5 The Multiple-Choice Question

In our society, success is generally measured in relation to levels of achievement. Before you entered a formal institution of learning, your achievement was subjectively appraised by your family and friends. Success was rewarded by smiles, positive statements, and perhaps favors or gifts. Lack of achievement or failure was acknowledged by omission of recognition, verbal corrections, and possibly punishment or scorn. When you entered school, your performance was directly measured against acceptable standards. In an effort to eliminate subjectivity, you were exposed to objective testing. These tests included true/false questions, matching columns, and multiple-choice questions. Achievement was reflected by numerical grades or letter grades. These grades indicated your level of achievement and by themselves provided rewards and punishments.

In nursing education, achievement can be assessed in a variety of ways: a patient's physiological response (Did the patient's condition improve?), a patient's verbal response (Did the patient verbalize improvement?), student nurses' clinical performance (Did the students do what they were supposed to do?), and student nurses' levels of cognitive competency (Did the students know what they were supposed to know?). You must pass the National Council Licensing Examination known as NCLEX-PN to work legally as a Licensed Practical Nurse or the NCLEX-RN to work legally as a Registered Nurse. These examinations consist of multiple-choice and alternate-format items. Consequently, both types of questions are frequently used in schools of nursing to evaluate student progress throughout the nursing curriculum. They also are used because they are objective, are time efficient, and can assess comprehensively the understanding of curriculum content that has depth and breadth. Therefore, it is important for you to understand the components and dynamics of multiple-choice and alternate-format items early in your nursing education.

In the spring of 2003, alternate-format items were introduced in nursing licensure examinations. **Alternate-format items** require the test taker to select multiple answers to a multiple-choice question, perform a calculation and fill in the blank, place options in priority order, or respond to a question in relation to an exhibit. For information about and examples of alternate-format items, review Chapter 8, Testing Formats Other Than Multiple-Choice Questions. Multiple-choice questions are addressed in this chapter.

COMPONENTS OF A MULTIPLE-CHOICE QUESTION

A multiple-choice question is an objective test item. It is objective because the perceptions or opinions of another person do not influence the grade. In a multiple-choice question, a question is asked, three or more potential answers are presented, and only one of the potential answers is correct. The student answers the question either correctly or incorrectly.

The entire multiple-choice question is called an **item.** Each item consists of two parts. The first part is known as the **stem.** The stem is the statement that asks the question. The second part contains the possible responses offered by the item, which are called **options.** One of the options answers the question posed in the stem and is the **correct answer.** The remaining options are the incorrect answers and are called **distractors.** They are referred to as "distractors" because they are designed to distract you from the correct answer.

The correct answers and the rationales for all the options of the sample items in this chapter are at the end of the chapter. Test yourself and see if you can correctly answer the sample items.

SAMPLE ITEM 5-1
Which should the nurse do immediately before performing any procedure?
1. Shut the door. (DISTRACTOR)
2. Wash the hands. (CORRECT ANSWER)
3. Close the curtain. (DISTRACTOR)
4. Drape the patient. (DISTRACTOR)

SAMPLE ITEM 5-2
A nurse is assessing placement of a nasogastric tube. Where should the distal end of the tube be within the body?
1. Stomach (CORRECT ANSWER)
2. Bronchi (DISTRACTOR)
3. Trachea (DISTRACTOR)
4. Duodenum (DISTRACTOR)

SAMPLE ITEM 5-3
A parent says to the nurse, "My kid is difficult to get along with and is only concerned about the opinions of friends." How old is the child?
1. 3 years old (DISTRACTOR)
2. 7 years old (DISTRACTOR)
3. 14 years old (CORRECT ANSWER)
4. 22 years old (DISTRACTOR)

THE STEM

The stem is the initial part of a multiple-choice item. The purpose of the stem is to present a problem in a clear and concise manner. The stem should contain all the details necessary to answer the question.

The stem of an item can be a complete sentence that asks a question. It also can be presented as an incomplete sentence that becomes a complete sentence when it is combined with one of the options of the item.

In addition to sentence structure, a characteristic of a stem that must be considered is its polarity. The polarity of the stem can be formulated in either a positive or negative context. A stem with a positive polarity asks the question in relation to what is true, whereas a stem with negative polarity asks the question in relation to what is false.

The Stem That Is a Complete Sentence

A complete sentence is a group of words that is capable of standing independently. When a stem is a complete sentence, it will ask a question and end with a question mark (?). It should clearly and concisely formulate a problem that can be answered before reading the options.

