

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. What type of assessment data is this?
 - a. Objective
 - b. Reflective
 - c. Subjective
 - d. Introspective

ANS: A

Objective data is 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)

MSC: Client Needs: Safe and Effective Care Environment: Management of Care

2. A patient tells the nurse that he is very nervous, nauseous, and “feels hot.” What type of assessment data is this?
 - a. Objective
 - b. Reflective
 - c. Subjective
 - d. Introspective

ANS: C

Subjective data is what the person says about him or herself during history taking. Objective data is 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)

MSC: Client Needs: Safe and Effective Care Environment: Management of Care

3. What do the patient’s record, laboratory studies, objective data, and subjective data combine to form?
 - a. Database
 - 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 database. The other items are not part of the patient’s record, laboratory studies, or data.

DIF: Cognitive Level: Remembering (Knowledge)

MSC: Client Needs: Safe and Effective Care Environment: Management of Care

4. When listening to a patient’s breath sounds, the nurse is unsure of a sound that is heard. Which action should the nurse take *next*?
 - a. Notify the patient’s physician.
 - b. Document the sound exactly as it was heard.
 - c. Validate the data by asking another nurse 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 by either repeating the assessment themselves or asking another nurse to assess the breath sounds. If the nurse has less experience analyzing breath sounds, then he or she should ask an expert to listen. When unsure of a sound heard while listening to a patient’s breath sounds, the nurse should validate the data before documenting to ensure accuracy and before notifying the patient’s physician. To validate that data, the nurse either repeats the assessment himself or herself or asks another nurse to assess the breath sounds.

DIF: Cognitive Level: Analyzing (Analysis)

MSC: Client Needs: Safe and Effective Care Environment: Management of Care

5. The nurse is conducting a class for new graduate nurses. While teaching the class, what should the nurse keep in mind regarding what novice nurses, without a background of skills and experience from which to draw upon, are more likely to base their decisions on?
 - 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 to make decisions. It takes time, perhaps a few years, in similar clinical situations to achieve competency and it is functioning at the level of an expert practitioner when intuition is included in making clinical decisions. Intuition is included in decision making when functioning at the level of an expert practitioner. While information in journal articles and advice from supervisors may assist in making decisions, novice nurses do not typically base their decisions on them. It would also be important that if information from journal articles and advice from supervisors were used, that they were evidence based.

DIF: Cognitive Level: Understanding (Comprehension)

MSC: Client Needs: General

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

ANS: C

EBP is a systematic approach to practice that emphasizes the use of research evidence in combination with the clinician's expertise and clinical knowledge (physical assessment), as well as patient values and preferences, 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)

MSC: Client Needs: Safe and Effective Care Environment: Management of Care

7. 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?
- Patient with postoperative pain
 - Newly diagnosed patient with diabetes who needs diabetic teaching
 - Individual with a small laceration on the sole of the foot
 - 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). Postoperative pain, diabetic teaching for a patient newly diagnosed with diabetes, and a small laceration on sole of the foot are not considered first-level priority problems.

DIF: Cognitive Level: Understanding (Comprehension)

MSC: Client Needs: Safe and Effective Care Environment: Management of Care

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

ANS: C

Abnormal laboratory values are a second-level priority problem. 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). Low self-esteem and lack of knowledge are considered third-level priority as although they are important to a patient's health, they can be addressed after more urgent health problems are addressed. Severely abnormal vital signs would be considered a first-level priority problem.

DIF: Cognitive Level: Understanding (Comprehension)

MSC: Client Needs: Safe and Effective Care Environment: Management of Care

9. Which critical-thinking skill helps the nurse see relationships among the data?
- Validation
 - Clustering related cues
 - Identifying gaps in data
 - Distinguishing relevant from irrelevant

ANS: B

Clustering related cues involves clustering, or grouping together, assessment data that appear to be associated, or related, and helps the nurse see relationships among the data. Identifying gaps is looking for missing information and validation involves ensuring accuracy, and distinguishing relevant and irrelevant data involves identifying data the fit, or support the problem, but none of those help the nurse to see relationships.

DIF: Cognitive Level: Understanding (Comprehension)

MSC: Client Needs: Safe and Effective Care Environment: Management of Care

10. The nursing process is a sequential method of problem solving that nurses use and includes which steps?
- Assessment, treatment, planning, evaluation, discharge, and follow-up
 - Admission, assessment, diagnosis, treatment, and discharge planning
 - Admission, diagnosis, treatment, evaluation, and discharge planning
 - 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)

MSC: Client Needs: Safe and Effective Care Environment: Management of Care

11. 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?
- Breathing, pain, and sleep
 - Breathing, sleep, and pain
 - Sleep, breathing, and pain
 - 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)

MSC: Client Needs: Safe and Effective Care Environment: Management of Care

12. Which is a barrier to incorporating EBP?
- Nurses' lack of research skills in evaluating the quality of research studies
 - Lack of significant research studies
 - Insufficient clinical skills of nurses
 - 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. Lack of significant research studies, insufficient clinical skills of nurses, and inadequate physical assessment skills are not barriers to incorporating EBP. Instead, 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 which are barriers to incorporating EBP.

