DIF: Cognitive Level: Knowledge REF: p. 11 OBJ: Theory #8 TOP: Capitated Cost
KEY: Nursing Process Step: N/A MSC: NCLEX: N/A

2. In the United States, the Young Women‘s Christian Association (YMCA) in New York opened The School, the first practical nursing school.

ANS:
Ballard

In 1892, the YMCA opened The Ballard School, a 3-month course in practical nursing that was the first school of practical nursing.

DIF: Cognitive Level: Knowledge REF: p. 2 OBJ: Theory #4 TOP: Ballard School
KEY: Nursing Process Step: N/A MSC: NCLEX: N/A

3. Such health services as surgical procedures, restorative care, and home health care would be classified as care.

ANS:
secondary
Surgical procedures, restorative caNrUe,RaSnINdGhToBm.CeOhMealth are part of the many services classified as secondary care.

DIF: Cognitive Level: Comprehension REF: p. 11|Box 1-2
OBJ: Theory #10 TOP: Health Care Services KEY: Nursing Process Step: N/A MSC: NCLEX: N/A

Chapter 02: Concepts of Health, Illness, Stress, and Health Promotion Williams: deWit's Fundamental Concepts and Skills for Nursing, 5th Edition

MULTIPLE CHOICE

1. The nurse is aware that any description of health would include the concept that:
a. health is the absence of illness, and illness is the presence of chronic disease.
b. culture, education, and socioeconomic status influence one‘s definition of health or illness.
c. illness is a biological malfunction, and health is biological soundness.
d. lifestyle factors are the major determinants of health or illness.
ANS: B
The concept of health is influenced by culture, education, and socioeconomic factors.

DIF: Cognitive Level: Comprehension REF: p. 15 OBJ: Theory #1 TOP: Views of

Health and Illness KEY: Nursing Process Step: Planning
MSC: NCLEX: Health Promotion and Maintenance: Prevention and Detection of Disease

2. The nurse takes into consideration that the patient with an admitting diagnosis of Type 2 diabetes mellitus and influenza is described as having:
a. two chronic illnesses.
b. two acute illnesses.
c. one chronic and one acute illness.
d. one acute and one infectious illness.
ANS: C
Chronic illnesses can be controlled but not cured, and are long-lasting. Acute illnesses develop suddenly and resolve in a short time. Type 2 diabetes mellitus would be considered chronic, whereas influenza would be considered acute.

DIF: Cognitive Level: Application REF: p. 15 OBJ: Theory #1 TOP: Classification of Illnesses KEY: Nursing Process Step: Planning
MSC: NCLEX: Health Promotion and Maintenance: Prevention and Detection of Disease

3. The nurse explains that an idiopathic disease is one that:
a. is caused by inherited characteristics.
b. develops suddenly, related to new viruses.
c. results from injury during labor or delivery.
d. has an unknown cause.

ANS: D
Idiopathic disease is defined as disease whose cause is unknown.

DIF: Cognitive Level: Knowledge REF: p. 15 OBJ: Theory #1 TOP: Classification of Illnesses KEY: Nursing Process Step: Implementation MSC: NCLEX: Health Promotion and Maintenance: Prevention and Detection of Disease

4. The nurse assesses a terminal illness in:
a. a 76-year-old admitted to a nursing home with Alzheimer disease who is pacing and asking to go home.

b. a 43-year-old with Lou Gehrig‘s disease who is refusing food and fluid.
c. a 2-year-old child who burned her esophagus by drinking drain cleaner and who is being fed by a tube.
d. a 52-year-old diagnosed with lung cancer who had part of one lung removed and has a

closed chest drainage device in place.
ANS: B
A terminal illness is defined as one in which a person will live only a few months, weeks, or days. A person who refuses food and hydration will generally not live more than a few days.

DIF: Cognitive Level: Comprehension REF: p. 15 OBJ: Theory #1 TOP: Stages of Illness KEY: Nursing Process Step: Assessment MSC: NCLEX: Physiological Integrity: Physiological Adaptation

5. The nurse clarifies to a patient who now has an abscess following a ruptured appendix that the abscess is considered to be:
a. a secondary illness.
b. a life-threatening complication.
c. an expected event following any surgery.
d. a disorder easily treated with antibiotics.
ANS: A
A secondary illness is an illness that arises from a primary disorder.

