Chapter 1, The Nurse's Role in Health Assessment

MULTIPLE CHOICE

1. Which is one of the broad goals within nursing?
   A) To provide cost-effective care
   B) To form broad nursing diagnoses
   C) To promote self-care
   D) To treat human responses

   ANS: D
   Feedback: Four broad goals are within nursing: (1) to promote health (state of optimal functioning or well-being with physical, social, and mental components); (2) to prevent illness; (3) to treat human responses to health or illness; and (4) to advocate for individuals, families, communities, and populations. The other options listed are not broad goals. Nursing focuses on promoting health; while cost-effective care is strived for, it is not a part of the broad goal, and therefore this is not a broad goal within nursing. Nursing looks to develop specific nursing diagnoses, not broad. Promoting self-care is important, but does not correctly answer the question.

   PTS: 1 REF: Page: 4 | Header: Roles of the Professional Nurse
   OBJ: 1
   NAT: Client Needs: Safe, Effective Care Environment: Management of Care
   TOP: Chapter: 1 KEY: Integrated Process: Caring
   BLM: Cognitive Level: Remember

2. The nurse is conducting a physical assessment. The data the nurse would collect vary depending on what?
   A) How much time the nurse has
   B) The client's acuity
   C) The client's cooperation
   D) Onset of current symptoms

   ANS: B
   Feedback: Data that nurses collect during a physical assessment vary depending on a client's acuity (condition), health history, and current symptoms. The data collected during a physical assessment do not depend on how much time the nurse has, how cooperative the client is, or the onset of the current symptoms.

   PTS: 1 REF: Page: 6 | Header: What is health assessment?
   OBJ: 5
   NAT: Client Needs: Safe, Effective Care Environment: Management of Care
   TOP: Chapter: 1 KEY: Integrated Process: Nursing Process
   BLM: Cognitive Level: Apply

3. A nursing instructor is discussing the purposes of health assessment. Which is one purpose of health assessment?
   A) To establish a database against which subsequent assessments can be measured
   B) To establish rapport with the client and family

C) To gather information for specialists to whom the client might be referred
D) To quantify the degree of pain a client may be experiencing

ANS: A
Feedback: A health assessment is performed to gain further insight into the current condition and to establish a database that subsequent assessments can be measured against.

PTS: 1 REF: Page: 6 | Header: What is health assessment?
OBJ: 2
NAT: Client Needs: Safe, Effective Care Environment: Management of Care
TOP: Chapter: 1 KEY: Integrated Process: Nursing Process
BLM: Cognitive Level: Apply

4. How do nurses facilitate the achievement of high-level wellness with a client?
A) Encouraging the client to keep appointments
B) Providing the client information on alternative treatments
C) Promoting health in the client
D) Providing good client care

ANS: C
Feedback: High-level wellness is a process by which people maintain balance and direction in the most favorable environment. The role of nurses is to facilitate this achievement through health promotion and teaching. Nurses do not facilitate the achievement of high-level wellness by encouraging clients to keep appointments, providing information on alternative treatments, or providing "good" patient care.

PTS: 1 REF: Page: 6 | Header: Wellness and Illness
OBJ: 1
NAT: Client Needs: Safe, Effective Care Environment: Management of Care
TOP: Chapter: 1 KEY: Integrated Process: Caring
BLM: Cognitive Level: Understand

5. The nurse is caring for a client who, on the continuum between wellness and illness, is moving toward illness and premature death. How would the nurse know this to be true?
A) The client stops doing wellness-promoting activities.
B) The client develops signs and symptoms.
C) The client begins exercising.
D) The client verbalizes anxiety over the cost of medications.

ANS: B
Feedback: The person who moves toward illness and premature death develops signs, symptoms, and disability, which, unfortunately, is when most treatment occurs in the current health care system. The client may stop doing wellness-promoting activities and not tell the nurse of this fact, which makes "The client stops doing wellness-promoting activities" incorrect. "The client begins exercising" is incorrect because a client who begins exercising is moving toward wellness, not illness. "The client verbalizes anxiety over the cost of medications" is incorrect because the verbalization of anxiety over financial matters is not an indication of illness.