DIF: Cognitive Level: Understanding (Comprehension)

MSC: Client Needs: General

13. 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?
- Form a committee to conduct research studies.
 - Post published research studies on the unit's bulletin boards.
 - Encourage the nurses to visit the library to review studies.
 - Teach the nurses how to conduct electronic searches for research studies.

ANS: D

Facilitating support for EBP includes teaching the nurses how to conduct electronic searches and time to go to the library. However, the best method to help that staff incorporate evidence-based clinical decision making into their practice would be to teach them how to conduct electronic literature searches for pertinent studies 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. Although allowing time for nurses to visit the library may help to support evidence-based questions, time to do so may not be available for many nurses. A better method to facilitate support for EBP would be teaching the nurses how to conduct electronic searches. Just posting published research studies on the unit's bulletin board does not facilitate EBP, as not all published research is valid or pertinent to the nurses' practice. 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)

MSC: Client Needs: Safe and Effective Care Environment: Management of Care

14. When reviewing the concepts of health, the nurse recalls that the components of holistic health include which of these?
- Disease originates from the external environment.
 - The individual human is a closed system.
 - Nurses are responsible for a patient's health state.
 - 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 and functioning as a whole within the environment. 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. The basis of disease originates from both the external environment and from within the person; the individual human is an open system, continually changing and adapting; and each person is responsible for his or her own personal health state (not the nurse).

DIF: Cognitive Level: Understanding (Comprehension)

MSC: Client Needs: Safe and Effective Care Environment: Management of Care

15. The nurse recognizes that which concept of prevention is essential in describing health?
- Disease can be prevented by treating the external environment.
 - The majority of deaths among Americans under age 65 years are not preventable.
 - Prevention places the emphasis on the link between health and personal behavior.
 - 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. Although treating the environment may help in preventing some diseases, not all diseases can be prevented by treating the external environment. The majority of deaths among Americans under age 65 years *are* preventable. The means to prevention is achieved through counseling primary care providers designed to change people's unhealthy behaviors r/t smoking, alcohol and other drug use, lack of exercise, poor nutrition, injuries, and sexually transmitted infections.

DIF: Cognitive Level: Understanding (Comprehension)

MSC: Client Needs: General

16. The nurse is performing a physical assessment on a newly admitted patient. Which is an example of objective information obtained during the physical assessment?
- Patient's history of allergies
 - Patient's use of medications at home
 - Last menstrual period 1 month ago
 - 2 × 5 cm scar on the right lower forearm

ANS: D

Objective data is 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. A patient's history of allergies, use of medications at home, and date of last menstrual periods are all subjective data.

DIF: Cognitive Level: Applying (Application)

MSC: Client Needs: Safe and Effective Care Environment: Management of Care

17. A visiting nurse is making an initial home visit for a patient who has several chronic medical problems. Which type of database is most appropriate to collect in this setting?
- A follow-up database
 - A focused database
 - A complete database
 - An emergency database

ANS: C

A complete database is collected in primary care settings, 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. A follow-up database is performed to follow up, or evaluate changes, on short-term and chronic health problems, but would be collected at appropriate intervals *after* a complete database was collected at the initial visit. A focused database is conducted for a limited or short-term problem, not for a patient with several chronic problems. An emergency database is an urgent, rapid collection of data often compiled concurrently while lifesaving measures are being performed.

DIF: Cognitive Level: Applying (Application)

MSC: Client Needs: Safe and Effective Care Environment: Management of Care

18. In which situation is it most appropriate for the nurse to perform a focused or problem-centered history?
- Patient is admitted to a long-term care facility.
 - Patient has a sudden and severe shortness of breath.
 - Patient is admitted to the hospital for a scheduled surgery.
 - Patient in an outpatient clinic has cold and influenza-like symptoms.

ANS: D

In a focused or problem-centered database, the nurse collects a "mini" database, which is smaller in scope than the completed database. This mini database primarily concerns one problem, one cue complex, or one body system. A complete database should be conducted for a patient being admitted to a long-term care facility or being admitted for a scheduled surgery. An emergency database should be conducted for a patient with sudden and severe shortness of breath.

DIF: Cognitive Level: Applying (Application)

MSC: Client Needs: Safe and Effective Care Environment: Management of Care

19. The clinic nurse is caring for a patient who has been coming to the clinic weekly for blood pressure checks since she changed medications 2 months ago. Which is the most appropriate action for the nurse to take?
- Collect a follow-up database and then check the patient's blood pressure.
 - Ask the patient to read her health record and indicate any changes since her last visit.
 - Check the patient's blood pressure.
 - Obtain a complete health history on the patient before checking her blood pressure.

