

MULTIPLE CHOICE

1. The nurse manager of a pediatric clinic could confirm that the new nurse recognized the purpose of the HEADSS Adolescent Risk Profile when the new nurse responds that it is used to review for needs related to
 - a. anticipatory guidance.
 - b. low-risk adolescents.
 - c. physical development.
 - d. sexual development.

ANS: A

The HEADSS Adolescent Risk Profile is a psychosocial assessment screening tool which reviews home, education, activities, drugs, sex, and suicide for the purpose of identifying high-risk adolescents and the need for anticipatory guidance. It is used to identify high-risk, not low-risk, adolescents. Physical development is reviewed with anthropometric data. Sexual development is reviewed using physical examination.

OBJ: NCLEX Client Needs Category: Health Promotion and Maintenance

2. The nurse preparing a teaching plan for a preschooler knows that, according to Piaget, the expected stage of development for a preschooler is
 - a. concrete operational.
 - b. formal operational.
 - c. preoperational.
 - d. sensorimotor.

ANS: C

The expected stage of development for a preschooler (3–4 years old) is pre-operational. Concrete operational describes the thinking of a school-age child (7–11 years old). Formal operational describes the thinking of an individual after about 11 years of age. Sensorimotor describes the earliest pattern of thinking from birth to 2 years old.

OBJ: NCLEX Client Needs Category: Health Promotion and Maintenance

3. The school nurse talking with a high school class about the difference between growth and development would best describe growth as
 - a. processes by which early cells specialize.
 - b. psychosocial and cognitive changes.
 - c. qualitative changes associated with aging.
 - d. quantitative changes in size or weight.

ANS: D

Growth is a quantitative change in which an increase in cell number and size results in an increase in overall size or weight of the body or any of its parts. The processes by which early cells specialize are referred to as *differentiation*. Psychosocial and cognitive changes are referred to as *development*. Qualitative changes associated with aging are referred to as *maturation*.

OBJ: NCLEX Client Needs Category: Health Promotion and Maintenance

4. The *most* appropriate response of the nurse when a mother asks what the Denver II does is that it
- can diagnose developmental disabilities.
 - identifies a need for physical therapy.
 - is a developmental screening tool.
 - provides a framework for health teaching.

ANS: C

The Denver II is the most commonly used measure of developmental status used by healthcare professionals; it is a screening tool. Screening tools do not provide a diagnosis. Diagnosis requires a thorough neurodevelopment history and physical examination. Developmental delay, which is suggested by screening, is a symptom, not a diagnosis. The need for any therapy would be identified with a comprehensive evaluation, not a screening tool. Some providers use the Denver II as a framework for teaching about expected development, but this is not the primary purpose of the tool.

OBJ: NCLEX Client Needs Category: Health Promotion and Maintenance

5. To plan early intervention and care for an infant with Down syndrome, the nurse considers knowledge of other physical development exemplars such as
- cerebral palsy.
 - failure to thrive.
 - fetal alcohol syndrome.
 - hydrocephaly.

ANS: D

Hydrocephaly is also a physical development exemplar. Cerebral palsy is an exemplar of adaptive developmental delay. Failure to thrive is an exemplar of social/emotional developmental delay. Fetal alcohol syndrome is an exemplar of cognitive developmental delay.

OBJ: NCLEX Client Needs Category: Health Promotion and Maintenance

6. To plan early intervention and care for a child with a developmental delay, the nurse would consider knowledge of the concepts most significantly impacted by development, including
- culture.
 - environment.
 - functional status.
 - nutrition.

ANS: C

Function is one of the concepts most significantly impacted by development. Others include sensory-perceptual, cognition, mobility, reproduction, and sexuality. Knowledge of these concepts can help the nurse anticipate areas that need to be addressed. Culture is a concept that is considered to significantly affect development; the difference is the concepts that affect development are those that represent major influencing factors (causes); hence determination of development would be the focus of preventive interventions. Environment is considered to significantly affect development. Nutrition is considered to significantly affect development.

OBJ: NCLEX Client Needs Category: Health Promotion and Maintenance

7. A mother complains to the nurse at the pediatric clinic that her 4-year-old child always talks to her toys and makes up stories. The mother wants her child to have a psychological evaluation. The nurse's *best* initial response is to
- refer the child to a psychologist immediately.
 - explain that playing make believe is normal at this age.
 - complete a developmental screening using a validated tool.
 - separate the child from the mother to get more information.

