Chapter 1. Critical Thinking, Clinical Judgment, and the Nursing Process

Multiple Choice
Identify the choice that best completes the statement or answers the question.

____ 1. The nurse is caring for a group of patients on a medical–surgical unit. The licensed practical nurse/licensed vocational nurse (LPN/LVN) assesses the patient experiencing a low blood glucose first. Which process was needed to make this decision?
1. Application of clinical judgment
2. Recommendation of the registered nurse (RN)
3. Understanding of what regulates blood glucose levels
4. Knowing the patient's past medical history

ANS: 1
Chapter: Chapter 1. Critical Thinking, Clinical Judgment, and the Nursing Process
Objective: 7. Explain the difference between critical thinking and clinical judgment.
Page: 2
Heading: Clinical Judgment
Integrated Process: Clinical Problem-Solving Process (Nursing Process)
Client Need: SECE: Coordinated Care
Cognitive Level: Comprehension [Understanding]
Concept: Clinical Judgment
Difficulty: Difficult

	Feedback
1	Clinical judgment is the observed outcome of critical thinking and decision making. The nurse identified the patient at high risk and decided to assess this person first.
2	The LPN/LVN needs to make clinical decisions independently from the RN.
3	Understanding the pathophysiology of the disease does not determine how decisions are made.
4	Past medical history is important, but the current clinical cues will determine prioritized nursing actions.

PTS: 1
CON: Patient-Centered Care

____ 2. The LPN/LVN enters the room of a patient who is angry and yells, "I asked 5 minutes ago for my pain medication. You're so worthless!" Which action by the nurse demonstrates intellectual integrity?
1. Refusing to share details of the interaction with colleagues
2. Responding to the patient that the unlicensed assistive personnel (UAP) did not communicate the information
3. Refusing to provide care for the patient
4. Getting the medication without saying another word

ANS: 1
Chapter: Chapter 1. Critical Thinking, Clinical Judgment, and the Nursing Process
Objective: 4. Describe attitudes of good critical thinkers.
Page: 3
Heading: Critical Thinking Attitudes
Integrated Process: Communication and Documentation
Client Need: Psychosocial Integrity
Cognitive Level: Application [Applying]
Concept: Communication
Difficulty: Moderate

	Feedback
1	This action demonstrates intellectual integrity, as the nurse refuses to speak poorly about a patient's behavior.
2	This action does not allow for accountability and places blame.
3	This action does not demonstrate the attitudes of critical thinking.
4	Nurses should not allow patients to demean them. The nurse should tell the patient that they now have the opportunity to obtain the medication and will do so.

PTS: 1
CON: Communication

____ 3. The nurse is collecting data on a patient. Which data is considered cues?
1. Respiratory rate of 26 per minute
2. The doctor will be at the agency in 5 minutes
3. The patient has three daughters
4. The client prefers to use a bedpan rather than a commode chair

ANS: 1
Chapter: Chapter 1. Critical Thinking, Clinical Judgment, and the Nursing Process
Objective: 2. Discuss why critical thinking and clinical judgment are essential in nursing.
Page: 4
Heading: Clinical Judgment Process
Integrated Process: Clinical Problem-Solving Process (Nursing Process)

Client Need: SECE: Coordinated Care
Cognitive Level: Application [Applying]
Concept: Clinical Judgment
Difficulty: Moderate

	Feedback
1	Respiratory rate of 26 per minute is an example of a cue that alerts the nurse to a possible problem.
2	The doctor's presence is not a cue, but just information.
3	The number of children that a patient has is informational, unless the nurse needs the support of the children to provide care, then it becomes important.
4	This is patient preference and not a cue.

PTS: 1
CON: Patient-Centered Care

____ 4. Which items are a part of "generate solutions" when using the clinical judgment process?
1. Reposition the patient.
2. Leg pain is rated at an 8/10.
3. Pain medication allowed the patient to sleep.
4. The leg pain is caused from immobility.

ANS: 1
Chapter: Chapter 1. Critical Thinking, Clinical Judgment, and the Nursing Process
Objective: 2. Discuss why critical thinking and clinical judgment are essential in nursing.
Page: 4
Heading: Clinical Judgement Process
Integrated Process: Clinical Problem-Solving Process (Nursing Process)
Client Need: SECE: Coordinated Care
Cognitive Level: Comprehension [Understanding]
Concept: Patient-Centered Care
Difficulty: Easy

	Feedback
1	Repositioning is an action or solution the nurse can use to provide comfort.
2	A pain scale rating is a cue.
3	The nurse is evaluating the outcome of the pain medication by recognizing that the patient is not sleeping.
4	Recognizing that the pain is from immobility is the step of prioritizing hypotheses.

