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Chapter 1: Critical Thinking and Clinical Reasoning in Nursing

MULTIPLE CHOICE

1. A client hears the nurse instructing a nursing peer to use critical thinking when planning a difficult dressing change. The client states, "Are you asking her to be critical of my current dressing? Is something wrong?" Which statement is best for the nurse to educate and reassure the client regarding that unfamiliar phrase?

1. "I was not being critical, just teaching a new technique."
2. "Critical thinking is a skill of using logic and reasoning to identify approaches to clinical or practice problems."
3. "Critical thinking is how we apply practice-based nursing principles to your dressing change."
4. "The dressing is fine; we just feel it could be done differently."

ANS:

2. During a nursing health history, information regarding recreational drug usage is needed. The nurse documents this statement: "The client reports the use of one marijuana product every weekend." That statement best demonstrates which Universal Intellectual Standard (UIS) of critical thinking?

1. Clarity
2. Accuracy
3. Precision
4. Depth

ANS:

3. Which statement best defines the American Nurses Association (ANA) Scope and Standards of Practice?

1. A set of tenets upon which the entire health assessment and physical examination of the client are conducted.
2. A set of legal boundaries that differentiate specific nursing and physician roles.
3. A process that allows the nurse to combine knowledge and assessment to prioritize and deliver safe client care.
4. A parameter that defines the number of clients a nurse can safely manage during a working shift.

ANS:

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4. The nurse is performing the health history interview for a new client. Which statement is true in relation to proper collection of that information?

1. The health history is a means of gathering objective data.
2. The nurse may gather information from any available source.
3. Health history data must be obtained from the client to ensure reliability.
4. Because of consistency in health-care documentation, data from previous medical records can be used without need of additional verification.

ANS:

5. A nurse contacts the physician and relays some pertinent background information on a client's reason for hospitalization, recent vital signs, and changes in lab work. What information should follow next in the nurse's communication with the physician if using the SBAR technique?

1. Client name, age, admitting diagnosis
2. Full name and credentials of the nurse
3. Action recommended by the nurse
4. Nurse's assessment of the situation

ANS:

6. The nurse is completing standard three of the Nursing Process. Which statement demonstrates additional information is needed to properly meet that standard?

1. The client met their goal of 5 pounds of weight loss within a 3-week period.
2. The client will stop using tobacco products within 3 months.
3. The client has been instructed on the need to reduce salt in their diet.
4. The client will use a cane correctly to avoid falling.

ANS:

7. The nurse is using the NCJMM to determine which information is the most important and immediately concerning. On which step of the Nursing Process is the nurse expanding?

1. Assessment
2. Planning
3. Implementing
4. Evaluating

ANS:

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8. The nurse is using the gold standard of techniques for passing client-specific information to another member of the health care team. Which statement best describes that technique?

1. It is a verbal communication technique to review the day's progress for an individual client.
2. It is a written informational tool that contains only information related to the current need.
3. It is a verbal communication technique to address a situation requiring immediate attention.
4. It is a written tool that meets the patient's protection and privacy rights when used in an email.

ANS:

9. While completing a health history with a client, the nurse notices that information being shared by the client is not consistent. During which step of the Nursing Process will the nurse seek to validate or add data for interpretation?

1. Outcomes Identification
2. Assessment
3. Evaluation
4. Diagnosis

ANS:

10. To accurately interpret information gathered from a client requires the nurse to decode hidden messages and clarify and categorize information. Which professional clinical skill is demonstrated when performing those specific activities?

1. Clinical Reasoning
2. Nursing Process
3. Critical Thinking
4. Clinical Judgment

ANS:

11. The ANA Standards of Nursing Practice outlines six actions for the registered nurse to follow during health assessment and physical examination of a client. Which activity demonstrates adhering to the standard of Outcomes Identification?

1. The nurse documents that the client has met their goal to walk 50 feet without assistance.
2. The nurse collects information related to the distance that a client can walk without assistance.
3. The nurse coordinates with physical therapy to document 50 feet in the hallway for the client to measure progress towards walking that distance without assistance.
4. The nurse discusses with the client a safe distance for walking without assistance.

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ANS:

12. Which statement in the nurse's documentation shows completion of the second step of the Nursing Process?

1. The client is awake and alert.
2. The client is at risk of falling.
3. The client's pain level is reduced after their medication.
4. The client will be served small, frequent meals.

ANS:

13. A nurse is teaching a nursing student the proper steps to take when communicating with physicians. Which order is correct if the nurse is teaching use of the gold standard tool for verbal communication?

1. Recommendation, Assessment, Background, Situation
2. Background, Assessment, Situation, Recommendation
3. Assessment, Background, Recommendation, Situation
4. Situation, Background, Assessment, Recommendation

ANS:

14. Upon observation of diffuse tan skin discolorations, the nurse teaches the client that the use of sunscreen helps to protect from the harmful effects of sun. Which two standards from the ANA Standards of Professional Nursing Practice are being demonstrated in this scenario?

1. Planning and Diagnosis
2. Assessment and Evaluation
3. Diagnosis and Implementation
4. Evaluation and Planning

ANS:

15. Institutions may have their own method for charting, each with advantages and disadvantages. Which commonly used written documentation method is most seen in both academic and clinical settings for recording client progress?

1. Focus charting
2. PIO: Problem/diagnosis, intervention, outcome
3. CBE: Charting by exception

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4. SOAP: Subjective, objective, analysis, plan

ANS:

16. During a hand-off, the nurse transfers client-specific information to another team of caregivers. According to the Joint Commission, what is the purpose of the hand-off?

1. A hand-off ensures continuity and safety of the client's care.
2. A hand-off enhances trust in the next team of caregivers.
3. A hand-off serves to confirm that all tasks are completed prior to the change in care team.
4. A hand-off's purpose is to prevent medical errors.

ANS:

17. The nurse is using Maslow's Hierarchy of Needs to aid in planning a client's care. The client has just been admitted for observation after a lengthy stay in the emergency room. Which action demonstrates correct use of that prioritization element of Planning?

1. Acknowledge the client's position as a hospital administrator; then provide water at the bedside.
2. Teach the family that they are always allowed to be present; then darken the room for sleep.
3. Provide the client with a meal from nutrition services; then invite family to enter the room.
4. Secure the client's valuables; then provide a meal from nutrition services.

ANS:

18. During a clinical experience, the student nurse is learning the six steps involved in completion of the Nursing Process from the nurse. The nurse recognizes that the student incorrectly documented which action as one of those six steps?

1. Planning
2. Recognize cues
3. Evaluation
4. Diagnosis

ANS:

19. Which statement best describes the relationship between the six steps of the Nursing Process and the six cognitive skills of the NCJMM?

1. The NCJMM illustrates the Nursing Process to better define the assessment skills needed to complete a client history.

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2. The NCJMM augments the Nursing Process to allow usage by the entire health-care team.
3. The NCJMM replaces the Nursing Process to define the specific skills related to physical assessment of a client.
4. The NCJMM aligns with the Nursing Process to expand and highlight cognitive skills needed to make appropriate clinical judgments.

ANS:

20. The nurse is completing an admission health history on a client who does not make eye contact, offers only brief answers to questions, and shifts uncomfortably in the chair. The nurse will use which element of critical thinking to correctly categorize the client's behaviors?

1. Interpretation
2. Inference
3. Explanation
4. Evaluation

ANS:

21. The nurse is teaching a student nurse to properly formulate a nursing diagnosis. Which statement is the nurse's best choice to use in that education?

1. A nursing diagnosis helps to guide the client's medication needs.
2. A nursing diagnosis is a clinical judgment of a human response to health-care situations.
3. A nursing diagnosis is a key piece of information needed for insurance billing.
4. A nursing diagnosis guides the health and physical assessment.

ANS:

22. The nurse is progressing through the Nursing Process and seeking to properly formulate a nursing diagnosis. Using the data collected during the client assessment, in which order will the nurse perform the required steps?

1. Collect, Interpret, Cluster, Name
2. Cluster, Interpret, Name, Collect
3. Interpret, Name, Cluster, Collect
4. Name, Cluster, Collect, Interpret

ANS:

23. The experienced nurse is reflecting on critical thinking skills that were used for the initial portion of a client's health history. After determining which skills were most effective,

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adjustments are made for the remaining portion of the interview. What is the nurse demonstrating?

1. Evaluation
2. Self-regulation
3. Analysis
4. Inference

ANS:

24. The nurse is collecting a client's dietary history and documents the following statement: "The client consumes excessive amounts of caffeine." Which statement would best edit that documentation to meet the UIS for Critical Thinking?

1. The client consumes two 16-oz. energy drinks, two 8-oz. coffees, and two chocolate donuts each morning.
2. The client stops at a convenience store each morning for products that contain high amounts of caffeine.
3. The client admits to excessive consumption of caffeine.
4. The client states that morning coffee is part of their daily routine.

ANS:

25. The nurse examines answers to questions obtained during a client history and notices that the client denied any surgical history. On physical assessment the client was observed to have a well-healed abdominal scar. The nurse uses which critical thinking element to reflect on the reason for that discrepancy?

1. Explanation
2. Evaluation
3. Analysis
4. Inference

ANS:

26. The nurse is completing a health history with a new client. The client asks the nurse the reason for the many questions, stating, "Why did you ask about my family? Most of this is not related to why I came here today, and my doctor already knows." What is the nurse's best response to the client's stated concern?

1. "The hospital requires that all the blanks be filled in, so thank you for your patience."
2. "The doctor does not fill this out for us, so thank you for your continued cooperation."

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3. “I am collecting this to share with the team to positively impact your health status, so thank you for your help.”
4. “The insurance company requires all the blanks be filled in, so thank you for your cooperation.”

ANS:

27. When formulating a nursing diagnosis, what must the nurse consider most for interpreting data collected during the health history and physical assessment?

1. The source of specific information
2. The provision of privacy in the room
3. The client’s abnormal lab values
4. The standards of that specific client’s population

ANS:

28. The nurse has identified all data from a health history and clustered them into a NANDA-I domain. What is the nurse’s next and final step to complete formulation of the nursing diagnosis?

1. Assessment
2. Naming
3. Analyzing
4. Collecting

ANS:

29. The nurse is reviewing planned documentation by the student nurse related to the nursing diagnosis. The nurse recognizes that one of the NANDA-I domains as noted in the student’s work is incorrect. What needs to be edited by the student nurse prior to entering in the client’s record?

1. Grief counseling
2. Stress tolerance
3. Self-perception
4. Life principles

ANS:

30. To complete formal and concise charting, the nurse is seeking to categorize a client’s nursing diagnosis. What is the proper category for assessment information concerning a client’s family’s vulnerability to a community-acquired disease?

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1. Collaboration
2. Problem-focused
3. Health promotion
4. Risk

ANS:

31. The nurse is formulating goals for the client related to ANA Standard 3: Outcomes Identification. Which is the best description of a proper goal statement?

1. A goal is a broad statement that is not measurable.
2. A goal must contain specific data points.
3. A goal must be chosen from an approved listing.
4. A goal determines when clients may be discharged to go home.

ANS:

32. A student nurse approaches the nursing instructor to share this complaint from a client: "Nutrition service staff are only including liquids on the tray." What is the best action by the instructor?

