1. A client reports to a health care facility with complaints of abdominal pain and vomiting. The client's wife informs the nurse that the client had gone out for dinner the previous night. Which of the following would be the primary source of assessment data?
   A) Client's friends
   B) Client's wife
   C) Client himself
   D) Test reports
   Ans: C
   Feedback:
   As the client is in a conscious state, he himself is the primary source of information since he can give firsthand information. The client's wife, friends, and test results would be the secondary sources of data.

2. A client with HIV has been admitted to a health care facility. Which of the following nursing diagnoses should be of the highest priority, keeping in mind the client's condition?
   A) Risk for activity intolerance
   B) Risk for ineffective coping
   C) Risk for infection
   D) Risk for imbalanced nutrition
   Ans: C
   Feedback:
   Clients with HIV have decreased immunity and are prone to infections. Infection in a client with HIV is life-threatening, because it makes the client vulnerable to other infections, and also impairs his or her already weakened immune functions. Clients with HIV may not have problems with other activities and food. They may often feel depressed, but this is not the highest priority.

3. A client is being prepared for cardiac catheterization. The nurse performs an initial assessment and records the vital signs. Which of the following data collected can be classified as subjective data?
   A) Blood pressure
   B) Nausea
   C) Heart rate
   D) Respiratory rate
   Ans: B
   Feedback:
   Subjective data are those that the client can feel and describe. Nausea is subjective data, as it can only be described and not measured. Blood pressure, heart rate, and respiratory rate are measurable factors and are therefore objective data.

4. A client who has to undergo a thyroidectomy is worried that he may have to wear a scarf around his neck after surgery. What nursing diagnosis should the nurse document in the care plan?
   A) Risk for impaired physical mobility due to surgery
   B) Ineffective denial related to poor coping mechanisms
   C) Disturbed body image related to the incision scar
   D) Risk of injury related to surgical outcomes
   Ans: C
   Feedback:
   The client is concerned about the surgery scar on his neck, which would disturb his body image; therefore, the appropriate diagnosis should be disturbed body image related to the incision scar. Risk for impaired physical mobility may be present after surgery, but is not related to the concerns expressed by the client. Likewise, ineffective denial related to poor coping mechanisms and injury related to surgical outcomes are also not related to the client's concern.

5. A nurse is giving postoperative care to a client after knee arthroplasty. Which of the following is a possible short-term goal for this client?
   A) To ambulate the client to a bedside chair
   B) To help the client return to activities of daily life
   C) To maintain a healthy and active lifestyle
   D) To prevent repeat surgery in the client
   Ans: A
   Feedback:
   The short-term goal in this case is to help the client ambulate to the bedside chair. The other goals, such as helping the client return to activities of daily life, to maintain a healthy and active lifestyle, and to prevent repeat surgery in the client are long-term goals and may take weeks or months to achieve. On the other hand, short-term goals can be achieved in a day or a week.

6. A nurse who is caring for a client admitted to the nursing unit with acute abdominal pain formulates the care plan for the client. Which of the following nursing diagnoses is the highest priority for this client?
   A) Impaired comfort
   B) Disturbed body image
   C) Disturbed sleep pattern
   D) Activity intolerance
   Ans: A
   Feedback:
   Acute pain in the abdomen disturbs all the systems of the body. Relieving the pain should be the nurse's first priority. According to Maslow, physiologic needs are the highest priority. The client may have disturbed body image, disturbed sleep patterns, or activity intolerance, but all these are secondary to pain.

7. The nurse is performing an assessment of a client diagnosed with excess fluid volume due to renal failure. Which of the following assessment data is the nurse likely to find?
   A) Hypotension
   B) Feeble pulse
   C) Crackles
   D) Drowsiness
   Ans: C
   Feedback:
   Crackles are the most important sign found in excess fluid volume. The client has the nursing diagnosis of excess fluid volume. The signs of increased fluid volume are adventitious lung sounds, a bounding pulse, and high blood pressure; therefore, a diagnosis of hypotension or feeble pulse would be incorrect. Consciousness may become impaired at later stages when the fluid shift starts. The adventitious lung sounds indicate excess fluid volume.

