Health and Physical Assessment in Nursing 4th edition Fenske Test Bank

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Health & Physical Assessment in Nursing, 4e **(Fenske/Watkins/Saunders/D'Amico/Barbarito)**
Chapter 1 Health Assessment

1) A client with a self-reported history of type 2 diabetes mellitus and an ulcer wound on the left foot states to the nurse, "I am healthy, I don't know why I have to be here to get a check-up." Which statement by the nurse is the most appropriate?

1. "I feel that you are in denial about your health status."
2. "Tell me about your definition of being healthy."
3. "Do you understand what diabetes is?"
4. "Is there anything else you are not telling me?"

Answer: 2
Explanation: 1. More information would be needed before the nurse could attribute the client's viewpoint as denial or lack of knowledge.
2. During the process of gathering the subjective data from the client, the nurse must be attuned to what the patient says, along with the signs, symptoms, behaviors, and cues offered by the patient. This situational awareness and focused data collection will enable the nurse to create a comprehensive database about the patient.
3. The client's history of type 2 diabetes requires further investigation but the nurse must first ascertain the client's definition of what healthy means.
4. There is not enough information to determine the client's withholding of information to the nurse.
Page Ref: 4
Cognitive Level: Analyzing
Client Need & Sub: Physiological Adaptation; Illness Management
Standards: QSEN Competencies: I.B.1. Elicit patient values, preferences, and expressed needs as part of clinical interview, implementation of care plan, and evaluation of care. | AACN Essentials Competencies: IX.1. Conduct comprehensive and focused physical, behavioral, psychological, spiritual, socioeconomic, and environmental assessments of health and illness parameters in patients, using developmentally and culturally appropriate approaches. | NLN Competencies: Context and Environment: Environmental health; health promotion/disease prevention (e.g., transmission of disease, disease patterns, epidemiological principles); chronic disease management; healthcare systems; transcultural approaches to health; and family dynamics. | Nursing/Integrated Concepts: Nursing Process: Assessment
Learning Outcome: 1.5: Apply the critical thinking process to health assessment in nursing.
MNL Learning Outcome: 1.2: Recognize the significance of evidence-based practice and its use in nursing.

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2) The nurse is preparing to provide teaching to a client at risk for diabetes. During which time should the nurse recognize is the most effective moment for teaching?

1. During health promotion.
2. When the client is ready to learn.
3. During the discussion of disease prevention.
4. When a knowledge deficit has been identified.

Answer: 2

Explanation: 1. Health promotion is important; however, if the client is not ready to learn new information, the teaching may be ineffective.
2. A client must be ready to learn new information or the teaching may be ineffective.
3. Disease prevention is important; however, if the client is not ready to learn new information, the teaching may be ineffective.
4. Once the knowledge deficit is identified, it is important that client is ready to learn or the teaching may be ineffective.

Page Ref: 2

Cognitive Level: Applying

Client Need & Sub: Health Promotion and Maintenance; Health Promotion/Disease Prevention

Standards: QSEN Competencies: III.B.3. Base individualized care plan on patient values, clinical expertise, and evidence. | AACN Essentials Competencies: IX.7. Provide appropriate patient teaching that reflects developmental stage, age, culture, spirituality, patient preferences, and health literacy considerations to foster patient engagement in their care. | NLN Competencies: Relationship Centered Care: Factors that contribute to or threaten health; communicate information effectively; and listen openly and cooperatively. | Nursing/Integrated Concepts: Nursing Process: Planning

Learning Outcome: 1.3: Explain the steps of the nursing process.

MNL Learning Outcome: 1.1: Distinguish between the various roles of the professional nurse in healthcare.

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3) The nurse is conducting a workshop on wellness and health promotion using the initiatives of Healthy People 2020. After the session, which statement by a participant indicates an understanding of the initiatives?

1. "It will allow healthcare providers to lobby legislators for more funding."
2. "The primary goal of *Healthy People 2020* is to assist healthcare providers in determining risk factors for premature birth."
3. "*Healthy People 2020* seeks to promote health, prevent illness, disability, and premature death."
4. "The initiatives will outline standards of care for providers in managing diseases."

Answer: 3

Explanation: 1. Healthcare providers and other persons interested in programs to promote health have found the document to be a useful source of information in their efforts to gain funding.
2. The *Healthy People 2020* initiative is a 10-year strategy intended to promote health, prevent illness, disability, and premature death. The document identifies leading health indicators that reflect public health concerns. Risk factors for premature birth may be part of those health indicators, but the scope of the document covers broad areas of concern.
3. The *Healthy People 2020* initiative is a 10-year strategy intended to promote health, prevent illness, disability, and premature death.
4. Standards of care in disease management is not a component of the document.

Page Ref: 7

Cognitive Level: Applying

Client Need & Sub: Health Promotion and Maintenance; Health Promotion/Disease Prevention

Standards: QSEN Competencies: I.A.1. Integrate understanding of multiple dimensions of patient centered care; patient/family/community preferences and values; coordination and integration of care; information, communication, and education; physical comfort and emotional support; involvement of family and friends; and transition and continuity. | AACN Essentials Competencies: IX.2. Recognize the relationship of genetics and genomics to health, prevention, screening, diagnostics, prognostics, selection of treatment, and monitoring of treatment effectiveness, using a constructed pedigree from collected family history information as well as standardized symbols and terminology. | NLN Competencies: Teamwork: Adapt communication to the team and situation to share information or solicit input and initiate requests for help when appropriate. | Nursing/Integrated Concepts: Nursing Process: Assessment

Learning Outcome: 1.6: Describe the concepts of health, wellness, and health disparities.

MNL Learning Outcome: 1.2: Recognize the significance of evidence-based practice and its use in nursing.

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4) The nurse is reviewing the advanced practice roles in nursing. Which role should the nurse recognize is most likely to provide indirect patient care?

1. Nurse Researcher.
2. Nurse Administrator.
3. Nurse Educator.
4. Nurse Anesthetist.

Answer: 2

Explanation: 1. A nurse researcher may provide direct care through their work in a clinic, hospital, or laboratory focusing on patient care outcomes, administering treatments for clinical trial, or collecting data to help understand population based outcomes.

2. The nurse administrator does not provide direct patient care but may be utilized for consultation. Other responsibilities vary and could include management of complex patient care areas, staffing, budgets, organizational and staff performance, and ensuring that the goals of the agency are being accomplished.

3. The nurse educator is responsible for didactic and clinical teaching, curriculum development, clinical placement, and evaluation of learning. Direct patient care occurs during clinical teaching.

