

Test Bank for Fundamentals of Nursing 10th Edition Taylor (2023/2024)| 9781975168155 | Chapter 1-47 | Complete Questions and Answers A+

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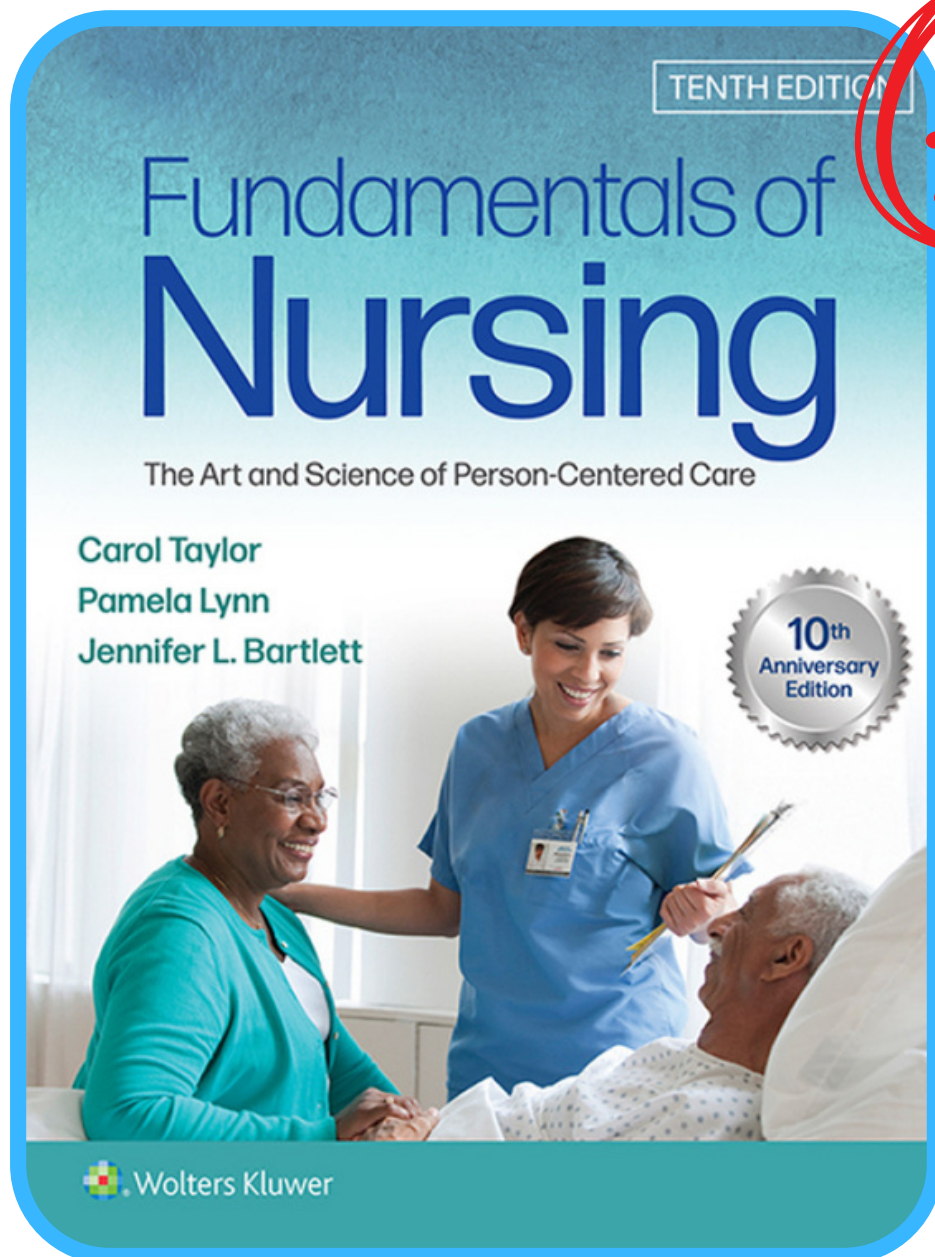
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Chapter 01: Introduction to Nursing and Professional Formation

1. Which of the following statements accurately describe an element of nursing?
Select all that apply.
 - A) The skills involved in nursing are primarily technical in nature.
 - B) The primary focus of nursing is to assist individuals to recover from illness.
 - C) The science of nursing is the knowledge base for the care that is given.
 - D) The art of nursing is the collection of knowledge through research.
 - E) Nursing is considered to be both an art and a science.
 - F) Nursing is a profession that used specialized knowledge and skills.

2. Which of the following set of terms best describes nursing at the end of the Middle Ages?
 - A) continuity, caring, critical thinking
 - B) purpose, direction, leadership
 - C) assessment, interventions, outcomes
 - D) advocacy, research, education



3. Which of the following is a characteristic of nursing practiced from early civilization to the 16th century?
 - A) Most early civilizations believed that illness had supernatural causes.
 - B) The physician was the priest who treated disease with prayer.
 - C) The nurse was a nun committed to caring for the needy and homeless.
 - D) Nursing changed from a spiritual focus to an emphasis on knowledge expansion.
4. In what time period did nursing care as we now know it begin?
 - A) pre-civilization
 - B) early civilization to 16th century
 - C) 16th to 17th century
 - D) 18th to 19th century
5. Who is considered to be the founder of professional nursing?
 - A) Dorothea Dix
 - B) Lillian Wald
 - C) Florence Nightingale



D) Clara Barton

6. Which of the following nursing pioneers established the Red Cross in the United States in 1882?

A) Florence Nightingale

B) Clara Barton

C) Dorothea Dix

D) Jane Addams

7. What was one barrier to the development of the nursing profession in the United States after the Civil War?

A) lack of educational standards

B) hospital-based schools of nursing

C) lack of influence from nursing leaders

D) independence of nursing orders

8. Which of the following individuals provided community-based care and founded public health nursing?

A) Adelaide Nutting



- B) Lillian Wald
 - C) Sojourner Truth
 - D) Clara Barton
9. Which of the following nursing groups provides a definition and scope of practice for nursing?
- A) ICN
 - B) AAN
 - C) ANA
 - D) The Joint Commission
10. Teaching a woman about breast self-examination is an example of what broad aim of nursing?
- A) promoting health
 - B) preventing illness
 - C) restoring health
 - D) facilitating coping with disability and death



11. What nursing activity would meet the broad nursing aim of facilitating coping with disability and death? Select all that apply.
- A) conducting a blood pressure screening program
 - B) teaching testicular self-examination
 - C) referring to a community diabetic support group
 - D) administering intravenous fluids
 - E) admitting a patient to a hospice program
 - F) performing a physical assessment on a patient
12. A nurse caring for a patient with diabetes chooses an appropriate plan of care and devises interventions to accomplish the desired outcomes. This is an example of using which of the following type of nursing skills?
- A) Technical
 - B) Cognitive
 - C) Interpersonal
 - D) Ethical/Legal
13. Which one of the following examples of nursing actions would be considered an ethical/legal skill?



- A) A nurse helps a patient prepare a living will.
 - B) A nurse obtains a urine sample for a urinalysis.
 - C) A nurse explains the rationale for a patient's plan of care.
 - D) A nurse holds the hand of a woman whose baby died in childbirth.
14. A nurse practitioner is caring for a couple who are the parents of an infant diagnosed with Down's Syndrome. The nurse makes referrals for a parent support group for the family. This is an example of which nursing role?
- A) Teacher/Educator
 - B) Leader
 - C) Counselor
 - D) Collaborator
15. A nurse is providing nursing care in a neighborhood clinic to single pregnant teens. Which of the following actions is the best example of using the collaborator role as a nurse?
- A) Discussing the legal aspects of adoption for teens wishing to place their infants with a family
 - B) Searching the Internet for information on child care for the teens who wish to return to school



- C) Conducting a patient interview and documenting the information on the patients chart
 - D) Referring a teen who admits having suicidal thoughts to a mental healthcare specialist
16. A nurse instructor explains the concept of health to her students. Which of the following statements accurately describes this state of being?
- A) Health is a state of optimal functioning.
 - B) Health is an absence of illness.
 - C) Health is always an objective state.
 - D) Health is not determined by the patient.
17. A nurse incorporates the health promotion guidelines established by the U.S. Department of Health document: *Healthy People 2010*. Which of the following is a health indicator discussed in this document?
- A) cancer
 - B) obesity
 - C) diabetes
 - D) hypertension



18. A nurse conducts a smoking-cessation program for patients of a neighborhood clinic. This is an example of which of the following aims of nursing?
- A) promoting health
 - B) preventing illness
 - C) restoring health
 - D) facilitating coping with disability or death
19. Which of the following is a criteria that defines nursing as profession?
- A) an undefined body of knowledge
 - B) a dependence on the medical profession
 - C) an ability to diagnose medical problems
 - D) a strong service orientation
20. Although all of the following are nursing responsibilities, which one would be expected of a nurse with a baccalaureate degree?
- A) providing direct physical care
 - B) using research findings to improve practice



- C) administering medications as prescribed
 - D) collaborating with other healthcare providers
21. Amy Jones, a high school senior, wants to become a geriatric nurse practitioner. What nursing degree will she need to attain this goal?
- A) licensed practical nurse
 - B) associate degree
 - C) baccalaureate degree
 - D) masters degree
22. Why are nursing organizations important for the continued development and improvement of nursing as a whole?
- A) to provide socialization and networking for members
 - B) to regulate work activities for members
 - C) to set standards for nursing education and practice
 - D) to provide information to nurses about legal requirements
23. Which of the following organizations has established standards for clinical nursing practice?



- A) American Nurses Association
 - B) National League for Nursing
 - C) International Council of Nurses
 - D) State Board of Nursing
24. What is the primary purpose of standards of nursing practice?
- A) to provide a method by which nurses perform skills safely
 - B) to ensure knowledgeable, safe, comprehensive nursing care
 - C) to establish nursing as a profession and a discipline
 - D) to enable nurses to have a voice in healthcare policy
25. After graduation from an accredited program in nursing and successfully passing the NCLEX, what gives the nurse a legal right to practice?
- A) enrolling in an advanced degree program
 - B) filing NCLEX results in the county of residence
 - C) being licensed by the State Board of Nursing



- D) having a signed letter confirming graduation
26. A nurse has been tried and found guilty of the felony crime of forgery. How might this affect the nurses license to practice nursing?
- A) It will have no effect on the ability to practice nursing.
- B) The nurse can practice nursing at a less-skilled level.
- C) The license may be revoked or suspended.
- D) The license will permanently carry the felony conviction.
27. Nurses use the nursing process to focus care on human responses to what?
- A) interactions with the environment
- B) physical effects of disease
- C) outcomes of medical or surgical treatment
- D) actual or potential health problems
28. Which age group in the population is expanding most rapidly, resulting in changes in the delivery of healthcare?
- A) older adults



- B) young adults
- C) school-aged children
- D) newborns

29. Which of the following is a current trend affecting nursing education and practice?

- A) over abundance of graduating nurses
- B) office-based care delivery systems
- C) increase in length of hospital stay
- D) increase in chronic health conditions

Answer Key

- 1. C, E, F
- 2. B
- 3. A
- 4. D
- 5. C



6. B
7. A
8. B
9. B
10. B
11. C, E
12. B
13. A
14. C
15. D
16. A
17. B
18. B
19. D



20. B

21. D

22. C

23. A

24. B

25. C

26. C

27. D

28. A

29. D



Chapter 02: Theory, Research, and Evidence-Based Practice

1. What phrase best describes the science of nursing?
 - A) application of clinical skills
 - B) body of nursing knowledge
 - C) holistic patient care
 - D) art of individualized nursing

2. The practice of changing patients bedclothes each day in acute care settings is an example of what type of knowledge?
 - A) authoritative
 - B) traditional
 - C) scientific
 - D) applied

3. A student nurse learns how to give injections from the nurse manager. This is an example of the acquisition of what type of knowledge?
 - A) authoritative



- B) traditional
 - C) scientific
 - D) applied
4. Which of the following sources of knowledge is based on objective data?
- A) authoritative
 - B) traditional
 - C) scientific
 - D) applied
5. A patient undergoing chemotherapy for a brain tumor believes that having a good attitude will help in the healing process. This is an example of what type of knowledge?
- A) science
 - B) philosophy
 - C) process
 - D) virtue



6. Which of the following examples represents the type of knowledge known as process? Select all that apply.
- A) A nurse dispenses medications to patients.
 - B) A nurse changes the linens on a patients bed.
 - C) A nurse studies a nursing journal article on infection control.
 - D) A nurse consults an ethics committee regarding an ethical dilemma.
 - E) A nurse believes in providing culturally competent nursing care.
 - F) A nurse monitors the vital signs of a postoperative patient.
7. Which of the following accurately describes Florence Nightingales influence on nursing knowledge?
- A) She defined nursing practice as the continuation of medical practice.
 - B) She differentiated between health nursing and illness nursing.
 - C) She established training for nurses under the direction of the medical profession.
 - D) She established a theoretical base for nursing that originated outside the profession.



8. During the first half of the 20th century, a change in the structure of society resulted in changed roles for women and, in turn, for nursing. What was one of these changes?
- A) More women retired from the workforce to raise families.
 - B) Women became more dependent and sought higher education.
 - C) The focus of nursing changed to hands-on training.
 - D) Nursing research was conducted and published.
9. Who was the first nurse to develop a nursing theory?
- A) Clara Barton
 - B) Dorothea Dix
 - C) Florence Nightingale
 - D) Virginia Henderson
10. A nurse observes that certain patients have less pain after procedures than do others, and forms a theory of why this happens. What is a theory?
- A) a concept used to directly prove a fact or a group of facts
 - B) an understanding borrowed from other disciplines



- C) a best guess based on intangible ideas
 - D) a statement of an occurrence based on observed facts
11. A staff nurse asks a student, Why in the world are you studying nursing theory? How would the student best respond?
- A) Our school requires we take it before we can graduate.
 - B) We do it so we know more than your generation did.
 - C) I think it explains how we should collaborate with others.
 - D) It helps explain how nursing is different from medicine.
12. Why are the developmental theories important to nursing practice?
- A) They describe how parts work together as a system.
 - B) They outline the process of human growth and development.
 - C) They define human adaptation to others and to the environment.
 - D) They explain the importance of legal and ethical care.
13. Breaking the healthcare community into separate entities (such as the medical community, the nursing staff, management, support staff) and analyzing how they work as a whole together is an example of which nursing theory?



- A) general systems theory
 - B) adaptation theory
 - C) developmental theory
 - D) compartment theory
14. There are four concepts common in all nursing theories. Which one of the four concepts is the focus of nursing?
- A) person
 - B) environment
 - C) health
 - D) nursing
15. Which of the following are characteristics of nursing theories? Select all that apply.
- A) They provide rational reasons for nursing interventions.
 - B) They are based on descriptions of what nursing should be.
 - C) They provide a knowledge base for appropriate nursing responses.



- D) They provide a base for discussion of nursing issues.
 - E) They help resolve current nursing issues and establish trends.
 - F) They use complex terminology to resolve specific nursing issues.
16. What is the ultimate goal of expanding nursing knowledge through nursing research?
- A) learn improved ways to promote and maintain health
 - B) develop technology to provide hands-on nursing care
 - C) apply knowledge to become independent practitioners
 - D) become full-fledged partners with other care providers
17. What was significant about the promotion of the National Center for Nursing Research to the current National Institute of Nursing Research (NINR)?
- A) Increased numbers of articles are published in research journals.
 - B) NINR gained equal status with all other National Institutes of Health.
 - C) NINR became the major research body of the International Council of Nurses.
 - D) It decreased emphasis on clinical research as an important area for nursing.



18. Which of the following terms are part of quantitative research?
- A) process
 - B) concept
 - C) ethnography
 - D) variable
19. A nurse uses the process of quantitative research to study the incidence and causes of hospital-acquired pneumonia in her hospital. The statement of what the researcher expects to find in these studies is called the:
- A) variable
 - B) data
 - C) hypothesis
 - D) instrument
20. Information is collected for analysis in both quantitative and qualitative research. What is the information called?
- A) surveys
 - B) answers



- C) interviews
 - D) data
21. A patient in a clinical research study has given informed consent. This means that the patient has certain rights. These rights include which of the following? Select all that apply.
- A) confidentiality
 - B) free medical care
 - C) refusal to participate
 - D) protection from harm
 - E) guarantee of treatment
 - F) consent knowledgeably
22. Which of the following represents the basic framework of the research process?
- A) Qualitative data
 - B) Quantitative data
 - C) Nursing Process



- D) Nursing Theory
23. Which of the following is a responsibility of an institutional review board (IRB)?
- A) secure informed consent for researchers
 - B) review written accuracy of research proposals
 - C) determine risk status of all studies
 - D) secure funding for institutional research
24. Before developing a procedure, a nurse reviews all current research-based literature on insertion of a nasogastric tube. What type of nursing will be practiced based on this review?
- A) institutional practice
 - B) authoritative nursing
 - C) evidence-based nursing
 - D) factual-based nursing
25. Which of the following are examples of characteristics of evidence-based practice? Select all that apply.
- A) It is a problem-solving approach.



- B) It uses the best evidence available.
 - C) It is generally accepted in clinical practice.
 - D) It is based on current institutional protocols.
 - E) It blends the science and art of nursing.
 - F) It is not concerned with patient preferences.
26. One step in implementing evidence-based practice is to ask a question about a clinical area of interest or an intervention. The most common method is the PICO format. Which of the following accurately defines the letters in the PICO acronym?
- A) P = population
 - B) I = institution
 - C) C = compromise
 - D) O = output
27. A beginning student is reading a published research article. Where in the article would the student find the abstract?
- A) in the introduction
 - B) in the methods section



C) after the references

D) at the beginning

Answer Key

1. B

2. B

3. A

4. A

5. B

6. A, B, F

7. B

8. D

9. C

10. D

11. D



12. B

13. A

14. A

15. A, C, D, E

16. A

17. B

18. D

19. C

20. D

21. A, C, D, F

22. C

23. C

24. C

25. A, B, E



26. A

27. D



Chapter 03: Health, Wellness, and Health Disparities

1. What phrase best describes health?
 - A) individually defined by each person
 - B) experienced by each person in exactly the same way
 - C) the opposite of illness
 - D) the absence of disease

2. Which of the following most accurately defines illness?
 - A) the inability to carry out normal activities of living
 - B) a pathologic change in mind or body structure or function
 - C) the response of a person to a disease
 - D) achieving maximum potential and quality of life

3. A patient makes a decision to quit smoking and joins a smoking cessation class. This is an example of which of Dunns processes that help a person know who and what he or she is?
 - A) being



- B) belonging
 - C) becoming
 - D) befitting
4. Which of the following statements accurately describes the concepts of disease and illness?
- A) A disease is traditionally diagnosed and treated by a nurse.
 - B) The focus of nurses is the person with an illness.
 - C) A person with an illness cannot be considered healthy.
 - D) Illness is a normal process that affects level of functioning.
5. A rapid onset of symptoms that last a relatively short time indicates what health problem?
- A) a chronic illness
 - B) an acute illness
 - C) actual risk factor
 - D) potential for wellness



6. A nurse caring for patients with diabetes knows that the following is a characteristic of a chronic illness:
- A) It is a temporary change.
 - B) It causes reversible alterations in A&P.
 - C) It requires special patient education for rehabilitation.
 - D) It requires a short period of care or support.
7. What manifestation is the most significant symptom indicating an illness?
- A) bleeding
 - B) runny nose
 - C) pain
 - D) itching
8. A nurse calls in to his unit to report he has the flu and will not be at work. What stage of illness behavior is he exhibiting?
- A) experiencing symptoms
 - B) assuming the sick role



- C) assuming a dependent role
 - D) achieving recovery and rehabilitation
9. A patient accepts the fact that he needs bypass surgery for a blocked artery and is admitted into the hospital. Which one of the following stages of illness is this patient experiencing?
- A) Stage 1
 - B) Stage 2
 - C) Stage 3
 - D) Stage 4
10. Which of the following is an example of a characteristic of the Stage 2 of illness?
- A) A person tells his family that he is sick and allows them to take care of him.
 - B) A person experiences a headache and sore throat and takes an aspirin.
 - C) A person visits a physician to receive treatment for symptoms of an infection.
 - D) A person begins rehabilitation following a stroke that left him paralyzed on one side.
11. A 4-year-old child has leukemia but is now in remission. What does it mean to be in remission when one has a chronic illness?



- A) The chronic disease has been cured.
 - B) Nothing further can be done in terms of treatment.
 - C) Severe symptoms of the chronic illness have reappeared.
 - D) The disease is present, but symptoms are not experienced.
12. What may happen to the family when an illness occurs in one of the family members?
- A) alterations in values and religious beliefs
 - B) more public displays of affection
 - C) changes in roles for the patient and family
 - D) increased resistance to stress
13. A baby is born with Down syndrome, which influences his health/illness status. This is an example of which of the following human dimensions?
- A) Physical
 - B) Emotional
 - C) Environmental



D) Sociocultural

14. Which of the following is an example of the sociocultural dimension influencing a persons health status?

A) A family lives in a city environment where the air pollution levels are high.

B) A father who is a practicing Jehovahs Witness refuses a blood transfusion for his son.

C) A teenager who was in an automobile accident worries that his scars will cause him to lose friends.

D) A single mother of two applies for food stamps in order to feed her family.

15. A nurse is caring for a 17-year-old female patient whose left leg was amputated after being crushed in a motor vehicle accident. Which of the following interventions might the nurse perform to accommodate the patients intellectual dimension?

A) considering the patients developmental stage when planning nursing care

B) encouraging friends and relatives to visit often and bring games to distract her

C) teaching her how to care for the stump and explaining the rehabilitation program

D) providing the opportunity for a counselor to come in and talk to her about her loss



16. Which of the following statements accurately describe how risk factors may increase a persons chances for illness or injury? Select all that apply.
- A) Risks factors are unrelated to the person or event.
 - B) All risk factors are modifiable.
 - C) An increase in risk factors increases the possibility of illness.
 - D) A family history of breast cancer is not a modifiable risk factor.
 - E) School-aged children are at high risk for communicable diseases.
 - F) Multiple sexual relationships increase the risk for sexually transmitted diseases.
17. Which of the following nursing interventions are examples of health promotion and preventive care on the primary level? Select all that apply.
- A) A nurse counsels a teenager to stop smoking.
 - B) A nurse conducts a health fair for high blood pressure screening.
 - C) A nurse counsels the family of a patient diagnosed with lung cancer.
 - D) A home healthcare nurse arranges for rehabilitation services for a patient.
 - E) A school nurse arranges for a career seminar for graduating seniors.



- F) A nurse devises a low-calorie diet for an obese teenager.
18. Which of the following topics is important when teaching teens and young adults?
- A) safer sex practices
 - B) blood pressure control
 - C) immunization for measles
 - D) effective hand hygiene
19. Which of the following statements illustrates the effect of the sociocultural dimension on health and illness?
- A) Why shouldn't I drink and drive? Everyone else does.
 - B) My mother has sickle cell anemia, and so do I.
 - C) I know I have heart problems, so I have changed my diet.
 - D) I used biofeedback to lower my blood pressure.
20. A middle-aged woman is 40 pounds over her ideal weight. Which of the following statements best illustrates the effect of her self-concept on health and illness?
- A) I am just too busy with my kids to bother about a diet.



- B) Why should I lose weight? Ill still be fat.
- C) My sister is thin, but I dont think she looks that good.
- D) My husband loves me this way.
21. A camp nurse is teaching a group of adolescent girls about the importance of monthly breast self-examination. What level of preventive care does this activity represent?
- A) primary
- B) secondary
- C) tertiary
- D) restorative
22. On which of the following components is Rosenstocks health belief model based? Select all that apply.
- A) perceived susceptibility to a disease
- B) perceived consequences of treating disease
- C) perceived seriousness of a disease
- D) perceived benefits of action



- E) perceived immunity to disease
 - F) perceived benefits of health insurance
23. A nurse refers a 67-year-old male patient to group counseling for alcohol cessation. According to Rosenstocks health belief model, the patients knowledge of the diseases that may occur with alcoholism is a:
- A) demographic variable
 - B) sociopsychological variable
 - C) structural variable
 - D) intellectual variable
24. Which of the following models of health promotion and illness prevention was developed to illustrate how people interact with their environment as they pursue health?
- A) the health promotion model
 - B) the health belief model
 - C) the healthillness continuum
 - D) the agenthostenvironment model



25. Which of the following factors constitute the environment component of the agent-host-environment model of health and illness (Leavell and Clark, 1965)? Select all that apply.
- A) bacteria/viruses
 - B) chemical substances
 - C) health habits
 - D) family history
 - E) cultural factors
 - F) biologic factors
26. Nurses use new resources for healthcare practices to promote health and serve as an advocate for patients and families in all settings. Which one of the following resources has been most instrumental in improving access to care for people living in rural or underserved areas of the nation?
- A) telehealth practice
 - B) industrial programs
 - C) community centers
 - D) nontraditional healthcare sites



27. Which of the following statements explain why models of health promotion and illness prevention are useful when planning healthcare? Select all that apply.
- A) They help healthcare providers understand health-related behaviors.
 - B) They are useful for adapting care to people from diverse backgrounds.
 - C) They help overcome barriers related to increased number of people without healthcare.
 - D) They overcome barriers to care for the predicted downward trend in minority populations.
 - E) They overcome barriers to care for low-income and rural populations.
 - F) They explain why people take advantage of low-cost screens and healthcare information.
28. What is the nurses primary role in promoting health?
- A) educating others about health promotion activities
 - B) avoiding smoking or drinking in public
 - C) being a role model for health promotion
 - D) implementing stress reduction activities

Answer Key



1. A

2. C

3. D

4. B

5. B

6. C

7. C

8. B

9. C

10. A

11. D

12. C

13. A

14. D



15. C
16. C, D, E, F
17. A, F
18. A
19. A
20. B
21. A
22. A, C, D
23. C
24. A
25. E, F
26. A
27. A, B, C, E
28. C



Chapter 04: Health of the Individual, Family, Community, and Environment

1. According to Maslows basic human needs hierarchy, which needs are the most basic?
 - A) physiologic
 - B) safety and security
 - C) love and belonging
 - D) self-esteem

2. Which of the following is a tenant of Maslows basic human needs hierarchy?
 - A) A need that is unmet prompts a person to seek a higher level of wellness.
 - B) A person feels ambivalence when a need is successfully met.
 - C) Certain needs are more basic than others and must be met first.
 - D) People have many needs and should strive to meet them simultaneously.

3. An 80-year-old woman states, I have successfully raised my family and had a good life. This statement illustrates meeting which basic human need?
 - A) safety and security



- B) love and belonging
 - C) self-esteem
 - D) self-actualization
4. A 2-year-old boy arrives at the emergency department of a local hospital with difficulty breathing from an asthmatic attack. Which of the following would be the priority nursing intervention?
- A) giving him his favorite stuffed animal to hold
 - B) assessing respirations and administering oxygen
 - C) raising the side rails and restraining his arms
 - D) asking his mother what are his favorite foods
5. A 75-year-old man is being discharged to his home following a fall in his kitchen that resulted in a fractured pelvis. The home health nurse makes a home assessment that will be used to design interventions to meet which priority need?
- A) sleep and rest
 - B) support from family members
 - C) protection from potential harm
 - D) feeling a sense of accomplishment



6. A nurse caring for a patient in a long-term health care facility measures his intake and output and weighs him to assess water balance. These actions help to meet which of Maslows hierarchy of needs?
- A) physiologic
 - B) safety and security
 - C) love and belonging
 - D) self-actualization
7. What action by a nurse will help a patient meet self-esteem needs?
- A) verbally negate the patients negative self-perceptions
 - B) freely give compliments to increase positive self-regard
 - C) independently establish goals to improve self-esteem
 - D) respect the patients values and belief systems
8. A nurse caring for a female patient with TB who is in isolation is aware that the patients love and belonging needs may not be properly met. Which of the following nursing action would help to meet these needs?
- A) respecting the patients values and beliefs
 - B) focusing on the patients strengths rather than problems



- C) using hand hygiene and sterile technique to prevent infection
 - D) encouraging family to visit and help in the care of the patient
9. Which of the following statements accurately describes how Maslows theory can be applied to nursing practice?
- A) Nurses can apply this theory to the nursing process.
 - B) Nurses can identify met needs as healthcare needs.
 - C) Nurses cannot use the theory on infants or children.
 - D) Nurses use the theory for ill, as opposed to healthy patients.
10. Jim and Alice were recently married. Each has previously been married and had two children. What name is given to this type of family?
- A) extended family
 - B) nuclear family
 - C) blended family
 - D) cohabiting family
11. Which of the following groups involves all parts of a persons life and is concerned with meeting basic human needs to promote health?



- A) peers
 - B) family
 - C) community
 - D) healthcare providers
12. David and Susan are in a committed relationship and live together with their adopted twin boys. Which of the following best describes this type of family?
- A) nuclear family
 - B) extended family
 - C) blended family
 - D) adoptive family
13. When providing nursing care to a patient, the nurse provides family-centered nursing care. What is one rationale for this nursing action?
- A) The nurse does not want the patient to feel lonely.
 - B) The patient will be more compliant with medical instructions.
 - C) The family will be more willing to listen to instructions.



- D) Illness in one family member affects all family members.
14. A mother teaches her son to respect his elders. This is an example of which of the following family functions?
- A) physical
 - B) economic
 - C) affective and coping
 - D) socialization
15. What is the purpose of the affective and coping function of the family?
- A) providing a safe environment for growth and development
 - B) ensuring financial assistance for family members
 - C) providing emotional comfort and identity
 - D) transmitting values, attitudes, and beliefs
16. A nurse provides health promotion and accident prevention programs for a family with adolescents and young adults. Which of the following is a task of a family at this stage?
- A) Establish a mutually satisfying marriage.



- B) Adjust to cost of family life.
 - C) Maintain supportive home base.
 - D) Maintain ties with younger and older generations.
17. Friedman, Bowden, and Jones (2003) identified the importance of family-centered nursing care, based on four rationales. Which of the following is one of these rationales?
- A) The family is composed of dependent members who affect one another.
 - B) If a family member is ill, it does not necessarily affect other family members.
 - C) A strong relationship exists between the family and health status of members.
 - D) The level of health of the family is established early and is not influenced by health promotion.
18. Which of the following individuals would the nurse assess as being most at risk for altered family health?
- A) an unmarried adolescent with a newborn
 - B) a newly married couple who ask about birth control
 - C) a middle-aged man and woman with no children
 - D) an older adult, living in an assisted-living community



19. What is the major effect of a health crisis on family structure?
- A) adaptation to stress
 - B) change in roles of family members
 - C) respect for family values
 - D) loss of individual identities
20. Mrs. Dunn has cared for her husband with Alzheimers disease for 2 years. She comes to a local health center because she is feeling worn out and stressed. What might be an appropriate nursing diagnosis for Mrs. Dunn?
- A) Dysfunctional Family Processes
 - B) Health-Seeking Behaviors
 - C) Risk for Caregiver Burden
 - D) Risk for Anxiety
21. Which of the following statements accurately describes a characteristic of a community?
- A) Communities do not exist in rural areas.
 - B) Communities are formed by the characteristics of people and other factors.



- C) Communities are not limited by geographic boundaries.
 - D) Communities have little or no effect of the health of residents.
22. Which of the following is an example of a community factor that may affect health?
- A) rural setting
 - B) air and water quality
 - C) number of residents
 - D) educational level
23. Which of the following factors may be a barrier to healthcare services for those living in rural areas?
- A) inadequate healthcare insurance
 - B) lack of knowledge about needed care
 - C) living long distances from services
 - D) decreased interest in health promotion
24. Which of the following definitions best describes community-based nursing?



- A) a focus on populations within the community
 - B) a focus on older adults living in nursing homes
 - C) care provided in the patients home for chronic illnesses
 - D) care centered on individual and family healthcare needs
25. What is one method by which a nurse can be a role model to promote health in the community?
- A) by demonstrating a healthy lifestyle
 - B) by becoming a member of a family
 - C) by meeting own basic needs
 - D) by exhibiting self-actualization

Answer Key

- 1. A
- 2. C
- 3. D
- 4. B



5. C

6. A

7. D

8. D

9. A

10. C

11. B

12. A

13. D

14. D

15. C

16. C

17. C

18. A



19. B

20. C

21. B

22. B

23. C

24. D

25. A



Chapter 05: Culturally Respectful Care

1. How is culture learned by each new generation?
 - A) ethnic heritage
 - B) involvement in religious activities
 - C) formal and informal experiences
 - D) belonging to a subculture

2. A nurse caring for patients in a culturally diverse neighborhood knows that culture affects the nurses interactions with patients. Which of the following is a characteristic of culture? Select all that apply.
 - A) Culture guides what is acceptable behavior for people in a specific group.
 - B) Modeling behavior is the primary means of transmitting culture.
 - C) Culture is generally not affected by the groups social and physical environment.
 - D) Cultural practices and beliefs mainly remain constant as long as they satisfy a groups needs.
 - E) Culture influences the way people of a group view themselves, have expectations, and behave.



F) Because of individual influences, there are differences both within and among cultures.

3. Which of the following statements is true of cultural assimilation?

A) Mutual cultural assimilation occurs when characteristics from two groups are traded.

B) Cultural assimilation is the integration of a majority group with a minority group.

C) Moving to a different culture may result in psychological discomfort.

D) Cultural assimilation is identifying with a collective cultural group, primarily based on common heritage.

4. Mr. Perez is a Mexican immigrant who migrated to the United States and lives in a Spanish-speaking community with other relatives. He is taken to the ER following a fall at work and is admitted to the hospital for observation. Which of the following is the nurse caring for Mr. Perez aware that he is at risk for?

A) cultural assimilation

B) cultural shock

C) cultural imposition

D) cultural blindness

5. What characteristic is used to describe racial categories?



- A) language
 - B) skin color
 - C) music preferences
 - D) food likes and dislikes
6. A 20-year-old housekeeper, born and educated in Iraq, wears her traditional clothing and head covering. A 50-year-old patient tells the nurse, They are in America and should dress like we do. What is this statement an example of?
- A) cultural assimilation
 - B) cultural blindness
 - C) cultural conflict
 - D) cultural imposition
7. A nurse walks by a patients room and observes a Shaman performing a healing ritual for the patient. The nurse then remarks to a coworker that the ritual is a waste of time and disruptive to the other patients on the floor. This nurse is displaying the feelings associated with:
- A) culture conflict
 - B) cultural blindness



- C) stereotyping
 - D) cultural shock
8. Which of the following statements accurately describe cultural factors that may influence healthcare? Select all that apply.
- A) Nurses and patients generally agree upon the health practices that are being instituted.
 - B) Certain racial and ethnic groups are more prone to developing specific diseases and conditions.
 - C) Although pain affects people differently, most people react to pain in the same manner.
 - D) Most mental health norms are based on research and observations made of white, middle-class people.
 - E) In many cultures, the man is the dominant figure and generally makes decisions for all family members.
 - F) When people move to the United States, they may speak their own language fluently but have difficulty speaking English.
9. A nurse is doing preoperative teaching for an African American man before he has abdominal surgery. What topic should be included in the teaching?
- A) the possibility of developing a keloid over the healed incision
 - B) the increased risk of developing an infection in the incision



- C) his racial characteristics that will slow healing
 - D) cultural influences on his response to surgery
10. A nurse is caring for a patient from Taiwan who constantly requests pain medication. What should the nurse consider when assessing the patients pain?
- A) Most people react to pain in the same way.
 - B) Pain in adults is less intense than pain in children.
 - C) The patient is a constant complainer.
 - D) Pain is what the patient says it is.
11. A father, mother, grandmother, and three school-aged children have immigrated to the United States from Thailand. Which member(s) of the family are likely to learn to speak English more rapidly?
- A) unemployed father
 - B) stay-at-home mother
 - C) grandmother
 - D) children



12. A 40-year-old nurse is taking a health history from a 20-year-old Hispanic man and notes that he looks down at the floor when he answers questions. What should the nurse understand about this behavior?
- A) The patient is embarrassed by the questions.
 - B) This is culturally appropriate behavior.
 - C) The patient dislikes the nurse.
 - D) The patient does not understand what is being asked.
13. An older adult woman of Chinese ancestry refuses to eat at the nursing home, stating, Im just not hungry. What factors should the staff assess for this problem?
- A) The woman does not like to eat with other residents of the home.
 - B) The woman is using this as a means of going home.
 - C) The food served may not be culturally appropriate.
 - D) The food served may violate religious beliefs.
14. Although all of the following are factors to consider when caring for patients with limited income, which one is the most important?
- A) basic human needs may go unmet
 - B) limited access to reliable transportation



- C) decreased access to healthcare services
 - D) risk for increased incidence of disease
15. The nurse is providing home care for a patient who traditionally drinks herbal tea to treat an illness. How should the nurse respond to a request for the herbal tea?
- A) We do not allow our patients to drink herbal tea.
 - B) Why in the world would you want to drink that stuff?
 - C) Let me check with the doctor to make sure it is okay with your medicines.
 - D) I have to fill out a lot of forms that you will have to sign before I can do that.
16. A nurse in a large metropolitan city enjoys working in a health clinic that primarily serves Hispanic patients. What does this statement imply about the nurse?
- A) The nurses knowledge and skills are not adequate to care for patients with acute illnesses.
 - B) The nurse respects and values providing culturally competent care.
 - C) The nurse is attempting to overcome cultural blindness.
 - D) This employment makes the nurse feel superior to a minority group of people.
17. A nurse is providing care for a Cambodian patient. The nurse says, You have to get up and walk whether you want to or not. What is this statement an example of?



- A) culture shock
 - B) stereotyping
 - C) cultural imposition
 - D) cultural competence
18. Which of the following are considered cultural norms of the healthcare system?
Select all that apply.
- A) inability to define health and illness
 - B) frequent use of jargon and documentation
 - C) professional deference to pecking order
 - D) use of a problem-solving methodology
 - E) belief in the fallibility of technology
 - F) use of certain procedures for birth and death
19. A nurse is caring for an African American in an acute care setting. Which one of the following might be a special nursing consideration for this patient?
- A) The patient might request a visit from a folk healer.



- B) The patient may be upset by drawing blood for a test.
 - C) The patient may perceive illness as a punishment from God.
 - D) The patient may expect the caregiver to deduce the problem by instinct.
20. In which of the following populations should the nurse carefully assess the patients use of over-the-counter medications?
- A) African American
 - B) Hispanic
 - C) White middle class
 - D) Asian
21. A nurse is caring for an Appalachian patient following her hysterectomy. Which of the following Appalachian values and beliefs should be considered when planning nursing care for this patient? Select all that apply.
- A) Isolation is considered as a way of life.
 - B) Dependence and self-determination are valued.
 - C) Lifestyle is more revered than compliance with healthcare issues.
 - D) They may be fatalistic about losses and deaths.



- E) There is a deep love, respect, and affection between people and the land.
 - F) Death is seen as a part of life and not feared.
22. What is one way in which nurses can develop cultural self-awareness?
- A) Ask peers and colleagues about practicing cultural competence.
 - B) Objectively examine own beliefs, values, and practices.
 - C) Realize nothing can be done to change ones values and beliefs.
 - D) Assert to others that personal biases cannot be changed.
23. A home health nurse is visiting a 60-year-old patient. During the initial visit, the patients husband answers all of the questions. What would the nurse assess based on this behavior?
- A) The patient does not want the nurse to visit.
 - B) The husband does not trust his wife to answer questions.
 - C) The patient is not able to answer the questions.
 - D) The husband is the dominant member of the family.

Answer Key

1. C



2. A, D, E, F

3. A

4. B

5. B

6. D

7. A

8. B, D, E, F

9. A

10. D

11. D

12. B

13. C

14. A

15. C



16. B

17. C

18. B, C, D, F

19. A

20. C

21. A, B, D

22. B

23. D



Chapter 06: Values, Ethics, and Advocacy

1. Which of the following phrases best describes a value?
 - A) questions about how one should act and live
 - B) the process by which one decides what is important in life
 - C) a belief about the worth of something to guide behavior
 - D) dispositions of character that motivate goodness

2. Mrs. Jones always thanks clerks at the grocery store. Her 6-year-old daughter echoes her thank you. The child is demonstrating what mode of value transmission?
 - A) modeling
 - B) moralizing
 - C) reward and punishment
 - D) responsible choice

3. What is one negative aspect for children of learning values through the moralizing mode of transmission?
 - A) little likelihood of developing acceptable behaviors



- B) can lead to confusion and conflict
 - C) unacceptable behaviors are punished
 - D) not much opportunity to weigh values
4. Which of the following modes of value transmission is most likely to lead to confusion and conflict?
- A) modeling
 - B) moralizing
 - C) laissez-faire
 - D) responsible choice
5. A nurse in a womens health clinic values abstinence as the best method of birth control. However, she offers compassionate care to unmarried pregnant adolescents. What is the nurse demonstrating?
- A) modeling of value transmission
 - B) conflict in values acceptance
 - C) nonjudgmental value neutral care
 - D) values conflict that may lead to stress



6. Which of the following are examples of a nurse demonstrating the professional value of altruism? Select all that apply.
- A) The nurse arranges for an interpreter for a patient whose primary language is Spanish.
 - B) The nurse calls the physician of a patient whose pain medication is not strong enough.
 - C) The nurse provides information for a patient so he is capable of participating in planning his care.
 - D) The nurse reviews a patient chart to determine who may be informed of the patient's condition.
 - E) The nurse documents patient care accurately and honestly and reviews the entry to ensure there are no errors.
 - F) The nurse encourages legislation for nationalized healthcare insurance for low-income families.
7. Values theorists describe the process of valuing as focusing on three main activities. What is the first activity in the valuing process?
- A) choosing
 - B) prizing
 - C) acting



- D) doing
8. Which of the following illustrates the activity of acting in values clarification?
- A) respecting the human dignity of all patients
 - B) seeking public affirmation for actions
 - C) disregarding several alternatives when choosing
 - D) considering consequences of actions
9. While at lunch, a nurse heard other nurses at a nearby table talking about a patient they did not like. When they asked him what he thought, he politely refused to join in the conversation. What value was the nurse demonstrating?
- A) the importance of food in meeting a basic human need
 - B) basic respect for human dignity
 - C) men do not gossip with women
 - D) a low value on collegiality and friendship
10. A middle-aged man is having increasing difficulty breathing. He never exercises, eats fast food regularly, and smokes two packs of cigarettes a day. He tells the nurse practitioner that he wants to change the way he lives. What is one means of helping him change behaviors?



- A) ethical change strategy
- B) values neutrality choices
- C) values transmission
- D) values clarification

11. Which of the following words is most closely associated with the term ethics?

- A) values
- B) modeling
- C) reward
- D) conduct

12. Which of the following statements accurately describe a characteristic of ethics?
Select all that apply.

- A) The ability to be ethical begins in young adulthood.
- B) Ethics cannot be defined as a code of professional conduct.
- C) Ethics usually refers to personal or communal standards of right and wrong.



- D) It is important to distinguish ethics from religion, law, custom, and institutional practices.
 - E) Values are intimately related to, and direct, ethical conduct.
 - F) Ethics is a systematic inquiry into principles of right and wrong conduct.
13. Which branch of bioethics is most concerned with ethical problems that arise within the context of caring for patients wherever they are found?
- A) moral development
 - B) clinical ethics
 - C) bioethics
 - D) nursing ethics
14. Which of the following best describes the utilitarian theory of ethics?
- A) If an action is useful, it is ethically correct.
 - B) The consequences of an action determine if it is right or wrong.
 - C) All actions are either right or wrong, regardless of consequences.
 - D) There is no way to determine whether an action is ethical or not.



15. Which component of nursing care is central to the care-based approach to bioethics?
- A) provision of physical care
 - B) relationships with healthcare providers
 - C) nursepatient relationship
 - D) management of care
16. A nurse using the principle-based approach to patient care seeks to avoid causing harm to patients in all situations. This principle is known as:
- A) nonmaleficence
 - B) justice
 - C) fidelity
 - D) autonomy
17. A nurse provides patient care within a philosophy of ethical decision making and professional expectations. What is the nurse using as a framework for practice?
- A) Code of Ethics
 - B) Standards of Care



- C) Definition of Nursing
 - D) Values Clarification
18. Which of the following are ANA standards of clinical nursing practice? Select all that apply.
- A) The nurses practice and actions are guided by hospital policy and regulations.
 - B) The nurse maintains patient confidentiality within legal and regulatory parameters.
 - C) The nurse is the patient advocate and discourages patients to advocate for themselves.
 - D) The nurse delivers care in a nonjudgmental manner that is sensitive to patient diversity
 - E) The nurse delivers care in a manner that preserves or protects patient dependency, dignity, and rights.
 - F) The nurse seeks available resources to help formulate ethical decisions and use them in practice.
19. What document was developed to improve workplaces and ensure nurses ability to provide safe, quality patient care?
- A) Code of Ethics for Nurses
 - B) Standards of Clinical Nursing Practice



- C) Bioethics Clinical Guidelines
 - D) Bill of Rights for Registered Nurses
20. A patient nearing the end of life requests that he be given no food or fluids. The physician orders the insertion of a nasogastric tube to feed the patient. What situation does this create for the nurse providing care?
- A) nurse must follow the physicians orders
 - B) an inability to provide care for the patient
 - C) an ethical dilemma about inconsistent courses of action
 - D) a barrier to establishing an effective nursepatient relationship
21. A nurse who forgets to give a patient her medication throws away the medicine and documents that it was dispensed on the patient chart. The nurse then becomes uneasy about her action and vows never to falsify a record again. This is an example of which of the following?
- A) ethical uncertainty
 - B) ethical distress
 - C) ethical residue
 - D) ethical disengagement



22. Two children need a kidney transplant. One is the child of a famous sports figure, whereas the other child comes from a low-income family. What ethically relevant consideration is important to the nurse as an advocate for these patients?
- A) balance between benefits and harms in patient care
 - B) norms of family life
 - C) considerations of power
 - D) cost-effectiveness and allocation
23. Which of the following is an example of paternalistic behavior?
- A) telling a patient that a painful procedure will not hurt
 - B) intercepting a visitors gift of candy to a patient with diabetes
 - C) deciding to close the intensive care unit when all beds are full
 - D) discussing a patients condition with the patients roommate
24. A student nurse is working in the library on her plan of care for a clinical assignment. The patients name is written at the top of her plan. What ethical responsibility is the student violating?
- A) confidentiality



- B) accountability
 - C) trust
 - D) informed consent
25. A nurse is concerned about the practice of routinely ordering a battery of laboratory tests for patients who are admitted to the hospital from a long-term care facility. An appropriate source in handling this ethical dilemma would be which of the following?
- A) the patients family
 - B) the admitting physician
 - C) the nurse in charge of the unit
 - D) the institutional ethics committee
26. A patient tells the nurse that he does not want to have a painful procedure. By respecting and supporting the patients right to make decisions, what is the nurse demonstrating?
- A) confidentiality
 - B) advocacy
 - C) altruism



D) justice

27. A patient, unsure of the need for surgery, asks the nurse, What should I do? What answer by the nurse is based on advocacy?

