Physical Examination and Health Assessment 6th Edition Test Bank – Jarvis

Sample

Jarvis: Physical Examination & Health Assessment, 6th Edition

Chapter 28: Bedside Assessment of the Hospitalized Adult

Test Bank

MULTIPLE CHOICE

1. At the beginning of rounds, when the nurse enters the room, what should the nurse do first?

A) Check the intravenous infusion site for swelling or redness.

B) Check the infusion pump settings for accuracy.

C) Make eye contact with the patient and introduce himself or herself as the patient's

nurse.

D) Offer the patient something to drink.

ANS: C

When entering a patient's room, the nurse should make direct eye contact, without allowing distraction by IV pumps and other equipment, and introduce himself or herself as the patient's nurse.

PTS: 1 DIF: Cognitive Level: Analyzing (Analysis)

REF: Page: 788

MSC: Client Needs: Safe and Effective Care Environment: Management of Care

2. During an assessment, the nurse is unable to palpate pulses in the left lower leg. What should the nurse do next?

A) Document that the pulses are not palpable.

B) Reassess the pulses in 1 hour.

C) Have the patient turn to the side and then palpate for the pulses again. D) Use a Doppler device to assess the pulses.

ANS: D

The nurse should be prepared to assess pulses in the lower extremities by Doppler measurement if they cannot be detected by palpation.

PTS: 1 DIF:

REF: Pages: 790-791

MSC: Client Needs: Safe and Effective Care Environment: Management of Care

3. During a morning assessment, the nurse notices that a patient's urine output is below the expected amount. What should the nurse do next?

A) Obtain an order for a Foley catheter.
B) Obtain an order for a straight catheter.

C) Perform a bladder scan test.

D) Refer the patient to a urologist.

ANS: C

Cognitive Level: Applying (Application)

Test Bank 28-2

If urine output is below the expected value, then the nurse should perform a bladder scan according to institutional policy to check for retention.

PTS: 1 DIF:

REF: Pages: 790-791

MSC: Client Needs: Safe and Effective Care Environment: Management of Care

4. What should the nurse assess before entering the patient's room on morning rounds? A) Posted conditions, such as isolation precautions

B) The patient's input and output chart from the previous
shift C) The patient's general appearance

D) The presence of any visitors in the room

ANS: A

On the way to the room, the nurse should assess the presence of conditions such as isolation precautions, latex allergies, or fall precautions.

PTS: 1 DIF: Cognitive Level: Applying (Application)

REF: Page: 788

MSC: Client Needs: Safe and Effective Care Environment: Safety and Infection Control

5. The nurse has administered a pain medication to a patient by an intravenous infusion. The nurse should reassess the patient's response to the pain medication within _____ minutes. A) 5

B) 15

C) 30 D) 60

ANS: B

If pain medication is given, then the nurse should reassess the patient's response in 15 minutes for IV administration or 1 hour for oral administration.

PTS: 1 DIF: Cognitive Level: Applying (Application)

REF: Page: 788

MSC: Client Needs: Physiological Integrity: Pharmacological and Parenteral Therapies

6. During an assessment of a hospitalized patient, the nurse pinches a fold of skin under the clavicle or on the forearm to test:

A) mobility and turgor.

B) the patient's response to pain.

C) the percentage of the patient's fat-to-muscle ratio. D) the presence of edema.

ANS: A

Pinch up a fold of skin under the clavicle or on the forearm to note mobility and turgor.

Cognitive Level: Applying (Application)

PTS: 1 DIF:

REF: Pages: 790-791

MSC: Client Needs: Safe and Effective Care Environment: Management of Care

Cognitive Level: Applying (Application)

Test Bank 28-3

7. When assessing the neurologic system of a hospitalized patient during morning rounds, the nurse should include which of these during the assessment?

A) Blood pressure

B) The patient's rating of pain on a 1 to 10 scale

C) The patient's ability to communicate D) The patient's personal hygiene level

ANS: C

Assessment of a patient's ability to communicate is part of the neurologic assessment. Blood pressure and pain rating are measurements, and personal hygiene is assessed under general appearance.

PTS: 1 DIF: Cognitive Level: Applying (Application)

REF: Pages: 789-790

MSC: Client Needs: Safe and Effective Care Environment: Management of Care

8. When assessing a patient's general appearance, the nurse should include which of these questions?

A) Is the patient's muscle strength equal in both arms? B) Is ptosis or facial droop present?

