Chapter 5. Nursing Process: Planning Outcomes

MULTIPLE CHOICE

1.What do initial, ongoing, and discharge planning have in common?

a) They are based on assessment and diagnosis.

b) They focus on the patient's perception of his needs.

c) They require input from a multidisciplinary team.

d) They have specific time lines in which to be completed.

ANS: A

All planning is based on nursing assessment data and identified nursing diagnoses. The patient should have input, and multidisciplinary input may be used; however, the planning is based on the nursing assessment. The different types of planning are intertwined and may or may not be done at distinct, separate times. Discharge planning often requires a multidisciplinary team, but initial and ongoing planning may not. Initial planning is usually begun after the first patient contact, but there is no specified time for completion. Ongoing planning is more or less continuous and is done as the need arises. Discharge planning must be done before discharge.

Difficulty: Moderate

Nursing Process: Planning

Client Need: Safe and Effective Nursing Care

Cognitive Level: Analysis

PTS: 1

2.Which client has the *greatest* need for comprehensive discharge planning?

a) A woman who has just given birth to her second child and lives with her husband and 18-month-old daughter

b) A man who has been readmitted for exacerbation of his chronic obstructive pulmonary disease

c) A 12-year-old boy who had outpatient surgery on his knee and lives with his mother

d) A woman who was just diagnosed with renal failure and has started peritoneal dialysis

ANS: D

Comprehensive discharge planning should be done for patients who have a newly diagnosed chronic disease (e.g., renal failure) or have complex needs (e.g., peritoneal dialysis). The other patients may require discharge planning, but the planning would not be as comprehensive as it would be for someone with a new diagnosis resulting in a complex treatment regimen.

Difficulty: Moderate

Nursing Process: Planning

Client Need: Safe and Effective Nursing Care

Cognitive Level: Analysis

PTS: 1

3.How are standardized (model) care plans *similar to* unit standards of care? Standardized (model) care plans:

a) Describe the care needed by patients in defined situations

b) Include specific goals and nursing orders

c) Become a part of the patient's comprehensive care plan

d) Usually describe ideal nursing care

ANS: A

All of the statements are true for standardized care plans, but only one statement is true of *both* standardized care plans and unit standards of care. Both describe care needed by patients in defined situations, although unit standards usually describe care for groups of patients (e.g., all women admitted to a labor unit), and standardized care plans are often organized around a particular or all nursing diagnoses commonly occurring with a particular medical diagnosis. Unit standards are more general and do not have goals for each patient. Unit standards are kept on file in a central place on the unit and do not become a part of the care plan. Unit standards describe minimal, not ideal, care.

Difficulty: Difficult

Requires analysis of text discussion.

Nursing Process: Planning

Client Need: Safe and Effective Nursing Care

Cognitive Level: Analysis

PTS: 1

4.The nurse is planning care for a patient. She is using a standardized care plan for Impaired Walking related to left-side weakness. Which of the following activities will the nurse perform when individualizing the plan for the patient?

a) Validating conflicting data with the patient

b) Transcribing medical orders

c) Stating the frequency for ambulation

d) Performing a comprehensive assessment

ANS: C

Individualizing the care plan means identifying specific problems, outcomes, and interventions and the frequency of those interventions to meet the patient's needs. Validating data ensures your assessment is accurate. Transcribing orders is a part of developing and implementing the care plan but not of individualizing the plan. Performing an assessment is the beginning step in developing a care plan. Assessment helps you to know the ways in which a standardized plan needs to be individualized.

Difficulty: Moderate

Nursing Process: Planning

Client Need: Safe and Effective Nursing Care

Cognitive Level: Application

PTS: 1

5.Which of the following is the best example of an outcome statement? The patient will:

a) Use the incentive spirometer when awake

b) Walk two times during day and evening shift

c) Maintain oxygen saturation above 92% while performing ADLs each morning

d) Tolerate 10 sets of range-of-motion exercises with physical therapy

ANS: C

Outcome statements should have specific performance criteria and a target time; "maintain oxygen saturation" is the only one that meets those criteria. The incentive spirometer goal should state how many times the incentive spirometer should be used each hour as well as the volume. The walking

goal should state how far the patient should walk. In the range-of-motion goal, *tolerate* is a vague word and is difficult to measure, and the outcome needs to specify how often.

