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Jarvis, Forbes & Watt: *Jarvis's Physical Examination & Health Assessment*, 3rd ANZ edition

Chapter 02: Critical thinking in health assessment

Test Bank

MULTIPLE CHOICE

1. After completing an initial assessment on a patient, the nurse has charted that his respirations are eupnoeic and his pulse is 58. This type of data would be:
    a. objective.
    b. reflective.
    c. subjective.
    d. introspective.

    ANS: a
    Objective data are what the health professional observes by inspecting, percussing, palpating and auscultating during the physical exam.
    REF: Page 12

2. A patient tells the nurse that he is very nervous, that he is nauseated, and that he 'feels hot'. This type of data would be:
    a. objective.
    b. reflective.
    c. subjective.
    d. introspective.

    ANS: c
    Subjective data are what the person says about themself during history taking.
    REF: Page 12

3. Novice nurses, without a background of skills and experience to draw from, are more likely to make their decisions using:
    a. intuition.
    b. a set of rules.
    c. articles in journals.
    d. advice from supervisors.

    ANS: b
    Novice nurses operate from a set of rules.
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4. Expert nurses learn to attend to a pattern of assessment data based on past experiences. This is referred to as:
   a. intuition.
   b. the nursing process.
   c. clinical knowledge.
   d. diagnostic reasoning.

   ANS: a
   Intuition is characterised by pattern recognition—expert nurses learn to attend to a pattern of assessment data and act without consciously labelling it.
   REF: Page 14

5. Which critical thinking skill helps the nurse to see relationships among the data?
   a. Validation
   b. Clustering related cues
   c. Identifying gaps in data
   d. Distinguishing relevant from irrelevant

   ANS: b
   Clustering related cues helps the nurse to see relationships among the data.
   REF: Page 12

6. The nurse knows that developing appropriate nursing interventions for a patient relies on the appropriateness of the:
   a. nursing diagnosis.
   b. medical diagnosis.
   c. admission diagnosis.
   d. collaborative diagnosis.

   ANS: a
   An accurate nursing diagnosis provides the basis for selection of nursing interventions to achieve outcomes for which the nurse is accountable.
   REF: Page 13

7. What is the step of the nursing process that includes data collection by health history, physical examination and interview?
   a. Planning
   b. Diagnosis
   c. Evaluation
   d. Assessment

   ANS: d
   Data collection, including performing the health history, physical examination and interview, is the assessment step of the nursing process.
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8. When nursing diagnoses are being classified, which of the following would be considered a potential health diagnosis?

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a. Identifying existing levels of wellness.
b. Evaluating previous problems and goals.
c. Identifying potential problems the individual may develop.
d. Focusing on strengths and reflecting an individual's transition to higher levels of wellness.

ANS: c
Potential health diagnoses are potential problems that an individual does not currently have but is particularly vulnerable to develop.
REF: Page 13

9. Which term best describes a proficient nurse?
a. A nurse who has little experience with a specified population and uses rules to guide performance.
b. A nurse who has an intuitive grasp of a clinical situation and quickly identifies the accurate solution.
c. A nurse who sees actions in the context of daily plans for patients.
d. A nurse who understands a patient situation as a whole rather than a list of tasks and sees long-term goals for the patient.

ANS: d
The proficient nurse, with more time and experience than the novice nurse, is able to understand a patient situation as a whole rather than as a list of tasks and is able to see how today's nursing actions apply to the point the nurse wants the patient to reach at a future time.
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