

Chapter 1. Critical Thinking and the Nursing Process

Multiple Choice

Identify the choice that best completes the statement or answers the question.

- _____ 1. While providing care on a medical unit, which of the following patients should the LPN/LVN see first?
 - a. A patient who has a temperature of 106°F (41.1°C)
 - b. A patient who needs assistance to ambulate
 - c. A patient who needs discharge teaching
 - d. A patient who states, “No one cares about me”

- _____ 2. During a class discussion, one nursing student states belief in the practice of restraining patients. Another student has presented information regarding the unrestrained environment. Both students understand each other’s points of view. This is an example of what component of critical thinking?
 - a. Intellectual empathy
 - b. Intellectual integrity
 - c. Intellectual courage
 - d. Intellectual sense of justice

- _____ 3. Which of these human needs is being met when staff members have a potluck dinner with a congratulatory cake for a newly licensed practical nurse?
 - a. Physiological
 - b. Safety and security
 - c. Self-esteem
 - d. Self-actualization

- _____ 4. The nurse is caring for a patient with a newly fractured femur who reports a pain level of 8/10. The nurse checks the medication record and finds that the analgesic medication is not due for another 50 minutes. Which of these actions would be appropriate for the nurse to take next?
 - a. Tell the patient it is too early for pain medication.
 - b. Notify the registered nurse or physician.
 - c. Give the medication in 30 minutes.
 - d. Reposition the patient.

- _____ 5. Which of these is an appropriate description of critical thinking?
 - a. Directed thinking
 - b. Indirect thinking
 - c. Crisis thinking
 - d. Criticizing thinking

- _____ 6. Which of these individuals would be most appropriate to include when planning care for a newly admitted patient and setting goals for the desired outcome?
 - a. Patient’s family members
 - b. Patient’s physician
 - c. Nurse manager
 - d. Patient

- _____ 7. While caring for a patient 4 hours after a surgical procedure, the LPN/LVN notes serosanguineous drainage on the dressing. Which of the following statements best documents this finding?
 - a. “Normal drainage noted.”
 - b. “Scant sersanguineous drainage seen on dressing.”
 - c. “Moderate drainage recently noted.”

d. "Pale pink drainage 2 cm by 1 cm noted on dressing."

- _____ 8. The nurse is caring for a patient who is scheduled for surgery. Which data should the nurse collect to identify safety and security needs?
- a. Sexual activity patterns
 - b. Anxiety about surgery
 - c. Sleep patterns
 - d. Meal patterns
- _____ 9. Which of these data is objective patient information?
- a. Patient is pleasant.
 - b. "It has been a good day."
 - c. Patient's appetite is poor.
 - d. Urine output is 300 mL.
- _____ 10. Which of these nursing diagnoses would be the highest priority for the nurse to address in a postoperative patient?
- a. Deficient knowledge
 - b. Impaired mobility
 - c. Impaired skin integrity
 - d. Acute pain
- _____ 11. A patient who has hypertension that is not well controlled with medication has been prescribed a new medication. The patient reports fatigue and lightheadedness after taking the first dose. The physician says not to worry about it and to continue giving the medication. The nurse is still concerned, however, and does some independent research on the drug on the Internet. This is an example of what type of critical thinking skill?
- a. Intellectual courage
 - b. Intellectual perseverance
 - c. Intellectual empathy
 - d. Sense of justice
- _____ 12. Which is the best example of a measurable outcome for a patient with deficient fluid volume?
- a. Fluids will be at the bedside for the patient.
 - b. Fluids the patient likes will be at the bedside.
 - c. Patient's intake will be 3,000 mL daily.
 - d. Patient's intake will be measured daily.
- _____ 13. The nurse is caring for a patient with a nursing diagnosis of fluid volume excess. Which of the following would the LPN/LVN use to best determine that care was effective?
- a. Discuss the patient's care plan with the RN.
 - b. Teach the patient to monitor fluid balance.
 - c. Check the patient's weight each day.
 - d. Restrict the patient's fluid intake.
- _____ 14. The LPN and LVN assist the RN in many phases of the nursing process. Which phase can the LPN or LVN carry out independently, once it has been delegated by the RN?
- a. Assessment
 - b. Nursing diagnosis
 - c. Planning care
 - d. Implementation
 - e. Evaluation

