Chapter 1: Critical Thinking in the Role of the Medical-Surgical Nurse

MULTIPLE CHOICE

1. Which statement represents an accurate understanding of the concepts of holistic health?

A. It is the absence of disease or infirmity.
B. It focuses on curing illnesses of the mind and body.
C. It considers mind, body, and spirit as integral to a person’s being.
D. It focuses on the health care provider’s responsibility to attain client wellness.

ANS: B

The holistic view of human beings considers the mind, body, and spirit as dimensions of the person’s being. Holistic health focuses on promoting health and preventing illness, with emphasis on the client’s ability to achieve high-level wellness.

DIF: Cognitive Level: Comprehension TOP: Nursing Process Step: N/A

MSC: Client Needs Category: Safe, Effective Care Environment;
2. An African American client’s health history includes hypertension, diabetes, and heart disease. What major factor accounts for the increase in these diseases among some populations?

A. Lack of access to health care
B. Medical insurance that fails to cover drug treatment
C. Religious beliefs that conflict with health promotion activities
D. Inconsistent adherence to medical regimens by African Americans

ANS: A

Lack of access to health care is the primary factor implicated in the increase in chronic diseases such as diabetes, hypertension, and heart disease among African Americans.

DIF: Cognitive Level: Knowledge TOP: Nursing Process Step: N/A
MSC: Client Needs Category: N/A

3. A 42-year-old female client is referred for a screening mammography by her primary health care provider. What level of illness prevention is being practiced in this situation?

A. Primary prevention
B. Secondary prevention
C. Tertiary prevention
D. Principal prevention

ANS: B

Screening examinations are considered part of secondary prevention because some cases of disease will be uncovered along with examinations that have normal results. In primary prevention, interventions are delivered to avoid or delay disease onset. Tertiary prevention involves rehabilitation that occurs after a disease state stabilizes.

DIF: Cognitive Level: Comprehension TOP: Nursing Process Step: Intervention
MSC: Client Needs Category: Physiological Integrity

4. What are the goals of the Healthy People 2010 campaign?
A. To provide culturally congruent care across the life span
B. To increase years of healthy life while eliminating health disparities
C. To eliminate all chronic and acute diseases affecting the population
D. To provide specific population-focused health care delivery across the life span

ANS: B

*Healthy People 2010* is a revision of the goals of *Healthy People 2000*; this revision presents a more aggressive plan to improve the nation’s health through improved health promotion practices. The primary goals are (1) to increase quality and years of healthy life and (2) to eliminate health disparities among different demographic groups.

DIF: Cognitive Level: Knowledge TOP: Nursing Process Step: N/A

MSC: Client Needs Category: N/A

5. What role of the medical-surgical nurse is being practiced when a nurse performs an assessment of a client’s health care needs across the health care continuum?

A. Caregiver
B. Educator
C. Critical thinker
D. Continuing care planner

ANS: D

The medical-surgical nurse performs many roles, including caregiver, educator, coordinator of care, and critical thinker. When a nurse provides home assessment and health teaching to meet client health care needs across the health care continuum, the nurse is acting as a continuing care planner.

DIF: Cognitive Level: Comprehension TOP: Nursing Process Step: Assessment

MSC: Client Needs Category: Physiological Integrity

6. Which of the following scenarios best demonstrates the use of evidence-based practice by a nurse?

A. Care based upon the nurse’s previous experience with caring for clients
B. Care based upon the traditions and conjunctures within the discipline
C. Care based upon the judgment of the primary health care provider
D. Care based upon research and identified standards
ANS: D

Evidence-based practice refers to care delivery that is based upon research and identified standards.

DIF: Cognitive Level: Comprehension TOP: Nursing Process Step: Implementation

MSC: Client Needs Category: Safe, Effective Care Environment;

7. Which action by the nurse demonstrates understanding of a best practice intervention for client education?

A. Breaking complex skills into small parts
B. Using only visual and oral educational aids
C. Providing standardized educational information
D. Using client goals developed by the nursing staff
ANS: A

Best practices for adult learning include the following: breaking complex skills and information into small parts; assessing willingness to learn, including family/significant others in the education as appropriate; assessing factors that may influence learning, such as educational level; using psychomotor skills in addition to visual aids to enhance learning; and providing the client with a contact for follow-up questions.

