Test Bank for Health Assessment in Nursing 8th Weber

Test Bank Questions
Chapter 1: The Nurse's Role in Health Assessment

1. When performing the steps of the assessment phase of the nursing process, which of the following would the nurse do **first**?
A) Collect objective data
B) Validate the data
C) Collect subjective data
D) Document the data

2. An instructor is describing a comprehensive nursing health assessment to a group of students. The instructor determines that the teaching was successful when the students identify which of the following as the overall purpose?
A) Collect large quantities of data
B) Assist the health care provider
C) Validate previous data
D) Make a clinical judgment

3. A client has presented to the emergency department (ED) reporting abdominal pain. Which member of the care team would most likely be responsible for collecting the subjective data on the client during the initial comprehensive assessment?
A) Gastroenterologist
B) ED nurse
C) Admissions clerk
D) Diagnostic technician

4. The nurse has completed an initial assessment of a newly admitted client and is applying the nursing process to plan the client's care. What principle should the nurse apply when using the nursing process?
A) Each step is independent of the others.
B) It is ongoing and continuous.
C) It is used primarily in acute care settings.
D) It involves independent nursing actions.

5. The nurse who provides care at an ambulatory clinic is preparing to meet a client and perform a comprehensive health assessment. Which of the following actions should the nurse perform **first**?
A) Review the client's medical record.
B) Obtain basic biographic data.
C) Consult clinical resources explaining the client's diagnosis.
D) Validate information with the client.

6. In response to a client's query, the nurse is explaining the differences between the health care provider's medical exam and the comprehensive health assessment performed by the nurse. The nurse should describe the fact that the nursing assessment focuses on which aspect of the client's situation?
A) Current physiologic status
B) Effect of health on functional status
C) Past medical history
D) Motivation for adherence to treatment

7. After teaching a group of students about the phases of the nursing process, the instructor determines that the teaching was successful when the students identify which phase as being foundational to all other phases?
A) Assessment
B) Planning
C) Implementation
D) Evaluation

8. The nurse has completed the comprehensive health assessment of a client who has been admitted for the treatment of community-acquired pneumonia. Following the completion of this assessment, the nurse periodically performs a partial assessment primarily for which reason?
A) Reassess previously detected problems
B) Provide information for the client's record
C) Address areas previously omitted
D) Determine the need for crisis intervention

9. After gathering basic data about a client who has health problems related to alcohol use, the nurse reflects on their personal feelings about the client and their circumstances. The nurse does this primarily to accomplish which of the following?
A) Determine if pertinent data has been omitted
B) Identify the need for referral
C) Avoid biases and judgments
D) Construct a plan of care

10. Which of the following would the nurse categorize as objective data?
A) Family history
B) Occupation
C) Appearance
D) History of present health concern

11. An older adult client has been admitted to the hospital with failure to thrive resulting from complications of diabetes. Which of the following would the nurse implement in response to a collaborative problem?
A) Encourage the client to increase oral fluid intake.

B) Provide the client with a bedtime protein snack.
C) Assist the client with personal hygiene.
D) Measure the client's blood glucose four times daily.

12. A nurse on the subacute medical unit is planning to perform a client's focused assessment. Which of the following statements should inform the nurse's practice?
A) The focused assessment should be done before the physical exam.
B) The focused assessment replaces the comprehensive database.
C) The focused assessment addresses a particular client problem.
D) The focused assessment is done after gathering subjective data.

13. A nurse will complete an initial comprehensive assessment of a client who is new to the clinic. What goal should the nurse identify for this type of assessment?
A) Identify the most appropriate forms of medical intervention for the client.
B) Determine the most likely prognosis for the client's health problem.
C) Identify the status of the client's airway, breathing, and circulation.
D) Establish a baseline for the comparison of future health changes.

