Medical-Surgical Nursing in Canada (Canadian) 4th edition Lewi Test Bank

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MULTIPLE CHOICE

1. When caring for clients using evidence-informed practice, which of the following does the nurse use?
   a. Clinical judgement based on experience
   b. Evidence from a clinical research study
   c. The best available evidence to guide clinical expertise
   d. Evaluation of data showing that the client outcomes are met

   ANS: C
   Evidence-informed nursing practice is a continuous interactive process involving the explicit, conscientious, and judicious consideration of the best available evidence to provide care. Four primary elements are: (a) clinical state, setting, and circumstances; (b) client preferences and actions; (c) best research evidence; and (d) health care resources. Clinical judgement based on the nurse's clinical experience is part of EIP, but clinical decision making also should incorporate current research and research-based guidelines. Evidence from one clinical research study does not provide an adequate substantiation for interventions. Evaluation of client outcomes is important, but interventions should be based on research from randomized control studies with a large number of subjects.

   DIF: Cognitive Level: Comprehension TOP: Nursing Process: Planning

2. Which of the following best explains the nurses' primary use of the nursing process when providing care to clients?
   a. To explain nursing interventions to other health care professionals
   b. As a problem-solving tool to identify and treat clients' health care needs
   c. As a scientific-based process of diagnosing the client's health care problems
   d. To establish nursing theory that incorporates the biopsychosocial nature of humans

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

   DIF: Cognitive Level: Comprehension TOP: Nursing Process: Implementation

3. The nurse is caring for a critically ill client in the intensive care unit and plans an every 2-hour turning schedule to prevent skin breakdown. Which type of nursing function is demonstrated with this turning schedule?
   a. Dependent
   b. Cooperative
   c. Independent
   d. Collaborative

   ANS: D

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

DIF: Cognitive Level: Application TOP: Nursing Process: Implementation

4. The nurse is caring for a client who has been admitted to the hospital for surgery and tells the nurse, "I do not feel right about leaving my children with my neighbour." Which action should the nurse take next?
   a. Reassure the client that these feelings are common for parents.
   b. Have the client call the children to ensure that they are doing well.
   c. Call the neighbour to determine whether adequate childcare is being provided.
   d. Gather more data about the client's feelings about the childcare arrangements.

   ANS: D
   Since a complete assessment is necessary in order to identify a problem and choose an appropriate intervention, the nurse's first action should be to obtain more information. The other actions may be appropriate, but more assessment is needed before the best intervention can be chosen.

   DIF: Cognitive Level: Application TOP: Nursing Process: Assessment

5. The nurse is caring for a client who has left-sided paralysis as the result of a stroke and assesses a pressure injury on the client's left hip. Which of the following is the most appropriate nursing diagnosis for this client?
   a. Impaired physical mobility related to decrease in muscle control (left-sided paralysis)
   b. Risk for impaired tissue integrity as evidenced by insufficient knowledge about protecting tissue integrity
   c. Impaired skin integrity related to pressure over bony prominence (impaired circulation)
   d. Ineffective tissue perfusion related to sedentary lifestyle

   ANS: C
   The client's major problem is the impaired skin integrity as demonstrated by the presence of a pressure injury. The nurse is able to treat the cause of altered circulation and pressure by frequently repositioning the client. Although left-sided weakness is a problem for the client, the nurse cannot treat the weakness. The "risk for" diagnosis is not appropriate for this client, who already has impaired tissue integrity. The client does have ineffective tissue perfusion, but the impaired skin integrity diagnosis indicates more clearly what the health problem is.

   DIF: Cognitive Level: Application TOP: Nursing Process: Diagnosis

6. The nurse caring for a client with an infection has a nursing diagnosis of deficient fluid volume related to excessive diaphoresis. Which of the following is an appropriate client outcome?
   a. Client has a balanced intake and output.
   b. Client's bedding is changed when it becomes damp.

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c. Client understands the need for increased fluid intake.
d. Client's skin remains cool and dry throughout hospitalization.

