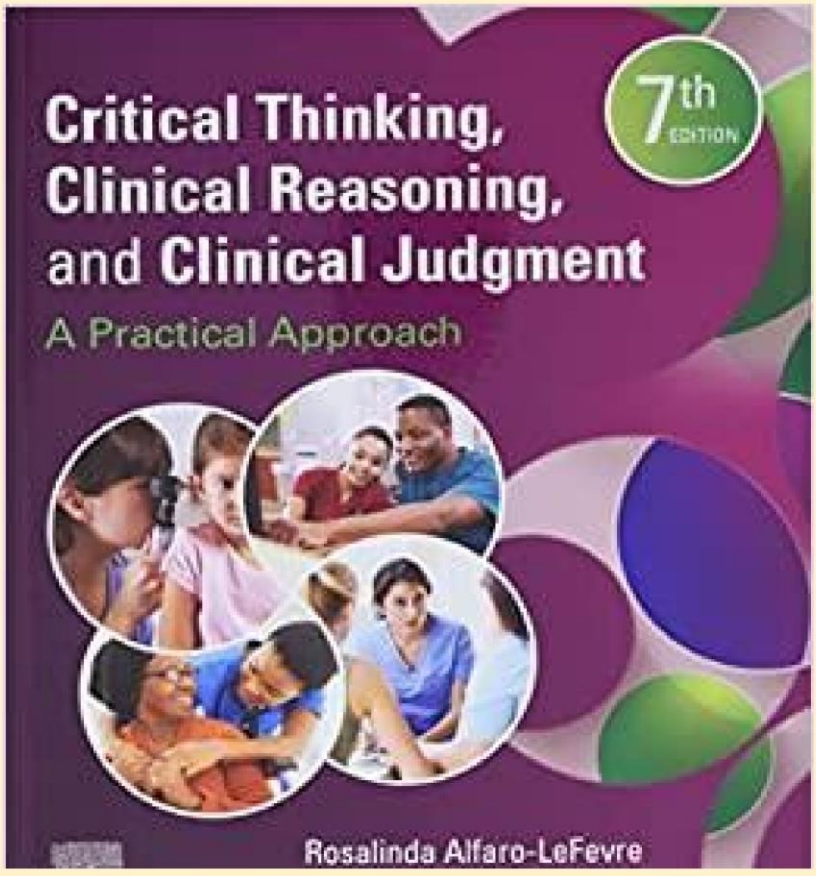
TEST BANK

Critical Thinking Clinical Reasoning and Clinical Judgment:

A Practical Approach

7th Edition

by Rosalinda Alfaro-LeFevre



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Chapter 1. What are Critical Thinking, Clinical Reasoning, and Clinical Judgment?

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Multiple Choice
Identify the choice that best completes the statement or answers the question.

1. Which of the following characteristics do the various definitions of critical thinking have in common? Critical thinking
1) Requires reasoned thought
2) Asks the questions why? or how?
3) Is a hierarchical process
4) Demands specialized thinking skills

ANS: 1
The definitions listed in the text as well as definitions in Box 2-1 state that critical thinking requires reasoning or reasoned thinking. Critical thinking is neither linear nor hierarchical. That means that the steps involved in critical thinking are not necessarily sequential, where mastery of one step is necessary to proceed to the next. Critical thinking is a purposeful, dynamic, analytic process that contributes to reasoned decisions and sound contextual judgments.

PTS:1DIF:Moderate high-level question, answer not stated verbatim
KEY: Nursing process: N/A | Client need: SECE | Cognitive level: Analysis

2. A few nurses on a unit have proposed to the nurse manager that the process for documenting care on the unit be changed. They have described a completely new system. Why is it important for the nurse manager to have a critical attitude? It will help the manager to
1) Consider all the possible advantages and disadvantages
2) Maintain an open mind about the proposed change
3) Apply the nursing process to the situation
4) Make a decision based on past experience with documentation

ANS: 2

A critical attitude enables the person to think fairly and keep an open mind.
PTS:1DIF:ModerateKEY: Nursing process: N/A | Client need: SECE | Cognitive level: Comprehension

3. The nurse has just been assigned to the clinical care of a newly admitted patient. To know how to best care for the patient, the nurse uses the nursing process. Which step would the nurse probably do first? 1) Assessment
2) Diagnosis
3) Plan outcomes
4) Plan interventions

ANS: 1
Assessment is the first step of the nursing process. The nursing diagnosis is derived from the data gathered during assessment, outcomes from the diagnosis, and interventions from the outcomes.