A) If I were you, I sure would not have this surgical procedure.

B) Gosh, I dont know what I would do if I were you.

C) Tell me more about what makes you think you dont want surgery.

D) Let me talk to your doctor and I will get back to you as soon as I can.

Answer Key

1. C

2. A

3. D

4. C

5. C

6. A, B

7. A



8. A
9. B
10. D
11. D
12. A, C, D, E, F
13. B
14. B
15. C
16. A
17. A
18. B, D, F
19. D
20. C
21. C



22. D

23. B

24. A

25. D

26. B

27. C



Chapter 07: Legal Dimensions of Nursing Practice

1. A nurse is arrested for possession of illegal drugs. What kind of law is involved with this type of activity?
 - A) civil
 - B) private
 - C) public
 - D) criminal

2. A lawyer quotes a precedent for punishment of a crime committed by the defendant in a trial. What is court-made law is known as?
 - A) public law
 - B) statutory law
 - C) common law
 - D) administrative law

3. A patient is suing a nurse for malpractice. What is the term for the person bringing suit?
 - A) plaintiff



- B) defendant
 - C) litigator
 - D) witness
4. A nurse is providing patient care in a hospital setting. Who has full legal responsibility and accountability for the nurses actions?
- A) the nurse
 - B) the head nurse
 - C) the physician
 - D) the hospital
5. What type of law regulates the practice of nursing?
- A) common law
 - B) public law
 - C) civil law
 - D) criminal law
6. What is the legal source of rules of conduct for nurses?



- A) agency policies and protocols
 - B) constitution of the United States
 - C) American Nurses Association
 - D) Nurse Practice Acts
7. A nurse moves from Ohio to Missouri. Where can a copy of the Nurse Practice Act in Missouri be obtained?
- A) Ohio State Board of Nursing
 - B) Missouri State Board of Nursing
 - C) federal government nursing guidelines
 - D) National League for Nursing
8. Which of the following best describes voluntary standards?
- A) Voluntary standards are guidelines for peer review, guided by the public's expectation of nursing.
 - B) Voluntary standards set requirements for licensure and nursing education.



- C) Voluntary standards meet criteria for recognition, specified area of practice.
- D) Voluntary standards determine violations for discipline and who may practice.
9. Which of the following statements accurately describe an aspect of the credentialing process used in nursing practice? Select all that apply.
- A) Credentialing refers to the way in which professional competence is ensured and maintained.
- B) Accreditation is the process by which the state determines a person meets minimum requirements to practice nursing.
- C) Certification grants recognition in a specified practice area to people who meet certain criteria.
- D) Legal accreditation of a school preparing nursing personnel by the state Board of Nursing is voluntary.
- E) Once earned, a license to practice is a property right and may not be revoked without due process.
- F) A nurse must be licensed by the state board of nursing in each state in which he or she desires to practice.
10. Which of the following accreditations is a legal requirement for a school of nursing to exist?
- A) National League for Nursing Accrediting Commission
- B) American Association of Colleges of Nursing accreditation



- C) State Board of Nursing accreditation
 - D) educational institution accreditation
11. In comparison with licensure, which measures entry-level competence, what does certification validate?
- A) innocence of any disciplinary violation
 - B) specialty knowledge and clinical judgment
 - C) more than 10 years of nursing practice
 - D) ability to practice in more than one area
12. Which of the following is the most frequent reason for revocation or suspension of a nurses license?
- A) fraud
 - B) mental impairment
 - C) alcohol or drug abuse
 - D) criminal acts
13. A nurse does not assist with ambulation for a postoperative patient on the first day after surgery. The patient falls and fractures a hip. What charge might be brought against the nurse?



- A) assault
 - B) battery
 - C) fraud
 - D) negligence
14. A patient refuses to have a pain medication administered by injection. A nurse says, If you dont let me give you the shot, I will get help to hold you down and give it. With what crime might the nurse be charged?
- A) assault
 - B) battery
 - C) negligence
 - D) defamation
15. Two nurses are discussing a patients condition in an elevator full of visitors. With what crime might the nurses be charged?
- A) defamation of character
 - B) invasion of privacy
 - C) unintentional negligence



- D) intentional negligence
16. A lawsuit has been brought against a nurse for malpractice. The patient fell and suffered a skull fracture, resulting in a longer hospital stay and need for rehabilitation. What does the description of the patient represent as proof of malpractice?
- A) damages
- B) causation
- C) duty
- D) breach of duty
17. Which of the following nursing actions would be considered a violation of HIPPA regulations? Select all that apply.
- A) A nurse ambulates a patient through a hospital hallway in a hospital gown that is open in the back.
- B) A nurse shoves a confused bedridden patient into bed after he made several attempts to get up.
- C) A nurse inadvertently administers the wrong dose of morphine to a patient in the ICU.
- D) A nurse uses a patients chart as a sample teaching case without changing the patients name.



- E) A nurse reports the condition of a patient to the patients employer.
 - F) A nurse misrepresents herself to obtain a license to practice nursing.
18. According to HIPPA regulations, which of the following is a patient right regarding the patients medical record? Select all that apply.
- A) to see the health record
 - B) to copy the health record
 - C) to make additions to the health record
 - D) to cross out sections of the health record
 - E) to restrict certain disclosures of the health record
 - F) to destroy the health record
19. A nurse has been named as a defendant in a lawsuit. With whom should the nurse discuss the case?
- A) colleagues
 - B) reporters
 - C) plaintiff



D) attorney

20. A nurse is accused of malpractice by a patient. Place all of the steps in the malpractice litigation listed below in the order in which they normally occur. Use all options.

A) All parties named as defendants work toward a fair settlement.

B) Trial takes place and a decision or verdict is reached.

C) Pretrial discovery activities occur including review of medical record.

D) The defendant contests allegations believing there is no basis for them.

E) The case is presented to a malpractice arbitration pane and is accepted or rejected.

F) If the verdict is not accepted by both sides, it may be appealed to an appellate court.

21. A competent adult patient is scheduled for surgery. Who signs the informed consent form to allow the surgery?

A) a relative

B) the physician

C) a nurse



- D) the patient
22. A nurse explains the informed consent form to a patient who is scheduled for heart bypass surgery. Which of the following are elements of this consent form? Select all that apply.
- A) Disclosure
- B) Organ donation
- C) DNR orders
- D) Comprehension
- E) Competence
- F) Voluntariness
23. Which of the following is the nurses best legal safeguard?
- A) collective bargaining
- B) written or implied contracts
- C) competent practice
- D) patient education



24. A nurse has taken a telephone order from a physician for an emergency medication. The dose of the medication is abnormally high. What should the nurse do next?
- A) administer the medication based on the order
 - B) question the order for the medication
 - C) refuse to administer the medication
 - D) document concerns about the order
25. A patient gets out of bed following hip surgery and falls and re-injures her hip. The nurse caring for her knows that it is her duty to make sure an incident report is filed. Which of the following statements accurately describes the correct procedure for filing an incident report?
- A) The physician in charge should fill out the report.
 - B) The names of the staff involved should not be included.
 - C) The reports are used for disciplinary action against the staff.
 - D) The report should contain all the variables related to the incident.

Answer Key

- 1. D
- 2. C



3. A
4. A
5. C
6. D
7. B
8. A
9. A, C, E
10. C
11. B
12. C
13. D
14. A
15. B
16. A



17. A, D, E

18. A, B, E

19. D

20. A

21. D

22. A, D, E, F

23. C

24. B

25. D



Chapter 08: Communication

1. A nurse touches a patient's hand to indicate caring and support. What channel of communication is the nurse using?
 - A) auditory
 - B) visual
 - C) olfactory
 - D) kinesthetic

2. A nurse is teaching a home care patient how to administer a topical medication. The patient is watching television while the nurse is talking. What might be the result of this interaction?
 - A) The message will likely be misunderstood.
 - B) The stimulus for communication is unclear.
 - C) The receiver will accurately interpret the message.
 - D) The communication will be reciprocal.

3. A nurse gives a speech on nutrition to a group of pregnant women. What is the speech itself known as?



- A) stimulus
 - B) source
 - C) message
 - D) channel
4. The family of a patient in a burn unit asks the nurse for information. The nurse sits with the family and discusses their concerns. What type of communication is this?
- A) intrapersonal
 - B) interpersonal
 - C) organizational
 - D) focused
5. Which of the following is an example of nonverbal communication?
- A) A nurse says, I am going to help you walk now.
 - B) A nurse presents information to a group of patients.
 - C) A patient's face is contorted with pain.



- D) A patient asks the nurse for a pain shot.
6. A student caring for an unconscious patient knows that communication is important even if the patient does not respond. Which nonverbal action by the student would communicate caring?
- A) making constant eye contact with the patient
- B) waving to the patient when entering the room
- C) sighing frequently while providing care
- D) holding the patients hand while talking
7. Which of the following statements is true of factors that influence communication?
- A) Nurses provide the same information to all patients, regardless of age.
- B) Men and women have similar communication styles.
- C) Culture and lifestyle influence the communication process.
- D) Distance from a patient has little effect on a nurses message.
8. A nurse is sitting near a patient while conducting a health history. The patient keeps edging away from the nurse. What might this mean in terms of personal space?
- A) The nurse is too far away from the patient.



- B) The nurse is in the patient's personal space.
 - C) The patient does not like the nurse.
 - D) The patient has concerns about the questions.
9. Why is communication important to the assessing step of the nursing process?
- A) The major focus of assessing is to gather information.
 - B) Assessing is primarily focused on physical findings.
 - C) Assessing involves only nonverbal cues.
 - D) Written information is rarely used in assessment.
10. Which of the following statements accurately describe the relationship between therapeutic communication and the nursing process? Select all that apply.
- A) Effective communication techniques, as well as observational skills, are used extensively during the assessment step.
 - B) Only the written word in the form of a medical record is used during the diagnosing step of the nursing process.
 - C) The implementing step requires communication among the patient, nurse, and other team members to develop interventions and outcomes.



- D) Verbal and nonverbal communication are used to teach, counsel, and support patients and their families during the implementation phase.
 - E) Nurses rely on the verbal and nonverbal cues they receive from their patients to evaluate whether patient objectives or goals have been achieved.
 - F) Because one nurse cannot provide 24-hour coverage for patients, significant information must be passed on to others through implementation.
11. A nurse uses the SBAR method to hand off the communication to the healthcare team. Which of the following might be listed under the B of the acronym?
- A) vital signs
 - B) mental status
 - C) patient problem
 - D) further testing
12. What is the goal of the nurse in a helping relationship with a patient?
- A) to provide hands-on physical care
 - B) to ensure safety while caring for the patient
 - C) to assist the patient to identify and achieve goals
 - D) to facilitate the patients interactions with others



13. Which of the following is a characteristic of the helping relationship?
- A) it occurs spontaneously
 - B) it is similar to a social relationship
 - C) it is an unequal sharing of communication
 - D) it is based on the needs of the nurse
14. What action by the nurse will facilitate the helping relationship during the orientation phase?
- A) providing assistance to meet activities of daily living
 - B) introducing himself or herself to the patient by name
 - C) designing a specific teaching plan of care
 - D) preparing for termination of the relationship
15. Which of the nursing roles is primarily performed during the working phase of the helping relationship?
- A) teacher and counselor



- B) provider of care
 - C) leader and manager
 - D) researcher
16. A nurse who is discharging a patient is terminating the helping relationship. Which of the following actions might the nurse perform in this phase? Select all that apply.
- A) making formal introductions
 - B) making a contract regarding the relationship
 - C) providing assistance to achieve goals
 - D) helping patient perform activities of daily living
 - E) examining goals of relationship for achievement
 - F) helping patient establish helping relationship with another nurse
17. What term describes a nurse who is sensitive to the patients feelings but remains objective enough to help the patient achieve positive outcomes?
- A) competent
 - B) caring



- C) honest
 - D) empathic
18. What is the primary focus of communication during the nursepatient relationship?
- A) time available to the nurse
 - B) nursing activity to be performed
 - C) patient and patient needs
 - D) environment of the patient
19. Which of the following is an example of a closed-ended question or statement?
- A) How did that make you feel?
 - B) Did you take those drugs?
 - C) What medications do you take at home?
 - D) Describe the type of pain you have.
20. A patient tells the nurse that he is very worried about his surgery. Which of the following responses by the nurse is a cliché?



- A) Tell me what you are worried about.
 - B) What is it that you are worried about?
 - C) Do you want to cancel your surgery?
 - D) Dont worry, everything will be fine.
21. A nurse tells a patient, Why wont you get out of bed? Are you always this lazy? This is an example of which of the following barriers to communication?
- A) using comments that give advice
 - B) using judgmental language
 - C) using leading questions
 - D) using probing questions
22. A nurse is caring for a patient who is visually impaired. Which of the following is a recommended guideline for communication with this patient?
- A) Ease into the room without acknowledging presence until the patient can be touched.
 - B) Speak in a louder tone of voice to make up for lack of visual cues.
 - C) Explain reason for touching patient before doing so.



D) Keep communication simple and concrete.

Answer Key

1. D
2. A
3. C
4. B
5. C
6. D
7. C
8. B
9. A
10. A, D, E
11. B
12. C



13. C

14. B

15. A

16. E, F

17. D

18. C

19. B

20. D

21. B

22. C



Chapter 09: Teaching and Counseling

1. A diabetes nurse educator is teaching a patient, newly diagnosed with diabetes, about his disease process, diet, exercise, and medications. What is the goal of this teaching?
 - A) to help the patient develop self-care abilities
 - B) to ensure the patient will return for follow-up care
 - C) to facilitate complete recovery from the disease
 - D) to implement ordered teaching and counseling

2. A nurse in a neighborhood clinic is conducting educational sessions on weight loss. What aim of nursing is met by these educational programs?
 - A) practicing advocacy
 - B) preventing illness
 - C) restoring health
 - D) facilitating coping

3. A nurse refers a patient with a new colostomy to a support group. This nurse is practicing which of the following aims of nursing?



- A) promoting health
 - B) preventing illness
 - C) restoring health
 - D) facilitating coping
4. Which of the following is an essential component of the definition of learning?
- A) increases self-esteem
 - B) decreases stress
 - C) can be measured
 - D) cannot be measured
5. A nursing faculty member is teaching a class of second-degree students who have an average age of 32. What is important to remember when teaching adult learners?
- A) a focus on the immediate application of new material
 - B) a need for support to reduce anxiety about new learning
 - C) older students may feel inferior in terms of new learning



- D) all students, regardless of age, learn the same
6. A nurse is designing a teaching program for individuals who have recently immigrated to the United States from Iraq. Which of the following considerations is necessary for culturally competent patient teaching?
- A) Use materials developed previously for U.S. citizens.
- B) Use all visual materials when teaching content.
- C) Use a lecture format to teach content with few questions.
- D) Develop written materials in the patients native language.
7. What patient characteristic is important to assess when using the health belief model as the framework for teaching?
- A) developmental level
- B) source of information
- C) motivation to learn
- D) family support
8. According to Rosenstock, which of the following are health beliefs critical for patient motivation? Select all that apply.
- A) Patients view themselves as susceptible to the disease in question.



- B) Patients view the disease as a serious threat.
 - C) Patients believe there are actions they can take to reduce the probability of contracting the disease.
 - D) Patients believe the threat of taking these actions is greater than the disease itself.
 - E) Patients view themselves as victims of the disease in question.
 - F) Patients feel powerless to modify their perception of disease susceptibility.
9. The National Patient Safety Foundation recently collaborated with the Partnership for Clear Health Communication (2007) to create awareness of the need for improved health literacy and developed the Ask Me 3 tool. Which of the following is an Ask Me 3 question? Select all that apply.
- A) Who will be my healthcare provider?
 - B) What is my main problem?
 - C) What do I need to do?
 - D) Where will I get help?
 - E) Why is it important for me to do this?



- F) When will I start my program?
10. Which of the following strategies might a nurse use to increase compliance with teaching?
- A) Include the patient and family as partners.
 - B) Use short, simple sentences for all ages.
 - C) Provide verbal instruction at all times.
 - D) Maintain clear role as the authority.
11. A nurse teaching a new mother how to bathe her infant uses the acronym TEACH to maximize the effectiveness of the teaching plan. Which of the following are guidelines based on this acronym? Select all that apply.
- A) Tune out the individual patient.
 - B) Edit patient information.
 - C) Act on every teaching moment.
 - D) Always refer a patient to counseling.
 - E) Clarify often.
 - F) Honestly answer patient questions.



12. A young mother asks the nurse in a pediatric office for information about safety, diet, and immunizations for her baby. Which nursing diagnosis would be appropriate for this patient?
- A) Knowledge Deficit: Infant care
 - B) Impaired Health Maintenance
 - C) Readiness for Enhanced Parenting
 - D) Readiness for Enhanced Coping
13. Developing a teaching plan is comparable to what other nursing activity?
- A) documenting in the nurses notes
 - B) formulating a nursing care plan
 - C) performing a complex technical skill
 - D) using a standardized form or format
14. A student is developing a teaching plan for her assigned patient. The student wants to teach the patient about what symptoms to report after chemotherapy. What would the student need to do first?
- A) Ask other students what should be included in content.
 - B) Ask the patient what he or she wants to know.



- C) Tell the instructor that this topic hasn't been covered yet.
 - D) Review information available in writing and on the Internet.
15. A nurse is writing learning outcomes for a patient recovering from severe burns. Which of the following verbs would be good choices to use when preparing outcomes related to learning how to change dressings? Select all that apply.
- A) assembles
 - B) demonstrates
 - C) gives examples
 - D) identifies
 - E) chooses
 - F) values
16. A mother of a toddler wants to learn how to do CPR. What teaching strategy would be most effective in helping her learn?
- A) lecture
 - B) discussion
 - C) demonstration



- D) discovery
17. A nurse asks a patient to tell him the side effects of a medication. What learning domain is the nurse evaluating?
- A) affective
- B) cognitive
- C) psychomotor
- D) emotional
18. When is the best time to evaluate ones own teaching effectiveness?
- A) during the teaching session
- B) immediately after a teaching session
- C) 1 week after the teaching session
- D) 1 month after the teaching session
19. A 42-year-old male patient recovering from a MI is having difficulty following the care plan to stop smoking and exercise. What is the nurses best response to this patient?
- A) Praise him for any efforts he makes to improve his health.



- B) Tell him that he will have another MI and it will be his own fault.
 - C) Tell him that his cigarettes will be taken away if he smokes again.
 - D) Ignore the behavior and recommend a behavior modification program.
20. What is the most critical element of documentation of teaching?
- A) a summary of the teaching plan
 - B) the implementation of the teaching plan
 - C) the patient need for learning
 - D) evidence that learning has occurred
21. What word or phrase best describes an effective counselor?
- A) technically skilled
 - B) knowledgeable
 - C) practical
 - D) caring



22. An elderly patient is very stressed about who will care for his pets while he is hospitalized for a fall that caused a fractured hip and hospitalization. What type of counseling would the nurse conduct?
- A) none
 - B) long-term
 - C) short-term
 - D) motivational
23. A nurse is using motivational interviewing to find out why a patient refuses to participate in the recommended rehabilitation program. Which of the following is an example of using the skill of reflective listening to help motivate this patient?
- A) So, you feel that you are not ready to start a program this week?
 - B) Why do you feel that you are not ready to start rehabilitation?
 - C) I understand that you are afraid to start rehabilitation; where do you see yourself in a week?
 - D) Remember we discussed what needs to be done to get you back on your feetHow do you feel about getting started?

Answer Key

1. A



2. B
3. D
4. C
5. A
6. D
7. C
8. A, B, C
9. B, C, E
10. A
11. B, C, E
12. C
13. B
14. D
15. A, B



16. C

17. B

18. B

19. D

20. D

21. D

22. C

23. A



Chapter 10: Leading, Managing, and Delegating

1. A head nurse assumes the leadership role when directing and supervising coworkers. Which of the following are attributes of a leader? Select all that apply.
 - A) philosophical
 - B) task-oriented
 - C) charismatic
 - D) dynamic
 - E) intimidating
 - F) self-confident

2. A senior student nurse has been elected class president. What type of power will the student have in this position?
 - A) explicit power
 - B) assumed power
 - C) absolute power
 - D) implied power



3. A senior student has been elected president of the Student Nurses Association. Which of the following qualities is essential to being a nursing leader?
- A) physical stamina
 - B) physical attractiveness
 - C) flexibility
 - D) independence
4. Which of the following types of skills is not needed for nursing leadership?
- A) communication skills
 - B) technical skills
 - C) problem-solving skills
 - D) self-evaluation skills
5. A nurse strives to establish trusting interpersonal relationships with patients, peers, subordinates, and superiors to facilitate goal achievement and personal growth of all participants. Which of the following skills is this nurse demonstrating?
- A) communication skills
 - B) problem-solving skills



- C) management skills
 - D) self-evaluation skills
6. A nurse manager makes all of the decisions for staff activities. What type of leadership is demonstrated by this action?
- A) democratic
 - B) self-governance
 - C) laissez-faire
 - D) autocratic
7. What type of leader shares decisions and activities with group participants?
- A) democratic
 - B) autocratic
 - C) laissez-faire
 - D) situational
8. A nurse leader is described as charismatic, motivational, and passionate. Communications are open and honest, and the nurse is willing to take risks. What type of leadership is the nurse practicing?



- A) democratic
 - B) autocratic
 - C) quantum
 - D) transformational
9. How is change viewed in the new quantum age currently experienced in society?
- A) constant and predictable
 - B) dynamic and constantly unfolding
 - C) evolving very slowly
 - D) an entity needing planning
10. A nurse is described as a quantum leader. Which of the following actions characterize this type of leadership?
- A) A nurse conducts a blind survey to evaluate her leadership skills.
 - B) A nurse relinquishes power to a group deciding hospital policy.
 - C) A nurse makes policy decisions for coworkers without consulting them.



- D) A nurse sticks to the tried and true methods when implementing patient care.
11. A nurse working in a physicians office uses the managerial function known as organizing. What is involved in this function?
- A) resources
 - B) problems
 - C) workforce
 - D) evaluation
12. A specific nursing unit practices functional nursing. What was the basis for this concept?
- A) individual patient care
 - B) primary nursing
 - C) case management
 - D) industrial assembly line
13. When comparing team nursing with functional nursing, what characteristic is found?
- A) Team nursing is very similar to functional nursing.



- B) Team nursing focuses on individual patient care.
 - C) Functional nursing has a stronger focus on the patient.
 - D) Functional nursing is based on total patient care.
14. A nurse believes in listening to patients and coworkers more than talking to them, allowing more personal control for all involved. This is a quality of which of the following managerial mind-sets?
- A) reflective
 - B) analytical
 - C) worldly
 - D) collaborative
15. In which of the following conflict resolution strategies is the conflict rarely resolved?
- A) collaborating
 - B) compromising
 - C) competing
 - D) smoothing



16. In Lewins classic theory of change, what happens during unfreezing?
- A) Planning is conducted.
 - B) Change is initiated.
 - C) Change becomes operational.
 - D) The need for change is recognized.
17. Planned change is a purposeful, systematic effort to alter or bring about change. What occurs next after alternative solutions to a problem are determined and analyzed?
- A) All of the alternative solutions are implemented.
 - B) A course of action is chosen from among the alternatives.
 - C) The effects of the change are evaluated.
 - D) The change is stabilized and established.
18. A nurse is attempting to change the method for documenting patient care in a hospital setting. Which of the following should be considered before planning change? Select all that apply.
- A) What is amenable to change?
 - B) How does the group function as a unit?



- C) Is the group ready for change?
 - D) Are the changes major or minor?
 - E) What are the consequences of change?
 - F) Who should institute change?
19. Which of the following statements accurately describe recommended guidelines for overcoming resistance to change? Select all that apply.
- A) Explain the proposed changes only to the managers of the people involved.
 - B) Whenever possible, use technical language to describe the changes.
 - C) List the advantages of the proposed change for members of the group.
 - D) Avoid relating the change to the groups existing beliefs and values.
 - E) If possible, introduce change gradually.
 - F) Provide incentives for commitment to change.
20. In general, how do most people view change?
- A) by how it affects the cohesiveness of the group



- B) by how much it will cost in time and resources
 - C) by how they are affected personally
 - D) by how it will affect others on the staff
21. A nurse manager has encountered resistance to a planned change. What is one way the nurse can overcome the resistance?
- A) Tell the staff that if they don't like it, they can quit.
 - B) Implement change rapidly and all at once.
 - C) Encourage open communication and feedback.
 - D) Let the staff know that the change is mandated.
22. Which of the following statements accurately describes the use of power by change agents?
- A) They know that power comes from one source/management.
 - B) When introducing change they do not enlist the support of key power players.
 - C) They are often accomplished professional women.
 - D) They do not recognize their own strengths and weaknesses.



23. A nurse working on leadership skills should keep in mind the following accurate statement regarding leaders:
- A) People are born leaders.
 - B) Leadership should be approached quickly.
 - C) Leaders develop leadership skills in undefined situations.
 - D) All nurse leaders began as inexperienced nurses.
24. Andrew has just graduated with a baccalaureate degree in nursing. What type of nursing leadership will he be expected to provide?
- A) nursing care of the individual patient
 - B) demonstration of selected critical skills
 - C) ability to be a follower rather than a leader
 - D) nursing care of groups of patients
25. A nurse is considering the delegation of administering medications to an unskilled assistant. What is the first question the nurse must ask herself before doing so?
- A) Has the assistant been trained to perform the task?
 - B) Have I evaluated the patients response to this task?



- C) Is the delegated task permitted by law?
 - D) Is appropriate supervision available?
26. The ANA, which is committed to monitoring the regulation, education, and use of NAPs, recommends adherence to which one of the following principles:
- A) It is the nursing profession that determines the scope of nursing practice.
 - B) It is the RN who defines and supervises the education, training, and use of any unlicensed assistant roles.
 - C) It is the assigned NAP who is responsible and accountable for his or her nursing practice.
 - D) It is the purpose of the RN to work in a supportive role to the assistive personnel.
27. Which of the following tasks could be delegated to unlicensed assistive personnel?
- A) an initial assessment of a patient
 - B) determination of a nursing diagnosis
 - C) evaluation of patient progress with the nursing care plan
 - D) assisting patients with hygiene
28. Which of the following is a characteristic of mentorship?



- A) It is a paid position to orient new nurses to the workplace.
- B) It involves membership in a professional organization.
- C) It is a link to a protg with common interests.
- D) It is not encouraged in healthcare settings

Answer Key

- 1. A, C, D, F
- 2. A
- 3. C
- 4. B
- 5. A
- 6. D
- 7. A
- 8. D
- 9. B



10. A
11. A
12. D
13. B
14. D
15. D
16. D
17. B
18. A, B, C, D
19. C, E, F
20. C
21. C
22. C
23. D



24. A

25. C

26. A

27. D

28. C



Chapter 11: Health Care Delivery System

1. Which of the following statements accurately describe an aspect of managed care? Select all that apply.
 - A) Managed care systems control the cost of care with a lower quality of care.
 - B) The care of the patient is carefully planned and monitored by the primary care provider.
 - C) The nurse is considered the gatekeeper in the managed care system.
 - D) The managed care system expands the choice of care providers.
 - E) The managed care system may required approval for specialty care.
 - F) Planning and monitoring are conducted to ensure standards are followed.

2. Which of the following is a characteristic of primary healthcare? Select all that apply.
 - A) It is essential healthcare based on sound methods and technology.
 - B) It is made universally accessible to individuals and families in the community.
 - C) It does not require the full participation of the individual and family.
 - D) It brings healthcare as close as possible to where people live and work.



- E) It is the same concept as primary healthcare in that it refers to the delivery of healthcare.
 - F) The concept was developed based on an increase in illness and death in third-world countries.
3. Which of the following phrases is characteristic of case management as a method of healthcare delivery?
- A) brings healthcare to where people live and work
 - B) essentially the same method as primary care
 - C) planned and monitored by patients themselves
 - D) maximize positive outcomes and contain costs
4. Which of the following phrases best describes hospitals today?
- A) focus on chronic illnesses
 - B) focus on acute care needs
 - C) primary care centers
 - D) voluntary agencies
5. A man is scheduled for hospital outpatient surgery. He tells the nurse, I don't know what that word, *outpatient*, means. How would the nurse respond?



- A) It means you will have surgery in the hospital and stay for 2 days.
 - B) It means the surgeon will come to your home to do the surgery.
 - C) Why would you ask such a question? Don't worry about it.
 - D) You will have surgery and go home that same day.
6. What is one responsibility of nurses who work in physicians' offices?
- A) prescribing medications
 - B) conducting health assessments
 - C) performing minor surgery
 - D) making independent home visits
7. A nurse in a walk-in healthcare setting provides technical services, such as, administering medications, determines the priority of care needs, and provides patient teaching on all aspects of care. Which of the following terms best describes this type of healthcare setting?
- A) hospital
 - B) physician's office
 - C) ambulatory center



- D) long-term care
8. Nurses who are employed in home care have a variety of responsibilities. Which of the following is one of those responsibilities?
- A) provide all care and services
- B) maintain a clean home environment
- C) advise patients on financial matters
- D) collaborate with other care providers
9. Which of the following is true of long-term care facilities?
- A) They provide care only to older adults.
- B) They provide care for homeless adults.
- C) They provide care to people of any age.
- D) They care for people only with dementia.
10. A grade school is preparing a series of classes on the dangers of smoking. Who would be most likely to teach the classes?
- A) the principal



- B) an outside consultant
 - C) a teacher
 - D) the school nurse
11. An elderly woman has total care of her husband with Alzheimers disease. What type of care might the nurse suggest to give her some much-needed time of her own?
- A) primary care
 - B) respite care
 - C) bereavement care
 - D) palliative care
12. What population do hospice nurses provide with care?
- A) those requiring care to improve health
 - B) children with chronic illnesses
 - C) dying persons and their loved ones
 - D) older adults requiring long-term care



13. Who provides physicians with the authority to admit and provide care to patients requiring hospitalization?
- A) the healthcare institution itself
 - B) Board of Healing Arts
 - C) American Medical Association
 - D) State Board of Nursing
14. After a stroke, a patient is having difficulty swallowing. The nurse may make a referral to what member of the healthcare team?
- A) physical therapist
 - B) speech therapist
 - C) social worker
 - D) respiratory therapist
15. Medicare uses a prospective payment plan based on diagnosis-related groups (DRGs). What are DRGs?
- A) locally supported healthcare financing, usually by donations
 - B) a public assistance program for low-income individuals



- C) predetermined payment for services based on medical diagnoses
 - D) a private insurance plan for subscribers who pay a copayment
16. A patient has a private insurance policy that pays for most healthcare costs and services. Why is this plan called a third-party payer?
- A) The insurance company pays all or most of the costs.
 - B) The family of the patient is required to pay costs.
 - C) The patient gets the bill and pays out-of-pocket costs.
 - D) Medicare and Medicaid will pay most of the costs.
17. A person receiving healthcare insurance from his employer knows that he should check the approved list of contracted healthcare providers before seeking services in order to receive them at a lower cost. What type of insurance is most likely involved?
- A) Medicaid
 - B) preferred provider organization
 - C) health maintenance organization
 - D) long-term care insurance
18. What is the primary focus of healthcare today?



- A) care of acute illnesses
 - B) care of chronic illnesses
 - C) health promotion
 - D) health restoration
19. In which of the following ways have cost-containment issues affected the delivery of healthcare in the U.S.? Select all that apply.
- A) The U.S. healthcare system has been experiencing a financial crisis.
 - B) The cost of healthcare in the United States has decreased dramatically.
 - C) Short- and long-term results of cost-containment measures are undetermined.
 - D) Historically, payment for healthcare services encouraged the use of expensive services.
 - E) In the past, healthcare focused primarily on prevention of illnesses since it was covered by insurance.
 - F) Competition among hospitals has further fueled the increase in health costs.
20. A patient who requires treatment for breast cancer is referred to an oncologist. She is receiving chemotherapy at a hospital and interacts with many other healthcare providers in the course of her treatment. What is the confusion that might arise concerning her treatment and care is a problem known as?



- A) cost containment
- B) fragmentation of care
- C) healthcare rationing
- D) knowledgeable consumers

21. Which of the following is a trend to watch in healthcare delivery?

- A) decreasing diversity
- B) lower costs of healthcare
- C) uneducated consumers
- D) current nursing shortage

22. What is one way in which nurses can help shape healthcare reform?

- A) do their job and do it well
- B) refuse to participate in organizations
- C) support legislation to improve care
- D) become a member of a support group



Answer Key

1. B, E, F
2. A, B, D
3. D
4. B
5. D
6. B
7. C
8. D
9. C
10. D
11. B
12. C
13. A



14. B

15. C

16. A

17. B

18. C

19. A, C, D, F

20. B

21. D

22. C



Chapter 12: Interprofessional Collaborative Practice and Care Coordination Across Settings

1. Which of the following phrases best describes continuity of care?
 - A) focusing on acute care in the hospital
 - B) serving the needs of children
 - C) facilitating transition between settings
 - D) providing single-episode care services

2. Which of the following roles of the nurse are most important in providing continuity of care to patients? Select all that apply.
 - A) teacher
 - B) collaborator
 - C) mentor
 - D) advocate
 - E) role model
 - F) researcher



3. A focus of healthcare today is community-based care. What is community-based care?
- A) care provided to patients within a defined geographic area
 - B) a focus on providing appropriate care for mental health
 - C) a focus on the health of the community
 - D) an emphasis on population-based care
4. Which of the following is a result of the effect of increasing healthcare costs on hospital admissions?
- A) decreased length of hospital stay
 - B) decreased number of surgeries
 - C) increased hospital admissions
 - D) fewer surgeries in ambulatory centers
5. Which of the following nursing diagnoses would be appropriate for almost all patients entering a healthcare setting?
- A) Impaired Elimination
 - B) Dysfunctional Grieving



- C) Fatigue
 - D) Anxiety
6. A nurse is admitting an older woman (Grace Staples) to a long-term care facility. How should the nurse address the woman?
- A) We will just call you Grace while you live here. Okay?
 - B) I know you have lots of grandchildren, Grandma.
 - C) What name do you want us to use for you?
 - D) I think you will enjoy living here, Sweetie.
7. How can a nurse best provide care to patients whose cultural and religious backgrounds are different from the nurses?
- A) ignore differences and treat everyone the same
 - B) respect values and beliefs even if they differ from the nurses beliefs
 - C) convince patients to change to the nurses beliefs
 - D) refuse to care for patients with different beliefs
8. A nurse is admitting a patient to the hospital for surgery. Which of the following pieces of information must be obtained from the patient? Select all that apply.



- A) address
 - B) date of birth
 - C) admitting physician
 - D) symptoms experienced
 - E) Immunizations
 - F) religious preference
 - G) admitting diagnosis
9. Which of the following is the major goal of ambulatory care facilities?
- A) to save money by not paying hospital rates
 - B) to provide care to patients capable of self-care at home
 - C) to perform major surgery in a community setting
 - D) to perform tests prior to being admitted to the hospital
10. A nurse is preparing a room for a new patient. Which of the following is an accepted guideline for this activity? Select all that apply.



- A) Position the bed in the highest position for ambulatory patients.
 - B) Open the bed by folding back the top linens.
 - C) Assemble routine equipment and supplies.
 - D) Provide a hospital gown to be worn by the patient at all times.
 - E) If lab work has not been done, provide a container for a clean urine specimen.
 - F) Adjust the temperature to 65F and turn off overhead lights.
11. According to established standards, what healthcare provider should conduct a holistic assessment for all patients admitted to the hospital?
- A) physician
 - B) admission clerk
 - C) licensed practical nurse
 - D) registered nurse
12. Regardless of the type of ambulatory care facility, what need is common to all patients cared for?
- A) referrals



- B) teaching
 - C) advocacy
 - D) surgery
13. What information does HIPAA mandate be given to patients upon admission to a healthcare facility?
- A) what type of insurance is necessary for care
 - B) who will be providing different types of care
 - C) what different levels of care are provided
 - D) how health information will be used
14. Which healthcare provider is responsible for ensuring the room is prepared for admission and the patient is welcomed?
- A) nursing assistant
 - B) admitting room clerk
 - C) social worker
 - D) nurse



15. A patient has suddenly become very ill, and a nurse is transferring him to the intensive care unit (ICU). How does the nurse provide information to ensure continuity of care?
- A) by giving a verbal report to nurses in the ICU
 - B) by ensuring that the chart and all belongings are moved
 - C) by delegating a nursing assistant to provide information
 - D) by asking the family to provide the information
16. A patient is being transferred from a hospital to a long-term care facility. What will happen to the patient's medical record (chart)?
- A) It goes with the patient to the facility.
 - B) It remains in the hospital records.
 - C) It is shredded by special personnel.
 - D) The original and a copy go with the patient.
17. What is the rationale for conducting discharge planning?
- A) to ensure the best possible care in the acute care setting
 - B) to provide a means of documenting nursing care



- C) to enlist family members in providing home care
 - D) to ensure patient and family needs are met consistently
18. At what point during hospital-based care does planning for discharge begin?
- A) on admission to the hospital
 - B) after the patient is settled in a room
 - C) immediately before discharge
 - D) after leaving the hospital
19. Which of the following patients would not be discharged to be cared for by the family?
- A) a patient who needs sterile dressings changed
 - B) a patient with a feeding tube in place
 - C) a patient receiving IV medications
 - D) a patient who lacks knowledge of the treatment plan
20. A nurse, preparing for a patient's discharge after surgery, is teaching the patient's wife to change the dressing. How can the nurse be certain the wife knows the procedure?



- A) Tell the wife exactly how to do it.
 - B) Give the wife information about supplies.
 - C) Have the wife demonstrate the procedure.
 - D) Ask another nurse to reinforce teaching.
21. What is required of a patient who leaves the hospital against medical advice (AMA)?
- A) nothing, the hospital has no legal concerns
 - B) full reimbursement of any medical expenses
 - C) providing contact phone numbers if needed
 - D) signing a form releasing legal responsibility

Answer Key

- 1. C
- 2. A, B, D
- 3. A
- 4. A



5. D
6. C
7. B
8. A, B, C, F, G
9. B
10. B, C, E
11. D
12. B
13. D
14. D
15. A
16. B
17. D
18. A



19. D

20. C

21. D



Chapter 13: Blended Competencies, Clinical Reasoning, and Processes of Person-Centered Care

1. Which of the following is an essential feature of professional nursing? Select all that apply.
 - A) provision of a caring relationship to facilitate health and healing
 - B) attention to a range of human experiences and responses to health and illness
 - C) use of objective data to negate the patients subjective experience
 - D) use of judgment and critical thinking to form a medical diagnosis
 - E) advancement of professional nursing knowledge through scholarly inquiry
 - F) influence on social and public policy to promote social justice

2. What nursing organization first legitimized the use of the nursing process?
 - A) National League for Nursing
 - B) American Nurses Association
 - C) International Council of Nursing
 - D) State Board of Nursing



3. Which of the following group of terms best describes the nursing process?
- A) nursing goals, medical terminology, linear
 - B) nurse-centered, single focus, blended skills
 - C) patient-centered, systematic, outcomes-oriented
 - D) family-centered, single point in time, intuitive
4. A patient comes to the emergency department complaining of severe chest pain. The nurse asks the patient questions and takes vital signs. Which step of the nursing process is the nurse demonstrating?
- A) assessing
 - B) diagnosing
 - C) planning
 - D) implementing
5. A nurse is examining a 2-year-old. Based on her findings, she initiates a care plan for a potential problem with normal growth and development. Which step of the nursing process identifies actual and potential problems?
- A) assessing
 - B) diagnosing



- C) planning
 - D) implementing
6. A home health nurse reviews the nursing care with the patient and family and then mutually discusses the expected outcomes of the nursing care to be provided. Which step of the nursing process is the nurse illustrating?
- A) diagnosing
 - B) planning
 - C) implementing
 - D) evaluating
7. Based on an established plan of care, a nurse turns a patient every 2 hours. What part of the nursing process is the nurse using?
- A) assessing
 - B) planning
 - C) implementing
 - D) evaluating
8. Which of the following statements indicates that a plan to assist a patient in developing and following an exercise program has been effective?



- A) I have just been too busy to do my daily exercises.
 - B) I guess I will begin the activity we discussed next week.
 - C) I know I should exercise, but my health is not very good.
 - D) I have lost 10 pounds because I walk 2 miles every day.
9. What name is given to standardized plans of care?
- A) critical pathways
 - B) computer databases
 - C) nursing problems
 - D) care plan templates
10. Which of the following groups developed standard language to increase the visibility of nursings contribution to patient care by continuing to develop, refine, and classify phenomena of concern to nurses?
- A) NANDA
 - B) NIC
 - C) NOC



D) HHCC

11. Legally speaking, how would the nurse ensure that care was not negligent?

A) verbally reporting assessments to the patients physician

B) keeping private notes about the care given to each assigned patient

C) documenting the nursing actions in the patients record

D) tape recording complete information for each oncoming shift

12. A nurse interviews a pregnant teenager and documents her answers on the patient record. At the same time, the nurse responds to the patients concerns and makes a referral for counseling and maternity care. This scenario is an example of which of the descriptors of the nursing process?

A) systematic

B) dynamic

C) outcome oriented

D) universally applicable

13. A nurse working in an outpatient surgery center is responsible for taking a health history and performing a physical assessment on each patient scheduled for surgery. Why is establishing this database so important for nursing care?



- A) to ensure good nursepatient relationships before surgery
 - B) to ensure medical and surgical safety
 - C) it is a routine part of any admission procedure
 - D) to identify strengths and problems
14. An experienced ICU nurse is mentoring a student. The nurse tells the student, I think something is going wrong with your patient. What type of clinical decision making is the experienced nurse demonstrating?
- A) trial-and-error problem solving
 - B) intuitive thinking
 - C) scientific problem solving
 - D) methodical reasoning
15. A nurse is caring for a patient in the ER who was injured in a snow mobile accident. The nurse documents the following patient data: uncontrollable shivering, weakness, pale and cold skin, and suspects the patient is experiencing hypothermia. Upon further assessment, the nurse notes a heart rate of 53 BPM and core internal temperature of 90F, which confirms the initial diagnosis. The nurse then devises a plan of care and continues to monitor the patient to evaluate the outcomes. This nurse is using which of the following types of problem solving in her care of this patient?
- A) trial-and-error



- B) scientific
 - C) intuitive
 - D) critical thinking
16. Nurses make decisions in their practice every day. Which of the following are potential errors in this decision-making process? Select all that apply.
- A) placing emphasis on the last data received
 - B) avoiding information contrary to ones opinion
 - C) selecting alternatives to maintain status quo
 - D) being predisposed to multiple solutions
 - E) prioritizing problems in order of importance
 - F) failing to use appropriate resources
17. Which of the following is one example of a patient benefit of using the nursing process?
- A) greater personal satisfaction
 - B) decreased reliance on the nursing staff



- C) continuity of care
 - D) decreased incidence of medical errors
18. What is a systematic way to form and shape ones thinking?
- A) critical thinking
 - B) intuitive thinking
 - C) trial-and-error
 - D) interpersonal values
19. What step in the nursing process is most closely associated with cognitively skilled nurses?
- A) assessing
 - B) planning
 - C) implementing
 - D) evaluating
20. A nurse asks a multidisciplinary team to collaborate to develop the most appropriate plan of care to meet the needs of an adolescent with a severe head injury. Which of the blended skills essential to nursing practice is the nurse using?



