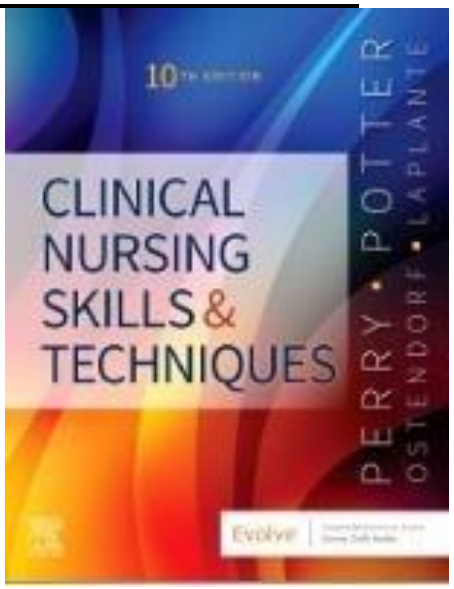
Test Bank For Clinical Nursing Skills and Techniques 10th Edition by Anne Griffin Perry, Patricia A. Potter Chapter 1-43 Complete Guide

Complete Test Bank For Clinical Nursing Skills and Techniques 10th Edition by Anne



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Chapter 01: Using Evidence in Nursing Practice Perry et al.: Clinical Nursing Skills & Techniques, 10th Edition

MULTIPLE CHOICE

1. Evidence-based practice is a problem-solving approach to making decisions about patient care that is grounded in:
   a. the latest information found in textbooks.
   b. systematically conducted research studies.
   c. tradition in clinical practice.
   d. quality improvement and risk-management data.

ANS: B
The best evidence comes from well-designed, systematically conducted research studies described in scientific journals. Portions of a textbook often become outdated by the time it is published. Many health care settings do not have a process to help staff adopt new evidence in practice, and nurses in practice settings lack easy access to risk-management data, relying instead on tradition or convenience. Some sources of evidence do not originate from research. These include quality improvement and risk-management data; infection control data; retrospective or concurrent chart reviews; and clinicians‘ expertise. Although non–research-based evidence is often very valuable, it is important that you learn to rely more on research-based evidence.

DIF: CognitiveLevel: Comprehension OBJ: Discuss the benefits of evidence-based practice. TOP: Evidence-Based Practice KEY: Nursing Process Step: Assessment MSC: NCLEX: Safe and Effective Care Environment (management of care)

2. When evidence-based practice is used, patient care will be:
   a. standardized for all.
   b. unhampered by patient culture.
   c. variable according to the situation.
   d. safe from the hazards of critical thinking.

ANS: C
Using your clinical expertise and considering patients‘ cultures, values, and preferences ensures that you will apply available evidence in practice ethically and appropriately. Even when you use the best evidence available, application and outcomes will differ; as a nurse, you will develop critical thinking skills to determine whether evidence is relevant and appropriate.

DIF: CognitiveLevel: Application OBJ: Discuss the benefits of evidence-based practice.
TOP: Evidence-Based Practice KEY: Nursing Process Step: Assessment

MSC: NCLEX: Safe and Effective Care Environment (management of care)

3. When a PICOT question is developed, the letter that corresponds with the usual standard of care is:

a. P.

b. I.

c.

c. CHOICE BLANK

d. O.

ANS: C

C = Comparison of interest. What standard of care or current intervention do you usually use now in practice?

P = Patient population of interest. Identify your patient by age, gender, ethnicity, disease, or health problem.

I = Intervention of interest. What intervention (e.g., treatment, diagnostic test, and prognostic factor) do you think is worthwhile to use in practice?

O = Outcome. What result (e.g., change in patient‘s behavior, physical finding, and change in patient‘s perception) do you wish to achieve or observe as the result of an intervention?

DIF: CognitiveLevel: Knowledge OBJ: Develop a PICO question.
TOP: PICO KEY: Nursing Process Step: Implementation
MSC: NCLEX: Safe and Effective Care Environment (management of care)

4. A well-developed PICOT question helps the nurse:
   a. search for evidence.
   b. include all five elements of the sequence.
   c. find as many articles as possible in a literature search.
   d. accept standard clinical routines.

ANS: A

The more focused a question that you ask is, the easier it is to search for evidence in the scientific literature. A well-designed PICOT question does not have to include all five elements, nor does it have to follow the PICOT sequence. Do not be satisfied with clinical routines. Always question and use critical thinking to consider better ways to provide patient care.

DIF: CognitiveLevel: Analysis OBJ: Describe the six steps of evidence-based practice.
TOP: Evidence-Based Practice KEY: Nursing Process Step: Implementation MSC: NCLEX: Safe and Effective Care Environment (management of care)

5. The nurse is not sure that the procedure the patient requires is the best possible for the situation. Utilizing which of the following resources would be the quickest way to review research on the topic?

a. CINAHL
b. PubMed
c. MEDLINE
d. The Cochrane Database

ANS: D
The Cochrane Community Database of Systematic Reviews is a valuable source of synthesized evidence (i.e., pre-appraised evidence). The Cochrane Database includes the full text of regularly updated systematic reviews and protocols for reviews currently happening. MEDLINE, CINAHL, and PubMed are among the most comprehensive databases and represent the scientific knowledge base of health care.

DIF: CognitiveLevel: Synthesis OBJ: Describe the six steps of evidence-based practice.
TOP: Evidence-Based Practice KEY: Nursing Process Step: Implementation
MSC: NCLEX: Safe and Effective Care Environment (management of care)

6. The nurse is getting ready to develop a plan of care for a patient who has a specific need. The best source for developing this plan of care would probably be: a. The Cochrane Database.
   b. MEDLINE.
   c. NGC.
   d. CINAHL.

ANS: C
The National Guidelines Clearinghouse (NGC) is a database supported by the Agency for Healthcare Research and Quality (AHRQ). It contains clinical guidelines—systematically developed statements about a plan of care for a specific set of clinical circumstances involving a specific patient population. The NGC is a valuable source when you want to develop a plan of care for a patient. The Cochrane Community Database of Systematic Reviews, MEDLINE, and CINAHL are all valuable sources of synthesized evidence (i.e., pre-appraised evidence).

DIF: CognitiveLevel: Synthesis OBJ: Describe the six steps of evidence-based practice.
TOP: Evidence-Based Practice KEY: Nursing Process Step: Implementation
MSC: NCLEX: Safe and Effective Care Environment (management of care)

7. The nurse has done a literature search and found 25 possible articles on the topic that she is studying. To determine which of those 25 best fit her inquiry, the nurse first should look at: a. the abstracts.
   b. the literature reviews.
   c. the ―Methods‖ sections.
   d. the narrative sections.