PTS: 1
CON: Patient-Centered Care

____ 5. The nurse is prioritizing care based on Maslow's hierarchy of needs. Which need does the nurse identify as having the highest priority?
1. Job-related stress
2. Feelings of loneliness
3. Poor sleep habits
4. Lack of confidence

ANS: 3
Chapter: Chapter 1. Critical Thinking, Clinical Judgment, and the Nursing Process
Objective: 7. Prioritize patient care activities based on Maslow's hierarchy of human needs.
Page: 6
Heading: Prioritize Care
Integrated Process: Caring
Client Need: SECE: Coordinated Care
Cognitive Level: Comprehension [Understanding]
Concept: Patient-Centered Care
Difficulty: Easy

	Feedback
1	Job-related stress falls under safety, according to Maslow, and is addressed after physiological needs.
2	According to Maslow, loneliness is addressed under social needs, following physiological and safety needs.
3	Sleep is a physiological need and is the highest priority.
4	Lack of confidence falls under self-esteem, according to Maslow, and is addressed following physiological, safety, and social needs.

PTS: 1
CON: Patient-Centered Care

____ 6. The nurse is using the clinical judgment process to provide care to a patient experiencing nausea. During the process of generating solutions, the patient begins to vomit. What should the nurse do next?
1. Take actions as prepared.
2. Evaluate outcomes of the solutions generated.
3. Identify and analyze the new cues presented.
4. Generate different solutions.

ANS: 3
Chapter: Chapter 1. Critical Thinking, Clinical Judgment, and the Nursing Process
Objective: 2. Discuss why critical thinking and clinical judgment are essential.
in nursing.

Page: 5
Heading: Clinical Judgment Process
Integrated Process: Clinical Problem-Solving Process (Nursing Process)
Client Need: SECE: Management of Care
Cognitive Level: Application [Applying]
Concept: Clinical Judgment
Difficulty: Moderate

	Feedback
1	At any point in the cycle of clinical judgment, if a problem is encountered or something changes, the nurse should go back a step or two in the process and try again.
2	At any point in the cycle of clinical judgment, if a problem is encountered or something changes, the nurse should go back a step or two in the process and try again.
3	At any point in the cycle of clinical judgment, if a problem is encountered or something changes, the nurse should go back a step or two in the process and try again.
4	At any point in the cycle of clinical judgment, if a problem is encountered or something changes, the nurse should go back a step or two in the process and try again.

PTS: 1
CON: Patient-Centered Care

____ 7. While caring for a patient 4 hours after a surgical procedure, the LPN/LVN notes serosanguineous drainage on the dressing. Which phase of clinical judgment does this represent?
1. Identify cues
2. Prioritize hypotheses
3. Generate solutions
4. Evaluate outcomes

ANS: 1
Chapter: Chapter 1. Critical Thinking, Clinical Judgment, and the Nursing Process
Objective: 2. Discuss why critical thinking and clinical judgment are essential in nursing.
Page: 4
Heading: Clinical Judgment Process
Integrated Process: Clinical Problem-Solving Process (Nursing Process)
Client Need: SECE: Management of Care
Cognitive Level: Comprehension [Understanding]
Concept: Clinical Judgment
Difficulty: Easy

	Feedback
1	The nurse notes a change in the dressing appearance, this is identify cues.
2	The nurse notes a change in the dressing appearance, this is identify cues.
3	The nurse notes a change in the dressing appearance, this is identify cues.
4	The nurse notes a change in the dressing appearance, this is identify cues.

PTS: 1
CON: Patient-Centered Care

____ 8. The nurse is caring for a patient using the nursing process. Which step should the nurse take first?
1. Implementation
2. Planning
3. Nursing diagnosis
4. Assessment

ANS: 4
Chapter: Chapter 1. Critical Thinking, Clinical Judgment, and the Nursing Process
Objective: 3. Compare the nursing process to the clinical judgment process.
Page: 3
Heading: The Nursing Process and Clinical Judgment
Integrated Process: Clinical Problem-Solving Process (Nursing Process)
Client Need: SECE: Coordinated Care
Cognitive Level: Knowledge [Remembering]
Concept: Patient-Centered Care
Difficulty: Easy

	Feedback
1	The steps of the nursing process are data collection/assessment, nursing diagnosis, planning, implementation, and evaluation.
2	The steps of the nursing process are data collection/assessment, nursing diagnosis, planning, implementation, and evaluation.
3	The steps of the nursing process are data collection/assessment, nursing diagnosis, planning, implementation, and evaluation.
4	Assessment, or data collection, is the first step in the nursing process and is used to evaluate a patient's condition before providing care. The other steps, in order, are nursing diagnosis, planning, implementation, and evaluation.