- A) cognitive skills
 - B) interpersonal skills
 - C) technical skills
 - D) ethical/legal skills
21. A student is asked to perform a skill for which he is not prepared. When using the method of critical thinking, what would be the first step to resolve the situation?
- A) purpose of thinking
 - B) adequacy of knowledge
 - C) potential problems
 - D) helpful resources
22. Members of the staff on a hospital unit are critical of a patient's family who has different cultural beliefs about health and illness. A student assigned to the patient does not agree, based on her care of the patient and family. What critical thinking attitude is the student demonstrating?
- A) being curious and persevering
 - B) being creative
 - C) demonstrating confidence



- D) thinking independently
23. Nurses apply critical thinking to clinical reasoning and judgment in their nursing practice every day. Which of the following are characteristics of this practice? Select all that apply.
- A) It is guided by standards, policies and procedures, ethics codes, and laws.
 - B) It is based on principles of nursing process, problem solving, and the scientific method.
 - C) It carefully identifies the key problems, issues, and risks involved.
 - D) It is driven by the nurses need to document competent, efficient care.
 - E) It calls for strategies that make the most of human potential.
 - F) It is a skill that has been studied and evaluated to the point of perfection.
24. As a beginning student in nursing, what is essential to the mastery of technical skills, such as giving an injection?
- A) Read the steps of the procedure before clinical assignments.
 - B) Even if you do not know how to give an injection, act as if you do.
 - C) Practice giving injections in the learning laboratory until you feel comfortable.
 - D) Tell your instructor that you dont think you can ever give a shot.



25. Which of the following interpersonal skills is essential to the practice of nursing?

- A) performing technical skills knowledgeably and safely
- B) maintaining emotional distance from patients and families
- C) keeping shared patient personal information confidential
- D) promoting the dignity and respect of patients as people

26. A nurse believes her employer has violated the law and reports this to the appropriate law enforcement agency. What is this type of action called?

- A) short stopping
- B) whistle-blowing
- C) mud smearing
- D) low balling

Answer Key

- 1. A, B, E, F
- 2. B
- 3. C



4. A
5. B
6. B
7. C
8. D
9. A
10. A
11. C
12. B
13. D
14. B
15. B
16. B, C, F
17. C



18. A

19. B

20. B

21. A

22. D

23. A, B, C, E

24. C

25. D

26. B



Chapter 14: Clinical Judgment

1. A modern approach to the development of clinical decisions and clinical judgments is the use of human patient simulators in simulation laboratories on campus. Human patient simulators are best described as
 - A) Life-sized mannequins with a sophisticated computer interface
 - B) Small doll-like devices used for measuring vital signs
 - C) Healthcare equipment that has practice modes
 - D) Life-saving equipment that resuscitates patients in cardiac arrest

Ans: A

Feedback:

The human patient stimulator, a life-sized mannequin with a sophisticated computer interface, presents students with clinical scenarios that evolve based on decisions that students make.

2. What is meant by intellectual and affective activities in which individuals engage to explore their experiences in order to lead to new meanings and appreciations?
 - A) Memorization
 - B) Reflection



- C) Reminiscing
- D) Evangelization

Ans: B

Feedback:

Reflection is defined as those intellectual and affective activities in which individuals engage to explore their experiences in order to lead to new understandings and appreciations.

3. The nurse is caring for a newly admitted patient. How can a nurse arrive at a more complete database for this patient?
- A) Through clustering of data
 - B) Analysis of lab values
 - C) Review of the chart
 - D) Consult with several sources

Ans: D

Feedback:



By having a more complete database from several sources, including the patient, the nurse can arrive at a more accurate conclusion. The nurse can obtain data from secondary sources, such as family members, significant others, other healthcare professionals, health records, and literature review.

4. A patient complains of weakness following his administration of insulin. The nurse decides to assess the patients blood sugar and prepare a snack in case the blood sugar is low. What action has the nurse implemented?

- A) Clinical reasoning
- B) Caring
- C) Reflection
- D) Assessment

Ans: A

Feedback:

Clinical reasoning is the process of making a nursing judgement that will provide safe and quality care.

5. A nursing student is caring for a patient who has diabetes mellitus. The patient takes insulin two times per day. Based on the students knowledge of insulins onset of action, he makes sure the patients meals arrive in coordination with the insulins effect. The knowledge used by the student is

- A) Evaluative



- B) Lacking
- C) Integrated
- D) Creative

Ans: C

Feedback:

This scenario indicates the integration of a student's knowledge in the provision of safe patient care.

6. For the nursing student to implement the most effective care for her patients, she must
- A) Have rudimentary critical-thinking skills
 - B) Apply preexisting knowledge
 - C) Apply clinical knowledge to theoretic knowledge
 - D) Establish a clinical log for evaluation

Ans: B

Feedback:



To deal with the patients problems appropriately, the student nurse will need to use his or her knowledge base from previous classes.

7. What type of learning best takes place in the nursing laboratory?

- A) Kinesthetic learning
- B) Auditory learning
- C) Concrete learning
- D) Collaborative learning

Ans: A

Feedback:

Learning in the clinical setting or nursing laboratory may be more active, kinesthetic, and random.

8. Which of the following learners enjoy learning that takes place in the clinical setting?

- A) Sequential thinkers
- B) Grade-oriented students
- C) Learning-oriented students



D) Active experimenters

Ans: D

Feedback:

Active experimenters enjoy clinical rotations and skills laboratories.

9. A nurse is educating a pregnant woman in preterm labor on the use of her home monitoring equipment and her medications. What factor could impede the patients ability to learn?

A) Preparation

B) Intelligence

C) Previous knowledge

D) Anxiety

Ans: D

Feedback:

Too much anxiety can paralyze high-order thinking skills.



10. A patient who has limited finances and limited capacity for education requires home healthcare for a chronic illness. For the nurse to provide a high level of care to this patient, she must first
- A) Implement critical-thinking skills
 - B) Develop a relationship with the patient
 - C) Engage the services of a social worker
 - D) Determine what care has been provided

Ans: A

Feedback:

Critical thinking requires nurses to choose solutions or identify options for patient care situations.

11. The nurse assesses a patient's blood pressure, which was 160/90. Two hours following the administration of hydrochlorothiazide, the nurse reassesses the blood pressure at 140/78. This nursing action is
- A) Evaluation
 - B) Assessment
 - C) Planning



D) Implementation

Ans: B

Feedback:

The nurse is collecting data when measuring the patients blood pressure. Collection of patient data is considered assessment regardless of when it occurs.

12. When the nurse assesses the patients blood sugar, the type of skill that the nurse is using is termed?

A) Technical

B) Therapeutic

C) Interactional

D) Adaptive

Ans: A

Feedback:

Technical skills are used to carry out treatments and procedures.

13. When the nurse administers pain medication to a postoperative patient, the phase of the nursing process that is occurring is which of the following phases?



- A) Assessment
- B) Nursing diagnosis
- C) Planning
- D) Implementation

Ans: D

Feedback:

Implementation refers to the action phase of the nursing process in which nursing care is provided.

14. When the nurse is administering Lasix 20 mg to a patient in congestive heart failure, what phase of the nursing process does this represent?

- A) Assessment
- B) Planning
- C) Implementation
- D) Evaluation

Ans: C



Feedback:

Implementation refers to the action phase of the nursing process in which nursing care is provided.

15. The functional health patterns provide the nurse with a(an)

- A) Framework for collecting assessment data
- B) Method for evaluation of diagnostic testing
- C) Preparation of diagnostic statements
- D) System for documenting patient care

Ans: A

Feedback:

The functional health patterns provide a framework for the collection of assessment data.

16. Clustering of data to ascertain a nursing diagnosis is accomplished through the use of:

- A) general systems theory process.
- B) problem-solving process.



- C) decision-making process.
- D) information-processing theory.

Ans: D

Feedback:

Nurses use information-processing theory to help cluster data to arrive at a diagnosis.

17. A nurse ascertains that the patient is showing signs and symptoms of dehydration due to nausea and vomiting. The nurse makes the patient NPO and calls the physician. The nursing action of making the patient NPO is

- A) General systems theory process
- B) Problem-solving process
- C) Decision-making process
- D) Information-processing theory

Ans: C

Feedback:



Making decisions about patient care is the essence of nursing practice. Decision making is integral to every step of the nursing process.

18. The information that enters the system or data collected during the assessment is considered to be the:

- A) input.
- B) immediate outcome.
- C) throughput.
- D) output.

Ans: A

Feedback:

Input, the information that enters a system, is the data collected during the assessment step.

19. Three weeks after surgery the nurse notes the patient has partial healing of the surgical wound. This assessment would occur in which phase of the nursing process?

- A) Outcome
- B) Nursing diagnosis
- C) Planning



D) Evaluation

Ans: D

Feedback:

In the evaluation phase, nurses collect data to determine if patient goals have been met.

20. Nursing actions should be

A) Associated with the family

B) Goal-directed

C) Individually attained

D) Evaluated by team members

Ans: B

Feedback:

Nursing actions are goal-directed, assisting the patient to reach maximum functional health.

21. The nurse changes a patient's surgical dressing daily. This is considered to be part of which phase of the nursing process?



- A) Nursing diagnosis
- B) Patient goal
- C) Outcome identification
- D) Implementation

Ans: D

Feedback:

Implementation is the action phase of the nursing process.

22. A written plan of care for each patient is required by what organization?

- A) The Joint Commission
- B) The National Institutes of Health
- C) The American Association on the Accreditation of Colleges of Nursing
- D) The American Nurses Association

Ans: A

Feedback:



The patient plan of care is a written summary of care that a patient is to receive. The Joint Commission requires a written plan of care for each patient.

23. When the nurse formulates three nursing diagnoses for an adult patient hospitalized for abdominal surgery, the nurse has focused on the patients

- A) Medical record.
- B) Actual health problems
- C) Medical diagnosis
- D) Past medical history

Ans: B

Feedback:

Formulating the diagnostic statement requires knowledge of the differences among actual, risk, possible, and wellness nursing diagnoses.

24. After the nurse has formulated expected outcomes, the next step of the nursing process is to:

- A) outline evaluation strategies.
- B) prepare an oral report.
- C) document the rationale.



D) write the plan of care.

Ans: D

Feedback:

Nurses work together with patients to identify goals and intervention strategies that will address identified problems.

25. What is the primary goal of the planning phase of the nursing process?

A) To identify goals for the patient

B) To prepare a plan of care

C) To establish priorities for care

D) To acknowledge patient needs

Ans: B

Feedback:

The planning phase involves preparing a patient plan of care, which directs the activities of the nursing staff in the provision of patient care.

26. The nurse writes the following on the patients chart: The patient will have complete healing of the surgical incision on the right lower quadrant of the abdomen in 3 weeks. This is a(n)



- A) Nursing diagnosis
- B) Assessment
- C) Evaluation
- D) Outcome identification

Ans: D

Feedback:

According to the ANAs *Nursing: Scope and Standards of Practice*, outcome identification refers to formulating and documenting measurable, realistic, patient-focused goals.

27. Which organization defines the nursing diagnosis?

- A) American Nurses Association
- B) North American Nursing Diagnosis AssociationInternational
- C) American Association of Colleges of Nursing
- D) Sigma Theta Tau International

Ans: B



Feedback:

The North American Nursing Diagnosis Association International defines the nursing diagnosis as a clinical judgment about individual, family, or community responses to actual or potential health problems/life processes.

28. Which of the following healthcare professionals are licensed to make a nursing diagnosis?
- A) Licensed practical nurses
 - B) Registered nurses
 - C) Social workers
 - D) Physicians assistants

Ans: B

Feedback:

Registered nurses are educated and licensed to make nursing diagnoses.

29. A patient has had an appendectomy. He has an incision at the right lower quadrant of the abdomen. Nurse has written: Alteration in skin integrity related to incision at right lower quadrant of the abdomen. This is
- A) A planned outcome



- B) Subjective data
- C) A nursing intervention
- D) An actual nursing diagnosis

Ans: D

Feedback:

Diagnosing human responses to actual or potential health problems is the second phase of the nursing process.

30. An in-depth history and physical builds the

- A) Plan of care
- B) Future interventions
- C) Database
- D) Secondary source

Ans: C

Feedback:



An in-depth history and physical assessment are usually required at admission to a hospital or long-term care facility, or during the first visit by community or home health nurse.

31. The nurse caring for a newly admitted patient recognizes that the patients past chart at an acute care facility is considered to be the

- A) Primary source
- B) Secondary source
- C) Subjective data
- D) Nursing diagnosis

Ans: B

Feedback:

Secondary sources include family members, significant others, other healthcare professionals, health records, and literature review.

32. A patient states, I am having a severe headache with pain over my right eye. This statement is classified as

- A) Primary source
- B) Objective data



- C) Symptom identification
- D) Planning care

Ans: A

Feedback:

This patient is the primary source of information for assessment.

33. Which of the following is a distinct nursing function in the nursing process?

- A) Assessment
- B) Planning
- C) Nursing diagnosis
- D) Evaluation

Ans: C

Feedback:

In the 1980s, further support was gained for making diagnosis a distinct nursing function and a separate step of the nursing process. In the landmark *Nursing: A Social Policy Statement*, the ANA again identified diagnosis of actual and potential health problems as an integral part of nursing practice.



34. The term *nursing process* is synonymous with the

- A) Identification of health problems
- B) Verification of wellness issues
- C) Application of nursing diagnosis
- D) Problem-solving approach

Ans: D

Feedback:

The term *nursing process* is synonymous with the problem-solving approach for discovering the healthcare and nursing care needs of patients.

35. In 1955, Lydia Hall introduced the nursing process. Nursing care delivery changed based on

- A) Guidelines from the medical model
- B) Information from the scientific process
- C) The patients and nurses interaction
- D) The process of pathophysiology



Ans: C

Feedback:

The nursing process is that which goes on between a patient and a nurse in a given setting; it records the behaviors of patient and nurse and the resulting interaction.



Chapter 15: Assessing

1. Which of the following group of terms best defines assessing in the nursing process?
 - A) problem focused, time lapsed, emergency based
 - B) design a plan of care, implement nursing interventions
 - C) collection, validation, communication of patient data
 - D) nurse focused, establishing nursing goals

2. A nurse performing triage in an emergency room makes assessments of patients using critical thinking skills. Which of the following are critical thinking activities linked to assessment? Select all that apply.
 - A) carrying out a physicians order to intubate a patient
 - B) teaching a novice nurse the principles of triage
 - C) using the nursing process to diagnose a blocked airway
 - D) interviewing a patient suspected of being a victim of abuse privately
 - E) checking the data supplied by a patient with dementia with the family
 - F) teaching a diabetic patient about the importance of proper foot care



3. On admission, a physician diagnoses a patient with rheumatoid arthritis. The nurse uses assessments to make the nursing diagnosis of Chronic Pain. What is the nurse diagnosing?
 - A) the pathology of the illness
 - B) the response of the patient to the illness
 - C) information from a nursing textbook
 - D) knowledge from more experienced nurses
4. The nurse completes a health history and physical assessment on a patient who has been admitted to the hospital for surgery. What is the purpose of this initial assessment?
 - A) to gather data about a specific and current health problem
 - B) to identify life-threatening problems that require immediate attention
 - C) to compare and contrast current health status to baseline data
 - D) to establish a database to identify problems and strengths
5. Mrs. James comes to her healthcare providers office because she is having abdominal pain. She has been seen for this problem before. What type of assessment would the nurse do?
 - A) initial assessment



- B) focused assessment
 - C) emergency assessment
 - D) time-lapsed assessment
6. A nurse is assisting with lunch at a nursing home. Suddenly, one of the residents begins to choke and is unable to breathe. The nurse assesses the residents ability to breathe and then begins CPR. Why did the nurse assess respiratory status?
- A) to identify a life-threatening problem
 - B) to establish a database for medical care
 - C) to practice respiratory assessment skills
 - D) to facilitate the residents ability to breathe
7. A nurse performs an assessment of a patient in a long-term care facility and records baseline data. The nurse reassesses the patient a month later and makes revisions in the plan of care. What type of assessment is the second assessment?
- A) comprehensive
 - B) focused
 - C) time-lapsed
 - D) emergency



8. Which of the following statements best describes the relationship between nursing diagnosis and medical diagnosis?
- A) The nursing diagnosis confirms the medical diagnosis.
 - B) The nursing diagnosis duplicates the medical diagnosis.
 - C) There is no relationship between nursing and medical diagnoses.
 - D) The nursing diagnosis is based on patient response to the medical diagnosis.
9. Of the following information collected during a nursing assessment, which are subjective data?
- A) vomiting, pulse 96
 - B) respirations 22, blood pressure 130/80
 - C) nausea, abdominal pain
 - D) pale skin, thick toenails
10. A nurse in the emergency department is completing an emergency assessment for a teenager just admitted from a car crash. Which of the following is objective data?
- A) My leg hurts so bad. I cant stand it.
 - B) Appears anxious and frightened.



- C) I am so sick; I am about to throw up.
 - D) Unable to palpate femoral pulse in left leg.
11. Who or what is the primary source of information for a nursing history?
- A) previous medical records
 - B) other healthcare personnel
 - C) the patient
 - D) family members
12. A nurse is collecting information from Mr. Koeppe, a patient with dementia. The patient's daughter, Sarah, accompanies the patient. Which of the following statements by the nurse would recognize the patient's value as an individual?
- A) Sarah, can you tell me how long your father has been this way?
 - B) Sarah, I have to go and read your father's old charts before we talk.
 - C) Mr. Koeppe, tell me what you do to take care of yourself.
 - D) Mr. Koeppe, I know you can't answer my questions, but it's okay.
13. What type of patient record data would the nurse find in the medical history and progress notes?



- A) findings of the physicians assessment and treatment
 - B) results of laboratory and diagnostic studies
 - C) nursing documentation and plan of care
 - D) information from other members of the healthcare team
14. A nurse is collecting data from a home care patient. In addition to information about the patients health status, what is another observation the nurse should make?
- A) number of rooms in the house
 - B) safety of the immediate environment
 - C) frequency of home visits to be made
 - D) friendliness of the patient and family
15. Of the following data, what type would be collected during a physical assessment?
- A) color, moisture, and temperature of the skin
 - B) type, amount, and duration of pain
 - C) foods eaten that cause nausea



- D) specific allergies resulting in itching
16. A nurse is preparing to conduct a health history for a patient who is confined to bed. How should the nurse position herself?
- A) standing at the end of the bed
- B) standing at the side of the bed
- C) sitting at least 6 feet from the bedside
- D) sitting at a 45-degree angle to the bed
17. Which of the following questions or statements would be appropriate in eliciting further information when conducting a health history interview?
- A) Why didn't you go to the doctor when you began to have this pain?
- B) Are you feeling better now than you did during the night?
- C) Tell me more about what caused your pain.
- D) If I were you, I would not wait to get medical help next time.
18. Which of the following questions or statements would be an appropriate termination of the health history interview?
- A) Well, I can't think of anything else to ask you right now.



- B) Can you think of anything else you would like to tell me?
 - C) I wish you could have remembered more about your illness.
 - D) Perhaps we can talk again sometime. Goodbye.
19. Which of the following are examples of common factors that may influence assessment priorities? Select all that apply.
- A) a patients diet and exercise program
 - B) a patients standing in the community
 - C) a patients ability to pay for services
 - D) a patients developmental stage
 - E) a patients need for nursing
20. After collecting data from a patient with respiratory distress, the nurse prioritizes the patient interventions to provide oxygen to the patient first. This is an example of which of the following models for organizing data?
- A) Hierarchy of Human Needs
 - B) Functional Health Patterns
 - C) Human Response Patterns



D) Body Systems Model

21. A nurse is conducting a health history interview for a woman at an assisted-living facility. The woman says, I have been so constipated lately. How should the nurse respond?

A) Do you have a family history of chest problems?

B) Why don't you use a laxative every night?

C) Do you take anything to help your constipation?

D) Everyone who ages has bowel problems.

22. A nurse who collected and organized data during a patient history realizes that there is not enough information to plan interventions. Which of the following would be the best remedy to prevent this from happening in the future?

A) The nurse should practice interviewing strategies.

B) The nurse should modify data collection tool.

C) The nurse should determine specific purpose of data collection.

D) The nurse should review and practice communication techniques.

23. What is the primary purpose of validation as a part of assessment?

A) to identify data to be validated



- B) to establish an effective nursepatient communication
 - C) to maintain effective relationships with coworkers
 - D) to plan appropriate nursing care
24. Which of the following examples of patient data needs to be validated? Select all that apply.
- A) A patient has trouble reading an informed consent, but states he does not need glasses.
 - B) An elderly patient explains that the black and blue marks on his arms and legs are due to a fall.
 - C) A nurse examining a patient with a respiratory infection documents fever and chills.
 - D) A patient in a nursing home states that she is unable to eat the food being served.
 - E) A pregnant patient is experiencing contractions that are 2 minutes apart.
 - F) Following a MVA, the teenage driver with alcohol on his breath states that he was not drinking.
25. A student takes an adult patients pulse and counts 20 beats/min. Knowing this is not the normal range for an adult pulse, what should the student do next?
- A) Record the pulse rate on the appropriate vital signs sheet in the chart.



- B) Ask the instructor or a staff nurse to take the pulse.
 - C) Discuss this finding during postconference with other students.
 - D) Wait 4 hours and take the patients pulse again.
26. Which of the following entries would be an example of appropriate documentation?
- A) Patient appears depressed and tired.
 - B) I am so down today, and I just dont have any energy.
 - C) Patient had a good bowel movement.
 - D) Complains of abdominal pain. Probably constipated.

Answer Key

- 1. C
- 2. C, D, E
- 3. B
- 4. D
- 5. B



6. A
7. C
8. D
9. C
10. D
11. C
12. C
13. A
14. B
15. A
16. D
17. C
18. B
19. A, D, E



20. A

21. C

22. A

23. D

24. A, B, F

25. B

26. B



Chapter 16: Diagnosis/Problem Identification

1. In addition to identifying responses to actual or potential health problems, what is another purpose of the diagnosing step in the nursing process?
 - A) to collect information about subjective and objective data
 - B) to correlate nursing and medical diagnostic criteria
 - C) to identify etiologies of health problems
 - D) to evaluate mutually developed expected outcomes
2. Which of the following patient care concerns is clearly a nursing responsibility?
 - A) prescribing medications
 - B) monitoring health status changes
 - C) ordering diagnostic examinations
 - D) performing surgical procedures
3. After completing assessments, a nurse uses the data collected to identify appropriate nursing diagnoses for a patient. What are the nursing diagnoses used for?



- A) selecting nursing interventions to meet expected outcomes
 - B) establishing a database of information for future comparison
 - C) mutually establishing desired outcomes of the plan of care
 - D) evaluating the effectiveness of the established plan of care
4. Which of the following are examples of nursing responsibilities? Select all that apply.
- A) recognizing the signs and symptoms of pancreatitis when it presents in a patient
 - B) making a diagnosis of uterine cancer following diagnostic testing
 - C) referring a patient diagnosed with lung cancer to a smoke-cessation group
 - D) researching and prescribing medication for an adolescent with uncontrolled asthma
 - E) performing range-of-motion exercises on an elderly patient who is in a wheelchair
 - F) teaching a group of high school students about the dangers of having unprotected sex
5. Which of the following statements accurately describe the legal responsibility of the nurse making a diagnosis for a patient?



- A) The nurse may make a diagnosis, but the physician is responsible for making sure it is appropriate for the patient.
 - B) The nurse practitioner is responsible for making all nursing diagnoses and determining if they are appropriate for the patient.
 - C) The nurse must decide if he or she is qualified to make a nursing diagnosis and will accept responsibility for treating it.
 - D) The healthcare facility directs the nursing diagnosis in order to receive payment for services performed.
6. A student is reviewing a patient's chart before giving care. She notes the following diagnoses in the contents of the chart: appendicitis and acute pain. Which of the diagnoses is a medical diagnosis?
- A) neither appendicitis nor acute pain
 - B) both appendicitis and acute pain
 - C) appendicitis
 - D) acute pain
7. A nurse develops a plan of care to meet the needs of a patient who has had a large loss of blood after a snowmobile crash. The interventions include administering and monitoring the patient's physiologic response to intravenous fluids and blood. What has the nurse focused care on?
- A) a medical diagnosis



- B) a nursing diagnosis
 - C) a collaborative problem
 - D) a goal for care
8. A nurse is reviewing the health history and physical assessment findings for a patient who is having respiratory problems. Of the following data collected, what data from the health history would be a cue to a nursing diagnosis for this problem?
- A) I often have diarrhea after I eat spicy foods.
 - B) My skin is so dry I just cant keep from scratching.
 - C) I get out of breath when I walk a few steps.
 - D) I just feel so bad about myself these days.
9. What is the focus of a diagnostic statement for a collaborative problem?
- A) the patient problem
 - B) the potential complication
 - C) the nursing diagnosis
 - D) the medical diagnosis



10. Successful implementation of each step of the nursing process requires high-level skills in critical thinking. Which of the following statements accurately describe a guideline for using this process?
- A) Trust clinical judgment and experience over asking for help.
 - B) Respect clinical intuition, but never allow it to determine a diagnosis.
 - C) Recognize personal biases as a strength in formulating diagnoses.
 - D) Keep an open mind and trust your intuition when formulating diagnoses.
11. The nurse takes a patients vital signs and finds the pulse rate to be 120 beats/min. What would the nurse do next to interpret and analyze this pulse rate?
- A) Compare the patients pulse rate to the standard range.
 - B) Notify the patients healthcare provider.
 - C) Document the pulse in the appropriate chart page.
 - D) Ask another nurse to verify the pulse rate.
12. A nurse observes a new mother tenderly holding and softly talking to her baby. What does this observation tell the nurse about the babys strengths?
- A) Nothing; this observation is not important.
 - B) The mother is just behaving as all mothers do.



- C) A baby is not capable of having strengths.
- D) Nurturing is a strength for developing infants.
13. A nurse completes a health history and physical assessment for an adolescent before he begins football practice. Based on findings, the nurse recommends reinforcing health habits. What conclusion did the nurse reach after interpreting and analyzing the data?
- A) no problem
- B) possible problem
- C) actual problem
- D) clinical problem
14. A nurse caring for an elderly patient in a long-term care facility notices that the bedding is wet when the patient gets up in the morning. The nurse collects more data to form a conclusion. What type of problem is involved in this scenario?
- A) no problem
- B) possible problem
- C) actual problem
- D) clinical problem



15. A nurse is formulating a nursing diagnosis for a patient with a respiratory disease. Which of the following would be correct?

- A) needs nasal oxygen to improve breathing
- B) cough related to ineffective airway clearance
- C) ineffective airway clearance related to thick mucus
- D) refuses to cough and expectorate thick mucus

16. A nurse writes the following nursing diagnosis for a patient with Alzheimers: Disturbed Thought Processes related to Alzheimers disease as evidenced by incoherent language. Which part of this diagnosis is considered the problem statement?

- A) disturbed thought processes
- B) related to
- C) Alzheimers disease
- D) incoherent language

17. A nurse is formulating a diagnosis for a patient who is reliving a brutal mugging that took place several months ago. The patient is crying uncontrollably and states that he cant live with this fear. Which of the following diagnoses for this patient is correctly written?

- A) post-trauma syndrome related to being attacked



- B) psychological overreaction related to being attacked
 - C) needs assistance coping with attack
 - D) mental distress related to being attacked
18. Of the following types of nursing diagnoses, which one is validated by the presence of major defining characteristics?
- A) risk nursing diagnosis
 - B) actual nursing diagnosis
 - C) possible nursing diagnosis
 - D) wellness diagnosis
19. Which of the following nursing diagnoses is an example of a wellness diagnosis?
- A) Acute Pain
 - B) Risk for Infection
 - C) Readiness for Enhanced Parenting
 - D) Possible Chronic Low Self-Esteem



20. A nursing diagnosis is written as Disturbed Self-Esteem related to presence of large scar over left side of face. What does the phrase Disturbed Self-Esteem identify?
- A) the expected outcome of the plan of care
 - B) a cue to determining a health problem
 - C) the major defining characteristic of a health problem
 - D) the health state or problem of the patient
21. In the nursing diagnosis Disturbed Self-Esteem related to presence of large scar over left side of face, what part of the nursing diagnosis is presence of large scar over left side of face?
- A) etiology
 - B) problem
 - C) defining characteristics
 - D) patient need
22. A student identifies Fatigue as a health problem and nursing diagnosis for a patient receiving home care for treatment of metastatic cancer. What statement or question would be best to validate this patient problem?
- A) I have assessed you and find you are fatigued.



- B) I analyzed and interpreted your information as fatigue.
 - C) Why are you so tired all the time?
 - D) I think fatigue is a problem for you; do you agree?
23. Of all the benefits of using nursing diagnoses, which one is probably the most important to nurses?
- A) defining the domain of nursing practice
 - B) informing patients of their care
 - C) improving communication among nurses
 - D) structuring curricular content

Answer Key

- 1. C
- 2. B
- 3. A
- 4. A, C, E, F
- 5. C



6. C

7. C

8. C

9. B

10. D

11. A

12. D

13. A

14. B

15. C

16. A

17. A

18. B

19. C



20. D

21. A

22. D

23. C



Chapter 17: Outcome Identification and Planning

1. What is the primary purpose of the outcome identification and planning step of the nursing process?
 - A) to collect and analyze data to establish a database
 - B) to interpret and analyze data to identify health problems
 - C) to write appropriate patient-centered nursing diagnoses
 - D) to design a plan of care for and with the patient

2. Critical thinking is an essential component in all phases of the nursing process. What question might be used to facilitate critical thinking during outcome identification and planning?
 - A) How do I best cluster these data and cues to identify problems?
 - B) What problems require my immediate attention or that of the team?
 - C) What major defining characteristics are present for a nursing diagnosis?
 - D) How do I document care accurately and legally?



3. Nurses identifying outcomes and related nursing interventions must refer to the standards and agency policies for setting priorities, identifying and recording expected patient outcomes, selecting evidence-based nursing interventions, and recording the plan of care. Which of the following are recognized standards? Select all that apply.
- A) professional physicians organizations
 - B) state Nurse Practice Acts
 - C) The Joint Commission
 - D) the Agency for Health Care Research and Quality
 - E) the Patient Health Partnership
 - F) the Patient Bill of Rights
4. A nurse admits a patient to the hospitals short-stay unit and completes a health history and physical assessment. Using these data, the nurse develops a(n) _____ plan of care, based on _____ planning?
- A) intermittent, focused
 - B) comprehensive, initial
 - C) single-use, ongoing
 - D) standard, emergency



5. Although each care plan is individualized, there are certain risks and health problems that, for example, patients undergoing similar medical or surgical treatment have in common. What name is given to this type of care plan?
- A) initial
 - B) ongoing
 - C) discharge
 - D) standardized
6. A nurse is discharging a patient from the hospital. When should discharge planning be initiated?
- A) at the time of discharge from an acute healthcare setting
 - B) at the time of admission to an acute healthcare setting
 - C) before admission to an acute healthcare setting
 - D) when the patient is at home after acute care
7. A nurse assesses the vital signs of a patient who is one day postsurgery in which a colostomy was performed. The nurse then uses the data to update the patient plan of care. What are these actions considered?
- A) initial planning



- B) comprehensive planning
 - C) on-going planning
 - D) discharge planning
8. A father runs into the emergency room with his 18-month-old son in his arms. The father screams, Help, he is not breathing! The nursing diagnosis of Impaired Gas Exchange is what level of priority diagnosis?
- A) no priority
 - B) low priority
 - C) medium priority
 - D) high priority
9. The nursing diagnosis Impaired Gas Exchange, prioritized by Maslows hierarchy of basic human needs, is appropriate for what level of needs?
- A) physiologic
 - B) safety
 - C) love and belonging
 - D) self-actualization



10. A resident of a long-term care facility refuses to eat until she has had her hair combed and her make-up applied. In this case, what patient need should have priority?
- A) the need to have nutrition
 - B) the need to feel good about oneself
 - C) the need to live in a safe environment
 - D) the need for love from others
11. In which of the following patients has the order of priorities for nursing diagnoses changed? Select all that apply.
- A) a patient in a long-term care facility who had a stroke
 - B) a patient who is recovering from a broken leg
 - C) a patient who insists on using the bathroom instead of a bedpan
 - D) a patient who appears confused after taking pain medication
 - E) a pregnant patient whose contractions are progressing as anticipated
 - F) a patient who has wounds that require stitches as well as a concussion
12. From what part of the nursing diagnoses are outcomes derived during outcome identification and planning?



- A) the defining characteristics
 - B) the related factors
 - C) the problem statement
 - D) the database
13. A nurse writes down the following outcome for a depressed patient: By 6/9/12, the patient will state three positive benefits of receiving counseling. This is an example of which of the following types of outcomes?
- A) psychomotor
 - B) cognitive
 - C) affective
 - D) realistic
14. Which of the following is categorized as a psychomotor outcome?
- A) Within 2 days of teaching, the patients wife will demonstrate abdominal dressing change.
 - B) Within 1 week of attending class, the patient will have cut smoking from 20 to 10 cigarettes per day.



- C) The patient will verbalize understanding of need to continue to take medications as prescribed.
 - D) The patients skin will remain smooth, moist, and without breakdown or ulceration.
15. A nurse is developing outcomes for a specific problem statement. What is one of the most important considerations the nurse should have?
- A) that the written outcomes are designed to meet nursing goals
 - B) to encourage the patient and family to be involved
 - C) to discourage additions by other healthcare providers
 - D) why the nurse believes the outcome is important
16. Which of the following outcomes is correctly written?
- A) Abdominal incision will show no signs of infection.
 - B) On discharge, patient will be free of infection.
 - C) On discharge, patient will be able to list five symptoms of infection.
 - D) During home care, nurse will not observe symptoms of infection.
17. Which of the following are verbs that are helpful in writing measurable outcomes? Select all that apply.



- A) know
 - B) define
 - C) hear
 - D) verbalize
 - E) feel
 - F) list
18. Which of the following illustrates a common error when writing patient outcomes?
- A) Patient will drink 100 mL of fluid every 2 hours from 6 a.m. to 9 p.m.
 - B) Patient will demonstrate correct sequence of exercises by next office visit.
 - C) Patient will be less anxious and fearful before and after surgery.
 - D) On discharge, patient will list five symptoms of infection to report.
19. Which of the following groups of terms best describes a nurse-initiated intervention?
- A) dependent, physician-ordered, recovery



- B) autonomous, clinical judgment, patient outcomes
 - C) medical diagnosis, medication administration
 - D) other healthcare providers, skill acquisition
20. What part of the nursing diagnosis statement suggests the nursing interventions to be included in the plan of care?
- A) problem statement
 - B) defining characteristics
 - C) etiology of the problem
 - D) outcomes criteria
21. What is true of nursing responsibilities with regard to a physician-initiated intervention (physicians order)?
- A) Nurses do not carry out physician-initiated interventions.
 - B) Nurses do carry out interventions in response to a physicians order.
 - C) Nurses are responsible for reminding physicians to implement orders.
 - D) Nurses are not legally responsible for these interventions.



22. A nurse is using a structured care methodology that follows a set of steps based on a clinician's decision process to help standardize nursing care plans. What is the term for this element of a structured care methodology?
- A) algorithm
 - B) national guidelines
 - C) standard of care
 - D) clinical practice guideline
23. What name is given to tools that are used to communicate a standardized interdisciplinary plan of care for patients within a case management healthcare delivery system?
- A) Kardex care plans
 - B) computerized plans of care
 - C) clinical pathways
 - D) student care plans
24. A nurse has developed a plan of care with nursing interventions designed to meet specific patient outcomes. The outcomes are not met by the time specified in the plan. What should the nurse do now in terms of evaluation?
- A) Continue to follow the written plan of care.



- B) Make recommendations for revising the plan of care.
 - C) Ask another healthcare professional to design a plan of care.
 - D) State goal will be met at a later date.
25. A nurse records patient data on a folded card and places it in a central file, where it is easily accessible to staff. Which system of care is this nurse using?
- A) critical pathways
 - B) case management
 - C) Kardex care plan
 - D) concept map care plan
26. Which of the following types of care plans is most likely to enable the nurse to take a holistic view of the patients situation?
- A) Kardex
 - B) case management
 - C) critical pathways
 - D) concept map care plan



27. Which of the following is an example of a well-stated nursing intervention?
- A) Patient will drink 100 mL of water every 2 hours while awake.
 - B) Offer patient 100 mL of water every 2 hours while awake.
 - C) Offer patient water when he complains of thirst.
 - D) Patient will continue to increase oral intake when awake.
28. What common problem is related to outcome identification and planning?
- A) failing to involve the patient in the planning process
 - B) collecting sufficient data to establish a database
 - C) stating specific and measurable outcomes based on nursing diagnoses
 - D) writing nursing orders that are clear and resolve the problem
29. Which of the following statements accurately describe the impact on nursing of using NIC/NOC standardized languages? Select all that apply.
- A) They demonstrate the impact that nurses have on the system of healthcare delivery.
 - B) They standardize and define the knowledge base for nursing curricula and practice.



- C) They limit the number of appropriate nursing intervention to be selected.
- D) They hinder the teaching of clinical decision making to novice nurses.
- E) They enable researchers to examine the effectiveness and cost of nursing care.
- F) They slow the development and use of nursing information systems.

Answer Key

- 1. D
- 2. B
- 3. B, C, D
- 4. B
- 5. D
- 6. B
- 7. C
- 8. D
- 9. A



10. B

11. A, C, D, F

12. C

13. C

14. A

15. B

16. C

17. B, D, F

18. C

19. B

20. C

21. B

22. A

23. C



24. B

25. C

26. D

27. B

28. A

29. A, B, E



Chapter 18: Implementing

1. What is the unique focus of nursing implementation?
 - A) patient response to health and illness
 - B) patient response to nursing diagnosis
 - C) patient compliance with treatment regimen
 - D) patient interview and physical assessment
2. What is one advantage of having a standard classification of nursing interventions?
 - A) to standardize nomenclature (names or terms)
 - B) to legitimize the use of the nursing process
 - C) to classify indicators of patient outcomes
 - D) to facilitate documentation of expected goals
3. The researchers developing classifications for interventions are also committed to developing a classification of which of the following?
 - A) diagnoses



- B) outcomes
 - C) goals
 - D) data clusters
4. What activity is carried out during the implementing step of the nursing process?
- A) Assessments are made to identify human responses to health problems.
 - B) Mutual goals are established and desired patient outcomes are determined.
 - C) Planned nursing actions (interventions) are carried out.
 - D) Desired outcomes are evaluated and, if necessary, the plan is modified.
5. What role of the nurse is crucial to the prevention of fragmentation of care?
- A) advocate
 - B) teacher
 - C) counselor
 - D) coordinator
6. What phrase best describes nurse-initiated interventions?



- A) nurse-prescribed interventions
 - B) physician-prescribed interventions
 - C) healthcare team interventions
 - D) interventions based on medical orders
7. Which of the following examples of nursing actions involve direct care of the patient? Select all that apply.
- A) A nurse counsels a young family who is interested in natural family planning.
 - B) A nurse massages the back of a patient while performing a skin assessment.
 - C) A nurse arranges for a consultation for a patient who has no health insurance.
 - D) A nurse helps a patient in hospice fill out a living will form.
 - E) A nurse arranges for physical therapy for a patient who had a stroke.
 - F) A nurse comforts a distraught patient whose baby was stillborn.
8. A nurse documents the following diagnosis for a hospitalized patient: Risk for Imbalanced Nutrition: More Than Body Requirements. What is the major goal of interventions for a risk diagnosis?
- A) reduce or eliminate contributing factors



- B) prevent the problem
 - C) collect additional data
 - D) promote higher-level wellness
9. A nurse is changing a sterile pressure ulcer dressing based on an established protocol. What does this mean?
- A) The nurse is using critical thinking to implement the dressing change.
 - B) The patient has specified how the dressing should be changed.
 - C) Written plans are developed that specify nursing activities for this skill.
 - D) The physician verbally requested specific steps of the dressing change.
10. What must occur before physician-initiated interventions can be carried out?
- A) They must be written on the nursing plan of care.
 - B) The nurse relinquishes all responsibility for them.
 - C) Any healthcare provider may order them.
 - D) The physician gives a verbal or written order.



11. A patient who was previously awake and alert suddenly becomes unconscious. The nursing plan of care includes an order to increase oral intake. Why would the nurse review the plan of care?
- A) to implement evidence-based practice
 - B) to ensure the order follows hospital policy
 - C) to be sure interventions are individualized
 - D) to be sure the intervention is safe
12. A nurse is preparing to insert an intravenous line and begin administering intravenous fluids. The patient has visitors in the room. What should the nurse do?
- A) Ask the visitors to leave the room.
 - B) Ask the patient if visitors should remain in the room.
 - C) Tell the patient to ask the visitors to leave the room.
 - D) Wait until the visitors leave to begin the procedure.
13. A nurse is catheterizing a patient. What action illustrates respect for the patients privacy?
- A) explaining the procedure to the family
 - B) leaving the patients pajamas on



- C) closing the door to the room
 - D) asking another nurse if he wants to watch
14. A student is ambulating a patient for the first time after surgery. What would the student do to anticipate and plan for an unexpected outcome?
- A) Take the patients vital signs after ambulation.
 - B) Ask the patients wife to assist with ambulation.
 - C) Delay ambulation until the following shift.
 - D) Ask another student to help with ambulation.
15. Each time a nurse administers an insulin injection to a patient with diabetes, she tells the patient what she is doing and demonstrates each step of preparing and giving the injection. What is the nurse promoting?
- A) self-care
 - B) dependence
 - C) coping with disability
 - D) nursepatient relationship
16. Which of the following statements accurately describe a recommended guideline for implementation? Select all that apply.



- A) When implementing nursing care, remember to act independently, regardless of the wishes of the patient/family.
 - B) Before implementing any nursing action, reassess the patient to determine whether the action is still needed.
 - C) Assume that the nursing intervention selected is the best of all possible alternatives.
 - D) Consult colleagues and the nursing and related literature to see if other approaches might be more successful.
 - E) Reduce your repertoire of skilled nursing interventions to ensure a greater likelihood of success.
 - F) Check to make sure that the nursing interventions selected are consistent with standards of care.
17. The staff in a long-term care facility often plays loud rock music on the radio and designs childrens games as exercise. What is the staff doing in this situation?
- A) considering the hearing level of older adults
 - B) failing to consider visual deficits that occur with aging
 - C) ignoring the developmental needs of older adults
 - D) meeting needs for sensory input and exercise



18. A nurse administers a medication for pain but forgets to document it in the patients medical record. Legally, what does this mean?
- A) Nothing, the nurses honesty will not be questioned.
 - B) The nurse can add the documentation after the patient goes home.
 - C) The physician will verify that the nurse carried out the order.
 - D) In the eyes of the law, if it is not documented, it was not done.
19. A nurse delegates a specific intervention to a UAP. What implications does this have for the nurse?
- A) The UAP is responsible and accountable for his or her own actions.
 - B) Nurses do not have authority to delegate interventions.
 - C) The nurse transfers responsibility but is accountable for the outcome.
 - D) The UAP can function in an independent role for all interventions.
20. According to the American Nurses Association, who determines the scope of nursing practice?
- A) nurses
 - B) lawyers



- C) physicians
 - D) consumers
21. What characteristic of a competent nurse practitioner enables nurses to be role models for patients?
- A) sense of humor
 - B) writing ability
 - C) organizational skills
 - D) good personal health
22. What core value of nursing care is missing when a nursing intervention is delegated to a UAP?
- A) communication
 - B) patient teaching
 - C) nurse/patient dynamic
 - D) competent care

Answer Key



1. A
2. A
3. B
4. C
5. C
6. A
7. A, B, D, E
8. B
9. C
10. D
11. D
12. B
13. C
14. D



15. A

16. B, D, F

17. C

18. D

19. C

20. A

21. D

22. C



Chapter 19: Evaluating

1. Which of the following best summarizes the evaluating step of the nursing process?
 - A) The nurse completes a health assessment to establish a database.
 - B) The patient and family have met healthcare goals and no longer need care.
 - C) The nurse and patient identify nursing diagnoses and appropriate interventions.
 - D) The nurse and patient measure achievement of planned outcomes of care.
2. What is the purpose of evaluation in the nursing process?
 - A) to direct future nursing interventions
 - B) to formulate a database of nursing diagnoses
 - C) to complete an initial plan of care
 - D) to transfer medical orders to the plan of care
3. Which of the following would **not** be part of the nurses decision about care after evaluating the patients responses to the plan of care?
 - A) terminate the plan of care



- B) modify the plan of care
 - C) continue the plan of care
 - D) begin the plan of care
4. Nurses evaluate many aspects of the healthcare delivery system. Which of the following is always the primary concern when performing the evaluating step of the nursing process?
- A) the nurse
 - B) the patient
 - C) the healthcare system
 - D) outcome achievement
5. What cognitive processes must the nurse use to measure patient achievement of outcomes during evaluation?
- A) intuitive thinking
 - B) critical thinking
 - C) traditional knowing
 - D) rote memory



6. A nurse is evaluating an established plan of care. After identifying the evaluative criteria and standards (expected patient outcomes), what must the nurse do next?
- A) Interpret and summarize findings.
 - B) Document his or her judgment.
 - C) Collect data about patient responses.
 - D) Formulate a new plan of care.
7. Which of the following is a descriptor that helps to define the term criteria?
- A) immeasurable qualities
 - B) established by authority
 - C) acceptable level of performance
 - D) evidence-based practice
8. A nurse is evaluating the outcomes of a plan of care to teach an obese patient about the calorie content of foods. What type of outcome is this?
- A) psychomotor
 - B) affective



- C) physiologic
 - D) cognitive
9. A nurse is teaching a patient how to administer insulin, with the expected outcome that the patient will be able to self-administer the insulin injection. How would this outcome be evaluated?
- A) asking the patient to verbally repeat the steps of the injection
 - B) asking the patient to demonstrate self-injection of insulin
 - C) asking family members how much trouble the patient is having with injections
 - D) asking the patient how comfortable he or she is with injections
10. A nurse is counseling a novice nurse who gives 150% effort at all times and is becoming frustrated with a healthcare system that provides substandard care to patients. Which of the following advice would be appropriate in this situation? Select all that apply.
- A) Tell the new nurse to help other nurses perform their jobs to ensure quality patient care is being delivered.
 - B) Encourage the new nurse to leave her problems at work behind, instead of rehashing them at home.
 - C) After establishing a reputation for delivering quality nursing care, have her seek creative solutions for nursing problems.