4. The nurse anesthetist has direct patient care by providing a full range of anesthesia services.

Page Ref: 2

Cognitive Level: Applying

Client Need & Sub: Management of Care; Concepts of Management

Standards: QSEN Competencies: II.B.4. Function competently within own scope of practice as a member of the healthcare team. | AACN Essentials Competencies: VI.1. Compare/contrast the roles and perspectives of the nursing profession with other care professionals on the healthcare team (i.e. scope of discipline, education, and licensure requirements). | NLN Competencies: Teamwork: Clarify roles and integrate the contributions of others who play a role in helping the patient/family achieve health goals; function competently within one's own scope of practice as leader or member of the healthcare team; and manage delegation effectively. |

Nursing/Integrated Concepts: Nursing Process: Assessment

Learning Outcome: 1.1: Explain the roles of the professional nurse in healthcare.

MNL Learning Outcome: 1.1: Distinguish between the various roles of the professional nurse in healthcare.

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5) The nurse conducts a health history while admitting a client to the acute care facility. When collecting primary subjective data, which source should the nurse use?

1. The client's physical assessment.
2. The client's self-reports.
3. The client's healthcare provider.
4. The client's significant other.

Answer: 2

Explanation: 1. The physical assessment will be recorded as objective data.
2. Subjective data are gathered from the interview. The interview includes the health history and focused interview of the patient which is considered primary subjective data.
3. The client's healthcare provider and significant other may contribute in the data collection process. The information obtained from friends and family members is considered subjective. This source of information is termed secondary.
4. The client's significant other may contribute in the data collection process but that input is classified as secondary data.

Page Ref: 6

Cognitive Level: Applying

Client Need & Sub: Health Promotion and Maintenance; Health Promotion/Disease Prevention

Standards: QSEN Competencies: I.B.1. Elicit patient values, preferences and expressed needs as part of clinical interview, implementation of care plan, and evaluation of care. | AACN Essentials Competencies: IX.1. Conduct comprehensive and focused physical, behavioral, psychological, spiritual, socioeconomic, and environmental assessments of health and illness parameters in patients, using developmentally and culturally appropriate approaches. | NLN Competencies: Relationship Centered Care: Communicate effectively with all members of the healthcare team, including the patient and the patient's support network. | Nursing/Integrated Concepts: Nursing Process: Assessment

Learning Outcome: 1.2: Explain evidence-based practice and its significance in nursing.

MNL Learning Outcome: 1.3: Examine the steps of the nursing process and their association with critical thinking.

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6) The nurse is reviewing a client's medical records. Which should the nurse recognize as subjective data?

1. The client tells the nurse their abdomen hurts on the left side after eating.
2. The client's abdomen is tender on the left side during palpation.
3. The CAT scan reveals a large mass in the left lower quadrant of the abdomen.
4. The client's hemoglobin is 14.1 gm/dL.

Answer: 1

Explanation: 1. Subjective reports by the client are those feelings or symptoms that cannot be observed by others. The statement "My abdomen hurts," is subjective data.
2. Physical examination findings, radiographic findings, and laboratory analysis reports are objective data.
3. Physical examination findings, radiographic findings, and laboratory analysis reports are objective data.
4. Physical examination findings, radiographic findings, and laboratory analysis reports are objective data.

Page Ref: 6

Cognitive Level: Applying

Client Need & Sub: Health Promotion and Maintenance; Health Screening

Standards: QSEN Competencies: I.B.1. Elicit patient values, preferences, and expressed needs as part of clinical interview, implementation of care plan, and evaluation of care. | AACN Essentials Competencies: IX.1. Conduct comprehensive and focused physical, behavioral, psychological, spiritual, socioeconomic, and environmental assessments of health and illness parameters in patients, using developmentally and culturally appropriate approaches | NLN Competencies: Personal and Professional Development: Identify problems and contribute to assessment of outcome achievement. | Nursing/Integrated Concepts: Nursing Process: Assessment

Learning Outcome: 1.5: Apply the critical thinking process to health assessment in nursing.

MNL Learning Outcome: 1.4: Examine the components of health assessment.

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7) The nurse is reviewing a client's medical record. Which documented data should the nurse recognize is objective?

1. The client states, "fell and hurt myself."
2. The client states, "I am six years old."
3. "Six-year-old child observed holding a towel to her forehead."
4. "Client states that she was running and fell at the playground."

Answer: 3

Explanation: 1. Statements the client makes are subjective data.
2. Statements the client makes are subjective data.
3. Objective data are data that can be observed or measured by the nurse. The nurse can see the child holding the towel to her head.
4. Statements the client makes are subjective data.

Page Ref: 6

Cognitive Level: Applying

Client Need & Sub: Health Promotion and Maintenance; Health Screening

Standards: QSEN Competencies: I.B.1. Elicit patient values, preferences, and expressed needs as part of clinical interview, implementation of care plan, and evaluation of care. | AACN Essentials Competencies: IX.1. Conduct comprehensive and focused physical, behavioral, psychological, spiritual, socioeconomic, and environmental assessments of health and illness parameters in patients, using developmentally and culturally appropriate approaches. | NLN Competencies: Personal and Professional Development: Identify problems; Contribute to assessment of outcome achievement. | Nursing/Integrated Concepts: Nursing Process: Assessment

Learning Outcome: 1.5: Apply the critical thinking process to health assessment in nursing.

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8) The nurse is evaluating the plan of care and notes that none of the goals have been met for the client with impaired gas exchange. Which action should the nurse take?

1. Report the lack of achievement of the goals to the healthcare provider.
2. Review the data and modify the plan.
3. Reformulate the nursing diagnosis to a more realistic one.
4. Request a consult for the client to be seen by a pulmonologist.

Answer: 2

Explanation: 1. Reporting the lack of achievement of the goals to the healthcare provider is not appropriate, though reporting undesirable client physiologic responses may be.
2. The plan of care should be evaluated periodically at established time frames to determine achievement of the goals. If goals have not been achieved, revisions should be made which may include adding, changing, or discontinuing nursing diagnoses or nursing interventions.
3. Reformulating the nursing diagnosis to a more realistic one is not the best course of action, as the diagnosis established came from subjective and objective data specific to that diagnosis.
4. There is no data to support the need for additional medical consultations.

