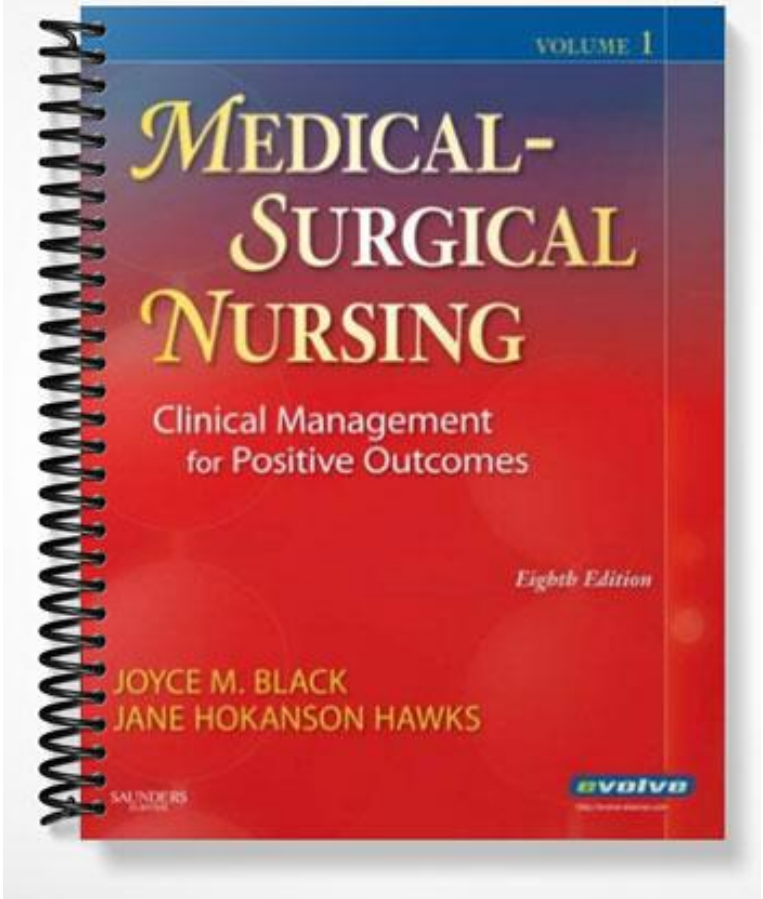
TEST BANK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Test Bank

Chapter 2: Health Assessment

MULTIPLE CHOICE

1. A nurse is collecting a health history from a client and feels the client is not reliable. One recommended way to verify some of the client data is to
   a. ask the client the same questions but in a different manner.
   b. confront the client with your suspicions.
   c. find and question a secondary source.
   d. have another nurse try to get data from the client

   ANS: C
   Clients may be poor historians and unable to provide accurate data. If there is a secondary source such as a significant other or family member available, ask them some of the health history questions. A client who is confused will not be able to answer accurately even if you ask questions in different ways. Confrontation can lead to alienation. Having another nurse question an unreliable client is unlikely to garner valid data.

   DIF: Application/Applying REF: p. 29 OBJ: Assessment
   MSC: Physiological Integrity Reduction of Risk Potential

2. The nurse is collecting a health history on a middle-aged African American male. The nurse asks about past blood pressure screening because the incidence of hypertension is higher in this ethnic group than in others. This is an example of
   a. a generalization based on the nurse's limited experience with African Americans.
   b. bias, and the nurse should not question the client about blood pressure screening.
   c. stereotyping the client based on the client's ethnic/racial group.
   d. using valid research data to focus questions on the client's specific risks.

   ANS: D
   Reliable research finding concerning group characteristics or similarities may be applied to a specific client who belongs to that group. Generalizations, stereotypes, and biases have no place in nursing care.

   DIF: Application/Applying REF: pp. 29-30 OBJ: Assessment
   MSC: Health Promotion and Maintenance Health Screening

3. A client had surgery yesterday and is complaining of pain. The best action by the nurse is to
   a. ask the patient which pain medication she/he took last.

b. do a complete assessment of the pain.
c. prepare to administer the ordered pain medication.
d. record the client's complaints thoroughly and get the pain medication.

ANS: B
This is an example of symptom analysis. Nurses should use a recognized approach to fully assess each client complaint, such as the OLDCART or PQRST method. It is best to understand the source of a complaint before treating it. In this case, the postoperative client could be having a nonrelated problem such as angina. Without a further assessment, the nurse would administer the postoperative pain medication, which might mask the new symptoms or delay diagnosis and treatment.

DIF: Analysis/Analyzing REF: p. 31 OBJ: Assessment
MSC: Health Promotion and Maintenance Safety and Infection Control-Error Prevention

4. A client is being admitted to the hospital and the nurse has the client's electronic record, including past medical history. What should the nurse do with this information?
a. Copy the information from the electronic database to the admission database.
b. Not use it because it is preferred to ask clients about past history at each encounter.
c. Save time and skip this part of the history-taking because the record is electronic.
d. Verify with the client that the list is current, complete, and correct.