SAMPLE ITEM 5-4
Which should be the first action of the nurse when a fire alarm rings in a health-care facility?

1. Determine if it is a fire drill or a real fire.
2. Move patients laterally toward the stairs.
3. Take an extinguisher to the fire scene.
4. Close doors on the unit.

SAMPLE ITEM 5-5
Which is the most common reason why older adults become incontinent of urine?

1. They use incontinence to manipulate others.
2. The muscles that control urination become weak.
3. They tend to drink less fluid than younger patients.
4. Their increase in weight places pressure on the bladder.

SAMPLE ITEM 5-6
Which part of the body requires special hygiene when a patient has a nasogastric feeding tube?

1. Rectum
2. Abdomen
3. Oral cavity
4. Perineal area

The Stem That Is an Incomplete Sentence

When a stem is an incomplete sentence, it is a group of words that forms the beginning portion of a sentence. The sentence becomes complete when it is combined with one of the options in the item. Some tests will have a period at the completion of each option and others will not. Whether there is a period or not, each option should complete the sentence with grammatical accuracy. However, the answer is the only option that correctly completes the sentence in relation to the informational content. When reading a stem that is an incomplete sentence, usually it is necessary to read the options before the question can be answered.

SAMPLE ITEM 5-7
To **best** understand what a patient is saying, the nurse should:

1. Listen carefully.
2. Employ touch.
3. Show interest.
4. Remain silent.

SAMPLE ITEM 5-8
The **most** important reason why nurses should teach people not to smoke in bed is because it can:
1. Upset a family member.
2. Precipitate lung cancer.
3. Trigger a smoke alarm.
4. Result in a fire.

SAMPLE ITEM 5-9
When assisting a female patient with dementia to groom her hair, the nurse should:
1. Offer constant support and encouragement.
2. Set time aside for a long teaching session.
3. Alternate using a brush and a comb.
4. Teach her how to braid her hair.

The Stem With Positive Polarity

The stem with positive polarity is concerned with truth. It asks the question with a positive statement. The correct answer is accurately related to the statement. It is in accord with a fact or principle, or it is an action that should be implemented. A positively worded stem attempts to determine if you are able to understand, apply, or differentiate correct information.

SAMPLE ITEM 5-10
An older adult who is dying starts to cry and says, "I was always concerned about myself first, and I hurt many people during my life." Which is the underlying feeling being expressed by the patient?
1. Ambivalence
2. Sadness
3. Anger
4. Guilt

SAMPLE ITEM 5-11
Which nursing intervention most accurately supports the concept of informed consent for a surgical procedure?
1. Explaining what is being done and why
2. Involving the family in the teaching plan
3. Obtaining the patient's signature on the document
4. Teaching preoperative deep breathing and coughing

SAMPLE ITEM 5-12
Which should the nurse do when a patient appears to be asleep but does not react when called by name?

1. Loudly say, "Are you awake?"
2. Say to the patient, "Can you squeeze my hand?"
3. Inform the nurse manager in charge immediately.
4. Gently touch the patient's arm while saying the patient's name.

The Stem With Negative Polarity

The stem with negative polarity is concerned with what is false. It asks the question with a negative statement. The stem usually incorporates words such as "except," "not," or "never." These words are obvious. However, sometimes the words that are used are more obscure, for example, "contraindicated," "further," "unacceptable," "least," and "avoid." When a negative term is used, it may be emphasized by an underline (except), italics (*least*), boldface type (**not**), or capitals (NEVER). A negatively worded stem requires you to recognize exceptions, detect errors, or identify interventions that are unacceptable or contraindicated. Many nursing examinations do not have questions with negative polarity or do not emphasize the negative word when used in a stem. However, this information is included here in the event that you may be challenged by questions with negative polarity.

SAMPLE ITEM 5-13
On what part of the body should the nurse avoid using soap when bathing a patient?

1. Eyes
2. Back
3. Under the breasts
4. Glans of the penis

SAMPLE ITEM 5-14
The nurse determines that range-of-motion (ROM) exercises should NOT be done:

1. For comatose patients.
2. On limbs that are paralyzed.
3. Beyond the point of resistance.
4. For patients with chronic joint disease.

SAMPLE ITEM 5-15
Which suggestion by the nurse is the least therapeutic when teaching the patient about promoting personal energy?

1. Eat breakfast every day.
2. Exercise three times a week.
3. Get adequate sleep each night.
4. Drink a cup of coffee each morning.

