Appendix A Answers to Test Your Knowledge

Chapter 1: Historical and Contemporary Nursing Practice

1. **Answer:** 1, 4, and 5. **Rationale:** Option 2, Florence Nightingale, contributed to the nursing care of soldiers in the Crimean War. Option 3, Fabiola, used her wealth to provide houses of caring and healing during the Roman Empire. **Cognitive Level:** Knowledge. **Client Need:** N/A. **Nursing Process:** N/A. **Learning Outcome:** 1-1.
2. **Answer:** 2, 3, and 5. **Rationale:** State boards of nursing set minimum educational requirements for licensure. Professional organizations establish educational criteria for program accreditation. The National Council of State Boards of Nursing conducts practice studies and creates the NCLEX-RN®. Neither physicians (option 1) nor hospital administrators (option 4) are involved in setting nursing curricula. **Cognitive Level:** Remembering. **Client Need:** N/A. **Nursing Process:** N/A. **Learning Outcome:** 1-3.
3. **Answer:** 2. **Rationale:** Continuing education refers to formalized experiences designed to enhance the knowledge or skill of practitioners. The other answers are examples of in-service education, which is designed to upgrade the knowledge or skills of current employees with regard to the specific setting, and is usually less formal in presentation. **Cognitive Level:** Analyzing. **Client Need:** Safe, Effective Care Environment. **Nursing Process:** N/A. **Learning Outcome:** 1-4.
4. **Answer:** 3. **Rationale:** Health promotion focuses on maintaining normal status without consideration of diseases. Option 1 is an example of illness prevention. Option 2 is aesthetic (i.e., not needed for health promotion or disease prevention). Option 4 focuses on disease detection. **Cognitive Level:** Remembering. **Client Need:** N/A. **Nursing Process:** N/A. **Learning Outcome:** 1-6.
5. **Answer:** 3. **Rationale:** All are noted nurses. Linda Richards was America's first trained nurse, and Mary Mahoney was America's first Black trained nurse. **Cognitive Level:** Remembering. **Client Need:** N/A. **Nursing Process:** N/A. **Learning Outcome:** 1-2.
6. **Answer:** 2. **Rationale:** Option 1, the advanced beginner, demonstrates marginally acceptable performance. Option 3, the proficient practitioner, has 3 to 5 years of experience and has developed a holistic understanding of the client. Option 4, the expert practitioner, demonstrates highly skilled intuitive and analytic ability in new situations. **Cognitive Level:** Remembering. **Client Need:** N/A. **Nursing Process:** N/A. **Learning Outcome:** 1-11.
7. **Answer:** 4. **Rationale:** The National Student Nurses Association developed the Code of Academic and Clinical Conduct for nursing students in 2001. Option 1, ANA, developed *Standards of Nursing Practices*. Option 2, NLN, focuses on nursing education. Option 3, the American Association of Colleges of Nursing (AACN), is the national organization that focuses on the advancement and maintenance of America's baccalaureate and higher degree nursing education programs. **Cognitive Level:** Remembering. **Client Need:** N/A. **Nursing Process:** N/A. **Learning Outcome:** 1-13.
8. **Answer:** 1. **Rationale:** All will impact nursing but not necessarily the supply and demand issue. The aging population contributes to more older adults needing specialized care (increasing the demand). Fewer nursing faculty to educate students and fewer nurses practicing because of retirement contribute to the decreasing supply. **Cognitive Level:** Analyzing. **Client Need:** N/A. **Nursing Process:** N/A. **Learning Outcome:** 1-12.
9. **Answer:** 2. **Rationale:** All of the expanded roles function as health care advocates and all could work with individuals affected by violence. However, the forensic nurse specifically integrates forensic skills into nursing practice. **Cognitive Level:** Remembering. **Client Need:** N/A. **Nursing Process:** N/A. **Learning Outcome:** 1-9.
10. **Answer:** Progression **Rationale:** The focus has changed to academic progression for all nurses. **Cognitive Level:** Remembering. **Client Need:** N/A. **Nursing Process:** N/A. **Learning Outcome:** 1-3.

Chapter 2: Evidence-Based Practice and Research in Nursing

1. **Answer:** 4. **Rationale:** Trial and error is not considered valid evidence, and may even be harmful to clients. Clinical experience (option 1), the opinions of experts (option 2), and client values and preferences (option 3) are all considered valid evidence in evidence-based practice. **Cognitive Level:** Remembering. **Client Need:** N/A **Nursing Process:** N/A. **Learning Outcome:** 2-3
2. **Answer:** 1. **Rationale:** Quantitative research collects numerical data. Sleep deprivation can be defined by numbers of hours without sleep and wound healing can be measured by the size of the wound in relation to a period of time. While some of the other options may be calculated using sophisticated numerical processes, they are not as easily measured and may be more appropriate for qualitative research methods. **Cognitive Level:** Applying. **Client Need:** N/A. **Nursing Process:** N/A. **Learning Outcome:** 2-4.
3. **Answer:** 3. This study investigates the subjective experience of stress, through the collection of narrative data. Options 1, 2, and 4 are examples of quantitative research using numbers and values. **Cognitive Level:** Applying. **Client Need:** N/A. **Nursing Process:** N/A. **Learning Outcome:** 2-4.
4. **Answer:** 2. **Rationale:** The key purpose of a study's methodology is to generate data that are reliable and valid, thus controlling extraneous variables is a major function. The hypotheses that are tested are formed during the problem identification phase of a study (option 1). Grants and funding sources are not related to methodology (option 3). Protecting subjects' rights (option 4) is an important consideration, but not the key purpose of a methodology. **Cognitive Level:** Understanding. **Client Need:** N/A. **Nursing Process:** N/A. **Learning Outcome:** 2-5.
5. **Answer:** 2. **Rationale:** PICO stands for patient/client, population, or problem; intervention; comparison; and outcome. These are helpful components of a research question and help to identify key terms for a literature search. Options 1, 3, and 4 are incorrect. **Cognitive Level:** Remembering. **Client Need:** N/A. **Nursing Process:** N/A. **Learning Outcome:** 2-5.
6. **Answer:** 2. **Rationale:** Since the primary purpose of research is to improve the quality of client care, the nurse should determine if published research results are applicable to the specific client population. Published studies may have flawed designs, data collection, or analysis (option 1). Although more than one well-conducted study with similar findings supports usefulness of the results, applicability must still be determined for the specific client population (option 3). It is not realistic for the nurse to rerun the raw data to check the results of the study. **Cognitive Level:** Applying. **Client Need:** N/A. **Nursing Process:** N/A. **Learning Outcome:** 2-6.
7. **Answer:** 1. **Rationale:** A research critique is the thoughtful consideration of a study's strengths and weaknesses, and how these affect the quality and usefulness of study results. Options 2 and 3 describe elements of a research critique. The summary of a study and its key findings

(option 4) comprise an abstract. **Cognitive Level:** Remembering. **Client Need:** N/A. **Nursing Process:** N/A. **Learning Outcome:** 2-5.

8. **Answer:** 4. **Rationale:** The right to self-determination means that subjects feel free of constraints, coercion, or any undue influence to participate in a study. There is not enough information given to indicate if any of the other rights in options 1, 2, and 3 have been violated. **Cognitive Level:** Applying. **Client Need:** N/A. **Nursing Process:** N/A. **Learning Outcome:** 2-7.
9. **Answer:** 3, 2, 1, 5, 4, 6. **Cognitive Level:** Remembering. **Client Need:** N/A. **Nursing Process:** N/A. **Learning Outcome:** 2-2.
10. **Answer:** 3. **Rationale:** There may have been unique aspects to this research that would not be applicable in a different setting or with different clients. Not all research is flawed (option 1) and it may or may not have taken cost into consideration (option 2). Research is not limited to the study of physiological problems (option 4). **Cognitive Level:** Understanding. **Client Need:** N/A. **Nursing Process:** N/A. **Learning Outcome:** 2-1.

Chapter 3: Nursing Theories and Conceptual Frameworks

1. **Answer:** 3. **Rationale:** A supposition or system of ideas proposed to explain a given phenomenon is a theory. Concepts are mental images that are included within a theory (option 1); a conceptual framework is a group of related ideas, statements, or concepts (option 2); and a paradigm is a pattern of shared understandings and assumptions about reality and the world (option 4). **Cognitive Level:** Remembering. **Client Need:** N/A. **Nursing Process:** N/A. **Learning Outcome:** 3-1.
2. **Answer:** 2. **Rationale:** A group of related ideas or statements is a conceptual framework. A philosophy is a belief system (option 1); a supposition or system of ideas proposed to explain a given phenomenon is a theory (option 3); and a paradigm is a pattern of shared understandings and assumptions about reality and the world (option 4). **Cognitive Level:** Remembering. **Client Need:** N/A. **Nursing Process:** N/A. **Learning Outcome:** 3-1.
3. **Answer:** 4. **Rationale:** A set of shared understandings and assumptions about reality and the world is a paradigm. A concept is a mental image (option 1); a conceptual framework is a group of related ideas, statements, or concepts (option 2); and a practice discipline is a field of study in which the central focus is performance of a professional role (option 3). **Cognitive Level:** Remembering. **Client Need:** N/A. **Nursing Process:** N/A. **Learning Outcome:** 3-1.
4. **Answer:** 1. **Rationale:** Practice disciplines are fields of study in which the central focus is performance of a professional role. Time and experience are necessary for developing proficiency in any profession or career (option 2). Research and theory development do not have performance as their primary focus. The primary focus of nursing is providing quality service to humans (option 3). Team or group practice can be a part of a career in humanities, computer science, or rocket science (option 4). **Cognitive Level:** Analyzing. **Client Need:** N/A. **Nursing Process:** N/A. **Learning Outcome:** 3-5.
5. **Answer:** 2. **Rationale:** Person/client, environment, health, and nursing are relevant when providing care for any client whether in the hospital, at home, in the community, or in elementary school systems. These elements can be used to understand diseases, conduct and apply research, and develop nursing theories, as well as implement the nursing process. **Cognitive Level:** Applying. **Client Need:** N/A. **Nursing Process:** N/A. **Learning Outcome:** 3-3.
6. **Answer:** 1. **Rationale:** Practice theories assist the nurse to reflect on nursing care. Theories describing the interrelationships among a broad range of concepts within nursing are grand theories, not midlevel, and both require more testing through nursing research (option 2). Schools of nursing in the United States may or may not be organized around any theory or conceptual model (option 3). Nursing theory guides the direction of research and education and practice (option 4). **Cognitive Level:** Applying. **Client Need:** N/A. **Nursing Process:** N/A. **Learning Outcome:** 3-4.
7. **Answer:** 3. **Rationale:** The purpose of any theory is to help interpret phenomena. Programs of research should have a theoretical framework but the theory is not the reason for the research (option 1). Theory is as applicable in science as it is in art (options 3 and 4). **Cognitive Level:** Understanding. **Client Need:** N/A. **Nursing Process:** N/A. **Learning Outcome:** 3-2.

Chapter 4: Legal Aspects of Nursing

1. **Answer:** 3. **Rationale:** This is the best answer because the nurse is assessing the client's level of knowledge as a result of the discussion with the primary care provider. Based on this assessment, the nurse may initiate other actions (e.g., call the primary care provider if the client has many questions). In option 1, the nurse is not assessing if the client received enough information to give consent. Option 2 is one way to assess the client's level of knowledge regarding the procedure. However, it is not the best approach because it is a closed-ended question, asking for only a "yes" or "no" response. Option 3 provides more information from the client in his or her own words. The statement in option 4 is true; however, the nurse should first verify if the client received enough information to give consent. After the assessment, this statement may be appropriate but the assessment needs to be done first. **Cognitive Level:** Applying. **Client Need:** Safe, Effective Care Environment. **Nursing Process:** Assessment. **Learning Outcome:** 4-4.
2. **Answer:** 4. **Rationale:** Battery is the willful touching of a person without permission. Another name for an unintentional tort is professional negligence/malpractice. This situation is an *intentional* tort because the nurse executed the act on purpose. Assault is the attempt or threat to touch another person unjustifiably or without permission. Invasion of privacy injures the feelings of the person and does not take into consideration how revealing information or exposing the client will affect the client's feelings. **Cognitive Level:** Analyzing. **Client Need:** Safe, Effective Care Environment. **Nursing Process:** N/A. **Learning Outcome:** 4-10.
3. **Answer:** 2. **Rationale:** The nurse should call the person who wrote the order for clarification. Administering the medication is incorrect because knowing the dose is outside the normal range and not questioning the order could lead to client harm and liability for the nurse. Calling the pharmacist is not the best answer because it will not solve the problem, and the nurse needs to seek clarification from the person who wrote the order. The nurse should suspend administration but not refuse to administer the medication until the issue is resolved. **Cognitive Level:** Applying. **Client Need:** Safe, Effective Care Environment. **Nursing Process:** Implementation. **Learning Outcome:** 4-7.
4. **Answer:** 1. **Rationale:** All elements such as duty, foreseeability, causation, harm/injury, and damages must be present for professional negligence to be proven. The nurse is a licensed professional responsible for individual actions. Notifying the primary care provider does not exempt the nurse from liability. Because it is apparent the standard of practice was not performed, a breach of duty does exist. Violation/omission of the standard of practice resulted in an excessive dosage. Therefore foreseeability is present; however, no harm occurred to the client. **Cognitive Level:** Analyzing. **Client Need:** Safe, Effective Care Environment. **Nursing Process:** Evaluation. **Learning Outcome:** 4-9.
5. **Answer:** 4. **Rationale:** A sterile, invasive procedure that places the client at significant risk for infection is generally outside the scope of practice of a UAP. Even though the UAP is a nursing student, the agency job description should be followed. The job description is the standard of care in this situation. **Cognitive Level:** Applying. **Client Need:** Safe, Effective Care Environment. **Nursing Process:** Implementation. **Learning Outcome:** 4-13.

6. **Answer:** 3. **Rationale:** A DNR order only controls CPR and similar lifesaving treatments. All other care continues as previously ordered. Competent clients can still decide about their own care (including the DNR order). Nothing about the DNR order is related to when the client may die. Because clients' medical conditions and their views of their lives can change, a new DNR order is required for each admission to a health care agency. Once admitted, that order stands until changed or until it expires according to agency policy. **Cognitive Level:** Applying. **Client Need:** Psychosocial Integrity. **Nursing Process:** Planning. **Learning Outcome:** 4-7.
7. **Answer:** 3. **Rationale:** The only person entitled to information without written consent is the client and those providing direct care. The nurse has open access to information regarding assigned clients only. **Cognitive Level:** Applying. **Client Need:** Safe, Effective Care Environment. **Nursing Process:** Implementation. **Learning Outcome:** 4-11.
8. **Answer:** 1, 2, and 5. **Rationale:** The nurse is subject to the limitation of the state law and should be familiar with the Good Samaritan laws in the specific state. Gross negligence would be described by the individual state law. Unless there is another equally or more qualified person present, the nurse needs to stay until the injured person leaves. The nurse should ask someone else to call or go for additional help. Since there was no prior agreement, the nurse cannot accept compensation. Also, the nurse is not employed by the accident victim. The same client rights apply at the scene of an accident as well as those in the workplace. **Cognitive Level:** Applying. **Client Need:** Safe, Effective Care Environment. **Nursing Process:** Planning. **Learning Outcome:** 4-12.
9. **Answer:** 1, 3, and 4. **Rationale:** Interacting with others (versus isolating self from others) and setting limits on the number of hours working are positive behaviors and not indicative of possible impairment. The other options are warning signs for impairment. **Cognitive Level:** Analyzing. **Client Need:** Safe, Effective Care Environment. **Nursing Process:** Evaluation. **Learning Outcome:** 4-6.
10. **Answer:** 2 and 3. **Rationale:** Standards of practice require a complete assessment. A nurse needs to be sure the client's needs have been met. They both can impact client safety and do not follow standards of care. The other options meet the standards of practice. **Cognitive Level:** Analyzing. **Client Need:** Safe, Effective Care Environment. **Nursing Process:** Implementation. **Learning Outcome:** 4-7.

Chapter 5: Values, Ethics, and Advocacy

1. **Answer:** 1. **Rationale:** A nurse's actions in an ethical dilemma must be defensible according to moral and ethical standards. The nurse may have strong personal beliefs but distancing oneself from the situation does not serve the client (option 2). A team is not always required to reach decisions (option 3), and the nurse is not obligated to follow the client's wishes automatically when they may have negative consequences for self or others (option 4). **Cognitive Level:** Applying. **Client Need:** Safe, Effective Care Environment. **Nursing Process:** Planning. **Learning Outcome:** 5-2.
2. **Answer:** 2. **Rationale:** The nurse has an ethical responsibility to act only when actions are safe or risks minimized. This nurse is putting the client at unnecessary risk for a medication error. Many medical practices are controversial but not necessarily unethical (option 1). The nurse should follow agency policy. Although some may view nurses' strikes as unethical, supporting others who are striking is a personal decision (option 3). Although a client statement in confidence to a nurse may have ethical overtones, it does not automatically constitute an ethical dilemma. Since the assigned health care provider is a member of the team, principles of confidentiality do not include him or her (option 4). **Cognitive Level:** Analyzing. **Client Need:** Safe, Effective Care Environment. **Nursing Process:** N/A. **Learning Outcome:** 5-4.
3. **Answer:** 1. **Rationale:** Autonomy is the client's (or surrogate's) right to make his or her own decision. The nurse is obliged to respect a client's or significant other's informed decision. These parents may modify their decision as time goes on and the child's condition, or their feelings, change. This situation is not clearly one of nonmaleficence (do no harm) in option 2 or beneficence (do good) in option 3 since there are many aspects of both. If the child appeared to be suffering or an effective treatment was being denied, these principles might apply. Justice (fairness) generally applies when the rights of one client are being balanced against those of another client (option 4). **Cognitive Level:** Applying. **Client Need:** Safe, Effective Care Environment. **Nursing Process:** N/A. **Learning Outcome:** 5-3.
4. **Answer:** 3. **Rationale:** In values clarification, clients are assisted to think about the factors that influence their beliefs and decisions. Any judgmental statement that reflects the rightness or wrongness of the client's thoughts or actions will impede this process (options 1, 2, and 4). **Cognitive Level:** Applying. **Client Need:** Safe, Effective Care Environment. **Nursing Process:** Implementation. **Learning Outcome:** 5-2.
5. **Answer:** 4. **Rationale:** A major role of the client advocate is to mediate between conflicting parties. The nurse needs to assess the situation before offering an intervention. Informing the family is an intervention without assessment (option 1). If the primary care provider sends the client home, the nurse has not acted to assist in resolving or reducing the conflict (option 2). If the nurse assists in resolving or reducing the conflict, the added expense of an attorney may not be needed. However, legal action should be a last resort (option 3). **Cognitive Level:** Analyzing. **Client Need:** Safe, Effective Care Environment. **Nursing Process:** Implementation. **Learning Outcome:** 5-5.
6. **Answer:** 4. **Rationale:** The nurse is obliged to design care and to act according to the professional code of ethics even if the nurse holds different values. The client's need for value-based care takes precedence over the nurse's values; however, nurses can choose not to participate in care with which they have conflicting values (options 1 and 2). The client outcome can be the same even when different moral frameworks are used (option 3). **Cognitive Level:** Applying. **Client Need:** Safe, Effective Care Environment. **Nursing Process:** Planning. **Learning Outcome:** 5-1.

Chapter 6: Health Care Delivery Systems

1. **Answer:** 3. **Rationale:** Actions such as diet modification that help to prevent an illness or detect it in its early stages are primary preventions. Treatment of a disease such as with antibiotic therapy (option 1) or surgery (option 4) is secondary prevention, while rehabilitation efforts following an illness (option 2) are considered tertiary prevention. **Cognitive Level:** Analyzing. **Client Need:** Health Promotion and Maintenance. **Nursing Process:** N/A. **Learning Outcome:** 6-1.
2. **Answer:** 2. **Rationale:** City, county, state, or federal government funds pay for health department and agency activities aimed at the global health of the community. Hospitals may provide a variety of wellness and clinic programs in addition to inpatient services (option 1). Surgery may be performed in outpatient surgery centers and physicians' offices in addition to within hospitals (option 3). Skilled nursing, extended care, and long-term care facilities provide care to persons of all ages who require rehabilitation or subacute care. This is not necessarily related to insurance coverage for hospital stays (option 4). **Cognitive Level:** Analyzing. **Client Need:** N/A. **Nursing Process:** N/A. **Learning Outcome:** 6-2.
3. **Answer:** 1. **Rationale:** Primary care providers are limited to generalist physicians and advanced practice nurses. In some cases a gynecologist may qualify as a primary care provider and in other cases not. Physical therapists (option 2) do not have a scope of practice broad enough to serve as primary care providers. Pharmacists (option 3) and case managers/discharge planners (option 4) are not responsible for providing direct client care. **Cognitive Level:** Analyzing. **Client Need:** Safe, Effective Care Environment. **Nursing Process:** Planning. **Learning Outcome:** 6-3.

4. **Answer:** 2. **Rationale:** When people have inadequate insurance for health costs, they tend to avoid early and preventive care. This results in eventual use of much more costly resources such as emergency departments. Methods to provide minimum levels of insurance coverage have been successful in other countries. The number of children is increasing, but in the United States and Canada, this is a nonmodifiable factor (option 1). Also, the majority of health care costs are incurred by adults and older adults who tend to have multiple and chronic health conditions. There is currently a significant shortage of nurses and maldistribution of physicians so reducing their numbers would only worsen the problem (option 3). Competition among manufacturers is more likely to cause costs to fall than to rise (option 4). **Cognitive Level:** Applying. **Client Need:** N/A. **Nursing Process:** Diagnosis. **Learning Outcome:** 6-4.
5. **Answer:** 4. **Rationale:** A health maintenance organization involves a set monthly membership fee and predictable visit or deductible costs. Medicare covers a minimal number of preventive and outpatient services so the cost cannot be anticipated (option 1). Individual fee-for-service insurance is perhaps the most costly to the client, with potentially large differences between the amount of coverage the insurance company pays and the provider's charges (option 2). PPOs are less costly than fee-for-service entities, but more expensive than HMOs (option 3). **Cognitive Level:** Analyzing. **Client Need:** Safe, Effective Care Management. **Nursing Process:** Planning. **Learning Outcome:** 6-6.

Chapter 7: Community Nursing and Care Continuity

1. **Answer:** 3. **Rationale:** The *Health System Reform Agenda* (ANA, 2008) called for case management of those with ongoing health care needs. Options 1, 2, and 4 are incorrect because the agenda also proposed that primary care be community based but that essential services be paid for by a combination of public and private funding sources (not just public funds) and be phased in gradually. **Cognitive Level:** Applying. **Client Need:** N/A. **Nursing Process:** N/A. **Learning Outcome:** 7-1.
2. **Answer:** 1. **Rationale:** The Pew Commission identified the need for modern health care providers to be proficient in the use of technology. Care should be emphasized in primary, rather than tertiary, settings (option 2). The commission also identified the need for contemporary (not traditional) clinical strategies (option 3) and for collaborative decision making with clients (option 4). **Cognitive Level:** Analyzing. **Client Need:** N/A. **Nursing Process:** N/A. **Learning Outcome:** 7-5.
3. **Answer:** 2. **Rationale:** In community-based health care, clients are cared for according to their geographic locations such as where they live or work, rather than at a major medical center or similar provider setting, which facilitates access. The other options are incorrect because emphasis is more on client wellness and prevention than on illness and may be paid for through any of the usual forms of insurance or payment (including managed care, private pay, or welfare). **Cognitive Level:** Analyzing. **Client Need:** Safe, Effective Care Environment. **Nursing Process:** N/A. **Learning Outcome:** 7-4.
4. **Answer:** 2. **Rationale:** In collaboration, each member of the team, including the client, participates in sharing ideas and reaching consensus on the best plan of care. The team is generally led by the health care professional most skilled in the client's specific areas of need (option 1). Once the plan is established, it may be implemented by any member of the team or a designate at an appropriate time and place (option 3). It is not necessarily delegated by the nurse (option 4). **Cognitive Level:** Analyzing. **Client Need:** Safe, Effective Care Environment. **Nursing Process:** N/A. **Learning Outcome:** 7-6.
5. **Answer:** 4. **Rationale:** Effective discharge planning would have included an assessment of home care needs prior to the client leaving the hospital. The kind of care is determined before the client leaves the current setting. That is why it is called discharge "planning." Following a thorough assessment, the client would be taught self-care strategies and a basic plan of care for the coming days (option 3). Obtaining medications and a ride home does not indicate the client possesses the knowledge and skills needed to manage care after discharge (option 2). If the client will need care at home, those referrals would be made by the discharge planner and communicated to the client. Option 4 indicates the client knows and accepts these referrals. **Cognitive Level:** Analyzing. **Client Need:** Safe, Effective Care Environment. **Nursing Process:** Evaluation. **Learning Outcome:** 7-7.
6. **Answer:** 4. **Rationale:** The home health nurse more commonly works with one person or family at one time—addressing their particular needs that may be similar to or different from those of others. The community health nurse will focus on activities that influence the larger group of individuals affected. These include options 1 and 2—prevention and monitoring of infectious disease plus actions that will promote health for multiple affected individuals (e.g., food, water, and shelter). **Cognitive Level:** Understanding. **Client Need:** Safe, Effective Care Environment. **Nursing Process:** Implementation. **Learning Outcome:** 7-5.

Chapter 8: Home Care

1. **Answer:** 3. **Rationale:** Although hospitals have recently become more welcoming to families, a major strength of home care is the involvement and proximity of loved ones. Curative and lifesaving approaches may be used both at home and in the hospital (option 1). An asset of home care nurses is their ability to manage complex symptoms (option 2). This includes expertise in pain management, but the same legal strategies are available in either in-home care or hospitals (option 4). **Cognitive Level:** Applying. **Client Need:** N/A. **Nursing Process:** N/A. **Learning Outcome:** 8-2.
2. **Answer:** 1. **Rationale:** Assuming the client is medically stable, feeding and bathing are tasks within the aide's abilities. Options 2, 3, and 4 are incorrect because teaching the client about or adjusting medications (and oxygen is considered a medication) and performing assessments are duties restricted to the registered nurse. **Cognitive Level:** Applying. **Client Need:** Safe and Effective Care Environment. **Nursing Process:** Planning. **Learning Outcome:** 8-4.
3. **Answer:** 2. **Rationale:** The nurse needs to encourage the client to express feelings or thoughts that led to the refusal so that misunderstandings can be clarified and other possible solutions explored. The nurse should apply the principle that all behavior has meaning. Otherwise, the nurse is intervening before assessing the situation (option 1). The approach in option 3 did not work the first time. A reason for the refusal needs to be explored. Option 4 is almost a threat and has a paternalistic implication. Clients are entitled to make informed decisions to perform or not perform recommended activities. Notifying the primary care provider is implementing an intervention before the nurse has done an assessment. **Cognitive Level:** Applying. **Client Need:** Health Promotion and Maintenance. **Nursing Process:** Implementation. **Learning Outcome:** 8-5.
4. **Answer:** 1. **Rationale:** If the caregiver's own health is becoming threatened, it may be a sign of overload. It would be appropriate for the caregiver to ask for assistance from others (option 2), or to ask for clarification of ways he or she can assist the client (option 3). Sadness related to a poor prognosis would be a normal and expected response as long as it does not evolve into depression (option 4). **Cognitive Level:** Applying. **Client Need:** Psychosocial Integrity. **Nursing Process:** Diagnosis. **Learning Outcome:** 8-7.
5. **Answer:** 4. **Rationale:** A physician's authorization of the plan of care is needed before home health care by a nurse can be initiated. Insurance coverage is not required although the agency may need proof of the client's ability to pay if insurance is not available or adequate (option 1).

Many clients benefit from home health care even if there is no in-home caregiver present or needed (option 2). The health problem for which home care is needed may be chronic or acute and may necessitate preventive, curative, or palliative therapy (option 3). **Cognitive Level:** Applying. **Client Need:** Safe and Effective Care Environment. **Nursing Process:** Planning. **Learning Outcome:** 8-3.

6. **Answer:** 1, 3, and 6. **Rationale:** Nurses may work with hospice clients as a subset of home health. In home health, nurses care for both client and family and perform physical, psychosocial, and emotional interventions. Skilled nursing facilities are not considered locations for home health nursing (option 2). Home health can include high-tech equipment and procedures (option 4). Clients may have home care whether or not they can afford other health care. **Cognitive Level:** Remembering. **Client Need:** Safe and Effective Care Environment. **Nursing Process:** Planning. **Learning Outcome:** 8-4.
7. **Answer:** 4. **Rationale:** The emergency response necklace only works within the client's home in proximity to the base station. It will not activate away from home. The client needs to wear it at all times when home. It can be worn when away from home but the client must understand that activating it when away will not summon assistance. It is appropriate for the client to wear a medical alert bracelet at all times (option 1) and have a list of medications posted on the refrigerator (option 2). Area rugs should be removed if clients could trip on them (option 3). **Cognitive Level:** Applying. **Client Need:** Safe and Effective Care Environment. **Nursing Process:** Evaluation. **Learning Outcome:** 8-6.

