Chapter 02: Critical Thinking and Nursing Process

MULTIPLE CHOICE

1. Basic to the ability to apply critical thinking, the nurse must have:
   a. unshakable beliefs and values.
   b. an open attitude.
   c. the ability to disregard evidence inconsistent with set goals.
   d. the ability to recognize the perfect solution.

   ANS: B
   An open attitude not clouded by unshakable beliefs and values or preset goals allows the application of critical thinking. Acceptance that there may not be a perfect solution leaves the field open to new ideas.

   DIF: Cognitive Level: Comprehension REF: 14-15 OBJ: 2 (theory)
   TOP: Factors Influencing Critical Thinking KEY: Nursing Process Step: NA
   MSC: NCLEX: Health Promotion and Maintenance

2. The nurse explains that a fundamental basis for the nursing process is:
   a. that basic needs must be met by the individual without assistance.
   b. that patients and families appreciate an efficient health care system that functions without their input.
   c. a focus on disease control.
   d. that all persons have worth and dignity.

   ANS: D
   The nursing process is based on the belief that all people have worth and dignity. Patient-centered care that is applied to all aspects of the patient's health, and is not just disease oriented, is appreciated by the family and patient. Holistic care approach can support the patient to meet basic needs.

   DIF: Cognitive Level: Application REF: 16 OBJ: 5 (theory)
   TOP: Basic Beliefs Pertinent to the Nursing Process
   KEY: Nursing Process Step: Implementation
   MSC: NCLEX: Safe, Effective Care Environment: Coordinated Care

3. Upon a patient's admission to the facility, the nurse collects the following data: patient's temperature is 100° F, oxygen saturation is 89%, frothy mucus is expectorated, and the patient's chest feels tight. The nurse correctly identifies tightness in the chest as:
   a. judgmental.
   b. objective data.
   c. subjective data.
   d. drawing a conclusion.

   ANS: C
   Subjective data is information given by the patient that cannot be measured otherwise. The other data are considered objective data. Objective data are pieces of information that can be measured by the examiner. The nurse should avoid making judgments or conclusions when obtaining data.

DIF: Cognitive Level: Application REF: 18 OBJ: 2 (clinical)
TOP: Assessment Data KEY: Nursing Process Step: Planning
MSC: NCLEX: Safe, Effective Care Environment: Coordinated Care

4. The newly admitted patient is describing his recent symptoms to the nurse. The nurse is aware that the source of this information is considered:
   a. primary.
   b. objective.
   c. secondary.
   d. complete.

   ANS: A
   The patient is the primary source of information. Objective refers to a type of data obtained by the nurse that is measured or can be verified through assessment techniques, secondary information is obtained from relatives or significant others, and information is not necessarily complete when the patient is the source.

   DIF: Cognitive Level: Application REF: 19 OBJ: 2 (clinical)
   TOP: Sources of Information KEY: Nursing Process Step: Assessment
   MSC: NCLEX: Safe, Effective Care Environment: Coordinated Care

5. The nurse performing an intake interview on a new resident to the long-term care facility detects the odor of acetone from the patient's breath. The assessment is done by:
   a. inspection.
   b. observation.
   c. auscultation.
   d. olfaction.

   ANS: D
   Olfaction is an assessment method of smells. Inspection and observation use the sense of vision. Auscultation refers to use of the sense of hearing.

   DIF: Cognitive Level: Comprehension REF: 20 OBJ: 3 (clinical)
   TOP: Olfaction KEY: Nursing Process Step: Assessment
   MSC: NCLEX: Health Promotion and Maintenance

6. The nurse's assessment reveals edema of both feet and ankles. The best documentation of these findings is:
   a. pitting edema present in both feet and ankles.
   b. edema in both feet and ankles approximately 4 mm deep.
   c. 4 mm pitting edema quickly resolving.
   d. bilateral pitting edema in feet and ankles: 4 mm deep resolving in 3 seconds.

   ANS: D
   Edema should be recorded as to location, depth of pitting, and time for resolution.

   DIF: Cognitive Level: Application REF: 20 OBJ: 3 (theory)
   TOP: Palpation KEY: Nursing Process Step: Assessment
   MSC: NCLEX: Physiological Integrity: Basic Care and Comfort

7. To assess skin turgor, the nurse would:
   a. examine mucous membranes of the mouth.

b. compare limbs for similar color.
c. pinch skinfold on chest for tenting.
d. palpate ankles for evidence of pitting edema.