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

DIF: Cognitive Level: Application TOP: Nursing Process: Planning

7. Which of the following represents a nursing activity that is carried out during the evaluation phase of the nursing process?
a. Determining if interventions have been effective in meeting client outcomes
b. Documenting the nursing care plan in the progress notes in the medical record
c. Deciding whether the client's health problems have been completely resolved
d. Asking the client to evaluate whether the nursing care provided was satisfactory

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

DIF: Cognitive Level: Comprehension TOP: Nursing Process: Evaluation

8. Which of the following would the nurse perform during the assessment phase of the nursing process?
a. Obtains data with which to diagnose client problems
b. Uses client data to develop priority nursing diagnoses
c. Teaches interventions to relieve client health problems
d. Assists the client to identify realistic outcomes to health problems

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

DIF: Cognitive Level: Knowledge TOP: Nursing Process: Assessment

9. Which of the following is an example of a correctly written nursing diagnosis statement?
a. Altered tissue perfusion related to heart failure
b. Risk for impaired tissue integrity related to sacral redness
c. Ineffective coping related to insufficient sense of control.
d. Altered urinary elimination related to urinary tract infection

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

DIF: Cognitive Level: Comprehension TOP: Nursing Process: Diagnosis

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10. Which of the following includes the components required for a complete nursing diagnosis statement?
    a. A problem and the suggested client goals or outcomes
    b. A problem, its cause, and objective data that support the problem
    c. A problem with all its possible causes and the planned interventions
    d. A problem with its etiology and the signs and symptoms of the problem

    ANS: D
    The PES format is used when writing nursing diagnoses. The subjective, as well as objective, data should be included in the defining characteristics. Interventions and outcomes are not included in the nursing diagnosis statement.

    DIF: Cognitive Level: Knowledge TOP: Nursing Process: Diagnosis

11. Which of the following refers to a situation that results in unintended harm to the client and is related to the care or services provided rather than the client's medical condition?
    a. Negligence
    b. Adverse event
    c. Incident report
    d. Nonmaleficence

    ANS: B
    An adverse event is an event that results in unintended harm to the client and is related to the care or services provided to the client rather than to the client's underlying medical condition.

    DIF: Cognitive Level: Knowledge TOP: Nursing Process: Evaluation

12. When using the Five Steps of the **e**vidence-**i**nformed **p**ractice (EIP) Process, which of the flowing elements is the final step when constructing a clinical question?
    a. Comparison of interest
    b. Population of interest
    c. Outcome of interest
    d. Timeframe of interest

    ANS: D
    The order of the nurse's statements follows the PICOT format with the final step being the "T", or timeframe of interest.

    DIF: Cognitive Level: Application TOP: Nursing Process: Implementation

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MULTIPLE CHOICE

1. The nurse is caring for a client with a new diagnosis of pneumonia and explains to the client that together they will plan the client's care and set goals for discharge. The client asks, "How is that different from what the doctor does?" Which response by the nurse is most appropriate?
   a. "The role of the nurse is to administer medications and other treatments prescribed by your doctor."
   b. "The nurse's job is to help the doctor by collecting data and communicating when there are problems."
   c. "Nurses perform many of the procedures done by physicians, but nurses are here in the hospital for a longer time than doctors."
   d. "In addition to caring for you while you are sick, the nurses will assist you to develop an individualized plan to maintain your health."

   ANS: D
   This response is consistent with the **C**anadian **N**urses **A**ssociation (CNA) definition of nursing. Registered nurses are self-regulated health care professionals who work autonomously and in collaboration with others. RNs enable individuals, families, groups, communities and populations to achieve their optimal level of health. RNs coordinate health care, deliver direct services, and support clients in their self-care decisions and actions in situations of health, illness, injury, and disability in all stages of life. The other responses describe some of the dependent and collaborative functions of the nursing role but do not accurately describe the nurse's role in the health care system.