Chapter 9: Electronic Health Records and Information Technology

1. **Answer:** 1, 2, 4, and 5. **Rationale:** Technology can facilitate almost every aspect of nursing administration. Both individual employee and overall institutional compliance with accreditation standards and criteria are tracked (option 1). Most common medical diagnoses and costs of all care can be retrieved from the electronic databases (option 2). Financial performance, as well as the results of client satisfaction surveys, are common computer applications (options 4 and 5).
   Option 3 is incorrect because, although the results of performance appraisals may be entered into a computer program for tracking purposes, it would be an overstatement to say that this indicates which employees are doing the best job since that is a very subjective determination. Computers do a better job in providing concrete, quantitative data. **Cognitive Level:** Remembering. **Client Need:** N/A. **Nursing Process:** N/A. **Learning Outcome:** 9-4.
2. **Answer:** 3. **Rationale:** Control over who has access to confidential computerized data is the greatest concern. Computer hackers can bypass codes and gain access to personal information, which could result in identity theft. The benefits often outweigh the cost (option 1). Computerized data can be much more accurate than paper-and-pencil data (option 2). Due to ease of making copies and backups, electronic data can last forever (option 4). **Cognitive Level:** Analyzing. **Client Need:** Safe, Effective Care Environment. **Nursing Process:** N/A. **Learning Outcome:** 9-2.
3. **Answer:** 4. **Rationale:** Since learners may do their online work at different times and do much of their work offline, it may be harder for them to feel and act like a class group. The courses are often self-paced and, thus, may take a longer or shorter time to complete than on-campus courses (option 1). Interpersonal communication is possible through e-mail and chat, plus audio and video file sharing allow learners to see and hear the faculty as well as each other (option 2). For most web-based courses, learners may log on at their convenience (option 3). **Cognitive Level:** Understanding. **Client Need:** N/A. **Nursing Process:** N/A. **Learning Outcome:** 9-1.
4. **Answer:** 3. **Rationale:** Although all steps of the research process can be accomplished with and without computers, electronic analysis of quantitative data helps ensure accuracy and speeds the process immensely. **Cognitive Level:** Analyzing. **Client Need:** N/A. **Nursing Process:** N/A. **Learning Outcome:** 9-5.
5. **Answer:** 1. **Rationale:** Each website is different and the practitioner is compelled to evaluate the site and the treatment to determine if it is evidence based, safe, and appropriate for the client. Website-described treatments often report results of extensive research (option 2). One of the most important advantages of posting treatment information and results on the Internet is that many different people can determine if the treatment is useful for their clients (option 3). Some websites are actually advertising, but many are sponsored by legitimate organizations such as the National Cancer Institute (option 4). **Cognitive Level:** Applying. **Client Need:** Health Promotion and Maintenance. **Nursing Process:** Implementation. **Learning Outcome:** 9-3.

Chapter 10: Critical Thinking and Clinical Reasoning

1. **Answer:** 2. **Rationale:** The nurse has inferred and concluded something that is beyond the available information (and in this case may not be accurate). The prescription and the diarrhea are facts (option 1). It would be judgment and opinion if the nurse stated that the laxative would make the diarrhea worse and should not be given (options 3 and 4). (*Note:* Critical thinking will cause this nurse to examine the assumptions made and gather more data before acting.) **Cognitive Level:** Analyzing. **Client Need:** N/A. **Nursing Process:** Evaluation. **Learning Outcome:** 10-1.
2. **Answer:** 1. **Rationale:** The nurse recognizes that many assumptions (beliefs) could interfere with the client eating—such as that the food presented is not culturally appropriate. These assumptions must be clarified with the process of clinical reasoning. Options 2 and 3 reach conclusions not supported by the facts. In option 4, the nurse has made a judgment or has an opinion that may not be accurate. Also, the nurse is acting without assessment. Implementation should be preceded by assessment. **Cognitive Level:** Applying. **Client Need:** Physiological Integrity. **Nursing Process:** Assessment. **Learning Outcome:** 10-2.
3. **Answer:** 2. **Rationale:** Reviewing evidence-based literature and identifying similarities in the clinical manifestations of symptoms is an act of clinical reasoning. Past experiences in care enhance the nurse's ability to recognize and respond in the delivery of client-centered care. Clinical judgment in nursing is a decision-making process to ascertain the right action to implement at the appropriate time during client care (option 1). Reflection is the nurse's review of the care provided to determine strategies to improve future care (option 3), Intuition is a problem-solving approach that relies on a nurse's inner sense (option 4). **Cognitive Level:** Applying. **Client Need:** Physiological Integrity. **Nursing Process:** N/A. **Learning Outcome:** 10-2.
4. **Answer:** 1. **Rationale:** The research method uses a research study-based approach to problem solving. Trial and error (option 2) and intuition (option 3) would involve unstructured approaches resulting in less predictable results. The nursing process generally uses application of known interventions, previously determined by the scientific (research) process (option 4). **Cognitive Level:** Applying. **Client Need:** N/A. **Nursing Process:** N/A. **Learning Outcome:** 10-5.
5. **Answer:** 4. **Rationale:** It is important to project what problems might interfere with the plan and have appropriate responses prepared to prevent the interferences. The purpose for the decision should have been clear enough at the outset as to not require reexamination at this point (option 1). Clients and families should be consulted early—in the purpose-setting and criteria-setting steps. Criteria should not be set until all significant participants have an opportunity to present their point of view (option 2). Considering various means for reaching the outcomes is the same as examining alternatives (option 3). **Cognitive Level:** Applying. **Client Need:** N/A. **Nursing Process:** Planning. **Learning Outcome:** 10-4.

6. **Answer:** 2. **Rationale:** The nurse's intuition is like a sixth sense that allows the nurse to recognize cues and patterns to reach correct conclusions. The nurse appropriately obtains vital signs and an oxygen saturation to assess the client's clinical picture more fully. Option 1 supports appropriate nursing actions, but the client's respiratory status should be assessed first. Usually, a physician must order a chest x-ray (option 2). The rapid response team (option 4) may be needed if the client's condition becomes more critical. **Cognitive Level:** Applying. **Client Need:** Physiological Integrity. **Nursing Process:** Implementing. **Learning Outcome:** 10-2.
7. **Answer:** 1. **Rationale:** By reconsidering the type of dressing used based on research, the nurse is using integrity. Options 2 and 3 are critical thinking attitudes characterized by an awareness of the limits of one's own knowledge, and being trustworthy. Option 4 indicates an attitude of not being easily swayed by the opinions of others. **Cognitive Level:** Applying. **Client Need:** Health Promotion and Maintenance. **Nursing Process:** Planning. **Learning Outcome:** 10-4.
8. **Answer:** 1. **Rationale:** Nurses must embrace exploration of the perspectives of individuals from different ages, cultures, religions, socioeconomic levels, and family structures to create environments that support critical thinking. Option 2 relates to nurses who should increase their tolerance for ideas that contradict previously held beliefs. Option 3 is conducted when a nurse benefits from a rigorous personal assessment to determine which attitudes he or she already possesses and which need to be cultivated. Option 4 occurs when nurses find it valuable to attend conferences in clinical or educational settings that support open examination of all sides of issues and respect for opposing viewpoints. **Cognitive Level:** Applying. **Client Need:** Physiological Integrity. **Nursing Process:** Assessment. **Learning Outcome:** 10-1.
9. **Answer:** 2. **Rationale:** The nurse recognizes the need to obtain further information from the client in order to respond directly to the client's statement. Option 1 passes off the client's educational needs to another practitioner. Options 3 and 4 are nontherapeutic. **Cognitive Level:** Applying. **Client Need:** Physiological Integrity. **Nursing Process:** Planning. **Learning Outcome:** 10-5.
10. **Answer:** 4. **Rationale:** A nurse thinks critically, evaluates possible solutions, and uses problem solving. Intuition (option 1) is not a sufficient basis for implementing wound care when significant data on alternative care strategies are available. Research (option 2) is a more comprehensive rigorous process and not typically implemented while caring for an infected wound. Trial and error (option 3) is unsafe and inappropriate for care of an infected wound. **Cognitive Level:** Understanding. **Client Need:** Physiological Integrity. **Nursing Process:** Planning. **Learning Outcome:** 10-5.

Chapter 11: Assessing

1. **Answer:** 1. **Rationale:** Identifying problems/needs is part of a nursing diagnosis. For example, a client with difficulty breathing would have *Impaired Gas Exchange* related to constricted airways as manifested by shortness of breath (dyspnea) as a nursing diagnosis. Organizing the family history is part of the assessment phase. Establishing goals is part of the planning phase. Administering an antibiotic is part of the implementation phase. **Cognitive Level:** Applying. **Client Need:** N/A. **Nursing Process:** Diagnosis. **Learning Outcome:** 11-1.
2. **Answer:** 3. **Rationale:** During assessment, data are collected, organized, validated, and documented. Hypotheses are generated during diagnosing; outcomes are set during planning; and documentation occurs throughout the nursing process. **Cognitive Level:** Applying. **Client Need:** N/A. **Nursing Process:** Assessment. **Learning Outcome:** 11-1.
3. **Answer:** 2. **Rationale:** Primary data come from the client (option 4), whereas secondary data come from any other source (chart, family). Subjective data are covert (reported or an opinion), whereas objective data can be measured or validated (weight—option 1, edema—option 3). If the spouse had stated that the client had eaten only toast and tea, this would be secondary objective (measured) data. **Cognitive Level:** Applying. **Client Need:** N/A. **Nursing Process:** Assessment. **Learning Outcome:** 11-5.
4. **Answer:** 3. **Rationale:** Eliciting feelings requires an open-ended question that does more than seek factual information (option 1) and cannot be answered with a single word (option 2). The family can provide indirect information about the client, but is not most likely to provide the most accurate information (option 4). **Cognitive Level:** Analyzing. **Client Need:** N/A. **Nursing Process:** Assessment. **Learning Outcome:** 11-8.
5. **Answer:** 4. **Rationale:** Frameworks help the nurse be systematic in data collection. Other members of the health care team may use very different conceptual organizing frameworks so data may not correlate (option 1). Cost-effective care (option 2) is more likely to occur with systematic application of the nursing process, but use of a framework for assessment alone may not accomplish this goal. Because the framework is structured and because of the nature of client needs/problems, creativity and intuition in care planning are not assured (option 3). **Cognitive Level:** Applying. **Client Need:** N/A. **Nursing Process:** Assessment. **Learning Outcome:** 11-10.
6. **Answer:** 1. **Rationale:** Assessing provides a database of the client's physiological and psychosocial responses to his or her health status. Client strengths and problems (option 2) are identified in the diagnosing phase of the nursing process, a care plan is established (option 3) in the planning phase, and care, prevention, and wellness promotion (option 4) are part of the implementing phase. **Cognitive Level:** Remembering. **Client Need:** N/A. **Nursing Process:** Assessment. **Learning Outcome:** 11-3.
7. **Answer:** 3. **Rationale:** In validating, the nurse confirms that data is complete and accurate. Subjective data is collected in the collecting activity (option 1), a framework is applied to the data in the organizing activity (option 2), and data is recorded in the documenting activity (option 4). **Cognitive Level:** Understanding. **Client Need:** N/A. **Nursing Process:** Assessment. **Learning Outcome:** 11-4.
8. **Answer:** 1. **Rationale:** The nursing process focuses on client needs. It is dynamic rather than static (option 2), emphasizes client responses rather than physiology and illness (option 3), and is collaborative rather than used exclusively by nurses (option 4). **Cognitive Level:** Understanding. **Client Need:** N/A. **Nursing Process:** Assessment. **Learning Outcome:** 11-4.
9. **Answer:** 4. **Rationale:** Interpreting collected data is necessary to help validate its accuracy. Observing includes the senses of smell, hearing, and touch in addition to vision (option 1). Using priority setting, observing must often be performed simultaneously with other activities (option 2). A systematic approach to observing data helps ensure nothing is missed and the nurse pays attention to the most important data first (option 4). **Cognitive Level:** Understanding. **Client Need:** N/A. **Nursing Process:** Assessment. **Learning Outcome:** 11-6.
10. **Answer:** 2, 4, and 5. **Rationale:** The nurse plans the interview so that privacy is observed. A comfortable distance between nurse and client to respect the client's personal space is about 3 feet. Using a standard form will help ensure the nurse doesn't omit gathering any vital information. Lighting should be at a normal level—neither bright nor dim (option 1). The nurse should be at the same height as the client, usually sitting, at approximately a 45° angle facing the client. The nurse standing over the client creates an uncomfortable atmosphere for an interview (option 3). **Cognitive Level:** Applying. **Client Need:** N/A. **Nursing Process:** Planning. **Learning Outcome:** 11-9.

Chapter 12: Diagnosing

1. **Answer:** 2. **Rationale:** In diagnosing, data from assessment (option 1) are analyzed and problems, risks, and strengths are identified before diagnostic statements can be established. Interventions (option 3) are more commonly part of the planning and implementing phases of the nursing

process. Cost (option 4) is an important consideration but would be estimated in the planning phase. **Cognitive Level:** Applying. **Client Need:** N/A. **Nursing Process:** Diagnosis. **Learning Outcome:** 12-4.

2. **Answer:** 2. **Rationale:** Because the venous return is impaired, fluid is static, resulting in swelling. Therefore, decreased venous return is the cause (etiology) of the problem. *Excess Fluid Volume* is the nursing diagnosis, and edema of the lower extremity is the sign/symptom or critical attribute. The cause is known. **Cognitive Level:** Application. **Client Need:** N/A. **Nursing Process:** Diagnosis. **Learning Outcome:** 12-6.
3. **Answer:** 1. **Rationale:** States the relationship between the stem (caregiver role strain) and the cause of the problem. Option 2: The diagnostic statement says the same thing as the related factor (falls and collapse). Option 3: It is inappropriate to use medical diagnoses such as stroke within a nursing diagnosis statement. Option 4 is vague. The statement must be specific and guide the plan of care (fatigue may be a result of sleep deprivation and does not direct intervention). **Cognitive Level:** Applying. **Client Need:** N/A. **Nursing Process:** Diagnosis. **Learning Outcome:** 12-2.
4. **Answer:** 4. **Rationale:** The PES format assists with comprehensive and accurate organization of client data. More efficient planning may or may not reduce health care costs. Nursing diagnostic statements should be confirmed with the client but using PES does not ensure this. PES statements can be wellness or illness focused. **Cognitive Level:** Applying. **Client Need:** N/A. **Nursing Process:** Diagnosis. **Learning Outcome:** 12-5.
5. **Answer:** 1. **Rationale:** A collaborative (multidisciplinary) problem is indicated when both medical and nursing interventions are needed to prevent or treat the problem. If nursing care alone (whether that care involves independent or dependent nursing actions) can treat the problem, a nursing diagnosis is indicated. If medical care alone can treat the problem, a medical diagnosis is indicated. **Cognitive Level:** Applying. **Client Need:** N/A. **Nursing Process:** Diagnosis. **Learning Outcome:** 12-3.
6. **Answer:** 1. **Rationale:** A risk nursing diagnosis is appropriate when the evidence for the problem indicates that a condition exists that makes the client vulnerable to a problem. A syndrome diagnosis is assigned by a nurse's clinical judgment to describe a cluster of nursing diagnoses that have similar interventions (option 2). Health promotion diagnoses are used when the client seeks to increase well-being but need not currently be well (option 3). An actual diagnosis is used when the client already exhibits the problem (option 4). **Cognitive Level:** Remembering. **Client Need:** N/A. **Nursing Process:** Diagnosis. **Learning Outcome:** 12-1.
7. **Answer:** 3. **Rationale:** Diagnostic labels are continuously reviewed and revised as indicated by research—much more of which is needed. The original taxonomy has been replaced by Taxonomy II and is no longer based on a nurse theorist (options 1 and 2). New diagnoses are approved by NANDA International's Diagnostic Review Committee, not by a vote of nurses (option 4). **Cognitive Level:** Remembering. **Client Need:** N/A. **Nursing Process:** Diagnosis. **Learning Outcome:** 12-7.
8. **Answer:** 1, 4, and 5. **Rationale:** A client's movement toward a goal (option 1) or whose behavior is inconsistent with population norms (options 4 and 5) represents a cue that further analysis toward creating a nursing diagnosis is required. Corrected vision (option 2) and bladder and bowel control at age 18 months (option 3) are consistent with population norms. **Cognitive Level:** Analyzing. **Client Need:** N/A. **Nursing Process:** Diagnosis. **Learning Outcome:** 12-4.

Chapter 13: Planning

1. **Answer:** 4. **Rationale:** Strategic planning is an ongoing process focused on organizational change rather than individual clients so it is least useful and not relevant in this case. The client requires initial planning because he has just arrived on the orthopedic unit for the first time (option 1). Of the three types of planning that need to be done at this time, initial is the highest priority since he has just had surgery. The client also requires the ongoing type of planning necessary to determine the care appropriate for this shift (option 2). Discharge planning needs to start on admission to ensure adequate client preparation for management of health needs outside the health agency (option 3). **Cognitive Level:** Applying. **Client Need:** Safe, Effective Care Environment. **Nursing Process:** Planning. **Learning Outcome:** 13-2.
2. **Answer:** 1. **Rationale:** Policy and procedure documents provide data about how certain situations are handled. Standardized care plans (option 2) and standards of care (option 4) are written for groups of clients with similar medical or nursing diagnoses. They generally do not address questions such as hospital routines and nonmedical client needs. *Note:* Even hospital policies are not absolute. Each situation must be analyzed and responded to individually. Orthopedic protocols (option 3) would address elements specifically associated with the surgery, not whether the family slept in the room. **Cognitive Level:** Applying. **Client Need:** Psychosocial Integrity. **Nursing Process:** Planning. **Learning Outcome:** 13-5.
3. **Answer:** 2. **Rationale:** More detailed assessment data and consultation with the client would be needed to absolutely confirm the priority. Postoperative nausea to the level of inhibiting oral intake has the greatest likelihood of leading to complications and requires nursing intervention now. The client's pain level is not extreme considering the recency of the surgery, and pain intervention can be assumed to be effective (option 1). Although the constipation is probably bordering on abnormal, a nursing intervention would most likely begin with oral treatment, which is not possible due to the nausea. More invasive interventions such as an enema or suppository would not be commonly administered the first day postoperative (option 3). Wound infection can occur, but there are no data to indicate that this requires a change in the current plan (option 4). **Cognitive Level:** Applying. **Client Need:** Physiological Integrity. **Nursing Process:** Planning. **Learning Outcome:** 13-5.
4. **Answer:** 3. **Rationale:** The goal or outcome should state the opposite of the nursing diagnosis stem, and thus healthy intact skin is the reverse condition of impaired skin integrity. Turning in bed, applying lotion, and using a special mattress are all interventions that may result in achieving the goal (options 1, 2, and 4). **Cognitive Level:** Applying. **Client Need:** Physiological Integrity. **Nursing Process:** Planning. **Learning Outcome:** 13-8.
5. **Answer:** 3. **Rationale:** Although there may be standard policies or routines for measuring intake and output, the nursing intervention should specify if this is to be done "routinely" or at specific intervals (e.g., q4h). The nurse is also aware, however, that critical thinking indicates that the intake and output should be monitored more frequently than ordered if assessment reveals abnormal findings. **Cognitive Level:** Understanding. **Client Need:** Physiological Integrity. **Nursing Process:** Planning. **Learning Outcome:** 13-9.
6. **Answer:** 3, 1, 4, and 2. **Rationale:** In planning, first the nurse sets priorities and then writes goals/outcomes, selects interventions, and then writes the nursing care plan. **Cognitive Level:** Understanding. **Client Need:** N/A. **Nursing Process:** Planning. **Learning Outcome:** 13-1.
7. **Answer:** 2. **Rationale:** Standardized care plans provide a list of interventions from which the nurse can choose. The plan must still be individualized (option 1). Standardized plans could be longer or shorter than nurse-authored ones (option 3), but have not been approved by any outside accreditor (option 4). **Cognitive Level:** Applying. **Client Need:** N/A. **Nursing Process:** Planning. **Learning Outcome:** 13-3.
8. **Answer:** 1. **Rationale:** Goal statements provide the standard against which outcomes are measured. Nursing diagnoses are prioritized before goals are written (option 2). Both independent and dependent interventions may be appropriate for any goal (option 3). Clarity of

the goal does not influence delegation of the intervention (option 4). **Cognitive Level:** Analyzing. **Client Need:** N/A. **Nursing Process:** Planning. **Learning Outcome:** 13-6.

9. **Answer:** 4. **Rationale:** NOC outcomes should reflect both the nurse's and the client's values of what is trying to be achieved. The outcomes still must be customized (option 1), but address only one nursing diagnosis at a time (option 2). Outcomes are narrow/specific end points, not broad (option 3). **Cognitive Level:** Applying. **Client Need:** N/A. **Nursing Process:** Planning. **Learning Outcome:** 13-7.
10. **Answer:** 1. **Rationale:** Interventions should address the etiology of the nursing diagnosis. Both independent and dependent interventions should be selected if appropriate (option 2) and several interventions may be needed for a single outcome (option 3). Both action and assessment-type interventions can be used (option 4). **Cognitive Level:** Applying. **Client Need:** N/A. **Nursing Process:** Planning. **Learning Outcome:** 13-10.

Chapter 14: Implementing and Evaluating

1. **Answer:** 3. **Rationale:** The first step of implementing is reassessing the client to determine that the activity is still indicated and safe. The next action would be to determine if assistance is required (option 2), then implement the intervention (delegating if appropriate) (option 1), and last document the intervention (option 4). **Cognitive Level:** Understanding. **Client Need:** N/A. **Nursing Process:** Implementation. **Learning Outcome:** 14-3.
2. **Answer:** 4. **Rationale:** It is never acceptable practice for the nurse to document a nursing activity before it is carried out. This would be very unsafe because many things can cause an activity to be postponed or canceled and prior charting would be inaccurate, misleading, and potentially dangerous. In a few situations, it may be permissible to chart frequent or routine activities some time following the activities such as at the end of a shift or after a particular interval (e.g., every 4 hours) rather than immediately following the activity. **Cognitive Level:** Applying. **Client Need:** N/A. **Nursing Process:** Implementation. **Learning Outcome:** 14-4.
3. **Answer:** 1. **Rationale:** The desired outcomes and indicator statements reflect the parameters by which success will be measured. The goal can be met even if the nursing activities were not carried out or were ineffective (options 2 and 3). Although the desired outcome, by definition, indicates a change in the client's condition (behavior, knowledge, or attitude), only specific changes (desired outcomes) reflect the success of the care plan (option 4). **Cognitive Level:** Understanding. **Client Need:** N/A. **Nursing Process:** Evaluation. **Learning Outcome:** 14-5.
4. **Answer:** 2. **Rationale:** There is no reason to delete (option 1) or modify (option 3) the nursing diagnosis or demote its priority (option 4) because the risk factors that prompted it are still present. **Cognitive Level:** Analyzing. **Client Need:** Safe, Effective Care Environment. **Nursing Process:** Evaluation. **Learning Outcome:** 14-7.
5. **Answer:** 2. **Rationale:** Because this assessment focuses on how care is provided, it is a process evaluation. A structure evaluation (option 1) would focus on the setting (e.g., how well equipment functions), and outcome evaluations (option 3) focus on changes in client status (e.g., whether reported satisfaction levels vary with type of person who answers the call light). An audit (option 4) would be a chart or document review. **Cognitive Level:** Analyzing. **Client Need:** N/A. **Nursing Process:** Evaluation. **Learning Outcome:** 14-8.
6. **Answer:** 1. **Rationale:** During implementing, the nurse also assesses and compares with the initial assessment. Evaluating follows implementing (option 2), mobilization of other health care teams is a part of implementing (option 3), and evaluating occurs during or immediately after each intervention, not waiting for all interventions to be completed (option 4). **Cognitive Level:** Applying. **Client Need:** N/A. **Nursing Process:** Evaluation. **Learning Outcome:** 14-1.
7. **Answer:** 3. **Rationale:** This client needs psychosocial support rather than skills related to knowledge (options 1 and 2) or hands-on activity (option 4). **Cognitive Level:** Understanding. **Client Need:** N/A. **Nursing Process:** Evaluation. **Learning Outcome:** 14-2.
8. **Answer:** 1, 4, and 5. **Rationale:** Nurses should always have clear rationales for their actions, clients should be given options whenever possible, and client teaching is a constant, integral part of implementing. Primary care provider orders must be critically evaluated and modified to meet individual client needs (option 2). Clients may have nurses provide needed care but should take care of themselves whenever possible since dependency has its own complications (option 3). **Cognitive Level:** Analyzing. **Client Need:** N/A. **Nursing Process:** Evaluation. **Learning Outcome:** 14-4.
9. **Answer:** 2. **Rationale:** Evaluating requires that client behavior be compared to expected outcomes. Goals may be partially met in addition to completely met or unmet (option 1). An outcome may be achieved but not be a direct result of the plan or interventions (option 3). A care plan should be continued, modified, or terminated based on achievement of outcomes (option 4). **Cognitive Level:** Analyzing. **Client Need:** N/A. **Nursing Process:** Evaluation. **Learning Outcome:** 14-6.
10. **Answer:** 4. **Rationale:** Quality improvement (QI) plans corrective actions for problems. QI focuses on process rather than outcomes (option 1), client care rather than structure (option 2), and aims for improvement rather than confirmation of quality (option 3). **Cognitive Level:** Understanding. **Client Need:** N/A. **Nursing Process:** Evaluation. **Learning Outcome:** 14-9.

Chapter 15: Documenting and Reporting

1. **Answer:** 3. **Rationale:** All of the other answers endanger the client's confidentiality. **Cognitive Level:** Applying. **Client Need:** Safe, Effective Care Environment. **Nursing Process:** Implementation. **Learning Outcome:** 15-1.
2. **Answer:** 1. **Rationale:** Critical pathways work best for clients with one diagnosis. Option 2 is a possibility; however, there may be many individualized needs. Because that information is not available, the best answer is 1. Options 3 and 4 have too many diagnoses to work well with a critical pathway. **Cognitive Level:** Applying. **Client Need:** Safe, Effective Care Environment. **Nursing Process:** Assessment. **Learning Outcome:** 15-3.
3. **Answer:** 4. **Rationale:** It is the most complete answer. The client's record is a legal record and should not be altered with correcting liquid. You may see "error" written above a mistake even though many authors suggest not writing it. It is important to also put your name or initials next to the words of the mistaken entry. **Cognitive Level:** Applying. **Client Need:** Safe, Effective Care Environment. **Nursing Process:** Implementation. **Learning Outcome:** 15-6.
4. **Answer:** 4. **Rationale:** Option 4 is the "best" answer although it could be more complete by adding the response of the primary care provider. Option 1 is too vague because it is not clear if the nurse found the client or was present when the client fell. Also, there is no need to write the word *client* because it is the client's chart. Option 2 is judgmental, revealing a negative attitude toward the person. It would be better to describe specific signs and symptoms such as staggering, slurred speech, and smell of alcohol on breath. Option 3 is too general and can be more specific by charting "2 cm × 3 cm purplish bruise on mid-inner thigh along with color." **Cognitive Level:** Analyzing. **Client Need:** Safe, Effective Care Environment. **Nursing Process:** Evaluation. **Learning Outcome:** 15-6.
5. **Answer:** 1. No known allergies; 2. Bathroom privileges; 3. When necessary; 4. Diet as tolerated. **Cognitive Level:** Remembering. **Client Need:** Safe, Effective Care Environment. **Nursing Process:** Implementation. **Learning Outcome:** 15-6.

6. **Answer:** 2. **Rationale:** The graphic record provides the trend of the vital signs. Option 1, verbal information, is not appropriate for validation assessment that is measurable. This is more appropriate for pain or dizziness. The medication record would not include documentation of blood pressure ranges (option 3). The progress notes (option 4) provide information about how the client is progressing. It may have information about the client's BP if it was a problem. The best answer is option 2. **Cognitive Level:** Applying. **Client Need:** Safe, Effective Care Environment. **Nursing Process:** Assessment. **Learning Outcome:** 15-4.
7. **Answer:** 1, 2, and 4. **Rationale:** Option 3 is incorrect because it could be a HIPAA violation if others hear protected health information. Option 5 is not needed unless it is a concern and it would not be done for every client. **Cognitive Level:** Analyzing. **Client Need:** Safe, Effective Care Environment. **Nursing Process:** Implementation. **Learning Outcome:** 15-8.
8. **Answer:** 2, 3, and 5. **Rationale:** Option 1: "MS" is on the "Do Not Use" list—the nurse needs to write out morphine sulfate. Option 4 has three errors—should not have a trailing zero after the decimal point; "u" and "SQ" are on the "Do Not Use" list. **Cognitive Level:** Analyzing. **Client Need:** Safe, Effective Care Environment. **Nursing Process:** Implementation. **Learning Outcome:** 15-7.
9. **Answer:** 1. **Rationale:** Option 1 is the most specific, nonassuming, and nonjudgmental charting. Option 2 could be more specific by describing the lesions and not calling them "burns." Option 3 is making a judgment of elder abuse, and option 4 is also making an assumption that the lesions are from cigarette burns. **Cognitive Level:** Analyzing. **Client Need:** Safe, Effective Care Environment. **Nursing Process:** Evaluation. **Learning Outcome:** 15-6.
10. **Answer:** 1, 2, and 4. **Rationale:** Military time is commonly used; documenting worries or concerns provides clues to other nurses; gossip, unprofessional comments or thoughts, or personnel issues should not be recorded in the client's chart. Option 3 is incorrect because charting should be done as events occur. Waiting until the end of the shift increases the chance of forgetting something. **Cognitive Level:** Applying. **Client Need:** Safe, Effective Care Environment. **Nursing Process:** Implementation. **Learning Outcome:** 15-6.