Page Ref: 5

Cognitive Level: Applying

Client Need & Sub: Physiological Integrity; Illness Management

Standards: QSEN Competencies: III.B.3. Base individualized care plan on patient values, clinical expertise, and evidence. | AACN Essentials Competencies: III.6. Integrate evidence, clinical judgment, interprofessional perspectives, and patient preferences in planning, implementing, and evaluating outcomes of care. | NLN Competencies: Personal and Professional Development: Identify problems and contribute to assessment of outcome achievement. | Nursing/Integrated Concepts: Nursing Process: Evaluation

Learning Outcome: 1.3: Explain the steps of the nursing process.

MNL Learning Outcome: 1.3: Examine the steps of the nursing process and their association with critical thinking.

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9) The preceptor has created a teaching plan about the concepts of health and wellness for a new nurse. Which statement by the nurse indicates an understanding of health?
1. "Health is the absence of illness, disease, and symptoms."
2. "Health is a state of well-being and when the client feels good."
3. "Health is the state when a person is viewed as a holistic being."
4. "Health is a state of complete physical, mental, and social well-being."
Answer: 4
Explanation: 1. Health extends beyond the absence of illness and disease.
2. Defining health as a state of well-being is limiting as it does not encompass all of the elements of an individual's being.
3. While health does require a holistic approach, this definition does not explore the context of health.
4. Health is a physical, psychosocial, and spiritual wellness.
Page Ref: 7
Cognitive Level: Applying
Client Need & Sub: Health Promotion and Maintenance; Health Screening
Standards: QSEN Competencies: III.B.3. Base individualized care plan on patient values, clinical expertise, and evidence. | AACN Essentials Competencies: VII.5; IX.7. Use evidence-based practices to guide health teaching, health counseling, screening, outreach, disease and outbreak investigation, and referral and follow-up throughout the lifespan. Provide appropriate patient teaching that reflects developmental stage, age, culture, spirituality, patient preferences, and health literacy considerations to foster patient engagement in their care. | NLN Competencies: Knowledge and Practice: Health promotion/disease prevention | Nursing/Integrated Concepts: Nursing Process: Evaluation
Learning Outcome: 1.5: Apply the critical thinking process to health assessment in nursing.
MNL Learning Outcome: 1.2: Recognize the significance of evidence-based practice and its use in nursing.

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10) The nurse is caring for a client who is recovering from abdominal surgery. Which goal should the nurse include in this client's plan of care?
1. The client will verbalize pain relief using an intensity rating in 1 hour.
2. The client will state that they feel fine in 1 hour.
3. The nurse will observe fewer signs of pain in the client's every 1 hour.
4. The nurse will re-evaluate the client's pain level every 1 hour.
Answer: 1
Explanation: 1. The goal s is directly related to the nursing diagnosis. Goals are stated in a positive fashion and have measurable criteria.
2. This statement is not related directly to the diagnosis and is not measurable.
3. A goal must be reflective of client activities. This is an incorrect answer because it reflects activities of the nurse and not the client.
4. A goal must be reflective of the client's activities. This is an incorrect answer because it reflects activities of the nurse and is not client directed. Although there is a time frame listed, it is not correct as it is related to nursing actions.
Page Ref: 5
Cognitive Level: Applying
Client Need & Sub: Physiological Integrity; Basic Care and Comfort
Standards: QSEN Competencies: I.A.3. Demonstrate comprehensive understanding of the concepts of pain and suffering, including physiologic models of pain and comfort. | AACN Essentials Competencies: III.6. Integrate evidence, clinical judgment, interprofessional perspectives, and patient preferences in planning, implementing, and evaluating outcomes of care. | NLN Competencies: Personal and Professional Development: Identify problems and contribute to assessment of outcome achievement. | Nursing/Integrated Concepts: Nursing Process: Planning
Learning Outcome: 1.3: Explain the steps of the nursing process.
MNL Learning Outcome: 1.2: Recognize the significance of evidence-based practice and its use in nursing.

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11) The nurse is developing the plan of care for a client who is recovering from abdominal surgery. Which intervention should the nurse implement to address this client's pain?
1. The healthcare provider will prescribe additional analgesics.
2. The client will have reduced pain after administration of analgesics.
3. The client will vocalize reduced levels of pain within 1 hour.
4. The client will be assisted with guided imagery to manage pain levels.
Answer: 4
Explanation: 1. The prescribing of additional analgesics does not determine the characteristics of the pain and does not provide for the assessment of subjective information.
2. This is a goal statement, not an intervention.
3. This is a goal statement, not an intervention.
4. Nursing interventions, such as assisting the client with guided imagery, are geared to assist in meeting client goals. The interventions are based upon nursing actions.
Page Ref: 5
Cognitive Level: Applying
Client Need & Sub: Physiological Integrity; Non-Pharmacological Comfort Interventions
Standards: QSEN Competencies: I.A.3. Demonstrate comprehensive understanding of the concepts of pain and suffering, including physiologic models of pain and comfort. | AACN Essentials Competencies: IX.1. Conduct comprehensive and focused physical, behavioral, psychological, spiritual, socioeconomic, and environmental assessments of health and illness parameters in patients, using developmentally and culturally appropriate approaches. | NLN Competencies: Personal and Professional Development: Identify problems and contribute to assessment of outcome achievement. | Nursing/Integrated Concepts: Nursing Process: Planning
Learning Outcome: 1.5: Apply the critical thinking process to health assessment in nursing.
MNL Learning Outcome: 1.2: Recognize the significance of evidence-based practice and its use in nursing.

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12) A new nurse asks the preceptor how the Healthy People 2020 goals can affect a hospitalized client. Which response by the educator is the most appropriate?
1. "*Healthy People 2020* is a tool for the healthcare providers to offer information to their clients."
2. "*Healthy People 2020* seeks to improve health and prevent illness, disability, and premature death."
3. "The purpose of *Healthy People 2020* is to reduce healthcare costs for hospitalized clients."
4. "*Healthy People 2020* is seen as a tool by hospitals to reduce length of stay."
Answer: 2
Explanation: 1. *Healthy People 2020* is a resource tool for all healthcare professionals but its purpose is not to provide patient education between the healthcare provider and client.
2. *Healthy People 2020* presents a 10-year strategy with objectives intended to enhance health and prevent illness, disability, and premature death.
3. Reduction of hospital costs is the not the primary purpose of *Healthy People 2020*.
4. Reduction of length of stay is the not the primary purpose of *Healthy People 2020*.
Page Ref: 7
Cognitive Level: Applying
Client Need & Sub: Health Promotion and Maintenance; Health Promotion/Disease Prevention
Standards: QSEN Competencies: II.B.11. Solicit input from other team members to improve individual, as well as team, performance. | AACN Essentials Competencies: IX.4. Communicate effectively with all members of the healthcare team, including the patient and the patient's support network | NLN Competencies: Knowledge and Practice: Health promotion/disease prevention. | Nursing/Integrated Concepts: Nursing Process: Implementation
Learning Outcome: 1.7: Examine how national health policy is structured to enhance individual and population health.
MNL Learning Outcome: 1.2: Recognize the significance of evidence-based practice and its use in nursing.