   DIF: Cognitive Level: Comprehension TOP: Nursing Process: Implementation
   MSC: NCLEX: Safe and Effective Care Environment

2. When caring for clients using evidence-informed practice, which of the following does the nurse use?
   a. Clinical judgement based on experience
   b. Evidence from a clinical research study
   c. The best available evidence to guide clinical expertise
   d. Evaluation of data showing that the client outcomes are met

   ANS: C
   Evidence-informed nursing practice is a continuous interactive process involving the explicit, conscientious, and judicious consideration of the best available evidence to provide care. Four primary elements are: (a) clinical state, setting, and circumstances; (b) client preferences and actions; (c) best research evidence, and (d) health care resources. Clinical judgement based on the nurse's clinical experience is part of EIP, but clinical decision making also should incorporate current research and research-based guidelines. Evidence from one clinical research study does not provide an adequate substantiation for interventions. Evaluation of client outcomes is important, but interventions should be based on research from randomized control studies with a large number of subjects.

   DIF: Cognitive Level: Comprehension TOP: Nursing Process: Planning

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MSC: NCLEX: Safe and Effective Care Environment

3. Which of the following best explains the nurses' primary use of the nursing process when providing care to clients?
   a. To explain nursing interventions to other health care professionals
   b. As a problem-solving tool to identify and treat clients' health care needs
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   d. To establish nursing theory that incorporates the biopsychosocial nature of humans

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

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4. The nurse is caring for a critically ill client in the intensive care unit and plans an every-2-hour turning schedule to prevent skin breakdown. Which type of nursing function is demonstrated with this turning schedule?
   a. Dependent
   b. Cooperative
   c. Independent
   d. Collaborative

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

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

5. The nurse is caring for a client who has been admitted to the hospital for surgery and tells the nurse, "I do not feel right about leaving my children with my neighbour." Which action should the nurse take next?
   a. Reassure the client that these feelings are common for parents.
   b. Have the client call the children to ensure that they are doing well.
   c. Call the neighbour to determine whether adequate childcare is being provided.
   d. Gather more data about the client's feelings about the childcare arrangements.

   ANS: D
   Since a complete assessment is necessary in order to identify a problem and choose an appropriate intervention, the nurse's first action should be to obtain more information. The other actions may be appropriate, but more assessment is needed before the best intervention can be chosen.

   DIF: Cognitive Level: Application TOP: Nursing Process: Assessment

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MSC: NCLEX: Psychosocial Integrity

6. The nurse is caring for a client who has left-sided paralysis as the result of a stroke and assesses a pressure injury on the client's left hip. Which of the following is the most appropriate nursing diagnosis for this client?
   a. Impaired physical mobility related to decrease in muscle control (left-sided paralysis)
   b. Risk for impaired tissue integrity as evidenced by insufficient knowledge about protecting tissue integrity
   c. Impaired skin integrity related to pressure over bony prominence (impaired circulation)
   d. Ineffective peripheral tissue perfusion related to sedentary lifestyle

   ANS: C
   The client's major problem is the impaired skin integrity as demonstrated by the presence of a pressure injury. The nurse is able to treat the cause of impaired circulation and pressure over bony prominence by frequently repositioning the client. Although left-sided weakness is a problem for the client, the nurse cannot treat the weakness. The "risk for" diagnosis is not appropriate for this client, who already has impaired tissue integrity. The client does have ineffective peripheral tissue perfusion, but the impaired skin integrity diagnosis indicates more clearly what the health problem is.

   DIF: Cognitive Level: Application TOP: Nursing Process: Diagnosis
   MSC: NCLEX: Physiological Integrity

7. The nurse caring for a client with an infection has a nursing diagnosis of deficient fluid volume related to excessive fluid loss through normal route (diaphoresis). Which of the following is an appropriate client outcome?
   a. Client has a balanced intake and output.
   b. Client's bedding is changed when it becomes damp.
   c. Client understands the need for increased fluid intake.
   d. Client's skin remains cool and dry throughout hospitalization.

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

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

8. Which of the following represents a nursing activity that is carried out during the evaluation phase of the nursing process?
   a. Determining if interventions have been effective in meeting client outcomes.
   b. Documenting the nursing care plan in the progress notes in the medical record.
   c. Deciding whether the client's health problems have been completely resolved.
   d. Asking the client to evaluate whether the nursing care provided was satisfactory.

