
MULTIPLE CHOICE :

1. The nurse is caring for a client with a new diagnosis of pneumonia and explains to the client that together they will plan the client's care and set goals for discharge. The client asks, "How is that different from what the doctor does?" Which response by the nurse is most appropriate?
 - a. "The role of the nurse is to administer medications and other treatments prescribed by your doctor."
 - b. "The nurse's job is to help the doctor by collecting data and communicating when there are problems."
 - c. "Nurses perform many of the procedures done by physicians, but nurses are here in the hospital for a longer time than doctors."
 - d. "In addition to caring for you while you are sick, the nurses will assist you to develop an individualized plan to maintain your health."

ANS: D

This response is consistent with the Canadian Nurses Association (CNA) definition of nursing. Registered nurses are self-regulated health care professionals who work autonomously and in collaboration with others. RNs enable individuals, families, groups, communities and populations to achieve their optimal level of health. RNs coordinate health care, deliver direct services, and support clients in their self-care decisions and actions in situations of health, illness, injury, and disability in all stages of life. The other responses describe some of the dependent and collaborative functions of the nursing role but do not accurately describe the nurse's role in the health care system.

DIF: Cognitive Level: Comprehension TOP: Nursing Process: Implementation
MSC: NCLEX: Safe and Effective Care Environment

2. When caring for clients using evidence-informed practice, which of the following does the nurse use?
 - a. Clinical judgement based on experience
 - b. Evidence from a clinical research study
 - c. The best available evidence to guide clinical expertise
 - d. Evaluation of data showing that the client outcomes are met

ANS: C

Evidence-informed nursing practice is a continuous interactive process involving the explicit, conscientious, and judicious consideration of the best available evidence to provide care. Four primary elements are: (a) clinical state, setting, and circumstances; (b) client preferences and actions; (c) best research evidence, and (d) health care resources. Clinical judgement based on the nurse's clinical experience is part of EIP, but clinical decision making also should incorporate current research and research-based guidelines. Evidence from one clinical research study does not provide an adequate substantiation for interventions. Evaluation of client outcomes is important, but interventions should be based on research from randomized control studies with a large number of subjects.

DIF: Cognitive Level: Comprehension TOP: Nursing Process: Planning
MSC: NCLEX: Safe and Effective Care Environment

3. Which of the following best explains the nurses' primary use of the nursing process when providing care to clients?
- To explain nursing interventions to other health care professionals
 - As a problem-solving tool to identify and treat clients' health care needs
 - As a scientific-based process of diagnosing the client's health care problems
 - To establish nursing theory that incorporates the biopsychosocial nature of humans

ANS: B

The nursing process is an assertive problem-solving approach to the identification and treatment of clients' problems. Diagnosis is only one phase of the nursing process. The primary use of the nursing process is in client care, not to establish nursing theory or explain nursing interventions to other health care professionals.

DIF: Cognitive Level: Comprehension TOP: Nursing Process: Implementation
MSC: NCLEX: Safe and Effective Care Environment

4. The nurse is caring for a critically ill client in the intensive care unit and plans an every-2-hour turning schedule to prevent skin breakdown. Which type of nursing function is demonstrated with this turning schedule?
- Dependent
 - Cooperative
 - Independent
 - Collaborative

ANS: D

When implementing collaborative nursing actions, the nurse is responsible primarily for monitoring for complications of acute illness or providing care to prevent or treat complications. Independent nursing actions are focused on health promotion, illness prevention, and client advocacy. A dependent action would require a physician order to implement. Cooperative nursing functions are not described as one of the formal nursing functions.

DIF: Cognitive Level: Application TOP: Nursing Process: Implementation
MSC: NCLEX: Safe and Effective Care Environment

5. The nurse is caring for a client who has been admitted to the hospital for surgery and tells the nurse, "I do not feel right about leaving my children with my neighbour." Which action should the nurse take next?
- Reassure the client that these feelings are common for parents.
 - Have the client call the children to ensure that they are doing well.
 - Call the neighbour to determine whether adequate childcare is being provided.
 - Gather more data about the client's feelings about the childcare arrangements.

ANS: D

Since a complete assessment is necessary in order to identify a problem and choose an appropriate intervention, the nurse's first action should be to obtain more information. The other actions may be appropriate, but more assessment is needed before the best intervention can be chosen.

