Nursing

Case-Management-Nurse
Case Management Nurse Certification Exam

Questions And Answers PDF Format:

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Question: 1

When dealing with the psychosocial aspects of chronic illness, the nurse case manager should do all of the following EXCEPT:

A. assume the role of therapist for the client and family.
B. listen and learn about the impact of the illness on the client and family.
C. empower clients and families to develop coping strategies.
D. provide referrals to support groups and social services.

Answer: A

Explanation:
Assume the role of therapist for the client and family. While the nurse case manager should be sensitive to the needs of the patient and family listen and provide support, and understand the impact of the illness or injury on family dynamics, he or she should not attempt to assume a strictly therapeutic role. Instead, referrals should be made to support groups and social services (e.g., counseling, as needed) for any in-depth psychological services. However, staying well informed, monitoring progress, and relaying essential psychosocial information to relevant members of the health care team is a crucial role of the nurse case manager.

Question: 2

Discovering, respecting, and incorporating the values of clients and families in the health care experience refers to:

A. sociodemographic tolerance.
B. cultural competence.
C. individuality integration.
D. psychosocial acknowledgment,

Answer: B

Explanation:
Cultural competence. The term includes the collective influences from religion, ethnicity, age, gender, geography, language, and socioeconomic status. Cultural competence does not ignore the fact that there are always individual differences and idiosyncrasies from one person to another but refers to an underlying awareness and context that can inform and facilitate the process of understanding and working with each individual. Principles of "diversity" acknowledge that "religion" and "spirituality" are not always the same thing (i.e„ one implies membership, while the other refers to personal practice and belief) and that variations exist in behavioral norms, rules, beliefs, values, taboos, and habits among people everywhere. Integration of a cultural assessment

into the care plan can aid in issues of communication, treatment compliance, and in the identification and resolution of treatment obstacles.

Question: 3

Medical practice standards and care algorithms are often referred to as:

A. clinical practice guidelines.
B. best practices or clinical protocols.
C. care pathways or care maps.
D. all of the above.

Answer: D

Explanation:
All of the above. In nursing case management, the term "clinical practice guidelines" is often used, but the other terms listed in the question also appear frequently in nursing and other medical literature. Clinical guidelines attempt to integrate key treatment decisions with optimum outcomes as derived from research-based evidence of the risks, benefits, and costs associated with various clinical options in a given medical scenario. The research used to develop such guidelines must be "evidence-based" and "practice-based" to ensure that effective outcomes and goals are achieved. Existing clinical guidelines must be frequently reviewed and updated (at least annually) to incorporate ongoing learning and new research findings.

Question: 4

The health education "Stages of Change Model" was developed by:

A. Diniz, Schmidt and Stothers.
B. Malcolm Knowles.
C. James Prochaska.
D. Hildegarde Peplau.

Answer: C

Explanation:
James Prochaska. James Prochaska produced the health education plan, known as "Stages of Change Model," in 1979 and refined it later with Carlo DiClemente. The model summarizes the six stages that people tend to pass through when attempting to introduce changes in their health-related habits. Stage 1 is called the "pre-contemplation" stage: patients are oblivious to or not seriously considering the need for change. Stage 2 is the "contemplation" stage: people are thinking seriously about making a change. Stage 3 is the "preparation" stage: people make formal plans for an impending change. Stage 4 refers to the "action" stage: the plans are now applied. Stage 5 is the "maintenance" stage: people work past lapses to retain the change. Stage 6 is the "termination" stage: relapse tendencies are resolved, and the change is fully incorporated.

Question: 5

The 1966 "Partnership for Health Act" defined health as:

A. a state of complete well-being.
B. an interdisciplinary enterprise.
C. a case management outcome.
D. the promotion of wellness.

Answer: A

Explanation:
A state of complete well-being. A state of complete well-being includes physical, mental, and social health. The intent of the Partnership for Health Act was to move away from prior definitions of health that focused on an absence of illness or injury. Thus, the goal was revised from providing treatment resources and access in response to illness and injury to the preemptive promotion of wellness to circumvent and prevent illness and injury. This goal remains a work in progress, as health care delivery systems in the United States continue to be oriented toward responding to situations of disease and injury as opposed to preventing them and promoting greater overall health in society.

Question: 6

The fundamental starting point for a case manager and patient is:

A. an understanding of the patient's disease or injury.
B. an appreciation of the patient's sociocultural situation.
C. a holistic understanding of the patient in all life dimensions.
D. diagnostic clarity and a medically effective care plan.

Answer: C

Explanation:
A holistic understanding of the patient in all life dimensions. A segmented understanding of a patients diagnosis, disease, injury treatment protocols, or sociocultural context can never replace a holistic and integrated understanding of a patient in all of his or her personal life domains. For example, every medical insight and treatment advantage may fail if confounding sociocultural factors exist. A holistic view imbues all care plan interventions with greater efficacy and value. From activity logs, to changes in health patterns, to reports of key indices of risk and outcomes, all have greater meaning and import when placed in a holistic patient context.

Question: 7

The term "least restrictive setting" refers to:

A. the voluntary nature of patient-provider health care delivery.
B. a "start low and go slow" approach to treatment.
C. protocols regarding the use of patient physical restraints.
D. treatment in settings that promote maximal patient autonomy.

Answer: D

Explanation:
Treatment in settings that promote maximal patient autonomy. Historically, patient treatment was provided in settings that optimized a health care provider's convenience and control. Over the years, it was discovered that patients could become overly dependent and even "institutionalized" by such approaches, leaving them unable to function independently or to return to normal life patterns. To counteract this historical mindset, regulations and policies were promulgated that fostered maximal patient autonomy and independence, ultimately benefiting patients, providers, and the institutional care settings.

Question: 8

Health information and identified demographics of a single person are referred to as:

A. individual data.
B. personal data.
C. singular data.
D. prime data.

Answer: A

Explanation:
Individual data. Health and demographic data pertaining to a single individual consist of information necessary to understand and respond to a patient’s health care situation. These data are needed to shape an effective plan of care. Inaccurate, unavailable, or lost information can lead to expensive testing redundancy and associated risks, inaccurate diagnoses, untoward reactions to treatments and interventions, and other adverse outcomes. Consequently, the collection, maintenance, and availability of this information are important.

Question: 9

Health information and demographics gathered by repeated measurements or by combining a collection of individual data are referred to as:

A. population data.
B. cumulative data.
C. aggregate data.
D. collective data.

Answer: C

Explanation:
Aggregate data. Aggregate data are necessary to identify and understand health care trends, unique issues, and probabilities as related to health changes over time or changes related to targeted groups and populations. Aggregate data can also be used to track the overall effectiveness of various treatment approaches and other health care interventions. Consequently, aggregate data can be extremely important to nurse case managers as they work with their clients and referral sources.

Question: 10

Quality data have all of the following characteristics EXCEPT they are:

A. predictable.
B. reliable.
C. unbiased.
D. valid.

Answer: A

Explanation:
Predictable. Data need not be predictable (i.e„ providing results or findings that are expected). However, quality data must be reliable (i.e„ with results that are consistently repeatable in subsequent measurements), unbiased (i.e., free of systematic errors that compromise the information), and valid (i.e„ actually measuring what they purport to measure).

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