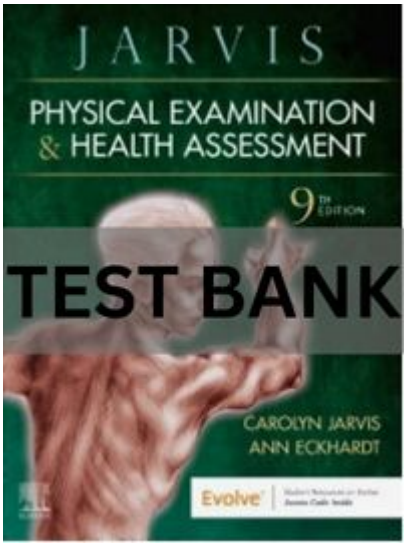
Physical Examination and Health Assessment 9th Edition Test Bank

Chapter 01: Evidence-Based Assessment
Jarvis: Physical Examination and Health Assessment, 9th Edition



MULTIPLE CHOICE

1. After completing an initial assessment of a patient, the nurse has charted that his respirations are eupneic and his pulse is 58 beats per minute. What type of assessment data is this?
   a. Objective
   b. Reflective
   c. Subjective
   d. Introspective

   ANS: A
   Objective data is what the health professional observes by inspecting, percussing, palpating, and auscultating during the physical examination. Subjective data is what the person *says* about him or herself during history taking. The terms *reflective* and *introspective* are not used to describe data.

   DIF: Cognitive Level: Understanding (Comprehension)
   MSC: Client Needs: Safe and Effective Care Environment: Management of Care

2. A patient tells the nurse that he is very nervous, nauseous, and "feels hot." What type of assessment data is this?
   a. Objective
   b. Reflective
   c. Subjective
   d. Introspective

   ANS: C
   Subjective data is what the person says about him or herself during history taking. Objective data is what the health professional observes by inspecting, percussing, palpating, and auscultating during the physical examination. The terms *reflective* and *introspective* are not used to describe data.

   DIF: Cognitive Level: Understanding (Comprehension)
   MSC: Client Needs: Safe and Effective Care Environment: Management of Care

3. What do the patient's record, laboratory studies, objective data, and subjective data combine to form?
   a. Database
   b. Admitting data
   c. Financial statement
   d. Discharge summary

   ANS: A
   The objective and subjective data together with the patient's record and laboratory studies, form the database. The other items are not part of the patient's record, laboratory studies, or data.

   DIF: Cognitive Level: Remembering (Knowledge)
   MSC: Client Needs: Safe and Effective Care Environment: Management of Care

4. When listening to a patient's breath sounds, the nurse is unsure of a sound that is heard. Which action would the nurse take *next*?
   a. Notify the patient's physician.
   b. Document the sound exactly as it was heard.
   c. Validate the data by asking another nurse to listen to the breath sounds.
   d. Assess again in 20 minutes to note whether the sound is still present.

   ANS: C
   When unsure of a sound heard while listening to a patient's breath sounds, the nurse validates the data to ensure accuracy by either repeating the assessment themselves or asking another nurse to assess the breath sounds. If the nurse has less experience analyzing breath sounds, then he or she should ask an expert to listen. When unsure of a sound heard while listening to a patient's breath sounds, the nurse should validate the data before documenting to ensure accuracy and before notifying the patient's physician. To validate that data, the nurse either repeats the assessment himself or herself or asks another nurse to assess the breath sounds.

   DIF: Cognitive Level: Applying (Application)
   MSC: Client Needs: Safe and Effective Care Environment: Management of Care

5. The nurse is conducting a class for new graduate nurses. While teaching the class, what would the nurse keep in mind regarding what novice nurses, without a background of skills and experience from which to draw upon, are more likely to base their decisions on?
   a. Intuition
   b. A set of rules
   c. Articles in journals
   d. Advice from supervisors

   ANS: B
   Novice nurses operate from a set of defined, structured rules to make decisions. It takes time, perhaps a few years, in similar clinical situations to achieve competency and it is functioning at the level of an expert practitioner when intuition is included in making clinical decisions. While information in journal articles and advice from supervisors may assist in making decisions, novice nurses do not typically base their decisions on them. It would also be important that if information from journal articles and advice from supervisors were used, that they were evidence based.

   DIF: Cognitive Level: Understanding (Comprehension) MSC: Client Needs: General

6. The nurse is reviewing information about evidence-based practice (EBP). Which statement best reflects EBP?
   a. EBP relies on tradition for support of best practices.
   b. EBP is simply the use of best practice techniques for the treatment of patients.
   c. EBP emphasizes the use of best evidence with the clinician's experience.
   d. EBP does not consider the patient's own preferences as important.