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13) The preceptor is reviewing a new nurse's goal statement of, "The client will resume normal bowel elimination patterns," created for the care plan of a client with irritable bowel syndrome. Which feedback should the preceptor provide the nurse?
1. "This plan of care has an appropriate goal statement which meets criteria."
2. "This goal statement requires a time frame to be appropriate."
3. "This goal statement is not reflective of the client's diagnosis."
4. "This care plan is accurate and should be entered in the client's medical record."
Answer: 2
Explanation: 1. This goal statement does not meet criteria as it lacks a time frame.
2. Time frames are an important component of goal statements and provide guidelines for when to evaluate the achievement of the goal.
3. The defining characteristics of the diagnosis and the etiology of the diagnosis are components of the diagnostic statement.
4. This goal statement does not meet criteria as it lacks a time frame.
Page Ref: 5
Cognitive Level: Applying
Client Need & Sub: Physiological Integrity; Elimination
Standards: QSEN Competencies: II.B.11. Solicit input from other team members to improve individual, as well as team, performance. | AACN Essentials Competencies: IX.14. Demonstrate clinical judgment and accountability for patient outcomes when delegating to and supervising other members of the healthcare team. | NLN Competencies: Teamwork: Adapt communication to the team and situation to share information or solicit input; initiate requests for help when appropriate. | Nursing/Integrated Concepts: Nursing Process: Evaluation
Learning Outcome: 1.3: Explain the steps of the nursing process.
MNL Learning Outcome: 1.2: Recognize the significance of evidence-based practice and its use in nursing.

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14) The nurse is caring for a newly admitted client with Methicillin-resistant Staphylococcus Aureus (MRSA). Which goals should the nurse include in the initial health assessment? Select all that apply.

1. Determine the client's current state of health.
2. Predict risks to current health status.
3. Use only objective data to determine client allergies.
4. Identify the client's ongoing health activities.
5. Identify the client's ability to adhere to treatment.

Answer: 1, 4

Explanation: 1. Health assessment goals are used to determine the client's current state of health.

2. Health assessment activities are used to predict risks to health and identify health status both current and future.

3. The initial health assessment includes both objective and subjective information.

4. Health assessment goals are used to determine ongoing health promoting activities.

5. The health assessment is not focused on the client's compliance to treatment.

Page Ref: 5

Cognitive Level: Applying

Client Need & Sub: Physiological Adaptation; Alterations in Body Systems

Standards: QSEN Competencies: I.B.3. Provide patient-centered care with sensitivity and respect for the diversity of human experience. | AACN Essentials Competencies: III.6. Integrate evidence, clinical judgment, interprofessional perspectives, and patient preferences in planning, implementing, and evaluating outcomes of care. | NLN Competencies: Personal and Professional Development: Identify problems and contribute to assessment of outcome achievement. | Nursing/Integrated Concepts: Nursing Process: Assessment

Learning Outcome: 1.5: Apply the critical thinking process to health assessment in nursing.

MNL Learning Outcome: 1.4: Examine the components of health assessment.

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15) During a physical assessment of a client, the nurse notes wheezing and documents the findings in the medical record. Which phase of critical thinking is represented by the nurse's actions?
1. Collection of information.
2. Evaluation.
3. Generation of alternatives.
4. Analysis of the situation.
Answer: 1
Explanation: 1. Collection of information is the initial step in the process. During this phase, the nurse will assess available information and document the findings in the medical record.
2. Evaluation is the final step in the process. During evaluation, the nurse will determine the effectiveness of actions taken.
3. When generating alternatives for action, the nurse will use critical thinking skills to determine available options for action.
4. Analysis of the situation occurs when the nurse employs assessment skills to review and analyze the situation. The analysis will provide the nurse with the understanding of what the best plan of action will be.
Page Ref: 7
Cognitive Level: Applying
Client Need & Sub: Physiological Adaptation; Alterations in Body Systems
Standards: QSEN Competencies: III.C.5. Value the need for continuous improvement in clinical practice based on new knowledge. | AACN Essentials Competencies: IX.1. Conduct comprehensive and focused physical, behavioral, psychological, spiritual, socioeconomic, and environmental assessments of health and illness parameters in patients, using developmentally and culturally appropriate approaches. | NLN Competencies: Personal and Professional Development: Identify problems and contribute to assessment of outcome achievement. | Nursing/Integrated Concepts: Nursing Process: Evaluation
Learning Outcome: 1.5: Apply the critical thinking process to health assessment in nursing.
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16) The nurse is obtaining an admission assessment. Which should the nurse document as subjective data? Select all that apply.
1. The client's mother informs the nurse that her daughter has not been sleeping due to pain.
2. The client states, "I have pain in my belly that is 7 out of 10."
3. Abdominal assessment reveals a firm, hard abdomen.
4. The client is weak and looks pale.
5. The client appears nervous during the data collection period.
Answer: 1, 2
Explanation: 1. Subjective data is information the client experiences and communicates to the nurse. This information can be provided by either the client or other individuals.
2. Subjective data is information the client experiences and communicates to the nurse.
3. Objective data is obtained through observation by the examiner.
4. Objective data is obtained through observation by the examiner.
5. Objective data is obtained through observation by the examiner.
Page Ref: 6
Cognitive Level: Applying
Client Need & Sub: Physiological Adaptation; Alterations in Body Systems
Standards: QSEN Competencies: I.B.1. Elicit patient values, preferences, and expressed needs as part of clinical interview, implementation of care plan, and evaluation of care. | AACN Essentials Competencies: IX.1. Conduct comprehensive and focused physical, behavioral, psychological, spiritual, socioeconomic, and environmental assessments of health and illness parameters in patients, using developmentally and culturally appropriate approaches. | NLN Competencies: Personal and Professional Development: Identify problems and contribute to assessment of outcome achievement. | Nursing/Integrated Concepts: Nursing Process: Assessment
Learning Outcome: 1.5: Apply the critical thinking process to health assessment in nursing.
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17) The nurse is admitting a client to the unit. Which should the nurse consider when regarding the confidentiality of the client?
1. Information sharing is limited to those directly involved in the client care.
2. All members of the unit's healthcare team may have access to the chart.
3. The Health Insurance Portability and Accountability Act (HIPAA) determines who can communicate with the client.
4. The medical records are open to any hospital employee, including administration.
Answer: 1
Explanation: 1. Confidentiality means that information sharing is limited to those directly involved in the client care.
2. Access to the chart is limited to only those directly caring for the client, not to all members of the healthcare team on the unit.
3. The Health Insurance Portability and Accountability Act (HIPAA) does not dictate who is allowed to communicate with the client.
4. The medical records are not open to any hospital employee, including administration.
Page Ref: 7
Cognitive Level: Applying
Client Need & Sub: Safe and Effective Care Environment; Confidentiality/Information Security
Standards: QSEN Competencies: II.B.4. Function competently within own scope of practice as a member of the healthcare team. | AACN Essentials Competencies: VIII.10. Protect patient privacy and confidentiality of patient records and other privileged communications. | NLN Competencies: Context and Environment: Act in accordance with legal and regulatory requirements, including HIPAA, for faculty's students, patients, and families. |
Nursing/Integrated Concepts: Nursing Process: Assessment
Learning Outcome: 1.1: Explain the roles of the professional nurse in healthcare.
MNL Learning Outcome: 1.2: Recognize the significance of evidence-based practice and its use in nursing.

