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MULTIPLE CHOICE

1. The nurse is aware that any description of health would include the concept that:
   a. health is the absence of illness, and illness is the presence of chronic disease.
   b. culture, education, and socioeconomic status influence one's definition of health or illness.
   c. illness is a biological malfunction, and health is biological soundness.
   d. lifestyle factors are the major determinants of health or illness.

   ANS: B
   The concept of health is influenced by culture, education, and socioeconomic factors.

   DIF: Cognitive Level: Comprehension REF: p. 15 OBJ: Theory #1
   TOP: Views of Health and Illness KEY: Nursing Process Step: Planning
   MSC: NCLEX: Health Promotion and Maintenance: Prevention and Early Detection of Disease

2. The nurse takes into consideration that the patient with an admitting diagnosis of Type 2 diabetes mellitus and influenza is described as having:
   a. two chronic illnesses.
   b. two acute illnesses.
   c. one chronic and one acute illness.
   d. one acute and one infectious illness.

   ANS: C
   Chronic illnesses can be controlled but not cured and are long-lasting. Acute illnesses develop suddenly and resolve in a short time. Type 2 diabetes mellitus would be considered chronic, whereas influenza would be considered acute.

   DIF: Cognitive Level: Application REF: p. 15 OBJ: Theory #1
   TOP: Classification of Illnesses KEY: Nursing Process Step: Planning
   MSC: NCLEX: Health Promotion and Maintenance: Prevention and Early Detection of Disease

3. The nurse explains that an idiopathic disease is one that:
   a. is caused by inherited characteristics.
   b. develops suddenly, related to new viruses.
   c. results from injury during labor or delivery.
   d. has an unknown cause.

   ANS: D
   Idiopathic disease is defined as disease whose cause is unknown.

   DIF: Cognitive Level: Knowledge REF: p. 15 OBJ: Theory #1
   TOP: Classification of Illnesses KEY: Nursing Process Step: Implementation
   MSC: NCLEX: Health Promotion and Maintenance: Prevention and Early Detection of

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Disease

4. The nurse assesses a terminal illness in:
   a. a 76-year-old admitted to a nursing home with Alzheimer disease who is pacing and asking to go home.
   b. a 43-year-old with Lou Gehrig's disease who is refusing food and fluid.
   c. a 2-year-old child who burned her esophagus by drinking drain cleaner and who is being fed by a tube.
   d. a 52-year-old diagnosed with lung cancer who had part of one lung removed and has a closed chest drainage device in place.

   ANS: B
   A terminal illness is defined as one in which a person will live only a few months, weeks, or days. A person who refuses food and hydration will generally not live more than a few days.

   DIF: Cognitive Level: Comprehension REF: p. 15 OBJ: Theory #1
   TOP: Stages of Illness KEY: Nursing Process Step: Assessment
   MSC: NCLEX: Physiological Integrity: Physiological Adaptation

5. The nurse clarifies to a patient who now has an abscess following a ruptured appendix that the abscess is considered to be:
   a. a secondary illness.
   b. a life-threatening complication.
   c. an expected event following any surgery.
   d. a disorder easily treated with antibiotics.

   ANS: A
   A secondary illness is an illness that arises from a primary disorder.

   DIF: Cognitive Level: Comprehension REF: p. 15 OBJ: Theory #1
   TOP: Views of Health and Illness KEY: Nursing Process Step: Intervention
   MSC: NCLEX: Physiological Integrity: Physiological Adaptation

6. The nurse uses a diagram to demonstrate how Dunn's theory of health and illness can be compared with a:
   a. plant that grows from a seed, blossoms, wilts, and dies.
   b. continuum, with peak wellness and death at opposite ends; the person moves back and forth in a dynamic state of change.
   c. ladder; from birth to death the individual moves progressively downward a ladder to eventual death.
   d. state of mind dependent on the individual perception of their own health or illness.

   ANS: B
   Dunn's theory of a health continuum shows how an individual moves between peak wellness and death in a constant process.