ANS: A

An abstract is a brief summary of an article that quickly tells you whether the article is research based or clinically based. An abstract summarizes the purpose of the study or clinical query, the major themes or findings, and the implications for nursing practice. The literature review usually gives you a good idea of how past research led to the researcher‘s question. The ―Methods‖ or ―Design‖ section explains how a research study is organized and conducted to answer the research question or to test the hypothesis. The narrative of a manuscript differs according to the type of evidence-based article—clinical or research.

DIF: CognitiveLevel: Application
OBJ: Discuss elements to review when critiquing the scientific literature.
TOP: Randomized Controlled Trials KEY: Nursing Process Step: Implementation MSC: NCLEX: Safe and Effective Care Environment (management of care)

8. The nurse wants to determine the effects of cardiac rehabilitation program attendance on the level of postmyocardial depression for individuals who have had a myocardial infarction. The type of study that would best capture this information would be a: a. randomized controlled trial.
b. qualitative study.
c. case control study.
d. descriptive study.

ANS: B

Qualitative studies examine individuals‘ experiences with health problems and the contexts in which these experiences occur. A qualitative study is best in this case of an individual nurse who wants to examine the effectiveness of a local program. Randomized controlled trials involve close monitoring of control groups and treatment groups to test an intervention against the usual standard of care. Case control studies typically compare one group of subjects with a certain condition against another group without the condition, to look for associations between the condition and predictor variables. Descriptive studies focus mainly on describing the concepts under study.

DIF: CognitiveLevel: Synthesis
OBJ: Discuss ways to apply evidence in nursing practice.
TOP: Randomized Controlled Trials KEY: Nursing Process Step: Implementation MSC: NCLEX: Safe and Effective Care Environment (management of care)

9. Six months after an early mobility protocol was implemented, the incidence of deep vein thrombosis in patients was decreased. This is an example of what stage in the EBP process?
a. Asking a clinical question
b. Applying the evidence
c. Evaluating the practice decision
d. Communicating your results

ANS: C

After implementing a practice change, your next step is to evaluate the effect. You do this by analyzing the outcomes data that you collected during the pilot project. Outcomes evaluation tells you whether your practice change improved conditions, created no change, or worsened conditions.

DIF: CognitiveLevel: Application
OBJ: Discuss ways to apply evidence in nursing practice. TOP: Evidence-Based Practice
KEY: Nursing Process Step: Evaluation
MSC: NCLEX: Safe and Effective Care Environment (safety and infection control)

MULTIPLE RESPONSE

1. To use evidence-based practice appropriately, you need to collect the most relevant and best evidence and to critically appraise the evidence you gather. This process also includes: (*Select all that apply.*)
   a. asking a clinical question.
   b. applying the evidence.
   c. evaluating the practice decision.
   d. communicating your results.

ANS: A, B, C, D
EBP comprises six steps (Melnyk and Fineout-Overholt, 2010):
1. Ask a clinical question.
2. Search for the most relevant and best evidence that applies to the question.
3. Critically appraise the evidence you gather.
4. Apply or integrate evidence along with one‘s clinical expertise and patient preferences and values in making a practice decision or change.
5. Evaluate the practice decision or change.
6. Communicate your results.

DIF: CognitiveLevel: Analysis OBJ: Describe the six steps of evidence-based practice.
TOP: Evidence-Based Practice KEY: Nursing Process Step: Implementation MSC: NCLEX: Safe and Effective Care Environment (management of care)

2. In a clinical environment, evidence-based practice has the ability to improve: (*Select all that apply.*)
   a. the quality of care provided.
   b. patient outcomes.
   c. clinician satisfaction.
   d. patients‘ perceptions.

ANS: A, B, C, D
EBP has the potential to improve the quality of care that nurses provide, patient outcomes, and clinicians‘ satisfaction with their practice. Your patients expect nursing professionals to be

informed and to use the safest and most appropriate interventions. Use of evidence enhances nursing, thereby improving patients‘ perceptions of excellent nursing care.

DIF: CognitiveLevel: Application OBJ: Discuss the benefits of evidence-based practice.
TOP: Randomized Controlled Trials KEY: Nursing Process Step: Implementation
MSC: NCLEX: Safe and Effective Care Environment (management of care)

3. During the application stage of evidence-based practice change, it is important to consider: (*Select all that apply.*) a. cost.
   b. the need for new equipment.
   c. management support.
   d. adequate staff.

ANS: A, B, C, D
One important step for an individual or an interdisciplinary EBP committee is to consider the resources needed for a practice change project. Are added costs or new equipment involved with a practice change? Do you have adequate staff to make the practice change work as planned? Do management and medical staff support you in the change? If the barriers to practice change are excessive, adopting a practice change can be difficult, if not impossible.

DIF: CognitiveLevel: Application OBJ: Describe the six steps of evidence-based practice.
TOP: Evidence-Based Practice KEY: Nursing Process Step: Implementation MSC: NCLEX: Safe and Effective Care Environment (management of care)

COMPLETION

1. _____ is a guide for making accurate, timely, and appropriate clinical decisions.

ANS:
Evidence-based practice

Evidence-based practice is a guide for making accurate, timely, and appropriate clinical decisions.

DIF: CognitiveLevel: Knowledge OBJ: Define the key terms listed.
TOP: Evidence-Based Practice KEY: Nursing Process Step: Assessment MSC: NCLEX: Safe and Effective Care Environment (management of care)

2. Evidence-based practice requires good _____.

ANS:
nursing judgment

Evidence-based practice requires good nursing judgment; it does not consist of finding research evidence and blindly applying it.

DIF: CognitiveLevel: Comprehension OBJ: Discuss the benefits of evidence-based practice. TOP: Evidence-Based Practice KEY: Nursing Process Step: Assessment MSC: NCLEX: Safe and Effective Care Environment (management of care)

3. While caring for patients, the professional nurse must question _____.

ANS:
what does not make sense

Always think about your practice when caring for patients. Question what does not make sense to you, and question what you think needs clarification.

DIF: CognitiveLevel: Analysis OBJ: Describe the six steps of evidence-based practice. TOP: Evidence-Based Practice KEY: Nursing Process Step: Implementation MSC: NCLEX: Safe and Effective Care Environment (management of care)

4. A systematic review explains whether the evidence that you are searching for exists and whether there is good cause to change practice. In _____, all entries include information on systematic reviews.

