Answers

CHAPTER 1 CRITICAL THINKING, CLINICAL JUDGMENT, AND THE NURSING PROCESS

AUDIO CASE STUDY

Jane Practices Clinical Judgment

1. Identify and analyze cues; prioritize hypotheses; generate solutions; take action; evaluate outcomes; repeat.
2. Jane was exhausted, failed a test, and was pulled in too many directions. She was also crying in her car and had poor study habits and not enough sleep.
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 exist!
4. Critical thinking—*the why*: Jane uses critical thinking to determine why her current plan isn't working. She thinks honestly about her poor study habits, her time-management problems, and the impact this is having on her and her family.
   Clinical judgment—the *do*: Jane uses her thinking to develop and carry out a plan that uses her resources and provides more productive study time and more quality time with her kids.

VOCABULARY

Sample sentences will vary for the Vocabulary problems.

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.

Clinical judgment

Definition: The observed outcome of critical thinking and decision making. A process that uses nursing knowledge to collect appropriate data, identify a patient problem, and determine the best possible plan of action. Clinical judgment is based on good critical thinking.

Cue

Definition: Significant or relevant data. Not all data are cues (relevant), but all cues are data.

Collaboration

Definition: Working together with the health team to improve patient outcomes.

Intervention

Definition: Taking action to carry out a plan.

Evaluation

Definition: Comparing the outcomes you expected with actual outcomes. Did the plan work? Were expected outcomes met?

Vigilance

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

CRITICAL THINKING AND CLINICAL JUDGMENT

Critical thinking and clinical judgment both follow a similar format. Both follow steps from collecting data to determining problems and outcomes, developing and taking actions, and evaluating outcomes. However, critical thinking helps you think *about* the problem: What is it? Why is it happening? And clinical judgment leads you to *do* something to manage the problem.

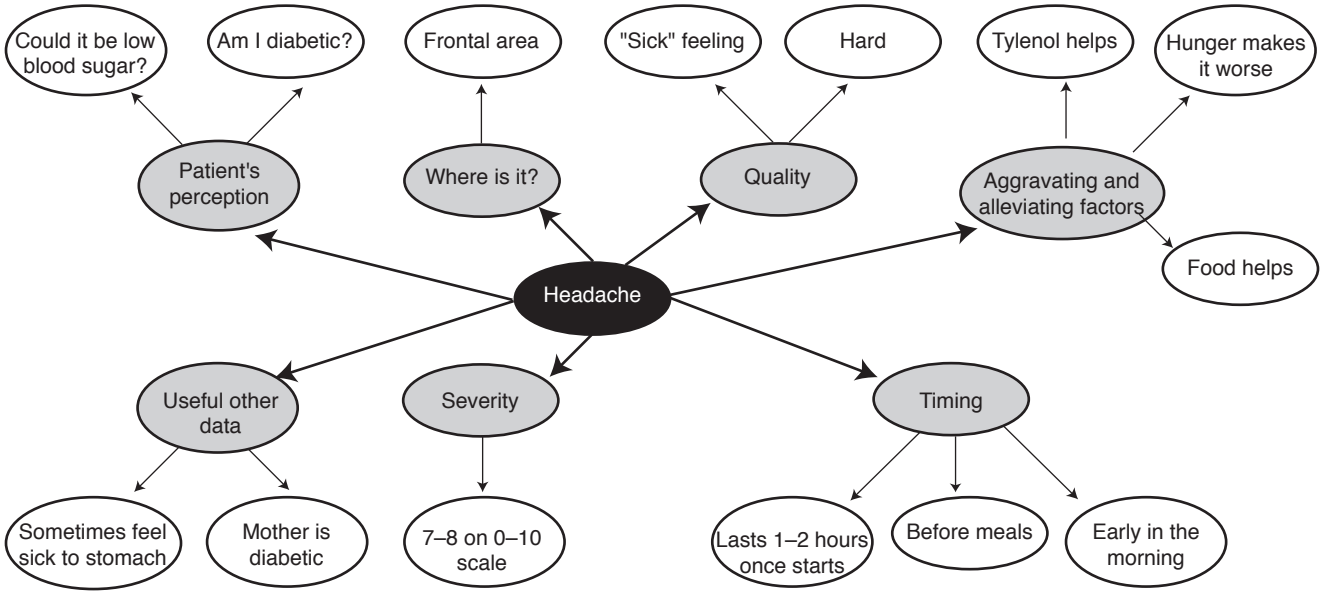
CUE RECOGNITION

You will do many things for each individual, but the FIRST thing is listed below.

1. Sit the patient upright.
2. Call 911 while running across the street.
3. Elevate the feet off the bed by placing a pillow under the calves and allowing the feet to hang off the edge of the pillow.
4. Check blood glucose and have a glucose source ready.
5. Turn the patient to the side to prevent aspiration.

CRITICAL THINKING

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



REVIEW QUESTIONS

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

1. (**2**) Critical thinking can lead to better outcomes for the patient. (1, 3, 4) may be true but are not the best answer.
2. (**4**) is correct. The nurse who can admit to not knowing something is exhibiting intellectual humility. (1) shows expertise but not necessarily intellectual humility; (2) reporting an error shows intellectual integrity; (3) empathizing is positive but does is not evidence of humility.
3. (**3, 4, 5, 1, 2**) is the correct order.
4. (**1**) is the best definition. (2, 3, 4) do not define critical thinking but are examples of good thinking.
5. (**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.
6. (**1**) is correct. The licensed practical nurse/licensed vocational nurse (LPN/LVN) can collect data, which includes taking vital signs; data collection 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 LPN/LVN may assist the registered nurse with these. Nitroglycerin should not be administered without first knowing the patient's blood pressure.
7. (**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.
8. (**3, 1, 2, 4**) is the correct order according to Maslow.
9. (**5, 2, 1, 4, 6, 3**) is the correct order.
10. (**3**) shows the patient is actually taking action. (1, 2, 4) are all positive but do not show intent to take action.
11. (**4**) is the nurse's analysis of the situation. (1, 2) are data; (3) is a recommendation.
12. (**1, 2, 3, 4**) should be present. Since the data provides only hip replacement as the patient's problem, (5) the dietitian is not necessary.