Chapter 3. Nursing Process: Assessment

Multiple Choice
Identify the choice that best completes the statement or answers the question.

____ 1. What is the role of the Joint Commission in regard to patient assessment?
The Joint Commission
1)
States what assessments are collected by individuals with different credentials
2)
Regulates the time frames for when assessments should be completed
3)
Identifies how data are to be collected and documented
4)
Sets standards for what and when to assess the patient

ANS: 4
The Joint Commission sets detailed standards regarding what and when to assess but does not address credentials. Nurse practice acts specify what data are collected and by whom. Agency policy may set time frames for when assessments should be done and how they should be documented. Nursing knowledge identifies "how" data are to be collected.

PTS: 1 DIF: Moderate REF: p. 39
KEY: Nursing process: Assessment | Client need: SECE | Cognitive level: Recall

____ 2. Which of the following is an example of data that should be validated?
1)
The client's weight measures 185 lb at the clinic.
2)
The client's liver function test results are elevated.
3)
The client's blood pressure is 160/94 mm Hg; he states that that is typical for him.
4)
The client states she eats a low-sodium diet and reports eating processed food.

ANS: 4
Validation should be done when the client's statements are inconsistent (processed foods are generally high in sodium). Validation is not necessary for laboratory data when you suspect an error has been made in the results. Personal information that patients might be embarrassed about, such as weight, is best validated with a scale.

PTS: 1 DIF: Moderate REF: p. 47
KEY: Nursing process: Assessment | Client need: PHSI | Cognitive level: Application

____ 3. Which of the following examples includes both objective and subjective data?
1)
The client's blood pressure is 132/68 and her heart rate is 88.
2)
The client's cholesterol is elevated, and he states he likes fried food.
3)
The client states she has trouble sleeping and that she drinks coffee in the evening.
4)
The client states he gets frequent headaches and that he takes aspirin for the pain.

ANS: 2
Elevated cholesterol is objective, and "states he likes fried food" is subjective. Objective data can be observed by someone other than the patient (e.g., from physical assessments or lab and diagnostic tests). Subjective data are information given by the client. Blood pressure and heart rate measurements are both objective. "States . . . trouble sleeping and . . . drinks coffee . . ." are both subjective. States ". . . frequent headaches and . . . takes aspirin . . ." are both subjective.

PTS: 1 DIF: Moderate REF: pp. 40
KEY: Nursing process: Assessment | Client need: PHSI | Cognitive level: Analysis

____ 4. The Joint Commission requires which type of assessment to be performed on all patients?
1)
Functional ability
2)
Pain
3)
Cultural
4)
Wellness

ANS: 2
The Joint Commission requires that pain and nutrition assessment be performed on all patients. Other special needs assessments should be performed when cues indicate there are risk factors.

PTS: 1 DIF: Moderate REF: p. 39
KEY: Nursing process: Assessment | Client need: PHSI | Cognitive level: Analysis

____ 5. Which of the following is an example of an ongoing assessment?
1)
Taking the patient's temperature 1 hour after giving acetaminophen (Tylenol)
2)
Examining the patient's mouth at the time she complains of a sore throat
3)
Requesting the patient to rate intensity on a pain scale with the first perception of pain
4)
Asking the patient in detail how he will return to his normal exercise activities

ANS: 1
An ongoing assessment occurs when a previously identified problem is being reassessed—for example, taking an hourly temperature when a patient has a fever. Examining the mouth is a focused assessment to explore the patient's complaint of sore throat. Asking for a pain rating is a focused assessment at the first complaint of pain. A detailed interview about exercise is a special needs assessment; there is no way to know if it is initial or ongoing.

PTS: 1 DIF: Moderate REF: p. 41
KEY: Nursing process: Assessment | Client need: PHSI | Cognitive level: Application

____ 6. When should the nurse make systematic observations about a patient?
1)
When the patient has specific complaints
2)
With the first assessment of the shift
3)
Each time the nurse gives medications to the patient
4)
Each time the nurse interacts with the patient

ANS: 4
The nurse should make observations about the patient each time she enters the room or interacts with the patient to gain ongoing data about the patient.

PTS: 1 DIF: Easy REF: p. 41-42
KEY: Nursing process: Assessment | Client need: SECE | Cognitive level: Application

____ 7. Which of the following is an example of an open-ended question?
1)

Have you had surgery before?
2)
When was your last menstrual period?
3)
What happens when you have a headache?
4)
Do you have a family history of heart disease?

