# Chapter 04, The Nursing Process

1. A nurse concludes a nursing diagnosis of Altered Health Management is appropriate for a client who has stopped taking prescribed medications. Which factor would be most important for the nurse to determine?
   A) When the client stopped taking the drug
   B) What adverse reactions the client experienced
   C) What was the exact reason for stopping the drug
   D) Whether the client's symptoms were relieved with the drug

   Answer: C

   Rationale: Lack of adherence with drugs can occur for numerous reasons. Therefore, it is most important for the nurse to determine the exact reason that the client stopped the therapy. Additional information can then be obtained, such as when the client stopped, if and what adverse reactions the client experienced, and if relief was obtained.
   Question Format: Multiple Choice
   Chapter: 4
   Learning Objective: 4
   Cognitive Level: Apply
   Client Needs: Physiological Integrity: Pharmacological Therapies
   Integrated Process: Clinical Problem-solving Process (Nursing Process)
   BLM: Cognitive Level: Apply
   Reference: p. 51, Altered Health Management

2. A nurse has collected all the relevant data and is now clustering the information to determine the client's needs. The nurse is involved in which phase of the nursing process?
   A) Assessment
   B) Analysis
   C) Planning
   D) Implementation

   Answer: B

   Rationale: Analysis is the way nurses cluster data into similar groupings to determine client needs. Assessment is the collection of data that is used for analysis. Planning involves the development of client-oriented goals and expected outcomes and identifying actions to achieve these outcomes. Implementation is carrying out the plan of action.
   Question Format: Multiple Choice
   Chapter: 4
   Learning Objective: 2
   Cognitive Level: Apply
   Client Needs: Physiological Integrity: Pharmacological Therapies

Integrated Process: Clinical Problem-solving Process (Nursing Process)
Reference: p. 50, Analysis

3. A nurse caring for a client is articulating the steps for carrying out nursing activities that will assist in achieving client goals. The nurse is in which phase of the nursing process?
   A) Assessment
   B) Planning
   C) Implementation
   D) Evaluation

   Answer: B

   Rationale: The planning phase of the nursing process involves describing steps for carrying out nursing activities that will assist in achieving client goals or expected outcomes. The assessment phase involves collecting facts by means of a physical examination and through information supplied by the client or the client's family. During the implementation phase, the nurse carries out a defined plan of action. Evaluation is a decision-making process that involves determining the effectiveness of the nursing interventions in meeting the expected outcomes.
   Question Format: Multiple Choice
   Chapter: 4

   Learning Objective: 1
   Cognitive Level: Apply
   Client Needs: Safe and Effective Care Environment: Coordinated Care
   Integrated Process: Clinical Problem-solving Process (Nursing Process)
   Reference: p. 50, Planning

4. After teaching a group of nursing students about nursing diagnoses, the instructor determines that the teaching was successful when the students correctly point out which item as the most useful related to the nursing diagnoses developed by the North American Nursing Diagnosis Association-International (NANDA-I)?
   A) Identifying client problems related to drug therapy
   B) Classifying the clients according to their age groups
   C) Categorizing the drugs based on their therapeutic actions
   D) Identifying the expected outcomes of treatments given

   Answer: A

Rationale: Some of the nursing diagnoses developed by NANDA-I are useful in identifying client problems related to drug therapy and are more commonly used when administering drugs. The nursing diagnoses developed by NANDA-I do not classify the clients according to their age groups or the drugs based on their actions. NANDA-I nursing diagnoses do not identify the expected outcome of treatments given. An expected outcome will be specifically related to the kind of drug treatment given to the client. After the nursing diagnoses are formulated, the nurse develops expected outcomes, which are client oriented. The expected outcomes will be generated through efficient planning and implementation of the care plan. NANDA-I nursing diagnoses are not used to identify expected outcomes for clients.
Question Format: Multiple Choice
Chapter: 4
Learning Objective: 1
Cognitive Level: Analyze
Client Needs: Safe and Effective Care Environment: Coordinated Care
Integrated Process: Teaching/Learning
Reference: p. 50, Nursing Diagnosis

