National Patient Safety Goals have been established to promote safe delivery of care. The nurse should use at least 2 reliable ways to identify the patient such as asking the patient's full name and date of birth before medication administration. Other actions that improve patient safety include performing hand hygiene, disposing of unlabeled medications, completing appropriate assessments before administering medications, and giving a list of the current medicines to the patient and caregiver before discharge.

DIF: Cognitive Level: Apply (Application)
TOP: Nursing Process: Implementation MSC: NCLEX: Safe and Effective Care Environment

3. Which actions by a nurse would demonstrate an aspect of nursing clinical judgment? (*Select all that apply.*)
   a. Identifying priority problems
   b. Noticing a change in patient status
   c. Memorizing the steps of a procedure
   d. Assessing data about a patient situation
   e. Generating possible solutions to a patient problem
   f. Making decisions based on the implications of a patient's situation

   ANS: A, B, D, E, F
   Clinical judgment is evident when the nurse assesses data or situations, notices a change in a patient's status, identifies priority problems, generates the best possible solutions, and makes decisions about patient care based on analysis of the situation. Clinical judgment is not memorizing a list of facts or the steps of a procedure.

   DIF: Cognitive Level: Understand (Comprehension)
   TOP: Nursing Process: Implementation MSC: NCLEX: Safe and Effective Care Environment

Chapter 02: Social Determinants of Health
Harding: Lewis's Medical-Surgical Nursing, 12th Edition

MULTIPLE CHOICE

1. Which data from the patient's health history would be the nurse's focus for patient teaching?
   a. Family history
   b. Age and gender
   c. Dietary fat intake
   d. Race and ethnicity

   ANS: C
   Behaviors are strongly linked to many health care problems. The patient's fat intake is a behavior that the patient can change. The other information will be useful as the nurse develops an individualized plan for improving the patient's health but will not be the focus of patient teaching for behavior change.

   DIF: Cognitive Level: Apply (Application) TOP: Nursing Process: Planning
   MSC: NCLEX: Health Promotion and Maintenance

2. The nurse works in a clinic located in a community where many of the residents are Hispanic. Which strategy, if implemented by the nurse, would decrease health care disparities and promote health equity for this community?
   a. Improve public transportation to the clinic.
   b. Update equipment and supplies at the clinic.
   c. Teach clinic staff about cultural health beliefs.
   d. Obtain low-cost medications for clinic patients.

   ANS: C
   Health care disparities are caused by stereotyping, biases, and prejudice of health care providers. The nurse can decrease these through staff education. The other strategies may also be addressed by the nurse but will not directly impact health disparities.

   DIF: Cognitive Level: Apply (Application) TOP: Nursing Process: Planning
   MSC: NCLEX: Health Promotion and Maintenance

3. Which information would the nurse collect as a measure of community health?
   a. Air pollution levels
   b. Number of healthy food stores
   c. Most common causes of death
   d. Education level of the individuals

   ANS: C
   Health status measures of a community include birth and death rates, life expectancy, access to care, and morbidity and mortality rates related to disease and injury. Although air pollution, access to health food stores, and education level are factors that affect a community's health status, they are not health measures.

   DIF: Cognitive Level: Understand (Comprehension)
   TOP: Nursing Process: Assessment MSC: NCLEX: Health Promotion and Maintenance

4. The nurse is caring for a patient who has traditional Native American beliefs about health and illness. Which action by the nurse would demonstrate cultural competence?
   a. Explain the hospital schedule for meal times, care, and family visits.
   b. Ask the patient whether it is important that a cultural healer is contacted.
   c. Avoid asking health questions unless the patient initiates the conversation.
   d. Obtain information about the patient's cultural beliefs from a family member.

   ANS: B
   Because the patient has traditional health care beliefs, it is appropriate for the nurse to ask whether the patient would like a visit by cultural healer. There is no cultural reason for the nurse to avoid asking the patient questions because these questions are necessary to obtain health information. The patient (rather than the family) should be consulted first about personal cultural beliefs. The hospital routines for meals, care, and visits should be adapted to the patient's preferences rather than expecting the patient to adapt to the hospital schedule.

   DIF: Cognitive Level: Apply (Application)
   TOP: Nursing Process: Implementation MSC: NCLEX: Psychosocial Integrity

5. The nurse is caring for a patient being admitted to the hospital who is Asian. Which action would be respectful for the nurse to take when interviewing this patient?
   a. Avoid any eye contact with the patient.

b. Look directly at the patient when interacting.
c. Observe and follow the patient's use of eye contact.
d. Ask a family member about the patient's cultural beliefs.

