Name: _____ Class: _____ Date: _____ ID: C

Nursing Process 1 Quiz #2

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

____ 1. Which of these outcomes would be most appropriate for a patient with a nursing diagnosis of *Constipation related to slowed gastrointestinal motility secondary to pain medications*?
   a. Patient will walk unassisted to bathroom by the end of shift.
   b. Patient will have one soft, formed bowel movement by end of shift.
   c. Patient will not take laxatives or stool softeners this shift.
   d. Patient will not take any pain medications this shift.

____ 2. The nurse is evaluating whether patient goals and outcomes have been met. Which option below is an expected outcome for a patient with *Impaired physical mobility*?
   a. The patient will deny pain while walking in the hallway.
   b. The patient's level of mobility will improve.
   c. The nurse provides assistance while the patient is walking in the hallways.
   d. The patient is able to ambulate in the hallway with crutches.

____ 3. Which intervention is most appropriate for the nursing diagnostic statement, *Impaired skin integrity related to shearing forces*?
   a. Do not document the wound appearance in the chart.
   b. Keep the bed side rails up at all times.
   c. Perform the ordered dressing change twice daily.
   d. Administer pain medication every 4 hours as needed.

____ 4. A nurse is providing education to a patient about self-administering subcutaneous injections. Which of these patient statements indicates that the patient understands the instructions?
   a. "I need to throw the syringe and needle into the garbage when I am done giving myself my shot."
   b. "My belly is a good place to give my injection."
   c. "I will give the medicine deep into my deltoid."
   d. "I need to use a needle 1/2 inch longer than my thumb."

____ 5. Which of these interventions, to be included in the plan of care, is appropriate for the patient outcome that states, "The patient will verbalize a pain level at 3 or below on a 0 to 10 scale throughout this shift."?
   a. Medicate the patient based on previous shift assessment findings.
   b. Discuss only nonpharmacological methods of pain relief.
   c. Medicate the patient immediately after all procedures.
   d. Teach the patient about side effects of pain medications.

____ 6. A hospital's wound nurse consultant made a recommendation for nurses on the unit to continue the patient's dressing changes as previously ordered. The nurses on the unit should incorporate this recommendation into the patient's plan of care by
   a. Assuming that the wound nurse will perform all dressing changes.
   b. Requesting that the physician look at the wound herself.
   c. Encouraging the patient to perform the dressing changes.
   d. Including dressing change instructions and frequency in the plan of care.

____ 7. A patient recovering from a leg fracture after a fall states that he has dull pain in the affected leg and rates it as a 7 on a 0 to 10 scale. The patient is not able to walk around in the room with crutches because of leg discomfort. What is the priority nursing intervention for this patient?
   a. Administer pain medication.
   b. Obtain a walker for the patient.
   c. Assist the patient to walk in the room with crutches.
   d. Consult physical therapy.

____ 8. A patient was recently diagnosed with pneumonia. The nurse and the patient have established a goal that the patient will not experience shortness of breath with activity in 3 days with an expected outcome of having no secretions present in the lungs in 48 hours. Which of the following is an appropriate evaluative measure demonstrating progress toward this goal?
   a. Scattered rhonchi throughout all lung fields in 2 days
   b. Lungs clear to auscultation following use of inhaler
   c. Respirations 30/minute in 1 day
   d. Nonproductive cough present in 4 days

____ 9. Which is the appropriate initial intervention for the nursing diagnostic statement *Impaired skin integrity related to poor wound healing*?
   a. Document wound characteristics.
   b. Reinforce the wound dressing as needed with 4 × 4 gauze.
   c. Assess wound appearance each shift.
   d. Perform the ordered dressing change twice daily.

____ 10. A nurse identifies a nursing diagnosis of *Risk for falls* when assessing a patient upon admission. The nurse and the patient agree that the goal is for the patient to remain free from falls. However, the patient fell just before shift change. What is the nurse's priority action when evaluating the patient's plan of care?
   a. Remove the fall risk sign from the patient's door because the patient has suffered a fall.
   b. Counsel the nursing assistive personnel on duty when the patient fell.
   c. Identify factors interfering with goal achievement.
   d. Request that the more experienced charge nurse complete the documentation about the fall.

____ 11. What is the first step in making a consult?
   a. Identify the problem.
   b. Ensure that the right professional, with the appropriate knowledge and expertise, is contacted.
   c. Provide the consultant with relevant information about the problem.
   d. Avoid bias by not providing a lot of information based on opinion to the consultant.

____ 12. After assessing the patient and identifying the need for headache relief, the nurse administers acetaminophen (Tylenol) for the patient's headache. What is the nurse's next priority action for this patient?
   a. Revise the plan of care.
   b. Direct the nursing assistant to ask if the patient's headache is relieved.
   c. Eliminate *Acute pain* from the nursing care plan.
   d. Reassess the patient's pain level in 30 minutes.

____ 13. What is the primary goal of outcomes management for professional nurses?
   a. To decrease the number of medication errors in nursing
   b. To promote purposeful actions focused on improving a patient's health condition
   c. To support the delegation of more nursing tasks to nursing assistive personnel
   d. To fine-tune nursing assessment skills

____ 14. In which step of the nursing process does the nurse determine if the patient's condition has improved and whether the patient has met expected outcomes?
   a. Implementation
   b. Planning
   c. Evaluation
   d. Assessment

____ 15. Which of the following is a nursing intervention?
   a. Provide assistance while the patient walks in the hallway twice this shift with crutches.
   b. The patient is unable to bear weight on right lower extremity.
   c. *Impaired physical mobility related to inability to bear weight on right leg*
   d. The patient will ambulate in the hallway twice this shift using crutches correctly.

