factors in life that challenge spiritual beliefs.

B) Attend church services on a weekly basis.

C) Share feelings about religion with other health care providers.

D) Commit to reading passages from the Bible daily.

Ans: A

Feedback:

Goals and expected outcomes for clients in spiritual distress do not need to be individualized. An appropriate expected outcome would be that the client will identify factors in life that challenge spiritual beliefs.

26. The U.S. Religious Landscape Survey of 35,000 Americans by the Pew Research Center’s Forum on Religion & Public Life (2008) finds that most Americans are religious and they have a nondogmatic approach to faith. Which of the following statements accurately describes religion in America? Select all that apply.

A) A majority of Americans who are affiliated with a religion believe their religion is the only way to salvation.

B) More than half of Americans rank the importance of religion very highly in their lives, attend religious services regularly, and pray daily.

C) A plurality of adults who are affiliated with a religion want their religion to adjust to new circumstances or adopt modern beliefs and practices.

D) Significant minorities across nearly all religious traditions see a conflict between being a devout person and living in a modern society.

E) While more than 50% of Americans believe in the existence of God or a universal spirit, there is considerable variation in the nature and certainty of this belief.

F) Sixty percent of adults believe that God is a person with whom people can have a relationship; but one out of four—including about half of Jews and Hindus—see God as an impersonal force.

Ans: B, D, F

Feedback:

A majority of Americans who are affiliated with a religion do not believe their religion is the only way to salvation. And almost the same number believes that there is more than one true way to interpret the teachings of their religion. More than half of Americans rank the importance of religion very highly in their lives, attend religious services regularly, and pray daily. A plurality of adults who are affiliated with a religion want their religion to preserve its traditional beliefs and practices, rather than adjust to new circumstances or adopt modern beliefs and practices. Significant minorities across nearly all religious traditions see a conflict between being a devout person and living in a modern society. While 92% of Americans believe in the existence of God or a universal spirit, there is considerable variation in the nature and certainty of this belief. Six out of 10 adults believe that God is a person with whom people can have a relationship; but one out of four—including about half of Jews and Hindus—see God as an impersonal force.

27. While admitting a clilent who is having elective surgery tomorrow, the nurse asks if he has a preferred religion or faith. The client indicates that he does not believe in a higher power and therefore has no preferred religion. The nurse knows that which of the following terms describes the client's feelings about religion?

A) Atheist

B) Jehovah's Witness

C) Agnostic

D) Spiritualist

Ans: A

Feedback:

An atheist is a person who denies the existence of a higher power. An agnostic is one who holds that nothing can be known about the existence of a higher power. Jehovah's Witnesses are an organized religion. A spiritualist is one who believes in spirituality.

28. This is the nurse's third day of caring for a client who recently underwent a colectomy that resulted in a colostomy. As the nurse goes about the physical assessment, a discussion about spirituality develops. The client tells the nurse that his religion believes in a basic harmony between religion and science. You interpret this as which of the following groups?

A) Buddhism

B) Baha'i International Community

C) Mormon

D) Jehovah's Witness

Ans: B

Feedback:

The Baha'i International Community believe in a basic harmony between religion and science. Jehovah's Witnesses oppose the false teachings of other sects; opposition often extends to modern science, including medicine. Buddhists believe in the Four Noble Truths and the Noble Eightfold Path. Mormons believe in divine healing through the laying on of hands."

29. Then nurse is caring for a female client today. As the nurse is giving the client her morning medications, she begins a conversation about her belief in a higher power. The nurse knows that this can be interpreted as which of the following? Choose all that apply.

A) Faith

B) Spirituality

C) Religion

D) God

E) Atheism

Ans: A, B, C, D

Feedback:

Spirituality is anything that pertains to a person's relationship with a nonmaterial life force or higher power. An atheist is a person who denies the existence of a higher power. Faith generally refers to a confident belief in something for which there is no proof or material evidence, such as a higher power. God is defined as a higher power. Religion refers to an organized system of beliefs about a higher power.

30. Then nurse is caring for a hospice client who tells the nurse that she is worried about how she has treated a younger sister. She asks the nurse how to make things right. The nurse recognizes this as which of the following spiritual needs?

A) Meaning

B) Forgiveness

C) Purpose

D) Love

Ans: B

Feedback:

According to Shelly and Fish (1988), there are three spiritual needs underlying all religious traditions and common to all people: (1) the need for meaning and purpose, (2) the need for love and relatedness, and (3) the need for forgiveness.

31. The nurse's client today informs her that he receives regular visits from a parish nurse, who helps him with his diet-controlled diabetes. The nurse is aware that parish nurses do which of the following? Choose all that apply.

A) Provide medicine at no charge

B) Refer clients to appropriate resources

C) Perform physical assessments

D) Promote personal responsibility for health

E) Provide health education

Ans: B, D, E

Feedback:

Parish nurses are not visiting nurses or home health nurses who provide direct bedside care. The key roles of the parish nurse are health educator, personal health counselor, referral agent, trainer of volunteers, developer of support groups, integrator of faith and health, and health advocate.

32. The nurse is caring for a client today who asks to have the coffee removed from his tray. The client informs the nurse that his religion precludes the intake of caffeine. The nurse is aware that religions often guide daily living habits in which of the following ways? Choose all that apply.

A) Diet

B) Medical treatments

C) Clothing

D) Education

E) Automobile makes

Ans: A, B, C

Feedback:

Many religions have significance in regard to daily life. For instance, some religions have dietary requirements and restrictions. The Mormons have special undergarments that are worn by some members. Some religions restrict medical treatments, such as blood products. Education and automobile makes are not restricted by most religions.

33. A client informs the nurse that her physician has planned a procedure that may be in conflict with the client's personal spiritual belief. The client asks the nurse for assistance. The nurse is aware that her role should include assisting the client to do which of the following?

A) Confront the physician and refuse to undergo the procedure.

B) Explore and research alternative medicine therapies.

C) Poll other physicians about alternate treatment options.

D) Obtain accurate information in order to make a good decision.

Ans: D

Feedback:

The nurse's role is to assist the client in obtaining the information needed to make an informed decision, and to support the client's decision making. The nurse should never interfere between a client and the client's physician.

34. A client requests the nurse not touch his lips when administering his oral medications. Based on the nurse's understanding of the major religions, the nurse identifies this request as reflecting which of the following?

A) Judaism

B) Christianity

C) Islam

D) Hinduism

Ans: D

Feedback:

In the Hindu religion, the nurse administering oral medications should avoid touching the client's lips. Judaism, Christianity, and Islam do not require this.

35. The nurse caring for a Native American client should inquire if the client utilizes which of the following?

A) Medicine man or woman

B) Priest

C) Rabbi

D) Preacher

Ans: A

Feedback:

Many Native Americans utilize a medicine men and women, who have specialized spirits from whom they receive the mission to cure. Priest is a term used for holy men in the Roman Catholic religion; rabbi in the Jewish religion; preacher in the protestant faiths.