ANS: C
Observation of the patient's use of eye contact will be most useful in determining the best way to communicate effectively with the patient. Looking directly at the patient or avoiding eye contact may be appropriate, depending on the patient's individual cultural beliefs. The nurse should assess the patient, rather than asking family members about the patient's beliefs.

DIF: Cognitive Level: Apply (Application)
TOP: Nursing Process: Implementation MSC: NCLEX: Psychosocial Integrity

6. The nurse is caring for a patient who speaks a different language. If an interpreter or interpretation phone service is not available, which action would the nurse take?
a. Talk slowly so that each word is clearly heard.
b. Use gestures or pictures to demonstrate meaning.
c. Speak loudly in close proximity to the patient's ears.
d. Repeat important words so that the patient will recognize them.

ANS: B
The use of gestures or pictures will enable some information to be communicated to the patient. The other actions will not improve communication with the patient.

DIF: Cognitive Level: Understand (Comprehension)
TOP: Nursing Process: Implementation MSC: NCLEX: Psychosocial Integrity

7. Which action would the nurse include in the plan of care for a hospitalized patient who uses culturally based treatments?
a. Encourage the use of additional diagnostic procedures.
b. Teach the patient that folk remedies will interfere with prescribed orders.
c. Ask the patient to discontinue the cultural treatments during hospitalization.
d. Coordinate the use of requested treatments with prescribed medical therapies.

ANS: D
Many culturally based therapies can be accommodated along with the use of Western treatments and medications. The nurse should attempt to use both traditional folk treatments and the ordered Western therapies when possible. Some culturally based treatments can be effective in treating "Western" diseases. Not all folk remedies interfere with Western therapies. It may be appropriate for the patient to continue some culturally based treatments while he or she is hospitalized.

DIF: Cognitive Level: Apply (Application) TOP: Nursing Process: Planning
MSC: NCLEX: Psychosocial Integrity

8. The nurse is caring for a newly admitted patient. Which intervention is considered appropriate across most cultures?
a. Maintain a personal space of at least 2 ft when assessing the patient.
b. Insist that family members provide most of the patient's personal care.
c. Ask permission before touching a patient during the physical assessment.
d. Consider the patient's ethnicity as the most important factor in planning care.

ANS: C
Many cultures consider it disrespectful to touch a patient without asking permission, so asking a patient for permission is always culturally appropriate. The other actions may be appropriate for some patients but are not appropriate across most cultural groups or for most individual patients. Ethnicity may not be the most important factor in planning care, especially if the patient has urgent physiologic problems.

DIF: Cognitive Level: Understand (Comprehension)
TOP: Nursing Process: Implementation MSC: NCLEX: Psychosocial Integrity

9. A staff nurse expresses frustration that a patient who is Native American always has several family members at the bedside. Which action would the charge nurse take?
   a. Request that family members leave until a different nurse can be assigned.
   b. Ask about the nurse's beliefs regarding family support during hospitalization.
   c. Have the nurse explain to the family that too many visitors will tire the patient.
   d. Suggest that the nurse ask family members to leave the room during patient care.

   ANS: B
   The first step in providing culturally competent care is to understand one's own beliefs and values related to health and health care. Asking the nurse about personal beliefs will help achieve this step. Asking family members to leave the room or explaining that too many visitors will tire the patient are not culturally appropriate for this patient.

   DIF: Cognitive Level: Apply (Application)
   TOP: Nursing Process: Implementation MSC: NCLEX: Psychosocial Integrity

10. An older patient who is Asian American tells the nurse that she has lived in the United States for 50 years. The patient speaks English and lives in a predominantly Asian neighborhood. Which **initial** action would the nurse take?
    a. Include a shaman when planning the patient's care.
    b. Avoid direct eye contact with the patient during care.
    c. Ask the patient about any special cultural beliefs or practices.
    d. Involve the patient's oldest son to assist with health care decisions.

    ANS: C
    Further assessment of the patient's health care preferences is needed before making further plans for culturally appropriate care. The other responses indicate stereotyping of the patient based on ethnicity and would not be appropriate initial actions.