DIF: Cognitive Level: Comprehension REF: p. 15 OBJ: Theory #1 TOP: Views of Health and Illness KEY: Nursing Process Step: Intervention MSC: NCLEX: Physiological Integrity: Physiological Adaptation

6. The nurse uses a diagram to demonstrate how Dunn‘s theory of health and illness can be compared with a:
a. plant that grows from a seed, blossoms, wilts, and dies.
b. continuum, with peak wellness and death at opposite ends; the person moves back and forth in a dynamic state of change.
c. ladder; from birth to death the individual moves progressively downward a ladder to eventual death.
d. state of mind dependent on the individual perception of their own health or illness.
ANS: B
Dunn‘s theory of a health continuum shows how an individual moves between peak wellness and death in a constant process.

DIF: Cognitive Level: Knowledge REF: p. 16 OBJ: Theory #1 TOP: Views of Health and Illness KEY: Nursing Process Step: Intervention MSC: NCLEX: Physiological Integrity: Physiological Adaptation

7. A patient has been advised by the primary care provider to take medication for high cholesterol and to change eating habits after discharge home. The home health nurse discovered that the patient refused to follow the medical and nutritional directions. The nurse‘s best initial response to this situation is to:
a. emphasize to the patient how important it is to follow the doctor‘s advice.
b. determine whether any cultural, socioeconomic, or religious values conflict, thus interfering with the patient‘s compliance.

c. explain that without diet and medication the condition will worsen and serious problems will develop.
d. inform the primary care provider that the patient is unable to understand the instructions.
ANS: B
The patient may have cultural, socioeconomic, or religious values that cause conflicts that prevent her from following the doctor‘s instructions.

DIF: Cognitive Level: Application REF: p. 16 OBJ: Theory #5 TOP: Concepts of Health and Illness, Cultural Influences
KEY: Nursing Process Step: Assessment
MSC: NCLEX: Psychological Integrity: Coping and Adaptation

8. A nurse practicing a holistic approach to nursing care must:
a. recognize that a change in one aspect of the person‘s life can alter the whole of that person‘s life.
b. take responsibility for health care decisions.
c. promote state of the art technology.
d. discourage the use of more natural remedies and alternative methods of health care.
ANS: A
Holistic nursing requires that the nurse recognizes that a change in one aspect of the patient‘s life (biological, sociological, psychological, and spiritual) will bring about changes in that patient‘s whole life.

DIF: Cognitive Level: ComprehensNioUnRSINRGETFB:.CpO.M19 OBJ: Theory #6 TOP: Holistic Approach to Caring KEY: Nursing Process Step: Assessment MSC: NCLEX: N/A

9. Included in Maslow‘s hierarchy, physiological needs are those that:
a. nurture intimacy.
b. foster independence.
c. encourage social interaction.
d. protect from harm.
ANS: D
Physiological needs are those that are essential to human life, such as oxygenation, nutrition, and elimination. Protection from physical harm, from a nursing standpoint, is often equivalent in importance to physical needs.

DIF: Cognitive Level: Application REF: p. 20 OBJ: Theory #7 TOP: Maslow‘s Hierarchy of Needs KEY: Nursing Process Step: N/A MSC: NCLEX: Physiological Integrity: Physiological Adaptation

10. The factors involved in assessing the importance the patient attaches to the relief of a particular deficit include:
a. needs that the nurse must assess to prioritize care, because they may be different from person to person.

b. ordering needs according to Maslow‘s hierarchy, with lower level needs being least compelling.

c. needs based on a hierarchy in which higher level needs are more prominent and demand attention before lower level needs.
d. needs that are usually not known to the patient and that must be determined by the nurse.
ANS: A
A person‘s concern relative to a needs deficit must be assessed by the nurse to meet the needs of each patient. Needs are viewed differently from one person to the next.

DIF: Cognitive Level: Comprehension REF: p. 20 OBJ: Theory #7 TOP: Maslow‘s Hierarchy of Needs KEY: Nursing Process Step: Assessment MSC: NCLEX: Physiological Integrity: Physiological Adaptation

11. The nurse believes that patient teaching of how to give insulin and monitor blood glucose levels will improve the level of the patient‘s:
a. physiological well-being.
b. security, by providing psychological comfort.
c. self-esteem, by promoting independence and learning.
d. self-actualization, by seeking knowledge and truth.
ANS: C
Patient education activities that are to be used after discharge enhance independence and promote self-esteem.

DIF: Cognitive Level: Application REF: p. 27 OBJ: Theory #7 TOP: Maslow‘s Hierarchy of Needs KEY: Nursing Process Step: Implementation MSC: NCLEX: Psychosocial Integrity: Psychosocial Adaptation

12. Homeostasis can be described as:
a. the unchanging steady condition of humans in a changing external environment.

b. a tendency of biological systems toward stability of the internal environment by continuously adjusting to survive.
c. biological wellness that comes from the ability of the body to change and respond to physical changes in the environment.

d. a response to stress that results from a person‘s choice of coping mechanisms to deal with the stress.
ANS: B
Homeostasis results from the constant adjustment of the internal environment in response to change; it is mental, emotional, and biological, as well as conscious and unconscious.

