

Jarvis: Physical Examination & Health Assessment, 2nd Canadian Edition

Chapter 01: Critical Thinking and Evidence-Informed Assessment

Test Bank

MULTIPLE CHOICE

1. After completing an initial assessment on a patient, the nurse has charted that his respirations are eupneic 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 care provider observes by inspecting, percussing, palpating, and auscultating during the physical examination.

DIF: Comprehension

REF: Page 2

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 patient says about himself or herself during history taking.

DIF: Comprehension

REF: Page 2

3. The patient’s record, laboratory studies, objective data, and subjective data together form the:
 - 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.

DIF: Knowledge REF: Page 2

4. When listening to a patient's breath sounds, the nurse is unsure about a sound that is heard. The nurse should:
- notify the patient's physician immediately.
 - document the sound exactly as it was heard.
 - validate the data by asking a colleague to listen to the breath sounds.
 - assess again in 20 minutes to note whether the sound is still present.

ANS: C

Validate any data when you need to ensure their accuracy. If you have less experience in an area, ask an expert to listen to the sound.

DIF: Analysis REF: Page 3

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

ANS: B

Novice nurses operate from a set of rules (such as the nursing process).

DIF: Comprehension REF: Page 3

6. Expert nurses learn to attend to a pattern of assessment data and act without consciously labelling it. This is referred to as:
- intuition.
 - the nursing process.
 - clinical knowledge.
 - 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 labelling it.

DIF: Comprehension REF: Page 3

7. Critical thinking in the expert nurse is greatly enhanced by opportunities to:
- apply theory in real situations.
 - work with physicians to provide patient care.
 - follow physician orders in providing patient care.
 - develop nursing diagnoses for commonly occurring illnesses.

ANS: A

Critical thinking is the means by which nurses learn to assess and modify, if indicated, before acting, and this happens in the clinical setting. The depth and breadth of expert knowledge, largely gained from opportunities to apply theory in real situations, greatly enhances a nurse's critical thinking ability.

DIF: Comprehension

REF: Page 4

8. Which of the following is an example of a first-level priority problem?
- A patient with postoperative pain
 - A patient newly diagnosed with diabetes who needs teaching about diabetes
 - An individual with a small laceration on the sole of the foot
 - An individual with shortness of breath and respiratory distress

ANS: D

First-level priority problems are those that are emergent, are life-threatening, and require immediate action (e.g., establishing airway, supporting breathing, maintaining circulation, and monitoring vital signs).

DIF: Comprehension

REF: Page 6

9. Which of the following are considered second-level priority problems?
- Low self-esteem
 - Lack of knowledge
 - Abnormal laboratory values
 - Severely abnormal vital signs

ANS: C

Second-level priority problems are those that require prompt intervention to prevent further deterioration (e.g., mental status change, acute pain, abnormal laboratory values, and risks to safety or security).

DIF: Comprehension

REF: Page 6

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

ANS: B

Clustering-related cues help the nurse recognize relationships among data.

DIF: Comprehension

REF: Page 5

11. The nurse knows that developing appropriate nursing interventions for a patient relies on the appropriateness of the:
- nursing diagnosis.
 - medical diagnosis.
 - admission diagnosis.
 - collaborative diagnosis.

ANS: A

An accurate nursing diagnosis provides the basis for selecting nursing interventions to achieve outcomes for which the nurse is accountable.

DIF: Comprehension

REF: Page 5

12. Which six phases are included in the nursing process?
- Assessment, treatment, client outcome, evaluation, discharge, follow-up
 - Admission, assessment, outcome identification, diagnosis, treatment, discharge planning
 - Admission, diagnosis, expected outcome, treatment, evaluation, discharge planning
 - Assessment, diagnosis, outcome identification, planning, implementation, evaluation

ANS: D

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

DIF: Comprehension

REF: Page 3

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?
- Breathing, pain, sleep
 - Breathing, sleep, pain
 - Sleep, breathing, pain
 - Sleep, pain, breathing

ANS: A

First-level priority problems are immediate priorities (remember the ABCs), followed by second-level problems, and then third-level problems.

