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Brown & Edwards: Lewis's Medical Surgical Nursing, 4th Edition

Chapter 01: The Importance of Nursing

Test Bank

MULTIPLE CHOICE

1. The nurse completes an admission database and explains that the plan of care and discharge goals will be developed with the patient's input. The patient states, "How is this different from what the doctor does?" Which response would be most appropriate for the nurse to make?

   a. "The role of the nurse is to administer medications and other treatments prescribed by your doctor."
   b. "The nurse's job is to help the doctor by collecting information and communicating any problems that occur."
   c. "Nurses perform many of the same procedures as the doctor, but nurses are with the patients for a longer time than the doctor."
   d. "In addition to caring for you while you are sick, the nurses will assist you to develop an individualized plan to maintain your health."

   ANS: D

   This response is consistent with the American Nurses Association (ANA) definition of nursing, which describes the role of nurses in promoting health. The other responses describe some of the dependent and collaborative functions of the nursing role but do not accurately describe the nurse's role in the health care system.

   DIF: Cognitive Level: Understand (comprehension)
   TOP: Nursing Process: Implementation
   MSC: NCLEX: Safe and Effective Care Environment

2. The nurse describes to a student nurse how to use evidence-based practice guidelines when caring for patients. Which statement, if made by the nurse, would be the most accurate?

   a. "Inferences from clinical research studies are used as a guide."
   b. "Patient care is based on clinical judgment, experience, and traditions."
   c. "Data are evaluated to show that the patient outcomes are consistently met."
   d. "Recommendations are based on research, clinical expertise, and patient preferences."

   ANS: D

Evidence-based practice (EBP) is the use of the best research-based evidence combined with clinician expertise. Clinical judgment based on the nurse's clinical experience is part of EBP, but clinical decision making should also incorporate current research and research-based guidelines. Evaluation of patient outcomes is important, but interventions should be based on research from randomized control studies with a large number of subjects.

DIF: Cognitive Level: Remember (knowledge)
TOP: Nursing Process: Planning
MSC: NCLEX: Safe and Effective Care Environment

3. The nurse teaches a student nurse about how to apply the nursing process when providing patient care. Which statement, if made by the student nurse, indicates that teaching was successful?

a. "The nursing process is a scientific-based method of diagnosing the patient's health care problems."
b. "The nursing process is a problem-solving tool used to identify and treat patients' health care needs."
c. "The nursing process is based on nursing theory that incorporates the biopsychosocial nature of humans."
d. "The nursing process is used primarily to explain nursing interventions to other health care professionals."

ANS: B

The nursing process is a problem-solving approach to the identification and treatment of patients' problems. Diagnosis is only one phase of the nursing process. The primary use of the nursing process is in patient care, not to establish nursing theory or explain nursing interventions to other health care professionals.

DIF: Cognitive Level: Understand (comprehension)
TOP: Nursing Process: Implementation
MSC: NCLEX: Safe and Effective Care Environment

4. A patient has been admitted to the hospital for surgery and tells the nurse, "I do not feel comfortable leaving my children with my parents." Which action should the nurse take next?

a. Reassure the patient that these feelings are common for parents.
b. Have the patient call the children to ensure that they are doing well.
c. Gather more data about the patient's feelings about the child-care arrangements.
d. Call the patient's parents to determine whether adequate child care is being provided.

ANS: C

Since a complete assessment is necessary in order to identify a problem and choose an appropriate intervention, the nurse's first action should be to obtain more information. The other actions may be appropriate, but more assessment is needed before the best intervention can be chosen.

DIF: Cognitive Level: Apply (application)
OBJ: Special Questions: Prioritization
TOP: Nursing Process: Assessment
MSC: NCLEX: Psychosocial Integrity

5. A patient who is paralyzed on the left side of the body after a stroke develops a pressure ulcer on the left hip. Which nursing diagnosis is most appropriate?

a. Impaired physical mobility related to left-sided paralysis
b. Risk for impaired tissue integrity related to left-sided weakness
c. Impaired skin integrity related to altered circulation and pressure
d. Ineffective tissue perfusion related to inability to move independently

ANS: C

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

DIF: Cognitive Level: Apply (application)
TOP: Nursing Process: Diagnosis
MSC: NCLEX: Physiological Integrity

6. A patient with a bacterial infection has a nursing diagnosis of deficient fluid volume related to excessive diaphoresis. Which outcome would the nurse recognize as most appropriate for this patient?

a. Patient has a balanced intake and output.
b. Patient's bedding is changed when it becomes damp.
c. Patient understands the need for increased fluid intake.
d. Patient's skin remains cool and dry throughout hospitalization.