DIF: Cognitive Level: Application TOP: Nursing Process: Assessment
MSC: NCLEX: Psychosocial Integrity

6. The nurse is caring for a client who has left-sided paralysis as the result of a stroke and assesses a pressure injury on the client's left hip. Which of the following is the most appropriate nursing diagnosis for this client?
- Impaired physical mobility related to decrease in muscle control (left-sided paralysis)
 - Risk for impaired tissue integrity as evidenced by insufficient knowledge about protecting tissue integrity
 - Impaired skin integrity related to pressure over bony prominence (impaired circulation)
 - Ineffective peripheral tissue perfusion related to sedentary lifestyle

ANS: C

The client's major problem is the impaired skin integrity as demonstrated by the presence of a pressure injury. The nurse is able to treat the cause of impaired circulation and pressure over bony prominence by frequently repositioning the client. Although left-sided weakness is a problem for the client, the nurse cannot treat the weakness. The "risk for" diagnosis is not appropriate for this client, who already has impaired tissue integrity. The client does have ineffective peripheral tissue perfusion, but the impaired skin integrity diagnosis indicates more clearly what the health problem is.

DIF: Cognitive Level: Application TOP: Nursing Process: Diagnosis
MSC: NCLEX: Physiological Integrity

7. The nurse caring for a client with an infection has a nursing diagnosis of deficient fluid volume related to excessive fluid loss through normal route (diaphoresis). Which of the following is an appropriate client outcome?
- Client has a balanced intake and output.
 - Client's bedding is changed when it becomes damp.
 - Client understands the need for increased fluid intake.
 - Client's skin remains cool and dry throughout hospitalization.

ANS: A

This statement gives measurable data showing resolution of the problem of deficient fluid volume that was identified in the nursing diagnosis statement. The other statements would not indicate that the problem of deficient fluid volume was resolved.

DIF: Cognitive Level: Application TOP: Nursing Process: Planning
MSC: NCLEX: Physiological Integrity

8. Which of the following represents a nursing activity that is carried out during the evaluation phase of the nursing process?
- Determining if interventions have been effective in meeting client outcomes.
 - Documenting the nursing care plan in the progress notes in the medical record.
 - Deciding whether the client's health problems have been completely resolved.
 - Asking the client to evaluate whether the nursing care provided was satisfactory.

ANS: A

Evaluation consists of determining whether the desired client outcomes have been met and whether the nursing interventions were appropriate. The other responses do not describe the evaluation phase.

DIF: Cognitive Level: Comprehension TOP: Nursing Process: Evaluation
MSC: NCLEX: Safe and Effective Care Environment

9. Which of the following would the nurse perform during the assessment phase of the nursing process?
- Obtains data with which to diagnose client problems.
 - Uses client data to develop priority nursing diagnoses.
 - Teaches interventions to relieve client health problems.
 - Assists the client to identify realistic outcomes to health problems.

ANS: A

During the assessment phase, the nurse gathers information about the client. The other responses are examples of the intervention, diagnosis, and planning phases of the nursing process.

DIF: Cognitive Level: Knowledge TOP: Nursing Process: Assessment
MSC: NCLEX: Safe and Effective Care Environment

10. Which of the following is an example of a correctly written nursing diagnosis statement?
- Altered tissue perfusion related to heart failure.
 - Risk for impaired tissue integrity related to sacral redness.
 - Ineffective coping related to insufficient sense of control.
 - Altered urinary elimination related to urinary tract infection.

ANS: C

This diagnosis statement includes a NANDA nursing diagnosis and an etiology that describes a client's response to a health problem that can be treated by nursing. The use of a medical diagnosis (as in the responses beginning "Altered tissue perfusion" and "Altered urinary elimination") is not appropriate. The response beginning "Risk for impaired tissue integrity" uses the defining characteristics as the etiology.

DIF: Cognitive Level: Comprehension TOP: Nursing Process: Diagnosis
MSC: NCLEX: Safe and Effective Care Environment

11. Which of the following includes the components required for a complete nursing diagnosis statement?
- A problem and the suggested client goals or outcomes.
 - A problem, its cause, and objective data that support the problem.
 - A problem with all its possible causes and the planned interventions.
 - A problem with its etiology and the signs and symptoms of the problem.

ANS: D

The PES format is used when writing nursing diagnoses. The subjective, as well as objective, data should be included in the defining characteristics. Interventions and outcomes are not included in the nursing diagnosis statement.