- D) Tell her to view nursing care concerns as challenges rather than overwhelming obstacles and seek help for solutions.
 - E) State that if resources do not permit quality care, it is not the role of the new nurse to explore change strategies within the institution.
 - F) Tell the nurse that if administration is not supportive, moving to another practice setting might be more appropriate.
11. A plan of care for a patient with a low potassium level includes providing information about the effect of medications and dietary intake of foods high in potassium. How would a nurse measure achievement of an outcome for this plan?
- A) physical assessment
 - B) health history
 - C) laboratory data
 - D) patient statements
12. A nurse in a community health center has been having regular meetings with a woman who wants to stop smoking. Which of the following outcome decision options would the nurse document if the woman has not smoked for 3 months?
- A) outcome met
 - B) outcome partially met
 - C) outcome not met



- D) outcome inappropriate
13. Patient lost 2 of the 5 pound/month goal. How should the nurse alter the plan of care in response to this new data?
- A) The nurse should not alter the plan of care.
- B) The nurse should change the diet.
- C) The nurse should delete the nursing diagnosis.
- D) The nurse should modify the time criteria.
14. A nurse has developed a plan of care for the nursing diagnosis Risk for Loneliness for a recently widowed man. When evaluating the plan, the man tells the nurse new information about his active social life. What would the nurse do next?
- A) Continue with the plan.
- B) Delete the nursing diagnosis.
- C) Tell the patient he is lonely.
- D) Adjust the time criteria.
15. A nurse is interested in improving patient care on the unit through performance improvement. What is the first step in this process?
- A) Discover the problem.



- B) Plan a strategy.
 - C) Implement a change.
 - D) Assess the change.
16. A nurse working in a hospital setting discovers problems with the delivery of nursing care on the pediatric unit. Which of the following suggestions from the Institute of Medicines Committee on Quality of Health Care in America (Kohn, Corrigan, & Donaldson, 2000) could help redesign and improve care? Select all that apply.
- A) Base care on continuous healing relationships.
 - B) Customize care based on available resources.
 - C) Keep the nurse as the source of control.
 - D) Share knowledge and allow for free flow of information
 - E) Practice evidence-based decision making
 - F) Emphasize safety as a system property.
17. The nursing staff on a hospital unit are using peer review to improve professional performance. Who performs the review?
- A) unit manager



- B) nurses
- C) patients
- D) visitors

18. Why are quality-assurance programs important in nursing?

- A) They enable nursing to be accountable for the quality of care.
- B) They facilitate increased enrollment in educational programs.
- C) They specify how resources are used or not used.
- D) They allow increased retention of qualified nurses.

19. Which of the following are major premises of a quality-improvement program?
Select all that apply.

- A) It focuses on organizational structure.
- B) It is driven by external factors.
- C) It focuses on processes rather than individuals.
- D) It has no end points.



- E) Its outcome is focused on assuring quality.
 - F) It focuses on data and statistical thinking.
20. A hospital is evaluating its policies and procedures. What type of evaluation is the hospital conducting?
- A) outcome
 - B) process
 - C) quality
 - D) structure
21. What is evaluated when conducting a nursing audit?
- A) physical environment
 - B) policies and procedures
 - C) patient records
 - D) patient satisfaction
22. A nurse evaluates nursing care and outcomes for a current patient by using direct observation of nursing care, patient interviews, and chart review to determine whether the specified evaluative criteria are met. This practice is known as:



- A) a nursing audit
 - B) a concurrent evaluation
 - C) a retrospective evaluation
 - D) an evaluation of patient satisfaction
23. A nurse forgets to raise the railings of the bed of a patient who is confused after taking pain medications. The patient attempts to get out of bed, and suffers a minor fall. The nurse asks a colleague who witnessed the fall not to mention it to anyone because the patient only had minor bruises. What would be the appropriate action of the colleague?
- A) No other steps need to be taken, since the patient was not seriously injured.
 - B) The colleague should inform the nurse that a full report of the incident needs to be made.
 - C) The colleague should monitor the patient closely for any adverse effects of the fall.
 - D) The colleague should report the incident in a peer review of the nurse.

Answer Key

- 1. D
- 2. A



3. D
4. B
5. B
6. C
7. C
8. D
9. B
10. B, C, D, F
11. C
12. A
13. D
14. B
15. A
16. A, D, E, F



17. B

18. A

19. C, D, F

20. D

21. C

22. B

23. B



Chapter 20: Documenting and Reporting

1. What is the nurses best defense if a patient alleges nursing negligence?
 - A) testimony of other nurses
 - B) testimony of expert witnesses
 - C) patients record
 - D) patients family

2. A nurse is documenting the intensity of a patients pain. What would be the most accurate entry?
 - A) Patient complaining of severe pain.
 - B) Patient appears to be in a lot of pain and is crying.
 - C) Patient states has pain; walking in hall with ease.
 - D) Patient states pain is a 9 on a scale of 1 to 10.

3. Which of the following data entries follows the recommended guidelines for documenting data?
 - A) Patient is overwhelmed by the diagnosis of pancreatic cancer.



- B) Patient kidneys are producing sufficient amount of measured urine.
 - C) Following oxygen administration, vital signs returned to baseline.
 - D) Patient complained about the quality of the nursing care provided on previous shift.
4. Alice Jones, a registered nurse, is documenting assessments at the beginning of her shift. How should she sign the entry?
- A) Alice J, RN
 - B) A. Jones, RN
 - C) Alice Jones
 - D) AJRN
5. In which of the following cases should a progress note be written? Select all that apply.
- A) for any nursepatient interaction
 - B) when admitting a patient
 - C) when receiving a patient postoperatively
 - D) when assisting a patient with ADLs



- E) when a procedure is performed
 - F) when a patient sends back an untouched dinner tray
6. A student has reviewed a patients chart before beginning assigned care. Which of the following actions violates patient confidentiality?
- A) writing the patients name on the student care plan
 - B) providing the instructor with plans for care
 - C) discussing the medications with a unit nurse
 - D) providing information to the physician about laboratory data
7. Which of the following are examples of breaches of patient confidentiality? Select all that apply.
- A) A nurse discusses a patient with a coworker in the elevator.
 - B) A nurse shares her computer password with a relative of a patient.
 - C) A nurse checks the medical record of a patient to see who should be called in an emergency.
 - D) A nurse updates the employer of a patient regarding the patients return to work.
 - E) A nurse uses a computer to document a patients response to pain medication.



- F) A head nurse accesses the medical records of a nurse on her shift to check her condition.
8. Which of the following are examples of incidental disclosures of patient health information that are permitted? Select all that apply.
- A) A nurse working in a physicians office puts out a sign-in sheet for incoming patients.
- B) Two nurses are overheard talking about a patient through the door of an empty patient room.
- C) A nurse places a patient chart in a holder on the examining room door with the name facing out.
- D) A nurse leaves an x-ray on a light board in the hallway that leads to the examining rooms.
- E) A nurse calls out the name of a patient who is seated in the waiting room.
- F) A nurse leaves a reminder for an appointment on a patients answering machine along with the results of lab work.
9. A patient asks to see his medical record (chart). How would the nurse respond?
- A) I cant let you do that without a doctors order.
- B) Our hospital policy is that you cant do that.
- C) I will get your chart and provide you with privacy to read it.



- D) Why would you want to do that? It will only make you worry.
10. A physicians order reads up ad lib. What does this mean in terms of patient activity?
- A) may walk twice a day
 - B) may be up as desired
 - C) may only go to the bathroom
 - D) must remain on bed rest
11. Which of the following abbreviations are on the list of the Joint Commission do not use abbreviations? Select all that apply.
- A) U (unit)
 - B) QD (daily)
 - C) NPO (nothing per os)
 - D) mL (milliliters)
 - E) > (greater than)
 - F) mcg (micrograms)



12. What is the primary purpose of the patient record?
- A) communication
 - B) advocacy
 - C) research
 - D) education
13. In what type of documentation method would a nurse document narrative notes in a nursing section?
- A) problem-oriented medical record
 - B) source-oriented record
 - C) PIE charting system
 - D) focus charting
14. Which one of the following methods of documentation is organized around patient diagnoses rather than around patient information?
- A) problem-oriented medical record (POMR)
 - B) source-oriented record



- C) PIE charting system
 - D) focus charting
15. What is the primary purpose of focus charting?
- A) nursing diagnoses
 - B) medical problems
 - C) patient concerns
 - D) expected outcomes
16. A nurse organizes patient data using the SOAP format. Which of the following would be recorded under S of this acronym?
- A) patient complaints of pain
 - B) patient symptoms
 - C) patients chief complaint
 - D) patient interventions
17. Which of the following methods of documenting patient data is least likely to hold up in court if a case of negligence is brought against a nurse?



- A) problem-oriented medical record
 - B) charting by exception
 - C) PIE charting system
 - D) focus charting
18. Which of the following information would a nurse include as part of a minimum data set when using electronic medical records? Select all that apply.
- A) patient sex
 - B) patient admission date
 - C) patient physical assessment
 - D) patient insurance
 - E) patient history
 - F) patient ethnicity
19. A nurse has access to computerized standardized plans of care. After printing one for a patient, what must be done next?
- A) Date it and put it in the patients record.



- B) Sign it and put it in the Kardex.
 - C) Individualize it to the specific patient.
 - D) Use it as printed, based on common needs.
20. What part of the patients record is commonly used to document specific patient variables, such as vital signs?
- A) progress notes
 - B) nursing notes
 - C) critical paths
 - D) graphic record
21. A nurse is documenting information about a patient in a long-term care facility. What is used in a Medicare-certified facility as a comprehensive assessment and as the foundation for the Resident Assessment Instrument (RAI)?
- A) PIE system
 - B) minimum data set
 - C) OASIS
 - D) charting by exception



22. What is the primary purpose of an incident report?
- A) means of identifying risks
 - B) basis for staff evaluation
 - C) basis for disciplinary action
 - D) format for audiotaped report
23. A group of nurses visits selected patients individually at the beginning of each shift. What are these procedures called?
- A) nursing care conferences
 - B) staff visits
 - C) interdisciplinary referrals
 - D) nursing care rounds
24. A nurse uses informatics to plan nursing care for a patient. Which three terms best describes this science as it is applied to nursing?
- A) data, information, knowledge
 - B) process, documentation, analysis



C) research, controls, variables

D) hypothesis, nursing, practice

Answer Key

1. C

2. D

3. C

4. B

5. B, C, E

6. A

7. A, B, D, F

8. A, B, E

9. C

10. B

11. A, B, E



12. A

13. B

14. A

15. C

16. A

17. B

18. A, B, D, F

19. C

20. D

21. B

22. A

23. D

24. A



Chapter 21: Informatics and Health Care Technologies

1. Because several disciplines support the foundation of informatics nursing, it is important for the informatics nurse to understand that:
 - A) informatics nursing differs from other disciplines, as it focuses on supporting the process of obtaining data.
 - B) informatics nursing uses the concepts, tools, and methods of various disciplines to facilitate nursing process.
 - C) information technology and nursing technology are synonymous, as they have the same goal.
 - D) the boundaries between the various disciplines are clearly defined.
2. Knowledge that is patterned for use in reasoning is known as:
 - A) artificial intelligence.
 - B) knowledge query.
 - C) knowledge representation.
 - D) neural computing.
3. Which document articulates the primary factors that guide professional nursing judgment, regarding confidential patient information?
 - A) Administrative Simplification Provisions.
 - B) Code of Ethics for Nurses with Interpretive Statements.
 - C) Health Insurance Portability and Accountability Act.
 - D) Nursing Informatics: Scope and Standards of Practice.
4. In promoting change, the people who are recognized as opinion leaders and role models are known as the:
 - A) early adopters.
 - B) early majority.
 - C) innovators.
 - D) risk takers.
5. The basic network protocol that determines the rules used to create and route



packets of data between computers is:

- A) HL7.
- B) URL.
- C) TCP/IP.
- D) XML.

6. Applications that are designed to run on a common platform, operate in a common environment, and communicate through direct data transfer are known as:

- A) integrated.
- B) interfaced.
- C) normalized.
- D) optimized.

7. What is the most common risk to patient privacy and confidentiality?

- A) An organization's employees.
- B) Inadequate firewall protection.
- C) Inadequate system design.
- D) Viruses, worms, and Trojan horses.

8. Adherence to a standardized nursing language will lead to:

- A) a barrier in national interoperability.
- B) a larger database of interventions.
- C) improved evaluation of nursing outcomes.
- D) increased nursing competencies.

9. The informatics nurse violates a patient's legal right to privacy and confidentiality, by:

- A) discussing a patient's diagnosis with an authorized family member.
- B) discussing care-related information with the patient's physical therapist.
- C) looking up a colleague's diagnosis and laboratory results while he or she is hospitalized.
- D) providing a handoff report containing patient information to another



department.

10. Using parallel strategy for the roll-out of an electronic medication administration system means that all:

- A) data entries are cosigned by two health care team members.
- B) medications are documented using both the current method and the new system.
- C) notebook computers and bar code scanners are positioned on the same surface.
- D) vital signs are entered on the same screen as is medication administration.

11. In project management, the critical path is best described as a series of activities that:

- A) includes the path with the most slack or float.
- B) indicates the earliest possible time a project can be completed.
- C) is scheduled for the next current phase of the process.
- D) shows the shortest path through the network diagram.

12. The foundation of strategic system planning begins with a review of the:

- A) existing computing environment.
- B) health care industry.
- C) information system plan.
- D) organization's business mission.

13. The focus of data analysis is to:

- A) collect data from various sources.
- B) evaluate data for efficiency.
- C) identify data sources for later inclusion.
- D) transform data into a usable form.

14. Which tool tracks resources, milestones, and time frames associated with the implementation of a new clinical program?

- A) A database.
- B) An expert system.



C) Project management software.

D) Spreadsheet software.

15. What process produces a blueprint that details how hardware and software meet the needs of the organization?

A) Benchmarking.

B) Feasibility study.

C) System analysis.

D) System design.

16. A downtime of the electronic health record (EHR) system is planned for three months from today. The informatics nurse is formulating a communication plan for the clinical staff about the downtime. The nurse plans to:

A) announce the upcoming downtime at system-wide meetings, and at department meetings of specific system hospitals affected by the downtime.

B) bring copies of the communication plan to IT meetings, and discuss it with the IT directors and managers.

C) present the information at the super-user meetings, department and unit meetings, and at other specialty clinician meetings, in addition to having a message posted on the message-of-the-day screen in the EHR.

D) print fliers with the downtime plan and post them in bathrooms and breakrooms, as well as on bulletin boards in various locations in the hospitals.

17. Adult learners most effectively learn about a new clinical information system when the instructor:

A) assumes that the learner knows nothing about the system.

B) begins the formal training as early as possible in the implementation process.

C) emphasizes the technical specifications of the structure of the system.

D) encourages the learner to use previous experience to interpret new learning.

18. As an ambulatory provider reviews the patient's chart, the provider reads lab data from an external organization. This scenario exemplifies:

A) a health information exchange.

B) a system to update patient records.

C) a violation of privacy regulations.



D) an electronic health record.

19. The problems of an existing system have been identified, along with possible solutions. What is the next step in the systems analysis stage?

A) A feasibility study.

B) Requirements gathering.

C) Systems design.

D) Systems testing.

20. What type of testing is performed on functionally grouped components to ensure that the subset works with the entire system?

A) Integration.

B) System.

C) Unit.

D) User acceptance.

21. The informatics nurse is working on a chart to demonstrate the increasing incidence of obesity in the patient population at a health clinic. The data will represent patients who are of normal weight, overweight, obese, and morbidly obese, and it will include the percentage of the total population for each group. This type of data is most effectively represented by a:

A) bar chart.

B) column chart.

C) line chart.

D) pie chart.

22. Integrating clinical practice guidelines with an electronic health record facilitates quality improvement measurement by:

A) comparing guideline parameters to clinical outcomes.

B) presenting results at the point of treatment decisions.

C) providing reference information to measurement staff.

D) representing patient acuity data.

23. System analysis is the process by which:



- A) a proposed design is reviewed for feasibility.
- B) potential vendor solutions are explored.
- C) the management needs are identified.
- D) the system's functional requirements are derived from users' needs.

Answer Key

- 1. B
- 2. C
- 3. B
- 4. A
- 5. C
- 6. A
- 7. A
- 8. C
- 9. C
- 10. B
- 11. B



12. D

13. D

14. C

15. D

16. C

17. D

18. A

19. A

20. A

21. D

22. A

23. D



Chapter 22: Developmental Concepts

1. A child gains weight and becomes taller each year. What is this process called?
 - A) development
 - B) orderly change
 - C) progression
 - D) growth

2. All humans learn from both formal and informal experiences. What orderly pattern of changes results in part from learning?
 - A) development
 - B) growth
 - C) maturity
 - D) aging

3. As the fetus develops, certain growth and development trends are regular and predictable. The first trend is cephalocaudal growth. What does this mean?
 - A) Legs and feet develop first.



- B) Both sides of the body develop equally.
 - C) Head and brain develop first.
 - D) Gross motor skills are learned last.
4. A second trend occurring with growth and development of the infant states that development is proximodistal. This means:
- A) Growth progresses from gross motor movements to fine motor movements.
 - B) Both sides of the body grow equally.
 - C) All humans experience the same growth patterns.
 - D) As nerve pathways develop, they become more specialized.
5. Many different factors affect growth and development. For example, why does Mary have blonde hair and blue eyes while John has brown hair and green eyes?
- A) childhood illnesses
 - B) genetic inheritance
 - C) prenatal influences
 - D) maternal nutrition



6. Which of the following statements accurately describe factors that may affect an individual's growth and development? Select all that apply.
- A) Physical characteristics such as height, bone size, and eye and hair color are inherited from the family of origin.
 - B) Fetal development can be altered by maternal age or inadequate maternal nutrition or substance abuse.
 - C) Abuse of alcohol and drugs is more prevalent in teenagers who have poor family relationships, low self-esteem, and poor social skills.
 - D) Infants who are malnourished in utero develop fewer brain cells than infants who have had adequate prenatal nutrition.
 - E) Environmental factors such as poverty and violence do not have a direct effect on growth and development.
 - F) Inadequate caregiving skills may affect growth of the individual, but it has no effect on predetermined development.
7. According to Freud, what is the name given to the part of the mind that represents one's conscience?
- A) unconscious mind
 - B) id
 - C) ego



- D) superego
8. The mother of a 6-month-old infant asks the nurse at a community health center what she should do about her baby, who always wants to put everything in his mouth. What would be an appropriate response by the nurse, based on Freud's theory?
- A) There must be something wrong; your baby should not be doing that.
- B) I don't know if that is normal or not, but I will check on it.
- C) Babies at this age explore and enjoy their world with their mouths.
- D) This usually does not happen until babies are 2 years old.
9. A 10-year-old boy tells his mother that he is going to be just like his father when he grows up. According to Freud, what stage of development is this child experiencing?
- A) anal
- B) phallic
- C) latency
- D) genital
10. Based on Piaget's theory of cognitive development, what type of activities would a nurse recommend to parents of children in the preoperational stage?
- A) play activities



- B) toilet training
 - C) church lessons
 - D) organized sports
11. A nurse is teaching a 7-year old diabetic child who is in Piagets concrete operational stage about insulin injections. Based on Piagets theory, what would be the nurses best method of preparation for this child?
- A) Show the child a video about diabetes and insulin.
 - B) Give the child a pamphlet on diabetes to read.
 - C) Demonstrate the procedure on a teddy bear.
 - D) Explain the procedure to the child in detail.
12. According to Erikson, normal adolescent behavior includes trying on new roles and possibly even rebelling. What is the purpose of this behavior in adolescents?
- A) to establish a sense of security
 - B) to establish a sense of identity
 - C) to gain autonomy
 - D) to avoid inferiority



13. Using Eriksons theory, which of the following activities would the nurse use to provide a sense of fulfillment and purpose in later adulthood?
- A) becoming involved within the community
 - B) making a commitment to others
 - C) trying on new and different roles
 - D) reminiscing about life events
14. Based on Havighursts theory, which of the following is one of the developmental tasks of middle adulthood?
- A) achieving personal independence
 - B) adjusting to physical changes
 - C) taking on civic responsibility
 - D) affiliating with ones age group
15. Goulds theory of transformation in adults included which developmental phase for those ages 50 to 60?
- A) challenging false assumptions
 - B) accepting life is neither simple nor controllable



- C) having increased self-approval and acceptance
 - D) questioning self and values
16. Levinson and associates based their theory on individual life structure, patterned at any point in time by the interaction of three components. Which one of the following is **not** a component of this theory?
- A) self
 - B) social and cultural aspects
 - C) individualized set of roles
 - D) degree of wellness
17. Which of the following actions would generally take place in the settling down stage of Daniel Levinsons Individual Life Structure theory? Select all that apply.
- A) breaking away from the family
 - B) making initial career choices
 - C) trying new lifestyles
 - D) striving to gain respect
 - E) investing in family



- F) maximizing self-approval
18. A school-aged child always follows the rules and obeys traffic lights when crossing the street. Based on Kohlbergs theory, what type of development is being demonstrated?
- A) cognitive
- B) intellectual
- C) moral
- D) psychosocial
19. In contrast to Kohlberg, Gilligan developed a theory of moral development specifically for women. What is the central theme of Gilligans theory?
- A) response and care
- B) rights and justice
- C) adult transformation
- D) individual life structure
20. In which of Gilligans stages does acceptance by others become critical, with the ability to protect and care for others seen as the defining characteristic of female goodness?



- A) Level 1: selfishness
 - B) Level 2: goodness
 - C) Level 3: nonviolence
 - D) Level 4: responsiveness
21. According to Fowlers theory, who or what initiates the development of faith in the infant?
- A) church attendance
 - B) daycare activities
 - C) primary caregivers
 - D) siblings
22. A 7-year-old attending a Roman Catholic Mass with his parents stands and holds his hymnal to sing the opening song. According to Fowler, what stage of development is this child experiencing?
- A) undifferentiated faith
 - B) intuitiveprojective faith
 - C) mythicalliteral faith



- D) syntheticconventional faith
23. A nurse wants to teach children about oral health. Based on Piagets theory, to what age group would it be most appropriate to teach this topic?
- A) preschoolers
- B) third and fourth graders
- C) junior high school age
- D) high school age
24. Using Eriksons theory, a nurse asks a young adult questions about family, friends, and support systems. Why is this important during assessments of adolescents?
- A) Without peer acceptance, feelings of inferiority may result.
- B) Overprotection by parents may result in feelings of shame and doubt.
- C) Restrictions on new experiences may lead to feelings of guilt.
- D) Fear of commitments may lead to loneliness and isolation.
25. During a health history, a middle-aged man tells the nurse, I will always take care of my children because my parents took care of me. Based on Kohlbergs theory, what level of moral development is the man demonstrating?
- A) preconventional



- B) conventional
 - C) postconventional
 - D) goodness
26. A 2-year-old child is hospitalized for a surgical procedure. Although previously all fluids were taken from a cup, the toddler wants a bottle to suck on. The nurse recognizes this behavior as what?
- A) totally unacceptable
 - B) proof that the child is sick
 - C) normal regression
 - D) abnormal behavior
27. Which of the following is an important role for the nurse when incorporating principles and theories of growth and development?
- A) Provide developmentally challenging environments and experiences.
 - B) Provide physical care to meet comfort needs of children.
 - C) Initiate activities that involve passive interactions with others.
 - D) Initiate interventions to meet specific outcomes of care.



Answer Key

1. D
2. A
3. C
4. A
5. B
6. A, B, C, D
7. D
8. C
9. C
10. A
11. C
12. B
13. D



- 14. B
- 15. C
- 16. D
- 17. D, E
- 18. C
- 19. A
- 20. B
- 21. C
- 22. B
- 23. B
- 24. D
- 25. B
- 26. C
- 27. A



Chapter 23: Conception Through Young Adulthood

1. A nurse is teaching a 2-week pregnant woman what is occurring in the development of her baby. Which of the following occur in this preembryonic stage? Select all that apply.
 - A) The zygote implants in the uterine wall.
 - B) Rapid growth and differentiation of the cell layers occurs.
 - C) All basic organs are established.
 - D) Some human features are recognizable.
 - E) Three distinct layers of cells exist.
 - F) The heartbeat can be heard by doppler.

2. A pregnant woman is at the end of her first trimester. The nurse tells her that normally the following developments have occurred in her fetus. Select all that apply.
 - A) some reflexes are present
 - B) kidney secretion begins
 - C) the sex of the infant is distinguishable



- D) sleepwake patterns are established
 - E) lung surfactant is produced
 - F) eyelids open
3. A nurse is teaching a young woman about healthy behaviors during the embryonic stage of pregnancy. Which of the following should the nurse emphasize to prevent congenital anomalies?
- A) adequate intake of food and fluids
 - B) importance of rest and sleep
 - C) avoidance of alcohol and nicotine
 - D) progression of stages during delivery
4. A nurse is teaching a pregnant woman about nutritional needs. Which of the following nutritional deficiencies during pregnancy might result in neural tube defects in the developing fetus?
- A) vitamin D
 - B) iodine
 - C) calcium
 - D) folic acid



5. At birth, the neonate must adapt to extrauterine life through several significant physiologic adjustments. Which of the following is the most important adjustment that occurs?
- A) body temperature responds to the environment
 - B) reflexes develop
 - C) stool and urine are eliminated
 - D) breathing begins
6. A nurse documents the following data upon assessment of a neonate: heart rate 89 BPM, slow respiratory effort, flaccid muscle tone, weak cry, and pale skin tone. What would be the Apgar score for this neonate?
- A) 2
 - B) 3
 - C) 4
 - D) 5
7. A mother watches as a neonate cries, spreads his arms, and draws them in again in response to being pulled up and laid back down. She asks the nurse what is going on with her baby. What is the best explanation for this response?
- A) Your baby is experiencing gas, and this movement helps to expel it.



- B) Your baby is demonstrating a normal CNS response called the Moro reflex.
 - C) Your baby is experiencing the signs and symptoms of an abnormal neural response to being startled.
 - D) Your babys actions are normal automatic movements to help maintain core body temperature.
8. Of the following components of psychosocial development in the neonate and infant, which one facilitates emotional linkage between a baby and caregiver?
- A) bonding
 - B) attachment
 - C) play
 - D) temperament
9. A nurse is teaching a group of parents about the dangers of Sudden Infant Death Syndrome (SIDS). The nurse recommends that parents place their children on a firm surface laying on their:
- A) left side
 - B) right side
 - C) abdomen



- D) back
10. A nurse is observing a group of toddlers at play. What behavior illustrates normal physiologic development in children of this age?
- A) attempting to feed self
- B) using fingers to pick up small objects
- C) throwing and catching a ball
- D) understanding the feelings of others
11. A nurse watches as a child continuously tells her mother no! to each comment the mother makes. The nurse knows that this behavior termed negativism is characteristic of which of the following developmental groups?
- A) toddler
- B) preschooler
- C) school-aged child
- D) adolescent
12. A preschooler is in Kohlbergs preconventional phase of moral reasoning. What is the focus of the phase?
- A) to learn sex differences and modesty



- B) a sexual desire for the opposite sex
 - C) obeying rules to avoid punishment
 - D) literal concept of God as a male human
13. Which of the following sets of terms best characterizes the school-aged child?
- A) reflexes, alert state, temperament
 - B) negativism, regression, anal stage
 - C) preoperational, asking why, fears
 - D) doing, succeeding, accomplishing
14. What social group prepares the school-aged child to get along in the larger world and teaches appropriate sex role behavior?
- A) parents
 - B) peers
 - C) siblings
 - D) grandparents



15. A student nurse reading a patient's chart notes that the physician has documented an adolescent as prepubescent. What does the term prepubescent mean?
- A) adult secondary sex characteristics are present
 - B) ova and sperm are produced by the reproductive organs
 - C) reproductive organs do not yet produce ova and sperm
 - D) active sexual behavior has been initiated
16. A 20-year-old college student is preparing for a career as a teacher. What need initially influences the decision to establish a career?
- A) overcoming low self-esteem
 - B) becoming independent of one's family
 - C) establishing one's own moral philosophy
 - D) demonstrating industry and spirituality
17. A nurse is teaching a young couple about the normal changes during pregnancy. What should be included in the teaching sessions about the expectant father's role?
- A) Nothing, the mother's preparation is more important.
 - B) In a traditional family, the mother is responsible for childcare.



- C) The importance of feeling pride as a future parent.
 - D) The provision of support in meeting maternal needs.
18. What is the primary risk to the developing fetus of cocaine use during pregnancy?
- A) decreased fetal circulation and oxygenation
 - B) increased maternal weight gain and edema
 - C) neural tube defects and low birth weight
 - D) respiratory difficulties and excess mucus
19. A nurse is teaching the parents of an infant about possible health problems during infancy. Which of the following health problems during infancy is most serious?
- A) colic
 - B) seborrheic dermatitis
 - C) failure to thrive
 - D) SIDS
20. A nurse is explaining ADHD to a community parents group. What characteristics of this disorder are exhibited by an affected child?



- A) daydreams, math difficulties, speech problems
 - B) inattention, impulsiveness, hyperactivity
 - C) enuresis, shyness, scoliosis
 - D) separation anxiety, reading difficulties, boredom
21. An adolescent patient tells the nurse, I just don't want to live anymore. What should the nurse do next?
- A) Document the adolescent's statement in the patient record.
 - B) Sit down and discuss all the reasons there are for living.
 - C) Make an immediate referral to a suicide-prevention professional.
 - D) Laughingly, teach the adolescent about making scary statements.
22. A mother of three children under the age of 4 tells the nurse, I don't understand why my children are so hard to toilet train before they are 2. How should the nurse respond?
- A) Bladder control during the day usually occurs by ages 2.5 to 3 years.
 - B) Do you think you are doing something wrong? They should be trained.
 - C) I don't know. I will have to talk to your doctor, and I will let you know.



- D) I had that same problem. You just have to try harder.
23. A nurse is teaching a group of expectant parents about infant safety. Which of the following is mandated by the law to promote infant safety?
- A) lowering temperatures on hot water heaters
 - B) covering electrical outlets with safety prongs
 - C) removing all cords from mini-blinds and drapes
 - D) using special car safety seats and restraints
24. A student nurse is assigned to care for a preschool child who is scheduled for surgery. How can the student decrease the child's fears about the surgery?
- A) Explain that nothing is going to hurt and that it will soon be over.
 - B) Be honest about pain and use words the child can understand.
 - C) Ask the child's parents to pretend that nothing is going to be done.
 - D) Ignore the child's fears and focus on teaching the parents.
25. Which of the following would be an appropriate topic for a nurse to present at an elementary school PTA meeting?
- A) prevention of congenital anomalies



- B) dangers of smoking and drinking during pregnancy
 - C) importance of bonding and attachment
 - D) commonality of communicable diseases
26. A young adult tells the nurse that he has been sexually active with his girlfriend. What teaching is most important for this individual?
- A) proper hygiene
 - B) condom use
 - C) relationships
 - D) stress
27. A school nurse is concerned about the almost skeletal appearance of one of the high school students. Although all of the following nutritional problems can occur in adolescents, which one is most often associated with a negative self-concept?
- A) eating fast foods
 - B) obesity
 - C) fad dieting
 - D) anorexia nervosa



Answer Key

1. A, E
2. A, B, C
3. C
4. D
5. D
6. B
7. B
8. A
9. D
10. B
11. A
12. C
13. D



14. B

15. C

16. B

17. D

18. A

19. D

20. B

21. C

22. A

23. D

24. B

25. D

26. B

27. D



Chapter 24: Middle and Older Adulthood

1. According to the free radical theory of aging, what substance is affected by aging and causes damage?
 - A) carbohydrates
 - B) proteins
 - C) water
 - D) lipids

2. Which aging theory describes a chemical reaction that produces damage to the DNA and cell death?
 - A) genetic theory
 - B) immunity theory
 - C) cross-linkage theory
 - D) free radical theory

3. According to Erikson, the middle adult is in a period of generativity versus stagnation. What happens if developmental tasks are not achieved?
 - A) physical changes are denied



- B) health needs become a major concern
 - C) motivation to learn is decreased
 - D) awareness of own mortality increases
4. A middle adult requests visits by the hospital chaplain and reads the Bible each day while hospitalized for treatment of heart problems. What is the individual illustrating?
- A) midlife transition
 - B) support of the rights of others
 - C) fear for the future
 - D) trust in spiritual strength
5. Which of the following are physical changes that occur in middle adulthood? Select all that apply.
- A) Body fat is redistributed.
 - B) The skin is more elastic.
 - C) Cardiac output begins to increase.
 - D) Muscle mass gradually decreases.



- E) There is a loss of calcium from bones.
 - F) Hormone production increases.
6. According to Havighurst, which of the following are developmental tasks of middle adulthood?
- A) Accept and adjust to physical changes.
 - B) Maintain a satisfactory occupation.
 - C) Assist children to become responsible adults.
 - D) Maintain social contacts and relationships.
 - E) Relate to ones spouse or partner as a person..
 - F) Be flexible and adapt to age-related roles.
7. While conducting a health assessment with an older adult, the nurse notices it takes the person longer to answer questions than is usual with younger patients. What should the nurse do?
- A) Stop asking questions so as not to confuse the patient.
 - B) Slow the pace and allow extra time for answers.
 - C) Realize that the patient has some dementia.



- D) Ask a family member to answer the questions.
8. A nurse says to an older adult who is being cared for at home, Tell me what your life was like when you were first married. What does this statement encourage the patient to do?
- A) Explain why he or she has certain emotions.
- B) Become more introspective and self-focused.
- C) Practice life review or reminiscence.
- D) Look backward with regret for undone tasks.
9. An older adult, newly widowed, has been unable to adjust to her change in roles or form new relationships. What is this experience called?
- A) social isolation
- B) social ineptness
- C) ineffective coping
- D) negativism of aging
10. What is one reason for the middle-aged spread often seen in middle adults?
- A) changes in hormones



- B) loss of satisfactory roles
 - C) decreased physical activity
 - D) satisfaction with ones life
11. A nurse teaches adults preventive measures to avoid problems of middle adult years. Which of the following are the major health problems during the middle adult years?
- A) cardiovascular disease, cancer
 - B) upper respiratory infections, fractures
 - C) communicable diseases, dementia
 - D) sexually transmitted diseases, drug abuse
12. Which of the following statements is true for nursing care of older adults?
- A) Most older adults are unable to care for themselves independently.
 - B) Most older adults are functional, benefiting from health-oriented interventions.
 - C) Fewer older adults will require nursing care during the 21st century.
 - D) Interventions for older adults are no different from those for young adults.



13. A nurse is developing a plan of care for an older adult with chronic heart disease. Which of the following factors must be considered?
- A) Family members do not need to be as involved in care of the older adult.
 - B) Almost 100% of all older adults have limitations from multiple chronic illnesses.
 - C) Few older adults want to maintain their health and independence.
 - D) Medications, hospitalizations, and medical supplies increase economic difficulties.
14. Mrs. Ash, an 88-year-old woman who lives alone, has deficits in vision and hearing. Her blood pressure medicine is making her dizzy. What response to these health problems would the home health nurse identify?
- A) decreased social interaction
 - B) altered consciousness
 - C) risk for accidental injury
 - D) risk for impaired judgment
15. The daughter of an older adult calls the nurse practitioner to report that her mother is becoming very confused after dark. What is this type of confusion named?
- A) night-time confusion



- B) sundowning syndrome
 - C) Alzheimers disease
 - D) cognitive dysfunction
16. During a health assessment, a 49-year-old woman tells the nurse that she is just so tired and has been having mood swings and hot flashes. Based on this information, the nurse would conduct a more thorough history and assessment of what body system?
- A) reproductive
 - B) cardiovascular
 - C) respiratory
 - D) cranial nerves
17. While caring for an elderly man, the nurse observes that his skin is dry and wrinkled, his hair is gray, and he needs glasses to read. Based on these observations, what would the nurse conclude?
- A) These are normal physiologic changes of aging.
 - B) The observations are not typically found in older adults.
 - C) These are abnormal observations and must be reported.



- D) Extra teaching will be necessary to prevent complications.
18. A teenager states, Old people are different. They don't need the same things that young people do. What is this statement an example of?
- A) racism
- B) ageism
- C) indifference
- D) knowledge
19. Which of the following statements is true of the older adult population?
- A) Old age begins at 65 years of age.
- B) Most older adults live in nursing homes.
- C) Older adults are not interested in sex.
- D) Incontinence is not a part of aging.
20. A nurse is teaching a group of middle adults about health promotion. What statement by one of the participants indicates the need for additional teaching?
- A) I will make exercise a part of my daily activities.



- B) I should eat a diet high in fats but low in fiber.
 - C) I will begin a smoking cessation program this week.
 - D) I only have one glass of wine a day with dinner.
21. In general, what is the focus of care for nurses who work with older adults?
- A) providing all necessary physical care
 - B) referring patients for needed emotional support
 - C) establishing goals and expected outcomes for the patient
 - D) assisting patients to function as independently as possible
22. Family members of older adults with limitations from chronic illnesses have many psychological stressors. Which of the following is not considered a change?
- A) assisting the older family member to function independently
 - B) coping with the physical and economic needs of the ill older adult
 - C) becoming a caregiver, with resultant changes in lifestyle
 - D) assuming a new role, such as providing care for a parent



23. A nurse is providing care to an older adult at home after major abdominal surgery. Which of the following nursing diagnoses would most likely be appropriate?
- A) Adult Failure to Thrive
 - B) Anticipatory Grieving
 - C) Impaired Memory
 - D) Risk for Infection
24. A nurse documents the following assessment on an elderly patients chart: dry, thin skin. Which of the following nursing diagnosis would be appropriate for this patient?
- A) risk for falls
 - B) risk for imbalanced body temperature
 - C) risk for infection
 - D) risk for sedentary lifestyle
25. An older adult lives in a facility that provides, housing, group meals, personal care and support, social activities, and minimal healthcare services. What type of facility does this describe?
- A) nursing home



- B) assisted living
- C) accessory apartment
- D) home modification

Answer Key

1. D
2. C
3. B
4. D
5. A, D, E
6. A, B, C, E
7. B
8. C
9. A
10. C



11. A

12. B

13. D

14. C

15. B

16. A

17. A

18. B

19. D

20. B

21. D

22. A

23. D

24. C



25. B



Chapter 25: Asepsis and Infection Control

1. Which of the following most accurately defines an infection?
 - A) an illness resulting from living in an unclean environment
 - B) the result of lack of knowledge about food preparation
 - C) a disease resulting from pathogens in or on the body
 - D) an acute or chronic illness resulting from traumatic injury

2. A patient who has had abdominal surgery develops an infection in the wound while still hospitalized. Which of the following agents is most likely the cause of the infection?
 - A) virus
 - B) bacteria
 - C) fungi
 - D) spores

3. A nurse caring for a patient who has gas gangrene knows that this infection originated in which of the following reservoirs?
 - A) other people



- B) food
 - C) soil
 - D) animals
4. A patient with an upper respiratory infection (common cold) tells the nurse, I am so angry with the nurse practitioner because he would not give me any antibiotics. What would be the most accurate response by the nurse?
- A) Antibiotics have no effect on viruses.
 - B) Let me talk to him and see what we can do.
 - C) Why do you think you need an antibiotic?
 - D) I know what you mean; you need an antibiotic.
5. A woman tests positive for the human immunodeficiency virus antibody but has no symptoms. She is considered a carrier. What component of the infection cycle does the woman illustrate?
- A) a reservoir
 - B) an infectious agent
 - C) a portal of exit
 - D) a portal of entry



6. A man on an airplane is sitting by a woman who is coughing and sneezing. If she has an infection, what is the most likely means of transmission from the woman to the man?
- A) direct contact
 - B) indirect contact
 - C) vectors
 - D) airborne route
7. A nurse is caring for an adolescent who is diagnosed with mononucleosis, commonly called the kissing disease. The nurse explains that the organisms causing this disease were transmitted by:
- A) direct contact.
 - B) indirect contact.
 - C) airborne route.
 - D) vectors.
8. Of all possible nursing interventions to break the chain of infection, which is the most effective?



- A) administering medications
 - B) providing good skin care
 - C) practicing hand hygiene
 - D) wearing gloves at all times
9. A nurse teaches a rural community group how to avoid contracting West Nile virus by using approved insect repellent and wearing proper coverings when outdoors. By what means is the pathogen involved in West Nile virus transmitted?
- A) direct contact
 - B) indirect contact
 - C) airborne route
 - D) vectors
10. Which of the following questions asked by the nurse when taking a patient's health history would collect data about infection control?
- A) Tell me what you eat in each 24-hour period.
 - B) Do you sleep well and wake up feeling healthy?
 - C) What were the causes of death for your family members?



- D) When did you complete your immunizations?
11. A college-aged student has influenza. At what stage of the infection is the student most infectious?
- A) incubation period
 - B) prodromal stage
 - C) full stage of illness
 - D) convalescent period
12. Which of the following are characteristics of the stage of infection known as full stage of illness? Select all that apply.
- A) It is the interval between the pathogens invasion of the body and the appearance of symptoms of infection .
 - B) The presence of specific signs and symptoms indicates the full stage of illness.
 - C) During the full stage of illness, the organisms are growing and multiplying.
 - D) The signs and symptoms disappear, and the person returns to a healthy state.
 - E) Early signs and symptoms of disease are present, but these are often vague and nonspecific.



- F) The type of infection determines the length of the illness and the severity of the manifestations.
13. Which of the following statements accurately describe a component of the inflammatory response? Select all that apply.
- A) The inflammatory response is a protective mechanism that eliminates the invading pathogen and allows for tissue repair to occur.
- B) Inflammation helps the body to neutralize, control, or eliminate the offending agent and to prepare the site for repair.
- C) The inflammatory response involves specific body responses to an invading foreign protein, such as bacteria, or in some cases, to the body's own proteins.
- D) The antigen-antibody reaction, also known as humoral immunity, is one component of the overall inflammatory response.
- E) The vascular and cellular stages are the main components of the inflammatory process and these physiological processes are responsible for the appearance of the cardinal signs.
- F) One of the first lines of defense against infection is the inflammatory response, which helps to keep potentially harmful bacteria from invading the body.
14. Which of the following is an example of the body's defense against infection?
- A) racial characteristics
- B) body shape and size



- C) immune response
 - D) level of susceptibility
15. A nurse has seen several patients at a community health center. Which of the patients would be most at risk for developing an infection?
- A) an older adult with several chronic illnesses
 - B) an infant who has just received first immunizations
 - C) an adolescent who had a basketball physical
 - D) a middle-aged adult with joint pain and stiffness
16. A patient comes to the emergency department with major burns over 40% of his body. Although all of the following are true, which one would provide the rationale for a nursing diagnosis of Risk for Infection?
- A) Stress may adversely affect normal defense mechanisms.
 - B) White blood cells provide resistance to certain pathogens.
 - C) Intact skin and mucous membranes protect against microbial invasion.
 - D) Age, race, sex, and hereditary factors influence susceptibility to infection.
17. A nurse is teaching adolescents how to prevent infections. What statement by one of the adolescents indicates that more teaching is needed?



- A) I will wash my hands before and after going to the bathroom.
 - B) I don't wear a condom when I have sex, but I know my partners.
 - C) I always eat fruits and vegetables, and I sleep 8 hours a night.
 - D) When I have an infection, I rest and take my medications.
18. Mrs. Treem is on isolation because she acquired a methicillin-resistant *S. aureus* (MRSA) infection after hospitalization for hip replacement surgery. What name is given to this type of infection?
- A) nosocomial
 - B) viral
 - C) iatrogenic
 - D) antimicrobial
19. The following procedures have been ordered and implemented for a hospitalized patient. Which procedure carries the greatest risk for a nosocomial infection?
- A) enema
 - B) intramuscular injections
 - C) heat lamp



- D) urinary catheterization
20. A nursing home recently has had a significant number of nosocomial infections. Which of the following measures might be instituted to decrease this trend?
- A) mandating antibiotics for all nursing home residents
- B) having written infection-prevention practices for all employees
- C) requiring all employees to have monthly screenings for skin flora
- D) restricting visitors and community activities for residents
21. What are the recommended cleansing agents for hand hygiene in any setting when the risk of infection is high?
- A) liquid or bar hand soap
- B) cold water
- C) hot water
- D) antimicrobial products
22. A nurse has completed morning care for a patient. There is no visible soiling on her hands. What type of technique is recommended by the CDC for hand hygiene?
- A) Do not wash hands, apply clean gloves.



- B) Wash hands with soap and water.
 - C) Clean hands with an alcohol-based handrub.
 - D) Wash hands with soap and water, follow with handrub.
23. How long should a healthcare worker scrub hands that are not visibly soiled for effective hand hygiene?
- A) 15 seconds
 - B) 30 seconds
 - C) 1 minute
 - D) 5 minutes
24. Which of the following statements is true of healthcare personnel and good hand hygiene?
- A) Hand hygiene is carefully followed.
 - B) Compliance is difficult to achieve.
 - C) Only nurses need to practice hand hygiene.
 - D) Wearing gloves reduces the need for hand hygiene.



