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Concepts for Nursing Practice

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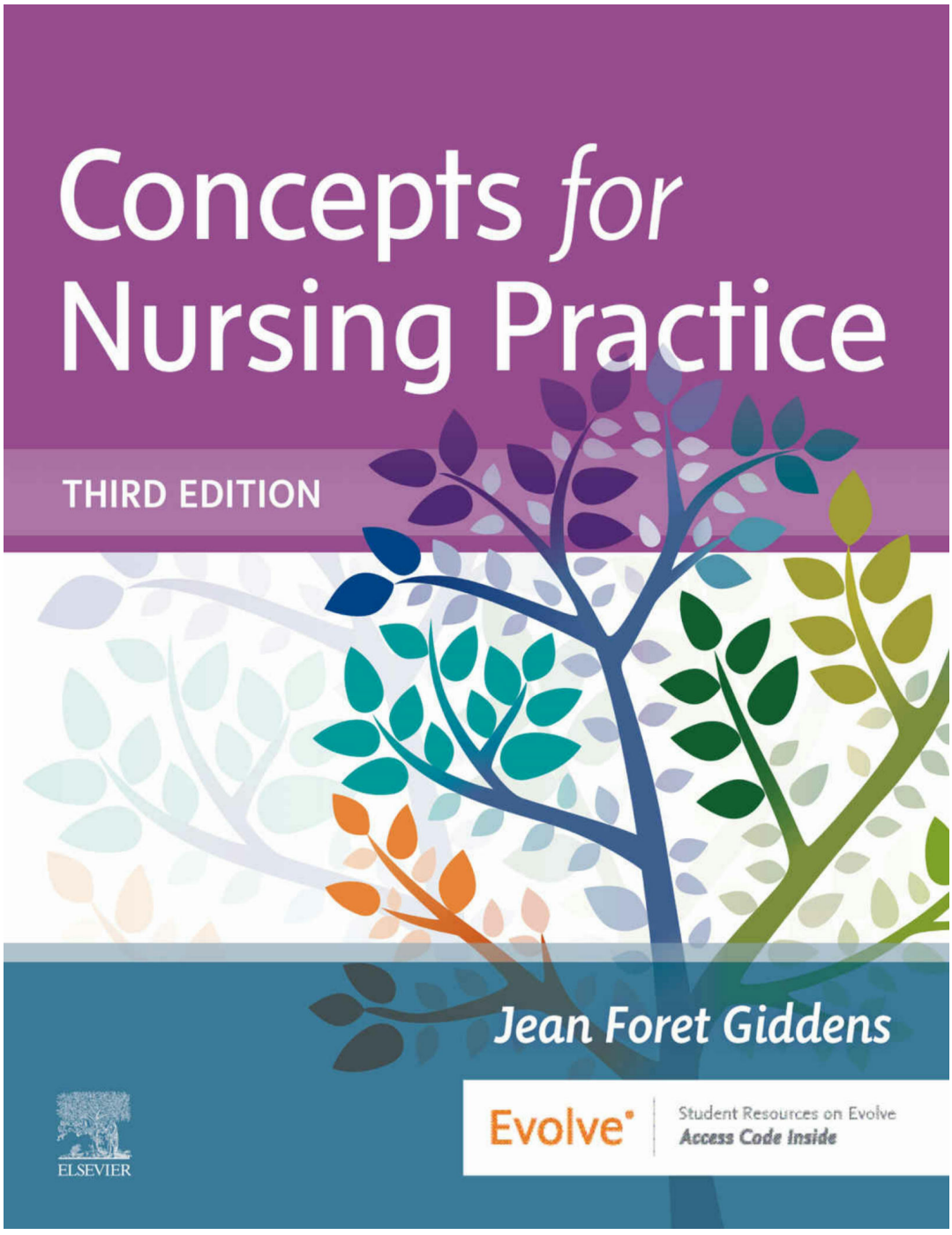
3rd Edition



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Concept 01: Development
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MULTIPLE CHOICE

1. The nurse manager of a pediatric clinic could confirm that the new nurse recognized the purpose of the HEADSS Adolescent Risk Profile when the new nurse responds that it is used to assess for needs related to
   a. anticipatory guidance.
   b. low-risk adolescents.
   c. physical development.
   d. sexual development.