   DIF: Cognitive Level: Knowledge REF: p. 16 OBJ: Theory #1
   TOP: Views of Health and Illness KEY: Nursing Process Step: Intervention
   MSC: NCLEX: Physiological Integrity: Physiological Adaptation

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7. A patient has been advised by the primary care provider to take medication for high cholesterol and to change eating habits after discharge home. The home health nurse discovered that the patient refused to follow the medical and nutritional directions. The nurse's best initial response to this situation is to:
   a. emphasize to the patient how important it is to follow the doctor's advice.
   b. determine whether any cultural, socioeconomic, or religious values conflict, thus interfering with the patient's compliance.
   c. explain that without diet and medication the condition will worsen and serious problems will develop.
   d. inform the primary care provider that the patient is unable to understand the instructions.

   ANS: B
   The patient may have cultural, socioeconomic, or religious values that cause conflicts that prevent her from following the doctor's instructions.

   DIF: Cognitive Level: Application REF: p. 16 OBJ: Theory #5
   TOP: Concepts of Health and Illness, Cultural Influences
   KEY: Nursing Process Step: Assessment
   MSC: NCLEX: Psychological Integrity: Coping and Adaptation

8. A nurse practicing a holistic approach to nursing care must:
   a. recognize that a change in one aspect of the person's life can alter the whole of that person's life.
   b. take responsibility for health care decisions.
   c. promote state of the art technology.
   d. discourage the use of more natural remedies and alternative methods of health care.

   ANS: A
   Holistic nursing requires that the nurse recognizes that a change in one aspect of the patient's life (biological, sociological, psychological, and spiritual) will bring about changes in that patient's whole life.

   DIF: Cognitive Level: Comprehension REF: p. 18 OBJ: Theory #6
   TOP: Holistic Approach to Caring KEY: Nursing Process Step: Assessment
   MSC: NCLEX: N/A

9. Included in Maslow's hierarchy, physiological needs are those that:
   a. nurture intimacy.
   b. foster independence.
   c. encourage social interaction.
   d. protect from harm.

   ANS: D
   Physiological needs are those that are essential to human life, such as oxygenation, nutrition, and elimination. Protection from physical harm, from a nursing standpoint, is often equivalent in importance to physical needs.

   DIF: Cognitive Level: Application REF: p. 20 OBJ: Theory #7

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TOP: Maslow's Hierarchy of Needs KEY: Nursing Process Step: N/A
MSC: NCLEX: Physiological Integrity: Physiological Adaptation

10. The factors involved in assessing the importance the patient attaches to the relief of a particular deficit include:
    a. needs that the nurse must assess to prioritize care, because they may be different from person to person.
    b. ordering needs according to Maslow's hierarchy, with lower level needs being least compelling.
    c. needs based on a hierarchy in which higher level needs are more prominent and demand attention before lower level needs.
    d. needs that are usually not known to the patient and that must be determined by the nurse.

    ANS: A
    A person's concern relative to a needs deficit must be assessed by the nurse to meet the needs of each patient. Needs are viewed differently from one person to the next.

    DIF: Cognitive Level: Comprehension REF: p. 20 OBJ: Theory #7
    TOP: Maslow's Hierarchy of Needs KEY: Nursing Process Step: Assessment
    MSC: NCLEX: Physiological Integrity: Physiological Adaptation

11. The nurse believes that patient teaching of how to give insulin and monitor blood glucose levels will improve the level of the patient's:
    a. physiological well-being.
    b. security, by providing psychological comfort.
    c. self-esteem, by promoting independence and learning.
    d. self-actualization, by seeking knowledge and truth.

    ANS: C
    Patient education activities that are to be used after discharge enhance independence and promote self-esteem.

    DIF: Cognitive Level: Application REF: p. 21 OBJ: Theory #7
    TOP: Maslow's Hierarchy of Needs KEY: Nursing Process Step: Implementation
    MSC: NCLEX: Psychosocial Integrity: Psychosocial Adaptation

12. Homeostasis can be described as:
    a. the unchanging steady condition of humans in a changing external environment.
    b. a tendency of biological systems toward stability of the internal environment by continuously adjusting to survive.
    c. biological wellness that comes from the ability of the body to change and respond to physical changes in the environment.
    d. a response to stress that results from a person's choice of coping mechanisms to deal with the stress.

