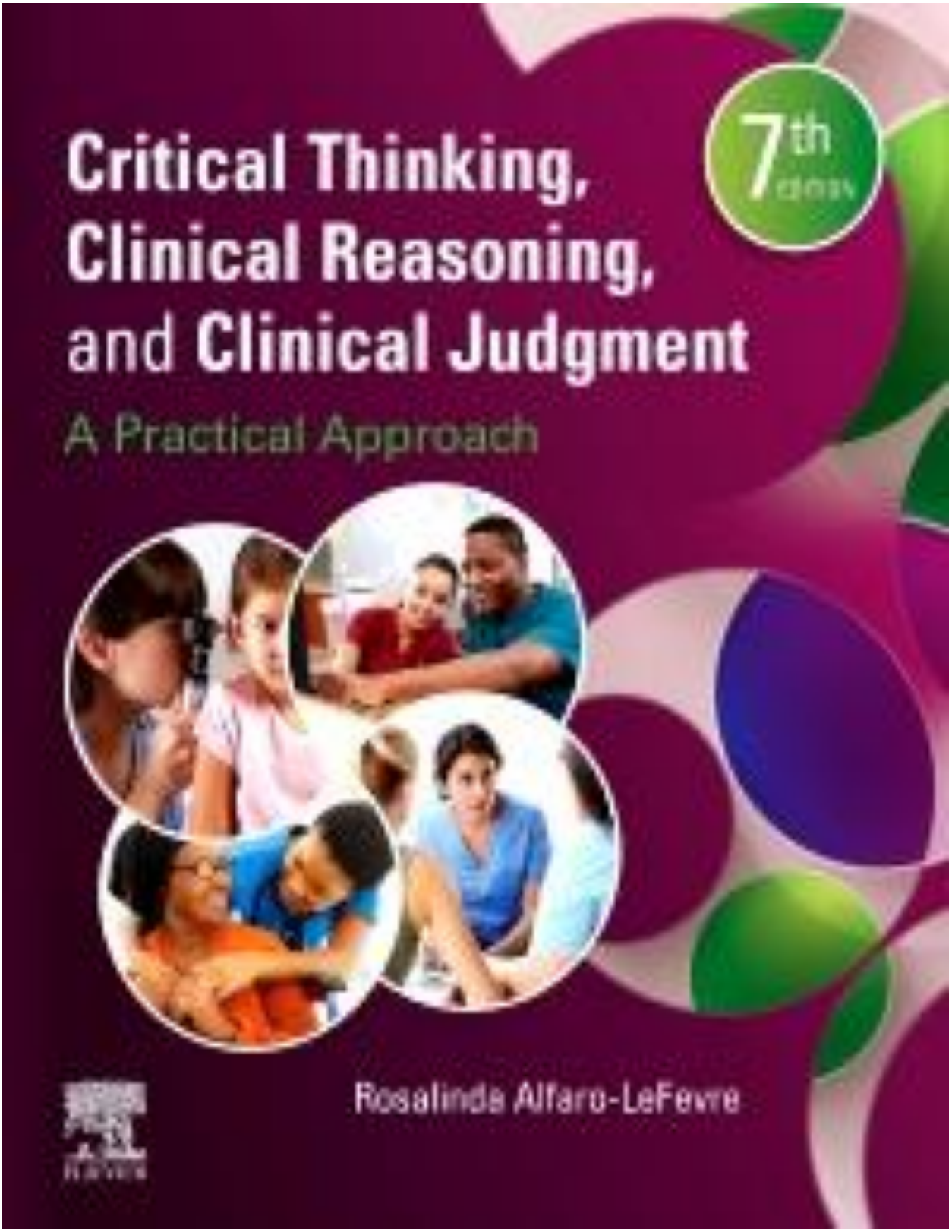
TEST BANK


Critical Thinking,
Clinical Reasoning,
and Clinical Judgment
A Practical Approach
7th edition
Rosalinda Alfaro-LeFevre

Test Bank For Critical Thinking, Clinical Reasoning, and Clinical Judgment A Practical Approach 7th Edition – by Rosalinda Alfaro-LeFevre

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Chapter 1. What are Critical Thinking, Clinical Reasoning, and Clinical Judgment?