    DIF: Cognitive Level: Apply (Application) TOP: Nursing Process: Planning
    MSC: NCLEX: Psychosocial Integrity

11. The nurse plans health care for a community with a large number of recent immigrants from Vietnam. Which intervention would the nurse plan to implement?
    a. Hepatitis testing
    b. Tuberculosis screening
    c. Contraceptive teaching
    d. Colonoscopy information

    ANS: B

Tuberculosis (TB) is endemic in many parts of Asia, and the incidence of TB is much higher in immigrants from Vietnam than in the general U.S. population. Teaching about contraceptive use, colonoscopy, and testing for hepatitis may also be appropriate for some patients but is not generally indicated for all members of this community.

DIF: Cognitive Level: Analyze (Analysis) TOP: Nursing Process: Planning
MSC: NCLEX: Physiological Integrity

12. During an admission assessment, the nurse notices that the patient pauses before answering each question about the health history. Which action would the nurse take?
    a. Wait for the patient to answer the questions.
    b. Give the patient an assessment form and a pen.
    c. Interview a family member instead of the patient.
    d. Remind the patient that other patients also need care.

    ANS: A
    Patients from some cultures take time to consider a question carefully before answering. The nurse will show respect for the patient and help develop a trusting relationship by allowing the patient time to give a thoughtful answer. Interviewing family members, shaming the patient by referring to the needs of other patients or handing the patient a form indicate that the nurse does not have time for the patient.

    DIF: Cognitive Level: Apply (Application)
    TOP: Nursing Process: Assessment MSC: NCLEX: Psychosocial Integrity

13. Which strategy would the nurse **prioritize** when planning care for a patient with diabetes who is uninsured?
    a. Obtain the least expensive medications.
    b. Follow evidence-based practice guidelines.
    c. Assist with dietary changes as the first action.
    d. Teach about the impact of exercise on diabetes.

    ANS: B
    The use of standardized evidence-based guidelines will reduce the incidence of health care disparities among various socioeconomic groups. The other strategies may also be appropriate, but the priority concern should be that the patient receives care that meets the accepted standard.

    DIF: Cognitive Level: Analyze (Analysis) TOP: Nursing Process: Planning
    MSC: NCLEX: Health Promotion and Maintenance

14. The nurse performs a cultural assessment with a patient from a different culture. Which action would the nurse take **first**?
    a. Request an interpreter before interviewing the patient.
    b. Wait until a family member is available to help with the assessment.
    c. Ask the patient about any affiliation with a particular cultural group.
    d. Tell the patient what the nurse already knows about the patient's culture.

    ANS: C
    An early step in performing a cultural assessment is to determine whether the patient feels an affiliation with any cultural group. The other actions may be appropriate if the patient does identify with a particular culture or speak another language.

DIF: Cognitive Level: Apply (Application)
TOP: Nursing Process: Assessment MSC: NCLEX: Psychosocial Integrity

15. The nurse working in a clinic in a primarily black community notes a higher incidence of uncontrolled hypertension in the patients. To address this health disparity and promote health equity, which action would the nurse take **first**?
    a. Initiate a regular home-visit program by nurses working at the clinic.
    b. Schedule teaching sessions about low-salt diets at community events.
    c. Assess the perceptions of community members about the care at the clinic.
    d. Obtain low-cost antihypertensive drugs using funding from government grants.

    ANS: C
    Before other actions are taken, additional assessment data are needed to determine the reason for the disparity. The other actions also may be appropriate, but additional assessment is needed before the next action is selected.

    DIF: Cognitive Level: Apply (Application)
    TOP: Nursing Process: Assessment MSC: NCLEX: Health Promotion and Maintenance

MULTIPLE RESPONSE

1. The nurse is performing an admission assessment for a patient from China who does not speak English. Which actions by the nurse would enhance communication? (*Select all that apply.*)
    a. Ask the patient's young child to interpret.
    b. Use a telephone-based medical interpreter.
    c. Wait until an agency interpreter is available.
    d. Use exaggerated gestures to convey information.
    e. Use an electronic translation software application.

    ANS: B, C, E
    Electronic translation applications, telephone-based interpreters, and agency interpreters are all appropriate to use to communicate with non–English-speaking patients. When no interpreter is available, family members may be considered, but some information that will be needed in an admission assessment may be misunderstood or not shared if a child is used as the interpreter. Gestures are appropriate to use for some information, but exaggeration of the gestures is not needed.

    DIF: Cognitive Level: Apply (Application)
    TOP: Nursing Process: Assessment MSC: NCLEX: Psychosocial Integrity

Chapter 03: Health History and Physical Examination
Harding: Lewis's Medical-Surgical Nursing, 12th Edition

MULTIPLE CHOICE

1. A patient who is actively bleeding is admitted to the emergency department. Which approach would the nurse use to obtain an accurate health history?
    a. Briefly interview the patient while obtaining vital signs.
    b. Obtain subjective data about the patient from family members.
    c. Omit subjective data collection and obtain the physical examination.

d. Use the health care provider's medical history to obtain subjective data.