14. A nurse who provides care in a hospital setting is creating a plan of nursing care for a client who has a diagnosis of chronic renal failure. The nurse's plan specifies frequent ongoing assessments. The frequency of these nursing assessments should be primarily determined by what variable?
A) The client's age
B) The unit's protocols
C) The client's acuity
D) The nurse's potential for liability

15. A client has been admitted to the emergency department (ED) with reports of abdominal pain and vomiting for the past 6 hours. Which type of assessment will the nurse complete on this client?
A) focused assessment
B) comprehensive assessment
C) emergency assessment
D) ongoing assessment

16. When the nurse collects objective data, which finding requires **immediate** follow-up?
A) cerumen in the ear
B) acne lesions on the face and upper chest
C) moist nasal mucosa
D) enlarged lymph node in the neck

17. The nurse is completing an assessment on a new client at the community health clinic and would like to screen the client's cognitive ability. There are

many resources that provide screening tools for nurses. Which agency would be **most** helpful in directing the nurse to a screening tool to assess the client's cognitive ability?
A) the American Diabetic Association (ADA)
B) the American Heart Association (AHA)
C) the Alzheimer's Association (AA)
D) the American Ophthalmology Association (AAO)

18. The nurse is working in an ambulatory care clinic that is located in a busy, inner-city neighborhood. Which client would the nurse determine to be in **most** need of an emergency assessment?
A) A client with chest pain and diaphoresis for 1 hour
B) A client who is crying because they think they are pregnant
C) A client with fever, rash, and sore throat
D) A client with a 3-inch shallow laceration on the leg

19. The nurse is reviewing a client's health history and the results of the most recent physical examination. Which of the following data would the nurse identify as being subjective? **Select all that apply.**
A) "I feel so tired sometimes."
B) Weight: 145 lbs
C) Lungs clear to auscultation
D) Client reports a headache
E) "My parent died of a heart attack."
F) Pupils equal, round, and reactive to light

20. The nurse prepares to complete a holistic assessment of a client with a chronic health problem. Which areas will the nurse include in this assessment? **Select all that apply.**
A) Spiritual
B) Physiologic
C) Recreational
D) Sociocultural
E) Psychological
F) Developmental

21. The nurse is gathering objective information from the medical record of a newly admitted client to the medical-surgical unit of an acute care facility. Which of the following data would the nurse consider as a **priority** in assessing the client? **Select all that apply.**
A) the client's medical diagnosis
B) recent abnormal laboratory findings
C) the client's recent divorce
D) the client's tonsillectomy 45 years ago
E) recent changes in the client's blood pressure readings

22. The nurse has gathered objective and subjective data during the initial client assessment at an acute care facility. At the end of the assessment, the nurse will make informed clinical judgments. Which statement(s) reflects what the nurse will do **next**? **Select all that apply.**
A) Identify medical problems that require immediate referral.
B) Identify client problems that require nursing care.
C) Identify how the family is affected by the client's health status.
D) Identify collaborative problems that require interdisciplinary care.
E) Identify need for client teaching and health promotion.

23. A nurse is completing an assessment that will involve gathering subjective and objective information. Which data would the nurse identify as objective? **Select all that apply.**
A) health care provider's report
B) BP 135/78, heart rate 74 beats/min, respirations 16 breaths/min
C) reported symptoms
D) family history
E) client's name, age, and occupation

24. The nurse is performing a health assessment on a community-dwelling client who is recovering from hip replacement surgery. Which action should the nurse **prioritize** during assessment?
A) Use as much information as possible to understand the client's health in context.
B) Compare the assessment of the client with other clients in their age group.
C) Corroborate the client's statements with trusted sources like family members.
D) Ask another nurse for a second opinion on assessment findings.

25. During an assessment of a client with type 1 diabetes, the nurse learns that the client is having trouble paying for their prescribed insulin. What should the nurse do **next** after completing the physical examination?
A) Analyze cues gathered in the assessment.
B) Refer the client to social services.
C) Determine the appropriate nursing diagnosis.
D) Document the client's concern verbatim.

