1. A nurse has been offered a position on an obstetric unit and has learned that the unit offers therapeutic abortions, a procedure which contradicts the nurse's personal beliefs. What is the nurse's ethical obligation to these patients?
   A) The nurse should adhere to professional standards of practice and offer service to these patients.
   B) The nurse should make the choice to decline this position and pursue a different nursing role.
   C) The nurse should decline to care for the patients considering abortion.
   D) The nurse should express alternatives to women considering terminating their pregnancy.
   Ans: B
   Feedback:
   To avoid facing ethical dilemmas, nurses can follow certain strategies. For example, when applying for a job, a nurse should ask questions regarding the patient population. If a nurse is uncomfortable with a particular situation, then not accepting the position would be the best option. The nurse is only required by law (and practice standards) to provide care to the patients the clinic accepts; the nurse may not discriminate between patients and the nurse expressing his or her own opinion and providing another option is inappropriate.

2. A terminally ill patient you are caring for is complaining of pain. The physician has ordered a large dose of intravenous opioids by continuous infusion. You know that one of the adverse effects of this medicine is respiratory depression. When you assess your patient's respiratory status, you find that the rate has decreased from 16 breaths per minute to 10 breaths per minute. What action should you take?
   A) Decrease the rate of IV infusion.
   B) Stimulate the patient in order to increase respiratory rate.
   C) Report the decreased respiratory rate to the physician.
   D) Allow the patient to rest comfortably.
   Ans: C
   Feedback:
   End-of life issues that often involve ethical dilemmas include pain control, “do not resuscitate” orders, life-support measures, and administration of food and fluids. The risk of respiratory depression is not the intent of the action of pain control. Respiratory depression should not be used as an excuse to withhold pain medication for a terminally ill patient. The patient's respiratory status should be carefully monitored and any changes should be reported to the physician.

3. An adult patient has requested a “do not resuscitate” (DNR) order in light of his recent diagnosis with late stage pancreatic cancer. The patient's son and daughter-in-law are strongly opposed to the patient's request. What is the primary responsibility of the nurse in this situation?
   A) Perform a “slow code” until a decision is made.
   B) Honor the request of the patient.
   C) Contact a social worker or mediator to intervene.
   D) Temporarily withhold nursing care until the physician talks to the family.
   Ans: B
   Feedback:
   The nurse must honor the patient's wishes and continue to provide required nursing care. Discussing the matter with the physician may lead to further communication with the family, during which the family may reconsider their decision. It is not normally appropriate for the nurse to seek the assistance of a social worker or mediator. A “slow code” is considered unethical.

4. An elderly patient is admitted to your unit with a diagnosis of community-acquired pneumonia. During admission the patient states, “I have a living will.” What implication of this should the nurse recognize?
   A) This document is always honored, regardless of circumstances.
   B) This document specifies the patient's wishes before hospitalization.
   C) This document that is binding for the duration of the patient's life.
   D) This document has been drawn up by the patient's family to determine DNR status.
   Ans: B
   Feedback:
   A living will is one type of advance directive. In most situations, living wills are limited to situations in which the patient's medical condition is deemed terminal. The other answers are incorrect because living wills are not always honored, they are not binding for the duration of the patient's life, and they are not drawn up by the patient's family.

5. A nurse has been providing ethical care for many years and is aware of the need to maintain the ethical principle of nonmaleficence. Which of the following actions would be considered a contradiction of this principle?
   A) Discussing a DNR order with a terminally ill patient
   B) Assisting a semi-independent patient with ADLs
   C) Refusing to administer pain medication as ordered
   D) Providing more care for one patient than for another
   Ans: C
   Feedback:
   The duty not to inflict as well as prevent and remove harm is termed nonmaleficence. Discussing a DNR order with a terminally ill patient and assisting a patient with ADLs would not be considered contradictions to the nurse's duty of nonmaleficence. Some patients justifiably require more care than others.

