

**MULTIPLE CHOICE**

1. The nurse completes an admission database and explains that the plan of care and discharge goals will be developed with the patient's input. The patient states, "How is this different from what the doctor does?" Which response would be **most** appropriate for the nurse to make?
  - 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 information and communicating any problems that occur."
  - c. "Nurses perform many of the same procedures as the doctor, but nurses are with the patients for a longer time than the doctor."
  - 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 American Nurses Association (ANA) definition of nursing, which describes the role of nurses in promoting health. 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: Understand (comprehension)

REF: 3

TOP: Nursing Process: Implementation MSC: NCLEX: Safe and Effective Care Environment

2. The nurse describes to a student nurse how to use evidence-based practice guidelines when caring for patients. Which statement, if made by the nurse, would be the **most** accurate?
  - a. "Inferences from clinical research studies are used as a guide."
  - b. "Patient care is based on clinical judgment, experience, and traditions."
  - c. "Data are evaluated to show that the patient outcomes are consistently met."
  - d. "Recommendations are based on research, clinical expertise, and patient preferences."

ANS: D

Evidence-based practice (EBP) is the use of the best research-based evidence combined with clinician expertise. Clinical judgment based on the nurse's clinical experience is part of EBP, but clinical decision making should also incorporate current research and research-based guidelines. Evaluation of patient outcomes is important, but interventions should be based on research from randomized control studies with a large number of subjects.

DIF: Cognitive Level: Remember (knowledge)

REF: 15

TOP: Nursing Process: Planning MSC: NCLEX: Safe and Effective Care Environment

3. The nurse teaches a student nurse about how to apply the nursing process when providing patient care. Which statement, if made by the student nurse, indicates that teaching was successful?
  - a. "The nursing process is a scientific-based method of diagnosing the patient's health care problems."
  - b. "The nursing process is a problem-solving tool used to identify and treat patients'

- health care needs.”
- c. “The nursing process is used primarily to explain nursing interventions to other health care professionals.”
  - d. “The nursing process is based on nursing theory that incorporates the biopsychosocial nature of humans.”

ANS: B

The nursing process is a problem-solving approach to the identification and treatment of patients’ problems. Diagnosis is only one phase of the nursing process. The primary use of the nursing process is in patient care, not to establish nursing theory or explain nursing interventions to other health care professionals.

DIF: Cognitive Level: Understand (comprehension) REF: 5  
TOP: Nursing Process: Implementation MSC: NCLEX: Safe and Effective Care Environment

4. A patient has been admitted to the hospital for surgery and tells the nurse, “I do not feel comfortable leaving my children with my parents.” Which action should the nurse take **next**?
  - a. Reassure the patient that these feelings are common for parents.
  - b. Have the patient call the children to ensure that they are doing well.
  - c. Gather more data about the patient’s feelings about the child-care arrangements.
  - d. Call the patient’s parents to determine whether adequate child care is being provided.

ANS: C

Because 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: Apply (application) REF: 6  
OBJ: Special Questions: Prioritization TOP: Nursing Process: Assessment  
MSC: NCLEX: Psychosocial Integrity

5. A patient who is paralyzed on the left side of the body after a stroke develops a pressure ulcer on the left hip. Which nursing diagnosis is **most** appropriate?
  - a. Impaired physical mobility related to left-sided paralysis
  - b. Risk for impaired tissue integrity related to left-sided weakness
  - c. Impaired skin integrity related to altered circulation and pressure
  - d. Ineffective tissue perfusion related to inability to move independently

ANS: C

The patient’s major problem is the impaired skin integrity as demonstrated by the presence of a pressure ulcer. The nurse is able to treat the cause of altered circulation and pressure by frequently repositioning the patient. Although left-sided weakness is a problem for the patient, the nurse cannot treat the weakness. The “risk for” diagnosis is not appropriate for this patient, who already has impaired tissue integrity. The patient does have ineffective tissue perfusion, but the impaired skin integrity diagnosis indicates more clearly what the health problem is.

