Chapter 3. Assessment

Multiple Choice

Identify the choice that best completes the statement or answers the question.

____ 1. The nurse is collecting data on a new patient at an adult clinic. Which data does the nurse need to validate?
   1. The client's weight is 185 lb (83.9 kg) at the clinic.
   2. The client's liver function test results are elevated.
   3. The client states that blood pressure (BP) of 160/94 mm Hg is typical.
   4. The client reports eating processed foods on a low-sodium diet.

____ 2. After collecting data on a client, the nurse reviews and sorts the information. Which example includes both objective and subjective data?
   1. The client's blood pressure reading is 132/68 mm Hg, and heart rate is 88 beats/min.
   2. The client's cholesterol is elevated, and he admits to liking and eating fried food.
   3. The client reports having trouble sleeping and admits drinking coffee in the evening.
   4. The client verbally reports having frequent headaches and taking aspirin for the pain.

____ 3. The nurse manager in an acute care facility is orienting new graduate nurses to a patient care unit. While reviewing The Joint Commission standards, a discussion begins about assessment. Which type of assessment is to be performed on all patients in compliance with The Joint Commission?
   1. Nutritional status
   2. Pain
   3. Cultural
   4. Wellness

____ 4. The nurse is providing care for a variety of patients in an acute care facility. Which of the following constitutes an ongoing assessment?
   1. Obtaining a patient's temperature 1 hour after giving acetaminophen
   2. Examining a patient's throat after soreness with swallowing is reported
   3. Requesting a patient to rate pain intensity level using a scale of 0 to 10
   4. Asking a patient the details of a plan to return to normal exercise activities

____ 5. Each time the nurse comes into contact with a patient, a systematic observation is made. For which reason is this type of assessment performed so frequently?
   1. Time constraints support small portions of assessment at a time.
   2. Validating an absence of change decreases the need to document.
   3. Critical changes are less likely to occur with constant observation.
   4. Repetition makes it less likely the nurse will miss an assessment area.

____ 6. The nurse is obtaining the health history of a client. Which question is an example of the nurse using an open-ended question?
   1. "Have you had surgery before?"

2. “When was your last menstrual period?”
3. “What happens when you have a headache?”
4. “Do you have a family history of heart disease?”

____ 7. The nurse is interviewing a patient being admitted for gastrointestinal issues. The patient informs the nurse that he has persistent vomiting and diarrhea. Which type of assessment is the nurse performing by asking, “When did you first begin to have the vomiting and diarrhea?”?
1. Comprehensive assessment
2. Ongoing focused assessment
3. Special needs assessment
4. Initial focused assessment

____ 8. The nurse is currently performing the initial assessment on a newly admitted client. The nurse receives notification of another client’s admission to the unit. Which professional standard influences the nurse’s decision about who will be assigned to perform the assessment of the second client?
1. The state board for nursing-assistant testing
2. The American Nurses Association (ANA)
3. The facility policy and procedure committee
4. The bargaining committee for facility nurses

____ 9. The nurse is obtaining information from a newly admitted patient during the initial nursing assessment. Which difference does the nurse recognize between the nursing history and the medical history?
1. A nursing history focuses on the patient’s responses and needs to the health problem.
2. The same information is gathered in both; the difference is in who obtains the information.
3. A nursing history is gathered by using a specific format.
4. A medical history collects more in-depth information.

____ 10. During the initial assessment of a newly admitted client, the nurse asks about use of nutritional and herbal supplements. For which reason is it important for the nurse to obtain this specific information?
1. To determine what type of therapies are acceptable to the client
2. To identify whether the client has a nutrition deficiency
3. To help the nurse understand the client’s cultural and spiritual beliefs
4. To be aware of potential interaction with prescribed medication

____ 11. After completing an initial patient assessment, for which reason does the nurse utilize a nursing assessment model?
1. To sort and cluster assessment data into specific categories
2. To organize assessment data according to body systems
3. To validate the use of the nursing process to collect data
4. To follow the American Nurses Association (ANA) Standards of Care

____ 12. For which reason does the nurse use nondirective interviewing as an assessment technique?
1. Allows the nurse to have control of the interview

2. Is an efficient way to interview a patient
3. Facilitates open communication
4. Helps focus the attention of patients who are anxious

____ 13. A nursing instructor is guiding nursing students on best practices for interviewing patients. Which of the following comments by a student would indicate a need for further instruction?
1. "My patient is a young adult, so I plan to talk to her without her parents in the room."
2. "Because my patient is old enough to be my grandfather, I will address him with 'Mr.'"
3. "When reading my patient's health record, I thought of a few questions to ask."
4. "When I give my patient his pain medication, I will have time to ask questions."

____ 14. A patient comes to the urgent care clinic because of injury from stepping on a rusty nail. Which type of assessment does the nurse perform?
1. Comprehensive
2. Ongoing
3. Initial focused
4. Special needs

____ 15. The nurse is providing care to a patient who has left-sided weakness because of a recent stroke. Which type of special needs assessment is **most** important for the nurse to perform?
1. Family
2. Functional
3. Community
4. Psychosocial

____ 16. The nurse is interviewing a patient with a recent onset of migraine headaches. The patient is very anxious and cannot seem to focus on what the nurse is saying. Which comment by the nurse is **best** when beginning to gather data about the headaches?
1. "When did your migraines begin?"
2. "Tell me about your family history of migraines."
3. "What are the things that trigger your headaches?"
4. "Describe for me what your headaches feel like."

____ 17. The nurse is conducting an assessment interview with a newly admitted client. When asking open-ended questions, which action by the nurse indicates an active listening behavior?
1. Taking frequent notes
2. Asking for more details
3. Leaning toward the patient
4. Sitting comfortably with legs crossed

____ 18. A nursing instructor asked his nursing students to discuss their experiences with charting assessment data. Which comment by the student indicates the need for further teaching?
1. "I find it difficult to avoid using phrases like 'the patient tolerated the procedure well.'"
2. "It's confusing to have to remember which abbreviations this hospital allows."
3. "I need to work on charting assessments and interventions right after they are

done."
4. "My patient was really quiet and didn't say much, so I charted that he acted depressed."

