Test Bank - Chapter 01

Q1: Which is a judgement about a particular patient's potential need or problem?

A. A goal
B. An assessment
C. Subjective data
D. A nursing diagnosis (Correct)

Rationale: Nursing diagnosis is the phase of the nursing process during which a clinical judgement is made about how a patient responds to health conditions and life processes or vulnerability for that response.

Q2: The patient is to receive oral furosemide (Lasix) every day; however, because the patient is unable to swallow, he cannot take medication orally, as ordered. The nurse needs to contact the physician. What type of problem is this?

A. A "right time" problem
B. A "right dose" problem
C. A "right route" problem (Correct)
D. A "right medication" problem

Rationale: This is a "right route" problem: the nurse cannot assume the route and must clarify the route with the prescriber. This is not a "right time" problem because the ordered frequency has not changed. This is not a "right dose" problem because the dose is not related to an inability to swallow. This is not a "right medication" problem because the medication ordered will not change, just the route.

Q3: The nurse has been monitoring the patient's progress on his new drug regimen since the first dose and has been documenting signs of possible adverse effects. What nursing process phase is the nurse practising?

A. Planning
B. Evaluation (Correct)
C. Implementation
D. Nursing diagnosis

Rationale: Monitoring the patient's progress is part of the evaluation phase. Planning, implementation, and nursing diagnosis are not illustrated by this example.

Q4: The nurse is caring for a patient who has been newly diagnosed with type 1 diabetes mellitus. Which statement best illustrates an outcome criterion for this patient?

A. The patient will follow instructions.
B. The patient will not experience complications.
C. The patient adheres to the new insulin treatment regimen.

D. The patient demonstrates safe insulin self-administration technique. (Correct)

Rationale: Having the patient demonstrate safe insulin self-administration technique is a specific and measurable outcome criterion. Following instructions and avoiding complications are not specific criteria. Adherence to the new insulin treatment regimen is not objective and would be difficult to measure.

Q5: Which activity best reflects the implementation phase of the nursing process for the patient who is newly diagnosed with type 1 diabetes mellitus?

A. Providing education regarding self-injection technique (Correct)

B. Setting goals and outcome criteria with the patient's input

C. Recording a history of over-the-counter medications used at home

D. Formulating nursing diagnoses regarding knowledge deficits related to the new treatment regimen

Rationale: Education is an intervention that occurs during the implementation phase. Setting goals and outcome criteria reflects the planning phase. Recording a drug history reflects the assessment phase. Formulating nursing diagnoses regarding a knowledge deficit reflects analysis of data as part of the planning phase.

Q6: The nurse is working during a very busy night shift, and the health care provider has just given the nurse a medication order over the telephone, but the nurse does not recall the route. What is the best way for the nurse to avoid medication errors?

A. Recopy the order neatly on the order sheet, with the most common route indicated

B. Consult with the pharmacist for clarification about the most common route

C. Call the health care provider to clarify the route of administration (Correct)

D. Withhold the drug until the health care provider visits the patient

Rationale: If a medication order does not include the route, the nurse must ask the health care provider to clarify it. Never assume the route of administration.

Q7: Which constitutes the traditional Five Rights of medication administration?

A. Right drug, right route, right dose, right time, and right patient (Correct)

B. Right drug, right effect, right route, right time, and right patient

C. Right patient, right strength, right diagnosis, right drug, and right route

D. Right patient, right diagnosis, right drug, right route, and right time

Rationale: The traditional Five Rights of medication administration were considered to be right drug, right route, right dose, right time, and right patient. Right effect, right strength, and right diagnosis are not part of the traditional Five Rights.

Q8: What correctly describes the nursing process?

A. Diagnosing, planning, assessing, implementing, and finally evaluating

B. Assessing, diagnosing, implementing, and ending with evaluating

C. A linear direction that begins with assessing and continues through diagnosing, planning, and finally implementing

D. An ongoing process that begins with assessing and continues with diagnosing, planning, implementing, and evaluating (Correct)

Rationale: The nursing process is an ongoing, flexible, adaptable, and adjustable five-step process that begins with assessing and continues through diagnosing, planning, implementing, and finally evaluating, which may then lead back to any of the other phases.

Q9: When the nurse is considering the timing of a drug dose, which is most important to assess?

A. The patient's identification

B. The patient's weight

C. The patient's last meal (Correct)

D. Any drug or food allergies

Rationale: The pharmacokinetic and pharmacodynamic properties of the drug need to be assessed with regard to any drug–food interactions or compatibility issues. The patient's identification, weight, and drug or food allergies are not affected by the drug's timing.

Q10: The nurse is writing nursing diagnoses for a plan of care. Which reflects the correct format for her nursing diagnosis?

