# Chapter 1: Nursing Process: An Overview

**MULTIPLE CHOICE**

1. The term *process* to describe nursing was first used in
   a. 1955 by Lydia Hall
   b. 1855 by Florence Nightingale
   c. 1961 by Ida Orlando
   d. 1967 by Yra and Walsh

   ANS: A PTS: 1

2. When was nursing diagnosis added as a separate and distinct step in the nursing process?
   a. 1959
   b. 1963
   c. 1974
   d. 1985

   ANS: C PTS: 1

3. Currently, the steps in the nursing process are
   a. assessment, planning, and evaluation
   b. assessment, planning, implementation, and evaluation
   c. assessment, analysis, planning, implementation, and evaluation
   d. assessment, diagnosis, outcome identification and planning, implementation, and evaluation

   ANS: D PTS: 1

4. The nurse is assessing a client. Which data are considered data from a primary source?
   a. The client's spouse tells the nurse that the client seems upset.
   b. The client reports right lower quadrant pain.
   c. The physician describes the client as being overanxious.
   d. The laboratory report shows an elevated white cell count.

   ANS: B PTS: 1

5. Which is subjective data?
   a. The client states, "My head hurts."
   b. The laboratory report shows an elevated white cell count.
   c. The client weighs 148 pounds.
   d. The nurse hears bilateral sounds.

   ANS: A PTS: 1

6. The nurse takes the client's vital signs. The data collected are
   a. subjective
   b. objective
   c. irrelevant
   d. secondary

   ANS: B PTS: 1

7. Which is objective data?
   a. The client states, "I have a headache."
   b. The client complains of a sore throat.
   c. The client's temperature is 100.4 degrees Fahrenheit.
   d. The client says he doesn't sleep well at night.

   ANS: C PTS: 1

8. Which is *not* a part of assessment?
   a. collection of data
   b. validation of data
   c. clustering of data
   d. analysis of data

   ANS: D PTS: 1

9. Which is an example of an actual NANDA nursing diagnosis?
   a. Risk for Impaired Skin Integrity Related to Inability to Change Positions
   b. Potential for Enhanced Nutrition
   c. Fluid Volume Deficient Related to Nausea and Vomiting
   d. Risk for Infection Related to Indwelling Urinary Catheter

   ANS: C PTS: 1

10. A possible nursing diagnosis indicates
    a. a situation in which a problem could arise unless preventive action is taken
    b. that a problem does not yet exist but special risk factors are present
    c. the client's expression of a desire to attain a higher level of wellness in some area of function
    d. that a problem exists

    ANS: A PTS: 1

11. Which *best* describes a goal?
    a. It is measurable and has a time limit.
    b. It is a broad statement that describes the intended change in the client's behavior within a specified time period.
    c. It is a direct result of analysis of collected data within a specified time.
    d. It includes both objective and subjective data.

    ANS: B PTS: 1

12. Which is the *best* example of an expected outcome?
    a. Turn, cough, and deep breathe every 2 hours.
    b. The client will maintain nutritional status.
    c. The client will walk the length of the corridor twice a day by the second day after surgery.
    d. The client has gained 3 pounds within 2 months as stated.

    ANS: C PTS: 1

13. Which statement is *not* true regarding nursing diagnosis?
    a. A nursing diagnosis is generally the same as a medical diagnosis.
    b. Nursing diagnosis provides the basis for selection of nursing interventions to achieve outcomes for which the nurse is accountable.
    c. A nursing diagnosis focuses on the responses to actual or potential health problems; a medical diagnosis focuses on the illness, injury, or disease.
    d. Nursing diagnoses change as the client's health problems change.

    ANS: A PTS: 1

14. In which step of the nursing process are nursing diagnoses prioritized?
    a. assessment
    b. diagnosis
    c. outcome identification and planning
    d. evaluation

ANS: C PTS: 1

15. Critical thinking involves
    a. repeating memorized facts
    b. finding meaning in facts
    c. acting immediately on data
    d. engaging in "groupthink"

    ANS: B PTS: 1

16. All of the following statements about critical thinking are true *except*
    a. it is a criterion outcome of the nursing education curriculum identified by NLN and supported by the AACN
    b. it is a functional skill
    c. it is guided by logic
    d. it is guided by sound judgment

    ANS: B PTS: 1

17. Which of the following is *not* a cognitive skill of clinical judgment that relies on the application of critical thinking skills?
    a. biased inquiry
    b. evaluation
    c. intuition
    d. creative analysis of a cause and effect

    ANS: A PTS: 1

18. Which of the following is *not* a characteristic of critical thinking?
    a. dependent thinking
    b. proactive
    c. intellectual humility
    d. creative

    ANS: A PTS: 1

19. Which critical thinking skill is associated with query of evidence, conjecture alternatives, and drawing conclusions?
    a. evaluation
    b. interpretation
    c. explanation
    d. inference

    ANS: D PTS: 1

20. Which of the following is *not* considered to be a barrier of creative thinking?
    a. fear of making mistakes
    b. open mindset
    c. hasty decision making
    d. stereotypical perception of client care

    ANS: B PTS: 1

21. Which statement about nursing diagnosis is true? Nursing diagnosis
    a. remains constant until a cure is effected
    b. focuses on the response to actual or potential health problems or life processes
    c. focuses on disease process
    d. focuses on cure

    ANS: B PTS: 1

22. Which of the following is *not* a type of nursing diagnosis?

a. collaborative problems
b. wellness conditions
c. actual problems
d. medical diagnosis

ANS: D PTS: 1

23. Which type of diagnosis is defined as physiological complications monitored by nurses to assess changes in client status?
a. risk nursing diagnosis
b. wellness nursing diagnosis
c. collaborative problem
d. actual diagnosis

ANS: C PTS: 1