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18) The preceptor is reviewing the effective use of the nursing process with a new nurse. Which statement by the nurse indicates an understanding of the information?
1. "The correct order of the nursing process is diagnosis, assessment, planning, implementation, and evaluation."
2. "The correct order of the nursing process is assessment, diagnosis, planning, implementation, and evaluation."
3. "The correct order of the nursing process is planning, assessment, diagnosis, implementation, and evaluation."
4. "The correct order of the nursing process is assessment, planning, diagnosis, implementation, and evaluation."
Answer: 2
Explanation: 1. The nursing process is a systematic, rational, dynamic, and cyclic process used by the nurse for planning and providing care for the client. The assessment phase, step 1, involves the collection of data. Step 2 of the nursing process is diagnosis. Step 3 of the process is planning. Implementation is step 4. The final stage in the process, step 5, is evaluation.
2. The nursing process is a systematic, rational, dynamic, and cyclic process used by the nurse for planning and providing care for the client. The assessment phase, step 1, involves the collection of data. Step 2 of the nursing process is diagnosis. Step 3 of the process is planning. Implementation is step 4. The final stage in the process, step 5, is evaluation.
3. The nursing process is a systematic, rational, dynamic, and cyclic process used by the nurse for planning and providing care for the client. The assessment phase, step 1, involves the collection of data. Step 2 of the nursing process is diagnosis. Step 3 of the process is planning. Implementation is step 4. The final stage in the process, step 5, is evaluation.
4. The nursing process is a systematic, rational, dynamic, and cyclic process used by the nurse for planning and providing care for the client. The assessment phase, step 1, involves the collection of data. Step 2 of the nursing process is diagnosis. Step 3 of the process is planning. Implementation is step 4. The final stage in the process, step 5, is evaluation.
Page Ref: 5
Cognitive Level: Remembering
Client Need & Sub: Safe and Effective Care Environment; Management of Care
Standards: QSEN Competencies: I.B.3. Provide patient-centered care with sensitivity and respect for the diversity of human experience. | AACN Essentials Competencies: III.6. Integrate evidence, clinical judgment, interprofessional perspectives, and patient preferences in planning, implementing, and evaluating outcomes of care. | NLN Competencies: Personal and Professional Development: Identify problems and contribute to assessment of outcome achievement. | Nursing/Integrated Concepts: Nursing Process: Implementation
Learning Outcome: 1.3: Explain the steps of the nursing process.
MNL Learning Outcome: 1.3: Examine the steps of the nursing process and their association with critical thinking.

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19) The nurse is reviewing the role of the nurse practitioner. Which should the nurse recognize is the primary role?
1. Manage complex patient care areas.
2. Attend to the health of women of all ages.
3. Engagement in quality improvement.
4. Provide primary care in acute settings.
Answer: 4
Explanation: 1. Nurse administrators manage common complex patient care areas.
2. The certified nurse midwife attends to the health of women of all ages.
3. The nurse researcher may be engaged in continuous quality improvement projects in institutions and agencies.
4. The nurse practitioner can provide primary care in acute settings.
Page Ref: 3
Cognitive Level: Understanding
Client Need & Sub: Safe and Effective Care Environment; Concepts of Management
Standards: QSEN Competencies: II.B.4 Function competently within own scope of practice as a member of the healthcare team. | AACN Essentials Competencies: VI.1. Compare/contrast the roles and perspectives of the nursing profession with other care professionals on the healthcare team (i.e. scope of discipline, education, and licensure requirements). | NLN Competencies: Teamwork: Function competently within one's own scope of practice as leader or member of the healthcare team and manage delegation effectively and clarify roles and integrate the contributions of others who play a role in helping the patient/family achieve health goals | Nursing/Integrated Concepts: Nursing Process: Assessment
Learning Outcome: 1.1: Explain the roles of the professional nurse in healthcare.
MNL Learning Outcome: 1.1: Distinguish between the various roles of the professional nurse in healthcare.

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20) The nurse recognizes that there needs to be a change in practice on the unit to improve the client outcomes. Which is the quickest method the nurse should consider to change current practice?
1. Research.
2. Literature review.
3. Quality improvement project.
4. Document patient outcomes.
Answer: 3
Explanation: 1. Research can be done to identify evidence-based changes in practice.
2. A literature review can help identify evidence-based changes in practice.
3. A quality improvement project led by nurses has shortened the gap of time it takes to implement evidence-based practice.
4. Documenting patient outcomes is not a formal method for effectively changing practice on a unit. The outcomes should be monitored through a quality improvement project.
Page Ref: 3
Cognitive Level: Applying
Client Need & Sub: Safe and Effective Care Environment; Performance Improvement (Quality Improvement)
Standards: QSEN Competencies: III.C.5. Value the need for continuous improvement in clinical practice based on new knowledge | AACN Essentials Competencies: III.5. Participate in the process of retrieval, appraisal, and synthesis of evidence in collaboration with other members of the healthcare team to improve patient outcomes. | NLN Competencies: Quality and Safety: Current best practices | Nursing/Integrated Concepts: Nursing Process: Planning
Learning Outcome: 1.2: Explain evidence-based practice and its significance in nursing.
MNL Learning Outcome: 1.2: Recognize the significance of evidence-based practice and its use in nursing.

