Arnold: Interpersonal Relationships, 6th Edition

Chapter 02: Professional Guides to Action in Interpersonal Relationships

Test Bank

MULTIPLE CHOICE

1. Legal documents developed at the state level that govern the provision of professional nursing care are known as:
   a. NCLEX
   b. Nurse Practice Acts
   c. Professional standards of care
   d. Tort laws

   ANS: B
   Professional nursing practice is legally regulated through state licensure, with national certifications required for advanced practice. Each state sets forth professional nursing standards and interpretive guidelines through its Nurse Practice Act. NCLEX is the National Council Licensure Examination. Professional standards of care are statements that describe levels of care or performance common to the nursing profession. Tort laws are legal tenets.

   DIF: Cognitive Level: Knowledge REF: p. 24
   TOP: Step of the Nursing Process: All phases
   MSC: Client Needs: Management of Care

2. A preoperative assessment shows that a client's hemoglobin level is dropping. The anesthetist orders 3 units of blood to be administered. The nurse administers the first unit before discovering that the client is a Jehovah's Witness, as documented in the record. This is an example of:
   a. Professional conduct
   b. A negligent act
   c. Physical abuse
   d. Breaching client confidentiality

   ANS: B
   The nurse was negligent by not checking the record and by failure to obtain written consent from the client for the procedure. This is an example of misconduct, not professional conduct. The nurse did not intend to physically harm the patient. The nurse did not breach client confidentiality.

   DIF: Cognitive Level: Application REF: p. 26
   TOP: Step of the Nursing Process: All phases
   MSC: Client Needs: Management of Care

3. Which of the following is a violation of client confidentiality? Reporting:

a. Certain communicable diseases
b. Child abuse
c. Gunshot wounds
d. Client data to a colleague in a nonprofessional setting

ANS: D
Releasing information to people not directly involved in the client's care is a breach of confidentiality. Certain communicable diseases, child abuse, and gunshot wounds require mandatory reporting.

DIF: Cognitive Level: Knowledge REF: p. 40
TOP: Step of the Nursing Process: All phases
MSC: Client Needs: Management of Care

4. A 16-year-old trauma victim arrives in the emergency department with a life-threatening condition and requires emergency surgery. The nurse knows that:
   a. A parent/guardian must give consent
   b. The client can give consent if she provides proof of emancipation
   c. The client must first be evaluated for competency before obtaining consent
   d. Surgery can be performed without consent

   ANS: D
   Surgery can be performed without consent because it is a life-threatening emergency. Normally parents or a guardian must give consent, but in a life-threatening emergency, medical care can be administered without consent. Providing proof of emancipation is not necessary in a life-threatening situation. The client does not deed to first be evaluated for competency in a life-threatening situation.

   DIF: Cognitive Level: Application REF: p. 40
   TOP: Step of the Nursing Process: All phases
   MSC: Client Needs: Management of Care

5. In regard to informed consent, which of the following statements is true?
   a. Only legally incompetent adults can give consent.
   b. Only parents can give consent for minor children.
   c. It is not required that the client be told about costs and alternatives to treatment.
   d. Consent must be voluntary.

   ANS: D
   For legal consent to be valid, it must be voluntary. Only legally *competent* adults can give consent. Parents or legal guardians can give consent for minor children. Clients must have full disclosure about risks/benefits including costs and alternatives.

   DIF: Cognitive Level: Knowledge REF: p. 41
   TOP: Step of the Nursing Process: All phases
   MSC: Client Needs: Management of Care

6. Which of the following provides the health care team with information regarding the client's wishes regarding life-prolonging treatment protocols?
   a. Advance directive
   b. Informed consent
   c. Statement of clients' rights
   d. Professional code of ethics

   ANS: A
   An *advance directive* is a legal document, executed by a competent client or legal proxy, specifically identifying individual preferences for the level of care at end of life, related to treatment, medications, hydration, and nutrition. Informed consent is made at or shortly before treatment. A statement of clients' rights is a broad, general statement about clients' rights. The professional code of ethics outlines principled behaviors and values expected of professional nurses.