ANS: B

By the end of the fourth year, it is expected that a child will engage in fantasy, so this is normal at this age. A referral to a psychologist would be premature based only on the complaint of the mother. Completing a developmental screening would be very appropriate but not the initial response. The nurse would certainly want to get more information, but separating the child from the mother is not necessary at this time.

OBJ: NCLEX Client Needs Category: Health Promotion and Maintenance

8. A 17-year-old girl is hospitalized for appendicitis, and her mother asks the nurse why she is so needy and acting like a child. The *best* response of the nurse is that in the hospital, adolescents
- have separation anxiety.
 - rebel against rules.
 - regress because of stress.
 - want to know everything.

ANS: C

Regression to an earlier stage of development is a common response to stress. Separation anxiety is most common in infants and toddlers. Rebellion against hospital rules is usually not an issue if the adolescent understands the rules and would not create childlike behaviors. An adolescent may want to "know everything" with their logical thinking and deductive reasoning, but that would not explain why they would act like a child.

OBJ: NCLEX Client Needs Category: Health Promotion and Maintenance

MULTIPLE CHOICE

1. The nurse is reviewing a patient's functional ability. Which patient *best* demonstrates the definition of functional ability?
 - a. Considers self as a healthy individual; uses cane for stability
 - b. College educated; travels frequently; can balance a checkbook
 - c. Works out daily, reads well, cooks, and cleans house on the weekends
 - d. Healthy individual, volunteers at church, works part time, takes care of family and house

ANS: D

Functional ability refers to the individual's ability to perform the normal daily activities required to meet basic needs; fulfill usual roles in the family, workplace, and community; and maintain health and well-being. The other options are good; however, healthy individual, church volunteer, part time worker, and the patient who takes care of the family and house fully meets the criteria for functional ability.

OBJ: NCLEX Client Needs Category: Physiological Integrity: Basic Care and Comfort

2. The nurse is reviewing a patient's functional performance. What assessment parameters will be *most* important in this assessment?
 - a. Continence assessment, gait assessment, feeding assessment, dressing assessment, transfer assessment
 - b. Height, weight, body mass index (BMI), vital signs assessment
 - c. Sleep assessment, energy assessment, memory assessment, concentration assessment
 - d. Health and well-being, amount of community volunteer time, working outside the home, and ability to care for family and house

ANS: A

Functional impairment, disability, or handicap refers to varying degrees of an individual's inability to perform the tasks required to complete normal life activities without assistance. Height, weight, BMI, and vital signs are part of a physical assessment. Sleep, energy, memory, and concentration are part of a depression screening. Healthy, volunteering, working, and caring for family and house are functional abilities, not performance.

OBJ: NCLEX Client Needs Category: Physiological Integrity: Reduction of Risk Potential

3. The nurse is reviewing a patient with a mobility dysfunction and wants to gain insight into the patient's functional ability. What question would be the *most* appropriate?
 - a. "Are you able to shop for yourself?"
 - b. "Do you use a cane, walker, or wheelchair to ambulate?"
 - c. "Do you know what today's date is?"
 - d. "Were you sad or depressed more than once in the last 3 days?"

ANS: B

“Do you use a cane, walker, or wheelchair to ambulate?” will assist the nurse in determining the patient’s ability to perform self-care activities. A nutritional health risk assessment is not the functional assessment. Knowing the date is part of a mental status exam. Reviewing sadness is a question to ask in the depression screening.

OBJ: NCLEX Client Needs Category: Physiological Integrity: Physiological Adaptation

4. The nurse is developing an interdisciplinary plan of care using the Roper-Logan-Tierney Model of Nursing for a patient who is currently unconscious. Which interventions would be most critical to developing a plan of care for this patient?
- Eating and drinking, personal cleansing and dressing, working and playing
 - Toileting, transferring, dressing, and bathing activities
 - Sleeping, expressing sexuality, socializing with peers
 - Maintaining a safe environment, breathing, maintaining temperature

ANS: D

The most critical aspects of care for an unconscious patient are safe environment, breathing, and temperature. Eating and drinking are contraindicated in unconscious patients. Toileting, transferring, dressing, and bathing activities are BADLs. Sleeping, expressing sexuality, and socializing with peers are a part of the Roper-Logan-Tierney Model of Nursing; however, these are not the most critical for developing the plan of care in an unconscious patient.

