Smith Chapter 2

1. The nurse is planning care for a newly admitted client. Which behavior indicates that the nurse is using critical thinking?
1. Recalls a similar client situation
2. Asks the healthcare provider for suggestions
3. Looks at a care plan written for another client
4. Expects the oncoming nurse to complete the care plan

Correct Answer: 1

Rationale 1: An important aspect of critical thinking is the ability to use reflection and language properly. Reflection is the action of thinking back or recalling an earlier clinical situation, remembering nursing actions that worked or didn't work, and determining whether this information is helpful in the current situation.

Rationale 2: Asking a healthcare provider for suggestions when planning client care does not exemplify critical thinking.

Rationale 3: Looking at a care plan written for another client does not exemplify critical thinking.

Rationale 4: Expecting the oncoming nurse to complete the care plan does not exemplify critical thinking

Global Rationale: An important aspect of critical thinking is the ability to use reflection and language properly. Reflection is the action of thinking back or recalling an earlier clinical situation, remembering nursing actions that worked or didn't work, and determining whether this information is helpful in the current situation. Asking a healthcare provider for suggestions, looking at a care plan written for another client; and expecting the oncoming nurse to complete the care plan do not exemplify critical thinking.

Cognitive Level: Applying
Client Need: Safe and Effective Care Environment
Client Need Sub: Management of Care
QSEN Competencies: I.A. 1. Integrate understanding of multiple dimensions of patient centered care
AACN Essential Competencies: III. 6. Integrate evidence, clinical judgment, interprofessional perspectives and patient preferences in planning, implementing, and evaluating outcomes of care
NLN Competencies: Context and Environment; Practice; apply health promotion/disease prevention strategies; apply health policy
Nursing/Integrated Concepts: Nursing Process: Planning
Learning Outcome: 2.1 Define the term critical thinking.
Page Number: 23

2. The nurse is assigned to care for a newly admitted client. Which approach should be used to address the client's responses to the illness?
1. Best practices
2. Nursing process
3. Critical thinking
4. Evidence-based practice

Correct Answer: 2

Rationale 1: Best practice is a generic or general phrase for a process of infusing nursing practice with research-based knowledge.

Rationale 2: The nursing process is used to diagnose and treat human responses to health and illness.

Rationale 3: Critical thinking involves the careful acquisition and interpretation of information and use of it to reach a well-justified conclusion.

Rationale 4: Evidence-based nursing practice is defined as the application to clinical practice of the best available empirical evidence that applies recent research findings, in order to aid clinical decision making.

Global Rationale: The nursing process is used to diagnose and treat human responses to health and illness. Best practice is a generic or general phrase for a process of infusing nursing practice with research-based knowledge. Critical thinking involves the careful acquisition and interpretation of information and use of it to reach a well-justified conclusion. Evidence-based nursing practice is defined as the application to clinical practice of the best available empirical evidence that applies recent research findings, in order to aid clinical decision making.

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Nursing/Integrated Concepts: Nursing Process: Planning
Learning Outcome: 2.2 Define the term nursing process.
Page Number: 24

3. The nurse is reviewing care provided to a client. Which behavior indicates that the nurse is using critical thinking?
1. Administers prescribed medications
2. Studies the results of diagnostic tests

3. Individually analyzes client problems
4. Documents responses to care provided

Correct Answer: 3

Rationale 1: Administering prescribed medications is an action and would not be conducted when reviewing care.

Rationale 2: Studying the results of diagnostic tests would be an action completed during the assessment phase of the nursing process.

Rationale 3: The nursing process is a systematic, problem-solving approach that is considered a critical thinking competency that assists the nurse to intervene in client care.

Rationale 4: Documentation is an action that would not be completed when reviewing care provided to a client.

Global Rationale: The nursing process is a systematic, problem-solving approach that is considered a critical thinking competency that assists the nurse to intervene in client care. Administering prescribed medications is an action and would not be conducted when reviewing care. Studying the results of diagnostic tests would be an action completed during the assessment phase of the nursing process. Documentation is an action that would not be completed when reviewing care provided to a client.