DIF: Cognitive Level: Apply (application) REF: 7  
TOP: Nursing Process: Diagnosis MSC: NCLEX: Physiological Integrity

6. A patient with a bacterial infection has a nursing diagnosis of deficient fluid volume related to excessive diaphoresis. Which outcome would the nurse recognize as appropriate for this patient?
- Patient has a balanced intake and output.
  - Patient's bedding is changed when it becomes damp.
  - Patient understands the need for increased fluid intake.
  - Patient'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: Apply (application) REF: 7  
TOP: Nursing Process: Planning MSC: NCLEX: Physiological Integrity

7. A nurse asks the patient if pain was relieved after receiving medication. What is the purpose of the evaluation phase of the nursing process?
- To determine if interventions have been effective in meeting patient outcomes
  - To document the nursing care plan in the progress notes of the medical record
  - To decide whether the patient's health problems have been completely resolved
  - To establish if the patient agrees that the nursing care provided was satisfactory

ANS: A

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

DIF: Cognitive Level: Understand (comprehension) REF: 5  
TOP: Nursing Process: Evaluation MSC: NCLEX: Safe and Effective Care Environment

8. The nurse interviews a patient while completing the health history and physical examination. What is the purpose of the assessment phase of the nursing process?
- To teach interventions that relieve health problems
  - To use patient data to evaluate patient care outcomes
  - To obtain data with which to diagnose patient problems
  - To help the patient identify realistic outcomes for health problems

ANS: C

During the assessment phase, the nurse gathers information about the patient to diagnose patient problems. The other responses are examples of the planning, intervention, and evaluation phases of the nursing process.

DIF: Cognitive Level: Understand (comprehension) REF: 5  
TOP: Nursing Process: Assessment MSC: NCLEX: Safe and Effective Care Environment

9. Which nursing diagnosis statement is written correctly?
- Altered tissue perfusion related to heart failure
  - Risk for impaired tissue integrity related to sacral redness
  - Ineffective coping related to response to biopsy test results
  - Altered urinary elimination related to urinary tract infection

ANS: C

This diagnosis statement includes a NANDA nursing diagnosis and an etiology that describes a patient's response to a health problem that can be treated by nursing. The use of a medical diagnosis as an etiology (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 characteristic as the etiology.

DIF: Cognitive Level: Understand (comprehension)

REF: 7

TOP: Nursing Process: Diagnosis

MSC: NCLEX: Safe and Effective Care Environment

10. The nurse admits a patient to the hospital and develops a plan of care. What components should the nurse include in the nursing diagnosis statement?
- The problem and the suggested patient goals or outcomes
  - The problem with possible causes and the planned interventions
  - The problem, its cause, and objective data that support the problem
  - The problem with an etiology and the signs and symptoms of the problem

ANS: D

When writing nursing diagnoses, this format should be used: problem, etiology, and signs and symptoms. 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: Remember (knowledge)

REF: 7

TOP: Nursing Process: Diagnosis

MSC: NCLEX: Safe and Effective Care Environment

11. A nurse is caring for a patient with heart failure. Which task is appropriate for the nurse to delegate to experienced unlicensed assistive personnel (UAP)?
- Monitor for shortness of breath or fatigue after ambulation.
  - Instruct the patient about the need to alternate activity and rest.
  - Obtain the patient's blood pressure and pulse rate after ambulation.
  - Determine whether the patient is ready to increase the activity level.

ANS: C

UAP education includes accurate vital sign measurement. Assessment and patient teaching require registered nurse education and scope of practice and cannot be delegated.

DIF: Cognitive Level: Apply (application)

REF: 11

OBJ: Special Questions: Delegation

TOP: Nursing Process: Planning

MSC: NCLEX: Safe and Effective Care Environment

12. A nurse is caring for a group of patients on the medical-surgical unit with the help of one float registered nurse (RN), one unlicensed assistive personnel (UAP), and one licensed practical/vocational nurse (LPN/LVN). Which assignment, if delegated by the nurse, would be inappropriate?
- Measurement of a patient's urine output by UAP
  - Administration of oral medications by LPN/LVN
  - Check for the presence of bowel sounds and flatulence by UAP
  - Care of a patient with diabetes by RN who usually works on the pediatric unit

ANS: C

Assessment requires RN education and scope of practice and cannot be delegated to an LPN/LVN or UAP. The other assignments made by the RN are appropriate.

