Chapter 2 - Nursing Process

1. A client with HIV has been admitted to a health care facility. Which nursing diagnosis should be the **priority**, keeping in mind the client's condition?
A. Risk for Activity Intolerance
B. Risk for Ineffective Coping
C. Risk for Infection
D. Risk for Imbalanced Nutrition

Answer: C

Rationale: Clients with HIV have decreased immunity and are prone to infections. Infection in a client with HIV is life-threatening, because it makes the client vulnerable to other infections, and also impairs their already weakened immune functions. Clients with HIV may not have problems with other activities and food. They may often feel depressed, but this is not the highest priority.
Question format: Multiple Choice
Chapter 2: Nursing Process
Cognitive Level: Analyze
Client Needs: Safe, Effective Care Environment: Management of Care
Integrated Process: Nursing Process
Reference: p. 25

2. A client is being prepared for cardiac catheterization. The nurse performs an initial assessment and records the vital signs. Which data collected can be classified as subjective data?
A. Blood pressure
B. Nausea
C. Heart rate
D. Respiratory rate

Answer: B

Rationale: Subjective data are those that only the client can experience and describe. Nausea is subjective data, as it can only be described and not measured. Blood pressure, heart rate, and respiratory rate are measurable factors and are therefore objective data.
Question format: Multiple Choice
Chapter 2: Nursing Process
Cognitive Level: Understand
Client Needs Pn: Physiological Integrity: Reduction of Risk Potential
Client Needs: Physiological Integrity: Reduction of Risk Potential
Integrated Process: Nursing Process
Reference: p. 20

3. A client who has to undergo a parathyroidectomy is worried about possibly having to wear a scarf around the neck after surgery. What nursing diagnosis should the nurse document in the care plan?
A. Risk for Impaired Physical Mobility due to surgery
B. Ineffective Denial related to poor coping mechanisms
C. Disturbed Body Image related to the incision scar
D. Risk of Injury related to surgical outcomes

Answer: C

Rationale: The client is concerned about the surgery scar on the neck, which would disturb the client's body image; therefore, the appropriate diagnosis should be Disturbed Body Image related to the incision scar. Risk for Impaired Physical Mobility may be present after surgery, but is not related to the concerns expressed by the client. Likewise, Ineffective Denial related to poor coping mechanisms and Injury related to surgical outcomes are also not related to the client's concern.
Question format: Multiple Choice
Chapter 2: Nursing Process
Cognitive Level: Apply
Client Needs: Psychosocial Integrity
Client Needs Pn: Psychosocial Integrity
Integrated Process: Nursing Process
Reference: p. 25

4. A nurse is giving postoperative care to a client after knee arthroplasty. What is a possible short-term goal for this client?
A. The client will ambulate with assistance by the nurse to a bedside chair.
B. The client will return to performing activities of daily living.
C. The client will walk 1 mile briskly five times per week.
D. The client will not undergo repeat surgery.

Answer: A

Rationale: The short-term goal in this case is to help the client ambulate to the bedside chair. The other goals, like helping the client return to activities of daily living, to maintain a healthy and active lifestyle, and to prevent repeat surgery are long-term goals and may take weeks or months to achieve. On the other hand, short-term goals can be achieved in a day or a week.
Question format: Multiple Choice
Chapter 2: Nursing Process
Cognitive Level: Analyze
Client Needs: Physiological Integrity: Physiological Adaptation
Integrated Process: Nursing Process
Reference: p. 25

5. A nurse, who is caring for a client admitted to the patient care unit with acute abdominal pain, formulates the care plan for the client. Which nursing diagnosis is the **priority** for this client?
A. Impaired Comfort
B. Disturbed Body Image
C. Disturbed Sleep Pattern
D. Activity Intolerance

