Chapter 02: Clinical Judgment and Systems Thinking
Ignatavicius: Medical-Surgical Nursing, 10th Edition

MULTIPLE CHOICE

1. A nurse asks the charge nurse to explain the difference between critical thinking and clinical judgment. What statement by the charge nurse is **best**?
   a. <Clinical judgment is often clouded by erroneous hypotheses.=
   b. <Clinical judgment is the observable outcome of critical thinking.=
   c. <Critical thinking requires synthesizing interactions within a situation.=
   d. <Critical thinking is the highest level of nursing judgment.=

   ANS: B
   Clinical judgment is the observable outcome of critical thinking and decision making. It can be, but most often is not, clouded by erroneous hypotheses. Recognizing, understanding, and synthesizing interactions and interdependencies in a set of components designed for a specific purpose is systems thinking. Critical thinking is not the highest level of nursing judgment.

   DIF: Understanding TOP: Integrated Process: Teaching/Learning
   KEY: Clinical judgment
   MSC: Client Needs Category: Safe and Effective Care Environment: Management of Care

2. The nurse understands which information regarding patient-centered care?
   a. A competency recognizing the client as the source of control of his or her care
   b. A project addressing challenges in implementing patient-centered care
   c. Purposeful, informed, and outcome-focused care of clients or families
   d. The ability to use best evidence and practice when making care-related decisions

   ANS: A
   Patient-centered care is a QSEN competency that recognizes the patient or caregiver as the source of control and full partner in providing compassionate and coordinated care based on respect for the patient9s preferences, values, and needs. QSEN is a project addressing the challenge of preparing future nurses with the knowledge, skills, and attitudes (KSAs) necessary to continuously improve the quality and safety of the health care systems in which they work. Critical thinking is the application of purposeful, informed, and outcome-focused care. The ability to use best evidence and practice when making care-related decisions is evidence-based practice.

   DIF: Understanding TOP: Integrated Process: Teaching/Learning
   KEY: Patient-centered care
   MSC: Client Needs Category: Safe and Effective Care Environment: Management of Care

3. A nurse wishes to participate in an activity that will influence health outcomes. What action by the nurse **best** meets this objective?
   a. Creating a transportation system for health care appointments
   b. Lobbying with a national organization for health care policy
   c. Organizing a food pantry in an impoverished community
   d. Running for election to the county public health board

   ANS: B

All options are good choices for an altruistic nurse wishing to influence health outcomes; however, being involved in policy creation and health care reform is an activity specifically recognized to improve health outcomes. This action will also affect a wider population than the more local options.

DIF: Applying TOP: Integrated Process: Communication and Documentation
KEY: Health outcomes
MSC: Client Needs Category: Safe and Effective Care Environment: Management of Care

4. What factor **best** predicts a nurse9s willingness to employ critical thinking?
   a. Caring
   b. Knowledge
   c. Presence
   d. Skills

   ANS: A
   All attributes are important in nursing, however; the nurse9s willingness to think critically is predicted by caring behaviors, self-reflection, and insight.

   DIF: Remembering TOP: Integrated Process: Nursing Process: Assessment
   KEY: Critical thinking
   MSC: Client Needs Category: Safe and Effective Care Environment: Management of Care

5. To demonstrate clinical reasoning skills, what action does the nurse take?
   a. Collaborating with co-workers to buddy up for lunch breaks
   b. Delegating frequent vital signs on a new postoperative patient
   c. Documenting a complete history and physical on an admission
   d. Requesting the provider order medication for a client with high potassium

   ANS: D
   The components of clinical reasoning include assessing, analyzing, planning, implementing, and evaluating. This nurse shows the ability to analyze by interpreting the meaning of the lab value, to plan by anticipating the consequences of the lab value, and to implement by taking action.

   DIF: Analyzing TOP: Integrated Process: Nursing Process: Implementation
   KEY: Clinical judgment
   MSC: Client Needs Category: Safe and Effective Care Environment: Management of Care

6. The new nurse asks the preceptor how context affects clinical judgment. What response by the preceptor is **best**?
   a. <Context considers the whole of the patient9s story and circumstances.=
   b. <It shouldn9t, only nursing knowledge would affect clinical judgment.=
   c. <Outside influences such as environment in which you provide care, influence your decisions.=
   d. <The context of the situation provides an extra layer of complexity to consider.=

   ANS: C
   The context of a situation considers and supports clinical judgment. The factors within this layer4such as environment, time pressure, availability or content of electronic health records, resources, and individual nursing knowledge4have a direct impact on clinical judgment. The other two options are too vague to provide appropriate information.