- _____ 15. The nurse is caring for a patient with a painful back injury that occurred 6 months ago. Which nursing diagnosis—using the Problem-Etiology-Symptoms (PES) system—is best?
- Acute pain related to patient pain rating of 6 as evidenced by muscle spasms and nerve compression
 - Chronic pain related to muscle spasms as evidenced by patient pain rating of 8 and difficulty walking
 - Acute pain related to inability to sit as evidenced by muscle spasms
 - Pain as evidenced by herniated lumbar disk
- _____ 16. An LVN assisted an RN in revising the care plan for a patient who was not eating well. The RN added the intervention of sitting with the patient during meals. The LVN finds that the patient is still not eating today, even after staying with the patient for breakfast and lunch. What should the LVN do next?
- Develop a new plan of care.
 - Revise the patient outcome to one that is achievable.
 - Provide data to the RN to assist in evaluation of the plan.
 - Collaborate on a new nursing diagnosis with the RN.
- _____ 17. A new shift is starting, and the LPN is given a list of assigned patients. Of the following patients, whom should the LPN see first?
- A patient reporting constipation and stomach cramps
 - A 2-day postsurgical patient reporting pain at a level of 6
 - A patient with pneumonia who is short of breath and anxious
 - A patient scheduled for an MRI due to back pain
- _____ 18. For a patient who has all of the following nursing diagnoses, which should be given highest priority?
- Anxiety
 - Constipation
 - Deficient fluid volume
 - Ineffective airway clearance
- _____ 19. The nurse planning patient care uses the systematic organizing framework of the nursing process. Which of these responses gives the nursing process steps in order?
- Data collection, intervention, nursing diagnosis, rationale, evaluation
 - Nursing diagnosis, intervention, rationale, evaluation, planning
 - Assessment, nursing diagnosis, planning, implementation, evaluation
 - Data collection, evaluation, nursing diagnosis, implementation, rationale
- _____ 20. What is the term used in the nursing process for the patient's problem?
- Patient data
 - Nursing diagnosis
 - Nursing intervention
 - Outcome planning
- _____ 21. Which of the following provides measurable information to determine achievement of patient outcomes?
- Subjective terminology
 - Open-ended time frames
 - Objective observations
 - P-E-S format
- _____ 22. Which of the following needs on Maslow's hierarchy has the lowest priority?
- Physiological needs
 - Self-actualization
 - Self-esteem

d. Safety and security

- ____ 23. Which of the following needs on Maslow's hierarchy is given highest priority?
- a. Physiological
 - b. Self-actualization
 - c. Self-esteem
 - d. Safety and security
- ____ 24. The nurse is in a restaurant and observes a person who appears to be in respiratory distress. The person's family is becoming excited. The nurse goes to the table to help. Which of these actions should the nurse take first?
- a. Diagnose the problem.
 - b. Collect data about the person's condition.
 - c. Gather data from the family.
 - d. Assist the patient to lie down.

Multiple Response

Identify one or more choices that best complete the statement or answer the question.

- ____ 25. Which of the following are official NANDA nursing diagnoses? (Select all that apply.)
- a. Diabetes
 - b. Acute pain
 - c. Impaired physical mobility
 - d. Pancreatitis
 - e. Activity intolerance
- ____ 26. A nurse is admitting a patient with high blood glucose levels, confusion, an unsteady gait, and dehydration. The patient has a family history of diabetes. Which of these are appropriate nursing diagnoses for the nursing care plan? (Select all that apply.)
- a. Hyperglycemia
 - b. Diabetes
 - c. Risk for falls
 - d. Dehydration
 - e. Deficient fluid volume

Other

27. The nurse is providing care for a patient recovering from a hip replacement who has a history of respiratory disease. Place the following nursing diagnoses in order of priority (1–4).
- A. ____ Risk for injury related to unsteady gait
 - B. ____ Knowledge deficit related to use of a walker
 - C. ____ Acute pain related to surgery
 - D. ____ Impaired gas exchange related to compromised respiratory system

Chapter 1. Critical Thinking and the Nursing Process

Answer Section

MULTIPLE CHOICE

1. ANS: A

According to Maslow, humans' basic needs (physiological) have the highest priority, and these patients should be seen first. Life-threatening needs are ranked first, health-threatening needs are second, and health-promoting needs are last. The elevated temperature has the greatest urgency. B, C, and D are not as high a priority.

