Lewis: Medical-Surgical Nursing in Canada, 2nd Edition

Chapter 1: Nursing Practice in Canada

Test Bank

MULTIPLE CHOICE

1. The nurse explains to the client that together they will plan the client's care and set goals to achieve by discharge. The client asks how this differs from what the physician does. Which statement best describes the difference between the roles of nursing and medicine in planning the client's care and setting goals to achieve discharge?
   a. Medicine cures; nursing cares.
   b. Nurses assist physicians to diagnose and treat clients with health care problems.
   c. Very little role difference exists between medicine and nursing; nurses perform many of the procedures done by physicians.
   d. Medicine focuses on diagnosis and treatment of the health problem; nursing focuses on diagnosis and treatment of the client's response to the health problem.

   ANS: D
   This response is consistent with the Canadian Nurses Association's (CNA) definition of registered nursing, which states that registered nurses enable individuals, families, groups, communities, and populations to achieve their optimal level of 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: Comprehension REF: p. 10

2. A woman with hypertension is concerned that if she sees the nurse practitioner (an advanced practice nurse), only her hypertension will be assessed, and she is worried that another health problem may not be diagnosed. What should the nurse tell the client regarding nurse practitioners' scope of practice as it relates to diagnosis?
   a. They diagnose and treat all major health problems.
   b. They have the same role and scope of practice as physicians.
   c. They write prescriptions for all classifications of medications.
   d. They focus on primary care and health promotion, including diagnosis.

   ANS: D
   Nurse practitioners focus on the management of primary care and health promotion for a wide variety of health problems in various specialties; roles include physical examination, diagnosis, treatment of health problems, client and family education, and counselling.

   DIF: Cognitive Level: Comprehension REF: p. 5

3. What does the nurse use when providing client care using evidence-informed practice (EIP)?
   a. Clinical judgement based on experience
   b. The application of the findings of a clinical research study
   c. Best research evidence coupled with clinical expertise
   d. Observation of the evidence that client outcomes have been met

   ANS: C
   EIP is use of the best research-based evidence combined with clinical expertise. Clinical judgement based on the nurse's clinical experience is part of EIP, but clinical decision making should also incorporate current research and research-based guidelines. Evidence from one clinical research study does not provide an adequate substantiation for interventions. Evaluation of client outcomes is important, but interventions should be based on research from randomized controlled studies with a large number of subjects.

   DIF: Cognitive Level: Comprehension REF: p. 6

4. How does the nurse primarily use the nursing process in the care of clients?
   a. As a science-based process of diagnosing the client's health care problems
   b. To establish nursing theory that incorporates the bio-psycho-social nature of humans
   c. To promote the management of client care in collaboration with other health care professionals
   d. As a tool to organize the nurse's thinking and clinical decision making about the client's health care needs

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

   DIF: Cognitive Level: Comprehension REF: p. 8

5. An emaciated older adult client is admitted to the intensive care unit. The nurse plans a q2h turning schedule to prevent skin breakdown. This is considered to be what type of nursing action?
   a. Dependent
   b. Cooperative
   c. Independent
   d. Collaborative

ANS: D
When implementing collaborative nursing actions, the nurse is responsible primarily for monitoring for complications or providing care to prevent or treat complications. Independent nursing actions are focused on health promotion, illness prevention, and client advocacy. A dependent action would require a physician order to implement. Cooperative nursing functions are not described as one of the formal nursing functions.

DIF: Cognitive Level: Application REF: pp. 9–10

6. A woman who is a lone parent is about to undergo gallbladder surgery. She tells the nurse on admission that she is uneasy about being in the hospital and leaving her two preschool children with a neighbour. During the assessment phase, what is an appropriate nursing action?
   a. Reassure the client that her children are fine.
   b. Call the neighbour to determine whether she is an adequate care provider.
   c. Have the client call the children to reassure herself that they are doing well.
   d. Gather more data about the client's feelings about the child care arrangements.

ANS: D
The assessment phase includes gathering multidimensional data about the client. The other nursing actions may be appropriate during the implementation phase (after the nurse accomplishes further assessment of the client's concerns), but they are not part of the assessment phase.