   ANS: A
   The HEADSS Adolescent Risk Profile is a psychosocial assessment screening tool which assesses home, education, activities, drugs, sex, and suicide for the purpose of identifying high-risk adolescents and the need for anticipatory guidance. It is used to identify high-risk, not low-risk, adolescents. Physical development is assessed with anthropometric data. Sexual development is assessed using physical examination.

   OBJ: NCLEX Client Needs Category: Health Promotion and Maintenance

2. The nurse preparing a teaching plan for a preschooler knows that, according to Piaget, the expected stage of development for a preschooler is
   a. concrete operational.
   b. formal operational.
   c. preoperational.
   d. sensorimotor.

   ANS: C
   The expected stage of development for a preschooler (3–4 years old) is pre-operational. Concrete operational describes the thinking of a school-age child (7–11 years old). Formal operational describes the thinking of an individual after about 11 years of age. Sensorimotor describes the earliest pattern of thinking from birth to 2 years old.

   OBJ: NCLEX Client Needs Category: Health Promotion and Maintenance

3. The school nurse talking with a high school class about the difference between growth and development would best describe growth as
   a. processes by which early cells specialize.
   b. psychosocial and cognitive changes.
   c. qualitative changes associated with aging.
   d. quantitative changes in size or weight.

   ANS: D

Growth is a quantitative change in which an increase in cell number and size results in an increase in overall size or weight of the body or any of its parts. The processes by which early cells specialize are referred to as *differentiation.* Psychosocial and cognitive changes are referred to as *development.* Qualitative changes associated with aging are referred to as *maturation.*

OBJ: NCLEX Client Needs Category: Health Promotion and Maintenance

4. The *most* appropriate response of the nurse when a mother asks what the Denver II does is that it
   a. can diagnose developmental disabilities.
   b. identifies a need for physical therapy.
   c. is a developmental screening tool.
   d. provides a framework for health teaching.

   ANS: C
   The Denver II is the most commonly used measure of developmental status used by healthcare professionals; it is a screening tool. Screening tools do not provide a diagnosis. Diagnosis requires a thorough neurodevelopment history and physical examination. Developmental delay, which is suggested by screening, is a symptom, not a diagnosis. The need for any therapy would be identified with a comprehensive evaluation, not a screening tool. Some providers use the Denver II as a framework for teaching about expected development, but this is not the primary purpose of the tool.

   OBJ: NCLEX Client Needs Category: Health Promotion and Maintenance

5. To plan early intervention and care for an infant with Down syndrome, the nurse considers knowledge of other physical development exemplars such as
   a. cerebral palsy.
   b. autism.
   c. attention-deficit/hyperactivity disorder (ADHD).
   d. failure to thrive.

   ANS: D
   Failure to thrive is also a physical development exemplar. Cerebral palsy is an exemplar of motor/developmental delay. Autism is an exemplar of social/emotional developmental delay. ADHD is an exemplar of a cognitive disorder.

   OBJ: NCLEX Client Needs Category: Health Promotion and Maintenance

6. To plan early intervention and care for a child with a developmental delay, the nurse would consider knowledge of the concepts most significantly impacted by development, including
   a. culture.
   b. environment.
   c. functional status.
   d. nutrition.

   ANS: C

Function is one of the concepts most significantly impacted by development. Others include sensory-perceptual, cognition, mobility, reproduction, and sexuality. Knowledge of these concepts can help the nurse anticipate areas that need to be addressed. Culture is a concept that is considered to significantly affect development; the difference is the concepts that affect development are those that represent major influencing factors (causes); hence determination of development would be the focus of preventive interventions. Environment is considered to significantly affect development. Nutrition is considered to significantly affect development.

OBJ: NCLEX Client Needs Category: Health Promotion and Maintenance

7. A mother complains to the nurse at the pediatric clinic that her 4-year-old child always talks to her toys and makes up stories. The mother wants her child to have a psychological evaluation. The nurse's *best* initial response is to
   a. refer the child to a psychologist immediately.
   b. explain that playing make believe is normal at this age.
   c. complete a developmental screening using a validated tool.
   d. separate the child from the mother to get more information.