DIF: Understanding TOP: Integrated Process: Teaching/Learning
KEY: Clinical judgment
MSC: Client Needs Category: Safe and Effective Care Environment: Management of Care

7. Once the nurse has considered all possible collaborative and client problems, what action does the nurse take next?
   a. Act on the observed cues.
   b. Determine desired outcomes.
   c. Generate solutions.
   d. Prioritize the hypotheses.

   ANS: D
   Analyzing cues lead to a list of potential hypotheses. The nurse prioritizes them, determines the desired outcomes, generates solutions, and acts. This is part of the six-step clinical judgment model.

   DIF: Understanding TOP: Integrated Process: Nursing Process: Diagnosis
   KEY: Clinical judgment
   MSC: Client Needs Category: Safe and Effective Care Environment: Management of Care

8. A nurse working in a medical home would do which of the following as part of the job?
   a. Advocate with insurance companies.
   b. Coordinate interprofessional care.
   c. Hold monthly team meetings.
   d. Provide out-of-network specialty referrals.

   ANS: B
   The medical home concept came into being to decrease the fragmentation of care. On a daily basis, this nurse would expect to coordinate with the interprofessional care team. Advocating with insurance companies would not be a daily function. Monthly team meetings may or may not be needed. Out of network referrals would not be needed as the interprofessional team strives to provide comprehensive care.

   DIF: Remembering
   TOP: Integrated Process: Nursing Process: Implementation KEY: Medical home
   MSC: Client Needs Category: Safe and Effective Care Environment: Management of Care

9. A nurse is confused on why systems thinking is important since working on the unit involves caring for a few specific clients. What explanation by the nurse manager is **best**?
   a. <It9s a good way to conduct root-cause analysis.=
   b. <It is important for quality improvement and safety.=
   c. <Systems thinking helps you see the bigger picture.=
   d. <You may enter management 1 day and need to know this.=

   ANS: B
   A systems thinking approach to care reinforces the nurse9s role in safety and quality improvement while expanding clinical judgment to include the patient9s place within the greater health care system in the context of care decisions. Root-cause analyses would be a small portion of systems thinking. It does give the nurse a big-picture view, but this answer is vague. The nurse may or may not ever join management.

DIF: Understanding TOP: Integrated Process: Teaching/Learning
KEY: Systems thinking
MSC: Client Needs Category: Safe and Effective Care Environment: Management of Care

MULTIPLE RESPONSE

1. The expert nurse understands that critical thinking requires which elements to be present? (*Select all that apply.*)
   a. Based on logic, creativity, and intuition
   b. Driven by needs
   c. Focused on safety and quality
   d. Grounded in a specific theory
   e. Guided by standards
   f. Requires forming options about evidence

   ANS: A, B, C, E
   Critical thinking must be based on logic, creativity, and intuition; driven by patient, family, or community needs; focused on safety and quality; guided by standards, policies, ethics, and laws; based on principles of nursing process, problem-solving, and the scientific method (requires forming opinions and making decisions based on evidence); centered on identification of the key problems, issues, and risks; and grounded in strategies that make the most of human potential. It is not dependent on using a specific theory.

   DIF: Understanding TOP: Integrated Process: Nursing Process: Planning
   KEY: Critical thinking
   MSC: Client Needs Category: Safe and Effective Care Environment: Management of Care

2. The nurse manager is conducting an annual evaluation of a staff nurse and is appraising the nurse9s clinical reasoning. What nurse actions does the manager observe to help form this judgment? (*Select all that apply.*)
   a. Anticipating consequences of actions
   b. Delegating appropriately
   c. Interpreting data
   d. Noticing cues
   e. Setting priorities

   ANS: A, C, D, E
   The phases of clinical reasoning include assessing (noticing cues), analyzing (interpreting data), planning (anticipating consequences and setting priorities), implementing, and evaluating. Delegating appropriately is not included in this model.