ANS: A
In an emergency situation, the nurse may need to ask only the most pertinent questions for a specific problem and obtain more information later. A complete health history will include subjective information that is not available in the health care provider's medical history. Family members may be able to provide some data, but only the patient will be able to give subjective information about the bleeding. Because the subjective data about the cause of the patient's bleeding will be essential, obtaining the physical examination alone will not provide sufficient information.

DIF: Cognitive Level: Apply (Application)
TOP: Nursing Process: Assessment MSC: NCLEX: Health Promotion and Maintenance

2. Immediate surgery is planned for a patient with acute abdominal pain. Which question by the nurse will elicit direct information about the patient's coping–stress tolerance pattern?
   a. "Can you rate your pain on a 0 to 10 scale?"
   b. "What do you think caused this abdominal pain?"
   c. "Are there other problems or concerns right now?"
   d. "How do you feel about yourself and being hospitalized?"

   ANS: C
   The coping–stress tolerance pattern includes information about other major stressors confronting the patient. The health perception–health management pattern includes information about the patient's ideas about risk factors. Feelings about self and the hospitalization are assessed in the self-perception–self-concept pattern. Intensity of pain is part of the cognitive–perceptual pattern.

   DIF: Cognitive Level: Apply (Application)
   TOP: Nursing Process: Assessment MSC: NCLEX: Psychosocial Integrity

3. During the health history interview, a patient tells the nurse about periodic fainting spells. Which question would the nurse ask to elicit any associated clinical manifestations?
   a. "How frequently do you have the fainting spells?"
   b. "Do the spells occur at any particular time of day?"
   c. "Where are you when you have the fainting spells?"
   d. "Do you have other symptoms along with the spells?"

   ANS: D
   Asking about other associated symptoms will provide the nurse more information about all the clinical manifestations related to the fainting spells. Information about the setting is obtained by asking where the patient was and what the patient was doing when the symptom occurred. The other questions from the nurse are appropriate for obtaining information about chronology and frequency.

   DIF: Cognitive Level: Apply (Application)
   TOP: Nursing Process: Assessment MSC: NCLEX: Health Promotion and Maintenance

4. The nurse records the following general survey: “The patient is a 50-year-old Asian female accompanied by her husband and two daughters. Alert and oriented. Does not make eye contact with the nurse and responds slowly, but appropriately, to questions. No apparent disabilities or distinguishing features.” What additional information should the nurse add to this general survey?
   a. Nutritional status
   b. Intake and output
   c. Reasons for contact with the health care system
   d. Comments of family members about the condition

   ANS: A
   The general survey also describes the patient’s general nutritional status. The other information will be obtained when doing the complete nursing history and examination but is not obtained through the initial scanning of a patient.

   DIF: Cognitive Level: Understand (Comprehension)
   TOP: Nursing Process: Assessment MSC: NCLEX: Health Promotion and Maintenance

5. A nurse performs a health history and physical examination with a patient who has a right leg fracture. Which data would be a pertinent negative finding?
   a. Patient has several bruised and swollen areas on the right leg.
   b. Patient states that there have been no other recent health problems.
   c. Patient refuses to bend the right knee because of the associated pain.
   d. Patient denies having pain when the area over the fracture is palpated.

   ANS: D
   The nurse expects that a patient with a leg fracture will have pain over the fractured area. The bruising and swelling and pain with bending are positive findings. Having no other recent health problems is neither a positive nor a negative finding with regard to a leg fracture.

   DIF: Cognitive Level: Apply (Application)
   TOP: Nursing Process: Assessment MSC: NCLEX: Health Promotion and Maintenance

6. The nurse asks an older adult patient with rectal bleeding, “Have you ever had a colonoscopy?” Which type of assessment is the nurse performing?
   a. Focused assessment
   b. Emergency assessment
   c. Detailed health assessment
   d. Comprehensive assessment

   ANS: A
   A focused assessment is an abbreviated assessment used to evaluate the status of previously identified problems and monitor for signs of new problems. It can be done when a specific problem is identified. An emergency assessment is done when the nurse needs to obtain information about life-threatening problems quickly while simultaneously taking action to maintain vital function. A comprehensive assessment includes a detailed health history and physical examination of one body system or many body systems. It is typically done on admission to the hospital or onset of care in a primary care setting.