____ 19. The nurse prefers to review patient data on a graphic flow sheet, when possible. Which situation is the **best** example of the reason a graphic flowsheet is superior to other methods of recording data?
1. Provides easy documentation of routine vital signs
2. Visually reflects the patterns of a patient's fever
3. Describes symptoms accompanying vital sign changes
4. Enables a quick check for patient tolerance of care

____ 20. The nurse is aware that patient data are often difficult to analyze. Which is the **most** obvious reason for using a framework for collecting and recording patient data?
1. Prioritizes collection of assessment data
2. Organizes and clusters data efficiently
3. Separates subjective and objective data
4. Identifies both primary and secondary data

____ 21. The nurse is preparing to conduct an admission interview with an adult client who is alert and oriented. The client's spouse and two children are visiting and are watching television. Which action by the nurse is conducive to a successful interview?
1. Provide enough chairs for the family to sit facing the client.
2. Ask the client's preference for how to be addressed by the nurse.
3. Ask if the client is willing to answer questions after the family leaves.
4. Give the client the option of having the interview while the family watches television.

____ 22. The nurse obtains information from a patient during admission. The patient is noted to be alert and oriented, be married, have a history of heart disease. Obtaining this information is an example of which process?
1. Collecting data
2. Analyzing data
3. Categorizing data
4. Physical assessment

____ 23. The nurse on a medical-surgical unit receives the third admission over a period of 1.5 hours. A certified nursing assistant (CNA) offers to assist the nurse with the assessment process. Which response by the nurse is the **most** appropriate?
1. "Thank you. I am having a busy day, and I can use your help."
2. "I'm sorry, but nurses are responsible for all patient assessments."
3. "If you start an assessment on the last patient, I will continue it later."
4. "If you could obtain and record the vital signs, it would be a big help."

____ 24. During the assessment process, the patient tells the nurse, "I am having numbness and tingling in my right arm." Which type of data does the nurse recognize on the basis of the patient's statement?
1. Subjective data
2. Objective data
3. Secondary data

4. Comprehensive data

____ 25. The nurse is performing an initial interview with an older adult patient. Which statement by the patient indicates a need for a special needs assessment by the nurse?
1. "I don't go to church as much as I used to, but I watch services on TV."
2. "I have fallen twice at home in the past 6 months, but I have not injured myself."
3. "I don't eat much red meat anymore, but I get my protein from other foods."
4. "I had a toothache recently, so I made an appointment to see the dentist."

____ 26. A patient comes to the emergency department to be evaluated after feeling ill at home. Which is the first question the nurse asks in the initial nursing interview with the patient?
1. "Do you live alone?"
2. "Are you having any pain?"
3. "What is your past medical history?"
4. "Why did you come to the hospital today?"

____ 27. The patient comes to the emergency department complaining of chest pain. Which question by the nurse will encourage the patient to provide the most details about the pain?
1. "When did your chest pain begin?"
2. "On a scale of 0 to 10, what is your pain level?"
3. "Can you give a description of the pain you are having?"
4. "Have you taken any medication for your pain?"

____ 28. Nurses are aware that documentation is essential in monitoring and validating appropriate patient care. Which statement is the **best** example of high-quality nursing documentation?
1. "Patient breathing is normal. No pain noted. Urine output is adequate at this time."
2. "Good strength in both lower extremities. Ambulating with walker in the hall."
3. "Started on solid foods. Ate 75% of dinner. No complaints of any nausea or vomiting."
4. "Patient seems upset with visiting spouse. Physical assessment planned at a later time."

Multiple Response

Identify one or more choices that best complete the statement or answer the question.

____ 29. The nurse is conducting an interview with a patient in a clinic setting. Which questions will be effective for obtaining information from the patient? Select all that apply.
1. "How did this happen to you?"
2. "What was your first symptom?"
3. "Why didn't you seek healthcare earlier?"
4. "When did you start having symptoms?"
5. "Why did you decide to seek help now?"

____ 30. A nurse, with a large caseload of patients, needs to delegate some assessment tasks to other members of the healthcare team. The nurse is unsure which tasks can be delegated to nursing assistive personnel (NAP) and which are appropriate for a licensed practical nurse (LPN) instead of a registered nurse (RN). Which sources does the nurse consult for clarification related to delegation? Select all that apply.
1. Nurse practice act of the nurse's state
2. American Medical Association (AMA) guidelines
3. Code of Ethics for Nurses
4. American Nurses Association (ANA) Scope and Standards of Practice
5. Facility policy and procedure guidelines

____ 31. Which of the following are cues rather than inferences? Select all that apply.
1. Patient ate 50% of the meal.
2. Patient feels better today.
3. Patient states, "I slept well."
4. Patient's white blood cell (WBC) count is 15,000/mm^3.
5. Patient does not appear to be in pain.

____ 32. Nurses use the professional standards of nursing assessment when formulating patient care. Which statements regarding professional standards of nursing assessment are true? Select all that apply.
1. Assessment is a professional nursing responsibility.
2. Assessment helps the nurse identify problems and priorities.
3. Assessment helps the nurse formulate the medical diagnosis.
4. Assessment of pain is focused on patients indicating the presence of pain.
5. Assessments can be delegated according to state practice acts and agency policies.

____ 33. The nurse recognizes which examples of objective data? Select all that apply.
1. Blood pressure of 120/80 mm Hg
2. Pain rated as 6 on a pain scale of 0 to 10
3. Moderate amount of yellow drainage from right ear
4. Spouse stating the client is not sleeping well at night
5. Patient reporting the presence of stomach pain

____ 34. The nurse manager is reviewing documentation performed by newly hired nurses. Which of the examples does the nurse manager recognize as high-quality nursing documentation? Select all that apply.
1. Patient states, "I feel dizzy in the morning."
2. Patient is alert and oriented to person, place, and time.
3. Drainage from midline abdominal incision appears normal.
4. Patient appears angry and is refusing to talk to the spouse.
5. Patient expresses no complaints of pain at this time.

____ 35. The nurse is conducting a patient interview in an acute care setting. Which statements made by the nurse during the interview are appropriate? Select all that apply.
1. "You shouldn't be smoking cigarettes; you have already had one heart attack."
2. "Why don't you take your blood pressure medications? Your blood pressure remains high."