DIF: Cognitive Level: Apply (application) REF: 11  
OBJ: Special Questions: Delegation TOP: Nursing Process: Planning  
MSC: NCLEX: Safe and Effective Care Environment

13. Which task is appropriate for the nurse to delegate to a licensed practical/vocational nurse (LPN/LVN)?
- Complete the initial admission assessment and plan of care.
  - Document teaching completed before a diagnostic procedure.
  - Instruct a patient about low-fat, reduced sodium dietary restrictions.
  - Obtain bedside blood glucose on a patient before insulin administration.

ANS: D

The education and scope of practice of the LPN/LVN include activities such as obtaining glucose testing using a finger stick. Patient teaching and the initial assessment and development of the plan of care are nursing actions that require registered nurse education and scope of practice.

DIF: Cognitive Level: Apply (application) REF: 11  
OBJ: Special Questions: Delegation TOP: Nursing Process: Planning  
MSC: NCLEX: Safe and Effective Care Environment

14. A nurse is assigned as a case manager for a hospitalized patient with a spinal cord injury. The patient can expect the nurse functioning in this role to perform which activity?
- Care for the patient during hospitalization for the injuries.
  - Assist the patient with home care activities during recovery.
  - Determine what medical care the patient needs for optimal rehabilitation.
  - Coordinate the services that the patient receives in the hospital and at home.

ANS: D

The role of the case manager is to coordinate the patient's care through multiple settings and levels of care to allow the maximal patient benefit at the least cost. The case manager does not provide direct care in either the acute or home setting. The case manager coordinates and advocates for care but does not determine what medical care is needed; that would be completed by the health care provider or other provider.

DIF: Cognitive Level: Apply (application) REF: 9  
TOP: Nursing Process: Implementation MSC: NCLEX: Safe and Effective Care Environment

15. The nurse is caring for an older adult patient who had surgery to repair a fractured hip. The patient needs continued nursing care and physical therapy to improve mobility before returning home. The nurse will help to arrange for transfer of this patient to which facility?
- A skilled care facility
  - A residential care facility
  - A transitional care facility
  - An intermediate care facility

ANS: C

Transitional care settings are appropriate for patients who need continued rehabilitation before discharge to home or to long-term care settings. The patient is no longer in need of the more continuous assessment and care given in acute care settings. There is no indication that the patient will need the permanent and ongoing medical and nursing services available in intermediate or skilled care. The patient is not yet independent enough to transfer to a residential care facility.

DIF: Cognitive Level: Apply (application) REF: 8  
TOP: Nursing Process: Planning MSC: NCLEX: Safe and Effective Care Environment

16. A home care nurse is planning care for a patient who has just been diagnosed with type 2 diabetes mellitus. Which task is appropriate for the nurse to delegate to the home health aide?
- Assist the patient to choose appropriate foods.
  - Help the patient with a daily bath and oral care.
  - Check the patient's feet for signs of breakdown.
  - Teach the patient how to monitor blood glucose.

ANS: B

Assisting with patient hygiene is included in home health-aide education and scope of practice. Assessment of the patient and instructing the patient in new skills, such as diet and blood glucose monitoring, are complex skills that are included in registered nurse education and scope of practice.

DIF: Cognitive Level: Apply (application) REF: 11  
OBJ: Special Questions: Delegation TOP: Nursing Process: Implementation  
MSC: NCLEX: Safe and Effective Care Environment

17. The nurse is providing education to nursing staff on quality care initiatives. Which statement is an accurate description of the impact of health care financing on quality care?
- "If a patient develops a catheter-related infection, the hospital receives additional funding."
  - "Payment for patient care is primarily based on clinical outcomes and patient satisfaction."
  - "Hospitals are reimbursed for all costs incurred if care is documented electronically."
  - "Because hospitals are accountable for overall care, it is not nursing's responsibility to monitor care delivered by others."

ANS: B

Payment for health care services programs reimburses hospitals for their performance on overall quality-of-care measures. These measures include clinical outcomes and patient satisfaction. Nurses are responsible for coordinating complex aspects of patient care, including the care delivered by others, and identifying issues that are associated with poor quality care. Payment for care can be withheld if something happens to the patient that is considered preventable (e.g., acquiring a catheter-related urinary tract infection).