Test Bank Answer Key
Chapter 1: The Nurse's Role in Health Assessment

1. **C.** With assessment, subjective then objective data is collected. This is followed by validation and then documentation of data.

Format: Multiple Choice
Chapter 1: The Nurse's Role in Health Assessment
Client Needs: Health Promotion and Maintenance
Cognitive Level: Apply
Integrated Process: Nursing Process (Clinical Problem-solving Process)
Page and Header: 2, Focus of Health Assessment in Nursing

2. **D.** The purpose of a nursing health assessment is to collect subjective and objective data to determine a client's overall level of functioning to make a professional clinical judgment.

Format: Multiple Choice
Chapter 1: The Nurse's Role in Health Assessment
Client Needs: Health Promotion and Maintenance
Cognitive Level: Understand
Integrated Process: Nursing Process (Clinical Problem-solving Process)
Page and Header: 2, Focus of Health Assessment in Nursing

3. **B.** The nurse typically collects the subjective data, especially those related to the client's overall function. However, depending on the setting, other members of the health care team may participate in various parts of the objective data collection. Referral to a medical specialist would not take place at this early stage of assessment.

Format: Multiple Choice
Chapter 1: The Nurse's Role in Health Assessment
Client Needs: Safe and Effective Care Environment: Management of Care
Cognitive Level: Remember
Integrated Process: Nursing Process (Clinical Problem-solving Process)
Page and Header: 2, Focus of Health Assessment in Nursing

4. **B.** Although the assessment phase of the nursing process precedes other phases in the formal nursing process, nurses are always aware that assessment is ongoing and continuous throughout all the phases of the nursing process. Therefore, the nursing process should be thought of as circular, not linear.

Format: Multiple Choice
Chapter 1: The Nurse's Role in Health Assessment

Client Needs: Safe and Effective Care Environment: Management of Care
Cognitive Level: Understand
Integrated Process: Nursing Process (Clinical Problem-solving Process)
Page and Header: 2, ASSESSMENT: STEP 1 OF THE NURSING PROCESS

5. **A.** Before actually beginning the health assessment, the nurse should review the client's record. It provides basic biographic data and a background about chronic diseases. It also gives clues to how a present illness may impact the client's activities of daily living. Validating the information with the client occurs during the assessment. Consulting clinical resources is not an immediate priority.

Format: Multiple Choice
Chapter 1: The Nurse's Role in Health Assessment
Client Needs: Health Promotion and Maintenance
Cognitive Level: Apply
Integrated Process: Nursing Process (Clinical Problem-solving Process)
Page and Header: 5, Preparing for the Assessment

6. **B.** The comprehensive health assessment focuses on how the client's health status affects the activities of daily living and how the client's activities and choices affect health status. The nurse collects physiologic, psychological, sociocultural, developmental, and spiritual data about the client. In addition, the nurse assesses how clients interact within their family and community, and how the clients' health status affects the family and community. In contrast, the health care provider performing a medical examination focuses primarily on the client's physiologic development status, with less focus on psychological, sociocultural, or spiritual well-being.

Format: Multiple Choice
Chapter 1: The Nurse's Role in Health Assessment
Client Needs: Health Promotion and Maintenance
Cognitive Level: Understand
Integrated Process: Teaching/Learning
Page and Header: 2, Focus of Health Assessment in Nursing

7. **A.** Assessment is the first and most critical phase of the nursing process. If data collection is inadequate or inaccurate, incorrect nursing judgments may be made that adversely affect the remaining phases of the process.

Format: Multiple Choice
Chapter 1: The Nurse's Role in Health Assessment
Client Needs: Physiological Integrity: Basic Care and Comfort
Cognitive Level: Remember
Integrated Process: Teaching/Learning
Page and Header: 2, ASSESSMENT: STEP 1 OF THE NURSING PROCESS

8. **A.** A periodic partial assessment consists of a mini-overview of the client's body systems and holistic health patterns as a follow-up on health status. Any

problems that were initially detected in the client's body system or holistic health patterns are reassessed in less depth to determine any major changes from the baseline data. In addition, a brief reassessment of the client's normal body system or holistic health patterns is performed whenever the nurse or another health care professional has an encounter with the client.

