Psychiatric Mental Health Nursing 5th Edition Fortinash Test Bank
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Fortinash: Psychiatric Mental Health Nursing, 5th Edition

Chapter 03: The Nursing Process and Standards of Practice

Test Bank

MULTIPLE CHOICE

1. The patient asks the nurse, "I've heard the student nurses talk about the nursing process. Why is there so much emphasis on using the nursing process?" The response that explains the need for nurses to understand and use the nursing process is:
a. "Do you think you have a better method we might use?"
b. "The nursing process is a systematic problem-solving method encompassing all components necessary to care for patients."
c. "Using the nursing process is a way of legitimizing our profession and placing us on an equal footing with the pure sciences."
d. "The nursing process is a unidimensional, static, linear approach used to guide nurses as they make clinical judgments."

ANS: B
This response best explains the importance of the nursing process by description and relationship to patient care. Suggesting that the patient may have a better method is challenging and does not address the question posed by the patient. Providing legitimacy to the profession is a very limited explanation for use of the nursing process. The nursing process is not one-dimensional, static, or linear.

DIF: Cognitive Level: Knowledge REF: Page 40
TOP: Nursing Process: Implementation MSC: NCLEX: Safe and Effective Care Environment

2. When preparing to conduct a nursing history and assessment on a patient transferred from the emergency department (ED) whose family believes the patient to be a questionable historian due to cognitive impairment, the nurse initially begins the interview by:
a. Reviewing the ED chart
b. Contacting the admitting physician
c. Directing the questions to the family members
d. Establishing a line of communication with the patient

ANS: D
The nurse should begin establishing the nurse–patient relationship by initially directing the questions to the patient. The nurse can confirm information and/or obtain supplementary information from the sources identified by the other options.

DIF: Cognitive Level: Application REF: Page 40
TOP: Nursing Process: Assessment MSC: NCLEX: Safe and Effective Care Environment

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3. The nurse shows the ability to effectively state a nursing diagnosis reflective of the implications of depression on a patient's life processes when stating in the patient's plan of care that:
a. Patient outcomes were partially attained. Implementation of present plan to continue.
b. Patient will initiate and support conversation with nurse therapist by (date 3 weeks in future).
c. Oral medication for anxiety should be administered when depression is assessed to be at the moderate level.
d. Impaired verbal communication r/t impoverished thoughts secondary to depression as evidenced by monosyllabic responses.

ANS: D
This statement contains the various components of a nursing diagnosis while expressing the existence of an altered life process. The remaining options reflect other steps, such as evaluation and intervention planning.

DIF: Cognitive Level: Application REF: Pages 47-48 TOP: Nursing Process: Analysis
MSC: NCLEX: Safe and Effective Care Environment

4. When engaging in outcomes identification, the nurse:
a. Interviews and collects patient-focused data
b. Re-assesses the patient's physical and emotional status evaluation
c. Reviews the patient's existing problems and projects the results of the nursing care
d. Considers the patient's presenting symptoms and identifies nursing-related problems

ANS: C
Outcomes are projections of expected influence that nursing interventions will have on the patient. Interviewing and collecting data is involved in the assessment process, re-assessing is involved in the evaluation process, and identifying related nursing problems is involved in determining appropriate nursing diagnoses.

DIF: Cognitive Level: Application REF: Page 49
TOP: Nursing Process: Implementation MSC: NCLEX: Safe and Effective Care Environment

5. While discussing assessment of suicidal patients, a novice nurse mentions, "I was taught to always base my care on concrete, evidence-based scientific reasoning and never to rely on intuition." Which response by the experienced nurse shows understanding of intuitive reasoning?
a. "That's wise, because intuition went out of favor with the scientific revolution."
b. "Critical thinking and intuition are at opposite poles. Keep relying on your expertise."

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c. "It's possible that intuition about suicidality is generated by transfer of feelings from the patient to the nurse."
d. "It's been determined that intuition is nothing more that extrasensory perception, so some folks have it, and some don't."

ANS: C
A "strong hunch" or a "gut feeling" is an example of intuitive reasoning that is believed to come from the therapeutic relationship's sharing of feelings between nurse and patient. Most nurses agree that intuition is compatible with scientific reasoning, because both are likely linked to practice and experience. A nurse learns intuitive reasoning through clinical practice rather than from school or books.