ANS: A

This statement gives measurable data showing resolution of the problem of deficient fluid volume that was identified in the nursing diagnosis statement. The other statements would not indicate that the problem of deficient fluid volume was resolved.

DIF: Cognitive Level: Apply (application)
TOP: Nursing Process: Planning
MSC: NCLEX: Physiological Integrity

7. A nurse asks the patient if pain was relieved after receiving medication. What is the purpose of

the evaluation phase of the nursing process?

a. To determine if interventions have been effective in meeting patient outcomes
b. To document the nursing care plan in the progress notes of the medical record
c. To decide whether the patient's health problems have been completely resolved
d. To establish if the patient agrees that the nursing care provided was satisfactory

ANS: A

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

DIF: Cognitive Level: Understand (comprehension)
TOP: Nursing Process: Evaluation
MSC: NCLEX: Safe and Effective Care Environment

8. The nurse interviews a patient while completing the health history and physical examination. What is the purpose of the assessment phase of the nursing process?

a. To teach interventions that relieve health problems
b. To use patient data to evaluate patient care outcomes
c. To obtain data with which to diagnose patient problems
d. To help the patient identify realistic outcomes for health problems

ANS: C

During the assessment phase, the nurse gathers information about the patient to diagnose patient problems. The other responses are examples of the planning, intervention, and evaluation phases of the nursing process.

DIF: Cognitive Level: Understand (comprehension)
TOP: Nursing Process: Assessment
MSC: NCLEX: Safe and Effective Care Environment

9. Which nursing diagnosis statement is written correctly?

a. Altered tissue perfusion related to heart failure
b. Risk for impaired tissue integrity related to sacral redness
c. Ineffective coping related to response to biopsy test results
d. Altered urinary elimination related to urinary tract infection

ANS: C

This diagnosis statement includes a NANDA nursing diagnosis and an etiology that describes a patient's response to a health problem that can be treated by nursing. The use of a medical diagnosis as an etiology (as in the responses beginning "Altered tissue perfusion" and "Al-

tered urinary elimination") is not appropriate. The response beginning "Risk for impaired tissue integrity" uses the defining characteristic as the etiology.

DIF: Cognitive Level: Understand (comprehension)
TOP: Nursing Process: Diagnosis
MSC: NCLEX: Safe and Effective Care Environment

10. The nurse admits a patient to the hospital and develops a plan of care. What components should the nurse include in the nursing diagnosis statement?

a. The problem and the suggested patient goals or outcomes
b. The problem with possible causes and the planned interventions
c. The problem, its cause, and objective data that support the problem
d. The problem with an etiology and the signs and symptoms of the problem

ANS: D

When writing nursing diagnoses, this format should be used: problem, etiology, and signs and symptoms. The subjective, as well as objective, data should be included in the defining characteristics. Interventions and outcomes are not included in the nursing diagnosis statement.

DIF: Cognitive Level: Remember (knowledge)
TOP: Nursing Process: Diagnosis
MSC: NCLEX: Safe and Effective Care Environment

11. A nurse is caring for a patient with heart failure. Which task is appropriate for the nurse to delegate to experienced unlicensed assistive personnel (UAP)?

a. Monitor for shortness of breath or fatigue after ambulation.
b. Instruct the patient about the need to alternate activity and rest.
c. Obtain the patient's blood pressure and pulse rate after ambulation.
d. Determine whether the patient is ready to increase the activity level.

ANS: C

UAP education includes accurate vital sign measurement. Assessment and patient teaching require registered nurse education and scope of practice and cannot be delegated.