3. “I can see you are in pain. I will bring pain medication and complete the interview later.”
4. “If it is a good time for you, we can complete your interview now.”
5. “Have you noticed any changes in your ability to sleep or patterns of sleeping?”

Chapter 3. Assessment
Answer Section

MULTIPLE CHOICE

1. ANS: 4
   Chapter: Chapter 3 Assessment
   Objective: Describe circumstances in which you should validate data.
   Page: 45 (V1)
   Heading: Types and Sources of Data
   Integrated Processes: Nursing Process
   Client Need: Safe and Effective Care Environment: Management of Care
   Cognitive Level: Analysis [Analyzing]
   Concept: Patient-Centered Care
   Difficulty: Moderate

	Feedback
1	This is incorrect. Personal information that patients might be embarrassed about, such as weight, is best validated with a scale.
2	This is incorrect. Validation is not necessary for laboratory data unless the nurse suspects an error has been made in the results. Retesting needs a prescription from the physician.
3	This is incorrect. If data, such as blood pressure, are gathered by using an objective method, validation is not necessary. The patient's comment does not affect the validity of the data one way or another.
4	This is correct. Validation is done when the client's statements are inconsistent, as in the client reporting consumption of processed foods on a low-sodium diet.

   PTS: 1 CON: Patient-Centered Care
2. ANS: 2
   Chapter: Chapter 3 Assessment
   Objective: Identify the following types of data: subjective, objective, primary source, secondary source.
   Page: 45 (V1)
   Heading: Types and Sources of Data
   Integrated Processes: Nursing Process
   Client Need: Safe and Effective Care Environment: Management of Care
   Cognitive Level: Analysis [Analyzing]
   Concept: Patient-Centered Care
   Difficulty: Moderate

	Feedback
1	This is incorrect. Objective data can be observed by someone other than the patient (e.g., from physical assessments or laboratory and diagnostic tests).

	Subjective data are information given by the client. Blood pressure and heart rate measurements are both objective.
2	This is correct. Elevated cholesterol is objective data, and the patient's stated food preference is subjective.
3	This is incorrect. When the patient verbally expresses trouble sleeping and the consumption of coffee in the evening, all of the data are subjective.
4	This is incorrect. When the patient verbally reports frequent headaches and of treating the pain with aspirin, all the data are subjective.

PTS: 1 CON: Patient-Centered Care

3. ANS: 2
Chapter: Chapter 3 Assessment
Objective: Name three requirements of The Joint Commission regarding patient assessment.
Page: 44 (V1)
Heading: What Do Professional Standards Say About Assessment?
Integrated Processes: Nursing Process
Client Need: Safe and Effective Care Environment: Management of Care
Cognitive Level: Analysis [Analyzing]
Concept: Patient-Centered Care
Difficulty: Moderate

	Feedback
1	This is incorrect. The Joint Commission does not require assessment on nutritional status unless cues indicate there are risk factors.
2	This is correct. The Joint Commission requires that assessments for pain and the risk for falls be performed on all patients. Other special needs assessments should be performed when cues indicate there are risk factors.
3	This is incorrect. The Joint Commission does not require a cultural assessment.
4	This is incorrect. The Joint Commission does not require a wellness assessment.

PTS: 1 CON: Patient-Centered Care

4. ANS: 1
Chapter: Chapter 3 Assessment
Objective: Describe and differentiate initial, ongoing, comprehensive, focused, and special needs assessments.
Page: 45 (V1)
Heading: Types and Sources of Data
Integrated Processes: Nursing Process
Client Need: Safe and Effective Care Environment: Management of Care
Cognitive Level: Application [Applying]
Concept: Patient-Centered Care
Difficulty: Moderate

	Feedback
1	This is correct. An ongoing assessment occurs when a previously identified problem is being reassessed—for example, taking an hourly temperature when a

	patient has a fever.
2	This is incorrect. Examining a patient's throat is a focused assessment to explore the possible source of pain with swallowing.
3	This is incorrect. Asking for a pain rating using a scale of 0 to 10 is a focused assessment.
4	This is incorrect. Asking a patient for details of a plan to return to normal exercise activities is a special needs assessment. There is no way to determine if this assessment will be ongoing.

PTS: 1 CON: Patient-Centered Care

5. ANS: 4
Chapter: Chapter 3 Assessment
Objective: Describe and differentiate initial, ongoing, comprehensive, focused, and special needs assessments.
Page: 46 (V1)
Heading: Nursing Assessment Skills
Integrated Processes: Nursing Process
Client Need: Safe and Effective Nursing Care Environment: Management of Care
Cognitive Level: Analysis [Analyzing]
Concept: Patient-Centered Care
Difficulty: Difficult

	Feedback
1	This is incorrect. Systematic observation, like other types of assessment, is not performed in a parameter of time constraints. Complete assessments at the beginning of a shift are a vital tool to identify change.
2	This is incorrect. Systematic observation is a type of assessment focused on patient well-being; it does not influence the need to document.
3	This is incorrect. In itself, systematic observation does not prevent critical changes in a patient's status; however, the process does alert the nurse to changes in a timely manner.
4	This is correct. By making systematic observations each time the nurse is with a patient, the nurse is less likely to miss an assessment area and/or overlook changes in the patient's status.

PTS: 1 CON: Patient-Centered Care

6. ANS: 3
Chapter: Chapter 3 Assessment
Objective: Compare open-ended and closed questions, including definitions, uses, advantages, and disadvantages.
Page: 47 (V1)
Heading: Types of Interviews
Integrated Processes: Communication and Documentation
Client Need: Safe and Effective Nursing Care Environment: Management of Care
Cognitive Level: Application [Applying]
Concept: Communication

Difficulty: Moderate

	Feedback
1	This is incorrect. Questions that require a simple answer, such as a "yes" or a "no," are considered closed-ended questions. This question would be open ended if the nurse asked, "What surgeries have you had?"
2	This is incorrect. Questions that require a specific answer, such as a date, is considered closed-ended question. This question would be open ended if the nurse asked, "What can you tell me about your menstrual periods?"
3	This is correct. Open-ended questions—for example, "What happens when you have a headache?"—are broadly worded to encourage the patient to elaborate.
4	This is incorrect. Questions that require a simple answer, such as a "yes" or a "no," are considered closed-ended questions. This question would be open ended if the nurse asked, "Who are your family members with heart disease?"