Format: Multiple Choice
Chapter 1: The Nurse's Role in Health Assessment
Client Needs: Safe and Effective Care Environment: Management of Care
Cognitive Level: Understand
Integrated Process: Nursing Process (Clinical Problem-solving Process)
Page and Header: 4, Types of Health Assessment

9. **C.** Once the nurse has gathered some basic data about a client, they need to reflect on personal feelings to ensure keeping an open mind and avoiding premature judgments that may alter the ability to collect accurate data and maintain objectivity. The other listed actions may be necessary, but none is accomplished through reflection.

Format: Multiple Choice
Chapter 1: The Nurse's Role in Health Assessment
Client Needs: Safe and Effective Care Environment: Management of Care
Cognitive Level: Understand
Integrated Process: Caring
Page and Header: 5, Preparing for the Assessment

10. **C.** Appearance can be directly observed by the nurse and is considered objective data. Present concern, family history, and occupation are considered subjective as they are reported by the client.

Format: Multiple Choice
Chapter 1: The Nurse's Role in Health Assessment
Client Needs: Health Promotion and Maintenance
Cognitive Level: Understand
Integrated Process: Nursing Process (Clinical Problem-solving Process)
Page and Header: 6, Collecting Objective Data

11. **D.** Collaborative problems, such as changes in blood glucose, are certain physiologic complications that nurses monitor to detect onset or changes in status. Nurses manage collaborative problems by implementing both physician- and nurse-prescribed interventions to reduce further complications. Nutrition (oral fluids, bedtime snack) and hygiene are most often considered to be independent nursing concerns.

Format: Multiple Choice
Chapter 1: The Nurse's Role in Health Assessment
Client Needs: Safe and Effective Care Environment: Management of Care
Cognitive Level: Apply
Integrated Process: Nursing Process (Clinical Problem-solving Process)

Page and Header: 7, ANALYZING CUES TO IDENTIFY CLIENT CONCERNS: STEP 2 OF THE NURSING PROCESS

12. **C.** A focused assessment gathers specific data for a particular client problem usually discovered during the physical exam. This assessment "focuses" on the particular problem only and does not cover areas unrelated to the problem.

Format: Multiple Choice
Chapter 1: The Nurse's Role in Health Assessment
Client Needs: Physiological Integrity: Reduction of Risk Potential
Cognitive Level: Remember
Integrated Process: Nursing Process (Clinical Problem-solving Process)
Page and Header: 4, Types of Health Assessment

13. **D.** An initial comprehensive assessment is needed when the client first enters a health care system and periodically thereafter to establish baseline data against which future health status changes can be measured and compared. It does not form the basis for medical treatment. The client's "ABCs" are included, but this is not the primary focus of an initial assessment.

Format: Multiple Choice
Chapter 1: The Nurse's Role in Health Assessment
Client Needs: Health Promotion and Maintenance
Cognitive Level: Understand
Integrated Process: Nursing Process (Clinical Problem-solving Process)
Page and Header: 3, Types of Health Assessment

14. **C.** The frequency of ongoing assessment is determined by the acuity of the client. This factor is more important than the nurse's liability, the client's age, or the protocols of the unit.

Format: Multiple Choice
Chapter 1: The Nurse's Role in Health Assessment
Client Needs: Safe and Effective Care Environment: Management of Care
Cognitive Level: Remember
Integrated Process: Nursing Process (Clinical Problem-solving Process)
Page and Header: 4, Types of Health Assessment

15. **A.** A focused assessment may occur in all health care settings. It is smaller in scope than a comprehensive assessment, but more in depth related to the problem being presented. It usually involves one or two body systems. Data gathered and analyzed will determine the cause of the client's report. A comprehensive assessment includes the collection of objective data (data gathered during a step-by-step physical examination) and subjective data (the client's perception of the health of all body parts or systems, past health history, family history, lifestyle and health practices, including overall functioning). An emergency assessment is a very rapid assessment performed in life-threatening

situations. In such situations (choking, cardiac arrest, drowning), an immediate assessment is needed to provide prompt treatment.