____ 16. Which of these options is a patient outcome indicating positive progress toward resolving the nursing diagnosis of *Acute confusion*?
   a. Patient denies pain while ambulating with assistance.
   b. Patient correctly states names of family members in the room.
   c. Side rails are up with bed alarm activated.
   d. Patient wanders halls at night.

____ 17. After completing a thorough database and analyzing the data to identify any problems, the nurse should proceed to what step of the nursing process?
a. Planning
b. Evaluation
c. Implementation
d. Assessment

____ 18. Which patient outcome statement includes all seven guidelines for writing goal and outcome statements?
a. The patient will ambulate in hallways.
b. The nurse will administer pain medication every 4 hours to keep the patient free from discomfort.
c. The nurse will monitor the patient's heart rhythm continuously this shift.
d. The patient will feed self at all mealtimes today without complaints of shortness of breath.

____ 19. The standing orders for a patient include acetaminophen (Tylenol) 650 mg every 4 hours prn for headache. After assessing the patient, identifying the need for headache relief, and determining that the patient has not had Tylenol in the past 4 hours, the nurse
a. Administers the Tylenol.
b. Notifies the health care provider to obtain a verbal order.
c. Directs the nursing assistant to give the Tylenol.
d. Performs a pain assessment only after administering the Tylenol.

____ 20. A patient visiting with family members in the waiting area tells the nurse that his stomach is not feeling good. Before intervening, what should the nurse do?
a. Tell the patient that his dinner tray will be ready in 15 minutes.
b. Ask the patient when his last bowel movement was and to lie down on the sofa.
c. Request that the family leave, so the patient can rest.
d. Ask the patient to return to his room so the nurse can inspect his abdomen.

____ 21. After completing a thorough database and carrying out nursing interventions based on priority diagnoses, the nurse proceeds to which step of the nursing process?
a. Planning
b. Evaluation
c. Assessment
d. Implementation

____ 22. The nurse is caring for a patient who has an open wound. When evaluating the progress of wound healing, what is the nurse's priority action?
a. Measure the wound and observe for redness, swelling, or drainage.
b. Ask the nursing assistive personnel if the wound looks better.
c. Leave the dressing off the wound for easier access and more frequent assessments.
d. Document the progress of wound healing as "better" in the patient's chart.

____ 23. A goal for a patient with a diagnosis of *Ineffective coping* is to demonstrate effective coping skills. Which of these patient behaviors indicates that interventions performed to meet this outcome have been successful?
   a. Spends most of the day in bed
   b. Continues to consume several alcoholic beverages a day
   c. States he feels better after talking with his family and friends
   d. Dislikes the support group meetings

____ 24. Vital signs for a patient reveal a high blood pressure of 187/100. Orders state to notify the health care provider for diastolic blood pressure greater than 90. What is the nurse's first action?
   a. Assess the patient for other symptoms or problems, and then notify the health care provider.
   b. Administer an antihypertensive medication from the stock supply, and then notify the health care provider.
   c. Review the most recent lab results for the patient's potassium level.
   d. Follow the clinical protocol for a stroke.

____ 25. A nursing assessment for a patient with a spinal cord injury leads to several pertinent problems that a nurse can treat. While developing the plan of care, which nursing diagnosis is the highest priority for this patient?
   a. *Spiritual distress*
   b. *Risk for impaired skin integrity*
   c. *Reflex urinary incontinence*
   d. *Risk for infection*

____ 26. The nurse defines a clinical guideline or protocol as a
   a. Hospital policy designating each nurse's duty according to standards of care and a code of ethics.
   b. Document that assists the clinician in making decisions and choosing interventions for specific health care problems or conditions.
   c. Prescriptive order form that individualizes the plan of care.
   d. Guideline to follow that replaces the nursing care plan.

____ 27. Which of the following options correctly explains what the nurse should do with the plan of care for a patient after it is developed?
   a. Place the original copy in the chart, so it cannot be tampered with or revised.
   b. Send the plan of care to quality assurance for review.
   c. Communicate the plan of care to all health care professionals involved in the patient's care.
   d. Send the plan of care to the administration office to be filed.

____ 28. The nurse is intervening for an identified nursing diagnosis of *Risk for infection.* Which direct care nursing intervention is most appropriate?
   a. Leaving side rails up at all times
   b. Teaching the family proper handwashing technique
   c. Counseling the family on stress reduction techniques
   d. Teaching the patient how to use crutches

____ 29. The nurse describes evidence-based practice as
   a. Planning care based on tradition.
   b. Implementing interventions based on scientific rationale.
   c. Practice based on the evidence presented in court.
   d. Using standardized care plans.

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

____ 1. Identify elements of the evaluation process. *(Select all that apply.)*
   a. Documenting findings
   b. Setting priorities for patient care
   c. Terminating, continuing, or revising the care plan
   d. Collecting subjective and objective data to determine whether criteria or standards are met
   e. Ambulating 25 feet in the hallway with the patient