1. Once a nurse assesses a client's condition and identifies appropriate nursing diagnoses, a:

A. Plan is developed for nursing care.
B. Physical assessment begins
C. List of priorities is determined.
D. Review of the assessment is conducted with other team members.

2. Planning is a category of nursing behaviors in which:

A. The nurse determines the health care needed for the client.
B. The Physician determines the plan of care for the client.
C. Client-centered goals and expected outcomes are established.
D. The client determines the care needed.

3. Priorities are established to help the nurse anticipate and sequence nursing interventions when a client has multiple problems or alterations. Priorities are determined by the client's:

A. Physician
B. Non Emergent, non-life threatening needs
C. Future well-being.
D. Urgency of problems

4. A client centered goal is a specific and measurable behavior or response that reflects a client's:

A. Desire for specific health care interventions
B. Highest possible level of wellness and independence in function.
C. Physician's goal for the specific client.
D. Response when compared to another client with a like problem.

5. For clients to participate in goal setting, they should be:

A. Alert and have some degree of independence.
B. Ambulatory and mobile.
C. Able to speak and write.
D. Able to read and write.

6. The nurse writes an expected outcome statement in measurable terms. An example is:

A. Client will have less pain.
B. Client will be pain free.
C. Client will report pain acuity less than 4 on a scale of 0-10.
D. Client will take pain medication every 4 hours around the clock.

7. As goals, outcomes, and interventions are developed, the nurse must:

A. Be in charge of all care and planning for the client.
B. Be aware of and committed to accepted standards of practice from nursing and other disciples.
C. Not change the plan of care for the client.
D. Be in control of all interventions for the client.

8. When establishing realistic goals, the nurse:

A. Bases the goals on the nurse's personal knowledge.
B. Knows the resources of the health care facility, family, and the client.
C. Must have a client who is physically and emotionally stable.
D. Must have the client's cooperation.

9. To initiate an intervention the nurse must be competent in three areas, which include:

A. Knowledge, function, and specific skills
B. Experience, advanced education, and skills.
C. Skills, finances, and leadership.
D. Leadership, autonomy, and skills.

10. Collaborative interventions are therapies that require:

A. Physician and nurse interventions.
B. Nurse and client interventions.
C. Client and Physician intervention.
D. Multiple health care professionals.

11. Well formulated, client-centered goals should:

A. Meet immediate client needs.
B. Include preventative health care.
C. Include rehabilitation needs.
D. All of the above.

12. The following statement appears on the nursing care plan for an immunosuppressed client: The client will remain free from infection throughout hospitalization. This statement is an example of a (an):

A. Nursing diagnosis
B. Short-term goal
C. Long-term goal
D. Expected outcome

13. The following statements appear on a nursing care plan for a client after a mastectomy: Incision site approximated; absence of drainage or prolonged erythema at incision site; and client remains afebrile. These statements are examples of:

A. Nursing interventions
B. Short-term goals
C. Long-term goals
D. Expected outcomes.

14. The planning step of the nursing process includes which of the following activities?

A. Assessing and diagnosing
B. Evaluating goal achievement.
C. Performing nursing actions and documenting them.
D. Setting goals and selecting interventions.

15. The nursing care plan is:

A. A written guideline for implementation and evaluation.
B. A documentation of client care.

C. A projection of potential alterations in client behaviors
D. A tool to set goals and project outcomes.

16. After determining a nursing diagnosis of acute pain, the nurse develops the following appropriate client-centered goal:

A. Encourage client to implement guided imagery when pain begins.
B. Determine effect of pain intensity on client function.
C. Administer analgesic 30 minutes before physical therapy treatment.
D. Pain intensity reported as a 3 or less during hospital stay.

17. When developing a nursing care plan for a client with a fractured right tibia, the nurse includes in the plan of care independent nursing interventions, including:

A. Apply a cold pack to the tibia.
B. Elevate the leg 5 inches above the heart.
C. Perform range of motion to right leg every 4 hours.
D. Administer aspirin 325 mg every 4 hours as needed.

18. Which of the following nursing interventions are written correctly? Select all that apply.

A. Apply continuous passive motion machine during day.
B. Perform neurovascular checks.
C. Elevate head of bed 30 degrees before meals.
D. Change dressing once a shift.

19. A client's wound is not healing and appears to be worsening with the current treatment. The nurse first considers:

A. Notifying the physician.
B. Calling the wound care nurse
C. Changing the wound care treatment.
D. Consulting with another nurse.

20. When calling the nurse consultant about a difficult client-centered problem, the primary nurse is sure to report the following:

A. Length of time the current treatment has been in place.
B. The spouse's reaction to the client's dressing change.
C. Client's concern about the current treatment.
D. Physician's reluctance to change the current treatment plan.