ANS: 3
Open-ended questions such as "What happens when you have a headache?" are broad so as to encourage the patient to elaborate. The questions about surgery, menstrual period, and family history can all be answered with a "yes," "no," or short, specific answer (a date).

PTS: 1 DIF: Moderate REF: pp. 45
KEY: Nursing process: Assessment | Client need: SECE | Cognitive level: Application

____ 8. Of the following recommended interviewing techniques, which one is the *most* basic? (That is, without that intervention, the others will all be less effective.)
1)
Beginning with neutral topics
2)
Individualizing your approach
3)
Minimizing note taking
4)
Using active listening

ANS: 4
All are important techniques, but active listening focuses the attention on the patient and lets her know you are trying to understand her needs. The interviewer is more likely to get the patient to open up. Patients will forgive you for most errors in technique, but if they think you are not listening, that can negatively affect your relationship.

PTS: 1 DIF: Difficult REF: 47
KEY: Nursing process: Assessment | Client need: PHSI | Cognitive level: Application

____ 9. Which of the following is an example of the most basic motivation in Maslow's hierarchy of needs?
1)
Experiencing loving relationships
2)

Having adequate housing
3)
Receiving education
4)
Living in a crime-free neighborhood

ANS: 2
The most basic needs are centered on physiological survival—shelter (housing), food, and water. All other options are for higher needs. The order from most basic to highest level is physiologic, safety and security, love and belonging, esteem, and self-actualization. Loving relationships fall under the love and belonging category. Education is a form of self-actualization. Living in a crime-free neighborhood meets the need for safety and security.

PTS: 1 DIF: Moderate REF: p. 48
KEY: Nursing process: Assessment | Client need: PHSI | Cognitive level: Application

____ 10. What makes a nursing history different from a medical history?
1)
A nursing history focuses on the patient's responses to the health problem.
2)
The same information is gathered; the difference is in who obtains the information.
3)
A nursing history is gathered using a specific format.
4)
A medical history collects more in-depth information.

ANS: 1
A medical history focuses on the patient's current and past medical/surgical problems. A nursing history focuses on the patient's responses to and perception of the illness/injury or health problem, his coping ability, and resources and support. Nursing history formats vary depending on the patient, the agency, and the patient's needs. Both nursing and medical histories typically use a specific format. A medical history does not necessarily contain more in-depth information. A nursing history can be in-depth, covering a wide range of topics, including biographical data, reason(s) patient is seeking healthcare, history of present illness, patient's perception of health status and expectations for care, past medical history, use of complementary modalities, and review of functional ability associated with activities of daily living. Other topics might deal with nutrition, psychosocial needs, pain assessment, or other special needs topics.

PTS: 1 DIF: Moderate REF: pp. 44-45
KEY: Nursing process: Assessment | Client need: SECE | Cognitive level: Comprehension

____ 11. Why is it important to obtain information about nutritional and herbal supplements as well as about complementary and alternative therapies?
1)
To determine what type of therapies are acceptable to the client
2)
To identify whether the client has a nutrition deficiency
3)
To help you to understand cultural and spiritual beliefs
4)
To identify potential interaction with prescribed medication and therapies

ANS: 4
Herbs and nutritional supplements can interact with prescription medications, and complementary and alternative treatments can interfere with conventional therapies. Physical assessment and laboratory tests are needed to assess a nutritional deficiency. To identify cultural and spiritual beliefs and well as what therapies are acceptable to the client, you need more than just information about nutritional and herbal supplements.

PTS: 1 DIF: Difficult REF: p. 45
KEY: Nursing process: Assessment | Client need: HPM | Cognitive level: Application

____ 12. What do the nursing assessment models have in common?
1)
They assess and cluster data into model categories.
2)
They organize assessment data according to body systems.
3)
They specify use of the nursing process to collect data.
4)
They are based on the ANA Standards of Care.

ANS: 1
All the models categorize or cluster data into functional health patterns, domains, or categories. None of the assessment models clusters data according to body system. Assessment is the first step of the nursing process; the nurse does not use the entire nursing process in data collection. The ANA Standards of Care describe a competent level of clinical nursing practice based on the nursing process; nursing models are not based on the ANA Standards of Care.

PTS: 1 DIF: Difficult REF: pp. 48
KEY: Nursing process: Assessment | Client need: SACE | Cognitive level: Analysis

____ 13. Nondirective interviewing is a useful technique because it
1)
Allows the nurse to have control of the interview
2)
Is an efficient way to interview a patient
3)
Facilitates open communication
4)
Helps focus patients who are anxious

ANS: 3
Nondirective interviewing helps build rapport and facilitates open communication. Because it puts the patient in control, it can be very time-consuming (inefficient) and produce information that is not relevant. Directive interviewing should be used to focus anxious patients.