Chapter 16: Health Promotion

1. **Answer:** 3. **Rationale:** Holism implies consideration of all aspects of the client's life. Although arranging for home care (option 1), facilitating spirituality (option 2), and offering coping resources (option 4) may be appropriate, the nurse begins a holistic approach to care by examining, with the client, in what ways the illness influences the various segments of her life. The client is the best source of information regarding personal needs. Assessment should always precede intervention. **Cognitive Level:** Applying. **Client Need:** Psychosocial Integrity. **Nursing Process:** Implementation. **Learning Outcome:** 16-1.
2. **Answer:** 3. **Rationale:** Learning about sleep will increase the older adult's well-being, which is the focus of health promotion. Prevention of falls (option 1) is health protection because the focus is avoiding injury. Learning about cardiovascular risk factors (option 2) relates to health protection/disease prevention. How to stop smoking (option 4) focuses on health protection and avoiding illness. **Cognitive Level:** Applying. **Client Need:** Health Promotion/Maintenance and Psychosocial Integrity. **Nursing Process:** Planning. **Learning Outcome:** 16-5.
3. **Answer:** 2. **Rationale:** Choices are often related to learned experiences, lifestyle, and values. The client obviously values the business more than physical health. When a person feels strongly enough, a lower level need (rest) can be postponed until a higher level need (success, safety) is met. It is very likely that no one else can meet that need for him and the lower need must still be met eventually. **Cognitive Level:** Applying. **Client Need:** Health Promotion and Maintenance. **Nursing Process:** Assessment. **Learning Outcome:** 16-3.
4. **Answer:** 3. **Rationale:** A person in this stage recognizes there is a problem, is seriously considering changing, actively gathers information, and verbalizes plans to change in the near future. Option 1 reflects the precontemplation stage in which the person denies there is a problem. Option 2 reflects the planning stage in which the person makes final plans to accomplish the change, and option 4 is the maintenance stage in which the person made the change and demonstrates the appropriate behavioral change. **Cognitive Level:** Analyzing. **Client Need:** Health Promotion and Maintenance. **Nursing Process:** Assessment. **Learning Outcome:** 16-8.
5. **Answer:** 2. **Rationale:** Perceived self-efficacy is the confidence the person has for achieving the desired outcome. Option 1 is a person's perceptions about available time, inconvenience, expense, and difficulty performing the activity. Option 3 is the person's perceptions concerning the behaviors, beliefs, or attitudes of others. Option 4 refers to the person's perception of the environment and how it assists or detracts from the healthy behavior. **Cognitive Level:** Applying. **Client Need:** Health Promotion and Maintenance. **Nursing Process:** Planning. **Learning Outcome:** 16-7.
6. **Answer:** 2, 3, and 5. **Rationale:** The *Healthy People 2020* goals are broad based. Options 1 and 4 are specific methods to promote healthy behaviors and would be seen in the objectives for a *Healthy People 2020* topic area. **Cognitive Level:** Comprehending. **Client Need:** Health Promotion and Maintenance. **Nursing Process:** N/A. **Learning Outcome:** 16-4.
7. **Answer:** 1. **Rationale:** Option 2 is a strategy for the contemplation stage, option 3 is a strategy for the preparation stage, and option 4 is a strategy for the maintenance stage. **Cognitive Level:** Applying. **Client Need:** Health Promotion and Maintenance. **Nursing Process:** Implementation. **Learning Outcome:** 16-9.
8. **Answer:** 4. **Rationale:** Change is a complex process and a nurse should not give up or assume that the client does not want to change (option 1). People often resist a tough approach because it can make them feel cornered. This approach may work for some people but not for everyone (option 2). The goal of teaching is to try to help the client become the expert as well (option 3). **Cognitive Level:** Applying. **Client Need:** Health Promotion and Maintenance. **Nursing Process:** Implementation. **Learning Outcome:** 16-11.
9. **Answer:** 1. **Rationale:** The compensatory mechanism of increasing the heart rate is the body's way of trying to balance an ineffective cardiac output since the BP has decreased. Decompensation (option 2) occurs when the compensatory mechanism is ineffective. Self-regulation (option 3) refers to the homeostatic mechanisms that come into play automatically in the healthy person. Equilibrium (option 4) is balance through adaptation to the environment. **Cognitive Level:** Applying. **Client Need:** Health Promotion and Maintenance. **Nursing Process:** Assessment. **Learning Outcome:** 16-2.
10. **Answer:** 3. **Rationale:** Option 1 is a physiological need. Option 2 is a love and belonging need, and option 4 is a safety and security need. **Cognitive Level:** Analyzing. **Client Need:** Health Promotion and Maintenance. **Nursing Process:** Assessment. **Learning Outcome:** 16-3.

Chapter 17: Health, Wellness, and Illness

1. **Answer:** 3. **Rationale:** Frustration is an example of an emotion. The client who chooses healthy foods (option 1) represents the physical component, taking parenting classes enhances the intellectual component (option 2), and the bowling league (option 4) enhances both the physical and social components. **Cognitive Level:** Understanding. **Client Need:** Health Promotion and Maintenance. **Nursing Process:** Assessment. **Learning Outcome:** 17-2.
2. **Answer:** 2. **Rationale:** The mother has taken on the sick role by expecting to be excused from her usual role responsibilities. The sick role states that individuals are not answerable for their illness, contrary to

the obese client's perspective (option 1). In the sick role, the client tries to get better as opposed to the man who misses his physical therapy appointments (option 3). The older adult is not following the sick role expectation to rely on competent help (option 4). **Cognitive Level:** Applying. **Client Need:** Health Promotion/Maintenance and Physiological Adaptation. **Nursing Process:** Assessment. **Learning Outcome:** 17-7.

3. **Answer:** 1. **Rationale:** The behavior is most representative of health promotion, which is the central focus of the health belief model. The clinical model focuses on relieving signs and symptoms of illness (option 2). The role performance model emphasizes social activities such as fulfilling a particular role (option 3). The agent–host–environment model focuses on predicting illness (option 4). **Cognitive Level:** Analyzing. **Client Need:** Health Promotion and Maintenance. **Nursing Process:** Analysis. **Learning Outcome:** 17-3.
4. **Answer:** 2, 3, and 4. **Rationale:** Significant evidence exists that a trusting relationship with the provider, effectiveness of the medication, and simple dosing regimen are important predictors of adherence to a medical regimen. Neither education nor sex has been shown to be a predictive factor (options 1 and 5). **Cognitive Level:** Applying. **Client Need:** Health Promotion and Maintenance. **Nursing Process:** Planning. **Learning Outcome:** 17-5.
5. **Answer:** 1. **Rationale:** Although not always practical, direct observation is the best method to measure adherence (for example, watching heroin addicts actually take their methadone dose). Because lack of adherence may be life threatening or damaging to the client as well as others, waiting until the client displays illness and waiting until laboratory values reflect a lack of adherence are not the best methods (options 2 and 3). Client report or recall is not always accurate, even if the client believes he or she is telling the truth (option 4). **Cognitive Level:** Analyzing. **Client Need:** Health Promotion and Maintenance. **Nursing Process:** Evaluation. **Learning Outcome:** 17-5.
6. **Answer:** 4. **Rationale:** The actual term used to describe the diagnosis is less important because the client may have no frame of reference for it. That is not to say that the diagnosis is unimportant because clients may be familiar with common diagnoses such as heart disease or cancer and ascribe historical meaning to them. Ability to perform usual activities, culture, and availability of health care will all be strong influences on the client's definition of health or wellness (options 1, 2, and 3). **Cognitive Level:** Analyzing. **Client Need:** Health Promotion and Maintenance. **Nursing Process:** Assessment. **Learning Outcome:** 17-1.
7. **Answer:** 4. **Rationale:** Genetics is an internal variable affecting health. Options 1, 2, and 3 are all external variables. **Cognitive Level:** Remembering. **Client Need:** Health Promotion and Maintenance. **Nursing Process:** Assessment. **Learning Outcome:** 17-4.
8. **Answer:** 2. **Rationale:** By definition, a chronic illness has no known cure, the person will always have it to some degree. Although acute illnesses may have severe symptoms, many chronic illnesses also have severe symptoms (option 1). Although signs and symptoms of chronic illnesses may never go completely away, they can get better and worse at different times (option 3). Chronic illnesses can be treated, just not cured (option 4). **Cognitive Level:** Understanding. **Client Need:** Health Promotion and Maintenance. **Nursing Process:** Planning. **Learning Outcome:** 17-6.
9. **Answer:** 3, 5, 1, 4, and 2. **Rationale:** The proper sequence of Suchman's stages of illness are signs and symptoms appear, the client takes on the sick role, the client makes contact with medical care, the client takes on a dependent role, and the client goes into rehabilitation/recovery. **Cognitive Level:** Remembering. **Client Need:** Health Promotion and Maintenance. **Nursing Process:** Evaluation. **Learning Outcome:** 17-8.
10. **Answer:** 1, 2, 3, and 5. **Rationale:** In the sick role, she would likely feel guilt and some anger but give up usual roles and accept help from others, and decrease social interactions. The only reaction that would be unlikely is that the woman would take on a job to pay expenses. This would be inconsistent with the sick role. **Cognitive Level:** Applying. **Client Need:** Health Promotion and Maintenance. **Nursing Process:** Planning. **Learning Outcome:** 17-9.

Chapter 18: Culturally Responsive Nursing Care

1. **Answer:** 3. **Rationale:** There is an ongoing shift in the U.S. population that includes a decreasing number of White Americans (formerly the majority population) and an increasing number of other cultural groups. The birth rate is actually decreasing (option 1); limited access to health care is a complex issue that is not the major factor here (option 2); and immigration has increased (option 4). **Cognitive Level:** Understanding. **Client Need:** Psychosocial Integrity. **Nursing Process:** N/A. **Learning Outcome:** 18-3.
2. **Answer:** 2. **Rationale:** Cultural differences may result in various interpretations of a medical regime. Cultural competence results in recognition of the right "not to fit." This is a standard of practice and should be initiated with all clients (option 1). Teaching or explaining the effects of lack of adherence would be more appropriate than warning (option 3). Asking a person of the same culture to assist may be helpful after the nurse discusses the matter with the client (option 4). **Cognitive Level:** Applying. **Client Need:** Psychosocial Integrity. **Nursing Process:** N/A. **Learning Outcome:** 18-10.
3. **Answer:** 3. **Rationale:** The nurse should indicate that he or she is open to diverse views and practices. Option 1 assumes the client follows this particular cultural practice, which may not be the case. The nurse should assess before intervening. It may be good to learn more about the culture (option 2), but that is not the best starting place to care for the client. Subcultures exist among all cultures. Reading books is helpful, but assessment of individual situations is the best approach. Option 4 reflects an incorrect approach to culturally appropriate care. The nurse needs to assess which customs and practices the individual client performs before drawing conclusions. **Cognitive Level:** Applying. **Client Need:** Psychosocial Integrity. **Nursing Process:** N/A. **Learning Outcome:** 18-10.
4. **Answer:** 3. **Rationale:** Culturally competent implies that, within the delivered care, the nurse understands and attends to the total context of the client's situation, including awareness of immigration, stress factors, and cultural differences. Options 1 and 2 do not show that the nurse needs to respect the choices made by the clients. Option 4 shows bias or stereotyping. **Cognitive Level:** Applying. **Client Need:** Psychosocial Integrity. **Nursing Process:** N/A. **Learning Outcome:** 18-4.
5. **Answer:** 3. **Rationale:** National cultural health goals include providing equal access to quality health care for everyone. It would be inappropriate for all cultures to receive the same care; care should be customized (option 1). The same life expectancy for all U.S. citizens is not realistic (option 2). Assimilation (option 4) is not an appropriate health goal because assimilation is a conscious effect. Therefore, it is not always possible and this may cause severe stress and anxiety. **Cognitive Level:** Applying. **Client Need:** Psychosocial Integrity. **Nursing Process:** Evaluation. **Learning Outcome:** 18-3.
6. **Answer:** 1. **Rationale:** Herbal teas are an example of a restoring health action. Prayer (option 2) and exercise (option 4) would be examples of maintaining actions, whereas wearing symbolic objects (option 3) is a protective action. **Cognitive Level:** Understanding. **Client Need:** Psychosocial Integrity. **Nursing Process:** Implementation. **Learning Outcome:** 18-6.
7. **Answer:** 2. **Rationale:** Steam is a natural substance and would be compatible with folk healing preferences. Hospitalization and medications are typical Western medical strategies (options 1 and 3). A watch-and-wait approach (option 4) is not particularly associated with a folk healing perspective. **Cognitive Level:** Applying. **Client Need:** Psychosocial Integrity. **Nursing Process:** Planning. **Learning Outcome:** 18-5.
8. **Answer:** 1, 2, 3, and 6. **Rationale:** Technology skills (option 4) and intelligence (option 5) are individual, personal characteristics and less

influenced by one's culture than valuing of elders (option 1), gender roles (option 2), nonverbal communication (option 3), or diet (option 6). Culture may, however, influence how technologic skills (option 4) and intelligence (option 5) are viewed and valued. **Cognitive Level:** Understanding. **Client Need:** Psychosocial Integrity. **Nursing Process:** Assessment. **Learning Outcome:** 18-5.

9. **Answer:** 4. **Rationale:** To gather assessment data regarding the client's heritage, nurses must explore clients' beliefs and practices. A good beginning would be to ask clients to indicate from the checklist which apply to them. Physical exam (option 1) and medical history (option 2) may suggest some cultural affiliation but the nurse cannot assume that these findings show significant affiliation from the client's perspective. Blood analysis generally provides little data for a heritage assessment although blood type and some immunologic or genetic data can be relevant (option 3). **Cognitive Level:** Analyzing. **Client Need:** Psychosocial Integrity. **Nursing Process:** Assessment. **Learning Outcome:** 18-9.
10. **Answer:** 2. **Rationale:** If an interpreter is not available at your agency, you must still meet the expectations of providing information in a way the client can comprehend it. Providing written instructions, whether in English or the client's language, is insufficient since the client may not be able to read and remains unable to have questions answered (option 1). Family members should not be relied on to interpret medical information (option 3). Option 4 is not an appropriate action. **Cognitive Level:** Applying. **Client Need:** Psychosocial Integrity. **Nursing Process:** Planning. **Learning Outcome:** 18-7.

Chapter 19: Complementary and Alternative Healing Modalities

1. **Answer:** 3. **Rationale:** Although the effectiveness of alternative therapies is sometimes not scientifically established, many people report significant benefit from them for a wide variety of conditions. Alternative therapies often cost less, but this is not a primary consideration (option 1). Clients often seek alternative therapies because traditional therapies are ineffective, but this is not the primary difference (option 2). Both traditional and alternative therapies utilize products from nature (option 4). **Cognitive Level:** Applying. **Client Need:** Physiological Integrity. **Nursing Process:** N/A. **Learning Outcome:** 19-1.
2. **Answer:** 1. **Rationale:** Spirituality gives us purpose and meaning in life; involves a relationship with oneself, others, and a higher power; and involves finding significant meaning in the entirety of life. Spirituality is a much broader concept than religion and religious services. Responsibility to life patterns is a concept of humanism. **Cognitive Level:** Applying. **Client Need:** Psychological Integrity. **Nursing Process:** N/A. **Learning Outcome:** 19-9.
3. **Answer:** 2. **Rationale:** Healing environments are created when nurses empower clients to make healthy decisions. They are not dependent on technology (option 1) or primary care providers' orders (option 4). A safe physical environment is neither necessary nor sufficient for there to be a healing environment (option 3). **Cognitive Level:** Applying. **Client Need:** Health Promotion/Maintenance and Psychosocial Integrity. **Nursing Process:** Implementation. **Learning Outcome:** 19-2.
4. **Answer:** 4. **Rationale:** Naturopathy focuses on the total person. The primary focus is disease prevention. Naturopathy may be the best choice in decreasing disease rates by empowering and educating people about ways to stay healthy. Belief in a higher being is not a core principle. **Cognitive Level:** Analyzing. **Client Need:** Health Promotion and Maintenance. **Nursing Process:** N/A. **Learning Outcome:** 19-5.
5. **Answer:** 2. **Rationale:** Qi is the flow of energy in the body that must be uninterrupted for a person to be in a healthy state. All other imbalances may result from an imbalance in the flow of qi or flow of vital energy through specific anatomic points along the surface of the body (options 1, 3, and 4). **Cognitive Level:** Understanding. **Client Need:** Health Promotion and Maintenance. **Nursing Process:** N/A. **Learning Outcome:** 19-7.
6. **Answer:** 2. **Rationale:** Thirty percent of current prescription drugs are derived from plants. Herbs and medications are similar in structure and therapeutic value (option 1). Some medications may be more powerful than herbs but not all are (option 3), and herbs tend to be less dangerous than medications (option 4). **Cognitive Level:** Remembering. **Client Need:** Physiological Integrity. **Nursing Process:** Implementation. **Learning Outcome:** 19-4.
7. **Answer:** 1. **Rationale:** Serious interactions can occur between herbs and medications. It is acceptable that people choose herbs as a way to maintain health and treat minor disorders (option 2). Although the knowledge the nurse gains may be helpful, contributing to research is not the primary reason for assessing herb use (option 3). While we hope clients share important information with us, they also have free will about what they choose to share (option 4). **Cognitive Level:** Applying. **Client Need:** Physiological Integrity. **Nursing Process:** Assessment. **Learning Outcome:** 19-10.
8. **Answer:** 4. **Rationale:** The oils in options 1, 2, and 3 will burn the skin if they are not diluted in a carrier oil. **Cognitive Level:** Understanding. **Client Need:** Physiological Integrity. **Nursing Process:** Planning. **Learning Outcome:** 19-10.
9. **Answer:** 1, 2, 4, and 5. **Rationale:** Massage is a way of communicating without words, including the caring intent of the provider. It provides mental and physical relaxation. Massage speeds the removal of metabolic waste products, allowing more oxygen and nutrients to reach the cells and tissues. It lowers blood pressure and slows the heart rate. Passive exercise from massage cannot strengthen muscles (option 3). **Cognitive Level:** Remembering. **Client Need:** Physiological Integrity. **Nursing Process:** Planning. **Learning Outcome:** 19-6.
10. **Answer:** 1. **Rationale:** There is no evidence that massage (option 2), herbs (option 3), or yoga (option 4) improves pregnancy rates, although relaxation and good physical conditioning are generally encouraged. **Cognitive Level:** Remembering. **Client Need:** Physiological Integrity. **Nursing Process:** Implementation. **Learning Outcome:** 19-10.

Chapter 20: Concepts of Growth and Development

1. **Answer:** 3. **Rationale:** The sequence of each stage of development is predictable, although the time of onset, the length of the stage, and the effects of each stage vary with the person. **Cognitive Level:** Applying. **Client Need:** Health Promotion and Maintenance. **Nursing Process:** Implementation. **Learning Outcome:** 20-2.
2. **Answer:** 4. **Rationale:** The study of growth (physical) and development (function and skills) is correct because the answer needs to have both components to be complete. Option 1 addresses only the growth aspects. Option 2 addresses only developmental aspects, and option 3 addresses only the environmental factors that might influence growth and development. **Cognitive Level:** Remembering. **Client Need:** Health Promotion and Maintenance. **Nursing Process:** Assessment. **Learning Outcome:** 20-1.
3. **Answer:** 3. **Rationale:** Toddlers typically demonstrate negative behavior and are hesitant around strangers, resisting close contact with people they do not know well. They do not have sophisticated language skills and often use crying or fussing to communicate. Older school-age children and adolescents are likely to cooperate without complaint in many health procedures (option 1). School-age children, engaged in the task of industry versus inferiority, display curiosity about how things work, asking many questions of nurses (option 2). Preschool-age children, who are in the fantasy, curiosity, and exploration stage, like to manipulate objects and play "pretend" (option 4). **Cognitive Level:** Analyzing. **Client Need:** Health Promotion and Maintenance. **Nursing Process:** Planning. **Learning Outcome:** 20-7.
4. **Answer:** 4. **Rationale:** Adolescents need to establish identity, which involves developing a more mature sense of independence and responsibility. Providing her with schoolwork keeps her connected to her

peer group and gives a sense of accomplishment. Also, it prevents the client from "worrying" about getting behind in school assignments. Interaction with peers is very important during this stage, but they are likely to be attending school during the day (option 1); an infant's sense of trust is reinforced if parents room-in, and older infants and toddlers experience less separation anxiety if parents are nearby (option 2); and preschool and school-age children would benefit from the distraction and social interaction of others in the recreation room (option 3). **Cognitive Level:** Applying. **Client Need:** Health Promotion and Maintenance. **Nursing Process:** Implementation. **Learning Outcome:** 20-5.

5. **Answer:** 2. **Rationale:** The client is in Erikson's stage of integrity versus despair. Finding meaning and purpose in his life after retirement is a sign of achievement. His comments regarding visits to his family and being asked by friends to help with their projects indicate that he is actively involved and purposeful (options 1 and 4). His comment regarding needing medication for knee pain can be expected in many older people, especially those who have been laborers or suffered injury when younger (option 3). **Cognitive Level:** Analyzing. **Client Need:** Health Promotion and Maintenance. **Nursing Process:** Evaluation. **Learning Outcome:** 20-5.
6. **Answer:** 2. **Rationale:** This stage includes the preadolescent period. The peer group increasingly influences behavior. Physical, cognitive, and social development increases and communication skills improve. One needs to allow time and energy for the school-age child to pursue hobbies and school activities and to recognize and support the child's achievement. Option 1 is a judgmental statement as this is not unusual and not indicative of problems in the home. It is good to be supportive of the school-age child; however, making her stay home with her family might cause anger and resentment (option 3). Option 4 is also a judgmental statement. Even though this is normal development, calling the father "silly" is not therapeutic communication. **Cognitive Level:** Applying. **Client Need:** Health Promotion and Maintenance. **Nursing Process:** Implementation. **Learning Outcome:** 20-8.
7. **Answer:** 2. **Rationale:** Erikson's late childhood stage focuses on initiative versus guilt. During this stage, the children are beginning to have the ability to evaluate their own behavior and are learning the degree to which assertiveness and purpose influence the environment. Option 1 is incorrect because Fowler's focus is spiritual development. Both options 3 and 4 are names of adult theorists. **Cognitive Level:** Applying. **Client Need:** Health Promotion and Maintenance. **Nursing Process:** Planning. **Learning Outcome:** 20-7.
8. **Answer:** 1. **Rationale:** Piaget identifies this phase as the intuitive thought phase with significant behaviors as follows: egocentric thinking diminishes, thinks of one idea at a time, includes others in the environment, words express thoughts. Erikson identifies this developmental stage as industry versus inferiority, and the children are learning the degree to which assertiveness and purpose influence the environment. They begin to have the ability to evaluate their own behavior. Fowler identifies this stage as intuitive-projective, a combination of images and beliefs given by trusted others, mixed with the child's own experience and imagination. Therefore, the nurse knows that this child has a normal imagination and needs to explore and learn about this new piece of equipment in language appropriate to his age. For option 2, imagination is normal for this age group, and stating that he needs to be "a big boy" is counterproductive. Option 3 is incorrect because his language skills are developing and he needs to understand the world around him. Option 4 is incorrect because adding to his fears will only increase his anxiety level and decrease his trust in you as a nurse. **Cognitive Level:** Applying. **Client Need:** Health Promotion and Maintenance. **Nursing Process:** Implementation. **Learning Outcome:** 20-11.
9. **Answer:** 1. **Rationale:** All of the nursing actions listed here are appropriate, but attachment theory emphasizes the importance of parents being available to their child when the child is experiencing stress. The best action would be to encourage the mother to stay with her child as much as possible. Putting a picture of the mother in the crib (option 2) may provide some comfort, since by 15 months of age, children demonstrate object permanence and people permanence, so the child "knows" the mother will return. Holding and cuddling the child (option 3) may also provide comfort, but the child must trust the caregiver, and the nurse's other responsibilities may restrict the amount of time and when he or she can be with the child. Distraction (option 4) can temporarily refocus the child's attention, but it does not address the need for emotional and physical contact with the parent. **Cognitive Level:** Applying. **Client Need:** Health Promotion and Maintenance. **Nursing Process:** Implementation. **Learning Outcome:** 20-10.
10. **Answer:** 2. **Rationale:** Although many young adults are choosing to live with their parents, often for economic reasons, option 2 raises concern, because it implies a degree of selfishness and lack of effort to establish independence. This may not be the case, however, and the nurse would need to gather more information before making any judgments. Twenty-five-year-olds, according to psychosocial development theory, have established a sense of self-identity, made a commitment to their community through work and the social group, and are engaged in intimate relationships. According to Erikson, they are in the stage of intimacy versus isolation, moving into the adult stage of generativity versus stagnation. From Havighurst's perspective, early adults are starting families of their own, managing a home, and taking on the responsibility of work and civic life. Avoiding a relationship and neglecting a career or lifestyle commitment are red flags for failure to achieve developmental milestones at this age. Engaging in healthy exercise (option 1) reflects a quality of self-identity for this individual. Option 3 suggests the client actively cooperates in his recovery and is able to focus on the future (wanting to recover from surgery). Option 4 indicates the client is part of a "congenial social group" (Havighurst). **Cognitive Level:** Applying. **Client Need:** Health Promotion and Maintenance. **Nursing Process:** Evaluation. **Learning Outcome:** 20-8.

Chapter 21: Promoting Health from Conception Through Adolescence

1. **Answer:** 4. **Rationale:** Providing opportunities for the parent to express worries and discuss facts about SIDS gives more control over the situation. The nurse can also provide her with information about the Back to Sleep campaign. Option 1: The highest incidence of SIDS occurs between 2 and 4 months of age, but it does occur in older infants. It is not the best response because it provides facts but does not address the parent's immediate concerns. Option 2: SIDS affects boys more than girls. However, this information is likely to increase anxiety and does not address the concerns of the parent. Option 3: There is no known cause of SIDS, although respiratory problems may be present in some infants. This response is insensitive to the needs of the mother. **Cognitive Level:** Applying. **Client Need:** Psychosocial Integrity. **Nursing Process:** Implementation. **Learning Outcome:** 21-8.
2. **Answer:** 3. **Rationale:** Preschool-age children use fantasy and make-believe to learn about, understand, and master their environment, including their concepts of death. The child's conceptualization of death is consistent with her cognitive development. The response in option 1 negates the child's understanding and limits her ability to develop fuller understanding and adapt to the loss. Option 2 negates the child's attempts to understand and deal with the loss. Option 4 is incorrect because at 4 years of age, children can hear explanations such as "when people get old they will die," but these children do not have a firm grasp of the meaning of time and age, and probably will not understand. **Cognitive Level:** Applying. **Client Need:** Health Promotion/Maintenance and Psychosocial Integrity. **Nursing Process:** Implementation. **Learning Outcome:** 21-6.

3. **Answer:** 1. **Rationale:** It is the responsibility of adults to supervise children constantly and closely when around water. Option 2, learning water safety and how to swim, is important and should be encouraged at an early age, but that still does not ensure a child's safety. Option 3 is incorrect because young children are at risk near any amount of water that can cover the nose and mouth. Option 4: Infants and toddlers can drown in a very small amount of water, even several inches in a bathtub or "kiddie pool." **Cognitive Level:** Applying. **Client Need:** Safe, Effective Care Environment and Health Promotion/Maintenance. **Nursing Process:** Planning. **Learning Outcome:** 21-8.
4. **Answer:** 2. **Rationale:** School-age children acquire stereognosis, the ability to identify an unseen object simply by touch. Option 1: Birth weight triples by about 12 months. Children enter school age weighing about 45 pounds and gain about 5 to 7 pounds per year. Option 3: Significant physical change occurs during the school-age years. Option 4: Fat deposits do not normally appear until puberty. **Cognitive Level:** Understanding. **Client Need:** Health Promotion and Maintenance. **Nursing Process:** Assessment. **Learning Outcome:** 21-1.
5. **Answer:** 1. **Rationale:** Increased fat deposits are normal as girls begin hormonal changes of puberty. During this stage of development, females become very sensitive about their appearance and need reassurance. Option 2: Puberty is a period when children become more self-conscious of their appearance. They need to be reassured that normal weight gain and body changes with fat deposits are to be expected. The nurse would need to perform further individual assessments before determining if a weight problem existed. Option 3: Regular strenuous exercise should be a part of the healthy adolescent's lifestyle, but its goal should be to provide energy and strength, not to control weight. Option 4: Dieting and efforts to lose weight can threaten the health of adolescents. This intervention lacks scientific evidence. Unless an actual or potential disease process exists, a balanced diet is most appropriate. **Cognitive Level:** Applying. **Client Need:** Health Promotion and Maintenance. **Nursing Process:** Planning. **Learning Outcome:** 21-1.
6. **Answer:** 2. **Rationale:** Many newborn babies have a misshapen head because of the molding made possible by fontanels in the bone structure of the skull and overriding of the sutures. This asymmetry is usually corrected within the first 7 to 10 days. Option 1: The client is crying and upset; the nurse's response needs to be more sensitive and caring. Option 3: Educational materials are not appropriate for a client who is crying and emotionally upset. Option 4: The client is concerned about the misshapen head right now. The most appropriate intervention should focus on relieving the current emotional state. **Cognitive Level:** Applying. **Client Need:** Psychosocial Integrity. **Nursing Process:** Implementation. **Learning Outcome:** 21-1.
7. **Answer:** 1. **Rationale:** Although toddlers like to explore the environment, they always need to have a significant person nearby. Parents need to know that young children experience acute separation anxiety and that abandonment is their greatest fear. Option 2: This is normal toddler development. Option 3: Child is probably not old enough to perform manipulative-type strategies. Option 4: This is normal behavior for this age group. **Cognitive Level:** Applying. **Client Need:** Health Promotion and Maintenance. **Nursing Process:** Assessment. **Learning Outcome:** 21-3.
8. **Answer:** 3. **Rationale:** The child can perform regular activities as long as the injured arm and the cast are not placed in jeopardy. Option 1: A competent nurse could answer this question. Option 2: A 5-year-old needs to be physically active. This would be more appropriate for health problems in which moving about could prevent healing or cause injury. Limiting a preschooler to only sitting activities is unrealistic. Option 4: Riding a bike and jumping rope could place the client at risk for injury. **Cognitive Level:** Applying. **Client Need:** Health Promotion and Maintenance. **Nursing Process:** Implementation. **Learning Outcome:** 21-2.
9. **Answer:** 1. **Rationale:** During the phase of concrete operations, children change from egocentric interactions to cooperative interactions. They also develop an increased understanding of concepts that are associated with specific objects. They learn to add and subtract and understand cause-and-effect relationships. Option 2 action is indicative of the preconceptual phase—an egocentric approach that uses magical thinking. Option 3 action is indicative of the formal operations phase—reasoning is deductive and futuristic. Option 4 is indicative of physical growth. **Cognitive Level:** Applying. **Client Need:** Health Promotion and Maintenance. **Nursing Process:** Assessment. **Learning Outcome:** 21-4.
10. **Answer:** 1. **Rationale:** Often the first noticeable sign of puberty in females is the appearance of the breast bud, although the appearance of hair along the labia may precede this. Option 2: The growth spurt in girls is between ages 10 and 14, but is too vague to be noticeable. Option 3: The eccrine glands are found over most of the body and produce sweat. The apocrine glands develop in the axillae, anal and genital areas, external auditory canals, and around the umbilicus and the areola of the breasts. Option 4: Mood swings are not as definitive as physical changes. **Cognitive Level:** Analyzing. **Client Need:** Health Promotion and Maintenance. **Nursing Process:** Assessment. **Learning Outcome:** 21-2.

