Chapter 2

Nursing Process and Critical Thinking

Test Item File

TEACHING/LEARNING STRATEGIES

1. Define Evidence Based Practice.

_____

_____

2. Describe the 4 step problem-solving process used with Evidence Based Practice.

a. _____

b. _____

c. _____

d. _____

3. Briefly list and describe the five phases of the nursing process.

a. _____

b. _____

c. _____

d. _____

e. _____

4. Critical thinking has been identified as

a. Purposeful and self-regulating.

b. Making judgements based on initial information.

c. The same process as problem-solving.

d. An element in defining nursing diagnosis.

5. Describe a nurse who is considered a critical thinker.

_____

_____

6. State the two critical thinking skills inherent in the planning step of the nursing process.

a. _____

b. _____

7. Differentiate between nursing diagnosis and medical diagnosis.

_____

_____

8. Match each statement in column B with an appropriate term in column A.

	Column A	**Column B**
_____	a. Preventative interventions	1. Erythema
_____	b. Defining characteristics	2. Altered circulation
_____	c. Physical findings	3. Request pressure- sensitive mattress
_____	d. Therapeutic interventions	4. Condition of skin
_____	e. Pathophysiologic factors	5. Provide pressure ulcer care
_____	f. Precipitating factors	6. Metabolic imbalance
		7. Massage bony prominences
		8. Abrasion
		9. Edema
		10. Sensory deficit

9. Based on nursing diagnosis terminology, which one of the following terms describes an actual or potential health problem?

a. Etiology

b. Defining characteristic

c. Pathophysiology

d. Diagnostic category

10. Select an example of nursing diagnosis from the following terms:

a. Potential pneumonia

b. Ineffective breathing patterns

c. Right-sided CVA

d. Metabolic imbalance

11. Define the PES format for organizing nursing diagnoses.

P

_____

E

_____

S

_____

12. The following steps of the nursing process are listed in proper sequence.

1. Assessment
2. Planning
3. Nursing diagnosis
4. Implementation
5. Evaluation

a. True

b. False

13. Which of the following is the *best* definition of nursing diagnosis?

a. Nursing diagnosis refers to a health problem or condition that nurses are legally licensed to treat.

b. Nursing diagnosis includes etiology and relates directly to the defining characteristics.

c. Nursing diagnosis is a clinical judgment about individual, family, or community responses to actual or potential health problems/life processes.

d. Nursing diagnosis is derived from the assessment phase of the nursing process.

14. The nurse gathers assessment data from the following sources:

1. Client's history
2. Client's physical assessment
3. Laboratory results
4. Knowledge of disease process

a. 1 and 2 only

b. 2 and 3 only

c. 2, 3, 4

d. All of the above

15. The implementation phase of the nursing process is best

described as the

a. Organizational aspects of the nursing process.

b. Action component of the nursing process.

c. Foundation for the therapeutic plan of care.

d. Problem-solving foundation of client care.

Clinical Situation: Questions 16 and 17 relate to the following situation:

John Jones, a 26-year-old college student, was involved in a motor vehicle accident and sustained a head injury. You provide nursing care for him on the surgical nursing unit.

16. The most appropriate goal included in John's care plan should be to monitor

1. Changes in level of consciousness.
2. Signs and symptoms.
3. Intake and output.
4. Skin color and integrity.

The phase of the nursing process illustrated in this question is

a. Assessment

b. Planning

c. Implementation

d. Evaluation

17. When you are caring for John, the most important nursing action is to

1. Use the Glascow coma scale every 15 minutes.
2. Select fluids John likes to increase his fluid intake.
3. Position John to increase respiratory effectiveness.
4. Turn John every 2 hours to prevent pressure ulcers.

Which phase of the nursing process is illustrated in this question?

a. Assessment

b. Planning

c. Implementation

d. Evaluation

18. When a client is in shock, the most important nursing

observation is a (an)

1. Increase in pulse rate.
2. Decrease in respirations.
3. Increase in blood pressure.
4. Decrease in blood pressure.

Which phase of the nursing process is illustrated in this question?

a. Assessment

b. Planning

c. Implementation

d. Evaluation

19. The LVN/LPN role in implementing the nursing process is

a. The same role as the RN.

b. Ensuring all health team members implement the nursing process in client care.

c. Implementing nursing care tasks using the nursing process.

d. Limited to following directions of the RN.

ANSWERS

Content Examination

1. It is the application of the best available empirical evidence that applies recent research findings to clinical practice in order to aid clinical decision-making.

2. a. Identify issues or problems based on analysis of current nursing knowledge and practice.

b. Identify relevant research through literature search.

c. Evaluate research by using criteria that has scientific merit.

d.Select interventions that have by using the most valid evidence.

[Ed: Please read d above for sense.]

3. a. Assessment—establishing a data base.

b. Analysis—comprehending and interpreting collected data obtained during the assessment phase.

c. Planning—identifying nursing actions to achieve

goals or desired outcomes.

d. Implementation (intervention phase)—setting priorities of nursing care.

e. Evaluation—reviewing outcomes of nursing actions to determine the extent to which goal achievement is attained.

4. a

5. A critical thinking nurse uses logic, creativity, good communication skills and is flexible and competent in the delivery of client care.

6. a. Listing the client problems and determining whether there are relationships between the problems.

b. Assigning the problems by highest priority.

7. The nurse is qualified and prepared to intervene and treat any condition that is stated as a nursing diagnosis. Nursing diagnosis is a statement of a client's biologic, social, or personal system. A medical diagnosis is not able to be treated by nursing intervention without a physician's order to do so.

8. a. 3, 7

b. 1, 8

c. 4

d. 5

e. 2, 6

f. 9, 10

9. d

10. b

11. P—Statement of the problem

E—Etiology or probable cause of the health problem

S—Relevant signs and symptoms

12. b. The correct sequence is 1, 3, 2, 4, 5.

13. c

14. d

15. b

16. b

17. c

18. a

19. c