   ANS: C
   EBP is a systematic approach to practice that emphasizes the use of research evidence in combination with the clinician's expertise and clinical knowledge (physical assessment), as well as patient values and preferences, when making decisions about care and treatment. EBP is more than simply using the best practice techniques to treat patients, and questioning tradition is important when no compelling and supportive research evidence exists.

   DIF: Cognitive Level: Understanding (Comprehension)
   MSC: Client Needs: Safe and Effective Care Environment: Management of Care

7. The nurse is conducting a class on priority setting for a group of new graduate nurses. Which is an example of a first-level priority problem?
   a. Patient with postoperative pain
   b. Newly diagnosed patient with diabetes who needs diabetic teaching
   c. Individual with a small laceration on the sole of the foot
   d. Individual with shortness of breath and respiratory distress

   ANS: D
   First-level priority problems are those that are emergent, life-threatening, and immediate (e.g., establishing an airway, supporting breathing, maintaining circulation, monitoring abnormal vital signs). Postoperative pain, diabetic teaching for a patient newly diagnosed with diabetes, and a small laceration on sole of the foot are not considered first-level priority problems.

   DIF: Cognitive Level: Understanding (Comprehension)
   MSC: Client Needs: Safe and Effective Care Environment: Management of Care

8. When considering priority setting of problems, the nurse keeps in mind that second-level priority problems include which of these aspects?
   a. Low self-esteem
   b. Lack of knowledge
   c. Abnormal laboratory values
   d. Severely abnormal vital signs

   ANS: C
   Abnormal laboratory values are a second-level priority problem. Second-level priority problems are those that require prompt intervention to forestall further deterioration (e.g., mental status change, acute pain, abnormal laboratory values, risks to safety or security). Low self-esteem and lack of knowledge are considered third-level priority as although they are important to a patient's health, they can be addressed after more urgent health problems are addressed. Severely abnormal vital signs would be considered a first-level priority problem.

   DIF: Cognitive Level: Understanding (Comprehension)
   MSC: Client Needs: Safe and Effective Care Environment: Management of Care

9. Which critical-thinking skill helps the nurse see relationships among the data?
   a. Validation

b. Clustering related cues
c. Identifying gaps in data
d. Distinguishing relevant from irrelevant

ANS: B
Clustering related cues involves clustering, or grouping together, assessment data that appear to be associated, or related, and helps the nurse see relationships among the data. Identifying gaps is looking for missing information and validation involves ensuring accuracy, and distinguishing relevant and irrelevant data involves identifying data the fit, or support the problem, but none of those help the nurse to see relationships.

DIF: Cognitive Level: Understanding (Comprehension)
MSC: Client Needs: Safe and Effective Care Environment: Management of Care

10. The nursing process is a sequential method of problem solving that nurses use and includes which steps?
a. Assessment, treatment, planning, evaluation, discharge, and follow-up
b. Admission, assessment, diagnosis, treatment, and discharge planning
c. Admission, diagnosis, treatment, evaluation, and discharge planning
d. Assessment, diagnosis, outcome planning, implementation, and evaluation

ANS: D
The nursing process is a method of problem solving that includes assessment, diagnosis, planning, implementation, and evaluation.

DIF: Cognitive Level: Understanding (Comprehension)
MSC: Client Needs: Safe and Effective Care Environment: Management of Care

11. A newly admitted patient is in acute pain, has not been sleeping well lately, and is having difficulty breathing. How should the nurse prioritize these problems?
a. Breathing, pain, and sleep
b. Breathing, sleep, and pain
c. Sleep, breathing, and pain
d. Sleep, pain, and breathing

ANS: A
First-level priority problems are immediate priorities, remembering the ABCs (airway, breathing, and circulation), followed by second-level problems (e.g., mental status change, acute pain, acute urinary elimination problems, untreated medical problems, abnormal laboratory values, risks of infection, or risk to safety or security), and then third-level problems (those that are important to the patient's health but can be attended to after more urgent health problems are addressed).