DIF: Cognitive Level: Application REF: Page 45
TOP: Nursing Process: Analysis (Caring)
MSC: NCLEX: Safe and Effective Care Environment

6. A nurse shows effective critical thinking skills directed towards nursing care of a cognitively impaired patient who continues to socially isolate by:
a. Clearly stating that the patient must socially interact once daily
b. Documenting that the patient continues to resist socialization
c. Asking the patient to identify which unit activity they are willing to attend
d. Suggesting that staff take the patient with them when running errands off the unit

ANS: D
Critical thinking in this case involves the creation of alternative solutions to a problem that was not resolved by conventional methods. The remaining options, although not inappropriate, do not show critical thinking skills

DIF: Cognitive Level: Application REF: Page 45 TOP: Nursing Process: Planning
MSC: NCLEX: Safe and Effective Care Environment

7. A depressed patient shares with the nurse that he, "has been thinking about ending it all". Based on NANDA recommendations, the nurse:
a. Implements suicide precautions for this patient
b. Includes 'Risk for Self Harm' to the patient's care plan
c. Documents regarding the patient's safety every 15 minutes
d. Reviews the patient's chart for references to past incidences of hopeless

ANS: B
NANDA states that a nurse is able to change any actual diagnosis on the NANDA list to a risk diagnosis if the problem has not occurred yet. The remaining options, although not inappropriate, do not related to NANDA.

DIF: Cognitive Level: Application REF: Page 48 TOP: Nursing Process: Analysis

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MSC: NCLEX: Safe and Effective Care Environment

8. The nurse shows an understanding of the appropriate use of nursing outcomes regarding triggers for a patient diagnosed with chronic alcohol abuse when stating:
a. "Can you work on identifying three situations that cause you to abuse alcohol?"
b. "I'll help you to identify three triggers for your drinking during today's session."
c. "I'm pleased you've identified three situations that trigger your abuse of alcohol."
d. "Do you think you will be able to avoid the three triggers that cause you to drink?"

ANS: C
Outcomes sometimes referred to as behavioral goals are used to describe and evaluate the effectiveness of nursing interventions. The correct option shows that the patient was successful at accomplishing an outcome inferring the nursing interventions were successful. The remaining options do not indicate an evaluation of success or failure.

DIF: Cognitive Level: Application REF: Page 49 TOP: Nursing Process: Evaluation
MSC: NCLEX: Psychosocial Integrity: Chemical and Other Dependencies

9. When a patient experiencing acute depression asks what the difference is between a medical and a nursing diagnosis, the nurse responds best when stating:
a. Actually they are very similar in that they both are concerned with helping you get better and lead a happier life.
b. Medical diagnoses are focused on why you are depressed whereas nursing diagnoses are concerned about making your life less sad.
c. Nursing diagnoses are more directed at caring for you, unlike medical diagnoses that focus on finding the cause for your problem.
d. The medical diagnosis identifies that you are experiencing depression whereas the nursing diagnosis identifies how the depression is affecting you.

ANS: D
The medical diagnosis involves identifying a mental or physical problem that results in the symptoms that negatively affect a patient's life. Although the nurse is knowledgeable about the disorders and their treatments, the nursing diagnosis focuses mainly on the patient's responses to the disorder and the effects that the disorder has on the patient. The types of diagnoses have different foci that result in different actions and concerns.

DIF: Cognitive Level: Application REF: Page 49
TOP: Nursing Process: Implementation (Teaching and Learning)
MSC: NCLEX: Psychosocial Integrity: Therapeutic Communication

10. A nurse best shows an understanding of the role of evidence-based research in achieving therapeutic patient care outcomes when:
a. Subscribing to and reading a monthly psychiatric research nursing journal
b. Working on a committee to revise current facility policies regarding the use of chemical restraints

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c. Registering to attend a psychiatric workshop on newly developed psychotropic medication therapies
d. Asking an experienced staff member to review the interventions being proposed for a newly admitted patient

ANS: B
Evidence-based practice is based on evidence and scientific principles that have been developed through research. The more closely clinical practice reflects relevant research, the more likely it is that patients will receive the best available care. The option that infers action directed at implementing the research is the one that shows best understanding. Reliance only on experience is not reflective of quality nursing care.

DIF: Cognitive Level: Application REF: Page 51 TOP: Nursing Process: Planning
MSC: NCLEX: Safe and Effective Care Environment

11. When caring for a patient admitted with a diagnosis if bipolar disorder, managed care regulations is the driving force behind the nurse's use of:
a. NANDA nursing diagnoses
b. Short-term stress management therapy
c. A specialized clinical pathway for such patients
d. Generic instead of brand name medications

ANS: C
Managed care regulations have brought about the use of clinical pathways (also called *critical pathways* or a *care maps*) which are standardized multidisciplinary planning tools that monitor patient care through projected caregiver interventions and expected patient outcomes with a projected timeline of success. NANDA nursing diagnoses are not related to regulations or payment concerns. The implementation of short-term stress management therapy in an acute care psychiatric environment would not be driven by managed care regulation or payment concerns. The use of generic medications when appropriate is primarily cost driven.