DIF: Cognitive Level: Comprehension REF: p. 22 OBJ: Theory #8 TOP: Homeostasis
KEY: Nursing Process Step: Assessment MSC: NCLEX: N/A

13. A patient admitted for diagnostic tests is frightened of hospital procedures and is nervous about the possible outcome of the tests. She states that her mouth is dry and her heart is pounding. Her blood pressure is 168/78 mm Hg (her usual blood pressure is 140/80 mm Hg), pulse is 112 beats/min, and respirations are 22 breaths/min. The nurse will recognize that these signs and symptoms are:
a. indicative of serious, acute health problems and should be reported to the primary care provider immediately.
b. most likely related to the disease for which the patient is admitted to the hospital.
c. the effects of the parasympathetic nervous system and can be ignored.
d. the effects of the sympathetic nervous system that can negatively affect the patient‘s health.
ANS: D
Fear stimulates the sympathetic nervous system to produce the symptoms identified in the question. If prolonged, they negatively affect a person‘s health.

DIF: Cognitive Level: Analysis REF: p. 26|Table 2-2
OBJ: Theory #10 TOP: Stress KEY: Nursing Process Step: Assessment MSC: NCLEX: Psychosocial Integrity: Coping and Adaptation

14. According to Hans Selye‘s general adaptation syndrome (GAS), a person who has experienced excessive and prolonged stress is likely to:
a. develop an illness or disease such as allergy, arthritis, or asthma.
b. become resistant to biological methods of treatment.
c. seek treatment for imagined illnesses and nonexistent symptoms.

d. be admitted to the hospital during the alarm stage.
ANS: A
Many diseases are known to be caused or exacerbated by prolonged stress. Selye concluded that stress-induced illnesses respond to biological methods of treatment.

DIF: Cognitive Level: Comprehension REF: p. 26|Box 2-2
OBJ: Theory #10 TOP: Adaptation KEY: Nursing Process Step: Assessment MSC: NCLEX: Psychosocial Integrity: Coping and Adaptation

15. The nurse is aware that a stressor NasUeRxSpINerGieTnBc.CedOMby an individual is usually perceived:
a. as a negative event or stimulus that affects homeostasis in maladaptive ways.
b. in different ways based on previous experience and personality traits.
c. as an opportunity for growth and learning.
d. in similar ways if age and education are similar.
ANS: B
Stressors are not perceived the same way by different people or even by the same person at different times. The experience of a stressor depends on previous experience and personality, as well as factors such as physical or emotional conditions, age, and education.

DIF: Cognitive Level: Comprehension REF: p. 26 OBJ: Theory #9 TOP: General Adaptation Syndrome KEY: Nursing Process Step: Planning MSC: NCLEX: Psychological Integrity: Psychosocial Adaptation

16. In 1946, the World Health Organization redefined health as the:
a. absence of disease or infirmity.
b. state of complete physical, mental, and social well-being.
c. presence of disease or infirmity.
d. state of incomplete physical, mental, and social well-being.
ANS: B
In 1946, the World Health Organization redefined health as ―the state of complete physical, mental, and social well–being, and not merely the absence of disease or infirmity.‖

DIF: Cognitive Level: Knowledge REF: p. 28 OBJ: Theory #1 TOP: Views of Health and Illness KEY: Nursing Process Step: N/A MSC: NCLEX: N/A

17. The nurse assesses that a person is in the acceptance stage of illness when the patient:
a. looks to home remedies to become well.
b. reassumes usual responsibilities and roles.
c. assumes the ―sick‖ role.

d. rejects medical treatment.
ANS: C
When a person enters the acceptance stage of illness, he or she assumes the ―sick role‖ and withdraws from usual responsibilities and will frequently seek medical treatment at this time.

DIF: Cognitive Level: Comprehension REF: p. 15 OBJ: Theory #1 TOP: Acceptance Stage KEY: Nursing Process Step: Assessment MSC: NCLEX: Physiological Integrity: Physiological Adaptation

18. The nurse instructs a patient that according to Selye‘s GAS theory, when stress is strong enough and occurs over a long enough period, the patient will enter the stage of:
a. convalescence.
b. alarm.
c. transition.
d. exhaustion.
ANS: D
The exhaustion stage in the GAS occurs when the stressor has been present for such a period that the patient will deplete the boNdUy‘RsSrIeNsGoTuBrc.CesOMfor adaption.
DIF: Cognitive Level: Comprehension REF: p. 24 OBJ: Theory #1 TOP: Exhaustion Stage of GAS KEY: Nursing Process Step: Intervention MSC: NCLEX: Psychosocial Integrity: Coping and Adaptation

19. The nurse explains defense mechanisms as a patient‘s attempt to:
a. justify the patient‘s assumption of the ―sick‖ role.
b. reduce anxiety.
c. problem solve.
d. increase dependence.
ANS: B
Defense mechanisms are unconscious strategies to reduce anxiety.