   DIF: Applying TOP: Integrated Process: Nursing Process: Evaluation
   KEY: Clinical reasoning
   MSC: Client Needs Category: Safe and Effective Care Environment: Management of Care

3. According to the WHO, what does primary care involve? (*Select all that apply.*)
   a. Empowered people and communities
   b. Essential public functions
   c. Multisectoral policy and action
   d. Primary care
   e. Priority consideration of chronic diseases

f. Elimination of chronic diseases

ANS: A, B, C, D
According to the WHO, primary care involves three main areas: empowered people and communities, primary care and essential public functions, and multisectoral policy and action. Primary care focuses on both prevention and management of chronic disease.

DIF: Remembering TOP: Integrated Process: Teaching/Learning
KEY: Primary care, Systems thinking
MSC: Client Needs Category: Safe and Effective Care Environment: Management of Care

4. A nurse wishes to work in a community-based practice setting. Which areas would this nurse explore for employment? (*Select all that apply.*)
   a. Hospice facility
   b. <Minute clinic=
   c. Mobile mammography unit
   d. Small community hospital
   e. Telehealth
   f. Home health care

   ANS: A, B, C, E, F
   The multiple avenues providing community-based care include hospice, <minute= or retail clinics, mobile screening and diagnostic services, telehealth, private medical practices, outpatient services, freestanding points of care, home health care, long-term ambulatory care, public health, and free clinics. Inpatient services in a hospital are not considered primary care sites.

   DIF: Remembering TOP: Integrated Process: NA
   KEY: Community-based care
   MSC: Client Needs Category: Safe and Effective Care Environment: Management of Care

MULTIPLE CHOICE

1. A nurse is caring for a client who is acidotic. The nurse asks the charge nurse why the client is breathing rapidly. What response by the charge nurse is **best**?
   a. Anxiety is causing the client to breathe rapidly.
   b. The client is trying to get rid of excess body acids.
   c. The rapid respirations cause buildup of bicarbonate.
   d. An increased respiratory rate is due to increased metabolism.

   ANS: B
   The client is acidotic, and the respiratory system is attempting to compensate by <blowing off= excess acid in the form of carbon dioxide. The increased respiratory rate is not due to anxiety or increased metabolism. An increased respiratory rate does not cause a buildup of bicarbonate.

   DIF: Understanding TOP: Integrated Process: Teaching/Learning
   KEY: Acid-base balance
   MSC: Client Needs Category: Physiological Integrity: Physiological Adaptation

2. A client had a recent thromboembolism and must resume work which requires frequent car and plane travel. What self-care measure does the nurse teach to reduce the risk of impaired clotting in this client?
   a. Get up and walk around at least every 2 hours while traveling.
   b. Use a soft toothbrush and an electric razor for safety.
   c. Be sure to sit with the legs elevated as much as possible.
   d. Increase fiber in the diet so as not to strain to move the bowels.

   ANS: A
   Clients who are at risk of increased clotting (as evidenced by prior thromboembolic event) can take several measures to reduce their risk of further problems. One measure is to get up and walk frequently when sitting for a long period of time. Using a soft toothbrush and an electric razor and needing to prevent constipation would be important for a client at risk of bleeding. Elevating the legs is not as beneficial as ambulating.

   DIF: Applying TOP: Integrated Process: Teaching/Learning
   KEY: Clotting, Health teaching
   MSC: Client Needs Category: Physiological Integrity: Physiological Adaptation

3. A nurse is caring for four clients. Which client does the nurse assess **first** for impaired cognition?
   a. A 28-year-old client 2 days post-open cholecystectomy
   b. An 88-year-old client 3 days post-hemorrhagic stroke
   c. A 32-year-old client with a 203pack-year history of smoking
   d. A 42-year-old client with a serum sodium of 134 mEq/L (134 mmol/L)

   ANS: B

There are many risk factors for impaired cognition including advanced age and diseases and disorders that affect the brain. The 88-year-old client who is recovering from a stroke has two such risk factors and is at highest risk for impaired cognition. The nurse assesses this client first. The other clients have a much lower risk of developing impaired cognition.

DIF: Analyzing TOP: Integrated Process: Nursing Process: Assessment
KEY: Cognition, Nursing assessment
MSC: Client Needs Category: Physiological Integrity: Reduction of Risk Potential

4. The assistive personnel (AP) reports to the registered nurse that a postoperative client has a pulse of 132 beats/min and a blood pressure of 168/90 mm Hg. What response by the nurse is **most** appropriate?
   a. Ask the AP to repeat the client9s vital signs in 15 minutes.
   b. Assess the client for pain.
   c. Ask the client if something is bothersome.
   d. Instruct the AP to reposition the client.