Cognitive Level: Analyzing
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Nursing/Integrated Concepts: Nursing Process: Evaluation
Learning Outcome: 2.3 Explain how critical thinking is used in each step of the nursing process.
Page Number: 24

4. After receiving morning report the nurse categorizes an assigned client's care according to priority needs. How does this behavior support the nursing process?
1. Organizes and structures care
2. Emphasizes client preferences
3. Follows Maslow's hierarchy of needs
4. Considers time needs for each nursing action

Correct Answer: 1

Rationale 1: The nursing process—assessment, analysis/nursing diagnosis, planning, implementation, and evaluation—provides an organized structure and framework for the delivery of nursing care in all settings.

Rationale 2: Client preferences may or may not coincide with care priorities.

Rationale 3: Maslow's hierarchy of needs may or may not coincide with care priorities.

Rationale 4: The time needed for nursing actions may or may not coincide with care priorities.

Global Rationale: The nursing process—assessment, analysis/nursing diagnosis, planning, implementation, and evaluation—provides an organized structure and framework for the delivery of nursing care in all settings. Client preferences, Maslow's hierarchy of needs, and time to complete nursing actions may or may not coincide with care priorities.

Cognitive Level: Analyzing
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Nursing/Integrated Concepts: Nursing Process: Planning
Learning Outcome: 2.4 Describe how the nursing process relates to nursing.
Page Number: 24

5. The nurse collects data slowly and methodically from a new client. Why is the nurse using this approach during this phase of the nursing process?
1. Ensures accuracy of data
2. Identifies client outcomes
3. Establishes a rapport with the client
4. Highlights the importance of the therapeutic relationship

Correct Answer: 1

Rationale 1: Assessment is a critical phase because all the other steps depend on the accuracy and reliability of the information obtained.

Rationale 2: Client outcomes are not identified during the assessment phase.

Rationale 3: Client rapport does become established during the assessment phase however this is not the reason for the nurse to collect data slowly and methodically.

Rationale 4: The therapeutic relationship is important however this is not the reason for the nurse to collect data slowly and methodically.

Global Rationale: Assessment is a critical phase because all the other steps depend on the accuracy and reliability of the information obtained. Client outcomes are not identified during the assessment phase. Client rapport and the therapeutic relationship are important however these are not reasons for the nurse to collect data slowly and methodically.

Cognitive Level: Applying
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Nursing/Integrated Concepts: Nursing Process: Assessment
Learning Outcome: 2.5 Discuss the term assessment, and describe how it influences the nursing process.
Page Number: 24

6. The nurse is preparing to assess a client new to the out-patient care environment. Which actions should the nurse expect to complete during this phase of the nursing process? Select all that apply.
1. Complete a client interview
2. Conduct a physical examination
3. Analyze test results and findings
4. Categorize data into meaningful patterns
5. Identify pertinent family health history issues

Correct Answer: 1, 2, 3, 5

Rationale 1: A client interview is a part of the assessment.

Rationale 2: A physical examination is a part of the assessment.

Rationale 3: Analyzing test results and findings is a part of the assessment.

Rationale 4: Categorizing data into meaningful patterns is a part of the nursing diagnosis phase of the nursing process.

Rationale 5: Identifying pertinent family health history issues is a part of the assessment.

Global Rationale: Client interview, physical examination, analysis and findings of diagnostic tests, and family health history issues are all parts of the assessment phase of the nursing process.

Categorizing data into meaningful patterns is a part of the nursing diagnosis phase of the nursing process.

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Nursing/Integrated Concepts: Nursing Process: Assessment
Learning Outcome: 2.6 List the components of the assessment step.
Page Number: 24

7. After completing an assessment the nurse analyzes all data collected. What is the significance of the nurse performing this analysis?
1. Confirms observations
2. Identifies client outcomes
3. Establishes a foundation for the client's care
4. Prioritizes interventions according to client needs

Correct Answer: 3

Rationale 1: Confirming observations occurs during the assessment phase.

Rationale 2: Identifying client outcomes occurs during the planning phase.

Rationale 3: Analysis which occurs during the nursing diagnosis phase provides the foundation for each individual client's therapeutic plan of care.

Rationale 4: Prioritizing interventions occurs during the implementation phase.

Global Rationale: Analysis which occurs during the nursing diagnosis phase provides the foundation for each individual client's therapeutic plan of care. Confirming observations occurs during the assessment phase. Identifying client outcomes occurs during the planning phase. Prioritizing interventions occurs during the implementation phase.

