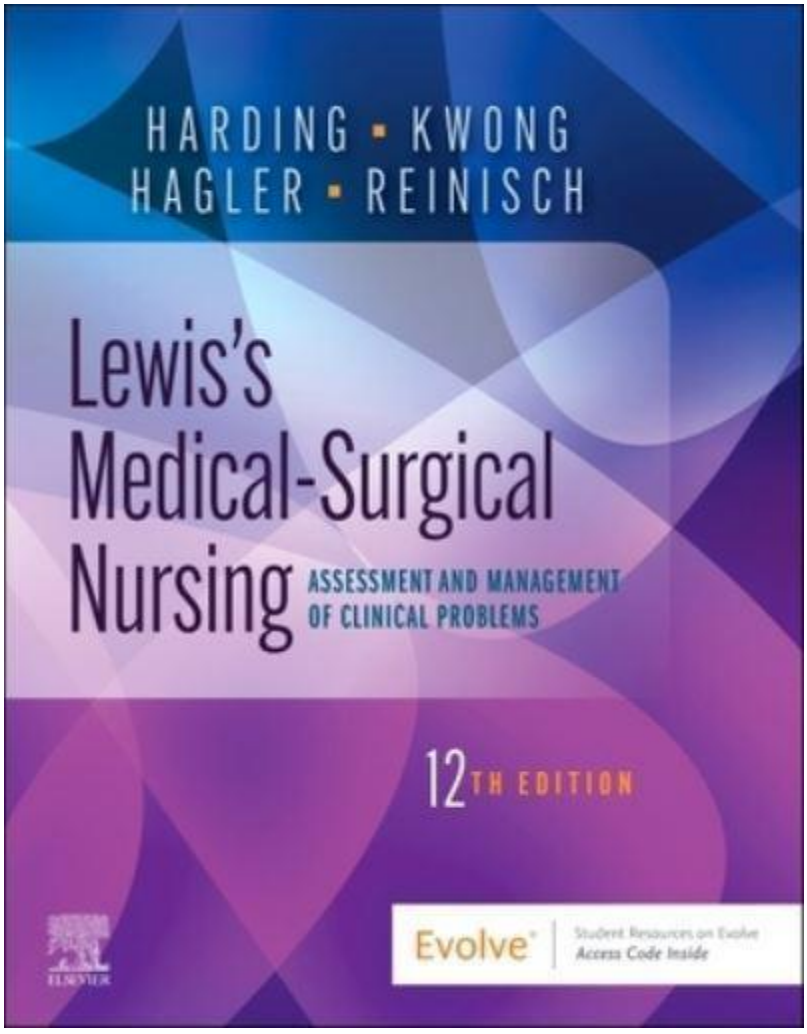
TEST BANK



Test Bank Lewis's Medical-Surgical Nursing, 12th Edition by Mariann M. Harding, Jeffrey Kwong, Debra Hagler and Courtney Reinisch

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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 asks, "How is this different from what the physician does?" Which response would the nurse provide?
   a. "The role of the nurse is to administer medications and other treatments prescribed by your physician."
   b. "In addition to caring for you while you are sick, the nurses will help you plan to maintain your health."
   c. "The nurse's job is to collect information and communicate any problems that occur to the physician."
   d. "Nurses perform many of the same procedures as the physician, but nurses are with the patients for a longer time than the physician."

   ANS: B
   The American Nurses Association (ANA) definition of nursing describes the role of nurses in promoting health. The other responses describe dependent and collaborative functions of the nursing role but do not accurately describe the nurse's unique role in the health care system.

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

2. Which statement by the nurse accurately describes the use of evidence-based practice (EBP)?
   a. "Patient care is based on clinical judgment, experience, and traditions."
   b. "Data are analyzed later to show that the patient outcomes are consistently met."
   c. "Research from all published articles are used as a guide for planning patient care."
   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 and consideration of patient preferences. 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 data analysis is not required to use EBP. All published articles do not provide research evidence; interventions should be based on credible research, preferably randomized controlled studies with a large number of subjects.

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

3. Which statement by the nurse provides a clear explanation of the nursing process?
   a. "The nursing process is a research method of diagnosing the patient's health care problems."
   b. "The nursing process is used primarily to explain nursing interventions to other health care professionals."
   c. "The nursing process is a problem-solving tool used to identify and manage the

patients‘ health care needs.”

d. “The nursing process is based on nursing theory that incorporates the biopsychosocial nature of humans.”

ANS: C

The nursing process is a problem-solving approach to the identification and treatment of patients‘ problems. Nursing process does not require research methods for diagnosis. 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: Evaluation
MSC: NCLEX: Safe and Effective Care Environment

4. A patient admitted to the hospital for surgery tells the nurse, “I do not feel comfortable leaving my children with my parents.” Which action would 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 information on the patient‘s concerns about the child care arrangements.
   d. Call the patient‘s parents to determine whether adequate child care is being provided.

   ANS: C

   Because 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: Analyze (Analysis)
   TOP: Nursing Process: Assessment MSC: NCLEX: Psychosocial Integrity

5. A patient with a bacterial infection is hypovolemic due to a fever and excessive diaphoresis. Which expected outcome would the nurse select for this patient?
   a. Patient has a balanced intake and output.
   b. Patient‘s bedding is kept clean and free of moisture.
   c. Patient understands the need for increased fluid intake.
   d. Patient‘s skin remains cool and dry throughout hospitalization.

   ANS: A

   Balanced intake and output gives measurable data showing resolution of the problem of deficient fluid volume. The other statements would not indicate that the problem of hypovolemia was resolved.

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

6. Which statement describes the purpose of the evaluation phase of the nursing process?
   a. To document the nursing care plan in the progress notes of the health record
   b. To determine if interventions have been effective in meeting patient outcomes
   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: B

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

7. Which statement describes 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 to diagnose patient strengths and 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 strengths and 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

8. When developing the plan of care, which components would the nurse include in the clinical problem statement?
   a. The problem and the suggested patient goals or outcomes
   b. The problem, its causes, and the signs and symptoms of the problem
   c. The problem with the possible etiology and the planned interventions
   d. The problem, its pathophysiology, and the expected outcome

   ANS: B
   When writing clinical problems or nursing diagnoses, the subjective as well as objective data to support the problem‘s existence should be included. Goals, outcomes, and interventions are not included in the problem statement.

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

9. Which patient care task would the nurse delegate to experienced assistive personnel (AP)?
   a. Instruct the patient about the need to alternate activity and rest.
   b. Monitor level of shortness of breath or fatigue after ambulation.
   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
   AP 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) TOP: Nursing Process: Planning
   MSC: NCLEX: Safe and Effective Care Environment