Format: Multiple Choice
Chapter 1: The Nurse's Role in Health Assessment
Client Needs: Physiological Integrity: Reduction of Risk Potential
Cognitive Level: Remember
Integrated Process: Nursing Process (Clinical Problem-solving Process)
Page and Header: 4, Types of Health Assessment

16. **D.** Objective data may be obtained by direct observation or physical examination using the four examination techniques of inspection, auscultation, palpation, and percussion. Cerumen in the ear (ear wax) is a normal objective finding during a physical examination and does not require immediate attention. Acne lesions on the face and upper chest may be a chronic condition and do not require immediate attention. Moist nasal mucosa is a common finding and does not require immediate attention. Usually, lymph nodes are small, distinct, and mobile. An enlarged lymph node suggests inflammation and requires an immediate follow-up with a reexamination of the area where it drains.

Format: Multiple Choice
Chapter 1: The Nurse's Role in Health Assessment
Client Needs: Physiological Integrity: Reduction of Risk Potential
Cognitive Level: Understand
Integrated Process: Nursing Process (Clinical Problem-solving Process)
Page and Header: 6, Collecting Objective Data

17. **C.** The best choice to assess the client's cognitive domain would be to obtain a screening tool from the Alzheimer's Association (AA), which offers assistance related to diseases affecting cognitive abilities. Many tools are available for nurses to use to screen clients for health risks. Although the ADA, AHA, and AAO provide screening tools for the nurse to identify at-risk clients with heart disease, diabetes, or eye disease, the ADA, AHA, and AAO would not be the best resources to elicit a screening tool for cognitive function.

Format: Multiple Choice
Chapter 1: The Nurse's Role in Health Assessment
Client Needs: Physiological Integrity: Reduction of Risk Potential
Cognitive Level: Apply
Integrated Process: Nursing Process (Clinical Problem-solving Process)
Page and Header: 3, Using Evidence to Promote Health and Prevent Disease

18. **A.** In situations such as chest pain, an immediate assessment is needed to provide prompt treatment. The major and only concern during this type of assessment is to determine the status of the client's life-sustaining physical functions. The other clients do not have life-threatening conditions necessitating an emergency assessment.

Format: Multiple Choice

Chapter 1: The Nurse’s Role in Health Assessment
Client Needs: Safe and Effective Care Environment: Management of Care
Cognitive Level: Analyze
Integrated Process: Nursing Process (Clinical Problem-solving Process)
Page and Header: 4, Types of Health Assessment

19. **A, D, E.** Subjective data include information obtained from the client through interviewing and therapeutic communication skills and are sensations or symptoms, feelings, perceptions, desires, preferences, beliefs, ideas, values, and personal information that can be elicited and verified only by the client. Feeling tired, reports of a headache, and the statement about the client's parent dying of a heart attack reflect subjective information. Weight, lung sounds, and pupil reaction are examples of objective data.

Format: Multiple Selection
Chapter 1: The Nurse’s Role in Health Assessment
Client Needs: Health Promotion and Maintenance
Cognitive Level: Analyze
Integrated Process: Nursing Process (Clinical Problem-solving Process)
Page and Header: 5, Collecting Subjective Data

20. **A, B, D, E, F.** The purpose of a nursing health assessment is to collect holistic data to determine a client's level of functioning and make professional clinical judgments. Holistic data includes spiritual, physiologic, sociocultural, psychological, and developmental data. Recreational data is not specifically identified when completing a holistic assessment.

