Chapter 01 - Nurse's Role in Health Assessment

1. Which individual typically would be responsible for collecting the subjective data on a client during the initial comprehensive assessment?
A. Physician
B. Nurse
C. Secretary
D. Technician

Answer: B

Rationale: The nurse typically collects the subjective data, especially those related to the client's overall function. However, depending on the setting, other members of the health care team may participate in various parts of the objective data collection.
Question Format: Multiple Choice
Chapter: 1
Cognitive Level: Remember
Client Needs: Safe, Effective Care Environment: Management of Care

2. When performing the steps of the assessment phase of the nursing process, which of the following would the nurse do first?
A. Collect objective data
B. Validate the data
C. Collect subjective data
D. Document the data

Answer: C

Rationale: With assessment, subjective then objective data is collected. This is followed by validation and then documentation of data.

Question Format: Multiple Choice
Chapter: 1
Cognitive Level: Apply
Client Needs: Health Promotion and Maintenance

3. An instructor is describing a comprehensive nursing health assessment to a group of students. The instructor determines that the teaching was successful when the students identify which of the following as the overall purpose?
A. Collect large quantities of data
B. Assist the physician
C. Validate previous data
D. Make a clinical judgment

Answer: D

Rationale: The purpose of a nursing health assessment is to collect subjective and objective data to determine a client's overall level of functioning to make a professional clinical judgment.
Question Format: Multiple Choice
Chapter: 1
Cognitive Level: Understand
Client Needs: Health Promotion and Maintenance

4. A nurse on a postsurgical unit is admitting a client following the client's cholecystectomy. What is the overall purpose of assessment for this client?
A. Collecting accurate data
B. Assisting the primary care provider
C. Validating previous data

D. Making clinical judgments

Answer: D

Rationale: The purpose of a nursing health assessment is to collect subjective and objective data to determine a client's overall level of functioning to make a professional clinical judgment. Collecting and validating data are means to this end. The primary purpose of assessment is not to assist the primary care provider.
Question Format: Multiple Choice
Chapter: 1
Cognitive Level: Understand
Client Needs: Safe, Effective Care Environment: Management of Care

5. A client has presented to the emergency department (ED) with complaints of abdominal pain. Which member of the care team would most likely be responsible for collecting the subjective data on the client during the initial comprehensive assessment?
A. Gastroenterologist
B. ED nurse
C. Admissions clerk
D. Diagnostic technician

Answer: B

Rationale: The nurse typically collects the subjective data, especially those related to the client's overall function. However, depending on the setting, other members of the health care team may participate in various parts of the objective data collection. Referral to a medical specialist would not take place at this early stage of assessment.
Question Format: Multiple Choice

Chapter : 1
Cognitive Level: Remember
Client Needs: Safe, Effective Care Environment: Management of Care

6. The nurse has completed an initial assessment of a newly admitted client and is applying the nursing process to plan the client's care. What principle should the nurse apply when using the nursing process?
A. Each step is independent of the others.
B. It is ongoing and continuous.
C. It is used primarily in acute care settings.
D. It involves independent nursing actions.

Answer: B

Rationale: Although the assessment phase of the nursing process precedes other phases in the formal nursing process, nurses are always aware that assessment is ongoing and continuous throughout all the phases of the nursing process. Therefore, the nursing process should be thought of as circular, not linear.
Question Format: Multiple Choice
Chapter: 1
Cognitive Level: Understand
Client Needs: Safe, Effective Care Environment: Management of Care
Client Needs: Physiological Integrity: Basic Care and Comfort

7. The nurse who provides care at an ambulatory clinic is preparing to meet a client and perform a comprehensive health assessment. Which of the following actions should the nurse perform first?
A. Review the client's medical record.
B. Obtain basic biographic data.