25. A home health nurse is completing a health history for a patient. What is one question that is important to ask to identify a latex allergy for this patient?
- A) Have you ever had an allergic reaction to shellfish or iodine?
 - B) Tell me what you use to wash your hands after toileting.
 - C) When you were a child, did you have frequent infections?
 - D) Have you had any unusual symptoms after blowing up balloons?
26. A nurse is caring for a patient with a serious bacterial infection. The patient is dehydrated. Knowledge of the physical effects of the infection would support which of the following nursing diagnoses?
- A) High Risk for Infection
 - B) Excess Fluid Volume
 - C) Risk for Imbalanced Body Temperature
 - D) Risk for Latex Allergy Response
27. What is the correct rationale for using body substance precautions?
- A) The risk of transmitting HIV in sputum and urine is nonexistent.



- B) Disease-specific isolation procedures are adequate protection.
 - C) Only actively infected patients are considered contagious.
 - D) All body substances are considered potentially infectious.
28. The latest CDC guidelines designate standard precautions for all substances except which of the following?
- A) urine
 - B) blood
 - C) sweat
 - D) vomitus
29. A student nurse is performing a urinary catheterization for the first time and inadvertently contaminates the catheter by touching the bed linens. What should the nurse do to maintain surgical asepsis for this procedure?
- A) Nothing, because the patient is on antibiotics.
 - B) Complete the procedure and then report what happened.
 - C) Apologize to the patient and complete the procedure.
 - D) Gather new sterile supplies and start over.



30. A nurse is performing a sterile dressing change. If new sterile items or supplies are needed, how can they be added to the sterile field?
- A) with sterile forceps or hands wearing sterile gloves
 - B) by carefully handling them with clean hands
 - C) with clean forceps that touch only the outermost part of the item
 - D) by clean hands wearing clean latex gloves
31. A nurse is positioning a sterile drape to extend the working area when performing a urinary catheterization. Which of the following is an appropriate technique for this procedure?
- A) Use sterile gloves to handle the entire drape surface.
 - B) Fold the lower edges of the drape over the sterile-gloved hands.
 - C) Touch only the outer 2 inches of the drape when not wearing sterile gloves.
 - D) When reaching over the drape do not allow clothing to touch the drape.

Answer Key

- 1. C
- 2. B



3. C
4. A
5. A
6. D
7. A
8. C
9. D
10. D
11. B
12. B, F
13. A, B, E
14. C
15. A
16. C



17. B

18. A

19. D

20. B

21. D

22. C

23. A

24. B

25. D

26. C

27. D

28. C

29. D

30. A



31. A



Chapter 26: Vital Signs

1. A nurse takes a patients vital signs. Which of the following is considered a vital sign?
 - A) mental status
 - B) visual acuity
 - C) blood pressure
 - D) urinary output

2. Which of the following patients should have their vital signs monitored at least every 4 hours?
 - A) a patient in a critical care unit
 - B) a patient hospitalized for high blood pressure
 - C) a resident in a long-term care facility
 - D) a long-term care resident on Medicare A

3. In which of the following situations is it protocol for the nurse to take a patients vital signs? Select all that apply.
 - A) upon admitting a patient to a hospital



- B) at a healthcare screening
 - C) when medications are given for a cardiac arrhythmia
 - D) following a diagnostic procedure
 - E) prior to an invasive procedure
 - F) when daily medications are dispensed
4. A nurse has an order to take the core temperature of a patient. At which of the following sites would a core body temperature be measured?
- A) tympanic
 - B) oral
 - C) axillary
 - D) skin surface
5. Which of the following is the primary source of heat in the body?
- A) hormones
 - B) metabolism
 - C) blood circulation



- D) muscles
6. A nurse places a fan in the room of a patient who is overheated. This is an example of heat loss related to which of the following mechanisms of heat transfer?
- A) evaporation
- B) radiation
- C) conduction
- D) convection
7. Which of the following is an average normal temperature in Centigrade for a healthy adult?
- A) oral: 37.0C
- B) rectal: 36.5C
- C) axillary: 37.5C
- D) tympanic: 34.4C
8. What anatomic site regulates the pulse rate and force?
- A) thermoregulatory center



- B) cardiac sinoatrial node
 - C) cardiac atria and valves
 - D) peripheral chemoreceptors
9. A patient is constipated and trying to have a bowel movement. How does holding the breath and pushing down (the Valsalva maneuver) affect the pulse?
- A) left ventricle pumps more forcefully; pulse is stronger
 - B) stimulates the vagus nerve to increase the rate
 - C) stimulates the vagus nerve to decrease the rate
 - D) right ventricle is less efficient; pulse is thready
10. The arterial blood gases for a patient in shock demonstrate increased carbon dioxide and decreased oxygen. What type of respirations would the nurse expect to assess based on these findings?
- A) absent and infrequent
 - B) shallow and slow
 - C) rapid and deep
 - D) noisy and difficult



11. A nurse walks into a patient's room and finds him having difficulty breathing and complaining of chest pain. He has bradycardia and hypotension. What should the nurse do next?
- A) Take vital signs again in 15 to 30 minutes.
 - B) Document the data and report it later.
 - C) Ask the patient if he is anxious or afraid.
 - D) Report findings to the physician immediately.
12. Which of the following pathologic conditions would result in release of ADH by the posterior pituitary?
- A) hemorrhage
 - B) allergies
 - C) obesity
 - D) asthma
13. A student is reading the medical record of an assigned patient and notes the patient has been afebrile for the past 12 hours. What does the term afebrile indicate?
- A) normal body temperature
 - B) decreased body temperature



- C) increased body temperature
- D) fluctuating body temperature
14. A nurse is assessing a patient who has a fever, has an infection of a flank incision, and is in severe pain. What type of pulse rate would be likely?
- A) bradycardia
- B) tachycardia
- C) dysrhythmia
- D) bigeminal
15. While assessing vital signs of a patient with a head injury and increased intracranial pressure (IICP), a nurse notes that the patients respiratory rate is 8 breaths/min. How will the nurse interpret this finding?
- A) bradypnea is uncommon in patient with IICP
- B) IICP most commonly results in tachypnea
- C) bradypnea is a response to IICP
- D) this is a normal respiratory rate
16. A nurse is conducting a health history for a patient with a chronic respiratory problem. What question might the nurse ask to assess for orthopnea?



- A) Do you have problems breathing when you walk up stairs?
 - B) Does your medication help you breathe better?
 - C) How many pillows do you sleep on at night to breathe better?
 - D) Tell me about your breathing difficulties since you stopped smoking.
17. What population is at greatest risk for hypertension?
- A) Hispanic
 - B) White
 - C) Asian
 - D) African American
18. A middle-aged, overweight adult man has had hypertension for 15 years. What pathologic event is he most at risk for?
- A) stroke
 - B) anemia
 - C) cancer



- D) infection
19. A nurse educator is teaching a patient about a healthy diet. What information would be included to reduce the risk of hypertension?
- A) Eat a diet high in fruits and vegetables.
- B) Remember to drink 8 to 10 glasses of water a day.
- C) It is important to have increased fats in your diet.
- D) Put away the salt shaker and eat low-salt foods.
20. A nurse is caring for a patient who is ambulating for the first time after surgery. Upon standing, the patient complains of dizziness and faintness. The patient's blood pressure is 90/50. What is the name for this condition?
- A) orthostatic hypotension
- B) orthostatic hypertension
- C) ambulatory bradycardia
- D) ambulatory tachycardia
21. What site for taking body temperature with a glass thermometer is contraindicated in patients who are unconscious?
- A) rectal



- B) tympanic
 - C) oral
 - D) axillary
22. A patient has been diagnosed with peripheral vascular disease of the lower extremities. What site would the nurse use to assess circulation of the legs?
- A) radial artery
 - B) dorsalis pedis artery
 - C) temporal artery
 - D) carotid artery
23. A nurse is taking a patient's temperature and wants the most accurate measurement, based on core body temperature. What site should be used?
- A) rectal
 - B) oral
 - C) axillary
 - D) forehead



24. A student nurse assesses a blood pressure on an adult and finds it to be 140/86. What term is used for the top number (140)?
- A) systolic pressure
 - B) diastolic pressure
 - C) pulse pressure
 - D) hypotension
25. A hospital unit has a policy that rectal temperatures may not be taken on patients who have had cardiac surgery. What rationale supports this policy?
- A) It is an embarrassing and painful assessment.
 - B) Thermometer insertion stimulates the vagus nerve.
 - C) It is less expensive to take oral temperatures.
 - D) It is to avoid perforating the wall of the rectum.
26. As adults age, the walls of their arterioles become less elastic, increasing resistance and decreasing compliance. How does this affect the blood pressure?
- A) The blood pressure does not change.
 - B) The blood pressure is erratic.



- C) The blood pressure decreases.
 - D) The blood pressure increases.
27. What equipment is needed to take an apical pulse?
- A) sphygmomanometer
 - B) electronic thermometer
 - C) stethoscope
 - D) no specific equipment
28. Two nurses collaborate in assessing an apical-radial pulse on a patient. The pulse deficit is 16 beats/min. What does this indicate?
- A) The radial pulse is more rapid than the apical pulse.
 - B) This is a normal finding and should be ignored.
 - C) The patient's arteries are very compliant.
 - D) Not all of the heartbeats are reaching the periphery.
29. A nurse is assessing the blood pressure on an obese woman. What error might occur if the cuff used is too narrow?



- A) reading is erroneously high
 - B) reading is erroneously low
 - C) pressure on the cuff will be painful
 - D) it will be difficult to pump up the bladder
30. Various sounds are heard when assessing a blood pressure. What does the first sound heard through the stethoscope represent?
- A) systolic pressure
 - B) diastolic pressure
 - C) auscultatory gap
 - D) pulse pressure
31. An adult patient is assessed as having an apical pulse of 140. How would the nurse document this finding?
- A) bradycardia
 - B) tachycardia
 - C) dysrhythmia



- D) normal pulse
32. A patient in a physicians office has a single blood pressure (BP) reading of 150/92. Should the patient be taught about hypertension?
- A) It depends on the time of day the BP was taken.
- B) It depends on whether the patient is male or female.
- C) No, a single BP reading should not be used.
- D) Yes, this reading is high enough to be significant.
33. All of the following patients have a body temperature of 38C (100.4F). About which patient would a nurse be most concerned?
- A) an older adult
- B) a pregnant adolescent
- C) a junior high football player
- D) a 2-month-old infant
34. A home healthcare nurse notices that his assigned patient uses a mercury thermometer. He asks the nurse what to do if it breaks. Which of the following is **not** correct?



- A) Just flush the glass and mercury down the toilet.
- B) Do not vacuum the area where it breaks.
- C) Open the windows and close off the room for an hour.
- D) Throw away any clothing exposed to the mercury.

Answer Key

- 1. C
- 2. B
- 3. A, B, C, D, E
- 4. A
- 5. B
- 6. D
- 7. A
- 8. B
- 9. C



10. C

11. D

12. A

13. A

14. B

15. C

16. C

17. D

18. A

19. D

20. A

21. C

22. B

23. A



24. A

25. B

26. D

27. C

28. D

29. A

30. A

31. B

32. C

33. D

34. A



Chapter 27: Health Assessment

1. Conducting a health assessment involves collecting, validating, and analyzing subjective data and objective data. Which of the following is an example of subjective data?
 - A) pain
 - B) rash
 - C) perspiration
 - D) fever
2. A nurse is conducting a health assessment. How will the information collected from the patient be used?
 - A) as a basis for the nursing process
 - B) to illustrate nursing competence
 - C) to facilitate nursepatient caring
 - D) as one component of medical care
3. A home health nurse is visiting a patient who recently was hospitalized for repair of a fractured hip. The patient tells the nurse, I have had a lot of pain in my abdomen. What type of assessment would the nurse conduct?



- A) comprehensive
 - B) ongoing partial
 - C) focused
 - D) emergency
4. An adolescent comes to a community health clinic with complaints of vaginal itching and discharge. She believes it is from having sex with her boyfriend. Which of the following responses should the nurse use during the health history to elicit information?
- A) Tell me about sexual activity with your boyfriend.
 - B) Why did you ever have sex with someone you dont know?
 - C) You are old enough to know to use condoms.
 - D) I dont understand how you could be so careless.
5. A nurse is preparing a patient for a physical assessment. The patient appears anxious about the assessment. Which statement by the nurse would be most appropriate?
- A) This is nothing to worry about. I wont hurt you.
 - B) Some of the examination may be painful, but I will be gentle.
 - C) Let me tell you what I will be doing. It should not be painful.



- D) I have to do this, so just relax and it wont last long.
6. What would a nurse ensure before beginning a health assessment?
- A) that the time needed for the assessment fits into the nurses work schedule
 - B) that the room is private, quiet, warm, and has adequate light
 - C) that family members are present to answer specific questions
 - D) that there is a written physicians order for the assessment
7. A nurse working in a clinic is planning to conduct vision screenings for a group of low-income women. What equipment would be needed to test vision?
- A) Snellen chart
 - B) stethoscope
 - C) ophthalmoscope
 - D) otoscope
8. When using assessment equipment that will touch the patient, what should the nurse do before conducting the assessment?
- A) Describe the equipment and how it works.



- B) Show pictures of functions of the equipment.
 - C) Draw pictures of the anatomy to be assessed.
 - D) Warm the equipment with hands or warm water.
9. A school nurse is preparing to test the auditory function of grade school students. What equipment will be needed for this examination?
- A) tuning fork
 - B) percussion hammer
 - C) speculum
 - D) ophthalmoscope
10. A nurse is preparing to examine the breasts of a patient. In what position should the nurse place the patient?
- A) prone
 - B) standing
 - C) dorsal recumbent
 - D) lithotomy



11. Which of the following positions should not be used to assess the abdomen?
- A) supine
 - B) dorsal recumbent
 - C) kneechest
 - D) Sims
12. A nurse is using inspection as an assessment technique. What does the nurse use during inspection?
- A) equipment such as a stethoscope
 - B) both hands to produce sounds
 - C) light palpation to detect surfaces
 - D) senses of vision, hearing, smell
13. Which of the following can a nurse assess by palpation?
- A) heart sounds, lung sounds, blood pressure
 - B) temperature, turgor, moisture



- C) vision, hearing, cranial nerves
 - D) tissue density, gait, reflexes
14. A nurse is conducting a physical examination and is percussing the gastric area of a patient. What percussion tone is normally heard in this area?
- A) flat
 - B) dull
 - C) resonant
 - D) tympany
15. When auscultating a patient's abdomen, a nurse notes gurgling sounds. What characteristic of sound would the nurse document?
- A) resonance
 - B) turgor
 - C) quality
 - D) texture
16. A nurse is performing a general survey of a patient admitted to the hospital. Which of the following actions is an element of this procedure?



- A) taking vital signs
 - B) palpating the integument
 - C) identifying risk factors for altered health
 - D) assessing the head and neck
17. When inspecting the skin of a patient, the nurse notes a bluish tinge to the skin. What condition would the nurse document?
- A) jaundice
 - B) cyanosis
 - C) erythema
 - D) pallor
18. The nurse palpating the skin of a patient documents a firm 1.5 cm mass on the lower right leg. What type of skin lesion does this describe?
- A) macule
 - B) wheal
 - C) vesicle



- D) nodule
19. A nurse assesses a patient's eyes by testing the cardinal fields of vision for coordination and alignment. What eye characteristic is being assessed by this process?
- A) visual acuity
- B) extraocular movements
- C) peripheral vision
- D) existence of cataracts
20. A nurse performing physical assessments of residents in a long-term care facility describes to the student nurse common head and neck variations in the older adult. Which of the following accurately defines these variations? Select all that apply.
- A) decreased color vision and peripheral vision
- B) increased adaptation to light and dark
- C) a blue ring around the cornea (arcus senilis)
- D) entropion and ectropion
- E) impaired conductive hearing
- F) larger, more easily palpated lymph glands



21. While conducting a physical examination of the thorax, a nurse notes and documents breath sounds as moderate blowing sounds with equal inspiration and expiration. What type of breath sounds are these?
- A) bronchial
 - B) bronchovesicular
 - C) vesicular
 - D) adventitious
22. A nurse is conducting a health assessment for an African American patient. What should the nurse consider in terms of cultural sensitivity?
- A) All individuals, regardless of culture, have the same anatomy and physiology.
 - B) asking specific questions about race during the health history
 - C) cultural risk factors for alterations in health and normal racial variations
 - D) differences in emotional, social, and spiritual basic human needs
23. When conducting a physical assessment, what should the nurse assess and document about size and shape of body parts?
- A) actual measurements in centimeters
 - B) symmetry (comparison of bilateral body parts)



- C) indications of general health status
 - D) vital signs of all extremities (arms and legs)
24. A nurse is inspecting the ear canals and tympanic membranes of an 18-month-old child. How would the pinna be moved to achieve better visualization?
- A) There is no need to move the pinna.
 - B) Gently pull the pinna up and back.
 - C) Gently pull the pinna down and back.
 - D) Pull the pinna parallel to the side of the head.
25. While assessing breath sounds, a nurse hears crackles. What causes these abnormal sounds?
- A) air in the lungs
 - B) a narrowing of the upper airway
 - C) narrowed small air passages
 - D) moisture in air passages
26. When assessing the abdomen, which assessment technique is used last?



- A) inspection
- B) auscultation
- C) percussion
- D) palpation

27. What is one purpose of documentation of the health assessment?

- A) to identify the nurses role in healthcare
- B) to identify actual and potential health problems
- C) to expand nursing knowledge and skills
- D) to provide a basis for evidence-based nursing

28. While giving a patient a bath, a student nurse observes the color of the patients skin as having a yellowish tinge. What term would be used to document this assessment?

- A) cyanosis
- B) pallor
- C) jaundice



D) erythema

29. A nurse is preparing a patient for a barium enema. Which one of the following is a nurses responsibility for diagnostic procedures and tests?

A) writing the order for the procedure or test

B) delegating care during a procedure to others

C) ensuring results of diagnostic tests are recorded

D) providing emotional and physical preparation

Answer Key

1. A

2. A

3. C

4. A

5. C

6. B

7. A



8. D
9. A
10. C
11. B
12. D
13. B
14. D
15. C
16. A
17. B
18. D
19. B
20. A, D, E
21. B



22. C

23. B

24. C

25. D

26. D

27. B

28. C

29. D



Chapter 28: Safety, Security, and Emergency Preparedness

1. What generalization can be made about safety in patient care?
 - A) Healthcare providers exclude safety as a patient need.
 - B) Although safety is a basic human need, it is provided by self-care.
 - C) Safety is an important need, but not as important as self-actualization.
 - D) Safety is a paramount concern underlying all nursing care.

2. A nurse making a home visit for a patient living in a high-crime area observes that the apartment building does not have outside lighting. Why is this an important assessment?
 - A) It will make the patient less able to go to social gatherings.
 - B) Assessment includes risk factors in the home.
 - C) Although important, this assessment is irrelevant to care.
 - D) Nurses in home healthcare are not concerned with safety.

3. Which of the following are examples of developmental risk factors? Select all that apply.



- A) A toddler is allowed to crawl in a house that has not been childproofed.
 - B) A machinist works in an environment that exposes him to loud noises.
 - C) A sales executive worries that he won't make his yearly sales quota.
 - D) An elderly woman in a long-term healthcare facility is at high risk for falls.
 - E) A 42-year-old woman is unable to move her left side following a stroke.
 - F) A teenager has difficulty ambulating following multiple fractures from a MVA.
4. A patient is very anxious and states, I am so stressed. Why do these factors affect the patient's safety?
- A) stress increases retention of information
 - B) stress affects interpersonal relationships
 - C) stress increases concern about hazards
 - D) stress tends to narrow the attention span
5. A nurse is assessing a patient who recently had a stroke. What is one area of assessment necessary to promote safety?
- A) skin integrity



- B) neuromuscular status
 - C) hygiene
 - D) abdominal integrity
6. A patient with type 1 diabetes has impaired sensation in her lower extremities. What teaching would be necessary to reduce her risk of injury?
- A) Always test the temperature of bath water before stepping in.
 - B) Take your insulin twice a day as we have discussed.
 - C) Remember to follow your diet so you lose weight this month.
 - D) Rub lotion on the skin of your legs and feet twice a day.
7. Which of the following people is at greater risk for accidental injury?
- A) an infant just learning to crawl
 - B) an older adult who walks 2 miles a day
 - C) an athlete who exercises on a regular basis
 - D) a worker who operates industrial machines



8. What age group is most vulnerable to toxic fumes or asphyxiation?
- A) young children
 - B) adolescents
 - C) young adults
 - D) middle adults
9. Which of the following nursing diagnoses would be appropriate for teaching interventions for a single mother who leaves her toddler unattended in the bathtub?
- A) Noncompliance
 - B) Risk for Suffocation
 - C) Risk for Falls
 - D) Risk for Imbalanced Body Temperature
10. A confused elderly woman who keeps attempting to remove tubes from her surgical incision is placed in wrist restraints. Which of the following diagnoses would be appropriate for this patient?
- A) Risk for Contamination
 - B) Risk for Trauma



- C) Risk for Falls
 - D) Risk for Disuse Syndrome
11. Which set of terms best describes first-aid care?
- A) long-term, chronic illness
 - B) professional, hospital
 - C) immediate, temporary
 - D) skilled, complex
12. A nurse is conducting a prenatal class for expectant parents. What is one topic that should be addressed to promote safety in the developing fetus?
- A) alcohol consumption and smoking
 - B) infant hygiene and feeding
 - C) the stages of labor with possible complications
 - D) the role of the father in proper prenatal care
13. What safety device for children is mandated by law in all 50 states?
- A) bumper pads in baby cribs



- B) infant car seats and carriers
 - C) automatic hot water heater controls
 - D) parental controls for Internet access
14. An emergency room nurse is assessing a toddler with multiple bruises and burns. The nurse suspects the toddler has been abused. What is legally required of the nurse?
- A) Nothing; the nurse has no control over the toddlers home.
 - B) Refer the caregivers of the toddler to a home health nurse.
 - C) Verbally confront the caregivers about the suspicions.
 - D) Report suspicions about the abuse to proper authorities.
15. A grade school nurse is addressing parents at a PTA meeting regarding car safety. Which of the following is a recommended safety guideline for this age group?
- A) All school-aged children need to be secured in safety seats.
 - B) Booster seats should be used for children until they are 4-feet 9-inches tall or at least 8 years of age.
 - C) Children under 8 years old should ride in the back seat.
 - D) All school-aged children need to be secured in lap seat belts.



16. An adolescent has recently had a ring inserted into her navel. What is the adolescent at risk for developing?
- A) a scar over the navel
 - B) a local and/or systemic infection
 - C) a greater acceptance by peers
 - D) a strained relationship with parents
17. A nurse is teaching parents about Internet safety for their children. Which of the following are recommended guidelines for Internet use? Select all that apply.
- A) Keep identifying information posted on the Web sites.
 - B) Use filtering software to block objectionable information.
 - C) Investigate any public chat rooms used by the children.
 - D) Emphasize that everything read online is usually true.
 - E) Be alert for downloaded files with suffixes that indicate images or pictures.
 - F) Consider locating the computer in a central location in the house.
18. A nurse specializes in caring for victims of domestic violence. Which of the following statements accurately describes domestic violence in the United States? Select all that apply.



- A) Studies indicate that each year, more than 2,000,000 adults in the United States are victims of intimate partner violence.
 - B) Intimate partner violence is domestic violence or battering between two people who are married.
 - C) More than 85% of those abused in intimate partner violence are women.
 - D) Many men who batter their spouses also batter their children.
 - E) There is no evidence linking childhood sexual abuse to adult physical symptoms or substance abuse.
 - F) Nurses are advised to suggest other resources for the victims of violence instead of providing their own counseling.
19. Nurses provide many interventions to prevent falls in healthcare settings. Which of the following would be an appropriate fall-prevention intervention?
- A) Keep bed in the high position.
 - B) Keep side rails up at all times.
 - C) Apply restraints to all confused patients.
 - D) Lock wheels on beds and wheelchairs.
20. A nurse has conducted a timed get up and go test to assess an older adults risk for a fall. The patient completes the test in 30 seconds. Based on the finding, what will the nurse do?



- A) Continue with the plan of care for this fully mobile patient.
 - B) Document the time of the test and observe the patient.
 - C) Develop a care plan for Impaired Physical Mobility.
 - D) Maintain the patient on bedrest to prevent falling.
21. An elderly woman in a long-term care facility has fallen and sustained several injuries. Which of her injuries would be the most serious fall-related injury?
- A) fractured hip
 - B) fractured ulna
 - C) lacerated lip
 - D) thigh contusion
22. The nurse is following the Joint Commissions national patient safety goals when giving medications. Based on these goals, how can the nurse improve the accuracy of patient identification?
- A) Use two patient identifiers (neither to be the room number).
 - B) Use two patient identifiers (one may be the room number).
 - C) Check the patients armband three times.



- D) Say to the patient are you Mrs. Jones?
23. A nurse makes a medication error and fills out an incident report. What will the nurse do with the incident report once it is filled out?
- A) Place it in the patients medical record.
- B) Take it home and keep it locked up.
- C) Maintain it according to agency policy.
- D) Include it with documentation of the error.
24. In what situation would the use of side rails not be considered a restraint?
- A) The nurse keeps them raised at all times.
- B) The institutions policies mandate using side rails.
- C) A visitor requests their use.
- D) A patient requests they be up at night.
25. *Bioterrorism* has become a commonly used term. What is the definition of bioterrorism?
- A) a verbal threat by those wishing to harm specific individuals



- B) a written threat calculated to produce terror in a family
 - C) the deliberate spread of pathogens into a community
 - D) a worldwide plan to produce illness and injury
26. A patient arrives at the Emergency Department with nausea, hematemesis, fever, abdominal pain, and severe diarrhea. There is a suspicion the patient has been exposed to the anthrax bacillus. What category of medications will be administered?
- A) antimicrobials
 - B) narcotics
 - C) antihistamines
 - D) antacids
27. If an individual has smallpox, how would it most likely be spread?
- A) fecal-oral route
 - B) direct contact
 - C) contaminated items
 - D) by birds



28. Which of the following is an example of a natural disaster?
- A) toxic spill
 - B) war
 - C) terrorist event
 - D) earthquake
29. When should a healthcare facility determine how to deliver care if an emergency or disaster occurs?
- A) as soon as the disaster is announced publicly
 - B) when it is officially informed that a disaster has occurred
 - C) after the first disaster has been experienced
 - D) in advance of a possible emergency or disaster
30. What statement by a patient would indicate that a nurse had successfully implemented a teaching/learning strategy to prevent injury in the home?
- A) I will turn off the outside lights and lock the doors every night.
 - B) Do you think it would be best for me to buy a gun?



C) I am going to remove all those throw rugs on the floor.

D) Well, I always let the boys play in the bathtub; they love it.

Answer Key

1. D

2. B

3. A, D

4. D

5. B

6. A

7. D

8. A

9. B

10. D

11. C



12. A
13. B
14. D
15. B
16. B
17. B, E, F
18. A, C, D
19. D
20. C
21. A
22. A
23. C
24. D
25. C



26. A

27. B

28. D

29. D

30. C



Chapter 29: Complementary and Integrative Health

1. A 35-year-old woman diagnosed with diabetes tells her nurse that she would be interested in finding out about complementary therapies that are available. What would be the nurses best response to this patient?
 - A) It is best to stick with allopathic medicine when dealing with diabetes.
 - B) Complementary therapies are not available for this disease state.
 - C) Complementary therapies are not covered by your insurance plan.
 - D) Complementary therapies are being used as an answer to the problem of chronic illness.

2. A nurse attempts to integrate complementary and alternative therapies (CAT) into nursing practice. Which of the following are basic principles of CAT? Select all that apply.
 - A) Illness occurs in either the mind or the body, which are separate entities.
 - B) Health is the absence of disease.
 - C) Health is a state characterized by a dynamic balance of mind, body, and spirit.
 - D) Illness is a manifestation of imbalance or disharmony and is a process.
 - E) Curing is accomplished by external agents.



- F) Healing is a natural, slow process that involves the body, mind, and spirit.
3. A nurse practices holistic patient care. Which of the following is a guiding principle of this practice?
- A) Holism is focused on reductionism.
- B) All living organisms exist independently.
- C) The body is the sum of its parts.
- D) The body is a unified, dynamic whole.
4. Which of the following nursing actions is an example of using integrative care?
- A) A nurse instructs a laboring woman to use breathing exercises and assists with the administration of an epidural for her pain.
- B) A nurse monitors the heartbeat of a fetus and charts the height of the mother's fundus on the medical record.
- C) A nurse provides music therapy along with relaxation techniques for residents of a long-term facility.
- D) A nurse performing a home assessment of an elderly patient recommends a referral to social services.
5. A young mother experiences nausea and diarrhea when stressed. What mindbody messenger is believed to be responsible for these responses?



- A) reproductive hormones
 - B) white blood cells
 - C) neuropeptides
 - D) pancreatic insulin
6. Which of the following populations are more inclined to use CAT? Select all that apply.
- A) women
 - B) adults aged 20 to 30
 - C) people living in the east
 - D) former smokers
 - E) adults who are poor
 - F) adults with higher levels of education
7. A nurse caring for a patient who is in pain following abdominal surgery investigates the use of CAT for pain. Which of the following modalities could be used to relieve this patients pain? Select all that apply
- A) massage



- B) acupuncture
 - C) guided imagery
 - D) Ayurveda
 - E) yoga
 - F) shamanism
8. Which of the following complementary and alternative therapies is based on the belief of supporting the body while the symptoms are allowed to run their course.
- A) homeopathy
 - B) qi Gong
 - C) traditional Chinese medicine
 - D) Ayurveda
9. A patient with rheumatoid arthritis complains of soreness in his joints. Which of the following homeopathic remedies might the nurse recommend for this patient?
- A) arnica
 - B) calendula



- C) nux vomica
 - D) ignatia
10. A nurse uses Therapeutic Touch to decrease a postoperative patients nausea. Which of the following is a principle of this CAT modality?
- A) A human being is a closed energy system.
 - B) A human being is bilaterally asymmetric.
 - C) Illness is an imbalance in a persons energy field.
 - D) Humans do not have the ability to transform.
11. What is the ultimate goal of increasing the parasympathetic system influence on the body through relaxation or meditation?
- A) stimulate improved gastrointestinal function
 - B) increase cardiac output and blood pressure
 - C) facilitate respiratory function and cough
 - D) reduce the effects of stress on the body
12. A nurse who is a traditional Chinese medicine practitioner is providing home care to a patient who also uses traditional Chinese medicine for healthcare. What specific assessments would the nurse make?



- A) tongue and pulses
 - B) abdominal muscles and respirations
 - C) muscle tone and cranial nerves
 - D) vision and hearing
13. A patient interested in acupuncture asks a nurse, Just exactly what does it do? What would the nurse explain?
- A) Acupuncture is based on a philosophy of laying on of hands.
 - B) I dont think it does anything, so I dont know anything about it.
 - C) It uses a manual process of adjusting the spine.
 - D) It changes the flow of energy and helps healing.
14. A nurse is applying healing touch to a postoperative patients wound. What benefits of healing touch would the nurse tell the patients family?
- A) It will decrease the need for fluids after surgery.
 - B) It will help your family relationships.
 - C) It will help the wound heal.



- D) It will improve the nursepatient relationship.
15. A nurse is teaching a patient about the proper use of herbs and supplements. Which of the following statements would be included?
- A) Look on the Internet for the products you want to try.
- B) The federal government regulates supplements.
- C) It doesnt matter how much you take.
- D) The product may take a longer time to be effective.
16. A patient is taking ginkgo biloba, a botanical supplement. She asks the nurse if it would be safe to take aspirin for her arthritis at the same time. The nurses response is based on what knowledge?
- A) Ginkgo biloba affects platelet function and should not be taken with aspirin.
- B) Aspirin will not have any effect if taken at the same time as ginkgo biloba.
- C) Ginkgo biloba does not have any effect on the blood, so it is safe.
- D) Ginkgo biloba has an anticoagulant effect and aspirin decreases clotting.
17. What is one belief of Native American healing practices?
- A) Modern life facilitates potential healing agents.



- B) Healing takes time, time contributes to healing.
 - C) A balance of yin and yang is important to health.
 - D) Energy flows through meridians throughout the body.
18. Which of the following essential oils can be used during aromatherapy to treat nausea?
- A) lavender
 - B) garlic
 - C) parsley
 - D) peppermint
19. A nurse is conducting a health history and asks the patient about use of complementary and alternative therapies (CAT) to treat her chronic headaches. What response would require further questions?
- A) I practice meditation.
 - B) I use relaxation to help me go to sleep.
 - C) Each week, I have a total body massage.
 - D) I take herbs to treat my headaches.



20. What philosophy underlies the use of CAT?
- A) The mind, body, and spirit function as a unified whole.
 - B) The mind and the body are separate and distinct.
 - C) Parts of an organism rarely interact or change.
 - D) Traditional medicine is most effective for chronic illnesses.
21. A nurse practitioner uses integrative care in his practice. What does this mean?
- A) He uses allopathic medicine to treat all patients.
 - B) He uses both allopathic medicine and CAT.
 - C) The nurse uses CAT, a physician-prescribed medication.
 - D) The nurse provides care for patients of all age groups.
22. A nurse is practicing imagery to relieve stress. What might accompany the imagery to even further promote relaxation?
- A) bright lighting
 - B) bodywork techniques
 - C) talking on the phone



- D) listening to music
23. A nurse listens to a tape of humorous stories at least once a week for its therapeutic effect. What system is improved by laughter?
- A) cardiovascular system
- B) respiratory system
- C) immune system
- D) lymphatic system
24. A nurse is researching a standardized herbal supplement to help a patient with pain. What does the word standardized mean?
- A) It is an all-natural product.
- B) It is not contaminated by other ingredients.
- C) It contains a certain amount of an active ingredient.
- D) It can be toxic in higher than regular doses.
25. A nurse is teaching her patients about a holistic approach to food choices. Which of the following would the nurse recommend?
- A) Consume more dairy products.



- B) Use artificial sweeteners instead of sugar.
 - C) Drink diet sodas instead of regular sodas.
 - D) Reduce intake of refined and natural sugars.
26. A trained nurse uses the technique of Rolfing to break up tension in patient body structures. What type of CAT is being used by this nurse?
- A) Therapeutic Touch
 - B) therapeutic massage
 - C) acupuncture
 - D) healing touch
27. Nursing is expanding its knowledge base to include information that explains selected CAT. Which of the following describes an aspect of CAT?
- A) market driven
 - B) nurse driven
 - C) government regulated
 - D) last-resort therapy

Answer Key



1. D
2. C, D, F
3. D
4. A
5. C
6. A, D, F
7. A, B, C
8. A
9. A
10. C
11. D
12. A
13. D
14. C



15. D

16. A

17. B

18. D

19. D

20. A

21. B

22. D

23. C

24. C

25. D

26. B

27. A



Chapter 30: Medications

1. Which of the following healthcare providers have prescriptive authority? Select all that apply.
 - A) licensed practical nurse
 - B) pharmacist
 - C) physician
 - D) social worker
 - E) dentist
 - F) advance practice nurses

2. What federal agency enforces the official standards for drugs in the United States?
 - A) Centers for Disease Control and Prevention
 - B) Judicial branch of the administration
 - C) Controlled Substance Act
 - D) Food and Drug Administration



3. A patient who is taking Tylenol for a fever asks a nurse if there is a generic form that is less expensive. What would the nurse tell him?
- A) No, Tylenol is all that is available.
 - B) No, not that I am aware of.
 - C) Yes, and it is acetaminophen.
 - D) Yes, and it is also called Tylenol.
4. A nurse is administering a medication to a patient for acute pain. Of the various routes for drug administration, which would be chosen because it is absorbed more rapidly?
- A) injected medications
 - B) liquid oral medications
 - C) topical skin medications
 - D) oral-coated medications
5. A physician has ordered peak and trough levels of a medication. When would the nurse schedule the trough level specimen?
- A) before administering the first dose



- B) immediately after the first dose
 - C) 30 minutes before the next dose
 - D) 24 hours after the last dose
6. A patient taking insulin has his levels adjusted to ensure the concentration of drug in the blood serum produces the desired effect without causing toxicity. What is the term for this desired effect?
- A) peak level
 - B) trough level
 - C) half-life
 - D) therapeutic range
7. A patient who is taking an oral narcotic for pain relief tells the nurse he is constipated. What is this common response to narcotics called?
- A) therapeutic effect
 - B) adverse effect
 - C) toxic effect
 - D) idiosyncratic effect



8. A nurse is conducting an interview for a health history. In addition to asking the patient about medications being taken, what else should be asked to assess the risk for drug interactions?
- A) the effects of prescribed medications
 - B) type and amount of foods eaten
 - C) daily amount of intake and output
 - D) use of herbal supplements
9. A nurse is administering lithium to a Japanese patient. What cultural factor should the nurse consider regarding the effects of the medications?
- A) elevated serum levels may occur causing symptoms of drug toxicity
 - B) expected side effects should be no different than in other patients
 - C) the patient may require a larger-than-normal dose of a drug
 - D) more rapid metabolism may interfere with drug absorption
10. A nurse is converting the dosage of a medication to a different unit in the metric system. The medication label specifies the drug as being 0.5 g per tablet. The order is for 500 mg. How many tablets will the nurse give?
- A) 1



- B) 2
- C) 5
- D) 10
11. A physician orders Cipro 500 mg, PO q12h for a patient with bronchial pneumonia. The nurse has Cipro 250 mg on hand. How many tablets would the nurse dispense?
- A) 1/2 tablet
- B) 1 tablet
- C) 2 tablets
- D) 2 1/2 tablets
12. What factor is used to most accurately calculate drug dosages for a child?
- A) age
- B) developmental level
- C) weight
- D) body surface area (BSA)



13. A nurse is conducting an interview with a patient to collect a medication history. Which of the following questions would be used to ensure safe medication administration?
- A) Have you noticed any change in your bowel habits?
 - B) How do you feel about taking medications?
 - C) Do you have any allergies to medications?
 - D) At what times do you take your medications?
14. A hospitalized patient asks the nurse for some aspirin for my headache. There is no order for aspirin for this patient. What will the nurse do?
- A) Go ahead and give the patient aspirin, a common self-prescribed drug.
 - B) Ask the patients visitors if they have any aspirin for the patient.
 - C) Ask the patients family to bring some aspirin from home.
 - D) State that an order from the doctor is legally required and check with the doctor.
15. A physician has ordered that a medication be given stat for a patient who is having an anaphylactic drug reaction. At what time would the nurse administer the medication?
- A) at the next scheduled medication time



- B) immediately after the order is noted
 - C) not until verifying it with the patient
 - D) whenever the patient asks for it
16. What type of order would a physician most likely write to treat the symptoms of a disease?
- A) stat
 - B) p.r.n.
 - C) standing
 - D) single
17. What does the nurse do to verify an order for a medication listed on a medication administration record (MAR)?
- A) Compare it with the original physicians order.
 - B) Ask another nurse what the drug is.
 - C) Look up the drug in a textbook.
 - D) Call the pharmacist for verification.



18. What must a nurse do each time medications are administered to ensure that medication errors do not occur?
- A) Verify the number of medications to be administered.
 - B) Review information about classification of drugs.
 - C) Ask another nurse to double-check the medications.
 - D) Observe the three checks and five rights.
19. A nurse is administering a medication that is formulated as enteric-coated tablets. What is the rationale for not crushing or chewing enteric-coated tablets?
- A) to prevent absorption in the mouth
 - B) to prevent absorption in the esophagus
 - C) to facilitate absorption in the stomach
 - D) to prevent gastric irritation
20. A nurse is administering a liquid medication to an infant. Where will the nurse place the medication to prevent aspiration?
- A) between the gum and the cheek
 - B) in front of the teeth and gums



- C) on the front of the tongue
 - D) under the tongue
21. A nurse is teaching an older adult at home about taking newly prescribed medications. Which of the following would be included?
- A) You can identify your medications by their color.
 - B) I have written the names of your drugs with times to take them.
 - C) You won't forget a medication if you count them every day.
 - D) Don't worry if the label comes off; just look at the shapes.
22. A student nurse is administering medications through a nasogastric tube connected to continuous suction. How will the student do this accurately?
- A) Briefly disconnect tubing from the suction to administer medications, then reconnect.
 - B) Realize this can't be done, and document information.
 - C) Disconnect tubing from the suction before giving drugs, and clamp tubing for 20 to 30 minutes.
 - D) Leave the suction alone and give medications orally or rectally.



23. What would a nurse instruct a patient to do after administration of a sublingual medication?
- A) Take a big drink of water and swallow the pill.
 - B) Try not to swallow while the pill dissolves.
 - C) Swallow frequently to get the best benefit.
 - D) Chew the pill so it will dissolve faster.
24. A nurse is administering an intramuscular injection of a viscous medication using the appropriate-gauge needle. What does the nurse need to know about needle gauges?
- A) All needles for parenteral injection are the same gauge.
 - B) The gauge will depend on the length of the needle.
 - C) Ask the patient what size needle is preferred.
 - D) Gauges range from 18 to 30, with 18 being the largest.
25. Which of the following parts of the syringe and needle must be kept sterile when preparing and administering an injection? Select all that apply.
- A) the outside of the cap
 - B) the outside of the barrel



- C) the needle hub
 - D) the needle
 - E) inside the barrel
 - F) part of plunger entering barrel
26. A nurse has administered an intramuscular injection. What will the nurse do with the syringe and needle?
- A) Recap the needle and place it in a puncture-resistant container.
 - B) Do not recap the needle and place it in a puncture-resistant container.
 - C) Break off the needle, place it in the barrel, and throw it in the trash.
 - D) Take off the needle and throw the syringe in the patient's trash can.
27. A nurse is preparing an injection by withdrawing the solution from a multidose vial. What is necessary to facilitate withdrawing a medication from the vial?
- A) first inject an equal amount of air into the vial
 - B) withdraw the liquid and then inject an equal amount of air
 - C) insert the needle and slowly withdraw the liquid



- D) insert a separate needle to equalize the pressure
28. An adult with diabetes receives 20 units of insulin each morning and evening. How will the nurse teach the patient to administer the insulin?
- A) Use a 1-mL syringe and give 0.4 mL.
- B) Use a 5-mL syringe and give 0.40 mL.
- C) Use a tuberculin syringe and give 4/10 mL.
- D) Use an insulin syringe and give 20 units.
29. A clinic nurse is preparing for a tuberculosis screening. Knowing the injections will be administered intradermally, what size needles and syringes will the nurse prepare?
- A) 10-mL syringe, 3-inch 18-gauge needle
- B) 5-mL syringe, 2-inch 20-gauge needle
- C) insulin syringe, 1-inch 16-gauge needle
- D) tuberculin syringe, 1/2-inch 26-gauge needle
30. Which anatomic site is recommended for intramuscular injections for adults?
- A) vastus lateralis



- B) epidermis of inner forearm
 - C) ventrogluteal muscles
 - D) subcutaneous fat
31. A nurse is preparing to administer a medication by intravenous piggyback. Where will the piggyback container be placed?
- A) higher than the primary solution container
 - B) lower than the primary solution container
 - C) at an equal height with the primary solution container
 - D) below the level of the patients heart
32. A nurse flushes an intravenous lock before and after administering a medication. What is the rationale for this step?
- A) to keep the inside of the needle or catheter sterile
 - B) to facilitate patient comfort and decrease anxiety
 - C) to clear medication and prevent clot formation
 - D) to dilute the infusion and maintain homeostasis



33. Which of the following accurately describes a step in this procedure?
- A) The medication is injected just below the dermis of the skin.
 - B) Transdermal patches that contain estrogen should be applied to breast tissue.
 - C) When indicated, apply a cold pack to the area to promote absorption.
 - D) The nurse would wear gloves while massaging in the medication.

Answer Key

- 1. C, E, F
- 2. D
- 3. C
- 4. A
- 5. C
- 6. D
- 7. B
- 8. D



9. A

10. A

11. C

12. D

13. C

14. D

15. B

16. B

17. A

18. D

19. D

20. A

21. B

22. C



23. B

24. D

25. D, E, F

26. B

27. A

28. D

29. D

30. C

31. A

32. C

33. D



Chapter 31: Perioperative Nursing

1. Sara Thomas is scheduled for liposuction surgery to reduce her weight. Based on urgency, how is this surgery classified?
 - A) urgent
 - B) elective
 - C) emergency
 - D) emergent

2. A diabetic patient is undergoing surgery to amputate a gangrenous foot. This procedure would be considered which of the following categories of surgery based on purpose?
 - A) Diagnostic
 - B) Ablative
 - C) Palliative
 - D) Reconstructive

3. A patient scheduled for major surgery will receive general anesthesia. Why is inhalation anesthesia often used to provide the desired actions?



- A) rapid excretion and reversal of effects
 - B) safe administration in the patients own room
 - C) involves only the respiratory system and skin
 - D) slow onset of action and maintains reflexes
4. Which of the following are desired outcomes of general anesthesia? Select all that apply.
- A) loss of consciousness
 - B) analgesia
 - C) relaxed skeletal muscles
 - D) loss of sensation in specific area
 - E) depressed reflexes
 - F) altered mood with some degree of amnesia
5. A nurse is teaching a patient about regional anesthesia. Which of the following statements is accurate about this type of anesthesia?
- A) You will be asleep and wont be aware of the procedure.