    ANS: B
    Homeostasis results from the constant adjustment of the internal environment in response to change; it is mental, emotional, and biological, as well as conscious and unconscious.

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DIF: Cognitive Level: Comprehension REF: p. 22 OBJ: Theory #8
TOP: Homeostasis KEY: Nursing Process Step: Assessment MSC: NCLEX: N/A

13. A patient admitted for diagnostic tests is frightened of hospital procedures and is nervous about the possible outcome of the tests. She states that her mouth is dry and her heart is pounding. Her blood pressure is 168/78 mm Hg (her usual blood pressure is 140/80 mm Hg), pulse is 112 beats/min, and respirations are 22 breaths/min. The nurse will recognize that these signs and symptoms are:
    a. indicative of serious, acute health problems and should be reported to the primary care provider immediately.
    b. most likely related to the disease for which the patient is admitted to the hospital.
    c. the effects of the parasympathetic nervous system and can be ignored.
    d. the effects of the sympathetic nervous system that can negatively affect the patient's health.

    ANS: D
    Fear stimulates the sympathetic nervous system to produce the symptoms identified in the question. If prolonged, they negatively affect a person's health.

    DIF: Cognitive Level: Analysis REF: p. 24|Table 2-2
    OBJ: Theory #10 TOP: Stress KEY: Nursing Process Step: Assessment
    MSC: NCLEX: Psychosocial Integrity: Coping and Adaptation

14. According to Hans Selye's general adaptation syndrome (GAS), a person who has experienced excessive and prolonged stress is likely to:
    a. develop an illness or disease such as allergy, arthritis, or asthma.
    b. become resistant to biological methods of treatment.
    c. seek treatment for imagined illnesses and nonexistent symptoms.
    d. be admitted to the hospital during the alarm stage.

    ANS: A
    Many diseases are known to be caused or exacerbated by prolonged stress. Selye concluded that stress-induced illnesses respond to biological methods of treatment.

    DIF: Cognitive Level: Comprehension REF: p. 25|Box 2-2
    OBJ: Theory #10 TOP: Adaptation KEY: Nursing Process Step: Assessment
    MSC: NCLEX: Psychosocial Integrity: Coping and Adaptation

15. The nurse is aware that a stressor as experienced by an individual is usually perceived:
    a. as a negative event or stimulus that affects homeostasis in maladaptive ways.
    b. in different ways based on previous experience and personality traits.
    c. as an opportunity for growth and learning.
    d. in similar ways if age and education are similar.

    ANS: B
    Stressors are not perceived the same way by different people or even by the same person at different times. The experience of a stressor depends on previous experience and personality, as well as factors such as physical or emotional conditions, age, and education.

    DIF: Cognitive Level: Comprehension REF: p. 23 OBJ: Theory #9

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TOP: General Adaptation Syndrome KEY: Nursing Process Step: Planning
MSC: NCLEX: Psychological Integrity: Psychosocial Adaptation

16. In 1946, the World Health Organization redefined health as the:
    a. absence of disease or infirmity.
    b. state of complete physical, mental, and social well-being.
    c. presence of disease or infirmity.
    d. state of incomplete physical, mental, and social well-being.

    ANS: B
    In 1946, the World Health Organization redefined health as "the state of complete physical, mental, and social well–being, and not merely the absence of disease or infirmity."

    DIF: Cognitive Level: Knowledge REF: p. 28 OBJ: Theory #1
    TOP: Views of Health and Illness KEY: Nursing Process Step: N/A
    MSC: NCLEX: N/A

17. The nurse assesses that a person is in the acceptance stage of illness when the patient:
    a. looks to home remedies to become well.
    b. reassumes usual responsibilities and roles.
    c. assumes the "sick" role.
    d. rejects medical treatment.