DIF: Cognitive Level: Apply (application) REF: 4  
TOP: Nursing Process: Implementation MSC: NCLEX: Safe and Effective Care Environment

18. The nurse documenting the patient's progress in the care plan in the electronic health record before an interprofessional discharge conference is demonstrating competency in which QSEN category?
- a. Patient-centered care
  - b. Quality improvement
  - c. Evidence-based practice
  - d. Informatics and technology

ANS: D

The nurse is displaying competency in the QSEN area of informatics and technology. Using a computerized information system to document patient needs and progress and communicate vital information regarding the patient with the interprofessional care team members provides evidence that nursing practice standards related to the nursing process have been maintained during the care of the patient.

DIF: Cognitive Level: Apply (application) REF: 13  
TOP: Nursing Process: Implementation MSC: NCLEX: Safe and Effective Care Environment

### MULTIPLE RESPONSE

1. Which information will the nurse consider when deciding what nursing actions to delegate to a licensed practical/vocational nurse (LPN/LVN) who is working on a medical-surgical unit (*select all that apply*)?
- a. Institutional policies
  - b. Stability of the patient
  - c. State nurse practice act
  - d. LPN/LVN teaching abilities
  - e. Experience of the LPN/LVN

ANS: A, B, C, E

The nurse should assess the experience of LPN/LVNs when delegating. In addition, state nurse practice acts and institutional policies must be considered. In general, whereas the LPN/LVN scope of practice includes caring for patients who are stable, registered nurses should provide most of the care for unstable patients. Because the LPN/LVN scope of practice does not include patient education, this will not be part of the delegation process.

DIF: Cognitive Level: Apply (application) REF: 11  
OBJ: Special Questions: Delegation TOP: Nursing Process: Planning  
MSC: NCLEX: Safe and Effective Care Environment

2. The nurse is administering medications to a patient. Which actions by the nurse during this process are consistent with promoting safe delivery of care (*select all that apply*)?
- a. Throws away a medication that is not labeled
  - b. Uses a hand sanitizer before preparing a medication
  - c. Identifies the patient by the room number on the door
  - d. Checks laboratory test results before administering a diuretic
  - e. Gives the patient a list of current medications upon discharge

ANS: A, B, D, E

National Patient Safety Goals have been established to promote safe delivery of care. The nurse should use at least two reliable ways to identify the patient such as asking the patient's full name and date of birth before medication administration. Other actions that improve patient safety include performing hand hygiene, disposing of unlabeled medications, completing appropriate assessments before administering medications, and giving a list of the current medicines to the patient and caregiver before discharge.

DIF: Cognitive Level: Apply (application) REF: 12  
TOP: Nursing Process: Implementation MSC: NCLEX: Safe and Effective Care Environment

## OTHER

1. The nurse uses the Situation-Background-Assessment-Recommendation (SBAR) format to communicate a change in patient status to a health care provider. In which order should the nurse make the following statements? (*Put a comma and a space between each answer choice [A, B, C, D].*)
  - a. "The patient needs to be evaluated immediately and may need intubation and mechanical ventilation."
  - b. "The patient was admitted yesterday with heart failure and has been receiving furosemide (Lasix) for diuresis, but urine output has been low."
  - c. "The patient has crackles audible throughout the posterior chest, and the most recent oxygen saturation is 89%. Her condition is very unstable."
  - d. "This is the nurse on the surgical unit. After assessing the patient, I am very concerned about increased shortness of breath over the past hour."

ANS:  
D, B, C, A

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

DIF: Cognitive Level: Apply (application) REF: 11  
OBJ: Special Questions: Prioritization TOP: Nursing Process: Implementation  
MSC: NCLEX: Safe and Effective Care Environment

## Chapter 02: Health Disparities and Culturally Competent Care

### Lewis: Medical-Surgical Nursing, 10th Edition

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#### MULTIPLE CHOICE

1. The nurse is obtaining a health history from a new patient. Which data will be the focus of patient teaching?
  - a. Age and gender
  - b. Saturated fat intake
  - c. Hispanic/Latino ethnicity
  - d. Family history of diabetes

ANS: B

Behaviors are strongly linked to many health care problems. The patient's saturated fat intake is a behavior that the patient can change. The other information will be useful as the nurse develops an individualized plan for improving the patient's health, but will not be the focus of patient teaching.