- B) You will be asleep but may feel some pain during the procedure.
 - C) You will be awake but will not be aware of the procedure.
 - D) You will be awake and will not have sensation of the procedure.
6. A nurse has been asked to ensure informed consent for a surgical procedure. What might be a role of the nurse?
- A) securing informed consent from the patient
 - B) signing the consent form as a witness
 - C) ensuring the patient does not refuse treatment
 - D) refusing to participate based on legal guidelines
7. A patient, scheduled for open-heart surgery, tells the nurse he does not want to be saved if he dies during surgery. What should the nurse do next?
- A) discuss with and document the wishes of the patient and family
 - B) administer the ordered oral and intravenous preoperative medications
 - C) notify the physician after completion of the surgical procedure
 - D) verbally report the patients wishes to the operating room supervisor



8. Which of the following is a factor influencing the increased incidence of outpatient/same day surgery?
- A) lower healthcare costs
 - B) increase in length of hospital stays
 - C) increase in minor surgeries
 - D) decrease in number of surgeons
9. A nurse is giving a patient scheduled for outpatient surgery preoperative information. Which of the following are recommended teaching guidelines? Select all that apply.
- A) Continue with all medications routinely taken.
 - B) Notify the surgeons office if a cold or infection develops before surgery.
 - C) List allergies and be sure the operating staff is aware of these.
 - D) Wear clothing without buttons or zippers.
 - E) Have someone available for transportation home after recovery from anesthesia.
 - F) Continue with regular consumption of food and beverages until the morning of surgery.



10. An operating room nurse is preparing for a surgical procedure for an infant. The nurses perioperative care is based on what physiologic factor that puts infants at greater risk from surgery than adults?
- A) increased vascular rigidity
 - B) diminished chest expansion
 - C) lower total blood volume
 - D) decreased peripheral circulation
11. A nurse preparing an elderly patient for hip replacement surgery is aware of the surgical risks related to the patients age. Which of the following accurately describe these risks? Select all that apply.
- A) increased cardiac output
 - B) decreased peripheral circulation
 - C) increased vascular rigidity
 - D) increased oxygenation of blood
 - E) decreased thermoregulation ability
 - F) increased skin moisture and elasticity



12. A nurse caring for an elderly postsurgical patient helps the patient perform leg exercises. Which age-related change makes these exercises even more important?
- A) reduced vital capacity
 - B) decreased peripheral circulation
 - C) decreased oxygenation of blood
 - D) decreased reaction time and coordination
13. After conducting a preoperative health assessment, the nurse documents that the patient has physical assessments supporting the medical diagnosis of emphysema. Based on this finding, what postoperative interventions would be included on the plan of care?
- A) Perform sterile dressing changes each morning.
 - B) Administer pain medications as needed.
 - C) Conduct a head-to-toe assessment each shift.
 - D) Monitor respirations and breath sounds.
14. A preoperative assessment finds a patient to be 75 pounds overweight. The patient is to have abdominal surgery. What nursing diagnosis would be appropriate based on the patient's weight?
- A) Risk for Aspiration



- B) Risk for Imbalanced Body Temperature
 - C) Risk for Infection
 - D) Risk for Falls
15. Which of the following interventions is of major importance during preoperative teaching?
- A) performing skills necessary to gastrointestinal preparation
 - B) encouraging the patient to identify and verbalize fears
 - C) discussing the site and extent of the surgical incision
 - D) telling the patient not to worry or be afraid of surgery
16. A nurse is reviewing results of preoperative screening tests and notes the patient's potassium level is dangerously low. What should the nurse do next?
- A) Nothing; potassium levels have no influence on surgical outcome.
 - B) Include the information in the postoperative end of shift report.
 - C) Document the data and notify the physician who will do the surgery.
 - D) Ask the patient and family members why the potassium is low.



17. A nurse is teaching a surgical patient about postoperative p.r.n. pain control. Which of the following should be included?
- A) We will bring you pain medications; you don't need to ask.
 - B) Even if you have pain, you may get addicted to the drugs.
 - C) You won't have much pain so just tough it out.
 - D) You need to ask for the medication before the pain becomes severe.
18. A nurse is teaching a preoperative patient how to cough effectively. What can the nurse tell the patient to do to facilitate coughing?
- A) Hold a pillow or folded bath blanket over the incision.
 - B) Get up and walk before you try to cough.
 - C) It would be best if you do not cough until you feel better.
 - D) When you cough, cover your nose and mouth with a tissue.
19. A cleansing enema is ordered for a patient who is scheduled to have colon surgery. What is the rationale for this procedure?
- A) Surgical patients routinely are given a cleansing enema.
 - B) Cleansing enemas are given before surgery at the patient's request.



- C) There will be less flatus and discomfort postoperatively.
 - D) Peristalsis does not return for 24 to 48 hours after surgery.
20. Which of the following would be an appropriate expected outcome for a patient during surgery?
- A) remains asleep during the surgical procedure
 - B) remains free of neuromuscular injury
 - C) verbalizes freedom from anxiety and restlessness
 - D) expresses understanding of preoperative teaching
21. A nurse working in a PACU is responsible for conducting assessments on immediate postoperative patients. What is the purpose of these assessments?
- A) to determine the length of time to recover from anesthesia
 - B) to use intraoperative data as a basis for comparison
 - C) to focus on cardiovascular data and findings
 - D) to prevent complications from anesthesia and surgery
22. A nurse is providing ongoing postoperative care to a patient who has had knee surgery. The nurse assesses the dressing and finds it saturated with blood. The patient is restless and has a rapid pulse. What should the nurse do next?



- A) Document the data and apply a new dressing.
 - B) Apply a pressure dressing and report findings.
 - C) Reassure the family that this is a common problem.
 - D) Make assessments every 15 minutes for 4 hours.
23. A postoperative home care patient has developed thrombophlebitis in her right leg. What category of medications will probably be prescribed for this cardiovascular complication?
- A) anticoagulants
 - B) antibiotics
 - C) antihistamines
 - D) antigens
24. A student is assessing a postoperative patient who has developed pneumonia. The plan of care includes positioning the patient in the Fowlers or semi-Fowlers position. What is the rationale for this position?
- A) It increases blood flow to the heart.
 - B) The patient will be more comfortable and have less pain.
 - C) It facilitates nursing assessments of skin color and temperature.



- D) It promotes full aeration of the lungs.
25. A young woman has been in an automobile crash that resulted in an amputation of her left lower leg. She verbalizes grief and loss. What knowledge by the nurse is used to provide interventions to help the patient cope?
- A) The patient should be grateful to be alive.
- B) This is a normal, appropriate response.
- C) This is an abnormal, inappropriate response.
- D) Tissue healing will help the patient adapt.
26. A nurse in an outpatient surgical center is teaching a patient about what will be necessary for discharge to home. What information should the nurse include about transportation?
- A) The patient is not allowed to drive a car home.
- B) If the patient is not dizzy, driving a car is allowed.
- C) Only adults over the age of 25 may drive home.
- D) None; this is not necessary information.
27. Which of the following interventions are recommended guidelines for meeting patient postoperative elimination needs?



- A) Assess abdominal distention, especially if bowel sounds are audible or are low pitched.
 - B) Assess for the return of peristalsis by auscultating bowel sounds every 4 hours when the patient is awake.
 - C) Encourage food and fluid intake when ordered, especially dairy products and low-fiber foods.
 - D) Assess for bladder distention by palpating below the symphysis pubis if the patient has not voided within 8 hours after surgery.
28. A nurse is assisting a postoperative patient with deep-breathing exercises. Which of the following is an accurate step for this procedure?
- A) Place the patient in prone position, with the neck and shoulders supported.
 - B) Ask the patient to place the hands over the stomach, so he or she can feel the chest rise as the lungs expand.
 - C) Ask the patient to exhale rapidly and completely and inhale through the nose rapidly and completely.
 - D) Ask the patient to hold his or her breath for 3 to 5 seconds and mentally count one, one thousand, two, one thousand and so forth.
29. A nurse is assisting a postsurgical patient with effective coughing. How often should this exercise be performed?
- A) every hour



B) every 2 hours

C) every 4 hours

D) every shift

Answer Key

1. B

2. B

3. A

4. A, B, C, E

5. D

6. B

7. A

8. A

9. B, C, D, E

10. C



11. B, C, E

12. B

13. D

14. C

15. B

16. C

17. D

18. A

19. D

20. B

21. D

22. B

23. A

24. D



25. B

26. A

27. B

28. D

29. B



Chapter 32: Hygiene

1. Which of the following factors does **not** affect personal hygiene practices?
 - A) culture
 - B) income level
 - C) health state
 - D) gender

2. A homeless person uses the soap and towels in a public restroom to wash up. This is an example of which of the following factors affecting personal hygiene practices?
 - A) socioeconomic class
 - B) culture
 - C) developmental level
 - D) health state

3. Which of the following patients are at an increased risk for oral problems? Select all that apply.
 - A) a comatose patient



- B) a confused patient
 - C) a depressed patient
 - D) a patient undergoing chemotherapy
 - E) a hypertensive patient
 - F) an obese patient
4. A nurse is assessing the skin of an older patient with dry skin and notices several areas of scratches and abrasion. Interventions should be implemented to meet what goal?
- A) investigate the possibility of elder abuse
 - B) decrease the risk of infection
 - C) promote safety during daily hygiene
 - D) increase the patients self-esteem
5. Which of the following patients would be at greatest risk for injury to the skin and mucous membranes?
- A) 10-day-old infant with no health problems
 - B) 17-year-old adolescent with asthma



- C) 44-year-old man with hemorrhoids
 - D) 77-year-old man with diabetes
6. What physical changes during adolescence predispose the adolescent to body odor and acne?
- A) growth of long bones
 - B) loss of calcium from bones
 - C) hormonal changes
 - D) decreased skin secretions
7. An 80-year-old woman tells the nurse that she just itches all the time and her skin seems very dry. How do these symptoms relate to aging skin?
- A) activity of the glands in the skin lessens
 - B) the symptoms are indicators of a disease
 - C) skin gland activity increases, leading to acne
 - D) the symptoms are unrelated to aging skin
8. A patient has had food poisoning with severe vomiting and diarrhea. What would this acute illness most likely cause?



- A) edema
 - B) dehydration
 - C) jaundice
 - D) eczema
9. A nurse is conducting a health history for a patient with a skin problem. What question or statement would be most useful in eliciting information about personal hygiene?
- A) Perhaps you don't recognize your bad body odor.
 - B) You must eat a lot of greasy foods to have this acne.
 - C) Tell me about what you do to take care of your skin.
 - D) Why do you only take a bath once a week?
10. Which of the following patients would be most at risk for alterations in oral health?
- A) infant who is breast fed
 - B) man with a nasogastric tube
 - C) woman who is pregnant



- D) healthy young adult
11. A home health nurse is visiting a patient who is receiving chemotherapy for cancer treatment. What condition may result from chemotherapy?
- A) changes in skin color
- B) excess hair growth
- C) loss of hair
- D) dry, brittle nails
12. A student has been assigned to provide hygiene care to four patients. Which one would require special consideration for perineal care?
- A) middle-aged man with a nasogastric tube
- B) young adult man who has had a hernia repair
- C) young woman who has had cosmetic surgery
- D) middle-aged woman with a Foley catheter
13. A nurse is developing a plan of care for an older adult who is malnourished and on bed rest. Which of the following interventions would be included to prevent skin alterations?
- A) turn and reposition every 2 hours



- B) limit fluids to 500 mL every 24 hours
 - C) do not use lotions or creams on skin
 - D) assess vital signs every 4 hours
14. Which of the following statements by a patient would alert the nurse to an increased risk for skin cancer?
- A) I take a shower three times a day.
 - B) This wart has changed color.
 - C) My skin is just so dry and it itches.
 - D) My cast is rubbing a blister.
15. While conducting an oral assessment, a nurse notices the patients gums are red and swollen, some teeth are loose, and blood and pus can be expressed when the gums are palpated. What condition do these symptoms indicate?
- A) periodontitis
 - B) plaque
 - C) halitosis
 - D) caries



16. A school nurse is assessing children in the third grade for pediculosis capitis. What assessments should be made?
- A) the pubic area for growth of hair
 - B) the head for nits on hair shafts
 - C) the nails for evidence of cleanliness
 - D) the body for evidence of abuse
17. A student has been assigned to provide morning care to a patient. The plan of care includes the information that the patient requires partial care. What will the student do?
- A) Provide total physical hygiene, including perineal care.
 - B) Provide total physical hygiene, excluding hair care.
 - C) Provide supplies and orient to the bathroom.
 - D) Provide supplies and assist with hard-to-reach areas.
18. Which of the following is one of the most important benefits of a nurse helping with bathing?
- A) The patient sees professional staff.
 - B) The nurse improves technical skills.



- C) Staffnurse relationships are more collegial.
 - D) Nursepatient relationships are facilitated.
19. Before a long-term care resident goes to sleep at night, his dentures are placed in a denture cup with clean water. What rationale supports placing dentures in water?
- A) none; they should be placed in saline
 - B) to increase comfort when replaced in the mouth
 - C) to prevent drying and warping of plastic
 - D) to ensure the dentures are not thrown away
20. A nurse is providing oral care to a patient with dentures. What action would the nurse do first?
- A) Assess the mouth and gums.
 - B) Don gloves.
 - C) Wash the patients face.
 - D) Apply lubricant.
21. A patient tells a nurse that he always uses boric acid solution to wash out his eyes. What would the nurse teach the patient?



- A) Boric acid should not be used; it is toxic when absorbed.
 - B) Good work! Continue with your cleansing routine.
 - C) Why in the world would you do such a thing?
 - D) Maybe you should try something a little stronger.
22. The mother of a 2 year old tells the nurse she always cleans the child's ears with a hairpin. What would the nurse tell the mother?
- A) That's not good. Use a Q-tip or your finger instead.
 - B) You really like to keep your child clean. Good for you!
 - C) That is dangerous; you might puncture the eardrum.
 - D) Show me exactly how you use the hairpin.
23. A nurse is caring for a patient with long hair. The patient asks if something could be done about her hair to be more comfortable. How would the nurse respond?
- A) Yes, I can braid it for you if you want me to.
 - B) Well I guess I could just cut it all off.
 - C) You will have to ask your family to do that.



- D) No, that is not a part of my job as a nurse.
24. A nurse is helping an older woman undress and notices the woman's knee-high hose have left deep indentations. The woman has diabetes. Does this pose a risk to the patient?
- A) No, the indentations will go away.
- B) No, knee-high hose are more comfortable.
- C) Yes, these are a safety hazard and should not be worn.
- D) Yes, these can obstruct lower extremity circulation.
25. A nurse is providing perineal care to a female patient. In which direction would the nurse move the washcloth?
- A) from the pubic area toward the anal area
- B) from the anal area to the pubic area
- C) from side to side within the labia
- D) the direction does not make any difference
26. A female patient in a reproductive health clinic tells the nurse practitioner that she douches every day. Should the nurse tell the patient to continue this practice?
- A) Yes, this helps prevent vaginal odor.



- B) Yes, this decreases vaginal secretions.
 - C) No, douching removes normal bacteria.
 - D) No, douching may increase secretions.
27. The family of a patient being discharged home has arranged to rent a hospital bed. What should the nurse teach the family about safety when using the bed?
- A) how to apply the bed linens
 - B) proper maintenance
 - C) how to move the patient in bed
 - D) advisable positions and controls
28. A nurse is making a bed occupied by a patient. Which of the following is a recommended step for this procedure?
- A) Lower side rail on opposite side of you.
 - B) Discard soiled linen onto the floor.
 - C) Fan-fold soiled linens as close to patient as possible.
 - D) Place the drawsheet under the patients knees.



29. A nurse is teaching an adolescent patient how to care for her acne. Which of the following is a recommended guideline?
- A) Squeeze infected areas to prevent infection.
 - B) Rigorously cleanse the acne with soap and hot water.
 - C) Use water-based moisturizers and make-up.
 - D) Use sun-tanning booths to dry up pustules.
30. A nurse is shaving the facial hair of a bed-ridden patient. Which of the following is a recommended guideline for this procedure?
- A) Fill bath basin with cool water.
 - B) Apply shaving cream approximately 1 inch thick.
 - C) Shave with the direction of hair growth in downward, short strokes.
 - D) Do not use aftershave or lotion on area shaved.

Answer Key

- 1. D
- 2. A



3. A, B, C, D

4. B

5. D

6. C

7. A

8. B

9. C

10. B

11. C

12. D

13. A

14. B

15. A

16. B



17. D

18. D

19. C

20. B

21. A

22. C

23. A

24. D

25. A

26. C

27. D

28. C

29. C

30. C



Chapter 33: Skin Integrity and Wound Care

1. A student nurse studying anatomy and physiology learns that the largest organ of the body is the:
 - A) heart
 - B) lungs
 - C) skin
 - D) intestines

2. Which of the following are functions of the skin? Select all that apply.
 - A) protection
 - B) temperature regulation
 - C) psychosocial, sensation
 - D) vitamin C production
 - E) immunological
 - F) lipid reduction



3. Which of the following patients would be considered at risk for skin alterations?
Select all that apply.

- A) a teenager with multiple body piercings
- B) a homosexual in a monogamous relationship
- C) a patient receiving radiation therapy
- D) a patient undergoing cardiac monitoring
- E) a patient with diabetes mellitus
- F) a patient with a respiratory disorder

4. Which of the following statements accurately describes a developmental consideration when assessing skin integrity of patients?

- A) In children younger than 2 years, the skin is thicker and stronger than it is in adults.
- B) An infants skin and mucous membranes are injured easily and are subject to infection.
- C) A childs skin becomes increasingly at risk for injury and infection.
- D) In the older adult, circulation and collagen formation are increased.



5. A nurse assessing the skin of patients knows that the following are health states that may predispose patients to skin alterations. Select all that apply.
- A) obesity
 - B) excessive perspiration
 - C) cataracts
 - D) hypertension
 - E) low BMI
 - F) Jaundice
6. What is the most accurate definition of a wound?
- A) a disruption in normal skin and tissue integrity
 - B) a change in the function of internal organs
 - C) any injury that results in changes in nervous tissue
 - D) any trauma resulting in serious damage and pain
7. Which of the following best describes an unintentional wound?



- A) clean wound edges, controlled bleeding
 - B) jagged wound edges, uncontrolled bleeding
 - C) little risk for infection, shorter healing time
 - D) the result of surgery, intravenous therapy
8. A nurse documents a closed wound on a patient chart. Which of the following is an example of a closed wound?
- A) abrasion
 - B) ecchymosis
 - C) incision
 - D) puncture wound
9. What are the two major processes involved in the inflammatory phase of wound healing?
- A) bleeding is stimulated, epithelial cells are deposited
 - B) granulation tissue is formed, collagen is deposited
 - C) collagen is remodeled, avascular scar forms



- D) blood clotting is initiated, WBCs move into the wound
10. A nurse is caring for a patient who is 2 days postoperative after abdominal surgery. What nursing intervention would be important to promote wound healing at this time?
- A) Administer pain medications on a p.r.n. and regular basis.
- B) Assist in moving to prevent strain on the suture line.
- C) Tell the patient that a mild fever is a normal response.
- D) If a scar forms over a joint, it may limit movement.
11. A home health nurse has a caseload of several postoperative patients. Which one would be most likely to require a longer period of care?
- A) an infant
- B) a young adult
- C) a middle adult
- D) an older adult
12. A nurse is teaching a postoperative patient about essential nutrition for healing. What statement by the patient would indicate a need for more information?
- A) I will drink a lot of orange juice and drink milk too.



- B) I will take the zinc supplement the doctor recommended.
 - C) I will restrict my diet to fats and carbohydrates.
 - D) I will drink 8 to 10 glasses of water every day.
13. What nursing diagnosis would be a priority for a patient who has a large wound from colon surgery, is obese, and is taking corticosteroid medications?
- A) Self-care Deficit
 - B) Risk for Imbalanced Nutrition
 - C) Anxiety
 - D) Risk for Infection
14. A nurse working in long-term care is assessing residents at risk for the development of a decubitus ulcer. Which one would be most at risk?
- A) an 83-year-old who is mobile
 - B) a 92-year-old who uses a walker
 - C) a 75-year-old who uses a cane
 - D) an 86-year-old who is bedfast



15. When patients are pulled up in bed rather than lifted, they are at increased risk for the development of a decubitus ulcer. What is the name given to the factor responsible for this risk?
- A) friction
 - B) necrosis of tissue
 - C) ischemia
 - D) shearing force
16. What intervention should be included on a plan of care to prevent pressure ulcer development in healthcare settings?
- A) Change position at least once each shift.
 - B) Implement a turning schedule every 2 hours.
 - C) Use ring cushions for heels and elbows.
 - D) Do not turn, use pressure-relieving support surface.
17. A nurse assesses an area of pale white skin over a patient's coccyx. After turning the patient on her side, the skin becomes red and feels warm. What should the nurse do about these assessments?
- A) Immediately report to the physician that the patient has a pressure ulcer.



- B) Recognize that this is ischemia, followed by reactive hyperemia.
 - C) Document the presence of a pressure ulcer and develop a care plan.
 - D) Implement nursing interventions for Altered Skin Integrity.
18. A nurse is assessing a patient with a stage IV pressure ulcer. What assessment of the ulcer would be expected?
- A) full-thickness skin loss
 - B) skin pallor
 - C) blister formation
 - D) eschar formation
19. During a dressing change, the nurse assesses protrusion of intestines through an opened wound. What would the nurse do after covering the wound with towels moistened with sterile 0.9% sodium chloride solution?
- A) Document the assessments and intervention.
 - B) Reinforce the dressing with additional layers.
 - C) Administer pain medications intramuscularly.
 - D) Notify the physician and prepare for surgery.



20. A nurse is assessing wound drainage during the immediate postoperative period for a patient who has had a breast removed. In addition to assessing the dressing, where would the nurse also check for drainage?
- A) under the skin
 - B) under the patient
 - C) on the output sheet
 - D) in the axilla
21. A nurse assessing a patient's wound documents the finding of purulent drainage. What is the composition of this type of drainage?
- A) clear, watery blood
 - B) large numbers of red blood cells
 - C) mixture of serum and red blood cells
 - D) white blood cells, debris, bacteria
22. A home care nurse makes the following assessments of a wound: increased drainage and pain, increased body temperature, red and swollen wound, and purulent wound drainage. What wound complication do these assessments indicate?
- A) evisceration



- B) infection
 - C) dehiscence
 - D) fistula
23. The plan of care for a postoperative patient specifies that sterile 0.9% sodium chloride solution be used to clean the wound. What should the nurse do after reading this information?
- A) Question the physician about the accuracy of this agent.
 - B) Refuse to use 0.9% normal saline on a wound.
 - C) Document the rationale for not changing the dressing.
 - D) Continue with the dressing change as planned.
24. A young man who has had a traumatic mid-thigh amputation of his right leg refuses to look at the wound during dressing changes. Which response by the nurse is appropriate?
- A) Oh, for gosh sakes it doesn't look that bad!
 - B) I understand, but you are going to have to look someday.
 - C) I respect your wish not to look at it right now.
 - D) You won't be able to go home until you look at it.



25. A nurse is teaching a patient on home care how to apply hot packs to an infected leg ulcer. What statement by the patient indicates the need for further teaching?
- A) I understand the rebound effect of heat.
 - B) I will put the heat packs only on the sore on my leg.
 - C) I will only leave the heat packs on for 20 minutes.
 - D) I will leave the heat packs on for an hour.
26. Of the many topics that may be taught to patients or caregivers about home wound care, which one is the most significant in preventing wound infections?
- A) taking medications as prescribed
 - B) proper intake of food and fluids
 - C) thorough hand hygiene
 - D) adequate sleep and rest
27. Heat applications are often used to promote tissue healing. What is the rationale for this type of treatment?
- A) Physiologic effects of heat accelerate the inflammatory response.
 - B) Local heat increases cardiac output and pulse rate.



- C) Heat reduces blood flow to tissues resulting in decreased edema.
- D) Heat reduces muscle tension to promote relaxation.
28. A nurse is applying cold therapy to a patient with a contusion of the arm. Which of the following is an effect of cold therapy? Select all that apply.
- A) constricts peripheral blood vessels
- B) reduces muscle spasms
- C) increases blood flow to tissues
- D) increases the local release of pain-producing substances
- E) reduces the formation of edema and inflammation.
- F) alters tissue sensitivity (producing numbness)
29. Which of the following considerations should be made when assessing a patient for the application of cold or heat therapy?
- A) prolonged exposure decreases tolerance
- B) the neck and perineum are less sensitive to thermal change
- C) open tissue or abraded skin is less sensitive to thermal changes



- D) applications of heat or cold to large areas of the body cause systemic responses
30. Which of the following is a recommended guideline nurses follow when using an electric heating pad on a patient?
- A) Secure the heating pad to the patients clothing with safety pins.
- B) Place a heavy towel or blanket over the heating pad to maximize heat effects.
- C) Use a heating pad with a selector switch that can be turned up by the patient if needed.
- D) Place a heating pad anteriorly or laterally to, not under, the body part.

Answer Key

1. C
2. A, B, C, E
3. A, C, E
4. B
5. A, B, E, F
6. A



7. B

8. B

9. D

10. B

11. D

12. C

13. D

14. D

15. D

16. B

17. B

18. A

19. D

20. B



21. D

22. B

23. D

24. C

25. D

26. C

27. A

28. A, B, E, F

29. D

30. D



Chapter 34: Activity

1. What function of the skeletal system is essential to proper function of all other cells and tissues?
 - A) supporting soft tissues of the body
 - B) protecting delicate body structures
 - C) providing storage area for fats
 - D) producing blood cells
2. What is the role of the flat bones in the body?
 - A) height
 - B) shape
 - C) movement
 - D) length
3. A patient with severe osteoarthritis is having a surgical hip replacement. This is possible because of the type of joint found in the hip. What type is it?
 - A) pivot joint



- B) gliding joint
 - C) ball-and-socket joint
 - D) hinge joint
4. A nurse performing range-of-motion exercises on a bedfast patient moves the patients chin down onto the chest and then back to an upright position. The nurse then tilts the head as far as possible to each shoulder. What therapeutic movement is the nurse achieving with this exercise? Select all that apply.
- A) flexion
 - B) adduction
 - C) extension
 - D) dorsiflexion
 - E) pronation
 - F) abduction
5. While performing range-of-motion exercises on a patient, a nurse bends a patients foot so that the toes are brought up, as though to point them at the knee. What is the term for this type of movement?
- A) dorsiflexion



- B) inversion
 - C) rotation
 - D) eversion
6. What term is used to describe the correction or prevention of disorders of body structures used in locomotion?
- A) pediatrics
 - B) obstetrics
 - C) geriatrics
 - D) orthopedics
7. A nurse is assessing the activity level of a 5-month-old baby. What normal findings would be assessed?
- A) ability to sit and head control
 - B) ability to pick up small objects
 - C) progress toward running and jumping
 - D) progress toward unassisted walking



8. Which of the following activities are normally acquired in the toddler years? Select all that apply
- A) rolling over
 - B) pulling to a standing position
 - C) walking
 - D) running
 - E) jumping
 - F) climbing stairs
9. A nurse is teaching an older adult about activity. What information would be included in the teaching plan?
- A) the requirement of frequent inactivity
 - B) the recognition that exercise is not important
 - C) the importance of regular exercise
 - D) the possibility of exercise-induced fractures
10. A nurse is assessing the muscles of an older adult. What will be assessed?



- A) temperature, turgor, moisture
 - B) mass, tone, strength
 - C) degree of flexion, associated pain
 - D) reflexes, range of motion
11. Which of the following postural deformities might be assessed in a teenager?
- A) kyphosis
 - B) rickets
 - C) osteoporosis
 - D) scoliosis
12. A nurse is providing home care for an older woman with severe osteoporosis. What complication of this disease process must the nurse consider in the plan of care?
- A) diarrhea
 - B) fractures
 - C) visual deficits



- D) skin disorders
13. A nurse is teaching an older woman how to move and lift her disabled husband. The woman has osteoarthritis of the hips and knees. What is the goal of the nurses teaching plan?
- A) minimize stress on the wifes joints
- B) provide exercise for the husband
- C) increase socialization with neighbors
- D) maintain self-esteem of the wife
14. Why is it important for the nurse to teach and role model proper body mechanics?
- A) to ensure knowledgeable patient care
- B) to promote health and prevent illness
- C) to prevent unnecessary insurance claims
- D) to demonstrate knowledge and skills
15. Bedrest, with resultant immobility, affects the whole body. What is one effect on the musculoskeletal system?
- A) impaired gas exchange



- B) increased risk for venous thrombosis
 - C) increased risk for contractures
 - D) decreased sensory stimulation
16. A middle-aged man walks 2 miles each day. What type of exercise is he getting by this activity?
- A) isotonic
 - B) isometric
 - C) isokinetic
 - D) isostretching
17. What body system benefits the most from aerobic exercises?
- A) musculoskeletal
 - B) neurologic
 - C) respiratory
 - D) cardiovascular



18. A nurse recommends a regular exercise program for a patient who has difficulty sleeping. The patient asks how this will help. How would the nurse respond?
- A) The fresh air will stimulate your metabolism.
 - B) Improved sleep is one benefit of regular exercise.
 - C) Exercise can help you control your weight.
 - D) Take my word for it. It sure helped me.
19. A nurse is assessing the vital signs of a patient who has exercised regularly for several years. What vital sign findings would be expected?
- A) increased body temperature and respirations
 - B) increased pulse and blood pressure
 - C) decreased pulse and blood pressure
 - D) exercise has no effect on vital signs
20. A patient at a community health center is discussing a planned exercise program. The patient is being treated for cardiovascular disease. What would the nurse recommend?
- A) Begin the exercise program immediately.
 - B) It would be best if you did not exercise.



- C) Be sure to take your pulse before you begin.
- D) See your doctor and have a checkup first.
21. Of the following guidelines, which would **not** be recommended to a person who has sustained an orthopedic injury during exercise?
- A) ice
- B) warmth
- C) rest
- D) elevation
22. Immobility affects the body in many ways. What is one serious effect of immobility on the cardiovascular system?
- A) increased cardiac workload
- B) decreased cardiac workload
- C) increased venous return
- D) increased peripheral resistance
23. An immobile person has decreased movement of respiratory secretions. What condition is a greater risk as a result?



- A) respiratory tract infection
 - B) increased gas exchange
 - C) greater thoracic expansion
 - D) increased respiratory rate
24. Laboratory results for a patient on prolonged bedrest include a high level of urinary calcium. What risk does this pose for the patient?
- A) urinary calcium is not a concern
 - B) renal calculi (kidney stones)
 - C) increased urinary output
 - D) imbalanced intake/output
25. At what time would a nurse assess the gait of an ambulatory patient?
- A) after the neurologic assessment
 - B) at the end of the physical examination
 - C) while the patient is lying supine on the examining table



- D) when the patient walks into the room
26. What term is used to document impaired muscle strength or weakness?
- A) paralysis
- B) paresis
- C) spasticity
- D) flaccidity
27. A patient has chronic obstructive pulmonary disease and is unable to perform basic self-care activities or activities of daily living. Which of the following would be an appropriate nursing diagnosis?
- A) Risk for Injury: Pathologic Fractures
- B) Activity Intolerance
- C) Altered Tissue Perfusion
- D) Altered Thought Processes
28. A nurse is caring for a comatose patient. What can happen to the feet if they are unsupported in the dorsiflexed position?
- A) heel extension and pain



- B) toe contractures and numbness
 - C) plantar extension and arch loss
 - D) plantar flexion and footdrop
29. A nurse is placing a patient in Fowlers position. What should she teach the family about this position?
- A) Use at least two big pillows to support the head.
 - B) Cross the arms over the patients abdomen.
 - C) Do not raise the knees with the knee gatch.
 - D) Keep the hands lower than the rest of the body.
30. A nurse is ambulating a patient who has had a stroke. The patient has paresis on the right side of the upper body. Where would the nurse stand to walk the patient?
- A) on the weak side
 - B) on the strong side
 - C) in front of the patient
 - D) in back of the patient



31. A college student fell and sprained his right ankle. The student health physician recommends the student use crutches to facilitate healing. Which of the following would the nurse teach the student?
- A) The crutches should be as long as the student is tall.
 - B) The support of the body should be in the axilla.
 - C) The support of the body should be the hands and arms.
 - D) Walk fast and use long steps when using the crutches.
32. A nurse is following a plan of care for passive range-of-motion (ROM) exercises. What specifics will be included on the plan?
- A) Ask the patient to demonstrate ROM at 9 a.m. each day.
 - B) Do ROM exercises two times a day, each exercise two to five times.
 - C) Request family be available twice a day to perform ROM.
 - D) Move each joint until the patient complains of pain.

Answer Key

- 1. D
- 2. B



3. C
4. A, C
5. A
6. D
7. A
8. C, D, E
9. C
10. B
11. D
12. B
13. A
14. B
15. C
16. A



17. D

18. B

19. C

20. D

21. B

22. A

23. A

24. B

25. D

26. B

27. B

28. D

29. C

30. A



31. C

32. B



Chapter 35: Rest and Sleep

1. Which of the following groups of terms best describes sleep?
 - A) decreased state of activity, refreshed
 - B) altered consciousness, relative inactivity
 - C) comatose, immobility
 - D) alert, responsive

2. An individual awakens from a sound sleep in the middle of the night because of abdominal pain. Why does this happen?
 - A) stimuli from peripheral organs to the RAS
 - B) stimuli to the wake center in the cerebral cortex
 - C) messages from chemoreceptors to the brain
 - D) messages from baroreceptors to the spinal cord

3. A nurse is caring for a patient who is sleeping for abnormally long periods of time. This condition may be caused by injury to which of the following body structures?
 - A) spinal cord



- B) pancreas
 - C) hypothalamus
 - D) thyroid
4. What name is given to the rhythmic biologic clock that exists in humans?
- A) sleep-wake cycle
 - B) alert-unaware process
 - C) circadian rhythm
 - D) yo-yo theory
5. A nurse working the night shift assesses a patient's vital signs at 4 a.m. (0340). What would be the expected findings, based on knowledge of NREM sleep?
- A) decreased TPR and BP
 - B) increased TPR and BP
 - C) no change from daytime readings
 - D) highly individualized, cannot predict



6. A nurse teaches a young couple to put their newborn on his back to sleep. What is the rationale for this information?
- A) prone position increases the risk for sudden infant death syndrome
 - B) prone position decreases the risk for sudden infant death syndrome
 - C) supine position may alter the size and shape of the infants head
 - D) supine position makes changing diapers and feeding difficult
7. A nurse teaches the parents of a toddler about normal sleep patterns for this age group. How many hours of sleep per night is normal near the end of this stage?
- A) 7 8 hours
 - B) 8 10 hours
 - C) 10 12 hours
 - D) 12 15 hours
8. Based on the circadian cycle, the body prepares for sleep at night by decreasing the body temperature and releasing which of the following chemicals?
- A) neonephrine
 - B) seratonin



- C) melatonin
 - D) dopamine
9. A middle-aged adult man has just started an exercise program. What would the nurse teach him about timing of exercise and sleep?
- A) exercise immediately before bedtime enhances ability to sleep
 - B) exercise within 2 hours of bedtime can hinder ability to sleep
 - C) the time of day does not matter; exercise facilitates sleep
 - D) the fatigue from exercise may be a hindrance to sleep
10. A nurse is discussing sleep problems with a patient. What type of foods would she recommend to promote sleep?
- A) one cup of hot chocolate
 - B) three glasses of red wine
 - C) a high-protein snack
 - D) a carbohydrate snack
11. A patient who previously was a smoker has recently stopped smoking but reports having a lot of trouble sleeping at night. How would the nurse respond?



- A) You have to decide what is more important: smoking or sleep.
 - B) If you are sleep deprived, it might be better to smoke.
 - C) Sleep problems from stopping smoking are temporary.
 - D) Since you were a smoker, this will always be a problem.
12. Which of the following medications is least likely to affect sleep quality?
- A) diuretic
 - B) steroid
 - C) antidepressant
 - D) Ambien
13. Which of the following individuals is likely to require more hours of sleep?
- A) a 75 year old
 - B) a 43 year old
 - C) a 25 year old
 - D) a 15 year old



14. A patient's bed partner reports the patient often has irregular snoring and silence followed by a snort. Does this warrant further assessment?
- A) no, snoring has varied patterns
 - B) no, this is a description of normal snoring
 - C) yes, this is an indicator of obstructive apnea
 - D) yes, the bed partner is unable to sleep at night
15. Which of the following is the most common sleep disorder?
- A) hypersomnia
 - B) parasomnia
 - C) insomnia
 - D) dyssomnia
16. A nurse is explaining the use of sleep hygiene to a patient experiencing insomnia. Which of the following statements accurately describe recommended guidelines for the use of this technique? Select all that apply.
- A) drink an alcoholic drink before bedtime
 - B) take frequent naps during the day



- C) eat a light meal before bedtime
 - D) sleep in a warm, dark room
 - E) take a warm bath before bedtime
 - F) eliminate the use of a clock in the bedroom
17. A patient who has a sleep disorder is trying stimulus control to improve amount and quality of sleep. What is recommended in this type of therapy?
- A) use the bedroom for sleep and sex only
 - B) use the bedroom for reading and eating
 - C) go to bed at the same time every night
 - D) sleep alone with minimal coverings
18. A patient is diagnosed with narcolepsy. Which of the following is a characteristic of this disorder?
- A) waking during sleep
 - B) restless leg syndrome
 - C) uncontrollable desire to sleep



- D) decrease in the amount or quality of sleep
19. A nurse assessing a patient with a sleep disorder documents cataplexy as a finding. Which of the following is a feature of this condition?
- A) irresistible urge to sleep, regardless of the type of activity in which the patient is engaged
 - B) sudden loss of motor tone that may cause the person to fall asleep; usually experienced during a period of strong emotion
 - C) nightmare or vivid hallucinations experienced during sleep time
 - D) skeletal paralysis that occurs during the transition from wakefulness to sleep
20. What is the rationale for using CPAP to treat sleep apnea?
- A) positive air pressure holds the airway open
 - B) negative air pressure holds the airway closed
 - C) delivery of oxygen facilitates respiratory effort
 - D) alternating waves of air stimulate breathing
21. The parents of a 10-year-old son are worried about his sleepwalking (somnambulism). What topic should the nurse discuss with the parents?
- A) sleep deprivation



- B) privacy
 - C) schoolwork
 - D) safety
22. A patient has been instructed to increase fluid intake but as a result has lost sleep to get up to void several times a night. What can the nurse recommend to decrease the interruption of sleep?
- A) Drink most of the liquids during the night.
 - B) Drink most of the liquids before 5 p.m.
 - C) Try drinking coffee instead of water.
 - D) Drink the total amount of liquids before noon.
23. What independent nursing action can be used to facilitate sleep in hospitalized patients who are on bedrest?
- A) administering prescribed sleep medications
 - B) changing the bed with fresh linens
 - C) encouraging naps during the daytime
 - D) giving a back massage



24. A sedative-hypnotic has been prescribed to help a patient sleep. What should the nurse teach the patient about this medication?
- A) it should be taken every night for several months
 - B) it is useful for sleep but is better taken with alcohol
 - C) it loses its effectiveness after 1 or 2 weeks
 - D) it should be taken in the morning for long-term effects
25. What is the most common method for ordering sleep medications?
- A) stat
 - B) p.r.n
 - C) single order
 - D) daily dose
26. What condition have studies confirmed to occur when adults and children do not get recommended hours of sleep at night?
- A) Obesity
 - B) Anxiety



- C) Diabetes
 - D) Hypertension
27. Which of the following drugs normalizes sleep cycles by enabling the bodys supply of melatonin to naturally promote sleep?
- A) flurazepam (Dalmane)
 - B) temazepam (Restoril)
 - C) eszopiclone (Lunesta)
 - D) ramelton (Rozerem)
28. Which of the following expected outcomes demonstrates the effectiveness of a plan of care to promote rest and sleep?
- A) verbalizes inability to sleep without medications
 - B) continues to read in bed for hours each night
 - C) identifies factors that interfere with normal sleep pattern
 - D) reports minimal improvement in quality of rest and sleep

Answer Key



1. B

2. A

3. C

4. C

5. A

6. A

7. B

8. C

9. B

10. D

11. C

12. D

13. D

14. C



15. C

16. C, E, F

17. A

18. C

19. B

20. A

21. D

22. B

23. D

24. C

25. B

26. A

27. D

28. C



Chapter 36: Comfort and Pain Management

1. The Joint Commission supports the patients right to pain management and published standards for assessment and management of pain in hospitals, ambulatory care settings, and home care settings (Joint Commission, 2008b). Which of the following are recommended guidelines for pain management? Select all that apply.
 - A) Teach all patients to use a pain rating scale
 - B) Determine a pain-rating goal with each patient.
 - C) Use pharmacologic pain relief measures first.
 - D) Manipulate factors that affect the pain experience.
 - E) Keep the primary care provider in charge of all pain relief measures.
 - F) Ensure the ethical and legal responsibility to relieve pain.
2. Of the following individuals, who can best determine the experience of pain?
 - A) the person who has the pain
 - B) the persons immediate family
 - C) the nurse caring for the patient
 - D) the physician diagnosing the cause



3. A patient who has breast cancer is said to be in remission. What does this term signify?
- A) The patient is experiencing symptoms of the disease.
 - B) The patient has end-stage cancer.
 - C) The patient is experiencing unremitting pain.
 - D) The disease is present but the patient is not experiencing symptoms.
4. Which of the following patients would be classified as having chronic pain?
- A) a patient with rheumatoid arthritis
 - B) a patient with pneumonia
 - C) a patient with controlled hypertension
 - D) a patient with the flu
5. A patient has a severe abdominal injury with damage to the liver and colon from a motorcycle crash. What type of pain will predominate?
- A) psychogenic pain
 - B) neuropathic pain



- C) cutaneous pain
 - D) visceral pain
6. A patient in the Emergency Department is diagnosed with a myocardial infarction (heart attack). The patient describes pain in his left arm and shoulder. What name is given to this type of pain?
- A) cutaneous pain
 - B) referred pain
 - C) allodynia
 - D) nociceptive
7. Why is acute pain said to be protective in nature?
- A) It warns an individual of tissue damage or disease.
 - B) It enables the person to increase personal strength.
 - C) As a subjective experience, it serves no purpose.
 - D) As an objective experience, it aids diagnosis.
8. Which of the following statements is true of chronic pain?



- A) It lasts for less than 6 months.
 - B) It is always present and intense.
 - C) It interferes with normal functioning.
 - D) It disappears with treatment.
9. A child with a leg cast tells the nurse that he has pain inside his cast. What type of pain is this most likely to be?
- A) thermal
 - B) chemical
 - C) electrical
 - D) mechanical
10. A patient who has had a recent below-knee amputation tells the nurse that he feels as though his toes are cramping. What would the nurse say in return?
- A) Oh, that is all in your mind. Just forget it.
 - B) That is called phantom pain, and it is not unusual.
 - C) Well, that is really strange. I will notify the doctor.



- D) I think it might be good to refer you to a psychiatrist.
11. A patient tells the nurse that she is experiencing stabbing pain in her mouth, gums, teeth, and chin following brushing her teeth. These are symptoms of which of the following pain syndromes?
- A) complex regional pain syndrome
 - B) postherpetic neuralgia
 - C) trigeminal neuralgia
 - D) diabetic neuropathy
12. A nurse implements a back massage as an intervention to relieve pain. What theory is the motivation for this intervention?
- A) gate control theory
 - B) neuromodulation
 - C) large/small fiber theory
 - D) prostaglandin stimulation
13. A patient has been taught relaxation exercises before beginning a painful procedure. What chemicals are believed to be released in the body during relaxation to relieve pain?



- A) narcotics
 - B) sedatives
 - C) A-delta fibers
 - D) endorphins
14. How may a nurse demonstrate cultural competence when responding to patients in pain?
- A) Treat every patient exactly the same, regardless of culture.
 - B) Be knowledgeable and skilled in medication administration.
 - C) Know the action and side effects of all pain medications.
 - D) Avoid stereotyping responses to pain by patients.
15. Which of the following patients would be most likely to have decreased anxiety about, and response to, pain as a result of past experiences?
- A) one who had pain but got adequate relief
 - B) one who had pain but did not get relief
 - C) one who has had chronic pain for years



- D) one who has had multiple pain experiences
16. Which of the following misconceptions is common in patients in pain?
- A) I will get addicted to pain medications.
 - B) I need to ask for pain medications.
 - C) The nurses are here to help relieve the pain.
 - D) I do not have to fight the pain without help.
17. A nurse is assessing the vital signs of a patient who is moaning with pain. What would be the expected findings?
- A) decreased pulse and respirations
 - B) increased pulse and blood pressure
 - C) increased temperature
 - D) no change from usual results
18. A nurse asks a patient to rate his pain on a scale of 0 to 10, with 0 being no pain and 10 being worst pain. What characteristic of pain is the nurse assessing?
- A) duration



- B) location
 - C) chronology
 - D) intensity
19. A mother calls the nurse practitioner to say, I don't know what is wrong with my baby. He cried all night and kept pulling at his ear. How would the nurse respond?
- A) Oh, he probably was just hungry and wet. Did you feed him?
 - B) Babies at that age cry at night. Think nothing of it.
 - C) That means his ear hurt. Bring him in to be checked.
 - D) That probably means he had a tummy ache. How is he now?
20. A postoperative patient has not voided for 8 hours (since surgery). He is restless and complains of abdominal pain. How and what would the nurse assess before administering pain medications?
- A) Check database for last bowel movement.
 - B) Auscultate abdomen for bowel sounds.
 - C) Percuss abdomen for sounds of tympany.
 - D) Palpate abdomen for distended bladder.



