08 December 2023 09:20

To be as sharp as possible when answering test questions, follow these steps

Identify the parts of a question

-the scenario which tells you about the situation

-the stem which contains the actual problem/question to be answered

Which of the following is a basic nursing responsibility related to drug administration? (Correct)

1. Monitoring the client's response to the administration of the drug

2. Determining the appropriate drug dosage

3. Selecting the best route of administration of the drug

4. Ordering the drug from the pharmacy

Example:

Which is the best definition of a medication? (correct)

1. Chemical that treats symptoms of disease

2. Drug used for a therapeutic effect

3. Pharmacological preparation used to reverse disease

4 Plant, animal, or mineral substance which prevents. disease

APPROACHES TO SPECIFIC TYPES OF QUESTIONS

Questions That Require Priority Setting

Guidelines for establishing priorities are as follows

The nurse should always assess (gather pertinent data) before deciding on and taking an action. This is reflected in the steps of the Nursing Process, assess, diagnose, plan, intervene, and evaluate.

(1) • Physiological needs must be met first. The client must be kept alive for anything else to be important. Next in importance are safety needs and then come psychological needs. This is outlined in Maslows hierarchy

• When prioritizing physiological needs remember your ABCs airway, breathing, and circulation

• Which answer will keep the client sale/prevent client harm? It is especially relevant when the question deals with laboratory values, drug administration, and nursing.

Communication Questions

Therapeutic communication promotes expression of feelings and ideas and also conveys acceptance and respect. Like any communication, it involves both verbal and nonverbal components. Major techniques to facilitate therapeutic communication are as follows:

Communicate in an accepting and respectful manner. Address (refer to) the client by his/her given name- not by a nickname, a room number, or "sweetie " Names other than the given name should only be used upon the client's request or permission. Clients should be asked, not told, whenever appropriate. This allows for client decision making and hence communicates respect for the client as an able, intelligent individual.

Examples:

What would you like to do first?

What would you like to talk about?

• Use open-ended questions. These are questions that cannot be answered with a Yes or a No.

Examples:

What do you think about this plan?

What questions do you have?

How do you feel about going home tomorrow?

Tell me about your headaches.

Reflect feelings expressed by the client. Remember that feelings are expressed verbally and nonverbally. These may be contradictory but feelings expressed nonverbally are usually true because nonverbal communication is harder to control. Reflection indicates empathy, allows validation of the perceived feelings, and allows the client to "look at" his/her feelings. Words used in reflection should be neutral unless the client uses an emotionally charged word.

Examples: You seen sad.

You seem unsure You must feel lonely sometimes.

I get the feeling you are upset.

Do not say -

You are depressed

You can't make a decision.

It must be awful being alone all the time.

You must be really mad at your neighbor. Focus the conversation on important areas

Examples: Let's talk a little more about

You were talking about the problem you had with changing your dressing, lets go back and explore that further.

• Paraphrase or restate what the client has said in your own words. This allows the client to validate the

further.

• Paraphrase or restate what the client has said in your own words. This allows the client to validate the message or correct misunderstanding

Examples:

What you are saying is

Let me make sure I understand

What I hear you saying is.

Summarize the communication.

Therapeutic communication also involves (a) active listening, (b) stating observations made about the client but never any that would embarrass or anger the client ("You look rested or "You seem quiet today. Not "You look terrible."), (c) reflecting empathy or an understanding of the importance of a situation to the client in a neutral, nonjudgmental manner ("It must be very disheartening "), (d) sharing hope, humor, and feelings, (e) using touch and silence, (f) asking pertinent questions, and (g) giving information.

Nontherapeutic (blocking) communication techniques hinder further communication and expression of feelings. and may induce negative responses. Some examples of non-therapeutic communication techniques are: Asking unnecessary personal questions: "Why are you just living with Mary rather than marrying her?" "Why are you still living at home?" "How come you haven't bought a house?

Giving personal advice or opinions: "If I were you I would make my son move out." "I think you should stop cooking for the whole family

• Flip or automatic responses, use of cliches. "Everything will work out." "Don't worry." "It happens all the time , it doesn't mean anything"

Example:

A client who has been hospitalized for 2 weeks says to the nurse "I can't stay here anymore, I have to get back to my family. Which is the most appropriate response for the nurse to make?

A. "Don't worry, Your family will be fine."
B. "If I were you, I'd take advantage of the rest you're get ting while away from the family
C. "Would you like to talk about how you feel?
D. "Is your family unable to get along without you?"

