ATI PN MED SURG PROCTORED EXAM

(Detail Solutions)

1. A nurse who is caring for a patient with a pressure ulcer applies the recommended dressing according to hospital policy. Which standard is the nurse following?

a. Fairness

b. Intellectual standards

c. Independent reasoning

d. Institutional practice guidelines

ANS: D

The standards of professional responsibility that a nurse tries to achieve are the standards cited in Nurse Practice Acts, institutional practice guidelines (hospital/facility policy), and professional organizations' standards of practice (e.g., The American Nurses Association Standards of Professional Performance). Intellectual standards are guidelines or principles for rational thought. Fairness and independent reasoning are two examples of critical thinking attitudes that are designed to help nurses make clinical decisions.

2. A nurse is reviewing care plans. Which finding, if identified in a plan of care, should the registered nurse revise?

a. Patient's outcomes for learning

b. Nurse's assumptions about hospital discharge

c. Identification of several actual health problems

d. Documentation of patient's ability to meet the goal

ANS: B

The nurse should not assume when a patient is going to be discharged and document this information in a plan of care. Making assumptions is not an example of a critical thinking skill. The purpose of the nursing process is to diagnose and treat human responses (e.g., patient symptoms, need for knowledge) to actual or potential health problems. Use of the process allows nurses to help patients meet agreed-on outcomes for better health. The patient's outcomes, having several actual health problems, and a description of the patient's abilities to meet the goal are all appropriate to document in the

nursing plan of care.

3. In which order will the nurse use the nursing process steps during the clinical decision-making process?

1. Evaluating goals
2. Assessing patient needs
3. Planning priorities of care
4. Determining nursing diagnoses
5. Implementing nursing interventions

a. 2, 4, 3, 5, 1

b. 4, 3, 2, 1, 5

c. 1, 2, 4, 5, 3

d. 5, 1, 2, 3, 4

ANS: A

The American Nurses Association developed standards that set forth the framework necessary for critical thinking in the application of the five-step nursing process: assessment, diagnosis, planning, implementation, and evaluation.

MULTIPLE RESPONSE

1. Which findings will alert the nurse that stress is present when making a clinical decision? (*Select all that apply*.)

a. Tense muscles

b. Reactive responses

c. Trouble concentrating

d. Very tired feelings

e. Managed emotions

ANS: A, B, C, D

Learn to recognize when you are feeling stressed—your muscles will tense, you become reactive when others communicate with you, you have trouble concentrating, and you feel very tired. Emotions are not managed when stressed.

The nurse is using critical thinking skills during the first phase of the nursing process. Which action indicates the nurse is in the first phase?

a. Completes a comprehensive database

b. Identifies pertinent nursing diagnoses

c. Intervenes based on priorities of patient care

d. Determines whether outcomes have been achieved

ANS: A

The assessment phase of the nursing process involves data collection to complete a thorough patient database and is the first phase. Identifying nursing diagnoses occurs during the diagnosis phase or second phase. The nurse carries out interventions during the implementation phase (fourth phase), and determining whether outcomes have been achieved takes place during the evaluation phase (fifth phase) of the nursing process.

2. A nurse is using the problem-oriented approach to data collection. Which action will the nurse take **first**?

a. Complete the questions in chronological order.

b. Focus on the patient's presenting situation.

c. Make accurate interpretations of the data.

d. Conduct an observational overview.

ANS: B

A problem-oriented approach focuses on the patient's current problem or presenting situation rather than on an observational overview. The database is not always completed using a chronological approach if focusing on the current problem. Making interpretations of the data is not data collection. Data interpretation occurs while appropriate nursing diagnoses are assigned. The question is asking about data collection.

3. After reviewing the database, the nurse discovers that the patient's vital signs have not been recorded by the nursing assistive personnel (NAP). Which clinical decision should the nurse make?

a. Administer scheduled medications assuming that the NAP would have reported abnormal vital signs.