6. You have just taken report for your shift and you are doing your initial assessment of your patients. One of your patients asks you if an error has been made in her medication. You know that an incident report was filed yesterday after a nurse inadvertently missed a scheduled dose of the patient's antibiotic. Which of the following principles would apply if you give an accurate response?
   A) Veracity
   B) Confidentiality
   C) Respect
   D) Justice
   Ans: A
   Feedback:
   The obligation to tell the truth and not deceive others is termed veracity. The other answers are incorrect because they are not obligations to tell the truth.

7. A nurse has begun creating a patient's plan of care shortly after the patient's admission. It is important that the wording of the chosen nursing diagnoses falls within the taxonomy of nursing. Which organization is responsible for developing the taxonomy of a nursing diagnosis?
   A) American Nurses Association (ANA)
   B) NANDA
   C) National League for Nursing (NLN)
   D) Joint Commission
   Ans: B
   Feedback:
   NANDA International is the official organization responsible for developing the taxonomy of nursing diagnoses and formulating nursing diagnoses acceptable for study. The ANA, NLN, and Joint Commission are not charged with the task of developing the taxonomy of nursing diagnoses.

8. In response to a patient's complaint of pain, the nurse administered a PRN dose of hydromorphone (Dilaudid). In what phase of the nursing process will the nurse determine whether this medication has had the desired effect?
   A) Analysis
   B) Evaluation
   C) Assessment
   D) Data collection
   Ans: B
   Feedback:
   Evaluation, the final step of the nursing process, allows the nurse to determine the patient's response to nursing interventions and the extent to which the objectives have been achieved.

9. A medical nurse has obtained a new patient's health history and completed the admission assessment. The nurse has followed this by documenting the results and creating a care plan for the patient. Which of the following is the most important rationale for documenting the patient's care?
   A) It provides continuity of care.
   B) It creates a teaching log for the family.
   C) It verifies appropriate staffing levels.
   D) It keeps the patient fully informed.
   Ans: A
   Feedback:
   This record provides a means of communication among members of the health care team and facilitates coordinated planning and continuity of care. It serves as the legal and business record for a health care agency and for the professional staff members who are responsible for the patient's care. Documentation is not primarily a teaching log; it does not verify staffing; and it is not intended to provide the patient with information about treatments.

10. The nurse is caring for a patient who is withdrawing from heavy alcohol use and who is consequently combative and confused, despite the administration of benzodiazepines. The patient has a fractured hip that he suffered in a traumatic accident and is trying to get out of bed. What is the most appropriate action for the nurse to take?
    A) Leave the patient and get help.
    B) Obtain a physician's order to restrain the patient.
    C) Read the facility's policy on restraints.
    D) Order soft restraints from the storeroom.
    Ans: B
    Feedback:
    It is mandatory in most settings to have a physician's order before restraining a patient. Before restraints are used, other strategies, such as asking family members to sit with the patient, or utilizing a specially trained sitter, should be tried. A patient should never be left alone while the nurse summons assistance.

11. A patient admitted with right leg thrombophlebitis is to be discharged from an acute-care facility. Following treatment with a heparin infusion, the nurse notes that the patient's leg is pain-free, without redness or edema. Which step of the nursing process does this reflect?
    A) Diagnosis
    B) Analysis
    C) Implementation
    D) Evaluation
    Ans: D
    Feedback:
    The nursing actions described constitute evaluation of the expected outcomes. The findings show that the expected outcomes have been achieved. Analysis consists of considering assessment information to derive the appropriate nursing diagnosis. Implementation is the phase of the nursing process where the nurse puts the care plan into action. This nurse's actions do not constitute diagnosis.

12. During report, a nurse finds that she has been assigned to care for a patient admitted with an opportunistic infection secondary to AIDS. The nurse informs the clinical nurse leader that she is refusing to care for him because he has AIDS. The nurse has an obligation to this patient under which legal premise?
    A) Good Samaritan Act
    B) Nursing Interventions Classification (NIC)
    C) Patient Self-Determination Act
    D) ANA Code of Ethics
    Ans: D
    Feedback:
    The ethical obligation to care for all patients is clearly identified in the first statement of the ANA Code of Ethics for Nurses. The Good Samaritan Act relates to lay people helping others in need. The NIC is a standardized classification of nursing treatment that includes independent and collaborative interventions. The Patient Self-Determination Act encourages people to prepare advance directives in which they indicate their wishes concerning the degree of supportive care to be provided if they become incapacitated.