PTS: 1 REF: Page: 6 | Header: Wellness and Illness

OBJ: 1
NAT: Client Needs: Safe, Effective Care Environment: Management of Care
TOP: Chapter: 1 KEY: Integrated Process: Caring
BLM: Cognitive Level: Understand

6. A nurse is writing a care plan for a newly admitted client. When formulating the diagnostic statements in the care plan, what would the nurse use?
   A) Rationale
   B) American Nurses Association recommendations
   C) Physical assessment skills
   D) Diagnostic reasoning

   ANS: D
   Feedback: Nurses use diagnostic reasoning and critical thinking to formulate diagnostic statements. Rationale, ANA recommendations, and physical assessment skills are not part of formulating diagnostic statements. Rationale supports the nursing interventions of the nursing care plan. The American Nurses Association does not have recommendations regarding formulation of diagnostic statements for the care plan. Physical assessment skills are important in the assessment step of the nursing process, not the formulation of the diagnostic statements.

   PTS: 1 REF: Page: 9 | Header: Diagnostic Reasoning
   OBJ: 4
   NAT: Client Needs: Safe, Effective Care Environment: Management of Care
   TOP: Chapter: 1 KEY: Integrated Process: Communication and Documentation
   BLM: Cognitive Level: Apply

7. A nurse is caring for three clients whose care involves complex situations and multiple responsibilities. What is the key to resolving problems for this nurse?
   A) Diagnostic reasoning
   B) Physical assessment
   C) Critical thinking
   D) Nursing care plan

   ANS: C
   Feedback: Nurses are frequently involved in complex situations with multiple responsibilities. They are required to think through the analysis, develop alternatives, and implement the best interventions. Critical thinking is the key to resolving problems. Diagnostic reasoning is important in developing diagnostic statements, not in caring for multiple clients with complex care needs. Physical assessment is important in building the foundation of the nursing care plan. The nursing care plan directs the care that will be provided for the individual client, but does not address the needs of caring for multiple clients.

   PTS: 1 REF: Page: 8 | Header: Critical Thinking OBJ: 4
   NAT: Client Needs: Safe, Effective Care Environment: Management of Care
   TOP: Chapter: 1 KEY: Integrated Process: Nursing Process
   BLM: Cognitive Level: Apply

8. A community health nurse is planning individualized care for a community. What does the nurse use as a framework for this plan?
   A) Nursing process
   B) Diagnostic reasoning
   C) Critical thinking
   D) Community care map

   ANS: A
   Feedback: The nursing process serves as a framework for providing individualized care not only to individuals but also to families and communities. Diagnostic reasoning, critical thinking, and community care maps are not frameworks for providing individualized care to a community.

   PTS: 1 REF: Page: 7 | Header: Nursing Process OBJ: 1
   NAT: Client Needs: Safe, Effective Care Environment: Management of Care
   TOP: Chapter: 1 KEY: Integrated Process: Teaching/Learning
   BLM: Cognitive Level: Analyze

9. A nurse performs a comprehensive assessment on a client. Which is included only in a comprehensive assessment?
   A) Circulatory assessment
   B) Assessment of the airway
   C) Complete health history
   D) Disability assessment

   ANS: C
   Feedback: The comprehensive assessment includes a complete health history and physical assessment. It is done annually on an outpatient basis, following admission to a hospital or long-term care facility, or as defined in a facility's standards of care in the acute care setting. Circulatory assessment, assessment of the airway, and disability assessment are part of an emergency assessment.

   PTS: 1 REF: Page: 9 | Header: Comprehensive Assessment
   OBJ: 6
   NAT: Client Needs: Safe, Effective Care Environment: Management of Care
   TOP: Chapter: 1 KEY: Integrated Process: Nursing Process
   BLM: Cognitive Level: Understand

10. The nurse is admitting a client to the clinic and performs a focused assessment. What makes a focused assessment different from a comprehensive assessment?
    A) A focused assessment covers the body head to toe, unlike a comprehensive assessment.
    B) A focused assessment occurs only in the clinic area, unlike a comprehensive assessment.
    C) A focused assessment involves all body systems, unlike a comprehensive assessment.
    D) A focused assessment is more in-depth on specific issues, unlike a comprehensive assessment.