1. Call nutrition services and change the tray to meet the client's requests as the diet order was likely an error.
2. Inform the client that no changes can be made until the physician arrives but offer additional liquids from the unit's floor stock.
3. Teach the student that implementation of the plan of care is a dynamic process that can be changed based on new information. Return to the client for further assessment.
4. Tell the student to provide options from the unit's stock of light snacks to enhance client satisfaction and independence.

ANS:

33. A nurse receives hand-off information to assume care of a critically ill client. The physical assessment exhibits multiple abnormal findings. What action best reflects the nurse's first responsibility when using the NCJMM?

1. Include all information that exhibited abnormal findings.
2. Address the abnormal findings that are most easily remedied first.
3. Ask a peer to repeat the assessment for clarity.
4. Consider what is the most urgent, relevant, and important finding.

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34. The nurse is concerned regarding an assessed increase in a client's temperature relative to previous values. Which tool is the nurse's best choice for obtaining help for the client's acute need?

1. SBAR
2. SOAP
3. PIE
4. PIO

ANS:

35. The NCSBN identifies six skills that the registered nurse will utilize in the performance of client care. Which action best describes the nurse's use of those NCJMM skills?

1. The nurse identifies outcomes.
2. The nurse generates solutions.
3. The nurse plans client care.
4. The nurse makes a diagnosis.

ANS:

36. The nurse is discussing planning of care with the client, seeking to prioritize nursing diagnoses and select care strategies. What is the most important reason the nurse is discussing prioritization with the client?

1. The nurse is scheduling time to meet all assigned clients' needs.
2. The nurse knows that clients who are actively involved are more likely to be agreeable to the plan of care.
3. The nurse is teaching regarding Maslow's Hierarchy of Needs.
4. The nurse is engaging the family for the client's accountability.

ANS:

37. The nurse is using the Nursing Process for planning client care, ANA Standard 4: Planning. Which statement best defines parameters that will be needed for properly meeting that standard?

1. Clients may only have one nursing intervention for each level of Maslow's Hierarchy.
2. Clients should not be involved in this portion of the Nursing Process.
3. The interventions must be independent, not collaborative, with physicians.
4. Each outcome must have its own nursing intervention.

ANS:

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38. The client informs the nurse that a large section of his right arm has suddenly become numb and feels cold. The nurse is employed by an academic facility that uses SOAP notes for charting. Which section of SOAP notes would be used to document the client's new complaint?

1. S
2. O
3. A
4. P

ANS:

39. Nurse A is sending client data to another person, releasing the care of that client to Nurse B. This is a demonstration of what specific health-care event?

1. SBAR Communication
2. Hand-off
3. Diagnostic Testing
4. Discharge

ANS:

40. The Nursing Process is dynamic, framing the nurse's work to place clients in an optimal health state. Which statement best describes the nurse's performance of a step as outlined by the Nursing Process?

1. The nurse takes action.
2. The nurse recognizes cues.
3. The nurse analyzes cues.
4. The nurse performs an assessment.

ANS: 4

41. The nurse is using the six steps of the Nursing Process to optimize a client's care and health state. Documentation of the client's laboratory and diagnostic data contributes directly to which step being used by the nurse?

1. Assessment
2. Evaluation
3. Outcomes Identification
4. Planning

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ANS:

42. The nurse is talking with a client, seeking to determine which explanations regarding hypotheses are most likely, and which possible explanations are the most serious. Which Nursing Clinical Judgment Measurement Model (NCJMM) skill is the nurse using?

1. Take Action
2. Analyze Cues
3. Prioritize Hypotheses
4. Recognize Cues

ANS:

43. The registered nurse is applying Universal Intellectual Standards (UIS) to evaluate critical thinking used during conversation with a client. Which UIS principle involves reflecting on how the client encounter was conducted and whether an accurate representation was made?

1. Breadth
2. Precision
3. Clarity
4. Fairness

ANS:

44. The nurse is orienting a newly hired peer regarding the use of SOAP notes for documentation. What should be included as a correct identification of a term in the SOAP acronym?

1. Status
2. Overview
3. Action
4. Plan

ANS:

45. The charge nurse is assigning the complex care of a client to a clinical staff nurse, choosing between registered nurses with varying experience. Which statement is important for the unit manager to consider when completing the assignment?

1. The experienced nurse makes intuitive links for client care needs.
2. The novice nurse relies on analytical thinking for client care planning.
3. The experienced nurse can better focus on isolated items when determining care needs.

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4. The novice nurse uses evidence-based practice.

ANS:

46. The nursing instructor asks the class to properly categorize information using the Nursing Process. Which information should be listed under ANA Standard 4?

1. Health Teaching and Health Promotion
2. Coordination of Care
3. Intervention Selection
4. Implementation

ANS:

47. The registered nurse seeks input from physical therapy, a pharmacist, and a registered dietician to coordinate optimal care delivery for a client. Which ANA Standard is the nurse demonstrating?

1. 4
2. 5
3. 6
4. 2

ANS:

48. The nurse is seeking scientific and nursing literature to justify the use of a new skin care regimen for a client. What component of critical thinking is the nurse addressing with that research?

1. Evaluation
2. Analysis
3. Explanation
4. Inference

ANS:

49. The nursing instructor is teaching students to apply identified optimal approaches to a specific situation to determine the relevance of evidence and science as it applies to a client. Which topic is the instructor teaching to the students?

1. Critical Thinking
2. Clinical Reasoning
3. Clinical Judgment

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4. Clinical Inference

ANS:

NEXT GEN

50. Critical thinking is a set of skills needed by nurses to identify health-care solutions and approaches that best suit a client's needs. Six of those many skills are discussed in the text related to health assessment and physical examination. The nurse evaluates the quality of critical thinking by applying the nine Universal Intellectual Standards (UIS). Correctly categorize each of the listed items as a skill or standard. *Place an X in the box that correctly corresponds to that selection.*

Skills and Standards	**Critical Thinking Skill**	**Universal Intellectual Standard (UIS) for Critical Thinking**
1. Explanation		
2. Depth		
3. Accuracy		
4. Interpretation		
5. Fairness		
6. Inference		
7. Clarity		
8. Analysis		
9. Self-regulation		

ANS: Critical Thinking Skill UIS

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Chapter 1: Critical Thinking and Clinical Reasoning in Nursing—Answers and Rationales

MULTIPLE CHOICE

1. A client hears the nurse instructing a nursing peer to use critical thinking when planning a difficult dressing change. The client states, "Are you asking her to be critical of my current dressing? Is something wrong?" Which statement is best for the nurse to educate and reassure the client regarding that unfamiliar phrase?

1. "I was not being critical, just teaching a new technique."
2. "Critical thinking is a skill of using logic and reasoning to identify approaches to clinical or practice problems."
3. "Critical thinking is how we apply practice-based nursing principles to your dressing change."
4. "The dressing is fine; we just feel it could be done differently."

ANS: 2
Chapter: 1, Critical Thinking and Clinical Reasoning in Nursing
Outcome: Discuss the components of critical thinking, clinical reasoning, and clinical judgment.
Heading: Critical Thinking, Clinical Reasoning, and Clinical Judgement
Integrated Process: Nursing Process
Client Need: Safe and Effective Care Environment: Management of Care
Cognitive Level: Applying
Concept: Communication
Difficulty: Moderate

	Feedback
1.	The nurse needs to educate and reassure the client. This statement is not the best to use for that purpose.
2.	The American Association of Colleges of Nursing defines critical thinking as the skill of using logic and reasoning to identify the strengths and weaknesses of alternative health-care solutions, conclusions, or approaches to clinical or practice problems. This is the best statement to be used by the nurse.
3.	The application of practice-based principles to a specific situation, as selected using critical thinking is known as clinical reasoning. This is not the best statement for the nurse to use to educate the client.
4.	Making conclusions about a client's needs and the decision to use or modify standard approaches is known as clinical judgement. This is not the best statement for the nurse to use to educate the client.

2. During a nursing health history, information regarding recreational drug usage is needed. The nurse documents this statement: "The client reports the use of one marijuana product every

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weekend." That statement best demonstrates which Universal Intellectual Standard (UIS) of critical thinking?

1. Clarity
2. Accuracy
3. Precision
4. Depth

ANS: 3
Chapter: 1, Critical Thinking and Clinical Reasoning in Nursing
Outcome: Discuss the components of critical thinking, clinical reasoning, and clinical judgment.
Heading: Critical Thinking, Clinical Reasoning, and Clinical Judgement>Universal Intellectual Standards for Critical Thinking
Integrated Process: Nursing Process
Client Need: Safe and Effective Care Environment: Management of Care
Cognitive Level: Applying
Concept: Clinical Judgment
Difficulty: Moderate

	Feedback
1.	The statement documented by the nurse is not seeking to clarify, but to precisely document data collected from the client. This is an example of the standard of Precision.
2.	The statement documented by the nurse is not seeking to confirm accuracy, but to precisely document data collected from the client. This is an example of the standard of Precision.
3.	The statement documented precisely documents data collected from the client. This is an example of the standard of Precision.
4.	The statement documented by the nurse does not indicate an action to delve more deeply into issue of recreational drug use, but precisely documents data collected from the client. This is an example of the standard of Precision.

3. Which statement best defines the American Nurses Association (ANA) Scope and Standards of Practice?

1. A set of tenets upon which the entire health assessment and physical examination of the client are conducted.
2. A set of legal boundaries that differentiate specific nursing and physician roles.
3. A process that allows the nurse to combine knowledge and assessment to prioritize and deliver safe client care.
4. A parameter that defines the number of clients that a nurse can safely manage during a working shift.

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ANS: 1
Chapter: 1, Critical Thinking and Clinical Reasoning in Nursing
Outcome: Define the American Nurses Association (ANA) Standards of Professional Nursing Practice.
Heading: Critical Thinking Frameworks: The Nursing Process and the Clinical Judgement Model
Integrated Process: Nursing Process
Client Need: Safe and Effective Care Environment: Management of Care
Cognitive Level: Understanding
Concept: Clinical Judgment
Difficulty: Moderate

	Feedback
1.	The ANA Scope of Standards of Practice is a set of tenets upon which the entire health assessment and physical examination of the client are conducted, and a broad professional guideline to which nurses can be held accountable in their practice. This is the best defining statement.
2.	The ANA Scope of Standards of Practice does not address specific tasks for either nurses or physicians but is a broad guideline for what nurses can be held accountable in their practice.
3.	The process that allows the nurse to combine knowledge and assessment to prioritize and deliver safe client care is the Nursing Clinical Judgment Measurement Model (NCJMM), not the ANA Scope of Standards of Practice.
4.	The ANA Scope of Standards of Practice does not address specifics such as numbers of clients that can be safely managed during a working shift. It is a broad guideline for what nurses can be held accountable in their practice.

4. The nurse is performing the health history interview for a new client. Which statement is true in relation to proper collection of that information?

1. The health history is a means of gathering objective data.
2. The nurse may gather information from any available source.
3. Health history data must be obtained from the client to insure reliability.
4. Because of consistency in healthcare documentation, data from previous medical records can be used without a need of additional verification.

