# Advanced Pharmacology for Prescribers 1st Edition Luu Kayingo Test Bank

## Chapter 1: An Introduction to Evidence-Based Clinical Practice Guidelines

MULTIPLE CHOICE

- What is the primary purpose of the nursing assessment?
    - Identifying underlying pathologic conditions
    - Assisting the physician in identifying medical conditions
    - Determining the patients mental status
    - Exploring patient responses to health problems

ANS: D

A nursing assessment is done to identify the patients response to health problems. During the nursing assessment phase, a comprehensive information base is developed through a physical examination, nursing history, medication history, and professional observation. Identifying underlying pathologic conditions and assisting the physician in identifying medical conditions is not part of the nursing process. Determining the patients mental status is one part of the nursing assessment, but it is not the primary purpose.

DIF: Cognitive Level: Comprehension
REF: dm 36 OBJ: 1 | 3 TOP: Nursing
Process Step: Assessment
MSC: NCLEX Client Needs Category: Health Promotion and Maintenance

- What is the basis of the NANDA I taxonomy?
    - Functional health patterns
    - Human response patterns
    - Basic human needs
    - Pathophysiologic needs

ANS: B

The NANDA I taxonomy identifies human response patterns. Functional components of health patterns are limited to activity, fluid volume, nutrition, self care, and sensory perception. Basic human needs comprise less than merely health patterns. Pathophysiologic needs are not part of the scope of NANDA I.

DIF: Cognitive Level: Knowledge
REF: pp. 37-38 OBJ: 5 TOP:
Nursing Process Step: Diagnosis
MSC: NCLEX Client Needs Category: Physiological Integrity

- Which task is included in the assessment step of the nursing process?
    - Establishing patient goals/outcomes
    - Implementing the nursing care plan (NCP)
    - Measuring goal/outcome achievement
    - Collecting and communicating data

ANS: D

Data are collected and communicated in the assessment phase of the nursing process. Establishing goals is the function of planning. Implementing the NCP is the function of implementation. Measuring outcome achievement is the function of evaluation.

DIF: Cognitive Level: Comprehension
REF: dm 36 OBJ: 2 | 3 TOP: Nursing
Process Step: Assessment
MSC: NCLEX Client Needs Category: Health Promotion and Maintenance

- Which statement regarding nursing diagnoses is accurate?
    - Nursing diagnoses remain the same for as long as the disease is present.
    - Nursing diagnoses are written to identify disease states.
    - Nursing diagnoses describe patient problems that nurses treat.
    - Nursing diagnoses identify causes related to illness.

ANS: C

Diagnostic statements identify problems a nurse is independently able to treat within the scope of professional practice. Nursing diagnoses vary with the changing condition of the patient. The response patterns are unique to the patient and are not disease specific. Nursing diagnoses describe the patients human response pattern.

DIF: Cognitive Level: Comprehension

REF: pp. 37-38 OBJ: 5 TOP: Nursing
Process Step: Diagnosis
MSC: NCLEX Client Needs Category: Physiological Integrity

- What do the classification systems NIC and NOC provide?
    - Individualized data banks of treatments related to disease processes
    - Standardized language for reporting and analyzing nursing care delivery
    - A measure for cost containment within medical institutions
    - Specialized interventions for rare diseases

ANS: B

Nursing classification systems such as NIC and NOC are designed to provide a standardized language for reporting and analyzing nursing care delivery that is individualized for each patient. Standardized terminology assists practitioners in the implementation of the five phases of the nursing process. Classification systems are not related to disease process and are not used for financial purposes. Classification systems include interventions for all health conditions.

DIF: Cognitive Level: Knowledge
REF: dm 34 OBJ: 11 TOP: Nursing
Process Step: Implementation
MSC: NCLEX Client Needs Category: Safe, Effective Care Environment

- Which type of nursing diagnosis will be written when the patient exhibits factors that makes him or her susceptible to the development of a problem?
    - Actual diagnosis
    - Risk diagnosis
    - Possible diagnosis
    - Wellness diagnosis

ANS: B

When patients have the potential or risk for a problem to develop, a risk diagnosis is written. These diagnoses are two part statements such as Risk for falls related to unsteady gait. An actual diagnosis consists of a NANDA diagnostic label, contributing factor (if known), and defining characteristics such as signs and symptoms. A possible nursing diagnosis

identifies a problem that may occur, but the assembled data are insufficient to confirm it. A wellness diagnosis applies to individuals for whom an enhanced level of wellness is possible.

DIF: Cognitive Level:
Comprehension REF: dm 38 OBJ: 5
TOP: Nursing Process Step:
Diagnosis
MSC: NCLEX Client Needs Category: Physiological Integrity

- Which outcome statement identified by the nurse is written correctly?
    - After surgery, patient will express acceptance of loss of breast.
    - Patient will die with dignity.
    - At the end of the shift, the nurse will determine whether the patient is more comfortable.
    - Within the next 8 hours, urine output will be greater than 30 mL/hr.

ANS: D

The statement, Within the next 8 hours, urine output will be greater than 30 mL/hr is patient oriented, realistic, and measurable, and has an appropriate time frame.

DIF: Cognitive Level: Application
REF: dm 42 OBJ: 11 TOP: Nursing
Process Step: Evaluation
MSC: NCLEX Client Needs Category: Safe, Effective Care Environment

- Which is an example of an interdependent nursing action?
    - Assess lung sounds every 4 hours.
    - Educate the patient about the prescribed medication.
    - Administer Demerol 50 mg intramuscularly (IM) every 4 hours PRN.
    - Encourage the patient to express feelings.

ANS: C

Administer Demerol 50 mg IM every 4 hours PRN requires the nurse to follow the parameters of the order, yet use nursing judgment to determine how often the medication is to be administered; therefore, it is an