ANS: C
Skin turgor can be assessed by tenting the skin on the chest and recording the speed at which the "tent" subsides.

DIF: Cognitive Level: Comprehension REF: 21 OBJ: 3 (clinical)
TOP: Practical Assessment KEY: Nursing Process Step: Assessment
MSC: NCLEX: Health Promotion and Maintenance: Prevention and Early Detection of Disease

8. The nursing student demonstrates an understanding of the Health Insurance Portability and Accountability Act (HIPAA) by:
   a. using the patient's full name only on clinical assignments submitted to the instructor.
   b. using the facility printer to copy lab reports on an assigned patient.
   c. shredding any documents that the student has been using that contain identifying patient information before leaving the clinical facility.
   d. asking the patient for permission to copy lab and diagnostic reports for educational purposes.

   ANS: C
   HIPAA forbids any information used for educational purposes to have any identifying information; therefore, shredding documents would be appropriate. Full names on documents, printing copies of chart forms, and asking the patient for permission to copy forms would be violations of HIPAA regulations.

   DIF: Cognitive Level: Application REF: 22 OBJ: 1 (clinical)
   TOP: HIPAA KEY: Nursing Process Step: Implementation
   MSC: NCLEX: Safe, Effective Care Environment: Coordinated Care

9. The diabetic patient who had blood drawn for an HbA_{1c} level says, "I don't know why they want to look at my hemoglobin." The most helpful reply by the nurse would be:
   a. "The test is to evaluate your present level of blood sugar."
   b. "The HbA_{1c} provides information relative to blood sugar levels from the past 2 to 3 months."
   c. "Hemoglobin levels and blood sugar levels are closely related."
   d. "The HbA_{1c} tells if you have type 1 or type 2 diabetes."

   ANS: B
   HbA_{1c} evaluates the average blood glucose level for the last 2 to 3 months.

   DIF: Cognitive Level: Comprehension REF: 24 OBJ: 2 (clinical)
   TOP: Diagnostic Studies KEY: Nursing Process Step: Implementation
   MSC: NCLEX: Health Promotion and Maintenance

10. The RN has chosen the nursing diagnosis of Risk for impaired skin integrity related to immobility. The correct goal/outcome statement for the diagnosis would be:
    a. patient will sit in chair at bedside for 15 minutes after each meal.
    b. nurse will assist patient to chair every shift.
    c. nurse will assess skin and record condition every shift.

d. patient will change position frequently.

ANS: A
The goal/outcome statement is directed at the etiology and should be patient oriented. The statement should be realistic and measurable and reflect what the patient will do.

DIF: Cognitive Level: Application REF: 26 OBJ: 5 (clinical)
TOP: Goals KEY: Nursing Process Step: Planning
MSC: NCLEX: Physiological Integrity: Basic Care and Comfort

11. The nurse who has recently moved from Louisiana to Texas is uncertain about the LPN/LVN's role in applying the nursing process. The most appropriate source for the nurse to consult is:
    a. hospital policies.
    b. the Texas State Board of Nursing.
    c. rules and regulations of the Louisiana Nurse Practice Act.
    d. the National Association of Practical Nurse Education and Service.

    ANS: B
    Each state has different guidelines for areas of care planning, intravenous therapy, teaching, and delegation. The Texas State Board of Nursing is the most reliable source.

    DIF: Cognitive Level: Application REF: 16 OBJ: 6 (theory)
    TOP: Nursing Process KEY: Nursing Process Step: NA
    MSC: NCLEX: Safe, Effective Care Environment: Coordinated Care

12. The nurse adds a nursing order to the care plan related to a patient with a nursing diagnosis of Nutrition: less than body requirement related to nausea and vomiting. The statement that is a nursing order is:
    a. medicate with an antiemetic before each meal.
    b. offer crackers and iced drink before each meal.
    c. change diet to clear liquids.
    d. give nothing by mouth until nausea subsides.

    ANS: B
    Offering crackers and iced drinks are within the scope of nursing; the other options would require a medical order to complete.