DIF: Cognitive Level: Knowledge REF: p. 26 OBJ: Theory #9 TOP: Defense Mechanisms KEY: Nursing Process Step: Implementation MSC: NCLEX: Psychological Integrity: Coping and Adaptation

20. In giving nursing care to persons of Asian origin, the nurse should:
a. keep the room warm and free of drafts.
b. look the patient directly in the eye.
c. ask permission before touching the patient.
d. warmly clasp the patient‘s hand in greeting.
ANS: C

Seek permission before touching persons of Asian extraction, because they may be sensitive to physical, personal contact.

DIF: Cognitive Level: Application REF: p. 18|Table 2-1 OBJ: Theory #4 TOP: Cultural Sensitivity
KEY: Nursing Process Step: Implementation
MSC: NCLEX: Psychological Integrity: Coping and Adaptation

21. Sickle cell anemia is an example of a biological trait found primarily in:
a. Asian populations.
b. African populations.
c. American Indian populations.
d. Hispanic populations.
ANS: B
Sickle cell anemia is a biological variation found predominantly in people of African descent.

DIF: Cognitive Level: Knowledge REF: p. 18|Table 2-1
OBJ: Theory #5 TOP: Cultural Influences KEY: Nursing Process Step: N/A MSC: NCLEX: N/A

22. When a young family man hospitalized after breaking his leg confides to the nurse that he is concerned about the well-being of his family and financial stress, the nurse can best support his sense of security by:

a. reassuring him that his leg will heal quickly.
b. actively listening to his concerns.
c. encouraging family to make frequent visits.
d. distracting him from his conceNrnUsRbSIyNsGoTcBia.CliOzaMtion.
ANS: B
A nurse‘s ability to use active listening will enhance the sense of security when patients feel that their needs are perceived accurately.

DIF: Cognitive Level: Application REF: p. 21 OBJ: Theory #7 TOP: Maslow‘s Hierarchy of Needs KEY: Nursing Process Step: Intervention MSC: NCLEX: Psychosocial Integrity: Coping and Adaptation

23. The nurse assesses successful adaptation in a post stroke patient when the patient:
a. learns to walk and maintain balance with the aid of a walker.
b. consistently takes antihypertensive drugs.
c. attempts to get out of bed unassisted.
d. refuses assistance with feeding.
ANS: A
Adaptation is a readjustment in habits to limitations and disabilities. Learning to walk and

maintain balance with the aid of a walker is an example of this.

DIF: Cognitive Level: Application REF: p. 22 OBJ: Theory #1 TOP: Adaptation KEY: Nursing Process Step: Assessment
MSC: NCLEX: Physiological Integrity: Physiological Adaptation

24. The nurse takes into consideration that in the stage of resistance in Selye‘s GAS, the patient:

a. regresses to a dependent state.
b. continues to battle for equilibrium.
c. becomes maladaptive.
d. begins to develop stress-related disorders.
ANS: B

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The resistance stage is the second stage in the GAS when a patient is still attempting to find equilibrium.

DIF: Cognitive Level: Comprehension REF: p. 24 OBJ: Theory #10 TOP: Salye‘s GAS KEY: Nursing Process Step: Planning MSC: NCLEX: Physiological Integrity: Physiological Adaptation

25. A patient states, ―I am not obese. My entire family is large.‖ The nurse assesses that the patient is using the defense mechanism of:
a. sublimation.
b. projection.
c. denial.
d. displacement.
ANS: C
Denial is a defense mechanism that allows a person to live as though an unwanted piece of information or reality does not exist. There is a persistent refusal to be swayed by the evidence.

DIF: Cognitive Level: Application REF: p. 27|Table 2-3
OBJ: Theory #8 TOP: Denial KEY: Nursing Process Step: Assessment MSC: NCLEX: Psychosocial IntegriNtyU:RCSoIpNiGngTBan.CdOAMdaptation
26. A child who has just been scolded by her mother proceeds to hit her doll with a hairbrush. The nurse recognizes the child‘s actions are characteristics of:
a. denial.