ANS: D
A previously recorded past health history is useful to have, but the nurse must verify its accuracy with the client. Diagnoses may change because of second opinions, because they have been cured, or because they have been surgically corrected.

DIF: Application/Applying REF: p. 32 OBJ: Assessment
MSC: Health Promotion and Maintenance Management of Care-Continuity of Care

5. To assess precipitating factors, the nurse interviewer would ask
a. "Do you remember the first time you had this problem?"
b. "How many times has the problem been related to activity?"
c. "What measures relieve this problem for you?"
d. "What were you doing when you first noticed the problem?"

ANS: D
To ask what the client was doing and where he was at the time the manifestation was noticed is an abbreviated way to obtain information as to cause or environmental precipitators. The other options are related to timing, aggravating factors, and remedy.

DIF: Application/Applying REF: p. 33 OBJ:

Intervention
MSC: Health Promotion and Maintenance Techniques of Assessment

6. Because the psychosocial assessment includes many more personal aspects of the client's history, the most significant variable that may affect the quality and usefulness of the collected data is the
   a. nurse's ability to establish a therapeutic relationship.
   b. nurse's difficulty in differentiating normal from abnormal.
   c. reluctance of most clients to share information with health care providers.
   d. value the client places on the health interview.

   ANS: A
   The client must feel comfortable to share some of the information assessed in the psychosocial portion; therefore the nurse's ability to establish a therapeutic relationship is the major element in securing accurate data.

   DIF: Analysis/Analyzing REF: p. 33 OBJ: Assessment
   MSC: Psychosocial Integrity Therapeutic Communication

7. In the preparation of a nursing care plan relative to the client's mental status, the least helpful data would be those resulting from
   a. client's overall response to the interview.
   b. formal psychological tests.
   c. notation of appropriateness of affect.
   d. observation of nonverbal behavior.

   ANS: B
   Mental status assessment consists of evaluation of verbal and nonverbal responses to the individualized questions, as well as evaluation of mood and affect. Psychological tests cannot measure these factors.

   DIF: Comprehension REF: p. 34 OBJ: Assessment
   MSC: Health Promotion and Maintenance Techniques of Assessment

MULTIPLE RESPONSE

1. A client is brought to the emergency department in serious condition and needs an operation within the next hour. Which of the following principles does the nurse use to guide the health history? (Select all that apply.)
   a. Assess the client's current health status.
   b. Collect data pertinent to the immediate problem.
   c. Strive to collect only pertinent data while being thorough.
   d. Update the database when the client's condition allows.
   e. Use a systematic approach to gather the client's entire health history.

ANS: A, B, C, D
Many factors influence the depth of health history the nurse should obtain. In this case, the client is in an emergent situation that does not warrant gathering information on the client's entire history. However, for client safety, the nurse must assess the client's current health status, collect data relevant to the current situation, and strive to be as thorough as possible within these limitations. When the client is more stable, more data can be collected.

DIF: Application/Applying REF: p. 30 OBJ: Intervention
MSC: Health Promotion and Maintenance Health and Wellness

2. The nurse collecting data on a client's social history asks questions regarding the client's (select all that apply)
   a. exposure to communicable diseases.
   b. home life.
   c. immunization history.
   d. lifestyle.
   e. social roles.

ANS: A, B, D, E
Immunization history, while an important component of health history, is not included in social history.

DIF: Comprehension/Understanding REF: p. 35 OBJ: Assessment
MSC: Health Promotion and Maintenance High Risk Behaviors

3. Which principles of assessment does the nurse use when working with hospitalized clients? (Select all that apply.)
   a. Assess each client at the beginning of each shift.
   b. Base the frequency of assessment on client condition.
   c. Begin with the most seriously ill client.
   d. Record findings as they are assessed, not later.
   e. Wait for physician orders to determine the frequency of assessments.

ANS: A, B, C, D
These answers are all good principles on which to base nursing assessments. Assessing a client is an independent nursing function. While the physician may write for assessments to be done at a specified minimum time frame, nurses use their own professional judgment to obtain client assessments as appropriate.

DIF: Application/Applying REF: pp. 40-41 OBJ: Assessment
MSC: Health Promotion and Maintenance Techniques of Assessment

MATCHING

Match each item to the correct description below.
Place the following physical assessment techniques in their usual order during a physical exam.
a. 1
b. 2
c. 3
d. 4

1. Auscultation
2. Inspection
3. Palpation
4. Percussion

1. ANS: B DIF: Knowledge/Remembering REF: pp. 37-39
   OBJ: Assessment MSC: Health Promotion and Maintenance Techniques of Assessment
2. ANS: C DIF: Knowledge/Remembering REF: pp. 37-39
   OBJ: Assessment MSC: Health Promotion and Maintenance Techniques of Assessment
3. ANS: D DIF: Knowledge/Remembering REF: pp. 37-39
   OBJ: Assessment MSC: Health Promotion and Maintenance Techniques of Assessment
4. ANS: A DIF: Knowledge/Remembering REF: pp. 37-39
   OBJ: Assessment MSC: Health Promotion and Maintenance Techniques of Assessment