    DIF: Cognitive Level: Analysis REF: 26 OBJ: 6 (clinical)
    TOP: Nursing Orders KEY: Nursing Process Step: Planning
    MSC: NCLEX: Physiological Integrity: Basic Care and Comfort

13. Because the evaluation of the nursing care plan reflects lack of progress toward the goal, the nurse will confer with the patient to plan a:
    a. more accessible goal.
    b. revision of interventions.
    c. different nursing diagnosis.
    d. new evaluation.

    ANS: B
    When lack of progress to reach the goal is seen on evaluation, the interventions are reviewed and/or revised.

DIF: Cognitive Level: Application REF: 27 OBJ: 2 (clinical)
TOP: Evaluation KEY: Nursing Process Step: Planning
MSC: NCLEX: Safe, Effective Care Environment: Coordinated Care

14. During the intake interview, the nurse notices that, although the patient denies pain, he is grimacing and holding his hand over his stomach. The nurse's best approach would be to:
    a. examine the history closely for etiology of pain.
    b. question the patient about having feelings of pain.
    c. record that patient denies pain but seems to be having abdominal discomfort.
    d. physically examine the patient's abdomen.

    ANS: B
    The nurse should try to resolve any incongruence between body language and verbal responses.

    DIF: Cognitive Level: Application REF: 17-20 OBJ: 1 (clinical)
    TOP: Patient Interview KEY: Nursing Process Step: Assessment
    MSC: NCLEX: Health Promotion and Maintenance

15. During the admission interview, when asked about pain, the patient responds, "No. I'm pretty wobbly." Which action by the nurse would be most appropriate?
    a. Ask, "Did you hear me? I asked you about pain."
    b. Say, "What do you mean 'wobbly'?"
    c. Record the patient denied pain.
    d. Record the patient stated he was wobbly.

    ANS: B
    The nurse should ask for clarification if unsure of what is meant by one of the patient's responses.

    DIF: Cognitive Level: Application REF: 17-20 OBJ: 1 (clinical)
    TOP: Patient Interview KEY: Nursing Process Step: Assessment
    MSC: NCLEX: Health Promotion and Maintenance

16. The nurse writes an intervention for the goal: Patient will sleep for 5 hours uninterrupted each night. The best nursing intervention is:
    a. medicate with sedative each night.
    b. offer warm fluids frequently.
    c. arrange for a large meal at supper.
    d. discourage daytime napping.

    ANS: D
    Discouraging daytime napping increases the probability of sleep. Giving medication is a collaborative intervention as it requires an order. Large meal and large fluid intakes may interrupt sleep.

    DIF: Cognitive Level: Analysis REF: 26-27 OBJ: 2 (clinical)
    TOP: Nursing Intervention KEY: Nursing Process Step: Planning
    MSC: NCLEX: Physiological Integrity: Basic Care and Comfort

17. The nursing team prioritizing the nursing diagnoses of an overweight hospital patient will select as the highest priority the nursing diagnosis of:
    a. Risk for dehydration related to vomiting.
    b. Activity intolerance related to shortness of breath.
    c. Knowledge deficit related to weight reduction diet.
    d. Altered self-image related to excessive weight.

    ANS: B
    Activity intolerance is the highest priority as it has to do with activities that are essential to life. The second is Knowledge deficit related to weight reduction diet, followed by Altered self-image related to excessive weight, and the last is Risk for dehydration related to vomiting.

    DIF: Cognitive Level: Analysis REF: 24-27 OBJ: 2 (clinical)
    TOP: Setting Priorities KEY: Nursing Process Step: Planning
    MSC: NCLEX: Physiological Integrity: Basic Care and Comfort

18. The nurse explains that, in addition to the NANDA stem and etiology, the complete nursing diagnosis should include:
    a. a time reference for meeting the need.
    b. a designation of what the patient should do.
    c. signs and symptoms of the problem assessed.
    d. a specifically worded medical diagnosis.

    ANS: C
    A complete nursing diagnosis must have a NANDA stem, etiology, and signs and symptoms (etiology) of the problem.

    DIF: Cognitive Level: Comprehension REF: 24-25 OBJ: 7 (clinical)
    TOP: Nursing Diagnosis KEY: Nursing Process Step: Planning
    MSC: NCLEX: Health Promotion and Maintenance

19. The nurse explains to a patient that inclusion of potential problems in the nursing care plan:
    a. alerts nursing staff to prevent potential complications.
    b. reminds the family of potential problems.
    c. broadens the assessment of the caregiver.
    d. educates the patient to aspects of her health.