DIF: Cognitive Level: Knowledge TOP: Nursing Process: Diagnosis
MSC: NCLEX: Safe and Effective Care Environment

12. Which of the following refers to a situation that results in unintended harm to the client and is related to the care or services provided rather than the client's medical condition?
- Negligence
 - Adverse event
 - Incident report
 - Nonmaleficence

ANS: B

An adverse event is an event that results in unintended harm to the client and is related to the care or services provided to the client rather than to the client's underlying medical condition.

DIF: Cognitive Level: Knowledge TOP: Nursing Process: Evaluation
MSC: NCLEX: Safe and Effective Care Environment

13. Which of these nursing actions for the client with heart failure is appropriate for the nurse to delegate to experienced unregulated care providers?
- Assess for shortness of breath or fatigue after ambulation.
 - Instruct the client about the need to alternate activity and rest.
 - Obtain the client's blood pressure and pulse rate after ambulation.
 - Determine whether the client is ready to increase the activity level.

ANS: C

Unregulated care provider education varies according to the type of worker; however, unregulated care providers are able to measure vital signs. Assessment and client teaching require RN education and scope of practice and cannot be delegated.

DIF: Cognitive Level: Application TOP: Nursing Process: Planning
MSC: NCLEX: Safe and Effective Care Environment

14. Which action by a newly graduated RN working on the postsurgical unit indicates that more education about delegation and assignment is needed?
- The nurse delegates measurement of client oral intake and urine output to an unregulated care provider.
 - The nurse delegates assessment of a client's bowel sounds to an experienced unregulated care provider.
 - The nurse assigns an LPN/LVN to administer oral medications to several clients.
 - The nurse assigns a "float" RN from pediatrics to care for a client with diabetes.

ANS: B

Assessment requires RN education and scope of practice and cannot be delegated to an unregulated care provider. The other actions by the new RN are appropriate.

DIF: Cognitive Level: Application TOP: Nursing Process: Planning
MSC: NCLEX: Safe and Effective Care Environment

15. Which of these tasks is appropriate for the registered nurse to delegate to an unregulated care provider?
- Perform a sterile dressing change for an infected wound.
 - Complete the clients' initial bath.
 - Teach a client about the effects of prescribed medications.
 - Document client teaching about a routine surgical procedure.

ANS: B

Unregulated care providers are able to provide personal care to clients. Client teaching and the initial assessment and development of the plan of care are nursing actions that require RN-level education and scope of practice when working with clients that are not stable.

DIF: Cognitive Level: Comprehension TOP: Nursing Process: Planning
MSC: NCLEX: Safe and Effective Care Environment

MULTIPLE RESPONSE

1. When using the Five Steps of the Evidence-Informed Practice (EIP) Process, in which order should the nurse construct a clinical question? (*Select all that apply.*)
 - a. Comparison of interest
 - b. Population of interest
 - c. Outcome of interest
 - d. Intervention of interest
 - e. Timeframe

ANS: A, B, C, D, E

The order of the nurse's statements follows the PICOT format.

DIF: Cognitive Level: Application TOP: Nursing Process: Implementation
MSC: NCLEX: Safe and Effective Care Environment

Chapter 02: Cultural Competence and Health Equity in Nursing Care Lewis: Medical-Surgical Nursing in Canada, 4th Canadian Edition

MULTIPLE CHOICE

1. Which of the following terms refer to characteristics of a group whose members share a common social, cultural, linguistic, or religious heritage?
 - a. Diversity
 - b. Ethnicity
 - c. Ethnocentrism
 - d. Cultural imposition

ANS: B

Ethnicity is the common social, cultural, linguistic, or religious heritage of a group of people. Diversity is a presence of persons with differences from the majority or dominant group that is assumed to be the norm. Ethnocentrism is a tendency of individuals to believe that their way of viewing and responding to the world is the most correct, natural, and superior one. Cultural imposition is imposition of one person's own cultural beliefs and practices, intentionally or unintentionally, on another person or group of people.

DIF: Cognitive Level: Comprehension TOP: Nursing Process: Planning
MSC: NCLEX: Psychosocial Integrity

2. The nurse is caring for Indigenous clients in a community clinic setting. Which of the following would the nurse include when developing strategies to decrease health care disparities?

- a. Improve public transportation.
- b. Obtain low-cost medications.
- c. Update equipment and supplies for the clinic.
- d. Educate staff about Indigenous health beliefs.