DIF: Cognitive Level: Application REF: Page 51
TOP: Nursing Process: Implementation MSC: NCLEX: Safe and Effective Care Environment

12. A benefit of the implementation of clinical pathways is evidenced when the patient states:
a. "I know my doctors and nurses really care about me."
b. "My medication has really helped lessen my symptoms."
c. "I have hopes that I will be able to lead a productive, healthy life."
d. "My care team has really helped me manage most of my problems."

ANS: D

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Clinical pathways are tools that among other things promote interdisciplinary care thus providing for holistic care of the patient. The remaining options do not involve the additional recognized benefits of clinical pathways that include cost effectiveness and access to patient status reports.

DIF: Cognitive Level: Application REF: Page 54 TOP: Nursing Process: Evaluation
MSC: NCLEX: Safe and Effective Care Environment

13. A nurse shows the best understanding of the legal importance of the patient's chart when stating:
a. "You always document in ink and never erase or use "white out" in the nursing notes."
b. "It's a document that shows proof that the patient received care that met the expected standards."
c. "Patient charts are carefully protected from unlawful access by inappropriate individuals or institutions."
d. "The patient has a legal right to the information contained in the chart but not the original documentation itself."

ANS: B
The patient's chart is a legal document that effectively communicates patient outcomes, medications, treatments, responses, and unusual incidents reflecting the healthcare systems attempts at meet the standard of care appropriate for this patient. The other options are not as inclusive in describing the legal status of the chart.

DIF: Cognitive Level: Application REF: Page 56
TOP: Nursing Process: Implementation; (Teaching and Learning)
MSC: NCLEX: Safe and Effective Care Environment

14. The nurse best fulfills the obligation to be accountable for providing care that meets the expected standards of care when:
a. Developing a therapeutic relations with the patient
b. Applying evidence-based nursing practice to the plan of care
c. Providing appropriate discharge planning to meet the patient's needs
d. Evaluating the effectiveness of interventions through achievement of outcomes

ANS: D
Evaluation of the patient's progress and the nursing activities involved are critical because nurses are accountable for the standards of care in each discipline. Although the other options reflect appropriate and expected nursing interventions, they are not the primary means of assuring that standard of care has been met.

DIF: Cognitive Level: Application REF: Page 56 TOP: Nursing Process: Planning
MSC: NCLEX: Safe and Effective Care Environment

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15. The nurse assesses a patient's judgment by asking:
a. "Why did you run away?"
b. "When did you first start hearing voices?"
c. "What would you do if you smelled smoke in your home?"
d. "Do you believe you hear voices, or do you think it is in your mind?"

ANS: C
Judgment is the ability to assess and evaluate situations, make rational decisions, understand consequences of behavior, and take responsibility for actions. Judgment may be assessed by asking a question that has a common-sense answer. The other options ask about motivation, elicits historical information about the illness or seeks information about insight.

DIF: Cognitive Level: Application REF: Page 43
TOP: Nursing Process: Implementation
MSC: NCLEX: Safe and Effective Care Environment; Psychological Integrity

16. The nurse responsible for the care plan of a patient diagnosed with cognitive impairment includes rationales for the nursing interventions primarily to:
a. Provide a means for outcome evaluation
b. Account for the reasoning that drives the nursing action
c. Support the patient's success in achieving the expected outcome
d. Provide information to aide in the implementation of the nursing action

ANS: B
Rationales primarily reflect nurses' accountability for their actions by explaining why the action is necessary and expected to positively impact the patient's condition. Rationales are not used to support or evaluate the success of the intervention nor to educate how the action should be preformed.

DIF: Cognitive Level: Application REF: Page 56 TOP: Nursing Process: Planning
MSC: NCLEX: Safe and Effective Care Environment

17. A patient who has a nursing diagnosis of ineffective coping related to ineffective problem solving has been involved in treatment for 6 months. The nurse determines that the planned interventions require revision when the patient states:
a. "I really don't think my psychiatrist actually helps me."
b. "I can't decide if I should get my own apartment or not."
c. "I can't accept that I will never be able to comfortably make decisions."
d. "I don't think I'm liked well enough to seek election as a committee chairperson."

ANS: B

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Nursing interventions describe a specific course of action or a therapeutic activity that helps the patient to move toward a more functional state; in this case problem solving. The statement indicates indecision and suggests that problem solving is still a patient problem. Showing dislike of the physician actually shows a decision. Not accepting the realization of ineffective decision making is not related to ineffective coping but rather shows focus on affecting the problem. Expressing the perception that one is not liked concerns self-esteem.

