Chapter 01: Introduction to Medical-Surgical Nursing Practice in Canada
Tyerman: Lewis's Medical-Surgical Nursing in Canada, 5th Edition

MULTIPLE CHOICE

1. When caring for patients using evidence-informed practice, which of the following does the nurse use?
   a. Clinical judgement based on experience
   b. Evidence from a clinical research study
   c. The best available evidence to guide clinical expertise
   d. Evaluation of data showing that the patient outcomes are met

   ANS: C
   Evidence-informed nursing practice is a continuous interactive process involving the explicit, conscientious, and judicious consideration of the best available evidence to provide care. Four primary elements are: (1) clinical state, setting, and circumstances; (2) patient preferences and actions; (3) best research evidence; and (4) health care resources. Clinical judgement based on the nurse's clinical experience is part of EIP, but clinical decision making also should incorporate current research and research-based guidelines. Evidence from one clinical research study does not provide an adequate substantiation for interventions. Evaluation of patient outcomes is important, but interventions should be based on research from randomized control studies with a large number of subjects.

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

2. Which of the following best explains the nurses' primary use of the nursing process when providing care to patients?
   a. To explain nursing interventions to other health care professionals
   b. As a problem-solving tool to identify and treat patients' health care needs
   c. As a scientific-based process of diagnosing the patient's health care problems
   d. To establish nursing theory that incorporates the biopsychosocial nature of humans

   ANS: B
   The nursing process is an assertive problem-solving approach to the identification and treatment of patients' problems. Diagnosis is only one phase of the nursing process. The primary use of the nursing process is in patient care, not to establish nursing theory or explain nursing interventions to other health care professionals.

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

3. The nurse is caring for a critically ill patient in the intensive care unit and plans an every 2-hour turning schedule to prevent skin breakdown. Which type of nursing function is demonstrated with this turning schedule?
   a. Dependent
   b. Cooperative
   c. Independent
   d. Collaborative

   ANS: D

When implementing collaborative nursing actions, the nurse is responsible primarily for monitoring for complications of acute illness or providing care to prevent or treat complications. Independent nursing actions are focused on health promotion, illness prevention, and patient advocacy. A dependent action would require a physician order to implement. Cooperative nursing functions are not described as one of the formal nursing functions.

DIF: Cognitive Level: Application TOP: Nursing Process: Implementation

4. The nurse is caring for a patient who has been admitted to the hospital for surgery and tells the nurse, "I do not feel right about leaving my children with my neighbour." Which action should the nurse take next?
   a. Reassure the patient that these feelings are common for parents.
   b. Have the patient call the children to ensure that they are doing well.
   c. Call the neighbour to determine whether adequate childcare is being provided.
   d. Gather more data about the patient's feelings about the childcare arrangements.

   ANS: D
   Since a complete assessment is necessary in order to identify a problem and choose an appropriate intervention, the nurse's first action should be to obtain more information. The other actions may be appropriate, but more assessment is needed before the best intervention can be chosen.

   DIF: Cognitive Level: Application TOP: Nursing Process: Assessment

5. The nurse is caring for a patient who has left-sided paralysis as the result of a stroke and assesses a pressure injury on the patient's left hip. Which of the following is the most appropriate nursing diagnosis for this patient?
   a. Impaired physical mobility related to decrease in muscle control (left-sided paralysis)
   b. Risk for impaired tissue integrity as evidenced by insufficient knowledge about protecting tissue integrity
   c. Impaired skin integrity related to pressure over bony prominence (impaired circulation)
   d. Ineffective tissue perfusion related to sedentary lifestyle

   ANS: C
   The patient's major problem is the impaired skin integrity as demonstrated by the presence of a pressure injury. The nurse is able to treat the cause of altered circulation and pressure by frequently repositioning the patient. Although left-sided weakness is a problem for the patient, the nurse cannot treat the weakness. The "risk for" diagnosis is not appropriate for this patient, who already has impaired tissue integrity. The patient does have ineffective tissue perfusion, but the impaired skin integrity diagnosis indicates more clearly what the health problem is.