13. An emergency department nurse is caring for a 7-year-old child suspected of having meningitis. The patient is to have a lumbar puncture performed, and the nurse is doing preprocedure teaching with the child and the mother. The nurse's action is an example of which therapeutic communication technique?
    A) Informing
    B) Suggesting
    C) Expectation-setting
    D) Enlightening
    Ans: A
    Feedback:
    Informing involves providing information to the patient regarding his or her care. Suggesting is the presentation of an alternative idea for the patient's consideration relative to problem solving. This action is not characterized as expectation-setting or enlightening.

14. The nurse, in collaboration with the patient's family, is determining priorities related to the care of the patient. The nurse explains that it is important to consider the urgency of specific problems when setting priorities. What provides the best framework for prioritizing patient problems?
    A) Availability of hospital resources
    B) Family member statements
    C) Maslow's hierarchy of needs
    D) The nurse's skill set
    Ans: C
    Feedback:
    Maslow's hierarchy of needs provides a useful framework for prioritizing problems, with the first level given to meeting physical needs of the patient. Availability of hospital resources, family member statements, and nursing skill do not provide a framework for prioritization of patient problems, though each may be considered.

15. A medical nurse is caring for a patient who is palliative following metastasis. The nurse is aware of the need to uphold the ethical principle of beneficence. How can the nurse best exemplify this principle in the care of this patient?
    A) The nurse tactfully regulates the number and timing of visitors as per the patient's wishes.
    B) The nurse stays with the patient during his or her death.
    C) The nurse ensures that all members of the care team are aware of the patient's DNR order.
    D) The nurse liaises with members of the care team to ensure continuity of care.
    Ans: B
    Feedback:
    Beneficence is the duty to do good and the active promotion of benevolent acts. Enacting the patient's wishes around visitors is an example of this. Each of the other nursing actions is consistent with ethical practice, but none directly exemplifies the principle of beneficence.

16. The care team has deemed the occasional use of restraints necessary in the care of a patient with Alzheimer's disease. What ethical violation is most often posed when using restraints in a long-term care setting?
    A) It limits the patient's personal safety.
    B) It exacerbates the patient's disease process.
    C) It threatens the patient's autonomy.
    D) It is not normally legal.
    Ans: C
    Feedback:
    Because safety risks are involved when using restraints on elderly confused patients, this is a common ethical problem, especially in long-term care settings. By definition, restraints limit the individual's autonomy. Restraints are not without risks, but they should not normally limit a patient's safety. Restraints will not affect the course of the patient's underlying disease process, though they may exacerbate confusion. The use of restraints is closely legislated, but they are not illegal.

17. While receiving report on a group of patients, the nurse learns that a patient with terminal cancer has granted power of attorney for health care to her brother. How does this affect the course of the patient's care?
    A) Another individual has been identified to make decisions on behalf of the patient.
    B) There are binding parameters for care even if the patient changes her mind.
    C) The named individual is in charge of the patient's finances.
    D) There is a document delegating custody of children to other than her spouse.
    Ans: A
    Feedback:
    A power of attorney is said to be in effect when a patient has identified another individual to make decisions on her behalf. The patient has the right to change her mind. A power-of-attorney for health care does not give anyone the right to make financial decisions for the patient nor does it delegate custody of minor children.

18. In the process of planning a patient's care, the nurse has identified a nursing diagnosis of Ineffective Health Maintenance related to alcohol use. What must precede the determination of this nursing diagnosis?
    A) Establishment of a plan to address the underlying problem
    B) Assigning a positive value to each consequence of the diagnosis
    C) Collecting and analyzing data that corroborates the diagnosis
    D) Evaluating the patient's chances of recovery
    Ans: C
    Feedback:
    In the diagnostic phase of the nursing process, the patient's nursing problems are defined through analysis of patient data. Establishing a plan comes after collecting and analyzing data; evaluating a plan is the last step of the nursing process and assigning a positive value to each consequence is not done.