PTS:1DIF:Easy
KEY: Nursing process: Assessment | Client need: SECE | Cognitive level: Application

4. Which of the following is an example of theoretical knowledge?
1) A nurse uses sterile technique to catheterize a patient.
2) Room air has an oxygen concentration of 21%.
3) Glucose monitoring machines should be calibrated daily. 4) An irregular apical heart rate should be compared with the radial pulse.

ANS: 2
Theoretical knowledge consists of research findings, facts, principles, and theories. The oxygen concentration of room air is a scientific fact. The others are examples of practical knowledgewhat to do and how to do it.

PTS:1DIF:Moderate; high-level question, answer not stated verbatim
KEY: Nursing process: N/A | Client need: SECE | Cognitive level: Application

5. Which of the following is an example of practical knowledge? (Assume all are true.)
1) The tricuspid valve is between the right atrium and ventricle of the heart.
2) The pancreas does not produce enough insulin in type 1 diabetes.
3) When assessing the abdomen, you should auscultate before palpating.
4) Research shows pain medication given intravenously acts faster than by other routes.

ANS: 3

Practical knowledge is knowing what to do and how to do it, such as how to do an assessment. The others are examples of theoretical knowledge, anatomy (tricuspid valve), fact (type 1 diabetes), and research (IV pain medication).
PTS:1DIF:Moderate high-level question, answer not stated verbatim
KEY: Nursing process: N/A | Client need: SECE | Cognitive level: Application

6. Which of the following is an example of self-knowledge? The nurse thinks, I know that I
1) Should take the clients apical pulse for 1 minute before giving digoxin
2) Should follow the clients wishes even though it is not what I would want
3) Have religious beliefs that may make it difficult to take care of some clients
4) Need to honor the clients request not to discuss his health concern with the family ANS: 3
Self-knowledge is being aware of your religious and cultural beliefs and values. Taking the pulse is an example of practical knowledge. Following client wishes and honoring client requests are examples of ethical knowledge.

PTS:1DIFifficult; high-level question, answer not stated verbatim | V1, high-level question, answer not stated verbatim
KEY: Nursing process: N/A | Client need: SECE | Cognitive level: Application

7. Which of the following is the most important reason for nurses to be critical thinkers?
1) Nurses need to follow policies and procedures.
2) Nurses work with other healthcare team members.
3) Nurses care for clients who have multiple health problems.
4) Nurses have to be flexible and work variable schedules.
ANS: 3
Critical thinking is essential for client care, particularly when the care is complex, involving numerous health issues. Following policies and procedures does not necessarily require critical thinking, and working with others or being flexible and working different schedules do not necessarily require critical thinking.
PTS:1DIF:Moderate; high-level question, answer not stated verbatim
KEY: Nursing process: N/A | Client need: SECE | Cognitive level: Application

8. The nurse administering pain medication every 4 hours is an example of which aspect of patient care? 1) Assessment data
2) Nursing diagnosis
3) Patient outcome
4) Nursing intervention

ANS: 4
Interventions are activities that will help the patient achieve a goal, such as administering pain-relieving medication. An example of assessment data might be, Patient reports pain is a 5 on a 1 to 10 scale. The nursing diagnosis would be Pain. The nurse might define the patient outcome in this scenario as, The patient will state the level of pain is less than 4.
PTS:1DIF:Moderate; high-level question, answer not stated verbatim
KEY: Nursing process: Interventions | Client need: SECE | Cognitive level: Application

9. How does nursing diagnosis differ from a medical diagnosis? A nursing diagnosis is
1) Terminology for the clients disease or injury
2) A part of the clients medical diagnosis
3) The clients presenting signs and symptoms
4) A clients response to a health problem

ANS: 4
A nursing diagnosis is the clients response to actual or potential health problems.
PTS:1DIF:ModerateKEY: Nursing process: Diagnosis | Client need: SECE | Cognitive level: Recall

10. Which statement about the nursing process is correct?
1) It was developed from the ANA Standards of Care.
2) It is a problem-solving method to guide nursing activities.
3) It is a linear process with separate, distinct steps.
4) It involves care that only the nurse will give.

ANS: 2
The nursing process is a problem-solving process that guides nursing actions. The ANA organizes its Standards of Care around the nursing process, but the process was not developed from the standards. The nursing process is cyclical and involves care the nurses give or delegate to other members of the healthcare team.
PTS:1DIF:EasyKEY:Nursing process: N/A | Client need: SECE | Cognitive level: Recall

11. What do critical thinking and the nursing process have in common?
1) They are both linear processes used to guide ones thinking.
2) They are both thinking methods used to solve a problem.
3) They both use specific steps to solve a problem.
4) They both use similar steps to solve a problem.