C. Consult clinical resources explaining the client's diagnosis.
D. Validate information with the client.

Answer: A

Rationale: Before actually beginning the health assessment, the nurse should review the client's record. It provides basic biographic data and a background about chronic diseases. It also gives clues to how a present illness may impact the client's activities of daily living. Validating the information with the client occurs during the assessment. Consulting clinical resources is not an immediate priority.
Question Format: Multiple Choice
Chapter: 1
Cognitive Level: Apply
Client Needs: Health Promotion and Maintenance

8. In response to a client's query, the nurse is explaining the differences between the physician's medical exam and the comprehensive health assessment performed by the nurse. The nurse should describe the fact that the nursing assessment focuses on which aspect of the client's situation?
A. Current physiologic status
B. Effect of health on functional status
C. Past medical history
D. Motivation for adherence to treatment

Answer: B

Rationale: The comprehensive health assessment focuses on how the client's health status affects the activities of daily living and how the client's activities and choices affect health status. The nurse collects

physiologic, psychological, sociocultural, developmental, and spiritual data about the client. In addition, the nurse assesses how clients interact within their family and community, and how the clients' health status affects the family and community. In contrast, the physician performing a medical examination focuses primarily on the client's physiologic development status, with less focus on psychological, sociocultural, or spiritual well-being.
Question Format: Multiple Choice
Chapter: 1
Cognitive Level: Understand
Client Needs: Health Promotion and Maintenance

9. After teaching a group of students about the phases of the nursing process, the instructor determines that the teaching was successful when the students identify which phase as being foundational to all other phases?
A. Assessment
B. Planning
C. Implementation
D. Evaluation

Answer: A

Rationale: Assessment is the first and most critical phase of the nursing process. If data collection is inadequate or inaccurate, incorrect nursing judgments may be made that adversely affect the remaining phases of the process.
Question Format: Multiple Choice
Chapter: 1
Cognitive Level: Remember
Client Needs: Physiological Integrity: Basic Care and Comfort

10. The nurse has completed the comprehensive health assessment of a client who has been admitted for the treatment of community-acquired pneumonia. Following the completion of this assessment, the nurse periodically performs a partial assessment primarily for which reason?
A. Reassess previously detected problems
B. Provide information for the client's record
C. Address areas previously omitted
D. Determine the need for crisis intervention

Answer: A

Rationale: A periodic partial assessment consists of a mini-overview of the client's body systems and holistic health patterns as a follow-up on health status. Any problems that were initially detected in the client's body system or holistic health patterns are reassessed in less depth to determine any major changes from the baseline data. In addition, a brief reassessment of the client's normal body system or holistic health patterns is performed whenever the nurse or another health care professional has an encounter with the client.
Question Format: Multiple Choice
Chapter: 1
Cognitive Level: Understand
Client Needs: Safe, Effective Care Environment: Management of Care

11. The nurse is working in an ambulatory care clinic that is located in a busy, inner-city neighborhood. Which client would the nurse determine to be in most need of an emergency assessment?
A. A 14-year-old girl who is crying because she thinks she is pregnant
B. A 45-year-old man with chest pain and diaphoresis for 1 hour

C. A 3-year-old child with fever, rash, and sore throat
D. A 20-year-old man with a 3-inch shallow laceration on his leg

Answer: B

Rationale: In such situations like chest pain, an immediate assessment is needed to provide prompt treatment. The major and only concern during this type of assessment is to determine the status of the client's life-sustaining physical functions. The girl who is crying, the 3-year-old with a rash and fever, and the 20-year-old do not have life-threatening conditions necessitating an emergency assessment.
Question Format: Multiple Choice
Chapter: 1
Cognitive Level: Analyze
Client Needs: Safe, Effective Care Environment: Management of Care

12. A nurse has completed gathering some basic data about a client who has multiple health problems that stem from heavy alcohol use. The nurse has then reflected on her personal feelings about the client and his circumstances. The nurse does this primarily to accomplish which of the following?
A. Determine if pertinent data has been omitted
B. Identify the need for referral
C. Avoid biases and judgments
D. Construct a plan of care