In some cases, the question may be asking you to identify the nontherapeutic or misappropriate response. Be alert for this when reading questions and then select the option containing a response that would be incorrect for the nurse to make as the answer..

Example:

A client states "My family doesn't seem to understand my illness." Which response on the part of the nurse would most likely block further discussion?

a. "They may not seem to, but I'm sure they do

b. "In what way do they react to give you that feeling?"

C. "Your family doesn't seem to understand"

d. "What makes you think that?"

Client-Teaching Questions

There are different types of client-teaching questions. Some are very straightforward simply asking what should the nurse teach.

Example

Which instruction/information should the nurse include in the teaching plan for a client with genital herpes? Which instruction/information should the nurse give to a client with genital herpes?

A variation on this type of question asks you to identify not what needs to be taught but when or by whom, teaching is needed.

Example:

Which client should be taught about the need for potassium in the daily diet?

a. Client taking daily NSAIDS for arthritis

b. Client taking Toprol XL daily for hypertension

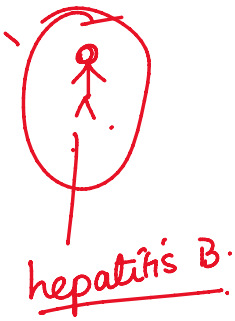
c. Client takes along Fosamax weekly for osteoporosis

d. Client taking Hydrodiuril daily for fluid retention

Positive questions ask you to select an answer that is a correct statement in activity something that should be done or said.

Examples of positively phrased questions: Which statement made by a client with hepatitis B following discharge teaching indicates that instruction was effective?

Which statement made by a client with hepatitis B indicates that discharge instructions were understood?



Negatively phrased questions ask you to identify the answer that indicates the client does not know, has misunderstood, or has not learned. It requires that you identify an incorrect statement-not a correct one. Negative questions require that you choose from the options the one that is incorrect or should not be said or done. Note that negative questions do not necessarily have a negative word (not, no, incorrect, etc.) in the stem

Examples of negatively phrased questions;

Which statement made by a client taking Fosamax once a week for the treatment of osteoporosis indicates that the directions for taking the medication were not understood?

Which action taken by a client who has been taught to self-administer insulin indicates that further teaching/ instruction is necessary?

WORKSHEET

IDENTIFYING FACILITATING AND BLOCKING RESPONSES

Directions: Read each statement or set of statements and decide if therapeutic communication is being facilitated or blocked. Write your decision at the end of each.

1. Client: "I'm so worried about my surgery
   Nurse: "We do 10 of these procedures every week and they all come out fine." Blocked.

2. Client: "I keep thinking about my husband and how he is managing at home by himself."

Nurse: "You just have to put him out of your mind and concentrate on getting better" Blocked.

3. Client: "I don't know how I am going to cope with all the bills from being in the hospital."

Nurse: "I'll have a social worker stop by to go over your insurance" Blocked.

4. Client's daughter: "I don't know how I am going to arrange care for my mother at home while I work."

Nurse: "If it were me I would put her in a nursing home where she would have round-the-clock care. Blocked.

5. Client: "I am such a burden on everybody since I had the stroke."

Nurse: "What makes you say that?" Facilitated.

6. Client: "I'll never learn how to give myself this injection."
   Nurse: "Of course you will." Blocked

7. Infant client's mother. "I'm afraid that I will forget how to correctly prepare the baby's formula when I get home."

Nurse: "Would you like me to go over the procedure with you one more time?" Facilitated

8. Client: "Having that test was the worst experience I've had in my whole life"

Nurse: "Tell me what happened." Facilitated.

9. Client: I have to begin to have my husband help with the housework when I get home.

Nurse "Do you have a plan. in mind as to how you are going to do this!"

10. Client: "I can't use a diaphragm anymore, its just too

messy and inconvenient.

Nurse: "Would you like information on other forms of birth control?"

11. Client. "My son doesn't want to visit me anymore. He says I am always complaining

Nurse: "Children expect their parents to be perfect. He'll get over it

12 Nurse: "You shouldn't feel that way. Things will be different when you're better."

. Client: "I can't do anything right."

13. Client: "I am so upset about my roommate's visitor tripping over my slippers yesterday."

Nurse: "My advice to you is to forget it she didn't get hurt."