   ANS: B
   The <fight-or-flight= syndrome can occur from sympathetic nervous stimulation due to acute pain. Symptoms can include nausea, vomiting, diaphoresis, tachycardia, tachypnea, hypertension, and dilated pupils. Since this client is postoperative, it is reasonable to believe that he or she might be in pain. The nurse first assesses for pain or discomfort and treats it. If the client is not in pain, the nurse would conduct further assessments to determine the cause of the abnormal vital signs.

   DIF: Applying TOP: Integrated Process: Nursing Process: Assessment
   KEY: Pain, Nursing assessment
   MSC: Client Needs Category: Physiological Integrity: Physiological Adaptation

5. A client has urinary incontinence. Which assessment finding indicates that outcomes for a priority nursing diagnosis have been met?
   a. Client reports satisfaction with undergarments for incontinence.
   b. Client reports drinking 8 to 9 glasses of water each day.
   c. Skin in perineal area is intact without redness on inspection.
   d. Family states that client is more active and socializes more.

   ANS: C
   Urinary incontinence can lead to skin breakdown and possibility of infection. Skin that is intact without redness shows that a major goal for this client has been met. Becoming more social is a positive finding as many adults with incontinence limit their social activities, but this psychosocial outcome is not the priority over a physical outcome. Being satisfied with undergarments is also not the priority. Drinking adequate water can sometimes help with incontinence and is important for general health, but is not directly related to an important goal for this client.

   DIF: Analyzing TOP: Integrated Process: Nursing Process: Evaluation
   KEY: Tissue integrity, Incontinence
   MSC: Client Needs Category: Physiological Integrity: Reduction of Risk Potential

6. The registered nurse asks the nursing assistant why a cardiac client9s morning weight has not yet been done. The nursing assistant says, <I9ll get to it, what9s the big deal?= When deciding how to respond, the nurse considers what information about weight?
   a. Decisions on treatment often depend on the daily weight.
   b. The nursing assistant needs to ensure that tasks are done on time.
   c. Weight is the most accurate noninvasive indicator of fluid status.
   d. A change in weight may indicate the need to change IV fluids.

   ANS: C
   Weight is the best (noninvasive) indicator of fluid status. Primary health care providers may base treatment decisions on weight, because the weight reflects fluid balance, but this answer does not explain why. IV fluid rates or solutions may change for the same reason. The nursing assistant would perform tasks on a timely basis, but this is not related to information about weight.

   DIF: Applying TOP: Integrated Process: Teaching/Learning
   KEY: Fluid and electrolytes
   MSC: Client Needs Category: Physiological Integrity: Physiological Adaptation

7. The nurse in the emergency department (ED) is caring for four clients. Which client does the nurse assess for gas exchange abnormalities **first**?
   a. Involved in motor vehicle crash, has broken femur.
   b. Brought in unconscious by roommate after opioid overdose.
   c. Asthmatic client being discharged after bronchodilator therapy.
   d. History of COPD, presents to ED after being bitten by a dog.

   ANS: B
   Opioid medications can cause respiratory depression, so this client is most at risk for gas exchange problems. Diminished respirations will allow a buildup of carbon dioxide in the blood. The clients with asthma and COPD have the potential for gas exchange problems but this is not indicated in answer option as he or she is being discharged. The client with a broken femur does not have information suggesting gas exchange problems.

   DIF: Applying TOP: Integrated Process: Nursing Process: Assessment
   KEY: Gas exchange, Risk factors
   MSC: Client Needs Category: Safe and Effective Care Environment: Management of Care

8. The nurse caring for a client with malnutrition assesses which laboratory value as the **priority**?
   a. Albumin
   b. Prealbumin
   c. Prothrombin time
   d. Serum sodium

   ANS: B
   Both albumin and prealbumin are indicators for nutrition. However, prealbumin changes more rapidly with decreased nutrition, so it is the better test. Prothrombin time and serum sodium are not directly related to nutritional status.

   DIF: Remembering TOP: Integrated Process: Nursing Process: Assessment
   KEY: Nutrition, Laboratory values

9. A nurse is planning primary prevention measures for community-dwelling adults to prevent visual impairment. What action by the nurse will **best** meet this objective?
   a. Provide glaucoma screening.
   b. Assess visual acuity.
   c. Teach clients about instilling eyedrops.
   d. Offer a healthy lifestyle class.