Answer: C

Rationale: Once the nurse has gathered some basic data about a client, he or she needs to reflect on personal feelings to ensure keeping an open mind and avoiding premature judgments that may alter the ability to

collect accurate data and maintain objectivity. The other listed actions may be necessary, but none is accomplished through reflection.
Question Format: Multiple Choice
Chapter: 1
Cognitive Level: Understand
Client Needs: Safe, Effective Care Environment: Management of Care

13. The nurse is collecting data from a client who has recently been diagnosed with type 1 diabetes and who will begin an educational program. The nurse is collecting subjective and objective data. Which of the following would the nurse categorize as objective data?
A. Family history
B. Occupation
C. Appearance
D. History of present health concern

Answer: C

Rationale: Appearance is something that can be directly observed by the nurse and is considered objective data. Present concern, family history, and occupation are considered subjective.
Question Format: Multiple Choice
Chapter: 1
Cognitive Level: Understand
Client Needs: Safe, Effective Care Environment: Management of Care

14. An older adult client has been admitted to the hospital with failure to thrive resulting from complications of diabetes. Which of the following would the nurse implement in response to a collaborative problem?
A. Encourage the client to increase oral fluid intake.

B. Provide the client with a bedtime protein snack.
C. Assist the client with personal hygiene.
D. Measure the client's blood glucose four times daily.

Answer: D

Rationale: Collaborative problems, such as changes in blood glucose, are certain physiologic complications that nurses monitor to detect onset or changes in status. Nurses manage collaborative problems by implementing both physician- and nurse-prescribed interventions to reduce further complications. Nutrition (oral fluids, bedtime snack) and hygiene are most often considered to be independent nursing concerns.
Question Format: Multiple Choice
Chapter: 1
Cognitive Level: Apply
Client Needs: Safe, Effective Care Environment: Management of Care

15. The nurse at a busy primary care clinic is analyzing the data obtained from the following clients. For which client would the nurse most likely expect to facilitate a referral?
A. An 80-year-old client who lives with her daughter
B. A 50-year-old client newly diagnosed with diabetes
C. An adult presenting for an influenza vaccination
D. A teenager seeking information about contraception

Answer: B

Rationale: During the comprehensive assessment, the nurse identifies problems that require the assistance of other health care professionals. A client who is newly diagnosed with diabetes would benefit from a referral to a diabetes education program. Assistance from other health care

professionals would not necessarily be required for the older adult client, the client wanting a vaccination, or the teenager seeking information.
Question Format: Multiple Choice
Chapter: 1
Cognitive Level: Analyze
Client Needs: Safe, Effective Care Environment: Management of Care

16. A 38-year-old client has been admitted to the emergency department (ED) with reports of abdominal pain and vomiting for the past 6 hours. Which type of assessment will the nurse complete on this client?

A. focused assessment
B. comprehensive assessment
C. emergency assessment
D. ongoing assessment

Answer: A

Rationale: A focused assessment may occur in all health care settings. It is smaller in scope than a comprehensive assessment, but more in depth related to the problem being presented. It usually involves one or two body systems. Data gathered and analyzed will determine the cause of the client's report. A comprehensive assessment includes the collection of objective data (data gathered during a step-by-step physical examination) and subjective data (the client's perception of the health of all body parts or systems, past health history, family history, lifestyle and health practices, including overall functioning). An emergency assessment is a very rapid assessment performed in life-threatening situations. In such situations (choking, cardiac arrest, drowning), an immediate assessment is needed to provide prompt treatment.
Question Format: Multiple Choice
Chapter: 1
Cognitive Level: Remember

Client Needs: Physiological Integrity: Reduction of Risk Potential

17. When the nurse collects objective data, which finding requires **immediate** follow-up?

A. cerumen in the ear
B. acne lesions on the face and upper chest
C. moist nasal mucosa
D. enlarged lymph node in the neck