   ANS: B
   By the end of the fourth year, it is expected that a child will engage in fantasy, so this is normal at this age. A referral to a psychologist would be premature based only on the complaint of the mother. Completing a developmental screening would be very appropriate but not the initial response. The nurse would certainly want to get more information, but separating the child from the mother is not necessary at this time.

   OBJ: NCLEX Client Needs Category: Health Promotion and Maintenance

8. A 17-year-old girl is hospitalized for appendicitis, and her mother asks the nurse why she is so needy and acting like a child. The *best* response of the nurse is that in the hospital, adolescents
   a. have separation anxiety.
   b. rebel against rules.
   c. regress because of stress.
   d. want to know everything.

   ANS: C
   Regression to an earlier stage of development is a common response to stress. Separation anxiety is most common in infants and toddlers. Rebellion against hospital rules is usually not an issue if the adolescent understands the rules and would not create childlike behaviors. An adolescent may want to "know everything" with their logical thinking and deductive reasoning, but that would not explain why they would act like a child.

   OBJ: NCLEX Client Needs Category: Health Promotion and Maintenance

Concept 02: Functional Ability
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MULTIPLE CHOICE

1. The nurse is assessing a patient's functional ability. Which patient *best* demonstrates the definition of functional ability?
   a. Considers self as a healthy individual; uses cane for stability
   b. College educated; travels frequently; can balance a checkbook
   c. Works out daily, reads well, cooks, and cleans house on the weekends
   d. Healthy individual, volunteers at church, works part time, takes care of family and house

   ANS: D
   Functional ability refers to the individual's ability to perform the normal daily activities required to meet basic needs; fulfill usual roles in the family, workplace, and community; and maintain health and well-being. The other options are good; however, healthy individual, church volunteer, part time worker, and the patient who takes care of the family and house fully meets the criteria for functional ability.

   OBJ: NCLEX Client Needs Category: Physiological Integrity: Basic Care and Comfort

2. The nurse is assessing a patient's functional performance. What assessment parameters will be *most* important in this assessment?
   a. Continence assessment, gait assessment, feeding assessment, dressing assessment, transfer assessment

   b. Height, weight, body mass index (BMI), vital signs assessment
   c. Sleep assessment, energy assessment, memory assessment, concentration assessment
   d. Health and well-being, amount of community volunteer time, working outside the home, and ability to care for family and house

   ANS: A
   Functional impairment, disability, or handicap refers to varying degrees of an individual's inability to perform the tasks required to complete normal life activities without assistance. Height, weight, BMI, and vital signs are part of a physical assessment. Sleep, energy, memory, and concentration are part of a depression screening. Healthy, volunteering, working, and caring for family and house are functional abilities, not performance.

   OBJ: NCLEX Client Needs Category: Physiological Integrity: Reduction of Risk Potential

3. The nurse is assessing a patient with a mobility dysfunction and wants to gain insight into the patient's functional ability. What question would be the *most* appropriate?
   a. "Are you able to shop for yourself?"
   b. "Do you use a cane, walker, or wheelchair to ambulate?"
   c. "Do you know what today's date is?"
   d. "Were you sad or depressed more than once in the last 3 days?"

   ANS: B

"Do you use a cane, walker, or wheelchair to ambulate?" will assist the nurse in determining the patient's ability to perform self-care activities. A nutritional health risk assessment is not the functional assessment. Knowing the date is part of a mental status exam. Assessing sadness is a question to ask in the depression screening.

OBJ: NCLEX Client Needs Category: Physiological Integrity: Physiological Adaptation

4. The nurse is developing an interdisciplinary plan of care using the Roper-Logan-Tierney Model of Nursing for a patient who is currently unconscious. Which interventions would be most critical to developing a plan of care for this patient?
   a. Eating and drinking, personal cleansing and dressing, working and playing
   b. Toileting, transferring, dressing, and bathing activities
   c. Sleeping, expressing sexuality, socializing with peers
   d. Maintaining a safe environment, breathing, maintaining temperature

   ANS: D
   The most critical aspects of care for an unconscious patient are safe environment, breathing, and temperature. Eating and drinking are contraindicated in unconscious patients. Toileting, transferring, dressing, and bathing activities are BADLs. Sleeping, expressing sexuality, and socializing with peers are a part of the Roper-Logan-Tierney Model of Nursing; however, these are not the most critical for developing the plan of care in an unconscious patient.