Cognitive Level: Analyzing
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Nursing/Integrated Concepts: Nursing Process: Nursing Diagnosis
Learning Outcome: 2.7 Describe the primary purpose of the analysis phase of the nursing process.
Page Number: 25

8. The instructor is preparing a lecture on the nursing process. Which statement should the instructor use that best describes nursing diagnosis?
1. It is an educated judgment about a client's potential or actual health problems
2. It refers to the priority nursing actions or interventions performed to accomplish a specified goal
3. It involves the careful acquisition and interpretation and use of information to reach a conclusion
4. It is the action of thinking back about an earlier clinical situation, recalling actions that worked or didn't work, and determining if this information is helpful in the current situation

Correct Answer: 1

Rationale 1: Nursing diagnosis is an educated judgment about potential or actual health problem or problems of a client.

Rationale 2: The implementation phase of the nursing process refers to the priority nursing actions or interventions performed to accomplish a specified goal.

Rationale 3: Critical thinking involves the careful acquisition and interpretation and use of information to reach a conclusion.

Rationale 4: Reflection is the action of thinking back about an earlier clinical situation, recalling actions that worked or didn't work, and determining if this information is helpful in the current situation.

Global Rationale: Nursing diagnosis is an educated judgment about potential or actual health problem or problems of a client. The implementation phase of the nursing process refers to the priority nursing actions or interventions performed to accomplish a specified goal. Critical thinking involves the careful acquisition and interpretation and use of information to reach a conclusion. Reflection is the action of thinking back about an earlier clinical situation, recalling actions that worked or didn't work, and determining if this information is helpful in the current situation.

Cognitive Level: Applying
Client Need: Safe and Effective Care Environment
Client Need Sub: Management of Care
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NLN Competencies: Context and Environment; Practice; apply health promotion/disease prevention strategies; apply health policy
Nursing/Integrated Concepts: Nursing Process: Nursing Diagnosis
Learning Outcome: 2.8 Define the term nursing diagnosis.
Page Number: 25

9. The nurse is completing the planning phase of the nursing process with a client. Which should the nurse perform during this phase? Select all that apply.
1. Identify short- and long-term goals
2. Strategize approaches for goal outcomes
3. List nursing measures when delivering care
4. Create outcomes that are measurable and realistic
5. Organize defining characteristics of data into meaningful patterns

Correct Answer: 1, 2, 3, 4

Rationale 1: Identification of short- and long-term goals occurs during the planning phase.

Rationale 2: Strategizing approaches for goal outcomes occurs during the planning phase.

Rationale 3: Listing nursing measures when delivering care occurs during the planning phase.

Rationale 4: Creating outcomes that are measurable, realistic in addition to being time-specific and quantifiable occurs during the planning phase.

Rationale 5: Organizing defining characteristics of data into meaningful patterns occurs during the nursing diagnosis phase.

Global Rationale: Actions performed during the planning phase include identifying short- and long-term goals, strategizing approaches for goal outcomes, listing nursing measures when delivering care, and creating outcomes that are measureable and realistic in addition to being time-specific and quantifiable. Organizing defining characteristics of data into meaningful patterns occurs during the nursing diagnosis phase.

Cognitive Level: Applying
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Nursing/Integrated Concepts: Nursing Process: Planning

Learning Outcome: 2.9 Define outcome planning and identification, and give an example of this step in the nursing process.
Page Number: 25

10. The nurse is implementing a client's plan of care. Which action should the nurse perform at this time?
1. Record relevant information
2. Motivate and maintain optimum wellness
3. Coordinate care and community resources
4. Anticipate needs of client and family based on priorities

Correct Answer: 2

Rationale 1: Recording relevant information occurs during the planning phase.

Rationale 2: Motivating and maintaining optimum wellness occurs during the implementation phase.

Rationale 3: Coordinating care and community resources occurs during the planning phase.

Rationale 4: Anticipating the needs of the client and the family based on priorities occurs during the planning phase.

Global Rationale: Motivating and maintaining optimum wellness occurs during the implementation phase. Recording relevant information occurs during the planning phase. Coordinating care and community resources occurs during the planning phase. Anticipating the needs of the client and the family based on priorities occurs during the planning phase.