5. A nurse is caring for a client diagnosed with a respiratory condition for which drug therapy has been prescribed. What would the nurse need to address when developing appropriate expected outcomes related to the drug therapy?
   A) Amount of time the client will take to recover fully
   B) Number of drugs the client will require during the treatment
   C) Possible adverse reactions that could occur during the therapy
   D) Maximum level of wellness reasonably attainable for the client

   Answer: D

   Rationale: The nurse should know that the expected outcome describes the maximum level of wellness that is reasonably attainable for the client and that the therapeutic effect is achieved. The expected outcome for a client does not include the amount of time the client will take to recover fully, the number of drugs the client will require during the treatment, or the possible adverse reactions that could occur during the therapy.
   Question Format: Multiple Choice
   Chapter: 4
   Learning Objective: 2
   Cognitive Level: Apply
   Client Needs: Physiological Integrity: Pharmacological Therapies
   Integrated Process: Clinical Problem-solving Process (Nursing Process)
   Reference: p. 50, Planning

6. A client with a cardiac disorder is being discharged home. What would the nurse include when teaching the client about administering the prescribed drug therapy at home?
   A) Composition of the drug
   B) Disorders treated using the drug
   C) Method of drug administration
   D) Contraindications of the drug

Answer: C

Rationale: When the client is willing and able to manage the treatment regimen, the nurse should provide information concerning the drug, the method of administration, what type of reactions to expect, and what to report to the primary health care provider. A client willing to take responsibility for their treatment may need the nurse to develop a teaching plan that gives the client the information needed to properly manage the therapeutic regimen. The nurse need not educate the client on the composition of the drug or the disorders for which the drug is used, because this information will not assist the client in administering the drug by themselves to achieve the therapeutic effect. The nurse ensures that the drug is not contraindicated for the client before its administration. Therefore, it is considered safe for the client to take the drug independently.
Question Format: Multiple Choice
Chapter: 4
Learning Objective: 4
Cognitive Level: Apply
Client Needs: Physiological Integrity: Pharmacological Therapies
Integrated Process: Teaching/Learning
Reference: p. 51, Nursing Actions Based Upon Nursing Diagnoses

7. A nurse is providing care to a client who has been admitted to the health care facility. When administering drugs to this client, what would be most important for the nurse to do before administering a drug to the client?
   A) Review the subjective and objective data.
   B) Provide the basis for the selection of nursing interventions.
   C) Review the related nursing diagnosis.
   D) List the potential goals to be achieved by the client.

Answer: A

Rationale: Before administering a drug, the nurse should review the subjective and objective data obtained on assessment and consider any additional data, such as blood pressure, pulse, or statements made by the client. The decision of whether to administer the drug is based on an analysis of all information. Listing the potential goals to be achieved helps in determining the expected outcome for the client from the therapy. The nurse does not need to list the potential outcome to be achieved by the client before administering a drug. Nursing diagnosis provides a framework for the selection of nursing interventions, but it is not a nursing intervention, which should be performed before administering a drug. Nursing diagnosis helps in formulating a care plan for the client. The nurse does not need to review the nursing diagnosis before administering drugs to the client.
Question Format: Multiple Choice
Chapter: 4
Learning Objective: 3
Cognitive Level: Apply
Client Needs: Physiological Integrity: Pharmacological Therapies

Integrated Process: Clinical Problem-solving Process (Nursing Process)
Reference: p. 48, Assessment

8. A nurse who has been caring for a client determines that the plan has been successful based on which factor?
   A) Expected outcomes are accomplished.
   B) Client does not experience anxiety during therapy.
   C) Client is better able to communicate with the nurse.
   D) Subjective and objective data are successfully obtained.