ANS:
The Cochrane Database

A systematic review explains whether the evidence that you are searching for exists and whether there is good cause to change practice. In The Cochrane Database, all entries include information on systematic reviews.

DIF: CognitiveLevel: Analysis OBJ: Describe the six steps of evidence-based practice. TOP: Evidence-Based Practice KEY: Nursing Process Step: Implementation MSC: NCLEX: Safe and Effective Care Environment (management of care)

5. The researcher explains how to apply findings in a practice setting for the types of subjects studied in the _____ section of a research article.

ANS:
―Clinical Implications‖
Clinical Implications

A research article includes a section that explains whether the findings from the study have ―clinical implications.‖ The researcher explains how to apply findings in a practice setting for the types of subjects studied.

DIF: CognitiveLevel: Application
OBJ: Discuss elements to review when critiquing the scientific literature.
TOP: Randomized Controlled Trials KEY: Nursing Process Step: Implementation MSC: NCLEX: Safe and Effective Care Environment (management of care)

6. _____ is the extent to which a study‘s findings are valid, reliable, and relevant to your patient population of interest.

ANS:
Scientific rigor

Scientific rigor is the extent to which a study‘s findings are valid, reliable, and relevant to your patient population of interest.

DIF: CognitiveLevel: Application OBJ: Define the key terms listed.
TOP: Randomized Controlled Trials KEY: Nursing Process Step: Implementation MSC: NCLEX: Safe and Effective Care Environment (management of care)

7. Patient fall rates are an example of an _____.

ANS:
outcome measurement

Data collected within a health care agency offer important trending information about clinical conditions and problems. Staff in the agency review the data periodically to identify problem areas and to seek solutions.

DIF: CognitiveLevel: Application OBJ: Define the key terms listed.
TOP: Quality Improvement KEY: Nursing Process Step: Implementation MSC: NCLEX: Safe and Effective Care Environment (management of care)

Chapter 02: Communication and Collaboration Perry et al.: Clinical Nursing Skills & Techniques, 10th Edition

MULTIPLE CHOICE

1. The patient is a 54-year-old man who has made a living as a construction worker. He dropped out of high school at age 16 and has been a laborer ever since. He never saw any need for ―book learning,‖ and has lived his life ―my way‖ since he was a teenager. He has smoked a pack of cigarettes a day for 40 years and follows no special diet, eating a lot of ―fast food‖ while on the job. He now is admitted to the coronary care unit for complaints of chest pain and is scheduled for a cardiac catheterization in the morning. Which of the following would be the best way for the nurse to explain why he needs the procedure?
   a. ―The doctor believes that you have atherosclerotic plaques occluding the major arteries in your heart, causing ischemia and possible necrosis of heart tissue.‖
   b. ―There may be a blockage of one of the arteries in your heart, causing the chest discomfort. He needs to know where it is to see how he can treat it.‖
   c. ―We have pamphlets here that can explain everything. Let me get you one.‖
   d. ―It‘s just like a clogged pipe. All the doctor has to do is _Roto-Rooter‘ it to get it cleaned out.‖

ANS: B
To send an accurate message, the sender of verbal communication must be aware of different developmental perspectives as well as cultural differences between sender and receiver, such as the use of dialect or slang.

DIF: CognitiveLevel: Application OBJ: Explain the communication process.
TOP: Verbal Communication KEY: Nursing Process Step: Implementation MSC: NCLEX: Psychosocial Integrity

2. The nurse is assessing a patient who says that she is feeling fine. The patient, however, is wringing her hands and is teary eyed. The nurse should respond to the patient in which of the following ways?
   a. ―You seem anxious today. Is there anything on your mind?‖
   b. ―I‘m glad you‘re feeling better. I‘ll be back later to help you with your bath.‖
   c. ―I can see you‘re upset. Let me get you some tissue.‖
   d. ―It looks to me like you‘re in pain. I‘ll get you some medication.‖

ANS: A
When assessing a patient‘s needs, assess both the verbal and the nonverbal messages and validate them. In this case, if you see a patient wringing her hands and sighing, it is appropriate to ask, ―You seem anxious today. Is there anything on your mind?‖ It is not enough to accept only the verbal message if nonverbal signals conflict, and it is inappropriate to jump to conclusions about what the nonverbal signals mean.

DIF: CognitiveLevel: Application OBJ: Explain the communication process.
TOP: Nonverbal Communication KEY: Nursing Process Step: Implementation MSC: NCLEX: Psychosocial Integrity

3. Nonverbal communication incorporates messages conveyed by: a. touch.
   b. cadence.
   c. tone quality.
   d. use of jargon.

ANS: A
Nonverbal communication describes all behaviors that convey messages without the use of words. This type of communication includes body movement, physical appearance, personal space, and touch. Cadence, tone quality, and the use of jargon are all part of verbal communication.

DIF: CognitiveLevel: Knowledge OBJ: Explain the communication process.
TOP: Nonverbal Communication KEY: Nursing Process Step: Implementation MSC: NCLEX: Psychosocial Integrity

4. The patient is an elderly male who had hip surgery 3 days ago. He states that his hip hurts, but he does not like how the medicine makes him feel. He believes that he can tolerate the pain better than he can tolerate the medication. What would be the best response from the nurse?
    a. Explain the need for the pain medication using a slower rate of speech.
    b. Explain the need for the pain medication using a simpler vocabulary.
    c. Explain the need for the pain medication, but ask the patient if he would like the doctor called and the medication changed.
    d. Explain in a loud manner the need for the pain medication.

ANS: C
Suggesting, which is presenting alternative ideas for patient consideration relative to problem solving, can be effective in helping the patient maintain control by increasing the patient‘s perceived options or choices. Nurses often use elder-speak, which includes a slower rate of speech, greater repetition, and simpler grammar than normal adult speech, when caring for older adults. However, many older patients perceive this type of communication as patronizing.

DIF: CognitiveLevel: Application
OBJ: Identify the purpose of therapeutic communication, communication in various phases of the nurse-patient relationship, and special issues related to communication.
TOP: Communication with the Elderly KEY: Nursing Process Step: Implementation MSC: NCLEX: Psychosocial Integrity

5. When comparing therapeutic communication versus social communication, the professional nurse realizes that therapeutic communication:
    a. allows equal opportunity for personal disclosure.
    b. allows both participants to have personal needs met.
    c. is goal directed and patient centered.
    d. provides an opportunity to compare intimate details.