PTS: 1 CON: Communication

7. ANS: 4
Chapter: Chapter 3 Assessment
Objective: Describe and differentiate initial, ongoing, comprehensive, focused, and special needs assessments.
Page: 46 (V1)
Heading: Types of Assessment
Integrated Processes: Nursing Process
Client Need: Safe and Effective Care Environment: Management of Care
Cognitive Level: Analysis [Analyzing]
Concept: Patient-Centered Care
Difficulty: Difficult

	Feedback
1	This is incorrect. A comprehensive assessment provides the nurse with holistic information about the client's overall health status; enables identification of client problems and strengths; enhances the nurse's sensitivity to a patient's culture, values, beliefs, and economic situation; and uses the nursing skills of observation, physical assessment, and interviewing.
2	This is incorrect. An ongoing focused assessment is used to evaluate the status of existing problems and goals. The nurse performs ongoing focused assessment periodically throughout the period of providing patient care.
3	This is incorrect. A special needs assessment is a type of focused assessment that provides in-depth information about a particular area of client functioning and often involves using a specially designed form. The nurse will perform a special needs assessment any time assessment cues suggest risk factors or problems for a client, such as nutrition status or pain management.
4	This is correct. An initial focused assessment is used to follow up on client-reported symptoms or unusual findings during the first examination. The nurse is seeking additional information about specific symptoms reported by the patient—in this scenario, vomiting, and diarrhea.

PTS: 1 CON: Patient-Centered Care

8. ANS: 2
Chapter: Chapter 3 Assessment
Objective: State the ANA position on delegating assessment.
Page: 44 (V1)
Heading: What Do Professional Standards Say About Assessment?
Integrated Processes: Nursing Process
Client Need: Safe and Effective Care Environment: Managing Care
Cognitive Level: Application [Applying]
Concept: Professionalism
Difficulty: Moderate

	Feedback
1	This is incorrect. Most states have a method of testing for nursing assistant personnel, but it is not necessarily the state board of nursing. Nurse aides or other unlicensed assistive personnel (UAP) may collect certain information, such as vital signs, pain reports, and finger stick blood glucose levels. However, it is the professional nurse's responsibility to assign those tasks, validate the data collected, conduct the interview, and complete the physical assessment.
2	This is correct. The ANA's Scope and Standards of Practice (2015), which applies to professional nurses (registered nurses [RNs]), identifies assessment as a professional responsibility. The Joint Commission, the National Council of State Boards of Nursing (NCSBN), and nurse practice acts support the ANA standard.
3	This is incorrect. Agency policies/procedures state which caregivers can collect and document specified data within that agency/facility. However, the parameters of professional standards are observed with the development of agency policy/procedures.
4	This is incorrect. Bargaining committees for a facility's nurses will observe the parameters of professional standards. Not all care facilities will have bargaining committees.

PTS: 1 CON: Professionalism

9. ANS: 1
Chapter: Chapter 3 Assessment
Objective: Discuss the relationship between the nursing process and collaborative care.
Page: 49 (V1)
Heading: Interviewing to Obtain a Nursing Health History
Integrated Processes: Nursing Process
Client Need: Safe and Effective Nursing Care Environment: Management of Care
Cognitive Level: Comprehension [Understanding]
Concept: Patient-Centered Care
Difficulty: Moderate

	Feedback
1	This is correct. A nursing history focuses on the patient's responses to and

	perception of the illness/injury or health problem, the patient's coping ability, and the patient's resources and support.
2	This is incorrect. A medical history focuses on the patient's current and past medical/surgical problems.
3	This is incorrect. Nursing history formats vary, depending on the patient, the agency, and the patient's needs. Both nursing and medical histories typically use a specific format.
4	This is incorrect. A medical history does not necessarily contain more in-depth information. A nursing history can be thorough, covering a wide range of topics, including biographical data, reason(s) patient is seeking healthcare, history of present illness, patient's perception of health status and expectations for care, past medical history, use of complementary modalities, and review of functional ability associated with activities of daily living.

PTS: 1 CON: Patient-Centered Care

10. ANS: 4
Chapter: Chapter 3 Assessment
Objective: Identify the following types of data: subjective, objective, primary source, secondary source.
Page: 49 (V1)
Heading: Interviewing to Obtain a Nursing Health History
Integrated Processes: Nursing Process
Client Need: Safe and Effective Care Environment: Safety and Infection Control
Cognitive Level: Analysis [Analyzing]
Concept: Patient-Centered Care
Difficulty: Difficult

	Feedback
1	This is incorrect. The information alone does not specifically address the client's acceptance of certain types of therapy.
2	This is incorrect. Physical assessment and laboratory tests are needed to assess a nutritional deficiency.
3	This is incorrect. To identify the client's cultural and spiritual beliefs and well as what therapies are acceptable to the client, the nurse would need more than just information about nutritional and herbal supplements.
4	This is correct. Herbs and nutritional supplements can interact with prescription medications, and complementary and alternative treatments can interfere with conventional therapies.

PTS: 1 CON: Patient-Centered Care

11. ANS: 1
Chapter: Chapter 3 Assessment
Objective: Use nursing frameworks to organize data.
Page: 50 (V1)
Heading: How Can I Organize Data?

Integrated Processes: Nursing Process
Client Need: Safe and Effective Nursing Care Environment: Management of Care
Cognitive Level: Analysis [Analyzing]
Concept: Professionalism
Difficulty: Difficult

	Feedback
1	This is correct. Nursing assessment models categorize or cluster data into functional health patterns, domains, or categories to make the data easier to use.
2	This is incorrect. None of the nursing assessment models cluster data according to body systems.
3	This is incorrect. Assessment is the first step in the nursing process; however, the nurse does not use the entire nursing process in data collection.
4	This is incorrect. The ANA Standards of Care describe a competent level of clinical nursing practice based on the nursing process; nursing models are not based on the ANA Standards of Care.