Multiple Choice
Identify the choice that best completes the statement or answers the question.
____ 1. Which of the following characteristics do the various definitions of critical thinking have in common? Critical thinking
1)
Requires reasoned thought
2)
Asks the questions why? or how?
3)
Is a hierarchical process
4)
Demands specialized thinking skills
ANS: 1
The definitions listed in the text as well as definitions in Box 2-1 state that critical thinking requires reasoning or reasoned thinking. Critical thinking is neither linear nor hierarchical. That means that the steps involved in critical thinking are not necessarily sequential, where mastery of one step is necessary to proceed to the next. Critical thinking is a purposeful, dynamic, analytic process that contributes to reasoned decisions and sound contextual judgments.
PTS:1DIF:Moderate high-level question, answer not stated verbatim
KEY: Nursing process: N/A | Client need: SECE | Cognitive level: Analysis
____ 2. A few nurses on a unit have proposed to the nurse manager that the process for documenting care on the unit be changed. They have described a completely new system. Why is it important for the nurse manager to have a critical attitude? It will help the manager to
1)
Consider all the possible advantages and disadvantages
2)
Maintain an open mind about the proposed change
3)
Apply the nursing process to the situation
4)
Make a decision based on past experience with documentation
ANS: 2
A critical attitude enables the person to think fairly and keep an open mind.
PTS:1DIF:ModerateKEY: Nursing process: N/A | Client need: SECE | Cognitive level: Comprehension

____ 3. The nurse has just been assigned to the clinical care of a newly admitted patient. To know how to best care for the patient, the nurse uses the nursing process. Which step would the nurse probably do first?
1)
Assessment
2)
Diagnosis
3)
Plan outcomes
4)
Plan interventions
ANS: 1
Assessment is the first step of the nursing process. The nursing diagnosis is derived from the data gathered during assessment, outcomes from the diagnosis, and interventions from the outcomes.
PTS:1DIF:Easy
KEY: Nursing process: Assessment | Client need: SECE | Cognitive level: Application
____ 4. Which of the following is an example of theoretical knowledge?
1)
A nurse uses sterile technique to catheterize a patient.
2)
Room air has an oxygen concentration of 21%.
3)
Glucose monitoring machines should be calibrated daily.
4)
An irregular apical heart rate should be compared with the radial pulse.
ANS: 2
Theoretical knowledge consists of research findings, facts, principles, and theories. The oxygen concentration of room air is a scientific fact. The others are examples of practical knowledgewhat to do and how to do it.
PTS:1DIF:Moderate; high-level question, answer not stated verbatim
KEY: Nursing process: N/A | Client need: SECE | Cognitive level: Application
____ 5. Which of the following is an example of practical knowledge? (Assume all are true.)
1)
The tricuspid valve is between the right atrium and ventricle of the heart.
2)
The pancreas does not produce enough insulin in type 1 diabetes.
3)
When assessing the abdomen, you should auscultate before palpating.
4)
Research shows pain medication given intravenously acts faster than by other routes.
ANS: 3

Practical knowledge is knowing what to do and how to do it, such as how to do an assessment. The others are examples of theoretical knowledge, anatomy (tricuspid valve), fact (type 1 diabetes), and research (IV pain medication).
PTS:1DIF:Moderate high-level question, answer not stated verbatim
KEY: Nursing process: N/A | Client need: SECE | Cognitive level: Application
____ 6. Which of the following is an example of self-knowledge? The nurse thinks, I know that I
1)
Should take the clients apical pulse for 1 minute before giving digoxin
2)
Should follow the clients wishes even though it is not what I would want
3)
Have religious beliefs that may make it difficult to take care of some clients
4)
Need to honor the clients request not to discuss his health concern with the family
ANS: 3
Self-knowledge is being aware of your religious and cultural beliefs and values. Taking the pulse is an example of practical knowledge. Following client wishes and honoring client requests are examples of ethical knowledge.
PTS:1DIFifficult; high-level question, answer not stated verbatim | V1, high-level question, answer not stated verbatim
KEY: Nursing process: N/A | Client need: SECE | Cognitive level: Application
____ 7. Which of the following is the most important reason for nurses to be critical thinkers?
1)
Nurses need to follow policies and procedures.
2)
Nurses work with other healthcare team members.
3)
Nurses care for clients who have multiple health problems.
4)
Nurses have to be flexible and work variable schedules.
ANS: 3
Critical thinking is essential for client care, particularly when the care is complex, involving numerous health issues. Following policies and procedures does not necessarily require critical thinking, and working with others or being flexible and working different schedules do not necessarily require critical thinking.
PTS:1DIF:Moderate; high-level question, answer not stated verbatim
KEY: Nursing process: N/A | Client need: SECE | Cognitive level: Application
____ 8. The nurse administering pain medication every 4 hours is an example of which aspect of patient care?
1)
Assessment data
2)
Nursing diagnosis