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21) The nurse is reviewing the advanced practice roles of the nurse. Which should the nurse recognize as the primary responsibility of the clinical nurse specialist?
1. Identify problems in regards to patient care, designs plans of study, and develops tools.
2. Provide generalized healthcare services, such as family planning, obstetric, and gynecological care.
3. Provide direct patient care, direct and teach other team members providing care, and conduct research within an area of specialization.
4. Combine expertise in diagnosis and illness with a nurse's understanding of health promotion and prevention.
Answer: 3
Explanation: 1. The role of the Nurse Researcher includes the identification of problems in regards to patient care, designing plans of study, and developing tools.
2. The Certified Nurse Midwife is an independent practitioner that provides generalized healthcare services, such as family planning, obstetric, and gynecological care.
3. The role of the Clinical Nurse Specialist includes the provision of direct patient care, directing and teaching other team members, and providing care and conduct research within an area of specialization.
4. The role of the Nurse Practitioner includes combining expertise in diagnosis and illness with a nurse's understanding of health promotion and prevention.
Page Ref: 3
Cognitive Level: Understanding
Client Need & Sub: Safe and Effective Care Environment; Concepts of Management
Standards: QSEN Competencies: II.B.4. Function competently within own scope of practice as a member of the healthcare team. | AACN Essentials Competencies: VI.1. Compare/contrast the roles and perspectives of the nursing profession with other care professionals on the healthcare team (i.e. scope of discipline, education, and licensure requirements). | NLN Competencies: Personal and Professional Development: Identify problems and contribute to assessment of outcome achievement. | Nursing/Integrated Concepts: Nursing Process: Planning
Learning Outcome: 1.1: Explain the roles of the professional nurse in healthcare.
MNL Learning Outcome: 1.1: Distinguish between the various roles of the professional nurse in healthcare.

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22) The nurse is preparing to conduct a focused interview on an older adult client who is being admitted for a urinary tract infection (UTI). Which initial action should the nurse take?
1. Obtain a urine sample.
2. Monitor the client's vital signs.
3. Assess the client's about dietary preferences.
4. Assess the characteristics of the client's pain.
Answer: 4
Explanation: 1. The client may need to have a urine specimen but that does not directly relate to obtaining more information about the client's chief complaints.
2. The client's vital signs will be taken but they do not directly relate to obtaining more information about the client's chief complaints.
3. Dietary preferences of clients are recorded but are not a part of the focused assessment.
4. The focused interview is used to allow for clarification of information from the initial interview. The focused interview is the portion of the interview in which the nurse asks the patient to clarify points, provide missing information, and elucidate information identified in the health history.
Page Ref: 6
Cognitive Level: Applying
Client Need & Sub: Physiological Adaptation; Alterations in Body Systems
Standards: QSEN Competencies: I.B.1. Elicit patient values, preferences, and expressed needs as part of clinical interview, implementation of care plan, and evaluation of care. | AACN Essentials Competencies: IX.1. Conduct comprehensive and focused physical, behavioral, psychological, spiritual, socioeconomic, and environmental assessments of health and illness parameters in patients, using developmentally and culturally appropriate approaches. | NLN Competencies: Personal and Professional Development: Identify problems and contribute to assessment of outcome achievement. | Nursing/Integrated Concepts: Nursing Process: Assessment
Learning Outcome: 1.5: Apply the critical thinking process to health assessment in nursing.
MNL Learning Outcome: 1.4: Examine the components of health assessment.

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23) The nurse is preparing to obtain a health history. Which should the nurse understand is the main purpose of obtaining a health history before a physical assessment?
1. Allows the nurse to gather objective data.
2. Provides a **s**ystematic means of gathering information.
3. Enables a nursing diagnosis to be generated.
4. Assists the examiner in accurately conducting a physical assessment.
Answer: 2
Explanation: 1. A purpose of a health history is to obtain information about the client's health in their own words and based on their own perceptions.
2. The main purpose of conducting an interview prior to obtaining a physical assessment is to systematically gather information about the client.
3. A nursing diagnosis is not generated until both subjective and objective data have been obtained.
4. Accurately conducting a physical assessment is based on the nurse's ability to systematically and consistently use evidence-based methods of data collection.
Page Ref: 6
Cognitive Level: Applying
Client Need & Sub: Physiological Adaptation; Alterations in Body Systems
Standards: QSEN Competencies: I.B.1. Elicit patient values, preferences, and expressed needs as part of clinical interview, implementation of care plan, and evaluation of care. | AACN Essentials Competencies: IX.1. Conduct comprehensive and focused physical, behavioral, psychological, spiritual, socioeconomic, and environmental assessments of health and illness parameters in patients, using developmentally and culturally appropriate approaches. | NLN Competencies: Personal and Professional Development: Identify problems and contribute to assessment of outcome achievement. | Nursing/Integrated Concepts: Nursing Process: Assessment
Learning Outcome: 1.4: Define health assessment and identify key components.
MNL Learning Outcome: 1.4: Examine the components of health assessment.

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24) The nurse is reviewing the goal statements for a postoperative client. Which goal statements should the nurse recognize needs further development? Select all that apply.
1. The nurse will assess the vital signs every 2 hours.
2. The client will ambulate every 6 hours on the first postoperative day.
3. The client will report feeling better by the end of the day.
4. The client will begin a clear liquid diet on the first postoperative day.
5. The nurse will administer oral analgesics as prescribed.
Answer: 1, 3, 5
Explanation: 1. Goal statements are used to provide planned outcomes for the client. Goal statements must be measurable and are reflective of client activities. This statement reflects actions of the nurse, not the client.
2. The goal statement is used to provide planned outcomes for the client. Goal statements must be measurable and reflective of client activities. All elements needed for an appropriate goal statement are represented.
3. Goal statements must be measurable and reflective of client activities. This statement is vague and does not provide a definitive means for measurement.
4. Goal statements are used to provide planned client outcomes. This statement contains the needed elements for a successful goal statement.
5. This statement is not a client-centered goal statement. This statement reflects an intervention performed by the healthcare provider.
Page Ref: 5
Cognitive Level: Applying
Client Need & Sub: Physiological Adaptation; Alterations in Body Systems
Standards: QSEN Competencies: I.B.3. Provide patient-centered care with sensitivity and respect for the diversity of human experience. | AACN Essentials Competencies: III.6. Integrate evidence, clinical judgment, interprofessional perspectives, and patient preferences in planning, implementing, and evaluating outcomes of care. | NLN Competencies: Personal and Professional Development: Identify problems and contribute to assessment of outcome achievement. | Nursing/Integrated Concepts: Nursing Process: Evaluation
Learning Outcome: 1.5: Apply the critical thinking process to health assessment in nursing.
MNL Learning Outcome: 1.2: Recognize the significance of evidence-based practice and its use in nursing.