OBJ: NCLEX Client Needs Category: Physiological Integrity: Physiological Adaptation

5. The home care nurse is trying to determine the necessary services for a 65-year-old patient who was admitted to the home care service after left knee replacement. Which tool is the *best* for the nurse to utilize?
- Minimum Data Set (MDS)
 - Functional Status Scale (FSS)
 - 24-Hour Functional Ability Questionnaire (24hFAQ)
 - The Edmonton Functional Assessment Tool

ANS: C

The 24hFAQ reviews the postoperative patient in the home setting. The MDS is for nursing home patients. The FSS is for children. The Edmonton is for cancer patients.

OBJ: NCLEX Client Needs Category: Health Promotion and Maintenance

6. The nurse is reviewing a patient’s functional abilities and asks the patient, “How would you rate your ability to prepare a balanced meal?” “How would you rate your ability to balance a checkbook?” “How would you rate your ability to keep track of your appointments?” Which tool would be indicated for the best results of this patient’s perception of their abilities?
- Functional Activities Questionnaire (FAQ)TM
 - Mini Mental Status Exam (MMSE)
 - 24hFAQ
 - Performance-based functional measurement

ANS: A

The FAQ is an example of a self-report tool which provides information about the patient's perception of functional ability. The MMSE reviews cognitive impairment. The 24hFAQ is used to review functional ability in postoperative patients. Performance-based tools involve actual observation of a standardized task, completion of which is judged by objective criteria.

OBJ: NCLEX Client Needs Category: Health Promotion and Maintenance

MULTIPLE RESPONSE

1. A 65-year-old female patient has been admitted to the medical/surgical unit. The nurse is reviewing the patient's risk for falls so that falls prevention can be implemented if necessary. Select all the risk factors that apply from this patient's history and physical. (*Select all that apply.*)
 - a. Being a woman
 - b. Taking more than six medications
 - c. Having hypertension
 - d. Having cataracts
 - e. Muscle strength 3/5 bilaterally
 - f. Incontinence

ANS: B, D, E, F

Adverse effects of medications can contribute to falls. Cataracts impair vision, which is a risk factor for falls. Poor muscle strength is a risk factor for falls. Incontinence of urine or stool increases risk for falls. Men have a higher risk for falls. Hypertension itself does not contribute to falls. Taking medications to treat hypertension that may lead to hypotension and dizziness is a fall risk. Dizziness does contribute to falls.

OBJ: NCLEX Client Needs Category: Physiological Integrity: Reduction of Risk Potential

Concept 03: Family Dynamics
Giddens: Concepts for Nursing Practice, 3rd Edition

MULTIPLE CHOICE

1. The *most* appropriate initial nursing intervention when the nurse notes dysfunctional interactions and lack of family support for a patient would be to
 - a. enforce hospital visiting policies.
 - b. monitor the dysfunctional interactions.
 - c. notify the primary care provider.
 - d. role model appropriate support.

ANS: D

Nurses can, at times, role model more appropriate interactions or provide suggestions for improving communication and interactions among family members. If the nurse determines that the number of visitors has a negative impact on the patient, hospital policy may be to limit visitors, but that would not be the initial action. Monitoring the dysfunctional interactions would not be an adequate response. The primary care provider should certainly be notified, but that would not be the initial response.

OBJ: NCLEX Client Needs Category: Psychosocial Integrity

2. The nurse caring for a patient would identify a need for additional interventions related to family dynamics when
 - a. extended family offers to help.
 - b. family members express concern.
 - c. the ill member demands attention.
 - d. memories are shared.

ANS: C

It is not uncommon for the ill family member to become demanding and indicate that they deserve special treatment and care, and the supportive family may need assistance in understanding the dynamics of the illness in order to continue to be supportive. Offers from extended family to help can be indicative of positive dynamics. Concern expressed by family members can be indicative of positive dynamics. Sharing of family memories can be indicative of positive dynamics.

OBJ: NCLEX Client Needs Category: Psychosocial Integrity

3. Two women have an established long-term relationship and are attending parenting classes in anticipation of finalizing adoption of a baby. The nurse identifies them as which type of family?
 - a. Cohabiting
 - b. Nuclear
 - c. Same-sex
 - d. Single parent

ANS: C

This family would be considered a same-sex family. *Cohabiting* refers to a couple who live together with no legal bond. *Nuclear* refers to the traditional male and female core family with one or more children. *Single parent* refers to a family with one adult and one or more children.