19. You are following the care plan that was created for a patient newly admitted to your unit. Which of the following aspects of the care plan would be considered a nursing implementation?
    A) The patient will express an understanding of her diagnosis.
    B) The patient appears diaphoretic.
    C) The patient is at risk for aspiration.
    D) Ambulate the patient twice per day with partial assistance.
    Ans: D
    Feedback:
    Implementation refers to carrying out the plan of nursing care. The other listed options exemplify goals, assessment findings, and diagnoses.

20. The physician has recommended an amniocentesis for an 18-year-old primiparous woman. The patient is 34 weeks' gestation and does not want this procedure. The physician is insistent the patient have the procedure. The physician arranges for the amniocentesis to be performed. The nurse should recognize that the physician is in violation of what ethical principle?
    A) Veracity
    B) Beneficence
    C) Nonmaleficence
    D) Autonomy
    Ans: D
    Feedback:
    The principle of autonomy specifies that individuals have the ability to make a choice free from external constraints. The physician's actions in this case violate this principle. This action may or may not violate the principle of beneficence. Veracity centers on truth-telling and nonmaleficence is avoiding the infliction of harm.

21. During discussion with the patient and the patient's husband, you discover that the patient has a living will. How does the presence of a living will influence the patient's care?
    A) The patient is legally unable to refuse basic life support.
    B) The physician can override the patient's desires for treatment if desires are not evidence-based.
    C) The patient may nullify the living will during her hospitalization if she chooses to do so.
    D) Power-of-attorney may change while the patient is hospitalized.
    Ans: C
    Feedback:
    Because living wills are often written when the person is in good health, it is not unusual for the patient to nullify the living will during illness. A living will does not make a patient legally unable to refuse basic life support. The physician may disagree with the patient's wishes, but he or she is ethically bound to carry out those wishes. A power-of-attorney is not synonymous with a living will.

22. Your older adult patient has a diagnosis of rheumatoid arthritis (RA) and has been achieving only modest relief of her symptoms with the use of nonsteroidal anti-inflammatory drugs (NSAIDs). When creating this patient's plan of care, which nursing diagnosis would most likely be appropriate?
    A) Self-care deficit related to fatigue and joint stiffness
    B) Ineffective airway clearance related to chronic pain
    C) Risk for hopelessness related to body image disturbance
    D) Anxiety related to chronic joint pain
    Ans: A
    Feedback:
    Nursing diagnoses are actual or potential problems that can be managed by independent nursing actions. Self-care deficit would be the most likely consequence of rheumatoid arthritis. Anxiety and hopelessness are plausible consequences of a chronic illness such as RA, but challenges with self-care are more likely. Ineffective airway clearance is unlikely.

23. You are writing a care plan for an 85-year-old patient who has community-acquired pneumonia and you note decreased breath sounds to bilateral lung bases on auscultation. What is the most appropriate nursing diagnosis for this patient?
    A) Ineffective airway clearance related to tracheobronchial secretions
    B) Pneumonia related to progression of disease process
    C) Poor ventilation related to acute lung infection
    D) Immobility related to fatigue
    Ans: A
    Feedback:
    Nursing diagnoses are not medical diagnoses or treatments. The most appropriate nursing diagnosis for this patient is “ineffective airway clearance related to copious tracheobronchial secretions.” “Pneumonia” and “poor ventilation” are not nursing diagnoses. Immobility is likely, but is less directly related to the patient's admitting medical diagnosis and the nurse's assessment finding.

24. You are providing care for a patient who has a diagnosis of pneumonia attributed to *Streptococcus pneumonia* infection. Which of the following aspects of nursing care would constitute part of the planning phase of the nursing process?
    A) Achieve $SaO_2 \geq 92\%$ at all times.
    B) Auscultate chest q4h.
    C) Administer oral fluids q1h and PRN.
    D) Avoid overexertion at all times.
    Ans: A
    Feedback:
    The planning phase entails specifying the immediate, intermediate, and long-term goals of nursing action, such as maintaining a certain level of oxygen saturation in a patient with pneumonia. Providing fluids and avoiding overexertion are parts of the implementation phase of the nursing process. Chest auscultation is an assessment.