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25) The nurse administrator is explaining their role to a new nurse. Which statement made by the new nurse indicates further teaching is required?
1. "You are available for consultation."
2. "You will be conducting research."
3. "You are responsible for staffing."
4. "You will be monitoring the goals of the organization."
Answer: 2
Explanation: 1. The nurse administrator may function as a consultant.
2. The nurse administrator is not involved in conducting research.
3. The nurse administrator may be responsible for staffing.
4. The nurse administrator monitors the goals of the organization.
Page Ref: 2
Cognitive Level: Applying
Client Need & Sub: Safe and Effective Care Environment; Concepts of Management
Standards: QSEN Competencies: II.B.4 Function competently within own scope of practice as a member of the healthcare team. | AACN Essentials Competencies: VI.1. Compare/contrast the roles and perspectives of the nursing profession with other care professionals on the healthcare team (i.e. scope of discipline, education, and licensure requirements). | NLN Competencies: Teamwork: Function competently within one's own scope of practice as leader or member of the healthcare team and manage delegation effectively. Clarify roles and integrate the contributions of others who play a role in helping the patient/family achieve health goals. | Nursing/Integrated Concepts: Nursing Process: Evaluation
Learning Outcome: 1.5: Apply the critical thinking process to health assessment in nursing.
MNL Learning Outcome: 1.1: Distinguish between the various roles of the professional nurse in healthcare.

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26) The new nurse is reviewing a client's plan of care with the preceptor. Which statement made by the nurse should the preceptor be concerned with?
1. "I have created one goal per nursing diagnosis."
2. "I have created my goals based on the nursing diagnosis."
3. "I identified measurable goals during the planning."
4. "I have written the interventions based on my goals."
Answer: 1
Explanation: 1. A single nursing diagnosis may generate more than one patient goal.
2. The goals for the client are based on the nursing diagnosis.
3. Measurable goals are identified during the stage of planning.
4. Interventions are based on the identified goals.
Page Ref: 5
Cognitive Level: Applying
Client Need & Sub: Safe and Effective Care Environment; Assignment, Delegation, and Supervision
Standards: QSEN Competencies: I.B.3. Provide patient-centered care with sensitivity and respect for the diversity of human experience. | AACN Essentials Competencies: IX.14. Demonstrate clinical judgment and accountability for patient outcomes when delegating to and supervising other members of the healthcare team | NLN Competencies: Teamwork: Adapt communication to the team and situation to share information or solicit input and initiate requests for help when appropriate. | Nursing/Integrated Concepts: Nursing Process: Evaluation
Learning Outcome: 1.3: Explain the steps of the nursing process.
MNL Learning Outcome: 1.2: Recognize the significance of evidence-based practice and its use in nursing.

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27) The nurse is reviewing a client's care plan. Which part of the nursing process should the nurse use to determine if new problems exist?
1. Assessment.
2. Evaluation.
3. Implementation.
4. Planning.
Answer: 2
Explanation: 1. The assessment process begins during the first encounter of the patient or the chart. The collection, organization, and validation of subjective and objective information are obtained during the assessment.
2. During the evaluation, the nurse determines if a new problem exists.
3. During the implementation of the nursing process, the nurse carries out relevant nursing interventions specific to the patient.
4. During the phase of planning, the nurse identifies measurable goals or outcomes, sets priorities, and selects evidence-based nursing interventions that promote achievement of measurable patient goals or outcomes.
Page Ref: 7
Cognitive Level: Applying
Client Need & Sub: Safe and Effective Care Environment; Management of Care
Standards: QSEN Competencies: I.B.3. Provide patient-centered care with sensitivity and respect for the diversity of human experience. | AACN Essentials Competencies: VII.1. Assess protective and predictive factors, including genetics, which influence the health of individuals, families, groups, communities, and populations. | NLN Competencies: Personal and Professional Development: Identify problems. Apply decision-making skills, particularly in the context of uncertainty and ambiguity. | Nursing/Integrated Concepts: Nursing Process: Evaluating
Learning Outcome: 1.3: Explain the steps of the nursing process.
MNL Learning Outcome: 1.2: Recognize the significance of evidence-based practice and its use in nursing.

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28) The preceptor is assessing a new nurse's ability to critically think. Which should the preceptor include in the assessment? Select all that apply.
1. Application of logic.
2. Use of resources.
3. Ability to problem solving.
4. Use of the nursing process.
5. Use of cognitive skills.
Answer: 1, 2, 4, 5
Explanation: 1. Critical thinking is a way to apply logic to the complexities of patient care.
2. Critical thinking involves the use of resources.
3. Critical thinking is more than problem solving.
4. Critical thinking parallels the nursing process.
5. Critical thinking is a way to apply cognitive skills to the complexities of patient care.
Page Ref: 7
Cognitive Level: Applying
Client Need & Sub: Safe and Effective Care Environment; Management of Care
Standards: QSEN Competencies: II.B.11. Solicit input from other team members to improve individual, as well as team, performance. | AACN Essentials Competencies: I.1. Integrate theories and concepts from liberal education into nursing practice. | NLN Competencies: Personal and Professional Development: Identify problems and apply decision-making skills, particularly in the context of uncertainty and ambiguity. | Nursing/Integrated Concepts: Nursing Process: Evaluation
Learning Outcome: 1.5: Apply the critical thinking process to health assessment in nursing.
MNL Learning Outcome: 1.3: Examine the steps of the nursing process and their association with critical thinking.