ANS: C
Therapeutic communication empowers patients to make decisions but differs from social communication in that it is patient centered and goal directed with limited disclosure from the professional. Social communication involves equal opportunity for personal disclosure, and both participants seek to have personal needs met. Nurses do not share with patients intimate details of their personal lives.

DIF: CognitiveLevel: Application
OBJ: Develop skills for therapeutic communication in various phases of the nurse-patient relationship. TOP: Establishing the Nurse-Patient Relationship
KEY: Nursing Process Step: Implementation
MSC: NCLEX: Psychosocial Integrity

6. The nurse is explaining a procedure to a 2-year-old child. Which is the best approach to use?
    a. Showing the needles and bandages in advance

b. Telling the patient exactly what discomfort to expect
c. Using dolls and stories to demonstrate what will be done
d. Asking the child to draw pictures of what he or she thinks will happen

ANS: C
Some age-appropriate communication techniques for a 2-year-old child include storytelling and drawing. Showing the child needles or telling the child about discomfort would increase anxiety. Having a child draw what he expects does not explain what is going to happen.

DIF: CognitiveLevel: Application
OBJ: Develop skills for therapeutic communication in various phases of the nurse-patient relationship. TOP: Establishing the Nurse-Patient Relationship—Pediatric Considerations
KEY: Nursing Process Step: Implementation
MSC: NCLEX: Psychosocial Integrity

7. The nurse is about to go over the patient‘s preoperative teaching per hospital protocol. She finds the patient sitting in bed wringing her hands, which are sweaty, and acting slightly agitated. The patient states, ―I‘m scared that something will go wrong tomorrow.‖ How should the nurse respond?
   a. Redirect her focus to dealing with the patient‘s anxiety.
   b. Tell the patient that everything will be all right and continue teaching.
   c. Tell the patient that she will return later to do the teaching.
   d. Give the patient antianxiety medication.

ANS: A
Anxiety interferes with comprehension, attention, and problem-solving abilities and thus interferes with the patient‘s care and treatment. To ensure the effectiveness of treatment, the nurse should try to help the patient understand the source of the anxiety. Ignoring the anxiety, medicating for it, and postponing the discussion are all inappropriate.

DIF: CognitiveLevel: Application
OBJ: Develop therapeutic communication skills for communicating with anxious, angry, and depressed patients. TOP: Establishing the Nurse-Patient Relationship
KEY: Nursing Process Step: Implementation
MSC: NCLEX: Psychosocial Integrity

8. The nurse is attempting to teach the patient and his family about his care after discharge. The patient and the family demonstrate signs of anxiety during the teaching session. The nurse should consider doing what?
   a. Using more gestures or pictures
   b. Focusing on the physical complaints
   c. Getting another staff member to speak to the patient
   d. Repeating information to the patient and the family at a later time

ANS: D
Remember that patients and their family members who are under stress often require repeated explanations. Increasing gestures and pictures is additional stimulation that may increase anxiety. Physical complaints should be acknowledged, but dwelling on them can also increase the patient‘s anxiety. Involving another staff member would cause a break in the continuity of care.

DIF: CognitiveLevel: Application
OBJ: Develop therapeutic communication skills for communicating with anxious, angry, and depressed patients. TOP: Establishing the Nurse-Patient Relationship
KEY: Nursing Process Step: Implementation
MSC: NCLEX: Psychosocial Integrity

9. The patient is an elderly man who was brought to the hospital from an assisted-living community with complaints of anorexia and general malaise. The nurse at the assisted-living community reported that the patient was very ritualistic in his behavior and fastidious in his dress and always took a shower in the evening before bed. The patient became very angry and upset when the patient care technician asked him to take his bath in the morning. What does this behavior tell the nurse?
   a. The patient is exhibiting anxiety because of a change in his rituals.
   b. The patient is suffering from sensory overstimulation.
   c. The patient is basically an angry person.
   d. The patient has to follow hospital protocol.

ANS: A
Patients often become ritualistic and intent on performing activities a certain way. Anxiety develops as a result of a specific event or a general pattern of change.

DIF: CognitiveLevel: Analysis
OBJ: Develop therapeutic communication skills for communicating with anxious, angry, and depressed patients. TOP: Gerontological Considerations—Anxiety KEY: Nursing Process Step: Diagnosis MSC: NCLEX: Psychosocial Integrity

10. The nurse is preparing to give an intramuscular injection to the patient in room 320. The patient care technician comes to the medication room and tells the nurse that the patient in room 316 is very angry with his roommate and is threatening to hit him. How should the nurse respond?
    a. Tell the patient care technician to calm the patient down until she can get there.
    b. Have the angry patient‘s roommate moved to another location.
    c. Tell the angry patient to calm down until she can get there.
    d. Tell the angry patient that he has to act civilized in the hospital, and that‘s that.

ANS: B

A potentially violent patient needs to be in an environment with decreased stimuli and to have protection from injury to self and against others. Encourage other people, particularly those who provoke anger, to leave the room or area. De-escalation is a skill that cannot be delegated to nursing assistive personnel (NAP).

DIF: CognitiveLevel: Application
OBJ: Develop therapeutic communication skills for communicating with anxious, angry, and depressed patients. TOP: Communicating with the Angry Patient
KEY: Nursing Process Step: Implementation
MSC: NCLEX: Psychosocial Integrity

11. Which behavior should the nurse who is communicating with a potentially violent patient employ?
    a. Sit closer to the patient.
    b. Speak loudly and firmly.
    c. Use slow, deliberate gestures.
    d. Always block the door to prevent escape.

ANS: C

Make sure that gestures are slow and deliberate rather than sudden and abrupt. There is less chance for misinterpretation of the message, and slow, deliberate gestures are less threatening. Keep an adequate distance between yourself and the patient to reduce your risk of injury and to avoid making the patient feel pressured. Try to talk in a comfortable, reassuring voice. Position yourself closest to the door to facilitate escape from a potentially violent situation. Do not block the exit; if the patient feels unable to escape, this may cause a violent outburst.

DIF: CognitiveLevel: Application
OBJ: Develop therapeutic communication skills for communicating with anxious, angry, and depressed patients. TOP: Communicating with the Angry Patient KEY: Nursing Process Step: Intervention MSC: NCLEX: Psychosocial Integrity

12. The patient is sitting at the bedside. He has not been eating and is just staring out of the window. The nurse approaches the patient and asks, ―What are you thinking about?‖ What type of communication technique is this? a. Restating
    b. Clarification
    c. Broad openings
    d. Reflection

ANS: C
Broad openings encourage patients to select topics for discussion. They affirm the value of the patient‘s initiative. Restating is repeating a main thought that the patient has expressed. Clarification is attempting to put into words vague ideas or asking the patient to explain what he or she means. Reflection is directing back to the patient ideas, feelings, questions, or content.