Chapter 22: Promoting Health in Young and Middle-Aged Adults

1. **Answer:** 3. **Rationale:** The average age for the onset of menopause in American women is 47 years. Therefore, there is nothing abnormal about ongoing menses in a 45-year-old woman, and gynecologic care is not warranted (option 1). As a woman nears menopause, ovulation may become irregular and difficult to predict. Conception remains a possibility, and the lack of predictable ovulation may actually increase the likelihood of unintended pregnancy (option 2). Many women have no negative symptoms of menopause, and the experience of menopause is highly culturally determined (option 4). **Cognitive Level:** Analyzing. **Client Need:** Health Promotion and Maintenance. **Nursing Process:** Implementation. **Learning Outcome:** 22-2.
2. **Answer:** 2. **Rationale:** Generation X is characterized by both skepticism and resentment of people in authority (such as a nurse). Baby boomers tend to be interested in improving themselves, and health teaching may be viewed as self-improvement (option 1). Generation Y and Millennials are the same cohort, and are most likely to receive their health information from technologic sources, such as the Internet (options 3 and 4). **Cognitive Level:** Analyzing. **Client Need:** Health Promotion and Maintenance. **Nursing Process:** Implementation. **Learning Outcome:** 22-1.
3. **Answer:** 3. **Rationale:** Lung cancer is the most common cause of cancer death in women age 24 to 65 years. Breast cancer is common, but deaths related to breast cancer have declined. Lymphoma and colon cancer are significant diseases for both men and women (options 2, 3, and 4). **Cognitive Level:** Analyzing. **Client Need:** Health Promotion and Maintenance. **Nursing Process:** Assessment. **Learning Outcome:** 22-7.
4. **Answer:** 4. **Rationale:** Although HIV and syphilis may have more disastrous health effects, chlamydia is the most prevalent infectious disease in the United States. Gonorrhea is still common, and its prevalence may vary geographically, but chlamydia is more common and therefore the most likely contracted STI (option 3). **Cognitive Level:** Analyzing. **Client Need:** Health Promotion and Maintenance. **Nursing Process:** Implementation. **Learning Outcome:** 22-9.
5. **Answer:** 2. **Rationale:** Kohlberg's initial work indicated that moral development was completed by adulthood, but more recent research has demonstrated that moral development continues throughout adulthood. Moral development refers to a decision-making process of right and wrong, and proceeds in a series of predictable stages (option 3). Moral development and spirituality are unrelated, and represent very

different spheres of human thought and behavior (option 4). **Cognitive Level:** Analyzing. **Client Need:** Psychosocial Integrity. **Nursing Process:** Assessment. **Learning Outcome:** 22-5.

6. **Answer:** 2. **Rationale:** The middle-aged person is generally attempting to relate to adult children and grandchildren as well as assisting aging parents. Hence, continuous efforts to meet the needs of others occur. Selecting a life partner is the developmental task for young adults. Reviewing one's life course is the task for older adulthood (option 3). Establishing a sense of self is usually achieved during adolescence (option 4). **Cognitive Level:** Analyzing. **Client Need:** Health Promotion and Maintenance. **Nursing Process:** Assessment. **Learning Outcome:** 22-3.
7. **Answer:** 3. **Rationale:** Because individuals over 50 years of age tend to have multiple chronic illnesses as well as an aging immune system, the influenza vaccine is highly recommended. Influenza can lead to serious complications in older adults. The pneumococcal vaccine protects against the most common pathogens that cause pneumonia. The vaccine must be given every 10 years. Immunization for pertussis is only appropriate in children, and meningococcal vaccine is appropriate in adolescents and young adults living in congregate housing. **Cognitive Level:** Applying. **Client Need:** Health Promotion and Maintenance. **Nursing Process:** Implementation. **Learning Outcome:** 22-9.
8. **Answer:** 1, 2, 3, and 5. **Rationale:** Hypertension (elevated blood pressure) forces the heart to work harder, resulting in decreased function of the heart; the electrocardiogram assesses cardiac rhythm and rate; high cholesterol levels are directly related to a decrease in arterial size, which decreases circulation blood to the cardiac tissue; activity level (e.g., dyspnea on exertion) can indicate cardiovascular disease. While cardiac impairment may decrease sexual performance, which is important to assess, the others would have priority given the limitations for the screening program (option 4). **Cognitive Level:** Analyzing. **Client Need:** Health Promotion and Maintenance. **Nursing Process:** Assessment. **Learning Outcome:** 22-9.
9. **Answer:** 1. **Rationale:** Asking the individual if she or he is afraid of someone at home, or if someone hurt her or him, is a critical step in a comprehensive assessment. Intimate partner violence is a serious problem for women and men of all ages, cultures, and socioeconomic levels. The nurse should suspect it in people whose injuries are not consistent with the history they give. Referring the individual to a shelter without completing a thorough assessment may lead to inappropriate care (option 2); the nursing process requires assessment before intervention. Collaboration with other health care professionals may be very helpful but an assessment needs to be done first (option 3). Documentation of the assessment does not directly address, reduce, nor solve the concern (option 4). **Cognitive Level:** Analyzing. **Client Need:** Safe, Effective Care Environment. **Nursing Process:** Assessment. **Learning Outcome:** 22-7.
10. **Answer:** 3. **Rationale:** Each of these activities indicates achievement of a developmental task, but the nurse must know which task is appropriate for the client's chronological age. Obtaining and decorating a place to live is an activity that establishes independence from parents, a task for young adults. Creating a scrapbook is an important strategy to enhance ego integrity, a developmental task for older adults (option 1). Working with philanthropic groups is a hallmark of generativity, a developmental task for those in midlife (option 2). Considering career paths is more appropriate to the identity task of adolescence (option 4). **Cognitive Level:** Applying. **Client Need:** Health Promotion and Maintenance. **Nursing Process:** Assessment. **Learning Outcome:** 22-3.

Chapter 23: Promoting Health in Older Adults

1. **Answer:** 1, 3, and 4. **Rationale:** Grieving is a normal behavior after the death of a loved one, and the behaviors listed in options 1, 3, and 4 indicate signs of normal grieving. When grieving becomes extreme, and signs of self-neglect or alcohol or substance abuse are obvious, ineffective coping may be a problem. The nurse needs to be attentive to the problem and be prepared to call on appropriate resources, if needed. **Cognitive Level:** Applying. **Client Need:** Psychosocial Integrity. **Nursing Process:** Assessment. **Learning Outcome:** 23-11.
2. **Answer:** 3. **Rationale:** Because the hearing loss occurs in the ability to distinguish high-pitched tones, speaking in a low and distinctive voice tone is the most appropriate method of communicating with the clients. Hearing loss in the older adult includes a loss of the ability to discern higher frequencies, and speaking slowly at a particular volume is not the best way to communicate with the clients (option 1). The stem indicates the clients have noticeable hearing loss, but does not indicate the clients are deaf; large lettering is appropriate if the client has a visual problem (option 2); hearing aids are not usually effective when the problem is related to neural damage (option 4). **Cognitive Level:** Analyzing. **Client Need:** Health Promotion and Maintenance. **Nursing Process:** Assessment. **Learning Outcome:** 23-8.
3. **Answer:** 2. **Rationale:** Reminiscence about past life events, doing a "life review" of past experiences, especially if they were positive, is considered to be a normal psychosocial activity of older adults. It helps them focus on past accomplishments and contributions to society, thus increasing their self-concept. If behavioral or significant memory problems had been noted, then a geriatric psychiatric consult would be appropriate, but not in this situation (option 1). Other social activities and conversations should certainly be encouraged, but not to the point of demeaning the importance of his life stories (options 3 and 4). **Cognitive Level:** Applying. **Client Need:** Health Promotion and Maintenance. **Nursing Process:** Assessment. **Learning Outcome:** 23-12.
4. **Answer:** 4. **Rationale:** It is a myth regarding the aging process that most old people are depressed. By relating that depression is not a normal part of aging, the nurse can further dialogue with the daughter. The older client's number of losses is less important than how she copes (option 1). A depressed affect may be the older adult's usual look (option 2). It is yet to be determined if in fact she is depressed (option 3). **Cognitive Level:** Remembering. **Client Need:** Safe and Effective Care Environment. **Nursing Process:** Implementation. **Learning Outcome:** 23-15.
5. **Answer:** 3. **Rationale:** This option will provide the nurse with the most information for potential intervention. Options 1, 2, and 4 are incorrect because urinary incontinence is not normal and it is something the nurse should investigate. **Cognitive Level:** Analyzing. **Client Need:** Physiological Integrity. **Nursing Process:** Assessment. **Learning Outcome:** 23-15.
6. **Answer:** 1. **Rationale:** The client has lost muscle strength. Strengthening exercises will improve his mobility and lessen the possibility of a fall. Option 2: Information indicates the client has difficulty rising from a seating position, not standing after he reaches the position; further assessment is needed before implementing this intervention. Option 3: Praise should come after the proper intervention is implemented and a plan is in place so that the praise is focused toward a goal to resolve the problem. Option 4 resolves the problem immediately but does nothing to resolve the underlying problem. **Cognitive Level:** Applying. **Client Need:** Safe, Effective Care Environment. **Nursing Process:** Implementation. **Learning Outcome:** 23-8.
7. **Answer:** 4. **Rationale:** Sexual activity is possible for older adults although the responses are slower. The clients would need a health history and physical assessment of the cardiovascular system before drawing this conclusion (option 1). With the introduction of Viagra, older men are more able to perform than in the past (option 2). Older men's interest tends to decline, but it is not known whether it is related to impotence; apparently this older client is interested in sexual activity (option 3). **Cognitive Level:** Analyzing. **Client Need:** Health Promotion and Maintenance. **Nursing Process:** Implementation. **Learning Outcome:** 23-16.

8. **Answer:** 3. **Rationale:** Presbyopia is loss of near vision related to aging. Option 1 is loss of hearing ability related to aging. Option 2 is dry mouth related to a decrease in saliva, and option 4 is a decrease in the motility of the esophagus related to aging. **Cognitive Level:** Remembering. **Client Need:** Health Promotion and Maintenance. **Nursing Process:** Assessment. **Learning Outcome:** 23-8.
9. **Answer:** 4. **Rationale:** This response reflects an understanding of the different stages of independence and control an older adult experiences when admitted to the hospital and the need for the nurse to assess the client's need for control and autonomy. After admission, the client willingly gives up autonomy to the hospital routine because the client wants to get better (option 4). As the client's health improves and progresses, he or she wants to increase autonomy (option 1). Before discharge the client is thinking about if he or she can go home (option 2). Option 3 is not realistic given the usual hospital routine. **Cognitive Level:** Analyzing. **Client Need:** Psychosocial Integrity. **Nursing Process:** Planning. **Learning Outcome:** 23-6.
10. **Answer:** 3. **Rationale:** The nurse treats the older woman with empathy. Saying the sister is dead may trigger agitation or an argument. It may start the grieving process all over again and be distressing for the woman (option 1). These responses should be avoided. It is more compassionate to focus on the woman's feelings, and encourage her to talk about her sister and remembered events. Long-term memory remains functional in many clients with dementia compared to short-term memory. By having her reminisce, the nurse can stimulate the woman's recall of events from a long time ago (option 3). It is deceptive to say the sister won't visit today or that the woman should wait to see if she does visit today (option 4). **Cognitive Level:** Applying. **Client Need:** Psychosocial Integrity. **Nursing Process:** Implementation. **Learning Outcome:** 23-12.

Chapter 24: Promoting Family Health

1. **Answer:** 1. **Rationale:** Grandparents, aunts, and uncles are considered extended family members. Parents and spouse are considered immediate family members. Children who no longer live at home are considered immediate family members. Roommates and close family friends may be considered extended family members if grandparents, aunts, and uncles do not exist. **Cognitive Level:** Analyzing. **Client Need:** Health Promotion and Maintenance. **Nursing Process:** Assessment. **Learning Outcome:** 24-2.
2. **Answer:** 4. **Rationale:** The data indicate that Mary is at the greatest risk of developing a health problem due to her stress of repeating a year of high school, many colds, drug use, and no support indicated beyond her family. Although Alice has a heart problem, she also has strong support medically and spiritually. Bill has asthma but no other risk factors are identified. Kim has back problems, is the mother of four children, and is married for the second time to an alcoholic and is also at risk, but not as great a risk as Mary. **Cognitive Level:** Analyzing. **Client Need:** Health Promotion and Maintenance. **Nursing Process:** Diagnosis. **Learning Outcome:** 24-5.
3. **Answer:** 1. **Rationale:** The health history of the client's current living partners is critical information since many illnesses are communicable or environmental. Giving this advice, the nurse also validates that family are whoever the client says they are. History of illness data of blood relatives is also extremely valuable and should always be included, whether or not the client lives with them. Neither the history nor the physical exam is more important than the other—both are necessary for a complete plan of care. **Cognitive Level:** Applying. **Client Need:** Health Promotion and Maintenance. **Nursing Process:** Assessment. **Learning Outcome:** 24-4.
4. **Answer:** A visual representation of family members by gender, age, health status, and lines of relationships through the generations is referred to as a genogram. **Cognitive Level:** Remembering. **Client Need:** Health Promotion and Maintenance. **Nursing Process:** Assessment. **Learning Outcome:** 24-4.
5. **Answer:** 1, 2, and 4. **Rationale:** It is essential for the nurse to determine the duration of the illness, the meaning of the illness to the family and its significance to family systems, and the financial impact of the illness in order to completely assess the impact of the illness on the family as a whole. Duration of the illness will determine the degree of disruption and adaptation required. These factors affect the members of the family in addition to the ill client. Option 3: Coping mechanisms used by other families with similar illnesses may not be relevant because families vary greatly in their makeup and function patterns. Option 5: Knowing the incidence of the illness in the community at large is an important factor for the community health nurse in exploring epidemiologic issues such as prevention strategies and public health policies but is not as relevant for assisting the particular family. **Cognitive Level:** Understanding. **Client Need:** Psychosocial Integrity. **Nursing Process:** Assessment. **Learning Outcome:** 24-6.
6. **Answer:** 1. **Rationale:** Presenting to the clinic indicates the family is probably ready to face the health challenges caused by the previous activities. There is no evidence that the adult child or parent is experiencing disabling coping (option 2). *Impaired Parenting* applies when the parent is unable to care for a child rather than the reverse. Although some strain must be experienced by the child, evidence does not indicate that *Caregiver Role Strain* is the most important aspect of the situation. **Cognitive Level:** Analyzing. **Client Need:** Health Promotion and Maintenance. **Nursing Process:** Diagnosis. **Learning Outcome:** 24-6.
7. **Answer:** 3. **Rationale:** Establishing trust allows for effective communication and confirms that there is mutual commitment to the goals. Meetings with the family as a group should be goal oriented. A trusting relationship is important for communication as well as accepting and implementing a plan. While considering the cost of health care is important, it does not take priority over a trusting relationship with the nurse. A detailed history and examination of each family member is relevant but family members or the family as a whole will need to trust the nurse before providing the information. **Cognitive Level:** Applying. **Client Need:** Health Promotion and Maintenance. **Nursing Process:** Planning. **Learning Outcome:** 24-6.
8. **Answer:** 4. **Rationale:** The focus of activity on personal purposes does not promote effective family functioning. A family system that functions efficiently focuses primarily on purposes involving the total system, allows input from the outside, has personal boundaries that are well defined, and interdependent family members. **Cognitive Level:** Analyzing. **Client Need:** Health Promotion and Maintenance. **Nursing Process:** Evaluation. **Learning Outcome:** 24-3.
9. **Answer:** 2. **Rationale:** A family should provide an environment that supports the growth of the individual members. It is neither possible nor appropriate for the family to try to provide everything each member wants (option 1), nor that members are accepted into society (option 3). Although the family protects its members, a healthy family will share and use appropriate resources with the broader community (option 4). **Cognitive Level:** Applying. **Client Need:** Health Promotion and Maintenance. **Nursing Process:** Planning. **Learning Outcome:** 24-1.
10. **Answer:** 3. **Rationale:** A family with sudden loss of income and health insurance is at the greatest risk for developing a health problem because it may no longer be able to afford preventive or therapeutic care. Having family members in many different developmental stages may cause stressors but this is not of high priority (option 1). The history of adult-onset diabetes on the 42-year-old father's side and the sedentary lifestyle should be addressed but will not likely cause immediate health problems (options 2 and 4). **Cognitive Level:** Analyzing. **Client Need:** Health promotion and maintenance. **Nursing Process:** Planning. **Learning Outcome:** 24-5.

Chapter 25: Caring

1. **Answer:** 2. **Rationale:** This assessment activity gathers more information to help the nurse know the client's usual self-care practices. Option 1 aims to provide comfort. Option 3 is a therapeutic, not an assessment, activity. Option 4 does not meet the aim of knowing the client. **Cognitive Level:** Applying. **Client Need:** Psychosocial Integrity. **Nursing Process:** Implementation. **Learning Outcome:** 25-4.
2. **Answer:** 1. **Rationale:** Teaching the client to make self-care decisions at home empowers him to care for his illness. Empowerment is not the primary goal for options 2, 3, and 4. **Cognitive Level:** Applying. **Client Need:** Health Promotion and Maintenance. **Nursing Process:** Implementation. **Learning Outcome:** 25-4.
3. **Answer:** 3. **Rationale:** Mayeroff defines patience as "allowing the other to grow in his own way and time." Options 1, 2, and 4 are not clearly the goal. **Cognitive Level:** Remembering. **Client Need:** Psychosocial Integrity. **Nursing Process:** Planning. **Learning Outcome:** 25-3.
4. **Answer:** 1. **Rationale:** In this situation, culture care diversity addresses the differences between Indonesian medical practices and traditional American practices. Universality addresses the similarities among the cultures. Since Leininger's theory addresses cultural elements relevant to nursing, options 2, 3, and 4 are incorrect. **Cognitive Level:** Analyzing. **Client Need:** Psychosocial Integrity. **Nursing Process:** Evaluation. **Learning Outcome:** 25-2.
5. **Answer:** 3. **Rationale:** This represents an ethical dilemma. Options 1, 2, and 4 are ways of knowing less clearly related to the situation. **Cognitive Level:** Applying. **Client Need:** Psychosocial Integrity. **Nursing Process:** Assessment. **Learning Outcome:** 25-6.
6. **Answer:** 1. **Rationale:** The nurse's presence is most significant in this situation. Assessment (option 2), knowing the client (option 3), and empowering the client (option 4) are not the focus of the nurse's action. **Cognitive Level:** Applying. **Client Need:** Psychosocial Integrity. **Nursing Process:** Implementation. **Learning Outcome:** 25-6.
7. **Answer:** 2. **Rationale:** As depicted in Figure 25–1, this is the model for the theory of bureaucratic caring. **Cognitive Level:** Remembering. **Client Need:** Psychosocial Integrity. **Nursing Process:** Assessment. **Learning Outcome:** 25-2.
8. **Answer:** 1. **Rationale:** Empirical knowing is gained from studying scientific models and theories. Aesthetic knowing arises from application in practice (option 2). Personal knowing arises from self-examination (option 3). Ethical knowing arises from confronting conflicting values (option 4). **Cognitive Level:** Applying. **Client Need:** N/A. **Nursing Process:** N/A. **Learning Outcome:** 25-3.
9. **Answer:** 4. **Rationale:** Meditation involves the described behaviors. Storytelling involves communication with others (option 1). Yoga combines various postures with breathing practices (option 2). Music therapy involves listening to music (option 3). **Cognitive Level:** Analyzing. **Client Need:** N/A. **Nursing Process:** N/A. **Learning Outcome:** 25-5.
10. **Answer:** 3. **Rationale:** Twenty-five minutes of vigorous activity 3 days a week is the recommendation for a healthy lifestyle. Ten minutes is an insufficient amount of time for moderate exercise (option 1), as is 20 minutes (option 2). Daily vigorous activity for 30 minutes may be too strenuous (option 4), depending on the client's level of conditioning. **Cognitive Level:** Applying. **Client Need:** Health Promotion and Maintenance. **Nursing Process:** Implementation. **Learning Outcome:** 25-6.

Chapter 26: Communicating

1. **Answer:** 3. **Rationale:** Nonverbal, gentle touch is an important tool; overstimulation may affect the client in a negative way. Option 1: Written communication requires a higher level of consciousness than verbal. Option 2: The client does not have a hearing problem but lacks the ability to interpret and understand communication. Option 4: Lack of facial expression may increase fear. **Cognitive Level:** Applying. **Client Need:** Psychosocial Integrity. **Nursing Process:** Implementation. **Learning Outcome:** 26-9.
2. **Answer:** 3, 1, 2, 4. **Rationale:** During the preinteraction phase (option 3), the nurse gathers information about the client before meeting the client. During the introductory phase (option 1), the nurse usually engages in some social interaction to put the client at ease. During the working phase (option 2), the nurse helps the client to explore feelings and helps the client plan a program. During the termination phase (option 4), the nurse summarizes or reviews the process that took place. **Cognitive Level:** Analyzing. **Client Need:** Psychosocial Integrity. **Nursing Process:** Planning. **Learning Outcome:** 26-6.
3. **Answer:** 1 and 3. **Rationale:** Options 1 and 3 are listening behaviors; options 2, 4, and 5 are barriers to listening. **Cognitive Level:** Applying. **Client Need:** Psychosocial Integrity. **Nursing Process:** Implementation. **Learning Outcome:** 26-4.
4. **Answer:** 1. **Rationale:** Respect is correct because the nurse is validating the client's feeling. It is not genuineness (option 2) because the nurse is giving information versus being genuine. Concreteness (option 3) is giving a specific example. The nurse is not confronting (option 4) but supporting through respect for the client's feelings. **Cognitive Level:** Applying. **Client Need:** Psychosocial Integrity. **Nursing Process:** Implementation. **Learning Outcome:** 26-6.
5. **Answer:** 2. **Rationale:** Because anxiety and low self-esteem precede powerlessness, which results in indecisiveness, it is the most correct answer; nursing management always deals with the client's current display of needs. Options 1 (anxiety) and 3 (low self-esteem) may cause a sense of powerlessness that results in indecisiveness. Option 4: There is no evidence that the client's social interactions are less than adequate. **Cognitive Level:** Applying. **Client Need:** Psychosocial Integrity. **Nursing Process:** Diagnosis. **Learning Outcome:** 26-9.
6. **Answer:** 2 and 3. **Rationale:** Assessing possible visual or hearing problems allows the nurse to provide appropriate interventions (e.g., inserting hearing aid). Communicating what will be occurring at a stressful time helps the client feel more secure and can reduce anxiety. Option 1 is not the best answer as the client could say yes/no or nod the head and the nurse will not know if the client fully understands. It would be better to ask the client to tell you where he or she is. Option 4 is important to do; however, immediately after surgery is not the best time as the client may be in pain and/or groggy from the anesthesia. Option 5 is false reassurance because the nurse does not know if the client is going to feel better. **Cognitive Level:** Applying. **Client Need:** Psychosocial Integrity. **Nursing Process:** Implementation. **Learning Outcome:** 26-4.
7. **Answer:** 3. **Rationale:** All of the other options are forms of elderspeak. **Cognitive Level:** Analyzing. **Client Need:** Psychosocial Integrity. **Nursing Process:** Implementation. **Learning Outcome:** 26-3.
8. **Answer:** 4. **Rationale:** Option 4 is a therapeutic technique using an open-ended question that allows the client to elaborate. The other options are barriers to communication. Option 1 is incorrect because the client did not ask about the abilities of the surgeon and the response does not focus on the client. Option 2 is changing the subject, and option 3 is giving advice. **Cognitive Level:** Analyzing. **Client Need:** Psychosocial Integrity. **Nursing Process:** Implementation. **Learning Outcome:** 26-9.
9. **Answer:** 2. **Rationale:** Option 2 uses an "I" statement, which is assertive communication and is clear and direct. The message includes only the necessary information. Option 1 contains inflammatory language ("ineffective" and "you prescribed"). Options 3 and 4 do not provide the health care provider with specific information and could stimulate defensive behaviors. **Cognitive Level:** Analyzing. **Client Need:** Safe, Effective Care Environment. **Nursing Process:** Assessment. **Learning Outcome:** 26-12.
10. **Answer:** 1. **Rationale:** It encourages the client to verbalize and choose the topic of the conversation. Option 2 is used when the nurse is

unsure of the message and asks the client to repeat or restate the message. Option 3 is used to help a client differentiate the real from the unreal, and there is no information available to indicate this is a concern in this situation. Option 4 is used at the end of an interview or teaching session. **Cognitive Level:** Applying. **Client Need:** Psychosocial Integrity. **Nursing Process:** Assessment. **Learning Outcome:** 26-4.

Chapter 27: Teaching

1. **Answer:** 2. **Rationale:** Options 1 and 3 are psychomotor, and 4 is under the cognitive domain. **Cognitive Level:** Understanding. **Client Need:** Health Promotion and Maintenance. **Nursing Process:** Implementation. **Learning Outcome:** 27-3.
2. **Answer:** 3. **Rationale:** Options 1 and 2 are passive learning strategies. Learning is faster and retention better when the learner is actively involved. Option 4 promotes affective learning about adapting to a chronic health condition and is important. However, the question asks about learning diet information. **Cognitive Level:** Applying. **Client Need:** Physiological Integrity. **Nursing Process:** Implementation. **Learning Outcome:** 27-9.
3. **Answer:** 2. **Rationale:** The client most ready to learn is experiencing or has recently experienced the least amount of stress or is the least preoccupied with other concerns. There will be no separation anxiety because the parents are present. The storybook may allow the child to learn information about the hospital and ask questions. The client in option 1 will be preoccupied by his illness. The client in option 3 is most likely still in pain. It would be better to wait until the pain is resolved. It would also be important to check if the client is too sleepy because pain medication can have that effect also. The client in option 4 may be too tired after his physical therapy treatment. This would need to be assessed. **Cognitive Level:** Applying. **Client Need:** Psychosocial Integrity. **Nursing Process:** Assessment. **Learning Outcome:** 27-5.
4. **Answer:** 1. **Rationale:** Individuals learn in various ways, such as visually, group learning, auditory, and participatory. The individual knows how learning has occurred in the past. Option 2 is a component of the implementation phase of teaching, and the question is asking how to assess a client's style of learning. Options 3 and 4 involve others and it is best to ask the client. **Cognitive Level:** Remembering. **Client Need:** Health Promotion and Maintenance. **Nursing Process:** Assessment. **Learning Outcome:** 27-7.
5. **Answer:** 3. **Rationale:** Option 1 is an old diagnosis, which has been changed. Option 2 is a wellness nursing diagnosis; the data would need to address that the client is seeking health information and why in order to be the correct answer. The diagnosis of *Noncompliance* is associated with the intent to comply, but situational factors make it difficult. The data in the question do not support option 4. **Cognitive Level:** Remembering. **Client Need:** Physiological Integrity. **Nursing Process:** Diagnosis. **Learning Outcome:** 27-9.
6. **Answer:** 2, 3, and 5. **Rationale:** Options 2, 3 and 5 are open-ended questions that will give the client the opportunity to provide information that will help the nurse assess level of knowledge and subsequently provide/discuss needed information with the client. Options 1 and 4 are closed-ended (yes/no) questions. A "no" answer may cause a discussion but it will be difficult for the nurse to assess if it is the information the client really wants to know. **Cognitive Level:** Applying. **Client Need:** Psychosocial Integrity. **Nursing Process:** Assessment. **Learning Outcome:** 27-7.
7. **Answer:** 1, 2, 3, and 4. **Rationale:** All of these statements could indicate a low literacy skill. The nurse will need to assess which teaching strategies will be most appropriate and will also need to carefully evaluate if the client has learned the skill and necessary information. Option 5 reflects an ability to read the material with a request for additional clarification. **Cognitive Level:** Analyzing. **Client Need:** Physiological Integrity. **Nursing Process:** Assessment. **Learning Outcome:** 27-8.
8. **Answer:** 3. **Rationale:** All are important factors to assess. The priority, however, would be the potential economic factor because the medications can be very expensive and the client may not take them if he or she cannot afford them. **Cognitive Level:** Applying. **Client Need:** Physiological Integrity. **Nursing Process:** Assessment. **Learning Outcome:** 27-7.
9. **Answer:** 3. **Rationale:** This option is the easiest for the nurse to evaluate. Option 1 is difficult to evaluate because "understand" is too vague. Option 2 refers more to an affective outcome and the question is asking about a cognitive outcome. Option 4 is telling more about the husband than the client. **Cognitive Level:** Analyzing. **Client Need:** Health Promotion and Maintenance. **Nursing Process:** Evaluation. **Learning Outcome:** 27-13.
10. **Answer:** 2. **Rationale:** This is the only option that clearly reflects the teaching process, evaluation method, and the response of the client indicating evidence of learning. **Cognitive Level:** Analyzing. **Client Need:** Physiological Integrity. **Nursing Process:** Evaluation. **Learning Outcome:** 27-14.