SAMPLE ITEM 5-16
Which position is contraindicated for a patient who has dyspnea?
1. Fowler
2. Supine
3. Contour
4. Orthopneic

SAMPLE ITEM 5-17
Which action by the nurse is unacceptable during a bed bath?
1. Uncovering the area being washed
2. Using long, firm strokes toward the heart
3. Washing from the rectum toward the pubis
4. Replacing the top sheets with a cotton blanket

THE OPTIONS

All of the possible answers offered within an item are called "options." One of the options is the best response and is therefore the correct answer. The other options are incorrect and distract you from selecting the correct answer. These options are called "distractors." An item must have a minimum of three options to be considered a multiple-choice item, but the actual number varies among tests. The typical number of options is four or five responses, which reduces the probability of guessing the correct answer while limiting the amount of reading to a sensible level. Options usually are listed by number (1, 2, 3, and 4), lowercase letters (a, b, c, and d), or uppercase letters (A, B, C, and D). The grammatical presentation of options can appear in four different formats. An option can be a sentence, can complete the sentence begun in the stem, can be an incomplete sentence, or can be a single word.

The Option That Is a Sentence

A sentence is a unit of language that contains a stated or implied subject and verb. It is a statement that contains an entire thought and stands alone. Options can appear as complete sentences. Some tests have a period at the end of these options and others do not. Whether there is a period or not, each option should be grammatically correct. When the option is a verbal response, it should be grammatically correct and incorporate the appropriate punctuation, such as quotation marks (" "), comma (,) exclamation point (!), question mark (?), or period (.).

SAMPLE ITEM 5-18
Before performing a procedure, which should the nurse do first?
1. Collect the equipment for the procedure.
2. Position the patient for the procedure.
3. Explain the procedure to the patient.
4. Raise the bed to its highest position.

SAMPLE ITEM 5-19
A Catholic patient tells the nurse, "Before being hospitalized I went to mass and received Communion every morning." Which should the nurse do to meet this patient's spiritual needs?

1. Encourage the patient to say the rosary every day.
2. Make arrangements for the patient to receive communion.
3. Transfer the patient to a room with another Catholic patient.
4. Have a priest administer the Sacrament of Anointing of the Sick to the patient.

SAMPLE ITEM 5-20
A male patient is crying, and the only word the nurse understands is "wife." Which should the nurse say?

1. "I'm sure that your wife is fine."
2. "You are concerned about your wife?"
3. "What did your wife do to upset you?"
4. "Your wife will be visiting later today."

The Option That Completes the Sentence Begun in the Stem

When the option completes the sentence begun in the stem, the stem and the option together should form a sentence. Some tests have correct punctuation at the end of these options and others do not. Whether or not there is a period, each option should complete the stem in a manner that is grammatically accurate.

SAMPLE ITEM 5-21
A nurse understands that the primary etiology of obesity is a:

1. Lack of balance in the variety of nutrients
2. Glandular disorder that prevents weight loss
3. Caloric intake that exceeds metabolic needs
4. Psychological problem that causes overeating

SAMPLE ITEM 5-22
A nurse can best prevent the patient from getting a chill during a bed bath by:

1. Rubbing briskly to cause vasodilation.
2. Exposing only the area being washed.
3. Pulling the curtain around the bed.
4. Giving a hot drink before the bath.

SAMPLE ITEM 5-23
A nurse is to assist a patient with a bed bath. However, the patient has just returned from a diagnostic test, is in pain, and refuses the bath. The nurse should:
1. Encourage a shower instead.
2. Give a partial bath quickly.
3. Cancel the bath for today.
4. Delay the bath until later.

The Option That Is an Incomplete Sentence

When an option is an incomplete sentence, it does not contain all the parts of speech (e.g., subject and verb) necessary to construct a complete, autonomous statement. The option that is an incomplete sentence usually is a phrase or group of related words. Although not a complete sentence, it conveys a unit of thought, an idea, or a concept.

SAMPLE ITEM 5-24
Which nursing intervention is common when caring for all patients with infections?
1. Donning a mask
2. Wearing a gown
3. Washing the hands
4. Discouraging visitors

SAMPLE ITEM 5-25
When should the nurse administer mouth care to an unconscious patient?
1. Whenever necessary
2. Every four hours
3. Once a shift
4. Twice a day

SAMPLE ITEM 5-26
Which action by the nurse helps meet a patient's basic need for security and safety?
1. Addressing a patient by name
2. Accepting a patient's angry behavior
3. Ensuring a patient gets adequate nutrition
4. Explaining to a patient what is going to be done

The Option That Is a Word

A word is a series of letters that form a term. It is the most basic unit of language and is capable of communicating a message. The option that is a single word can be almost any part of speech (e.g., noun, pronoun, verb, or adverb) as long as it conveys information.

