Physical Examination and Health Assessment 7th edition Jarvis Test Bank

SKU: 9781455728107-TEST-BANK

MULTIPLE CHOICE

1. After completing an initial assessment of a patient, the nurse has charted that his respirations are eupneic and his pulse is 58 beats per minute. These types 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 examination. Subjective data is what the person *says* about him or herself during history taking. The terms *reflective* and *introspective* are not used to describe data.

   DIF: Cognitive Level: Understanding (Comprehension) REF: p. 2
   MSC: Client Needs: Safe and Effective Care Environment: Management of Care

2. A patient tells the nurse that he is very nervous, is nauseated, and "feels hot." These types of data would be:
   a. Objective.
   b. Reflective.
   c. Subjective.
   d. Introspective.

   ANS: C
   Subjective data are what the person says about him or herself during history taking. Objective data are what the health professional observes by inspecting, percussing, palpating, and auscultating during the physical examination. The terms *reflective* and *introspective* are not used to describe data.

   DIF: Cognitive Level: Understanding (Comprehension) REF: p. 2
   MSC: Client Needs: Safe and Effective Care Environment: Management of Care

3. The patient's record, laboratory studies, objective data, and subjective data combine to form the:
   a. Data base.
   b. Admitting data.
   c. Financial statement.
   d. Discharge summary.

   ANS: A
   Together with the patient's record and laboratory studies, the objective and subjective data form the data base. The other items are not part of the patient's record, laboratory studies, or data.

   DIF: Cognitive Level: Remembering (Knowledge) REF: p. 2
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4. When listening to a patient's breath sounds, the nurse is unsure of a sound that is heard. The nurse's next action should be to:
   a. Immediately notify the patient's physician.
   b. Document the sound exactly as it was heard.
   c. Validate the data by asking a coworker to listen to the breath sounds.
   d. Assess again in 20 minutes to note whether the sound is still present.

   ANS: C
   When unsure of a sound heard while listening to a patient's breath sounds, the nurse validates the data to ensure accuracy. If the nurse has less experience in an area, then he or she asks an expert to listen.

   DIF: Cognitive Level: Analyzing (Analysis) REF: p. 2
   MSC: Client Needs: Safe and Effective Care Environment: Management of Care

5. The nurse is conducting a class for new graduate nurses. During the teaching session, the nurse should keep in mind that novice nurses, without a background of skills and experience from which to draw, 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 defined, structured rules. The expert practitioner uses intuitive links.

   DIF: Cognitive Level: Understanding (Comprehension) REF: p. 3
   MSC: Client Needs: General

6. Expert nurses learn to attend to a pattern of assessment data and act without consciously labeling it. These responses are referred to as:
   a. Intuition.
   b. The nursing process.
   c. Clinical knowledge.
   d. Diagnostic reasoning.

   ANS: A
   Intuition is characterized by pattern recognition—expert nurses learn to attend to a pattern of assessment data and act without consciously labeling it. The other options are not correct.

   DIF: Cognitive Level: Understanding (Comprehension) REF: p. 4
   MSC: Client Needs: General

7. The nurse is reviewing information about evidence-based practice (EBP). Which statement best reflects EBP?
   a. EBP relies on tradition for support of best practices.
   b. EBP is simply the use of best practice techniques for the treatment of patients.
   c. EBP emphasizes the use of best evidence with the clinician's experience.
   d. The patient's own preferences are not important with EBP.

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ANS: C
EBP is a systematic approach to practice that emphasizes the use of best evidence in combination with the clinician's experience, as well as patient preferences and values, when making decisions about care and treatment. EBP is more than simply using the best practice techniques to treat patients, and questioning tradition is important when no compelling and supportive research evidence exists.

DIF: Cognitive Level: Applying (Application) REF: p. 5
MSC: Client Needs: Safe and Effective Care Environment: Management of Care

8. The nurse is conducting a class on priority setting for a group of new graduate nurses. Which is an example of a first-level priority problem?
   a. Patient with postoperative pain
   b. Newly diagnosed patient with diabetes who needs diabetic teaching
   c. Individual with a small laceration on the sole of the foot
   d. Individual with shortness of breath and respiratory distress

ANS: D
First-level priority problems are those that are emergent, life threatening, and immediate (e.g., establishing an airway, supporting breathing, maintaining circulation, monitoring abnormal vital signs) (see Table 1-1).

DIF: Cognitive Level: Understanding (Comprehension) REF: p. 4
MSC: Client Needs: Safe and Effective Care Environment: Management of Care

9. When considering priority setting of problems, the nurse keeps in mind that second-level priority problems include which of these aspects?
   a. Low self-esteem
   b. Lack of knowledge
   c. Abnormal laboratory values
   d. Severely abnormal vital signs

ANS: C
Second-level priority problems are those that require prompt intervention to forestall further deterioration (e.g., mental status change, acute pain, abnormal laboratory values, risks to safety or security) (see Table 1-1).