Answer: A

Rationale: Acute pain in the abdomen disturbs all the systems of the body. Relieving the pain should be the nurse's first priority. According to Maslow, physiologic needs are the highest

priority. The client may have Disturbed Body Image, Disturbed Sleep Pattern, or Activity Intolerance, but all these are secondary to pain.
Question format: Multiple Choice
Chapter 2: Nursing Process
Cognitive Level: Apply
Client Needs: Safe, Effective Care Environment: Management of Care
Integrated Process: Nursing Process
Reference: p. 25

6. A nurse is interviewing an asthmatic client who has a high respiratory rate and is having difficulty breathing. The client is consequently restless and can only speak a few words before pausing to catch a breath. What appropriate nursing diagnosis should the nurse document?
A. Impaired Gas Exchange related to the disease condition
B. Impaired Verbal Communication related to the breathing problem
C. Inability to Speak due to ineffective airway clearance
D. Impaired Physical Mobility related to tachypnea

Answer: B

Rationale: The client has a high respiratory rate and difficulty breathing; the client therefore has trouble communicating. Impaired Verbal Communication related to the breathing problem is the appropriate diagnosis. Although Impaired Gas Exchange may occur in an asthma attack, it does not relate to the concern regarding the client's ability to communicate nor would it be of primary concern in this case. There is no evidence that the client is experiencing Impaired Physical Mobility due to the condition. Inability to Speak due to ineffective airway clearance is not a properly structured nursing diagnosis (it should include "related to" rather than "due to") and is not accurate, in that the client is able to speak, although the speech is impaired.
Question format: Multiple Choice
Chapter 2: Nursing Process
Cognitive Level: Apply
Client Needs: Physiological Integrity: Reduction of Risk Potential
Integrated Process: Nursing Process
Reference: p. 25

7. A client is brought to the emergency department in an unconscious condition. The client's spouse hands over the previous medical files and points out that the client suddenly fell unconscious after trying to get out of bed. Which is a primary source of information in this case?
A. The client's spouse
B. The client's medical documents
C. The client's test results
D. The client's assessment data

Answer: A

Rationale: In this case, the primary source of information is the client's spouse, as the client, who is normally the primary source of information, is unconscious. The spouse can provide a

detailed description of the incident as well as provide the medical history of the client. The client's medical files, test results, and assessment data are secondary sources of information.
Question format: Multiple Choice
Chapter 2: Nursing Process
Cognitive Level: Apply
Client Needs Pn: Safe, Effective Care Environment: Coordinated Care
Client Needs: Safe, Effective Care Environment: Management of Care
Integrated Process: Nursing Process
Reference: p. 20

8. A nurse is caring for a client with Parkinson's disease. Which nursing diagnosis identified by the nurse should be the **priority**?
A. Impaired Physical Mobility
B. Risk for Memory Loss
C. Ineffective Role Performance
D. Potential for Injury

Answer: D

Rationale: Clients with Parkinson's disease are at higher risk of injury due to their physical limitations and cognitive deficiencies. Therefore, it becomes important for the nurse to ensure that the environment is safe. The client may also have Impaired Physical Mobility, Risk for Memory Loss, and Ineffective Role Performance, but the highest priority is to prevent injury, as it may lead to other grave conditions.
Question format: Multiple Choice
Chapter 2: Nursing Process
Cognitive Level: Apply
Client Needs: Safe, Effective Care Environment: Safety and Infection Control
Integrated Process: Nursing Process
Reference: p. 25

9. Which action is a **priority** role of the nurse when caring for a client with collaborative problems?
A. Assessing the client's understanding of risk factors
B. Resolving health issues through independent nursing measures
C. Reporting trends that suggest the development of complications
D. Managing an emerging problem with the help of another registered nurse

Answer: C

Rationale: For a client with collaborative problems, the nurse should report trends that suggest the development of complications to bring to notice the need for collaborative intervention for the client. Collaborative problems are physiologic complications that require both nurse- and physician-prescribed interventions. Actions that exclude members of other disciplines are not characteristic of collaborative problem management. The development of complications is a priority over assessment of the client's knowledge of risk factors, even though the nurse must assess these.
Question format: Multiple Choice
Chapter 2: Nursing Process
Cognitive Level: Apply

Client Needs Pn: Safe, Effective Care Environment: Coordinated Care
Client Needs: Safe, Effective Care Environment: Management of Care
Integrated Process: Nursing Process
Reference: p. 24

10. A nurse is evaluating and revising a plan of care for a client with cardiac catheterization. Which action should the nurse perform before revising a plan of care?
A. Discuss any lack of progress with the client.
B. Collect information on abnormal functions.
C. Identify the client's health-related problems.
D. Select appropriate nursing interventions.