14. Client "My son-in-law refused to bring my grand-

daughter to visit me Nurse "That's mean, it must make you angry"

15. Client: "I don't think I am going to make it out of here I am just so weak."

Nurse: "You are very depressed."

LEGAL RIGHTS AND RESPONSIBILITIES

PROFESSIONAL LEGAL ISSUES

Legal controls on the practice of nursing are to protect the public. Law provides a framework for identifying what nursing actions are legal, differentiating the nurses responsibilities from those of other health care professionals, establishing the boundaries of independent nursing actions, and assisting in maintenance of a standard of nursing practice.

Nurse Practice Act

This is a set of laws defining the scope of nursing practice. Each state has its own Nurse Practice Act usually administered by the State Board of Nursing. Most Nurse Practice Acts address performing services for compensation, specialized knowledge bases, use of the nursing process, and components of nursing practice.

Licensure

License is a legal credential conferred by a state granting permission to an individual to practice a given profession. It is commonly required for professions requiring direct contact with clients.

Licensure requires that a level of competency be demonstated by the individual seeking a license, for an RN license this is done by passing the NCLEX-RN. Mandatory licensure for registered nursing is the standard in the United States-one must have a valid nursing license to work in any state, territory, or province. RN Nurse Licensure Compact (NLC) is a mutual recognition licensure model which allows a nurse to be licensed in his or her state of residence but to practice physically or electronically in other compact states, Practice in compact states is subject to each states practice law and regulation.

Each state or jurisdiction establishes its own licensing laws, which usually require graduation from an approved nursing educational program, passing score on the NCLEX-RN, a good moral character, good physical and mental health, and disclosure of criminal convictions.

Standards of care are authoritative statements that define an acceptable level of patient care (professional practice). These are used to evaluate the quality of care provided by the nurse and, therefore, become legal guidelines for nursing practice.

American Nurses Association (ANA) has developed general standards and guidelines for more than 20 specialty nursing practice areas. State Nurse Practice Acts describe standards of practice that apply to a nurse in the particular state

• Individual health care agencies may have developed standards of care for selected patient problems, e.g, critical pathways, clinical pathways.

Malpractice

Malpractice is the term used when a nurse while performing her/his responsibilities commits an act of negligence resulting in harm to the patient.

• Harm must be based on the failure to act in a prudent professional manner and within professional standards.

Nurse must have had a professional duty towards the person receiving the care for malpractice to have occurred.

Practice Alerts

Regulation of the practice of nursing serves two purposes: protection of the public and accountability of the individual practitioner's actions.

Malpractice is present only if a breach of duty was the cause of the injury.

LEGAL ISSUES AFFECTING PATIENTS

Legal issues affecting patients are those that occur when a wrong has been committed against a patient or a patient's property.

Defamation of Character

Defamation of character occurs when information about an individual is detrimental to his/her reputation The communication, which is considered to be malicious and false, may be spoken (slander) or written and may be about patients or other health care providers.

Privileged Communication.

• Privileged communication is the information shared by an individual with certain professionals and that does not need to be revealed in a court of law.

Emergency Care

Certain actions provided by a health care professional may be legal in emergency situations and not legal in non emergency situations.

During a true emergency, consent is implied as the court considers that a reasonable person in a life-threatening situation would give permission for treatment.

"Good Samaritan Acts" protect the nurse against negligence when she/he provides voluntary assistance to an Individual in an emergency situation.

Within a health care agency, the emergency policies and procedures of the institution govern what the nurse can. do, and so a nurse must know these. The courts have held that a nurse can do things immediately necessary, even if the activity is normally considered a medical function, provided she/he has the expertise to carry out the act.

Refusing Treatment

This issue arises out of the belief in and respect for the autonomy of the patient.

The two forms of refusing treatment are when the patient discharges himself/herself from the hospital against medical advice or when he/she refuses certain treatment when in the hospital

CLIENT RIGHTS

Patients have the right to expect they will be treated in a certain way, receive adequate information, and have their confidentiality maintained when they are interacting with the health care system.

DIGNITY

Dignity is the right to receive compassionate nursing care. It is an essential professional nursing value.

AUTONOMY

Autonomy is the right of self-determination. The nurse must respect the patients right to make decisions about and for himself/herself.

Examples of respect for an individuals autonomy are

obtaining informed consent, facilitating patient choice for

treatment, allowing patient to refuse treatment, and main

twining confidentiality.