ANS: 2
Chapter: 1, Critical Thinking and Clinical Reasoning in Nursing
Outcome: Describe the steps of the Nursing Process.
Heading: Critical Thinking Frameworks: The Nursing Process and the Clinical Judgement Model >The Nursing Process
Integrated Process: Nursing Process
Client Need: Safe and Effective Care Environment: Management of Care
Cognitive Level: Analyzing

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Concept: Clinical Judgment
Difficulty: Moderate

	Feedback
1.	The health history is a means of collecting subjective data, usually from the client. It is subjective in that it cannot always be verified by an independent observer as it includes what the client thinks. Objective data is collected in the physical exam.
2.	The nurse can and should use every available medium to gather information which is then verified with the client when possible.
3.	The nurse can and should use every available medium to gather information which is then verified with the client when possible. Relatives, neighbors, friends, and even strangers may be possible sources of information depending on the client's condition.
4.	Data collected from previous medical records can be used but must be verified with the client when possible.

5. A nurse contacts the physician and relays some pertinent background information on a client's reason for hospitalization, recent vital signs, and changes in lab work. What information should follow next in the nurse's communication with the physician if using the SBAR technique?

1. Client name, age, admitting diagnosis
2. Full name and credentials of the nurse
3. Action recommended by the nurse
4. Nurse's assessment of the situation

ANS: 4
Chapter: 1, Critical Thinking and Clinical Reasoning in Nursing
Outcome: Describe verbal and written tools used to communicate client status and care.
Heading: Standardized Verbal Communication or Hand-off>SBAR
Integrated Process: Nursing Process
Client Need: Safe and Effective Care Environment: Management of Care
Cognitive Level: Analyzing
Concept: Clinical Judgment
Difficulty: Moderate

	Feedback
1.	When using the SBAR technique, information including the client's name, age, admitting diagnosis should be relayed prior to background information, not following.
2.	When using the SBAR technique, information regarding the nurse's name and credentials should be relayed first, not following the client's background information.
3.	The nurse's recommended plan of action is the final step. It does not follow next after background information when using the SBAR communication tool.

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4.	When using the SBAR technique, the nurse's assessment of the client's current situation should be summarized to the physician next after background information.

6. The nurse is completing standard three of the nursing process. Which statement demonstrates additional information is needed to properly meet that standard?

1. The client met their goal of five pounds of weight loss within a three-week period.
2. The client will stop using tobacco products within three months.
3. The client has been instructed on the need to reduce salt in their diet.
4. The client will use a cane correctly to avoid falling.

ANS: 4
Chapter: 1, Critical Thinking and Clinical Reasoning in Nursing
Outcome: Describe the steps of the Nursing Process.
Heading: Critical Thinking Frameworks: The Nursing Process and the Clinical Judgement Model >The Nursing Process
Integrated Process: Nursing Process
Client Need: Safe and Effective Care Environment: Management of Care
Cognitive Level: Analyzing
Concept: Clinical Judgment
Difficulty: Hard

	Feedback
1.	A review of progress toward attainment of a weight loss goal is documented in this statement. It is part of the evaluation standard of the Nursing Process, which is standard six.
2.	Standard three of the Nursing Process is Outcomes Identification. Each formulated outcome states the client's expected change in behavior within a stated time frame to meet a healthcare goal. No additional information is needed to meet the standard of client outcomes.
3.	Client education for health promotion related to the need to reduce salt in their diet would be part of standard five of the Nursing Process, Implementation.
4.	Standard three of the nursing process is Outcomes Identification. Each formulated outcome states the client's expected change in behavior within a stated time frame to meet a healthcare goal. No time frame was included here to allow for evaluation of the client outcomes.

7. The nurse is using the Nursing Clinical Judgment Measurement Model (NCJMM) to determine which information is the most important and immediately concerning. On which step of the Nursing Process is the nurse expanding?

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1. Assessment
2. Planning
3. Implementing
4. Evaluating

ANS: 1
Chapter: 1, Critical Thinking and Clinical Reasoning in Nursing
Outcome: Describe the components of the National Council of State Boards of Nursing (NCSBN) Nursing Clinical Judgment Measurement Model (NCJMM).
Heading: Critical Thinking Frameworks: The Nursing Process and the Clinical Judgment Model>The Nursing Clinical Judgement Measurement Model
Integrated Process: Nursing Process
Client Need: Safe and Effective Care Environment: Management of Care
Cognitive Level: Analyzing
Concept: Clinical Judgment
Difficulty: Moderate

	Feedback
1.	The NJMMM expands on the Nursing Process step of assessment by identifying relevant and important information.
2.	The NJMMM expands on the Nursing Process step of planning by identifying expected outcomes. This is not the correct step from the scenario.
3.	The NJMMM expands on the Nursing Process step of implementation by taking actions that address the highest priorities. This is not the correct step from the scenario.
4.	The NJMMM expands on the Nursing Process step of evaluating by comparing observed vs. expected outcomes. This is not the correct step from the scenario.

8. The nurse is using the gold standard of techniques for passing client-specific information to another member of the health care team. Which statement best describes that technique?

1. It is a verbal communication technique to review the day's progress for an individual client.
2. It is a written informational tool that contains only information related to the current need.
3. It is a verbal communication technique to address a situation requiring immediate attention.
4. It is a written tool that meets the patient's protection and privacy rights when used in an email.

ANS: 3
Chapter: 1, Critical Thinking and Clinical Reasoning in Nursing
Outcome: Describe verbal and written tools used to communicate client status and care.
Heading: Standardized Verbal Communication of Hand-Off>SBAR
Integrated Process: Nursing Process
Client Need: Safe and Effective Care Environment: Management of Care
Cognitive Level: Analyzing

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Concept: Clinical Judgment
Difficulty: Moderate

	Feedback
1.	The gold standard tool for passing information between healthcare providers is SBAR. It is used in the verbal format for addressing a situation requiring immediate attention. It is not used to review the client's day.
2.	The gold standard tool for passing information between healthcare providers is SBAR. It is used in the verbal format for addressing a situation requiring immediate attention. It is not used in a written format.
3.	The gold standard tool for passing information between healthcare providers is SBAR. Used in the verbal format, it contains situation, background, and assessment data, as well as recommendations for addressing a situation requiring immediate attention.
4.	The gold standard tool for passing information between healthcare providers is SBAR. It is used in the verbal format for addressing a situation requiring immediate attention. It is not designed for privacy protection in the email format.

9. While completing a health history with a client, the nurse notices that information being shared by the client is not consistent. During which step of the Nursing Process will be nurse seek to validate or add data for interpretation?

1. Outcomes Identification
2. Assessment
3. Evaluation
4. Diagnosis

ANS: 2
Chapter: 1, Critical Thinking and Clinical Reasoning in Nursing
Outcome: Describe the steps of the Nursing Process.
Heading: Critical Thinking Frameworks: The Nursing Process and the Clinical Judgement Model >The Nursing Process
Integrated Process: Nursing Process
Client Need: Safe and Effective Care Environment: Management of Care
Cognitive Level: Analyzing
Concept: Clinical Judgment
Difficulty: Moderate

	Feedback
1.	The dynamic nature of the assessment step of the Nursing Process requires the nurse to add, validate, and interpret data continuously to empower moving to the second step, the nursing diagnosis. Outcomes identification is the third step which takes place after diagnosis.

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2.	The dynamic nature of the assessment step of the Nursing Process requires the nurse to add, validate, and interpret data continuously to empower moving to the second step, the nursing diagnosis.
3.	The dynamic nature of the assessment step of the Nursing Process requires the nurse to add, validate, and interpret data continuously to empower moving to the second step, the nursing diagnosis. Evaluation is the final step in the Nursing Process.
4.	The dynamic nature of the assessment step of the Nursing Progress requires the nurse to add, validate, and interpret data continuously to empower moving to the second step, the nursing diagnosis. The second step uses the assessment data gained for formulating nursing diagnoses.

10. To accurately interpret information gathered from a client requires the nurse to decode hidden messages and clarify and categorize information. Which professional clinical skill is demonstrated when performing those specific activities?

1. Clinical Reasoning
2. Nursing Process
3. Critical Thinking
4. Clinical Judgement

ANS: 3
Chapter: 1, Critical Thinking and Clinical Reasoning in Nursing
Outcome: Discuss the components of critical thinking, clinical reasoning, and clinical judgment.
Heading: Critical Thinking, Clinical Reasoning, and Clinical Judgement
Integrated Process: Nursing Process
Client Need: Safe and Effective Care Environment: Management of Care
Cognitive Level: Analyzing
Concept: Clinical Judgment
Difficulty: Moderate

	Feedback
1.	The professional clinical skill of critical thinking is in use when the nurse properly receives, clarifies, and categorizes information. Then it is analyzed for proper association for clinical planning and implementation. This is not a demonstration of clinical reasoning.
2.	The professional clinical skill of critical thinking is in use when the nurse properly receives, clarifies, and categorizes information. Then it is analyzed for proper association for clinical planning and implementation. This is in addition to the elements of the nursing process.
3.	The professional clinical skill of critical thinking is in use when the nurse properly receives, clarifies, and categorizes information. Then it is analyzed for proper association for clinical planning and implementation.

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4.	The professional clinical skill of critical thinking is in use when the nurse properly receives, clarifies, and categorizes information. Then it is analyzed for proper association for clinical planning and implementation. This is not a demonstration of clinical judgement.

11. The American Nurses Association (ANA) Standards of Nursing Practice outlines six actions for the registered nurse to follow during health assessment and physical examination of a client. Which activity demonstrates adhering to the standard of Outcomes Identification?

1. The nurse documents that the client has met their goal to walk 50 feet without assistance.
2. The nurse collects information related to the distance that a client can walk without assistance.
3. The nurse coordinates with physical therapy to document 50 feet in the hallway for the client to measure progress towards walking that distance without assistance.
4. The nurse discusses with the client a safe distance for walking without assistance.

ANS: 4
Chapter: 1, Critical Thinking and Clinical Reasoning in Nursing
Outcome: Define the American Nurses Association (ANA) Standards of Professional Nursing Practice.
Heading: Critical Thinking Frameworks: The Nursing Process and the Clinical Judgement Model>Table 1-1
Integrated Process: Nursing Process
Client Need: Safe and Effective Care Environment: Management of Care
Cognitive Level: Analyzing
Concept: Clinical Judgment
Difficulty: Moderate

	Feedback
1.	Documenting progress towards attainment of goals is activity demonstrating the standard of Evaluation.
2.	The nurse collecting information related to the distance that a client can walk without assistance is demonstrating the standard of Assessment.
3.	Collaborative planning to develop strategies to achieve expected outcomes is demonstrating the standard of Planning.
4.	The nurse identifying and discussing an individualized plan for the client's safe unassisted walking distance demonstrates the standard of Outcomes Identification.

12. Which statement in the nurse's documentation shows completion of the second step of the Nursing Process?

1. The client is awake and alert.

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2. The client is at risk of falling.
3. The client's pain level is reducing after their medication.
4. The client will be served small, frequent meals.

ANS: 2
Chapter: 1, Critical Thinking and Clinical Reasoning in Nursing
Outcome: Describe the steps of the Nursing Process.
Heading: Critical Thinking Frameworks: The Nursing Process and the Clinical Judgement Model >The Nursing Process
Integrated Process: Nursing Process
Client Need: Safe and Effective Care Environment: Management of Care
Cognitive Level: Applying
Concept: Clinical Judgment
Difficulty: Hard

	Feedback
1.	Information regarding the client's mental status would show completion of the assessment. Assessment is the first step in the Nursing Process.
2.	This statement shows the formation of a nursing diagnosis, a clinical judgment concerning the client's vulnerability to falling. That shows completion of the second step of the Nursing Process, diagnosis.
3.	Information related to the client's progress or attainment of a goal reflects the nurse's completion of the sixth step of the Nursing Process, evaluation.
4.	The documentation that small, frequent meals will be served to the client demonstrates that a plan of care has been selected in response to a nursing diagnosis. This statement is reflective of planning, the fourth step in the Nursing Process.