DIF: Cognitive Level: Apply (application) REF: 18  
TOP: Nursing Process: Planning MSC: NCLEX: Health Promotion and Maintenance

2. The nurse works in a clinic located in a community with many Hispanics. Which strategy, if implemented by the nurse, would decrease health care disparities for the Hispanic patients?
  - a. Improve public transportation to the clinic.
  - b. Update equipment and supplies at the clinic.
  - c. Obtain low-cost medications for clinic patients.
  - d. Teach clinic staff about Hispanic health beliefs.

ANS: D

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

DIF: Cognitive Level: Apply (application) REF: 19  
TOP: Nursing Process: Planning MSC: NCLEX: Health Promotion and Maintenance

3. What information should the nurse collect when assessing the health status of a community?
  - a. Air pollution levels
  - b. Number of health food stores
  - c. Most common causes of death
  - d. Education level of the individuals

ANS: C

Health status measures of a community include birth and death rates, life expectancy, access to care, and morbidity and mortality rates related to disease and injury. Although air pollution, access to health food stores, and education level are factors that affect a community's health status, they are not health measures.

DIF: Cognitive Level: Understand (comprehension) REF: 18  
TOP: Nursing Process: Assessment MSC: NCLEX: Health Promotion and Maintenance

4. The nurse is caring for a Native American patient who has traditional beliefs about health and illness. Which action by nurse is **most** appropriate?
  - a. Avoid asking questions unless the patient initiates the conversation.
  - b. Ask the patient 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 patient's cultural beliefs from a family member.

ANS: B

Because the patient has traditional health care beliefs, it is appropriate for the nurse to ask whether the patient would like a visit by a *shaman* or other cultural healer. There is no cultural reason for the nurse to avoid asking the patient questions because these questions are necessary to obtain health information. The patient (rather than the family) should be consulted about personal cultural beliefs. The hospital routines for meals, care, and visits should be adapted to the patient's preferences rather than expecting the patient to adapt to the hospital schedule.

DIF: Cognitive Level: Apply (application) REF: 24  
TOP: Nursing Process: Implementation MSC: NCLEX: Psychosocial Integrity

5. The nurse is caring for an Asian patient who is being admitted to the hospital. Which action would be **most** appropriate for the nurse to take when interviewing this patient?
- a. Avoid eye contact with the patient.
  - b. Observe the patient's use of eye contact.
  - c. Look directly at the patient when interacting.
  - d. Ask a family member about the patient's cultural beliefs.

ANS: B

Observation of the patient's use of eye contact will be most useful in determining the best way to communicate effectively with the patient. Looking directly at the patient or avoiding eye contact may be appropriate, depending on the patient's individual cultural beliefs. The nurse should assess the patient, rather than asking family members about the patient's beliefs.

DIF: Cognitive Level: Apply (application) REF: 25  
TOP: Nursing Process: Implementation MSC: NCLEX: Psychosocial Integrity

6. A female staff nurse is assessing a male patient of Arab descent who is admitted with complaints of severe headaches. It is **most** important for the charge nurse to intervene if the nurse takes which action?
- a. The nurse explains the 0 to 10 intensity pain scale.
  - b. The nurse asks the patient when the headaches started.
  - c. The nurse sits down at the bedside and closes the privacy curtain.
  - d. The nurse calls for a male nurse to bring a hospital gown to the room.

ANS: C

Many men of Arab ethnicity do not believe it is appropriate to be alone with any female except for their spouse. The other actions are appropriate.

DIF: Cognitive Level: Apply (application) REF: 25  
TOP: Nursing Process: Implementation MSC: NCLEX: Psychosocial Integrity

7. The nurse is caring for a patient who speaks a different language. If an interpreter is not available, which action by the nurse is **most** appropriate?
- a. Talk slowly so that each word is clearly heard.
  - b. Speak loudly in close proximity to the patient's ears.
  - c. Repeat important words so that the patient recognizes their significance.

d. Use simple gestures to demonstrate meaning while talking to the patient.

ANS: D

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

DIF: Cognitive Level: Understand (comprehension) REF: 31  
TOP: Nursing Process: Implementation MSC: NCLEX: Psychosocial Integrity

8. The nurse plans care for a hospitalized patient who uses culturally based treatments. Which action by the nurse is **best**?
- Encourage the use of diagnostic procedures.
  - Coordinate the use of folk treatments with ordered medical therapies.
  - Ask the patient to discontinue the cultural treatments during hospitalization.
  - Teach the patient that folk remedies will interfere with orders by the health care provider.