PTS: 1 DIF: Easy REF: p. 45
KEY: Nursing process: Assessment | Client need: PSI | Cognitive level: Recall

____ 14. A nursing instructor is guiding nursing students on best practices for interviewing patients. Which of the following comments by a student would indicate the need for further instruction?
1)
"My patient is a young adult, so I plan to talk to her without her parents in the room."
2)
"Because my patient is old enough to be my grandfather, I will call him 'Mr.'"
3)
"When reading my patient's health record, I thought of a few questions to ask."
4)
"When I give my patient his pain medication, I will have time to ask questions."

ANS: 4
A patient should be comfortable when interviewing. The pain medication should have time to work before considering interviewing the patient, so asking questions when giving the medication is not a good idea. It is appropriate to interview patients without family/friends around. In nearly every culture, calling a patient Mr. or Mrs. shows respect and is therefore correct. Reading the patient's health record is appropriate preparation for an interview.

PTS: 1 DIF: Moderate REF: p. 46
KEY: Nursing process: Evaluation | Client need: SECE | Cognitive level: Application

____ 15. A patient comes to the urgent care clinic because he stepped on a rusty nail. What type of assessment would the nurse perform?
1)
Comprehensive
2)
Ongoing
3)
Initial focused
4)
Special needs

ANS: 3
An initial focused assessment is performed during a first exam for specific abnormal findings. A comprehensive assessment is holistic and is usually done upon admission to a healthcare facility. An ongoing assessment follows up after an initial database is completed or a problem is identified. A special needs assessment is performed when there are cues that more in-depth assessment is needed.

PTS: 1 DIF: Moderate REF: pp. 42–43
KEY: Nursing process: Assessment | Client need: PHSI | Cognitive level: Application

____ 16. A patient has left-sided weakness because of a recent stroke. Which type of special needs assessment would it be most important to perform?
1)
Family
2)
Functional
3)
Community
4)
Psychosocial

ANS: 2
A functional assessment is most important because of discharge needs (e.g., self-care ability at home) and patient safety. A family and community assessment would be helpful to evaluate support systems, and a psychosocial assessment would be helpful to evaluate a patient's understanding of and coping with his recent stroke. Remember that special needs assessments are lengthy and time-consuming, so they should be used only when in-depth information is needed about a topic.

PTS: 1 DIF: Moderate REF: pp. 43
KEY: Nursing process: Assessment | Client need: SECE | Cognitive level: Analysis

____ 17. The nurse is interviewing a patient who has a recent onset of migraine headaches. The patient is highly anxious and cannot seem to focus on what the nurse is saying. Which of the following questions would be best for the nurse to use to *begin* gathering data about the headaches?
1)
"When did your migraines begin?"
2)
"Tell me about your family history of migraines."
3)
"What are the types of things that trigger your headaches?"
4)
"Describe what your headaches feel like."

ANS: 1
For someone who is anxious, it is best to use closed questions. (When did your migraines begin?) A closed question can be answered in one or very few words and has a very specific answer. The other questions are open-ended questions.

PTS: 1 DIF: Moderate REF: p. 45
KEY: Nursing process: Assessment | Client need: PSI | Cognitive level: Application

____ 18. Which of the following is an example of an active listening behavior?
1)
Taking frequent notes
2)
Asking for more details
3)
Leaning toward the patient
4)
Sitting with legs crossed

ANS: 3
Active listening behaviors include leaning toward the patient; facing the patient; open, relaxed posture without crossing arms or legs; and maintaining eye contact. Taking frequent notes makes it difficult to keep eye contact. Asking for more details may seem like idle curiosity. Sitting with legs crossed may indicate to the patient that you are not open to her.

PTS: 1 DIF: Easy REF: p. 47
KEY: Nursing process: Assessment | Client need: SECE | Cognitive level: Comprehension

____ 19. A nursing instructor asked his nursing students to discuss their experiences with charting assessment data. Which comment by the student indicates the need for further teaching?
1)
"I find it difficult to avoid using phrases like, 'The patient tolerated the procedure well.'"
2)
"It's confusing to have to remember which abbreviations this hospital allows."
3)
"I need to work on charting assessments and interventions right after they are done."
4)
"My patient was really quiet and didn't say much, so I charted that he acted depressed."