   OBJ: NCLEX Client Needs Category: Physiological Integrity: Physiological Adaptation

5. The home care nurse is trying to determine the necessary services for a 65-year-old patient who was admitted to the home care service after left knee replacement. Which tool is the *best* for the nurse to utilize?
   a. Minimum Data Set (MDS)
   b. Functional Status Scale (FSS)
   c. 24-Hour Functional Ability Questionnaire (24hFAQ)
   d. The Edmonton Functional Assessment Tool

   ANS: C
   The 24hFAQ assesses the postoperative patient in the home setting. The MDS is for nursing home patients. The FSS is for children. The Edmonton is for cancer patients.

   OBJ: NCLEX Client Needs Category: Health Promotion and Maintenance

6. The nurse is assessing a patient's functional abilities and asks the patient, "How would you rate your ability to prepare a balanced meal?" "How would you rate your ability to balance a checkbook?" "How would you rate your ability to keep track of your appointments?" Which tool would be indicated for the best results of this patient's perception of their abilities?
   a. Functional Activities Questionnaire (FAQ)™
   b. Mini Mental Status Exam (MMSE)
   c. 24hFAQ
   d. Performance-based functional measurement

   ANS: A

The FAQ is an example of a self-report tool which provides information about the patient's perception of functional ability. The MMSE assesses cognitive impairment. The 24hFAQ is used to assess functional ability in postoperative patients. Performance-based tools involve actual observation of a standardized task, completion of which is judged by objective criteria.

OBJ: NCLEX Client Needs Category: Health Promotion and Maintenance

MULTIPLE RESPONSE

1. A 65-year-old female patient has been admitted to the medical/surgical unit. The nurse is assessing the patient's risk for falls so that falls prevention can be implemented if necessary. Select all the risk factors that apply from this patient's history and physical. (*Select all that apply*.)
   a. Being a woman
   b. Taking more than six medications
   c. Having hypertension
   d. Having cataracts
   e. Muscle strength 3/5 bilaterally
   f. Incontinence

   ANS: B, D, E, F

   Adverse effects of medications can contribute to falls. Cataracts impair vision, which is a risk factor for falls. Poor muscle strength is a risk factor for falls. Incontinence of urine or stool increases risk for falls. Men have a higher risk for falls. Hypertension itself does not contribute to falls. Taking me dications to treat hypertension that may lead to hypotension and dizziness is a fall risk. Dizziness does contribute to falls.

   OBJ: NCLEX Client Needs Category: Physiological Integrity: Reduction of Risk Potential

Concept 03: Family Dynamics
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MULTIPLE CHOICE

1. The *most* appropriate initial nursing intervention when the nurse notes dysfunctional interactions and lack of family support for a patient would be to
   a. enforce hospital visiting policies.
   b. monitor the dysfunctional interactions.
   c. notify the primary care provider.
   d. role model appropriate support.

   ANS: D
   Nurses can, at times, role model more appropriate interactions or provide suggestions for improving communication and interactions among family members. If the nurse determines that the number of visitors has a negative impact on the patient, hospital policy may be to limit visitors, but that would not be the initial action. Monitoring the dysfunctional interactions would not be an adequate response. The primary care provider should certainly be notified, but that would not be the initial response.

   OBJ: NCLEX Client Needs Category: Psychosocial Integrity

2. The nurse caring for a patient would identify a need for additional interventions related to family dynamics when
   a. extended family offers to help.
   b. family members express concern.
   c. the ill member demands attention.
   d. memories are shared.

   ANS: C
   It is not uncommon for the ill family member to become demanding and indicate that they deserve special treatment and care, and the supportive family may need assistance in understanding the dynamics of the illness in order to continue to be supportive. Offers from extended family to help can be indicative of positive dynamics. Concern expressed by family members can be indicative of positive dynamics. Sharing of family memories can be indicative of positive dynamics.

   OBJ: NCLEX Client Needs Category: Psychosocial Integrity

3. Two women have an established long-term relationship and are attending parenting classes in anticipation of finalizing adoption of a baby. The nurse identifies them as which type of family?
   a. Cohabiting
   b. Nuclear
   c. Same-sex
   d. Single parent

   ANS: C