Nursing home administrator / Chapter 26 & 29: More Cardiac Disorders 2023 /2024 graded A+

1. A nurse determines that the patient's condition has improved and has met expected outcomes. Which step of the nursing process is the nurse exhibiting?

a. Assessment

b. Planning

c. Implementation

d. Evaluation - ANSWER-ANS: D

Evaluation, the final step of the nursing process, is crucial to determine whether, after application of the first four steps of the nursing process, a patient's condition or well-being improves and if goals have been met. Assessment, the first step of the process, includes data collection. Planning, the third step of the process, involves setting priorities, identifying patient goals and outcomes, and selecting nursing interventions. During implementation, nurses carry out nursing care, which is necessary to help patients achieve their goals.

2. A nurse completes a thorough database and carries out nursing interventions based on priority diagnoses. Which action will the nurse take next?

a. Assessment

b. Planning

c. Implementation

d. Evaluation - ANSWER-ANS: D

Evaluation, the final step of the nursing process, is crucial to determine whether, after application of the first four steps of the nursing process, a patient's condition or well-being improves. Assessment involves gathering information about the patient. During the planning phase, patient outcomes are determined. Implementation involves carrying out appropriate nursing interventions.

3. A new nurse asks the preceptor to describe the primary purpose of evaluation. Which statement made by the nursing preceptor is most accurate?

a. "An evaluation helps you determine whether all nursing interventions were completed."

b. "During evaluation, you determine when to downsize staffing on nursing units."

c. "Nurses use evaluation to determine the effectiveness of nursing care."

d. "Evaluation eliminates unnecessary paperwork and care planning." - ANSWER-ANS: C

Evaluation is a methodical approach for determining if nursing implementation was effective in influencing a patient's progress or condition in a favorable way. During evaluation, you do not simply determine whether nursing interventions were completed. The evaluation process is not used to determine when to downsize staffing or how to eliminate paperwork and care planning.

4. After assessing the patient and identifying the need for headache relief, the nurse administers acetaminophen for the patient's headache. Which action by the nurse is priority for this patient?

a. Eliminate headache from the nursing care plan.

b. Direct the nursing assistive personnel to ask if the headache is relieved.

c. Reassess the patient's pain level in 30 minutes.

d. Revise the plan of care. - ANSWER-ANS: C

The nurse's priority action for this patient is to evaluate whether the nursing intervention of administering acetaminophen was effective. The nurse does not have enough evaluative data at this point to determine whether headache needs to be discontinued. Assessment is the nurse's responsibility and is not to be delegated to nursing assistive personnel. The nurse does not have enough evaluative data to determine whether the patient's plan of care needs to be revised.

5. A nurse is getting ready to discharge a patient who has a problem with physical mobility. What does the nurse need to do before discontinuing the patient's plan of care?

a. Determine whether the patient has transportation to get home.

b. Evaluate whether patient goals and outcomes have been met.

c. Establish whether the patient has a follow-up appointment scheduled.

d. Ensure that the patient's prescriptions have been filled to take home. - ANSWER-ANS: B

You evaluate whether the results of care match the expected outcomes and goals set for a patient before discontinuing a patient's plan of care. The patient needs transportation, but that does not address the patient's mobility status. Whether the patient has a follow-up appointment and ensuring that prescriptions are filled do not evaluate the problem of mobility.

6. The nurse is evaluating whether patient goals and outcomes have been met for a patient with physical mobility problems due to a fractured leg. Which finding indicates the patient has met an expected outcome?

a. The nurse provides assistance while the patient is walking in the hallways.

b. The patient is able to ambulate in the hallway with crutches.

c. The patient will deny pain while walking in the hallway.

d. The patient's level of mobility will improve. - ANSWER-ANS: B

The patient's being able to ambulate in the hallway with crutches is an expected outcome of nursing care. The outcomes of nursing practice are the measurable conditions of patient, family or community status, behavior, or perception. These outcomes are the criteria used to judge success in delivering nursing care. The option stating, "The patient's level of mobility will improve" is a broader goal statement. The nurse's assisting a patient to ambulate is an intervention. The patient's denying pain is an expected outcome for pain, not for physical mobility problems.

7. The nurse is evaluating whether a patient's turning schedule was effective in preventing the formation of pressure ulcers. Which finding indicates success of the turning schedule?

a. Staff documentation of turning the patient every 2 hours

b. Presence of redness only on the heels of the patient

c. Patient's eating 100% of all meals

d. Absence of skin breakdown - ANSWER-ANS: D

To determine whether a turning schedule is successful, the nurse needs to assess for the presence of skin breakdown. Redness on any part of the body, including only the patient's heels, indicates that the turning schedule was not successful. Documentation of interventions does not evaluate whether patient outcomes were met. Eating 100% of meals does not evaluate the effectiveness of a turning schedule.

8. A nurse has instituted a turn schedule for a patient to prevent skin breakdown. Upon evaluation, the nurse finds that the patient has a stage II pressure ulcer on the buttocks. Which action will the nurse take next?

a. Reassess the patient and situation.

b. Revise the turning schedule to increase the frequency.

c. Delegate turning to the nursing assistive personnel.

d. Apply medication to the area of skin that is broken down. - ANSWER-ANS: A

If a nursing diagnosis is unresolved or if you determine that a new problem has perhaps developed, reassessment is necessary. A complete reassessment of patient factors relating to an existing nursing diagnosis and etiology is necessary when modifying a plan. The nurse must assess before revising, delegating and applying medication. The breakdown may be a result of inadequate nutritional intake and medication cannot be applied unless there is an order.

9. A new nurse is confused about using evaluative measures when caring for patients and asks the charge nurse for an explanation. Which response by the charge nurse is most accurate?

a. "Evaluative measures are multiple-page documents used to evaluate nurse performance."

b. "Evaluative measures include assessment data used to determine whether patients have met their expected outcomes and goals."

c. "Evaluative measures are used by quality assurance nurses to determine the progress a nurse is making from novice to expert nurse."

d. "Evaluative measures are objective views for completion of nursing interventions." - ANSWER-ANS: B

You conduct evaluative measures to determine if your patients met expected outcomes, not if nursing interventions were completed. Evaluative measures are assessment skills and techniques. Evaluative measures are not multiple-page documents, and they are used to assess the patient's status, not the nurse's performance or progress from novice to expert.

10. The nurse is caring for a patient who has an open wound and is evaluating the progress of wound healing. Which priority action will the nurse take?

a. Ask the nursing assistive personnel if the wound looks better.

b. Document the progress of wound healing as "better" in the chart.

c. Measure the wound and observe for redness, swelling, or drainage.

d. Leave the dressing off the wound for easier access and more frequent assessments. - ANSWER-ANS: C

You examine the results of care by using evaluative measures, which are assessment skills and techniques (e.g., observations, physiological measurements, use of measurement scales, and patient interview). The nurse performs evaluative measures, such as completing a wound assessment, to evaluate wound healing. Nurses do not delegate assessment to nursing assistive personnel. Documenting "better" is subjective and does not objectively describe the wound. Leaving the dressing off for the nurse's benefit of easier access is not a part of the evaluation process.

11. The nurse is caring for a patient who has an order to change a dressing twice a day, at 0600 and 1800. At 1400, the nurse notices that the dressing is saturated and leaking. What is the nurse's next action?

a. Wait and change the dressing at 1800 as ordered.

b. Revise the plan of care and change the dressing now.

c. Reassess the dressing and the wound in 2 hours.

d. Discontinue the plan of care for wound care. - ANSWER-ANS: B