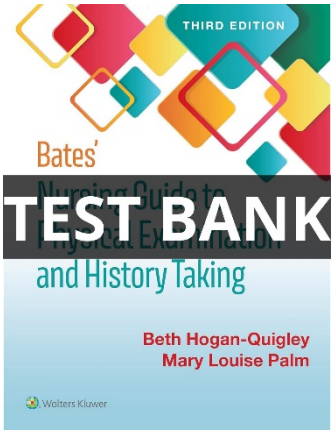
Chapter 1, Introduction to Health Assessment and Social Determinants of Health



1. What is the nurse's focus while conducting a health assessment with a client? (Select all that apply.)
A. Completing the health history.
B. Interpreting findings.
C. Formulating a plan of care
D. Implementing a plan of care.
E. Conducting a physical examination.

Answer: A, E

Rationale: A health assessment is comprised of the taking the client's health history then followed by a physical examination. Interpreting findings, formulating a plan of care, and implementing a plan of care are steps within the nursing process that use the data identified by the health assessment.
Question format: Multiple Select
Chapter: 1
Cognitive Level: Apply
Client Needs: Health Promotion and Maintenance
Integrated Process: Nursing Process
Reference: 5, Health Assessment

2. Before beginning a health assessment with a client, the nurse reviews Healthy People 2030 because of which of the following reasons.

A. It helps determine the client's plan of care.
B. It serves as a guide for the health assessment.
C. It identifies heath indicators, appropriate interventions, and resources.
D. It addresses most client health problems.

Answer: C

Rationale: Healthy People 2030 is a framework that identifies heath indicators, appropriate interventions, and resources in the United States. The goals and objectives serve to improve the health of individuals and communities, targeting the next 10 years. Its overall goal is to increase quality of life by creating guidelines for a healthy lifestyle as well as educating people and cultivating an awareness that will assist in the elimination of health disparities. Healthy People 2030 does not help determine every client's plan of care. Healthy People 2030 does not serve as a guide for the health assessment nor does it list specific interventions to address specific health problems. Instead, Healthy People 2030 indicators pertinent to individuals are determined as the nurse completes the health assessment on each patient.
Question format: Multiple Choice
Chapter: 1
Cognitive Level: Analyze
Client Needs: Health Promotion and Maintenance
Integrated Process: Nursing Process
Reference: 7–8, Health Assessment

3. After completing a health history, the nurse determines that a client would benefit from interventions to address the Healthy People 2030 indicator associated with the prevalence and mortality of chronic disease. What assessment data would related to this indicator? Select all that apply.
A. Client’s body mass index suggests obesity.

B. Client has been prescribed medication for hypertension.
C. Client is currently without health insurance.
D. Client was diagnosed with heart disease three years ago.
E. Client had a skin cancer lesion removed surgically four years ago.

Answer: B, D, E

Rationale: The Healthy People 2030 indicator "prevalence and mortality of chronic disease" has the objectives of reducing coronary heart disease deaths, reducing the number of people with hypertension, and reducing the overall cancer death rate. Because the client has a history of hypertension, has been diagnosed with heart disease, and was previously treated for skin cancer, the indicator "prevalence and mortality of chronic disease" would be appropriate for this client. The Healthy People 2030 indicator of "healthy behaviors" would be applicable for the body mass index of being overweight. The Healthy People 2030 indicator of "access to health services" would be applicable for the client currently without health insurance.
Question format: Multiple Select
Chapter: 1
Cognitive Level: Analyze
Client Needs: Health Promotion and Maintenance
Integrated Process: Nursing Process
Reference: 7–8, Health Assessment

4. The nurse is following a structured head-to-toe approach to identify changes in a client's body systems. Which component of the health assessment is the nurse completing with the client?
A. Health history
B. Physical examination
C. Goal setting
D. Planning care

Answer: B

Rationale: In the physical examination, the nurse uses a structured head-to-toe approach to identify changes in the client's body systems. The health history is when the nurse asks pertinent questions to gather data from the client and/or family. Goal setting and planning care are not parts of the health assessment.
Question format: Multiple Choice
Chapter: 1
Cognitive Level: Understand
Client Needs: Health Promotion and Maintenance
Integrated Process: Nursing Process
Reference: 5, Health Assessment

5. The nurse is conducting a health assessment on a client presenting to the emergency room with a critical condition. The nurse should initially ask questions regarding which topic(s) during the initial assessment? Select all that apply.
A. medications
B. allergies
C. adverse reactions
D. lifestyle changes
E. stress at work