DIF: Cognitive Level: Application REF: Page 54 TOP: Nursing Process: Evaluation
MSC: NCLEX: Safe and Effective Care Environment; Psychological Integrity

18. To best facilitate interdisciplinary communication regarding the plan of care for a patient diagnosed with paranoid schizophrenia, the nurse:
a. Requires weekly meetings of the care team
b. Ensures the team includes members from all appropriate disciplines
c. Uses the standardized NIC classification system of care interventions
d. Recognizes the need for team access to patient records and makes them available

ANS: C
The Nursing Interventions Classification (NIC) is the first comprehensive standardized classification of interventions. The NIC states that one should not change intervention labels and definitions so that there is no confusion across settings. Although not inappropriate, the remaining options do not directly minimize confusion related to communication.

DIF: Cognitive Level: Application REF: Page 55
TOP: Nursing Process: Implementation MSC: NCLEX: Safe and Effective Care Environment

19. When reviewing the history of a newly admitted patient diagnosed with severe chronic depression, the nurse is most concerned about patient safety issues when noting:
a. The patient's Axis II includes a diagnosis of mental retardation
b. Documentation that the patient has been noncompliant regarding medications
c. The patient's current Global Assessment of Functioning (GAF) Scale rating is 9
d. Reference to a recent physical injury resulting from the patient's impulsive behavior

ANS: C
The Global Assessment of Functioning (GAF) Scale is one of the tools use to assess patient functioning and possible prognosis. It is coded on a numerical continuum, with 1 indicating little danger and 10 indicating severe or persistent danger, and possible suicidal potential. Mental deficiency may contribute to issues of safety but it is not a significant risk factor. Noncompliance may contribute to the patient's depression but it is not the greatest concern identified. Although past history is considered a predictor of future behavior, this is more related to the safety of others than to the patient.

DIF: Cognitive Level: Application REF: Page 49

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TOP: Nursing Process: Assessment
MSC: NCLEX: Safe and Effective Care Environment; Psychological Integrity

20. An appropriate nursing diagnosis for a patient who manifests a psychological problem through frequent expressions of unfounded or excessive guilt or shame, states that he is unable to deal with situations, and has a hesitation to try new things would be:
a. Hopelessness
b. Powerlessness
c. Ineffective coping
d. Chronic low self-esteem

ANS: D
The behaviors mentioned in the situation are congruent with criteria for the diagnosis of chronic low self-esteem. The patient's symptoms go beyond powerlessness. Hopelessness does not involve feelings of guilt and shame. The data is not consistent with a diagnosis of ineffective coping.

DIF: Cognitive Level: Application REF: Page 47 TOP: Nursing Process: Analysis
MSC: NCLEX: Safe and Effective Care Environment; Psychological Integrity

21. A well-stated outcome criteria for a patient with a nursing diagnosis of risk for loneliness related to social isolation would include "The patient will:
a. No longer experience loneliness by the end of the fifth day of hospitalization."
b. Agree to attend two on-unit, staff-directed group sessions daily."
c. Continue to maintain social solitude 50% of the time."
d. Interact with a peer on a daily basis by discharge."

ANS: D
Outcome criteria for a risk diagnosis are developed from the risk factors—in this case, social isolation. Outcomes meet criteria when they are measurable, specific, and present a timeline for completion. The correct option meets all criteria. There is no stated means by which to measure loneliness. Agreeing to attend is not specifically directed at affecting social isolation since interaction is not an expectation. Social solitude promotes social isolation.

DIF: Cognitive Level: Application REF: Page 49 TOP: Nursing Process: Planning
MSC: NCLEX: Safe and Effective Care Environment; Psychological Integrity

22. Care planning for a patient diagnosed with paranoid schizophrenia will include:
a. Analyzing effectiveness of care provided
b. Determining the patient's needs and problems
c. Establishing realistic patient-focused outcome criteria
d. Identifying priorities of care based on the patient's condition

ANS: D

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Establishing priority nursing diagnoses is part of the process of planning. Determining needs is part of assessment. Analyzing effectiveness is an evaluation activity. Establishing realistic expectations is part of outcome identification.

DIF: Cognitive Level: Application REF: Page 51 TOP: Nursing Process: Planning
MSC: NCLEX: Safe and Effective Care Environment

23. The expert nurse is confident that the novice nurse understands the principles that guide the planning of patient care interventions when the:
a. Novice nurse asks the patient to identify their primary concerns
b. Patient successfully achieves the agreed upon nursing outcomes
c. Expert nurse requests that the novice nurse observe several care planning sessions
d. Novice nurse includes interventions that are supported by evidence-based practices

ANS: A
Working with the patient to determine treatment priorities is a characteristic of good care planning. Although successful achievement of expected outcomes and inclusion of EBP interventions reflect appropriate care planning, such success is influenced by many different factors. Although appropriate, observing care planning sessions does not necessarily affect successful care planning on the part of the novice nurse.

DIF: Cognitive Level: Application REF: Page 51 TOP: Nursing Process: Analysis
MSC: NCLEX: Safe and Effective Care Environment

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