CHAPTER 1: CRITICAL THINKING AND THE NURSING PROCESS

MULTIPLE CHOICE

1. The “art of nursing” refers mainly to the use of:
   a. imaginative caring strategies.
   b. creative approaches to patient problems.
   c. professional intuition based on experience.
   d. multiple levels of patient assessment

   ANS: C
   Professional intuition develops over time, as nurses begin to link certain patterns or events to specific patient outcomes. However, the novice may need guidance to perceive links intuitively recognized by the experienced nurse.

   PTS: 1 DIF: Comprehension REF: Introduction

2. The scientific approach to nursing places emphasis on:
   a. past experiences and current behaviors.
   b. scientific principles and research data.
   c. key factors such as pathophysiology.
   d. reducing emotional responses to objective data.

   ANS: B
   The science of nursing involves the use of analytical thinking. Causation, key factors, and possible outcomes to a situation may be identified. Thus the science of nursing is based on scientific principles such as physiology, pathophysiology, and environmental factors coupled with research data.

   PTS: 1 DIF: Knowledge REF: Introduction

3. A patient at 34 weeks’ gestation presents to labor and delivery with a complaint of burning on urination. The nurse then inquires about the presence of other signs and symptoms, such as frequency of urination, a backache that comes and goes in a regular manner, unusual vaginal discharge, increased pelvic pressure, and any menstrual-like cramping. She is assessing the patient for the possibility of preterm labor. This is an example of which component of critical thinking?
   a. inference
   b. evaluation
   c. interpretation
   d. analysis

   ANS: A
   Inference speculates, derives, or reasons a specific premise based on information and assumptions obtained from the patient.

   PTS: 1 DIF: Application REF: Components of Critical Thinking

4. Using the Universal Intellectual Standards (UIS) for critical thinking, which standard is exemplified in the following statement: “The patient reports taking 15 Vicodin every day”?
   a. clarity
   b. accuracy
   c. precision
   d. relevance

   ANS: C
   Clarity asks if the obtained message or information is clearly understood. Accuracy asks if the information obtained is accurate and without error. Precision asks if the information is exact and nonjudgmental. Relevance asks if all the information connects to the central problem.

   PTS: 1 DIF: Application
   REF: Universal Intellectual Standards for Critical Thinking

5. What is an important function of the nursing database?
   a. It can provide a baseline for future comparisons.
   b. It can be used to challenge the patient's uninformed views.
   c. It can be used to assess the performance of the physician.
   d. It can demonstrate nursing competency.

   ANS: A
   Developing the nursing database can establish a baseline for future encounters with the patient as well as serve as a point of comparison should the patient's condition change.

   PTS: 1 DIF: Comprehension REF: Assessment

6. Which source provides subjective information?
   a. physical assessment
   b. health history interview
   c. laboratory reports
   d. medical records

   ANS: B
   Subjective data are usually gathered from the patient during the health history interview.

   PTS: 1 DIF: Comprehension REF: Assessment

7. *Readiness for diabetic teaching* is an example of what type of nursing diagnosis?
   a. actual
   b. potential
   c. wellness
   d. chronic

   ANS: C
   Actual nursing diagnoses are typically problem oriented and describe human responses that have been validated by the nurse. Risk nursing diagnoses are defined as "human responses to health conditions and life processes that may develop in a vulnerable individual, family, or community." They are supported by risk factors that contribute to increased vulnerability Wellness nursing diagnoses represent the patient's striving for a higher level of health and wellness. They focus on the strengths of the patient. Chronic is not a type of nursing diagnosis.

   PTS: 1 DIF: Comprehension REF: Types of Nursing Diagnoses

8. One of Mr. P's nursing diagnoses is *anxiety related to perceived threat of death as evidenced by patient verbalization, restlessness, hand tremors, facial tension, and quivering voice*. The phrase "anxiety related to perceived threat of death" indicates that his anxiety:
   a. is a potential risk to health.
   b. has an organic cause.
   c. is an actual problem amenable to nursing intervention.
   d. requires medical intervention.

   ANS: C
   In the case of Mr. P, "anxiety related to perceived threat of death"is the human response amenable to nursing intervention as defined by NANDA (North American Nursing Diagnosis Association).

   PTS: 1 DIF: Application REF: Types of Nursing Diagnoses

9. In a nursing diagnosis statement, the phrase beginning with "as evidenced by" represents the:
   a. human response.
   b. health problem.
   c. related factors.
   d. defining characteristics.

   ANS: D
   Defining characteristics are signs, symptoms, and statements made by the patient that validate the existence of the actual or wellness nursing diagnosis.

   PTS: 1 DIF: Comprehension
   REF: Writing the Nursing Diagnosis

10. Which of the following is most appropriate to place immediately after the nursing diagnosis *body image disturbance*?
    a. related to actual bodily changes (e.g., below-the-knee amputation
    b. as evidenced by patient verbalizations (e.g., "I can't look at a mirror")
    c. due to intentional scalding with hot water
    d. secondary to second-degree and third-degree burns to the face

    ANS: A
    Body image disturbance is the nursing diagnosis. Next would come the "related factors," which would be the origin of the patient's health problem.