• Individuals may lose autonomy when they fall ill, family

interactions may leave the patient out of the decision-

making process.

PATIENT'S BILL OF RIGHTS

This document was developed by the American Hospital Association (AHA) in 1972 and was revised in 1992. It outlines an individual's right to inspect his/her medical record and to receive information about the medical care received during a hospital stay .In addition, the Bill speaks for the right to respectful care, relevant and understandable information, advance directive, consideration of privacy, consent or participation in research, continuity of care, and information of hospital policies and practices. In 2001, the McCain-Edwards-Kennedy/C. Dingell Patients Bill of Rights was passed. The Bill addresses such additional issues as shared decision making, the right to be informed of all medical options, and the right to refuse treatment.

ACCESS TO MEDICAL RECORD

The medical record contains medical information as well as personal information about the patient.

Information may be shared between health care providers who are responsible for patient care within a health care facility.

CONFIDENTIALITY/INFORMATION SECURITY

A patients privacy will be respected and information that is shared about a patient to a health care provider will not be made public without the patient's consent

HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT (HIPAA)

The Act is a federal privacy standard that protects the patients medical records and other identifiable health information whether maintained on paper, computer, or orally communicated.

COMPUTERIZED MEDICAL DATABASE

Serious concern arises around patient privacy and confidentiality as health care information becomes more and more electronically accessible.

INFORMED CONSENT

An individual has the right to understand the choices being offered around medical treatment and the right to voluntarily agree or refuse treatment. The client must receive a description of the procedure, alternatives for treatment, risks involved in treatment, and probable results.

The law holds obtaining consent for medical treatment to be the responsibility of the physician, but the nurse has a responsibility of notifying the physician if she/he determines that the client does not seem to understand.

Consent can be oral or written, although a written consent is usually preferred.

• To give consent, a person must be competent, i. e,, able to make judgments based on rational understanding . Clients have the right to change their mind and can withdraw consent, if this occurs, the nurse must notify the physician.

ADVANCED DIRECTIVES

These are the wishes of an individual expressed in a legal document when the individual is no longer capable of giving his/her own consent in certain health care situations. The document is prepared in advance of the situation and directs others how to act on behalf of the individual.

LIVING WILL

Provides preferences around end-of-life care.

"if-Then" plan: "If something happens, then "I want X done." "If" must be a diagnosis made by a physician.

DURABLE POWER OF ATTORNEY

• This is a legal document that designates a substitute decision maker for general or specific health care and medical decisions should the individuals not be able to decide for themselves.

Durable power of attorney can be combined with a living will. This document is considered the most flexible as the individual who has been assigned the durable power of attorney can make decisions as the situation changes.

PATIENT SELF-DETERMINATION ACT

Effective as of 1992, the Act requires health care facilities receiving Medicare and Medicaid reimbursement to recognize advance directives.

Patients on admission to a health care agency must be given the opportunity to determine what lifesaving or life prolonging actions they want to have carried out. The health care agency must follow the patient's advance directives. The agency is required to provide the individual with enough information to make an informed decision.

ETHICAL PRACTICE

• It involves reasoning that is rational, systematic, and based on ethical principles and codes rather than on emotions or intuition

Ethical decision making has the patient's well-being at the center of it

Nurses have a responsibility for ethical considerations to patients, employing agency, and physicians

PROFESSIONAL ETHICAL CODES

Ethical codes are guidelines that provide a framework for ethical behavior, which in turn provides

direction to moral reasoning and action.

ICN Code of Nursing Ethics

The ICN Code of Nursing Ethics was adopted in 1953. It contains four principal elements: standards for nurses and people, practice, profession, and coworkers.

RELATIONSHIPS

Nurses need to be concerned about their relationships with colleagues (nurses and physicians) as well as patients in order to provide compassionate care.

Nurse-Patient-Family Relationship

When patients enter the health care system, they have no option but to trust the nurse when they need care- unavoidable trust. An uneven power structure is created between patients and nurses, and patients and nurses and families. Nurses promise to be the best nurses they can be. They promise to be candid, sensitive, attentive, and never to abandon the patient.

Nurse-Nurse Relationship

Nurses are a community that works together for a common good using professional traditions to guide its practice,

When a nurse has reason to believe a colleague is placing a client in jeopardy or another colleague in harm, she/he has a responsibility to deal with the offending coworker.

Nurse-Physician Relationship

Physicians and nurses are members of the health care community working together for the health and well-being of the patient.