Answer: A

Rationale: The nurse should discuss any lack of progress with the client so that both the client and the nurse can speculate on what activities need to be discontinued, added, or changed. Collecting information on abnormal functions and risk factors is done during the assessment. Identification of the client's health-related problems is done during diagnosis. Nurses select appropriate nursing interventions and document the plan of care in the planning stage of the nursing process, not during evaluation.
Question format: Multiple Choice
Chapter 2: Nursing Process
Cognitive Level: Apply
Client Needs: Safe, Effective Care Environment: Management of Care
Integrated Process: Nursing Process
Reference: p. 28

11. Which action would the nurse perform in the assessment phase of the nursing process?
A. Developing a plan to manage the client's health problems
B. Coming up with a nursing diagnosis based on a potential health risk
C. Asking the client whether the client has cultural preferences
D. Determining whether the client's goals for wellness have been met

Answer: C

Rationale: Assessing the client involves gathering information about the client's physical and emotional health; cognition; spiritual, cultural, or religious preferences; and sociodemographics. Developing a plan to manage the client's health problems falls within the planning phase of the nursing process. Coming up with the nursing diagnosis falls within the diagnosing phase of the nursing process. Determining whether the client's goals for wellness have been met occurs in the evaluation phase of the nursing process.
Question format: Multiple Choice
Chapter 2: Nursing Process
Cognitive Level: Apply
Client Needs: Psychosocial Integrity
Integrated Process: Nursing Process
Reference: p. 20

12. The novice nurse demonstrates proper understanding of collaborative problems by making which statement?

A. "A medical diagnosis of heart failure with the possible consequence of fluid in the lungs could lead to the collaborative problem of pulmonary edema."
B. "The collaborative problem is the combination of the nursing diagnosis and the medical diagnosis, once it is approved by the physician."
C. "A physiologic human need could possibly result in a collaborative nursing diagnosis of Impaired Swallowing."
D. "The client has reached the goals, because treatment was implemented consistently, so nursing orders can be discontinued on the basis of collaborative problems."

Answer: A

Rationale: Physicians and nurses work together on collaborative problems. Understanding collaborative problems involves piecing together the medical diagnosis or medical treatment with the possible consequence. The combination of the nursing diagnosis and medical diagnosis does not equate to a collaborative problem. When discussing physiologic needs, this relates to the nursing diagnosis process. Describing client goals pertains to outcomes from evaluation.
Question format: Multiple Choice
Chapter 2: Nursing Process
Cognitive Level: Apply
Client Needs: Safe, Effective Care Environment: Management of Care
Integrated Process: Nursing Process
Reference: p. 24

13. A client is administered an anxiolytic. Which nursing action demonstrates the nurse evaluating the client?
A. Asking whether the client feels less anxious 30 minutes after administering the medicine
B. Assigning the client a new nursing diagnosis based on the client's controlled anxiety
C. Devising a plan for the client to practice anti-anxiety exercises at home
D. Collecting data about the client's history with anxiety

Answer: A

Rationale: Evaluation allows the nurse to determine whether the client has met the goal. By analyzing the client's response to the anxiolytic, the nurse determines the effectiveness of the nursing care. The other actions demonstrate other parts of the nursing process: assessment (collecting data about the client's history with anxiety), diagnosis (assigning the client a new nursing diagnosis based on the client's controlled anxiety), and planning (devising a plan for the client to practice anti-anxiety exercises at home).
Question format: Multiple Choice
Chapter 2: Nursing Process
Cognitive Level: Apply
Client Needs: Physiological Integrity: Pharmacological and Parenteral Therapies
Integrated Process: Nursing Process
Reference: p. 28

