Wilson & Giddens: Health Assessment for Nursing Practice, 5th Edition

Test Bank

Chapter 1: Why Learn Health Assessment?

MULTIPLE CHOICE

1. A male client enters the emergency department and tells the triage nurse at the desk that he is "having a heart attack." The nurse's top priority at this time is to:
a. Determine the client's personal data and insurance coverage.
b. Ask the client to take a seat in the waiting room until his name is called.
c. Request that a nurse collect data for a comprehensive history.
d. Ask a nurse to start a focused assessment of the client now.

ANS: D
Correct: The nurse needs to begin an assessment as soon as possible that is focused on the client's cardiovascular system. This type of health assessment performed by the nurse is also driven by client need.
Incorrect A: Personal data and insurance information will be obtained, but, in this situation, the data can wait until after the client is assessed.
Incorrect B: Rather than asking the client to wait, the nurse needs to begin data collection, such as vital signs, immediately to determine the client's health status.
Incorrect C: A comprehensive history is not indicated in this situation at this time. Some subjective data will be collected, such as allergies and medical history related to cardiovascular disease.

DIF: Cognitive Level: Application REF: 2-3
OBJ: NCLEX Client Need Category: Safe and Effective Care Environment: Management of Care: Establishing Priorities TOP: Adult Health: Assessment
MSC: Integrated Process: Nursing Process: Assessment

2. Which scenario described below illustrates a screening assessment?
a. A client visits an obstetric clinic for the first time, and the nurse conducts a detailed history and physical examination.
b. A hospital sponsors a health fair at a local mall and provides cholesterol and blood pressure checks to mall patrons.
c. The nurse in the triage area of an urgent care center checks the vital signs of a client who is complaining of leg pain.
d. A client makes an appointment 1 month after today's office visit for a follow-up test of fasting blood glucose level.

ANS: B
Correct: A health fair at a local mall that provides cholesterol and blood pressure checks is an example of a screening assessment focused on disease detection.

Incorrect A: A detailed history and physical examination conducted during a first-time visit to an obstetric clinic is an example of a comprehensive assessment.
Incorrect C: Assessing a client complaining of leg pain in the triage area of an urgent care center is an example of a problem-based/focused assessment.
Incorrect D: A client's return appointment 1 month after today's office visit to report fasting blood glucose levels is an example of an episodic/follow-up assessment.

DIF: Cognitive Level: Comprehension REF: 3
OBJ: NCLEX Client Need Category: Health Promotion and Maintenance: Health Screening TOP: Adult Health: Assessment
MSC: Integrated Process: Nursing Process: Assessment

3. At the beginning of a shift for a medical-surgical unit, a nurse performs a shift assessment on each assigned client. This is an example of:
a. A comprehensive assessment.
b. A problem-based assessment.
c. An episodic assessment.
d. A screening assessment.

ANS: C
Correct: An episodic assessment is performed during a shift assessment during which the nurse identifies changes in condition from baseline; thus the focus of the assessment is largely based on the condition or problem that the client is experiencing.
Incorrect A: A comprehensive assessment involves a detailed history and physical examination performed upon admission to a hospital, but not performed each shift.
Incorrect B: A problem-based/focused assessment involves a history and examination that is limited to a specific problem or complaint. Although the shift assessment focuses on a condition or problem, it is different from a focused assessment that includes a history and gathers baseline data about a problem or condition.
Incorrect D: A screening assessment involves a short, usually inexpensive, examination focused on disease detection.

DIF: Cognitive Level: Comprehension REF: 3
OBJ: NCLEX Client Need Category: Safe and Effective Care Environment: Management of Care: Establishing Priorities TOP: Adult Health: Assessment
MSC: Integrated Process: Nursing Process: Assessment

4. To successfully assess clients, a nurse:
a. Collects subjective and objective data and documents the findings.
b. Collects subjective and objective data and analyzes the findings.
c. Places more emphasis on subjective than objective data.
d. Requests that the client refrain from volunteering extraneous data.

ANS: B
Correct: After subjective and objective data are collected, the nurse clusters and analyzes the findings to determine the client's needs.

Incorrect A: Subjective and objective data are collected and documented, but the data must be analyzed and clustered to determine the client's needs.
Incorrect C: Subjective and objective data are of equal importance in assessment.
Incorrect D: Clients should feel free to volunteer data about themselves that the nurse does not have.

DIF: Cognitive Level: Comprehension REF: 3
OBJ: NCLEX Client Need Category: Safe and Effective Care Environment: Management of Care: Establishing Priorities TOP: Adult Health: Assessment
MSC: Integrated Process: Nursing Process: Assessment

5. Which is an example of data a nurse would collect during a physical examination?
a. The client's lack of hair and shiny skin over both shins
b. The client's stated concern about lack of money for prescriptions
c. The client's complaints of tingling sensations in the feet
d. The client's mother's statements that the client has been very nervous lately

ANS: A
Correct: The lack of hair and shiny skin over both shins are objective data or signs that are part of the physical examination.
Incorrect B: A client's statements about concerns about lack of money are subjective data and are part of the health history.
Incorrect C: A client's complaints of tingling sensations in the feet are subjective data and are part of the health history.
Incorrect D: A client's family statements are considered secondary data, are subjective data, and are part of the health history.