   Answer: A

   Rationale: The evaluation is complete and successful if the expected outcomes are accomplished or if progress occurs. If the outcomes are not accomplished, different interventions are needed. If the client does not experience anxiety during therapy, then the nurse is better able to implement the care planned for the client and expect maximum effectiveness during evaluation. The evaluation of the care plan is not considered complete just because the client does not experience anxiety during therapy, although it facilitates receiving a positive response during evaluation. Similarly, if the client is able to effectively communicate their feelings to the nurse, the nurse can implement the care plan in a better way to yield maximum therapeutic results for the client. Good communication alone should not be considered a factor that completes the evaluation for the client. Obtaining subjective and objective data is important for accurate drug administration and therapy implementation. Evaluation for a client cannot be considered complete only on the basis of subjective and objective data.
   Question Format: Multiple Choice
   Chapter: 4
   Learning Objective: 2
   Cognitive Level: Apply
   Client Needs: Physiological Integrity: Pharmacological Therapies
   Integrated Process: Clinical Problem-solving Process (Nursing Process)
   Reference: p. 53, Evaluation

9. A nurse is assigned to care for a client with a cardiac disorder. During assessment, which action would be most appropriate for the nurse to complete when obtaining objective data related to the client's condition?
   A) Review the client's health history.
   B) Auscultate heart and lung sounds.
   C) Review the client's family history.
   D) Inquire about the client's eating habits.

   Answer: B

Rationale: To obtain objective data from the client, the nurse would auscultate heart and lung sounds. Objective data include the facts obtained through physical assessment or physical examination. Reviewing the client's health and family history and inquiring about the client's eating habits will help the nurse in obtaining subjective data, which also include facts supplied by the client and the client's family.
Question Format: Multiple Choice
Chapter: 4
Learning Objective: 3
Cognitive Level: Apply
Client Needs: Physiological Integrity: Pharmacological Therapies
Integrated Process: Clinical Problem-solving Process (Nursing Process)
Reference: p. 48, Assessment

10. A nurse prepares to administer a prescribed medication and collects the necessary data. Based on this information, the nurse decides to withhold the drug and contact the prescriber. The nurse is in which phase of the nursing process?
    A) Assessment
    B) Planning
    C) Implementation
    D) Evaluation

    Answer: C

    Rationale: Giving or withholding a drug and contacting the client's health care provider are nursing activities related to the implementation phase of the nursing process. Assessment is reflected in the data collection that the nurse has completed. Planning anticipates what will happen in the implementation phase. Evaluation would occur after the drug is administered and the nurse determines if the client is experiencing therapeutic and/or adverse effects.
    Question Format: Multiple Choice
    Chapter: 4
    Learning Objective: 2
    Cognitive Level: Apply
    Client Needs: Physiological Integrity: Pharmacological Therapies
    Integrated Process: Clinical Problem-solving Process (Nursing Process)
    Reference: p. 51, Implementation

11. After administering a prescribed medication for pain relief, the nurse is evaluating the client's response to therapy. Which finding would the nurse document as objective data?
    A) Client identifies a pain rating of 3 out of 10.
    B) Client states that the pain is much less.
    C) Client's spouse reports the client was moaning during sleep.
    D) Client reports feeling sleepy after taking the drug.

    Answer: A

Rationale: Pain rating is an objective measure and thus would be documented as such. Client statements such as the pain being much less or reports of feeling sleepy are subjective data. Information from others, such as the client's spouse, would also be considered subjective data.
Question Format: Multiple Choice
Chapter: 4
Learning Objective: 3
Cognitive Level: Analyze
Client Needs: Physiological Integrity: Pharmacological Therapies
Integrated Process: Clinical Problem-solving Process (Nursing Process)
Reference: p. 48, Assessment

12. The nurse determines a nursing diagnosis of Altered Health Management for a client. What would the nurse most likely identify as the expected outcome?
    A) Client verbalizes understanding of when to call the health care provider.
    B) Client demonstrates ability to maintain adherence to prescribed drug therapy.
    C) Client verbalizes desire to manage prescribed medication schedule.
    D) Client identifies the reason for the prescribed drug therapy for the illness.