    PTS: 1 DIF: Application REF: Writing the Nursing Diagnosis

11. The nursing diagnosis *ineffective airway clearance related to inadequate suctioning* is an example of which error?
    a. formulating a nursing diagnosis on the basis of insufficient or unqualified data
    b. using legally inadvisable terms
    c. using incorrect data
    d. using medical diagnoses

    ANS: B
    The nurse is making an assessment of nursing care given to the patient and not assessing the signs and symptoms the patient presents.

    PTS: 1 DIF: Application
    REF: Nursing Tip Box: Common Errors in Writing Nursing Diagnoses

12. Planning is the fourth step of the nursing process. It involves the prioritization of nursing diagnoses and care and the selection of nursing interventions. According to Maslow's Hierarchy of Needs, which situation exemplifies a physiological need?
    a. a child experiencing an asthma episode
    b. an infant whose side rails are left down on her crib
    c. a high school girl who is not selected to be on the dance team
    d. a child whose parents constantly call him "stupid"

    ANS: A
    According to Maslow, basic needs such as oxygen, water, and food take priority over all other issues. The child experiencing an asthma episode must have her physiological need for oxygen met before safety needs are attended to. Side rails on a crib are a safety need. Not being chosen for a dance team is a belonging and self-esteem need. Constantly being called "stupid" relates to a self-esteem need.

    PTS: 1 DIF: Application REF: Planning: Prioritization

13. Patients are most likely to be motivated and agreeable to following their plan of care when:
    a. their health care provider explains the plan in terms they can understanc
    b. they participate in the decision-making process as the plan is developed.
    c. they establish their own nursing diagnoses.
    d. their physician and nurse collaborate in developing the plan.

    ANS: B
    Patients who are actively involved with the decision-making process are more likely to be amenable to nursing care, to assist with their care, and to be agreeable to following the plan of care.

    PTS: 1 DIF: Comprehension REF: Planning: Prioritization

14. According to Maslow's Hierarchy of Needs, which nursing diagnosis should take priority over the others?
    a. *Altered nutrition, less than body requirements related to difficulty swallowing*
    b. *Risk for poisoning related to exposure to chemicals in the workplace*
    c. *Ineffective individual coping related to uncertainty of course of disease and treatment*
    d. *Deficient knowledge related to lack of interest in learning*

    ANS: A
    According to Maslow, basic needs such as oxygen, water, and food take priority over all other issues.

    PTS: 1 DIF: Comprehension REF: Planning: Prioritization

15. Patient outcomes should be written as:
    a. broad statements without end points.
    b. realistic, measurable statements.
    c. a means of increasing patient knowledge.
    d. follow-ups to patient goals.

    ANS: B
    Patient outcomes indicate the progression toward goal achievement. Realistic and measurable patient outcomes are written by the nurse to ensure continuity in patient care.

    PTS: 1 DIF: Comprehension REF: Outcomes Identification

16. When writing patient outcomes and establishing time frames for completion, the nurse should ensure that each nursing diagnosis has:
    a. only one patient outcome.
    b. either short- or long-term time frames, but not both.
    c. multiple outcomes and time frames.
    d. a specific time frame for each patient outcome

    ANS: D
    Every patient outcome must include a time frame that designates the time by which the patient outcome should be met.

    PTS: 1 DIF: Comprehension REF: Outcomes Identification

17. The implementation phase of the nursing process is best described as the time in which the nurse:
    a. sequentially executes the planned interventions for each nursing diagnosi
    b. coordinates the implementation of planned interventions so that all patient outcomes are achieved at the same time.
    c. simultaneously implements the interventions developed for multiple nursing diagnoses and makes modifications as needed.
    d. organizes and delegates assignments so that all patient outcomes are met by the established deadline.

    ANS: C
    During the implementation phase, the nurse executes the interventions that were devised during the planning phase. The time frame of the implementation phase varies from patient to patient and from nursing diagnosis to nursing diagnosis. The nurse simultaneously implements the intervention from multiple nursing diagnoses for a patient at any given time. Implementation is a dynamic process. The nurse is continually interacting with the patient, the family, and other health care colleagues, changing the plan of care based on the continuous flow of information.

    PTS: 1 DIF: Comprehension REF: Implementation

18. The evaluation phase of the nursing process is:
    a. conducted weekly to monitor the effectiveness of the interventions and progress toward outcomes.
    b. carried out when all the patient outcomes are achieved.
    c. an ongoing process focused on evaluating the effectiveness of the interventions.
    d. a continual process focused on the progress patients make toward achieving established outcomes.

    ANS: D
    Evaluation is the final phase of the nursing process. During evaluation, the patient's progress in achieving the outcomes is determined. Even before the time frame for assessing outcomes is reached, the nurse is continually assessing the patient's progress toward the outcomes, making the evaluation a continual and dynamic process.