BIOETHICAL ISSUES

Bioethics is the domain of ethics that focuses on moral issues in the field of health care.

Acquired Immune Deficiency Syndrome

AIDS bears a social stigma due to its association with sexual behavior and drug use.

The primary ethical issues are testing for the presence of HIV and maintaining privacy, which include questions of whether health care providers and patients should undergo requited or voluntary testing and how much information should be released to others.

Statutory laws provide direction to the duty to warn sexual partners of individuals with HIV

There are only a few situations in which a nurse could ethically refuse to care for a patient with HIV, one example might be if the nurse was pregnant.

Abortion-Pro-Choice/Pro-Life

The central ethical dilemma is the right to life of the fetus or the women's right to control her own body by choosing whether or not to have a baby.
Abortion is legal during the first trimester. The US Supreme Court in Roe v. Wade ruled that states cannot ban abortion in the first and second trimester, except for certain reasons during the second trimester.

Child Abuse

Physical, sexual, emotional abuse, and neglect are actions considered to be forms of family violence.

Neglect is the most common form of child abuse.

The nurse must be alert for the signs of abuse and is required to report possible abuse. The responsibility to maintain confidentiality is waived when child abuse is suspected.

End of Life Right to Die

Technology and the increased elderly population have raised many ethical dilemmas. Nurses are involved in ethical decision making around such things as euthanasia, assisted suicide, and termination of lite-sustaining treatment

Genetic Screening

Genetic screening involves the professional counseling of individuals or couples about their risk for genetically linked diseases

Information obtained from genetic screening may be useful for individuals and couples, however, it can create a situation where the individuals involved do not know what to do with the information..

Stem cell research offers hope for correction of genetic diseases

Organ Transplant

Organs may come from living donors or from donors who have just died

CONCEPTS OF MANAGEMENT

Management is a process to achieve organizational goals

• Nursing management is the process of getting nursing staff

to provide care to patients.

The nurse manager plans, organizes, directs, and controls financial, material, and human resources in order to provide the most effective care possible to groups of patients and their families

Budget

Budget is the allocation of resources on the basis of forecasted needs. It is a numerical expression of expected revenues and expenditures of the nursing service department.

Setting Priorities

The nurse leader determines the importance of activities and establishes the order in which the activities will be carried out. Setting priorities involves decision making.

ORGANIZING

Organization involves determination of how the planning is to be accomplished, how the parts are to be arranged into a functioning whole, and how the activities are to be coordinated to achieve a goal.

Homework
WORKSHEET

TRUE & FALSE QUESTIONS

Mark each of the following statements True or False.
Correct all False statements in the space provided.

1. Case management, a type of nursing care delivery model, advances multidisciplinary collaboration

T/F

2. Critical pathways are guidelines that delineate patient care activities as well as outcomes, and standardize and reduce variation in patient care

T/F

3. Information shared by an individual with certain professionals that does not need to be revealed in a court of law is called privileged communication.

T/F

4. The standard of "reasonable care" is used when emergency care is given in a health care setting

5. Nursing audit is when patient records are reviewed to determine if specific criteria or standards

have been met

6. The process used to determine fiscal, human, and maternal needs of the nursing unit is called resource management

7. Staffing needs are determined by nurse-patient ratios, nurse-shift ratios, and stall mix ratios

8 The budgeting process consists of the operating budget, which includes equipment and renovations to meet long-term unit goals, and the capital budget, which focuses on revenues and expenses of the nursing unit for the upcoming year.

9 Ethical decision making has the patient's well-being at the center of it. TF

10. Neglect is the most common form of child abuse

11. The professional counseling of individuals or couples about their risk for genetically linked dis- cases is called genetic screening.

12. AIDS bears a social stigma due as association with the right to life of the fetus and organ harvesting.

13. When a patient is undergoing a medical procedure, she/he needs to receive a description of the medical procedure, alternatives for treatment, risks involved in the treatment, and probable results

14. Discharge planning begins on admission to a health care facility

15. A computerized medical record replaces or supplements the traditional written medical record.

16. The process of determining a preferential sequencing of activities is called delegation.

BOOKS Recommended to read for practice papers and notes-

1. Lippincott 's State Board Review For Nclex Pn Rn

2. Prioritization, Delegation and Assignment by Linda A La Charity , Caundice K. Kumagai , Shirley M Hosler .

3. Richardson's Pediatric Success