DIF: Cognitive Level: Comprehension TOP: Nursing Process Step: Implementation

MSC: Client Needs Category: N/A

8. How have recent changes in health care delivery affected practice settings for medical-surgical nurses?

   Third-party payment systems have restricted the delivery of medical-surgical nursing services to acute care hospitals.
   B. Managed care organizations prefer less expensive care delivered by unlicensed personnel.
C. Medical-surgical nursing is practiced in community centers and long-term care facilities.
D. The delivery of medical-surgical nursing practice is now limited to adults only.
ANS: C

Medical-surgical nursing is practiced in a wide variety of settings. Although hospitals remain the largest employer of nurses, community-based integrated health care centers and long-term care facilities also require nurses with medical-surgical nursing experience.

DIF: Cognitive Level: Knowledge TOP: Nursing Process Step: N/A
MSC: Client Needs Category: N/A

9. Which of the following are components of the nursing process?

A. Assessment, analysis, planning, implementation, and evaluation
B. Assessment, goals, planning, analysis, and intervention
C. Assessment, planning, goals, intervention, and reassessment
D. Assessment, implementation, planning, intervention, and re-evaluation
ANS: A

The steps of the nursing process consist of assessment, analysis, planning, implementation, and evaluation.

DIF: Cognitive Level: Knowledge TOP: Nursing Process Step: All
MSC: Client Needs Category: N/A

10. Which statement illustrates an example of a type of diagnosis amenable to a nursing intervention?

A. Potential complication: hemorrhage
B. Pattern of acute nausea and vomiting
C. Ineffective breathing pattern
D. Acute complication: sepsis
ANS: C
Ineffective breathing pattern is an example of a nursing diagnosis. Nursing diagnoses are clinical judgments that provide the basis of definitive therapy toward outcomes for which the nurse is accountable.

DIF: Cognitive Level: Application or higher

TOP: Nursing Process Step: Analysis

MSC: Client Needs Category: Physiological Integrity

11. The nurse has just completed an interview and physical examination of a newly admitted client. What sources of information should this nurse use in formulating expected outcomes for the client?

A. Identified nursing diagnoses and collaborative problems  
B. The goals for the client as set by family members  
C. The medical history and laboratory test results  
D. Client goals as set by the nursing staff

ANS: A

After establishing priorities, the client and nurse reach a mutual decision regarding expected outcomes based on identified nursing diagnoses and collaborative problems.

DIF: Cognitive Level: Comprehension TOP: Nursing Process Step: Planning

MSC: Client Needs Category: Physiological/Psychological Integrity

12. Which action by the nurse demonstrates an understanding of best practice for nursing documentation?

A. “Whiting out” all errors on the client record  
B. Using red ink to denote all significant events  
C. Waiting until the end of the day to record information  
D. Using a highlighter to denote discontinuance of an order

ANS: D
Best practices for charting includes using a highlighter to denote the discontinuation of an order. Using this practice, the original order may still be read. Correction fluid is never used on a legal document. All writing on a chart is done using blue or black ink. It is also recommended that all events are recorded as soon as possible to ensure the timely reporting and accuracy of events.

DIF: Cognitive Level: Comprehension TOP: Nursing Process Step: N/A

MSC: Client Needs Category: Safe, Effective Care Environment;

13. A client is scheduled for a mastectomy as part of her treatment for breast cancer. As she is about to receive the preoperative medication, she tells the nurse that she does not want to have her breast removed but wants a lumpectomy. Which response indicates that the nurse is acting as a client advocate?

A. Telling the client that her surgeon is excellent and knows what is best for her condition
B. Calling the surgeon to come and explain all treatment options to the client
C. Holding the client’s hand and offering to pray with her for a good outcome to the surgery
D. Long-term survivor of cancer

ANS: B

Clients have the right to be fully informed about their treatment plans and to change their minds. A client expressing doubt, uncertainty, or a change of feeling about a treatment plan should be supported by the nurse, heard by the health care provider, and be an active participant in treatment planning.