C) Does the patient respond appropriately to questions? D) Are the pupils equal in reaction and size?

ANS: C

Assessing whether the patient responds appropriately to questions is a component of assessment of the patient's general appearance. The other answers reflect components of the neurologic examination.

PTS: 1 DIF: Cognitive Level: Applying (Application)
REF: Page: 788
MSC: Client Needs: Safe and Effective Care Environment: Management of Care

9. When assessing a patient in the hospital setting, the nurse knows that which statement is true?

A) The patient will need a brief assessment at least every 4 hours.
B) The patient will need a consistent, specialized examination every 8 hours that

focuses on certain parameters.

C) The patient will need a complete head-to-toe physical examination every 24 hours. D) Most patients require a minimal examination each shift unless they are in critical

condition.

ANS: B

In a hospital setting, the patient does not require a complete head-to-toe physical examination during every 24-hour stay. The patient does require a consistent specialized examination every 8 hours that focuses on certain parameters.

PTS: 1 DIF: Cognitive Level: Applying (Application)
REF: Page: 787
MSC: Client Needs: Safe and Effective Care Environment: Management of Care

10. The nurse is giving report to the next shift and is using the SBAR framework for communication. Which of these statements reflects the Background portion of

the report? A) “I’m worried that his gastrointestinal bleeding is getting worse.”
B) “We need an order for oxygen.”
C) “My name is Ms. Smith and I’m giving report on Mrs. X in room 1104.”
D) “He is four days post-operative and his incision is open to air.”

ANS: D

During the Background portion, the nurse should state data pertinent to the moment’s problem such as the condition of the patient’s incision. During the Situation portion, the nurse provides his or her name and the patient’s name. During the Assessment portion, the nurse states what her or she thinks is happening (i.e., the gastrointestinal bleeding). During the Recommendation portion, the nurse should offer probable solutions or orders that may be implemented.

PTS: 1 DIF: Cognitive Level: Analyzing (Analysis)
REF: Page: 793
MSC: Client Needs: Safe and Effective Care Environment: Safety and Infection Control

MULTIPLE RESPONSE

1. The nurse is assessing the intravenous (IV) infusion at the beginning of the shift. Which of these should be included in the assessment of the infusion? Select all that apply.
A) Proper IV solution is infusing according to physician’s orders.
B) IV solution is infusing at the proper rate according to physician’s orders.

C) The infusion is proper according to the nurse’s assessment of the patient’s needs. D) Capillary refill in the fingers
E) IV site date
F) Whether the patient is voiding sufficiently

ANS: A, B, C, E

The nurse should verify that the proper IV solution is hanging and is flowing at the proper rate according to the physician’s orders and the nurse’s own assessment of the patient’s needs. In addition, the nurse should note the date of the IV site

and surrounding skin condition. Checking capillary refill is part of the cardiovascular assessment; checking the patient's voiding is part of the genitourinary assessment.

PTS: 1 DIF:
REF: Pages: 790-791
MSC: Client Needs: Physiological Integrity: Pharmacological and Parenteral Therapies

2. The nurse is completing an assessment on a patient who was just admitted from the emergency department. Which assessment findings would require immediate attention? Select all that apply.
A) Temperature is 101.4° F.

B) Systolic blood pressure is 150 mm Hg. C) Respiratory rate is 22 breaths per minute.

Cognitive Level: Applying (Application)

Test Bank 28-5

D) Heart rate is 130 beats per minute.

E) Oxygen saturation is 95%.

F) Patient exhibits sudden restlessness.

ANS: A,D,F
The following examination findings require immediate attention:

High or low temperature (less than or equal to 97° F or greater than or equal to 100° F High or low blood pressure (systolic pressure less than or equal to 90 mm Hg or

greater than or equal to 160 mm Hg

High or low number of respirations per minute (less than or equal to 12 or greater than

or equal to 28 breaths per minute)

High or low heart rate (less than or equal to 60 or greater than or equal to 90 beats per

minute)

Oxygen saturations less than or equal to 92%

Sudden restlessness or anxiety, altered level of consciousness, confusion, or difficulty

in arousing

PTS: 1 DIF: Cognitive Level: Applying (Application)

REF: Page: 791 MSC: Client Needs: Physiological Integrity: Physiological Adaptation