Chapter 01: The Nurse's Role in Health Assessment
Weber: Health Assessment in Nursing 7th Edition

1. Which individual typically would be responsible for collecting the subjective data on a client during the initial comprehensive assessment?
A. Physician
B. Nurse
C. Secretary
D. Technician

Answer: B

Rationale: 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.
Question Format: Multiple Choice
Chapter: 1
Cognitive Level: Remember
Client Needs: Safe, Effective Care Environment: Management of Care
Integrated Process: Nursing Process
Reference: p. 3, Types of Health Assessment

2. 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

Answer: C

Rationale: With assessment, subjective then objective data is collected. This is followed by validation and then documentation of data.

Question Format: Multiple Choice
Chapter: 1
Cognitive Level: Apply
Client Needs: Health Promotion and Maintenance
Integrated Process: Nursing Process
Reference: p. 4, Steps of Health Assessment

3. 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 physician
C. Validate previous data
D. Make a clinical judgment

Answer: D

Rationale: 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.
Question Format: Multiple Choice
Chapter: 1
Cognitive Level: Understand
Client Needs: Health Promotion and Maintenance
Integrated Process: Nursing Process
Reference: p. 2, Focus of Health Assessment in Nursing

4. A nurse on a postsurgical unit is admitting a client following the client's cholecystectomy. What is the overall purpose of assessment for this client?
A. Collecting accurate data
B. Assisting the primary care provider
C. Validating previous data
D. Making clinical judgments

Answer: D

Rationale: 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. Collecting and validating data are means to this end. The primary purpose of assessment is not to assist the primary care provider.
Question Format: Multiple Choice
Chapter: 1
Cognitive Level: Understand
Client Needs: Safe, Effective Care Environment: Management of Care
Integrated Process: Nursing Process
Reference: p. 2, Focus of Health Assessment in Nursing

5. A client has presented to the emergency department (ED) with complaints of 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

Answer: B

Rationale: 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.
Question Format: Multiple Choice
Chapter : 1
Cognitive Level: Remember

Client Needs: Safe, Effective Care Environment: Management of Care
Integrated Process: Nursing Process
Reference: p. 3, Types of Health Assessment

6. 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.

Answer: B

Rationale: 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. Question
Format: Multiple Choice
Chapter: 1
Cognitive Level: Understand
Client Needs: Safe, Effective Care Environment: Management of Care Client
Needs: Physiological Integrity: Basic Care and Comfort Integrated Process:
Nursing Process
Reference: p. 2, Assessment: Step 1 of the Nursing Process

7. 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.

Answer: A

Rationale: 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.
Question Format: Multiple Choice
Chapter: 1
Cognitive Level: Apply
Client Needs: Health Promotion and Maintenance
Integrated Process: Nursing Process
Reference: p. 5, Preparing for the Assessment

8. In response to a client's query, the nurse is explaining the differences between the physician'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

Answer: B

Rationale: 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 physician performing a medical examination focuses primarily on the client's

physiologic development status, with less focus on psychological, sociocultural, or spiritual well-being.
Question Format: Multiple Choice
Chapter: 1
Cognitive Level: Understand
Client Needs: Health Promotion and Maintenance
Integrated Process: Teaching/Learning
Reference: p. 2, Focus of Health Assessment in Nursing

9. 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

Answer: A

Rationale: 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.
Question Format: Multiple Choice
Chapter: 1
Cognitive Level: Remember
Client Needs: Physiological Integrity: Basic Care and Comfort
Integrated Process: Teaching/Learning
Reference: p. 2, Assessment: Step 1 of the Nursing Process

10. 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

Answer: A

Rationale: 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.
Question Format: Multiple Choice
Chapter: 1
Cognitive Level: Understand
Client Needs: Safe, Effective Care Environment: Management of Care
Integrated Process: Nursing Process
Reference: p. 3, Types of Health Assessment

11. 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 14-year-old girl who is crying because she thinks she is pregnant
B. A 45-year-old man with chest pain and diaphoresis for 1 hour
C. A 3-year-old child with fever, rash, and sore throat
D. A 20-year-old man with a 3-inch shallow laceration on his leg Answer:

B

Rationale: In such situations like 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 girl who is crying, the 3-year-old with a rash and fever, and the 20-year-old do not have life-threatening conditions necessitating an emergency assessment.
Question Format: Multiple Choice
Chapter: 1
Cognitive Level: Analyze
Client Needs: Safe, Effective Care Environment: Management of Care
Integrated Process: Nursing Process
Reference: p. 3–4, Types of Health Assessment

12. A nurse has completed gathering some basic data about a client who has multiple health problems that stem from heavy alcohol use. The nurse has then reflected on her personal feelings about the client and his 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

Answer: C

Rationale: Once the nurse has gathered some basic data about a client, he or she needs 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.
Question Format: Multiple Choice
Chapter: 1
Cognitive Level: Understand
Client Needs: Safe, Effective Care Environment: Management of Care
Integrated Process: Caring
Reference: p. 5, Preparing for the Assessment

13. The nurse is collecting data from a client who has recently been diagnosed with type 1 diabetes and who will begin an educational program. The nurse is collecting subjective and objective data. Which of the following would the nurse categorize as objective data?

A. Family history

B. Occupation

C. Appearance

D. History of present health concern

Answer: C

Rationale: Appearance is something that can be directly observed by the nurse and is considered objective data. Present concern, family history, and occupation are considered subjective.

Question Format: Multiple Choice

Chapter: 1

Cognitive Level: Understand

Client Needs: Safe, Effective Care Environment: Management of Care

Integrated Process: Nursing Process

Reference: p. 6, Collecting Objective Data

14. 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.

Answer: D

Rationale: 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.
Question Format: Multiple Choice
Chapter: 1
Cognitive Level: Apply
Client Needs: Safe, Effective Care Environment: Management of Care
Integrated Process: Nursing Process
Reference: p. 7, Analyzing Cues to Identify Client Concerns: Step 2 of the Nursing Process

15. The nurse at a busy primary care clinic is analyzing the data obtained from the following clients. For which client would the nurse most likely expect to facilitate a referral?
A. An 80-year-old client who lives with her daughter
B. A 50-year-old client newly diagnosed with diabetes
C. An adult presenting for an influenza vaccination
D. A teenager seeking information about contraception

Answer: B

Rationale: During the comprehensive assessment, the nurse identifies problems that require the assistance of other health care professionals. A client who is newly diagnosed with diabetes would benefit from a referral to a diabetes education program. Assistance from other health care professionals would not necessarily be required for the older adult client, the client wanting a vaccination, or the teenager seeking information.
Question Format: Multiple Choice
Chapter: 1
Cognitive Level: Analyze
Client Needs: Safe, Effective Care Environment: Management of Care
Integrated Process: Nursing Process
Reference: p. 7, Analyzing Cues to Identify Client Concerns: Step 2 of the Nursing Process