25. You are the nurse who is caring for a patient with a newly diagnosed allergy to peanuts. Which of the following is an immediate goal that is most relevant to a nursing diagnosis of “deficient knowledge related to appropriate use of an EpiPen”?
    A) The patient will demonstrate correct injection technique with today's teaching session.
    B) The patient will closely observe the nurse demonstrating the injection.
    C) The nurse will teach the patient's family member to administer the injection.
    D) The patient will return to the clinic within 2 weeks to demonstrate the injection.
    Ans: A
    Feedback:
    Immediate goals are those that can be reached in a short period of time. An appropriate immediate goal for this patient is that the patient will demonstrate correct administration of the medication today. The goal should specify that the patient administer the EpiPen. A 2-week time frame is inconsistent with an immediate goal.

26. A recent nursing graduate is aware of the differences between nursing actions that are independent and nursing actions that are interdependent. A nurse performs an interdependent nursing intervention when performing which of the following actions?
    A) Auscultating a patient's apical heart rate during an admission assessment
    B) Providing mouth care to a patient who is unconscious following a cerebrovascular accident
    C) Administering an IV bolus of normal saline to a patient with hypotension
    D) Providing discharge teaching to a postsurgical patient about the rationale for a course of oral antibiotics

    Ans: C

    Feedback:

    Although many nursing actions are independent, others are interdependent, such as carrying out prescribed treatments, administering medications and therapies, and collaborating with other health care team members to accomplish specific, expected outcomes and to monitor and manage potential complications. Irrigating a wound, administering pain medication, and administering IV fluids are interdependent nursing actions and require a physician's order. An independent nursing action occurs when the nurse assesses a patient's heart rate, provides discharge education, or provides mouth care.

27. A nurse has been using the nursing process as a framework for planning and providing patient care. What action would the nurse do during the evaluation phase of the nursing process?
    A) Have a patient provide input on the quality of care received.
    B) Remove a patient's surgical staples on the scheduled postoperative day.
    C) Provide information on a follow-up appointment for a postoperative patient.
    D) Document a patient's improved air entry with incentive spirometric use.

    Ans: D

    Feedback:

    During the evaluation phase of the nursing process, the nurse determines the patient's response to nursing interventions. An example of this is when the nurse documents whether the patient's spirometry use has improved his or her condition. A patient does not do the evaluation. Removing staples and providing information on follow-up appointments are interventions, not evaluations.

28. An audit of a large, university medical center reveals that four patients in the hospital have current orders for restraints. You know that restraints are an intervention of last resort, and that it is inappropriate to apply restraints to which of the following patients?
    A) A postlaryngectomy patient who is attempting to pull out his tracheostomy tube
    B) A patient in hypovolemic shock trying to remove the dressing over his central venous catheter
    C) A patient with urosepsis who is ringing the call bell incessantly to use the bedside commode
    D) A patient with depression who has just tried to commit suicide and whose medications are not achieving adequate symptom control

    Ans: C

    Feedback:

    Restraints should never be applied for staff convenience. The patient with urosepsis who is frequently ringing the call bell is requesting assistance to the bedside commode; this is appropriate behavior that will not result in patient harm. The other described situations could plausibly result in patient harm; therefore, it is more likely appropriate to apply restraints in these instances.

29. A patient has been diagnosed with small-cell lung cancer. He has met with the oncologist and is now weighing the relative risks and benefits of chemotherapy and radiotherapy as his treatment. This patient is demonstrating which ethical principle in making his decision?
    A) Beneficence
    B) Confidentiality
    C) Autonomy
    D) Justice

    Ans: C

    Feedback:

    Autonomy entails the ability to make a choice free from external constraints. Beneficence is the duty to do good and the active promotion of benevolent acts. Confidentiality relates to the concept of privacy. Justice states that cases should be treated equitably.