A. Anxiety

B. Anxiety related to new drug therapy

C. Anxiety related to anxious feelings about drug therapy, as evidenced by statements such as "I'm upset about having to give myself shots"

D. Anxiety related to new drug therapy, as evidenced by statements such as "I'm upset about having to give myself shots" (Correct)

Rationale: Formulation of nursing diagnoses is usually a three-step process. The only complete answer is "Anxiety related to new drug therapy, as evidenced by statements such as 'I'm upset about having to give myself shots.'" The answer "Anxiety" is missing the "related to" and "as evidenced by" portions. The answer "Anxiety related to new drug therapy" is missing the "as evidenced by" portion of defining characteristics. The "related to" section in "Anxiety related to anxious feelings about drug therapy, as evidenced by statements such as 'I'm upset about having to give myself shots'" is simply a restatement of the problem "anxiety," not a separate factor related to the response.

Q11: Place the phases of the nursing process in the correct order, starting with the first phase. A. Planning B. Evaluation C. Assessment D. Implementation E. Diagnosing

A. B, C, D, E, A

B. D, A, E, B, C

C. C, E, A, D, B (Correct)

D. A, D, B, C, E

Rationale: The five phases of the nursing process in order are assessment, diagnosis, planning, intervention and evaluation.

Review Questions - Chapter 01

Q1: In which step of the nursing process does the nurse determine the outcome of medication administration?

A. Planning
B. Evaluation (Correct)
C. Assessment
D. Implementation

Rationale: Evaluation occurs after the collaborative plan of care has been implemented. It is a systematic, ongoing, and dynamic part of the nursing process as related to drug therapy. It includes monitoring the fulfillment of goals and outcome criteria, as well as the patient's therapeutic response to the drug and its adverse effects and toxic effects.

Q2: The nurse plans care for a male patient who is 80 years of age. The nursing diagnosis is nonadherence with the medication regimen related to living alone, as evidenced by uncontrolled blood pressure. What should the nurse do next?

A. Enlist the help of a home care nurse for pharmacotherapy. (Correct)
B. Examine the results of nursing help with the medications.
C. Collaborate with the health care provider on a new medication regimen.
D. Assess the impact of home self-management of medications.

Rationale: After establishing the nursing diagnosis, the nurse plans care by determining the nursing goals and outcome criteria. As a means of working toward blood pressure control, the nurse chooses to set up nursing assistance for the patient in the home. By making a medication schedule and dispensing medication into a pill box (among other strategies), the home care nurse can help the patient adhere to the therapeutic regimen. The nurse assesses the patient before establishing the nursing diagnosis and evaluates care after implementing the plan. Collaboration on a new medication regimen is not indicated. Examining the results of nursing help with the medications is part of the evaluation process to determine if the plan is effective.

Q3: Which statement is an example of objective data? (Select all that apply.) *(Select all that apply.)*

A. The patient states that she has a headache.
B. The patient has clear urine. (Correct)
C. The patient says that she feels like someone is touching her arm.
D. The patient has had a fever for 5 days. (Correct)
E. The patient says that she has felt tired for almost a week.

Rationale: Objective data include information available through the senses, such as what is seen, felt, heard, and smelled. Among the sources of data are the patient's chart, laboratory test results, reports of diagnostic procedures, physical assessments, and examination findings. Examples of specific data are age, height, weight, allergies, medication profile, and health history.

Q4: What should the nurse check when reviewing a prescription with a patient? (Select all that apply.) *(Select all that apply.)*

A. The patient's home address
B. The route of administration (Correct)
C. The age of the patient
D. The signature of the prescriber (Correct)
E. The patient's emergency contact

Rationale: After the assessment of the patient and the drug has been completed, the specific prescription or medication order (from any prescriber) must be checked for the following six elements: (1) patient's name, (2) date the drug order was written, (3) name of drug(s), (4) drug dosage amount and frequency, (5) route of administration, and (6) prescriber's signature.

Q5: What information should the nurse chart when documenting medication administration? (Select all that apply.) *(Select all that apply.)*

A. The time of administration (Correct)
B. Information about an "incident report" in the patient's chart
C. The patient's age
D. The route of administration (Correct)
E. The dosage of medication administered (Correct)

Rationale: Documentation of administration is one of the Ten Rights of patient medication administration and should include patient response, teaching related to the medication, whether the medication was or was not given, and refusal of medication and the reason for refusal. Medication errors should be noted in an incident report but should not be documented as an incident report in the patient's chart. Information about "incident report" is never placed in the patient's chart but is sent to risk management. Statement of the patient's age is already a part of the patient's record and is not needed in the documentation of administration.