DIF: Analysis

REF: Page 6

14. Which of the following would be formulated by a nurse using diagnostic reasoning?
- Nursing diagnosis
 - Medical diagnosis
 - Diagnostic hypothesis
 - Diagnostic assessment

ANS: C

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

DIF: Comprehension

REF: Page 2

15. A nursing diagnosis made by a critical thinker using a dynamic nursing process would identify the actual problem and would also:
- continue to reassess.
 - predict potential problems.
 - check the appropriateness of goals.

d. modify the diagnosis if necessary.

ANS: B

A dynamic nursing process, as used by a critical thinker, would include under diagnoses: diagnoses of actual problems, prediction of potential problems, and identification of strengths.

DIF: Comprehension

REF: Page 5

16. What is the step of the nursing process that includes data collection through health history taking, physical examination, and interview?
- Planning
 - Diagnosis
 - Evaluation
 - Assessment

ANS: D

Data collection, which includes conducting health history taking, physical examination, and interview, is the assessment step of the nursing process.

DIF: Knowledge REF: Page 2

17. Which of the following statements illustrates the biomedical model of Western traditional views?
- Health is viewed as the absence of disease.
 - Optimal health is viewed as high-level wellness.
 - Health and disease are considered parts of a cyclical process.
 - The treatment of disease is nursing's primary focus.

ANS: A

The biomedical model of Western tradition views health as the absence of disease.

DIF: Knowledge REF: Page 8

18. The public's concept of health has changed since the 1950s. Which of the following statements most accurately describes this change?
- Lifestyle, personal habits, exercise, and nutrition are essential to health.
 - Assessment of health is critical to identifying disease-causing pathogens.
 - Accurate diagnosis and treatment by a physician are essential for all health care.
 - An individual is considered healthy when signs and symptoms of disease have been eliminated.

ANS: A

The accurate diagnosis and treatment of illness are still considered important parts of health care, but the public's concept of health has expanded since the 1950s. We have an increasing interest in lifestyle, personal habits, exercise and nutrition, and social and natural environments.

DIF: Comprehension

REF: Page 8

19. Why is the concept of prevention essential in describing health?
- Disease can be prevented by treating the external environment.
 - Most deaths among Canadians under age 65 are not preventable.
 - Prevention places emphasis on the link between health and personal behaviour.
 - The means to prevention is through treatment provided by primary health care practitioners.

ANS: C

A natural progression to prevention now rounds out our concept of health. Guidelines to prevention place emphasis on the link between health and personal behaviour.

DIF: Comprehension

REF: Pages 5, 8

20. Which of the following statements about nursing diagnoses is true? Nursing diagnoses:
- evaluate the etiology of disease.
 - are a process based on medical diagnosis.
 - evaluate the response of the whole person to actual or potential health problems.
 - focus on the function and malfunction of a specific organ system in response to disease.

ANS: C

Nursing diagnoses are used to evaluate the response of the whole person to actual or potential health problems.

DIF: Knowledge REF: Page 6

21. An example of objective information obtained during the physical assessment includes the patient's:
- history of allergies.
 - use of medications at home.
 - last menstrual period.
 - 2 × 5 cm scar present on the right forearm.

ANS: D

Objective data comprise the patient's record, results of laboratory studies, and information that the health care provider obtains by inspecting, percussing, palpating, and auscultating the patient during the physical examination.

DIF: Application REF: Page 2

22. A visiting nurse is making an initial home visit to a patient who has a number of chronic medical problems. Which type of database is most appropriate to collect in this setting?
- A follow-up database to evaluate changes at appropriate intervals
 - An episodic database because of the continuing, complex medical problems of this patient
 - A complete health database because of the nurse's primary responsibility for monitoring the patient's health
 - An emergency database because of the need to rapidly collect information and make

accurate diagnoses

ANS: C

The complete database 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 care agency. In these settings, the nurse is the first health care provider to see the patient and has the primary responsibility for monitoring the person's health care.

DIF: Application REF: Page 9

23. Which of the following situations is most appropriate for an episodic history?
- A patient's admission to a long-term care facility
 - A patient having sudden, severe shortness of breath
 - A patient's admission to the hospital for surgery the following day
 - A patient having cold and flulike symptoms and seen in an outpatient clinic

ANS: D

In an episodic or problem-centred database, the nurse collects a "mini" database, smaller in scope than a complete database. It concerns mainly one problem, one cue complex, or one body system.