PTS: 1 DIF: Medium REF: Page 9

KEY: Client Need: SECE—Coordinated Care | Cognitive Level: Application | Question to Guide Your Learning: 4

2. ANS: C

C. Intellectual courage allows one to look at other points of view. A. Intellectual empathy allows one to consider another's situation and feelings. B. Intellectual integrity is seeking the same level of proof for comparable items. D. Intellectual sense of justice is ensuring that one's thinking is not biased by analyzing motives.

PTS: 1 DIF: Medium REF: Page 4

KEY: Cognitive Level: Comprehension | Question to Guide Your Learning: 1

3. ANS: C

Recognizing a person's accomplishments will enhance his or her self-esteem. A, B, and D fall into other categories of human needs.

PTS: 1 DIF: Medium REF: Page 9

KEY: Cognitive Level: Application | Question to Guide Your Learning: 4

4. ANS: B

B. The patient should not have to wait for pain relief, so the LPN should inform the RN or physician so new pain relief orders can be obtained. A, C. These options do not provide immediate pain relief, which would be the positive outcome desired by the patient. D. The patient who has a fractured femur is having acute pain. Repositioning a patient with a new fracture is not likely to relieve pain.

PTS: 1 DIF: Medium REF: Page 5

KEY: Client Need: SECE—Coordinated Care | Cognitive Level: Application | Integrated Processes: Communication and Documentation | Question to Guide Your Learning: 5

5. ANS: A

Critical thinking is sometimes called directed thinking because it focuses on a goal. B, C, and D do not describe critical thinking.

PTS: 1 DIF: Medium REF: Page 4

KEY: Cognitive Level: Comprehension | Question to Guide Your Learning: 1

6. ANS: D

It is important to include the patient in the development of the plan of care. The patient must be in agreement with the plan for it to be successful in meeting the desired outcomes.

PTS: 1 DIF: Medium REF: Page 8

KEY: Client Need: SECE—Coordinated Care | Cognitive Level: Comprehension | Integrated Processes: Clinical Problem-Solving Process | Question to Guide Your Learning: 5

7. ANS: D

Objective data are factual information. Document exactly what you observed or heard stated by the patient, significant other, or health team members. Avoid interpreting the data and using words that have vague meanings, such as normal, scant, or moderate.

PTS: 1 DIF: Medium REF: Page 7

KEY: Client Need: PHYS—Physiological Adaptation | Cognitive Level: Application | Integrated Processes: Communication and Documentation | Question to Guide Your Learning: 3

8. ANS: B

A threat to a person's safety and security such as surgery creates anxiety, so it is the highest priority to address. A, C, and D are not likely related to the immediate safety and security needs of a patient facing surgery.

PTS: 1 DIF: Medium REF: Page 9

KEY: Client Need: PHYS—Reduction of Risk Potential | Cognitive Level: Application | Integrated Processes: Clinical Problem-Solving Process | Question to Guide Your Learning: 4

9. ANS: D

Objective data are factual information such as D. A, B, and C are subjective data.

PTS: 1 DIF: Medium REF: Page 7

KEY: Cognitive Level: Comprehension | Question to Guide Your Learning: 2

10. ANS: D

Using Maslow's hierarchy, pain would be the highest priority nursing diagnosis for a postoperative patient. While B, C, and D are all physiological needs, pain is the most urgent following surgery. The other options would be a lower priority.

PTS: 1 DIF: Medium REF: Page 9

KEY: Client Need: SECE—Coordinated Care | Cognitive Level: Comprehension | Integrated Processes: Clinical Problem-Solving Process | Question to Guide Your Learning: 6

11. ANS: B

Intellectual perseverance is not giving up. Intellectual courage looks at other points of view, even when the nurse does not agree with them. The nurse with intellectual empathy tries to understand how others feel when making decisions. The nurse with a sense of justice examines motives when making decisions.