DIF: Cognitive Level: Application or higher

TOP: Nursing Process Step: N/A

MSC: Client Needs Category: Safe, Effective Care Environment;

14. What assessment data should be collected first from a client admitted to the emergency department with a lacerated radial artery from a lawn mower accident?

A. Information regarding next of kin to notify in case the client dies
B. History about what medications the client is currently taking
C. Measurement of blood pressure, pulse, and capillary refill time

D. Measurement of the laceration size and depth

ANS: B
D. Assessment of rate and depth of respiration to ensure that the airway is patent
ANS: B

In establishing an emergency database, assessment first focuses on the immediate problem, especially with a high probability for a life-threatening consequence.

DIF: Cognitive Level: Application or higher

TOP: Nursing Process Step: Assessment

MSC: Client Needs Category: Safe, Effective Care Environment;

15. Which of the following client problems is considered a nursing diagnosis?

A. Blindness related to the inherited recessive disorder retinitis pigmentosa
B. Risk for injury related to decreased central vision
C. Potential for blindness related to bilateral eye infection
D. Psychotic reaction related to deteriorating visual acuity
ANS: B

Answers A and D are medical diagnoses. Answer C is a collaborative problem. Only B is a client problem in regard to a response to illness or disability and can be helped by nursing interventions.

DIF: Cognitive Level: Comprehension TOP: Nursing Process Step: Assessment

MSC: Client Needs Category: Safe, Effective Care Environment;

16. Assessing a client’s blood pressure is considered a nursing-initiated intervention under which of the following specified conditions?

A. When there is a change in the client’s mental status
B. When the client has just been returned to the floor after surgery
C. At regular intervals during administration of blood or blood products
D. Before administering a new medication categorized as an antihypertensive agent
ANS: A
Blood pressure measurement would be a part of expected or ordered care in conditions B, C, and D. Only in situation A is the measurement of blood pressure part of nursing judgment.

DIF:Cognitive Level: Application or higher

TOP:Nursing Process Step: Assessment

MSC: Client Needs Category: Physiological Integrity

17. Which entry in nursing documentation is considered nonjudgmental in reporting findings?

A. The client is confused.
B. The client is uncooperative.
C. The client demonstrates deceitful behavior.
D. The client does not recognize family members.

ANS: D

Only answer D describes an action or behavior that has taken place. Answers A, B, and C are interpretations of presenting activity or behavior.

DIF:Cognitive Level: Application or higher

TOP:Nursing Process Step: N/A

MSC: Client Needs Category: Psychological Integrity

18. Why are nursing care plans developed and used?

A. To establish a format from which nursing interventions can be scientifically tested
B. To comply with the Joint Commission on Accreditation of Health Care Organizations
C. To organize and prioritize nursing care for an individual
D. To ensure input from all disciplines in planning client care

ANS: C
Client care plans assist new students and neophyte nurses to follow the steps of the nursing process and to identify the rationale for selected nursing interventions. They are not required by JCAHCO nor are they interdisciplinary.

DIF: Cognitive Level: Knowledge TOP: Nursing Process Step: Planning

MSC: Client Needs Category: N/A

19. Which information gathered during assessment is considered to be subjective data?

A. The client’s urine is dark and foul-smelling.
B. The client’s total 24-hour urine output is 1800 mL.
C. The client indicates that pain and burning are present when urinating.
D. The client has been treated for urinary tract infections in the past.
ANS: C

Subjective data are not directly observable or measurable by people other than the person to whom the data relate.

DIF: Cognitive Level: Comprehension TOP: Nursing Process Step: Assessment

MSC: Client Needs Category: Physiological Integrity

20. What is the purpose of the evaluation phase of the nursing process?

A. Identifies physical, psychological, and emotional responses to illness
B. Provides a scientific basis for the testing and retesting of nursing diagnoses
C. Allows for the input from all members of the health care team
D. Determines the effectiveness of specific nursing interventions
ANS: D

Although considered the final step in the nursing process, evaluation is performed continually as the client responds to interventions so that ineffective interventions can be changed and the expected outcomes can be achieved.

DIF: Cognitive Level: Knowledge TOP: Nursing Process Step: Evaluation
21. Which of the following demonstrates the primary difference between a nursing history and a medical history?