SAMPLE ITEM 5-27
Which is a primary source for obtaining information related to the independent functions of a nurse?

1. Chart
2. Patient
3. Nurse manager
4. Health-care provider

SAMPLE ITEM 5-28
A patient's spouse just died. Which approach should be used by the nurse when caring for this grieving patient?

1. Confronting
2. Supporting
3. Avoiding
4. Limiting

SAMPLE ITEM 5-29
What is the nurse doing when formulating a nursing diagnosis?

1. Planning
2. Assessing
3. Analyzing
4. Implementing

SAMPLE ITEM 5-30
Which word **best** describes feelings associated with a child in Erikson's stage of autonomy versus shame and doubt?

1. Hers
2. Mine
3. Theirs
4. Nobody's

ANSWERS AND RATIONALES FOR SAMPLE ITEMS IN CHAPTER 5

5-1 1. Shutting the door should be done before washing the hands. The hands become contaminated when the door is touched.
2. Before touching the patient, the nurse should wash his or her hands to remove microorganisms.
3. Closing the curtain should be done before washing the hands. Curtains are considered contaminated. The hands should be washed after touching the curtains.
4. Draping the patient is done after washing the hands.

5-2 **1. The tube enters the nose, passes through the posterior nasopharynx and esophagus, and enters the stomach through the cardiac sphincter.**
2. The bronchi are passages between the trachea and bronchioles and are part of the respiratory system.
3. The trachea is a passage between the posterior nasopharynx and bronchi and is part of the respiratory system.
4. The duodenum is distal to the stomach and is the first portion of the small intestine; a nasogastric tube is designed to be advanced into the stomach, not the duodenum.

5-3 1. Toddlers are concerned about themselves and their autonomy, not others.
2. School-age children are easy to get along with and are concerned about performing and achieving.
3. Adolescents are concerned about their identity, independence, and peer relationships; this causes tension between them and their parents.
4. Young adults are developing intimate relationships and becoming socially responsible.

5-4 1. Whenever the fire alarm rings, it should always be considered an indication of a real fire.
2. Patients should be moved only if they are in danger.
3. The location of the fire must be identified before an extinguisher can be taken to the scene.
4. Closing the doors on the unit should be the initial action of the options provided. A closed door provides for patient safety because it is a barrier that impedes the spread of the fire.

5-5 1. This is untrue; most people want to be independent and in control of their bodily functions.
2. Muscles, particularly the perineal muscles, tend to lose strength as people age.
3. Incontinence is unrelated to fluid intake.
4. Older adults do not necessarily gain weight; many lose weight because of the loss of subcutaneous fat associated with aging. Body weight does not influence incontinence.

5-6 1. A nasogastric tube is unrelated to the rectum. Special care of this area of the body is unnecessary; care provided during a routine bed bath is adequate.
2. A nasogastric tube enters the body through the nose, not the abdomen. Cleansing of the abdomen during a routine bed bath is adequate.
3. A nasogastric tube feeding generally negates the need to chew; with lack of chewing, salivation decreases, which causes the mucous membranes to become dry.
4. The perineal area is unrelated to a nasogastric tube. Bathing of the perineal area during a routine bed bath is adequate.

5-7 **1. Attentive listening is important so that the nurse can pick up key words and identify emotional themes within the message.**
2. Touch is used to communicate a message of caring, not to receive, understand, or interpret a message from another person.
3. Although this may indicate acceptance and encourage ventilation of feelings, it does nothing to promote understanding by the nurse.
4. Although remaining silent may encourage further communication, it will not by itself promote understanding of the patient's message.

5-8 1. Although smoking can physically and emotionally disturb a family member, it is not the priority.
2. Although smoking may precipitate lung cancer, this is not the reason for not smoking in bed.
3. Smoke from a cigarette will not trigger a smoke alarm.