Answer: A, B, C

Rationale: The nurse should ask a client in critical condition brought into the emergency department about topics concerning the event, including medications, allergies, and adverse

reactions. When a client has a professional relationship with the nurse and has had a thorough health assessment at the initial meeting, the nurse may explore other assessment topics such as lifestyle changes and stress at work. The thorough health history would be completed when the patient was stable and able to answer further questions.
Question format: Multiple Select
Chapter: 1
Cognitive Level: Apply
Client Needs: Health Promotion and Maintenance
Integrated Process: Nursing Process
Reference: 6, Health Assessment

6. What will be the nurse's initial role when conducting a health assessment with a client reporting abdominal pain?
A. Teaching the client to draw knees to chest to help minimize the pain
B. Planning care to help minimize the client's pain
C. Collecting data regarding the nature of the pain
D. Identifying pain management interventions with input from the client

Answer: C

Rationale: The nurse's initial role in health assessment is to collect data. Teaching would occur later in the process. Planning care and identifying interventions are parts of the nursing process and not the health assessment.
Question format: Multiple Choice
Chapter: 1
Cognitive Level: Apply
Client Needs: Physiological Integrity: Basic Care and Comfort
Integrated Process: Nursing Process
Reference: 8, Role of the Nurse in Assessment

7. As the nurse assesses vital signs, he notices the client is shaking. The nurse notes a change in the client's tone and in a loud voice the hospitalized client insists, "You're not my wife. How did you get into my house?" Based upon the client's behavior, which assessment will the nurse now focus upon?
A. Mental
B. Physical
C. Spiritual
D. Interpersonal

Answer: A

Rationale: The client is demonstrating confusion related to time and place. A change in level of consciousness or confusion would be categorized as an alteration in the client's mental status and would require further assessment. Such confusion would not be categorized as being a physical, spiritual, or interpersonal change in the client's health status.
Question format: Multiple Choice
Chapter: 1
Cognitive Level: Apply
Client Needs: Psychosocial Integrity
Integrated Process: Nursing Process
Reference: 9, Role of the Nurse in Assessment

8. During an adult client’s follow-up visit, the client asks the nurse about the overall goal of Healthy People 2030. What should the nurse include in the response? Select all that apply.
A. Improve the health of individuals and communities.
B. Increase quality of life.
C. Create guidelines for healthy lifestyle.

D. Eliminate national health disparities.
E. Establish requirements for nursing assessment.

Answer: A, B, C, D

Rationale: The overall goal of Healthy People 2030 includes improving the health of individuals and communities, increasing quality of life, creating guidelines for healthy lifestyle, and eliminating national health disparities. The nurse should include these topics in the response. Healthy People 2030 does not establish requirements for nursing assessment.
Question format: Multiple Choice
Chapter: 1
Cognitive Level: Remember
Client Needs: Health Promotion and Maintenance
Integrated Process: Teaching/Learning
Reference: 6–7, Health Assessment

9. When doing an overall assessment of a client, the nurse is able to use findings for which primary purpose?
A. Identify conditions that the health care provider may have missed.
B. Identify in what areas the client can educate the family.
C. Identify in what areas the client needs the most care.
D. Identify the client's medical diagnosis.

Answer: C

Rationale: During the overall assessment of the client, the nurse is able to use the findings and decide in which areas the client is in need of the most care. The nurse should not identify conditions that the health care provider may have missed or identify the client’s medical diagnosis, as making medical diagnoses are not within the nursing scope of practice. The nurse may provide education to the client’s family throughout the client’s care; however, the nurse should not delegate education of the family to the client, because this is the nurse’s responsibility.
Question format: Multiple Choice
Chapter: 1
Cognitive Level: Apply
Client Needs: Health Promotion and Maintenance
Integrated Process: Nursing Process
Reference: 5, Health Assessment

10. During a health assessment, the client identifies having a 1 pack per day smoking habit. What should the nurse initially focus upon when approaching the client about the benefits of smoking cessation?
A. Determining whether the client wants to stop smoking
B. Educating the client on the detrimental effects smoking has on the entire body.
C. Identifying smoking as a modifiable risk factor for the client.
D. Sharing with the client that there are various smoking cessation methods available.

