



A nurse is assessing/collecting data from a client. Sort the findings into objective or subjective data.

Objective Data

- ✓ Respiratory rate is even and unlabored at 22/min
- ✓ The client's skin is consistent with genetic background, warm, and dry.
- ✓ An assistive personnel reports that the client walks with a limp.

Subjective Data

- ✓ The client's partner states, "They had burning leg pain after walking 10 minutes."
- ✓ The client's pain rating is 3 on a scale of 0 to 10.

✓ Well done!

You answered correctly. The nurse should analyze cues to identify objective and subjective data. Objective data includes information the nurse can feel, see, hear, or smell, through observation or physical measurement, such as respiratory rate, skin color, temperature, and characteristics, and observation that the client is walking with a limp. Subjective data includes a client's feelings, perceptions, and descriptions of health status, such as pain level, description of pain, and contributing factors to pain. NCLEX Connection: Health Promotion and Maintenance, Techniques of Physical Assessment



A charge nurse is talking with a newly licensed nurse about nursing interventions that require a provider's prescription and nursing interventions that are nurse initiated. Sort the following interventions into nurse-initiated or provider-initiated.

Provider-initiated

- ✓ Inserting a nasogastric tube to relieve gastric distention
- ✓ Writing a prescription for morphine as needed for pain

Nurse-initiated

- ✓ Showing a client how to use progressive muscle relaxation
- ✓ Performing a daily bath after the evening meal
- ✓ Repositioning a client every 2 hr to reduce pressure injury risk

✓ Well done!

You answered correctly. When analyzing cues, the nurse should identify that nursing interventions that require a provider's prescription include prescription for medications and insertion of a nasogastric tube. Nurse-initiated interventions include showing a client how to use progressive muscle relaxation, performing an evening bed bath, and repositioning a client to reduce pressure injury risk. NCLEX Connection: Health Promotion and Maintenance, Techniques of Physical Assessment



A nurse is caring for a client who is two days postoperative and has not achieved satisfactory pain relief. According to the nursing process, which of the following actions should the nurse take first?

A

✓ Check the client to determine the reason for inadequate pain relief.

B

✗ Determine whether the change in plan reduces the client's pain.

C

✗ Change the plan of care to provide a different method of pain relief.

D

✗ Educate the client about the plan of care for managing the pain.

✓ Well done!

You answered correctly. When prioritizing hypotheses, and using the nursing process, the first action the nurse should take is to check the client to determine the reason for inadequate pain relief. The nurse should collect objective and subjective data to determine a new plan of care to promote comfort and reduce the client's pain. NCLEX Connection: Reduction of Risk Potential, System-Specific Assessments



A charge nurse is observing a newly licensed nurse care for a client who is postoperative and reports pain. Match the actions of the newly licensed nurse with the nursing process.

The newly licensed nurse documents that the client's pain is causing the client to take shallow breaths and could lead to complications such as atelectasis.

✓ Analysis/ Diagnosis/Data Collection

The newly licensed nurse administered the pain medication to the client.

✓ Implementation

The newly licensed nurse asks the client to rate the severity of the pain on a scale of 0 to 10.

✓ Assessment/Data collection

The newly licensed nurse checks the client 40 min after administering the pain medication to determine the effectiveness of the medication in relieving the client's pain.

✓ Evaluation

The newly licensed determines the client is due to receive the pain medication and prepares to administer a dose to the client.

✓ Planning

✓ Well done!

You answered correctly. The charge nurse is recognizing cues when identifying that the newly licensed nurse is using the steps of the nursing process when caring for the client who is postoperative and reports pain. The newly licensed nurse uses the assessment/data



A charge nurse is discussing the nursing process with a newly licensed nurse who is caring for a client. Match the following statements by the newly licensed nurse with each step of the nursing process.

"I will determine the most important client problems that we should address."

✓ Planning

"I will review the past medical history in the client's medical record to obtain more information about the client."

✓ Assessment/Data collection

"I will ask the client if their nausea has resolved."

✓ Evaluation

"I will review objective and subjective client data to identify a potential client problem."

✓ Analysis/ Diagnosis/Data Collection

"I will administer prescriptions from the provider."

✓ Implementation

✓ Well done!

You answered correctly. The charge nurse is recognizing cues when identifying that the newly licensed nurse is using the steps of the nursing process when caring for the client. The newly licensed nurse uses the assessment/data collection step of the nursing process when reviewing the past medical history on the client's medical record to obtain more information about the client. Reviewing objective and subjective client data to identify a potential client problem is part of the analysis/ diagnosis/data collection step of the nursing process. The newly licensed nurse clusters and interprets data to determine a conclusion. The newly licensed nurse is using the planning step of the nursing process when prioritizing client problems. Administering prescribed medications to the client is part of the implementation step of the nursing process. The newly licensed nurse is using the evaluation step of the nursing process when asking the client if their nausea has resolved. NCLEX Connection: Management of Care, Legal Rights and Responsibilities