OBJ: NCLEX Client Needs Category: Psychosocial Integrity

4. The nurse identifies the family with a child graduating from college as having which effect on the family life cycle?
- Minimal impact
 - Considered to be a negative impact on the family unit
 - Leads to role confusion
 - Expectation of role change

ANS: D

The family life cycle developmental theory focuses on the growth and development of changes in role relationships during transitional periods. A child graduating from college is an example of a transition which requires a role change. As this is a transition, one would expect to see a change so minimal impact would not be expected. Graduation does not imply that it will be a negative change on the family life cycle or lead to role confusion.

OBJ: NCLEX Client Needs Category: Psychosocial Integrity

5. When reviewing the purposes of a family assessment, the nurse educator would identify a need for further teaching if the student responded that family assessment is used to gain an understanding of which aspect of the family?
- Development
 - Function
 - Political views
 - Structure

ANS: C

An understanding of the political views of family members is not a primary purpose of a family assessment. A family assessment provides the nurse with information and an understanding of family dynamics. This is important to nurses for the provision of quality health care. A family assessment provides an understanding of family development, function, and structure.

OBJ: NCLEX Client Needs Category: Health Promotion and Maintenance

6. A nurse is planning to review the structure of a family. Which question should the nurse ask?
- "Who lives with you in this home?"
 - "Who does the grocery shopping?"
 - "Who provides support in your family?"
 - "How old are the members of your family?"

ANS: A

The structure of the family includes who is in the family and what their relationship is. “Who does the shopping?” would provide information about family functioning. “Who provides support?” would provide information about family functioning. “How old are the members?” would provide information about family development.

OBJ: NCLEX Client Needs Category: Psychosocial Integrity

7. Which factors should alert the nurse to negative/dysfunctional family dynamics?
- a. Aging of family members
 - b. Chronic illness of a family member
 - c. Disability of a family member
 - d. Intimate partner violence

ANS: D

Intimate partner violence is an exemplar of negative/dysfunctional family dynamics. Aging of family members is an exemplar of changes to family dynamics. Chronic illness of a family member is an exemplar of changes to family dynamics. Disability of a family member is an exemplar of changes to family dynamics.

OBJ: NCLEX Client Needs Category: Psychosocial Integrity

Concept 04: Culture

Giddens: Concepts for Nursing Practice, 3rd Edition

MULTIPLE CHOICE

1. The nurse is caring for an older Chinese adult male who is grimacing and appears restless after abdominal surgery. What is the nurse's *best* action?
 - a. Ask the patient if he is anxious about his hospital stay.
 - b. Ask a translator to conduct a FACES pain scale assessment.
 - c. Ask the patient about pain and review vital signs.
 - d. Ask the patient about any history of depression or anxiety.

ANS: C

In the Chinese culture, elderly Chinese people believe that they must be stoic about pain and there is a stigma about talking about any mental health problems. The nurse should ask the patient about pain and also review vital signs for physiological signs of pain, since the patient may not admit to any pain. Assuming the patient is depressed or anxious is not the best action when considering individual cultural differences and the risk of pain after major surgery. The registered nurse should never delegate assessment to any unlicensed member of the healthcare team such as a translator. The translator may assist with communication, but the nurse is responsible for the pain assessment.

OBJ: NCLEX Client Needs Category: Psychosocial Integrity | NCLEX Client Needs Category: Physiological Integrity: Basic Care and Comfort

2. Understanding cultural differences in health care is important because it will help the nurse to understand the manner in which people decide on obtaining treatments and medical care. In independent cultures an individual will
 - a. put himself first.
 - b. consult family members for advice.
 - c. ask for a second opinion.
 - d. travel great distances to receive the best care.

ANS: A

In independent cultures, an individual will put himself first in the case of a life-threatening illness, whereas even in dire circumstances, members of collectivist cultures may still consult other family members for the best course of action. In independent cultures, an individual will not consult with other family members, ask for a second opinion, or travel great distances to receive the best care.

OBJ: NCLEX Client Needs Category: Psychosocial Integrity

3. When teaching an Asian patient with newly diagnosed diabetes, the nurse notes the patient nodding yes to everything that is being said. With a better understanding of cultural interdependence in self-concept, a nurse should *immediately*
 - a. write everything down for the patient to refer to later.
 - b. prompt further to elicit additional questions or concerns.
 - c. call the recognized elder for this patient.
 - d. call the oldest male relative for help with decision making.