Chapter 28: Leading, Managing, and Delegating

1. **Answer:** 1. **Rationale:** This is a situation in which urgent decisions are needed, and one person provides instructions without input from others (autocratic). This is especially appropriate if the rest of the group is not functioning at an appropriate level. Option 2 would be found in shared governance structures when the risks are low and there is time for collaboration. Option 3 is most effective in groups with high levels of professional and personal maturity and where cooperation and coordination are not significant. Option 4 involves the rigid use of rules. Because managing casualties is a highly unpredictable activity, enforcement of rules is not appropriate. **Cognitive Level:** Analyzing. **Client Need:** Safe, Effective Care Environment. **Nursing Process:** N/A. **Learning Outcome:** 28-2.
2. **Answer:** 1. **Rationale:** In this situation, the manager needs to verify and clarify the client's statement with the assigned nurse before taking any direct action. Assigning another nurse to administer the client's medications (option 2) could be dangerous because it assumes the client is accurate in his statement. It is premature to review proper medication procedures with the nurse before knowing for certain that the procedure has not been followed (option 3). If the manager determines that there is disagreement about whether or not the medications have been given, it might be appropriate for the manager, nurse, and client to discuss the situation together (option 4) but certainly not before the manager has a private conversation about the situation with the nurse. **Cognitive Level:** Applying. **Client Need:** Safe, Effective Care Environment. **Nursing Process:** Planning. **Learning Outcome:** 28-7.
3. **Answer:** 2. **Rationale:** The manager is responsible for evaluating the staff (accountable) but has no authority to terminate staff who do not meet the standards nor promote staff with outstanding performance. In option 1 the manager has authority to carry out the reduction, but is not accountable because the actions were delegated and not initiated independently. In option 3, the manager has only responsibility; in option 4, both authority and accountability. **Cognitive Level:** Applying. **Client Need:** Safe, Effective Care Environment. **Nursing Process:** Planning. **Learning Outcome:** 28-6.
4. **Answer:** 3. **Rationale:** A fresh postoperative client is, by definition, in a somewhat unstable condition and the nurse must assess and supervise this initial transfer. A UAP should be able to perform the transfer safely with a new wheelchair; the scenario does not indicate that the wheelchair had special features (option 1) or that the client is an older adult. Age does not determine need for assistance and the UAP should be able to transfer the older adult client (option 2). The task is simple and can be easily recalled safely after an absence (option 4). **Cognitive Level:** Analyzing. **Client Need:** Safe, Effective Care Environment. **Nursing Process:** Planning. **Learning Outcome:** 28-8.

5. **Answer:** 4. **Rationale:** Interaction between the two groups may lead to a compromise. Option 1: Although explaining the reasons for the desired change is useful, overemphasis on the rationale may not be useful since resistance is often more emotional than rational. Option 2: This situation does not meet the criteria for an autocratic leadership style. There is no urgency and the task primarily involves the staff. Option 3: If the manager were not solidly committed to the new proposal, it should not be introduced, because it will result in unnecessary disturbance. Option 4: The manager should be open to modification of the proposal if justified. **Cognitive Level:** Applying. **Client Need:** Safe, Effective Care Planning. **Nursing Process:** Implementation. **Learning Outcome:** 28-10.
6. **Answer:** 2. **Rationale:** Managers are employees and have been given authority by the institution for which they work. The other options are characteristic of leaders more than managers. **Cognitive Level:** Understanding. **Client Need:** Safe, Effective Care Planning. **Nursing Process:** N/A. **Learning Outcome:** 28-1.
7. **Answer:** 2, 3, and 5. **Rationale:** An effective leader is open to members' views on both sides of issues, orchestrates group activities, and is open to and solicits feedback on their style. They use the style most natural to them rather than adopt another (option 1) and use a style appropriate to the situation and the groups as a whole, not varying for each member (option 4). **Cognitive Level:** Applying. **Client Need:** Safe, Effective Care Planning. **Nursing Process:** Evaluation. **Learning Outcome:** 28-3.
8. **Answer:** 3. **Rationale:** Middle managers supervise first-level managers and serve as liaison between first- and upper-level managers. First-level managers supervise nonmanagerial staff (option 1) and report institutional changes to direct-care staff (option 2). Creating institutional goals and strategic plans is the responsibility of upper-level managers (option 4). **Cognitive Level:** Understanding. **Client Need:** Safe, Effective Care Planning. **Nursing Process:** Evaluation. **Learning Outcome:** 28-4.
9. **Answer:** 4. **Rationale:** Evaluating outcomes and effectiveness is part of the coordinating function of management. **Cognitive Level:** Remembering. **Client Need:** Safe, Effective Care Planning. **Nursing Process:** N/A. **Learning Outcome:** 28-5.
10. **Answer:** 3. **Rationale:** In this situation, the UAP was not given the right direction and communication—that the client was not permitted to be out of bed. UAPs commonly weigh clients so it was the right task and right person (options 1 and 2). Although supervision might have prevented the error, it was the nurse's responsibility to tell the UAP of the client's mobility status and, if necessary, the proper way to weigh such a client (option 4). **Cognitive Level:** Analyzing. **Client Need:** Safe, Effective Care Planning. **Nursing Process:** Evaluation. **Learning Outcome:** 28-9.

Chapter 29: Vital Signs

1. **Answer:** 2. **Rationale:** Although the temperature is slightly lower than expected for the morning, it would be best to determine the client's previous temperature range next. This may be a normal range for this client. Depending on that finding, the nurse might want to retake it in a few minutes—no need to wait 15 minutes (option 3) or with another thermometer to see if the initial thermometer was functioning properly. Chart after determining that the temperature has been measured properly (option 4). **Cognitive Level:** Applying. **Client Need:** Health Maintenance and Promotion. **Nursing Process:** Assessment. **Learning Outcome:** 29-4.
2. **Answer:** 3. **Rationale:** The apical rate would confirm the rate and determine the actual cardiac rhythm for a client with an abnormal rhythm; a radial pulse would only reveal the heart rate and suggest an arrhythmia. For clients in shock, use the carotid or femoral pulse (option 1). The radial pulse is adequate for determining a change in the orthostatic heart rate (option 2). The radial pulse is appropriate for routine postoperative vital sign checks for clients with regular pulses (option 4). **Cognitive Level:** Understanding. **Client Need:** Health Promotion and Maintenance. **Nursing Process:** Planning. **Learning Outcome:** 29-5.
3. **Answer:** 4. **Rationale:** Since the client's needs are always considered first, the measurement should be delayed unless the client is in distress or there are other urgent reasons. Option 1: Respirations should be measured for 30 seconds to 1 minute and are affected by talking. Option 2: There needs to be an important reason for interrupting the client. Option 3: It is inappropriate to wait and listen to the client's conversation. **Cognitive Level:** Understanding. **Client Need:** Health Promotion and Maintenance. **Nursing Process:** Planning. **Learning Outcome:** 29-3d.
4. **Answer:** 2. **Rationale:** If the cuff is inflated to about 30 mmHg over previous systolic pressure, that would be 168. To ensure that the diastolic has been determined, the cuff should be released slowly until the mid-60s mmHg (and then completely) for someone with a previous reading of 74. The cuff should be deflated at a rate of 2 to 3 mm per second. Thus, a range of 90 mmHg will require 30 to 45 seconds. **Cognitive Level:** Analyzing. **Client Need:** Health Promotion and Maintenance. **Nursing Process:** Implementation. **Learning Outcome:** 29-3e.
5. **Answer:** 1. **Rationale:** Vital signs measurement may be delegated to UAP if the client is in stable condition, the findings are expected to be predictable, and the technique requires no modification. Only the preoperative client meets these requirements. In addition, UAP are not delegated to take apical pulse measurements for the client with an irregular pulse as would be the case with the client newly started on antiarrhythmic medication (option 3). **Cognitive Level:** Applying. **Client Need:** Health Promotion and Maintenance. **Nursing Process:** Planning. **Learning Outcome:** 29-8.
6. **Answer:** 3, 4, and 5. **Rationale:** For this client, the nurse could take an axillary, tympanic, or temporal artery temperature. Due to the facial drooping and difficulty swallowing, the oral route is not recommended (option 1). Although the rectal route could be used, it would require unnecessary moving and positioning of a client who cannot assist, and it would not provide a significant advantage over the other routes (option 2). **Cognitive Level:** Applying. **Client Need:** Health Promotion and Maintenance. **Nursing Process:** Assessment. **Learning Outcome:** 29-1.
7. **Answer:** 4. **Rationale:** The posterior tibial and pedal pulses in the foot are considered peripheral and at least one of them should be palpable in normal individuals. Option 1: A bounding radial pulse is more indicative that perfusion exists. Options 2 and 3: Apical and carotid pulses are central and not peripheral. **Cognitive Level:** Analyzing. **Client Need:** Health Promotion and Maintenance. **Nursing Process:** Diagnosing. **Learning Outcome:** 29-9.
8. **Answer:** 3. **Rationale:** Dyspnea, difficult or labored breathing, is commonly related to inadequate oxygenation. Therefore, the client is likely to experience shortness of breath, that is, a sense that none of the breaths provide enough oxygen and an immediate second breath is needed. Option 1: Shallow respirations are seen in tachypnea (rapid breathing). Option 2: Wheezing is a high-pitched breathing sound that may or may not occur with dyspnea. Option 4: The medical term for coughing up blood is hemoptysis and is unrelated to dyspnea. **Cognitive Level:** Applying. **Client Need:** Health Promotion and Maintenance. **Nursing Process:** Evaluation. **Learning Outcome:** 29-7.
9. **Answer:** This blood pressure should be recorded as 180/105/95 mmHg using the systolic/1st diastolic/2nd diastolic convention. **Rationale:** Phase 1 first sound is a clear tapping when deflation of the cuff begins. Phase 2 has a muffled, swishing sound. In phase 3, blood is flowing freely via an increasingly open artery; sounds are more crisp and more intense but softer than phase 1. Phase 4 sounds become muffled and have a soft blowing quality. In phase 5 the last sound is heard followed by silence. **Cognitive Level:** Analyzing.

Client Need: Health Promotion and Maintenance. **Nursing Process:** Assessment. **Learning Outcome:** 29-9.

10. **Answer:** 4. **Rationale:** The SpO_2 in this case is 97%. Option 1 indicates the systolic blood pressure of 121 mmHg, option 2 the mean arterial pressure of 95 mmHg, option 3 the pulse of 87 beats/min, and option 5 the diastolic blood pressure of 84 mmHg. In addition, the client's temperature is shown. **Cognitive Level:** Understanding. **Client Need:** Health Promotion and Maintenance. **Nursing Process:** Assessment. **Learning Outcome:** 29-3f.

Chapter 30: Health Assessment

1. **Answer:** 2. **Rationale:** Resonance is a normal sound over the lung. Tympany would be heard over the stomach (air filled) (option 1), hyperresonance is never a normal finding (option 3), and dullness would be heard below (not above) the 10th intercostal space (option 4). **Cognitive Level:** Remembering. **Client Need:** Health Promotion and Maintenance. **Nursing Process:** Evaluation. **Learning Outcomes:** 30-3; 30-4k.
2. **Answer:** 4. **Rationale:** The client should sit for examination of the head and neck. For palpation of the abdomen (option 1), genitals (option 2), and breast (option 3), the client should be supine. **Cognitive Level:** Applying. **Client Need:** Health Promotion and Maintenance. **Nursing Process:** Planning. **Learning Outcome:** 30-2.
3. **Answer:** 1. **Rationale:** A bruit suggests abnormal turbulence in the aorta, and the primary care provider must be notified. For absence of bowel sounds to be considered abnormal, they must be silent for 3 to 5 minutes (option 2). Continuous bowel sounds are normally heard over the ileocecal valve following meals (option 3). Bowel sounds are more commonly irregular than they are regular (option 4). **Cognitive Level:** Understanding. **Client Need:** Health Promotion and Maintenance. **Nursing Process:** Evaluation. **Learning Outcomes:** 30-3; 30-4o; 30-8.
4. **Answer:** 1. **Rationale:** If a pedal pulse, which is more distal than the popliteal, is present, then adequate arterial circulation to the leg is present even though the popliteal artery has not been located. Presence of a femoral pulse would not provide confirmation that arterial flow exists below that point (option 2). Taking a thigh BP requires locating the popliteal pulse (option 3). Because the purpose of finding the popliteal pulse is to provide information about arterial circulation to the leg, checking the distal pulse before requesting assistance from another nurse is appropriate (option 4). **Cognitive Level:** Analyzing. **Client Need:** Health Promotion and Maintenance. **Nursing Process:** Planning. **Learning Outcomes:** 30-3; 30-4m.
5. **Answer:** 2. **Rationale:** Visual acuity often lessens with age. Facial hair is likely to become coarser, not finer (option 1). The sense of smell becomes less, rather than more acute (option 3). The respiratory rate and rhythm is regular at rest (option 4). However, both may change quickly with activity and be slow to return to the resting level. **Cognitive Level:** Analyzing. **Client Need:** Health Promotion and Maintenance. **Nursing Process:** Evaluating. **Learning Outcome:** 30-3.
6. Answers include color, turgor, temperature, moisture, lesions, odor, and edema. **Cognitive Level:** Remembering. **Client Need:** Health Promotion and Maintenance. **Nursing Process:** Assessment. **Learning Outcome:** 30-4b.
7. **Answer:** 3. **Rationale:** Recent memory includes events of the current day. Recalling a series of numbers tests immediate recall (option 1). Recalling childhood events tests remote (long-term) memory (option 2), and subtracting backwards from 100 tests attention span and calculation skills (option 4). **Cognitive Level:** Applying. **Client Need:** Health Promotion and Maintenance. **Nursing Process:** Planning. **Learning Outcomes:** 30-3; 30-4q.
8. **Answer:** 4. **Rationale:** If the client can only read the first three lines, vision is impaired and could lead to falls or other injuries. This impaired vision is not related to deficient knowledge (option 1) or memory (option 2) and may or may not be related to circulation (option 3). **Cognitive Level:** Analyzing. **Client Need:** Health Promotion and Maintenance. **Nursing Process:** Diagnosing. **Learning Outcomes:** 30-3; 30-8.
9. **Answer:** 3. **Rationale:** Use the pads of two fingers and a gentle rotating motion over the nodes. None of the other options is proper palpation of lymph nodes. **Cognitive Level:** Applying. **Client Need:** Health Promotion and Maintenance. **Nursing Process:** Implementation. **Learning Outcome:** 30-2.
10. **Answer:** Of the terms listed, only equal, symmetrical, and firm are normal findings. Atrophied, flaccid, contractured, hypertrophied, crepitation, spastic, and tremor are abnormal findings. Review the terms in the glossary to go over their meanings. **Cognitive Level:** Understanding. **Client Need:** Health Promotion and Maintenance. **Nursing Process:** Evaluation. **Learning Outcomes:** 30-4p; 30-8.

Chapter 31: Asepsis

1. **Answer:** 2. **Rationale:** Blocking the movement of the organism from the reservoir will succeed in preventing the infection of any other individuals. Since the carrier individual is the reservoir and the condition is chronic, it is not possible to eliminate the reservoir (option 1). Blocking the entry into a host (option 3) or decreasing the susceptibility of the host (option 4) will be effective for only that one single individual and, thus, is not as effective as blocking exit from the reservoir. **Cognitive Level:** Understanding. **Client Need:** Safe, Effective Care Environment. **Nursing Process:** Planning. **Learning Outcome:** 31-9.
2. **Answer:** 1. **Rationale:** Since the hands are frequently in contact with clients and equipment, they are the most obvious source of transmission. Regular and routine hand hygiene is the most effective way to prevent movement of potentially infective materials. PPE (gloves and masks) is indicated for situations requiring standard precautions (option 2). Isolation precautions are used for clients with known communicable diseases (option 3). Routine use of antibiotics is not effective and can be harmful due to the incidence of superinfection and development of resistant organisms (option 4). **Cognitive Level:** Applying. **Client Need:** Safe, Effective Care Environment. **Nursing Process:** Implementation. **Learning Outcome:** 31-8.
3. **Answer:** 3. **Rationale:** Standard precautions include all aspects of contact precautions with the exception of placing the client in a private room. A mask is indicated when working over a sterile wound rather than an infected one (option 1). Disposable food trays are not necessary for clients with infected wounds unlikely to contaminate the client's hands (option 2). Sterile technique (surgical asepsis) is not indicated for all contact with the client (option 4). The nurse would utilize clean technique when dressing the wound to prevent introduction of additional microbes. **Cognitive Level:** Applying. **Client Need:** Safe, Effective Care Environment. **Nursing Process:** Implementation. **Learning Outcome:** 31-10.
4. **Answer:** 1. **Rationale:** Unless overly contaminated by material that has splashed in the nurse's face and cannot be effectively rinsed off, goggles may be worn repeatedly (option 1). Since gowns are at high risk for contamination, they should be used only once and then discarded or washed (option 2). Surgical masks (option 3) and gloves (option 4) are never washed or reused. **Cognitive Level:** Understanding. **Client Need:** Safe, Effective Care Environment. **Nursing Process:** Implementation. **Learning Outcome:** 31-11b.
5. **Answer:** 4. **Rationale:** It should not be necessary to unroll this small edge of the cuff. The most important consideration is the sterility of the fingers and hand that will be used to perform the sterile procedure. The rolled-under portion is now contaminated and should not be unrolled by the nurse or colleague since it would then touch the remaining sterile portion of the glove (option 3). **Cognitive Level:** Applying. **Client Need:** Safe, Effective Care Environment. **Nursing Process:** Implementation. **Learning Outcome:** 31-11d.

6. **Answer:** 2, 3, and 4. **Rationale:** Flu shots are recommended for all adults over age 50. Only adults at risk need to receive hepatitis B and A vaccine (note that this is different than for children). Options 1 and 5 are incorrect because all adults should receive a tetanus booster every 10 years (or sooner if injured) and adults over age 60 should receive the herpes zoster vaccination. **Cognitive Level:** Remembering. **Client Need:** Safe, Effective Care Environment. **Nursing Process:** Assessment. **Learning Outcomes:** 31-8; 31-6.
7. **Answer:** Because a malnourished client with a wound is less able to resist an infection, *Risk for Infection* is the most likely nursing diagnosis. Others may include *Pain* or *Imbalanced Nutrition* but they are less focused on the immediate health risk. **Cognitive Level:** Applying. **Client Need:** Safe, Effective Care Environment. **Nursing Process:** Diagnosing. **Learning Outcome:** 31-7.
8. **Answer:** 2. **Rationale:** Raw foods touched by human hands can carry significant infectious organisms and must be washed or peeled. Antimicrobial soap is not indicated for regular use and may lead to resistant organisms. Hand hygiene should occur as needed. Hot water can dry and harm skin, increasing the risk of infection (option 1). Clients should learn all the signs of inflammation and infection (e.g., redness, swelling, pain, heat) and not rely on the presence of pus to indicate this (option 3). People should not share washcloths or towels (option 4). **Cognitive Level:** Analyzing. **Client Need:** Safe, Effective Care Environment. **Nursing Process:** Evaluation. **Learning Outcomes:** 31-8; 31-5.
9. **Answer:** 1. **Rationale:** Sterile objects are considered unsterile if placed lower than the waist. Only area 1 in this situation would be considered sterile. Above the neck, higher than 2 inches above the elbow, below the waist/table, and the back are all considered unsterile. **Cognitive Level:** Applying. **Client Need:** Physiological Integrity. **Nursing Process:** Planning. **Learning Outcomes:** 31-1; 31-11c.
10. **Answer:** 3. **Rationale:** All items within 1 inch of the edge of the sterile field are considered contaminated because the edge of the field is in contact with unsterile areas. When hands are ungloved, forceps tips are to be held downward to prevent fluid from becoming contaminated by the hands and then returned to the sterile field (option 1). Fields should be established immediately before use to prevent accidental contamination when not observed closely (option 2). Reaching over a sterile field increases the chances of dropping an unsterile item onto or touching the sterile field (option 4). **Cognitive Level:** Applying. **Client Need:** Safe, Effective Care Environment. **Nursing Process:** Evaluation. **Learning Outcome:** 31-11c.

Chapter 32: Safety

1. **Answer:** 3. **Rationale:** In the event of a fire, the nurse's priority responsibility is to rescue or protect the clients under his or her care. The next priorities are to report or alert the fire department, contain or confine, and extinguish the fire. **Cognitive Level:** Understanding. **Client Need:** Safe, Effective Care Environment. **Nursing Process:** Implementation. **Learning Outcome:** 32-6.
2. **Answer:** 1. **Rationale:** When educating a group of young to middle-aged adults on safety, it is important to instruct them on the leading cause of injuries in this group. The leading cause of injuries in this group is related to automobile use. Option 2 is the leading cause for school-age children. Option 3 is the leading cause for older adults, and option 4 relates to adolescents. **Cognitive Level:** Understanding. **Client Need:** Safe, Effective Care Environment. **Nursing Process:** Implementation. **Learning Outcome:** 32-4.
3. **Answer:** 3. **Rationale:** The placement of the bedside commode next to his bed will assist in decreasing the number of steps he is required to ambulate. This will assist in protecting him from injury due to falls. Option 1: Leaving the light on would assist the client in locating the bathroom, but would not reduce the risk of fall when rushing to the bathroom. Option 2: The nurse cannot withhold a client's medication without consulting with the primary care provider. Option 4: If the client has orders to be up with assistance and the side rails are up, he is at risk for falls as well as falling from a greater distance. **Cognitive Level:** Applying. **Client Need:** Safe, Effective Care Environment. **Nursing Process:** Implementation. **Learning Outcome:** 32-7.
4. **Answer:** 3. **Rationale:** A home that was built prior to 1978 has lead-based paint. The ingestion of lead-based paint chips places that child at risk for elevated serum lead levels and neurologic deficits. The most appropriate nursing diagnosis for this child is *Risk for Poisoning*. Option 1: The risk for suffocation is greater in infants and is not related to a home with lead-based paint. Options 2 and 4 are not related to lead-based paint. **Cognitive Level:** Applying. **Client Need:** Safe, Effective Care Environment. **Nursing Process:** Nursing Diagnosis. **Learning Outcome:** 32-5.
5. **Answer:** 4. **Rationale:** Option 4 is an intervention that can allow the client to feel independent and also alert the nursing and nursing staff when the client needs assistance. It is the most realistic answer that promotes client safety. Option 1 can increase agitation and confusion and removes the client's independence. Option 2 would help but transfers the responsibility to the family member. Option 3 is inappropriate since the client could fall during the unobserved interval and it is not a realistic answer for the nurse. **Cognitive Level:** Analyzing. **Client Need:** Safe, Effective Care Environment. **Nursing Process:** Implementation. **Learning Outcomes:** 32-6; 32-12a.
6. **Answer:** 2 and 5. **Rationale:** Options 2 and 5 are measures needed to keep the client safe in the event of another seizure. Option 1 is incorrect because the current nursing literature states to not put anything in the client's mouth during a seizure. Options 3 and 4 are more relevant after the cause of the seizure is known. Seizures are not all classified as epilepsy. **Cognitive Level:** Applying. **Client Need:** Safe, Effective Care Environment. **Nursing Process:** Planning. **Learning Outcomes:** 32-8; 32-12b.
7. **Answer:** 4. **Rationale:** Placing the bed in the lowest position results in a client falling the shortest distance. The client is least likely to fall when getting out of a bed that is at an appropriate height. Option 1 can cause a fall with injury because the client may fall from a higher distance when trying to get over the rail. Option 2 is important to do as certain medications can increase the risk of falling; however, this is not the best answer because it is not applicable to all clients. Option 3 would help the nurse to assess a client's risk for falling but would not prevent injury. **Cognitive Level:** Analyzing. **Client Need:** Safe, Effective Care Environment. **Nursing Process:** Implementation. **Learning Outcome:** 32-7.
8. **Answer:** 3, 4, and 5. **Rationale:** Reviewing near misses could identify flaws in the system or practices that placed the client at risk. Communication among staff and with clients will increase the efficiency and create an atmosphere where nurses are willing to discuss errors openly so that the flaws in the system can be corrected. Options 1 and 2 are inappropriate answers. A competent nurse may make medication errors. Also, evidence is needed to support these conclusions. **Cognitive Level:** Understanding. **Client Need:** Safe, Effective Care Environment. **Nursing Process:** Planning. **Learning Outcomes:** 32-1; 32-3.
9. **Answer:** 3. **Rationale:** Suicide and homicide are two leading causes of death among teenagers. Adolescent males commit suicide at a higher rate than adolescent females. Options 1 and 2 are true; however, neither would be as high a priority as preventing suicide. Option 4 is not true. A driver's education course does not ensure safe practice. **Cognitive Level:** Analysis. **Client Need:** Safe, Effective Care Environment. **Nursing Process:** Planning. **Learning Outcome:** 32-4.
10. **Answer:** 1, 3, 4, and 5. **Rationale:** Standards require documentation of the necessity for restraints. The implementation of range-of-motion exercises prevents joint stiffness and pain from disuse. Orienting the client helps the nurse determine the necessity of the restraint. Option 2 is inappropriate because it may cause injury if the side rail is lowered

without untying the restraint. **Cognitive Level:** Applying. **Client Need:** Safe, Effective Care Environment. **Nursing Process:** Implementation. **Learning Outcomes:** 32-9; 32-12c.

Chapter 33: Hygiene

1. **Answer:** 3. **Rationale:** The client fits the descriptors for a semidependent functional level (see Table 33–2). **Cognitive Level:** Applying. **Client Need:** Physiological Integrity. **Nursing Process:** Assessment. **Learning Outcome:** 33-3.
2. **Answer:** 3. **Rationale:** The client will be positioned in a side-lying position with the head of the bed lowered because the client is at risk for aspiration. The absence of the gag reflex lets the nurse know that the client has no natural defense (cough) and is at a higher risk for aspiration. All other answers are assessments more appropriate prior to bathing the client. **Cognitive Level:** Applying. **Client Need:** Physiological Integrity. **Nursing Process:** Assessment. **Learning Outcome:** 33-4.
3. **Answer:** 2. **Rationale:** A lotion will help moisten the skin. Perfumed lotions contain alcohol, which is drying to the skin. Soaking the feet for a long time or frequently also causes dry skin (option 1). Applying foot powder is appropriate to prevent or control unpleasant foot odor (option 3). Elastic stockings may decrease circulation (option 4). **Cognitive Level:** Applying. **Client Need:** Physiological Integrity. **Nursing Process:** Implementation. **Learning Outcome:** 33-15c.
4. **Answer:** 1. **Rationale:** Turn off the hearing aid. Option 2 is incorrect because an in-the-ear hearing aid is cleaned with a damp cloth. Option 3 is incorrect; make sure the volume is turned all the way down because a too loud volume is distressing. Check that the battery is in the hearing aid; do not remove the batteries (option 4). **Cognitive Level:** Applying. **Client Need:** Physiological Integrity. **Nursing Process:** Implementation. **Learning Outcome:** 33-15h.
5. **Answer:** 4. **Rationale:** Both the placement of the linens for a surgical bed and placing the bed in a high position facilitate the client's transfer from a stretcher into the bed. The linens for a closed bed are drawn up to the top of the bed and under the pillows (option 3). **Cognitive Level:** Remembering. **Client Need:** Physiological Integrity. **Nursing Process:** Implementation. **Learning Outcome:** 33-14.
6. **Answer:** 1, 2, and 4. **Rationale:** Moving quickly may agitate the client (option 3). Protesting, screaming, and crying are not normal. Stop the bath and approach again later (option 5). **Cognitive Level:** Applying. **Client Need:** Physiological Integrity. **Nursing Process:** Implementation. **Learning Outcome:** 33-8.
7. **Answer:** 4. **Rationale:** It is important to retract the foreskin to remove the smegma that collects under the foreskin and can cause bacterial growth. **Cognitive Level:** Analyzing. **Client Need:** Physiological Integrity. **Nursing Process:** Evaluation. **Learning Outcome:** 33-1.
8. **Answer:** 1, 3, and 5. **Rationale:** The developmental level warrants supervision. If the bottle is given during naps or bedtime, the solution has continuous contact with the toddler's teeth. The first visit to the dentist should occur between the ages of 2 and 3 (option 2). More than 50% of older adults have their own teeth (option 4). **Cognitive Level:** Applying. **Client Need:** Health Promotion and Maintenance. **Nursing Process:** Planning. **Learning Outcome:** 33-4.
9. **Answer:** 2. **Rationale:** The client needs to avoid walking barefoot because that could cause injury that may result in an infection. Also, neurologic impairment is likely as a result of the diabetes, which may result in decreased sensation. The client would be unaware of an injury. **Cognitive Level:** Analyzing. **Client Need:** Health Promotion and Maintenance. **Nursing Process:** Evaluation. **Learning Outcome:** 33-4.
10. **Answer:** 1. **Rationale:** Fowler's is a semisitting position that should ease the client's breathing. The head of the bed (HOB) in semi-Fowler's is lower (option 2). The HOB is lowered in the Trendelenburg position (option 3). Although the HOB is raised in the reverse Trendelenburg position, it is a straight tilt and may not be as comfortable as Fowler's (option 4). **Cognitive Level:** Applying. **Client Need:** Safe, Effective Care Environment. **Nursing Process:** Implementation. **Learning Outcome:** 33-13.

Chapter 34: Diagnostic Testing

1. **Answer:** 2. **Rationale:** Option 2 is very low and can lead to death. The client's red blood cells participate in oxygenation. Options 1, 3, and 4 are within normal range and should not be reported to the primary care provider. **Cognitive Level:** Applying. **Client Need:** Physiological Integrity. **Nursing Process:** Implementation. **Learning Outcome:** 34-3.
2. **Answer:** 3. **Rationale:** Option 3 is the most important nursing measure. This will inform the staff that the client is on a 24-hour urine collection. Option 1 is not appropriate since the first voided specimen is to be discarded. Option 2 is not an appropriate nursing measure since the specimen container is clean not sterile, and one container is needed—not individual containers. Option 4 is inappropriate because some 24-hour urine collections do not require refrigeration. **Cognitive Level:** Understanding. **Client Need:** Physiological Integrity. **Nursing Process:** Implementation. **Learning Outcome:** 34-6.
3. **Answer:** 2. **Rationale:** A KUB is an x-ray of the kidneys, ureters, and bladder. This does not require direct visualization. Option 1 is an IVP, an intravenous pyelogram, which requires the injection of a contrast media. Option 3 is a retrograde pyelography, which requires the injection of a contrast media. Option 4 is a cystoscopy, which uses a lighted instrument (cystoscope) inserted through the urethra, resulting in direct visualization. **Cognitive Level:** Remembering. **Client Need:** Physiological Integrity. **Nursing Process:** Assessment. **Learning Outcome:** 34-8.
4. **Answer:** 4. **Rationale:** This type of nuclear scan demonstrates the ability of tissues to absorb the chemical to indicate the physiology and function of an organ. Option 1 is an invasive procedure that focuses on blood flow through an organ. Options 2 and 3 provide information about density of tissue to help distinguish between normal and abnormal tissue of an organ. **Cognitive Level:** Remembering. **Client Need:** Physiological Integrity. **Nursing Process:** Assessment. **Learning Outcome:** 34-9.
5. **Answer:** 3. **Rationale:** Bone marrow aspiration includes deep penetration into soft tissue and large bones such as the sternum and iliac crest. This penetration can result in bleeding. The client should be observed for bleeding in the days following the procedure. Option 1 is a nursing action during a liver biopsy. Option 2 is a nursing action for a thoracentesis, and Option 4 is a nursing action for a lumbar puncture. **Cognitive Level:** Applying. **Client Need:** Physiological Integrity. **Nursing Process:** Implementation. **Learning Outcome:** 34-10.
6. **Answer:** 1 and 4. **Rationale:** ALT is an enzyme that contributes to protein and carbohydrate metabolism. An increase in the enzyme indicates damage to the liver. The liver contributes to the metabolism of protein, which results in the production of ammonia. If the liver is damaged, the ammonia level is increased. Options 2, 3, and 5 (myoglobin, cholesterol, and BNP) are relevant for heart disease. **Cognitive Level:** Applying. **Client Need:** Physiological Integrity. **Nursing Process:** Assessment. **Learning Outcome:** 34-2.
7. **Answer:** 3. **Rationale:** A glycosylated hemoglobin will indicate the glucose levels for a period of time, which is indicated by the nurse practitioner. Options 1 and 2 will provide information about the current blood glucose, not the past history. Option 4 is used to assess for liver disease. **Cognitive Level:** Remembering. **Client Need:** Physiological Integrity. **Nursing Process:** Planning. **Learning Outcome:** 34-2.
8. **Answer:** 2, 3, and 5. **Rationale:** The nurse should obtain the stool specimen from two different areas of the stool. The nurse should observe for a blue color change, which is indicative of a positive result. The nurse should assess for the ingestion of vitamin C by the client

because it is contraindicated for 3 days prior to taking the specimen. Option 1 is incorrect since the reagent is placed on the specimen after it is applied to the testing card. Option 4 is incorrect because a pink color would be considered negative and does not require verification. **Cognitive Level:** Applying. **Client Need:** Physiological Integrity. **Nursing Process:** Planning. **Learning Outcome:** 34-5.