A. Focus of the history  
B. Amount of detail present  
C. Health professional obtaining the history  
D. Person from whom the history was obtained  

ANS: A

The focus of a medical history is to determine what pathologic condition exists and what treatment approach is most suitable. A nursing history focuses on the physical, psychological, and emotional responses of the client and family regarding the illness and hospitalization. It is used as a basis for planning nursing care.

DIF: Cognitive Level: Comprehension  TOP: Nursing Process Step: Assessment

22. The nurse notes that the reddened area on the heel of a bedridden client is smaller 24 hours after placing a padded booty on the heel. What phase of the nursing process is reflected in the nurse’s action?

A. Analysis  
B. Planning  
C. Implementation  
D. Evaluation  

ANS: D

The nurse is evaluating the expected outcome (client response) to a specific intervention for a specific problem. This information is used to determine whether the intervention should be continued, discontinued, or modified.

DIF: Cognitive Level: Comprehension  TOP: Nursing Process Step: Evaluation
1. Which of the following data represent analysis? (Select all that apply.)

A. Temperature = 100° F  
B. Hypertension  
C. Pulse oximetry = 98%  
D. Tachycardia  
E. Nonpalpable dorsalis pedis pulses are not palpable

ANS: B, D

Rationale: Client problems are identified from the comparison of client findings to “normal” findings during analysis. Hypertension and tachycardia identify a blood pressure greater than 140/90 mm Hg and a heart rate greater than 100 beats per minute.

DIF: Cognitive Level: Comprehension  TOP: Nursing Process Step: Analysis  
MSC: Client Needs Category: Physiological Integrity

2. Which of the following practices facilitate learning for the older adult? (Select all that apply.)

A. Ensure that the area is well-lit.  
B. Provide small amounts of new information at a time.  
C. Carry out teaching activities in the quiet time after the evening meal.  
D. Ask the client to demonstrate a procedure several times.
E. Ensure that the client is not fatigued or in pain.

ANS:

A, B, D, E

Rationale: The older adult may take longer to process information. Adjustments to the teaching and learning processes, such as presenting small amounts of new information when the client is well-rested, increase the probability of comprehension and compliance.

DIF: Cognitive Level: Knowledge TOP: Nursing Process Step: Intervention
MSC: Client Needs Category: Health Promotion and Maintenance

3. Select the health practices that improve and maintain health in adults. (Select all that apply).

A. Maintaining a body weight of 140 pounds for a female who is 5 feet 8 inches tall

B. Engaging in aerobic exercises for at least 20 minutes every day

C. Liberally using sunscreen when out of doors

D. Getting 4 to 6 hours of sleep in 24 hours

E. Managing stress using appropriate coping methods

ANS:

A, C, E

Rationale: Regardless of gender, age, or economic status, exercising routinely; avoiding obesity, stress, and sun exposure; and getting regular sleep of about 8 hours a day have a positive correlation with health promotion in adults.

DIF: Cognitive Level: Comprehension TOP: Nursing Process Step: Intervention
Chapter 8: Substance Abuse

MULTIPLE CHOICE

1. Which statement regarding substance abuse is true?
   A. Substance abuse should not be considered a public health problem because it only affects individuals rather than society as a whole.
   B. Even when a person is not “addicted” to a substance, abuse can cause physical, psychological, and social problems.
   C. Substance abuse is rarely seen among middle-class clients.
   D. Cocaine is the most commonly abused substance.

   ANS: B

   Abuse of substances, not just addiction, leads to decreased productivity, acute and chronic health problems (some of which are irreversible), strained interpersonal relationships, and economic hardship.

   DIF: Cognitive Level: Knowledge
   TOP: Nursing Process Step: Assessment

2. How are stress and substance abuse interrelated?
   A. The neurotransmitters stimulated by many abused substances enhance the sense of well-being and cause the sensation of stress when the substance wears off.
   B. Chronic substance abuse leads to destruction of brain cells in the limbic area, causing an increased intensity of the stress response.
   C. Most abused substances are perceived by the body as physiologic stressors, which result in a heightened “fight-or-flight” response.
   D. As tolerance or addiction develop, more of the abused substance is needed to achieve the same pleasurable responses.