    ANS: C
    When a person enters the acceptance stage of illness, he or she assumes the "sick role" and withdraws from usual responsibilities and will frequently seek medical treatment at this time.

    DIF: Cognitive Level: Comprehension REF: p. 15 OBJ: Theory #1
    TOP: Acceptance Stage KEY: Nursing Process Step: Assessment
    MSC: NCLEX: Physiological Integrity: Physiological Adaptation

18. The nurse instructs a patient that according to Selye's GAS theory, when stress is strong enough and occurs over a long enough period, the patient will enter the stage of:
    a. convalescence.
    b. alarm.
    c. transition.
    d. exhaustion.

    ANS: D
    The exhaustion stage in the GAS occurs when the stressor has been present for such a period that the patient will deplete the body's resources for adaption.

    DIF: Cognitive Level: Comprehension REF: p. 24 OBJ: Theory #1
    TOP: Exhaustion Stage of GAS KEY: Nursing Process Step: Intervention
    MSC: NCLEX: Psychosocial Integrity: Coping and Adaptation

19. The nurse explains defense mechanisms as a patient's attempt to:
    a. justify the patient's assumption of the "sick" role.
    b. reduce anxiety.

c. problem solve.
d. increase dependence.

ANS: B
Defense mechanisms are unconscious strategies to reduce anxiety.

DIF: Cognitive Level: Knowledge REF: p. 25 OBJ: Theory #9
TOP: Defense Mechanisms KEY: Nursing Process Step: Implementation
MSC: NCLEX: Psychological Integrity: Coping and Adaptation

20. In giving nursing care to persons of Asian origin, the nurse should:
a. keep the room warm and free of drafts.
b. look the patient directly in the eye.
c. ask permission before touching the patient.
d. warmly clasp the patient's hand in greeting.

ANS: C
Seek permission before touching persons of Asian extraction, because they may be sensitive to physical, personal contact.

DIF: Cognitive Level: Application REF: p. 19|Table 2-1
OBJ: Theory #4 TOP: Cultural Sensitivity
KEY: Nursing Process Step: Implementation
MSC: NCLEX: Psychological Integrity: Coping and Adaptation

21. Sickle cell anemia is an example of a biological trait found primarily in:
a. Asian populations.
b. African populations.
c. American Indian populations.
d. Hispanic populations.

ANS: B
Sickle cell anemia is a biological variation found predominantly in people of African descent.

DIF: Cognitive Level: Knowledge REF: p. 19|Table 2-1
OBJ: Theory #5 TOP: Cultural Influences
KEY: Nursing Process Step: N/A MSC: NCLEX: N/A

22. When a young family man hospitalized after breaking his leg confides to the nurse that he is concerned about the well-being of his family and financial stress, the nurse can best support his sense of security by:
a. reassuring him that his leg will heal quickly.
b. actively listening to his concerns.
c. encouraging family to make frequent visits.
d. distracting him from his concerns by socialization.

ANS: B
A nurse's ability to use active listening will enhance the sense of security when patients feel that their needs are perceived accurately.

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DIF: Cognitive Level: Application REF: p. 21 OBJ: Theory #7
TOP: Maslow's Hierarchy of Needs KEY: Nursing Process Step: Intervention
MSC: NCLEX: Psychosocial Integrity: Coping and Adaptation

23. The nurse assesses successful adaptation in a post stroke patient when the patient:
    a. learns to walk and maintain balance with the aid of a walker.
    b. consistently takes antihypertensive drugs.
    c. attempts to get out of bed unassisted.
    d. refuses assistance with feeding.

    ANS: A
    Adaptation is a readjustment in habits to limitations and disabilities. Learning to walk and maintain balance with the aid of a walker is an example of this.

    DIF: Cognitive Level: Application REF: p. 23 OBJ: Theory #1
    TOP: Adaptation KEY: Nursing Process Step: Assessment
    MSC: NCLEX: Physiological Integrity: Physiological Adaptation

24. The nurse takes into consideration that in the stage of resistance in Selye's GAS, the patient:
    a. regresses to a dependent state.
    b. continues to battle for equilibrium.
    c. becomes maladaptive.
    d. begins to develop stress-related disorders.