    Answer: B
    Rationale: Demonstrating the ability to maintain adherence to the prescribed therapy would be the best outcome for a nursing diagnosis of Altered Health Management. Although there can be numerous reasons for nonadherence, this outcome addresses the importance of the therapeutic plan. Verbalizing an understanding of when to call the health care provider and identifying reasons for the prescribed drug would be appropriate outcomes for the nursing diagnosis. Verbalizing a desire to manage the prescribed medication schedule would correlate with an absence of this nursing diagnosis.
    Question Format: Multiple Choice
    Chapter: 4
    Learning Objective: 4
    Cognitive Level: Analyze
    Client Needs: Physiological Integrity: Pharmacological Therapies
    Integrated Process: Clinical Problem-solving Process (Nursing Process)
    Reference: p. 51, Altered Health Management

13. After teaching a group of students about the nursing process, the instructor determines that the teaching was successful when the students explain the goals and expected outcomes as components of which phase?
    A) Assessment
    B) Analysis
    C) Planning
    D) Implementation

    Answer: C

Rationale: Client-oriented goals and expected outcomes are developed during the planning phase. Assessment involves the collection of data. Analysis involves clustering of the data into similar groupings to determine client need. Implementation involves carrying out the actions identified during the planning phase.
Question Format: Multiple Choice
Chapter: 4
Learning Objective: 1
Cognitive Level: Analyze
Client Needs: Safe and Effective Care Environment: Coordinated Care
Integrated Process: Teaching/Learning
Reference: p. 50, Planning

14. A nursing instructor is teaching the nursing process to a group of nursing students. The instructor determines that the session was successful when the students choose which as a phase of the nursing process? Select all that apply.
    A) Evaluation
    B) Documentation
    C) Analysis
    D) Assessment
    E) Planning

    Answer: A, C, D, E
    Rationale: The nursing process is a framework for nursing action which consists of problem-solving steps that help provide effective client care. The five phases of the nursing process are assessment, analysis, planning, implementation, and evaluation. Documentation is the process used to record the various findings and results of the nursing process.
    Question Format: Multiple Select
    Chapter: 4
    Learning Objective: 1
    Cognitive Level: Apply
    Client Needs: Safe and Effective Care Environment: Coordinated Care
    Integrated Process: Teaching/Learning
    Reference: p. 48, The Five Phases of the Nursing Process

15. A nursing student is learning to apply the nursing process in the care of the clients. This student is prepared to become more proficient in this process by utilizing which steps? Select all that apply.
    A) Observe the actions of the mentor
    B) Teach the concepts to new students
    C) Practice the concepts with each client
    D) Gain proficiency by continuing to use the process
    E) Update nursing skills at each opportunity

    Answer: C, D, E

Rationale: The nursing process describes how the nurse cares for the client. It requires practice, experience, and a constant updating of knowledge. Observation of the client is a key component of assessment and teaching the client is a major intervention that the nurse implements.
Question Format: Multiple Select
Chapter: 4
Learning Objective: 1
Cognitive Level: Apply
Client Needs: Safe and Effective Care Environment: Coordinated Care
Integrated Process: Clinical Problem-solving Process (Nursing Process)
Reference: p. 48, Introduction

16. A nurse is preparing to document an assessment. Which findings would be documented as objective findings? Select all that apply.
    A) Temperature
    B) Heart rate
    C) Chief concern
    D) Medication history
    E) Respiratory rate

    Answer: A, B, E

    Rationale: Objective data are obtained through physical examination or assessment. Vital signs such as temperature, heart rate, and respiratory rate are all examples of objective data. Subjective data, which are supplied by the client or family, would include information such as chief concern and medication history.

    Question Format: Multiple Select
    Chapter: 4
    Learning Objective: 3
    Cognitive Level: Apply
    Client Needs: Safe and Effective Care Environment: Coordinated Care
    Integrated Process: Clinical Problem-solving Process (Nursing Process)
    Reference: p. 48, Assessment

17. The nurse is conducting an ongoing assessment of a client. Which factors will the nurse include in this process? Select all that apply.
    A) Obtain a medication history.
    B) Obtain vital signs.
    C) Formulate nursing diagnoses.
    D) Ask about chief concern.
    E) Determine therapeutic response.

