Answers

CHAPTER 1 CRITICAL THINKING AND THE NURSING PROCESS

AUDIO CASE STUDY

Jane and the Nursing Process

1. Assessment/data collection, diagnosis, planning, implementation, and evaluation.
2. Jane was exhausted, failed a test, and was pulled in too many directions.
3. Jane's resources included a good friend, sick time from work, and wasted time between classes that she could better utilize. Your resources will be different, but they're there!

VOCABULARY

Nursing Process

Definition: An organizing framework that links thinking with nursing actions. Steps include assessment/data collection, nursing diagnosis, planning, implementation, and evaluation.

Critical Thinking

Definition: The use of those cognitive (knowledge) skills or strategies that increase the probability of a desirable outcome. Also involves reflection, problem-solving, and related thinking skills.

Assessment

Definition: Gathering subjective and objective data to plan care.

Objective Data

Definition: Factual information obtained through physical assessment and diagnostic tests. Objective data are observable or knowable through the health care worker's five senses. Referred to as *signs.*

Subjective Data

Definition: Information that is provided verbally by the patient and referred to as *symptoms.*

Nursing Diagnosis

Definition: Per NANDA International, a nursing diagnosis is a "clinical judgment concerning a human response to health conditions/life processes, or a vulnerability for that response, by an individual, family, group or community. A nursing diagnosis provides the basis for selection of nursing interventions to achieve outcomes for which the nurse has accountability" (from www.nanda.org/glossary-of-terms).

Evaluation

Definition: Examination of outcomes and interventions to determine progress toward desired outcomes and effectiveness of interventions.

Vigilance

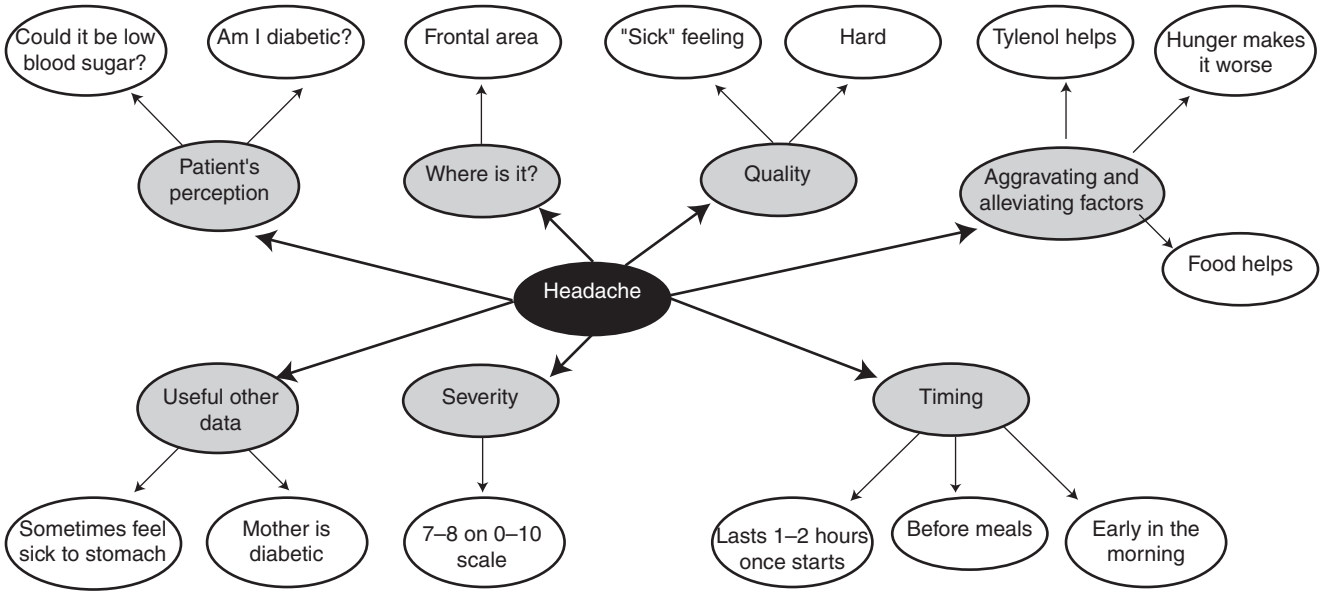
Definition: The act of being attentive, alert, and watchful.

SUBJECTIVE AND OBJECTIVE DATA

1. Subjective (symptom)
2. Subjective (symptom)
3. Objective (sign)
4. Objective (sign)
5. Subjective (symptom)
6. Objective (sign)
7. Subjective (symptom)
8. Objective (sign)
9. Subjective (symptom)
10. Subjective (symptom)
11. Objective (sign)
12. Objective (sign)
13. Subjective (symptom)
14. Objective (sign)
15. Objective (sign)

CRITICAL THINKING

This is just one possible way to complete a cognitive map.



REVIEW QUESTIONS—CONTENT REVIEW

*The correct answers are in **boldface.***

1. (**3**) is a nursing diagnosis. (1, 2, 4) are medical diagnoses.
2. (**1**) is a medical diagnosis. (2, 3, 4) are nursing diagnoses.
3. (**1**) is correct. The nurse who keeps trying until the problem is solved is exhibiting perseverance. (2, 3, 4) are incorrect.
4. (**3, 4, 5, 1, 2**) is the correct order.
5. (**1**) is the best definition. (2, 3, 4) do not define critical thinking but are examples of good thinking.

REVIEW QUESTIONS—TEST PREPARATION

*The correct answers are in **boldface.***

6. (**4**) is correct. Evaluation determines whether goals are achieved and interventions effective. (2) is the role of the physician. (1, 3) encompass data collection and implementation, which are earlier steps in the nursing process.
7. (**1**) is correct. The licensed practical nurse/licensed vocational nurse can collect data, which includes taking vital signs; assessment is the first step in the nursing process. (2, 3, 4) are all steps in the nursing process, for which the registered nurse is responsible; the licensed practical nurse/licensed vocational nurse may assist the registered nurse with these.
8. (**1, 4, 5**) can be observed through use of the five senses. (2, 3) are subjective data that the patient must report.
9. (**2**) indicates that the patient is concerned about freedom from injury and harm. (1) relates to basic needs such as air, oxygen, and water. (3) relates to feeling loved. (4) is related to having positive self-esteem.
10. (**4**) is objective, realistic, and measurable with a time frame. (1, 2, 3) are all good outcomes, but they relate to airway clearance, nutrition, and strength, not directly to swallowing.
11. (**2**) is correct. The three parts of a diagnosis include the problem (from the NANDA International [NANDA-I] list), etiology ("related to"), and symptoms ("as evidenced by"). (1) does not include symptoms. (3) is a medical diagnosis. (4) is not a NANDA-I diagnosis, and the evidence is not related to dyspnea.