ANS: 2
Critical thinking and the nursing process are ways of thinking that can be used in problem solving (although critical thinking can be used beyond problem-solving applications). Neither method of thinking is linear. The nursing process has specific steps; critical thinking does not. PTS:1DIFifficultKEY: Nursing process: N/A | Client need: SECE | Cognitive level: Analysis

12. A nurse admits a patient to the unit after completing a comprehensive interview and physical examination. To develop a nursing diagnosis, the nurse must now
1) Analyze the assessment data
2) Consult standards of care
3) Decide which interventions are appropriate
4) Ask the clients perceptions of her health problem

ANS: 1
The basis of the nursing diagnosis is the assessment data. Standards of care are referred to when establishing nursing interventions. Customizing interventions personalizes nursing care. Asking the patient about her perceptions is a method to validate whether the nurse has chosen the correct nursing diagnosis and would probably have been done during the comprehensive assessment.

PTS: 1 DIF: Moderate KEY: Nursing process: Diagnosis | Client need: SECE | Cognitive level: Application
13. The nurse developed a care plan for a patient to help prevent Impaired Skin Integrity. She has made sure that nursing assistive personnel change the patients position every 2 hours. In the evaluation phase of the nursing process, which of the following would the nurse do first?
1) Determine whether she has gathered enough assessment data.
2) Judge whether the interventions achieved the stated outcomes.
3) Follow up to verify that care for the nursing diagnosis was given.
4) Decide whether the nursing diagnosis was accurate for the patients condition.

ANS: 2
The evaluation phase judges whether the interventions were effective in achieving the desired outcomes and helped to alleviate the nursing diagnosis. This must be done before examining the nursing process steps and revising the care plan. PTS:1DIF:Moderate

14. In caring for a patient with comorbidities, the nurse draws upon her knowledge of diabetes and skin integrity. In a spirit of inquiry, she looks up the latest guidelines for providing skin care and includes them in the plan of care. The nurse provides skin care according to the procedural guidelines and begins regular monitoring to evaluate the effectiveness of the interventions. These activities are best described as
1) Full-spectrum nursing

2) Critical thinking
3) Nursing process
4) Nursing knowledge

ANS: 1
Full-spectrum nursing (1) involves the use of critical thinking, nursing knowledge, nursing process, and patient situation. Although the other answers are important for planning and delivering nursing care, they do not reflect all the nurse has demonstrated.
PTS:1DIFifficultKEY: Nursing process: N/A | Client need: PHSI | Cognitive level: Analysis

15. The nurse is preparing to admit a patient from the emergency department. The transferring nurse reports that the patient is obese. The nurse has been overweight at one time and works very hard now to maintain a healthy weight. She immediately thinks, I know I tend to feel negatively about obese people; I figure if I can stop eating, they should be able to. I must remember how very difficult that is and be very careful not to be judgmental of this patient. This best illustrates
1) Theoretical knowledge
2) Self-knowledge
3) Using reliable resources
4) Use of the nursing process

ANS: 2
Self-knowledge is self-understandingawareness of ones beliefs, values, biases, and so on. That best describes the nurses awareness that her bias can affect her patient care. Theoretical knowledge consists of information, facts, principles, and theories in nursing and related disciplines; it consists of research findings and rationally constructed explanations of phenomena. Using reliable resources is a critical thinking skill. The nursing process is a problem-solving process consisting of the steps of assessing, diagnosing, planning outcomes, planning interventions, implementing, and evaluating. The nurse has not yet met this patient, so she could not have begun the nursing process.

PTS:1DIFifficult KEY: Nursing process: N/A | Client need: PHSI | Cognitive level: Comprehension

Multiple Response
Identify one or more choices that best complete the statement or answer the question.

1. Which aspects of healthcare are affected by a clients culture? Select all that apply.
1) How the clients views healthcare
2) How the client views illness
3) How the client will pay for healthcare services
4) The types of treatments the client will accept 5) When the client will seek healthcare services

6) The environment where the healthcare services are provided
7) The ease of accessibility of healthcare services

ANS: 1, 2, 4, 5
Culture affects clients view of health and healthcare. It influences how they will define illness, when they will seek healthcare, and what treatments are acceptable in their culture. How services are paid for is related to economic status. Regardless of culture, anyone can be affected by previous healthcare experiences, the environment in which healthcare is provided, and accessibility of services.
PTS:1DIF:Moderate
KEY:Nursing process: N/A | Client need: SECE | Cognitive level: Recall