DIF: Cognitive Level: Analyzing (Analysis)
MSC: Client Needs: Safe and Effective Care Environment: Management of Care

12. Which is a barrier to incorporating EBP?
a. Nurses' lack of research skills in evaluating the quality of research studies
b. Lack of significant research studies
c. Insufficient clinical skills of nurses
d. Inadequate physical assessment skills

ANS: A

As individuals, nurses lack research skills in evaluating the quality of research studies, are isolated from other colleagues who are knowledgeable in research, and often lack the time to visit the library to read research. The other responses are not considered barriers. Lack of significant research studies, insufficient clinical skills of nurses, and inadequate physical assessment skills are not barriers to incorporating EBP. Instead, as individuals, nurses lack research skills in evaluating the quality of research studies, are isolated from other colleagues who are knowledgeable in research, and often lack the time to visit the library to read research which are barriers to incorporating EBP.

DIF: Cognitive Level: Understanding (Comprehension) MSC: Client Needs: General

13. During a staff meeting, nurses discuss the problems with identifying evidence-based practices to incorporate into their practice. Which suggestion by the nurse manager would *best* help these problems?
    a. Form a committee to conduct research studies.
    b. Post published research studies on the unit's bulletin boards.
    c. Teach the nurses how to conduct research.
    d. Ensuring time for staff to review current literature.

    ANS: D
    Facilitating support for EBP at the organizational level includes ensuring time for staff to review current literature; establishing a nursing research committee; holding EBP classes for interested staff; and ensuring access to resources. Forming a committee or teaching nurses to actually conduct research studies may be helpful in the long-run but not an immediate solution to reviewing existing research. Just posting published research studies on the unit's bulletin board does not facilitate EBP, as not all published research is valid or pertinent to the nurses' practice.

    DIF: Cognitive Level: Applying (Application)
    MSC: Client Needs: Safe and Effective Care Environment: Management of Care

14. When reviewing the concepts of health, the nurse recalls that the components of holistic health include which of these?
    a. Disease originates from the external environment.
    b. The individual human is a closed system.
    c. Nurses are responsible for a patient's health state.
    d. Holistic health views the mind, body, and spirit as interdependent.

    ANS: D
    Consideration of the whole person is the essence of holistic health, which views the mind, body, and spirit as interdependent and functioning as a whole within the environment. The basis of disease originates from both the external environment and from within the person; the individual human is an open system, continually changing and adapting; and each person is responsible for his or her own personal health state (not the nurse).

    DIF: Cognitive Level: Understanding (Comprehension)
    MSC: Client Needs: Safe and Effective Care Environment: Management of Care

15. The nurse is performing a physical assessment on a newly admitted patient. Which is an example of objective information obtained during the physical assessment?
    a. Patient's history of allergies
    b. Patient's use of medications at home

c. Last menstrual period 1 month ago
d. 2 × 5 cm scar on the right lower forearm

ANS: D
Objective data is the patient's record, laboratory studies, and condition that the health professional observes by inspecting, percussing, palpating, and auscultating during the physical examination. The other responses reflect subjective data. A patient's history of allergies, use of medications at home, and date of last menstrual periods are all subjective data.

DIF: Cognitive Level: Applying (Application)
MSC: Client Needs: Safe and Effective Care Environment: Management of Care

16. A visiting nurse is making an initial home visit for a patient who has several chronic medical problems. Which type of database is most appropriate to collect in this setting?
a. A follow-up database
b. A focused database
c. A complete database
d. An emergency database

ANS: C
A complete database is collected in primary care settings, such as a pediatric or family practice clinic, independent or group private practice, college health service, women's health care agency, visiting nurse agency, or community health agency. In these settings, the nurse is the first health professional to see the patient and has the primary responsibility for monitoring the person's health care. A follow-up database is performed to follow up, or evaluate changes, on short-term and chronic health problems, but would be collected at appropriate intervals *after* a complete database was collected at the initial visit. A focused database is conducted for a limited or short-term problem, not for a patient with several chronic problems. An emergency database is an urgent, rapid collection of data often compiled concurrently while lifesaving measures are being performed.

DIF: Cognitive Level: Applying (Application)
MSC: Client Needs: Safe and Effective Care Environment: Management of Care

17. In which situation is it most appropriate for the nurse to perform a focused or problem-centered history?
a. Patient is admitted to a long-term care facility.
b. Patient has a sudden and severe shortness of breath.
c. Patient is admitted to the hospital for a scheduled surgery.
d. Patient in an outpatient clinic has cold and influenza-like symptoms.

ANS: D
In a focused or problem-centered database, the nurse collects a "mini" database, which is smaller in scope than the complete database. This mini database primarily concerns one problem, one cue complex, or one body system. A complete database should be conducted for a patient being admitted to a long-term care facility or being admitted for a scheduled surgery. An emergency database should be conducted for a patient with sudden and severe shortness of breath.

