Chapter 7: Nursing Process Answer Key

Application Exercises Key

1. A. **CORRECT:** The nurse should collect further data on the client to determine why he has not achieved satisfactory pain relief, because various factors might be interfering with his comfort. The nursing process repeats in an ongoing manner across the span of client care.

   B. The nurse should not wait longer to see how the client would respond, but should to take action to determine why the client is not reaching achieving satisfactory pain relief.

   C. The nurse should not make random changes to the plan of care without gathering evidence to guide the nurse in knowing what new interventions can be necessary.

   D. The action by the nurse does not acknowledge the client's condition or that the current plan is ineffective.

   NCLEX® Connection: Reduction of Risk Potential, System Specific Assessments

2. A. **CORRECT:** The newly licensed nurse should have used the assessment step of the nursing process by asking the client to evaluate the severity of his pain on a 0 to 10 scale. She also should have asked about the characteristics of his pain and assessed for any changes that might have contributed to worsening of the pain.

   B. The newly licensed nurse used the planning step of the nursing process when she decided that it was appropriate to administer the medication and, recognizing her level of experience in administering pain medication, prepared the dose under supervision from the unit staff.

   C. The newly licensed nurse used the implementation step of the nursing process when she administered the medication.

   D. The newly licensed nurse used the evaluation step of the nursing process when she checked the effectiveness of the pain medication in relieving the client's pain.

   NCLEX® Connection: Health Promotion and Maintenance, Techniques of Physical Assessment

3. A. **CORRECT:** Objective data includes information the nurse measures, such as vital signs.

   B. Subjective data includes a client's reported symptoms, even if told by a secondary source.

   C. Subjective data includes a client's reported symptoms.

   D. **CORRECT:** Objective data includes information the nurse observes, such as skin appearance.

   E. **CORRECT:** Objective data includes information on observations of others, such as family and staff.

   NCLEX® Connection: Health Promotion and Maintenance, Techniques of Physical Assessment

4. A. The nurse must have a prescription from the provider to administer a medication. After obtaining the prescription, the nurse has the flexibility to determine when to administer a PRN medication.

   B. The nurse must have a prescription from the provider for the insertion of an NG tube. This is a provider-initiated intervention.

   C. **CORRECT:** Showing a client how to use progressive muscle relaxation is an appropriate nurse-initiated intervention for stress relief. Unless it is a contraindication for a specific client, the nurse can use this technique with clients without a provider's prescription.

   D. **CORRECT:** Performing a bath is a routine nursing care procedure. Unless it is a contraindication for a specific client, the nurse can determine when bathing is optimal for a client without a provider's prescription.

   E. **CORRECT:** Repositioning a client every 2 hr is an appropriate nurse-initiated intervention for clients. Unless it is a contraindication for a specific client, the nurse can use this strategy without a provider's prescription.

   NCLEX® Connection: Health Promotion and Maintenance, Techniques of Physical Assessment

5. A. **CORRECT:** The nurse should prioritize client problems during the planning step of the nursing process

   B. The nurse should review the client's history during the assessment/data collection step of the nursing process

   C. The nurse should implement nurse- and provider-initiated actions during the intervention step of the nursing process.

   D. The nurse should gather information about whether the client's problems have been resolved during the evaluation step of the nursing process

   NCLEX® Connection: Management of Care, Legal Rights and Responsibilities

PRACTICE Active Learning Scenario

A nurse educator is reviewing with a group of nursing students the actions and thought processes nurses use during the steps of the nursing process. Use the ATI Active Learning Template: Basic Concept to complete this item.

NURSING INTERVENTIONS

- List at three actions to take during the analysis or data collection step.
- List four factors to consider during the evaluation step when clients have not achieved their goals.

PRACTICE Answer

NURSING INTERVENTIONS

Analysis/data collection

- Recognize patterns or trends.
- Compare the data with expected standards or reference ranges.
- Arrive at conclusions to guide nursing care.

Factors to consider during evaluation for unmet goals

- An incomplete database
- Unrealistic client outcomes
- Nonspecific nursing interventions
- Inadequate time for the client to achieve the outcomes

NCLEX® Connection: Health Promotion and Maintenance, Techniques of Physical Assessment