    PTS: 1 DIF: Comprehension REF: Evaluation

19. In addition to the nurse, what other key people are involved in the evaluation phase of the nursing process?
    a. the nurse managers
    b. the patient and the family
    c. the patient and the physician
    d. all the health care professionals involved with the patient's care

    ANS: B
    During the evaluation phase, the nurse, in conjunction with the patient and the family, evaluates the status of the plan of care.

    PTS: 1 DIF: Knowledge REF: Evaluation

20. Critical pathways, used in the case management approach, consist of:
    a. rating scales for outcomes.
    b. lists of good and bad outcomes.
    c. maps that show the outcome of predetermined patient goals over a period of time.
    d. recommended activities for achieving patient care goals.

    ANS: C
    Critical pathways, or maps, show the outcome of predetermined patient goals over a period of time; for example, they state what activity the patient should be capable of performing daily based on the patient's diagnosis-related group (DRG).

    PTS: 1 DIF: Knowledge REF: Critical Pathways

21. The nurse documents his patient's progress on a problem using a SOAPIER note. In which section of the note would the physical examination appear?
    a. S
    b. O
    c. A
    d. P

    ANS: B
    The "S" refers to subjective. The physical examination is objective data and would be recorded in the "O" section. Analysis of data stated as a nursing diagnosis is recorded in the "A" section. The plan of care would be recorded in the "P" section. Intervention or implementation is recorded in the "I" section. "E" refers to evaluation. "R" refers to revision of the plan.

    PTS: 1 DIF: Comprehension
    REF: Documenting the Nursing Process

22. The main purpose of the nursing care plan is to:
    a. apply critical thinking to patient care.
    b. present nursing objectives to the patient and the family.
    c. help the nurse decide which interventions to use.
    d. communicate the patient's progress in a standard way.

    ANS: D
    The nursing care plan combines the elements of the nursing process to document the progress of patient care in a standard fashion. Nursing care plans serve as a means of communicating patient progress with other health care colleagues and ensuring continuity of care among the nursing staff.

    PTS: 1 DIF: Comprehension
    REF: Documenting the Nursing Process

COMPLETION

1. A purposeful, goal-directed process that strives to problem-solve patient care issues through the use of clinical reasoning is called _____ thinking.

   ANS:
   critical
   Rationale: Critical thinking is a purposeful, goal-directed thinking process that strives to problem-solve patient care issues through the use of clinical reasoning. It combines logic, intuition, and creativity. Clinical reasoning is a disciplined, creative, and reflective approach used together with critical thinking; its purpose is to establish potential strategies to assist patients in reaching their desired health goals. Critical thinking and clinical reasoning skills are essential to every nurse's clinical practice.

   PTS: 1 DIF: Knowledge REF: Critical Thinking and Clinical Reasoning

2. The purpose of the _____ is to define and establish the scope of nursing practice and provide the framework for the nursing process.

   ANS:
   American Nurses Association
   ANA
   Rationale: There are many frameworks for critical thinking in the health care professions. Nursing has developed its own unique tool to frame critical thinking, the nursing process. The nursing process is the framework on which the ANA developed the Nursing Scope and Standards of Practice. These standards give the profession broad guidelines to which nurses can be held accountable in their practice.

   PTS: 1 DIF: Knowledge REF: Critical Thinking and the Nursing Process

3. _____ are planned strategies based on scientific rationale and devised by the nurse to assist the patient in meeting the patient outcomes.

   ANS:
   Interventions
   Rationale: When appropriate, the patient, family, and significant others can assist in planning the interventions. Patients are more likely to be motivated and follow the interventions if they have been involved in the decision-making process. Every patient outcome has its own interventions. When appropriate, a frequency is included for each intervention, such as "turn every 2 hours."

   PTS: 1 DIF: Knowledge REF: Intervention Selection

OTHER

1. The nursing process includes six phases: (1) _____, (2) _____, (3) _____, (4) _____, (5) _____, and (6) _____.

   ANS:
   1. assessment
   2. nursing diagnosis
   3. outcome identification
   4. planning
   5. implementation
   6. evaluation

   Rationale: The nursing process includes six phases. It is a dynamic process that uses information in a meaningful way through problem-solving strategies to place the patient, family, or community in an optimal health state. The physical, emotional, mental, developmental, spiritual, and cultural assessments provide the foundation for the other steps of the nursing process.

   PTS: 1 DIF: Knowledge REF: Critical Thinking and the Nursing Process

2. Collaborative interventions refer to actions that are prescribed by the _____ and implemented by the _____.

   ANS:
   physician or doctor, nurse

   Rationale: Interventions can be independent and collaborative nursing actions. Independent nursing interventions are those that the nurse is legally capable of implementing based on education and experience. Collaborative interventions are physician prescribed and nurse implemented. With all interventions sound nursing judgment is required.

   PTS: 1 DIF: Knowledge REF: Intervention Selection