   DIF: Cognitive Level: Knowledge REF: p. 28 | p. 31
   TOP: Step of the Nursing Process: All phases
   MSC: Client Needs: Management of Care

7. The client has a living will in which he states he does not want to be kept alive by artificial means. The client's family wants to disregard the client's wishes and have him maintained on artificial life support. The most appropriate initial course of action for the nurse would be to:
   a. Tell the family that they have no legal rights
   b. Tell the family that they have the right to override the living will because the patient cannot speak
   c. Report the situation to the hospital ethics committee
   d. Allow the family to verbalize their feelings and concerns, while maintaining the role of client advocate

   ANS: D
   Allowing the family to verbalize their feelings and concerns is the most appropriate action at the time to assist the family to deal with their loss and come to terms with their family member's wishes. Telling the family that they have no legal rights would not be supportive and might create hostility. The family does not have the right to override a living will. It is not the most appropriate initial course of action to report the situation to the hospital ethics committee.

   DIF: Cognitive Level: Analysis REF: p. 28
   TOP: Step of the Nursing Process: Implementation
   MSC: Client Needs: Management of Care

8. The nurse collects both objective and subjective data. An example of subjective data is:
   a. Blood pressure of 140/80 mm Hg
   b. Skin color that reflects jaundice
   c. Client statement of "I have a headache."
   d. History of seizures

ANS: C
Subjective data refer to the client's perception of data and what the client says about the data. Objective data refer to data that are directly observable or verifiable through physical examination or tests. Blood pressure recording is objective. Jaundiced skin color observation by the nurse is an example of objective data. A history of seizures is an example of objective data.

DIF: Cognitive Level: Knowledge REF: p. 32
TOP: Step of the Nursing Process: Assessment
MSC: Client Needs: Physiological Integrity

9. The nurse observes a client pacing the floor. The nurse validates an inference when speaking to the client by stating
   a. "You are anxious, so let's talk about it."
   b. "Let's try some deep breathing to help you relax."
   c. "You seem anxious. Will you tell me what is going on?"
   d. "Clients who pace usually need to talk to a physician. Should I call yours?"

   ANS: C
   The nurse has inferred that the client is anxious but needs to ask further questions to validate the information. A nurse should not make assumptions without first confirming that the inference is correct. Deep breathing exercise is an intervention; it is not validating an inference.

   DIF: Cognitive Level: Application REF: p. 32
   TOP: Step of the Nursing Process: Assessment
   MSC: Client Needs: Psychosocial Integrity

10. A client who is scheduled for a bilateral inguinal hernia repair the next day is observed pacing the unit. After validating that the client is anxious about his upcoming surgery because he is afraid of pain, a relevant nursing diagnosis would be:
    a. Anxiety related to surgery
    b. Pain related to anxiety about surgery as evidenced by pacing
    c. Anxiety related to fear of postoperative pain as evidenced by pacing
    d. Pacing related to fear of postoperative pain

    ANS: C
    Anxiety is the problem to be addressed. *Related to* connects the problem to the etiology (fear of pain). The third part of the statement identifies the clinical evidence (pacing) that supports the diagnosis. There are three parts to a nursing diagnosis and the anxiety is related specifically to fear of pain after surgery. The problem to be addressed is the anxiety, not the pain, at this time. "Pacing related to fear of postoperative pain" contains only two parts to this statement. Pacing is the evidence, not the problem.

    DIF: Cognitive Level: Application REF: p. 33
    TOP: Step of the Nursing Process: Nursing Diagnosis
    MSC: Client Needs: Management of Care

11. Which of the following is an outcome for a client with a broken leg?
    a. Client will develop an ambulation program within 1 month.
    b. Client is encouraged to ambulate with cast using crutches.
    c. Client asks, "When will I walk again?"
    d. There is an alteration in mobility related to a broken leg.

    ANS: A
    Outcomes are goals that are measurable, achievable, and client-centered. Ambulation is a nursing intervention. A question from the client is not an outcome; it is a question. "Alteration in mobility related to a broken leg" is part of a nursing diagnosis.

    DIF: Cognitive Level: Application REF: p. 34-35
    TOP: Step of the Nursing Process: Outcome Identification
    MSC: Client Needs: Physiological Integrity

12. When caring for a client who is anxious about a surgical procedure, the nurse demonstrates an independent nursing intervention when:
    a. Medicating the client with an anxiolytic
    b. Talking with the client using therapeutic communication
    c. Checking the client's vital signs
    d. Notifying respiratory therapy the client needs a small volume nebulizer (SVN) treatment

    ANS: B
    Independent nursing interventions are those that nurses can provide without a physician's order or direction from another health professional. Medicating the client with an anxiolytic is a dependent nursing intervention. It requires a physician's order. Checking the client's vital signs is an example of a dependent nursing action. Notifying respiratory therapy that the client needs an SVN treatment is an example of a collaborative nursing intervention—working together with respiratory therapy.

