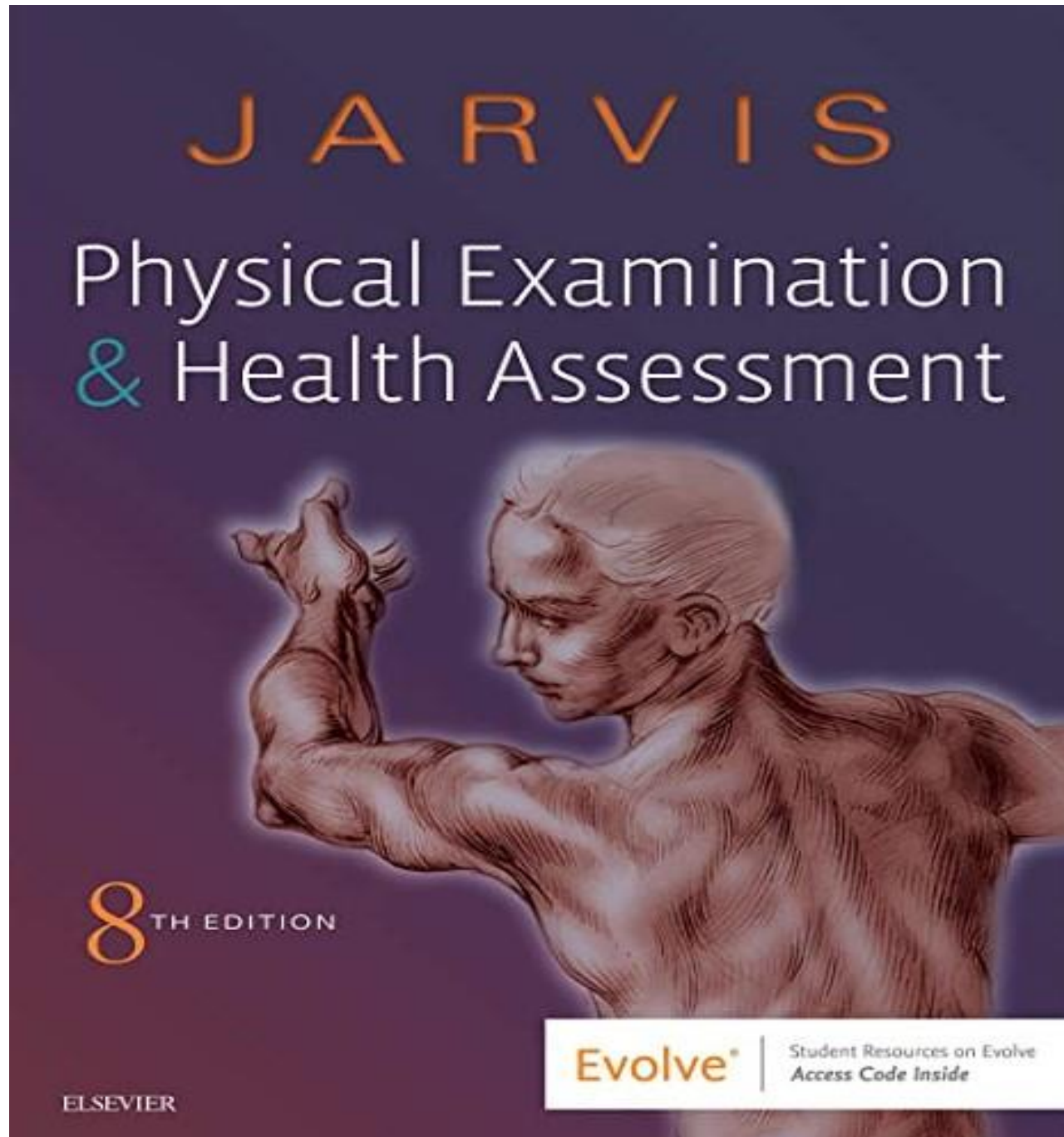


# TEST BANK



Test Bank for Physical Examination and Health Assessment 8th Edition by Jarvis

## Table of Contents

Table of Contents	1
Chapter 01: Evidence-Based Assessment	2
Chapter 02: Cultural Assessment	15
Chapter 03: The Interview	31
Chapter 04: The Complete Health History	49
Chapter 05: Mental Status Assessment	64
Chapter 06: Substance Use Assessment	80
Chapter 07: Domestic and Family Violence Assessment	86
Chapter 08: Assessment Techniques and Safety in the Clinical Setting	92
Chapter 09: General Survey and Measurement	111
Chapter 10: Vital Signs	118
Chapter 11: Pain Assessment	133
Chapter 12: Nutrition Assessment	141
Chapter 13: Skin, Hair, and Nails	155
Chapter 14: Head, Face, Neck, and Regional Lymphatics	176
Chapter 15: Eyes	194
Chapter 16: Ears	211
Chapter 17: Nose, Mouth, and Throat	228
Chapter 18: Breasts, Axillae, and Regional Lymphatics	246
Chapter 19: Thorax and Lungs	266
Chapter 20: Heart and Neck Vessels	284
Chapter 21: Peripheral Vascular System and Lymphatic System	303
Chapter 22: Abdomen	320
Chapter 23: Musculoskeletal System	337
Chapter 24: Neurologic System	358
Chapter 25: Male Genitourinary System	382
Chapter 26: Anus, Rectum, and Prostate	400
Chapter 27: Female Genitourinary System	414
Chapter 28: The Complete Health Assessment: Adult	436
Chapter 29: The Complete Physical Assessment: Infant, Child, and Adolescent	449
Chapter 30: Bedside Assessment and Electronic Documentation	452
Chapter 31: The Pregnant Woman	458
Chapter 32: Functional Assessment of the Older Adult	471

## Chapter 01: Evidence-Based Assessment

### 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)

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)

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

3. The patients 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 patients record and laboratory studies, the objective and subjective data form the data base. The other items are not part of the patients 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 patients breath sounds, the nurse is unsure of a sound that is heard. The nurses next action should be to:

- a. Immediately notify the patients 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 patients 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)

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)

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)

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 clinicians experience.
- d. The patients own preferences are not important with EBP.

ANS: C

EBP is a systematic approach to practice that emphasizes the use of best evidence in combination with the clinicians 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)

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).

DIF: Cognitive Level: Understanding (Comprehension)

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).

DIF: Cognitive Level: Understanding (Comprehension)

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)

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

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)

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)

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