    ANS: D

Feedback: A focused assessment is based on the client's issues. This type of assessment can occur in all settings, including the clinic, hospital, and home health. It usually involves one or two body systems and is smaller in scope than the comprehensive assessment but is more in-depth on the specific issue(s). The comprehensive assessment includes a head-to-toe evaluation.

PTS: 1 REF: Page: 10 | Header: Focused Assessment
OBJ: 5
NAT: Client Needs: Safe, Effective Care Environment: Management of Care
TOP: Chapter: 1 KEY: Integrated Process: Nursing Process
BLM: Cognitive Level: Understand

11. A nurse is admitting a client, having completed the health history, and is now doing a physical assessment. The physical assessment will provide what type of data?
A) Patient centered
B) Subjective
C) Unconfirmed
D) Objective

ANS: D
Feedback: The physical assessment follows the history and focused interview and includes objective data, which are measurable. Subjective data are gathered during the health history and generally provided by the patient. All data collected regardless of method should be patient centered. Unconfirmed data is common and will be evaluated through diagnostic studies regardless of how it was obtained.

PTS: 1 REF: Page: 12 | Header: Objective Data Collection
OBJ: 6
NAT: Client Needs: Safe, Effective Care Environment: Management of Care
TOP: Chapter: 1 KEY: Integrated Process: Nursing Process
BLM: Cognitive Level: Remember

12. The nurse is performing a health assessment on a new client. While taking the detailed history, the nurse knows to include what?
A) Functional status
B) Data focusing on the client complaint
C) A focused assessment of the client complaint
D) Family history for the past three generations

ANS: A
Feedback: A detailed history includes data on all systems, psychosocial and mental health, and functional status. Data must include information other than the client complaint. Family histories generally go back only to grandparents, not great-grandparents.

PTS: 1 REF: Page: 11 | Header: Components of the Health Assessment
OBJ: 7
NAT: Client Needs: Safe, Effective Care Environment: Management of Care
TOP: Chapter: 1 KEY: Integrated Process: Nursing Process
BLM: Cognitive Level: Apply

13. What does the Health Insurance Portability and Accountability Act (HIPAA, 1996) regulate?
    A) Who will provide client care
    B) Privacy of information
    C) How insurance information is obtained
    D) Where a chart can be stored

    ANS: B
    Feedback: HIPAA regulates the security and privacy of information. It does not regulate who will provide client care, how insurance information is obtained, or where a chart is stored.

    PTS: 1
    REF: Page: 12 | Header: Documentation and Interprofessional Communication
    OBJ: 6
    NAT: Client Needs: Safe, Effective Care Environment: Management of Care
    TOP: Chapter: 1 KEY: Integrated Process: Communication and Documentation
    BLM: Cognitive Level: Remember

14. The nursing instructor is teaching about health assessment and explains to students how to assess the roles and relationships of the client. The students know that this type of information is assessed in what type of assessment?
    A) Body systems
    B) Head to toe
    C) Functional
    D) Focused

    ANS: C
    Feedback: A functional assessment focuses on the patterns that all humans share: health perception and health management, activity and exercise, nutrition and metabolism, elimination, sleep and rest, cognition and perception, self-perception and self-concept, roles and relationships, coping and stress tolerance, sexuality and reproduction, and values and beliefs (Gordon, 1987). The body systems, the focused nor the head-to-toe assessment addresses the holistic needs of the client. The roles and relationships of the client would not be included in this assessment.

    PTS: 1 REF: Page: 12 | Header: Functional Assessment
    OBJ: 7
    NAT: Client Needs: Safe, Effective Care Environment: Management of Care
    TOP: Chapter: 1 KEY: Integrated Process: Nursing Process
    BLM: Cognitive Level: Apply

15. A clinical instructor is teaching a nursing student group about organizing data when documenting and communicating assessment findings. The clinical instructor knows that the method being taught promotes critical thinking and clustering of similar data. The instructor is teaching about which type of assessment?
    A) Body systems
    B) Comprehensive
    C) Head to toe
    D) Emergency

ANS: A
Feedback: A body systems approach is a logical tool for organizing data when documenting and communicating findings. This method promotes critical thinking and allows nurses to analyze findings as they cluster similar data. The comprehensive assessment is more encompassing in nature, including more aspects that the body systems approach. The head-to-toe assessment does not look at promoting critical thinking and clustering, rather going through a process to organize data in a logical fashion. The emergency assessment involves a life-threatening or unstable situation.

