Med surg practice questions essay

ASSIGN BUSTER

The nurse has admitted a patient with a new diagnosis of pneumonia and explained to the patient that together they will plan the patient's care and set goals for discharge. The patient says, " How is that different from what the doctor does? " Which response by the nurse is most appropriate? " In addition to caring for you while you are sick, the nurses will assist you to develop an individualized plan to maintain your health. " This response is consistent with the American Nurses Association (ANA) definition of nursing, which describes the role of nurses in promoting health.

The other responses describe some of the dependent and collaborative functions of the nursing role but do not accurately describe the nurse's role in the health care system. When providing patient care using evidence-based practice, the nurse uses evidence-based guidelines in addition to clinical expertise. Evidence-based practice (EBP) is the use of the best research-based evidence combined with clinician expertise. Clinical judgment based on the nurse's clinical experience is part of EBP, but clinical decision making also should incorporate current research and research-based guidelines.

Evidence from one clinical research study does not provide an adequate substantiation for interventions. Evaluation of patient outcomes is important, but interventions should be based on research from randomized control studies with a large number of subjects. The nurse primarily uses the nursing process in the care of patients as a problem-solving tool to identify and treat patients' health care needs The nursing process is a problem-solving approach to the identification and treatment of patients' problems. Diagnosis is only one phase of the nursing process.

The primary use of the nursing process is in patient care, not to establish nursing theory or explain nursing interventions to other health care professionals. The nurse plans an every 2-hour turning schedule to prevent skin breakdown for a critically ill patient in the intensive care unit. In this case, the nursing action is considered to be collaborative. When implementing collaborative nursing actions, the nurse is responsible primarily for monitoring for complications of acute illness or providing care to prevent or treat complications. Independent nursing actions are focused on health promotion, illness prevention, and patient advocacy.

A dependent action would require a physician order to implement. Cooperative nursing functions are not described as one of the formal nursing functions. A patient who has been admitted to the hospital for surgery tells the nurse, “ I do not feel right about leaving my children with my neighbor. ” Which action should the nurse take next? Gather more data about the patient’s feelings about the childcare arrangements. Since a complete assessment is necessary in order to identify a problem and choose an appropriate intervention, the nurse’s first action should be to obtain more information.

The other actions may be appropriate, but more assessment is needed before the best intervention can be chosen. A patient with a stroke is paralyzed on the left side of the body and has developed a pressure ulcer on the left hip. The best nursing diagnosis for this patient is impaired skin integrity related to altered circulation and pressure. The patient’s major problem is the impaired skin integrity as demonstrated by the presence of a

pressure ulcer. The nurse is able to treat the cause of altered circulation and pressure by frequently repositioning the patient.

Although left-sided weakness is a problem for the patient, the nurse cannot treat the weakness. The “ risk for” diagnosis is not appropriate for this patient, who already has impaired tissue integrity. The patient does have ineffective tissue perfusion, but the impaired skin integrity diagnosis indicates more clearly what the health problem is. A patient with an infection has a nursing diagnosis of deficient fluid volume related to excessive diaphoresis. An appropriate patient outcome identified by the nurse is that the patient has a balanced intake and output.

This statement gives measurable data showing resolution of the problem of deficient fluid volume that was identified in the nursing diagnosis statement. The other statements would not indicate that the problem of deficient fluid volume was resolved. A nursing activity that is carried out during the evaluation phase of the nursing process is determining if interventions have been effective in meeting patient outcomes. Evaluation consists of determining whether the desired patient outcomes have been met and whether the nursing interventions were appropriate. The other responses do not describe the evaluation phase.

During the assessment phase of the nursing process, the nurse obtains data with which to diagnose patient problems. During the assessment phase, the nurse gathers information about the patient. The other responses are examples of the intervention, diagnosis, and planning phases of the nursing process. An example of a correctly written nursing diagnosis statement is

ineffective coping related to response to biopsy test results. This diagnosis statement includes a NANDA nursing diagnosis and an etiology that describes a patient’s response to a health problem that can be treated by nursing.