Answer: D

Rationale: Objective data may be obtained by direct observation or physical examination using the four examination techniques of inspection, auscultation, palpation, and percussion. Cerumen in the ear (ear wax) is a normal objective finding during a physical examination and does not require immediate attention. Acne lesions on the face and upper chest may be a chronic condition and do not require immediate attention. Moist nasal mucosa is a common finding and does not require immediate attention. Usually lymph nodes are small, distinct, and mobile. An enlarged lymph node suggests inflammation and requires an immediate follow-up with a reexamination of the area where it drains.
Question Format: Multiple Choice
Chapter: 1
Cognitive Level: Understand
Client Needs: Physiological Integrity: Reduction of Risk Potential

18. The obstetric nurse is performing an initial assessment of a pregnant woman. Which subjective data will the nurse include in the assessment? Select all that apply.

A. fundal height 28 cm (11 inches)
B. health care practices
C. personal medical history
D. number of pregnancies
E. elevated blood pressure

Answer: B, C, D

Rationale: The source of subjective data is the client. Subjective data is based on client beliefs and perception. The nurse should include health care practices in the assessment, because they constitute subjective data, which can only be validated by the client. Personal medical history is also subjective data that the nurse should include in the assessment. During the review of systems (ROS) the client informs the nurse of the number of pregnancies the client has experienced. This is personal information, which is subjective data that the nurse should include in the assessment. Fundal height is objective, not subjective, data obtained by the nurse using the examination techniques of inspection and palpation. Measurements such as blood pressure are objective, not subjective, data completed by the nurse during a physical examination.
Question Format: Multiple Select
Chapter: 1
Cognitive Level: Understand
Client Needs: Health Promotion

19. A nurse has documented the findings of a comprehensive assessment of a new client. What is the primary rationale that the nurse should identify for accurate and thorough documentation?

A. Guaranteeing a continual assessment process
B. Identifying abnormal data
C. Assuring valid conclusions from analyzed data
D. Allowing for drawing inferences and identifying problems

Answer: C

Rationale: Documentation of assessment data is an important step in assessment because it forms the database for the entire nursing process and provides data for all other members of the health care team. Thorough and accurate documentation is vital to ensure valid conclusions are made when the data are analyzed in the second step of the nursing process. This rationale supersedes the other listed goals, although each is valid.
Question Format: Multiple Choice
Chapter: 1
Cognitive Level: Understand
Client Needs: Safe, Effective Care Environment: Management of Care

20. A community health nurse is assessing an older adult client in their home. When gathering subjective data, which of the following would the nurse identify?
A. The client's feelings of happiness
B. The client's posture
C. The client's affect
D. The client's behavior

Answer: A

Rationale: Subjective data are sensations, feelings, perceptions, desires, preferences, beliefs, ideas, values, and personal information that can be

elicited and verified only by the client. Happiness is a feeling and therefore subjective. Posture, affect, and behavior are observable and are thus considered objective data.
Question Format: Multiple Choice
Chapter: 1
Cognitive Level: Understand
Client Needs: Health Promotion and Maintenance

21. A nurse on the subacute medical unit is planning to perform a client's focused assessment. Which of the following statements should inform the nurse's practice?
A. The focused assessment should be done before the physical exam.
B. The focused assessment replaces the comprehensive database.
C. The focused assessment addresses a particular client problem.
D. The focused assessment is done after gathering subjective data.

Answer: C

Rationale: A focused assessment gathers specific data for a particular client problem usually discovered during the physical exam. This assessment "focuses" on the particular problem only and does not cover areas unrelated to the problem.
Question Format: Multiple Choice
Chapter: 1
Cognitive Level: Remember
Client Needs: Physiological Integrity: Reduction of Risk Potential

22. The nurse is reviewing a client's health history and the results of the most recent physical examination. Which of the following data would the nurse identify as being subjective? Select all that apply.