PTS: 1 CON: Professionalism

12. ANS: 3
Chapter: Chapter 3 Assessment
Objective: Describe the differences between directive and nondirective interviewing.
Page: 49 (V1)
Heading: Table 3-3: Comparison of Directive and Nondirective Interviews
Integrated Processes: Communication and Documentation
Client Need: Safe and Effective Care Environment: Management of Care
Cognitive Level: Comprehension [Understanding]
Concept: Patient-Centered Care
Difficulty: Easy

	Feedback
1	This is incorrect. With the use of nondirective interviewing, the patient controls the subject matter.
2	This is incorrect. Because nondirective interviewing puts the patient in control of the subject matter, the process can be very time consuming (inefficient) and produce information that is not relevant.
3	This is correct. Nondirective interviewing helps build rapport between the nurse and the patient and facilitates the use of open communication.
4	This is incorrect. Directive interviewing is used to focus the attention of anxious patients. The method focuses on obtaining factual, easily categorized information. The process is especially useful in an emergency situation.

PTS: 1 CON: Patient-Centered Care

13. ANS: 4
Chapter: Chapter 3 Assessment
Objective: Discuss how to prepare for and conduct an interview.
Page: 50 (V1)

Heading: Preparing for an Interview
Integrated Processes: Communication and Documentation
Client Need: Safe and Effective Nursing Care Environment: Management of Care
Cognitive Level: Application [Applying]
Concept: Patient-Centered Care
Difficulty: Moderate

	Feedback
1	This is incorrect. It is appropriate to interview patients without family/friends around; this decision does not require further instruction.
2	This is incorrect. In nearly every culture, addressing a patient with "Mr." or "Mrs." shows respect and is, therefore, correct and does not require further instruction.
3	This is incorrect. Reading the patient's health record is appropriate preparation for an interview. This decision does not require further instruction.
4	This is correct. A patient should be comfortable when interviewing. The pain medication should have time to work before the nurse would consider interviewing the patient, so asking questions when giving the medication is not a good idea. This decision requires further instruction.

PTS: 1 CON: Patient-Centered Care

14. ANS: 3
Chapter: Chapter 3 Assessment
Objective: Describe and differentiate initial, ongoing, comprehensive, focused, and special needs assessment.
Page: 47 (V1)
Heading: Focused Assessments
Integrated Processes: Nursing Process
Client Need: Safe and Effective Care Environment: Management of Care
Cognitive Level: Application [Applying]
Concept: Patient-Centered Care
Difficulty: Moderate

	Feedback
1	This is incorrect. A comprehensive assessment is holistic and is usually done upon the client's admission to a healthcare facility.
2	This is incorrect. An ongoing assessment is a follow-up procedure after an initial database is completed or a problem is identified.
3	This is correct. An initial focused assessment is performed during a first examination for specific abnormal findings.
4	This is incorrect. A special needs assessment is performed when there are cues that more in-depth assessment is needed.

PTS: 1 CON: Patient-Centered Care

15. ANS: 2
Chapter: Chapter 3 Assessment

Objective: Describe and differentiate initial, ongoing, comprehensive, focused, and special needs assessments.
Page: 48 (V1)
Heading: Special Needs Assessments
Integrated Processes: Nursing Process
Client Need: Safe and Effective Care Environment: Management of Care
Cognitive Level: Analysis [Analyzing]
Concept: Patient-Centered Care
Difficulty: Moderate

	Feedback
1	This is incorrect. A family assessment is helpful to evaluate the patient's support systems. This is probably the second-most important special needs assessment for the nurse to make for this patient.
2	This is correct. A functional assessment is the most important assessment because of discharge needs (e.g., self-care ability at home) and patient safety.
3	This is incorrect. A community assessment is helpful to evaluate community services available to assist the patient. However, this is not the most important special needs assessment.
4	This is incorrect. A psychosocial assessment is helpful to evaluate a patient's understanding of and coping with the recently diagnosed stroke. However, this is not the most important special needs assessment for the nurse to perform.

PTS: 1 CON: Patient-Centered Care

16. ANS: 1
Chapter: Chapter 3 Assessment
Objective: Describe the differences between directive and nondirective interviewing.
Page: 47 (V1)
Heading: Table 3-3: Comparison of Directive and Nondirective Interviews
Integrated Processes: Communication and Documentation
Client Need: Safe and Effective Care Environment: Management of Care
Cognitive Level: Application [Applying]
Concept: Patient-Centered Care
Difficulty: Moderate

	Feedback
1	This is correct. For someone who is anxious, it is best to use closed-ended questions. A closed-ended question can be answered in one or very few words and has a very specific answer.
2	This is incorrect. This statement requires the patient to give a detailed response, which is not suitable for interviewing an anxious patient.
3	This is incorrect. Asking what triggers the patient's migraine is an open-ended question, which requires a detailed response. This is not suitable for interviewing an anxious patient.
4	This is incorrect. Asking the patient for a description of how the headaches feel requires a detailed response, which is not suitable for interviewing an anxious patient.

PTS: 1 CON: Patient-Centered Care

17. ANS: 3
Chapter: Chapter 3 Assessment
Objective: Discuss how to prepare for and conduct an interview.
Page: 49 (V1)
Heading: Interviewing to Obtain a Nursing Health History
Integrated Processes: Communication and Documentation
Client Need: Safe and Effective Care Environment: Management of Care
Cognitive Level: Comprehension [Understanding]
Concept: Communication
Difficulty: Easy

	Feedback
1	This is incorrect. Taking frequent notes makes it difficult for the nurse to maintain eye contact with the client.
2	This is incorrect. Asking for more details may seem like idle curiosity to the client.
3	This is correct. The nurse is exhibiting active listening behaviors by leaning toward the client; facing the patient; exhibiting an open, relaxed posture without crossing the arms or legs; and maintaining eye contact.
4	This is incorrect. When the nurse is sitting with legs crossed, it may indicate to the client that the nurse is not receptive to the client.