PTS: 1 DIF: Medium REF: Page 4

KEY: Cognitive Level: Recall | Question to Guide Your Learning: 1

12. ANS: C

Response C represents a patient outcome with an objective measure. The other responses are not patient outcomes; they are goals for the nurse.

PTS: 1 DIF: Medium REF: Page 10

KEY: Client Need: PHYS—Physiological Adaptation | Cognitive Level: Application | Integrated Processes: Clinical Problem-Solving Process | Question to Guide Your Learning: 6

13. ANS: C

To evaluate the effectiveness of the plan of care and actions implemented, the nurse must assess the outcome for the patient's nursing diagnosis and determine if the outcome has been achieved or if revisions are needed. In this case, the patient should have fewer symptoms of fluid overload (stable or decreasing weight). C is the only assessment option. Although discussing the plan of care with the RN is relevant to the patient's care, it will not help determine the outcome of the stated diagnosis. Teaching the patient to monitor fluid balance is an intervention but will not evaluate the outcome. Restricting fluid intake is an implementation; evaluation is required to determine patient outcome and effective care.

PTS: 1 DIF: Hard REF: Page 11

KEY: Client Need: SECE—Coordinated Care | Cognitive Level: Application | Integrated Processes: Clinical Problem-Solving Process | Question to Guide Your Learning: 6

14. ANS: D

The LPN/LVN collects data, assists in formulating nursing diagnoses, assists in determining outcomes and planning care to meet patient needs, implements patient care interventions, and assists in evaluating the effectiveness of nursing interventions in achieving the patient's outcomes. The role of the LPN/LVN is to provide direct patient care.

PTS: 1 DIF: Medium REF: Page 6

KEY: Client Need: SECE—Coordinated Care | Cognitive Level: Comprehension | Integrated Processes: Clinical Problem-Solving Process | Question to Guide Your Learning: 6

15. ANS: B

“Chronic pain related to muscle spasms as evidenced by patient pain rating of 8 and difficulty walking” uses the PES system and uses measurable data as evidence. This best guides the nurse's care and evaluation of the outcome. The other options do not provide appropriate etiologies or measurable evidence.

PTS: 1 DIF: Medium REF: Page 8

KEY: Client Need: PHYS—Basic Care and Comfort | Cognitive Level: Application | Integrated Processes: Clinical Problem-Solving Process | Question to Guide Your Learning: 5

16. ANS: C

Roles of the LVN include data collection and assisting in evaluating the outcomes. The LVN should provide new data to the RN, so they can revise the plan of care together. A new plan, outcome, or diagnosis may be appropriate but are not carried out independently of the RN.

PTS: 1 DIF: Hard REF: Page 6

KEY: Client Need: SECE—Coordinated Care | Cognitive Level: Application | Integrated Processes: Caring | Question to Guide Your Learning: 6

17. ANS: C

Using Maslow's hierarchy of needs and considering which patient problems are life threatening, shortness of breath is most important. Pain, constipation, and scheduled tests are all important but are not immediately life threatening.

PTS: 1 DIF: Hard REF: Page 9

KEY: Client Need: PHYS—Physiological Adaptation | Cognitive Level: Analysis | Integrated Processes: Clinical Problem-Solving Process | Question to Guide Your Learning: 4

18. ANS: D

Ineffective airway clearance is the highest priority because, of the three physiological problems, it is most likely to be immediately life threatening. Anxiety is the lowest priority because it is not physiological.

PTS: 1 DIF: Medium REF: Page 9

KEY: Client Need: PHYS—Physiological Adaptation | Cognitive Level: Analysis | Integrated Processes:

Clinical Problem-Solving Process | Question to Guide Your Learning: 4

19. ANS: C

The nursing process is used to assess patient needs; formulate nursing diagnoses; and plan, implement, and evaluate care.