PTS: 1 REF: Page: 13 | Header: Body Systems Approach
OBJ: 7
NAT: Client Needs: Safe, Effective Care Environment: Management of Care
TOP: Chapter: 1 KEY: Integrated Process: Nursing Process
BLM: Cognitive Level: Apply

16. The nurse is assessing a teenage girl newly admitted to the pediatric unit. The nurse knows that an efficient assessment framework that provides additional modesty for the client is what?
A) Body systems
B) Functional
C) Focused
D) Head to toe

ANS: D
Feedback: The head-to-toe method is efficient and provides more modesty for clients. The body systems and functional assessment do not address the modesty issue in the question. The focused assessment is not appropriate for the newly admitted client.

PTS: 1 REF: Page: 12 | Header: Head-to-Toe Assessment
OBJ: 7 NAT: Client Needs: Health Promotion and Maintenance
TOP: Chapter: 1 KEY: Integrated Process: Nursing Process
BLM: Cognitive Level: Analyze

MULTIPLE RESPONSE

17. What do nursing activities that promote health and prevent disease accomplish? (Select all that apply.)
A) Reduce the risk of disease
B) Maintain optimal functioning
C) Reinforce good habits
D) Optimize self-care abilities
E) Create home care safety

ANS: A, B, C
Feedback: Nursing activities that promote health and prevent illness reduce the risk of disease, reinforce good habits, and maintain optimal functioning. They do not optimize self-care abilities or create home care safety.

PTS: 1 REF: Page: 4 | Header: Roles of the Professional Nurse

OBJ: 1
NAT: Client Needs: Safe, Effective Care Environment: Management of Care
TOP: Chapter: 1 KEY: Integrated Process: Teaching/Learning
BLM: Cognitive Level: Analyze

18. The purpose of a health assessment includes what? (Select all that apply.)
A) Identifying the client's major disease process
B) Collecting information about the health status of the client
C) Clarifying the client's ability to pay for health care
D) Evaluating client outcomes
E) Synthesizing collected data

ANS: B, D, E
Feedback: Health assessment is "gathering information about the health status of the patient, analyzing and synthesizing those data, making judgments about nursing interventions based on the findings and evaluating patient care outcomes" (AACN, 2008). While the nurse may elicit financial information and information about disease processes during a health assessment, the purposes of the activity are not to identify the patient's major disease process or ability to pay.

PTS: 1 REF: Page: 6 | Header: What is health assessment?
OBJ: 2
NAT: Client Needs: Safe, Effective Care Environment: Management of Care
TOP: Chapter: 1 KEY: Integrated Process: Nursing Process
BLM: Cognitive Level: Analyze

19. What interventions address a focus of the Risk Reduction: Healthy People Model developed by the U.S. Department of Health & Human Services (2017)? Select all that apply.
A) Providing the client with a nicotine patch
B) Screening for depression
C) Discussing healthy food choices
D) Providing information on safe sex practices
E) Offering advice regarding health care providers

ANS: A, B, C, D
Feedback: The leading areas of focus include tobacco use, responsible sexual behavior, mental health and obesity. General information concerning local health care providers may be shared with the client but nurses should never give advice regarding their preference regarding the professionals.

PTS: 1 REF: Page: 6 | Header: Risk Reduction: Healthy People Model
OBJ: 7
NAT: Client Needs: Safe, Effective Care Environment: Management of Care
TOP: Chapter: 1 KEY: Integrated Process: Nursing Process
BLM: Cognitive Level: Apply

20. What are the types of nursing assessments? (Select all that apply.)
A) Physical
B) Focused
C) Mental

D) Emergency
E) Comprehensive

ANS: B, D, E
Feedback: Three types of nursing assessments are common: emergency, focused, and comprehensive. Physical and mental assessments are areas addressed in the various types of nursing assessments.

PTS: 1 REF: Page: 9 | Header: Types of Nursing Assessments
OBJ: 5
NAT: Client Needs: Safe, Effective Care Environment: Management of Care
TOP: Chapter: 1 KEY: Integrated Process: Nursing Process
BLM: Cognitive Level: Remember