PTS: 1
CON: Patient-Centered Care

____ 9. The nurse hears the patient groan when getting out of bed and asks if there is pain, using a pain scale. This describes which step of the clinical judgment process?

1. Identify and analyze cues
2. Prioritize hypotheses
3. Take action
4. Evaluate outcomes

ANS: 1
Chapter: Chapter 1. Critical Thinking, Clinical Judgment, and the Nursing Process
Objective: 3. Compare the nursing process to the clinical judgment process.
Page: 4
Heading: Clinical Judgment Process
Integrated Process: Clinical Problem-Solving Process (Nursing Process)
Client Need: SECE: Coordination of Care
Cognitive Level: Application [Applying]
Concept: Patient-Centered Care
Difficulty: Moderate

	Feedback
1	Recognizing that the client is having pain is a part of identify and analyze cues.
2	Prioritize hypotheses occurs when the nurse begins to predict what is causing the pain.
3	Take action includes the process of treating the pain.
4	Evaluate outcomes determines if the treatment was effective.

PTS: 1
CON: Patient-Centered Care

____ 10. The nurse is evaluating outcomes for a patient with difficult breathing from asthma. Which determines a positive outcome after the delivery of medication?
1. The patient continues to have trouble breathing.
2. The patient requires additional medication for difficulty breathing.
3. The patient can walk to the restroom without reporting shortness of breath.
4. The patient tells the nurse they cannot tell a difference in breathing.

ANS: 3
Chapter: Chapter 1. Critical Thinking, Clinical Judgment, and the Nursing Process
Objective: 3. Compare the nursing process to the clinical judgment process.
Page: 4
Heading: Clinical Judgment Process
Integrated Process: Clinical Problem-Solving (Nursing Process)
Client Need: SECE: Coordinated Care
Cognitive Level: Application [Applying]
Concept: Patient-Centered Care
Difficulty: Moderate

	Feedback
1	Continuation of the symptoms does not show improvement.
2	Additional medication demonstrates the problem is not resolved.
3	Activity without breathing difficulty is a sign of improvement.
4	The client says it is not better, which is not an improvement.

PTS: 1
CON: Patient-Centered Care

____ 11. The nurse is speaking with a patient about a new medication. The patient asks the nurse a question that the nurse cannot answer confidently, and the nurse says, "I'm not sure, but I'll find out for you." What is the nurse practicing?

1. Intellectual humility
2. Intellectual courage
3. Intellectual autonomy
4. Intellectual integrity

ANS: 1
Chapter: Chapter 1. Critical Thinking, Clinical Judgment, and the Nursing Process
Objective: 4. Describe attitudes of good critical thinkers.
Page: 3
Heading: Critical Thinking Attitudes
Integrated Process: Caring
Client Need: Psychosocial Integrity
Cognitive Level: Comprehension [Understanding]
Concept: Professionalism
Difficulty: Moderate

	Feedback
1	Intellectual humility occurs when a nurse admits they don't have all the answers and seeks clarification.
2	Intellectual courage looks at other points of view, even when the nurse does not agree with them.
3	Intellectual autonomy allows the nurse to make decisions based on safety and not because of the choices of others.
4	A person with intellectual integrity values the truth.

PTS: 1
CON: Patient-Centered Care

____ 12. The nurse is evaluating outcomes for a patient who is dehydrated. Which outcome should the nurse use to guide this patient's care?

1. The patient's intake is measured daily.
2. The patient's intake is 3,000 mL daily.
3. Fluids are placed at the patient's bedside.
4. Fluids the patient likes will be at the patient's bedside.

ANS: 2
Chapter: Chapter 1. Critical Thinking, Clinical Judgment, and the Nursing Process
Objective: 2. Discuss why critical thinking and clinical judgment are essential in nursing.
Page: 4
Heading: Clinical Judgment Process
Integrated Process: Clinical Problem-Solving (Nursing Process)
Client Need: SECE: Coordinated Care
Cognitive Level: Application [Applying]
Concept: Clinical Judgment
Difficulty: Moderate

	Feedback
1	This statement is a nursing action.
2	This outcome provides objective, measurable evaluation data.
3	This statement is a nursing action.
4	This statement is a nursing action.

PTS: 1
CON: Patient-Centered Care

____ 13. Which statement is a part of the CUS acronym?
1. I am concerned!
2. You make me uneasy!
3. Care is most important!
4. Stop, drop, and roll!