   ANS: A

   Stimulation of the sympathetic division of the autonomic nervous system releases excitatory neurotransmitters that result in the expression of the stress response (tachycardia, increased mental awareness, insomnia, sense of danger or anxiety, dry mouth, “nervousness”). Most
abused substances either inhibit the sympathetic division of the autonomic nervous system or enhance the secretion of neurotransmitters that allow pleasurable sensations to override stressful sensations. When the substance wears off, the stressful sensations reappear, driving the person to seek more drug to reduce the stressful sensations.

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3. Why is it important to identify a substance abuser in the medical-surgical acute care setting?
A. To enable the staff to take appropriate actions to protect themselves and other clients
B. To anticipate additional care needs necessitated by withdrawal
C. To avoid being “taken in” by a manipulative client
D. To inform local authorities about illegal behavior
ANS: B

Often, in the acute care environment, the client who is a substance abuser is unable to obtain or unable to use the abused substance, thereby leading to withdrawal. The physiologic responses associated with withdrawal can have deleterious effects on the client’s health and may be mistaken for other complications.

4. Which characteristic response to stimulant drugs increases their potential for abuse?
A. They are not habit-forming.
B. They have sedating qualities.
C. They increase general metabolism
D. Their use is not controlled by the DEA.
ANS: C

Stimulants tend to increase mental awareness and general metabolism. One of the major reasons that they are abused is to control weight through the increase in metabolism. Their use is
regulated by the DEA (Drug Enforcement Administration).
DIF: Cognitive Level: Knowledge TOP: Nursing Process Step: N/A
MSC: Client Needs Category: N/A
5. The client has narcolepsy. The nurse should be prepared to teach the client about which drug category that has potential for abuse?
   A. Amphetamines
   B. Benzodiazepines
   C. Barbiturates
   D. Phencyclidines
ANS: A
A legitimate medical use of amphetamines is the treatment of narcolepsy.
DIF: Cognitive Level: Knowledge
TOP: Nursing Process Step: Implementation/Intervention
MSC: Client Needs Category: Physiological Integrity

3 6. Which characteristic, action, or behavior fails to meet the criteria for the nursing diagnosis of substance abuse?
   A. The client uses the substance daily.
   B. The client’s behavior when using the substance is not socially acceptable.
   C. The client continues to use the substance even though she or he has expressed a desire to stop.
   D. The client continues to use the substance even though it causes him or her to have chronic hypertension.
ANS: A
The criteria that are used to make a nursing diagnosis of substance abuse include the following:
· The client loses control of the drug.
· The client takes the drug even though the drug has caused adverse conditions in his or her body.
· The client demonstrates cognitive, behavioral, and physical disturbances.
· Many drugs, including substances that have potential for abuse, can be taken or used on a daily basis for years without causing problems or being considered abused.
DIF: Cognitive Level: Comprehension TOP: Nursing Process Step: Analysis
MSC: Client Needs Category: Psychological Integrity/Physiological Integrity

7. An unconscious client who has just been involved in a motor vehicle accident is brought to the emergency department. Which presenting clinical manifestation makes the nurse suspicious of an opioid overdose rather than increased intracranial pressure as a cause of the unconsciousness?
A. Pinpoint pupils  
B. Respiratory depression  
C. Hyporeflexive deep tendon reflexes  
D. Evidence that the client has vomited  
ANS: A

Morphine and other opioids bind tightly to the mu (µ) opioid receptor, which causes pupillary constriction. Head injuries resulting in increased intracranial pressure cause pupillary dilation. A symptom of withdrawal from opioids is pupillary dilation.
DIF: Cognitive Level: Comprehension  
TOP: Nursing Process Step: Assessment

MSC: Client Needs Category: Physiological Integrity

8. The client smokes three packs of cigarettes per day. The nurse should teach this client about his or her increased risk for which chronic health problem as a result of tobacco abuse?
A. Chronic pancreatitis  
B. Rheumatoid arthritis  
C. Cardiovascular disease  
D. Type 2 diabetes mellitus  
ANS: C

Tobacco use results in chronic nicotine ingestion, which causes vasoconstriction and increased peripheral vascular resistance. This increased resistance causes hypertension and increases the workload of the heart. The narrowed blood vessels decrease oxygen flow to vital organs, increasing the risk for ischemic events.
DIF: Cognitive Level: Comprehension
9. The nurse suspects that the client is a substance abuser. Which clinical manifestation causes the nurse to suspect cocaine abuse rather than barbiturates?
A. Shallow respirations
B. Pupillary constriction
C. Tachycardia
D. Flushing
ANS: C

The systemic effects of cocaine include peripheral vasoconstriction, tachycardia, hypertension, chills, fever, pupillary dilation, and paranoia.