A. "I feel so tired sometimes."
B. Weight: 145 lbs
C. Lungs clear to auscultation
D. Client complains of a headache
E. "My father died of a heart attack."
F. Pupils equal, round, and reactive to light

Answer: A, D, E

Rationale: Subjective data include information obtained from the client through interviewing and therapeutic communication skills and are sensations or symptoms, feelings, perceptions, desires, preferences, beliefs, ideas, values, and personal information that can be elicited and verified only by the client. Feeling tired, complaints of a headache, and the statement about the client's father dying of a heart attack reflect subjective information. Weight, lung sounds, and pupil reaction are examples of objective data.
Question Format: Multiple Select
Chapter: 1
Cognitive Level: Analyze
Client Needs: Safe, Effective Care Environment: Management of Care

23. A nurse is completing an assessment that will involve gathering subjective and objective information. Which data would the nurse identify as objective? Select all that apply.

A. review of systems (ROS)
B. physician’s report
C. B/P 135/78, heart rate 74 beats/min, respirations 16 breaths/min
D. family history
E. client’s name, age, and occupation

Answer: B, C,

Rationale: The nurse collects objective data through observation and using the four physical examination techniques of inspection, palpation, percussion, and auscultation. These techniques provide objective data about the client's body functions, such as temperature, heart rate, and respirations and may also be obtained from the client's medical record. The client's medical/health record also contains reports from other health care professionals, such as physicians. Family history; biographical information such as the client's name, age, and occupation; in addition to the ROS are part of the subjective information the nurse receives from the client during the interview.
Question Format: Multiple Select
Chapter: 1
Cognitive Level: Understand
Client Needs: Health Promotion and Maintenance

24. The nurse is performing a health assessment on a community-dwelling client who is recovering from hip replacement surgery. Which of the following actions should the nurse prioritize during assessment?
A. Focus the assessment on the client as a member of her age group.
B. Interpret the information about the client in context.
C. Corroborate the client's statements with trusted sources.
D. Gather information from a variety of sources.

Answer: B

Rationale: The client must be viewed holistically. Many systems are operating to create the context in which the client exists and functions. The nurse sees an individual client, but accurate interpretation of what

the nurse sees depends on perceiving the client in context. Culture, family, and community operate as systems interacting to form the context. Information does not normally need to be corroborated. The client's age is not the nurse's primary focus.
Question Format: Multiple Choice
Chapter: 1
Cognitive Level: Apply
Client Needs: Health Promotion and Maintenance

25. A client comes to the health care provider's office for a visit. The client has been seen in this office on occasion for the past 5 years and arrives today complaining of a fever and sore throat. Which type of assessment would the nurse most likely perform?
A. Comprehensive assessment
B. Ongoing assessment
C. Focused assessment
D. Emergency assessment

Answer: C

Rationale: The nurse would perform a focused assessment, which is done when a comprehensive database exists for a client who comes to the health care agency with a specific health concern. A comprehensive assessment is completed for this client when he or she first visited the office. An ongoing assessment would be done to evaluate problems identified earlier, to determine any changes. This might be the type of assessment done when the client returns after receiving treatment for the current complaints. An emergency assessment would be done if the client came in with a life-threatening complaint or problem.
Question Format: Multiple Choice
Chapter: 1

Cognitive Level: Remember
Client Needs: Physiological Integrity: Reduction of Risk Potential

26. After assessing a type 1 diabetic client who states they are unable to pay for their prescribed insulin, the nurse includes this information in the cluster of cues collected during the assessment. In which phase of the nursing process will this take place?