DIF: CognitiveLevel: Knowledge OBJ: Explain the communication process.
TOP: Therapeutic Communication Techniques
KEY: Nursing Process Step: Diagnosis MSC: NCLEX: Psychosocial Integrity

13. A patient tells the nurse, ―I want to die.‖ Which response is the most appropriate for the nurse to make?
    a. ―Why would you say that?‖
    b. ―Tell me more about how you are feeling.‖
    c. ―The doctor should be told how you feel.‖
    d. ―You have too much to live for to think that way.‖

ANS: B
Broad openings encourage the patient to select topics for discussion and indicate acceptance by the nurse and the value of the patient‘s initiative. ―Why‖ questions can cause defensiveness and can hinder communication. Saying you will inform the doctor leads the conversation away from the patient‘s feelings. Saying the patient has too much to live for is false reassurance and negates the patient‘s feelings.

DIF: CognitiveLevel: Application OBJ: Explain the communication process. TOP: Therapeutic Communication Techniques
KEY: Nursing Process Step: Intervention MSC: NCLEX: Psychosocial Integrity

14. The patient states, ―I don‘t know what my family will think about this.‖ The nurse wishes to use the communication technique of clarification. Which of the following statements would fit that need best?
    a. ―You don‘t know what your family will think?‖
    b. ―I‘m not sure that I understand what you mean.‖
    c. ―I think it would be helpful if we talk more about your family.‖
    d. ―I sense that you may be anxious about something.‖

ANS: B
The definition of *clarification* is attempting to put into words vague ideas or unclear thoughts of the patient to enhance the nurse‘s understanding, or asking the patient to explain what he or she means. Repeating main thoughts expressed by patients is known as ―restating.‖ Using questions or statements that help patients expand on a topic of importance is known as ―focusing.‖ Asking a patient to verify the nurse‘s understanding of what the patient is thinking or feeling is known as ―sharing perceptions.‖

DIF: CognitiveLevel: Application OBJ: Explain the communication process.
TOP: Therapeutic Communication Techniques
KEY: Nursing Process Step: Intervention MSC: NCLEX: Psychosocial Integrity

15. A patient tells the nurse, ―I think that I must be really sick. All of these tests are being done.‖ Which response by the nurse uses the specific communication technique of reflection? a. ―I sense that you are worried.‖
    b. ―I think that we should talk about this more.‖
    c. ―You think that you must be very sick because of all the tests.‖
    d. ―I‘ve noticed that this is an underlying issue whenever we talk.‖

    ANS: C
    Reflecting is directing back to the patient ideas, feelings, questions, or content, validating the nurse‘s understanding of what the patient is saying, and signifying empathy, interest, and respect for the patient. Asking the patient to confirm your sense of his or her anxiety is ―sharing perceptions.‖ Stating that ―we should talk about this more,‖ that is, putting forth questions or statements to expand on a topic, is ―focusing.‖ Pointing out underlying issues or problems that occur repeatedly is known as ―theme identification.‖

    DIF: CognitiveLevel: Application OBJ: Explain the communication process.
    TOP: Therapeutic Communication Techniques
    KEY: Nursing Process Step: Intervention MSC: NCLEX: Psychosocial Integrity

16. The patient is admitted to the hospital with complaints of headache, nausea, and dizziness. She states that she has a final exam in the morning and needs to do well on it to pass the course, but she can‘t seem to get into it. She appears nervous and distracted, and is unable to recall details. She most likely is showing manifestations of _____ anxiety. a. mild
    b. moderate
    c. severe
    d. panic state of

    ANS: C

    Severe anxiety manifests as a focus on fragmented details, as well as headache, nausea, dizziness, inability to see connections between details, and poor recall. Mild anxiety manifests as increased auditory and visual perception, increased awareness of relationships, and increased alertness and ability to problem-solve. Moderate anxiety manifests as selective inattention, decreased perceptual field, focus only on relevant information, muscle tension, and diaphoresis. Panic state of anxiety manifests as an inability to notice surroundings, feelings of terror, and inability to cope with any problem.

    DIF: CognitiveLevel: Analysis
    OBJ: Develop therapeutic communication skills for communicating with anxious, angry, and depressed patients. TOP: Manifestations of Anxiety
    KEY: Nursing Process Step: Diagnosis MSC: NCLEX: Physiological Integrity

17. The patient is admitted to the emergency department for trauma received in a fist fight. He states that he could not control himself. He says that his wife left him for another man. He thinks it was because he was always too tired after working to do things. He says he has to

work, and there is nothing he could do to change things. He says that he feels trapped in his job, but he knows nothing else. What was the altercation with the other man probably a manifestation of? a. Mild anxiety
b. Depression
c. Severe anxiety
d. Moderate anxiety

ANS: B
Symptoms of depression include apathy, sadness, sleep disturbances, hopelessness, helplessness, worthlessness, guilt, anger, fatigue, thoughts of death, decreased libido, ruminations of inadequacy, psychomotor agitation, verbal berating of self, spontaneous crying, dependency, and passiveness. Mild anxiety manifests as increased auditory and visual perception, increased awareness of relationships, increased alertness, and an increased ability to problem-solve. Moderate anxiety manifests as selective inattention, decreased perceptual field, focus only on relevant information, muscle tension, and diaphoresis. Severe anxiety manifests as a focus on fragmented details, headache, nausea, dizziness, an inability to see connections between details, and poor recall.

DIF: CognitiveLevel: Analysis
OBJ: Develop therapeutic communication skills for communicating with anxious, angry, and depressed patients. TOP: Manifestations of Depression
KEY: Nursing Process Step: Diagnosis MSC: NCLEX: Psychosocial Integrity

MULTIPLE RESPONSE

1. Verbal communication includes which of the following? (*Select all that apply.*) a. Speech
   b. Personal space
   c. Body movement
   d. Writing

ANS: A, D

Verbal communication includes both spoken word and written word. Nonverbal communication describes all behaviors that convey messages without the use of words. This type of communication includes body movement, physical appearance, personal space, and touch.