    Answer: A, B, D, E

Rationale: The ongoing assessment of the nursing process involves the continuing collection of subjective and objective data. Examples include taking medication history and vital signs, asking about the chief concern, and determining therapeutic response. Formulating nursing diagnoses would be completed after analyzing the information collected in the assessment.
Question Format: Multiple Select
Chapter: 4
Learning Objective: 2
Cognitive Level: Apply
Client Needs: Safe and Effective Care Environment: Coordinated Care
Integrated Process: Clinical Problem-solving Process (Nursing Process)
Reference: p. 48, Assessment

18. A nurse is completing an initial assessment of a client. What would the nurse include in this assessment? Select all that apply.
    A) Allergy history
    B) Treatment response
    C) Occupational history
    D) Vital signs
    E) Pregnancy status

    Answer: A, C, D, E

    Rationale: Allergy history, occupational history, vital signs, and pregnancy status are examples of what should be included in the nurse's initial assessment. Treatment response would be part of an ongoing assessment.
    Question Format: Multiple Select
    Chapter: 4
    Learning Objective: 2
    Cognitive Level: Apply
    Client Needs: Physiological Integrity: Pharmacological Therapies
    Integrated Process: Clinical Problem-solving Process (Nursing Process)
    Reference: p. 48, Assessment

19. When preparing a teaching plan for a group of nursing students about drug administration and the nursing process, the instructor expects to include information about the most frequently used nursing diagnoses associated with drug administration. Which diagnoses would the instructor most likely include? Select all that apply.
    A) Noncompliance
    B) Ineffective Coping
    C) Deficient Knowledge
    D) Health-Seeking Behavior
    E) Altered Health Management

    Answer: C, D, E

Rationale: Frequently used nursing diagnoses related to the administration of a drug include Deficient Knowledge, Health-Seeking Behavior, and Altered Health Management. Ineffective Coping is not frequently identified as a nursing diagnosis. Noncompliance is no longer used as a nursing diagnosis, and it is more commonly characterized as Altered Health Management.
Question Format: Multiple Select
Chapter: 4
Learning Objective: 4
Cognitive Level: Apply
Client Needs: Physiological Integrity: Pharmacological Therapies
Integrated Process: Teaching/Learning
Reference: p. 50, Nursing Diagnosis

20. A nurse identifies a nursing diagnosis of Altered Health Management for a client. Which factors would the nurse point out as supporting this nursing diagnosis? Select all that apply.
    A) Visual impairment
    B) Forgetfulness
    C) Cognitive deficits
    D) Mobility issues
    E) Order entry error

    Answer: A, B, C, D

    Rationale: Possible causes of Altered Health Management include visual or hearing defects, forgetfulness, cognitive deficits, and mobility issues among several others. Order entry error would be unrelated to the client's difficulty in managing medications.
    Question Format: Multiple Select
    Chapter: 4
    Learning Objective: 4
    Cognitive Level: Analyze
    Client Needs: Physiological Integrity: Pharmacological Therapies
    Integrated Process: Nursing Process
    Reference: p. 52, Box 4.1 Possible Causes of Altered Health Management

21. The nurse is prepared to compete the evaluation phase of the nursing process. Which activities will the nurse perform? Select all that apply.
    A) Independent nursing actions
    B) Collection of objective data
    C) Collection of subjective data
    D) Initial assessment
    E) Ongoing assessment

    Answer: B, C, E

Rationale: Evaluation is a decision-making process that involves determining the effectiveness of the nursing interventions in meeting the expected outcomes. To determine if the outcomes have been accomplished, the nurse collects additional data, both subjective and objective, through an ongoing assessment. An initial assessment is completed when the nurse first meets the client. Independent nursing actions are completed during the implementation phase of the nursing process.
Question Format: Multiple Select
Chapter: 4
Learning Objective: 2
Cognitive Level: Apply
Client Needs: Safe and Effective Care Environment: Coordinated Care
Integrated Process: Clinical Problem-solving Process (Nursing Process)
Reference: p. 52, Possible Causes of Altered Health Management