ANS: D

Health care disparities are due to stereotyping, biases, and prejudice of health care providers; the nurse can decrease these through staff education. The other strategies also may be addressed by the nurse but will not impact health disparities.

DIF: Cognitive Level: Application TOP: Nursing Process: Planning
MSC: NCLEX: Health Promotion and Maintenance

3. A family member of an elderly Hispanic client admitted to the hospital tells the nurse that the client has traditional beliefs about health and illness. Which of the following actions is most appropriate for the nurse in this situation?
 - a. Avoid asking any questions unless the client initiates conversation.
 - b. Ask the client whether it is important that cultural healers are contacted.
 - c. Explain the usual hospital routines for meal times, care, and family visits.
 - d. Obtain further information about the client's cultural beliefs from the daughter.

ANS: B

Because the client has traditional health care beliefs, it is appropriate for the nurse to ask whether the client would like a visit from a cultural healer. Nurses ask key questions with regard to language, diet, religion, and acculturation and eliciting the client's explanatory model of health and illness. There is no cultural reason for the nurse to avoid asking the client questions, and questions may be necessary to obtain necessary health information. The client (rather than the daughter) should be consulted about personal cultural beliefs. The hospital routines for meals, care, and visits should be adapted to the client's preferences rather than expecting the client to adapt to the hospital schedule.

DIF: Cognitive Level: Application TOP: Nursing Process: Implementation
MSC: NCLEX: Psychosocial Integrity

4. When caring for an Indigenous client, which of the following actions is the best initial approach in relation to eye contact for the nurse to take?
 - a. Avoid all eye contact with the client.
 - b. Observe the client's use of eye contact.
 - c. Look directly at the client when interacting.
 - d. Ask the family about the client's cultural beliefs.

ANS: B

Eye contact varies greatly among and within cultures so the nurse's initial action is to assess the client's use of eye contact. Although nurses are often taught to maintain direct eye contact, clients who are Asian, Arab, or Indigenous may avoid direct eye contact and consider direct eye contact disrespectful or aggressive. Looking directly at the client or avoiding eye contact may be appropriate, depending on the client's individual cultural beliefs. The nurse should assess the client, rather than asking family members about the client's beliefs.

DIF: Cognitive Level: Application TOP: Nursing Process: Implementation
MSC: NCLEX: Psychosocial Integrity

5. A graduate nurse is assessing a newly admitted non-English-speaking Chinese client who complains of severe headaches. Which of the following actions by the graduate nurse would cause the charge nurse to intervene during this assessment interview?
- Sit down at the bedside.
 - Palpate the client's scalp.
 - Call for a medical interpreter.
 - Avoid eye contact with the client.

ANS: B

Many people of Asian ethnicity believe that touching a person's head is disrespectful; the nurse should always ask permission before touching any client's head. The other actions are appropriate.

DIF: Cognitive Level: Application TOP: Nursing Process: Implementation
MSC: NCLEX: Psychosocial Integrity

6. The nurse is caring for a client who speaks a language different from the nurse's language and there is no interpreter available. Which of the following actions is the most appropriate for the nurse to implement?
- Use specific medical terms in the Latin form.
 - Talk loudly and slowly so that each word is clearly heard.
 - Repeat important words so that the client recognizes their importance.
 - Use simple gestures to demonstrate meaning while talking to the client.

ANS: D

The use of gestures will enable some information to be communicated to the client. The other actions will not improve communication with the client.

DIF: Cognitive Level: Comprehension TOP: Nursing Process: Implementation
MSC: NCLEX: Psychosocial Integrity

7. According to the ABC(DE)s of cultural competence, awareness of and sensitivity to cultural values is in which of the following domains?
- Skills domain
 - Affective domain
 - Knowledge domain
 - Behavioural domain

ANS: B

The affective domain reflects an awareness of and sensitivity to cultural values, needs, and biases. The skills domain does not reflect an awareness of and sensitivity to cultural values, needs, and biases. There is no skills or knowledge domain; with ABC(DE) it is affective, behavioural, and cognitive domains as well as dynamics of difference and environment.

DIF: Cognitive Level: Comprehension TOP: Nursing Process: Planning
MSC: NCLEX: Psychosocial Integrity

8. Which of the following actions represent the best example of culturally appropriate nursing care when caring for a newly admitted client?
- Have family members provide most of the client's personal care.