30. A patient with migraines does not know whether she is receiving a placebo for pain management or the new drug that is undergoing clinical trials. Upon discussing the patient's distress, it becomes evident to the nurse that the patient did not fully understand the informed consent document that she signed. Which ethical principle is most likely involved in this situation?
    A) Sanctity of life
    B) Confidentiality
    C) Veracity
    D) Fidelity
    Ans: C
    Feedback:
    Telling the truth (veracity) is one of the basic principles of our culture. Three ethical dilemmas in clinical practice that can directly conflict with this principle are the use of placebos (nonactive substances used for treatment), not revealing a diagnosis to a patient, and revealing a diagnosis to persons other than the patient with the diagnosis. All involve the issue of trust, which is an essential element in the nurse–patient relationship. Sanctity of life is the perspective that life is the highest good. Confidentiality deals with privacy of the patient. Fidelity is promise-keeping and the duty to be faithful to one's commitments.

31. The nursing instructor is explaining critical thinking to a class of first-semester nursing students. When promoting critical thinking skills in these students, the instructor should encourage them to do which of the following actions?
    A) Disregard input from people who do not have to make the particular decision.
    B) Set aside all prejudices and personal experiences when making decisions.
    C) Weigh each of the potential negative outcomes in a situation.
    D) Examine and analyze all available information.
    Ans: D
    Feedback:
    Critical thinking involves reasoning and purposeful, systematic, reflective, rational, outcome-directed thinking based on a body of knowledge, as well as examination and analysis of all available information and ideas. A full disregard of one's own experiences is not possible. Critical thinking does not denote a focus on potential negative outcomes. Input from others is a valuable resource that should not be ignored.

32. A care conference has been organized for a patient with complex medical and psychosocial needs. When applying the principles of critical thinking to this patient's care planning, the nurse should most exemplify what characteristic?
    A) Willingness to observe behaviors
    B) A desire to utilize the nursing scope of practice fully
    C) An ability to base decisions on what has happened in the past
    D) Openness to various viewpoints
    Ans: D
    Feedback:
    Willingness and openness to various viewpoints are inherent in critical thinking; these allow the nurse to reflect on the current situation. An emphasis on the past, willingness to observe behaviors, and a desire to utilize the nursing scope of practice fully are not central characteristics of critical thinkers.

33. Achieving adequate pain management for a postoperative patient will require sophisticated critical thinking skills by the nurse. What are the potential benefits of critical thinking in nursing? Select all that apply.
    A) Enhancing the nurse's clinical decision making
    B) Identifying the patient's individual preferences
    C) Planning the best nursing actions to assist the patient
    D) Increasing the accuracy of the nurse's judgments
    E) Helping identify the patient's priority needs
    Ans: A, C, D, E
    Feedback:
    Independent judgments and decisions evolve from a sound knowledge base and the ability to synthesize information within the context in which it is presented. Critical thinking enhances clinical decision making, helping to identify patient needs and the best nursing actions that will assist patients in meeting those needs. Critical thinking does not normally focus on identify patient desires; these would be identified by asking the patient.

34. A nurse is unsure how best to respond to a patient's vague complaint of “feeling off.” The nurse is attempting to apply the principles of critical thinking, including metacognition. How can the nurse best foster metacognition?
    A) By eliciting input from a variety of trusted colleagues
    B) By examining the way that she thinks and applies reason
    C) By evaluating her responses to similar situations in the past
    D) By thinking about the way that an “ideal” nurse would respond in this situation
    Ans: B
    Feedback:
    Critical thinking includes metacognition, the examination of one's own reasoning or thought processes, to help refine thinking skills. Metacognition is not characterized by eliciting input from others or evaluating previous responses.

35. The nursing instructor cites a list of skills that support critical thinking in clinical situations. The nurse should describe skills in which of the following domains? Select all that apply.
    A) Self-esteem
    B) Self-regulation
    C) Inference
    D) Autonomy
    E) Interpretation
    Ans: B, C, E
    Feedback:
    Skills needed in critical thinking include interpretation, analysis, evaluation, inference, explanation, and self-regulation. Self-esteem and autonomy would not be on the list because they are not skills.