DIF: Cognitive Level: Comprehension

TOP: Nursing Process Step: Assessment
MSC: Client Needs Category: Physiological Integrity

10. Which statement or information obtained from a client during assessment for alcohol abuse alerts the nurse to the possibility of alcohol addiction?
A. The client says he or she drinks alcohol to feel less stressed and have a good time.
B. The client has been arrested once for driving under the influence of alcohol.
C. The client uses alcohol to stop his or her hands from shaking.
D. The client drinks alcohol daily.
ANS: C

The major distinction between abusing alcohol and being addicted to alcohol is the presence of withdrawal symptoms when the client is not drinking. The fact that alcohol is used to prevent or stop the symptoms of withdrawal (tremors of the hands) is a strong indicator of physical addiction to alcohol.

DIF: Cognitive Level: Application or higher

TOP: Nursing Process Step: Assessment
MSC: Client Needs Category: Physiological Integrity

11. Which nursing diagnosis is appropriate for a woman who abuses anabolic steroids?
A. Risk for Injury related to decreased muscle coordination

B. Hypothermia related to decreased metabolic rate
C. Chronic Confusion related to sodium and water retention
D. Disturbed Body Image related to presence of facial hair

ANS: D

The use of anabolic steroids (testosterone) in women causes the physical changes of growth of facial hair, male pattern baldness, deepened voice, and changes in menstrual patterns.

DIF: Cognitive Level: Application or higher
TOP: Nursing Process Step: Analysis
MSC: Client Needs Category: Psychological Integrity

12. Which problem or manifestation in a 125-pound, 40-year-old woman, 1-day postoperative for a total abdominal hysterectomy, leads the nurse to suspect possible substance abuse?
A. She has vomited nine times during the first 24 hours after surgery.
B. Morphine 15 mg (subcutaneous) has failed to relieve her pain.
C. She has been unable to void after removal of the Foley.
D. Her wound drainage is greater than expected.

ANS: B

Many of the liver enzymes that detoxify abused substances also degrade morphine and other opioids. When people abuse drugs, even alcohol, the level of these degradative enzymes increases, and opioid medications are degraded more rapidly, increasing the client’s tolerance of these medications even though they may never have had an opioid previously. More drug is required to provide adequate pain relief.

DIF: Cognitive Level: Application or higher
TOP: Nursing Process Step: Analysis
MSC: Client Needs Category: Physiological Integrity

13. The client has been transferred to the medical-surgical unit from the emergency department. His admitting diagnosis is “barbiturate overdose.” What is the nurse’s priority intervention?
A. Performing neurologic checks every 4 hours
B. Providing emotional support
C. Restricting visitors to immediate family
D. Taking vital signs every 4 hours
ANS: D

Barbiturates depress the central nervous system and cause sedation, drowsiness, and a decrease in motor activity. Overdose symptoms include respiratory depression.

DIF: Cognitive Level: Application or higher
TOP: Nursing Process Step: Intervention
MSC: Client Needs Category: N/A

OTHER
1. Which of the following are not indicators of alcohol abuse? (Select all that apply.)
A. Craves alcohol
B. Drinks one 12-oz beer each day
C. Fails to fix meals at home
D. Frequent sick days at work
E. Grades at school drop
F. Loss of control
G. Physical dependence
ANS: A, F, G

Rationale: Alcohol abuse occurs when a person has problems with alcohol use. His or her use of alcohol interferes with the ability to carry out activities of daily living and to meet daily responsibilities at home, work, school, or in the community. It is not necessarily related to the quantity of alcohol consumed or the frequency of alcohol consumption.

DIF: Cognitive Level: Knowledge
TOP: Nursing Process Step: N/A
MSC: Client Needs Category: N/A