ANS: 4
When charting data, chart only what was observed, not what it meant. Inferences should not be made about a patient's behavior during data collection ("he acted depressed"); so that response reflects the student's lack of knowledge and need for teaching. Chart specific data, not vague phrases; the student is acknowledging the importance of this. There are no universally accepted phrases, just agency-approved abbreviations; the student is acknowledging the need to use agency-approved abbreviations. The student is correct that charting should be completed as soon after data collection as possible.

PTS: 1 DIF: Moderate REF: p. 50
KEY: Nursing process: Evaluation | Client need: SECE | Cognitive level: Application

____ 20. For which of the following purposes is a graphic flow sheet superior to other methods of recording data?
1)
Easy documentation of routine vital signs
2)
Seeing the patterns of a patient's fever
3)
Describing the symptoms accompanying a rising temperature
4)
Checking to make sure vital signs were taken

ANS: 2
All are benefits of the graphic flow sheet, but to easily and graphically see trends over time, the graphic flow sheet is superior to other methods of documentation. For the other options, other kinds of flow sheets would be equally effective.

PTS: 1 DIF: Moderate REF: p. 50

KEY: Nursing process: N/A | Client need: SECE | Cognitive level: Analysis

____ 21. The most obvious reason for using a framework when assessing a patient is to
1)
Prioritize assessment data
2)
Organize and cluster data
3)
Separate subjective and objective data
4)
Identify primary from secondary data

ANS: 2
A framework is used to organize and cluster data to find patterns. During the assessment phase, the nurse is collecting and recording data, not prioritizing the data. A framework includes subjective and objective data as well as primary and secondary data; it does not help you to separate them.

PTS: 1 DIF: Easy REF: p. 48
KEY: Nursing process: Assessment | Client need: SECE | Cognitive level: Recall

____ 22. Which situation is the most conducive to conducting a successful interview of an elderly woman whose husband and two children are in the hospital room visiting and watching television? The woman is alert and oriented.
1)
Provide enough chairs so the family and you are able to sit facing the client.
2)
Introduce yourself and ask, “Dear, what name do you prefer to go by?” before asking any questions.
3)
After the family leaves, ask the client if she is comfortable and willing to answer a few questions.
4)
Ask the client if you can talk with her while her family is watching the television.

ANS: 3
The interview should be done when the client is comfortable and there are no distractions. Endearing terms are inappropriate unless the client prefers them. Family members may offer information that may or may not be pertinent and may distract from the interview. The presence of family members may also inhibit full disclosure of information by the client.

PTS: 1 DIF: Difficult REF: p. 46-47
KEY: Nursing process: Assessment | Client need: PSI | Cognitive level: Application

Multiple Response
Identify one or more choices that best complete the statement or answer the question.

____ 23. Which of the following questions would be effective for obtaining information from a patient? Choose all that apply.
1)
"How did this happen to you?"
2)
"What was your first symptom?"
3)
"Why didn't you seek healthcare earlier?"
4)
"When did you start having symptoms?"

ANS: 1, 2, 4
How, what, and when are acceptable lines of questioning. Asking "why" can put the patient on the defensive and may suggest disapproval, limiting the amount of information the patient is willing give.

PTS: 1 DIF: Moderate REF: p. 45-46
KEY: Nursing process: Assessment | Client need: SECE | Cognitive level: Application

____ 24. A nurse with a large caseload of patients needs to delegate some assessment tasks to other members of the health team. The nurse is unsure which tasks can be delegated to nursing assistive personnel (NAP) and which are appropriate for a licensed practical nurse (LPN) or a registered nurse (RN). To which sources should the nurse turn for the answer to his question? Choose all that are appropriate.
1)
The nurse practice act of his state
2)
The American Medical Association guidelines
3)
The *Code of Ethics for Nurses*
4)
The American Nurses Association's *Scope and Standards of Practice*

ANS: 1, 4
State nurse practice acts specify which portions of the assessment can legally be completed by individuals with different credentials. The ANA *Scope and Standards of*

Practice provide a guide for who is ultimately responsible and qualified to collect assessment data. The American Medical Association provides guidelines and standards for physicians, not nurses. The *Code of Ethics for Nurses* says merely that the nurse should delegate tasks appropriately; it does not speak to credentials of personnel.

PTS: 1 DIF: Moderate REF: p. 40
KEY: Nursing process: Assessment | Client need: SECE | Cognitive level: Comprehension

____ 25. Which of the following are cues rather than inferences? Choose all correct answers.
1)
Ate 50% of his meal
2)
Patient feels better today
3)
States, "I slept well"
4)
White blood cell count 15,000/mm^3

ANS: 1, 3, 4
Cues are what the client says and what you observe. "Just the facts." The only inference in the list is "slept well." What did the nurse observe to tell her the client slept well? Those would be cues. If the client states, "I slept well" it is a cue, because it is a fact—that is what the client stated.