22. A nurse determining a client's blood pressure prior to administering a drug could be defined as which factor? Select all that apply.
    A) Assessment
    B) Implementation
    C) Subjective data
    D) Objective data
    E) Analysis

    Answer: A, D

    Rationale: A nurse's taking a client's blood pressure prior to administering a drug would be considered assessment of objective data because the nurse will need to analyze the actual blood pressure reading to determine which plan to implement. Implementation involves carrying out the plan, such as preparing and administering one or more drugs to the client. Subjective data involve information obtained directly from the client, such as if the client reported a headache. Analysis involves clustering data to determine the client's needs.
    Question Format: Multiple Select
    Chapter: 4
    Learning Objective: 2
    Cognitive Level: Apply
    Client Needs: Physiological Integrity: Pharmacological Therapies
    Integrated Process: Clinical Problem-solving Process (Nursing Process)
    Reference: p. 48, Assessment
23. A nurse is developing a teaching plan for a client who is receiving medications. Which points would the nurse expect to include in the teaching plan? Select all that apply.
    A) Chemical name of the drug
    B) Method for administering the drug
    C) Calculation for the prescribed dosage
    D) Expected effect of the drug
    E) Information to report to the primary health care provider

    Answer: B, D, E

Rationale: When developing a teaching plan, the nurse should include information about how to administer the drug, what to expect from the drug, and what to report to the primary health care provider. Information about the drug's chemical name is not necessary; however, the nurse should address the drug's generic and/or trade names. Typically, the client would not need to calculate the drug dosage, however, the nurse should review the dosage with the client.
Question Format: Multiple Select
Chapter: 4
Learning Objective: 2
Cognitive Level: Understand
Client Needs: Physiological Integrity: Pharmacological Therapies
Integrated Process: Teaching/Learning
Reference: p. 51, Health-Seeking Behavior

24. A nurse determines a nursing diagnosis of Altered Health Management is appropriate for a client. Which factors would the nurse point out as supporting this nursing diagnosis? Select all that apply.
    A) Financial difficulty in obtaining the medication
    B) Lack of information about the drug therapy
    C) Ability to follow the prescribed medication schedule
    D) Ability to remember to take the drug regimen
    E) No therapeutic effect seen by client

    Answer: A, B, E

    Rationale: Reasons for the nursing diagnosis of Altered Health Management include the inability of the client to afford the drug regimen, inadequate information about the drug therapy regimen, and a lack of therapeutic effect seen by the client.
    Question Format: Multiple Select
    Chapter: 4
    Learning Objective: 4
    Cognitive Level: Apply
    Client Needs: Physiological Integrity: Pharmacological Therapies
    Integrated Process: Clinical Problem-solving Process (Nursing Process)
    Reference: p. 51, Health-Seeking Behavior

25. A nurse is developing a plan of care for a client with a nursing diagnosis of Anxiety Related to Drug Therapy. Which action would be important to include to foster a trusting and comfortable nurse–client relationship? Select all that apply.
    A) Completing follow-up visits with the client
    B) Sending a certified letter to the client
    C) Calling the client on the telephone
    D) Accompanying the client to all health care provider appointments
    E) Encouraging the client to express feelings and concerns

    Answer: A, C, E

Rationale: To develop a trusting and comfortable relationship between the client and the nurse, the nurse should incorporate follow-up visits, telephone calls, and encouragement to express feelings and concerns. Sending a certified letter would be ineffective. It would be impossible for the nurse to accompany the client to all health care provider appointments.
Question Format: Multiple Select
Chapter: 4
Learning Objective: 4
Cognitive Level: Apply
Client Needs: Physiological Integrity: Pharmacological Therapies
Integrated Process: Caring
Reference: p. 52, Anxiety

26. After assessing a client, the nurse determines a nursing diagnosis of Deficient Knowledge related to drug self-administration applies to this client. Which findings would support this nursing diagnosis? Select all that apply.
    A) Inability to remember
    B) Lack of a college education
    C) Cognitive limitation
    D) Lack of interest in learning
    E) Lack of effectiveness of drug