ANS: 1
Chapter: Chapter 1. Critical Thinking, Clinical Judgment, and the Nursing Process
Objective: 7. Discuss the importance of collaboration in nursing practice.
Page: 3
Heading: Be Safe!
Integrated Process: Clinical Problem-Solving (Nursing Process)
Client Need: SECE: Safety and Infection Control
Cognitive Level: Knowledge [Remembering]
Concept: Communication
Difficulty: Easy

	Feedback

1	C stands for “I am Concerned!”
2	U stands for “I am Uncomfortable!”
3	C stands for “I am Concerned!”
4	S stands for “This is a Safety issue!”

PTS: 1
CON: Patient-Centered Care

____ 14. Why are only 23% of new nurses practice-ready upon graduation from nursing school?
1. They lack the clinical experience to be safe.
2. They fail to find jobs that properly prepare them.
3. They are unable to recognize a change in a patient’s condition.
4. They graduated from a substandard school of nursing.

ANS: 3
Chapter: Chapter 1. Critical Thinking, Clinical Judgment, and the Nursing Process
Objective: 7. Discuss the importance of collaboration in nursing practice.
Page: 1
Heading: Learning Outcomes
Integrated Process: Clinical Problem-Solving (Nursing Process)
Client Need: SECE: Coordinated Care
Cognitive Level: Knowledge [Remembering]
Concept: Clinical Judgment
Difficulty: Easy

	Feedback
1	Lack of clinical experience contributes to, but is not the reason for, new nurses lacking practice readiness.
2	Lack of job preparation contributes to, but is not the reason for, new nurses lacking practice readiness.
3	Many new nurses are “unable to recognize a change in a patient’s condition or identify the urgency of a situation” (Kavanaugh & Szweda, 2017). If a nurse is unable to recognize a change in condition and its urgency, a failure to rescue (FTR) can result.
4	Graduation from a substandard school contributes to, but is not the reason for, new nurses lacking practice readiness.

PTS: 1
CON: Patient-Centered Care

____ 15. Which factors lead to failure to rescue events?
1. Adequate resources

2. Good communication
3. Recognition of patient change
4. Poor staffing

ANS: 4
Chapter: Chapter 1. Critical Thinking, Clinical Judgment, and the Nursing Process
Objective: 2. Discuss why critical thinking and clinical judgment are essential in nursing.
Page: 1
Heading: Learning Outcomes
Integrated Process: Clinical Problem-Solving Process (Nursing Process)
Client Need: SECE: Coordinated Care
Cognitive Level: Knowledge [Remembering]
Concept: Clinical Judgment
Difficulty: Easy

	Feedback
1	Inadequate resources leads to failure to rescue.
2	Poor communication leads to failure to rescue.
3	Failure to identify patient change leads to failure to rescue.
4	Poor staffing can play a role in poor clinical judgment, which can lead to failure to rescue.

PTS: 1
CON: Patient-Centered Care

____ 16. Which critical thinking trait is demonstrated when the LPN/LVN is unsure of how to perform a dressing change and asks the RN for assistance?
1. Intellectual courage
2. Intellectual integrity
3. Intellectual humility
4. Intellectual empathy

ANS: 3
Chapter: Chapter 1. Critical Thinking, Clinical Judgment, and the Nursing Process
Objective: 4. Describe attitudes of good critical thinkers.
Page: 3
Heading: Intellectual Humility
Integrated Process: Communication and Documentation
Client Need: Psychosocial Integrity
Cognitive Level: Comprehension [Understanding]
Concept: Communication
Difficulty: Easy

	Feedback

1	Intellectual courage allows the nurse to look at other points of view, even if they do not agree.
2	Intellectual integrity is holding oneself to the same level of standards one expects others to meet.
3	The LPN/LVN is demonstrating intellectual humility, which is having the ability to ask for assistance when they are unsure.
4	Intellectual empathy allows the nurse to put themself in the patient's shoes.

PTS: 1
CON: Communication

____ 17. Which action should the nurse take after identifying and analyzing cues in a clinical situation?
1. Generate solutions
2. Take action
3. Evaluate outcomes
4. Prioritize hypotheses

ANS: 4
Chapter: Chapter 1. Critical Thinking, Clinical Judgment, and the Nursing Process
Objective: 3. Compare the nursing process to the clinical judgment process.
Page: 4
Heading: Clinical Judgment Process
Integrated Process: Clinical Problem-Solving Process (Nursing Process)
Client Need: SECE: Coordinated Care
Cognitive Level: Comprehension [Understanding]
Concept: Clinical Judgment
Difficulty: Easy

	Feedback
1	The nurse will prioritize hypotheses after identifying and analyzing cues.
2	The nurse will prioritize hypotheses after identifying and analyzing cues.
3	The nurse will prioritize hypotheses after identifying and analyzing cues.
4	The nurse will prioritize hypotheses after identifying and analyzing cues.