13. A nurse is teaching a nursing student the proper steps to take when communicating with physicians. Which order is correct if the nurse is teaching use of the gold standard tool for verbal communication?

1. Recommendation, Assessment, Background, Situation
2. Background, Assessment, Situation, Recommendation
3. Assessment, Background, Recommendation, Situation
4. Situation, Background, Assessment, Recommendation

ANS: 4
Chapter: 1, Critical Thinking and Clinical Reasoning in Nursing
Outcome: Describe verbal and written tools used to communicate client status and care.
Heading: Standardized Verbal Communication or Hand-off>SBAR
Integrated Process: Nursing Process
Client Need: Safe and Effective Care Environment: Management of Care
Cognitive Level: Applying

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Concept: Clinical Judgment
Difficulty: Moderate

	Feedback
1.	SBAR is the gold standard tool for nurses to use for physician communication regarding a need that needs immediate attention. The correct order is situation, background, assessment, and recommendation.
2.	SBAR is the gold standard tool for nurses to use for physician communication regarding a need that needs immediate attention. The correct order is situation, background, assessment, and recommendation.
3.	SBAR is the gold standard tool for nurses to use for physician communication regarding a need that needs immediate attention. The correct order is situation, background, assessment, and recommendation.
4.	SBAR is the gold standard tool for nurses to use for physician communication regarding a need that needs immediate attention. The correct order is situation, background, assessment, and recommendation.

14. Upon observation of diffuse tan skin discolorations, the nurse teaches the client that the use of sunscreen helps to protect from the harmful effects of sun. Which two standards from the American Nurses Association (ANA) Standards of Professional Nursing Practice are being demonstrated in this scenario?

1. Planning and Diagnosis
2. Assessment and Evaluation
3. Diagnosis and Implementation
4. Evaluation and Planning

ANS: 3
Chapter: 1, Critical Thinking and Clinical Reasoning in Nursing
Outcome: Define the American Nurses Association (ANA) Standards of Professional Nursing Practice.
Heading: Critical Thinking Frameworks: The Nursing Process and the Clinical Judgement Model>Table 1-1
Integrated Process: Nursing Process
Client Need: Safe and Effective Care Environment: Management of Care
Cognitive Level: Evaluating
Concept: Clinical Judgment
Difficulty: Moderate

	Feedback
1.	The nurse is exhibiting the standards of Diagnosis by analyzing assessment data to determine actual or potential issues, and Implementation of Standard 5B, Health Teaching and Promotion.

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2.	The nurse is exhibiting the standards of Diagnosis by analyzing assessment data to determine actual or potential issues, and Implementation of Standard 5B, Health Teaching and Promotion.
3.	The nurse is exhibiting the standards of Diagnosis by analyzing assessment data to determine actual or potential issues, and Implementation of Standard 5B, Health Teaching and Promotion.
4.	The nurse is exhibiting the standards of Diagnosis by analyzing assessment data to determine actual or potential issues, and Implementation of Standard 5B, Health Teaching and Promotion.

15. Institutions may have their own method for charting, each with advantages and disadvanges. Which commonly used written documentation method is most seen in both academic and clinical settings for recording client progress?

1. Focus charting
2. PIO: Problem/diagnosis, intervention, outcome
3. CBE: Charting by exception
4. SOAP: Subjective, objective, analysis, plan

ANS: 4
Chapter: 1, Critical Thinking and Clinical Reasoning in Nursing
Outcome: Describe verbal and written tools used to communicate client status and care.
Heading: Standardized Verbal Communication or Hand-off>Written Documentation
Integrated Process: Nursing Process
Client Need: Safe and Effective Care Environment: Management of Care
Cognitive Level: Applying
Concept: Clinical Judgment
Difficulty: Easy

	Feedback
1.	Although focus charting is still used to document client progress towards goals, SOAP notes are used most in both academic and clinical settings.
2.	Although PIO charting is still used to document client progress towards goals, SOAP notes are used most in both academic and clinical settings.
3.	Although CBE charting is still used to document client progress towards goals, SOAP notes are used most in both academic and clinical settings.
4.	Although many types of methods are used to document client progress towards goals, SOAP notes are used most in both academic and clinical settings.

16. During a hand-off, the nurse transfers client-specific information to another team of caregivers. According to the Joint Commission, what is the purpose of the hand-off?

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1. A hand-off ensures continuity and safety of the client's care.
2. A hand-off enhances trust in the next team of caregivers.
3. A hand-off serves to confirm that all tasks are completed prior to the change in care team.
4. A hand-off's purpose is to prevent medical errors.

ANS: 1
Chapter: 1, Critical Thinking and Clinical Reasoning in Nursing
Outcome: Describe verbal and written tools used to communicate client status and care.
Heading: Standardized Verbal Communication or Hand-Off
Integrated Process: Nursing Process
Client Need: Safe and Effective Care Environment: Management of Care
Cognitive Level: Evaluating
Concept: Clinical Judgment
Difficulty: Moderate

	Feedback
1.	The Joint Commission defines a hand-off as a transfer and acceptance of client-specific information for the purpose of ensuring the continuity and safety of the client's care.
2.	Although enhancing trust may be a result, the Joint Commission defines a hand-off as a transfer and acceptance of client-specific information for the purpose of ensuring the continuity and safety of the client's care.
3.	The Joint Commission defines a hand-off as a transfer and acceptance of client-specific information for the purpose of ensuring the continuity and safety of the client's care, not ensuring that all tasks are complete. .
4.	The Joint Commission defines a hand-off as a transfer and acceptance of client-specific information for the purpose of ensuring the continuity and safety of the client's care, not preventing medical errors.

17. The nurse is using Maslow's Hierarchy of Needs to aid in planning a client's care. The client has just been admitted for observation after a lengthy stay in the Emergency Room. Which action demonstrates correct use of that prioritization element of Planning?

1. Acknowledge the client's position as a hospital administrator, then provide water at the bedside.
2. Teach the family that they are allowed to always be present, then darken the room for sleep.
3. Provide the client with a meal from nutrition services then invite family to enter the room.
4. Secure the client's valuables, then provide a meal from nutrition services.

ANS: 3
Chapter: 1, Critical Thinking and Clinical Reasoning in Nursing
Outcome: Describe the steps of the Nursing Process.

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Heading: Critical Thinking Frameworks: The Nursing Process and the Clinical Judgment Model>The Nursing Process
Integrated Process: Nursing Process
Client Need: Safe and Effective Care Environment: Management of Care
Cognitive Level: Analyzing
Concept: Clinical Judgment
Difficulty: Moderate

	Feedback
1.	Acknowledging the client's position as a hospital administrator relates to the need for esteem. That action should follow provision of the physiological need for water after a long stay in the Emergency Room.
2.	The physiological need for sleep must be addressed first. Teaching the family that they are allowed to always be present allows for the client's need for love and belonging but may interfere with needs for sleep.
3.	Providing the client with lunch after a long stay in the Emergency Room before inviting family to enter the room demonstrates addressing physiological needs prior to love and belonging needs. This is the correct order for the nurse's actions using Maslow's Hierarchy.
4.	The provision of food after a lengthy stay in the Emergency Room is a higher priority of need than securing the client's property.

18. During a clinical experience, the student nurse is learning the six steps involved in completion of the Nursing Process from the nurse. The nurse recognizes that the student incorrectly documented which action as one of those six steps?

1. Planning
2. Recognize cues
3. Evaluation
4. Diagnosis

ANS: 2
Chapter: 1, Critical Thinking and Clinical Reasoning in Nursing
Outcome: Describe the components of the National Council of State Boards of Nursing (NCSBN) Nursing Clinical Judgment Measurement Model (NCJMM).
Heading: Critical Thinking Frameworks: The Nursing Process and the Clinical Judgment Model
Integrated Process: Nursing Process
Client Need: Safe and Effective Care Environment: Management of Care
Cognitive Level: Applying
Concept: Clinical Judgment
Difficulty: Moderate

	Feedback

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1.	Documentation related to planning is correctly used in relation to the Nursing Process.
2.	Documentation related to recognizing cues is incorrectly used in relation to the six steps of the Nursing Process. It is an element of the Nursing Clinical Judgment Measurement Model, an expansion of the Nursing Process.
3.	Documentation related to Evaluation is correctly used in relation to the Nursing Process.
4.	Documentation related to Diagnosis is correctly used in relation to the Nursing Process.

19. Which statement best describes the relationship between the six steps of the Nursing Process and the six cognitive skills of the Nursing Clinical Judgment Measurement Model (NCJMM)?

1. The NCJMM illustrates the nursing process to better define the assessment skills needed to complete a client history.
2. The NCJMM augments the nursing process to allow usage by the entire healthcare team.
3. The NCJMM replaces the nursing process to define the specific skills related to physical assessment of a client.
4. The NCJMM aligns with the nursing process to expand and highlight cognitive skills needed to make appropriate clinical judgments.

ANS: 4
Chapter: 1, Critical Thinking and Clinical Reasoning in Nursing
Outcome: Describe the components of the National Council of State Boards of Nursing (NCSBN) Nursing Clinical Judgment Measurement Model (NCJMM).
Heading: Critical Thinking Frameworks: The Nursing Process and the Clinical Judgment Model
Integrated Process: Nursing Process
Client Need: Safe and Effective Care Environment: Management of Care
Cognitive Level: Evaluating
Concept: Clinical Judgment
Difficulty: Moderate

	Feedback
1.	The NCJMM aligns with the nursing process to expand and highlight cognitive skills needed to make appropriate clinical judgments. It does not seek to better define the assessment skills needed to complete a client history.
2.	The NCJMM aligns with the nursing process to expand and highlight cognitive skills needed to make appropriate clinical judgments. It does not seek to allow usage by the entire healthcare team.
3.	The NCJMM aligns with the nursing process to expand and highlight cognitive skills needed to make appropriate clinical judgments. It does not seek to better define the assessment skills needed to complete a client history.

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4.	The NCJMM aligns with the nursing process to expand and highlight cognitive skills needed to make appropriate clinical judgments. This statement best describes the relationship between the two.

20. The nurse is completing an admission health history on a client who does not make eye contact, offers only brief answers to questions, and shifts uncomfortably in the chair. The nurse will use which element of critical thinking to correctly categorize the client's behaviors?

1. Interpretation
2. Inference
3. Explanation
4. Evaluation

ANS: 1
Chapter: 1, Critical Thinking and Clinical Reasoning in Nursing
Outcome: Discuss the components of critical thinking, clinical reasoning, and clinical judgment.
Heading: Critical Thinking, Clinical Reasoning, and Clinical Judgment>Components of Critical Thinking
Integrated Process: Nursing Process
Client Need: Safe and Effective Care Environment: Management of Care
Cognitive Level: Evaluating
Concept: Clinical Judgment
Difficulty: Moderate

	Feedback
1.	The nurse is using a component of critical thinking known as interpretation, using a situation to decode hidden messages, clarify, and categorize the information.
2.	The nurse is using a component of critical thinking known as interpretation, using a situation to decode hidden messages, clarify, and categorize the information. Inference would involve speculation on the reasons for the client's behavior.
3.	The nurse is using a component of critical thinking known as interpretation, using a situation to decode hidden messages, clarify, and categorize the information. Explanation would involve making conclusions regarding the client's behavior.
4.	The nurse is using a component of critical thinking known as interpretation, using a situation to decode hidden messages, clarify, and categorize the information. Evaluation would involve examining the validity of the client's behavior.

