**1. Match the phases of the nursing process with the descriptions (phases may be used more than once).**

1. Analysis of data ………………………………………………………………………
2. Priority setting ………………………………………………………………………
3. Nursing interventions ………………………………………………………………………
4. Data collection ………………………………………………………………………
5. Identifying patient strengths………………………………………………………………………
6. Measuring patient achievement of goals………………………………………………………………
7. Setting goals ………………………………………………………………………
8. Identifying health problems………………………………………………………………………
9. Modifying the plan of care ………………………………………………………………………
10. Documenting care provided ………………………………………………………………………

***(1. Assessment, 2. Diagnosis, 3. Planning, 4. Implementation, 5. Evaluation)***

**2. During the diagnosis phase of the nursing process, both nursing diagnoses and collaborative problems are identified. Which are collaborative problem statements (select all that apply)?**

a. Fatigue related to sleep deprivation

b. Infection related to immunosuppression

c. Excess fluid volume related to high sodium intake

d. Constipation related to irregular defecation habits

e. Hypoxia related to chronic obstructive pulmonary disease

f. Risk for cardiac dysrhythmias related to potassium deficiency

**3. For the nursing diagnoses and written patient outcomes listed below, use the Nursing Interventions Classification (NIC) to identify a specific nursing intervention to help the patient reach the outcome.**

1. **Nursing diagnosis:**

 Risk for impaired skin integrity related to immobility

**Patient outcome:**

Patient will demonstrate skin integrity free of pressure ulcers.

1. **Nursing diagnosis:**

 Constipation related to inadequate fluid and fiber intake

**Patient outcome:**

Patient will have daily soft bowel movements in 1 week.

4. **A patient with a seizure disorder is admitted to the hospital after a sustained seizure. When she tells the nurse that she has not taken her medication regularly, the nurse makes a nursing diagnosis of ineffective self-health management related to lack of knowledge regarding medication regimen and identifies the Nursing Outcomes Classification (NOC) outcome of Compliance behavior, with the indicator Performs treatment regimen as prescribed, at a target rate of 3 (sometimes demonstrated). When the nurse tries to teach the patient about the medication regimen, the patient tells the nurse that she knows about the medication but she does not always have the money to refill the prescription. Where was the mistake made in the nursing process with this patient?**

1. Planning
2. Diagnosis
3. Evaluation
4. Assessment
5. Implementation