DIF: Cognitive Level: Application REF: p. 10

7. A client with a stroke is paralyzed on the left side of the body and is not responsive enough to turn or move independently in bed. A pressure ulcer has developed on the client's left hip. What is the most appropriate nursing diagnosis?
   a. *Impaired physical mobility related to paralysis*
   b. *Impaired skin integrity related to altered circulation and pressure*
   c. *Risk for impaired tissue integrity related to impaired physical mobility*
   d. *Ineffective tissue perfusion related to inability to turn and move self in bed*

ANS: B
The client'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 client. Although impaired physical mobility is a problem for the client, the nurse cannot treat the paralysis. The "risk for" diagnosis is not appropriate for this client, who already has impaired tissue integrity. The client does have ineffective tissue perfusion, but the impaired skin integrity diagnosis indicates more clearly what the health problem is.

DIF: Cognitive Level: Application REF: p. 11

8. A client with an infection has a nursing diagnosis of *fluid volume deficit related to excessive diaphoresis*. What is an appropriate client outcome?
   a. Balanced intake and output
   b. Client verbalizes a need for increased fluid intake
   c. Bedding is changed when it becomes damp
   d. Skin remains cool and dry throughout hospitalization

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

DIF: Cognitive Level: Application REF: pp. 12–13

9. Which characteristic is consistent with critical thinking?
   a. Do not use abstract ideas.
   b. Think within alternative systems of thought.
   c. Encourage cooperative relationships from positions of power and authority.
   d. Use the trial and error method for effective problem-solving options.

ANS: B
Critical thinking is the art of analyzing and evaluating thinking with a view to improving it. Characteristics of critical thinking include thinking open-mindedly within alternative systems of thought and recognizing and assessing their assumptions, implications, and practical consequences.

DIF: Cognitive Level: Analysis REF: p. 4

10. The nurse reads on the care plan that a client is at risk for developing an infection. What does the nurse recognize about this client's problem?
    a. It is always a nursing diagnosis.
    b. It is always a collaborative problem.
    c. It may be either a nursing diagnosis or a collaborative problem, depending on the etiology.
    d. It should not be addressed as a special problem because all nursing measures should protect clients from infection.

ANS: C

If the source of the risk for infection is something that can be treated by nursing, then the problem is a nursing diagnosis. If it is one that requires treatment by other health care professionals, the problem is collaborative. In either case, the risk for infection should be included in the care plan.

DIF: Cognitive Level: Comprehension REF: pp. 9–10

11. Which nursing activity is carried out during the evaluation phase of the nursing process?
    a. Documenting the nursing care plan in the progress notes
    b. Evaluating whether the client's health problems have been alleviated
    c. Asking the client whether the nursing care provided was satisfactory
    d. Determining the effectiveness of nursing actions toward meeting client outcomes

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

DIF: Cognitive Level: Comprehension REF: p. 14

12. What does the nurse do during the assessment phase of the nursing process?
    a. Obtain data with which to diagnose client problems
    b. Teach interventions to relieve client health problems
    c. Evaluate the outcomes of the care that has been provided
    d. Help the client identify realistic outcomes to health problems

ANS: A
During the assessment phase, the nurse gathers information about the client. The other responses are examples of the intervention, diagnosis, and planning phases of the nursing process.

DIF: Cognitive Level: Knowledge REF: p. 10

13. Which is an example of a correctly written nursing diagnosis statement?
    a. *Altered tissue perfusion related to congestive heart failure*
    b. *Ineffective coping related to response to positive biopsy test results*
    c. *Altered urinary elimination related to urinary tract infection*
    d. *Risk for impaired tissue integrity related to client's refusal to turn*

ANS: B

This diagnosis statement includes a NANDA nursing diagnosis and an etiology that describes a client's response to a health problem and can be treated by nursing. The use of a medical diagnosis (as in the responses beginning "*Altered tissue perfusion*" and "*Altered urinary elimination*") is not appropriate. The response beginning "*Risk for impaired tissue integrity*" uses the defining characteristics as the etiology.

DIF: Cognitive Level: Comprehension REF: pp. 10–11

14. What should a complete nursing diagnosis statement include?
    a. A problem, its cause, and objective data that support the problem
    b. A problem with all of its possible causes and the planned interventions
    c. A projected or possible problem that could occur, with rationales for the diagnosis
    d. A problem, its etiology, and the signs and symptoms (PES) that define the diagnosis

ANS: D
The PES format is used when writing nursing diagnoses. 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: Knowledge REF: p. 11