    DIF: Cognitive Level: Application REF: p. 36
    TOP: Step of the Nursing Process: Implementation
    MSC: Client Needs: Psychosocial Integrity

13. When setting goals with a client, the nurse demonstrates which step of the nursing process?
    a. Assessment
    b. Planning
    c. Implementation
    d. Evaluation

    ANS: B
    Outcome identification occurs during the planning phase. Goals are identified during planning, not assessment. Nursing interventions are performed during the implementation phase. During evaluation, goal achievement is evaluated.

DIF: Cognitive Level: Knowledge REF: p. 31
TOP: Step of the Nursing Process: Outcome Identification and Planning
MSC: Client Needs: Management of Care

14. When the nurse identifies a health problem or alteration in a client's health status that requires a nursing intervention, the nurse is performing which step of the nursing process?
    a. Diagnosis
    b. Planning
    c. Intervention
    d. Evaluation

    ANS: A
    The nursing diagnosis consists of three parts: problem, etiology, and evidence. The problem is a statement identifying a health problem or alteration in a client's health status, requiring nursing intervention. Planning occurs after problem identification. Interventions occur during implementation. The effectiveness of the interventions is evaluated in the evaluation phase.

    DIF: Cognitive Level: Knowledge REF: p. 33
    TOP: Step of the Nursing Process: Diagnosis
    MSC: Client Needs: Management of Care

15. When evaluating the client's progress toward goal achievement, the nurse should ask which of the following questions?
    a. "Did the client tell the truth?"
    b. "Were the goals realistic?"
    c. "Did the physician diagnose the client's condition correctly?"
    d. "Was the length of stay too short?"

    ANS: B
    The goals need to be realistic and achievable in the time frame allotted for the interventions to be effective. Validation of information occurs in the assessment phase. Medical diagnosis is not part of the nursing process. The nurse needs to work within the time frame allotted.

    DIF: Cognitive Level: Comprehension REF: p. 36
    TOP: Step of the Nursing Process: Evaluation
    MSC: Client Needs: Management of Care

16. The nursing process helps the nurse to:
    a. Maintain confidentiality
    b. Attain self-actualization
    c. Maintain therapeutic communication
    d. Structure and organize nursing care

    ANS: D

The nursing process is the primary framework used to structure and organize nursing care. Maintaining confidentiality is a means of sharing information with the health care team. The nurse can use Maslow's hierarchy of needs to prioritize care. Therapeutic communication assists the nurse to use the nursing process.

DIF: Cognitive Level: Comprehension REF: p. 30
TOP: Step of the Nursing Process: All phases
MSC: Client Needs: Management of Care

17. Which of the following best describes a clinical decision-making tool?
    a. Uses only one data source
    b. Is very different from a clinical pathway
    c. Is research based
    d. Is not needed for guiding nursing care

ANS: C
Clinical decision-making tools are similar to clinical pathways and treatment algorithms used to guide treatment and nursing care. To be effective, clinical decision rules must follow strict protocols and be research based, valid, and reflective of multiple sources of data. Multiple sources of data are used.

DIF: Cognitive Level: Knowledge REF: p. 30
TOP: Step of the Nursing Process: All phases
MSC: Client Needs: Management of Care

18. During a routine visit, the nurse notes that a child has several bruises at various stages of healing. The child reports falling down. Failure to report these findings is an example of:
    a. Negligence
    b. Reasonable prudence
    c. Maintenance of confidentiality
    d. HIPAA regulation

ANS: A
Failing to report suspected physical or sexual child abuse is an example of a negligent act. Reasonable prudence is a nursing action that a reasonably prudent nurse would perform. In a situation where a child has several bruises, confidentiality must be breached. HIPAA regulations protect the privacy of client records.

DIF: Cognitive Level: Application REF: p. 27 | p. 40
TOP: Step of the Nursing Process: Implementation
MSC: Client Needs: Management of Care