   ANS: A

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

DIF: Cognitive Level: Comprehension TOP: Nursing Process: Evaluation
MSC: NCLEX: Safe and Effective Care Environment

9. Which of the following would the nurse perform during the assessment phase of the nursing process?
   a. Obtains data with which to diagnose client problems.
   b. Uses client data to develop priority nursing diagnoses.
   c. Teaches interventions to relieve client health problems.
   d. Assists the client to identify realistic outcomes to health problems.

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

   DIF: Cognitive Level: Knowledge TOP: Nursing Process: Assessment
   MSC: NCLEX: Safe and Effective Care Environment

10. Which of the following is an example of a correctly written nursing diagnosis statement?
    a. Altered tissue perfusion related to heart failure.
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    c. Ineffective coping related to insufficient sense of control.
    d. Altered urinary elimination related to urinary tract infection.

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

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

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    c. A problem with all its possible causes and the planned interventions.
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    ANS: D
    The PES format is used when writing nursing diagnoses. The subjective, as well as objective, data should be included in the defining characteristics. Interventions and outcomes are not included in the nursing diagnosis statement.

    DIF: Cognitive Level: Knowledge TOP: Nursing Process: Diagnosis
    MSC: NCLEX: Safe and Effective Care Environment

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12. Which of the following refers to a situation that results in unintended harm to the client and is related to the care or services provided rather than the client's medical condition?
    a. Negligence
    b. Adverse event
    c. Incident report
    d. Nonmaleficence

    ANS: B
    An adverse event is an event that results in unintended harm to the client and is related to the care or services provided to the client rather than to the client's underlying medical condition.

    DIF: Cognitive Level: Knowledge TOP: Nursing Process: Evaluation
    MSC: NCLEX: Safe and Effective Care Environment

13. Which of these nursing actions for the client with heart failure is appropriate for the nurse to delegate to experienced unregulated care providers?
    a. Assess for shortness of breath or fatigue after ambulation.
    b. Instruct the client about the need to alternate activity and rest.
    c. Obtain the client's blood pressure and pulse rate after ambulation.
    d. Determine whether the client is ready to increase the activity level.

    ANS: C
    Unregulated care provider education varies according to the type of worker; however, unregulated care providers are able to measure vital signs. Assessment and client teaching require RN education and scope of practice and cannot be delegated.

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

14. Which action by a newly graduated RN working on the postsurgical unit indicates that more education about delegation and assignment is needed?
    a. The nurse delegates measurement of client oral intake and urine output to an unregulated care provider.
    b. The nurse delegates assessment of a client's bowel sounds to an experienced unregulated care provider.
    c. The nurse assigns an LPN/LVN to administer oral medications to several clients.
    d. The nurse assigns a "float" RN from pediatrics to care for a client with diabetes.

    ANS: B
    Assessment requires RN education and scope of practice and cannot be delegated to an unregulated care provider. The other actions by the new RN are appropriate.

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

15. Which of these tasks is appropriate for the registered nurse to delegate to an unregulated care provider?
    a. Perform a sterile dressing change for an infected wound.
    b. Complete the clients' initial bath.
    c. Teach a client about the effects of prescribed medications.
    d. Document client teaching about a routine surgical procedure.

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ANS: B
Unregulated care providers are able to provide personal care to clients. Client teaching and the initial assessment and development of the plan of care are nursing actions that require RN-level education and scope of practice when working with clients that are not stable.

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

MULTIPLE RESPONSE

1. When using the Five Steps of the **E**vidence-**I**nformed **P**ractice (EIP) Process, in which order should the nurse construct a clinical question? (*Select all that apply.*)
   a. Comparison of interest
   b. Population of interest
   c. Outcome of interest
   d. Intervention of interest
   e. Timeframe

   ANS: A, B, C, D, E
   The order of the nurse's statements follows the PICOT format.

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