8. A nurse is interviewing an asthmatic client who has a high respiratory rate and is having difficulty breathing. What nursing diagnosis is the priority in this client's care?
   A) Impaired gas exchange related to the disease condition
   B) Impaired verbal communication related to the breathing problem
   C) Inability to speak due to ineffective airway clearance
   D) Impaired physical mobility related to shortness of breath
   Ans: A
   Feedback:
   The client is most likely experiencing impaired gas exchange as a result of the pathophysiology of asthma. This is a priority over mobility and communication issues, though each may be valid. Inability to speak due to ineffective airway clearance is not a proper nursing diagnosis.

9. A nurse is caring for a client with Parkinson disease. Which of the following nursing diagnoses identified by the nurse should be of the highest priority?
   A) Impaired physical mobility
   B) Risk for memory loss
   C) Ineffective role performance
   D) Risk for injury
   Ans: D
   Feedback:
   Clients with Parkinson disease are at higher risk of injury due to their physical limitations and cognitive deficiencies. Therefore, it becomes important for the nurse to ensure that the environment is safe. The client may also have impaired physical mobility, risk for memory loss, and ineffective role performance, but the highest priority is to prevent injury and ensure the client's safety.

10. A nurse is caring for a client with cancer who is experiencing pain. Which of the following would be the most appropriate assessment of the client's pain?
    A) Pain relief after nursing intervention
    B) Verbal and nonverbal cues of client
    C) The nurse's impression of the client's pain
    D) The client's pain based on a pain rating

    Ans: D

    Feedback:
    The client's assessment of pain, based on a pain rating, is the most appropriate assessment data. The pain is rated on a 1 to 10 scale and nursing actions are then implemented to reduce the pain. The nurse's impression of pain and nonverbal clues are subjective data. Pain relief after nursing intervention is appropriate, but is a part of evaluation.

11. A client is admitted to a psychiatric treatment unit with psychosis. Which of the following is the most appropriate diagnosis for this client?
    A) Dressing/grooming self-care deficit
    B) Disturbed thought process
    C) Risk for confusion
    D) Risk for imbalanced nutrition

    Ans: B

    Feedback:
    A client with psychosis is unable to recognize certain aspects of reality. The client may also experience hallucinations and delusions. Therefore, disturbed thought process is the most appropriate nursing diagnosis for such a client. The client may be at risk for confusion, have difficulty in dressing and grooming, and may not eat properly; however, the priority is the thought process because it is the main reason for all other symptoms.

12. When caring for a client, the nurse identifies and analyzes data to determine nursing diagnoses and collaborative problems. Which of the following is an important role of the nurse when caring for a client with collaborative problems?
    A) Identifying factors that place the client at risk
    B) Resolving health issues through independent nursing measures
    C) Reporting trends that suggest development of complications
    D) Managing an emerging problem with the help of the registered nurse

    Ans: C

    Feedback:
    The nurse should report trends that suggest development of complications to bring to notice the need for collaborative intervention for a client. Collaborative problems are physiologic complications that require both nurse- and physician-prescribed interventions. Identifying factors that place the client at risk, resolving health issues through independent nursing measures, and managing an emerging problem with the help of the registered nurse are nursing roles performed during a nursing diagnosis.

13. A nurse is documenting the plan of care for a client with AIDS. Which of the following is most important when documenting the plan of care?
    A) Avoid disclosing the client's name and address on the plan of care.
    B) Ensure that the client's medical record and nursing interventions are written.
    C) Ask one particular nurse to revise and update the plan of care daily.
    D) Ensure that the client's medical insurance number is stated on the sheet.

    Ans: B

    Feedback:

    The nurse should document the client's medical record and the planned nursing interventions in the plan of care as per the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) requirements. To communicate the plan of care, each nurse assigned to the client refers to the sheet, reviews it, and revises it daily. Stating the medical insurance number of the client on the sheet is of secondary importance as it ensures reimbursement from insurance companies. Nurses make certain that the client is identified on the plan of care.

14. A nurse is evaluating and revising a plan of care for a client with cardiac catheterization. Which of the following actions should the nurse perform before revising a plan of care?
    A) Discuss any lack of progress with the client.
    B) Collect information on expected outcomes.
    C) Identify the client's health-related problems.
    D) Select more appropriate nursing interventions.