DIF: Cognitive Level: Apply (application)
OBJ: Special Questions: Delegation
TOP: Nursing Process: Planning
MSC: NCLEX: Safe and Effective Care Environment

12. A nurse is caring for a group of patients on the medical-surgical unit with the help of one float registered nurse (RN), one unlicensed assistive personnel (UAP), and one licensed practical/vocational nurse (LPN/LVN). Which assignment, if delegated by the nurse, would be inappropriate?

a. Measurement of a patient's urine output by UAP
b. Administration of oral medications by LPN/LVN
c. Check for the presence of bowel sounds and flatulence by UAP
d. Care of a patient with diabetes by RN who usually works on the pediatric unit

ANS: C

Assessment requires RN education and scope of practice and cannot be delegated to an LPN/LVN or UAP. The other assignments made by the RN are appropriate.

DIF: Cognitive Level: Apply (application)
OBJ: Special Questions: Delegation
TOP: Nursing Process: Planning
MSC: NCLEX: Safe and Effective Care Environment

13. Which task is appropriate for the nurse to delegate to a licensed practical/vocational nurse (LPN/LVN)?

a. Complete the initial admission assessment and plan of care.
b. Document teaching completed before a diagnostic procedure.
c. Instruct a patient about low-fat, reduced sodium dietary restrictions.
d. Obtain bedside blood glucose on a patient before insulin administration.

ANS: D

The education and scope of practice of the LPN/LVN include activities such as obtaining glucose testing using a finger stick. Patient teaching and the initial assessment and development of the plan of care are nursing actions that require registered nurse education and scope of practice.

DIF: Cognitive Level: Apply (application)
OBJ: Special Questions: Delegation
TOP: Nursing Process: Planning
MSC: NCLEX: Safe and Effective Care Environment

14. A nurse is assigned as a case manager for a hospitalized patient with a spinal cord injury. The patient can expect the nurse functioning in this role to perform which activity?

a. Care for the patient during hospitalization for the injuries.
b. Assist the patient with home care activities during recovery.
c. Determine what medical care the patient needs for optimal rehabilitation.
d. Coordinate the services that the patient receives in the hospital and at home.

ANS: D

The role of the case manager is to coordinate the patient's care through multiple settings and

levels of care to allow the maximal patient benefit at the least cost. The case manager does not provide direct care in either the acute or home setting. The case manager coordinates and advocates for care but does not determine what medical care is needed; that would be completed by the health care provider or other provider.

DIF: Cognitive Level: Apply (application)
TOP: Nursing Process: Implementation
MSC: NCLEX: Safe and Effective Care Environment

15. The nurse is caring for an older adult patient who had surgery to repair a fractured hip. The patient needs continued nursing care and physical therapy to improve mobility before returning home. The nurse will help to arrange for transfer of this patient to which facility?

a. A skilled care facility
b. A residential care facility
c. A transitional care facility
d. An intermediate care facility

ANS: C

Transitional care settings are appropriate for patients who need continued rehabilitation before discharge to home or to long-term care settings. The patient is no longer in need of the more continuous assessment and care given in acute care settings. There is no indication that the patient will need the permanent and ongoing medical and nursing services available in intermediate or skilled care. The patient is not yet independent enough to transfer to a residential care facility.

DIF: Cognitive Level: Apply (application)
REF: eTables 1-1, 1-2
TOP: Nursing Process: Planning
MSC: NCLEX: Safe and Effective Care Environment

16. A home care nurse is planning care for a patient who has just been diagnosed with type 2 diabetes mellitus. Which task is appropriate for the nurse to delegate to the home health aide?

a. Assist the patient to choose appropriate foods.
b. Help the patient with a daily bath and oral care.
c. Check the patient’s feet for signs of breakdown.
d. Teach the patient how to monitor blood glucose.

ANS: B

Assisting with patient hygiene is included in home health-aide education and scope of practice. Assessment of the patient and instructing the patient in new skills, such as diet and blood glucose monitoring, are complex skills that are included in registered nurse education and scope of practice.

DIF: Cognitive Level: Apply (application)
OBJ: Special Questions: Delegation
TOP: Nursing Process: Implementation
MSC: NCLEX: Safe and Effective Care Environment

17. The nurse is providing education to nursing staff on quality care initiatives. Which statement would be the **most** accurate description of the impact of health care financing on quality care?

a. "Hospitals are reimbursed for all costs incurred if care is documented electronically."
b. "Payment for patient care is primarily based on clinical outcomes and patient satisfaction."
c. "If a patient develops a catheter-related infection, the hospital receives additional funding."
d. "Because hospitals are accountable for overall care, it is not nursing's responsibility to monitor care delivered by others."