DIF: CognitiveLevel: Analysis OBJ: Explain the communication process.
TOP: Verbal Communication KEY: Nursing Process Step: Assessment
MSC: NCLEX: Psychosocial Integrity

2. In caring for patients of different cultures, it is important for the nurse to: (*Select all that apply.*)
   a. use appropriate linguistic services.
   b. display empathy and respect.
   c. use accurate health history-taking techniques.

d. use patient-centered communication.

ANS: A, B, C, D
The following factors are essential in providing effective care for culturally and linguistically diverse patients: (1) use of appropriate linguistic services (e.g., interpreter or bilingual health care workers) and/or other communication strategies, (2) display of empathy and respect for culturally and linguistically diverse patients, (3) use of accurate health history-taking techniques for diagnostic and treatment purposes and health teaching, and (4) use of patient-centered communication behaviors, including participatory decision making. It also is helpful to speak plainly and to avoid mimicking a patient‘s accent or dialect.

DIF: CognitiveLevel: Comprehension
OBJ: Identify the purpose of therapeutic communication, communication in various phases of the nurse-patient relationship, and special issues related to communication.
TOP: Cultural Communication KEY: Nursing Process Step: Implementation
MSC: NCLEX: Psychosocial Integrity

3. The nurse observes that the patient is pacing in his room with clenched fists. When asked ―What‘s wrong?‖ the patient states, ―There‘s nothing wrong. I just want out of here.‖ He then bangs his fist on the table and yells, ―I‘ve had it!‖ How should the nurse respond? (*Select all that apply.*)
a. Tell the patient that he needs to calm down.
b. Pause to collect her own thoughts.
c. Block the doorway.
d. Notify the proper authorities.

ANS: B, D
Awareness and control of your own reaction and responses will facilitate more constructive interaction. Maintain an open exit. Position yourself closest to the door to facilitate escape from a potentially violent situation. Do not block the exit so the patient feels escape is unattainable; this may cause a violent outburst. An angry patient loses the ability to process information rationally and therefore may impulsively express anger through intimidation. If a strong likelihood of imminent harm to another is present upon discharge, notify the proper authorities (e.g., nurse manager).

DIF: CognitiveLevel: Synthesis
OBJ: Develop therapeutic communication skills for communicating with anxious, angry, and depressed patients. TOP: Communicating with the Angry Patient
KEY: Nursing Process Step: Implementation
MSC: NCLEX: Psychosocial Integrity

COMPLETION

1. The nurse is starting her first set of morning rounds. As she interacts with the patient, her questions revolve around his reactions to his disease process. She also asks if there is anything

that she can do to make him more comfortable. This type of interaction is known as _____.

ANS:
therapeutic communication

Therapeutic communication is an application of the process of communication to promote the well-being of the patient.

DIF: CognitiveLevel: Analysis
OBJ: Identify guidelines to use in therapeutic communication. TOP: Therapeutic Communication
KEY: Nursing Process Step: Implementation
MSC: NCLEX: Psychosocial Integrity

2. An active process of receiving information that nonverbally communicates to the patient the nurse‘s interest and acceptance is classified as _____.

ANS:
listening

Definition: An active process of receiving information and examining one‘s reaction to messages received. *Therapeutic value:* Nonverbally communicates to the patient the nurse‘s interest and acceptance.

DIF: CognitiveLevel: Knowledge OBJ: Explain the communication process.
TOP: Therapeutic Communication Techniques
KEY: Nursing Process Step: Diagnosis MSC: NCLEX: Psychosocial Integrity

3. The patient is talking about his fear of having surgery but is being vague and is using a lot of jargon. The nurse states, ―I‘m not sure what you mean. Could you tell me again?‖ This is an example of _____.

ANS:
clarification

Clarification is attempting to put into words vague ideas or unclear thoughts of the patient to enhance the nurse‘s understanding, or asking the patient to explain what he or she means. This may help to clarify the patient‘s feelings, ideas, and perceptions, and may provide an explicit correlation between them and the patient‘s actions.

DIF: CognitiveLevel: Application OBJ: Explain the communication process. TOP: Therapeutic Communication Techniques
KEY: Nursing Process Step: Diagnosis MSC: NCLEX: Psychosocial Integrity

4. Directing the conversation back to patient ideas, feelings, questions, or content is known as _____.

ANS:

reflection

Reflection or directing back to the patient ideas, feelings, questions, or content validates the nurse‘s understanding of what the patient is saying and signifies empathy, interest, and respect for the patient.

DIF: CognitiveLevel: Knowledge OBJ: Explain the communication process.
TOP: Therapeutic Communication Techniques
KEY: Nursing Process Step: Diagnosis MSC: NCLEX: Psychosocial Integrity

5. The patient tells the nurse that his mother left him when he was 5 years old. The nurse responds by saying, ―You say that your mother left you when you were 5 years old?‖ This is an example of _____.

ANS:
restating

Restating is a technique whereby the nurse repeats the main thought that the patient has expressed. It indicates that the nurse is listening, and validates, reinforces, or calls attention to something important that has been said.

DIF: CognitiveLevel: Application OBJ: Explain the communication process.
TOP: Therapeutic Communication Techniques
KEY: Nursing Process Step: Implementation
MSC: NCLEX: Psychosocial Integrity

6. The patient has been agitated for the entire morning but refuses to say why he is angry. Instead, whenever the nurse speaks to him, he smiles at her while clenching his fist at the same time. The nurse states, ―I can see that you‘re smiling, but I sense that you are really very angry.‖ This is an example of _____.

ANS:
sharing perceptions

Sharing perceptions is asking the patient to verify the nurse‘s understanding of what the patient is thinking or feeling. It conveys to the patient the nurse‘s understanding and has the potential for clearing up confusing communication.

DIF: CognitiveLevel: Application OBJ: Explain the communication process.
TOP: Therapeutic Communication Techniques
KEY: Nursing Process Step: Implementation
MSC: NCLEX: Psychosocial Integrity

7. Lack of verbal communication for a therapeutic reason is known as _____.

ANS:
therapeutic silence

Lack of verbal communication for a therapeutic reason is known as therapeutic silence. It allows the patient time to think and gain insights, slows the pace of the interaction, and encourages the patient to initiate conversation, while conveying the nurse‘s support, understanding, and acceptance.

DIF: CognitiveLevel: Comprehension OBJ: Explain the communication process. TOP: Therapeutic Silence KEY: Nursing Process Step: Assessment MSC: NCLEX: Psychosocial Integrity

8. Anxiety that is the source of inattention, decreased perceptual field, and diaphoresis is classified as _____.

ANS:
moderate anxiety

Moderate anxiety is characterized by selective inattention, decreased perceptual field, the ability to focus only on relevant information, muscle tension, and/or diaphoresis.