Matching
Match the critical thinking attitude on the left with the appropriate example on the right.
1) Reading the instruction manual of a new glucose monitoring machine
2) Asking for help with a procedure because you have not done it before
3) Obtaining the latest research about a new diagnostic procedure even though the articles are difficult to find
4) Questioning the reason for a new staffing policy
5) Realizing your feelings about alternative medicine may interfere with the care you give a patient
6) Asking a patients feelings about his cancer diagnosis
7) Questioning your feelings when a patients family requests withholding nutrition for a terminally ill client

1. Independent thinking
2. Intellectual curiosity
3. Intellectual humility
4. Intellectual empathy
5. Intellectual courage
6. Intellectual perseverance

1. ANS: 4 PTS: 1 DIF: Difficult
KEY: Nursing process: N/A | Client need: SECE | Cognitive level: Application
2. ANS: 1 PTS: 1 DIF: Difficult
KEY: Nursing process: N/A | Client need: SECE | Cognitive level: Application
3. ANS: 2 PTS: 1 DIF: Difficult
KEY: Nursing process: N/A | Client need: SECE | Cognitive level: Application
4. ANS: 6 PTS: 1 DIF: Difficult
KEY: Nursing process: N/A | Client need: SECE | Cognitive level: Application
5. ANS: 7 PTS: 1 DIF: Difficult

KEY: Nursing process: N/A | Client need: SECE | Cognitive level: Application
6. ANS: 3 PTS: 1 DIF: Difficult
KEY: Nursing process: N/A | Client need: SECE | Cognitive level: Application

Match the terms from the critical thinking model in your text with the correct example.
1) I wonder if my values about quality of life have affected my thinking.
2) What should I have done differently?
3) I need to talk with the client to make sure the family gave me the correct information.
4) I have been through a situation like this before.
5) There are several interventions that would work in this situation.
6) I need to follow the steps in the procedure manual.
7. Contextual awareness
8. Inquiry
9. Considering alternatives
10. Analyzing assumptions
11. Reflecting skeptically
7.ANS:4PTS:1DIFifficult
8.ANS:3PTS:1DIFifficult
9.ANS:5PTS:1DIFifficult
10.ANS:1PTS:1DIFifficult
11.ANS:2PTS:1DIFifficult

Chapter 2. Becoming a Critical Thinker MULTIPLE CHOICE

1. The nurse who uses the nursing process will:

a.	help reduce the obvious signs of discomfort.
b.	help the patient adhere to the physicians treatment protocol.
c.	approach the patients disorder in a step-by-step method.
d.	make all significant nursing care decisions involving patient care.

ANS: C
The nursing process is a collaborative process used throughout the patients stay. It is an organized method for identifying and meeting patient needs in a step-by-step manner.

2. A nurse will arrive at a nursing diagnosis through the nursing process step of:

a.	planning.

b.	evaluation.
c.	research.
d.	assessment.

ANS: D
As a result of the nursing assessment, a nursing diagnosis is established.

3. In the collaborative process of delivering care based on the nursing process, the responsibility of the LPN/LVN is to:

a.	collect data of health status.
b.	select a nursing diagnosis.
c.	organize data to help the RN evaluate patient progress.
d.	prioritize nursing diagnoses for more effective care.

ANS: A
The LPN/LVN collects data of the patients health status to assist the RN in selecting a nursing diagnosis.

4. The participants of the planning stage of the nursing process during which the health goals are defined include the:

a.	RN.
b.	health team led by the RN.
c.	health team, the patient, and the patients family.
d.	health team as directed by the physician.

ANS: C
The planning stage during which the health goals are defined are best shared by the entire health team, the patient, and the patients family for the optimum outcome.

5. When a resident in the nursing home complains of constipation, the nurse performs a digital rectal examination and finds a hard fecal mass. This is an example of:

a.	implementation.

b.	nursing diagnosis.
c.	assessment.
d.	evaluation.

ANS: C The examination to confirm and affirm the complaint of constipation is an assessment.

6. The nurse completing morning assessments on a patient who is sitting up in bed is told by the patient, Im having trouble breathingI cant seem to get enough air. The best nursing response is to:

a.	notify the doctor as soon as he or she comes in later in the morning.
b.	finish the vital signs for the assigned patients, and then notify the charge nurse.
c.	reassure the patient, if his blood pressure and pulse are normal.
d.	notify the charge nurse immediately of the patients statement.

ANS: B
The nurse should finish the assessment in order to confirm the complaint and inform the charge nurse.