PTS: 1
CON: Patient-Centered Care

____ 18. The LPN/LVN asks a patient who received 2 mg of morphine IV 30 minutes ago to rate their pain. Which step of the clinical judgment process is the nurse using?
1. Take action
2. Prioritize hypotheses
3. Identify and analyze cues

4. Evaluate outcomes

ANS: 4
Chapter: Chapter 1. Critical Thinking, Clinical Judgment, and the Nursing Process
Objective: 3. Compare the nursing process to the clinical judgment process.
Page: 4
Heading: Clinical Judgment Process
Integrated Process: Clinical Problem-Solving Process (Nursing Process)
Client Need: SECE: Coordinated Care
Cognitive Level: Application [Applying]
Concept: Clinical Judgment
Difficulty: Moderate

	Feedback
1	Determining the pain score after delivery of a medication is evaluate outcomes.
2	Determining the pain score after delivery of a medication is evaluate outcomes.
3	Determining the pain score after delivery of a medication is evaluate outcomes.
4	Determining the pain score after delivery of a medication is evaluate outcomes.

PTS: 1
CON: Patient-Centered Care

____ 19. The LPN/LVN is assisting the RN in generating solutions for a patient. Which is an example of a collaborative action?
1. Requesting a dietitian consultation
2. Giving a back rub at bedtime
3. Assessing a patient for discomfort
4. Teaching relaxation techniques before surgery

ANS: 1
Chapter: Chapter 1. Critical Thinking, Clinical Judgment, and the Nursing Process
Objective: 7. Discuss the importance of collaboration in nursing practice.
Page: 7
Heading: Collaboration
Integrated Process: Clinical Problem-Solving Process (Nursing Process)
Client Need: SECE: Coordinated Care
Cognitive Level: Comprehension [Understanding]
Concept: Clinical Judgment
Difficulty: Easy

	Feedback
1	Collaboration includes other health-care disciplines in providing care, like the provider, therapist, or dietician.
2	Collaboration includes other health-care disciplines in providing care, like the

	provider, therapist, or dietician
3	Collaboration includes other health-care disciplines in providing care, like the provider, therapist, or dietician.
4	Collaboration includes other health-care disciplines in providing care, like the provider, therapist, or dietician

PTS: 1
CON: Patient-Centered Care

____ 20. What is the purpose of clinical judgment?
1. It designates the orders written by the doctor.
2. It determines what the nurse does after thinking about a problem.
3. It establishes the jobs needing to be accomplished during a shift.
4. It is based on personal ethical beliefs.

ANS: 2
Chapter: Chapter 1. Critical Thinking, Clinical Judgment, and the Nursing Process
Objective: 1. Explain the difference between critical thinking and clinical judgment.
Page: 2
Heading: Clinical Judgment
Integrated Process: Clinical Problem-Solving Process (Nursing Process)
Client Need: SECE: Coordinated Care
Cognitive Level: Comprehension [Understanding]
Concept: Clinical Judgment
Difficulty: Easy

	Feedback
1	This is not the purpose of clinical judgment.
2	Clinical judgment is based on good critical thinking and determines what the nurse DOES after thinking about a problem.
3	This is not the purpose of clinical judgment.
4	This is not the purpose of clinical judgment.

PTS: 1
CON: Patient-Centered Care

____ 21. A nurse notes that a patient's blood glucose is low and properly treats the symptoms. The nurse continues to monitor for symptoms of low blood glucose throughout the remainder of the shift. What is the nurse practicing by this action?
1. Collaboration
2. Vigilance
3. Intelligence

4. Active listening

ANS: 2
Chapter: Chapter 1. Critical Thinking, Clinical Judgment, and the Nursing Process
Objective: 5. Define vigilance.
Page: 5
Heading: A Word About Vigilance
Integrated Process: Clinical Problem-Solving Process (Nursing Process)
Client Need: SECE: Coordinated Care
Cognitive Level: Comprehension [Understanding]
Concept: Clinical Judgment
Difficulty: Easy

	Feedback
1	The state of awareness that enables you to anticipate problems is called vigilance. Collaboration is working with other health-care team members.
2	The state of awareness that enables you to anticipate problems is called vigilance.
3	The state of awareness that enables you to anticipate problems is called vigilance. Intelligence is a part of critical-thinking attitudes.
4	The state of awareness that enables you to anticipate problems is called vigilance. Active listening is focused listening.