A. Step 1
B. Step 2
C. Step 3
D. Step 4

Answer: B

Rationale: There are four steps of the assessment phase of the nursing process. During Step 1, the nurse collects subjective data, based on the client's experiences, feelings, sensations, and expectations. During Step 2 of the assessment phase, the nurse identifies cues in the assessment that will lead to the identification of a client concern (nursing problem). When prioritized by the nurse, these cues will provide data that will lead to nursing interventions to address the client. Cues are not discovered in Step 1, during the collection of subjective data, or in Step 3, during validation of the data, or in Step 4, documentation of the data. Cues and clustering of cues is accomplished in Step 2 of the assessment phase of the nursing process.
Question Format: Multiple Choice
Chapter: 1
Cognitive Level: Analyze
Client Needs: Physiological Integrity: Reduction of Risk Potential

27. The nurse is completing an assessment on a new client at the community health clinic and would like to screen the client's cognitive ability. There are many resources that provide screening tools for nurses. Which agency would be **most** helpful in directing the nurse to a screening tool to assess the client's cognitive ability?

A. the American Diabetic Association (ADA)
B. the American Heart Association (AHA)
C. the Alzheimer's Association (AA)
D. the American Ophthalmology Association (AAO)

Answer: C

Rationale: The best choice to assess the client's cognitive domain would be to obtain a screening tool from the Alzheimer's Association (AA), which offers assistance related to diseases affecting cognitive abilities. Many tools are available for nurses to use to screen clients for health risks. Although the ADA, AHA, and AAO provide screening tools for the nurse to identify at-risk clients with heart disease, diabetes, or eye disease, the ADA, AHA, and AAO would not be the best resources to elicit a screening tool for cognitive function.
Question Format: Multiple Choice
Chapter: 1
Cognitive Level: Apply
Client Needs: Physiological Integrity: Reduction of Risk Potential

28. A nurse will complete an initial comprehensive assessment of a 60-year-old client who is new to the clinic. What goal should the nurse identify for this type of assessment?

A. Identify the most appropriate forms of medical intervention for the client.
B. Determine the most likely prognosis for the client's health problem.
C. Identify the status of the client's airway, breathing, and circulation.
D. Establish a baseline for the comparison of future health changes.

Answer: D

Rationale: An initial comprehensive assessment is needed when the client first enters a health care system and periodically thereafter to establish baseline data against which future health status changes can be measured and compared. It does not form the basis for medical treatment. The client's "ABCs" are included, but this is not the primary focus of an initial assessment.
Question Format: Multiple Choice
Chapter: 1
Cognitive Level: Understand
Client Needs: Health Promotion and Maintenance

29. A nurse who provides care in a hospital setting is creating a plan of nursing care for a client who has a diagnosis of chronic renal failure. The nurse's plan specifies frequent ongoing assessments. The frequency of these nursing assessments should be primarily determined by what variable?
A. The client's age
B. The unit's protocols
C. The client's acuity
D. The nurse's potential for liability

Answer: C

Rationale: The frequency of ongoing assessment is determined by the acuity of the client. This factor is more important than the nurse's liability, the client's age, or the protocols of the unit.
Question Format: Multiple Choice
Chapter: 1
Cognitive Level: Remember
Client Needs: Safe, Effective Care Environment: Management of Care

30. The nurse is reviewing the medical record of a newly admitted client to the rehabilitation center. Which subjective question should the nurse confirm with the client?
A. “What would you like for lunch today?”
B. “Are you aware of any allergies that you may have?”
C. “Do you have family coming to visit today?”
D. “Would you prefer a bed by the window or a bed by the door?”

Answer: B

Rationale: The question asked by the nurse about the possibility of allergies should be confirmed by the client when subjective data is being collected. The nurse can never assume that subjective data gathered is complete and should verify the possibility of allergies with the client to ensure safe care for the client. Personal care given to the client may include inquiring about the lunch of his choice, if family will be visiting, and choice for location of a bed. However, these are not subjective questions that will help complete a database on which to infer a clinical judgment.
Question Format: Multiple Choice
Chapter: 1
Cognitive Level: Understand
Client Needs: Physiological Integrity: Reduction of Risk Potential

