

**Test Bank for Forbes Jarvis's Health
Assessment and Physical Examination
ANZ 3rd Jarvis**

Jarvis, Forbes & Watt: *Jarvis's Physical Examination & Health Assessment*, 3rd ANZ edition

Chapter 02: Critical thinking in health assessment

Test Bank

MULTIPLE CHOICE

1. After completing an initial assessment on a patient, the nurse has charted that his respirations are eupnoeic and his pulse is 58. This type of data would be:
 - a. objective.
 - b. reflective.
 - c. subjective.
 - d. introspective.

ANS: a

Objective data are what the health professional observes by inspecting, percussing, palpating and auscultating during the physical exam.

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2. A patient tells the nurse that he is very nervous, that he is nauseated, and that he 'feels hot'. This type of data would be:
 - a. objective.
 - b. reflective.
 - c. subjective.
 - d. introspective.

ANS: c

Subjective data are what the person says about themselves during history taking.

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3. Novice nurses, without a background of skills and experience to draw from, are more likely to make their decisions using:
 - a. intuition.
 - b. a set of rules.
 - c. articles in journals.
 - d. advice from supervisors.

ANS: b

Novice nurses operate from a set of rules.

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4. Expert nurses learn to attend to a pattern of assessment data based on past experiences. This is referred to as:
- intuition.
 - the nursing process.
 - clinical knowledge.
 - diagnostic reasoning.

ANS: a

Intuition is characterised by pattern recognition—expert nurses learn to attend to a pattern of assessment data and act without consciously labelling it.

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5. Which critical thinking skill helps the nurse to see relationships among the data?
- Validation
 - Clustering related cues
 - Identifying gaps in data
 - Distinguishing relevant from irrelevant

ANS: b

Clustering related cues helps the nurse to see relationships among the data.

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6. The nurse knows that developing appropriate nursing interventions for a patient relies on the appropriateness of the:
- nursing diagnosis.
 - medical diagnosis.
 - admission diagnosis.
 - collaborative diagnosis.

ANS: a

An accurate nursing diagnosis provides the basis for selection of nursing interventions to achieve outcomes for which the nurse is accountable.

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7. What is the step of the nursing process that includes data collection by health history, physical examination and interview?
- Planning
 - Diagnosis
 - Evaluation
 - Assessment

ANS: d

Data collection, including performing the health history, physical examination and interview, is the assessment step of the nursing process.

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8. When nursing diagnoses are being classified, which of the following would be considered a potential health diagnosis?

- a. Identifying existing levels of wellness.
- b. Evaluating previous problems and goals.
- c. Identifying potential problems the individual may develop.
- d. Focusing on strengths and reflecting an individual's transition to higher levels of wellness.

ANS: c

Potential health diagnoses are potential problems that an individual does not currently have but is particularly vulnerable to develop.

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9. Which term best describes a proficient nurse?
- a. A nurse who has little experience with a specified population and uses rules to guide performance.
 - b. A nurse who has an intuitive grasp of a clinical situation and quickly identifies the accurate solution.
 - c. A nurse who sees actions in the context of daily plans for patients.
 - d. A nurse who understands a patient situation as a whole rather than a list of tasks and sees long-term goals for the patient.

ANS: d

The proficient nurse, with more time and experience than the novice nurse, is able to understand a patient situation as a whole rather than as a list of tasks and is able to see how today's nursing actions apply to the point the nurse wants the patient to reach at a future time.

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