36. The nurse is providing care for a patient with chronic obstructive pulmonary disease (COPD). The nurse's most recent assessment reveals an SaO_2 of 89%. The nurse is aware that part of critical thinking is determining the significance of data that have been gathered. What characteristic of critical thinking is used in determining the best response to this assessment finding?
    A) Extrapolation
    B) Inference
    C) Characterization
    D) Interpretation
    Ans: D
    Feedback:
    Nurses use interpretation to determine the significance of data that are gathered. This specific process is not described as extrapolation, inference, or characterization.

37. A nurse is admitting a new patient to the medical unit. During the initial nursing assessment, the nurse has asked many supplementary open-ended questions while gathering information about the new patient. What is the nurse achieving through this approach?
    A) Interpreting what the patient has said
    B) Evaluating what the patient has said
    C) Assessing what the patient has said
    D) Validating what the patient has said
    Ans: D
    Feedback:
    Critical thinkers validate the information presented to make sure that it is accurate (not just supposition or opinion), that it makes sense, and that it is based on fact and evidence. The nurse is not interpreting, evaluating, or assessing the information the patient has given.

38. A nurse uses critical thinking every day when going through the nursing process. Which of the following is an outcome of critical thinking in nursing practice?
    A) A comprehensive plan of care with a high potential for success
    B) Identification of the nurse's preferred goals for the patient
    C) A collaborative basis for assigning care
    D) Increased cost efficiency in health care
    Ans: A
    Feedback:
    Critical thinking in nursing practice results in a comprehensive plan of care with maximized potential for success. Critical thinking does not identify the nurse's goal for the patient or provide a collaborative basis for assigning care. Critical thinking may or may not lead to increased cost efficiency; the patient's outcomes are paramount.

39. A nurse provides care on an orthopedic reconstruction unit and is admitting two new patients, both status post knee replacement. What would be the best explanation why their care plans may be different from each other?
    A) Patients may have different insurers, or one may qualify for Medicare.
    B) Individual patients are seen as unique and dynamic, with individual needs.
    C) Nursing care may be coordinated by members of two different health disciplines.
    D) Patients are viewed as dissimilar according to their attitude toward surgery.
    Ans: B
    Feedback:
    Regardless of the setting, each patient situation is viewed as unique and dynamic. Differences in insurance coverage and attitude may be relevant, but these should not fundamentally explain the differences in their nursing care. Nursing care should be planned by nurses, not by members of other disciplines.

40. A class of nursing students is in their first semester of nursing school. The instructor explains that one of the changes they will undergo while in nursing school is learning to "think like a nurse." What is the most current model of this thinking process?
    A) Critical-thinking Model
    B) Nursing Process Model
    C) Clinical Judgment Model
    D) Active Practice Model
    Ans: C
    Feedback:
    To depict the process of "thinking like a nurse," Tanner (2006) developed a model known as the clinical judgment model.

41. Critical thinking and decision-making skills are essential parts of nursing in all venues. What are examples of the use of critical thinking in the venue of genetics-related nursing? Select all that apply.
    A) Notifying individuals and family members of the results of genetic testing
    B) Providing a written report on genetic testing to an insurance company
    C) Assessing and analyzing family history data for genetic risk factors
    D) Identifying individuals and families in need of referral for genetic testing
    E) Ensuring privacy and confidentiality of genetic information
    Ans: C, D, E
    Feedback:
    Nurses use critical thinking and decision-making skills in providing genetics-related nursing care when they assess and analyze family history data for genetic risk factors, identify those individuals and families in need of referral for genetic testing or counseling, and ensure the privacy and confidentiality of genetic information. Nurses who work in the venue of genetics-related nursing do not notify family members of the results of an individual's genetic testing, and they do not provide written reports to insurance companies concerning the results of genetic testing.

42. A student nurse has been assigned to provide basic care for a 58-year-old man with a diagnosis of AIDS-related pneumonia. The student tells the instructor that she is unwilling to care for this patient. What key component of critical thinking is most likely missing from this student's practice?
    A) Compliance with direction
    B) Respect for authority
    C) Analyzing information and situations
    D) Withholding judgment
    Ans: D
    Feedback:
    Key components of critical thinking behavior are withholding judgment and being open to options and explanations from one patient to another in similar circumstances. The other listed options are incorrect because they are not components of critical thinking.

