

- health care professionals.”
- c. “The nursing process is a problem-solving tool used to identify and treat the patients’ health care needs.”
  - d. “The nursing process is based on nursing theory that incorporates the biopsychosocial nature of humans.”

ANS: C

The nursing process is a problem-solving approach to the identification and treatment of patients’ problems. Nursing process does not require research methods for diagnosis. 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.

DIF: Cognitive Level: Understand (comprehension)  
MSC: NCLEX: Safe and Effective Care Environment

TOP: Nursing Process: Evaluation

4. A patient admitted to the hospital for surgery tells the nurse, “I do not feel comfortable leaving my children with my parents.” Which action should the nurse take **next**?
- a. Reassure the patient that these feelings are common for parents.
  - b. Have the patient call the children to ensure that they are doing well.
  - c. Gather information on the patient’s concerns about the child care arrangements.
  - d. Call the patient’s parents to determine whether adequate child care is being provided.

ANS: C

Because 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.

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DIF: Cognitive Level: Analyze (analysis)

ORR: Special Questions: Prioritization

MSC: NCLEX: Psychosocial Integrity

TOP: Nursing Process: Assessment

5. A patient with a bacterial infection is hypovolemic due to a fever and excessive diaphoresis. Which expected outcome would the nurse recognize as appropriate for this patient?
- a. Patient has a balanced intake and output.
  - b. Patient’s bedding is kept clean and free of moisture.
  - c. Patient understands the need for increased fluid intake.
  - d. Patient’s skin remains cool and dry throughout hospitalization.

ANS: A

Balanced intake and output gives measurable data showing resolution of the problem of deficient fluid volume. The other statements would not indicate that the problem of hypovolemia was resolved.

DIF: Cognitive Level: Apply (application)  
MSC: NCLEX: Physiological Integrity

TOP:

Nursing Process: Planning

6. After administering medication, the nurse asks the patient if pain was relieved. What is the purpose of the evaluation phase of the nursing process?
- a. To document the nursing care plan in the progress notes of the health record
  - b. To determine if interventions have been effective in meeting patient outcomes

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# Lewis Med Surg Test Bank Questions

**Linda Anne Silvestri, Angela Silvestri**



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## **Table of Contents Lewis Med Surg Test Bank Questions**

1. Understanding the eBook Lewis Med Surg Test Bank Questions
  - The Rise of Digital Reading Lewis Med Surg Test Bank Questions
  - Advantages of eBooks Over Traditional Books
2. Identifying Lewis Med Surg Test Bank Questions
  - Exploring Different Genres
  - Considering Fiction vs. Non-Fiction
  - Determining Your Reading Goals
3. Choosing the Right eBook Platform
  - Popular eBook Platforms
  - Features to Look for in an Lewis Med Surg Test Bank Questions
  - User-Friendly Interface
4. Exploring eBook Recommendations from Lewis Med Surg Test Bank Questions
  - Personalized Recommendations
  - Lewis Med Surg Test Bank Questions User Reviews and Ratings

- Lewis Med Surg Test Bank Questions and Bestseller Lists
- 5. Accessing Lewis Med Surg Test Bank Questions Free and Paid eBooks
  - Lewis Med Surg Test Bank Questions Public Domain eBooks
  - Lewis Med Surg Test Bank Questions eBook Subscription Services
  - Lewis Med Surg Test Bank Questions Budget-Friendly Options
- 6. Navigating Lewis Med Surg Test Bank Questions eBook Formats
  - ePub, PDF, MOBI, and More
  - Lewis Med Surg Test Bank Questions Compatibility with Devices
  - Lewis Med Surg Test Bank Questions Enhanced eBook Features
- 7. Enhancing Your Reading Experience
  - Adjustable Fonts and Text Sizes of Lewis Med Surg Test Bank Questions
  - Highlighting and Note-Taking Lewis Med Surg Test Bank Questions
  - Interactive Elements Lewis Med Surg Test Bank Questions
- 8. Staying Engaged with Lewis Med Surg Test Bank Questions
  - Joining Online Reading Communities
  - Participating in Virtual Book Clubs
  - Following Authors and Publishers Lewis Med Surg Test Bank Questions
- 9. Balancing eBooks and Physical Books Lewis Med Surg Test Bank Questions
  - Benefits of a Digital Library
  - Creating a Diverse Reading Collection Lewis Med Surg Test Bank Questions
- 10. Overcoming Reading Challenges
  - Dealing with Digital Eye Strain
  - Minimizing Distractions
  - Managing Screen Time
- 11. Cultivating a Reading Routine Lewis Med Surg Test Bank Questions
  - Setting Reading Goals Lewis Med Surg Test Bank Questions
  - Carving Out Dedicated Reading Time
- 12. Sourcing Reliable Information of Lewis Med Surg Test Bank Questions
  - Fact-Checking eBook Content of Lewis Med Surg Test Bank Questions
  - Distinguishing Credible Sources

13. Promoting Lifelong Learning
  - Utilizing eBooks for Skill Development
  - Exploring Educational eBooks
14. Embracing eBook Trends
  - Integration of Multimedia Elements
  - Interactive and Gamified eBooks

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