    ANS: B
    The resistance stage is the second stage in the GAS when a patient is still attempting to find equilibrium.

    DIF: Cognitive Level: Comprehension REF: p. 24 OBJ: Theory #10
    TOP: Salye's GAS KEY: Nursing Process Step: Planning
    MSC: NCLEX: Physiological Integrity: Physiological Adaptation

25. A patient states, "I am not obese. My entire family is large." The nurse assesses that the patient is using the defense mechanism of:
    a. sublimation.
    b. projection.
    c. denial.
    d. displacement.

    ANS: C
    Denial is a defense mechanism that allows a person to live as though an unwanted piece of information or reality does not exist. There is a persistent refusal to be swayed by the evidence.

    DIF: Cognitive Level: Application REF: p. 27|Table 2-3
    OBJ: Theory #8 TOP: Denial KEY: Nursing Process Step: Assessment
    MSC: NCLEX: Psychosocial Integrity: Coping and Adaptation

26. A child who has just been scolded by her mother proceeds to hit her doll with a hairbrush. The nurse recognizes the child's actions are characteristics of:

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a. denial.
b. displacement.
c. rationalization.
d. repression.

ANS: B
Displacement is a defense mechanism that characterizes discharging intense feelings for one person onto an object or another person who is less threatening, thereby satisfying an impulse with a substitute object.

DIF: Cognitive Level: Application REF: p. 27|Table 2-3
OBJ: Theory #8 TOP: Defense Mechanisms
KEY: Nursing Process Step: Assessment
MSC: NCLEX: Psychosocial Integrity: Coping and Adaptation

27. The nurse encourages a patient to participate in health maintenance by maintaining an ideal body weight as a method of:
a. primary prevention.
b. secondary prevention.
c. tertiary prevention.
d. simple prevention.

ANS: A
Primary prevention avoids or delays occurrence of a specific disease or disorder.

DIF: Cognitive Level: Comprehension REF: p. 26 OBJ: Theory #1
TOP: Primary Prevention KEY: Nursing Process Step: Implementation
MSC: NCLEX: Health Promotion and Maintenance: Prevention and Early Detection of Disease

28. A nurse clarifies that methods of tertiary prevention are designed for:
a. rehabilitation.
b. delay of the development of a disorder.
c. screening for early detection of disease.
d. using an established protocol of therapy for a specific disease.

ANS: A
Tertiary prevention consists of rehabilitation measures after the disease or disorder has stabilized. Latent prevention does not exist.

DIF: Cognitive Level: Comprehension REF: p. 26 OBJ: Theory #1
TOP: Tertiary Prevention KEY: Nursing Process Step: Implementation
MSC: NCLEX: Physiological Integrity: Physiological Adaptation

29. When a new admission to an extended care facility wanders about listlessly, eats only a small amount of each meal, and keeps himself isolated, the nurse can intervene by:
a. assisting with feeding at each meal.
b. reminding him that he is in a safe and secure area.
c. socializing with him in the privacy of his room.
d. supporting him to interact with an exercise group.

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ANS: D
The membership and social interaction in a group may provide a means for a sense of belonging.

DIF: Cognitive Level: Application REF: p. 27 OBJ: Theory #11
TOP: Love and Belonging KEY: Nursing Process Step: Implementation
MSC: NCLEX: Psychosocial Integrity: Psychosocial Adaptation

MULTIPLE RESPONSE

1. When the brain perceives a situation as threatening, the sympathetic nervous system reacts by stimulating which of the following physiological functions? (*Select all that apply.*)
   a. Constriction of the pupils
   b. Dilation of the bronchial tubes
   c. Decreased heart rate
   d. Dilation of the pupils

   ANS: B, D
   Activation of the sympathetic nervous system causes the pupils and bronchial tubes to dilate. It also causes the heart rate to increase.