DIF: Cognitive Level: Application REF: 1-2
OBJ: NCLEX Client Need Category: Physiological Integrity: Reduction of Risk Potential: System Specific Assessments TOP: Adult Health: Assessment
MSC: Integrated Process: Nursing Process: Assessment

6. After physical examination of a client, the nurse documents which finding as a symptom?
a. The client's skin feels warm to the touch.
b. The client is scratching his arm.
c. The client's temperature is 100° F.
d. The client complains of itching.

ANS: D
Correct: A client's complaint of itching is subjective information and is termed a symptom. The information is gathered from the client.
Incorrect A: The client's warm skin is objective information gathered by the nurse through palpation and is termed a sign.
Incorrect B: The client's scratching is objective information gathered by the nurse through observation and is termed a sign.
Incorrect C: The client's temperature elevation is objective information gathered by the nurse through measurement and is termed a sign.

DIF: Cognitive Level: Application REF: 1-2
OBJ: NCLEX Client Need Category: Physiological Integrity: Physiological Adaptation: Alterations in Body Systems TOP: Adult Health: Assessment
MSC: Integrated Process: Nursing Process: Assessment

7. Which datum below does the nurse document in the history component of the health assessment?
a. Vital signs
b. Perspiration on the client's forehead
c. Smoking habits
d. Facial symmetry

ANS: C
Correct: Smoking habits are data that come from the client, making it subjective data that is documented in the history.
Incorrect A: Vital signs are an objective measurement that is documented in the physical examination data.
Incorrect B: To note perspiration on the client's forehead, the nurse is observing the client, which is objective data documented in the physical examination.
Incorrect D: To note client's facial symmetry, the nurse is observing the client, which is objective data documented in the physical examination. This observation may be made while collecting subjective data from the client, but it is objective data because it came from an observation of the nurse rather than a statement by the client.

DIF: Cognitive Level: Application REF: 1-2
OBJ: NCLEX Client Need Category: Health Promotion and Maintenance: Health Screening TOP: Adult Health: Assessment
MSC: Integrated Process: Nursing Process: Assessment

8. After collecting the data, the nurse begins data analysis with which action?
a. Clustering data
b. Selecting appropriate nursing diagnoses
c. Reporting information to other health team members
d. Documenting information

ANS: A
Correct: After collecting data, nurses organize or cluster data so that the problems appear more clearly. To cluster data, the nurse interprets the assessment data collected.
Incorrect B: Before selecting an appropriate nursing diagnosis, the nurse clusters and interprets data.
Incorrect C: Before reporting data to health team members, the nurse clusters and interprets data.
Incorrect D: Before documenting information, the nurse clusters and interprets data.

DIF: Cognitive Level: Comprehension REF: 4
OBJ: NCLEX Client Need Category: Safe and Effective Care Environment: Management of Care: Establishing Priorities TOP: Adult Health: Assessment

MSC: Integrated Process: Nursing Process: Assessment

9. Which activity described below illustrates the concept of primary prevention?
a. Monthly breast self-examination
b. Annual cervical (Papanicolaou) smear examination
c. Education about living with asthma
d. Exercise three times a week

ANS: D
Correct: Exercise three times a week is an example of primary prevention that prevents disease from developing by maintaining a healthy lifestyle.
Incorrect A: Monthly breast self-examination is an example of secondary prevention and screening efforts to promote early detection of disease.
Incorrect B: Annual cervical (Papanicolaou) test is an example of secondary prevention and screening efforts to promote early detection of disease.
Incorrect C: Teaching a client how to live with a chronic disease is an example of tertiary prevention directed toward minimizing the disability from chronic disease and helping the client to maximize his or her health.

DIF: Cognitive Level: Comprehension REF: 6
OBJ: NCLEX Client Need Category: Health Promotion and Maintenance: Health Promotion Programs
TOP: Adult Health Intervention: Primary Prevention
MSC: Integrated Process: Nursing Process: Assessment

10. A nurse is teaching a client how to manage chronic obstructive pulmonary disease (COPD). What level of health promotion is most appropriate for this client?
a. Primary prevention
b. Secondary prevention
c. Tertiary prevention
d. Risk factor prevention

ANS: C
Correct: Teaching a client how to live with a chronic disease is an example of tertiary prevention directed toward minimizing the disability from chronic disease and helping the client to maximize his or her health.
Incorrect A: The focus of primary prevention is to prevent a disease from developing by promoting a healthy lifestyle.
Incorrect B: Secondary prevention consists of efforts to promote early detection of disease.
Incorrect D: Risk factor prevention is part of primary prevention that focuses on preventing disease by managing risk factors.