   DIF: Cognitive Level: Application TOP: Nursing Process: Diagnosis

6. The nurse caring for a patient with an infection has a nursing diagnosis of deficient fluid volume related to excessive diaphoresis. Which of the following is an appropriate patient outcome?

a. Patient has a balanced intake and output.
b. Patient's bedding is changed when it becomes damp.
c. Patient understands the need for increased fluid intake.
d. Patient's skin remains cool and dry throughout hospitalization.

ANS: A
This statement gives measurable data showing resolution of the problem of deficient fluid volume that was identified in the nursing diagnosis statement. The other statements would not indicate that the problem of deficient fluid volume was resolved.

DIF: Cognitive Level: Application TOP: Nursing Process: Planning

7. Which of the following represents a nursing activity that is carried out during the evaluation phase of the nursing process?
a. Determining if interventions have been effective in meeting patient outcomes
b. Documenting the nursing care plan in the progress notes in the medical record
c. Deciding whether the patient's health problems have been completely resolved
d. Asking the patient to evaluate whether the nursing care provided was satisfactory

ANS: A
Evaluation consists of determining whether the desired patient outcomes have been met and whether the nursing interventions were appropriate. The other responses do not describe the evaluation phase.

DIF: Cognitive Level: Comprehension TOP: Nursing Process: Evaluation

8. Which of the following would the nurse perform during the assessment phase of the nursing process?
a. Obtains data with which to diagnose patient problems
b. Uses patient data to develop priority nursing diagnoses
c. Teaches interventions to relieve patient health problems
d. Assists the patient to identify realistic outcomes to health problems

ANS: A
During the assessment phase, the nurse gathers information about the patient. The other responses are examples of the intervention, diagnosis, and planning phases of the nursing process.

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

9. Which of the following is an example of a correctly written nursing diagnosis statement?
a. Altered tissue perfusion related to heart failure
b. Risk for impaired tissue integrity related to sacral redness
c. Ineffective coping related to insufficient sense of control
d. Altered urinary elimination related to urinary tract infection

ANS: C

This diagnosis statement includes a NANDA nursing diagnosis and an etiology that describes a patient's response to a health problem that can be treated by nursing. The use of a medical diagnosis (as in the responses beginning "Altered tissue perfusion" and "Altered urinary elimination") is not appropriate. The response beginning "Risk for impaired tissue integrity" uses the defining characteristics as the etiology.

DIF: Cognitive Level: Comprehension TOP: Nursing Process: Diagnosis

10. Which of the following includes the components required for a complete nursing diagnosis statement?
    a. A problem and the suggested patient goals or outcomes
    b. A problem, its cause, and objective data that support the problem
    c. A problem with all its possible causes and the planned interventions
    d. A problem with its etiology and the signs and symptoms of the problem

    ANS: D
    The PES format is used when writing nursing diagnoses. The subjective, as well as objective, data should be included in the defining characteristics. Interventions and outcomes are not included in the nursing diagnosis statement.

    DIF: Cognitive Level: Knowledge TOP: Nursing Process: Diagnosis

11. Which of the following refers to a situation that results in unintended harm to the patient and is related to the care or services provided rather than the patient's medical condition?
    a. Negligence
    b. Adverse event
    c. Incident report
    d. Nonmaleficence

    ANS: B
    An adverse event is an event that results in unintended harm to the patient and is related to the care or services provided to the patient rather than to the patient's underlying medical condition.

    DIF: Cognitive Level: Knowledge TOP: Nursing Process: Evaluation

12. When using the Five Steps of the **e**vidence-**i**nformed **p**ractice (EIP) Process, which of the flowing elements is the final step when constructing a clinical question?
    a. Comparison of interest
    b. Population of interest
    c. Outcome of interest
    d. Timeframe of interest

    ANS: D
    The order of the nurse's statements follows the PICOT format with the final step being the "T", or timeframe of interest.

    DIF: Cognitive Level: Application TOP: Nursing Process: Implementation