PTS: 1 DIF: Easy REF: p. 50
KEY: Nursing process: Assessment | Client need: SECE | Cognitive level: Comprehension

Matching

26. Match the assessment technique to the data that should be collected. There may be more than one technique used to collect the data.
1)
Auscultation
2)
Inspection
3)
Palpation
4)
Percussion

____ 1. Skin pink, warm, and dry

____ 2. Lung sounds clear

____ 3. Abdomen is tympanic

____ 4. Abdomen soft and nontender

1. ANS: 2 PTS: 1 DIF: Moderate REF: p. 42
KEY: Nursing process: Assessment | Client need: PHSI | Cognitive level: Application

2. ANS: 1 PTS: 1 DIF: Moderate REF: p. 42
KEY: Nursing process: Assessment | Client need: PHSI | Cognitive level: Application

3. ANS: 4 PTS: 1 DIF: Moderate REF: p. 42
KEY: Nursing process: Assessment | Client need: PHSI | Cognitive level: Application

4. ANS: 3 PTS: 1 DIF: Moderate REF: p. 42
KEY: Nursing process: Assessment | Client need: PHSI | Cognitive level: Application

27. Match the type of special needs assessment with the correct example.
1)
Do you perform monthly breast self-exams?
2)
Do you live near any industrial manufacturing plants?
3)
Who can you talk to when you feel sad?
4)
Who do you live with?
5)
What is your understanding of your diet?
6)
Since you had your stroke, have you had any problems dressing yourself?
7)
Do you have a religious preference?

____ 5. Community

____ 6. Family

____ 7. Functional ability

____ 8. Nutrition

____ 9. Psychosocial

____ 10. Wellness

____ 11. Spiritual

5. ANS: 2 PTS: 1 DIF: Easy REF: pp. 43–44
KEY: Nursing process: Assessment | Client need: SECE | Cognitive level: Application

6. ANS: 4 PTS: 1 DIF: Easy REF: pp. 43–44
KEY: Nursing process: Assessment | Client need: SECE | Cognitive level: Application

7. ANS: 6 PTS: 1 DIF: Easy REF: pp. 43–44
KEY: Nursing process: Assessment | Client need: SECE | Cognitive level: Application

8. ANS: 5 PTS: 1 DIF: Easy REF: pp. 43–44
KEY: Nursing process: Assessment | Client need: SECE | Cognitive level: Application

9. ANS: 3 PTS: 1 DIF: Easy REF: pp. 43–44
KEY: Nursing process: Assessment | Client need: SECE | Cognitive level: Application

10. ANS: 1 PTS: 1 DIF: Easy REF: pp. 43–44
KEY: Nursing process: Assessment | Client need: SECE | Cognitive level: Application

11. ANS: 7 PTS: 1 DIF: Moderate REF: pp. 43-44
KEY: Nursing process: Assessment | Client need: SECE | Cognitive level: Recall

28. Match the assessment model with the intended use for that model.
1)
Categorizes nursing diagnoses, client outcomes, and nursing interventions
2)
Assesses the client's ability to achieve balance (homeostasis)
3)
Identifies deficits in activities of daily living that require nursing assistance
4)
Formulates a model for nursing assessment and diagnosis but is not a theory
5)
Categorizes nursing diagnoses

____ 12. Gordon's Functional Health Patterns

____ 13. NANDA Nursing Diagnosis Taxonomy II

____ 14. Taxonomy of Nursing Practice

____ 15. Roy's Adaptation model

____ 16. Orem's Self-Care model

12. ANS: 4 PTS: 1 DIF: Moderate REF: p. 49
KEY: Nursing process: Assessment | Client need: SECE | Cognitive level: Recall

13. ANS: 5 PTS: 1 DIF: Moderate REF: p. 49
KEY: Nursing process: Assessment | Client need: SECE | Cognitive level: Recall

14. ANS: 1 PTS: 1 DIF: Moderate REF: p. 49
KEY: Nursing process: Assessment | Client need: SECE | Cognitive level: Recall

15. ANS: 2 PTS: 1 DIF: Moderate REF: p. 49
KEY: Nursing process: Assessment | Client need: SECE | Cognitive level: Recall

16. ANS: 3 PTS: 1 DIF: Moderate REF: p. 49
KEY: Nursing process: Assessment | Client need: SECE | Cognitive level: Recall