DIF: CognitiveLevel: Comprehension
OBJ: Develop therapeutic communication skills for communicating with anxious, angry, and depressed patients. TOP: Anxiety KEY: Nursing Process Step: Diagnosis MSC: NCLEX: Psychosocial Integrity

Chapter 03: Admitting, Transfer, and Discharge Perry et al.: Clinical Nursing Skills & Techniques, 10th Edition

MULTIPLE CHOICE

1. The patient is scheduled to go home after having coronary angioplasty. What would be the most effective way to provide discharge teaching to this patient? a. Provide him with information on health care websites.
   b. Provide him with written information on what he has to do.
   c. Sit and carefully explain what is required before his follow-up.
   d. Use a combination of verbal and written information.

ANS: D

For discharge teaching, use a combination of verbal and written information. This most effectively provides patients with standardized care information, which has been shown to improve patient knowledge and satisfaction.

DIF: CognitiveLevel: Application

OBJ: Identify the ongoing needs of patients in the process of discharge planning.
TOP: Admission to DischargeProcess KEY: Nursing Process Step: Implementation MSC: NCLEX: Safe and Effective Care Environment

2. While preparing for the patient‘s discharge, the nurse uses a discharge planning checklist and notes that the patient is concerned about going home because she has to depend on her family for care. The nurse realizes that successful recovery at home is often based on: a. the patient‘s willingness to go home.
   b. the family‘s perceived ability to care for the patient.
   c. the patient‘s ability to live alone.
   d. allowing the patient to make her own arrangements.

ANS: B
Discharge from an agency is stressful for a patient and family. Before a patient is discharged, the patient and family need to know how to manage care in the home and what to expect with regard to any continuing physical problems. Family caregiving is a highly stressful experience. Family members who are not properly prepared for caregiving are frequently overwhelmed by patient needs, which can lead to unnecessary hospital readmissions.

DIF: CognitiveLevel: Analysis
OBJ: Identify the ongoing needs of patients in the process of discharge planning.
TOP: Medication Reconciliation KEY: Nursing Process Step: Assessment MSC: NCLEX: Psychosocial Integrity

3. The patient arrives in the emergency department complaining of severe abdominal pain and vomiting, and is severely dehydrated. The physician orders IV fluids for the dehydration and an IV antiemetic for the patient. However, the patient states that she is fearful of needles and adamantly refuses to have an IV started. The nurse explains the importance of and rationale for the ordered treatment, but the patient continues to refuse. What should the nurse do? a. Summon the nurse technician to hold the arm down while the IV is inserted.
   b. Use a numbing medication before inserting the IV.
   c. Document the patient‘s refusal and notify the physician.
   d. Tell the patient that she will be discharged without care unless she complies.

ANS: C

The Patient Self-Determination Act, effective December 1, 1991, requires all Medicare- and Medicaid-recipient hospitals to provide patients with information about their right to accept or reject medical treatment. The patient has the right to refuse treatment. Refusal should be documented and the health care provider consulted about alternate treatment.

DIF: CognitiveLevel: Application
OBJ: Describe the nurse‘s role in maintaining continuity of care through a patient‘s admission, transfer, and discharge from an acute care facility.
TOP: Patient Self-Determination Act KEY: Nursing Process Step: Implementation MSC: NCLEX: Safe and Effective Care Environment

4. An unconscious patient is admitted through the emergency department. How and when is identification of the patient made?
   a. Determined only when the patient is able
   b. Postponed until family members arrive
   c. Given an anonymous name under the ―blackout‖ procedure
   d. Determined before treatment is started

ANS: B

If a patient is unconscious, identification often is not made until family members arrive. Delaying treatment can cause deterioration of the patient‘s condition. Blackout procedures are intended mainly to protect crime victims.

DIF: CognitiveLevel: Application
OBJ: Describe the nurse‘s role in maintaining continuity of care through a patient‘s admission, transfer, and discharge from an acute care facility. TOP: The Unconscious Patient
KEY: Nursing Process Step: Implementation
MSC: NCLEX: Physiological Integrity

5. During admission of a patient, the nurse notes that the patient speaks another language and may have difficulty understanding English. What should the nurse do to facilitate communication?

a. Use hand gestures to explain.
b. Request and wait for an interpreter.
c. Work with the family to gather information.
d. Complete as much of the admission assessment as possible using simple phrases.

ANS: B

If the patient does not speak English or has a severe hearing impairment, the clerk must have access to an interpreter to assist during the admission procedure. Translation services are preferable to using family members to ensure correct translation of medical terminology. Hand gestures and simple phrases may not be adequate for everything that will be discussed at the time of admission.

DIF: CognitiveLevel: Application
OBJ: Describe the nurse‘s role in maintaining continuity of care through a patient‘s admission, transfer, and discharge from an acute care facility. TOP: The Patient Who Does Not Speak English
KEY: Nursing Process Step: Implementation
MSC: NCLEX: Safe and Effective Care Environment

6. The patient has been admitted to the emergency department after being beaten and raped. She is agitated and is frightened that her attacker may find her in the hospital and try to kill her. What should the nurse tell her?
a. She is safe in the hospital, and she needs to provide her name.
b. She can be admitted to the hospital without anyone knowing it.
c. Her records will be used as evidence in the trial.
d. Since she has come to the hospital, she has to be examined by the doctor.

ANS: B

A patient who has been a victim of crime can be admitted anonymously under an agency‘s ―blackout‖ or ―do not publish‖ procedure. HIPAA places limits on the institution‘s ability to use or disclose the patient‘s PHI. The Patient Self-Determination Act prohibits the hospital from requiring her to submit to an examination.

DIF: CognitiveLevel: Analysis

OBJ: Describe the nurse‘s role in maintaining continuity of care through a patient‘s admission, transfer, and discharge from an acute care facility. TOP: Victim of Crime

KEY: Nursing Process Step: Implementation

MSC: NCLEX: Psychosocial Integrity

7. The patient is admitted to the ICU after having been in a motor vehicle accident. He was intubated in the emergency department and needs to receive two units of packed red blood cells. He is conscious but is indicating that he is in pain by guarding his abdomen. To admit this patient, the nurse first will focus on:
   a. examining the patient and treating the pain.
   b. orienting the family to the ICU visitation policy.
   c. making sure that the consent forms are signed.
   d. informing the patient of his HIPAA rights.