DIF: Cognitive Level: Understanding (Comprehension) REF: p. 4
MSC: Client Needs: Safe and Effective Care Environment: Management of Care

10. Which critical thinking skill helps the nurse 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 see relationships among the data.

DIF: Cognitive Level: Understanding (Comprehension) REF: p. 2
MSC: Client Needs: Safe and Effective Care Environment: Management of Care

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11. The nurse knows that developing appropriate nursing interventions for a patient relies on the appropriateness of the _____ diagnosis.
    a. Nursing
    b. Medical
    c. Admission
    d. Collaborative

    ANS: A
    An accurate nursing diagnosis provides the basis for the selection of nursing interventions to achieve outcomes for which the nurse is accountable. The other items do not contribute to the development of appropriate nursing interventions.

    DIF: Cognitive Level: Understanding (Comprehension) REF: p. 6
    MSC: Client Needs: Safe and Effective Care Environment: Management of Care

12. The nursing process is a sequential method of problem solving that nurses use and includes which steps?
    a. Assessment, treatment, planning, evaluation, discharge, and follow-up
    b. Admission, assessment, diagnosis, treatment, and discharge planning
    c. Admission, diagnosis, treatment, evaluation, and discharge planning
    d. Assessment, diagnosis, outcome identification, planning, implementation, and evaluation

    ANS: D
    The nursing process is a method of problem solving that includes assessment, diagnosis, outcome identification, planning, implementation, and evaluation.

    DIF: Cognitive Level: Understanding (Comprehension) REF: p. 3
    MSC: Client Needs: Safe and Effective Care Environment: Management of Care

13. A newly admitted patient is in acute pain, has not been sleeping well lately, and is having difficulty breathing. How should the nurse prioritize these problems?
    a. Breathing, pain, and sleep
    b. Breathing, sleep, and pain
    c. Sleep, breathing, and pain
    d. Sleep, pain, and breathing

    ANS: A
    First-level priority problems are immediate priorities, remembering the ABCs (airway, breathing, and circulation), followed by second-level problems, and then third-level problems.

    DIF: Cognitive Level: Analyzing (Analysis) REF: p. 4
    MSC: Client Needs: Safe and Effective Care Environment: Management of Care

14. Which of these would be formulated by a nurse using diagnostic reasoning?
    a. Nursing diagnosis
    b. Medical diagnosis
    c. Diagnostic hypothesis
    d. Diagnostic assessment

    ANS: C

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Diagnostic reasoning calls for the nurse to formulate a diagnostic hypothesis; the nursing process calls for a nursing diagnosis.

DIF: Cognitive Level: Understanding (Comprehension) REF: p. 2
MSC: Client Needs: General

15. Barriers to incorporating EBP include:
    a. Nurses' lack of research skills in evaluating the quality of research studies.
    b. Lack of significant research studies.
    c. Insufficient clinical skills of nurses.
    d. Inadequate physical assessment skills.

ANS: A
As individuals, nurses lack research skills in evaluating the quality of research studies, are isolated from other colleagues who are knowledgeable in research, and often lack the time to visit the library to read research. The other responses are not considered barriers.

DIF: Cognitive Level: Understanding (Comprehension) REF: p. 6
MSC: Client Needs: General

16. What step of the nursing process 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 (see Figure 1-2).

DIF: Cognitive Level: Remembering (Knowledge) REF: p. 2
MSC: Client Needs: General

17. During a staff meeting, nurses discuss the problems with accessing research studies to incorporate evidence-based clinical decision making into their practice. Which suggestion by the nurse manager would best help these problems?
    a. Form a committee to conduct research studies.
    b. Post published research studies on the unit's bulletin boards.
    c. Encourage the nurses to visit the library to review studies.
    d. Teach the nurses how to conduct electronic searches for research studies.

ANS: D
Facilitating support for EBP would include teaching the nurses how to conduct electronic searches; time to visit the library may not be available for many nurses. Actually conducting research studies may be helpful in the long-run but not an immediate solution to reviewing existing research.

DIF: Cognitive Level: Applying (Application) REF: p. 6
MSC: Client Needs: Safe and Effective Care Environment: Management of Care

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18. When reviewing the concepts of health, the nurse recalls that the components of holistic health include which of these?
    a. Disease originates from the external environment.
    b. The individual human is a closed system.
    c. Nurses are responsible for a patient's health state.
    d. Holistic health views the mind, body, and spirit as interdependent.

    ANS: D
    Consideration of the whole person is the essence of holistic health, which views the mind, body, and spirit as interdependent. The basis of disease originates from both the external environment and from within the person. Both the individual human and the external environment are open systems, continually changing and adapting, and each person is responsible for his or her own personal health state.