ANS: B

Payment for health care services programs reimburses hospitals for their performance on overall quality-of-care measures. These measures include clinical outcomes and patient satisfaction. Nurses are responsible for coordinating complex aspects of patient care, including the care delivered by others, and identifying issues that are associated with poor quality care. Payment for care can be withheld if something happens to the patient that is considered preventable (e.g., acquiring a catheter-related urinary tract infection).

DIF: Cognitive Level: Apply (application)
TOP: Nursing Process: Implementation
MSC: NCLEX: Safe and Effective Care Environment

18. The nurse documenting the patient's progress in the care plan in the electronic health record before an interdisciplinary discharge conference is demonstrating competency in which QSEN category?

a. Patient-centered care
b. Quality improvement
c. Evidence-based practice
d. Informatics and technology

ANS: D

The nurse is displaying competency in the QSEN area of informatics and technology. Using a computerized information system to document patient needs and progress and communicate vital information regarding the patient with health care team members provides evidence that nursing practice standards related to the nursing process have been maintained during the care of the patient.

DIF: Cognitive Level: Apply (application)
TOP: Nursing Process: Implementation
MSC: NCLEX: Safe and Effective Care Environment

MULTIPLE RESPONSE

1. Which information will the nurse consider when deciding what nursing actions to delegate to a licensed practical/vocational nurse (LPN/LVN) who is working on a medical-surgical unit (*select all that apply*)?

   a. Institutional policies
   b. Stability of the patient
   c. State nurse practice act
   d. LPN/LVN teaching abilities
   e. Experience of the LPN/LVN

   ANS: A, B, C, E

   The nurse should assess the experience of LPN/LVNs when delegating. In addition, state nurse practice acts and institutional policies must be considered. In general, LPN/LVN scope of practice includes caring for patients who are stable, while registered nurses should provide most of the care for unstable patients. Since LPN/LVN scope of practice does not include patient education, this will not be part of the delegation process.

   DIF: Cognitive Level: Apply (application)
   OBJ: Special Questions: Delegation
   TOP: Nursing Process: Planning
   MSC: NCLEX: Safe and Effective Care Environment

2. The nurse is administering medications to a patient. Which actions by the nurse during this process are consistent with promoting safe delivery of care (*select all that apply*)?

   a. Throws away a medication that is not labeled
   b. Uses a hand sanitizer before preparing a medication
   c. Identifies the patient by the room number on the door
   d. Checks lab test results before administering a diuretic
   e. Gives the patient a list of current medications upon discharge

   ANS: A, B, D, E

   National Patient Safety Goals have been established to promote safe delivery of care. The nurse should use at least two reliable ways to identify the patient such as asking the patient's full name and date of birth before medication administration. Other actions that improve patient safety include performing hand hygiene, disposing of unlabeled medications, completing appropriate assessments before administering medications, and giving a list of the current medicines to the patient and caregiver before discharge.

   DIF: Cognitive Level: Apply (application)
   TOP: Nursing Process: Implementation
   MSC: NCLEX: Safe and Effective Care Environment

OTHER

1. The nurse uses the Situation-Background-Assessment-Recommendation (SBAR) format to communicate a change in patient status to a health care provider. In which order should the nurse make the following statements? *(Put a comma and a space between each answer choice [A, B, C, D].)*

   a. "The patient needs to be evaluated immediately and may need intubation and mechanical ventilation."
   b. "The patient was admitted yesterday with heart failure and has been receiving furosemide (Lasix) for diuresis, but urine output has been low."
   c. "The patient has crackles audible throughout the posterior chest and the most recent oxygen saturation is 89%. Her condition is very unstable."
   d. "This is the nurse on the surgical unit. After assessing the patient, I am very concerned about increased shortness of breath over the past hour."

   ANS: D, B, C, A

   The order of the nurse's statements follows the SBAR format.

   DIF: Cognitive Level: Apply (application)
   OBJ: Special Questions: Prioritization
   TOP: Nursing Process: Implementation
   MSC: NCLEX: Safe and Effective Care Environment