    ANS: A
    Addressing potential problems prevents complications by early action rather than waiting for a problem to materialize.

    DIF: Cognitive Level: Application REF: 24-25 OBJ: 7 (clinical)
    TOP: Potential Health Problems KEY: Nursing Process Step: Planning
    MSC: NCLEX: Health Promotion and Maintenance

20. During the admission process, the nurse receives orders for the patient to have arterial blood gases (ABGs) drawn. Which finding from the patient's history may cause concern?
    a. Taking ginkgo biloba for the last 6 months
    b. Having an increased hematocrit (Hct) level during the last physical exam
    c. Being diabetic for 10 years
    d. Having a decreased white blood cell (WBC) count

ANS: A
Ginkgo biloba may lower the platelet count and cause bleeding. Therefore, the nurse would be concerned about arterial bleeding occurring following ABGs being drawn. Increased Hct, a history of diabetes, and a decreased WBC count would not pose any problems with drawing a sample for ABGs.

DIF: Cognitive Level: Application REF: 23 OBJ: 2 (clinical)
TOP: Alternative Medicine KEY: Nursing Process Step: Assessment
MSC: NCLEX: Physiological Integrity: Reduction of Risk Potential

21. The LPN/LVN adheres to facility policy regarding core measures by performing which interventions during patient care?
    a. Administering the ordered amount of insulin to a patient with type 1 diabetes
    b. Performing a thorough patient assessment upon admission to the health care facility
    c. Documenting accurately and at appropriate intervals in the patient's record
    d. Providing patient teaching regarding proper diet for the patient diagnosed with renal failure

    ANS: A
    Core measures are interventions that are based on scientifically researched, evidenced-based standards of care and are used to treat the majority of patients with a specific illness which often develops complications. Insulin administration for diabetics is evidence-based researched practice. The remaining options are good practice but are not considered core measures.

    DIF: Cognitive Level: Analysis REF: 17 OBJ: 10 (clinical)
    TOP: Core Measures KEY: Nursing Process Step: Implementation
    MSC: NCLEX: Safe, Effective Care Environment: Management of Care

22. The nurse is caring for a patient diagnosed with pneumonia. The patient has a BP 160/94, P 102, R 28, crackles in posterior lower lobes bilaterally, oxygen saturation 89%, and complains of shortness of breath upon exertion. The highest priority nursing diagnosis for this patient is:
    a. Activity intolerance
    b. Impaired gas exchange
    c. Ineffective cardiopulmonary tissue perfusion
    d. Self-care deficit: Bathing and hygiene

    ANS: B
    While all nursing diagnoses may apply to this patient, Impaired gas exchange is the highest priority because this is the underlying problem for the other nursing diagnoses, as well as physiologically the highest priority.

    DIF: Cognitive Level: Application REF: 24-27 OBJ: 2 (clinical)
    TOP: Nursing Diagnosis KEY: Nursing Process Step: Planning
    MSC: NCLEX: Safe, Effective Care Environment: Management of Care

MULTIPLE RESPONSE

23. The nurse explains to the nursing student that the application of critical thinking to patient care involves: (*Select all that apply.*)
    a. identification of a patient problem.
    b. setting priorities.
    c. concentrating on the patient rather than family needs.
    d. use of logic and intuition.
    e. expansion of thought beyond the obvious.

    ANS: A, B, D, E
    Critical thinking as applied to nursing care requires setting priorities of patient problems and needs by using logic and intuition. Inclusion of the family in the care makes the approach family oriented. Critical thinking should go beyond the obvious.

    DIF: Cognitive Level: Comprehension REF: 14-16 OBJ: 2 (theory)
    TOP: Critical Thinking KEY: Nursing Process Step: Implementation
    MSC: NCLEX: Safe, Effective Care Environment: Coordinated Care

24. The nurse demonstrates application of the nursing process by: (*Select all that apply.)*
    a. performing a head-to-toe assessment.
    b. updating the patient care plan on a weekly basis.
    c. evaluating if patient goals have been met.
    d. determining if nursing interventions need to be changed based on lack of patient progress toward meeting goals.
    e. ensuring that all personnel caring for the patient are implementing the care plan and working toward the same goals.