3)
Patient outcome
4)
Nursing intervention
ANS: 4
Interventions are activities that will help the patient achieve a goal, such as administering pain-relieving medication. An example of assessment data might be, Patient reports pain is a 5 on a 1 to 10 scale. The nursing diagnosis would be Pain. The nurse might define the patient outcome in this scenario as, The patient will state the level of pain is less than 4.
PTS:1DIF:Moderate; high-level question, answer not stated verbatim
KEY: Nursing process: Interventions | Client need: SECE | Cognitive level: Application
____ 9. How does nursing diagnosis differ from a medical diagnosis? A nursing diagnosis is
1)
Terminology for the clients disease or injury
2)
A part of the clients medical diagnosis
3)
The clients presenting signs and symptoms
4)
A clients response to a health problem
ANS: 4
A nursing diagnosis is the clients response to actual or potential health problems.
PTS:1DIF:ModerateKEY: Nursing process: Diagnosis | Client need: SECE | Cognitive level: Recall
____ 10. Which statement about the nursing process is correct?
1)
It was developed from the ANA Standards of Care.
2)
It is a problem-solving method to guide nursing activities.
3)
It is a linear process with separate, distinct steps.
4)
It involves care that only the nurse will give.
ANS: 2
The nursing process is a problem-solving process that guides nursing actions. The ANA organizes its Standards of Care around the nursing process, but the process was not developed from the standards. The nursing process is cyclical and involves care the nurses give or delegate to other members of the healthcare team.
PTS:1DIF:EasyKEY:Nursing process: N/A | Client need: SECE | Cognitive level: Recall
____ 11. What do critical thinking and the nursing process have in common?
1)
They are both linear processes used to guide ones thinking.
2)

They are both thinking methods used to solve a problem.
3)
They both use specific steps to solve a problem.
4)
They both use similar steps to solve a problem.
ANS: 2
Critical thinking and the nursing process are ways of thinking that can be used in problem solving (although critical thinking can be used beyond problem-solving applications). Neither method of thinking is linear. The nursing process has specific steps; critical thinking does not.
PTS:1DIFifficultKEY: Nursing process: N/A | Client need: SECE | Cognitive level: Analysis
____ 12. A nurse admits a patient to the unit after completing a comprehensive interview and physical examination. To develop a nursing diagnosis, the nurse must now
1)
Analyze the assessment data
2)
Consult standards of care
3)
Decide which interventions are appropriate
4)
Ask the clients perceptions of her health problem
ANS: 1
The basis of the nursing diagnosis is the assessment data. Standards of care are referred to when establishing nursing interventions. Customizing interventions personalizes nursing care. Asking the patient about her perceptions is a method to validate whether the nurse has chosen the correct nursing diagnosis and would probably have been done during the comprehensive assessment.
PTS: 1 DIF: Moderate KEY: Nursing process: Diagnosis | Client need: SECE | Cognitive level: Application
____ 13. The nurse developed a care plan for a patient to help prevent Impaired Skin Integrity. She has made sure that nursing assistive personnel change the patients position every 2 hours. In the evaluation phase of the nursing process, which of the following would the nurse do first?
1)
Determine whether she has gathered enough assessment data.
2)
Judge whether the interventions achieved the stated outcomes.
3)
Follow up to verify that care for the nursing diagnosis was given.
4)
Decide whether the nursing diagnosis was accurate for the patients condition.
ANS: 2
The evaluation phase judges whether the interventions were effective in achieving the desired outcomes and helped to alleviate the nursing diagnosis. This must be done before examining the nursing process steps and revising the care plan.
PTS:1DIF:Moderate