PTS: 1 CON: Communication

18. ANS: 4
Chapter: Chapter 3 Assessment
Objective: Describe circumstances in which you should validate data.
Page: 53 (V1)
Heading: How Should I Document Data?
Integrated Processes: Communication and Documentation
Client Need: Safe and Effective Care Environment: Management of Care
Cognitive Level: Analysis [Analyzing]
Concept: Communication
Difficulty: Moderate

	Feedback
1	This is incorrect. Chart specific data, not vague phrases; the student is acknowledging the importance of this.
2	This is incorrect. There are no universally accepted phrases, just agency-approved abbreviations; the student is acknowledging the need to use agency-approved abbreviations.
3	This is incorrect. The student is correct that charting should be completed as soon after data collection as possible.
4	This is correct. When charting data, chart only what was observed, not what it

	meant. Inferences should not be made about a patient's behavior during data collection ("he acted depressed"), so this response reflects the student's lack of knowledge and need for teaching.

PTS: 1 CON: Communication

19. ANS: 2
Chapter: Chapter 3 Assessment
Objective: Describe circumstances in which you should validate data.
Page: 53 (V1)
Heading: Tools for Recording Assessment Data
Integrated Processes: Communication and Documentation
Client Need: Safe and Effective Care Environment: Management of Care
Cognitive Level: Analysis [Analyzing]
Concept: Communication
Difficulty: Moderate

	Feedback
1	This is incorrect. Flowsheets can be used to record various types of information, such as routine documentation of vital signs.
2	This is correct. To easily and graphically see trends over time, the graphic flowsheet is superior to other methods of documentation, allowing quick assessment of patient changes in status. The pattern of a patient's fever is the best example of the superiority of a graphic flowsheet.
3	This is incorrect. A description of the symptoms accompanying changes in vital signs is narrative information for which a graphic flowsheet may not be suitable.
4	This is incorrect. Patient tolerance of care is most likely to be documented in narrative form and not on a graphic flowsheet.

PTS: 1 CON: Communication

20. ANS: 2
Chapter: Chapter 3 Assessment
Objective: Use nursing frameworks to organize data.
Page: 50 (V1)
Heading: How Can I Organize Data?
Integrated Processes: Nursing Process
Client Need: Safe and Effective Care Environment: Management of Care
Cognitive Level: Comprehension [Understanding]
Concept: Patient-Centered Care
Difficulty: Moderate

	Feedback
1	This is incorrect. During the assessment phase, the nurse is collecting and recording data, not prioritizing data.
2	This is correct. The major concept of a framework is to assist the nurse to organize and cluster data to find patterns.
3	This is incorrect. A framework includes subjective and objective data but does

	not help the nurse to separate the two types of data.
4	This is incorrect. A framework includes primary and secondary data but does not help the nurse to separate the two types of data.

PTS: 1 CON: Patient-Centered Care

21. ANS: 3
Chapter: Chapter 3 Assessment
Objective: Discuss how to prepare for and conduct an interview.
Page: 50 (V1)
Heading: Preparing for an Interview
Integrated Processes: Communication and Documentation
Client Need: Safe and Effective Care Environment: Management of Care
Cognitive Level: Application [Applying]
Concept: Communication
Difficulty: Moderate

	Feedback
1	This is incorrect. Family members may offer information that may or may not be pertinent and may distract the client from the interview. The presence of family members may also inhibit full disclosure of information by the client.
2	This is incorrect. The nurse always needs to ask the client's preference for how they are addressed. However, this action alone does not ensure a successful interview.
3	This is correct. The interview should be done when the client is comfortable and there are no distractions.
4	This is incorrect. The family watching television during the nurse's interview of the client may be distracting to both the nurse and the client.

PTS: 1 CON: Communication

22. ANS: 1
Chapter: Chapter 3 Assessment
Objective: Identify at least four components of a nursing health history.
Page: 49 (V1)
Heading: Interviewing to Obtain a Nursing Health History
Integrated Processes: Nursing Process
Client Need: Safe and Effective Care Environment: Management of Care
Cognitive Level: Comprehension [Understanding]
Concept: Patient-Centered Care
Difficulty: Easy

	Feedback
1	This is correct. The nurse is collecting data on this patient; however, the data provided indicate that further data collection is warranted.
2	This is incorrect. Data are analyzed to formulate nursing diagnoses and a plan of care.
3	This is incorrect. After assessment, data are categorized to organize the

	information and add clarity.
4	This is incorrect. The information in the scenario indicates that a comprehensive physical assessment has not been completed.

PTS: 1 CON: Patient-Centered Care

23. ANS: 4
Chapter: Chapter 3 Assessment
Objective: State the ANA position on delegating assessment.
Page: 47 (V1)
Heading: What Do Professional Standards Say About Assessment?
Integrated Processes: Nursing Process
Client Need: Safe and Effective Care Environment: Management of Care
Cognitive Level: Analysis [Analyzing]
Concept: Professionalism
Difficulty: Moderate

	Feedback
1	This is incorrect. In making decisions about which parts of an assessment can be delegated to the CNA, the nurse must consider agency policies and the regulations of the state board of nursing.
2	This is incorrect. Certain assessment activities, such as vital signs, weighing the client, and maintaining output and intake measures, can be assigned to qualified CNAs.
3	This is incorrect. Nursing regulatory bodies specify that client assessment is the responsibility of the registered nurse. Therefore, the CNA cannot be instructed to start an assessment that will be completed by the nurse.
4	This is correct. In most states, the CNA can obtain vital signs and record them in the patient's chart; however, the ability to perform this task must first be validated by the nurse. The nurse is also responsible for validating the documentation of the information by the CNA.

PTS: 1 CON: Professionalism

24. ANS: 1
Chapter: Chapter 3 Assessment
Objective: Identify the following types of data: subjective, objective, primary source, secondary source.
Page: 45 (V1)
Heading: Types and Sources of Data
Integrated Processes: Nursing Process
Client Need: Safe and Effective Care Environment: Management of Care
Cognitive Level: Analysis [Analyzing]
Concept: Professionalism
Difficulty: Moderate

	Feedback
1	This is correct. The patient's statement about experiencing numbness and

	tingling down the right arm is an example of subjective data because the statement is in the patient's own words.
2	This is incorrect. Objective data are overt and gathered by the nurse through physical assessment, laboratory findings, or diagnostic testing results.
3	This is incorrect. Secondary data are obtained through a source other than the patient, such as a family member
4	This is incorrect. There is not enough information in the patient's statement to categorize it as comprehensive data because the nurse would have to complete a physical assessment and obtain all data.