21. Which of the following nonpharmacologic pain relief measures has been found to be effective for soothing agitated newborns and comatose patients?
- A) distraction
 - B) music
 - C) humor
 - D) imagery
22. What type of nonpharmacologic pain relief measure uses electrical stimulation to inhibit transmission of painful impulses?
- A) TENS
 - B) acupressure
 - C) acupuncture
 - D) hypnosis
23. What is the term used to describe a pharmaceutical agent that relieves pain?
- A) antacid
 - B) antihistamine



- C) analgesic
 - D) antibiotic
24. A patient with cancer pain is taking morphine for pain relief. Knowing constipation is a common side effect, what would the nurse recommend to the patient?
- A) Only take morphine when you have the most severe pain.
 - B) Increase fluids and high-fiber foods, and use a mild laxative.
 - C) Administer an enema to yourself every third day.
 - D) Constipation is nothing to worry about; take your medicine.
25. A nurse assesses a patient who is being given an opioid analgesic and finds the patient unresponsive to shaking or other stimuli. What drug might be ordered to reverse this state?
- A) Cortisone
 - B) Aspirin
 - C) Penicillin
 - D) Naloxone
26. Which of the following is the drug of choice to treat chronic pain in the home?



- A) oral morphine
- B) intravenous morphine
- C) NSAIDs
- D) antidepressants

27. Which of the following patients would benefit from a p.r.n. drug regimen?

- A) one who had thoracic surgery 12 hours ago
- B) one who had thoracic surgery 4 days ago
- C) one who has intractable pain
- D) one who has chronic pain

28. A nurse is teaching an alert patient how to use a PCA system in the home. How will she explain to the patient what he must do to self-manage pain?

- A) You don't have to do anything. The machine does it all.
- B) I will teach your family what they need to do.
- C) When you push the button, you will get the medicine.



- D) The medicine is going into your body all the time.
29. A physician orders a placebo for a patient. What is a placebo?
- A) an inactive substance given in place of a drug
 - B) a smaller than usual dose of an analgesic
 - C) an analgesic with no known side effects
 - D) an intravenous form of a potent analgesic
30. A nurse consults with a nurse practitioner trained to perform acupressure to teach the method to a patient being discharged. What process is involved in this pain relief measure?
- A) biofeedback
 - B) cutaneous stimulation
 - C) patient controlled analgesia
 - D) percutaneous electrical nerve stimulation

Answer Key

1. A, B, D, F



2. A

3. D

4. A

5. D

6. B

7. A

8. C

9. D

10. B

11. C

12. A

13. D

14. D

15. A



16. A

17. B

18. D

19. C

20. D

21. B

22. A

23. C

24. B

25. D

26. A

27. B

28. C

29. A



30. A



Chapter 37: Nutrition

1. A nurse researching a diet for a patient with diabetes includes foods that supply energy to the body. Which of the following are classes of nutrients that supply this energy? Select all that apply.
 - A) vitamins
 - B) proteins
 - C) fats
 - D) minerals
 - E) carbohydrates
 - F) water

2. Which of the following factors increase BMR? Select all that apply.
 - A) growth
 - B) infections
 - C) fever
 - D) emotional tension



- E) aging
 - F) fasting
3. A patient is discussing weight loss with a nurse. The patient says, I will not eat for 2 weeks, then I will lose at least 10 pounds. What should the nurse tell the patient?
- A) What a good idea. Go ahead. That will jump start your weight loss!
 - B) Many people find that to be an ideal way to lose weight quickly and easily.
 - C) That will increase your metabolic rate and help you lose weight.
 - D) That will decrease your metabolic rate and make weight loss more difficult.
4. Which of the following patients will have an increased metabolic rate and require nutritional interventions?
- A) a healthy young adult who works in an office
 - B) a retired person living in a temperate climate
 - C) a person with a serious infection and fever
 - D) an older, sedentary adult with painful joints
5. What best defines ideal body weight (IBW)?



- A) optimal weight for optimal health
 - B) weighing 10 pounds less than recommended
 - C) a weight that is predetermined for all people
 - D) the weight at which one feels most attractive
6. A nurse is establishing an ideal body weight for a 5'9" healthy female. Based on the rule-of-thumb method, what would be this patient's ideal weight?
- A) 130 lb
 - B) 135 lb
 - C) 140 lb
 - D) 145 lb
7. A nurse is helping a patient design a weight-loss diet. To lose 1 pound of fat (3,500 calories) per week, how many calories should be decreased each of the 7 days of the week?
- A) 100
 - B) 250
 - C) 500



- D) 1,000
8. A nurse performing a nutritional assessment determines BMI of a 5-foot 11-inch male patient who weighs 180 pounds. What would be the BMI for this patient?
- A) 18.5
- B) 20.3
- C) 25.1
- D) 28.2
9. What health problem may occur in a person who is on a low-carbohydrate diet for a long period of time?
- A) obesity
- B) fatigue
- C) ketosis
- D) infection
10. A hospitalized patient has been NPO with only intravenous fluid intake for a prolonged period. What assessments might indicate protein-calorie malnutrition?
- A) fever, joint pain, dehydration



- B) poor wound healing, apathy, edema
 - C) sleep disturbances, anger, increased output
 - D) weight gain, visual deficits, erythema of skin
11. Most nutritionists recommend increasing fiber in the diet. In addition to other benefits, how does fiber affect cholesterol?
- A) increases fecal excretion of cholesterol
 - B) decreases fecal excretion of cholesterol
 - C) facilitates intake and use of trans fat
 - D) raises blood cholesterol levels
12. How often would a nurse recommend a patient eat or drink a source of vitamin C?
- A) once a week
 - B) once a month
 - C) three times a week
 - D) every day



13. While reviewing an adult patients chart, a nurse notes average daily intake of fluids as 2,000 mL/day. What will the nurse do based on this information?
- A) Change the plan of care to include forcing fluids.
 - B) Ask the patient to drink more water during the day.
 - C) Post a sign limiting fluids to 1,000 mL each 24 hours.
 - D) Continue with care; this is a normal fluid intake.
14. A nurse has documented that a patient has anorexia. What does this term mean?
- A) eating more than daily requirements
 - B) lack of appetite
 - C) vitamin C deficiency
 - D) fluid deficit
15. At what percent of weight over ideal weight is a person considered obese?
- A) 20%
 - B) 40%



- C) 60%
- D) 100%
16. At what period of life do nutrient needs stabilize?
- A) infancy
- B) adolescence
- C) pregnancy
- D) adulthood
17. A nurse is discussing infant care with a woman who just had a baby girl. What type of nutrition would the nurse recommend for the infant?
- A) solid foods after the first month
- B) no solid foods until age 1 year
- C) bottle feeding with cows milk
- D) breastfeeding or formula with iron
18. A healthy, active 72-year-old woman asks a nurse if it is safe to take dietary supplements and, if so, what should be taken? What would the nurse tell her?



- A) Yes, take calcium, vitamin D, and vitamin B₁₂.
 - B) Yes, take iron, folic acid, and iodine.
 - C) No, instead increase intake of carbohydrates.
 - D) No, increase fat intake for fat-soluble vitamins.
19. A nurse is conducting a health history interview for an older adult. Which of the following questions or statements would be important for nutritional assessment?
- A) Why don't you eat more meat? You need protein.
 - B) When did you first notice that you had this sore on your heel?
 - C) What kinds of foods did you prepare when your husband was alive?
 - D) What prescribed and over-the-counter medicines do you take?
20. What information do anthropometric measurements provide in adults?
- A) indirect measure of protein and fat stores
 - B) direct measure of degree of obesity
 - C) indication of degree of growth rate



- D) reflection of social interaction with others
21. A nurse is teaching a young mother about meal preparation for good nutrition. What is one recommendation of the MyPyramid Food Guide?
- A) Increase intake of saturated fats.
 - B) Eat whole-grain foods with meals.
 - C) Change the number of food groups.
 - D) Decrease emphasis on chronic illness.
22. What independent nursing intervention can be implemented to stimulate appetite?
- A) Administer prescribed medications.
 - B) Recommend dietary supplements.
 - C) Encourage or provide oral care.
 - D) Assess manifestations of malnutrition.
23. A nurse is feeding a patient. Which of the following statements would help a person maintain dignity while being fed?
- A) I am going to feed you your cereal first and then your eggs.



- B) I wish I had more time so I could feed you all of your meal.
 - C) I know you don't like me to feed you, but you need to eat.
 - D) What part of your dinner would you like to eat first?
24. A patient has been prescribed a clear liquid diet. What food or fluids will be served?
- A) milk, frozen dessert, egg substitutes
 - B) high-calorie, high-protein supplements
 - C) hot cereals, ice cream, chocolate milk
 - D) Jell-O, carbonated beverages, apple juice
25. After the administration of a nasointestinal feeding tube, a patient complains of gas, abdominal pain, and dizziness. What do these symptoms indicate?
- A) aspiration of the feeding solution
 - B) lack of intestinal tone and constipation
 - C) a type of dumping syndrome
 - D) an infection of the gastrointestinal system



26. A student is following current recommendations for assessing tube placement. A staff nurse says, Oh, just insert air and listen for a whoosh sound. How would the student respond?

- A) Thank you. That would be much easier for me to do.
- B) That procedure has been found to be unreliable.
- C) My instructor told me to do it this way, so I will.
- D) I appreciate your advice. Let me ask the patient.

27. What is the most critical component of an enteral feeding formula?

- A) carbohydrates
- B) fats
- C) protein
- D) fiber

28. A nurse has assessed the residual amount before beginning a nasogastric tube feeding and has found 100 mL. What will the nurse do next?

- A) Nothing; this amount is within normal limits.
- B) Report the finding to the physician.



- C) Omit the feeding and document the reason.
 - D) Rinse the tube and repeat the assessment.
29. Which laboratory test is the best indicator of a patient in need of TPN?
- A) hemoglobin
 - B) hematocrit
 - C) serum albumin
 - D) creatinine
30. What is the route of administration for TPN?
- A) oral
 - B) subcutaneous
 - C) intramuscular
 - D) intravenous

Answer Key

1. B, C, E



2. A, B, C, D

3. D

4. C

5. A

6. D

7. C

8. C

9. C

10. B

11. A

12. D

13. D

14. B

15. A



16. D

17. D

18. A

19. D

20. A

21. B

22. C

23. D

24. D

25. C

26. B

27. C

28. A

29. C



30. D



Chapter 38: Urinary Elimination

1. The student nurse studying the anatomy and physiology of the urinary system knows that the following are functions of the bladder. Select all that apply.
 - A) The bladder serves as a temporary reservoir for urine.
 - B) The sympathetic system carries inhibitory impulses to the bladder .
 - C) Urine from the bladder empties into the pelvis of each kidney.
 - D) A fold of membrane in the bladder closes the entrance to the ureters when pressure exists.
 - E) The parasympathetic system carries motor impulses to the bladder and inhibitory impulses to the internal sphincter.
 - F) From the bladder, urine is transported by rhythmic peristalsis through the ureters to the kidneys.

2. A nurse is preparing to catheterize a female patient. What will the nurse consider when comparing the anatomy of the female urethra with that of the male urethra?
 - A) has different innervation
 - B) no connection with bladder
 - C) shorter in length



- D) longer in length
3. Which of the following describes the term micturition?
- A) emptying the bladder
- B) catheterizing the bladder
- C) collecting a urine specimen
- D) experiencing total incontinence
4. A nurse working in a community pediatric clinic explains the process of toilet training to mothers of toddlers. Which of the following is a recommended guideline for initiating this training?
- A) The child should be able to hold urine for 4 hours.
- B) The child should be between 18 and 24 months old.
- C) The child should be able to communicate the need to void.
- D) The child does not need to desire to gain control of voiding.
5. A nurse is caring for elderly patients in an assisted-living facility. Which of the following effects of aging should the nurse consider when performing a urinary assessment?



- A) The diminished ability of the kidneys to concentrate urine may result in urinary tract infection.
 - B) Increased bladder muscle tone may reduce the capacity of the bladder to hold urine, resulting in frequency.
 - C) Decreased bladder contractility may lead to urine retention and stasis, which increase the likelihood of urinary tract infection.
 - D) Neuromuscular problems may result in the patient finding urinary control too much trouble, resulting in incontinence.
6. A nurse is assessing the urine output of a patient with Parkinsons disease who is on levodopa. Which of the following is a common finding for a patient on this medication?
- A) The urine may be brown or black.
 - B) The urine may be blood tinged.
 - C) The urine may be green or blue-green.
 - D) The urine may be orange or orange-red.
7. A patient tells the nurse, Every time I sneeze, I wet my pants. What is this type of involuntary escape of urine called?
- A) urinary incontinence
 - B) urinary incompetence



- C) normal micturition
 - D) uncontrolled voiding
8. During a health history interview, a male patient tells the nurse that he does not feel that he completely empties his bladder when he voids. He has been diagnosed with an enlarged prostate. What is the name of this symptom?
- A) urinary incontinence
 - B) urinary retention
 - C) involuntary voiding
 - D) urinary frequency
9. A nurse is assessing the urine on a newborn's diaper. What would be a normal assessment finding?
- A) scanty to no urine
 - B) highly concentrated urine
 - C) light in color and odorless
 - D) dark in color and odorous



10. An older woman who is a resident of a long-term care facility has to get up and void several times during the night. This can be the result of what physiologic change with normal aging?
- A) diminished kidney ability to concentrate urine
 - B) increased bladder muscle tone causing urinary frequency
 - C) increased bladder contractility causing urinary stasis
 - D) decreased intake of fluids during daytime hours
11. A nurse is conducting a health history interview for an office patient who is having problems with urinary control. What would be an appropriate interview question to collect further data?
- A) Why don't you go to the bathroom more?
 - B) How have you handled this problem?
 - C) What does your wife think about this problem?
 - D) What makes you think you have a problem?
12. After surgery, a postoperative patient has not voided for 8 hours. Where would the nurse assess the bladder for distention?
- A) between the symphysis pubis and the umbilicus



- B) over the costovertebral region of the flank
 - C) in the left lower quadrant of the abdomen
 - D) between ribs 11 and 12 and the umbilicus
13. A nurse is delegating the collection of urinary output to an assistant. What should the nurse tell the assistant to do while measuring the urine?
- A) Compare the amount of output with intake.
 - B) Use a clean measuring cup for each voiding.
 - C) Tell the patient to wash the urethra before voiding.
 - D) Wear gloves when handling a patients urine.
14. A nurse has instructed a clinic patient about collecting a specimen for a routine urinalysis. The patient makes the following statements. Which one indicates a need for more teaching?
- A) I need to tell you that I am having my menstrual period.
 - B) I will void into the specimen bottle you gave me.
 - C) I will keep the toilet paper in the specimen.
 - D) I will be sure that no stool is included in my urine.



15. A student is collecting a sterile urine specimen from an indwelling catheter. How will the student correctly obtain the specimen?
- A) Pour urine from the collecting bag.
 - B) Remove the catheter and ask the patient to void.
 - C) Aspirate urine from the collecting bag.
 - D) Aspirate urine from the collection port.
16. A nurse is initiating a 24-hour urine collection for a patient at home. What will be the first thing the nurse will ask the patient to do at the beginning of the specimen collection?
- A) Void and discard the urine.
 - B) Begin the collection at a specific time.
 - C) Add the first voiding to the specimen.
 - D) Keep the urine warm during collection.
17. An elderly woman living alone at home is incontinent of urine. Which of the following nursing diagnoses would be appropriate for a plan of care?
- A) Risk for Activity Intolerance
 - B) Risk for Impaired Skin Integrity



- C) Risk for Falls
 - D) Risk for Infection
18. An older adult woman has constant dribbling of urine. The associated discomfort, odor, and embarrassment may support which of the following nursing diagnoses?
- A) Social Isolation
 - B) Impaired Adjustment
 - C) Defensive Coping
 - D) Impaired Memory
19. A male patient who has had outpatient surgery is unable to void while lying supine. What can the nurse do to facilitate his voiding?
- A) Assist him to a standing position.
 - B) Tell him he has to void to be discharged.
 - C) Pour cold water over his genitalia.
 - D) Ask his wife to assist with the urinal.
20. A nurse is teaching a patient about the amount of water to drink each day. What is the recommended daily fluid intake for adults?



- A) 1 to 2 (4-oz) glasses per day
 - B) 5 to 6 (6-oz) glasses per day
 - C) 8 to 10 (8-oz) glasses per day
 - D) 16 to 20 (12-oz) glasses per day
21. A nurse is carrying out an order to remove an indwelling catheter. What is the first step of this skill?
- A) Deflate the balloon by aspirating the fluid.
 - B) Ask the patient to take several deep breaths.
 - C) Tell the patient burning may initially occur.
 - D) Wash hands and put on gloves.
22. A nurse has catheterized a patient to obtain urine to measure postvoid residual (PVR) amount. The nurse obtains 40 mL of urine. What should the nurse do next?
- A) Report this abnormal finding to the physician.
 - B) Perform another catheterization to verify the amount.
 - C) Document this normal finding for postvoid residual.



- D) Palpate the abdomen for a distended bladder.
23. A nurse is inserting an indwelling urethral catheter. What type of supplies will the nurse need for this procedure?
- A) a clean catheter and rubber gloves
- B) a sterile catheterization kit or tray
- C) solutions to sterilize the urethra
- D) solutions to sterilize the vagina
24. A patient has been taught how to do Kegel exercises. What statement by the patient indicates a need for further information?
- A) I understand these will help me control stress incontinence.
- B) I know this is also called pelvic floor muscle training.
- C) I will do these 30 to 80 times a day for 2 months.
- D) I will contract the muscles in my abdomen and thighs.
25. A man with urinary incontinence tells the nurse he wears adult diapers for protection. What risks should the nurse discuss with this patient?
- A) public embarrassment



- B) skin breakdown and UTI
 - C) inability to control urine
 - D) odor and leakage
26. A patient complains of having to void frequently, burning on urination, and odorous urine. Based on these assessment findings, the nurse would suspect the patient has which of the following conditions?
- A) stress incontinence
 - B) urge incontinence
 - C) urinary tract infection
 - D) lower colon infection
27. A school nurse is teaching a class of middle-school girls how to promote urinary system health. Which of the following statements by one of the girls indicates a need for more information?
- A) I will take showers rather than baths.
 - B) I will wear underpants with cotton crotches.
 - C) I will tell my parents if I have burning or pain.
 - D) I will wipe back to front after going to the toilet.



28. A home care patient has an indwelling catheter connected to a leg bag. What can the nurse recommend to help prevent development of a urinary tract infection?
- A) Empty the leg bag at regular intervals.
 - B) Always wipe from front to back after voiding.
 - C) Restrict intake of fluids to decrease amount of urine.
 - D) Take the tubing apart and wash it each day.
29. A patient is taking diuretics. What should the nurse teach the patient about his urine?
- A) Urinary output will be decreased.
 - B) Urinary output will be increased.
 - C) Urine will be a pale yellow color.
 - D) Urine may be brown or black.
30. A nurse is preparing a patient for an invasive diagnostic procedure of the urinary system. What statement by the nurse would help reduce the patients anxiety?
- A) We do these procedures every day, so you dont need to worry.
 - B) I have had this done to me, and it only hurt for a little while.



C) Why are you so worried? Do you think you have a tumor?

D) Let me explain to you what they do during this procedure.

Answer Key

1. A, B, D, E

2. C

3. A

4. C

5. C

6. A

7. A

8. B

9. C

10. A

11. B



12. A

13. D

14. C

15. D

16. A

17. B

18. A

19. A

20. C

21. D

22. C

23. B

24. D

25. B



26. C

27. D

28. A

29. C

30. D



Chapter 39: Bowel Elimination

1. The student nurse studying bowel elimination learns that the following statements accurately describe the process of peristalsis. Select all that apply.
 - A) The sympathetic nervous system stimulates movement.
 - B) The autonomic nervous system innervates the muscles of the colon.
 - C) Peristalsis occurs every 3 to 12 minutes.
 - D) Mass peristaltic sweeps occur one to four times each 24-hour period in most people.
 - E) Mass peristalsis often occurs after food has been ingested.
 - F) One-third to one-half of ingested food waste is normally excreted in the stool within 48 hours.
2. Based on knowledge of the physiology of the gastrointestinal tract, what type of stools would the nurse assess in a patient with an illness that causes the stool to pass through the large intestine quickly?
 - A) hard, formed
 - B) black, tarry
 - C) soft, watery



- D) dry, odorous
3. What term is used to describe intestinal gas?
- A) feces
- B) stool
- C) peristalsis
- D) flatus
4. Which of the following statements accurately describes the act of defecation?
- A) Defecation refers to the emptying of the small intestine.
- B) Centers in the medulla and the spinal cord govern the reflex to defecate.
- C) When sympathetic stimulation occurs, the internal anal sphincter relaxes and the colon contracts sending fecal content to the rectum.
- D) Rectal distention leads to a decrease in intrarectal pressure, causing the muscles to stretch and thereby stimulating the defecation reflex.
5. A nurse is assessing the stools of a breastfed baby. What is the appearance of normal stools for this baby?
- A) yellow, loose, odorless



- B) brown, paste-like, some odor
 - C) brown, formed, strong odor
 - D) black, semifformed, no odor
6. A hospitalized toddler, previously bowel trained, has been having incontinent stools. What would the nurse tell the parents about this behavior?
- A) When he does this, scold him and he will quit.
 - B) I dont understand why this child is losing control.
 - C) This is normal when a child this age is hospitalized.
 - D) I will have to call the doctor and report this behavior.
7. A nurse caring for elderly patients in an assisted-living facility encourages patients to eat a diet high in fiber to avoid which of the following developmental risk factors for this group?
- A) diarrhea
 - B) fecal incontinence
 - C) constipation
 - D) flatus



8. A patient is having difficulty having a bowel movement on the bedpan. What is the physiologic reason for this problem?
- A) It is painful to sit on a bedpan.
 - B) The position does not facilitate downward pressure.
 - C) The position encourages the Valsalva maneuver.
 - D) The cause is unknown and requires further study.
9. The following foods are a part of a patient's daily diet: high-fiber cereals, fruits, vegetables, 2,500 mL of fluids. What would the nurse tell the patient to change?
- A) decrease high-fiber foods
 - B) decrease amount of fluids
 - C) omit fruits if eating vegetables
 - D) nothing; this is a good diet
10. A young woman comes to the Emergency Department with severe abdominal cramping and frequent bloody stools. Food poisoning is suspected. What diagnostic test would be used to confirm this diagnosis?
- A) routine urinalysis



- B) chest x-ray
 - C) stool sample
 - D) sputum sample
11. A patient with terminal cancer is taking high doses of a narcotic for pain. The nurse will teach the patient or family about what common side effect of opioids?
- A) inability to change positions
 - B) problems with communication
 - C) diarrhea
 - D) constipation
12. A nurse is assessing a patient the first day after colon surgery. Based on knowledge of the effects of anesthesia and manipulation of the bowel during surgery, what focused assessment will be included?
- A) bowel sounds
 - B) skin turgor
 - C) pulse character
 - D) urinary output



13. A nurse has auscultated the abdomen in all four quadrants for 5 minutes and has not heard any bowel sounds. How would this be documented?
- A) Auscultated abdomen for bowel sounds, bowel not functioning.
 - B) All four abdominal quadrants auscultated. Inaudible bowel sounds.
 - C) Bowel sounds auscultated. Patient has no bowel sounds.
 - D) Patient may have bowel sounds, but they cant be heard.
14. A nurse is conducting an abdominal assessment. What is the rationale for palpating the abdomen last when conducting an abdominal assessment?
- A) it is the most painful assessment method
 - B) it is the most embarrassing assessment method
 - C) to allow time for the examiners hands to warm
 - D) it disturbs normal peristalsis and bowel motility
15. What are two essential techniques when collecting a stool specimen?
- A) hand hygiene and wearing gloves
 - B) following policies and selecting containers



- C) wearing goggles and an isolation gown
 - D) using a no-touch method and toilet paper
16. A Hematest for occult blood in the stool has been ordered. What is occult blood?
- A) bright red visible blood
 - B) dark black visible blood
 - C) blood that contains mucus
 - D) blood that cannot be seen
17. A nurse is scheduling ordered diagnostic studies for a patient. Which of the following tests would be performed first?
- A) fecal occult blood test
 - B) barium study
 - C) endoscopic exam
 - D) upper gastrointestinal series
18. A patient has had frequent watery stools (diarrhea) for an extended period of time. The patient also has decreased skin turgor and dark urine. Based on these data, which of the following nursing diagnoses would be appropriate?



- A) Imbalanced Nutrition: Less than Body Requirements
 - B) Deficient Fluid Volume
 - C) Impaired Tissue Integrity
 - D) Impaired Urinary Elimination
19. An infant has had diarrhea for several days. What assessments will the nurse make to identify risks from the diarrhea?
- A) heart tones
 - B) lung sounds
 - C) skin turgor
 - D) activity level
20. A patient tells the nurse that he takes laxatives every day but is still constipated. The nurse's response is based on which of the following?
- A) Habitual laxative use is the most common cause of chronic constipation.
 - B) If laxatives are not effective, the patient should begin to use enemas.
 - C) A laxative that works by a different method should be used.



- D) Chronic constipation is nothing to be concerned about.
21. A patient who has been on a medication that caused diarrhea is now off the medication. What could the nurse suggest to promote the return of normal flora?
- A) stool-softening laxatives, such as Colace
- B) increasing fluid intake to 3,000 mL/day
- C) drinking fluids with a high sugar content
- D) eating fermented products, such as yogurt
22. A patient is on bedrest, and an enema has been ordered. In what position should the nurse position the patient?
- A) Fowlers
- B) Sims
- C) Prone
- D) Sitting
23. A patient is having liquid fecal seepage. He has not had a bowel movement for 6 days. Based on the data, what would the nurse assess?
- A) amount of intake and output



- B) color and amount of urine
 - C) color of the feces
 - D) consistency of the feces
24. Which of the following would be an expected outcome for a patient when the nurse is conducting a bowel training program?
- A) Have a soft, formed stool at regular intervals without a laxative.
 - B) Continue to use laxatives, but use one less irritating to the rectum.
 - C) Use oil-retention enemas on a regular basis for elimination.
 - D) Have a formed stool at least twice a day for 2 weeks.
25. A patient tells the nurse, I increased my fiber, but I am very constipated. What further information does the nurse need to tell the patient?
- A) Just give it a few more days and you should be fine.
 - B) Well, that shouldnt happen. Let me recommend a good laxative for you.
 - C) When you increase fiber in your diet, you also need to increase liquids.
 - D) I will tell the doctor you are having problems; maybe he can help.



26. A nurse is caring for a patient with a colostomy. What type of stools would she expect to find in the colostomy bag?
- A) liquid
 - B) watery
 - C) formed
 - D) none
27. A nurse is documenting the appearance of feces from a patient with a permanent ileostomy. Which of the following would she document?
- A) Ileostomy bag half filled with liquid feces.
 - B) Ileostomy bag half filled with hard, formed feces.
 - C) Colostomy bag intact without feces.
 - D) Colostomy bag filled with flatus and feces.
28. A nurse is assessing the stoma of a patient with an ostomy. What would the nurse assess in a normal, healthy stoma?
- A) pallor
 - B) purple-blue



- C) irritation and bleeding
- D) dark red and moist
29. A nurse is caring for a patient who is 1 day postoperative for a temporary colostomy. The nurse assesses no feces in the collection bag. What should the nurse do next?
- A) Notify the physician immediately.
- B) Ask another nurse to check her findings.
- C) Nothing; this is normal.
- D) Recheck the bag in 2 hours.
30. A nurse is providing discharge instructions for a patient with a new colostomy. Which of the following is a recommended guideline for long-term ostomy care?
- A) During the first 6 to 8 weeks after surgery, eat foods high in fiber.
- B) Drink at least 2 quarts of fluids, preferably water, daily.
- C) Use enteric-coated or sustained-release medications if needed.
- D) Use a mild laxative if needed.

Answer Key



1. B, C, D, E

2. C

3. D

4. B

5. A

6. C

7. C

8. B

9. D

10. C

11. D

12. A

13. B

14. D



15. A

16. D

17. A

18. B

19. C

20. A

21. D

22. B

23. D

24. A

25. C

26. C

27. A

28. D



29. C

30. B



Chapter 40: Oxygenation and Perfusion

1. A patient has had a head injury affecting the brainstem. What is located in the brainstem that may affect respiratory function?
 - A) chemoreceptors
 - B) stretch receptors
 - C) respiratory center
 - D) oxygen center

2. Which of the following diseases may result in decreased lung compliance?
 - A) emphysema
 - B) appendicitis
 - C) acne
 - D) chronic diarrhea

3. A nurse is caring for a patient with pneumonia. The patient's oxygen saturation is below normal. What abnormal respiratory process does this demonstrate?
 - A) changes in the alveolar-capillary membrane and diffusion



- B) alterations in the structures of the ribs and diaphragm
 - C) rapid decreases in atmospheric and intrapulmonic pressures
 - D) lower-than-normal concentrations of environmental oxygen
4. While reading a physicians progress notes, a student notes that an assigned patient is having hypoxia. What abnormal assessments would the student expect to find?
- A) abdominal pain, hyperthermia, dry skin
 - B) diarrhea, flatulence, decreased skin turgor
 - C) hypotension, reddened skin, edema
 - D) dyspnea, tachycardia, cyanosis
5. In what age group would a nurse expect to assess the most rapid respiratory rate?
- A) older adults
 - B) middle adults
 - C) adolescents
 - D) infants



6. A father of a preschool-aged child tells the nurse that his child has had a constant cold since going to daycare. How would the nurse respond?
- A) Your child must have a health problem that needs medical care.
 - B) Children in daycare have more exposure to colds.
 - C) Are you washing your hands before you touch the child?
 - D) Be sure and have your child wear a protective mask at school.
7. A 90-year-old woman has been in an automobile crash and sustained four fractured ribs on the left side of her thorax. Based on her age and the injury, what complication is she at risk for?
- A) pneumonia
 - B) altered thought processes
 - C) urinary incontinence
 - D) viral influenza
8. Which of the following individuals is at greater risk for respiratory illnesses from environmental causes?
- A) a farmer on a large farm
 - B) a factory worker in a large city



- C) a woman living in a small town
 - D) a child living in a rural area
9. A nurse is beginning to conduct a health history for a patient with respiratory problems. He notes that the patient is having respiratory distress. What would the nurse do next?
- A) Continue with the health history, but more slowly.
 - B) Ask questions of the family instead of the patient.
 - C) Conduct the interview later and let the patient rest.
 - D) Initiate interventions to help relieve the symptoms.
10. A nurse is percussing the thorax of a patient with chronic emphysema. What percussion sound would most likely be assessed?
- A) resonance
 - B) hyperresonance
 - C) flat
 - D) tympany



11. An emergency room nurse is auscultating the chest of a child who is having an asthmatic attack. Auscultation reveals the presence of wheezes. During what part of respirations do wheezes occur?
- A) inspiration and expiration
 - B) only on inspiration
 - C) only on expiration
 - D) when coughing
12. A patient is experiencing hypoxia. Which of the following nursing diagnoses would be appropriate?
- A) Anxiety
 - B) Nausea
 - C) Pain
 - D) Hypothermia
13. A nurse is caring for a toddler who is having an acute asthmatic attack with copious mucus and difficulty breathing. The child's skin is cyanotic, respirations are labored and rapid, and pulse is rapid. What nursing diagnosis would have priority for care of this child?
- A) Anxiety



- B) Ineffective Airway Clearance
 - C) Excess Fluid Volume
 - D) Disturbed Sensory Perception
14. What information would a home care nurse provide to a patient who is measuring peak expiratory flow rate at home?
- A) Although the test is uncomfortable, it is not painful.
 - B) You will be asked to forcefully exhale into a mouthpiece.
 - C) The test is used to determine how much air you inhale.
 - D) You will do this each morning while still lying in bed.
15. What does pulse oximetry measure?
- A) cardiac output
 - B) peripheral blood flow
 - C) arterial oxygen saturation
 - D) venous oxygen saturation



16. Of all factors, what is the most important risk factor in pulmonary disease?
- A) air pollution from vehicles
 - B) dangerous chemicals in the workplace
 - C) active and passive cigarette smoke
 - D) loss of the ozone layer of the atmosphere
17. A nurse is caring for a patient who suddenly begins to have respiratory difficulty. In what position would the nurse place the patient to facilitate respirations?
- A) supine
 - B) prone
 - C) high Fowlers
 - D) dorsal recumbent
18. A nurse is teaching a preoperative patient how to effectively deep breathe. Which of the following would be included?
- A) Make each breath deep enough to move the bottom ribs.
 - B) Breathe through the mouth when you inhale and exhale.



- C) Breathe in through the mouth and out through the nose.
 - D) Practice deep breathing at least once each week.
19. A nurse is teaching a home care patient how to do pursed-lip breathing. What is the therapeutic effect of this procedure?
- A) using upper chest muscles more effectively
 - B) replacing the use of incentive spirometry
 - C) reducing the need for p.r.n. pain medications
 - D) prolonging expiration to reduce airway resistance
20. A nurse is explaining a chest tube to family members who do not understand where it is placed. What would the nurse tell them?
- A) It is inserted into the space between the lining of the lungs and the ribs.
 - B) I dont exactly know, but I will make sure the doctor comes to explain.
 - C) It is inserted directly into the lung itself, connecting to a lung airway.
 - D) It is inserted into the peritoneal space and drains into the lungs.
21. What prevents air from re-entering the pleural space when chest tubes are inserted?



- A) the location of the tube insertion
 - B) the sutures that hold in the tube
 - C) a closed water-seal drainage system
 - D) respiratory inspiration and expiration
22. What is the action of codeine when used to treat a cough?
- A) antissuppressant
 - B) suppressant
 - C) antihistamine
 - D) expectorant
23. A nurse is teaching a patient who has congested lungs how to keep secretions thin and more easily coughed up and expectorated. What would be one self-care measure to teach?
- A) Limit oral intake of fluids to less than 500 mL per day.
 - B) Increase oral intake of fluids to 2 to 3 quarts per day.
 - C) Maintain bedrest for at least 3 days.



- D) Take warm baths every night for a week.
24. What category of medications may be administered by nebulizer or metered-dose inhaler to open narrowed airways?
- A) bronchoconstrictors
- B) antihistamines
- C) narcotics
- D) bronchodilators
25. A nurse is teaching a home care patient and his family about using prescribed oxygen. What is a critical factor that must be included in teaching?
- A) the importance of communicating with the patient
- B) the safety measures necessary to prevent a fire
- C) the cost and source of supply for the oxygen
- D) the need to provide good skin care
26. What can a nurse ask a patient to do before suctioning to prevent hypoxemia?
- A) Sit in an upright position and cough.



- B) Breathe normally for at least 5 minutes.
 - C) Lie flat in bed and practice relaxation.
 - D) Take several deep breaths.
27. A patient has had a tracheostomy and the nurse is prepared to conduct tracheostomy care. What part of the tracheostomy tube is removed for cleaning?
- A) obturator
 - B) outer cannula
 - C) inner cannula
 - D) cuff
28. What is the rationale for placing a writing board in the room of a patient who has had surgery to insert a tracheostomy tube?
- A) The patient is not able to speak.
 - B) Verbal communication will be too tiring.
 - C) It will occupy the patients time.
 - D) Voice rest will decrease pain levels.



29. A student observes a nurse instilling a small amount of saline into a tracheostomy tube before suctioning. What should the student discuss with the nurse?
- A) a description of how the nurse is carrying out the skill
 - B) saline is no longer recommended for routine suctioning
 - C) nothing; the nurse has been doing this for years
 - D) compliments for carrying out the procedure skillfully
30. A home care nurse finds a patient lying on the floor. The patient is not breathing. Her response is based on the ABCs of basic life support. What does the B stand for in these initials?
- A) blood
 - B) beware
 - C) breathing
 - D) be sure
31. A nurse is caring for older adults in a nursing home. Which of the following age-related changes may affect the respiratory functioning of the patients living there? Select all that apply.
- A) increased elastic recoil of the lungs



- B) less fibrous tissue in alveoli
 - C) increase in vital capacity and residual volume
 - D) less air exchange, more secretions in lungs
 - E) greater risk for aspiration due to slower gastric motility
 - F) impaired mobility and inactivity, effects of medication
32. Which of the following statements accurately describe a step for inserting an oropharyngeal airway? Select all that apply.
- A) Use an airway that is the correct size (size 90 mm is appropriate for the average adult).
 - B) Airway should reach from opening of mouth to the back angle of the jaw.
 - C) Position patient on his or her stomach with neck hyperextended (unless this is inappropriate).
 - D) Open patients mouth by using your thumb and index finger to gently pry teeth apart.
 - E) Insert the airway with the curved tip pointing up toward the roof of the mouth.
 - F) Rotate the airway 360 degrees as it passes the uvula.

Answer Key



1. C

2. A

3. A

4. D

5. D

6. B

7. A

8. B

9. D

10. B

11. A

12. A

13. B

14. B



15. C

16. C

17. C

18. A

19. D

20. A

21. C

22. B

23. B

24. D

25. B

26. D

27. C

28. A



29. B

30. C

31. D, E, F

32. A, B, D, E



Chapter 41: Fluid, Electrolyte, and Acid-Base Balance

1. The student nurse studying fluid and electrolyte balance learns that which of the following is a function of water? Select all that apply.
 - A) provide a medium for transporting wastes to cells and nutrients from cells
 - B) provide a medium for transporting substances throughout the body
 - C) facilitate cellular metabolism and proper cellular chemical functioning
 - D) act as a buffer for electrolytes and nonelectrolytes
 - E) help maintain normal body temperature
 - F) facilitate digestion and promote elimination

2. Which body fluid is the fluid within the cells, constituting about 70% of the total body water?
 - A) extracellular fluid (ECF)
 - B) intracellular fluid (ICF)
 - C) intravascular fluid
 - D) interstitial fluid



3. Based on knowledge of total body fluids, a nurse is especially watchful for a fluid volume deficit in an infant. Why would the nurse do this?
- A) Infants have less total body fluid and ECF than adults.
 - B) Infants have more total body fluid and ECF than adults.
 - C) Infants drink less fluid than adults.
 - D) Infants lose more fluids through output than adults.
4. What is the average adult fluid intake and loss in each 24 hours?
- A) 500 to 1,000 mL
 - B) 1,000 to 1,500 mL
 - C) 1,500 to 2,000 mL
 - D) 1,500 to 3500 mL
5. A nurse monitoring the intake and output of fluids for a patient with severe diarrhea knows that normally how many mL of body fluids is lost via the gastrointestinal tract?
- A) 300 mL
 - B) 1,000 mL



- C) 1,300 mL
- D) 2,600 mL
6. A nurse explains the homeostatic mechanisms involved in fluid homeostasis to a student nurse. Which of the following statements accurately describe this process? Select all that apply.
- A) The kidneys selectively retain electrolytes and water and excrete wastes and excesses according to the body's needs.
- B) The cardiovascular system is responsible for pumping and carrying nutrients and water throughout the body.
- C) The thyroid gland secretes aldosterone, a mineralocorticoid hormone that helps the body conserve sodium, helps save chloride and water, and causes potassium to be excreted.
- D) The lungs regulate oxygen and carbon dioxide levels of the blood, which is especially crucial in maintaining acid-base balance.
- E) Thyroxine, released by the adrenal glands, increases blood flow in the body, leading to increased renal circulation and resulting in increased glomerular filtration and urinary output.
- F) The parathyroid glands secrete parathyroid hormone, which regulates the level of calcium and phosphorus.
7. By what route do oxygen and carbon dioxide exchange in the lung?
- A) osmosis



- B) filtration
 - C) diffusion
 - D) active transport
8. Which of the following descriptions best summarizes fluid homeostasis?
- A) Almost every body organ and system helps maintain homeostasis.
 - B) The cardiovascular and renal systems primarily maintain homeostasis.
 - C) Homeostasis is maintained through intra- and extracellular exchange.
 - D) Homeostasis is maintained by the arterioles, capillaries, and venules.
9. A nurse reads the laboratory report for a patient and notes that the patient has hyponatremia. What physical assessment would be made?
- A) Observe skin color and texture.
 - B) Auscultate bowel sounds.
 - C) Percuss lung density.
 - D) Palpate skin of sternum.



10. A home care patient is complaining of weakness and leg cramps. Per order, the nurse draws blood and requests a potassium level. What is the rationale for this request?
- A) The nurse is concerned that the patient's diet has caused sodium loss.
 - B) The nurse recognizes these symptoms of hypokalemia.
 - C) The patient is actively seeking increased attention.
 - D) The patient had bananas and orange juice for breakfast.
11. A patient's PaCO_2 is abnormal on an ABG report. Which of the following illnesses would most likely be the medical diagnosis?
- A) rheumatoid arthritis
 - B) sexually transmitted infection
 - C) chronic obstructive pulmonary disease
 - D) infection of the bladder and ureters
12. A patient has metabolic (nonrespiratory) acidosis. What type of respirations would be assessed?
- A) periods of apnea
 - B) decreased depth and rate



- C) increased depth and rate
 - D) alternating fast and slow
13. Which of the following questions about fluid balance would be appropriate when conducting a health history for a patient?
- A) Describe your usual urination habits.
 - B) Describe your problems with constipation.
 - C) How did you feel when your calcium was low?
 - D) Do you eat fruits and vegetables each day?
14. A patient is taking a diuretic that increases her urinary output. What would be an appropriate nursing diagnosis on which to base a teaching plan?
- A) Impaired Skin Integrity
 - B) Risk for Deficient Fluid Volume
 - C) Impaired Urinary Elimination
 - D) Urinary Retention
15. A nurse measures a patients 24-hour fluid intake and documents the findings. To be an accurate indicator of fluid status, what must the nurse also do with the information?



- A) Compare the patients intake with the normal range of adult fluid intake.
 - B) Report the exact milliliter of intake to the physicians office nurse.
 - C) Compare the total intake and output of fluids for the 24 hours.
 - D) Ensure that the information is included in the verbal end-of-shift report.
16. A nurse reads a complete blood count report for a patient who has been admitted to the hospital with fluid overload from late-stage kidney disease. What abnormal result would the nurse expect to find?
- A) increased white blood cells
 - B) increased platelets
 - C) decreased hematocrit
 - D) increased hematocrit
17. A patient has a decreased potassium level. What high-potassium foods would the nurse teach the patient to eat?
- A) lunch meat, salted nuts, whole milk
 - B) buttermilk, hard candy, spinach
 - C) carbonated beverages, beer, olives



- D) oranges, bananas, broccoli
18. A physician writes an order to force fluids. What will be the first action the nurse will take in implementing this order?
- A) Explain to the patient why this is needed.
- B) Tell the patient and family to increase oral intake.
- C) Decide how much fluid to increase each 8 hours.
- D) Divide the intake so the largest amount is at night.
19. A patient has an order to restrict fluids. What is one comfort measure nurses can implement for this patient to alleviate a common problem?
- A) back rubs
- B) chewing gum
- C) hair care
- D) oral hygiene
20. A nurse is administering a potassium supplement to a patient. What will the nurse do to disguise the taste and decrease gastric irritation?
- A) dilute it



- B) give it after meals
 - C) mix it with food
 - D) freeze it
21. A student is learning how to administer intravenous fluids, including accessing a vein. Although all of the following may occur, which is the most potentially harmful risk posed for the patient when accessing the vein?
- A) discomfort
 - B) pain
 - C) minor bleeding
 - D) infection
22. Which of the following locations might the nurse use to assess the condition of an insertion site for a central venous access device?
- A) below the sternum
 - B) over the fourth intercostal space
 - C) over the jugular vein
 - D) the back of the hand



23. A specially trained nurse has inserted a PICC line. What would be done next?
- A) Start administration of prescribed fluids.
 - B) Explain the procedure to the patient and family.
 - C) Place the patient on restricted oral fluids.
 - D) Send the patient to the radiology department.
24. A woman has had her left breast removed for cancer. She also had an axillary node dissection on the left during surgery. How would this affect placement of an intravenous line?
- A) Either arm may be used.
 - B) Neither arm should be used.
 - C) The left arm should not be used.
 - D) The right arm should not be used.
25. Cross-matching of blood is ordered for a patient before major surgery. What does this process do?
- A) determines compatibility between blood specimens
 - B) determines a persons blood type



- C) predicts the amount of needed blood replacement
 - D) specifies the donor and the recipient of the blood
26. A patient asks a nurse if it is possible to contract a disease by donating blood. How would the nurse respond?
- A) There is only a very small chance; I know you will be safe.
 - B) Although hepatitis is possible, AIDS is not.
 - C) If I were you, I would request special handling of my blood.
 - D) There is no way you can contract a disease by giving blood.
27. A patient scheduled for surgery has arranged for an autologous transfusion. What type of blood transfusion is this?
- A) The patients family members have been donors.
 - B) The patient donates his or her own blood.
 - C) The patients blood has been rendered sterile.
 - D) The patient will only need fluids, not blood.
28. A patient is having a blood transfusion, but the fluid is dripping very slowly. The blood has been infusing for more than 4 hours. What should the nurse do next?