DIF: Cognitive Level: Comprehension REF: 6
OBJ: NCLEX Client Need Category: Health Promotion and Maintenance: Health Promotion Programs TOP: Adult Health: Intervention
MSC: Integrated Process: Teaching and Learning

11. Which activity described below illustrates the concept of secondary prevention?
a. Annual mammogram
b. Nutrition classes on low-fat cooking
c. Education on living with diabetes mellitus
d. Cardiac rehabilitation after coronary artery bypass surgery

ANS: A
Correct: A mammogram screens for breast cancer and is an example of secondary prevention to promote early detection of disease.
Incorrect B: Nutrition classes are an example of primary prevention to prevent a disease from developing by promoting a healthy lifestyle.
Incorrect C: Education about diabetes mellitus is an example of tertiary prevention directed toward minimizing the disability from chronic disease and helping the client to maximize his or her health.
Incorrect D: Cardiac rehabilitation after coronary artery bypass surgery is an example of tertiary prevention directed toward minimizing the disability from chronic disease and helping the client to maximize his or her health.

DIF: Cognitive Level: Comprehension REF: 6
OBJ: NCLEX Client Need Category: Health Promotion and Maintenance: Health Promotion Programs
TOP: Adult Health Intervention: Secondary Prevention
MSC: Integrated Process: Nursing Process: Assessment

12. In memory of the recent death of a past president, a community organization sponsors a health fair to increase awareness of colon cancer. At the health fair, colorectal cancer screening kits are distributed, and health care professionals are on hand to answer questions, take blood pressures, and distribute literature. These activities are examples of:
a. Primary prevention.
b. Secondary prevention.
c. Tertiary prevention.
d. Risk factor prevention.

ANS: B
Correct: Secondary prevention consists of screening efforts to promote early detection of disease—in this scenario, colorectal cancer and hypertension.
Incorrect A: Primary prevention is focused on preventing disease from developing through the promotion of a healthy lifestyle.
Incorrect C: Tertiary prevention is directed toward minimizing the disability from chronic disease and helping the client to maximize his or her health.
Incorrect D: Risk factor prevention is part of primary prevention that focuses on preventing disease by managing risk factors.

DIF: Cognitive Level: Application REF: 6
OBJ: NCLEX Client Need Category: Health Promotion and Maintenance: Health Promotion Programs
TOP: Adult Health Intervention: Secondary Prevention

MSC: Integrated Process: Nursing Process: Assessment

13. During an interview, a client shares that she has had very little time to take her usual walks and has not had the energy that she used to have to keep up with the housework. She states that she barely makes it through her day at work and that she comes home too tired to do anything. These data categorize which functional health pattern?
a. Nutrition-metabolism
b. Sleep-rest
c. Activity-exercise
d. Self-perception–self-concept

ANS: C
Correct: The activity and exercise pattern includes the client's level of activity, including leisure activities, exercise, level of energy with expenditure, and ability to complete activities of daily living. Based on the data from the client, activity and exercise are the behaviors missing from her usual pattern.
Incorrect A: The nutrition and metabolism pattern includes the foods and fluids consumed relative to the metabolic need, appetite and food preferences, weight loss/weight gain, and it focuses on metabolic activity and tissue integrity. Although the client states she has low energy, she gives no information about her diet.
Incorrect B: The sleep and rest pattern includes the client's routines and functions related to sleep, resting, and relaxing. Although the client states she is too tired to do anything when she comes home, she gives no information about her sleep or rest patterns.
Incorrect D: The self-perception and self-concept pattern includes attitudes towards self, such as body image, self-identity, and sense of self-worth and self-esteem. The client provides no information about her attitude toward herself.

DIF: Cognitive Level: Application REF: 4-5
OBJ: NCLEX Client Need Category: Health Promotion and Maintenance: Health Promotion Programs TOP: Adult Health: Assessment
MSC: Integrated Process: Nursing Process: Assessment

COMPLETION

1. The six steps of the nursing process are shown below, out of order. The correct order is _____. (Your answer should appear as six numbers separated by commas and spaces [e.g., 6, 5, 4, 3, 2, 1].)
1. Planning
2. Assessment
3. Evaluation
4. Diagnosis
5. Implementation
6. Outcome identification

ANS:
2, 4, 6, 1, 5, 3

The order of the steps in the nursing process are (2) Assessment, (4) Diagnosis, (6) Outcome identification, (1) Planning, (5) Implementation, and (3) Evaluation.

DIF: Cognitive Level: Analysis REF: 1-2
OBJ: NCLEX Integrated Processes: Nursing Process
TOP: Adult Health: Nursing process
MSC: Integrated Process: Nursing Process: Assessment