21. The nurse is teaching a student nurse to properly formulate a nursing diagnosis. Which statement is the nurse's best choice to use in that education?

1. A nursing diagnosis helps to guide the client's medication needs.

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2. A nursing diagnosis is a clinical judgment of a human response to health-care situations.
3. A nursing diagnosis is a key piece of information needed for insurance billing.
4. A nursing diagnosis guides the health and physical assessment.

ANS: 2
Chapter: 1, Critical Thinking and Clinical Reasoning in Nursing
Outcome: Define the American Nurses Association (ANA) Standards of Professional Nursing Practice.
Heading: Critical Thinking Frameworks: The Nursing Process and the Clinical Judgment Model>The Nursing Process
Integrated Process: Nursing Process
Client Need: Safe and Effective Care Environment: Management of Care
Cognitive Level: Applying
Concept: Clinical Judgment
Difficulty: Moderate

	Feedback
1.	The nursing diagnosis is formulated based on assessment data and is a clinical judgment by the nurse of a human response to health-care situations, or a vulnerability to that response. A client's medication needs are guided by the physician's diagnoses.
2.	The nursing diagnosis is formulated based on assessment data and is a clinical judgment by the nurse of a human response to health-care situations, or a vulnerability to that response. This is the nurse's best choice to use for educating the student nurse.
3.	The nursing diagnosis is formulated based on assessment data and is a clinical judgment by the nurse of a human response to health-care situations, or a vulnerability to that response. The insurance billing is based on the diagnoses identified by physicians.
4.	The nursing diagnosis is formulated based on assessment data and is a clinical judgment by the nurse of a human response to health-care situations, or a vulnerability to that response. The nursing diagnosis is formulated after the assessment data is analyzed.

22. The nurse is progressing through the Nursing Process and seeking to properly formulate a nursing diagnosis. Using the data collected during the client assessment, in which order will the nurse perform the required steps?

1. Collect, Interpret, Cluster, Name
2. Cluster, Interpret, Name, Collect
3. Interpret, Name, Cluster, Collect
4. Name, Cluster, Collect, Interpret

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ANS: 1
Chapter: 1, Critical Thinking and Clinical Reasoning in Nursing
Outcome: Define the American Nurses Association (ANA) Standards of Professional Nursing Practice.
Heading: Critical Thinking Frameworks: The Nursing Process and the Clinical Judgment Model>The Nursing Process
Integrated Process: Nursing Process
Client Need: Safe and Effective Care Environment: Management of Care
Cognitive Level: Applying
Concept: Clinical Judgment
Difficulty: Moderate

	Feedback
1.	The formulation of a nursing diagnosis involves four steps: collecting information, interpreting information, clustering information, and naming a cluster or problem formulation. This is the correct order the nurse should use.
2.	The formulation of a nursing diagnosis involves four steps: collecting information, interpreting information, clustering information, and naming a cluster or problem formulation. This is not the correct order the nurse should use.
3.	The formulation of a nursing diagnosis involves four steps: collecting information, interpreting information, clustering information, and naming a cluster or problem formulation. This is not the correct order the nurse should use.
4.	The formulation of a nursing diagnosis involves four steps: collecting information, interpreting information, clustering information, and naming a cluster or problem formulation. This is not the correct order the nurse should use.

23. The experienced nurse is reflecting on critical thinking skills that were used for the initial portion of a client's health history. After determining which skills were most effective, adjustments are made for the remaining portion of the interview. What is the nurse demonstrating?

1. Evaluation
2. Self-regulation
3. Analysis
4. Inference

ANS: 2
Chapter: 1, Critical Thinking and Clinical Reasoning in Nursing
Outcome: Discuss the components of critical thinking, clinical reasoning, and clinical judgment.
Heading: Critical Thinking, Clinical Reasoning, and Clinical Judgment>Components of Critical Thinking
Integrated Process: Nursing Process
Client Need: Safe and Effective Care Environment: Management of Care

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Cognitive Level: Applying
Concept: Clinical Judgment
Difficulty: Moderate

	Feedback
1.	Evaluation is an element of critical thinking in which the nurse examines the validity of information gathered from the interview. The nurse is demonstrating self-regulation, reflecting on positive and negative outcomes for development of professional expertise.
2.	Self-regulation is the process during which the nurse reflects on positive and negative outcomes for development of professional expertise. The nurse is demonstrating self-regulation in this scenario.
3.	Analysis is an element of critical thinking in which the nurse examines the information from the interview for any discrepancies. The nurse is demonstrating self-regulation, reflecting on positive and negative outcomes for development of professional expertise.
4.	Inference is an element of critical thinking in which the nurse derives a specific premise, drawing conclusions from answers to interview questions. The nurse is demonstrating self-regulation, reflecting on positive and negative outcomes for development of professional expertise.

24. The nurse is collecting a client's dietary history and documents the following statement: "The client consumes excessive amounts of caffeine." Which statement would best edit that documentation to meet the Universal Intellectual Standards (UIS) for Critical Thinking?

1. The client consumes two 16 oz. energy drinks, two 8 oz. coffees, and two chocolate donuts each morning.
2. The clients stops at a convenience store each morning for products that contain high amounts of caffeine.
3. The client admits to excessive consumption of caffeine.
4. The client states that morning coffee is part of their daily routine.

ANS: 1
Chapter: 1, Critical Thinking and Clinical Reasoning in Nursing
Outcome: Discuss the components of critical thinking, clinical reasoning, and clinical judgment.
Heading: Critical Thinking, Clinical Reasoning, and Clinical Judgment>Universal Intellectual Standards for Critical Thinking
Integrated Process: Nursing Process
Client Need: Safe and Effective Care Environment: Management of Care
Cognitive Level: Applying
Concept: Clinical Judgment
Difficulty: Moderate

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	Feedback
1.	The nurse needs to document specific data to quantify the client's dietary choices. This detailed statement should be used to list specific data regarding the consumption of caffeine that was collected from the client, meeting the UIS for precision.
2.	The nurse needs to document specific data to quantify the client's dietary choices, meeting the UIS for precision. This statement should not be used to support the nurse's assessment of excess caffeine usage.
3.	The nurse needs to document specific data to quantify the client's dietary choices, meeting the UIS for precision. This statement should not be used to support the nurse's assessment of excess caffeine usage.
4.	The nurse needs to document specific data to quantify the client's dietary choices, meeting the UIS for precision. This statement should not be used to support the nurse's assessment of excess caffeine usage.

25. The nurse examines answers to questions obtained during a client history and notices that the client denied any surgical history. On physical assessment the client was observed to have a well-healed abdominal scar. The nurse uses which critical thinking element to reflect on the reason for that discrepancy?

1. Explanation
2. Evaluation
3. Analysis
4. Inference

ANS: 3
Chapter: 1, Critical Thinking and Clinical Reasoning in Nursing
Outcome: Discuss the components of critical thinking, clinical reasoning, and clinical judgment.
Heading: Critical Thinking, Clinical Reasoning, and Clinical Judgment>Components of Critical Thinking
Integrated Process: Nursing Process
Client Need: Safe and Effective Care Environment: Management of Care
Cognitive Level: Analyzing
Concept: Clinical Judgment
Difficulty: Moderate

	Feedback
1.	The critical thinking skill of explanation requires that any inferences drawn from the data collection be correct and justifiable. The nurse is exhibiting the critical thinking element of analysis, examining the ideas and data that were presented, identifying any discrepancies, and reflecting on the reason for the discrepancies.
2.	The critical thinking skill of evaluation involves examining the validity of information and leads to a conclusion for implementation. The nurse is exhibiting the critical thinking element of analysis, examining the ideas and data that were

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	presented, identifying any discrepancies, and reflecting on the reason for the discrepancies.
3.	During analysis, the nurse examines the ideas and data that were presented, identifies any discrepancies, and reflects on the reason for the discrepancies. The nurse is exhibiting the critical thinking element of analysis.
4.	The critical thinking skill of inference involves deriving a specific premise based on information and assumptions obtained from the client. The nurse is exhibiting the critical thinking element of analysis, examining the ideas and data that were presented, identifying any discrepancies, and reflecting on the reason for the discrepancies.

26. The nurse is completing a health history with a new client. The client asks the nurse the reason for the many questions, stating, “Why did you ask about my family? Most of this is not related to why I came here today, and my doctor already knows.” What is the nurse’s best response to the client’s stated concern?

1. “The hospital requires that all the blanks be filled in, so thank you for your patience.”
2. “The doctor does not fill this out for us, so thank you for your continued cooperation.”
3. “I am collecting this to share with the team to positively impact your health status, so thank you for your help.”
4. “The insurance company requires all the blanks be filled in, so thank you for your cooperation.”

ANS: 3
Chapter: 1, Critical Thinking and Clinical Reasoning in Nursing
Outcome: Define the American Nurses Association (ANA) Standards of Professional Nursing Practice.
Heading: Critical Thinking Frameworks: The Nursing Process and the Clinical Judgment Model>The Nursing Process
Integrated Process: Nursing Process
Client Need: Safe and Effective Care Environment: Management of Care
Cognitive Level: Applying
Concept: Clinical Judgment
Difficulty: Moderate

	Feedback
1.	The nurse collects data for the purpose of positively impacting the client’s health status, not merely to fill in the blanks on the charting form. This is not the nurse’s best response as it reflects reasoning onto the hospital administration.
2.	The nurse collects data for the purpose of positively impacting the client’s health status, not merely to fill in the blanks on the charting form. This is not the nurse’s best response as it reflects reasoning onto the physician.

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3.	The nurse collects data for the purpose of positively impacting the client's health status, not merely to fill in the blanks on the charting form. This is the nurse's best response.
4.	The nurse collects data for the purpose of positively impacting the client's health status, not merely to fill in the blanks on the charting form. This is not the nurse's best response as it reflects reasoning onto the insurance company.

27. When formulating a nursing diagnosis, what must the nurse consider most for interpreting data collected during the health history and physical assessment?

1. the source of specific information
2. the provision of privacy in the room
3. the client's abnormal lab values
4. the standards of that specific client's population

ANS: 4
Chapter: 1, Critical Thinking and Clinical Reasoning in Nursing
Outcome: Define the American Nurses Association (ANA) Standards of Professional Nursing Practice.
Heading: Critical Thinking Frameworks: The Nursing Process and the Clinical Judgment Model>The Nursing Process
Integrated Process: Nursing Process
Client Need: Safe and Effective Care Environment: Management of Care
Cognitive Level: Analyzing
Concept: Clinical Judgment
Difficulty: Moderate

	Feedback
1.	Data collected becomes relevant through interpretation and must be evaluated against the standards for that specific client's population. This is what the nurse must consider most for interpreting the client's data, although the reliability of the source should be evaluated and charted.
2.	Data collected becomes relevant through interpretation and must be evaluated against the standards for that specific client's population. This is what the nurse must consider most for interpreting the client's data, although the provision of privacy is important in data collection.
3.	Data collected becomes relevant through interpretation and must be evaluated against the standards for that specific client's population. This is what the nurse must consider most for interpreting the client's data, although any lab values that may be noted as abnormal for the general population should be clarified.
4.	Data collected becomes relevant through interpretation and must be evaluated against the standards for that specific client's population. This action is what the nurse must consider most for interpreting the client's data.