9. **Answer:** 2. **Rationale:** The puncture site is usually on the posterior chest. The client should be positioned leaning forward. This will allow the ribs to separate for exposure of the site. Option 1 is incorrect. The client should not be placed in the Trendelenburg position because the site would not be exposed. Option 3 is incorrect since changes in vital signs do not routinely occur with this procedure. Option 4 is incorrect. The client does not need to be medicated for pain with this procedure. **Cognitive Level:** Analyzing. **Client Need:** Physiological Integrity. **Nursing Process:** Planning. **Learning Outcome:** 34-10.
10. **Answer:** 2, 4, and 5. **Rationale:** The sputum specimen should be sent immediately to the laboratory. The client should be provided mouth care before and after the specimen is collected. The sputum specimen should be collected for three consecutive days. Option 1 is incorrect because the sputum specimen is collected in the morning not in the evening. Option 3 is incorrect because the term *spit* indicates that saliva is being examined. The client needs to cough up or expectorate mucus or sputum. **Cognitive Level:** Analyzing. **Client Need:** Physiological Integrity. **Nursing Process:** Implementation. **Learning Outcome:** 34-7.

Chapter 35: Medications

1. **Answer:** 2. **Rationale:** If there is any doubt, the medication administration process should be interrupted until the question is clarified. Listen to the client. Find out any other information the client may have about that certain medication. For example, does he know the dosage of the medication taken at home? Do not administer the medication (option 1). Inform the client that you will check the chart first. Review the chart to make sure there is no discrepancy between the physician's order and the MAR. Review the physician's progress notes because the medication may have been increased or reduced as part of the treatment plan (option 3). Check with the pharmacist because sometimes a pill may be a different color or shape based on the pharmaceutical company. Do not leave medications at the bedside. Medications should never be left unattended (option 4). Inform the client of your findings. The client will appreciate that you took the time to make sure that he received the correct medication. While it takes time to check out the client's statement, you will be glad that you avoided a potential medication error. **Cognitive Level:** Applying. **Client Need:** Physiological Integrity. **Nursing Process:** Implementation. **Learning Outcome:** 35-11.
2. **Answer:** 4. **Rationale:** Options 1, 2, and 3 are written appropriately. Option 4 is incorrect because the dosage is missing from this order. **Cognitive Level:** Applying. **Client Need:** Physiological Integrity. **Nursing Process:** Evaluation. **Learning Outcome:** 35-6.
3. **Answer:** 1, 3, and 5. **Rationale:** Five milliliters is too large an amount to inject into one site. The nurse needs to divide the amount into two 2.5-mL injections. A 3-mL syringe could be used (option 1). The length of the needle will depend on the muscle development of the client. The nurse needs to assess the client. The presumption, based on the information provided, is that this client's muscle mass is within normal limits. The needle length would need to be 1 1/2 inches because the medication is ordered to be given "deep IM" (option 5). This also suggests that the medication should be given in the preferred site for IM injections—the ventrogluteal site—because it provides the greatest thickness of gluteal muscle. The gauge of the needle for an IM injection into the ventrogluteal muscle can range between #20 and #23 (option 3). The nurse needs to assess the viscosity of the medication. Smaller gauges (e.g., #23) produce less tissue trauma; however, viscous solutions may require a larger gauge (e.g., #20–#21). **Cognitive Level:** Analyzing. **Client Need:** Physiological Integrity. **Nursing Process:** Implementation. **Learning Outcome:** 35-5.
4. **Answer:** 3. **Rationale:** The type of syringe for subcutaneous injections depends on the medication to be given. This situation does not indicate that the medication is insulin and, thus, another syringe is needed. Generally a 2-mL syringe is used for most subcutaneous injections. Generally, a #20- to #23-gauge needle is used for IM injections. Needle size and length are based on the client's body mass, the intended angle of insertion, and the site of the injection. Generally, a #25-gauge, 5/8-inch needle is used for adults of normal weight and the needle is inserted at a 45° angle. Because 2 inches of tissue can be grasped or pinched at the site of the injection, the nurse should administer the medication at a 90° angle to ensure the medication reaches subcutaneous tissue. **Cognitive Level:** Analyzing. **Client Need:** Physiological Integrity. **Nursing Process:** Implementation. **Learning Outcome:** 35-18b.
5. **Answer:** 1. **Rationale:** A tuberculin test is given by intradermal injection. A tuberculin syringe is used because the dosage will most likely be 0.1 mL. A short, fine needle is needed to avoid entering the subcutaneous tissue. The needle should have a short bevel and usually be between #25 and #27 gauge. The needle should be between 1/4 to 5/8 inch long. **Cognitive Level:** Analyzing. **Client Need:** Physiological Integrity. **Nursing Process:** Implementation. **Learning Outcome:** 35-18a.
6. **Answer:** 4. **Rationale:** If the nurse goes by the amount of the medication (0.5 mL) only, the deltoid muscle would be the site. However, knowing and assessing the client is critical. The muscles of an older, emaciated client will most likely be diminished or atrophied. The nurse should consider the ventrogluteal site because that site will have the most muscle mass. **Cognitive Level:** Analyzing. **Client Need:** Physiological Integrity. **Nursing Process:** Implementation. **Learning Outcomes:** 35-17c; 35-12.
7. **Answer:** 1. **Rationale:** Due to renal insufficiency, the dose of the medication would need to be decreased in order to avoid accumulation of the medication and the risk of toxicity. **Cognitive Level:** Applying. **Client Need:** Physiological Integrity. **Nursing Process:** Assessment. **Learning Outcome:** 35-12.
8. **Answer:** 2. **Rationale:** To straighten the ear canal in children less than 3 years of age, the ear must be pulled down and back. In individuals over 3 years of age, the ear is pulled up and back. **Cognitive Level:** Applying. **Client Need:** Physiological Integrity. **Nursing Process:** Implementation. **Learning Outcome:** 35-20c.
9. **Answer:** 0.375 or rounded to 0.38 mL. **Rationale:** After converting to like numbers, the formula would be set up as follows:
   400 micrograms = 1 mL
   150 micrograms = X mL
   Cross multiply (400 X = 150)
   Divide by 400
   X = 0.375
   Cognitive Level: Applying. **Client Need:** Physiological Integrity. **Nursing Process:** Implementation. **Learning Outcome:** 35-9.
10. **Answer:** 3, 4, 1, 5, 2, 6, 7, and 8. **Rationale:** This is the correct order for this skill—first the nurse mixes the insulin, assesses the skin, and cleanses the skin. The nurse would then pinch the skin, insert the needle, inject the medication, count to five, and remove the syringe. **Cognitive Level:** Applying. **Client Need:** Physiological Integrity. **Nursing Process:** Implementation. **Learning Outcome:** 35-18b.

Chapter 36: Skin Integrity and Wound Care

1. **Answer:** 2. **Rationale:** A score ranging from 15 to 18 is considered at risk and a turning schedule is appropriate. Option 1 requires a score above 18 (normal and ongoing assessment is indicated). Option 3, moderate risk, for which a transparent barrier would be appropriate, is applied to persons with scores of 13 to 14. Option 4, very high risk,

is assigned for those with a score of 9 or less. **Cognitive Level:** Applying. **Client Need:** Safe, Effective Care Management. **Nursing Process:** Implementation. **Learning Outcome:** 36-2.

2. **Answer:** 1. **Rationale:** Wound culture specimens should be obtained from a cleaned area of the wound. Microbes responsible for the infection are more likely to be found in viable tissue. Collected drainage contains old and mixed organisms. An appropriate specimen can be obtained without causing the client the discomfort of debriding. The nurse does not generally debride the wound to obtain a specimen. Once systemic antibiotics have been begun, the interval following a dose will not significantly affect the concentration of wound organisms. **Cognitive Level:** Applying. **Client Need:** Physiological Integrity. **Nursing Process:** Implementation. **Learning Outcome:** 36-10.
3. **Answer:** 3. **Rationale:** Hydrocolloid dressings protect shallow ulcers and maintain an appropriate healing environment. Alginates (option 1) are used for wounds with significant drainage; dry gauze (option 2) will stick to new granulation tissue, causing more damage. A dressing is needed to protect the wound and enhance healing. **Cognitive Level:** Applying. **Client Need:** Physiological Integrity. **Nursing Process:** Implementation. **Learning Outcome:** 36-11.
4. **Answer:** 1. **Rationale:** The heating pad needs to be removed. After 30 minutes of heat application, the blood vessels in the area will begin to exhibit the rebound effect, resulting in vasoconstriction. Lowering the temperature, but still delivering heat—dry or moist—will not prevent the rebound effect. The visual appearance of the site on inspection (option 3) does not indicate if rebound is occurring. **Cognitive Level:** Analyzing. **Client Need:** Physiological Integrity. **Nursing Process:** Planning. **Learning Outcome:** 36-14.
5. **Answer:** 3. **Rationale:** Immobile and dependent persons should be repositioned at least every 2 hours, not every 4, so this client or family member requires further teaching. Warm water and moisturizing damp skin are correct techniques for skin care. Red areas that do not return to normal skin color should be reported. It would also be correct to use a foam pad to help relieve pressure. **Cognitive Level:** Analyzing. **Client Need:** Physiological Integrity. **Nursing Process:** Evaluation. **Learning Outcome:** 36-10.
6. **Answer:** Potential pressure ulcer sites for side-lying clients include ankles, knees, trochanters, ilia, shoulders, and ears. These are important areas to assess. Other answers may also be correct. **Cognitive Level:** Remembering. **Client Need:** Health Promotion and Maintenance. **Nursing Process:** Assessment. **Learning Outcome:** 36-8.
7. **Answer:** 2. **Rationale:** This client has an actual impairment of the integrity of the skin due to the rash and the scratching so is no longer "at risk." Because the damage is at the skin level, it is not impaired tissue integrity (option 3) since that would involve deeper tissues. Surface excoriation is also not prone to becoming infected. **Cognitive Level:** Analyzing. **Client Need:** Physiological Integrity. **Nursing Process:** Diagnosing. **Learning Outcome:** 36-9.
8. **Answer:** 1, 3, and 4. **Rationale:** Risk factors for pressure ulcers include low-protein diet, lengthy surgical procedures, and fever. Protein is needed for adequate skin health and healing. During surgery, the client is on a hard surface and may not be well protected from pressure on bony prominences. Fever increases skin moisture, which can lead to skin breakdown, plus the stress on the body from the cause of the fever could impair circulation and skin integrity. Insomnia (option 5) would generally involve restless sleeping, which transfers pressure to different parts of the body and would reduce the chances of skin breakdown. A waterbed (option 5) distributes pressure more evenly than a regular mattress and, thus, actually reduces the chances of skin breakdown. **Cognitive Level:** Remembering. **Client Need:** Health Promotion and Maintenance. **Nursing Process:** Assessment. **Learning Outcome:** 36-1.
9. **Answer:** 1, 2, and 4. **Rationale:** To irrigate a wound, the nurse uses clean gloves to remove the old dressing and to hold the basin collecting the irrigating fluid plus sterile gloves to apply the new dressing. A 60-mL syringe is the correct size to hold the volume of irrigating solution plus deliver safe irrigating pressure. The irrigation fluid should be room or body temperature—certainly not refrigerated. Forceps may be used to remove or apply a dressing but are not required for irrigation. **Cognitive Level:** Remembering. **Client Need:** Physiological Integrity. **Nursing Process:** Planning. **Learning Outcome:** 36-13b.
10. **Answer:** 2. **Rationale:** The knot of the triangle sling must be kept off the spinal processes because this would be uncomfortable and put unnecessary pressure on the vertebrae. The elbow should be flexed slightly less than 80° (not >90° as in option 1) so the hand is above the elbow to prevent dependent swelling. The sling must extend past the wrist in order to support the hand. Although the sling must be removed to check for circulation and skin integrity, every 2 hours (option 4) is unnecessarily frequent and impractical. **Cognitive Level:** Remembering. **Client Need:** Physiological Integrity. **Nursing Process:** Evaluation. **Learning Outcome:** 36-13c.

Chapter 37: Perioperative Nursing

1. **Answer:** 3. **Rationale:** These tests are specific to liver function. Option 1 evaluates fluid and electrolyte status. Option 2 evaluates renal status; option 4 evaluates nutritional status. **Cognitive Level:** Analyzing. **Client Need:** Physiological Integrity. **Nursing Process:** Assessment. **Learning Outcome:** 37-3.
2. **Answer:** 2. **Rationale:** Grieving is the state in which an individual experiences reactions in response to an expected significant loss. The definition for option 1 is "confusion in mental picture of one's self" and is often characterized by negative responses such as shame, embarrassment, guilt, or revulsion. Option 3, fear, is usually characterized by feelings of dread, fright, apprehension, or alarm. Ineffective coping, option 4, is usually characterized by verbalization of inability to cope or ask for help, inappropriate use of defense mechanisms, or inability to meet role expectations. **Cognitive Level:** Applying. **Client Need:** Psychological Integrity. **Nursing Process:** Diagnosis. **Learning Outcome:** 37-4.
3. **Answer:** 4. **Rationale:** Option 1 is incorrect because of the ASA guidelines for preoperative fasting. Option 2 is incorrect because clients are taught how to cough and also how to splint their incision to prevent complications. Option 3 is incorrect because anticoagulants are discontinued a few days before surgery to avoid excessive bleeding postoperatively. **Cognitive Level:** Applying. **Client Need:** Physiological Integrity. **Nursing Process:** Evaluation. **Learning Outcome:** 37-6.
4. **Answer:** 2. **Rationale:** The symptoms describe decreased cardiac output and not any of the other listed complications. **Cognitive Level:** Applying. **Client Need:** Physiological Integrity. **Nursing Process:** Assessment. **Learning Outcome:** 37-10.
5. **Answer:** 3. **Rationale:** Options 1 and 2 are incorrect because the client is still recovering from the anesthesia used during surgery. Option 4 is incorrect because pain usually decreases after the second or third postoperative day. **Cognitive Level:** Applying. **Client Need:** Physiological Integrity. **Nursing Process:** Implementation. **Learning Outcome:** 37-10.
6. **Answer: Splinting. Rationale:** If the incision is painful when the client coughs, splinting the abdomen may reduce the pain. **Cognitive Level:** Remembering. **Client Need:** Physiological Integrity. **Nursing Process:** Implementation. **Learning Outcome:** 37-6.
7. **Answer:** 4. **Rationale:** The tongue can obstruct the airway in a semiconscious client. Repositioning in the side-lying position with the face slightly down will help prevent occlusion of the pharynx and also allow drainage of mucus out of the mouth. Option 1 is incorrect because a pillow under the head increases the risk of aspiration or airway obstruction. Because the problem is airway obstruction, actions to promote an open airway are most appropriate. The nurse would want to keep the airway in place (option 2). The problem is obstruction, not

percentage of available oxygen (option 3). **Cognitive Level:** Applying. **Client Need:** Physiological Integrity. **Nursing Process:** Implementation. **Learning Outcome:** 37-9.

8. **Answer:** 1 and 3. **Rationale:** Anesthetics, narcotics, fasting, and inactivity all inhibit peristalsis. Oral fluids and food are started after the return of peristalsis. The client may feel hungry but peristalsis may not be present. The other options are important but not related specifically to advancing the client's diet. **Cognitive Level:** Applying. **Client Need:** Physiological Integrity. **Nursing Process:** Assessment. **Learning Outcome:** 37-9.
9. **Answer: Safety. Rationale:** The client's protective reflexes are compromised, especially with general anesthesia. Thus, the perioperative nurse needs to maintain the client's safety during surgery. **Cognitive Level:** Analyzing. **Client Need:** Safe, Effective Care Environment. **Nursing Process:** Planning. **Learning Outcome:** 37-5.
10. **Answer:** 2, 3, and 5. **Rationale:** Option 1 is incorrect because sterile technique is used. The suture material that is visible is in contact with bacteria and must not be pulled beneath the skin during removal (option 4). **Cognitive Level:** Applying. **Client Need:** Physiological Integrity. **Learning Outcome:** 37-12e.

Chapter 38: Sensory Perception

1. **Answer:** 4. **Rationale:** A sudden, unexpected admission for surgery may involve many experiences (e.g., lab work, x-rays, signing of forms) while the client is in pain or some form of discomfort. The time for orientation will thus be lessened. After surgery, the client may be in pain and possibly in a critical care setting. Options 1 and 2 reflect a greater risk for sensory deprivation, and option 3 is a normal activity for a teenager. **Cognitive Level:** Applying. **Client Need:** Psychosocial Integrity. **Nursing Process:** Evaluation. **Learning Outcome:** 38-3.
2. **Answer:** 3. **Rationale:** The transfer to a different setting can change the amount or patterning of incoming stimuli accompanied by a diminished, exaggerated, distorted, or impaired response to such stimuli. The onset of restlessness and agitation is a characteristic of acute confusion. Options 1 and 2: There is no evidence of longstanding or progressive deterioration of intellect and personality. Option 4: *Disturbed Thought Processes* is applied when cognitive abilities (e.g., dementia) interfere with the ability to accurately interpret stimuli. **Cognitive Level:** Applying. **Client Need:** Psychosocial Integrity. **Nursing Process:** Diagnosis. **Learning Outcome:** 38-6.
3. **Answer:** 2. **Rationale:** Because of the paraplegia (paralysis of lower body), the client is unable to feel discomfort. The client will be taught to lift self using chair arms every 10 minutes if possible. Option 1 is an actual problem versus a potential problem. In option 3, the client wears glasses that help correct the poor vision. Option 4 is more of a *Risk for Injury* diagnosis. **Cognitive Level:** Applying. **Client Need:** Psychosocial Integrity. **Nursing Process:** Diagnosis. **Learning Outcome:** 38-6.
4. **Answer:** 2. **Rationale:** This client could use an assistive device that flashes a light when the doorbell rings. Option 1 relates to safety of the environment rather than sensory alteration. Options 3 and 4 reflect how the client adapts to the sensory alteration. **Cognitive Level:** Analyzing. **Client Need:** Safe, Effective Care Environment. **Nursing Process:** Evaluation. **Learning Outcome:** 38-7.
5. **Answer:** 4. **Rationale:** Option 4 is the only response that helps orient the client and treats the client with respect. **Cognitive Level:** Applying. **Client Need:** Psychosocial Integrity. **Nursing Process:** Implementation. **Learning Outcome:** 38-7.
6. **Answer:** 1, 3, and 4. **Rationale:** Options 2 and 5 relate to interventions for a client with a hearing impairment. **Cognitive Level:** Applying. **Client Need:** Psychosocial Integrity. **Nursing Process:** Implementation. **Learning Outcome:** 38-7.
7. **Answer:** 3. **Rationale:** A disorganized, cluttered environment increases confusion. Option 1: Keeping the room well lit during waking hours promotes adequate sleep at night. It is important to eliminate unnecessary noise (option 2). Client does not meet the standard criteria for restraint application (option 4). **Cognitive Level:** Applying. **Client Need:** Safe, Effective Care Environment. **Nursing Process:** Implementation. **Learning Outcome:** 38-8.
8. **Answer:** 2, 4, and 5. **Rationale:** Options 1 and 3 are clinical signs of sensory overload. **Cognitive Level:** Remembering. **Client Need:** Psychosocial Integrity. **Nursing Process:** Assessment. **Learning Outcome:** 38-3.
9. **Answer:** Identifying taste: 5; Stereognosis: 3; Snellen chart: 1; Identifying aromas: 4; Tuning fork: 2. **Cognitive Level:** Remembering. **Client Need:** Health Promotion and Maintenance. **Nursing Process:** Assessment. **Learning Outcome:** 38-4.
10. **Answer:** 1. **Rationale:** The amplified telephone helps with hearing and provides a means for communicating with others. Option 2 refers to a tactile impairment. Option 3 relates to a visual impairment, and option 4 an olfactory impairment. **Cognitive Level:** Applying. **Client Need:** Psychosocial Integrity. **Nursing Process:** Planning. **Learning Outcome:** 38-7.

Chapter 39: Self-Concept

1. **Answer:** 1. **Rationale:** Sally has an inappropriate view of her physical self, which is body image. Personal identity is a sense of uniqueness (option 2); self-expectation consists of those things one believes the self should be able to do (option 3); and core self-concept includes the most vital central beliefs about one's identity (option 4). **Cognitive Level:** Applying. **Client Need:** Psychosocial Integrity. **Nursing Process:** Diagnosing. **Learning Outcome:** 39-2.
2. **Answer:** 3. **Rationale:** This is role conflict—several different roles are competing for the person's time, energy, and abilities. Role ambiguity results when there are unclear expectations of the role (option 1). Role strain exists when there are feelings of inadequacy in performing a role (option 2). Role enhancement is a nursing intervention (option 4). **Cognitive Level:** Understanding. **Client Need:** Psychosocial Integrity. **Nursing Process:** Diagnosing. **Learning Outcome:** 39-2.
3. **Answer:** 2. **Rationale:** This is a realistic and measurable outcome. Restored self-esteem is vague and not measurable (option 1). Teaching is an intervention, not an outcome (option 3). Decreased preoccupation with altered self relates to body image rather than self-esteem (option 4). **Cognitive Level:** Applying. **Client Need:** Psychosocial Integrity. **Nursing Process:** Planning. **Learning Outcome:** 39-6.
4. **Answer:** 1. **Rationale:** This response encourages the client to say more and focuses on the positive. Option 2 is condescending and closes the discussion. Both options 3 and 4 ignore the emotional component of the client's statement and do not address the person's feelings of worthlessness. **Cognitive Level:** Applying. **Client Need:** Psychosocial Integrity. **Nursing Process:** Implementation. **Learning Outcomes:** 39-6; 39-7.
5. **Answer:** 4. **Rationale:** A person who follows the crowd is demonstrating unsuccessful resolution of this task. Successful resolution would result in assertion of independence (option 1). Inability to express desires is symptomatic of unresolved toddlerhood autonomy versus shame and doubt (option 2), while difficulty being a team player suggests unresolved early school-age industry versus inferiority (option 3). **Cognitive Level:** Understanding. **Client Need:** Psychosocial Integrity. **Nursing Process:** Assessment. **Learning Outcome:** 39-1.
6. **Answer:** 3. **Rationale:** Self-awareness consists of the relationship between own and others' perceptions of the person. The other options reflect only how the nurse sees himself or herself. **Cognitive Level:** Analyzing. **Client Need:** Psychosocial Integrity. **Nursing Process:** Evaluation. **Learning Outcome:** 39-2.
7. **Answer:** 1. **Rationale:** A person who perceives herself primarily in terms of relationships with others must have the ability to perform those roles considered in planning care. Although it may seem

important for her to develop outside interests, she may not be able to do this, especially with a new diagnosis of a chronic condition. It is not mandatory for the family to be present during care planning, although items impacting their lives should be validated with them before the plan is finalized. Psychological counseling is not automatically indicated unless her role performance is unhealthy. **Cognitive Level:** Analyzing. **Client Need:** Psychosocial Integrity. **Nursing Process:** Planning. **Learning Outcomes:** 39-4; 39-6.

8. **Answer:** 2 and 5. **Rationale:** A person with chronic low self-esteem often is able to only make negative statements about self. The client would have difficulty confronting authority (option 1). Option 3 relates to role performance. Option 4 is incorrect because the client would have difficulty achieving even common/realistic goals and is not likely to set extremely high goals. Option 6, sleeping, is generally not impaired with low self-esteem. **Cognitive Level:** Applying. **Client Need:** Psychosocial Integrity. **Nursing Process:** Diagnosing. **Learning Outcome:** 39-5.
9. **Answer:** 2 and 3. **Rationale:** The client with poor self-concept should be encouraged to say positive self-statements and minimize negative ones. Such clients should not be encouraged to compare themselves with others (option 1). Having them care for others can be a very therapeutic intervention for such individuals (option 4). They should be given realistic and normal levels of expectations for their behavior. **Cognitive Level:** Applying. **Client Need:** Psychosocial Integrity. **Nursing Process:** Implementation. **Learning Outcome:** 39-6.
10. **Answer:** 4. **Rationale:** The social self is how one is perceived by others and is difficult, if not impossible, to influence since the client does not control the viewpoints of other persons. With planning, the number of the client's resources can be increased, self-knowledge improved, and core self-concept broadened since these are within the client's control. **Cognitive Level:** Analyzing. **Client Need:** Psychosocial Integrity. **Nursing Process:** Planning. **Learning Outcome:** 39-3.

Chapter 40: Sexuality

1. **Answer:** 4. **Rationale:** Clients still may feel shame and discomfort regarding sexuality. Most people assume that providers have a great deal of information (option 1). Many clients have questions and concerns (option 2). Although talking with someone of the same gender may make it easier for some women, it is not a requirement for assessment and intervention (option 3). **Cognitive Level:** Analyzing. **Client Need:** Health Promotion and Maintenance. **Nursing Process:** Planning. **Learning Outcome:** 40-1.
2. **Answer:** 2. **Rationale:** Transgender persons' anatomic gender is not the same gender as they feel themselves to be. Option 1 is the definition of intersex. Option 3 is the definition of bisexuality. Gender identity is a lifelong belief and not altered by an acute condition (option 4). **Cognitive Level:** Understanding. **Client Need:** Health Promotion and Maintenance. **Nursing Process:** Implementation. **Learning Outcome:** 40-3.
3. **Answer:** 4. **Rationale:** Masturbation is a normal activity for most people and assists with self-exploration of sexuality. There is no evidence that masturbation interferes with academic achievement (option 2). Individuals masturbate at all ages of life (option 3). **Cognitive Level:** Understanding. **Client Need:** Health Promotion and Maintenance. **Nursing Process:** Implementation. **Learning Outcome:** 40-5.
4. **Answer:** 2. **Rationale:** Orgasmic response and sex drive are often inhibited by antidepressants. If the depression lifts, there may be an improvement but the focus in option 1 is on the partner rather than where it should be—on the client. Retrograde ejaculation is associated with removal of the prostate gland (option 3). Skin hypersensitivity is not a side effect of antidepressant medications (option 4). **Cognitive Level:** Applying. **Client Need:** Health Promotion and Maintenance. **Nursing Process:** Planning. **Learning Outcome:** 40-8.
5. **Answer:** 4 **Rationale:** More information is needed before intervening. Also, the client needs the opportunity to express her feelings. Option 1 is an unprofessional response and false reassurance. The ANA Code of Ethics indicates that clients are entitled to a timely and appropriate response to their needs. Option 2 suggests postponing the discussion and that the primary care provider is the better person to deal with her concerns, which is untrue. Option 3 represents feeding into her negative self-concept and inappropriate self-disclosure. **Cognitive Level:** Applying. **Client Need:** Health Promotion and Maintenance. **Nursing Process:** Implementation. **Learning Outcome:** 40-4.
6. **Answer:** 1. **Rationale:** Dyspareunia is painful intercourse. Knowledge of the partner's awareness will contribute to resolution. Involuntary vaginal spasms are called vaginismus (option 2). Painful menstruation is called dysmenorrhea (option 3). Breast swelling can occur during portions of the menstrual cycle but is unrelated to painful intercourse (option 4). **Cognitive Level:** Analyzing. **Client Need:** Health Promotion and Maintenance. **Nursing Process:** Assessment. **Learning Outcomes:** 40-6; 40-7.
7. **Answer:** 3. **Rationale:** Antihypertensive medications are known to affect sexual functioning in several different ways, so some focused history questions would be indicated. There is no evidence of a relationship between sexual functioning and anti-inflammatories, hypnotics, or antihistamines (options 1, 2, and 4). However, the underlying condition that leads the client to take other medications could be important. Side effects of any medication could impact sexual interest or energy level, which reinforces the importance of including taking a sexual health history for all clients. **Cognitive Level:** Applying. **Client Need:** Health Promotion and Maintenance. **Nursing Process:** Assessment. **Learning Outcomes:** 40-6; 40-7; 40-8.
8. **Answer:** 2. **Rationale:** LI includes instructing clients regarding when sexual activity is safe or unsafe. P involves giving permission to be sexual beings and to discuss issues (option 1). SS includes specific suggestions that help clients promote optimal functioning (option 3). Intensive therapy (IT) requires special skills offered by a nurse specialist or sex therapist (option 4). **Cognitive Level:** Analyzing. **Client Need:** Health Promotion and Maintenance. **Nursing Process:** Implementation. **Learning Outcomes:** 40-1; 40-9.
9. **Answer:** 4. **Rationale:** A change in sexual frequency is not abnormal but may suggest an opportunity for enhanced knowledge if he desires. It does not suggest pathology or disturbed body image (options 1 and 2). It would be incorrect to assume his lifestyle is sedentary merely because the frequency of his sexual activity has decreased (option 3). Further assessment of the reason for the decrease in sexual activity is indicated. **Cognitive Level:** Applying. **Client Need:** Health Promotion and Maintenance. **Nursing Process:** Diagnosing. **Learning Outcomes:** 40-1; 40-2; 40-4; 40-8.
10. **Answer:** 3. **Rationale:** The key term is *ineffective*. If the suggestions given by the nurse are ineffective in reaching the desired goals, the client may require intervention from someone with more specialized skills. Verbalizing constructive methods of modifying sexual activity are healthy responses and do not require a more skilled therapist (option 1). The generalist nurse can refer the client to education and support groups (option 2). Experimenting with new sexual activities is probably a healthy direction and does not suggest the need for referral (option 4). **Cognitive Level:** Understanding. **Client Need:** Health Promotion and Maintenance. **Nursing Process:** Evaluation. **Learning Outcome:** 40-8.