PTS: 1 CON: Professionalism

25. ANS: 2
Chapter: Chapter 3 Assessment
Objective: Describe and differentiate initial, ongoing, comprehensive, focused, and special needs assessments.
Page: 46 (V1)
Heading: Types of Assessment
Integrated Processes: Nursing Process
Client Need: Safe and Effective Care Environment: Management of Care
Cognitive Level: Analysis [Analyzing]
Concept: Patient-Centered Care
Difficulty: Moderate

	Feedback
1	This incorrect. The patient verbalizes that he misses church but adds that he is able to view services on television.
2	This is correct. An older adult who has fallen twice in 6 months has a safety risk. There is no indication that a walker has been obtained. Falling and the risk for falls require the nurse to perform a special needs assessment related to functional status. The lack of injury does not diminish the need.
3	This is incorrect. The patient verbalizes eating less red meat but adds that protein is obtained from other sources. The nurse may want to determine what the other protein sources are before performing a special needs assessment.
4	This is incorrect. The client verbalizes a physiological concern regarding a toothache, but the patient has addressed the issue by making an appointment to see the dentist.

PTS: 1 CON: Patient-Centered Care

26. ANS: 4
Chapter: Chapter 3 Assessment
Objective: Describe the differences between directive and nondirective interviewing.
Page: 49 (V1)
Heading: Interviewing to Obtain a Nursing Health History
Integrated Processes: Nursing Process
Client Need: Safe and Effective Care Environment: Management of Care
Cognitive Level: Application [Applying]

Concept: Professionalism
Difficulty: Moderate

	Feedback
1	This is incorrect. It is appropriate to ask the patient about the home situation; however, this question can be addressed later when taking the health history and performing the physical assessment.
2	This is incorrect. It is appropriate to ask the patient about pain, but this question can be addressed later when taking the health history and performing the physical assessment or by following the patient's lead.
3	This is incorrect. It is appropriate to ask the patient about the medical history; however, this question can be addressed later when taking the health history and performing the physical assessment.
4	This is correct. The nurse should first ask in the initial interview why the patient is seeking nursing or medical assistance. This broad question will elicit the most information because it is open ended.

PTS: 1 CON: Professionalism

27. ANS: 3
Chapter: Chapter 3 Assessment
Objective: Describe the differences between directive and nondirective interviewing.
Page: 49 (V1)
Heading: Interviewing to Obtain a Nursing Health History
Integrated Processes: Nursing Process
Client Need: Safe and Effective Care Environment: Safety and Infection Control
Cognitive Level: Analysis [Analyzing]
Concept: Professionalism
Difficulty: Moderate

	Feedback
1	This is incorrect. Asking when the patient's pain began will only elicit a short answer specific to that question. Each question is asked in pain assessment; however, the question that will elicit the most information is the one that asks the patient to tell the nurse more about the pain.
2	This is incorrect. Asking to rate the level of pain on a scale of 0 to 10 will only elicit a short answer; of greater importance is the description of the pain present with chest pain.
3	This is correct. The most information is gained by asking the patient to tell the nurse more about the pain. This is an open-ended question and will give the nurse more information about the pain.
4	This is incorrect. Although asking the patient about medication taken for the pain is appropriate, the question will elicit only a short answer with a limited amount of information about the characteristics of the pain.

PTS: 1 CON: Professionalism

28. ANS: 3
Chapter: Chapter 3 Assessment

Objective: Use assessment skills to gather data during a nursing assessment.
Page: 53 (V1)
Heading: How Should I Document Data?
Integrated Processes: Communication and Documentation
Client Need: Safe and Effective Care Environment: Management of Care
Cognitive Level: Analysis [Analyzing]
Concept: Communication
Difficulty: Moderate

	Feedback
1	This is incorrect. Noting that patient breathing is normal and urine output is adequate does not give enough information about either function.
2	This is incorrect. "Good strength in both lower extremities" is vague as the word *good* is subjective.
3	This is correct. "Started on solid foods. Ate 75% of dinner. No complaints of nausea or vomiting" is clear, concrete, and specific.
4	This is incorrect. "Patient seems upset" does not give enough information and involves an assumption by the nurse. Also, the nurse does not document what things have not been done; this action can be used to show inadequate nursing care if litigation is ever initiated.

PTS: 1 CON: Communication

MULTIPLE RESPONSE

29. ANS: 1, 2, 4
Chapter: Chapter 3 Assessment
Objective: Discuss how to prepare for and conduct an interview.
Page: 50 (V1)
Heading: Preparing for an Interview
Integrated Processes: Communication and Documentation
Client Need: Communication and Documentation
Cognitive Level: Analysis [Analyzing]
Concept: Communication
Difficulty: Difficult

	Feedback
1.	This is correct. "How," "what," and "when" are acceptable lines of questioning. It will be beneficial for the nurse to ascertain how a patient's issue occurred.
2.	This is correct. "How," "what," and "when" are acceptable lines of questioning.
3.	This is incorrect. Asking "why" can put the patient on the defensive and may suggest disapproval, limiting the amount of information the patient is willing give. Questioning the patient's judgment for seeking care is inappropriate.
4.	This is correct. "How," "what," and "when" are acceptable lines of questioning.
5.	This is incorrect. Asking "why" can put the patient on the defensive and may suggest

	disapproval, limiting the amount of information the patient is willing give. Why the patient decided to seek help at this time is of least importance.