Difficulty: Moderate

Nursing Process: Planning

Client Need: Safe and Effective Nursing Care

Cognitive Level: Analysis

PTS: 1

6.How are critical pathways and standardized nursing care plans *similar*? Both:

a) Specify daily, or even hourly, outcomes and interventions

b) Prescribe minimal care needed to meet recommended lengths of stay

c) Describe care common to all patients with a certain condition or situation

d) Emphasize medical problems and interventions

ANS: C

Both critical pathways and standardized care plans are preplanned documents; they describe care common to all patients who have a certain condition (e.g., all patients who have a heart attack need some of the same interventions). The other statements are true of critical pathways but not of standardized nursing care plans.

Difficulty: Difficult

High-level question; answer not given verbatim

PTS: 1

7.How is NOC *different from* the Omaha System?

a) NOC can be used to write health restoration outcomes.

b) NOC can be used in all specialty and practice areas.

c) NOC can be used for individuals, families, or groups.

d) NOC formulates goals based on nursing diagnoses.

ANS: B

NOC was developed for all specialty and practice areas. The Omaha System was developed for community health nursing. Both address health restoration and can be used for individuals, families, or groups (community). Both base goals on nursing diagnoses, although Omaha does not use the NANDA-I taxonomy.

Difficulty: Moderate

Answer based on analysis of text discussion

PTS: 1

8.How are short-term goals *different from* long-term goals? Short-term goals:

a) Can be met within a few hours or a few days

b) Flow from the problem side of the nursing diagnosis

c) Must have target times with dates

d) Specify desired client responses to interventions

ANS: A

Short-term goals may be accomplished in hours or a few days; long-term goals usually are achieved over weeks, months, or even years. The other statements are true for both short-term and long-term goals.

Difficulty: Moderate

Nursing Process: Planning

Client Need: Safe and Effective Nursing Care

Cognitive Level: Analysis

PTS: 1

9.The nurse is individualizing Mr. Wu's plan of care by writing a plan for his nursing diagnosis of Anxiety. The nurse needs to write goals/outcomes on the plan of care because outcomes describe:

a) Desirable changes in the patient's health status

b) Specific patient responses to medical interventions

c) Specific nursing behaviors to improve a patient's health

d) Criteria to evaluate the appropriateness of a nursing diagnosis

ANS: A

Outcomes describe changes in the patient's health status in response to nursing rather than medical interventions. Outcomes relate to patient behavior, not nursing behaviors. Outcomes are a measure of the effectiveness of nursing care for a specific nursing diagnosis, not whether the nursing diagnosis is appropriate.

Difficulty: Moderate

Nursing Process: Planning

Client Need: Safe and Effective Nursing Care

Cognitive Level: Comprehension

PTS: 1

10.Which of the following outcome statements contains the best example of performance criteria? The patient will:

a) Turn herself in bed frequently while awake

b) Understand how to use crutches by day two

c) State that pain is decreased after being medicated

d) Eat 75% of each meal without complaint of nausea

ANS: D

Performance criteria should be specific and measurable. "75% of each meal" is specific and measurable. "Frequently" is vague. You cannot observe whether someone "understands." "Decreased" is vague; a numerical pain rating would be better.

Difficulty: Moderate

Nursing Process: Planning

Client Need: Safe and Effective Nursing Care

Cognitive Level: Application

PTS: 1

11.Which of the following is true for goals/outcomes for collaborative problems?

a) They are monitored only by other disciplines.

b) They are usually sensitive to nursing interventions.

c) They state that a complication will not occur.

d) They state only broad performance criteria.