Cognitive Level: Applying
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Nursing/Integrated Concepts: Nursing Process: Implementation
Learning Outcome: 2.10 Define what is meant by the implementation phase of the nursing process.
Page Number: 26

11. A client is being prepared for discharge. What should the nurse perform when evaluating this client's care? Select all that apply.
1. Reassess care plan
2. Record client responses

3. Determine effects of nursing actions
4. Communicate to client and client's family
5. Examine appropriateness of nursing actions

Correct Answer: 1, 2, 3, 5

Rationale 1: Reassessing the care plan is performed during the evaluation phase.

Rationale 2: Recording client responses is performed during the evaluation phase.

Rationale 3: Determining the effectiveness of nursing actions is performed during the evaluation phase.

Rationale 4: Communicating to the client and family occurs during the implementation phase.

Rationale 5: Examining appropriateness of nursing actions occurs during the evaluation phase.

Global Rationale: Actions completed during the evaluation phase include reassessing the care plan, recording client responses, determining the effectiveness of nursing actions, and examining appropriateness of nursing actions. Communicating to the client and family occurs during the implementation phase.

Cognitive Level: Applying
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Nursing/Integrated Concepts: Nursing Process: Evaluation
Learning Outcome: 2.11 Explain evaluation and include your understanding of why it is an important step in the nursing process.
Page Number: 27

12. The nurse is explaining nursing diagnoses to a group of first-year nursing students. What should the nurse include in this explanation? Select all that apply.
1. Focuses on client responses
2. Focuses on injury, illness, or disease
3. Requires physician orders to address
4. Remains the same until client discharge
5. Changes according to the client's needs

Correct Answer: 1, 5

Rationale 1: Nursing diagnoses focus on client responses.

Rationale 2: Medical diagnoses focus on injury, illness, or disease.

Rationale 3: Medical diagnoses require physician orders to address.

Rationale 4: Medical diagnoses remain the same until client discharge.

Rationale 5: Nursing diagnoses change according to the client's needs.

Global Rationale: Nursing diagnoses focus on client responses and change according to the client's needs. Medical diagnoses focus on injury, illness, or disease, require physician orders to address, and remain the same until the client is discharged.

Cognitive Level: Applying
Client Need: Safe and Effective Care Environment
Client Need Sub: Management of Care
QSEN Competencies: I.A. 1. Integrate understanding of multiple dimensions of patient centered care
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Nursing/Integrated Concepts: Nursing Process: Nursing Diagnosis
Learning Outcome: 2.12 Differentiate nursing diagnosis from medical diagnosis.
Page Number: 27

13. The nurse is researching nursing interventions appropriate for a particular nursing diagnosis. Which classification system should the nurse use when researching this information?
1. NIC
2. PES
3. NOC
4. NANDA

Correct Answer: 1

Rationale 1: The nursing interventions classification (NIC) is a system that provides uniformity to nursing actions because each intervention has a label name and a set of activities that are identified as steps to carry it out.

Rationale 2: PES or problem, etiology, and signs and symptoms is an approach used to create a nursing diagnosis statement.

Rationale 3: The nursing outcomes classification (NOC) is a comprehensive, standardized classification of client outcomes developed to evaluate the effects of interventions provided by nurses or other healthcare professionals.

Rationale 4: The North America Nursing Diagnosis Association (NANDA) is an organization that studies and approves nursing diagnostic statements.

Global Rationale: The nursing interventions classification (NIC) is a system that provides uniformity to nursing actions because each intervention has a label name and a set of activities that are identified as steps to carry it out. PES or problem, etiology, and signs and symptoms is an approach used to create a nursing diagnosis statement. The nursing outcomes classification (NOC) is a comprehensive, standardized classification of client outcomes developed to evaluate the effects of interventions provided by nurses or other healthcare professionals. The North America Nursing Diagnosis Association (NANDA) is an organization that studies and approves nursing diagnostic statements.

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Nursing/Integrated Concepts: Nursing Process: Planning
Learning Outcome: 2.13 Define NIC and NOC and their role in standardizing nursing language.
Page Number: 23

14. The nurse is identifying nursing diagnoses appropriate for a client's health issues. Which information should the nurse include when creating a three-part diagnostic statement?
1. Interventions
2. Learning needs
3. Expected outcomes
4. Signs and symptoms

Correct Answer: 4

Rationale 1: A three-part nursing diagnostic statement does not include interventions.