4. Confused, weak, or lethargic individuals may drop lighted cigarettes or ashes, which can ignite bed linens.

5-9 **1. People with dementia become confused easily and need support and encouragement to stay focused and motivated.**
2. People with dementia cannot concentrate long enough for a prolonged teaching session; learning occurs best with short, frequent teaching sessions.
3. Alternating a brush and a comb may promote confusion; patients with dementia need consistency.
4. Braiding the hair involves cognitive and psychomotor skills that the patient with dementia probably does not possess.

5-10 1. Ambivalence demonstrates two simultaneous conflicting feelings.
2. Although the patient may be unhappy about past behaviors, it is the underlying thoughts about hurting others that precipitated the patient's statement.
3. Anger is a feeling of displeasure caused by opposition or mistreatment and is demonstrated by the words or gestures used by the patient in an effort to fight back at the cause of the feeling.
4. Guilt is a painful feeling of self-reproach resulting from the belief that one has done something wrong.

5-11 **1. It is the surgeon's responsibility to explain what is going to be done and the potential negative and positive consequences (risks and benefits).**
2. Although the family may be involved, it is the patient who must sign the informed consent.
3. Legally a nurse may obtain a patient's signature on a consent form. The nurse's signature on the form only indicates that the patient was the person who signed the consent form. However, the nurse should identify the patient's understanding of the procedure to be performed and inform the surgeon if additional information is requested or necessary.
4. Preoperative teaching is necessary only if the patient consents to surgery.

5-12 1. Speaking loudly may frighten the patient; one of the patient's other senses should be stimulated because the patient previously has not responded to a verbal intervention.
2. The nurse must get the patient's attention before giving a direction.
3. The nurse should assess the patient further before informing the nurse in charge.
4. This action is the first step to assess this patient further. Touch and sound stimulate two senses, and using the patient's name is individualizing care.

5-13 **1. Soaps usually contain sodium or potassium salts of fatty acids, which are irritating and can injure the sensitive tissues of the eyes.**
2. The back needs soap and water to remove perspiration that collects on the skin.
3. Body surface areas that touch are dark, warm, and moist and must be washed with soap and water to limit the growth of microorganisms.
4. The glans of the penis needs soap and water to remove perspiration, urine, and smegma.

5-14 1. Range of motion should be performed for unconscious patients because they usually are immobile and are at risk for developing contractures.
2. Paralyzed limbs must be moved through full range of motion by the nurse to prevent loss of range secondary to inactivity.
3. Resistance indicates that there is strain on the muscles or joints; continuing range of motion beyond the point of resistance can cause injury and should be avoided.
4. People with chronic joint disease usually need gentle range-of-motion exercises to keep the joints mobile.

5-15 1. Food contains nutrients and calories, which provide energy.
2. Exercise promotes muscle tone and energy.
3. Sleep is restful and restorative.
4. Caffeine, although a stimulant, can be harmful to the body.

5-16 1. When the patient is in a Fowler position, the diaphragm is not being compressed by the abdominal contents; this allows for maximal thoracic expansion.
2. The abdominal contents press against the diaphragm when a person is in the supine position, which impedes

expansion of the thoracic cavity and subsequently the lungs.

3. This position is desirable because the abdominal contents drop by gravity, permitting efficient contraction of the diaphragm and expansion of the thoracic cavity.
4. An upright position with the head higher than the hips (orthopneic position) allows the diaphragm to move toward the abdominal cavity during inspiration with minimal pressure of the abdominal organs against the diaphragm.

5-17 1. Only the area being washed should be exposed, to permit adequate bathing and inspection.
2. Using long, firm strokes toward the heart is desirable because it promotes venous return.
3. This will contaminate the urinary meatus with microorganisms from the perianal area.
4. Using a cotton blanket is desirable; it absorbs moisture, provides warmth, and promotes privacy.

5-18 1. Equipment should be gathered after the patient agrees to the procedure.
2. Positioning the patient is done immediately before the procedure is performed.
3. Explaining the procedure meets the patient's right to know why and how care will be provided. It should be done before any step of the procedure is initiated.
4. This may be frightening if the patient does not know why the action is being done; also, not every procedure needs the bed to be raised to its highest position.

5-19 1. This focuses on a different ritual and denies the patient's concerns about missing mass and not receiving communion.
2. This helps to meet the patient's spiritual needs and is easily accomplished in a hospital setting.
3. The nurse should assist the patient to meet spiritual needs. The nurse should not expect other Catholic patients to assume this role.
4. The sacrament of Anointing of the Sick is a different ritual than attending mass and receiving communion.