The use of a medical diagnosis (as in the responses beginning “ Altered tissue perfusion” and “ Altered urinary elimination”) is not appropriate. The response beginning “ Risk for impaired tissue integrity” uses the defining characteristics as the etiology. The nurse writes a complete nursing diagnosis statement by including a problem with its etiology and the signs and symptoms of the problem. The PES format is used when writing nursing diagnoses. The subjective, as well as objective, data should be included in the defining characteristics. Interventions and outcomes are not included in the nursing diagnosis statement.

Using the Situation-Background-Assessment-Recommendation (SBAR) format, in which order should the nurse make these statements to communicate a change in patient status to a health care provider? This is the nurse on the surgical unit. I am calling about Mr. A in room 3. After assessing him, I am very concerned about his shortness of breath. A, D, B The order of the nurse’s statements follows the SBAR format. Which of these nursing actions for the patient with heart failure is appropriate for the nurse to delegate to experienced nursing assistive personnel (NAP)?

Obtain the patient’s blood pressure and pulse rate after ambulation. NAP education includes accurate vital sign measurement. Assessment and patient teaching require RN education and scope of practice and cannot be

delegated. Which action by a newly graduated RN working on the postsurgical unit indicates that more education about delegation and assignment is needed? The nurse delegates assessment of a patient’s bowel sounds to experienced NAP. Assessment requires RN education and scope of practice and cannot be delegated to NAP. The other actions by the new RN are appropriate.

Which of these tasks is appropriate for the registered nurse to delegate to a licensed practical/vocational nurse? Perform a sterile dressing change for an infected wound. The education and scope of practice of the LPN/LVN include activities such as sterile dressing changes. Patient teaching and the initial assessment and development of the plan of care are nursing actions that require RN-level education and scope of practice. The nurse obtains information about all these areas during the health interview for a new patient. Which area will be the focus of patient teaching?

Refined carbohydrate intake Behaviors are strongly linked to many health care problems. The patient’s carbohydrate intake is a behavior that the patient can change. The other information will be useful as the nurse develops an individualized plan for improving the patient’s health, but will not be the focus of patient education. When developing strategies to decrease health care disparities, the nurse working in a clinic located in a neighborhood with many Vietnamese individuals will include educating staff about Vietnamese health beliefs.

Health care disparities are due to stereotyping, biases, and prejudice of health care providers; the nurse can decrease these through staff education.

The other strategies also may be addressed by the nurse but will not impact health disparities. Which information will the nurse need to collect when assessing the health status of a community? Median life expectancy for the community Health status is the aggregate of all health measures for individuals in a community and includes data such as life expectancy, birth and death rates, and mortality from various diseases.

Although income, traffic patterns, and occupations are factors that impact a community’s health status, they are not health measures. A family member of an elderly Hispanic patient admitted to the hospital tells the nurse that the patient has traditional beliefs about health and illness. The best action by the nurse is to ask the patient whether it is important that cultural healers are contacted. Because the patient has traditional health care beliefs, it is appropriate for the nurse to ask whether the patient would like a visit by a curandero(a) or other cultural healers.

There is no cultural reason for the nurse to avoid asking the patient questions, and questions may be necessary to obtain necessary health information. The patient (rather than the daughter) should be consulted about personal cultural beliefs. The hospital routines for meals, care, and visits should be adapted to the patient’s preferences rather than expecting the patient to adapt to the hospital schedule. When caring for a patient who is Native American, the best initial action by the nurse is to observe the patient’s use of eye contact.

Observation of the patient’s use of eye contact will be most useful in determining the best way to communicate effectively with the patient.

Looking directly at the patient or avoiding eye contact may be appropriate, depending on the patient's individual cultural beliefs. The nurse should assess the patient, rather than asking family members about the patient's beliefs. A new RN graduate is assessing a newly admitted non–English-speaking Chinese patient who complains of severe headaches. The charge nurse should intervene if the new RN's first action is to Palpate the patient's scalp.