PTS: 1 CON: Communication

30. ANS: 1, 4
Chapter: Chapter 3 Assessment
Objective: State the ANA position on delegating assessment.
Page: 47 (V1)
Heading: What Do Professional Standards Say About Assessment?
Integrated Processes: Nursing Process
Client Need: Safe and Effective Care Environment: Management of Care
Cognitive Level: Analysis [Analyzing]
Concept: Professionalism
Difficulty: Difficult

	Feedback
1.	This is correct. State nurse practice acts specify which portions of the assessment can legally be completed by individuals with different credentials. The practice acts will vary from state board to state board.
2.	This is incorrect. The AMA provides guidelines and standards for physicians, not nurses.
3.	This is incorrect. The Code of Ethics for Nurses merely states that the nurse should delegate tasks appropriately; it does not speak directly to the specific credentials of personnel.
4.	This is correct. The ANA's *Scope and Standards of Practice* provides professional guidance for determining who is ultimately responsible and qualified to collect assessment data.
5.	This is incorrect. The facility policy and procedure index should reflect the professional nursing standards of practice; however, this is not the best source of validating delegation guidelines.

PTS: 1 CON: Professionalism

31. ANS: 1, 3, 4
Chapter: Chapter 3 Assessment
Objective: Use assessment skills to gather data during a nursing assessment.
Page: 47 (V1)
Heading: Guidelines for Recording Assessment Data
Integrated Processes: Nursing Process
Client Need: Safe and Effective Care Environment: Management of Care
Cognitive Level: Analysis [Analyzing]
Concept: Patient-Centered Care
Difficulty: Difficult

	Feedback
1.	This is correct. Cues are what the client says and what the nurse observes. The nurse

	can observe the percentage of the meal eaten by the client.
2.	This is incorrect. When the nurse states, “The patient feels better,” the nurse is making an inference. What did the nurse observe to validate that the client feels better? Those observations are cues.
3.	This is correct. Cues are what the client says and what the nurse observes. When the client states, “I slept well,” it is a verbal fact stated by the client and is a cue.
4.	This is correct. A laboratory value is a factual statement and, therefore, a cue.
5.	This is incorrect. When the nurse notes that the patient “does not appear to be in pain,” the nurse is making an inference. What validating cues does the nurse recognize?

PTS: 1 CON: Patient-Centered Care

32. ANS: 1, 2, 5
Chapter: Chapter 3 Assessment
Objective: Discuss professional standards affecting nursing process (e.g., American Nurses Association, The Joint Commission).
Page: 44 (V1)
Heading: What Do Professional Standards Say About Assessment?
Integrated Processes: Nursing Process
Client Need: Safe and Effective Care Environment: Management of Care
Cognitive Level: Analysis [Analyzing]
Concept: Patient-Centered Care
Difficulty: Difficult

	Feedback
1.	This is correct. Assessment is a professional responsibility as designated by professional standards.
2.	This is correct. Assessment is a professional responsibility that assists the nurse to identify problems and prioritize care.
3.	This is incorrect. Assessment helps the nurse formulate a nursing diagnosis; a medical diagnosis is not within the nurse’s scope of practice.
4.	This is incorrect. All patients are assessed for pain.
5.	This is correct. Parts of the assessment may be delegated, depending on state boards of nursing and agency policies.

PTS: 1 CON: Patient-Centered Care

33. ANS: 1, 3
Chapter: Chapter 3 Assessment
Objective: Identify the following types of data: subjective, objective, primary source, secondary source.
Page: 45 (V1)
Heading: Types and Sources of Data
Integrated Processes: Nursing Process
Client Need: Safe and Effective Care Environment: Management of Care
Cognitive Level: Analysis [Analyzing]

Concept: Patient-Centered Care
Difficulty: Difficult

	Feedback
1.	This is correct. A blood pressure reading is an example of objective data. Such data are obtained by the nurse through assessment and can be validated.
2.	This is incorrect. Pain that is rated on a scale of 0 to 10 is still considered subjective because it is rated on the patient's opinion. Objective data about pain includes crying, grimacing, or posturing.
3.	This is correct. The presence and description of drainage is an example of objective data. Such data are obtained by the nurse through assessment and can be validated.
4.	This is incorrect. The spouse's statement about the patient's quality of sleep is indicative of secondary data, which is vague and subjective.
5.	This is incorrect. The patient's report about the presence of stomach pain is subjective. Objective validation would include physical manifestations of pain.

PTS: 1 CON: Patient-Centered Care

34. ANS: 1, 2, 5
Chapter: Chapter 3 Assessment
Objective: Use assessment skills to gather data during a nursing assessment.
Page: 53 (V1)
Heading: How Should I Document Data?
Integrated Processes: Communication and Documentation
Client Need: Safe and Effective Care Environment: Management of Care
Cognitive Level: Analysis [Analyzing]
Concept: Communication
Difficulty: Difficult

	Feedback
1.	This is correct. Recording the patient's statement in the patient's own words is an example of high-quality documentation. The statement is not vague or subjective.
2.	This is correct. When the nurse documents validation of orientation and the means of evaluation, the documentation is an example of high-quality documentation.
3.	This is incorrect. The statement regarding the patient's incision is vague because what is considered *normal* cannot be measured.
4.	This is incorrect. Noting that the patient is angry and refuses to talk with the spouse is subjective and unclear.
5.	This is correct. Documentation that includes the patient's response to an assessment of pain is an example of high-quality documentation.

PTS: 1 CON: Communication

35. ANS: 3, 4, 5
Chapter: Chapter 3 Assessment
Objective: Discuss how to prepare for and conduct an interview.
Page: 49 (V1)

Heading: Interviewing to Obtain a Nursing Health History
Integrated Processes: Communication and Documentation
Client Need: Safe and Effective Care Environment: Management of Care
Cognitive Level: Analysis [Analyzing]
Concept: Communication
Difficulty: Difficult

	Feedback
1.	This is incorrect. Criticizing the patient's behavior and citing a medical situation diminishes the possibility of establishing a positive rapport between the patient and the nurse.
2.	This is incorrect. When the nurse asks a "why" question, it is often offensive to the patient. The nurse needs to use therapeutic communication skills to determine the patient's noncompliance with medical treatment.
3.	This is correct. Observing that the patient is in pain, offering pain medication, and postponing the interview are appropriate when performing the nursing interview. Pain and use of medication will make the interview process more difficult and possibly less accurate.
4.	This is correct. Asking the patient about the timing of the interview is appropriate and accommodating.
5.	This is correct. Asking the patient about sleeping patterns is appropriate when performing the nursing interview.

PTS: 1 CON: Communication