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29) The nurse is developing a client's plan of care. Which should the nurse base the plan of care on?
1. The nursing diagnosis.
2. The objective data.
3. The subjective data.
4. Client goals.
Answer: 1
Explanation: 1. The plan of care should be based on the nursing diagnosis.
2. Objective and subjective data are collected and used to formulate the nursing diagnosis.
3. Objective and subjective data are collected to formulate the nursing diagnosis.
4. Client goals are developed to help determine the success of the care delivered.
Page Ref: 5
Cognitive Level: Remembering
Client Need & Sub: Safe and Effective Care Environment; Management of Care
Standards: QSEN Competencies: I.B.3. Provide patient-centered care with sensitivity and respect for the diversity of human experience. | AACN Essentials Competencies: III.6. Integrate evidence, clinical judgment, interprofessional perspectives, and patient preferences in planning, implementing, and evaluating outcomes of care. | NLN Competencies: Personal and Professional Development: Identify problems and contribute to assessment of outcome achievement. | Nursing/Integrated Concepts: Nursing Process: Diagnosis
Learning Outcome: 1.3: Explain the steps of the nursing process.
MNL Learning Outcome: 1.4: Examine the components of health assessment.

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30) The nurse is preparing to focus on the third step of the nursing process. Which should the nurse anticipate obtaining?
1. Statement of client goals.
2. Collection of subjective data.
3. Performance of care activities.
4. Review of client's achievement of goals.
Answer: 1
Explanation: 1. The third step in the nursing process is the planning phase. During the planning phase, care interventions are determined, priorities are set, and client goals are stated.
2. Assessment is the first phase of the nursing process for which collection of subjective data occurs.
3. Implementation is the fourth phase of the nursing process for which care activities are implemented.
4. The client's progress toward achieving the identified goals is evaluated in the final stage of the nursing process.
Page Ref: 5
Cognitive Level: Remembering
Client Need & Sub: Safe and Effective Care Environment; Management of Care
Standards: QSEN Competencies: I.B.3. Provide patient-centered care with sensitivity and respect for the diversity of human experience. | AACN Essentials Competencies: III.6. Integrate evidence, clinical judgment, interprofessional perspectives, and patient preferences in planning, implementing, and evaluating outcomes of care. | NLN Competencies: Personal and Professional Development: Identify problems and contribute to assessment of outcome achievement. | Nursing/Integrated Concepts: Nursing Process: Planning
Learning Outcome: 1.3: Explain the steps of the nursing process.
MNL Learning Outcome: 1.3: Examine the steps of the nursing process and their association with critical thinking.

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31) The nurse is reviewing the client's record for reports of pain. Which should the nurse consider subjective data? Select all that apply.
1. The client's leg is red and swollen.
2. The client complains of leg tenderness.
3. The client's white blood cell count is elevated
4. The client demonstrates guarding behavior during the assessment
5. The client states they have leg cramps.
Answer: 2, 5
Explanation: 1. Objective information is observable by the examiner. The examiner is able to visualize the appearance of the extremity.
2. Subjective information refers to data reported by the client. The client's complaints are an example of subjective data.
3. The laboratory values are objective data based on measurement.
4. Objective information is observable such as the patient exhibiting guarding behavior during an assessment.
5. Subjective information refers to data reported by the client such as in a statement regarding the experience of pain.
Page Ref: 6
Cognitive Level: Applying
Client Need & Sub: Physiological Integrity; Basic Care and Comfort
Standards: QSEN Competencies: I.B.3. Assess presence and extent of pain and suffering. | AACN Essentials Competencies: IX.1. Conduct comprehensive and focused physical, behavioral, psychological, spiritual, socioeconomic, and environmental assessments of health and illness parameters in patients, using developmentally and culturally appropriate approaches. | NLN Competencies: Personal and Professional Development: Identify problems and contribute to assessment of outcome achievement. | Nursing/Integrated Concepts: Nursing Process: Assessment
Learning Outcome: 1.4: Define health assessment and identify key components.
MNL Learning Outcome: 1.4: Examine the components of health assessment.

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32) The nurse is evaluating the risk factors for health disparity. Which social determinant should the nurse consider places the clients in the community at risk?
1. Lack of access to healthcare services.
2. Nonadherence to health prevention.
3. Lack of participation in exercise.
4. Chronic substance abuse.
Answer: 1
Explanation: 1. Lack of access to healthcare services is a social determinant associated with health disparity.
2. Nonadherence to health prevention is a behavior.
3. Nonparticipation in exercise is not a health disparity, unless the reason the client cannot participate is due to an unsafe environment or disability.
4. Chronic substance abuse addiction is a behavior or an addiction.
Page Ref: 7
Cognitive Level: Applying
Client Need & Sub: Health Promotion and Maintenance; Health Promotion/Disease Prevention
Standards: QSEN Competencies: I.B.1. Integrate understanding of multiple dimensions of patient centered care: patient/family/community preferences and values; coordination and integration of care; information, communication, and education; physical comfort and emotional support; involvement of family and friends; and transition and continuity. | AACN Essentials Competencies: VII.1. Assess protective and predictive factors, including genetics, which influence the health of individuals, families, groups, communities, and populations. | NLN Competencies: Context of Environment: Environmental health; health promotion/disease prevention (e.g., transmission of disease, disease patterns, epidemiological principles); chronic disease management; healthcare systems; transcultural approaches to health; and family dynamics. | Nursing/Integrated Concepts: Nursing Process: Assessment
Learning Outcome: 1.6: Describe the concepts of health, wellness, and health disparities.
MNL Learning Outcome: 1.4: Examine the components of health assessment.

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33) Which should the nurse understand is the main focus of the Agency for Health Research and Quality?
1. Nursing practice guidelines.
2. Health promotion.
3. Produce evidence-based reports.
4. Address healthcare disparity.
Answer: 3
Explanation: 1. The AHRQ produces evidence reports and technology assessments.
2. The AHRQ produces evidence reports and technology assessments.
3. The AHRQ produces evidence reports and technology assessments.
4. The AHRQ produces evidence reports and technology assessments.
Page Ref: 3
Cognitive Level: Understanding
Client Need & Sub: Health Promotion and Maintenance; Health Promotion/Disease Prevention
Standards: QSEN Competencies: I.B.1. Integrate understanding of multiple dimensions of patient centered care: patient/family/community preferences and values; coordination and integration of care; information, communication, and education; physical comfort and emotional support; involvement of family and friends; and transition and continuity. | AACN Essentials Competencies: VII.1. Assess protective and predictive factors, including genetics, which influence the health of individuals, families, groups, communities, and populations. | NLN Competencies: Context of Environment: Environmental health; health promotion/disease prevention (e.g., transmission of disease, disease patterns, epidemiological principles); chronic disease management; healthcare systems; transcultural approaches to health; and family dynamics. | Nursing/Integrated Concepts: Nursing Process: Evaluation
Learning Outcome: 1.7: Examine how national health policy is structured to enhance individual and population health.
MNL Learning Outcome: 1.2: Recognize the significance of evidence-based practice and its use in nursing.

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