14. Which is an example of a subjective finding that the nurse would likely obtain when performing a review of systems (ROS)?
A. A blood glucose level of 108 mg/dL
B. A client report of shooting pain up the left leg

C. Grip weakness in the right hand
D. Crackles in bilateral lung bases

Answer: B

Rationale: Subjective data consists of information that the client can describe, also known as symptoms. Therefore, a client report of pain in the leg is an example of a subjective finding that the nurse would likely obtain when performing an ROS. A blood glucose level of 108 mg/dL, an observation of weakness in the right hand, and auscultation of crackles in bilateral lung bases are examples of objective data that the nurse or health care provider can observe and measure.
Question format: Multiple Choice
Chapter 2: Nursing Process
Cognitive Level: Remember
Client Needs: Health Promotion and Maintenance
Integrated Process: Nursing Process
Reference: p. 20

15. The nurse is caring for a client who is suspected of having a kidney infection. Which scenario involves the use of subjective data from the primary source?
A. The nurse tells the client to attempt to void.
B. The client tells the nurse that there is a burning sensation when voiding.
C. The physician prescribes medication to help the client void.
D. The client's spouse reports the client experienced incontinence a few days ago.

Answer: B

Rationale: Subjective data consist of information that only the client can describe, such as feelings, sensations, or experiences. An example of subjective data is a client's report of pain or fatigue. Objective data are those that can be measured and observed by others, a fever or a broken bone. The primary source is the client. Secondary sources include family members, reports, test results, and other health care providers.
Question format: Multiple Choice
Chapter 2: Nursing Process
Cognitive Level: Analyze
Client Needs: Physiological Integrity: Reduction of Risk Potential
Integrated Process: Nursing Process
Reference: p. 20

16. Which scenario represents a nurse demonstrating the critical thinking process?
A. assessing whether physician help is needed
B. assessing why a physician encounter form is missing from the record
C. collaborating with the respiratory therapist and physical therapist to address a complication
D. using power for more control and freedom over the daily tasks

Answer: A

Rationale: Critical thinking involves consistency, relevancy, and logical thinking. It enables the nurse to make decisions. Therefore, assessing whether physician help is needed is an example of the critical thinking process. The other actions support other nursing soft skills.
Question format: Multiple Choice
Chapter 2: Nursing Process
Cognitive Level: Understand
Client Needs: Safe, Effective Care Environment: Management of Care
Integrated Process: Nursing Process
Reference: p. 19

17. Which statement made by the nurse indicates data that would be documented as part of an objective assessment?
A. "The client's sister reports that the client has unrelieved pain."
B. "The client's right leg is cold to the touch, from the knee to the foot."
C. "The client reports nausea following eating."
D. "The client reports having heartburn after breakfast."

Answer: B

Rationale: Objective data are information that is observable and measurable, such as observing that the client's right leg is cold to the touch. Subjective data relate to phenomena that only the client can experience, such as unrelieved pain, nausea, or heartburn.
Question format: Multiple Choice
Chapter 2: Nursing Process
Cognitive Level: Understand
Client Needs: Physiological Integrity: Reduction of Risk Potential
Integrated Process: Nursing Process
Reference: p. 20

18. The client reports, "I have a few drinks with friends every week." Which nursing action exemplifies using a focused assessment in this case?
A. Obtaining data regarding the amount and frequency of drinking
B. Interviewing friends to ascertain the client's exercise habits
C. Asking the client to discuss social functioning
D. Performing an abdominal assessment