ANS: A

A follow-up database is used in all settings to follow up short-term or chronic health problems. The other responses are not appropriate for the situation. Asking the patient to read her health history and indicate any changes since her last visit is not appropriate. Just checking the patient's blood pressure without following up on or assessing for any changes in the patient's condition is inappropriate. It is not necessary to conduct a complete health history as one was conducted 2 months ago. Rather a follow-up assessment regarding the patient's blood pressure and factors associated with it are necessary.

DIF: Cognitive Level: Applying (Application)

MSC: Client Needs: Safe and Effective Care Environment: Management of Care

20. A patient is brought by ambulance to the emergency department with multiple injuries received in an automobile accident. He is alert and cooperative, but his injuries are quite severe. How would the nurse proceed with data collection?
- Collect history information first, then perform the physical examination and institute lifesaving measures.
 - Simultaneously ask history questions while performing the examination and initiating lifesaving measures.
 - Collect all information on the history form, including social support patterns, strengths, and coping patterns.
 - Perform lifesaving measures and delay asking any history questions until the patient is transferred to the intensive care unit.

ANS: B

The emergency database calls for a rapid collection of the database, often concurrently compiled with lifesaving measures. The other responses are not appropriate for the situation. This is an emergency situation and an emergency database with rapid collection of the database compiled concurrently with lifesaving measures.

DIF: Cognitive Level: Analyzing (Analysis)

MSC: Client Needs: Safe and Effective Care Environment: Management of Care

21. A 42-year-old patient of Asian descent is being seen at the clinic for an initial examination. Why is it important for the nurse to consider the basics of the patient's culture during the patient's health assessment?
- Identify the cause of his illness.
 - Make accurate disease diagnoses.
 - The U.S. is becoming increasingly diverse.
 - Provide culturally relevant health care.

ANS: D

It is important for the nurse to consider the basics of the patient's culture in order to ask the right questions to gather data that is accurate and meaningful in order to provide culturally relevant health care. Considering the basics of a patient's culture does not ensure the identification of the cause of a patient's illness or an accurate disease diagnosis. Although the U.S. is becoming increasingly diverse, that is not a reason for considering the basics of the patient's culture during the patient's health assessment. Instead it is to provide culturally relevant health care to this patient.

DIF: Cognitive Level: Understanding (Comprehension)

MSC: Client Needs: Psychosocial Integrity

22. What is a focus of the health professional in the health promotion model?
- Changing people's perceptions of disease
 - Identifying biomedical model interventions
 - Identifying negative health acts of people
 - Teaching and helping people choose a healthier lifestyle

ANS: D

In the health promotion model, the focus of the health professional is on teaching and helping the consumer choose a healthier lifestyle. Changing people's perception of disease, identifying biomedical model interventions, and identifying negative health acts of people are not the focus of the health promotion model. In the health promotion model, the focus of the health professional is on teaching and helping the consumer choose a healthier lifestyle.

DIF: Cognitive Level: Remembering (Knowledge)

MSC: Client Needs: Health Promotion and Maintenance

23. Which statement *best* describes a proficient nurse?
- Has little experience with a specified population and uses rules to guide performance.
 - Has an intuitive grasp of a clinical situation and quickly identifies the accurate solution.
 - Sees actions in the context of daily plans for patients.
 - 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. A nurse that has little experience with a specified population and uses rules to guide performance is a novice nurse. A nurse that has an intuitive grasp of a clinical situation and quickly identifies the accurate solution is an expert nurse. Seeing actions in the context of daily plans for patients describes competency or a competent nurse.

DIF: Cognitive Level: Applying (Application)

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.*)
- Inspiratory wheezes noted in left lower lobes
 - Hypoactive bowel sounds
 - Nonproductive cough
 - Edema, +2, noted on left hand
 - Patient reports dyspnea upon exertion
 - Rate of respirations 16 breaths per minute

ANS: A, C, E, F

Clustering related cues helps the nurse recognize relationships among the data. The cues r/t the patient's respiratory status (e.g., wheezes, cough, report of dyspnea, respiration rate and rhythm) are all related. Cues r/t bowels and peripheral edema are not r/t the respiratory cues. Hypoactive bowel sounds and +2 edema of the left hand are separate cues that do not relate to the other cues. The other cues (wheezes, cough, report of dyspnea, respiration rate and rhythm) all relate to the patient's respiratory status. The cues of bowel sounds and peripheral edema are not r/t the respiratory cues.

DIF: Cognitive Level: Analyzing (Analysis)

MSC: Client Needs: Safe and Effective Care Environment: Management of Care

OTHER

1. Put the following patient situations in order of the level of priority (from highest priority to lowest priority).
- First-level priority problem
 - Second-level priority problem
 - Third-level priority problem
- A teenager who was stung by a bee during a soccer match is having trouble breathing.
 - A patient newly diagnosed with type 2 diabetes mellitus does not know how to check his own blood glucose levels with a glucometer.
 - An older adult with a urinary tract infection is also showing signs of confusion and agitation.

ANS:

A, C, B

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.

DIF: Cognitive Level: Analyzing (Analysis)

MSC: Client Needs: Safe and Effective Care Environment: Management of Care