PTS: 1
CON: Patient-Centered Care

____ 22. The LPN/LVN is caring for a patient who begins to exhibit shortness of breath and chest pain. Which action should the nurse take after notifying the RN?
1. Take action
2. Identify and analyze additional cues
3. Evaluate outcomes
4. Generate solutions

ANS: 2
Chapter: Chapter 1. Critical Thinking, Clinical Judgment, and the Nursing Process
Objective: 3. Compare the nursing process to the clinical judgment process.
Page: 4
Heading: Clinical Judgment Process
Integrated Process: Clinical Problem-Solving Process (Nursing Process)
Client Need: SECE: Coordinated Care
Cognitive Level: Application [Applying]
Concept: Clinical Judgment
Difficulty: Moderate

	Feedback
1	More information needs to be gathered, so identify and analyze additional cues is the priority.
2	More information needs to be gathered, so identify and analyze additional cues is the priority.
3	More information needs to be gathered, so identify and analyze additional cues is the priority.
4	More information needs to be gathered, so identify and analyze additional cues is the priority.

PTS: 1
CON: Patient-Centered Care

____ 23. While applying a topical medication the patient begins to vomit. Which statement indicates the situation in SBAR communication?

1. The patient has a topical rash and has been nauseated since surgery.
2. The emesis was bile green in color.
3. The patient began vomiting.
4. I'd like to provide an anti-nausea medication.

ANS: 3
Chapter: Chapter 1. Critical Thinking, Clinical Judgment, and the Nursing Process
Objective: 8. Use the SBAR mnemonic to communicate a patient problem.
Page: 5
Heading: Communication With the Health-Care Team
Integrated Process: Communication and Documentation
Client Need: SECE: Coordinated Care
Cognitive Level: Comprehension [Understanding]
Concept: Communication
Difficulty: Easy

	Feedback
1	This statement tells the B or background of the situation.
2	This statement tells the A or assessment of the situation.
3	The S or situation is the immediate concern or reason for the communication.
4	This statement tells the R or recommendation for the situation.

PTS: 1
CON: Patient-Centered Care

____ 24. A nurse approaches a person in a restaurant who appears to be experiencing respiratory distress. Which action should the nurse perform first?

1. Diagnose the problem.
2. Assist the person to lie down.
3. Consider if the person can walk to a more private location.
4. Collect data about the person's condition.

ANS: 4
Chapter: Chapter 1. Critical Thinking, Clinical Judgment, and the Nursing Process
Objective: 3. Compare the nursing process to the clinical judgment process.
Page: 4
Heading: Clinical Judgment Process
Integrated Process: Clinical Problem-Solving Process (Nursing Process)
Client Need: SECE: Coordinated Care
Cognitive Level: Comprehension [Understanding]
Concept: Clinical Judgment
Difficulty: Moderate

	Feedback
1	Diagnosing the problem would occur after collecting data. This is prioritize hypotheses.
2	Assisting the person to lie down is implementing an action to address the problem. This is take action.
3	The nurse can collect data from other people if necessary. This is generate solutions.
4	The first step in the nursing process is to collect data, and the patient should come first. This is identify and analyze cues.

PTS: 1
CON: Patient-Centered Care

____ 25. A nurse is speaking to a patient about pain. Which statement by the nurse demonstrates active listening?

1. I hear you saying that your pain makes you feel defeated.
2. I can see that you are hurting. Let me get you something.
3. Are you having pain?
4. I'll get you pain medicine when I'm able.

ANS: 1
Chapter: Chapter 1. Critical Thinking, Clinical Judgment, and the Nursing Process
Objective: 8. Use the SBAR mnemonic to communicate a patient problem.
Page: 5
Heading: Active Listening
Integrated Process: Communication and Documentation
Client Need: SECE: Coordinated Care
Cognitive Level: Application [Applying]

Concept: Communication
Difficulty: Difficult

	Feedback
1	Active listening includes seeking clarification, which this statement does.
2	This statement does not include listening; it makes a plan without seeking verification.
3	This statement addresses the need for more information, but it is formatted as a "yes or no" answer, which does not allow the patient to share more.
4	This statement does not promote listening.