Answer: A

Rationale: A focused assessment is information that provides more details about specific problems and expands the original database. Obtaining data regarding the amount and frequency of drinking qualifies as a focused assessment. The other actions do not relate to the client's drinking habits or potential for alcohol overuse and thus would not be included in a focussed assessment of these issues.
Question format: Multiple Choice
Chapter 2: Nursing Process
Cognitive Level: Apply
Client Needs: Physiological Integrity: Reduction of Risk Potential
Integrated Process: Nursing Process
Reference: p. 20

19. A client is admitted to the mental health center after attempting suicide. Which client concern is the **priority** for the nurse to manage?
A. Risk of self-harm
B. Lack of support
C. Low self-esteem
D. Feelings of not belonging

Answer: A

Rationale: Safety and security are the priority for the client, so the risk of self-harm is what the nurse must address first. Lack of support, low self-esteem, and feelings of not belonging, although still important to address, are not as critical as safety and security.
Question format: Multiple Choice
Chapter 2: Nursing Process
Cognitive Level: Analyze
Client Needs: Safe, Effective Care Environment: Management of Care
Integrated Process: Nursing Process
Reference: p. 25

20. A client is admitted to a psychiatric treatment unit with psychosis. What is the **priority** diagnosis for this client?
A. Self-Care Deficit
B. Disturbed Thought Processes
C. Risk for Self-Harm
D. Risk for Imbalanced Nutrition: Less Than Body Requirements

Answer: B

Rationale: A client with psychosis is unable to recognize reality, their communication is impaired, and they cannot identify people. The client may also experience hallucinations and delusions. Therefore, Disturbed Thought Process is the most appropriate nursing diagnosis for such a client. The client may be at risk for suicidal thoughts, have difficulty in dressing and grooming, and may not eat properly; however, the priority is the thought process because it is the main reason for all other symptoms.
Question format: Multiple Choice
Chapter 2: Nursing Process
Cognitive Level: Apply
Client Needs: Safe, Effective Care Environment: Safety and Infection Control
Integrated Process: Nursing Process
Reference: p. 25

21. The nurse is assisting with the creation of a plan of care for a client with newly diagnosed diabetes mellitus. When creating the plan of care, what is the **priority** action for the nurse?
A. involving the client with all the steps of the process in care development
B. ensuring the client is informed after decisions are made with care delivery
C. requiring the client to evaluate the plan of care after implementation
D. implementing the standard plan of care for all clients with diabetes mellitus

Answer: A

Rationale: Because the plan of care should be client-centered, the client should be directly involved with all phases of the creation of the care plan. This will involve assessing the learning needs of the client as well as goal setting, implementation, and evaluation. The client should be involved and not just informed of decisions regarding care during the evaluation phase. The client may be involved with the evaluation but the nurse will assess to determine if the plan of care is effective and if the client's goals are being met. Standard plans of care do not address the needs of the individual and should be tailored to the individual client.
Question format: Multiple Choice
Chapter 2: Nursing Process
Cognitive Level: Apply
Client Needs Pn: Safe, Effective Care Environment: Coordinated Care
Client Needs: Safe, Effective Care Environment: Management of Care
Integrated Process: Nursing Process
Reference: p. 19

22. The home health nurse is performing an assessment related to the client's ability to manage activities of daily living in the home environment. Which assessment is the nurse performing?
A. comprehensive assessment
B. database assessment
C. focused assessment
D. functional assessment

Answer: D

Rationale: The nurse is performing a functional assessment that focuses on areas that relate to the physical performance of activities, such as how the client is able to meet activities of daily living, demonstration of cognitive abilities, and social functioning. A comprehensive assessment encompasses all of the assessment data for the client. The focused assessment relies on one area of funcitoning such as the respiratory system if a client is having an asthma attack. The database assessment is performed during the initial history and physical portion of the client's illness and represents a comprehensive and all inclusive initial collection of data.
Question format: Multiple Choice
Chapter 2: Nursing Process
Cognitive Level: Understand
Client Needs Pn: Health Promotion and Maintenance
Client Needs: Physiological Integrity: Basic Care and Comfort
Integrated Process: Nursing Process
Reference: p. 20