   DIF: Cognitive Level: Analysis REF: p. 23 OBJ: Theory #11
   TOP: Sympathetic Nervous System KEY: Nursing Process Step: N/A
   MSC: NCLEX: N/A

2. The nurse describes behaviors of the transition stage of illness, which are: (*Select all that apply.*)
   a. awareness of vague symptoms.
   b. denial of feeling ill.
   c. resorts to self-medication.
   d. withdrawal from roles and responsibilities.
   e. recovery from illness begins.

   ANS: A, B, C
   The transition stage (onset) of illness is demonstrated by the patient's awareness of vague symptoms, denial of feeling ill, and initiation of self-medication; however, he or she still fulfills the roles and responsibilities of life.

   DIF: Cognitive Level: Comprehension REF: p. 15 OBJ: Theory #1
   TOP: Stages of Illness KEY: Nursing Process Step: Assessment
   MSC: NCLEX: Physiological Integrity: Physiological Adaptation

3. Which defines the holistic approach to caring for the sick and promoting wellness? (*Select all that apply.*)
   a. The nurse's focus is specific to the disease or injury.
   b. The nurse realizes that each person has a responsibility for his or her own health.
   c. Health care providers are required to intervene on behalf of all persons to ensure that health goals are met.
   d. Providers combine traditional methods of health care with relaxation techniques

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for pain management.
e. A change in one aspect of a person's life may or may not alter the person as a whole.

ANS: B, C, D, E
The holistic approach to medicine treats the patient as a whole and may use a mix of traditional medicine and alternative medicine. Any change in one aspect of the whole may change the entire whole.

DIF: Cognitive Level: Comprehension REF: p. 18 OBJ: Theory #6
TOP: Holistic Approach KEY: Nursing Process Step: N/A
MSC: NCLEX: N/A

4. The responses during the *alarm stage* of the general adaptation syndrome as defined by Hans Selye include: (*Select all that apply.*)
   a. slight increase in body temperature.
   b. substantial increase in energy.
   c. decreased appetite.
   d. hormones released for mobilization for defense.
   e. the body's adaptation abilities temporarily overreacting.

   ANS: A, C, D
   The responses during the alarm stage according to the general adaptation syndrome include a slight rise in temperature, a loss of energy, decreased appetite, and a release of hormones that mobilizes the body's defenses.

   DIF: Cognitive Level: Comprehension REF: p. 24 OBJ: Theory #10
   TOP: GAS KEY: Nursing Process Step: N/A MSC: NCLEX: N/A

5. The nurse clarifies that a person who is self-actualized would have the characteristics of: (*Select all that apply.*)
   a. having met all other need levels.
   b. being certain of their beliefs and values.
   c. not being swayed by new ideas.
   d. having little need for creative self-expression.
   e. depending on significant others.

   ANS: A, B
   A self-actualized person has been able to meet all other basic need levels and is certain of his or her beliefs and values. He or she is open to new ideas and finds many ways of creative self-expression.

   DIF: Cognitive Level: Comprehension REF: p. 16 OBJ: Theory #7
   TOP: Self Actualization KEY: Nursing Process Step: Implementation
   MSC: NCLEX: Psychological Integrity: Coping and Adaptation

COMPLETION

1. Exercise can reduce stress and anxiety by the release of _____.

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ANS:
endorphins

The release of endorphins induces a feeling of well-being and tranquility.

DIF: Cognitive Level: Knowledge REF: p. 25 OBJ: Theory #11
TOP: Views of Health and Illness KEY: Nursing Process Step: N/A
MSC: NCLEX: N/A

2. Adequate _____ is necessary in the communication between nurse and patient in order to meet the higher basic needs of security, love, belonging, and self-esteem.

ANS:
feedback

Adequate feedback and clarification are essential in assisting the patient meet the higher-level needs.

DIF: Cognitive Level: Comprehension REF: p. 21 OBJ: Theory #7
TOP: Communication KEY: Nursing Process Step: N/A
MSC: NCLEX: N/A

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