21. The primary nurse asked a clinical nurse specialist (CNS) to consult on a difficult nursing problem. The primary nurse is obligated to:

A. Implement the specialist's recommendations.
B. Report the recommendations to the primary physician.
C. Clarify the suggestions with the client and family members.
D. Discuss and review advised strategies with CNS.

22. After assessing the client, the nurse formulates the following diagnoses. Place them in order of priority, with the most important (classified as high) listed first.

A. Constipation
B. Anticipated grieving
C. Ineffective airway clearance
D. Ineffective tissue perfusion.

23. The nurse is reviewing the critical paths of the clients on the nursing unit. In performing a variance analysis, which of the following would indicate the need for further action and analysis?

A. A client's family attending a diabetic teaching session.
B. Canceling physical therapy sessions on the weekend.
C. Normal VS and absence of wound infection in a post-op client.
D. A client demonstrating accurate medication administration following teaching.

24. The RN has received her client assignment for the day-shift. After making the initial rounds and assessing the clients, which client would the RN need to develop a care plan first?

A. A client who is ambulatory.
B. A client, who has a fever, is diaphoretic and restless.
C. A client scheduled for OT at 1300.
D. A client who just had an appendectomy and has just received pain medication.

25. Which of the following statements about the nursing process is most accurate?

A. The nursing process is a four-step procedure for identifying and resolving patient problems.
B. Beginning in Florence Nightingale's days, nursing students learned and practiced the nursing process.
C. Use of the nursing process is optional for nurses, since there are many ways to accomplish the work of nursing.
D. The state board examinations for professional nursing practice now use the nursing process rather than medical specialties as an organizing concept.

Answers and Rationale

1. Answer: A. Plan is developed for nursing care.

2. Answer: C. Client-centered goals and expected outcomes are established.

3. Answer: D. Urgency of problems

4. Answer: B. Highest possible level of wellness and independence in function.

5. Answer: A. Alert and have some degree of independence.

6. Answer: C. Client will report pain acuity less than 4 on a scale of 0-10.

7. Answer: B. Be aware of and committed to accepted standards of practice from nursing and other disciples.

8. Answer: B. Knows the resources of the health care facility, family, and the client.

9. Answer: A. Knowledge, function, and specific skills

10. Answer: D. Multiple health care professionals.

11. Answer: D. All of the above.

12. Answer: B. Short-term goal

13. Answer: D. Expected outcomes.

14. Answer: D. Setting goals and selecting interventions.

15. Answer: A. A written guideline for implementation and evaluation.

16. Answer: D. Pain intensity reported as a 3 or less during hospital stay.

This is measurable and objective.

17. Answer: B. Elevate the leg 5 inches above the heart.

This does not require a physician's order. A and D require an order; C is not appropriate for a fractured tibia.

18. Answer: C. Elevate head of bed 30 degrees before meals.

It is specific in what to do and when.

19. Answer: B. Calling the wound care nurse

Calling in the wound care nurse as a consultant is appropriate because he or she is a specialist in the area of wound management. Professional and competent nurses recognize limitations and seek appropriate consultation. **Option A** may be appropriate after deciding on a plan of action with the wound care nurse specialist. The nurse may need to obtain orders for special wound care products. **Option C** is possible unless the nurse is knowledgeable in wound management, this could delay wound healing. Also, the current wound management plan could have been ordered by the physician. As for **Option D**, another nurse most likely will not be knowledgeable about wounds, and the primary nurse would know the history of the wound management plan.

20. Answer: A. Length of time the current treatment has been in place.

This gives the consulting nurse facts that will influence a new plan. Other choices are subjective and emotional issues and conclusions about the current treatment plan may cause bias in the decision of a new treatment plan by the nurse consultant.

21. Answer: D. Discuss and review advised strategies with CNS.

The primary nurse requested the consultation, it is important that they communicate and discuss recommendations. The primary nurse can then accept or reject the CNS recommendations.

- **Option A:** Some of the recommendations may not be appropriate for this client. The primary nurse would know this information. A consultation requires review of the recommendations, but not immediate implementation.
- **Option B:** This would be appropriate after first talking with the CNS about recommended changes in the plan of care and the rationale. Then the primary nurse should call the physician.
- **Option C:** The client and family do not have the knowledge to determine whether new strategies are appropriate or not. Better to wait until the new plan of care is agreed upon by the primary nurse and physician before talking with the client and/or family.

22. Answer: C, D, A, B.

23. Answer: B. Canceling physical therapy sessions on the weekend.

24. Answer: B. A client, who has a fever, is diaphoretic and restless.

This client's needs are a priority.

25. Answer: D. The state board examinations for professional nursing practice now use the nursing process rather than medical specialties as an organizing concept.

Option A: The nursing process is a five-step process. Option B: The term nursing process was first used by Hall in 1955. Option C: Nursing process is not optional since standards demand the use of it.