    Ans: A

    Feedback:

    The nurse should discuss any lack of progress with the client so that both the client and the nurse can speculate on what activities need to be discontinued, added, or changed. Collecting information is done during the assessment. Identification of the client's health-related problems is done during diagnosis. Nurses select appropriate nursing interventions and document the plan of care in the planning stage of the nursing process, not during evaluation.

15. A nurse provides care in a variety of different settings but is aware of the fact that the nursing process is equally applicable to each of these settings. The nursing process is best defined as:
    A) A group of tasks that cumulatively result in the resolution of health problems
    B) A process by which diseases are cured with the full involvement of the client himself or herself
    C) An organized sequence of steps with the goal of managing a client's health problems
    D) A process for distributing finite nursing time and energy for maximum benefit to clients

    Ans: C

    Feedback:
    The nursing process is an organized sequence of problem-solving steps used to identify and to manage the health problems of clients. It is a way of thinking and not solely a group of tasks and it does not always lead to the curing of disease. The main goal of the nursing process is not the equitable distribution of finite resources, though this is often necessary.

16. A client has been admitted to the acute medical unit of the hospital after an exacerbation of chronic obstructive pulmonary disease. Which of the following aspects of this client's care exemplifies the seven characteristics of the nursing process? Select all that apply.
    A) The nurse ensures that interventions are within the legal scope of nursing.
    B) The nurse weighs treatment options in light of financial costs to the hospital.
    C) The nurse chooses interventions that can be performed without the involvement of other disciplines.
    D) The nurse applies a systematic critical thinking process when providing care to the client.
    E) The nurse seeks to involve the client in the planning and execution of care.

    Ans: A, D, E

    Feedback:
    Characteristics of the nursing process include active client involvement, critical thinking, and respect for legal parameters. The nurse does not choose interventions based on the fact that they exclude members of other health disciplines. Consideration of costs to the institution is not a primary characteristic of the nursing process.

17. A nurse is planning the nursing care of an elderly client who presented to the emergency department in respiratory distress and has been admitted to an inpatient unit. Which of the following nursing diagnoses is correctly worded?
    A) Excess fluid volume related to congestive heart failure as manifested by peripheral and pulmonary edema
    B) Exacerbation of congestive heart failure related to peripheral edema, excess fluid volume, and pulmonary edema
    C) Excess fluid volume and impaired gas exchanged related to congestive heart failure
    D) Congestive heart failure resulting ineffective airway clearance related to pulmonary edema

    Ans: A

    Feedback:

    The diagnosis, "Excess fluid volume related to congestive heart failure as manifested by peripheral and pulmonary edema" contains the three parts of a nursing diagnostic statement: problem, etiology, and signs and symptoms. The diagnostic statement should begin with the nursing diagnosis, not the etiology, and each statement should include only one nursing diagnosis.

18. Following the completion of a comprehensive assessment, a nurse has identified the following nursing diagnosis for a newly admitted client: Risk for aspiration related to dysphagia as evidenced by coughing during feeding. The phrase "related to dysphagia" constitutes what component of a nursing diagnostic statement?
    A) Etiology
    B) Pathophysiology
    C) Root cause
    D) Epidemiology

    Ans: A

    Feedback:

    The phrase "related to" denotes the etiology of a nursing diagnosis.

19. A nursing student has been providing care for a client at the health care facility for the past several days. The client has a number of comorbid health problems and is being simultaneously treated for many of these. The student has chosen to create a concept map because concept mapping allows the student to:
    A) Identify the health problem that is most deserving of the student's care and attention
    B) Identify the relationships between the various aspects of the client's health circumstances
    C) Create a plan that differentiates between nursing diagnoses and medical diagnoses
    D) Evaluate the applicability of nursing diagnoses and the effectiveness of nursing interventions

    Ans: B

    Feedback:
    A concept map is primarily a tool for organizing data and identifying relationships. It is not primarily a tool for prioritizing particular health problems or facilitating evaluation of interventions. Concept mapping can be used to inform care planning, but the two processes are not synonymous.