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28. The nurse has identified all data from a health history and clustered them into a NANDA-I domain. What is the nurse's next and final step to complete formulation of the nursing diagnosis?

1. Assessment
2. Naming
3. Analyzing
4. Collecting

ANS: 2
Chapter: 1, Critical Thinking and Clinical Reasoning in Nursing
Outcome: Define the American Nurses Association (ANA) Standards of Professional Nursing Practice.
Heading: Critical Thinking Frameworks: The Nursing Process and the Clinical Judgment Model>The Nursing Process
Integrated Process: Nursing Process
Client Need: Safe and Effective Care Environment: Management of Care
Cognitive Level: Applying
Concept: Clinical Judgment
Difficulty: Moderate

	Feedback
1.	When following the four steps for formulating a nursing diagnosis, the steps are collecting, interpreting, clustering, and naming. The next and final step for this nurse would be naming the NANDA-I clustered information. None of these steps can be completed until the data is collected through assessment.
2.	When following the four steps for formulating a nursing diagnosis, the steps are collecting, interpreting, clustering, and naming. The next and final step for this nurse would be naming the NANDA-I clustered information.
3.	When following the four steps for formulating a nursing diagnosis, the steps are collecting, interpreting, clustering, and naming. The next and final step for this nurse would be naming the NANDA-I clustered information, not analysis.
4.	Data is collected from all sources as the first step in formulating a nursing diagnosis. The next and final step for this nurse would be naming the NANDA-I clustered information.

29. The nurse is reviewing planned documentation by the student nurse related to the nursing diagnosis. The nurse recognizes that one of the NANDA-I domains as noted in the student's work is incorrect. What needs to be edited by the student nurse prior to entering in the client's record?

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1. Grief counseling
2. Stress tolerance
3. Self-perception
4. Life principles

ANS: 1
Chapter: 1, Critical Thinking and Clinical Reasoning in Nursing
Outcome: Define the American Nurses Association (ANA) Standards of Professional Nursing Practice.
Heading: Critical Thinking Frameworks: The Nursing Process and the Clinical Judgment Model>The Nursing Process
Integrated Process: Nursing Process
Client Need: Safe and Effective Care Environment: Management of Care
Cognitive Level: Analyzing
Concept: Clinical Judgment
Difficulty: Moderate

	Feedback
1.	There are thirteen NANDA-I domains that can be used to cluster information that was collected and interpreted using the health history and physical assessment. Grief counseling is not one of those choices and will need to be edited by the student.
2.	There are thirteen NANDA-I domains that can be used to cluster information that was collected and interpreted using the health history and physical assessment. Stress tolerance is one of those choices and will not need to be edited by the student.
3.	There are thirteen NANDA-I domains that can be used to cluster information that was collected and interpreted using the health history and physical assessment. Self-perception is one of those choices and will not need to be edited by the student.
4.	There are thirteen NANDA-I domains that can be used to cluster information that was collected and interpreted using the health history and physical assessment. Life principles is one of those choices and will not need to be edited by the student.

30. To complete formal and concise charting, the nurse is seeking to categorize a client's nursing diagnosis. What is the proper category for assessment information concerning a client's family's vulnerability to a community-acquired disease?

1. Collaboration
2. Problem-focused
3. Health promotion
4. Risk

ANS: 4
Chapter: 1, Critical Thinking and Clinical Reasoning in Nursing
Outcome: Define the American Nurses Association (ANA) Standards of

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Professional Nursing Practice.
Heading: Critical Thinking Frameworks: The Nursing Process and the Clinical Judgment Model>The Nursing Process
Integrated Process: Nursing Process
Client Need: Safe and Effective Care Environment: Management of Care
Cognitive Level: Analyzing
Concept: Clinical Judgment
Difficulty: Moderate

	Feedback
1.	There are three types of nursing diagnoses: problem-focused, health promotion, and risk. Collaboration refers to how the nurse, physician, and health-care team work together to treat a client but is not a diagnosis category.
2.	There are three types of nursing diagnoses: problem-focused, health promotion, and risk. Assessment information concerning a client's family's vulnerability to a community-acquired disease would be correctly categorized as a risk, not a problem-focused diagnosis.
3.	There are three types of nursing diagnoses: problem-focused, health promotion, and risk. Assessment information concerning a client's family's vulnerability to a community-acquired disease would be correctly categorized as a risk, not a health promotion diagnosis.
4.	There are three types of nursing diagnoses: problem-focused, health promotion, and risk. Assessment information concerning a client's family's vulnerability to a community-acquired disease would be correctly categorized as a risk diagnosis.

31. The nurse is formulating goals for the client related to ANA Standard 3: Outcomes Identification. Which is the best description of a proper goal statement?

1. A goal is a broad statement that is not measurable.
2. A goal must contain specific data points.
3. A goal must be chosen from an approved listing.
4. A goal determines when clients may be discharged to home.

ANS: 1
Chapter: 1, Critical Thinking and Clinical Reasoning in Nursing
Outcome: Define the American Nurses Association (ANA) Standards of Professional Nursing Practice.
Heading: Critical Thinking Frameworks: The Nursing Process and the Clinical Judgment Model>The Nursing Process
Integrated Process: Nursing Process
Client Need: Safe and Effective Care Environment: Management of Care
Cognitive Level: Analyzing
Concept: Clinical Judgment

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Difficulty: Moderate

	Feedback
1.	ANA Standard 3: Outcomes Identification includes the establishment of client specific goals that are broad statements and not measurable. The goal is then used to write expected client outcomes. This is the best descriptive statement.
2.	ANA Standard 3: Outcomes Identification includes the establishment of client specific goals that are broad statements and not measurable. The goal is then used to write expected client outcomes. No specific datapoints are included in the goal.
3.	ANA Standard 3: Outcomes Identification includes the establishment of client specific goals that are broad statements and not measurable. The goal is then used to write expected client outcomes. There is not an approved listing that must be used to select client goals.
4.	ANA Standard 3: Outcomes Identification includes the establishment of client specific goals that are broad statements and not measurable. The goal is then used to write expected client outcomes. The goal does not impact the client's discharge timing.

32. A student nurse approaches the nursing instructor to share this complaint from a client: "Nutrition service staff are only including liquids on the tray." What is the best action by the instructor?

1. Call nutrition services and change the tray to meet the client's requests as the diet order was likely an error.
2. Inform the client that no changes can be made until the physician arrives but offer additional liquids from the unit's floor stock.
3. Teach the student that implementation of the plan of care is a dynamic process that can be changed based on new information. Return to the client for further assessment.
4. Tell the student to provide options from the unit's stock of light snacks to enhance client satisfaction and independence.

ANS: 3
Chapter: 1, Critical Thinking and Clinical Reasoning in Nursing
Outcome: Describe the steps of the Nursing Process.
Heading: Critical Thinking Frameworks: The Nursing Process and the Clinical Judgment Model: The Nursing Process
Integrated Process: Nursing Process
Client Need: Safe and Effective Care Environment: Management of Care
Cognitive Level: Evaluating
Concept: Clinical Judgment
Difficulty: Moderate

	Feedback

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1.	The nursing process is dynamic and requires a flow of information. Interventions cannot be changed without proper assessment, alteration of the related nursing diagnosis, and then alterations in the intervention. Making assumptions regarding possible errors is not the instructor's best response.
2.	The nursing process is dynamic and requires a flow of information. Interventions cannot be changed without proper assessment, alteration of the related nursing diagnosis, and then alterations in the intervention. Assuming the client must only have liquids is not the instructor's best response.
3.	The nursing process is dynamic and requires a flow of information. Interventions cannot be changed without proper assessment, alteration of the related nursing diagnosis, and then alterations in the intervention. This is the instructor's best response.
4.	The nursing process is dynamic and requires a flow of information. Interventions cannot be changed without proper assessment, alteration of the related nursing diagnosis, and then alterations in the intervention. Assuming the client may have light snacks is not the instructor's best response.

33. A nurse receives hand-off information to assume care of a critically ill client. The physical assessment exhibits multiple abnormal findings. What action best reflects the nurse's first responsibility when using the Nursing Clinical Judgement Measurement Model (NCJMM)?

1. Include all information that exhibited abnormal findings.
2. Address the abnormal findings that are most easily remedied first.
3. Ask a peer to repeat the assessment for clarity.
4. Consider what is the most urgent, relevant, and important finding.

ANS: 4
Chapter: 1, Critical Thinking and Clinical Reasoning in Nursing
Outcome: Describe the components of the National Council of State Boards of Nursing (NCSBN) Nursing Clinical Judgment Measurement
Model (NCJMM).
Heading: Critical Thinking Frameworks: The Nursing Process and the Clinical Judgement Model>The Nursing Clinical Judgment Measurement Model
Integrated Process: Nursing Process
Client Need: Safe and Effective Care Environment: Management of Care
Cognitive Level: Analyzing
Concept: Clinical Judgment
Difficulty: Moderate

	Feedback
1.	When using the NCJMM to expand on the Nursing Process, the nurse must consider what information is relevant/irrelevant instead of including all abnormal findings. This is not the nurse's first responsibility.

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2.	When using the NCJMM to expand on the Nursing Process, the nurse must consider what is the most urgent, relevant, and important finding to address first, not the easiest to remedy.
3.	When using the NCJMM to expand on the Nursing Process, the nurse must consider what is the most urgent, relevant, and important finding and move to step two, analysis. Asking a peer to repeat the assessment will delay treatment of the urgent matters.
4.	When using the NCJMM to expand on the Nursing Process, the nurse must consider what is the most urgent, relevant, and important finding prior to moving to step two, analysis. This action best demonstrates use of the NCJMM.

34. The nurse is concerned regarding an assessed increase in a client's temperature relative to previous values. Which tool is the nurse's best choice for obtaining help for the client's acute need?

1. SBAR
2. SOAP
3. PIE
4. PIO

ANS: 1
Chapter: 1, Critical Thinking and Clinical Reasoning in Nursing
Outcome: Describe verbal and written tools used to communicate client status and care.
Heading: Standardized Verbal Communication for Hand-off>SBAR
Integrated Process: Nursing Process
Client Need: Safe and Effective Care Environment: Management of Care
Cognitive Level: Applying
Concept: Clinical Judgment
Difficulty: Moderate

	Feedback
1.	The SBAR protocol is a structured conversation between doctors and nurses for situations requiring immediate attention. This is the nurse's best tool to get the client help with the increased temperature.
2.	SOAP is a written form of communication to document assessment findings. Due to the acute nature of these changes, SOAP is not the nurse's best choice to get the client help.
3.	PIE is a written form of communication to document assessment findings. Due to the acute nature of these changes, PIE is not the nurse's best choice to get the client help.
4.	PIO is a written form of communication to document assessment findings. Due to the acute nature of these changes, PIO is not the nurse's best choice to get the client help.

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35. The National Council of State Boards of Nursing (NCSBN) identifies six skills that the registered nurse will utilize in the performance of client care. Which action best describes the nurse's use of those Nursing Clinical Judgment Measurement Model (NCJMM) skills?