    Answer: A, C, D

    Rationale: Inability to remember, cognitive limitation, and lack of interest in learning are aspects related to drug self-administration that support the nursing diagnosis of Deficient Knowledge. Lack of a college education would not be a supporting factor. Lack of drug effectiveness would more likely be associated with a nursing diagnosis of Noncompliance or Ineffective Self Health Management.
    Question Format: Multiple Select
    Chapter: 4
    Learning Objective: 4
    Cognitive Level: Analyze
    Client Needs: Safe and Effective Care Environment: Coordinated Care
    Integrated Process: Clinical Problem-solving Process (Nursing Process)
    Reference: p. 52, Deficient Knowledge

28. A nurse is preparing a presentation for a group of clients requiring long-term medication therapy. The nurse expects to include common reasons for nonadherence to self-medication administration. Which points would the nurse be most likely to include? Select all that apply.
    A) Lack of knowledge about expected results
    B) Bothersome adverse effects
    C) Depression
    D) Anxiety
    E) Lack of information about the drug

    Answer: A, B, D, E

Rationale: Reasons for nonadherent behavior in clients administering their own medications include knowledge deficit of expected results, bothersome adverse effects, anxiety, and lack of information about the drug. Depression is not recognized as a common reason.
Question Format: Multiple Select
Chapter: 4
Learning Objective: 4
Cognitive Level: Understand
Client Needs: Physiological Integrity: Pharmacological Therapies
Integrated Process: Teaching/Learning
Reference: p. 51, Altered Health Management

28. A client is experiencing anxiety related to drug therapy. Which factors would the nurse establish as possibly influencing the client's level of anxiety? Select all that apply.
    A) Fear
    B) Severity of illness
    C) Client's knowledge level
    D) Good comprehension of information
    E) Nonadherence to the plan

    Answer: A, B, C

    Rationale: The anxiety experienced during drug administration depends on fear, severity of illness, and the client's knowledge level. Anxiety usually decreases with understanding of the information. Anxiety can lead to nonadherence.
    Question Format: Multiple Select
    Chapter: 4
    Learning Objective: 4
    Cognitive Level: Apply
    Client Needs: Physiological Integrity: Pharmacological Therapies
    Integrated Process: Clinical Problem-solving Process (Nursing Process)
    Reference: p. 52, Anxiety

29. A nurse is evaluating a client's understanding of the prescribed drug therapy regimen. Which actions would the nurse use as part of this process? Select all that apply.
    A) Facial expressions
    B) “Yes” answers when asked about understanding
    C) Nodding of head through interaction
    D) Regimen being followed correctly
    E) Correct answers to questions asked

    Answer: A, D, E

Rationale: To evaluate the client's understanding of the drug regimen, behaviors are important. The nurse may note facial expressions, regimen being followed correctly, and correct answers to questions asked. The client may say "yes" but not truly understand. Additionally, nodding of the head, although suggesting yes, does not demonstrate understanding.
Question Format: Multiple Select
Chapter: 4
Learning Objective: 2
Cognitive Level: Apply
Client Needs: Physiological Integrity: Pharmacological Therapies
Integrated Process: Clinical Problem-solving Process (Nursing Process)
Reference: p. 53, Evaluation

30. A nurse is conducting an initial assessment of a client. Which factor would the nurse be most likely to address? Select all that apply.
    A) Use of over-the-counter drugs
    B) Effectiveness of pain relief
    C) History of allergies
    D) Auscultation of bowel sounds
    E) Understanding of newly prescribed medication

    Answer: A, C, D

    Rationale: An initial assessment is broad in scope and is used as a baseline for future comparisons. Typically, this would include information about the client's use of over-the-counter drugs, allergy history, and physical examination findings such as auscultation of bowel sounds. Effectiveness of pain relief and an understanding of prescribed medication are areas that would most likely be part of an ongoing assessment.
    Question Format: Multiple Select
    Chapter: 4
    Learning Objective: 2
    Cognitive Level: Apply
    Client Needs: Health Promotion and Maintenance
    Integrated Process: Clinical Problem-solving Process (Nursing Process)
    Reference: p. 48, Assessment