    DIF: Cognitive Level: Understanding (Comprehension) REF: p. 7
    MSC: Client Needs: Safe and Effective Care Environment: Management of Care

19. The nurse recognizes that the concept of prevention in describing health is essential because:
    a. Disease can be prevented by treating the external environment.
    b. The majority of deaths among Americans under age 65 years are not preventable.
    c. Prevention places the emphasis on the link between health and personal behavior.
    d. The means to prevention is through treatment provided by primary health care practitioners.

    ANS: C
    A natural progression to prevention rounds out the present concept of health. Guidelines to prevention place the emphasis on the link between health and personal behavior.

    DIF: Cognitive Level: Understanding (Comprehension) REF: p. 7
    MSC: Client Needs: General

20. The nurse is performing a physical assessment on a newly admitted patient. An example of objective information obtained during the physical assessment includes the:
    a. Patient's history of allergies.
    b. Patient's use of medications at home.
    c. Last menstrual period 1 month ago.
    d. 2 × 5 cm scar on the right lower forearm.

    ANS: D
    Objective data are the patient's record, laboratory studies, and condition that the health professional observes by inspecting, percussing, palpating, and auscultating during the physical examination. The other responses reflect subjective data.

    DIF: Cognitive Level: Applying (Application) REF: p. 2
    MSC: Client Needs: Safe and Effective Care Environment: Management of Care

21. A visiting nurse is making an initial home visit for a patient who has many chronic medical problems. Which type of data base is most appropriate to collect in this setting?
    a. A follow-up data base to evaluate changes at appropriate intervals
    b. An episodic data base because of the continuing, complex medical problems of this patient

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c. A complete health data base because of the nurse's primary responsibility for monitoring the patient's health
d. An emergency data base because of the need to collect information and make accurate diagnoses rapidly

ANS: C
The complete data base is collected in a primary care setting, such as a pediatric or family practice clinic, independent or group private practice, college health service, women's health care agency, visiting nurse agency, or community health agency. In these settings, the nurse is the first health professional to see the patient and has the primary responsibility for monitoring the person's health care.

DIF: Cognitive Level: Applying (Application) REF: p. 6
MSC: Client Needs: Safe and Effective Care Environment: Management of Care

22. Which situation is most appropriate during which the nurse performs a focused or problem-centered history?
a. Patient is admitted to a long-term care facility.
b. Patient has a sudden and severe shortness of breath.
c. Patient is admitted to the hospital for surgery the following day.
d. Patient in an outpatient clinic has cold and influenza-like symptoms.

ANS: D
In a focused or problem-centered data base, the nurse collects a "mini" data base, which is smaller in scope than the completed data base. This mini data base primarily concerns one problem, one cue complex, or one body system.

DIF: Cognitive Level: Applying (Application) REF: p. 7
MSC: Client Needs: Safe and Effective Care Environment: Management of Care

23. A patient is at the clinic to have her blood pressure checked. She has been coming to the clinic weekly since she changed medications 2 months ago. The nurse should:
a. Collect a follow-up data base and then check her blood pressure.
b. Ask her to read her health record and indicate any changes since her last visit.
c. Check only her blood pressure because her complete health history was documented 2 months ago.
d. Obtain a complete health history before checking her blood pressure because much of her history information may have changed.

ANS: A
A follow-up data base is used in all settings to follow up short-term or chronic health problems. The other responses are not appropriate for the situation.

DIF: Cognitive Level: Applying (Application) REF: p. 7
MSC: Client Needs: Safe and Effective Care Environment: Management of Care

24. A patient is brought by ambulance to the emergency department with multiple traumas received in an automobile accident. He is alert and cooperative, but his injuries are quite severe. How would the nurse proceed with data collection?
a. Collect history information first, then perform the physical examination and institute life-saving measures.
b. Simultaneously ask history questions while performing the examination and

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initiating life-saving measures.

c. Collect all information on the history form, including social support patterns, strengths, and coping patterns.
d. Perform life-saving measures and delay asking any history questions until the patient is transferred to the intensive care unit.

ANS: B
The emergency data base calls for a rapid collection of the data base, often concurrently compiled with life-saving measures. The other responses are not appropriate for the situation.

DIF: Cognitive Level: Analyzing (Analysis) REF: p. 7
MSC: Client Needs: Safe and Effective Care Environment: Management of Care

25. A 42-year-old patient of Asian descent is being seen at the clinic for an initial examination. The nurse knows that including cultural information in his health assessment is important to:
a. Identify the cause of his illness.
b. Make accurate disease diagnoses.
c. Provide cultural health rights for the individual.
d. Provide culturally sensitive and appropriate care.