PTS: 1
CON: Patient-Centered Care

____ 26. The LPN/LVN is caring for a group of patients. Which patient should the nurse assess first?
1. A patient crying about an upcoming divorce
2. A patient who fears that her partner will abuse her
3. A patient who has not slept for three nights and is exhausted
4. A patient who is being transferred to an assisted living facility

ANS: 3
Chapter: Chapter 1. Critical Thinking, Clinical Judgment, and the Nursing Process
Objective: 6. Prioritize patient care activities based on Maslow's hierarchy of human needs.
Page: 6
Heading: Prioritizing Care
Integrated Process: Clinical Problem-Solving Process (Nursing Process)
Client Need: SECE: Coordinated Care
Cognitive Level: Analysis [Analyzing]
Concept: Clinical Judgment
Difficulty: Difficult

	Feedback
1	Crying about an upcoming divorce falls under love and belonging, according to Maslow's hierarchy of human needs. This is not the highest priority.
2	Abuse falls under safety and security, according to Maslow's hierarchy of human needs. This is not the highest priority.
3	A lack of sleep falls under physiological needs, according to Maslow's hierarchy of human needs. This is the highest priority.
4	A transfer to assisted living falls under safety and security, according to Maslow's hierarchy of human needs. This is not the highest priority.

PTS: 1

CON: Patient-Centered Care

Multiple Response
Identify one or more choices that best complete the statement or answer the question.

____ 27. Which situations meet the priority physiological needs according to Maslow's hierarchy of human needs? (Select all that apply.)
1. A patient who is able to walk 10 feet after hip surgery
2. A patient with a stroke who cannot swallow without coughing
3. A patient with a pain of 6 on a 0–10 scale
4. A homeless person
5. A patient who has not had a bowel movement of 4 days

ANS: 2, 4, 5
Chapter: Chapter 1. Critical Thinking, Clinical Judgment, and the Nursing Process
Objective: 6. Prioritize patient care activities based on Maslow's hierarchy of human needs.
Page: 6
Heading: Prioritizing Care
Integrated Process: Clinical Problem-Solving Process (Nursing Process)
Client Need: SECE: Coordinated Care
Cognitive Level: Comprehension [Understanding]
Concept: Clinical Judgment
Difficulty: Easy

	Feedback
1.	Although exercise is a physiological need, ambulation post-surgery is an accomplishment and self-esteem, according to Maslow.
2.	Inability to swallow impairs the intake of food and is a physiological need.
3.	Pain is a part of maintaining comfort and designated as safety and security, according to Maslow.
4.	A homeless person lacks shelter, a physiological need, according to Maslow.
5.	Elimination is a physiological need, according to Maslow.

PTS: 1
CON: Patient-Centered Care

____ 28. An LPN/LVN notices that a patient with a history of diabetes is experiencing high blood glucose levels and confusion. The nurse realizes that the patient has not received insulin since being admitted 2 days ago. The nurse tells the RN. Which steps of clinical judgment are being used in this scenario? (Select all that apply.)

1. Identify and analyze cues
2. Prioritize hypotheses
3. Generate solutions
4. Take action
5. Evaluate outcomes

ANS: 1, 2, 3, 4
Chapter: Chapter 1. Critical Thinking, Clinical Judgment, and the Nursing Process
Objective: 3. Compare the nursing process to the clinical judgment process.
Page: 4
Heading: Clinical Judgment Process
Integrated Process: Clinical Problem-Solving Process (Nursing Process)
Client Need: SECE: Coordinated Care
Cognitive Level: Application [Applying]
Concept: Clinical Judgment
Difficulty: Difficult

	Feedback
1.	Noticing the symptoms and analyzing the information leads the nurse to prioritize the most likely cause and report the problem (insulin is not being administered) to the RN (a solution and taking action).
2.	Noticing the symptoms and analyzing the information leads the nurse to prioritize the most likely cause and report the problem (insulin is not being administered) to the RN (a solution and taking action).
3.	Noticing the symptoms and analyzing the information leads the nurse to prioritize the most likely cause and report the problem (insulin is not being administered) to the RN (a solution and taking action).
4.	Noticing the symptoms and analyzing the information leads the nurse to prioritize the most likely cause and report the problem (insulin is not being administered) to the RN (a solution and taking action).
5.	Noticing the symptoms and analyzing the information leads the nurse to prioritize the most likely cause and report the problem (insulin is not being administered) to the RN (a solution and taking action).

PTS: 1
CON: Patient-Centered Care

____ 29. The nurse identifies the risk for impaired breathing for a patient with pneumonia. Which findings evaluate outcomes? (Select all that apply.)

1. Apply oxygen 2 liters per nasal cannula.
2. Lung's clearer after coughing
3. Temperature decreased after antipyretic
4. Coarse crackles in right lower lung fields
5. Encourage to drink 240 mL of fluid every 2 hours.