Many people of Asian ethnicity believe that touching a person's head is disrespectful; the RN should ask permission before touching the patient's head. The other actions are appropriate. If an interpreter is not available when a patient speaks a language different from the nurse's language, it is appropriate for the nurse to use simple gestures to demonstrate meaning while talking to the patient. The use of gestures will enable some information to be communicated to the patient. The other actions will not improve communication with the patient.

When planning care for a hospitalized patient who uses culturally based treatments, the most appropriate action by the nurse is to coordinate the use of folk treatments with ordered medical therapies. Many culturally based therapies can be accommodated along with the use of Western treatments and medications. The nurse should attempt to use both traditional folk treatments and the ordered Western therapies as much as possible. Some culturally based treatments can be effective in treating " Western" diseases. Not all folk remedies interfere with Western therapies.

It may be appropriate for the patient to continue some culturally based treatments while he or she is hospitalized. The best example of culturally appropriate nursing care when caring for a newly admitted patient is asking permission before touching a patient during the physical assessment. Many cultures consider it disrespectful to touch a patient without asking permission, so asking a patient for permission is always culturally appropriate. The other actions may be appropriate for some patients but are not appropriate across all cultural groups or for all individual patients.

While talking with the nursing supervisor, a staff nurse expresses frustration that a Native American patient always has several family members at the bedside. The most appropriate action by the nursing supervisor is to ask about the nurse’s personal beliefs about family support during hospitalization. The first step in providing culturally competent care is to understand one’s own beliefs and values related to health and health care. Asking the nurse about personal beliefs will help to achieve this step.

Reminding the nurse that this cultural practice is important to the family and patient will not decrease the nurse’s frustration. The remaining responses (suggest that the nurse ask family members to leave the room, and have the nurse explain to family that too many visitors will tire the patient) are not culturally appropriate for this patient. An 82-year-old Asian American patient tells the nurse that she has lived in the United States for 50 years. The patient speaks English but lives in a predominantly Asian neighborhood.

The nurse will need to ask the patient about any special cultural beliefs or practices . Further assessment of the patient’s health care preferences is

needed before making further plans for culturally appropriate care. The other responses indicate stereotyping of the patient, based on ethnicity, and would not be appropriate initial actions. When planning health care for a community with a large number of recent immigrants from China, the most important intervention for the nurse to include is tuberculosis screening.

Tuberculosis (TB) is endemic in many parts of Asia, and the incidence of TB is much higher in immigrants from China than in the general U. S. population. Teaching about contraceptive use, colonoscopy, and testing for pregnancy also may be appropriate for some patients but is not generally indicated for all members of this community. When doing an admission assessment for a patient, the nurse notices that the patient pauses before answering questions about the health history. The most appropriate action by the nurse is to wait for the patient to answer the questions.

Patients from some cultures take time to consider a question carefully before answering. The nurse will show respect for the patient and help develop a trusting relationship by allowing the patient time to give a thoughtful answer. Asking the patient why the answers are taking so much time, stopping the assessment, and handing the patient a form indicate that the nurse does not have time for the patient. Which of these strategies should be a priority when the nurse is planning care for a hypertensive patient who is uninsured? Follow evidence-based national guidelines.

The use of standardized evidence-based guidelines will reduce the incidence of health care disparities among various socioeconomic groups. The other strategies also may be appropriate, but the priority concern should be that

the patient receives care that meets the accepted standard. A Hispanic patient complains of abdominal cramping caused by empacho. The nurse’s first action should be to ask the patient what treatments are likely to help. Further assessment of the patient’s cultural beliefs is appropriate before implementing any interventions for a culture-bound syndrome such as empacho.

Although medication, a visit by a curandero(a), or massage may be helpful, more information about the patient’s beliefs is needed to determine which intervention(s) will be most helpful. When performing a cultural assessment with a patient of a different culture, the nurse’s first action should be to ask the patient about any affiliation with a particular cultural group. An early step in performing a cultural assessment is to determine whether the patient feels an affiliation with any cultural group. The other actions may be appropriate if the patient does identify with a particular culture.