DIF: Application REF: Page 10

24. A patient is at the clinic to have her blood pressure checked. She has been coming to the clinic weekly since her medications were changed 2 months ago. The nurse should:
- 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 only the blood pressure because the patient's complete health history was documented 2 months ago.
 - obtain a complete health history before checking the blood pressure because much of the patient's information may have changed.

ANS: A

A follow-up database is used in all settings to follow up short-term or chronic health problems.

DIF: Application REF: Page 10

25. 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 should the nurse proceed with the data collection?
- Collect history information first, perform the physical examination next, and institute lifesaving measures.
 - 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 not ask any history questions until after the patient

has been transferred to the critical care unit.

ANS: B

The emergency database calls for rapid collection of the database, often compiled while performing lifesaving measures.

DIF: Analysis REF: Page 10

26. Which of the following statements is a characteristic of the clinical practice guidelines for infants and children for a periodic health examination?
- They are used to diagnose an illness.
 - They are helpful in identifying developmental delays in children.
 - They recommend that every individual receive an annual physical examination.
 - They list a frequency schedule for periodic health visits for a specific age group.

ANS: D

They include schedules for periodic well-child assessments, as well as other topics.

DIF: Knowledge REF: Page 10

27. A 42-year-old patient of Asian descent is being seen at the clinic for an initial examination. The nurse knows that it is important to include cultural information in his health assessment to:
- identify the cause of his illness.
 - make an accurate diagnosis.
 - provide cultural health rights for the individual.
 - provide culturally sensitive and appropriate care.

ANS: D

The inclusion of cultural considerations in the health assessment is of paramount importance to let nurses effectively and respectfully explore the interrelated biological, social, cultural, and economic factors.

DIF: Comprehension REF: Page 11

28. In the socioenvironmental model, the focus of the health care provider includes:
- changing the patient's perceptions of disease.
 - identification of biomedical model interventions.
 - identifying the negative health behaviours of the patient.
 - helping the patient view health as a resource.

ANS: D

In the socioenvironmental model, the focus of the health care provider is on helping the consumer choose a healthier lifestyle.

DIF: Knowledge REF: Page 8

29. Which of the following would be included in a total health database for a well person?
- Nursing goals for the patient

- b. Anticipated growth and development patterns
- c. A patient's perception of his or her health status
- d. The nurse's perception of disease as related to this patient

ANS: C

A total health database for the well person includes the person's health state, perception of health, strengths or assets such as the ability to engage in health maintenance or health-promoting practices, support systems, current developmental tasks, and any risk factors or social issues.

DIF: Comprehension

REF: Page 9

30. When nursing diagnoses are being classified, which of the following would be considered a risk diagnosis?
- 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

Risk diagnoses are problems that an individual does not currently have but is particularly vulnerable to develop.

DIF: Application REF: Page 5

31. The nurse has implemented several planned interventions to address the nursing diagnosis of acute pain. Which of the following would be the next appropriate action?
- a. Establishing priorities
 - b. Identifying expected outcomes
 - c. Evaluating the individual's condition and comparing actual outcomes with expected outcomes
 - d. Interpreting data, identifying clusters of cues, and making inferences

ANS: C

Evaluation is the next step after the implementation phase of the nursing process. During this step, the nurse should evaluate the individual's condition and compare actual outcomes with expected outcomes.

DIF: Application REF: Pages 3, 4

32. Which of the following 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 sees a patient's situation as a whole, with long-term goals for the patient, rather than as a list of tasks to be performed

ANS: D

The proficient nurse, who has practised longer and has more experience than has the novice nurse, is able to see a patient's situation as a whole, rather than as a list of tasks to be performed, 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.

DIF: Application REF: Page 3

MATCHING

Prioritize the following patient situations:

A = first-level priority problem

B = second-level priority problem

C = third-level priority problem

1. A patient newly diagnosed with type 2 diabetes mellitus who does not know how to check his own blood glucose levels with a glucometer
2. A teenager who was stung by a bee during a soccer match is having trouble breathing
3. An older adult with urinary tract infection who is showing signs of confusion and agitation

1. ANS: B DIF: Analysis REF: Page 6

2. ANS: C DIF: Analysis REF: Page 6

3. ANS: A DIF: Analysis REF: Page 6