ANS: 2, 3
Chapter: Chapter 1. Critical Thinking, Clinical Judgment, and the Nursing Process
Objective: 3. Compare the nursing process to the clinical judgment process.
Page: 4
Heading: Clinical Judgment Process
Integrated Process: Clinical Problem-Solving Process (Nursing Process)
Client Need: SECE: Coordinated Care
Cognitive Level: Application [Applying]
Concept: Clinical Judgment
Difficulty: Difficult

	Feedback
1.	Applying oxygen is a part of generating solutions, not evaluating outcomes.
2.	A change in condition after a nursing action is evaluating outcomes.
3.	A change in condition after a nursing action is evaluating outcomes.
4.	Coarse crackles is a cue.
5.	Applying oxygen is a part of generating solutions, not evaluating outcomes.

PTS: 1
CON: Patient-Centered Care

____ 30. The nurse is generating solutions for a patient with acute pain who is exhibiting tachypnea and hypertension. Which items demonstrate a possible solution? (Select all that apply.)
1. Pain level of 2 on a 0–10 scale 30 minutes after receiving morphine
2. Use of deep breathing and imagery during painful episodes
3. Medicating for pain within 10 minutes of reporting
4. Pain worse with ambulation
5. Blood pressure decreased after pain medication

ANS: 2, 3
Chapter: Chapter 1. Critical Thinking, Clinical Judgment, and the Nursing Process
Objective: 3. Compare the nursing process to the clinical judgment process.
Page: 4
Heading: Clinical Judgment Process
Integrated Process: Clinical Problem-Solving Process (Nursing Process)
Client Need: SECE: Coordinated Care
Cognitive Level: Application [Applying]
Concept: Clinical Judgment
Difficulty: Difficult

	Feedback
1.	A change in pain score is evaluate outcomes.
2.	This is a solution that can improve pain response.

3.	This is a solution that can help with pain.
4.	This is an example of identity and analyze cues.
5.	This is evaluate outcomes.

PTS: 1
CON: Patient-Centered Care

Ordered Response

31. The nurse is caring for a group of patients. Place in order the patients the nurse should see from highest to lowest priority (1–5).
1. A patient who underwent abdominal surgery yesterday and reports a pain level of 5 on a 0–10 scale
2. A patient with deep vein thrombosis (DVT) who reports shortness of breath
3. A patient who just finished running a marathon, 1 year after having knee surgery
4. A patient who can no longer perform his job as CEO because of chemotherapy treatments
5. A patient who just lost their spouse to cancer

ANS: 2, 1, 5, 4, 3
Chapter: Chapter 1. Critical Thinking, Clinical Judgment, and the Nursing Process
Objective: 6. Prioritize patient care activities based on Maslow's hierarchy of human needs.
Page: 6
Heading: Prioritizing Care
Integrated Process: Clinical Problem-Solving Process (Nursing Process)
Client Need: SECE: Coordinated Care
Cognitive Level: Analysis (Analyzing)
Concept: Clinical Judgment
Difficulty: Difficult

	Feedback
1.	Maslow: Safety and Security
2.	Maslow: Physiological
3.	Maslow: Self-Actualization
4.	Maslow: Self-Esteem
5.	Maslow: Love and Belonging

PTS: 1
CON: Patient-Centered Care

32. The nurse is caring for a patient recovering from a stroke. Place in the order of the clinical judgment process or actions provided while caring for this patient.
    1. Hand grasp absent left hand
    2. Alteration in cerebral perfusion
    3. Flexed left thumb and index finger
    4. Coached to squeeze rubber ball placed in left hand
    5. Self-feed using left hand

    ANS: 1, 2, 5, 4, 3
    Chapter: Chapter 1. Critical Thinking, Clinical Judgment, and the Nursing Process
    Objective: 3. Compare the nursing process to the clinical judgment process.
    Page: 4
    Heading: Clinical Judgment Process
    Integrated Process: Clinical Problem-Solving Process (Nursing Process)
    Client Need: SECE: Coordinated Care
    Cognitive Level: Analysis [Analyzing]
    Concept: Clinical Judgment
    Difficulty: Difficult

	Feedback
1.	Identify and analyze cues is the absence of a left-hand grasp.
2.	Prioritizing hypotheses is associated with the absence of a hand grasp is alteration in cerebral perfusion.
3.	The patient flexing the left thumb and index finger evaluates outcomes of the success of the action of squeezing a rubber ball in the left hand.
4.	Coaching to squeeze a rubber ball in the left hand is the nurse taking action to improve left hand function.
5.	Generating solutions of nursing care is for the patient to self-feed using the left hand.

    PTS: 1
    CON: Patient-Centered Care