Chapter 41: Spirituality

1. **Answer:** 4. **Rationale:** Options 1 and 2 involve assessment and diagnosis, not planning. Option 3, simply keeping the client busy, does not necessarily contribute to feeling fulfilled or purposeful. **Cognitive Level:** Applying. **Client Need:** Psychosocial Integrity. **Nursing Process:** Planning. **Learning Outcomes:** 41-1; 41-3; 41-6.

2. **Answer:** 3. **Rationale:** The best initial response is to assess. Option 1 may be interpreted as distancing by the client. Option 2 inserts the nurse's experience, which is generally inappropriate. Option 4 is not appropriate for someone in spiritual distress. **Cognitive Level:** Analyzing. **Client Need:** Psychosocial Integrity. **Nursing Process:** Evaluation. **Learning Outcomes:** 41-5; 41-6.
3. **Answer:** 3. **Rationale:** The key term is *full*. Option 1 would be inadequate; option 2 is only partial presencing; and option 4 is transcendent presencing. **Cognitive Level:** Remembering. **Client Need:** Psychosocial Integrity. **Nursing Process:** Implementation. **Learning Outcome:** 41-6.
4. **Answer:** 3. **Rationale:** This client portrays no distress (option 1) or risk for distress (option 2), but rather the potential for enhanced spiritual health as a result of the transformative illness experience. Option 4 is not a valid diagnosis. **Cognitive Level:** Applying. **Client Need:** Psychosocial Integrity. **Nursing Process:** Diagnosis. **Learning Outcomes:** 41-1; 41-2.
5. **Answer:** 4. **Rationale:** Assessment is always the first step of the process of spiritual caregiving or any nursing activity. Options 1, 2, and 3 may not respect the spiritual beliefs of either the nurse or the client. While an assessment may lead the nurse to share personal beliefs, these are never urged on the client. **Cognitive Level:** Applying. **Client Need:** Psychosocial Integrity. **Nursing Process:** Implementation. **Learning Outcomes:** 41-1; 41-4; 41-7.
6. **Answer:** 3. **Rationale:** Many older adults are religious and spiritually aware. Options 1, 2, and 4 are disputed by recent research evidence. **Cognitive Level:** Remembering. **Client Need:** Psychosocial Integrity. **Nursing Process:** Implementation. **Learning Outcomes:** 41-1; 41-3.
7. **Answer:** 3. **Rationale:** Options 1, 2, and 4 are potentially uncaring or unethical. Jehovah's Witnesses have a well-developed network of representatives who can be called to explain and explore medical options with their fellow believers and medical staff. **Cognitive Level:** Analyzing. **Client Need:** Psychosocial Integrity. **Nursing Process:** Evaluation. **Learning Outcomes:** 41-1; 41-4; 41-6.
8. **Answer:** 2. **Rationale:** Residing in the SNF likely will curb the client's participation in her church. Options 1, 3, and 4 are incorrect because it is not known if the relocation or an alteration in religious practice will affect her spiritual well-being in either a negative or positive way. **Cognitive Level:** Applying. **Client Need:** Psychosocial Integrity. **Nursing Process:** Diagnosis. **Learning Outcomes:** 41-1; 41-2; 41-5.
9. **Answer:** 4. **Rationale:** Recognizing personal emotional responses to events that parallel those experienced by a client, allows a nurse to identify an empathic response to a client's spiritual or emotional need. Options 1, 2, and 3 fail to show a nurse drawing deep to recognize inner experience that can inform empathy. **Cognitive Level:** Applying. **Client Need:** Psychosocial Integrity. **Nursing Process:** Implementation **Learning Outcome:** 41-8.
10. **Answer:** 1. **Rationale:** Although the mother is arguably angry, it is unknown whether this anger is impairing her religiosity or her coping. More data are needed before determining that either option 2 or 3 is the best diagnosis. The mother is experiencing distress versus being at risk for it (option 4). **Cognitive Level:** Applying. **Client Need:** Psychosocial Integrity. **Nursing Process:** Diagnosis. **Learning Outcomes:** 41-2; 41-5.

Chapter 42: Stress and Coping

1. **Answer:** 3. **Rationale:** Taking on additional work would only serve as an additional stressor. In addition, a nurse who has not begun resolution of feelings is unlikely to be able to meet clients' emotional needs. Effective coping may include verbalizing feelings (one-on-one or in groups) or initiating distractions (options 1, 2, and 4). Of course, the nurse may not disclose confidential information to her partner or others who would not already have this information. **Cognitive Level:** Analyzing. **Client Need:** Psychosocial Integrity. **Nursing Process:** Evaluation. **Learning Outcome:** 42-6.
2. **Answer:** 4. **Rationale:** Wearing glasses is another example of beginning a new strategy to assist with what will be a lifelong health need even though it is not necessarily a desired change. Interviewing for a job (option 1) is a very short-lived situational stressor. Coping strategies effective while a teenager may not be relevant at age 50 (option 2). Experiencing the stress of a divorce is a social/role stressor quite unlike that of a health problem (option 3). **Cognitive Level:** Analyzing. **Client Need:** Psychosocial Integrity. **Nursing Process:** Assessment. **Learning Outcome:** 42-9.
3. **Answer:** 1. **Rationale:** In the transaction model, stress is a very personal experience and varies widely among individuals. Option 2 represents the stimulus model, and option 3 represents the response model of stress. In option 4, external resources and support are a factor in determining stress levels but omit the key aspects of internal/personal influences. **Cognitive Level:** Applying. **Client Need:** Psychosocial Integrity. **Nursing Process:** Assessment. **Learning Outcome:** 42-1.
4. **Answer:** 3. **Rationale:** With stress, respirations increase, pupils dilate, peripheral blood vessels constrict, and the heart rate increases. **Cognitive Level:** Applying. **Client Need:** Psychosocial Integrity. **Nursing Process:** Assessment. **Learning Outcome:** 42-3.
5. **Answer:** 2. **Rationale:** It is too soon for *Caregiver Role Strain* to be an appropriate nursing diagnosis—especially since the child is not at home. *Ineffective Denial* and *Fear* are common reactions to this type of threat (options 1 and 3). The father demonstrates *Compromised Family Coping* by his difficulty in being supportive (option 4). **Cognitive Level:** Applying. **Client Need:** Psychosocial Integrity. **Nursing Process:** Diagnosing. **Learning Outcome:** 42-8.
6. **Answer:** 1, 3, and 4. **Rationale:** Common stressors among young adults include marriage, starting a new job, and leaving the parental home. Stressors from aging parents are more common among middle-aged adults (option 2); decreased physical abilities is a stressor in older adults (option 5); and changing body structure serves as a stressor in both children and older adults (option 6). **Cognitive Level:** Understanding. **Client Need:** Psychosocial Integrity. **Nursing Process:** Planning. **Learning Outcome:** 42-7.
7. **Answer:** 2. **Rationale:** All four areas of health promotion strategies may be important, but for this client sleep is likely to be the most adversely affected by travel in which changing time zones and unfamiliar sleeping quarters are common. It is easier for clients to adapt to modifying exercise (option 1), nutrition (option 3), and time management (option 4) during travel than it is to control sleep. Thus, it becomes the most important area requiring intervention to avoid worsening the existing stress. **Cognitive Level:** Applying. **Client Need:** Psychosocial Integrity. **Nursing Process:** Implementation. **Learning Outcome:** 42-9.
8. **Answer:** 4. **Rationale:** Unless the nurse feels in physical danger, it is important to remain with the client, allow the anger to dissipate, and then begin assessing the cause. Leaving the room provides no therapeutic action (option 1). Option 2 may be considered setting limits, which can be helpful, but cannot occur until the client is calmer. All behavior is meaningful; it is inappropriate to ignore the client's behavior (option 3). **Cognitive Level:** Applying. **Client Need:** Psychosocial Integrity. **Nursing Process:** Implementation. **Learning Outcome:** 42-9.
9. **Answer:** 1. **Rationale:** This client is exhibiting severe anxiety and, therefore, learning is impaired but not impossible (see Table 42–2). Therefore, it is most appropriate for the nurse to teach only those things that are critical for the client to learn at this time. The nurse also recognizes that learning may not be retained at this level of anxiety and plans to reinforce the teaching when the client is less anxious. **Cognitive Level:** Applying. **Client Need:** Psychosocial Integrity. **Nursing Process:** Planning. **Learning Outcome:** 42-4.
10. **Answer:** 1, 2, and 4. **Rationale:** Compensation (option 1) may allow the client to overcome a weakness. Displacement (option 2) allows the client to express feelings safely. Repression (option 4) protects the

client from further emotional trauma until able to cope. Minimization (option 3) prevents the client from accepting responsibility for actions. Regression (option 5) returns the client to a lower/previous developmental level. *Note:* Each of these may be more or less effective defenses depending on the exact context of the situation. **Cognitive Level:** Understanding. **Client Need:** Psychosocial Integrity. **Nursing Process:** Assessment. **Learning Outcome:** 42-5.

Chapter 43: Loss, Grieving, and Death

1. **Answer:** 1, 2, and 3. **Rationale:** Correct answers include abbreviated (normal grief that is briefly experienced), anticipatory grief (experienced before the loss/death but appropriate), and disenfranchised grief (the emotions are felt privately, just not expressed in public). Unhealthy/abnormal types of grief include complicated grief (option 4) in several different forms: Unresolved grief is extended in length and severity (option 5). With inhibited grief, symptoms are suppressed, and other effects, including somatic, are experienced instead (option 6). **Cognitive Level:** Remembering. **Client Need:** Psychosocial Integrity. **Nursing Process:** Diagnosing. **Learning Outcome:** 43-2.
2. **Answer:** 2. **Rationale:** When possible, modifications of policy that demonstrate respect for individual differences should be explored. The primary care provider is in no position to modify the implementation of hospital policy (option 3). Utilizing an empty room and a staff member for a deceased client is an inappropriate use of resources (option 4). **Cognitive Level:** Analyzing. **Client Need:** Psychosocial Integrity. **Nursing Process:** Planning. **Learning Outcome:** 43-8.
3. **Answer:** 1. **Rationale:** This statement acknowledges the family's grief simply. Avoid statements that may be interpreted as overly impersonal (option 2), false support (option 3), or harsh (option 4). **Cognitive Level:** Application. **Client Need:** Psychosocial Integrity. **Nursing Process:** Implementation. **Learning Outcome:** 43-8.
4. **Answer:** 3. **Rationale:** Until children are about 5 years old, they believe that death is reversible. Between ages 5 and 9, the child knows death is irreversible but believes it can be avoided (option 2). Between 9 and 12 years of age, the child recognizes that he, too, will someday die (option 3). At 12 to 18 years old, the child builds on previous beliefs and may fear death, but often pretends not to care about it (option 4). **Cognitive Level:** Remembering. **Client Need:** Psychosocial Integrity. **Nursing Process:** Assessment. **Learning Outcome:** 43-4.
5. **Answer:** 4. **Rationale:** Adaptive responses indicate the client can put the loss into perspective and begin to develop strategies for coping with the loss. Although the other options are responses the client might likely give and feel, and are not pathologic, they do not demonstrate movement toward a goal of adaptation nor problem solving. **Cognitive Level:** Application. **Client Need:** Psychosocial Integrity. **Nursing Process:** Evaluation. **Learning Outcome:** 40-3.
6. **Answer:** 1. **Rationale:** The nurse needs to assess and explore the meaning of the client's crying. Options 2 and 4 leap to assumptions about the meaning of the tears and ignore the possibility of the client's distress. Option 3 suggests that the client has the same feelings as the nurse, which may not be correct. **Cognitive Level:** Application. **Client Need:** Psychosocial Integrity. **Nursing Process:** Implementation. **Learning Outcome:** 43-3.
7. **Answer:** 4. **Rationale:** Quality of life is determined by the client and expressed in terms of his or her satisfaction with a variety of aspects of life. Although being able to pay for care (option 1), having apparent spiritual peace (option 2), and absence of physiological complications (option 3) may appear to contribute to good quality of life, only the client's expression of satisfaction can provide the data the nurse requires to evaluate the goal. **Cognitive Level:** Analyzing. **Client Need:** Psychosocial Integrity. **Nursing Process:** Evaluation. **Learning Outcome:** 43-5.
8. **Answer:** 4. **Rationale:** To plan with and assist the family, the nurse needs more data regarding the family's reactions to their loss. Information on issues such as insurance coverage (option 1) can wait until later and may be more appropriately the responsibility of social services rather than the nurse. It is important for the nurse to determine their understanding of their injuries but they are stated as minor (option 2). Once the nurse has assessed the family's responses it will be important to determine availability of outside resources to assist them (option 3). **Cognitive Level:** Analyzing. **Client Need:** Psychosocial Integrity. **Nursing Process:** Assessment. **Learning Outcome:** 43-1.
9. **Answer:** 3. **Rationale:** If there is no heartbeat, the client has died. Before death, the blood pressure may not be able to be heard on auscultation because it is very low (option 1). Loss of the gag reflex (option 2) occurs with loss of muscle tone but can exist in many circumstances unrelated to dying. Vasodilation and pooling of fluids at the end of life may cause cool and darkened extremities but these are not reliable signs of death (option 4). **Cognitive Level:** Comprehension. **Client Need:** Physiological Integrity. *Nursing Process*: Diagnosing. **Learning Outcome:** 43-6.
10. **Answer:** 1. **Rationale:** Assisting the client to die with dignity involves allowing the client to participate in and choose the direction of the remainder of his or her life. Sharing the nurse's own views about life after death (option 2) does not enhance client dignity. The nurse should not assume that avoiding talking about dying and emphasizing the present (option 3) is therapeutic for the client. Only if the client wishes to have someone else perform care is doing so supporting death with dignity (option 4). Otherwise, it may have the opposite effect. **Cognitive Level:** Application. **Client Need:** Psychological Integrity. **Nursing Process:** Planning. **Learning Outcome:** 43-7.

Chapter 44: Activity and Exercise

1. **Answer:** 2. **Rationale:** A key word in the question is *base*, and the feet provide this foundation. Leaning backward actually decreases balance (option 1), and tensing abdominal muscles alone (option 3) or bending the knees (option 4) does not affect the base of support. **Cognitive Level:** Applying. **Client Need:** Health Promotion and Maintenance. **Nursing Process:** Implementation. **Learning Outcome:** 44-7.
2. **Answer:** 1, 3, and 5. **Rationale:** Isotonic exercise increases muscle tone, mass, and strength, maintains joint flexibility, and improves circulation. During isotonic exercise, both heart rate and cardiac output quicken to increase blood flow to all parts of the body (option 4). Little or no change in blood pressure occurs (option 2). **Cognitive Level:** Remembering. **Client Need:** Physiological Integrity. **Nursing Process:** Planning. **Learning Outcome:** 44-2.
3. **Answer:** 1. **Rationale:** Vital signs that do not return to baseline 5 minutes after exercising indicate intolerance of exercise at that time. This is a real problem, not "at risk for," as in option 2. There is no evidence that the client requires assistance (impaired mobility, option 3), or is immobile (disuse syndrome, option 4). **Cognitive Level:** Analyzing. **Client Need:** Physiological Integrity. **Nursing Process:** Diagnosis. **Learning Outcome:** 44-6.
4. **Answer:** 3. **Rationale:** Although the crutches (or cane) are always used along with the weaker leg, the weaker leg should go down the stairs first. The stronger leg can support the body as the weaker leg moves forward. All of the other statements are correct. **Cognitive Level:** Analyzing. **Client Need:** Physiological Integrity. **Nursing Process:** Evaluation. **Learning Outcome:** 44-9.
5. **Answer:** 4. **Rationale:** When the client performs the movements systematically, using the same sequence during each session, the nurse can evaluate that the teaching was understood and is successful. When performing active ROM the client should exercise to the point of slight resistance, but never past that point of resistance in order to prevent further injury (option 1). The client should perform each exercise at least three times, not just once (option 2). The client should perform each series of exercises twice daily, not just once per day (option 3).

Cognitive Level: Applying. **Client Need:** Physiological Integrity. **Nursing Process:** Evaluation. **Learning Outcome:** 44-8.

6. **Answer:** 1. **Rationale:** Normal gait involves a level gaze, an initial rotation beginning in the spine, heel strike with follow-through to the toes, and opposite arm and leg swinging forward. **Cognitive Level:** Applying. **Client Need:** Physiological Integrity. **Nursing Process:** Assessment. **Learning Outcome:** 44-5.
7. **Answer:** 1, 4, and 5. **Rationale:** Eating and bathing will flex the elbow joint, and grasping and manipulating utensils to eat and write will take the thumb through its normal ROM. Walking flexes the hip. Shaving and eating require elbow flexion, not extension (option 2). Writing brings the fingers toward the inner aspect of the forearm, thus flexing the wrist joint (option 3). **Cognitive Level:** Applying. **Client Need:** Health Promotion and Maintenance. **Nursing Process:** Implementation. **Learning Outcome:** 44-1.
8. **Answer:** 3. **Rationale:** It is prudent for nurses to understand and use proper body mechanics at all times to decrease risk, while keeping in mind the importance of assistive devices and help from other staff. While it is generally accepted that proper body mechanics alone will not prevent injury, many work settings do not yet have "no manual lift" and "no solo lift" policies and resources in place. **Cognitive Level:** Analyzing. **Client Need:** Safe, Effective Care Environment. **Nursing Process:** Implementation. **Learning Outcome:** 44-7.
9. **Answer:** 4. **Rationale:** Placing the client in a safe position is the best maneuver. Leaving the client creates unsafe conditions because the client may faint before being able to return to her room (options 1 and 2). Rapid, shallow breathing (hyperventilation) may increase the dizziness (option 3). **Cognitive Level:** Applying. **Client Need:** Safe, Effective Care Environment. **Nursing Process:** Implementation. **Learning Outcome:** 44-10g.
10. **Answer:** 2. **Rationale:** The reddened area of the skin can lead to skin breakdown. The other options are within normal limits. **Cognitive Level:** Applying. **Client Need:** Physiological Integrity. **Nursing Process:** Assessment. **Learning Outcome:** 44-3g.

Chapter 45: Sleep

1. **Answer:** 2. **Rationale:** This is the brainstem where the reticular formation (and RAS) is located and which integrates sensory information from the peripheral nervous system and relays the information to the cerebral cortex. An intact cerebral cortex and reticular formation are necessary for the regulation of sleep and waking states. **Cognitive Level:** Remembering. **Client Need:** Physiological Integrity. **Nursing Process:** Assessment. **Learning Outcome:** 45-1.
2. **Answer:** 4. **Rationale:** Most clients with sleep apnea report excessive daytime sleepiness. If they don't volunteer this, clients should be asked if they fall asleep or struggle to stay awake at work. Although cardiac arrhythmias may occur, they are usually only detectable during a sleep study, and thus the client would not be aware of them (option 1). Nasal obstruction is rarely the cause of sleep apnea or a complaint of clients with sleep apnea (option 2). There are many causes of chest pain, and this is unlikely to be something reported by clients with sleep apnea unless they have underlying cardiac disease (option 3). **Cognitive Level:** Analyzing. **Client Need:** Physiological Integrity. **Nursing Process:** Assessment. **Learning Outcome:** 45-6.
3. **Answer:** 2. **Rationale:** Falling asleep within 20 to 30 minutes is normal for adults and would represent substantial improvement in the client's difficulties. Most adults do not need to sleep 8 to 10 hours per day (option 1). Although it would be ideal to remove the source of the client's stress, he is unlikely to have a plan to pay all his bills within 5 days (option 3). Distraction or keeping busy until bedtime will not prevent the client from worrying about his bills at bedtime (option 4). **Cognitive Level:** Analyzing. **Client Need:** Physiological Integrity. **Nursing Process:** Planning. **Learning Outcome:** 45-7.
4. **Answer:** 4. **Rationale:** Suddenly stopping barbiturate sleeping pills can precipitate a dangerous withdrawal. Doses should be tapered gradually and the tapering process supervised by the client's primary care provider. **Cognitive Level:** Analyzing. **Client Need:** Physiological Integrity. **Nursing Process:** Implementation. **Learning Outcome:** 45-4.
5. **Answer:** 1. **Rationale:** Preschool children require 10 to 12 hours of sleep per night. Young children often rise early, so it is more appropriate to put the child to bed earlier in the evening. **Cognitive Level:** Analyzing. **Client Need:** Health Promotion and Maintenance. **Nursing Process:** Implementation. **Learning Outcome:** 45-3.
6. **Answer:** 1, 3, and 5. **Rationale:** It is important to find out if he is obtaining sufficient sleep. If he gets more sleep on weekends than weekdays, insufficient sleep may be the cause of his difficulties staying awake in class. It is important to determine if his symptoms are chronic (e.g., longer than 3 months) or if they are of recent onset. Some prescribed and over-the-counter medications and herbal remedies can cause sleep disturbances. Although alcohol abuse or binge drinking can cause health problems, neither is likely to cause excessive daytime sleepiness (option 2). Unless the person is sleep deprived, boring classes will not induce sleep (option 4). **Cognitive Level:** Analyzing. **Client Need:** Health Promotion and Maintenance. **Nursing Process:** Assessment. **Learning Outcome:** 45-6.
7. **Answer:** 4. **Rationale:** The client's symptoms, combined with his weight, suggest that he has obstructive sleep apnea and should be referred to a sleep disorders specialist for further evaluation. It would not be wrong to refer him to a dietitian for weight loss counseling (option 2), but being evaluated by a sleep disorders specialist is more critical. Drinking alcohol or taking sleeping pills is not advised in clients with sleep apnea because they disrupt the client's sleep patterns (option 3). **Cognitive Level:** Analyzing. **Client Needs:** Physiological Integrity. **Nursing Process:** Implementation. **Learning Outcome:** 45-5.
8. **Answer:** 1. **Rationale:** Reducing exposure to bright light in the morning, when driving home, and when going to sleep will make it easier to fall asleep after work. Exercising before going to bed will increase arousal (option 2). Caffeine consumed at the beginning of a 12-hour shift will not assist the nurse in remaining awake during the latter part of the shift (option 3). Although working in a brightly lit area will reduce drowsiness, this strategy is rarely available to nurses working the night shift; lights are often dimmed in hospital corridors and client rooms (option 4). **Cognitive Level:** Analyzing. **Client Need:** Health Promotion and Maintenance. **Nursing Process:** Implementation. **Learning Outcome:** 45-7.
9. **Answer:** 3. **Rationale:** Napping frequently reappears in older adults. Unless the person has difficulty falling asleep at night, there is no reason an individual should not be allowed to take a 15- to 20-minute nap in the early afternoon. **Cognitive Level:** Analyzing. **Client Need:** Health Promotion and Maintenance. **Nursing Process:** Implementation. **Learning Outcome:** 45-3.
10. **Answer:** 1, 3, and 4. **Rationale:** Reducing environmental noise, as well as the number of times she is disturbed for medications and vital signs, will reduce the likelihood that she will awaken during the night. Delivering necessary care at 1.5- or 3-hour intervals is consistent with multiples of the 90-minute sleep cycle. Since it is unlikely that all of the noise in the environment can be eliminated, using a fan to generate a steady background noise may help mask sounds of people talking, carts being moved through the halls, and other noise. Music is not usually recommended because it can be interesting to listen to, thus encouraging wakefulness (option 2). The room temperature needs to be satisfactory for the client. A room that is too warm is not usually conducive for sleep (option 5). **Cognitive Level:** Analyzing. **Client Need:** Physiological Integrity. **Nursing Process:** Implementation. **Learning Outcome:** 45-8.

Chapter 46: Pain Management

1. **Answer:** 3. **Rationale:** During the transduction phase, tissue injury triggers the release of biochemical mediators such as prostaglandin. Ibuprofen works by blocking the production of prostaglandin. The coanalgesic medication in option 1 would affect the modulation phase because coanalgesics inhibit the reuptake of norepinephrine and serotonin, which increases the modulation phase that helps inhibit painful ascending stimuli. Opioids block the release of neurotransmitters, particularly substance P, which stops the pain at the spinal level that occurs during the transmission phase (option 2). Distraction is best used during the perception phase when the client becomes conscious of the pain. Distraction (e.g., music, guided imagery, TV) can help direct the client's attention away from the pain (option 4). **Cognitive Level:** Applying. **Client Need:** Physiological Integrity. **Nursing Process:** Implementation. **Learning Outcome:** 46-2.
2. **Answer:** 2. **Rationale:** The client's pain intensity needs to be assessed first for effective pain management. In a postoperative client it is important to assess pain intensity frequently to manage the acute pain experience. Option 1: The most pain a person is willing to tolerate before taking action can be discussed with the client after the pain intensity has been assessed. Option 3, location of pain, is important, but it is not the priority. Option 4: This information is important but not for a client in acute pain. The priority would be to assess the pain intensity. **Cognitive Level:** Analyzing. **Client Need:** Safe, Effective Care Environment. **Nursing Process:** Assessment. **Learning Outcome:** 46-5.
3. **Answer:** 3. **Rationale:** A rating of 7 is considered severe and demands immediate attention. **Cognitive Level:** Applying. **Client Need:** Physiological Integrity. **Nursing Process:** Assessment. **Learning Outcome:** 46-5.
4. **Answer:** 1. **Rationale:** This indicates an increasing level of sedation, which can be an early sign of impending respiratory depression. Option 2 is normal. Option 3 can indicate increasing sedation; however, option 1 describes a higher level of sedation and an intervention such as notifying the primary care provider. Option 4 indicates pain management that may be tolerable for the client. **Cognitive Level:** Applying. **Client Need:** Safe, Effective Care Environment. **Nursing Process:** Implementation. **Learning Outcome:** 46-7.
5. **Answer:** 4. **Rationale:** The client's perception/intensity rating of his pain is the most important even though other signs may suggest he is not having pain. His pain rating warrants a higher dose of the as-needed (prn) morphine. With option 1, you would be undermedicating the client based on his perception or rating of the pain. Option 2: Research shows that few clients become addicted, plus there are no signs of addiction. This answer, based on the data, would lead to the client being undermedicated. Option 3 does not address the intensity as well as option 4. **Cognitive Level:** Analyzing. **Client Need:** Physiological Integrity. **Nursing Process:** Evaluation. **Learning Outcome:** 46-7.
6. **Answer:** 4. **Rationale:** Options 2 and 3 are subcategories of physiological pain (option 1). A clue to the answer is that the client has diabetes, which often leads to diabetic peripheral neuropathy. **Cognitive Level:** Analyzing. **Client Need:** Physiological Integrity. **Nursing Process:** Assessment. **Learning Outcome:** 46-1.
7. **Answer:** 2, 4, and 5. **Rationale:** Massage, heat and cold, and acupressure are cutaneous stimulation techniques that can "close" the gates and inhibit the transmission of further pain. Options 1 and 3 are pharmacologic interventions, which are important; however, they inhibit the pain during the transmission phase of nociception. **Cognitive Level:** Applying. **Client Need:** Physiological Integrity. **Nursing Process:** Implementation. **Learning Outcome:** 46-3.
8. **Answer:** 2. **Rationale:** The words *pain* or *complain* may have emotional or sociocultural meanings (options 1 and 4). It is better to ask clients if they are having any discomfort—they can then elaborate in their own words. Option 3 is too general and expects clients to report their pain without being asked. **Cognitive Level:** Applying. **Client Need:** Safe, Effective Care Environment. **Nursing Process:** Assessment. **Learning Outcome:** 46-5.
9. **Answer:** 3 and 5. **Rationale:** Older clients may deny complaints of pain because it may indicate a worsening of their condition that may threaten their independence. Older adults may use words other than *pain*. Although many perceive pain as a natural outcome of aging, it is not a natural part of aging (option 1). Pain perception may decrease (option 2) and narcotics can be used with careful monitoring by the nurse (option 4). **Cognitive Level:** Understanding. **Client Need:** Physiological Integrity. **Nursing Process:** Planning. **Learning Outcome:** 46-7.
10. **Answer:** 1. **Rationale:** Based on the information provided, the nurse needs to determine the client's understanding of the effects of pain on recovery and if the client has misconceptions about pain. Option 2 usually pertains more to chronic pain and fatigue. Options 3 and 4 could be true, but the priority is option 1. Movement enhances respiratory, cardiovascular, and GI recovery from general anesthesia and the outcomes associated with a surgical procedure. **Cognitive Level:** Analyzing. **Client Need:** Physiological Integrity. **Nursing Process:** Diagnosis. **Learning Outcome:** 46-6.