DIF: Cognitive Level: Applying (Application)
MSC: Client Needs: Safe and Effective Care Environment: Management of Care

18. The clinic nurse is caring for a patient who has been coming to the clinic weekly for blood pressure checks since changing medications 2 months ago. Which is the most appropriate action for the nurse to take?
    a. Collect a follow-up database and then check the patient's blood pressure.
    b. Ask the patient to read her health record and indicate any changes since her last visit.
    c. Check the patient's blood pressure.
    d. Obtain a complete health history on the patient before checking her blood pressure.

    ANS: A
    A follow-up database is used in all settings to follow up on short-term or chronic health problems. The other responses are not appropriate for the situation. Asking the patient to read her health history and indicate any changes since her last visit is not appropriate. Just checking the patient's blood pressure without following up on or assessing for any changes in the patient's condition is inappropriate. It is not necessary to conduct a complete health history as one was conducted 2 months ago. Rather a follow-up assessment regarding the patient's blood pressure and factors associated with it are necessary.

    DIF: Cognitive Level: Applying (Application)
    MSC: Client Needs: Safe and Effective Care Environment: Management of Care

19. A patient is brought by ambulance to the emergency department with multiple injuries received in an automobile accident. The patient is alert and cooperative, but their injuries are quite severe. How would the nurse proceed with data collection?
    a. Collect history information first, then perform the physical examination and institute lifesaving measures.
    b. Simultaneously ask history questions while performing the examination and initiating lifesaving measures.
    c. Collect all information on the history form, including social support patterns, strengths, and coping patterns.
    d. Perform lifesaving measures and delay asking any history questions until the patient is transferred to the intensive care unit.

    ANS: B
    The emergency database calls for a rapid collection of data, often concurrently compiled with lifesaving measures. The other responses are not appropriate for the situation. This is an emergency situation and an emergency database with rapid collection of the data compiled concurrently with lifesaving measures.

    DIF: Cognitive Level: Applying (Application)
    MSC: Client Needs: Safe and Effective Care Environment: Management of Care

20. Which statement *best* describes a proficient nurse?
    a. Has little experience with a specified population and uses rules to guide performance.
    b. Has an intuitive grasp of a clinical situation and quickly identifies the accurate solution.
    c. Sees actions in the context of daily plans for patients.
    d. Understands a patient situation as a whole rather than a list of tasks and recognizes the 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. The proficient nurse is able to see how today's nursing actions can apply to the point the nurse wants the patient to reach at a future time. A nurse that has little experience with a specified population and uses rules to guide performance is a novice nurse. A nurse that has an intuitive grasp of a clinical situation and quickly identifies the accurate solution is an expert nurse. Seeing actions in the context of daily plans for patients describes competency or a competent nurse.

DIF: Cognitive Level: Understanding (Comprehension) MSC: Client Needs: General

MULTIPLE RESPONSE

1. The nurse is reviewing data collected after an assessment. Of the data listed below, which would be considered related cues that would be clustered together during data analysis? (*Select all that apply*.)
   a. Inspiratory wheezes noted in left lower lobes
   b. Hypoactive bowel sounds
   c. Nonproductive cough
   d. Edema, +2, noted on left hand
   e. Patient reports dyspnea upon exertion
   f. Rate of respirations 16 breaths per minute

   ANS: A, C, E, F
   Clustering related cues helps the nurse recognize relationships among the data. The cues related to the patient's respiratory status (e.g., wheezes, cough, report of dyspnea, respiration rate and rhythm) are all related. Cues related to bowels and peripheral edema are not related to the respiratory cues. Hypoactive bowel sounds and +2 edema of the left hand are separate cues that do not relate to the other cues. The other cues (wheezes, cough, report of dyspnea, respiration rate and rhythm) all relate to the patient's respiratory status. The cues of bowel sounds and peripheral edema are not related to the respiratory cues.

   DIF: Cognitive Level: Analyzing (Analysis)
   MSC: Client Needs: Safe and Effective Care Environment: Management of Care

OTHER

1. Put the following patient situations in order of the level of priority (from highest priority to lowest priority).
   1. First-level priority problem
   2. Second-level priority problem
   3. Third-level priority problem

   a. A teenager who was stung by a bee during a soccer match is having trouble breathing.
   b. A patient newly diagnosed with type 2 diabetes mellitus does not know how to check his own blood glucose levels with a glucometer.
   c. An older adult with a urinary tract infection is also showing signs of confusion and agitation.