43. A group of students have been challenged to prioritize ethical practice when working with a marginalized population. How should the students best understand the concept of ethics?
    A) The formal, systematic study of moral beliefs
    B) The informal study of patterns of ideal behavior
    C) The adherence to culturally rooted, behavioral norms
    D) The adherence to informal personal values
    Ans: A
    Feedback:
    In essence, ethics is the formal, systematic study of moral beliefs, whereas morality is the adherence to informal personal values.

44. Your patient has been admitted for a liver biopsy because the physician believes the patient may have liver cancer. The family has told both you and the physician that if the patient is terminal, the family does not want the patient to know. The biopsy results are positive for an aggressive form of liver cancer and the patient asks you repeatedly what the results of the biopsy show. What strategy can you use to give ethical care to this patient?
    A) Obtain the results of the biopsy and provide them to the patient.
    B) Tell the patient that only the physician knows the results of the biopsy.
    C) Promptly communicate the patient's request for information to the family and the physician.
    D) Tell the patient that the biopsy results are not back yet in order temporarily to appease him.

    Ans: C

    Feedback:

    Strategies nurses could consider include the following: not lying to the patient, providing all information related to nursing procedures and diagnoses, and communicating the patient's requests for information to the family and physician. Ethically, you cannot tell the patient the results of the biopsy and you cannot lie to the patient.

45. The nurse admits a patient to an oncology unit that is a site for a study on the efficacy of a new chemotherapeutic drug. The patient knows that placebos are going to be used for some participants in the study but does not know that he is receiving a placebo. When is it ethically acceptable to use placebos?
    A) Whenever the potential benefits of a study are applicable to the larger population
    B) When the patient is unaware of it and it is deemed unlikely that it would cause harm
    C) Whenever the placebo replaces an active drug
    D) When the patient knows placebos are being used and is involved in the decision-making process

    Ans: D

    Feedback:

    Placebos may be used in experimental research in which a patient is involved in the decision-making process and is aware that placebos are being used in the treatment regimen. Placebos may not ethically be used solely when there is a potential benefit, when the patient is unaware, or when a placebo replaces an active drug.

46. The nurse caring for a patient who is two days post hip replacement notifies the physician that the patient's incision is red around the edges, warm to the touch, and seeping a white liquid with a foul odor. What type of problem is the nurse dealing with?
    A) Collaborative problem
    B) Nursing problem
    C) Medical problem
    D) Administrative problem
    Ans: A
    Feedback:
    In addition to nursing diagnoses and their related nursing interventions, nursing practice involves certain situations and interventions that do not fall within the definition of nursing diagnoses. These activities pertain to potential problems or complications that are medical in origin and require collaborative interventions with the physician and other members of the health care team. The other answers are incorrect because the signs and symptoms of infection are a medical complication that requires interventions by the nurse.

47. While developing the plan of care for a new patient on the unit, the nurse must identify expected outcomes that are appropriate for the new patient. What resource should the nurse prioritize for identifying these appropriate outcomes?
    A) Community Specific Outcomes Classification (CSO)
    B) Nursing-Sensitive Outcomes Classification (NOC)
    C) State Specific Nursing Outcomes Classification (SSNOC)
    D) Department of Health and Human Services Outcomes Classification (DHHSOC)
    Ans: B
    Feedback:
    Resources for identifying appropriate expected outcomes include the NOC and standard outcome criteria established by health care agencies for people with specific health problems. The other options are incorrect because they do not exist.

48. The nurse has just taken report on a newly admitted patient who is a 15-year-old girl who is a recent immigrant to the United States. When planning interventions for this patient, the nurse knows the interventions must be which of the following? Select all that apply.
    A) Appropriate to the nurse's preferences
    B) Appropriate to the patient's age
    C) Ethical
    D) Appropriate to the patient's culture
    E) Applicable to others with the same diagnosis
    Ans: B, C, D
    Feedback:
    Planned interventions should be ethical and appropriate to the patient's culture, age, and gender. Planned interventions do not have to be in alignment with the nurse's preferences nor do they have to be shared by everyone with the same diagnosis.