1. The nurse identifies outcomes.
2. The nurse generates solutions.
3. The nurse plans client care.
4. The nurse makes a diagnosis.

ANS: 2
Chapter: 1, Critical Thinking and Clinical Reasoning in Nursing
Outcome: Describe the components of the National Council of State Boards of Nursing (NCSBN) Nursing Clinical Judgment Measurement Model (NCJMM).
Heading: Critical Thinking Frameworks: The Nursing Process and the Clinical Judgment Model
Integrated Process: Nursing Process
Client Need: Safe and Effective Care Environment: Management of Care
Cognitive Level: Analyzing
Concept: Clinical Judgment
Difficulty: Moderate

	Feedback
1.	Identifying outcomes is an element of the nursing process. It would be augmented by prioritizing hypotheses, a NCJMM skill.
2.	Generating solutions is a skill from the NCJMM skill set. It would augment the nursing process skill of planning. This is the correct action to best describe the nurse's use of the NCJMM skills.
3.	Planning is an element of the nursing process. It would be augmented by generating solutions, a NCJMM skill.
4.	Formulating a nursing diagnosis is an element of the nursing process. It would be augmented by analyzing cues, a NCJMM skill.

36. The nurse is discussing planning of care with the client, seeking to prioritize nursing diagnoses and select care strategies. What is the most important reason the nurse is discussing prioritization with the client?

1. The nurse is scheduling time to meet all assigned clients' needs.
2. The nurse knows that clients who are actively involved are more likely to be agreeable to the plan of care.
3. The nurse is teaching regarding Maslow's Hierarchy of Needs.
4. The nurse is engaging the family for the client's accountability.

ANS: 2

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Chapter: 1, Critical Thinking and Clinical Reasoning in Nursing
Outcome: Describe the steps of the Nursing Process.
Heading: Critical Thinking Frameworks: The Nursing Process and the Clinical Judgment Model>The Nursing Process
Integrated Process: Nursing Process
Client Need: Safe and Effective Care Environment: Management of Care
Cognitive Level: Analyzing
Concept: Clinical Judgment
Difficulty: Moderate

	Feedback
1.	When there is more than one nursing diagnosis, the nurse must prioritize and select care strategies. Working together with the client aids in agreement with and participation in the plan of care. That is not related to meeting other client needs.
2.	When there is more than one nursing diagnosis, the nurse must prioritize and select care strategies. Working together with the client aids in agreement with and participation in the plan of care. This is the most important reason.
3.	When there is more than one nursing diagnosis, the nurse must prioritize and select care strategies. Although Maslow's Hierarchy may guide the conversation, working together with the client functions to best gain agreement with and participation in the plan of care.
4.	When there is more than one nursing diagnosis, the nurse must prioritize and select care strategies. Working together with the client aids in agreement with and participation in the plan of care. The family might be involved, but the client must take ownership.

37. The nurse is using the Nursing Process for planning client care, ANA Standard 4: Planning. Which statement best defines parameters that will be needed for properly meeting that standard?

1. Clients may only have one nursing intervention for each level of Maslow's Hierarchy.
2. Clients should not be involved in this portion of the Nursing Process.
3. The interventions must be independent, not collaborative, with physicians.
4. Each outcome must have its own nursing intervention.

ANS: 4
Chapter: 1, Critical Thinking and Clinical Reasoning in Nursing
Outcome: Define the American Nurses Association (ANA) Standards of Professional Nursing Practice.
Heading: Critical Thinking Frameworks: The Nursing Process and the Clinical Judgment Model>The Nursing Process
Integrated Process: Nursing Process
Client Need: Safe and Effective Care Environment: Management of Care
Cognitive Level: Analyzing

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Concept: Clinical Judgment
Difficulty: Moderate

	Feedback
1.	Every client outcome has its own intervention, best chosen with the client's input, and can be collaborative or independent. The number of interventions per client outcome varies, but it is not restricted to one per level of Maslow's Hierarchy.
2.	Every client outcome has its own intervention, best chosen with the client's input, and can be collaborative or independent. This is not the best defining statement for ANA Standard 3.
3.	Every client outcome has its own intervention, best chosen with the client's input, and can be collaborative or independent. This statement is not correct.
4.	Every client outcome has its own intervention, best chosen with the client's input, and can be collaborative or independent. This statement best defines those parameters for ANA Standard 3.

38. The client informs the nurse that a large section of his right arm has suddenly become numb and feels cold. The nurse is employed by an academic facility that uses SOAP notes for charting. Which section of SOAP notes would be used to document the client's new complaint?

1. S
2. O
3. A
4. P

ANS: 1
Chapter: 1, Critical Thinking and Clinical Reasoning in Nursing
Outcome: Describe verbal and written tools used to communicate client status and care.
Heading: Written Documentation
Integrated Process: Nursing Process
Client Need: Safe and Effective Care Environment: Management of Care
Cognitive Level: Applying
Concept: Clinical Judgment
Difficulty: Moderate

	Feedback
1.	When using SOAP notes for charting, the S refers to subjective data. Complaints offered by the client should be charted under the S section.
2.	When using SOAP notes for charting, the O refers to objective data. Complaints offered by the client should be charted under the S section, not the O.
3.	When using SOAP notes for charting, the A refers to analysis of obtained data. Complaints offered by the client should be charted under the S section, not the A.

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4.	When using SOAP notes for charting, the P refers to the plan of care. Complaints offered by the client should be charted under the S section, not the P.

39. Nurse A is sending client data to another registered nurse, releasing the care of that client to Nurse B. This is a demonstration of what specific health-care event?

1. SBAR Communication
2. Hand-off
3. Diagnostic Testing
4. Discharge

ANS: 2
Chapter: 1, Critical Thinking and Clinical Reasoning in Nursing
Outcome: Describe verbal and written tools used to communicate client status and care.
Heading: Standardized Verbal Communication or Hand-off
Integrated Process: Nursing Process
Client Need: Safe and Effective Care Environment: Management of Care
Cognitive Level: Applying
Concept: Clinical Judgment
Difficulty: Moderate

	Feedback
1.	SBAR is a communication tool to structure communication between nurses and physicians in situations requiring immediate attention. A hand-off is the sharing of data real time between nurses for the purpose of transferring the client's care.
2.	A hand-off is the sharing of data real time between nurses for the purpose of transferring the client's care. Nurse A is the sender and Nurse B the receiver as required for a hand-off.
3.	The sharing of data real time between nurses for the purpose of transferring the client's care is known as a hand-off. This is not a description of diagnostic testing.
4.	The sharing of data real time between nurses for the purpose of transferring the client's care is known as a hand-off. At discharge, the client and significant others assume the client's care.

40. The Nursing Process is dynamic, framing the nurse's work to place clients in an optimal health state. Which statement best describes the nurse's performance of a step as outlined by the Nursing Process?

1. The nurse takes action.
2. The nurse recognizes cues.
3. The nurse analyzes cues.

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4. The nurse performs an assessment.

ANS: 4
Chapter: 1, Critical Thinking and Clinical Reasoning in Nursing
Outcome: Describe the components of the National Council of State Boards of Nursing (NCSBN) Nursing Clinical Judgment Measurement
Model (NCJMM).
Heading: Critical Thinking Frameworks: The Nursing Process and the Clinical Judgment Model
Integrated Process: Nursing Process
Client Need: Safe and Effective Care Environment: Management of Care
Cognitive Level: Analyzing
Concept: Clinical Judgment
Difficulty: Moderate

	Feedback
1.	Taking action is an element of NCJMM skills. That would augment Implementation, a step of the Nursing Process.
2.	Recognizing cues is an element of NCJMM skills. That would augment Assessment, a step of the Nursing Process.
3.	Analyzing cues is an element of NCJMM skills. That would augment Diagnosis, a step of the Nursing Process.
4.	The Nursing Process includes six steps: assessment, diagnosis, outcomes identification, planning, implementation, and evaluation. This is the best phrase to describe the nurse's performance of a step as outlined by the Nursing Process.

41. The nurse is using the six steps of the Nursing Process to optimize a client's care and health state. Documentation of the client's laboratory and diagnostic data contributes directly to which step being used by the nurse?

1. Assessment
2. Evaluation
3. Outcomes Identification
4. Planning

ANS: 1
Chapter: 1, Critical Thinking and Clinical Reasoning in Nursing
Outcome: Describe the steps of the Nursing Process.
Heading: Critical Thinking Frameworks: The Nursing Process and the Clinical Judgment Model>The Nursing Process
Integrated Process: Nursing Process
Client Need: Safe and Effective Care Environment: Management of Care
Cognitive Level: Analyzing
Concept: Clinical Judgment

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Difficulty: Moderate

	Feedback
1.	The nurse collects pertinent data and information relative to the consumer's health or situation in ANA Standard 1: Assessment. Laboratory and diagnostic data are part of that step in the Nursing Process.
2.	The nurse evaluates progress toward attainment of goals and outcomes in ANA Standard 6: Evaluation. The nurse collects pertinent data and information relative to the consumer's health or situation, including diagnostic and laboratory data, in ANA Standard 1: Assessment.
3.	The nurse identifies expected outcomes for an individualized client's plan during ANA Standard 3: Outcomes Identification. The nurse collects pertinent data and information relative to the consumer's health or situation, including diagnostic and laboratory data, in ANA Standard 1: Assessment.
4.	The nurse develops a collaborative plan encompassing strategies to achieve expected outcomes in ANA Standard 4: Planning. The nurse collects pertinent data and information relative to the consumer's health or situation, including diagnostic and laboratory data, in ANA Standard 1: Assessment.

42. The nurse is talking with a client, seeking to determine which explanations regarding hypotheses are most likely, and which possible explanations are the most serious. Which Nursing Clinical Judgment Measurement Model (NCJMM) skill is the nurse using?

1. Take Action
2. Analyze Cues
3. Prioritize Hypotheses
4. Recognize Cues

ANS: 3
Chapter: 1, Critical Thinking and Clinical Reasoning in Nursing
Outcome: Describe the components of the National Council of State Boards of Nursing (NCSBN) Nursing Clinical Judgment Measurement Model (NCJMM).
Heading: Critical Thinking Frameworks: The Nursing Process and the Clinical Judgment Model>The Nursing Clinical Judgment and Measurement Model
Integrated Process: Nursing Process
Client Need: Safe and Effective Care Environment: Management of Care
Cognitive Level: Analyzing
Concept: Clinical Judgment
Difficulty: Moderate

	Feedback
1.	The nurse's efforts to take actions that address the highest priorities is the skill of taking action. This nurse is using the NJCMM skill of prioritize hypotheses.

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2.	The NCJMM skills of analyzing cues involves organizing and linking assessed elements to the client's clinical presentation. This nurse is using the NJCMM skill of prioritize hypotheses.
3.	The nurse's efforts to determine which explanations regarding hypotheses are most likely, and which possible explanations are the most serious is the skill of prioritizing hypotheses. This is the correct skill selection.
4.	The nurse's efforts to identify relevant and important information from different sources is the skill of recognizing clues. This nurse is using the NJCMM skill of prioritize hypotheses.

43. The registered nurse is applying Universal Intellectual Standards (UIS) to evaluate critical thinking used during conversation with a client. Which UIS principle involves reflecting on how the client encounter was conducted and whether an accurate representation was made?