ANS: C

The goal for a collaborative problem is always that the complication will not occur. Other disciplines may be involved in helping to prevent the problem, but nurses still monitor for the complication. The outcomes to collaborative problems are not affected by nursing interventions alone. Goals for collaborative problems are specific to the medical condition/treatment.

Difficulty: Moderate

Nursing Process: Planning

Client Need: Safe and Effective Nursing Care

Cognitive Level: Analysis

PTS: 1

12.How are NANDA-I problem labels and NOC outcome labels alike? Both describe:

a) Health status in terms of human responses

b) Patient response before interventions are done

c) Patient response in positive terms

d) A pattern of related cues

ANS: A

Both NANDA-I and NOC labels are stated as human responses. A NOC label can be used to describe patient responses both before and after intervention—NANDA-I can be used before an intervention. NOC statements are neutral to allow for positive, negative, or no change in health status; NANDA-I diagnoses describe both problem responses and positive responses (wellness labels). NANDA-I labels are based on patterns of related cues; NOC labels are based on (linked to) NANDA-I labels.

Difficulty: Difficult

Nursing Process: Planning

Client need: Safe and Effective Nursing Care

Cognitive level: Analysis

PTS: 1

13.The nursing diagnosis is: Impaired Memory related to fluid and electrolyte imbalances AMB inability to Knowledge recent events. Which of the following goals/outcomes *must* be included on the care plan?

a) Checks current medications for mind-altering side effects

b) Demonstrates use of techniques to help with memory loss

c) Drinks at least 1,500 mL of fluid per day

d) Takes electrolyte supplements with meals

ANS: B

The essential goal/outcome is “Demonstrates use of techniques to help with memory loss.” An essential goal is aimed at the problem response—in this case, Impaired Memory. The other goals in this question address the etiology of the diagnosis

Difficulty: Moderate

Nursing Process: Planning

Client Need: PHSI

Cognitive Level: Application

PTS: 1

14.A client arrives in the emergency department. He is pale and breathing rapidly. He immediately becomes unconscious and collapses to the floor. The nurse rapidly assesses the patient and decides the first series of actions that are needed. This scenario demonstrates:

a) Formal planning

b) Informal planning

c) Ongoing planning

d) Initial planning

ANS: B

Informal planning is performed while doing other nursing process steps and is not written; this nurse is forming a plan in her mind. The end product of formal planning is a holistic plan of care that addresses the patient's unique problems and strengths; this nurse has no time to create a holistic plan of care. Ongoing planning refers to changes made in the plan as the nurse evaluates the patient's responses to care; no care has been given at this point. Initial planning does indeed begin with the first patient contact. However, it refers to the development of the initial comprehensive plan of care; this nurse does not have enough data for a comprehensive plan, nor does she have time to make such a plan at the moment.

Difficulty: Easy

Nursing Process: Planning

Client Need: Safe and Effective Nursing Care

Cognitive Level: Analysis

PTS: 1

MULTIPLE RESPONSE

15..A nurse is caring for an 80-year-old patient of Chinese heritage. When planning outcomes for this patient, which actions by the nurse would meet the American Nurses Association standards for outcomes identification? Select all that apply.

a) Developing culturally appropriate outcomes

b) Using the standardized outcomes on the clinical pathway

c) Choosing the best outcome for the patient, regardless of the cost

d) Involving the patient and family in formulating the outcomes

ANS: A, D

ANA standard 3 includes the following: "derives culturally appropriate expected outcomes from the diagnosis" and "involves the healthcare consumer, family . . . in formulating expected outcomes. . . ." It is acceptable for the nurse to use outcomes on a clinical pathway, but these are not individualized; ANA standard 3 says that the nurse "defines . . . outcomes in terms of the healthcare consumer. . . culture, values, and ethical considerations" The standard also says that the nurse should consider "associated risks, benefits, and costs. . . ."

Difficulty: Moderate

Nursing Process: Planning

Client Need: Safe and Effective Nursing Care

Cognitive Level: Comprehension

PTS: 1