Chapter 47: Nutrition

1. **Answer:** 2. **Rationale:** A BMI of 30 to 40 indicates moderate to severe obesity. A BMI of less than 18.5 indicates underweight (option 1). The nursing diagnosis of *Overweight* is defined by a BMI of 25–29.9. (option 3). There is no evidence to support a diagnosis of *Deficient Knowledge* (option 4). **Cognitive Level:** Applying. **Client Need:** Health Promotion and Maintenance. **Nursing Process:** Diagnosing. **Learning Outcome:** 47-13.
2. **Answer:** 4. **Rationale:** This client needs more grains in the diet. The client should have 6 to 7 oz grains per day, 3 cups/week dark green vegetables, 2 cups/week orange vegetables, 3 cups/week legumes, 3 cups/week starchy vegetables, 1.5 to 2 cups fruit per day, 5 to 6 oz meat and beans per day, and 3 cups milk, yogurt, and cheese per day. **Cognitive Level:** Applying. **Client Need:** Health Promotion and Maintenance. **Nursing Process:** Planning. **Learning Outcome:** 47-5.
3. **Answer:** 2, 3, 4, 6, and 8. **Rationale:** A full liquid diet contains only liquids or foods that turn to liquid at body temperature. Pudding, juices, hard candy, Cream of Wheat cereal, and fruit smoothies are permitted on a full liquid diet. Scrambled eggs (option 1), mashed potatoes (option 5), and oatmeal cereal (option 7) are not permitted until the client advances to a soft diet. **Cognitive Level:** Applying. **Client Need:** Physiological Integrity. **Nursing Process:** Implementation. **Learning Outcome:** 47-9.
4. **Answer:** 3. **Rationale:** Gastric secretions are acidic as evidenced by a pH of less than 6. If the tube were improperly placed in the client's airway, speaking would usually be impaired (option 1). Gagging during insertion is common and does not indicate that the tube is in the stomach (option 2). Ability to easily instill fluid into the tube does not relate to its placement. The lungs would offer no resistance to the flow of liquid (option 4). **Cognitive Level:** Analyzing. **Client Need:** Physiological Integrity. **Nursing Process:** Evaluation. **Learning Outcome:** 47-10a.
5. **Answer:** 1. **Rationale:** For proper flow, the feeding container hangs 1 foot above the tube insertion. Feedings may be administered if there is less than 90 to 100 mL of residual volume (unless agency policy specifies otherwise) (option 2). To prevent or reduce the risk of aspiration, the client should be placed in Fowler's position during feeding (option 3). The feeding should be warmed to room temperature before administration to decrease cramping and diarrhea (option 4). **Cognitive Level:** Applying. **Client Need:** Physiological Integrity. **Nursing Process:** Implementation. **Learning Outcome:** 47-10c.
6. **Answer:** 1. **Rationale:** The Dietary Guidelines recommend 30 minutes of physical activity on most days of the week to achieve optimal weight.

Some individuals benefit from a low-carbohydrate diet, but no particular diet is the solution for all individuals (option 2). A reasonable diet emphasizes balance and portion control rather than forbidding or requiring any specific foods (option 3). Fresh and chemical-free foods may be healthier than preserved foods but do not automatically assist with weight loss (option 4). **Cognitive Level:** Analyzing. **Client Need:** Health Promotion and Maintenance. **Nursing Process:** Evaluation. **Learning Outcome:** 47-8.

7. **Answer:** 3. **Rationale:** Always inquire into the client's favorite foods when planning a diet. Dairy may not be indicated for this client due to the high incidence of lactose intolerance in individuals of Asian heritage (option 1). Beer can be a source of calories and, in moderation, is not harmful, and may maintain the client's satisfaction with the dietary changes. The nurse will need to assess the ability to swallow beer safely, however (option 2). Calories from lipid sources should be kept below 35% and, when enhanced wound healing is indicated (not so with a stroke), increased protein and carbohydrates are needed rather than fats (option 4). **Cognitive Level:** Applying. **Client Need:** Health Promotion and Maintenance. **Nursing Process:** Planning. **Learning Outcome:** 47-9.
8. **Answer:** This client has lost 13 pounds which is 6.7%: (195 – 182)/195. If the weight loss has been steady during the past 2 months, that would indicate a 3.3% loss per month. Less than 5% loss in 1 month is not significant, but if this loss continues, the client will reach a 10% loss in 3 months, which is a severe loss. A more detailed assessment is indicated to determine the client's nutritional status. **Cognitive Level:** Applying. **Client Need:** Health Promotion and Maintenance. **Nursing Process:** Assessment. **Learning Outcome:** 47-6; 47-7; 47-8.
9. **Answer:** 2. **Rationale:** A small-bore nasal feeding tube tip is most commonly placed in the stomach. Option 1 indicates the esophagus. A tube tip placed there can lead to aspiration. Option 3 indicates the postpyloric duodenum. Small-bore nasal tubes can be advanced to this location if desired but such a placement is less common than gastric placement. Option 4 indicates the jejunum where feeding tubes can be placed but usually not from a nasally placed tube. **Cognitive Level:** Understanding. **Client Need:** Physiological Integrity. **Nursing Process:** Evaluation. **Learning Outcome:** 47-10a.
10. **Answer:** 4. **Rationale:** 3 ounces tuna + 2 slices whole wheat bread = 3.1 mg Fe; 1 ounce cheese = ~200 mg Ca^{2+}; pear = 4.2 g fiber. Option 1: 1/3 cup raisins = 1.75 mg Fe; 3 ounces cottage cheese = 90 mg Ca^{2+}; 1 banana = 2.1 g fiber. Option 3: 1/2 cup spaghetti + 2 ounces ground beef = 2.3 mg Fe; 1/2 cup ice cream = 97 mg Ca^{2+}; 1/2 cup lima beans = 3.2 g fiber. Option 2: 3 ounces chicken + 1/2 cup peanuts = 2.9 mg Fe; 1/2 cup broccoli ~158 mg Ca^{2+}; 1/2 cup broccoli = 2.4 g fiber. **Cognitive Level:** Applying. **Client Need:** Health Promotion and Maintenance. **Nursing Process:** Implementation. **Learning Outcome:** 47-1.

Chapter 48: Urinary Elimination

1. **Answer:** 4. **Rationale:** The capacity of the bladder may decrease with age but the muscle is weaker and can cause urine to be retained (option 4). Older adults do not ignore the urge to void and may have difficulty in getting to the toilet in time (option 2). The kidney becomes less able to concentrate urine with age (option 3). **Cognitive Level:** Remembering. **Client Need:** Physiological Integrity. **Nursing Process:** Assessment. **Learning Outcome:** 48-2.
2. **Answer:** 1, 2, 4, and 5. **Rationale:** The perineum may become irritated by the frequent contact with urine (option 1). Normal fluid intake is at least 1,500 mL/day and clients often decrease their intake to try to minimize urine leakage (option 2). UTIs can contribute to incontinence (option 4). A fecal impaction can compress the urethra, which can result in small amounts of urine leakage (option 5). Antihistamines can cause urinary retention rather than incontinence (option 3). **Cognitive Level:** Analyzing. **Client Need:** Physiological Integrity. **Nursing Process:** Assessment. **Learning Outcome:** 48-4.
3. **Answer:** 2. **Rationale:** The penis and condom should be checked one-half hour after application to ensure that it is not too tight. A 1-in. space should be left between the penis and the end of the condom (option 1). The condom is changed every 24 hours (option 3), and the tubing is taped to the leg or attached to a leg bag (option 4). An indwelling catheter is secured to the lower abdomen or upper thigh. **Cognitive Level:** Applying. **Client Need:** Safe, Effective Care Environment. **Nursing Process:** Implementation. **Learning Outcome:** 48-10a.
4. **Answer:** 1. **Rationale:** The catheter in the vagina is contaminated and cannot be reused. If left in place, it may help avoid mistaking the vaginal opening for the urinary meatus. A single failure to catheterize the meatus does not indicate that another nurse is needed although sometimes a second nurse can assist in visualizing the meatus (option 2). **Cognitive Level:** Applying. **Client Need:** Safe, Effective Care Environment. **Nursing Process:** Implementation. **Learning Outcome:** 48-10b.
5. **Answer:** 3. **Rationale:** Soaking in a bathtub can increase the risk of exposure to bacteria. The bag should be below the level of the bladder to promote proper drainage (option 1). Intake of cranberry juice creates an environment that inhibits infection (option 2). Clean technique is appropriate for touching the exterior portions of the system (option 4). **Cognitive Level:** Analyzing. **Client Need:** Health Promotion and Maintenance. **Nursing Process:** Evaluation. **Learning Outcome:** 48-7.
6. **Answer:** 4. **Rationale:** The key phrase is "the urge to void." Option 1 occurs when the client coughs, sneezes, or jars the body, resulting in accidental loss of urine. Option 2 occurs with involuntary loss of urine at somewhat predictable intervals when a specific bladder volume is reached. Option 3 is involuntary loss of urine related to impaired function. **Cognitive Level:** Applying. **Client Need:** Physiological Integrity. **Nursing Process:** Diagnosis. **Learning Outcome:** 48-6.
7. **Answer:** 2 and 4. **Rationale:** Option 2 validates the diagnosis. Cotton underwear promotes appropriate exposure to air, resulting in decreased bacterial growth (option 4). Increased fluids decrease concentration and irritation (option 1). The client should wipe the perineal area from front to back to prevent spread of bacteria from the rectal area to the urethra (option 3). Showers reduce exposure of area to bacteria (option 5). **Cognitive Level:** Applying. **Client Need:** Health Promotion and Maintenance. **Nursing Process:** Implementation. **Learning Outcome:** 48-7.
8. **Answer:** 2. **Rationale:** The ileal conduit and vesicostomy (options 1 and 4) are incontinent urinary diversions, and clients are required to use an external ostomy appliance to contain the urine. Clients with a neobladder can control their voiding (option 3). **Cognitive Level:** Analyzing. **Client Need:** Health Promotion and Maintenance. **Nursing Process:** Assessment. **Learning Outcome:** 48-9.
9. **Answer:** 3. **Rationale:** Because the bladder muscles will not contract to increase the intrabladder pressure to promote urination, the process is initiated manually. Options 1, 2, and 4: To promote continence, bladder contractions are required for habit training, bladder training, and increasing the tone of the pelvic muscles. **Cognitive Level:** Applying. **Client Need:** Physiological Integrity. **Nursing Process:** Implementation. **Learning Outcome:** 48-9.
10. **Answer:** 2 and 5. **Rationale:** It is important for the client to inhibit the urge-to-void sensation when a premature urge is experienced. Some clients may need diapers; this is not the BEST indicator of a successful program (option 3). Citrus juices may irritate the bladder (option 4). Carbonated beverages increase diuresis and the risk of incontinence (option 4). **Cognitive Level:** Applying. **Client Need:** Health Promotion and Maintenance. **Nursing Process:** Evaluation. **Learning Outcome:** 48-6.

Chapter 49: Fecal Elimination

1. **Answer:** 1. **Rationale:** Habitually ignoring the urge to defecate can lead to constipation through loss of the natural urge and the accumulation of feces. Diarrhea will not result—if anything, there is increased opportunity for water reabsorption because the stool remains in the colon, leading to firmer stool (option 2). Ignoring the urge shows a strong voluntary sphincter, not a weak one that could result in incontinence (option 3). Hemorrhoids would occur only if severe drying out of the stool occurs and, thus, repeated need to strain to pass stool (option 4). **Cognitive Level:** Understanding. **Client Need:** Physiological Integrity. **Nursing Process:** Implementation. **Learning Outcome:** 49-1.
2. **Answer:** 2. **Rationale:** The standard of practice in assisting older adults to maintain normal function of the gastrointestinal tract is regular ingestion of a well-balanced diet, adequate fluid intake, and regular exercise. If the bowel pattern is not regular with these activities, this abnormality should be reported. Stimulant laxatives can be very irritating and are not the preferred treatment for occasional constipation in older adults (option 2). In addition, a normal stool pattern for an older adult may not be daily elimination. **Cognitive Level:** Analyzing. **Client Need:** Physiological Integrity. **Nursing Process:** Evaluation. **Learning Outcome:** 49-3.
3. **Answer:** 4. **Rationale:** Small-volume enemas along with other preparations are used to prepare the client for this procedure. An oil retention enema is used to soften hard stool (option 1). Return flow enemas help expel flatus (option 2). Because of the risk of loss of fluid and electrolytes, high, large-volume enemas are seldom used (option 3). **Cognitive Level:** Analyzing. **Client Need:** Health Promotion and Maintenance. **Nursing Process:** Planning. **Learning Outcome:** 49-8.
4. **Answer:** 3. **Rationale:** An established stoma should be dark pink like the color of the buccal mucosa and is slightly raised above the abdomen. The skin under the appliance may remain pink/red for a while after the adhesive is pulled off. Feces from an ascending ostomy are very liquid, less so from a transverse ostomy, and more solid from a descending or sigmoid stoma. **Cognitive Level:** Applying. **Client Need:** Physiological Integrity. **Nursing Process:** Assessment. **Learning Outcome:** 49-9.
5. **Answer:** 2. **Rationale:** Once the cause of diarrhea has been identified and corrected, the client should return to his or her previous elimination pattern. This is not an example of an allergy to the antibiotic but a common consequence of overgrowth of bowel organisms not killed by the drug (option 1). Antidiarrheal medications are usually prescribed according to the number of stools, not routinely around the clock (option 3). Increasing intake of soluble fiber such as oatmeal or potatoes may help absorb excess liquid and decrease the diarrhea, but insoluble fiber will not (option 4). **Cognitive Level:** Analyzing. **Client Need:** Physiological Integrity. **Nursing Process:** Planning. **Learning Outcome:** 49-6.
6. **Answer:** 2. **Rationale:** The client has assessment findings consistent with complications of surgery. Option 1: Irrigating the stoma is a dependent nursing action, and is also intervention without appropriate assessment. Option 3: Assessing the peristomal skin area is an independent action, but administering an antiemetic is an intervention without appropriate assessment. Antiemetics are generally ordered to treat immediate postoperative nausea, not several days postoperative. Option 4: Administering a bulk-forming laxative to a nauseated postoperative client is contraindicated. **Cognitive Level:** Analyzing. **Client Need:** Physiological Integrity. **Nursing Process:** Implementation. **Learning Outcome:** 49-6.
7. **Answer:** 3. **Rationale:** This provides relief of postoperative flatus, stimulating bowel motility. Options 1, 2, and 4 manage constipation and do not provide flatus relief. **Cognitive Level:** Applying. **Client Need:** Physiological Integrity. **Nursing Process:** Implementation. **Learning Outcome:** 49-8.
8. **Answer:** 3. **Rationale:** Blood in the upper GI tract is black and tarry. Option 1 can be a sign of malabsorption in an infant, option 2 is normal stool, and option 4 is characteristic of an obstructive condition of the rectum. **Cognitive Level:** Analyzing. **Client Need:** Health Promotion and Maintenance. **Nursing Process:** Assessment. **Learning Outcome:** 49-2.
9. **Answer:** 1, 3, 4, and 5. **Rationale:** Option 1 is the most appropriate. The client is unable to decide when stool evacuation will occur. In option 3, client thoughts about self may be altered if unable to control stool evacuation. In option 4, client may not feel as comfortable around others. In option 5, increased tissue contact with fecal material may result in impairment. Option 2 is more appropriate for a client with diarrhea. Incontinence is the inability to control feces of normal consistency. **Cognitive Level:** Analyzing. **Client Need:** Physiological Integrity. **Nursing Process:** Diagnosis. **Learning Outcome:** 49-6.
10. **Answer:** 5. **Rationale:** Option 5 is a sigmoidostomy site. Option 1 is an ileostomy site, option 2 is ascending colostomy, option 3 is transverse colostomy, and option 4 is descending colostomy. **Cognitive Level:** Applying. **Client Need:** Physiological Integrity. **Nursing Process:** Assessment. **Learning Outcome:** 49-9.

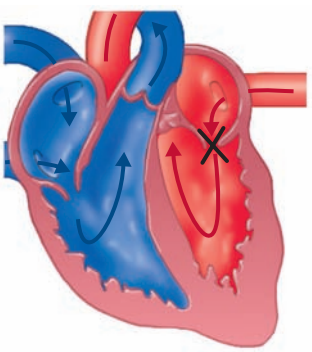
Chapter 50: Oxygenation

1. **Answer:** 4. **Rationale:** A bluish tinge to mucous membranes is called cyanosis. This is most accurate because it is what the nurse observes. The nurse can only observe signs/symptoms of hypoxia (option 1). More information is needed to validate this conclusion. Hypoxemia requires blood oxygen saturation data to be confirmed (option 2), and dyspnea is difficult breathing (option 3). **Cognitive Level:** Applying. **Client Need:** Physiological Integrity. **Nursing Process:** Assessment. **Learning Outcome:** 50-5.
2. **Answer:** 3. **Rationale:** Huff coughing helps keep the airways open and secretions mobilized. Huff coughing is an alternative for clients who are unable to perform a normal forceful cough (e.g., postoperatively). Deep breathing and coughing should be performed at the same time. Only at mealtimes is not sufficient (option 1). Extended forceful coughing fatigues the client, especially postoperatively (option 2). Diaphragmatic and pursed-lip breathing are techniques used for clients with obstructive airway disease (option 4). **Cognitive Level:** Applying. **Client Need:** Health Promotion and Maintenance. **Nursing Process:** Planning. **Learning Outcome:** 50-8.
3. **Answer:** 1. **Rationale:** Prior to starting the procedure, it is important to develop a means of communication by which the client can express pain or discomfort. The twill tape is not changed until after performing tracheostomy care (option 2). Cleaning the incision should be done after cleaning the inner cannula (option 3). Checking the tightness of the ties and knot is done after applying new twill tape (option 4). **Cognitive Level:** Applying. **Client Need:** Physiological Integrity. **Nursing Process:** Implementation. **Learning Outcome:** 50-11d.
4. **Answer:** 3. **Rationale:** Rotating the catheter prevents pulling of tissue into the opening on the catheter tip and side. Suction catheters may only be lubricated with water or water-soluble lubricant (petroleum jelly, e.g., Vaseline, has an oil base) (option 1). No suction should ever be applied while the catheter is being inserted because this can traumatize tissues (option 2). The client should be hyperoxygenated for only a few minutes before and after suctioning and this is generally limited to clients who are intubated or have a tracheostomy (option 4). **Cognitive Level:** Analyzing. **Client Need:** Safe, Effective Care Environment. **Nursing Process:** Implementation. **Learning Outcome:** 50-9.
5. **Answer:** 2. **Rationale:** Proper use of an SMI requires the client to take slow, steady inhalations, every hour or two, 5 to 10 breaths each time. Only the mouthpiece can be successfully rinsed or wiped clean. The device should not be submerged in water (option 4). **Cognitive Level:** Analyzing. **Client Need:** Health Promotion and Maintenance. **Nursing Process:** Evaluation. **Learning Outcome:** 50-8.

6. **Answer:** 2. **Rationale:** The tube should be reconnected to the water seal as quickly as possible. Assisting the client back to bed (option 1) and assessing the client's lung (option 3) are possible actions after the system is reconnected. **Cognitive Level:** Applying. **Client Need:** Safe, Effective Care Environment. **Nursing Process:** Implementation. **Learning Outcome:** 50-9.
7. **Answer:** 1. **Rationale:** Anemia is a condition of decreased red blood cells and decreased hemoglobin. Hemoglobin is how the oxygen molecules are transported to the tissues. Option 2 would depend on where the infection is located. Option 3: A fractured rib would interrupt transport of oxygen from the atmosphere to the airways. Option 4: Damage to the medulla would interfere with neural stimulation of the respiratory system. **Cognitive Level:** Applying. **Client Need:** Safe, Effective Care Environment. **Nursing Process:** Assessment. **Learning Outcome:** 50-7.
8. **Answer:** 3. **Rationale:** Respiratory difficulty related to a reclining position without other physical alterations is defined as orthopnea. **Cognitive Level:** Remembering. **Client Need:** Safe, Effective Care Environment. **Nursing Process:** Diagnosis. **Learning Outcome:** 50-5.
9. **Answer:** 4. **Rationale:** Glucocorticoids are prescribed because of their anti-inflammatory effect. Options 1, 2, and 3 are not achieved with glucocorticoids. **Cognitive Level:** Analyzing. **Client Need:** Physiological Integrity. **Nursing Process:** Implementation. **Learning Outcome:** 50-9.
10. **Answer:** 1. **Rationale:** Postural drainage results in expectoration of large amounts of mucus. Clients sometimes ingest part of the secretions. The secretions may also produce an unpleasant taste in the oral cavity, which could result in nausea/vomiting. This procedure should be done on an empty stomach to decrease client discomfort. **Cognitive Level:** Applying. **Client Need:** Safe, Effective Care Environment. **Nursing Process:** Planning. **Learning Outcome:** 50-8.

Chapter 51: Circulation

1. **Answer:** 1. **Rationale:** Regular physical activity will help promote healthy cardiac functioning and will also promote tissue perfusion. With physical activity the heart muscle becomes more powerful and efficient, and the client has cardiovascular risk factors. Option 2: Improving tissue perfusion may also improve renal perfusion but it is not the primary goal. Option 3: Red, not white, blood cells carry oxygen. Option 4: Effective breathing and airway clearance focus primarily on the respiratory system. **Cognitive Level:** Applying. **Client Need:** Health Promotion and Maintenance. **Nursing Process:** Planning. **Learning Outcome:** 51-4.
2. **Answer:** 3, 1, 4, 2, and 5. **Rationale:** See sequence described on page 1290. **Cognitive Level:** Remembering. **Client Need:** Health Promotion and Maintenance. **Nursing Process:** Assessment. **Learning Outcome:** 51-1.
3. **Answer:** 3. **Rationale:** Capillary refill is an assessment of capillary blood flow and thus tissue perfusion. Symmetrical chest expansion (option 1) is an assessment of respiratory function; pursed-lip breathing (option 2) is a technique used to assist clients with obstructive lung diseases to keep alveoli open during respirations. Activity intolerance (option 4) can occur because of low cardiac output (e.g., heart failure). Activity tolerance would indicate adequate tissue perfusion. **Cognitive Level:** Applying. **Client Need:** Physiological Integrity. **Nursing Process:** Planning. **Learning Outcome:** 51-4.
4. **Answer:** 3 and 5. **Rationale:** Creatine kinase (CK) and troponin are enzymes that are released into the blood when there is hypoxia and myocardial damage. Option 1 reflects renal function. Option 2 reflects the number of red blood cells. Option 4 reflects level of atherosclerosis, which if increased reflects a risk for myocardial infarction and other cardiovascular diseases. Altered levels 1, 2, and 4 do not cause chest pain. **Cognitive Level:** Applying. **Client Need:** Physiological Integrity. **Nursing Process:** Planning. **Learning Outcome:** 51-4.
5. **Answer:** 3. **Rationale:** Very rapid heart rates do not allow adequate time for the ventricles to fill, causing cardiac output to fall. Option 1 is a normal response to exercise and does not reflect poor cardiac output. It could reflect poor cardiac output if the client was experiencing difficulty in breathing. Option 2 is a normal cardiac output of 4,900 mL/min. The formula is SV × HR = CO, which is about 5 L/min. Option 4 is incorrect because positive inotropic drugs (e.g., digoxin) increase contractility of the cardiac muscle and thus increase stroke volume, which increases cardiac output. **Cognitive Level:** Applying. **Client Need:** Physiological Integrity. **Nursing Process:** Assessment. **Learning Outcome:** 51-1.
6. **Answer:** 3. **Rationale:** Because the clients would experience impaired tissue perfusion resulting in respiratory compensation, they are most likely to experience the sign/symptom of shortness of breath. The client with the MI will experience cardiac impairment resulting in decreased cardiac output as well as severe chest pain resulting in increased oxygen demand with decreased availability. Clients with heart failure will have decreased pumping ability of the cardiac muscle resulting in pulmonary congestion and decreased cardiac output. Clients with anemia have fewer RBCs to carry the oxygen to the tissues, resulting in hypoxia. Options 1 and 4 would be signs for the client with the MI. Option 2 is seen in heart failure. **Cognitive Level:** Analyzing. **Client Need:** Physiological Integrity. **Nursing Process:** Planning. **Learning Outcome:** 51-3.
7. **Answer:** 4. **Rationale:** The three cardinal signs of cardiac arrest are apnea, absence of a carotid or femoral pulse, and dilated pupils. **Cognitive Level:** Applying. **Client Need:** Health Promotion and Maintenance. **Nursing Process:** Implementation. **Learning Outcome:** 51-5.
8. **Answer:** 1, 3, and 5. **Rationale:** Option 1: An example of *Ineffective Tissue Perfusion* is a decrease in arterial circulation in the legs related to atherosclerosis. Option 3: Examples of *Decreased Cardiac Output* are clients with MI, heart failure, or tachycardia. Option 5: Not enough blood is being pumped by the heart to meet the demands of the body. *Activity Intolerance* is when the client doesn't have physiological energy for ADLs. Common reasons can be anemias and heart failure. Options 2 and 4: *Acute Confusion* and *Sleep Pattern Disturbance* are not directly related to cardiovascular disease. **Cognitive Level:** Applying. **Client Need:** Physiological Integrity. **Nursing Process:** Diagnosing. **Learning Outcome:** 51-4.
9. **Answer:** 2. **Rationale:** SCDs promote venous return from the legs to the heart. They inflate and deflate plastic sleeves wrapped around the legs to promote venous flow. The sequential inflation and deflation counteract blood stasis in the lower extremities. Option 1: Arterial flow is from the heart to the general circulation. Option 3: Afterload is related to the ventricles' ability to eject blood forward. These devices affect peripheral circulation. Option 4: There is no relationship between pain and the purpose of the devices. **Cognitive Level:** Applying. **Client Need:** Health Promotion and Maintenance. **Nursing Process:** Implementation. **Learning Outcome:** 51-6.
10. **Answer:**



Cognitive Level: Remembering. **Client Need:** Physiological Integrity. **Nursing Process:** Implementation. **Learning Outcome:** 51-1.

Chapter 52: Fluid, Electrolyte, and Acid–Base Balance

1. **Answer:** 2. **Rationale:** All other options are indicative of fluid volume excess. A client who has not eaten or drunk anything for several days would be experiencing fluid volume deficit. **Cognitive Level:** Applying. **Client Need:** Physiological Integrity. **Nursing Process:** Assessment. **Learning Outcomes:** 52-4; 52-5.
2. **Answer:** 2. **Rationale:** Further assessment is needed to determine appropriate action. While the nurse may perform some of the interventions in options 1, 3, and 4, assessment is needed initially. **Cognitive Level:** Applying. **Client Need:** Physiological Integrity. **Nursing Process:** Assessment. **Learning Outcome:** 52-8.
3. **Answer: Hypertonic. Cognitive Level:** Remembering. **Client Need:** Physiological Integrity. **Nursing Process:** Implementation. **Learning Outcome:** 52-1.
4. **Answer:** 2. **Rationale:** Because of the retention of CO_2, the clinical profile of respiratory acidosis includes decreased pH $<$ 7.35, $PaCO_2$ $>$ 42 mmHg, with varying levels of HCO_3 related to hypoventilation. Option 1 is respiratory alkalosis, which occurs because of blowing off of CO_2 resulting in a decreased level of acid and retention or production of bicarbonate, which in turn results in pH $>$7.45, $PaCO_2$ $<$ 38 mmHg, HCO_3 $>$ 26 mEq/L related to hyperventilation. Option 3: Metabolic acidosis occurs because of a gain of hydrogen ions or a loss of HCO_3 with a pH $<$ 7.35, normal $PaCO_2$ of 35–45 mmHg, and HCO_3 $<$ 22 mEq/L, often caused by diarrhea, bicarbonate infusion, or retention related to kidney failure. Option 4: Metabolic alkalosis is caused by gain of bicarbonate or loss of hydrogen ions related to vomiting, gastric suction, or loss of upper gastrointestinal secretions by various other methods. **Cognitive Level:** Applying. **Client Need:** Physiological Integrity. **Nursing Process:** Assessment. **Learning Outcomes:** 52-2; 52-5.
5. **Answer:** 1, 3, and 5. **Rationale:** Options 1, 3, and 5 relate to fluid volume deficit. The data indicate an actual problem, which excludes option 2. Option 4 relates more to fluid volume excess. **Cognitive Level:** Analyzing. **Client Need:** Physiological Integrity. **Nursing Process:** Diagnosis. **Learning Outcome:** 52-6.
6. **Answer:** 4. **Rationale:** Salt substitutes contain potassium. The client can still use it within reason. Option 1: Avocado is higher in potassium than most foods. Option 2: Hypokalemia can potentiate digoxin toxicity and checking the pulse will help the client avoid this. Option 3: It is important to take potassium with food to avoid gastric upset. **Cognitive Level:** Applying. **Client Need:** Physiological Integrity. **Nursing Process:** Evaluation. **Learning Outcomes:** 52-7; 52-8.
7. **Answer:** 2. **Rationale:** Sodium contributes to the function of neural tissue. Because calcium contributes to the function of voluntary muscle contraction, options 1 and 4 are more appropriate for calcium imbalances. Option 3: Because potassium and calcium contribute to cardiac function, irregular pulse is more likely to be associated with those alterations. **Cognitive Level:** Applying. **Client Need:** Physiological Integrity. **Nursing Process:** Assessment. **Learning Outcome:** 52-5.
8. **Answer:** 2. **Rationale:** Because of CO_2 retention the $PaCO_2$ is elevated. CO_2 is involved in production of acid, which will result in a decreased pH. HCO_3 will vary. Option 1: Metabolic acidosis involves a loss of bicarbonate, but no retention of CO_2. Option 3: Metabolic alkalosis involves a loss of acid or retention of HCO_3, but no retention of CO_2. Option 4: Respiratory alkalosis involves a loss of CO_2 resulting in an increased pH. **Cognitive Level:** Applying. **Client Need:** Physiological Integrity. **Nursing Process:** Assessment. **Learning Outcome:** 52-5.
9. **Answer:** 4. **Rationale:** The major clinical signs and symptoms of hypocalcemia are due to increased neuromuscular activity and not the renal, cardiac, or GI systems. **Cognitive Level:** Analyzing. **Client Need:** Physiological Integrity. **Nursing Process:** Implementation. **Learning Outcome:** 52-8.
10. **Answer:** 2, 4, and 5. **Rationale:** Options 1 and 3 relate to hypermagnesemia. **Cognitive Level:** Analyzing. **Client Need:** Physiological Integrity. **Nursing Process:** Assessment. **Learning Outcomes:** 52-4; 52-5.