PTS: 1 DIF: Easy REF: Page 6

KEY: Client Need: SECE—Coordinated Care | Cognitive Level: Recall | Integrated Processes: Clinical Problem-Solving Process | Question to Guide Your Learning: 5

20. ANS: B

A nursing diagnosis is a clinical judgment about individual, family, or community response to actual or potential health problems or life processes. Nursing diagnoses are standardized labels that make an identified problem understandable to all nurses. Patient data lead to the diagnosis, and interventions and outcomes are based on the diagnosis.

PTS: 1 DIF: Easy REF: Page 8

KEY: Client Need: SECE—Coordinated Care | Cognitive Level: Recall | Integrated Processes: Clinical Problem-Solving Process | Question to Guide Your Learning: 5

21. ANS: C

Measurable means that an outcome can be observed or is objective. It should not be vague or open to interpretation. Open-ended time frames do not help with measurement. Problem-Etiology-Symptoms (PES) format refers to nursing diagnoses, not outcomes measurement.

PTS: 1 DIF: Easy REF: Page 10

KEY: Client Need: SECE—Coordinated Care | Cognitive Level: Comprehension | Integrated Processes: Clinical Problem-Solving Process | Question to Guide Your Learning: 5

22. ANS: B

According to Maslow, humans must meet their most basic needs (those at the bottom of the triangle) first. They can then move up the hierarchy to meet higher-level needs. Self-actualization is at the top of the pyramid, making that the lowest priority.

PTS: 1 DIF: Easy REF: Page 9

KEY: Client Need: SECE—Coordinated Care | Cognitive Level: Recall | Integrated Processes: Clinical Problem-Solving Process | Question to Guide Your Learning: 4

23. ANS: A

According to Maslow, humans must meet their most basic needs—physiological—first. They can then move up the hierarchy to meet higher-level needs such as safety, self-esteem, and self-actualization.

PTS: 1 DIF: Easy REF: Page 9

KEY: Client Need: SECE—Coordinated Care | Cognitive Level: Recall | Integrated Processes: Clinical Problem-Solving Process | Question to Guide Your Learning: 4

24. ANS: B

The first step in the nursing process is to collect data, and the patient should come first. Further data collection and diagnosis follow next, then intervention.

PTS: 1 DIF: Medium REF: Page 5

KEY: Client Need: PHYS—Physiological Adaptation | Cognitive Level: Analysis | Integrated Processes: Clinical Problem-Solving Process | Question to Guide Your Learning: 4

MULTIPLE RESPONSE

25. ANS: B, C, E

Diabetes, Impaired physical mobility, and Activity intolerance are NANDA nursing diagnoses. Diabetes and Pancreatitis are medical diagnoses.

PTS: 1 DIF: Medium REF: Page 8

KEY: Cognitive Level: Recall | Question to Guide Your Learning: 5

26. ANS: C, E

Deficient fluid volume and Risk for falls are nursing diagnoses related to the patient's symptoms and condition. Hyperglycemia, Diabetes, and Dehydration are medical problems that the nurse can assist with, but the nurse does not diagnose and treat medical problems.

PTS: 1 DIF: Medium REF: Page 8

KEY: Client Need: PHYS—Physiological Adaptation | Cognitive Level: Comprehension | Integrated Processes: Clinical Problem-Solving Process | Question to Guide Your Learning: 5

OTHER

27. ANS:

A. ANS: 4

B. ANS: 3

C. ANS: 1

D. ANS: 2

In a nursing plan of care, the patient's most urgent problem is listed first. According to Maslow's hierarchy of human needs, this usually involves a physiological need such as oxygen or water, because these are life-sustaining needs. If several physiological needs are present, life-threatening needs are ranked first, health-threatening needs are second, and health-promoting needs, although important, are last. In this case, ineffective breathing is a potentially life-threatening need and would be first; acute pain is the next most urgent need, followed by risk for injury which is less critical than pain because it is a potential problem rather than an actual problem; knowledge deficit would be last because it is health promoting and considered psychosocial rather than physical/physiological.

PTS: 1 DIF: Medium REF: Page 9

KEY: Client Need: PHYS—Physiological Adaptation | Cognitive Level: Analysis | Integrated Processes: Clinical Problem-Solving Process | Question to Guide Your Learning: 4