5-20 1. This statement offers false reassurance and draws a conclusion based on insufficient information.
2. This response encourages further communication, which is necessary to obtain more information about what is upsetting the patient.
3. This is a judgmental statement that is not based on fact.
4. This is not an open-ended question that allows the patient to express concerns; this is a statement that may or may not be true.

5-21 1. A lack of balance in nutrients can result in malnutrition, not necessarily obesity; it also can result in weight loss.
2. Although glandular disorders such as hypothyroidism may result in obesity, they are not the primary causes of obesity.
3. If more calories are ingested than the body requires for energy, they will be converted to adipose tissue, which causes weight gain.
4. A psychological problem is just one of many factors that influence overeating; it is not the primary cause of obesity.

5-22 1. Vasodilation promotes heat loss.
2. Exposing only the area being washed limits the evaporation of fluids on the skin and radiation of heat from the body, which prevents the patient from getting a chill.
3. Although this may prevent drafts, it will not prevent the patient's getting a chill from the environmental temperature, excessive exposure, or evaporation of water from the skin.
4. A hot drink will not prevent a chill.

5-23 1. A shower may be an unsafe activity when a patient is in pain. The patient has a right to refuse care.
2. This ignores the patient's right to refuse care and the fact that the patient is in pain.
3. The bath may eventually be cancelled, but it should be delayed first.
4. Delaying the bath accepts the patient's present refusal to bathe; rest and pain reduction may make the patient more amenable to hygiene later in the day.

5-24 1. Donning a mask is not necessary for Standard Precautions and is not required for all Transmission-Based Precautions.
2. Wearing a gown is not part of Standard Precautions and is not required for all Transmission-Based Precautions.
3. Washing the hands before and after patient care and whenever contaminated

is the most important action for preventing the spread of microorganisms.

4. After they have been taught how to use Standard and Transmission-Based Precautions, people are permitted to visit patients with infections.

5-25 **1. Unconscious patients usually have dry mucous membranes of the oral cavity because they frequently breathe through the mouth, are not drinking fluids, and may be receiving oxygen; oral hygiene is required whenever necessary, which usually is at least every 2 hours.**

2. Every 4 hours is too long a period of time between providing oral care for an unconscious patient; drying, sores, and lesions of the mucous membranes can occur.
3. Once a shift is too long a period of time to elapse before providing oral care for an unconscious patient.
4. Twice a day is too long a period of time between oral care for an unconscious patient.

5-26 1. Addressing a patient by name meets the patient's need for self-esteem.
2. Accepting a patient's expression of feelings, including feelings of anger, meets self-esteem needs. Limits may be set on feelings that escalate and place the patient and/or others in danger.
3. This action meets the patient's basic physiological need for adequate nutrients for body processes.
4. Knowing what will happen and why provides for the patient's security needs; also, it is a patient's right. The unknown can be frightening.

5-27 1. The chart is a secondary source; it also contains primary health-care providers' prescriptions and orders, which are dependent functions of the nurse.
2. The primary and most important source for obtaining information referring to the patient is the patient. The independent functions of the nurse include interventions that relate to human responses, which are identified by direct contact with the patient.
3. A nurse manager is a secondary source; independent functions of the nurse can be performed independently of others.
4. A primary health-care provider is a secondary source of information; when the nurse follows a primary health care provider's prescription or order, it is a dependent function of the nurse.

5-28 1. A confrontation may take away the patient's current coping mechanisms and leave the patient defenseless.
2. A patient who is grieving is using defenses to cope with the crisis; these defenses should be supported.
3. Avoiding the patient is a form of abandonment; the nurse should be present to provide support.
4. Setting limits may take away the patient's coping mechanisms and leave the patient defenseless.

5-29 1. Planning occurs after the assessment and analysis phases of the nursing process.
2. Assessing involves collecting data, which must be gathered before it can be analyzed and nursing diagnoses formulated.
3. Data must be clustered and interpreted to identify human responses that indicate potential or actual health problems that can be treated by the nurse; statements that indicate actual or potential health problems treatable by the nurse are nursing diagnoses. These actions require analysis.
4. Implementation is putting the plan of care into action, which occurs after assessment, analysis, and planning.

5-30 1. The word "hers" is associated with others rather than the self or self-interests.
2. Toddlers are developing a sense of autonomy and are discovering the difference between independence and dependence; they are concerned about themselves and their mastery over their environment.
3. The word "theirs" is associated with others rather than the self or self-interests.
4. Toddlers are the center of their universe; they consider everything to be theirs.