ANS: B

Many culturally based therapies can be accommodated along with the use of Western treatments and medications. The nurse should attempt to use both traditional folk treatments and the ordered Western therapies as much as possible. Some culturally based treatments can be effective in treating “Western” diseases. Not all folk remedies interfere with Western therapies. It may be appropriate for the patient to continue some culturally based treatments while he or she is hospitalized.

DIF: Cognitive Level: Apply (application) REF: 22  
TOP: Nursing Process: Planning MSC: NCLEX: Psychosocial Integrity

9. The nurse is caring for a newly admitted patient. Which intervention is the **best** example of a culturally appropriate nursing intervention?
- Insist family members provide most of the patient’s personal care.
  - Maintain a personal space of at least 2 feet when assessing the patient.
  - Ask permission before touching a patient during the physical assessment.
  - Consider the patient’s ethnicity as the most important factor in planning care.

ANS: C

Many cultures consider it disrespectful to touch a patient without asking permission, so asking a patient for permission is always culturally appropriate. The other actions may be appropriate for some patients but are not appropriate across all cultural groups or for all individual patients. Ethnicity may not be the most important factor in planning care, especially if the patient has urgent physiologic problems.

DIF: Cognitive Level: Understand (comprehension) REF: 28  
TOP: Nursing Process: Implementation MSC: NCLEX: Psychosocial Integrity

10. A staff nurse expresses frustration that a Native American patient always has several family members at the bedside. Which action by the charge nurse is **most** appropriate?
- Remind the nurse that family support is important to this family and patient.
  - Have the nurse explain to the family that too many visitors will tire the patient.
  - Suggest that the nurse ask family members to leave the room during patient care.
  - Ask about the nurse’s personal beliefs about family support during hospitalization.

ANS: D

The first step in providing culturally competent care is to understand one's own beliefs and values related to health and health care. Asking the nurse about personal beliefs will help achieve this step. Reminding the nurse that this cultural practice is important to the family and patient will not decrease the nurse's frustration. The remaining responses (suggest that the nurse ask family members to leave the room and have the nurse explain to family that too many visitors will tire the patient) are not culturally appropriate for this patient.

DIF: Cognitive Level: Apply (application) REF: 23  
TOP: Nursing Process: Implementation MSC: NCLEX: Psychosocial Integrity

11. An older Asian American patient tells the nurse that she has lived in the United States for 50 years. The patient speaks English and lives in a predominantly Asian neighborhood. Which action by the nurse is **most** appropriate?
- Include a shaman when planning the patient's care.
  - Avoid direct eye contact with the patient during care.
  - Ask the patient about any special cultural beliefs or practices.
  - Involve the patient's oldest son to assist with health care decisions.

ANS: C

Further assessment of the patient's health care preferences is needed before making further plans for culturally appropriate care. The other responses indicate stereotyping of the patient based on ethnicity and would not be appropriate initial actions.

DIF: Cognitive Level: Apply (application) REF: 23  
TOP: Nursing Process: Planning MSC: NCLEX: Psychosocial Integrity

12. The nurse plans health care for a community with a large number of recent immigrants from Vietnam. Which intervention is the **most** important for the nurse to implement?
- Hepatitis testing
  - Tuberculosis screening
  - Contraceptive teaching
  - Colonoscopy information

ANS: B

Tuberculosis (TB) is endemic in many parts of Asia, and the incidence of TB is much higher in immigrants from Vietnam than in the general U.S. population. Teaching about contraceptive use, colonoscopy, and testing for hepatitis may also be appropriate for some patients but is not generally indicated for all members of this community.

DIF: Cognitive Level: Apply (application) REF: 28  
TOP: Nursing Process: Planning MSC: NCLEX: Physiological Integrity

13. When doing an admission assessment for a patient, the nurse notices that the patient pauses before answering questions about the health history. Which action by the nurse is **most** appropriate?
- Interview a family member instead.
  - Wait for the patient to answer the questions.
  - Remind the patient that you have other patients who need care.
  - Give the patient an assessment form listing the questions and a pen.

ANS: B