   DIF: Cognitive Level: Understand (Comprehension)
   TOP: Nursing Process: Assessment MSC: NCLEX: Health Promotion and Maintenance

7. The nurse is preparing to perform a focused assessment for a patient reporting shortness of breath. Which equipment will be needed?
   a. Flashlight
   b. Stethoscope
   c. Tongue blades
   d. Percussion hammer

   ANS: B
   A stethoscope is used to auscultate breath sounds. The other equipment may be used for a comprehensive assessment but will not be needed for a focused respiratory assessment.

   DIF: Cognitive Level: Understand (Comprehension)
   TOP: Nursing Process: Assessment MSC: NCLEX: Health Promotion and Maintenance

8. Which adaptation to the physical examination technique would the nurse include for an alert older adult patient?
   a. Avoid the use of touch as much as possible.
   b. Use slightly more pressure for palpation of the liver.
   c. Organize the sequence to minimize position changes.
   d. Speak softly and slowly when talking with the patient.

   ANS: C
   Older patients may have age-related changes in mobility that make it more difficult to change position. There is no need to avoid the use of touch when examining older patients. Less pressure should be used over the liver. Because the patient is alert, there is no indication that there is any age-related difficulty in understanding directions from the nurse.

   DIF: Cognitive Level: Apply (Application)
   TOP: Nursing Process: Assessment MSC: NCLEX: Health Promotion and Maintenance

9. While the nurse is taking the health history, a patient states, "My mother and sister both had double mastectomies and were unable to exercise for weeks." Which functional health pattern is represented by this patient's statement?
   a. Activity–exercise
   b. Cognitive–perceptual
   c. Coping–stress tolerance
   d. Health perception–health management

   ANS: D
   The information in the patient statement relates to risk factors and important information about the family history. Identification of risk factors falls into the health perception–health maintenance pattern.

   DIF: Cognitive Level: Understand (Comprehension)
   TOP: Nursing Process: Assessment MSC: NCLEX: Health Promotion and Maintenance

10. A patient has arrived at the hospital with severe abdominal pain and hypotension. Which type of assessment would the nurse do at this time?
    a. Focused assessment
    b. Subjective assessment
    c. Emergency assessment
    d. Comprehensive assessment

ANS: C
Because the patient is hemodynamically unstable, an emergency assessment is needed. Comprehensive and focused assessments may be needed after the patient is stabilized. Subjective information is needed, but objective data such as vital signs are essential for the unstable patient.

DIF: Cognitive Level: Understand (Comprehension)
TOP: Nursing Process: Assessment MSC: NCLEX: Health Promotion and Maintenance

11. The registered nurse (RN) cares for a patient who was admitted a few hours previously with back pain after a fall. Which action can the RN delegate to assistive personnel (AP)?
    a. Determine the patient's priority problems.
    b. Finish documenting the admission assessment.
    c. Obtain the health history from the patient's caregiver.
    d. Take the patient's temperature, pulse, and blood pressure.

    ANS: D
    The RN may delegate vital signs to the AP. Obtaining the health history, documenting the admission assessment, and determining priority problems require the education and scope of practice of the RN.

    DIF: Cognitive Level: Apply (Application) TOP: Nursing Process: Planning
    MSC: NCLEX: Safe and Effective Care Environment

12. Which action would the nurse take **first** to assess for a possible blood clot in a patient's lower leg?
    a. Visually inspect the leg.
    b. Feel the leg temperature.
    c. Check the patient's pedal pulses using the fingertips.
    d. Compress the nail beds to determine capillary refill time.

    ANS: A
    Inspection is the first of the major techniques used in the physical examination. Palpation and auscultation are then used later in the examination.

    DIF: Cognitive Level: Apply (Application)
    TOP: Nursing Process: Assessment MSC: NCLEX: Health Promotion and Maintenance

13. Which physical assessment action should the nurse take after inspecting a patient's abdomen?
    a. Feel for any masses.
    b. Palpate the abdomen.
    c. Listen for bowel sounds.
    d. Percuss the liver borders.

    ANS: C
    When assessing the abdomen, auscultation is done before palpation or percussion because palpation and percussion can cause changes in bowel sounds and alter the findings. All of the techniques are appropriate, but auscultation should be done first.

    DIF: Cognitive Level: Understand (Comprehension)
    TOP: Nursing Process: Assessment MSC: NCLEX: Health Promotion and Maintenance