    ANS: A, C, D, E
    The nursing care plan should be updated as necessary, not just on a weekly basis. Concepts of the nursing process are demonstrated by performing orderly, logical head-to-toe assessments, as well as ongoing evaluation of patient goals and interventions to meet those goals.

    DIF: Cognitive Level: Comprehension REF: 16 OBJ: 1 (clinical)
    TOP: Nursing Process KEY: Nursing Process Step: Implementation
    MSC: NCLEX: Safe, Effective Care Environment: Coordinated Care

25. The nurse demonstrates knowledge of the National Patient Safety Goals by performing patient care that includes: (*Select all that apply.)*
    a. identifying the patient prior to medication administration by asking the patient to state his or her name.
    b. reporting any sentinel event to the facility's quality assurance team.
    c. assessing the patient's heart rate prior to administration of digoxin.
    d. performing hand hygiene prior to performing a patient assessment.
    e. documenting the appropriate time of medication administration.

    ANS: C, D, E

Assessing the patient's heart rate prior to administration of digoxin demonstrates knowledge of medication actions and prevention of adverse effects; hand hygiene is required before any patient care, including assessment; and documentation of the time of medication administration is necessary to prevent medication errors. To meet National Patient Safety Goals, the nurse must use at least two methods of patient identification prior to medication administration. Reporting a sentinel event is required but demonstrates that National Patient Safety Goals were not met.

DIF: Cognitive Level: Application REF: 17 | Box 2-3 OBJ: 9 (clinical)
TOP: National Patient Safety Goals KEY: Nursing Process Step: Implementation
MSC: NCLEX: Safe, Effective Care Environment: Safety and Infection Control

COMPLETION

26. The nursing student demonstrates knowledge of the proper use of the _____ when determining that it is safe to administer meperidine (Demerol) and promethazine (Phenergan) together.

ANS:
Medication Reconciliation Form
The Medication Reconciliation Form tracks all medications the patient is taking as prescribed by different physicians and can identify overdoses or drugs that are not compatible.

DIF: Cognitive Level: Application REF: 19-20 OBJ: 2 (clinical)
TOP: Medication Reconciliation Form KEY: Nursing Process Step: Implementation
MSC: NCLEX: Safe, Effective Care Environment: Coordinated Care

27. Shortness of breath due to emphysema would be a major component of the _____ care plan.

ANS:
interdisciplinary
An interdisciplinary care plan involves all members of the health care team and is based on the medical diagnosis rather than a nursing diagnosis.

DIF: Cognitive Level: Application REF: 27 OBJ: 2 (clinical)
TOP: Interdisciplinary Care Plan KEY: Nursing Process Step: Planning
MSC: NCLEX: Health Promotion and Maintenance

MATCHING

Place the steps of the nursing process in their proper sequence.

a. Evaluation
b. Assessment
c. Implementation
d. Planning
e. Nursing diagnosis

28. Step 1
29. Step 2

30. Step 3
31. Step 4
32. Step 5

28. ANS: B DIF: Cognitive Level: Comprehension REF: 17
OBJ: 7 (clinical) TOP: Applying the Nursing Process
KEY: Nursing Process Step: Planning MSC: NCLEX: Health Promotion and Maintenance
29. ANS: E DIF: Cognitive Level: Comprehension REF: 17
OBJ: 7 (clinical) TOP: Applying the Nursing Process
KEY: Nursing Process Step: Planning MSC: NCLEX: Health Promotion and Maintenance
30. ANS: D DIF: Cognitive Level: Comprehension REF: 17
OBJ: 7 (clinical) TOP: Applying the Nursing Process
KEY: Nursing Process Step: Planning MSC: NCLEX: Health Promotion and Maintenance
31. ANS: C DIF: Cognitive Level: Comprehension REF: 17
OBJ: 7 (clinical) TOP: Applying the Nursing Process
KEY: Nursing Process Step: Planning MSC: NCLEX: Health Promotion and Maintenance
32. ANS: A DIF: Cognitive Level: Comprehension REF: 17
OBJ: 7 (clinical) TOP: Applying the Nursing Process
KEY: Nursing Process Step: Planning MSC: NCLEX: Health Promotion and Maintenance