- A) Continue with the transfusion and document the drip rate.
 - B) Report to the next shift the amount of blood left to infuse.
 - C) Take and record vital signs more often.
 - D) Discontinue the blood transfusion.
29. Which of the following patients would be the most likely candidate for the administration of total parenteral nutrition?
- A) a patient with severe pancreatitis
 - B) a patient with a myocardial infarction
 - C) a patient with hepatitis B
 - D) a patient with mild malnutrition
30. A nurse is initiating a peripheral venous access IV infusion ordered for a patient presurgically. In what position would the nurse place the patient to perform this skill?
- A) high Fowlers
 - B) low Fowlers
 - C) Sims



D) dorsal recumbent

Answer Key

1. B, C, E, F

2. B

3. B

4. D

5. A

6. A, B, D, F

7. C

8. A

9. D

10. B

11. C

12. C



13. A

14. B

15. C

16. C

17. D

18. A

19. D

20. A

21. D

22. C

23. D

24. C

25. A

26. D



27. B

28. D

29. A

30. B



Chapter 42: Self-Concept

1. Which of the following terms best describes an individual's self-concept?
 - A) self-esteem
 - B) self-actualization
 - C) self-realization
 - D) self-image

2. A young woman patient admits to a nurse that she cannot control her jealousy when she and her partner are out together and states, 'It's like we're back in high school again.' This is an example of which of the following identity disorders?
 - A) self-actualization
 - B) identity diffusion
 - C) depersonalization
 - D) lack of self-esteem

3. Which of the following are specific components of self-concept? Select all that apply.
 - A) personal identity



- B) personal wealth
 - C) body image
 - D) self-esteem
 - E) role performance
 - F) personal space
4. The wife of an elderly man has recently died. The couple was married for 32 years. What part of the mans self-concept may be influenced by this loss?
- A) ideal self
 - B) global self
 - C) body image
 - D) false self
5. A teenager describes herself as tall, attractive, female, student, intelligent. What part of her self-concept is she describing?
- A) self-expectations
 - B) self-esteem



- C) self-knowledge
 - D) self-evaluation
6. As a child grows, he unconsciously develops a component of self-concept based on the image of role models. What part of the self-concept does this describe?
- A) false self
 - B) evolving self
 - C) self-knowledge
 - D) self-expectations
7. What is the name given to the evaluative and affective component of the self-concept?
- A) ideal self
 - B) body image
 - C) self-esteem
 - D) self-knowledge
8. Which of the following are components of Maslows self-esteem needs? Select all that apply.



- A) strength
 - B) status
 - C) independence
 - D) mastery and competence
 - E) importance
 - F) appreciation
9. A nurse working with patients in a healthcare facility influences them to make healthy lifestyle choices. According to Coopersmith, which of the following bases of self-esteem for the nurse does this example represent?
- A) power
 - B) significance
 - C) competence
 - D) virtue
10. A child learns to feel secure within the bonds of his immediate family by interacting with his caretakers. What is the term for this process?
- A) self-reflection



- B) adaptation
 - C) attachment
 - D) globalization
11. An infant learns that the physical self is different from the environment. What term is used to describe this stage of self-concept?
- A) self-awareness
 - B) self-recognition
 - C) self-definition
 - D) self-concept
12. Who or what plays the most influential role in the internalization of self-concept in children?
- A) peers
 - B) parents
 - C) school
 - D) church



13. An adolescent rapidly develops secondary sex characteristics and body changes. What should the nurse assess to determine how these changes might affect the adolescents self-concept?
- A) expectations of the parents
 - B) developmental environment
 - C) meaningful use of time
 - D) understanding of changes
14. In which of the following age groups do interpersonal losses play a role in disturbances in self-concept?
- A) child
 - B) teenager
 - C) adult
 - D) older adult
15. The children of immigrants may have different values and practices than do their parents, causing them to abandon their parents cultural beliefs. What is this called?
- A) cultural expectations
 - B) cultural competence



- C) cultural dissonance
 - D) cultural modernization
16. Which of the following statements is an example of the effect of aging, illness, or trauma on self-concept?
- A) society values the wisdom of aging
 - B) society devalues aging and chronic illness
 - C) few people take a healthy body for granted
 - D) most people accept the inevitability of illness
17. During an assessment of a patient's self-esteem, a 45-year-old man tells the nurse that he lost his job due to downsizing and has been unemployed for 6 months. What would be the appropriate response from the nurse?
- A) You shouldn't feel bad about losing a job, it happens to everyone.
 - B) Do you need your job to support a family?
 - C) How has losing your job affected your life and the lives of your significant others?
 - D) There are more important things in life to worry about other than losing a job.



18. According to Aguilera, which of the following are factors that influence a persons response to crisis? Select all that apply.
- A) the persons perception of the event or situation
 - B) the persons social standing
 - C) the persons mental acuity
 - D) the persons situational supports (external resources)
 - E) the coping mechanisms the person possesses (internal resources.)
 - F) the persons disposition
19. What might a nurse ask during a health history to assess personal identity?
- A) Tell me how your illness has affected you in your job.
 - B) Tell me what you do for fun and what you do for work.
 - C) How do you believe others see you? Why do you believe that?
 - D) How would you describe yourself to others?
20. During a self-esteem assessment of a young woman undergoing a complicated divorce, a nurse states: Tell me something about the moralethical principles that govern your life. What aspect of self-esteem is the nurse assessing?



- A) significance
 - B) virtue
 - C) power
 - D) competence
21. A young woman has been in an automobile crash and sustained a laceration across the left side of her face, resulting in a large scar. What nursing diagnosis would be appropriate for this disfigurement?
- A) Anxiety
 - B) Disturbed Body Image
 - C) Deficient Knowledge
 - D) Impaired Memory
22. Which of the following nursing diagnoses reflects disturbance in self-concept as the etiology?
- A) Disturbed Personal Identity
 - B) Ineffective Role Performance
 - C) Chronic Low Self-Esteem



- D) Impaired Adjustment
23. Which of the following strategies can be used to help patients overcome powerlessness?
- A) Encourage patients to identify their weaknesses.
 - B) Encourage patients to identify their strengths.
 - C) Provide advice on how to handle problems.
 - D) Set goals and make decisions for the patient.
24. A nurse always addresses patients by the preferred name when entering a patients home or room. What is the nurse facilitating by this action?
- A) a sense of self and worth
 - B) reorientation to who they are
 - C) personal strengths
 - D) negative self-concept
25. A nurse caring for critically ill patients uses interventions to help patients maintain a sense of self. Which of the following are recommended interventions?
- A) Disregard the patients status.



- B) Do not use touch out of respect for the patients privacy.
 - C) Converse with the patient about his or her life experience.
 - D) Do not acknowledge or allow expression of negative feelings.
26. A nurse who works on the pediatric unit wants to help a child cope with the loss of a leg in a hunting accident. What would the nurse implement to help the child express feelings?
- A) support from other family members
 - B) television cartoons
 - C) story books
 - D) dolls or animals
27. A school nurse is teaching parents how to build self-esteem in their children. Which of the following is a recommended strategy?
- A) use praise and compliments judiciously
 - B) wait for your child to initiate conversation
 - C) focus on remedying the childs negative qualities
 - D) give your child many opportunities to display abilities

Answer Key



1. D
2. B
3. A, C, D, E
4. B
5. C
6. D
7. C
8. A, C, D
9. A
10. C
11. A
12. B
13. D
14. D



- 15. C
- 16. B
- 17. C
- 18. A, D, E
- 19. D
- 20. B
- 21. B
- 22. D
- 23. B
- 24. A
- 25. C
- 26. D
- 27. D



Chapter 43: Stress and Adaptation

1. According to Pender, Murdaugh, & Parsons, (2006), which of the following are major sources of stress in society? Select all that apply.
 - A) interpersonal relationships
 - B) physical threat
 - C) performance demands
 - D) religious affiliations
 - E) environmental effects
 - F) disease states

2. Which of the following are considered internal stressors? Select all that apply.
 - A) loud noises
 - B) pollution
 - C) illness
 - D) hormonal change



- E) fear
 - F) cold stress
3. Which of the following best describes stress?
- A) a response to changes in the normal balanced state
 - B) a perception that something is threatening
 - C) a response to internal environment for homeostasis
 - D) a localized response of a tissue or organ to a stressor
4. Cold temperatures and loud noises are stressors to one person but not another. Why does this occur?
- A) Although the perception is the same, the response is individualized.
 - B) Both individuals will respond the same, depending on the situation.
 - C) The perception and effects of stressors are highly individualized.
 - D) The internal environment of one person is more selective.
5. What is the term for the change that takes place in response to a stressor?



- A) rehabilitation
 - B) adaptation
 - C) positive movement
 - D) negative movement
6. A patient responds to bad news regarding test results by crying uncontrollably. What is the term for this response to a stressor?
- A) adaptation
 - B) homeostasis
 - C) coping mechanism
 - D) defense mechanism
7. Various physiologic mechanisms within the body respond to internal changes to maintain relative constancy in the internal environment. The state that results is called:
- A) nirvana
 - B) homeostasis
 - C) fight-or-flight response



D) anxiety

8. Which of the following body systems are the *primary* controllers of homeostatic mechanisms? Select all that apply.

A) autonomic nervous system

B) endocrine system

C) respiratory system

D) cardiovascular system

E) gastrointestinal system

F) renal system

9. A student is preparing for her first patient care assignment. She wakes up at 4:00 a.m. with a pounding pulse and diarrhea. What type of adaptive response to stress is she experiencing?

A) general adaptation syndrome

B) mindbody interaction

C) local adaptation syndrome

D) coping or defense mechanism



10. A patient with an inflamed appendix is feeling pain in the stomach area. What is the term for this body response to stress?
- A) local adaptation syndrome
 - B) general adaptation syndrome
 - C) physiological homeostasis
 - D) fight-or-flight response
11. What phase of the general adaptation syndrome is a patient in when he uses all of his adaptive mechanisms for dealing with stress, leaving no defense against the distress?
- A) alarm reaction stage
 - B) fight-or-flight stage
 - C) stage of resistance
 - D) stage of exhaustion
12. A patient who is being seen at a physicians office states that he has bad headaches all the time. Diagnostic tests are normal. What is this type of response to stress called?
- A) psychosomatic disorder
 - B) acute illness



- C) chronic illness
- D) pretend disorder
13. An individual steps into a tub of very hot water and immediately jumps out again. What mechanism caused this response?
- A) inflammatory response
- B) reflex pain response
- C) general adaptation syndrome
- D) fight-or-flight response
14. If a nurse assessed the vital signs of a person who was in the initial alarm reaction stage (shock phase) of the GAS, what would be the expected findings?
- A) slow, deep breathing
- B) fatigue and lethargy
- C) hypotension
- D) hypertension
15. Which of the following group of terms best describes anxiety?



- A) cognitive, known threat, depression
 - B) cognitive, visible threat, anger
 - C) known source, prolonged, solely physical
 - D) unknown cause, emotional, apprehensive
16. A young mother tells the nurse, I cant stop smoking. That is what I do to make myself feel better. What is the term used to describe this behavior?
- A) defense mechanism
 - B) coping mechanism
 - C) caregiver burden
 - D) crisis
17. A nurse is preparing to teach a patient about care at home. On entering the room, she finds the patient pacing around the room, hyperventilating, and complaining of nausea. Based on these manifestations of severe anxiety, what would the nurse do?
- A) Provide both verbal and written information to the patient.
 - B) Ignore the patient and teach the family the information.
 - C) Modify the teaching plan to the patients anxiety level.



- D) Postpone implementation of the teaching plan.
18. A woman who was assaulted in the street is brought to the emergency room for observation. A nurse documents that the woman has difficulty communicating verbally, is agitated, and complains of chest pain and a sense of impending doom. What type of anxiety is this patient experiencing?
- A) mild anxiety
- B) moderate anxiety
- C) severe anxiety
- D) panic
19. A man has noticed bright red blood in his bowel movements for over a month. He says to himself, Oh, its just my hemorrhoids. What defense mechanism is the man using?
- A) rationalization
- B) repression
- C) denial
- D) compensation
20. Which of the following illnesses has been associated with long-term stress?



- A) bacterial infections
 - B) cardiovascular disease
 - C) renal disease
 - D) fractures
21. The wife of a patient on hospice at home is diagnosed with caregiver burden. Which of the following best describes this syndrome?
- A) prolonged stress from caring for a family member at home
 - B) inability to provide competent care for a family member
 - C) insufficient funds to pay for medical care of a family member
 - D) effect of the illness causing stress in siblings
22. A friend has lost her job and is becoming increasingly anxious to the point of crisis. What type of crises is she experiencing?
- A) adventitious
 - B) maturational
 - C) situational
 - D) emotional



23. Which of the following is an example of developmental stress?

- A) a newborn who needs to be fed by bottle
- B) a school-aged child learning to read
- C) a teenager learning to drive a car
- D) a middle adult accepting signs of aging

24. Of the following physiologic stressors, which one is a physical agent?

- A) heat
- B) drugs
- C) bacteria
- D) hypoxia

25. Which of the following groups of nurses experience the highest levels of stress in the work setting?

- A) obstetric nurses



- B) pediatric nurses
 - C) new graduates
 - D) aging nurses
26. Which of the following questions would be helpful in eliciting data about the effects of stress during a health history?
- A) Why are you having so much difficulty breathing at night?
 - B) Why do you think smoking and drinking will calm you?
 - C) Do you often drink too much and have hangovers?
 - D) How does your body feel when you are upset?
27. Which one of the following diagnoses would be written for stress as the cause of the problem?
- A) Anxiety related to conflicts about values and goals in life
 - B) Caregiver Role Strain related to long-term stress of care for a parent with Alzheimers disease
 - C) Spiritual Distress related to inability to accept diagnosis of terminal illness
 - D) Hopelessness related to presence of disabling physical injuries



28. A nurse is teaching a patient about the benefits of exercise in reducing stress. How often would the nurse recommend the patient exercise?
- A) 2 hours every day
 - B) 1 hour once a week
 - C) 30 to 45 minutes, most days of the week
 - D) 60 to 75 minutes, four to five times a week
29. What philosophy for handling stress can nurses encourage patients to adopt?
- A) One for all and all for one.
 - B) Do today so that you do not have to do the same thing tomorrow.
 - C) If you have too much to do, just get busy and do it.
 - D) Accept what cant be changed, change what cant be accepted.
30. A nurse teaches a patient deep-breathing exercises to help control his anxiety. This is considered what type of stress management technique?
- A) meditation
 - B) relaxation



C) anticipatory guidance

D) guided imagery

Answer Key

1. A, C

2. C, D, E

3. A

4. C

5. B

6. C

7. B

8. A, B

9. B

10. A

11. D



12. A

13. B

14. D

15. D

16. B

17. D

18. D

19. C

20. B

21. A

22. C

23. D

24. A

25. C



26. D

27. A

28. C

29. D

30. B



Chapter 44: Loss, Grief, and Dying

1. A woman has had a breast removed to treat cancer. What type of loss will she most likely experience?
 - A) actual loss
 - B) perceived loss
 - C) maturational loss
 - D) anticipatory loss

2. Which of the following is an example of a perceived loss?
 - A) A patient mourns the loss of his amputated leg.
 - B) A patient grieves for the loss of his wife to cancer.
 - C) An older patient grieves for the loss of his independence.
 - D) A patient grieves for the loss of his job.

3. A man is diagnosed with terminal kidney failure. His wife demonstrates loss and grief behaviors. What type of loss is the wife experiencing?
 - A) maturational loss



- B) anticipatory loss
 - C) dysfunctional grieving
 - D) bereavement
4. Which one of the following statements accurately describes the process known as grief reaction?
- A) Reactions to grief and dying are different.
 - B) Reactions to grief are similar for all people.
 - C) Reactions to grief follow all stages of the grieving process.
 - D) Reactions to grief may differ from patient to family.
5. Which of the following statements is typical of the first stage of grieving described by Engel?
- A) No, not me.
 - B) Why me?
 - C) My husband was the best man in the world.
 - D) The funeral service helped me survive.



6. The husband of a patient who died of breast cancer is still grieving for his wife 2 years later. What type of grief is he experiencing?
- A) unresolved
 - B) situational
 - C) inhibited
 - D) maturational
7. According to the Harvard University Medical School committee, what function must be irreversibly lost to define death?
- A) respiratory functions
 - B) reflexes
 - C) consciousness
 - D) brain function
8. A nurse assesses a terminally ill patient with a DNR order, with findings of decreased blood pressure, urinary and bowel incontinence, loss of reflexes, and Cheyne-Stokes respirations. Based on these findings, the nurse recognizes which of the following?
- A) These are signs of impending death.



- B) These signs do not indicate any abnormality.
 - C) The patient requires immediate resuscitation.
 - D) The patients family should be asked to leave.
9. Which of the following are signs of a good death. Select all that apply.
- A) minimal or moderate pain experienced
 - B) The person dies according to the wishes of the family.
 - C) The person dies with dignity.
 - D) The person is prepared for death.
 - E) The person has a sense of completion of life.
 - F) The person has a good relationship with healthcare providers.
10. Kbler-Ross defines five stages of psychosocial responses to dying and death. Which of the following statements is characteristic of the bargaining stage?
- A) The doctors must have made a mistake.
 - B) Why did this happen to me? I always exercised.



- C) Just let me live to see my grandson born.
- D) I've had a good life and I can die in peace.
11. A patient is diagnosed with a terminal illness. Who is usually responsible for deciding what, when, and how the patient should be told?
- A) family
- B) clergy
- C) nurse
- D) physician
12. A nurse providing palliative care for a dying man and his family knows that the goal of palliative care is:
- A) to aggressively treat the disease.
- B) to provide care for the dying in the home.
- C) to aggressively treat the symptoms of the disease.
- D) to support the family of the dying patient.
13. A patient asks a nurse to explain a living will. What is the nurse's best answer?



- A) It specifies who will inherit the patients estate.
 - B) It determines an individuals quality of life.
 - C) It lists specific instructions for healthcare provisions.
 - D) It identifies a trusted person to make healthcare decisions.
14. A dying patient states in writing ahead of time what her choices would be for healthcare should certain circumstances develop. What is the term for this document?
- A) living will
 - B) advance directives
 - C) durable power of attorney
 - D) comfort measures only
15. A dying patient and family have requested that no attempts be made to resuscitate the patient in the event of death. A doctor has written a DNR order. What is the nurses responsibility if the patient dies?
- A) Follow his or her own conscience and perform CPR.
 - B) Make no attempt to resuscitate the patient.
 - C) Follow a verbal physicians order for a slow code.



- D) If the patient is at home, call 911 and begin CPR.
16. A terminally ill patient, in severe pain, asks a nurse to help her die. What must the nurse consider morally, ethically, and professionally before answering the patient?
- A) ANA Code for Nurses, ethical and professional standards
- B) own personal moral and ethical values and standards
- C) hospital or agency procedures and protocols
- D) Medical Code of Ethics, belief in active euthanasia
17. Which of the following persons is responsible for handling and filing a death certificate with proper authorities?
- A) mortician
- B) physician
- C) nurse
- D) hospital administrator
18. The parents of a teenager who is being maintained on life support after a motorcycle crash tell the nurse, We would like to donate his organs if he dies. What is the nurses role in organ donation?
- A) Realize that it is a legal responsibility to call the coroner.



- B) Review options and provide consent forms to the family.
 - C) Make arrangements for protocols for retrieving the organs.
 - D) None; organ donation is a physicians responsibility.
19. Although all of the following are factors that affect grief, which one is most likely to influence a persons expression of grief?
- A) socioeconomic factors
 - B) cultural influences
 - C) religious influences
 - D) cause of death
20. A nurse is talking to a patient who has been told he has a terminal illness and is responding in an angry manner. What statement by the nurse would best facilitate better patient outcomes?
- A) Why are you so angry? The doctor told you why you will not live.
 - B) Im sorry you are in pain right now, but we have to talk about this.
 - C) When you feel like talking about how you feel, let me know.
 - D) How much do you know and what do you want to know?



21. A dying patient is undergoing terminal weaning. What is the purpose of this intervention?
- A) to manage the symptoms of the illness
 - B) to prepare for resuscitation of the patient
 - C) to initiate life-sustaining measures for the patient
 - D) to gradually withdraw mechanical ventilation
22. A nurse is developing a plan of care for a dying patient. Which of the following physiologic basic human needs should be addressed?
- A) personal hygiene
 - B) risk for infection
 - C) family support
 - D) spirituality
23. Which of the following phrases can do much to instill hope in the dying patient?
- A) This is a hopeless situation.
 - B) Nothing more can be done.



- C) Everything will be fine, so don't worry.
- D) Let me tell you about your illness.
24. While caring for a patient near end of life, a student talks to her. Another student asks why she is talking to someone who is dying. Which response would be accurate?
- A) It makes me feel better to talk to my patients.
- B) I do this so I won't be so afraid the patient will die.
- C) I believe the patient can hear me as long as she is alive.
- D) I don't know; the nurse in charge of the patient told me to.
25. A nurse who provides bereavement counseling is working with the family of a child who recently died from cancer. Which of the following statements may be a common expression of grief and guilt by a family member?
- A) 65-year-old grandparent: It helped me prepare for my death.
- B) Parents: We did everything we could and we are at peace.
- C) Uncle: It was for the best.
- D) Sister: It is all my fault; I wanted him to die.
26. A dying patient is crying. She states, I can't pray. I can't forgive myself. What would be an appropriate nursing diagnosis based on this data?



- A) Noncompliance
 - B) Knowledge Deficit
 - C) Low Self-Esteem
 - D) Spiritual Distress
27. A hospice nurse is providing emotional care and support for a family who lost a son. The care will be provided based on what knowledge?
- A) All members of the family will react to loss in the same way.
 - B) Grief is an abnormal physical reaction to a loss.
 - C) Stages of grief reactions may overlap and are individualized.
 - D) Bereavement is a normal process, requiring little intervention.
28. Family members of a dying patient are in the room with the patient. As the patient nears death, what should the nurse tell the family?
- A) Please leave the room now. It is time to let go.
 - B) Only one family member at a time can stay in the room.



- C) Please stay with your loved one and talk to him.
- D) I will have to get an order for you to stay now.
29. A nurse is providing postmortem care. Which of the following nursing actions is a legal responsibility?
- A) placing the body in normal anatomic position
- B) removing tubes and soiled dressings
- C) washing the body to remove blood and excretions
- D) placing ID tags on the shroud and ankle

Answer Key

1. A
2. C
3. B
4. D
5. A
6. A



7. D
8. A
9. C, D, E, F
10. C
11. D
12. C
13. C
14. B
15. B
16. A
17. A
18. B
19. B
20. D



21. D

22. A

23. D

24. C

25. D

26. D

27. C

28. C

29. D



Chapter 45: Sensory Functioning

1. Which of the following accurately describe senses by which individuals maintain contact with the external environment? Select all that apply.
 - A) vision
 - B) hearing
 - C) smell
 - D) taste
 - E) kinesthesia
 - F) visceral

2. What term is used to describe the sense, usually at a subconscious level, of the movements and position of the body and especially its limbs, independent of vision?
 - A) stereognosis
 - B) visceral
 - C) proprioception
 - D) sensory perception



3. A patient says, What is that awful smell? What sense is being used?
- A) olfactory
 - B) gustatory
 - C) tactile
 - D) auditory
4. Which of the following best describes a stimulus?
- A) a sense organ that receives a message and converts it into a nerve impulse
 - B) conduction along a nerve pathway from the receptor to the brain
 - C) reception and translation of an impulse into a sensation
 - D) an act or agent that initiates a response by the nervous system
5. Which of the following are conditions that must be met for a person to receive the necessary data to experience the world? Select all that apply.
- A) A stimulus must be present.
 - B) A receptor or sense organ must receive the stimulus and convert it to a nerve impulse.



- C) The nerve impulse must be conducted along a nervous pathway from the receptor or sense organ to the brain.
 - D) The stimulus must be recognized by the cardiovascular system and sent to the brain.
 - E) The person must physically and mentally recognize the stimulus and accept or reject it in the brain.
 - F) A particular area in the brain must receive and translate the impulse into a sensation.
6. After assessing a patient, a nurse documents the state of awareness as confused. What part of the brain controls awareness?
- A) cranial nerves
 - B) reticular activating system
 - C) hypothalamus
 - D) medulla
7. How would a nurse document the condition in which a patient has a normal state of awareness?
- A) Aware of self and environment, responsive, well-oriented.
 - B) Easily distracted, alternates between drowsiness and excitability.



- C) Disoriented, restless, agitated, hallucinating.
 - D) Can't be aroused and does not respond to stimuli.
8. A nurse documents the following on a patient chart: patient manifests difficulties with spatial orientation, memory language, and changes in personality. What state of arousal/awareness does this describe?
- A) delirium
 - B) dementia
 - C) confusion
 - D) locked-in syndrome
9. Which of the following hospital units is more likely to cause severe sensory alterations?
- A) general unit
 - B) short-stay surgery
 - C) eye clinic
 - D) intensive care
10. In which of the following healthcare settings is a patient more likely to be at risk for sensory deprivation?



- A) hospital newborn nursery
 - B) community health center
 - C) emergency department
 - D) long-term care
11. What type of cognitive responses might a nurse assess in a patient with sensory deprivation?
- A) uncoordinated movements, altered sense of smell
 - B) decreased attention span, difficulty problem solving
 - C) apathy, depression
 - D) rapid mood changes, anxiety
12. A patient admitted to the hospital for major surgery is at risk for what type of sensory alteration?
- A) sensory deprivation
 - B) sensory deficits



- C) sensory overload
 - D) sensory stimulation
13. What intervention is recommended to reduce sensory stimulation for infants in the neonatal ICU?
- A) use bright lights
 - B) use limited light
 - C) play loud music
 - D) avoid touch
14. A patient tells his nurse that he has difficulty hearing related to working in a loud factory setting for 15 years. What is the term for this condition?
- A) sensory deficit
 - B) sensory deprivation
 - C) sensory overload
 - D) sensory stimulation
15. A nurse assesses a mother who rocks and cuddles her newborn son. What sense is the mother stimulating?



- A) auditory
 - B) kinesthetic
 - C) visual
 - D) gustatory
16. Is it important for a nurse to consider a patients culture when providing physical care?
- A) Yes, culture dictates the amount of sensory stimulation considered normal.
 - B) Yes, the nurses culture and the patients culture are often different.
 - C) No, the nurse must provide needed physical care to all patients.
 - D) No, the nurse is not required to consider culture when providing care.
17. A nurse is assessing a patient on the first day after major abdominal surgery. Which of the following internal stimuli would be increased and affect patient responses?
- A) lights and noise
 - B) visitors and caregivers
 - C) intravenous lines, pain



- D) ambulating, coughing
18. A nurse assessing older adults in a long-term care facility is aware that which of the following may result in sensory alterations for these patients?
- A) constipation
- B) anorexia
- C) dry skin
- D) presbyopia
19. A patient has an abrupt onset of a cluster of global changes in attention, cognition, and level of consciousness. What would be the most appropriate nursing diagnosis?
- A) Acute Confusion
- B) Chronic Confusion
- C) Impaired Memory
- D) Disturbed Sensory Perception
20. Which of the following nursing diagnoses describes disturbed sensory perception as the etiology?
- A) Altered environmental stimuli: excessive



- B) Altered sensory reception, transmission
 - C) Impaired memory related to situational causes
 - D) Ineffective Coping related to sensory overload
21. A home care patient has both visual and hearing deficits. Although all of the following are important, what would be a high priority concern when planning and implementing care?
- A) nutrition
 - B) comfort
 - C) safety
 - D) communication
22. A nurse asks the mother of a hospitalized 2-year-old patient to bring in his favorite blanket or stuffed animal. What sense is the nurse trying to stimulate with this intervention?
- A) gustatory
 - B) visual
 - C) tactile
 - D) auditory



23. Which of the following nonpharmacologic, independent nursing interventions may be used to promote relaxation without also causing sensory overload?
- A) talking with the patient
 - B) playing music the patient chooses
 - C) watching talk shows the nurse chooses
 - D) watching television reality shows that visitors choose
24. A community health nurse is conducting a seminar on vision self-care. What might be one topic included in the teaching plan?
- A) Wear sunglasses when working outside.
 - B) Close the eyes when working with chemicals.
 - C) Use over-the-counter eye drops when necessary.
 - D) When using aerosol sprays, spray toward self.
25. A nurse is teaching a lawn-care worker about the risk of hearing loss. What might be recommended?
- A) Listen to loud music with earphones while mowing.
 - B) Just ignore the noise; you are too young for damage.



- C) Wear earplugs while using lawn equipment.
 - D) Clean your ears with cotton-tipped applicators daily.
26. A nurse is making a home care visit to a patient with a hearing deficit. What can she do to facilitate communication with the patient?
- A) Ask for permission to turn off the television set during the visit.
 - B) Talk in a loud tone of voice at all times during the visit.
 - C) Use written communication rather than verbal communication.
 - D) Reduce the time spent with the patient to decrease frustration.
27. A nurse is caring for a person who is delusional. What is important for the nurse to do while communicating with the patient?
- A) Touch the patient gently while talking.
 - B) Avoid arguing about erroneous statements.
 - C) Reinforce reality for delusional statements.
 - D) Maintain eye contact at all times.
28. A nurse is caring for a patient who is unconscious. Which of the following is a recommended guideline for communication with this patient?



- A) Do not assume the person can hear you.
- B) Keep environmental noise level high to stimulate the patient.
- C) Be careful what is said in front of the patient as he or she might hear you.
- D) Touch the person before speaking to them.

Answer Key

- 1. A, B, C, D
- 2. C
- 3. A
- 4. D
- 5. A, B, C, F
- 6. B
- 7. A
- 8. A
- 9. D



10. D

11. B

12. C

13. B

14. A

15. B

16. A

17. C

18. D

19. A

20. D

21. C

22. C

23. B



24. A

25. C

26. A

27. C

28. C



Chapter 46: Sexuality

1. Which of the following best describes sexuality?
 - A) external appearance of ones genitalia
 - B) internal organ structure and function
 - C) physical, emotional, and mental gender
 - D) pleasure experienced during sexual activity

2. Which statement is true of gender identity?
 - A) It is the opposite of biologic identity.
 - B) It may be the same as or different from biologic identity.
 - C) It is determined by male (XY) or female (XX) chromosomes.
 - D) It guides ones gender role behavior as male or female.

3. A male patient tells the nurse taking a sexual history that he finds sexual pleasure with both female and male companions. What is the sexual orientation of this patient?
 - A) homosexual



- B) heterosexual
 - C) bisexual
 - D) transsexual
4. Which of the following are considered internal female genitalia? Select all that apply.
- A) mons pubis
 - B) labia majora
 - C) ovaries
 - D) uterus
 - E) fallopian tubes
 - F) clitoris
5. Which of the following are considered external male genitalia? Select all that apply.
- A) testes
 - B) scrotum
 - C) epididymis



- D) prostate gland
 - E) penis
 - F) seminal vesicles
6. As a result of loss of estrogen, postmenopausal women have decreased vaginal lubrication. What may occur as a result?
- A) frequent urination
 - B) excess fatigue
 - C) painful intercourse
 - D) painful menses
7. A woman tells a nurse, My husband wants to have sex when I have my period. Is that safe? What is an appropriate answer?
- A) No, the flow of blood could be slowed down.
 - B) No, it will tend to make your cramps worse.
 - C) Yes, but be sure to douche after sex.



- D) Yes, there is no reason not to have sex then.
8. A 15-year-old male patient is experiencing nocturnal emissions. What nursing intervention would be appropriate for this patient?
- A) Ask the parents to consult with a specialist.
- B) Tell the patient to limit physical activity in the evening.
- C) Ask the primary care provider to perform a physical examination.
- D) No intervention is necessary as this is a normal phenomenon.
9. In which of the phases of the sexual response cycle may secretions from Cowpers glands appear at the glans of the penis?
- A) excitement
- B) plateau
- C) orgasm
- D) resolution
10. Which of the following occurs in the male during the resolution phase of the sexual response cycle?
- A) The penis becomes erect due to increased pelvic congestion of blood.



- B) Involuntary spasmodic contractions occur in the penis.
 - C) The male orgasm occurs usually with ejaculation of semen from the penis.
 - D) The male experiences a period during which he is incapable of sexual response.
11. A male patient tells the nurse that he does not understand why he feels the way he does when he is sexually excited. What would the nurse teach the patient?
- A) I dont know, but I will ask my boyfriend if he can describe his feelings to me.
 - B) The sexual response cycle includes excitement, plateau, orgasm, and resolution.
 - C) That is something that just happens and nobody knows why.
 - D) Isnt sex wonderful? I think it has different parts to the experience.
12. A female nurse is giving a complete bed bath to a young male patient. She notices the patient has an erection. What should she do?
- A) Nothing; an erection is not under voluntary control.
 - B) Report and document the incident as sexual harassment.
 - C) Share the information to protect other staff.
 - D) Tell the patient she is offended by his physical response.



13. A 70-year-old woman tells the nurse that she is still sexually active. How would the nurse respond?
- A) You are too old for that kind of behavior.
 - B) Tell me what you enjoy the most.
 - C) You can be sexually active as long as you want to be.
 - D) There comes a time in life when this is no longer important.
14. A young woman has been diagnosed with human papilloma virus (HPV). As a result, she will be at increased risk for which of the following?
- A) infertility
 - B) genital warts
 - C) vaginal bleeding
 - D) cervical cancer
15. A nurse is teaching a student nurse how STIs affect the health of their patients. Which of the following statements accurately describes an effect of an STI?
- A) STIs are most common in young to middle adulthood populations.
 - B) The incidence of STIs is decreasing due to health promotion efforts.



- C) Most of the time STIs cause no symptoms, especially in women.
 - D) Health problems caused by STIs are more severe and frequent in men.
16. What term is used to describe painful intercourse?
- A) dyspareunia
 - B) dysmenorrhea
 - C) impotence
 - D) vulvodynia
17. An adolescent male tells the nurse that he is afraid his penis will be damaged because he masturbates every day. The nurses response is based on what knowledge?
- A) Masturbation is not a normal activity.
 - B) Only adult men masturbate.
 - C) Masturbation may delay puberty.
 - D) Self-stimulation is a normal activity.
18. A heterosexual couple enjoys anal intercourse. What may result from this type of intercourse?



- A) feelings of guilt and shame
 - B) vaginal infections
 - C) damage to the vagina
 - D) penile infections
19. Parents of a toddler express concern because he is touching his genitals. What should the nurse teach the parents?
- A) Self-manipulation of genitals is normal behavior.
 - B) Have the child wear clothes that prohibit touching.
 - C) If this bad behavior continues, seek counseling.
 - D) Make him have time out every time it happens.
20. A nurse is conducting a health history for a woman at a local clinic. The woman tells the nurse, I feel like I am a man trapped in this womans body. What term is given to this feeling?
- A) heterosexual
 - B) homosexual
 - C) bisexual



- D) transsexual
21. Which of the following questions or statements would be most useful in eliciting information about a patient's sexual history?
- A) I know this is hard to talk about, but it is important.
- B) Why did you have unprotected sex?
- C) How would you describe your problem?
- D) I need to know sex partners numbers.
22. While answering questions posed by a nurse during a health history, a young woman says, Before my period I get headaches, am moody, and my breasts hurt. What is the patient experiencing?
- A) perimenopause
- B) menarche
- C) PMS
- D) menses
23. What are the primary nursing considerations when assisting with or conducting a physical assessment of the genitalia?
- A) ensuring sterility of all equipment and supplies



- B) respecting the patients privacy and modesty
 - C) providing a means for cleansing the area
 - D) leaving the room during the assessment
24. What is the most significant difficulty regarding sexuality faced by people taking medications for hypertension?
- A) Medications result in increased desire for sex.
 - B) Medications change sexual functioning.
 - C) Patients experience a growth of body hair.
 - D) Patients experience increased body odors.
25. What do most nursing interventions pertaining to sexuality involve?
- A) teaching to promote sexual health
 - B) examinations to identify sexually transmitted infections
 - C) advocacy for those with sexual dysfunctions
 - D) maintaining confidentiality and privacy



26. A nurse is teaching a female patient about breast self-examination (BSE). At what time of the month would the nurse recommend BSE?
- A) any day of the month is satisfactory
 - B) once a month right after the menstrual period
 - C) once a month right before the menstrual period
 - D) on Friday evening or Saturday morning each week
27. A woman is using Depo-Provera as a method of birth control. What common side effect should the nurse explain to the patient?
- A) constipation
 - B) nausea
 - C) irregular bleeding
 - D) pregnancy
28. A nurse is explaining the use of an IUD to a female patient interested in obtaining contraception. Which of the following statements regarding the IUD is correct?
- A) The intrauterine device (IUD) is an object that is placed by the patient within the uterus to prevent implantation of a fertilized ovum.



- B) IUDs are small devices made of flexible plastic that provide irreversible birth control.
 - C) IUDs do not prevent fertilization of the egg.
 - D) IUDs seem to affect the way the sperm or egg moves.
29. A nurse is counseling a female victim of sexual assault. Which of the following statements accurately describe the increased risks for this patient?
- A) The patient is 3 times more likely to suffer from depression.
 - B) The patient is 10 times more likely to suffer from post-traumatic stress disorder.
 - C) The patient is 20 times more likely to abuse alcohol and 26 times more likely to abuse drugs.
 - D) The patient is 20 times more likely to contemplate suicide.
30. A nurse is responding to sexual harassment from a patient at work. Which of the following are recommended guidelines for dealing with this behavior?
- A) If confronted by management, deny any feelings about being harassed.
 - B) Do not confront the person harassing you in person.
 - C) Set and enforce limits to the behavior and maintain boundaries.



- Document the incident but do not report it to the supervisor unless harassment continues.
- D)

Answer Key

1. C
2. B
3. C
4. C, D, E
5. A, B, E
6. C
7. D
8. D
9. B
10. D
11. B
12. A



13. C

14. D

15. C

16. A

17. D

18. B

19. A

20. D

21. C

22. C

23. B

24. B

25. A

26. B



27. C

28. D

29. A

30. C



Chapter 47: Spirituality

1. According to Shelly and Fish (1988), which of the following are spiritual needs underlying all religious traditions that are common to all people? Select all that apply.
 - A) need for meaning and purpose
 - B) need for power
 - C) need for formal religion
 - D) need for love and relatedness
 - E) need for forgiveness
 - F) need for friends

2. According to Burghardt and Nagai-Jacobson (1997), which of the following statements accurately describe an element of spirituality? Select all that apply.
 - A) Spirituality is experienced as a dividing force, life principle, essence of being.
 - B) Spirituality is expressed and experienced in and through connectedness with nature, the earth, the environment, and the cosmos.
 - C) People express and experience spirituality in and through connectedness with nature.



- D) Spirituality shapes the self-becoming and is reflected in ones being, knowing, and doing.
 - E) Spirituality permeates life, providing purpose, meaning, strength, and guidance and shaping the journey.
 - F) Spirituality is based on a profound hope that good will finally prevail.
3. The *U.S. Religious Landscape Survey* of 35,000 Americans by the Pew Research Centers Forum on Religion & Public Life (2008) finds that most Americans are religious and they have a nondogmatic approach to faith. Which of the following statements accurately describe religion in America? Select all that apply.
- A) A majority of Americans who are affiliated with a religion believe their religion is the only way to salvation.
 - B) More than half of Americans rank the importance of religion very highly in their lives, attend religious services regularly, and pray daily.
 - C) A plurality of adults who are affiliated with a religion want their religion to adjust to new circumstances or adopt modern beliefs and practices.
 - D) Significant minorities across nearly all religious traditions see a conflict between being a devout person and living in a modern society.
 - E) While more than five-in-ten Americans believe in the existence of God or a universal spirit, there is considerable variation in the nature and certainty of this belief.
 - F) Six-in-ten adults believe that God is a person with whom people can have a relationship; but one-in-four including about half of Jews and Hindus see God as an impersonal force.



4. Which of the following group of terms best defines spiritual distress?
- A) spirituality, religion
 - B) alienation, despair
 - C) faith, prayer
 - D) forgiveness, purpose
5. What spiritual need is believed to underlie all religious traditions and is common to all people?
- A) love and relatedness
 - B) physical hygiene
 - C) religious education
 - D) church services
6. Nurses provide care to meet needs in all the human dimensions. What is one intervention nurses can implement to meet spiritual needs?
- A) Refer all questions to a spiritual advisor.
 - B) Remind patients that nurses are not ministers.



- C) Avoid any discussion of religion or spirituality.
 - D) Offer a compassionate presence.
7. A patient expresses confidence in his traditional healer to relieve symptoms of an illness. What is the patient demonstrating?
- A) hope
 - B) spirituality
 - C) faith
 - D) charity
8. A patient tells the nurse, I am an atheist. I do not believe in God. What would be an appropriate response by the nurse?
- A) Well, I believe in God and you should too.
 - B) I respect what you choose to believe in.
 - C) How can you deny the existence of God?
 - D) What makes you think you are an atheist?
9. A patient states that his life has meaning and purpose, he feels loved, and has experienced forgiveness in his life. What is the term that describes this state of spirituality?



- A) spiritual belief
 - B) spiritual alienation
 - C) spiritual health
 - D) spiritual bliss
10. What factor is necessary to express and experience spirituality?
- A) quiet time in isolation from others
 - B) membership in an organized religion
 - C) long-term suffering and pain
 - D) connectedness with other people
11. While reviewing the chart for an assigned patient before beginning care, a student notes that the patient does not belong to a specific religion. Based on this information, what should the student interpret about the patient?
- A) A person may be deeply spiritual but not profess a religion.
 - B) Belonging to an organized religion is essential to spirituality.
 - C) The student will not have to consider the spiritual dimension.



- D) The patient should be referred for spiritual counseling.
12. Which of the following healthcare practices may be influenced by a young woman's religion?
- A) yearly mammograms
 - B) annual physicals
 - C) birth-control measures
 - D) health assessments
13. How can religious life-affirming influences be compared with basic human needs?
- A) Life-affirming influences encourage self-actualization.
 - B) Life-affirming influences enhance life.
 - C) Life-affirming influences meet basic physiologic needs.
 - D) Life-affirming influences cultivate wisdom.
14. Some religious beliefs may conflict with prevalent healthcare practices. For example, what type of treatment is prohibited by the doctrine of Jehovah's Witnesses?
- A) using narcotics to treat pain



- B) administering blood transfusions
 - C) minor surgical procedures
 - D) diagnostic x-ray examinations
15. Each of the major religions has several characteristics in common. What is one of those characteristics?
- A) Ministers are addressed as Reverend.
 - B) An ethical code defines right and wrong.
 - C) Communion is delivered the same way.
 - D) Men and women are viewed as equals.
16. A nurse fills the following roles in the community: health educator, personal health counselor, referral agent, trainer of volunteers, developer of support groups, integrator of faith and health, and health advocate. What is the term for this type of nurse?
- A) parish nurse
 - B) religious nurse
 - C) visiting nurse
 - D) home health nurse



17. A nurse is caring for a hospitalized child. What would the nurse consider to meet the spiritual needs of the child?
- A) Nothing; children do not have a spiritual self.
 - B) Complete information from the child's parents.
 - C) Only terminally ill children believe in God.
 - D) Children have definite perceptions of God.
18. The parents of an infant are members of a faith-healing group. They refuse to give the baby antibiotics for meningitis. What does the American Academy of Pediatrics recommend for cases such as this?
- A) respect for the parents' wishes, even if the baby dies
 - B) exemption from child abuse charges
 - C) application of child abuse and neglect statutes
 - D) refusal to treat the child no matter how ill
19. A geriatric nurse practitioner is completing a health history for a newly admitted resident of a long-term care facility. Which of the following questions will elicit information about the patient's spirituality?
- A) Tell me what church you went to when you were a child.
 - B) Do you believe God will make you independent again?



- C) Why is it that you do not go to church on Sundays?
- D) Are you angry at God for allowing you to be here?
20. A nurse is using Anandarajah and Hights (2001) HOPE acronym to assess a patients spirituality and religious beliefs. Which of the following is a component of this acronym?
- A) H = heaven
- B) O = openness
- C) P = personal spirituality
- D) E = eternity
21. A patient scheduled for complex heart surgery has been reading the Bible for hours each day, cries often, and is not sleeping well. What might these observations cue the nurse about the patient?
- A) These behaviors are expected before major surgery.
- B) These behaviors are signs of spiritual distress.
- C) Family members live far away and the patient is lonely.
- D) The patient is naturally emotional and reactive.



22. A patient verbalizes to a mental health counselor that his life is meaningless since his wife divorced him and that he no longer wants to live. What nursing diagnosis, resulting from his spiritual distress, would be appropriate?
- A) Sexual Dysfunction
 - B) Fear
 - C) Powerlessness
 - D) Risk for Self-Directed Violence
23. A nurse is caring for a hospitalized patient. What intervention can the nurse use to help the patient continue normal spiritual practices?
- A) Discuss the nurses own religious beliefs with the patient.
 - B) Tell the patient that spiritual practices can be resumed later.
 - C) Request dietary consultation for the patients dietary restrictions.
 - D) Request medication from the physician to calm the patient.
24. Which of the following statements by a nurse would nurture spirituality by promoting love and relatedness?
- A) I know you are angry about your diagnosis.



- B) Tell me about what you do in your job.
 - C) Tell me about how you get along with others.
 - D) How often do you read the Bible each day?
25. What statement or question is useful for a nurse if a patient asks the nurse to pray with him or her?
- A) Im sorry, I am just too busy.
 - B) How would you like us to pray?
 - C) You will have to talk to your minister.
 - D) Why would you want me to do that?
26. A nurse is preparing a patients room to accommodate a visit from a spiritual counselor. Which of the following is a recommended practice?
- A) Dim or turn off the lights.
 - B) Place a candle on the bedside table.
 - C) Remove any unnecessary equipment.
 - D) Place a cross on the bedside table.



27. A patient tells a nurse that he does not think he can have the recommended heart surgery because transfusions are against his religion. What is the best response of the nurse in this situation?

- A) Tell the patient that the surgery is necessary to keep him alive and is the only choice.
- B) Obtain all the information needed for the patient to make an informed decision.
- C) Prepare the patient for a visit from his spiritual advisor.
- D) Have the patient sign a form stating his refusal of the treatment.

1.A, D, E

2.B, D, E

3.B, D, F

4.B

5.A

6.D

7.C

8.B

9.C

10.D

11.A

12.C

13.A

14.B



15.B

16.A

17.D

18.C

19.D

20.C

21.B

22.D

23.C

24.C

25.B

26.C

27.B

28.B

29.A