Answer: A

Rationale: Smoking cessation requires a dramatic change in behavior. The client must be truly motivated in order for such a change to occur. The nurse should initially discuss with the client if smoking cessation is a goal that the client may have. If the client is interested in no longer smoking, the remaining options are less relevant. Explaining the detrimental effects of smoking, identifying smoking as a modifiable risk factor and educating the client to the various smoking cessation methods are beneficial when discussing the situation with a client who has not yet made the decision to stop smoking.
Question format: Multiple Choice

Chapter: 1
Cognitive Level: Analyze
Client Needs: Health Promotion and Maintenance
Integrated Process: Nursing Process
Reference: 7, Role of the Nurse in Assessment

11. Which statement by the new nurse demonstrates an understanding of the nurse's responsibility to conduct an effective health assessment of the client?
A. "A health assessment requires both a client history as well as a physical examination."
B. "I always allow sufficient time to conduct the history portion of the assessment effectively."
C. "I am always trying to improve my assessment skills."
D. "The health assessment is the foundation of quality client care."

Answer: C

Rationale: Health assessment is an integral part of nursing practice, and the need for effective nursing assessment techniques is essential since the resulting information shapes the plan of care in order to optimize each individual's health status throughout the lifespan. Allowing sufficient time to conduct the various parts of the health assessment would be considered an assessment skill. The remaining options focus on the description of what a health assessment is rather than on the nursing responsibility to the assessment.
Question format: Multiple Choice
Chapter: 1
Cognitive Level: Analyze
Client Needs: Physiological Integrity: Reduction of Risk Potential
Integrated Process: Nursing Process
Reference: 6, Health Assessment

12. The nurse is performing a health assessment with a client who presented to the emergency department after falling as a result of feeling dizzy. Which questions demonstrates that the nurse understands the initial purpose of effectively conducting a health assessment? Select all that apply.
A. "Are you experiencing any pain at this time?"
B. "Are you feeling dizzy now?"
C. "Do you know what may have caused you to fall?"
D. "Do you know what your blood pressure is usually?"
E. "What do you think will help you from falling again?"

Answer: A, B, D

Rationale: The initial purpose of the nursing health assessment is to determine a client's health status, risk factors, and need for education as a basis for developing an immediate nursing plan of care. Identifying the presence of pain, dizziness, and baseline blood pressure are all relevant health assessment data. Knowing the cause of the dizziness and/or resulting fall and identifying factors to help prevent injury in the future are information that will help direct the future plan of care to help assure client safety.
Question format: Multiple Select
Chapter: 1
Cognitive Level: Analyze
Client Needs: Physiological Integrity: Reduction of Risk Potential
Integrated Process: Nursing Process
Reference: 5, Health Assessment

13. During a health assessment, a client shares, "I get a little dizzy when I get up from my chair too quickly." Which question will the nurse ask the client **first** when attempting to identify client needs and potential health risks?

A. "What do you mean by 'a little dizzy'?"
B. "Do you often feel dizzy?"
C. "Have you ever been dizzy enough to fall?"
D. Can you remember when you first started to feel dizzy?"

Answer: A

Rationale: Listening and understanding a client is key to discovering a client's needs. As more details are acquired and collated, actual health risks emerge. The nurse should first clarify what the client means by the statement. If is only then that the nurse can determine is a health risk exists. While knowing the details of when the symptom started, how often it occurs, and if falling has occurred is important, clarification of what the client means is the initial focus of the nurse.
Question format: Multiple Choice
Chapter: 1
Cognitive Level: Analyze
Client Needs: Physiological Integrity: Reduction of Risk Potential
Integrated Process: Nursing Process
Reference: 6, Health Assessment

14. A client is being admitted to the medical unit after being seen in the emergency department. Which statement by the nurse indicates an understanding of the importance of the appropriate timing of a health assessment?
A. "The client has been ordered a nutritional consult; I do the health assessment right after that is finished."
B. "I'll do the health assessment when the client's family leaves so that distractions will be minimal."
C. "I'm going to assess the client now so that I can begin formulating the care plan."
D. "The health assessment will be more thorough if I wait until the client is pain free."

Answer: C

Rationale: Each person needs a complete health assessment. Ideally this is done on admission, but extenuating circumstances may prohibit its completion in detail at this time. The sooner the health assessment is completed fully, the better the nurse knows the client, and more holistic care can be provided to ensure health promotion and quality of life. The assessment should not be postponed until after the consult. The family should be informed of the need for the assessment and asked to leave until it is completed, unless their input with the history is needed. While pain may complicate the assessment process, it is not advisable to wait until the client is pain free to complete the assessment.
Question format: Multiple Choice
Chapter: 1
Cognitive Level: Analyze
Client Needs: Safe, Effective Care Environment: Management of Care
Integrated Process: Nursing Process
Reference: 6, Health Assessment

15. A client admitted with reports of nausea and vomiting has not reported any vomiting in the last 6 hours. What initial response should the nurse have regarding this assessment information and its effect on the client's nursing plan of care?
A. Request that the health care team revise the plan of care.
B. Notify the primary health care provider of the change in the client's health status.
C. Recognize the need to reevaluate the client's plan of care.
D. Monitor the client frequently for other changes in health status.