7. The order in which the nursing process is approached is:

a.	planning, assessment, implementation, nursing diagnosis, evaluation.
b.	nursing diagnosis, evaluation, assessment, implementation, planning.
c.	assessment, nursing diagnosis, planning, implementation, evaluation.
d.	evaluation, nursing diagnosis, planning, implementation, assessment .

ANS: C

The order of assessment, nursing diagnosis, planning, implementation, and evaluation sets up a basis for an organized approach to nursing care.

8. Once the nursing plan has been initiated, the nursing care plan will:

a.	stay in place until all nursing goals have been met.
b.	change as the patients condition changes.
c.	remain on the patient record to show progress.
d.	be given to the patient for final approval.

ANS: B
The nursing care plan is always a work in progress and will change as the patient condition changes.

9. When a patient states, I cant walk very well, the first problem-solving step would be to:

a.	consider alternatives such as a wheelchair or walker.
b.	find out what the problem is, such as weakness or poor balance.
c.	choose the alternative with the best chance of success.
d.	consider the outcomes of the choices, such as danger of falling with a walker.

ANS: B
Defining the problem clearly assists in the interventions to reduce the problem.

10. A student nurse can begin to develop critical thinking skills by means of:

a.	working with a more experienced nurse.
b.	questioning every statement made by instructors to be sure of its correctness.
c.	memorizing class notes for tests and studying all night for big tests.
d.	listening attentively and focusing on the speakers words and

	meaning.

ANS: D
Critical thinking involves foundation skills such as effective reading and writing and attentive listening.

11. When a nurse prioritizes the patient care, consideration is given to:

a.	completing assessments before mid-shift.
b.	considering situations that may result in an alteration of health.
c.	assuming all health care activities for a group of patients.
d.	identifying who can assist with the aspect of care.

ANS: B
Priority setting includes addressing health-endangering situations and physiological needs first.

12. When the nurse checks to see whether a patient has had relief 45 minutes after administering pain medication, the nurse is performing a(n):

a.	nursing diagnosis.
b.	implementation.
c.	assessment.
d.	evaluation.

ANS: D
Evaluation is the step in which the nurse determines whether the plan and interventions are effective or need to be modified.

MSC: NCLEX: Physiological Integrity: basic care and comfort
13. The activity that is implementation in nursing care is:

a.	checking the assigned patients blood pressure, pulse, and respiration.
b.	changing the patients surgical dressing.
c.	asking the patient to demonstrate how to give himself medication after teaching him.

d.	discussing the patient with other team members to establish a care plan.

ANS: B

Changing a dressing that is soiled is a nursing intervention performed to meet a patients need. Checking vital signs is assessment. Demonstrating medication administration is evaluation. Discussing the patient with other team members is planning.

14. Constant nursing assessments and evaluations of the patient will most likely result in:

a.	the nursing care plan changing to reflect appropriate priorities.
b.	small changes in the patient condition being overlooked.
c.	cluttered and confusing documentation.
d.	impeded problem solving.

ANS: A

Continued assessment and evaluation are necessary; reprioritizing and reorganizing activities occur in response to the patients changing condition.

15. The effect of using a scientific problem-solving approach in nursing care will cause decision making to be:

a.	slowed down considerably by the multiple steps.
b.	rigid and non-patient oriented.
c.	improved nursing care outcomes.
d.	unrelated to the nursing process.

ANS: C

A scientific problem-solving approach is most likely to result in positive patient outcomes.

16. An emergency room nurse will give first priority to the patient with the most critical need, which is the patient who:

a.	is bleeding from a chin laceration.
b.	complains of a productive cough.

c.	has a fever of 102 F.
d.	complains of severe chest pain.

ANS: D

Because the chance of a bad outcome is highest for the patient with chest pain, it is most appropriate to assess this patient first.

COMPLETION

17. When the nurse constructs a nursing approach after careful judgment and sound reasoning, the nurse has used a system of___.

ANS:
critical thinking
Critical thinking is a concept in which decisions are made using solidly based judgments and reasoning.

18. Critical thinking is considered to be the keystone and foundation of the development of _____.

ANS:
clinical judgment
Clinical judgment is built on the ability to think critically.

19. The tasks of synthesizing data and linking nursing interventions with patient health problems are enhanced by the process of_____.

ANS:
concept mapping
Concept mapping is a method to promote critical thinking by visualizing relationships between patient health problems and effective intervention.

MULTIPLE RESPONSE

20. Activities considered to be aspects of the implementation step of the nursing process are: (*Select all that apply.*)

a.	documentation of care given.