ANS: A

When a critically ill patient reaches a hospital‘s nursing division, the patient immediately undergoes extensive examination and treatment procedures. Little time is available for the nurse to orient the patient and family to the division, or to learn of their fears or concerns.

DIF: CognitiveLevel: Analysis

OBJ: Describe the nurse‘s role in maintaining continuity of care through a patient‘s admission, transfer, and discharge from an acute care facility. TOP: Role of the Nurse

KEY: Nursing Process Step: Implementation

MSC: NCLEX: Physiological Integrity

8. The nurse is admitting the patient to the medical unit. The patient indicates that he has had several surgeries in the past and has been a diabetic for the past 15 years. He also stated that he is allergic to Morphine. What does this information prompt the nurse to do next? a. Provide the patient with an allergy armband and document his allergies.
   b. Postpone routine admission procedures immediately.
   c. Ask the patient if he wants a smoking room.

d. Have all family or friends leave the room.

ANS: A

Provide the patient with an allergy armband listing allergies to foods, drugs, latex, or other substances; document allergies according to hospital policy. Postpone routine admission procedures only if the patient is having acute physical problems. Smoking is prohibited throughout the hospital, and family or friends can remain if the patient wishes to have them assist with changing into a hospital gown or pajamas.

DIF: CognitiveLevel: Analysis
OBJ: Describe the nurse‘s role in maintaining continuity of care through a patient‘s admission, transfer, and discharge from an acute care facility. TOP: Allergies
KEY: Nursing Process Step: Implementation
MSC: NCLEX: Physiological Integrity

9. At what age is separation anxiety a common problem?
   a. School-aged children
   b. Preschoolers
   c. Middle infancy
   d. Newborns

ANS: C

Separation anxiety is most common from middle infancy throughout the toddler years, especially from ages 16 to 30 months. Preschoolers are better able to tolerate brief periods of separation, but their protest behaviors are more subtle than those of younger children (e.g., refusal to eat, difficulty sleeping, withdrawing from others). School-aged children are able to cope with separation but have an increased need for parental security and guidance.

DIF: CognitiveLevel: Synthesis
OBJ: Explain the role of the patient‘s family in the admission, transfer, or DischargeProcess.
TOP: Pediatric Considerations KEY: Nursing Process Step: Assessment MSC: NCLEX: Psychosocial Integrity

10. The patient is being transferred from the emergency department to another institution for treatment. Which of the following cannot be delegated to nursing assistive personnel (NAP)?

a. Helping the patient get dressed

b. Gathering IV equipment to go with the patient

c. Escorting the patient to the transport area

d. Assessing the patient‘s respiratory status before transport

ANS: D

The assessment and decision making conducted during transfers cannot be delegated to nursing assistive personnel. NAP can assist the patient with dressing, can gather and secure the patient‘s personal belongings and any necessary equipment, and can escort the patient to the nursing unit or transport area.

DIF: CognitiveLevel: Application

OBJ: Describe the nurse‘s role in maintaining continuity of care through a patient‘s admission, transfer, and discharge from an acute care facility. TOP: Delegation

KEY: Nursing Process Step: Implementation

MSC: NCLEX: Safe and Effective Care Environment

11. When does the plan for patient discharge from a health care facility begin? a. At admission

b. After a medical diagnosis has been determined

c. When the patient‘s physical needs are identified

d. After a home environment assessment is completed

ANS: A

Planning for discharge begins at admission and continues throughout the patient‘s stay in the agency. Separating the processes of admission and discharge is a critical error; the two are simultaneous and continuous.

DIF: CognitiveLevel: Comprehension

OBJ: Describe the nurse‘s role in maintaining continuity of care through a patient‘s admission, transfer, and discharge from an acute care facility. TOP: Discharge Planning

KEY: Nursing Process Step: Implementation

MSC: NCLEX: Safe and Effective Care Environment

12. The phase of the DischargeProcess where medical attention dominates discharge planning efforts is known as the _____ phase. a. transitional
    b. continuing
    c. acute
    d. multidisciplinary

ANS: C

The DischargeProcess occurs in three phases: acute, transitional, and continuing care. In the acute phase, medical attention dominates discharge planning efforts. During the transitional phase, the need for acute care is still present, but its urgency declines and patients begin to address and plan for their future health care needs. In the continuing care phase, patients participate in planning and implementing continuing care activities needed after discharge. There is no multidisciplinary stage; the discharge planning process is comprehensive and multidisciplinary.

DIF: CognitiveLevel: Comprehension
OBJ: Describe the nurse‘s role in maintaining continuity of care through a patient‘s admission, transfer, and discharge from an acute care facility. TOP: Discharge Planning
KEY: Nursing Process Step: Implementation
MSC: NCLEX: Physiological Integrity

13. Once a patient‘s discharge has been completed, which activity may be delegated to assistive personnel?
    a. Provision of prescriptions to the patient
    b. Completion of the discharge summary
    c. Gathering of the patient‘s personal care items
    d. Provision of instructions on community health resources

ANS: C

The assessment, care planning, and instruction included in discharging patients cannot be delegated to nursing assistive personnel. The nurse may direct the NAP to gather and secure the patient‘s personal items and any supplies that accompany the patient.

DIF: CognitiveLevel: Application
OBJ: Describe the nurse‘s role in maintaining continuity of care through a patient‘s admission, transfer, and discharge from an acute care facility. TOP: Discharge Planning
KEY: Nursing Process Step: Implementation
MSC: NCLEX: Safe and Effective Care Environment

14. The nurse is providing discharge instruction to an 80-year-old patient and her daughter. The patient lives in a two-story home. When asked if the patient has difficulty climbing stairs, the patient says ―No,‖ but the nurse notices a look of surprise on the daughter‘s face. What should the nurse do in this circumstance?
    a. Speak with the daughter separately.
    b. Cancel the discharge immediately.
    c. Order a visiting nurse consult.
    d. Notify the physician.

ANS: A
Patients and family members often disagree on the health care needs of a patient after discharge. Identifying these discrepancies early leads to more accurate development of the discharge plan. It is often necessary to talk with the patient and family separately to learn about their true concerns or doubts.

DIF: CognitiveLevel: Application
OBJ: Explain the role of the patient‘s family in the admission, transfer, or DischargeProcess.
TOP: Discharge Planning KEY: Nursing Process Step: Implementation MSC: NCLEX: Safe and Effective Care Environment

15. The patient has decided that he would like to create an advance directive. The nurse is asked if she would be a witness. What is the best response for the nurse to make to this request? a. Agree to be a witness.
    b. Refuse to be a witness.