1. Breadth
2. Precision
3. Clarity
4. Fairness

ANS: 4
Chapter: 1, Critical Thinking and Clinical Reasoning in Nursing
Outcome: Discuss the components of critical thinking, clinical reasoning, and clinical judgment.
Heading: Critical Thinking, Clinical Reasoning, and Clinical Judgment>Universal Intellectual Standards for Critical Thinking
Integrated Process: Nursing Process
Client Need: Safe and Effective Care Environment: Management of Care
Cognitive Level: Analyzing
Concept: Clinical Judgment
Difficulty: Moderate

	Feedback
1.	The UIS of breadth relates to whether there is additional information needed to gain an accurate impression of the client's situation. This nurse is exhibiting the UIS of fairness.
2.	The UIS of precision involves determining whether the message from a client gave exact values and parameters. This nurse is exhibiting the UIS of fairness.
3.	Clarity involves determining whether the message from a client was clear. This nurse is exhibiting the UIS of fairness.
4.	The UIS of fairness allows the nurse to reflect on how an encounter was conducted, and whether an accurate representation of the client was made. This is the correct selection of UIS for this scenario.

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44. The nurse is orienting a newly hired peer regarding the use of SOAP notes for documentation. What should be included as a correct identification of a term in the SOAP acronym?

1. Status
2. Overview
3. Action
4. Plan

ANS: 4
Chapter: 1, Critical Thinking and Clinical Reasoning in Nursing
Outcome: Describe verbal and written tools used to communicate client status and care.
Heading: Written Documentation
Integrated Process: Nursing Process
Client Need: Safe and Effective Care Environment: Management of Care
Cognitive Level: Applying
Concept: Clinical Judgment
Difficulty: Moderate

	Feedback
1.	The letters of the SOAP acronym denote Subjective data, Objective data, Analysis of data stated as a nursing diagnosis, and Plan. Status is not reflected in the acronym.
2.	The letters of the SOAP acronym denote Subjective data, Objective data, Analysis of data stated as a nursing diagnosis, and Plan. Overview is not reflected in the acronym.
3.	The letters of the SOAP acronym denote Subjective data, Objective data, Analysis of data stated as a nursing diagnosis, and Plan. Action is not reflected in the acronym.
4.	The letters of the SOAP acronym denote Subjective data, Objective data, Analysis of data stated as a nursing diagnosis, and Plan. Plan is the fourth term denoted by the acronym.

45. The charge nurse is assigning the complex care of a client to a clinical staff nurse, choosing between registered nurses with varying experience. Which statement is important for the unit manager to consider when completing the assignment?

1. The experienced nurse makes intuitive links for client care needs.
2. The novice nurse relies on analytical thinking for client care planning.
3. The experienced nurse can better focus on isolated items when determining care needs.
4. The novice nurse uses evidence-based practice.

ANS: 1
Chapter: 1, Critical Thinking and Clinical Reasoning in Nursing

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Outcome: Discuss the components of critical thinking, clinical reasoning, and clinical judgment.
Heading: Chapter Introduction
Integrated Process: Nursing Process
Client Need: Safe and Effective Care Environment: Management of Care
Cognitive Level: Evaluating
Concept: Clinical Judgment
Difficulty: Hard

	Feedback
1.	Experienced nurses can use their professional experiences and intuition to link events to certain outcomes such as would be needed for complex patient care. The charge nurse should consider this statement when making care assignments.
2.	The novice nurse has not developed the professional experiences and intuition for analytical thinking needed for client care needs. This is not the statement the unit manager should consider when completing the assignment.
3.	The experienced nurse has the analytical skills needed to address complete client care and prioritize, not focus on a single item. This is not the statement the unit manager should consider when completing the assignment.
4.	All registered nurses use evidence-based practice in the delivery of nursing care. This is not the statement the unit manager should consider when completing the assignment.

46. The nursing instructor asks the class to properly categorize information using the Nursing Process. Which information should be listed under ANA Standard 4?

1. Health Teaching and Health Promotion
2. Coordination of Care
3. Intervention Selection
4. Implementation

ANS: 3
Chapter: 1, Critical Thinking and Clinical Reasoning in Nursing
Outcome: Describe the steps of the Nursing Process.
Heading: Critical Thinking Frameworks: The Nursing Process and the Clinical Judgment Model>The Nursing Process
Integrated Process: Nursing Process
Client Need: Safe and Effective Care Environment: Management of Care
Cognitive Level: Analyzing
Concept: Clinical Judgment
Difficulty: Moderate

	Feedback

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1.	Health Teaching and Health Promotion is ANA Standard 5B, correctly categorized by the student.
2.	Coordination of care is ANA Standard 5A, correctly categorized by the student.
3.	Intervention selection is a component of ANA Standard 4: Planning.
4.	ANA Standard 5 is Implementation, correctly categorized by the student.

47. The registered nurse seeks input from physical therapy, a pharmacist, and a registered dietician to coordinate optimal care delivery for a client. Which ANA Standard is the nurse demonstrating?

1. 4
2. 5
3. 6
4. 2

ANS: 2
Chapter: 1, Critical Thinking and Clinical Reasoning in Nursing
Outcome: Define the American Nurses Association (ANA) Standards of Professional Nursing Practice.
Heading: Critical Thinking Frameworks: The Nursing Process and the Clinical Judgment Model>The Nursing Process
Integrated Process: Nursing Process
Client Need: Safe and Effective Care Environment: Management of Care
Cognitive Level: Applying
Concept: Clinical Judgment
Difficulty: Moderate

	Feedback
1.	Standard 4: Planning involves the development of a collaborative plan. This nurse is seeking to coordinate care, Standard 5.
2.	This nurse is seeking to coordinate care delivery between multiple departments, Standard 5: Implementation.
3.	Standard 6: Evaluation is the process of evaluating progress on goals and outcomes. This nurse is seeking to coordinate care delivery between multiple health professionals, Standard 5: Implementation.
4.	Standard 2: Diagnosis involves analyzing assessment data to determine actual or potential diagnoses, problems, and issues. This nurse is seeking to coordinate care delivery between multiple health professionals, Standard 5: Implementation.

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48. The nurse is seeking scientific and nursing literature to justify the use of a new skin care regimen for a client. What component of critical thinking is the nurse addressing with that research?

1. Evaluation
2. Analysis
3. Explanation
4. Inference

ANS: 3
Chapter: 1, Critical Thinking and Clinical Reasoning in Nursing
Outcome: Discuss the components of critical thinking, clinical reasoning, and clinical judgment.
Heading: Critical Thinking, Clinical Reasoning, and Clinical Judgment>Components of Critical Thinking
Integrated Process: Nursing Process
Client Need: Safe and Effective Care Environment: Management of Care
Cognitive Level: Analyzing
Concept: Clinical Judgment
Difficulty: Moderate

	Feedback
1.	The critical thinking element of evaluation involves the examination of the validity of information and leads to a conclusion that can be implemented. This nurse is seeking literature to explain the new skin care regimen, the element of explanation.
2.	The critical thinking element of analysis involves the examination of ideas and data, then identifies the reason for any discrepancies. This nurse is seeking literature to explain the new skin care regimen, the element of explanation.
3.	The critical thinking element of explanation requires that scientific and nursing literature provide the basis for justification of clinical activities. The nurse is seeking literature to justify the new skin care regimen, the element of explanation.
4.	The critical thinking element of inference speculates and derives a specific premise based on information and assumptions obtained from the client. This nurse is seeking literature to explain the new skin care regimen, the element of explanation.

49. The nursing instructor is teaching students to apply identified optimal approaches to a specific situation to determine the relevance of evidence and science as it applies to a client. Which topic is the instructor teaching to the students?

1. Critical Thinking
2. Clinical Reasoning
3. Clinical Judgment
4. Clinical Inference

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ANS: 2
Chapter: 1, Critical Thinking and Clinical Reasoning in Nursing
Outcome: Discuss the components of critical thinking, clinical reasoning, and clinical judgment.
Heading: Critical Thinking, Clinical Reason, and Clinical Judgment
Integrated Process: Nursing Process
Client Need: Safe and Effective Care Environment: Management of Care
Cognitive Level: Applying
Concept: Clinical Judgment
Difficulty: Moderate

	Feedback
1.	Clinical thinking is the skill of using logic and reasoning to identify optimal approaches for clinical problems. The instructor is teaching clinical reasoning, the application of clinical thinking to a client.
2.	Clinical reasoning is the skill of applying critical thinking to a specific situation, understanding the relevance of evidence and science as it applies to a client. This instructor is teaching clinical reasoning.
3.	Clinical judgment is the skill of interpreting a client's needs and determining whether to act on a plan of care, or to improvise. This instructor is teaching clinical reasoning.
4.	Inference is a component of critical thinking. This instructor is teaching clinical reasoning.

NEXT GEN

50. Critical thinking is a set of skills needed by nurses to identify health-care solutions and approaches that best suit a client's needs. Six of those many skills are discussed in the text related to health assessment and physical examination. The nurse evaluates the quality of critical thinking by applying the nine Universal Intellectual Standards (UIS). Correctly categorize each of the listed items as a skill or standard. *Place an X in the box that correctly corresponds to that selection.*

Skills and Standards	**Critical Thinking Skill**	**Universal Intellectual Standard (UIS) for Critical Thinking**
1. Explanation		
2. Depth		
3. Accuracy		
4. Interpretation		
5. Fairness		
6. Inference		
7. Clarity		
8. Analysis		
9. Self-regulation		

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ANS: Critical Thinking Skills: 1, 4, 6, 8, 9 UIS for Critical Thinking: 2, 3, 5, 7
Chapter: 1, Critical Thinking and Clinical Reasoning in Nursing
Outcome: Discuss the components of critical thinking, clinical reasoning, and clinical judgment.
Heading: Critical Thinking, Clinical Reasoning, and Clinical Judgment
Integrated Processes: Communication and Documentation
Client Need: Safe and Effective Care Environment
Cognitive Level: Analysis
Concepts: Communication
Question Type: Matrix/Grid
Difficulty: Moderate

Skills and Standards	Critical Thinking Skills	Universal Intellectual Standards (UIS) for Critical Thinking
1. Explanation	X	
2. Depth		X
3. Accuracy		X
4. Interpretation	X	
5. Fairness		X
6. Inference	X	
7. Clarity		X
8. Analysis	X	
9. Self-regulation	X	

Feedback:

1. The components of critical thinking skills from the text include interpretation, analysis, inference, explanation, evaluation, and self-regulation.
2. The UIS for critical thinking include clarity, accuracy, precision, relevance, depth, breadth, logic, significance and fairness.
3. The UIS for critical thinking include clarity, accuracy, precision, relevance, depth, breadth, logic, significance and fairness.
4. The components of critical thinking skills from the text include interpretation, analysis, inference, explanation, evaluation, and self-regulation.
5. The UIS for critical thinking include clarity, accuracy, precision, relevance, depth, breadth, logic, significance and fairness.
6. The components of critical thinking skills from the text include interpretation, analysis, inference, explanation, evaluation, and self-regulation.
7. The UIS for critical thinking include clarity, accuracy, precision, relevance, depth, breadth, logic, significance and fairness.
8. The components of critical thinking skills from the text include interpretation, analysis, inference, explanation, evaluation, and self-regulation.
9. The components of critical thinking skills from the text include interpretation, analysis, inference, explanation, evaluation, and self-regulation.

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