   ANS: D
   Primary prevention activities are those designed to actually prevent the onset of a disease or health problem. Secondary prevention focuses on screening and early diagnosis/detection. Tertiary measures are those that offer treatment and rehabilitation. Encouraging a healthy lifestyle through classes may help prevent diabetes, a common cause of visual impairment, and is a primary prevention measure. Assessing for glaucoma and visual acuity is a secondary prevention measure. Teaching clients how to instill eyedrops is tertiary.

   DIF: Applying TOP: Integrated Process: Nursing Process: Planning
   KEY: Sensory perception, Health teaching
   MSC: Client Needs Category: Health Promotion and Maintenance

10. The nurse tells the staff development nurse he/she is very uncomfortable discussing sexuality with clients, especially those who are older. What suggestion by the staff development nurse is **most** appropriate?
    a. <Find a trusted friend and role play.=
    b. <Don9t worry it will get easier.=
    c. <A sexual assessment is usually not needed.=
    d. <It9s hard for me to do, too.=

    ANS: A
    Discussing sexuality and sex is difficult for most people. Since it is important to be able to assess this aspect of people9s lives, the nurse needs to become comfortable. Role-playing with a trusted friend will build confidence and comfort. Saying that it will get easier and that it is hard for the staff development nurse too does not give the nurse any ideas for improvement. Sexuality is important to assess.

    DIF: Applying TOP: Integrated Process: Caring
    KEY: Sexuality, Nursing assessment MSC: Client Needs Category: Psychosocial Integrity

MULTIPLE RESPONSE

1. A nurse is planning a community education event-related to impaired cellular regulation. What teaching topics would the nurse include in this event? (*Select all that apply.*)
   a. Ways to minimize exposure to sunlight
   b. Resources available for smoking cessation
   c. Strategies to remain hydrated during hot weather
   d. Use of indoor tanning beds instead of sunbathing
   e. Creative cooking techniques to increase dietary fiber
   f. How to determine sodium content in food?

   ANS: A, B, E

Disrupted cellular regulation can lead to both benign and malignant tumors (cancer). Ways to minimize the risk of developing cancer include decreasing exposure to sunlight, smoking cessation, and increasing dietary fiber. Tanning beds do not reduce the risk of cancer as opposed to sunbathing. While staying hydrated is a good health measure, it is not related to cellular regulation. Maintaining a normal intake of sodium is also not related to cellular regulation.

DIF: Applying TOP: Integrated Process: Nursing Process: Planning
KEY: Cellular regulation, Health teaching
MSC: Client Needs Category: Health Promotion and Maintenance

2. A nurse is caring for clients on an inclient surgical unit. Which clients does the nurse identify as having a risk for impaired immunity? (*Select all that apply.*)
   a. 86 years old
   b. Has type 2 diabetes
   c. Taking prednisone
   d. Has many allergies
   e. Drinks a beer a day
   f. Low socioeconomic status

   ANS: A, B, C, F
   Risk factors for impaired immunity include but are not limited to: older adults (diminished immunity due to normal aging changes), low socioeconomic groups (inability to obtain proper immunizations), nonimmunized adults, adults with chronic illnesses that weaken the immune system, adults taking chronic drug therapy such as corticosteroids and chemotherapeutic agents, adults experiencing substance use disorder, adults who do not practice a healthy lifestyle, and adults who have a genetic risk for decreased or excessive immunity. Allergies and one beer a day are not risk factors.

   DIF: Remembering TOP: Integrated Process: Nursing Process: Planning
   KEY: Immunity
   MSC: Client Needs Category: Physiological Integrity: Reduction of Risk Potential

3. The nurse is caring for a client with severely impaired mobility. What actions does the nurse place on the care plan to address potential complications? (*Select all that apply.*)
   a. Perform a depression screen once a day.
   b. Consult physical therapy for range of motion.
   c. Increase fiber in the client9s diet.
   d. Decrease fluid intake.
   e. Allow client to stay in a position of comfort.

   ANS: A, B, C
   There are many complications of immobility including depression, pressure injuries, constipation, urinary calculi, and muscle atrophy. The nurse would address these by assessing for depression, consulting physical therapy for activities such as range of motion the client can do, and increase fiber so the client does not become constipated. Decreasing fluid intake would increase the possibility of calculi and allowing the client to stay in one position would increase the risk of pressure injuries.

   DIF: Applying TOP: Integrated Process: Nursing Process: Implementation
   KEY: Mobility