31. The nurse is gathering objective information from the medical record of a newly admitted client to the medical-surgical unit of an acute care facility. Which of the following data would the nurse consider as a **priority** in assessing the client? Select all that apply.
A. the client's medical diagnosis
B. recent abnormal laboratory findings
C. the client's recent divorce
D. the client's tonsillectomy 45 years ago
E. recent changes in the client's blood pressure readings

Answer: A, B, E

Rationale: Priority data that will be needed to assist the nurse in making informed clinical judgments include the client's medical diagnosis, recent abnormal lab findings, and recent changes in blood pressure readings. Objective data may be directly observed by the nurse as well as by using the four techniques of physical examination: inspection, auscultation, palpation, and percussion. Objective data are also available in the client's health record. The client's recent divorce and the tonsillectomy 45 years ago are not priority data needed to form a database on which an informed clinical judgment will be made.
Question Format: Multiple Select
Chapter: 1
Cognitive Level: Understand
Client Needs: Physiological Integrity: Reduction of Risk Potential

32. The nurse has gathered objective and subjective data during the initial client assessment at an acute care facility. At the end of the assessment, the nurse will make informed clinical judgments. Which statement(s) reflects what the nurse will do **next**? Select all that apply.

A. Identify medical problems that require immediate referral.
B. Identify client problems that require nursing care.
C. Identify how the family is affected by the client's health status.
D. Identify collaborative problems that require interdisciplinary care.
E. Identify need for client teaching and health promotion.

Answer: A, B, D, E

Rationale: Informed clinical judgments will be developed by the nurse when medical problems are identified, particularly those that require immediate referral, need nursing and interdisciplinary care, and require client teaching and health promotion. How the family is affected by the client's health status is important, but not a priority immediately following the completion of the health assessment.
Question Format: Multiple Select
Chapter: 1
Cognitive Level: Understand
Client Needs: Safe, Effective Care Environment: Management of Care

33. The nurse prepares to complete a holistic assessment of a client with a chronic health problem. Which areas will the nurse include in this assessment? Select all that apply.
A. Spiritual
B. Physiologic
C. Recreational
D. Sociocultural
E. Psychological
F. Developmental

Answer: A, B, D, E, F

Rationale: The purpose of a nursing health assessment is to collect holistic data to determine a client's level of functioning and make professional clinical judgments. Holistic data includes spiritual, physiologic, sociocultural, psychological and developmental data. Recreational data is not specifically identified when completing a holistic assessment.
Question Format: Multiple Select
Chapter: 1
Cognitive Level: Remember
Client Needs: Health Promotion and Maintenance

34. The nurse notes that an intervention provided to a client for a specific health problem was not effective. The nurse continues to monitor and care for the client. Which type of assessment is the nurse performing?
A. initial comprehensive
B. focused or problem oriented
C. emergency
D. ongoing or partial assessment

Answer: D

Rationale: The nurse continues to assess the client, monitoring client progress and outcomes. Client problems that were initially assessed will be reassessed to evaluate for improvement or deterioration (change of condition). A comprehensive assessment occurs prior to an ongoing or partial assessment. An ongoing or partial assessment is completed by the nurse after a comprehensive database has been established. A focused or problem-oriented assessment is performed when a specific problem has been identified, which is not indicated in the client scenario. An emergency assessment would be performed during life-threatening situations, which is not indicated in the client scenario.

Question Format: Multiple Choice
Chapter: 1
Cognitive Level: Apply
Client Needs: Safe, Effective Care Environment: Management of Care

35. The nurse prepares to collect objective data on a client new to a health clinic. What will the nurse use to collect this data? Select all that apply.
A. Palpation
B. Inspection
C. Percussion
D. Auscultation
E. The medical record

Answer: A, B, C, D

Rationale: Objective data is obtained by general observation and through the use of the physical assessment techniques: palpation, inspection, percussion, and auscultation. Even though the medical record would be a source of objective data, the client is new to the health clinic and medical record data would not exist.
Question Format: Multiple Select
Chapter: 1
Cognitive Level: Remember
Client Needs: Health Promotion and Maintenance