Answer: C

Rationale: The health assessment allows data to be collected that is specific to the client and his or her nursing care needs. Initially, the nurse must be aware that any change to the client's health status may require an change to this plan of care. If changes are required, the health care team will be asked to consider and recommend them. Monitoring the client for changes is always considered a nursing responsibility. Notifying the primary health care provider is not directly related to the nursing plan of care.
Question format: Multiple Choice
Chapter: 1
Cognitive Level: Analyze
Client Needs: Safe, Effective Care Environment: Management of Care
Integrated Process: Nursing Process
Reference: 10, Role of the Nurse in Assessment

16. The nurse recognizes the goals and objectives of the Healthy People 2030 guidelines when creating a plan of care that addresses which client-centered goals? Select all that apply.
A. living a healthy lifestyle
B. disease prevention
C. improving one's quality of life
D. providing affordable health care services
E. increasing the longevity of one's life

Answer: A, B, C, E

Rationale: The goals and objectives of Healthy People 2030 include promoting a healthy lifestyle, disease prevention, improved quality of life, and length of a person's life. Although important to the general wellness achieved by any individual, health care costs are not addressed by the Healthy People 2030 guidelines.
Question format: Multiple Select
Chapter: 1
Cognitive Level: Apply
Client Needs: Health Promotion and Maintenance
Integrated Process: Nursing Process
Reference: 6–7, Health Assessment

17. Consider the nurse's role in the health assessment of a client. What action will the nurse perform initially when admitting a client to a long-term care facility?
A. collecting information regarding the client's health status
B. stabilizing the client's physical condition
C. developing an effective, respectful nurse–client relationship
D. creating an environment that encourages client autonomy

Answer: A

Rationale: Regardless of the care setting, the nurse's initial role in health assessment is to collect data. While all the remaining options are relevant to quality client care, they are not associated directly with the nurse's role concerning health assessment.
Question format: Multiple Choice
Chapter: 1
Cognitive Level: Apply
Client Needs: Safe, Effective Care Environment: Management of Care
Integrated Process: Nursing Process
Reference: 8, Role of the Nurse in Assessment

18. The nurse has completed a health assessment on an older adult client being seen at a neighborhood clinic. What client-specific information should the nurse identify as being a **priority**?
A. lives alone

B. significantly impaired hearing
C. widowed 2 years ago
D. greatly concerned about cost of services

Answer: B

Rationale: As a nurse, it is vital to sift through all the client information and make decisions on what information will impact client safety and quality of care. The ability to identify what is important on a daily basis for each individual client is paramount for nursing care. Of the data provided, the client's impaired hearing poses the greatest safety risk and has the greatest impact on the client's quality of life and so has priority. While the other options could be potential factors related to quality of life and safety, the nurse will need to assess them further.
Question format: Multiple Choice
Chapter: 1
Cognitive Level: Analyze
Client Needs: Safe, Effective Care Environment: Management of Care
Integrated Process: Nursing Process
Reference: 8, Role of the Nurse in Assessment

19. Data being collected during a health assessment causes the nurse to believe there may be additional issues that are possibly affecting the client's health and wellness. What action should the nurse take to **best** address the suggestion of additional health concerns?
A. Concentrate first on planning care for the problem identified initially by the client.
B. Extend the time originally allotted for the completion of the initial health assessment.
C. Plan to reassess the client with the focus on the possible additional health issues.
D. Interview the family about the existence of additional health-related issues when they visit.

Answer: B

Rationale: When the assessment uncovers possible additional health issues, the nurse should allot additional time to sufficiently gather the necessary related data. The additional information is critical to the creation of an effective plan of care. The most effective time to gather the information is during the assessment that is currently being performed. While the family may be able to contribute relevant information, the primary source of information should be the client unless there are extenuating circumstances that make that difficult.
Question format: Multiple Choice
Chapter: 1
Cognitive Level: Apply
Client Needs: Health Promotion and Maintenance
Integrated Process: Nursing Process
Reference: 6, Health Assessment

20. When the client begins to cry, the nurse recognizes the need to focus the assessment on the client's emotional health. What factor will have the **greatest** effect on the nurse's ability to gather information concerning why the client is crying?
A. the client's ability to communicate verbally
B. the nurse's ability to ask relevant questions
C. the type and degree of physical issues the client is experiencing
D. the rapport that exists between the nurse and the client

Answer: D

Rationale: The amount of success that nurse has in discovering the reason behind the client's crying is heavily dependent upon the relationship (rapport) that exists between the nurse and