   ANS:
   A, C, B

First-level priority problems are immediate priorities, such as trouble breathing (remember the airway, breathing, circulation priorities). Second-level priority problems are next in urgency, but not life-threatening. Third-level priorities (e.g., patient education) are important to a patient's health but can be addressed after more urgent health problems are addressed.

DIF: Cognitive Level: Analyzing (Analysis)
MSC: Client Needs: Safe and Effective Care Environment: Management of Care

Chapter 02: Cultural Assessment
Jarvis: Physical Examination and Health Assessment, 9th Edition

MULTIPLE CHOICE

1. The nurse is reviewing the characteristics of culture. Which statement is *correct* regarding the development of one's culture?
   a. Learned through language acquisition and socialization
   b. Genetically determined on the basis of racial background
   c. A nonspecific phenomenon and is adaptive but unnecessary
   d. Biologically determined on the basis of physical characteristics

   ANS: A
   Culture is a complex phenomenon that includes attitude, beliefs, self-definitions, norms, roles, and values learned from birth through the processes of language acquisition and socialization. It is not biologically or genetically determined. It is learned by the individual. It is a universal phenomenon and is important because a person's culture defines health and illness, identifies when treatment is needed and which treatment is acceptable, and informs a person of how symptoms are expressed and which symptoms are important.

   DIF: Cognitive Level: Understanding (Comprehension)
   MSC: Client Needs: Psychosocial Integrity

2. During a class on the aspects of culture, the nurse shares that culture has four basic characteristics. Which statement correctly reflects one of the characteristics of culture?
   a. Static and unchanging
   b. Members share similar physical characteristics.
   c. Members share a common geographic origin and religion.
   d. Adapted to specific conditions related to environmental and technical factors

   ANS: D
   Culture has four basic characteristics, one of which is that it is adapted to specific conditions related to environmental and technical factors and to the availability of natural resources. The other three characteristics are: (1) learned from birth through the processes of language acquisition and socialization; (2) shared by all members of the cultural group; and (3) dynamic and ever changing. Culture is not static and unchanging but is dynamic and ever changing. Members of a culture do not necessarily share similar physical characteristics. Sharing similar physical characteristics refers to race. Members of a culture do not necessarily share a common geographic origin and religion. Sharing a common geographic origin and religion refers to ethnicity.

   DIF: Cognitive Level: Analyzing (Analysis)
   MSC: Client Needs: Psychosocial Integrity

3. During a seminar on cultural aspects of nursing, the nurse recognizes that the definition stating "the specific and distinct knowledge, beliefs, customs, and skills acquired by members of a society" reflects which term?
   a. Norms
   b. Culture
   c. Ethnicity
   d. Assimilation

   ANS: B
   The culture that develops in any given society is unique, encompassing all of the knowledge, beliefs, customs, and skills acquired by members of the society. The other terms do not fit the given definition. Norms refers to the typical or usual. Ethnicity refers to a social group that may possess shared traits, such as common geographic origin, migratory status, religion, language, values, traditions, or symbols and food preferences. Assimilation refers to taking on the characteristics of the dominant culture.

   DIF: Cognitive Level: Remembering (Knowledge)
   MSC: Client Needs: Psychosocial Integrity

4. The nurse is discussing the term *subculture* with a student nurse. Which statement by the nurse would best describe *subculture*?
   a. "Fitting as many people as possible into the majority culture."
   b. "Identifying small groups of people who do not want to be identified with the larger culture."
   c. "Singling out groups of people who suffer differential and unequal treatment as a result of cultural variations."
   d. "Recognizing groups of people within a culture with shared characteristics that are not common to all members of the culture."

   ANS: D
   Within cultures, groups of people share different beliefs, values, and attitudes. Differences occur because of ethnicity, religion, education, occupation, age, and gender. When such groups function within a large culture, they are referred to as *subcultural groups*. Fitting as many people as possible into the majority culture, identifying small groups of people who do not want to be identified with the larger culture, and singling out groups of people who suffer differential and unequal treatment as a result of cultural variations do not describe a subculture. A subculture is a group of people with a culture that share some different beliefs, values, or attitudes than the majority of the larger culture.

   DIF: Cognitive Level: Understanding (Comprehension)
   MSC: Client Needs: Psychosocial Integrity

5. When reviewing the demographics of ethnic groups in the United States, the nurse recalls that which is the largest and fastest growing population?
   a. Asian
   b. Hispanic
   c. American Indian
   d. African American/black

   ANS: B