ANS: D
The inclusion of cultural considerations in the health assessment is of paramount importance to gathering data that are accurate and meaningful and to intervening with culturally sensitive and appropriate care.

DIF: Cognitive Level: Understanding (Comprehension) REF: p. 8
MSC: Client Needs: Psychosocial Integrity

26. In the health promotion model, the focus of the health professional includes:
a. Changing the patient's perceptions of disease.
b. Identifying biomedical model interventions.
c. Identifying negative health acts of the consumer.
d. Helping the consumer choose a healthier lifestyle.

ANS: D
In the health promotion model, the focus of the health professional is on helping the consumer choose a healthier lifestyle.

DIF: Cognitive Level: Remembering (Knowledge) REF: p. 8
MSC: Client Needs: Health Promotion and Maintenance

27. The nurse has implemented several planned interventions to address the nursing diagnosis of acute pain. Which would be the next appropriate action?
a. Establish priorities.
b. Identify expected outcomes.
c. Evaluate the individual's condition, and compare actual outcomes with expected outcomes.
d. Interpret data, and then identify clusters of cues and make inferences.

ANS: C

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Evaluation is the next step after the implementation phase of the nursing process. During this step, the nurse evaluates the individual's condition and compares the actual outcomes with expected outcomes (See Figure 1-2).

DIF: Cognitive Level: Applying (Application) REF: p. 3
MSC: Client Needs: Safe and Effective Care Environment: Management of Care

28. Which statement *best* describes a proficient nurse? A proficient nurse is one who:
    a. Has little experience with a specified population and uses rules to guide performance.
    b. Has an intuitive grasp of a clinical situation and quickly identifies the accurate solution.
    c. Sees actions in the context of daily plans for patients.
    d. Understands a patient situation as a whole rather than a list of tasks and recognizes the 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. The proficient nurse is able to see how today's nursing actions can apply to the point the nurse wants the patient to reach at a future time.

DIF: Cognitive Level: Applying (Application) REF: p. 3
MSC: Client Needs: General

MULTIPLE RESPONSE

1. The nurse is reviewing data collected after an assessment. Of the data listed below, which would be considered related cues that would be clustered together during data analysis? *Select all that apply*.
    a. Inspiratory wheezes noted in left lower lobes
    b. Hypoactive bowel sounds
    c. Nonproductive cough
    d. Edema, +2, noted on left hand
    e. Patient reports dyspnea upon exertion
    f. Rate of respirations 16 breaths per minute

ANS: A, C, E, F
Clustering related cues help the nurse recognize relationships among the data. The cues related to the patient's respiratory status (e.g., wheezes, cough, report of dyspnea, respiration rate and rhythm) are all related. Cues related to bowels and peripheral edema are not related to the respiratory cues.

DIF: Cognitive Level: Analyzing (Analysis) REF: p. 4
MSC: Client Needs: Safe and Effective Care Environment: Management of Care

MATCHING

Put the following patient situations in order according to the level of priority.
a. A patient newly diagnosed with type 2 diabetes mellitus does not know how to

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check his own blood glucose levels with a glucometer.

b. A teenager who was stung by a bee during a soccer match is having trouble breathing.

c. An older adult with a urinary tract infection is also showing signs of confusion and agitation.

1. a = First-level priority problem
2. b = Second-level priority problem
3. c = Third-level priority problem

1. ANS: B DIF: Cognitive Level: Analyzing (Analysis)
   REF: p. 4
   MSC: Client Needs: Safe and Effective Care Environment: Management of Care
   NOT: First-level priority problems are immediate priorities, such as trouble breathing (remember the "airway, breathing, circulation" priorities). Second-level priority problems are next in urgency, but not life-threatening. Third-level priorities (e.g., patient education) are important to a patient's health but can be addressed after more urgent health problems are addressed (see Table 1-1).
2. ANS: C DIF: Cognitive Level: Analyzing (Analysis)
   REF: p. 4
   MSC: Client Needs: Safe and Effective Care Environment: Management of Care
   NOT: First-level priority problems are immediate priorities, such as trouble breathing (remember the "airway, breathing, circulation" priorities). Second-level priority problems are next in urgency, but not life-threatening. Third-level priorities (e.g., patient education) are important to a patient's health but can be addressed after more urgent health problems are addressed (see Table 1-1).
3. ANS: A DIF: Cognitive Level: Analyzing (Analysis)
   REF: p. 4
   MSC: Client Needs: Safe and Effective Care Environment: Management of Care
   NOT: First-level priority problems are immediate priorities, such as trouble breathing (remember the "airway, breathing, circulation" priorities). Second-level priority problems are next in urgency, but not life-threatening. Third-level priorities (e.g., patient education) are important to a patient's health but can be addressed after more urgent health problems are addressed (see Table 1-1).

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