Rationale 2: Learning needs is not included in a three-part nursing diagnostic statement.

Rationale 3: Expected outcomes are not included in a three-part nursing diagnostic statement.

Rationale 4: Signs and symptoms are included in a three-part nursing diagnostic statement.

Global Rationale: Signs and symptoms are included in a three-part nursing diagnostic statement. Interventions, learning needs, and expected outcomes are not included in a three-part nursing diagnostic statement.

Cognitive Level: Applying
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Nursing/Integrated Concepts: Nursing Process: Nursing Diagnosis
Learning Outcome: 2.14 Compare and contrast the two-part and three-part Nursing Diagnosis Statement.
Page Number: 29

15. The manager is reviewing care plans created for newly admitted clients. Which nursing diagnostic statement should the manager review with the nurse as needing to be amended?
1. Risk for injury related to left sided paralysis
2. Fluid volume overload related to congestive heart failure
3. Impaired coping related to recent death of spouse and son
4. Imbalanced nutrition: Less than body requirements related to mouth and throat ulcers

Correct Answer: 2

Rationale 1: This is a correctly written two-part nursing diagnostic statement.

Rationale 2: A nursing diagnosis statement does not include a medical diagnosis.

Rationale 3: This is a correctly written two-part nursing diagnostic statement.

Rationale 4: This is a correctly written two-part nursing diagnostic statement.

Global Rationale: A nursing diagnosis statement does not include a medical diagnosis. Risk for injury, impaired coping, and imbalanced nutrition are all correctly written nursing diagnostic statements.

Cognitive Level: Applying
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Nursing/Integrated Concepts: Nursing Process: Nursing Diagnosis

Learning Outcome: 2.15 State two examples of nursing diagnoses.
Page Number: 28

16. The nurse is explaining evidence-based practice to a group of new nursing students. Which statement should the nurse use during this explanation?
1. “Evidence-based nursing practice generates new knowledge.”
2. “Evidence-based nursing practice applies knowledge to practice.”
3. “Evidence-based nursing practice is measurable, time specific, quantifiable, and realistic.”
4. “Evidence-based nursing practice is based on the best evidence available from nursing research.”

Correct Answer: 2

Rationale 1: Research generates new knowledge.

Rationale 2: Evidence-based nursing practice applies knowledge to practice.

Rationale 3: Outcomes are measurable, time specific, quantifiable and realistic.

Rationale 4: Best practices are based on the best evidence available from nursing research.

Global Rationale: Evidence-based nursing practice applies knowledge to practice. Research generates new knowledge. Outcomes are measurable, time specific, quantifiable and realistic. Best practices are based on the best evidence available from nursing research.

Cognitive Level: Applying
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Nursing/Integrated Concepts: Nursing Process: Implementation
Learning Outcome: 2.16 Define evidence-based nursing practice.
Page Number: 30

17. The nurse manager determines that a staff nurse uses critical thinking when planning the outcomes for a client’s care. What did the manager observe to come to this conclusion?
1. Prioritized client problems
2. Critically analyzed all client outcomes
3. Clustered data to determine relationships
4. Used a systematic approach to collect data

Correct Answer: 1

Rationale 1: Prioritizing client problems demonstrates critical thinking during the planning phase.

Rationale 2: Critically analyzing all client outcomes demonstrates critical thinking during the evaluation phase.

Rationale 3: Clustering data to determine relationships demonstrates critical thinking during the nursing diagnosis phase.

Rationale 4: Using a systematic approach to collect data demonstrates critical thinking during the assessment phase.

Global Rationale: Prioritizing client problems demonstrates critical thinking during the planning phase. Critically analyzing all client outcomes demonstrates critical thinking during the evaluation phase. Clustering data to determine relationships demonstrates critical thinking during the nursing diagnosis phase. Using a systematic approach to collect data demonstrates critical thinking during the assessment phase.

Cognitive Level: Analyzing
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Learning Outcome: 2.3 Explain how critical thinking is used in each step of the nursing process.
Page Number: 26