Format: Multiple Selection
Chapter 1: The Nurse’s Role in Health Assessment
Client Needs: Health Promotion and Maintenance
Cognitive Level: Remember
Integrated Process: Nursing Process (Clinical Problem-solving Process)
Page and Header: 2, Focus of Health Assessment in Nursing

21. **A, B, E.** Priority data that will be needed to assist the nurse in making informed clinical judgments include the client's medical diagnosis, recent abnormal lab findings, and recent changes in blood pressure readings. Objective data may be directly observed by the nurse as well as by using the four techniques of physical examination: inspection, auscultation, palpation, and percussion. Objective data are also available in the client's health record. The client's recent divorce and the tonsillectomy 45 years ago are not priority data needed to form a database on which an informed clinical judgment will be made.

Format: Multiple Selection
Chapter 1: The Nurse’s Role in Health Assessment
Client Needs: Physiological Integrity: Reduction of Risk Potential
Cognitive Level: Understand
Integrated Process: Nursing Process (Clinical Problem-solving Process)
Page and Header: 5, Preparing for the Assessment

22. **A, B, D, E.** Informed clinical judgments will be developed by the nurse when medical problems are identified, particularly those that require immediate referral, need nursing and interdisciplinary care, and require client teaching and health promotion. How the family is affected by the client's health status is important, but not a priority immediately following the completion of the health assessment.

Format: Multiple Selection
Chapter 1: The Nurse’s Role in Health Assessment
Client Needs: Safe and Effective Care Environment: Management of Care
Cognitive Level: Understand
Integrated Process: Nursing Process (Clinical Problem-solving Process)
Page and Header: 3, Framework for Health Assessment in Nursing

23. **A, B.** The nurse collects objective data through observation and uses the four physical examination techniques of inspection, palpation, percussion, and auscultation. These techniques provide objective data about the client's body functions, such as temperature, heart rate, and respirations, and may also be obtained from the client's medical record. The client's medical/health record also contains reports from other health care professionals. Family history, biographical information such as the client's name, age, and occupation, in addition to the reported symptoms, are part of the subjective information the nurse receives from the client during the interview.

Format: Multiple Selection
Chapter 1: The Nurse’s Role in Health Assessment
Client Needs: Health Promotion and Maintenance
Cognitive Level: Understand
Integrated Process: Nursing Process (Clinical Problem-solving Process)
Page and Header: 6, Collecting Objective Data

24. **A.** The client must be viewed holistically. Many systems are operating to create the context in which the client exists and functions. The nurse sees an individual client, but the accurate interpretation of what the nurse sees depends on perceiving the client in context. Culture, family, and community operate as systems interacting to form the context. Information and assessments do not normally need to be corroborated. The client's age is not the nurse's primary focus, nor should they be understood only in comparison to others their age.

Format: Multiple Choice
Chapter 1: The Nurse’s Role in Health Assessment
Client Needs: Health Promotion and Maintenance
Cognitive Level: Apply
Integrated Process: Nursing Process (Clinical Problem-solving Process)
Page and Header: 7, CONTEXTUAL FACTORS INFLUENCING CLIENT’S HEALTH STATUS

25. **A.** There are four steps of the assessment phase of the nursing process. During step 1, the nurse collects subjective data based on the client's experiences, feelings, sensations, and expectations. During step 2 of the assessment phase, the nurse analyzes and identifies cues in the assessment that will lead to the identification of a client concern (nursing problem). It is not appropriate to take action, like reaching out to social services, until the assessment is complete. Documentation occurs at the end of the assessment.

Format: Multiple Choice
Chapter 1: The Nurse’s Role in Health Assessment
Client Needs: Physiological Integrity: Reduction of Risk Potential
Cognitive Level: Analyze
Integrated Process: Nursing Process (Clinical Problem-solving Process)
Page and Header: 7, ANALYZING CUES TO IDENTIFY CLIENT CONCERNS: STEP 2 OF THE NURSING PROCESS