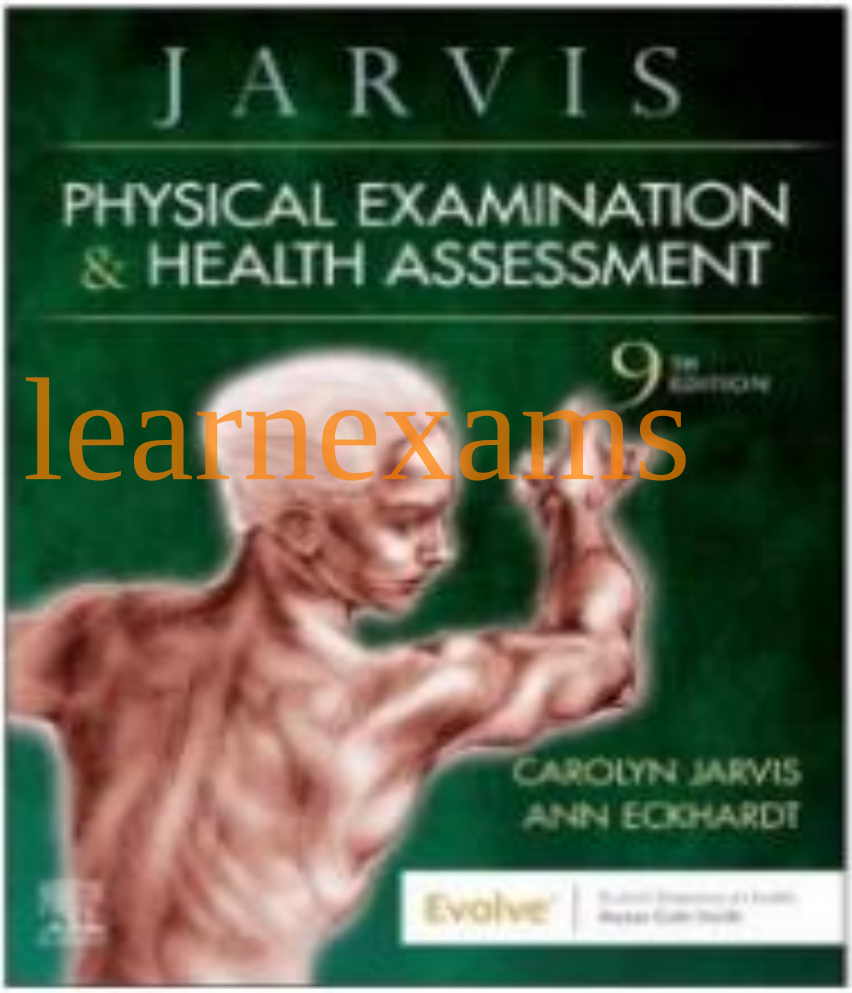
TEST BANK

Physical Examination and Health Assessment

Carolyn Jarvis PhD APN CNP, and Ann L. Eckhardt PhD RN

9th Edition



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Chapter 01: Evidence-Based Assessment
Jarvis: Physical Examination and Health Assessment, 9th Edition

MULTIPLE CHOICE

1. After completing an initial assessment of a patient, the nurse has charted that his respirations are eupneic and his pulse is 58 beats per minute. What type of assessment data is this?

a. Objective

b. Reflective

c. Subjective

d. Introspective

ANS: A

Objective data is what the health professional observes by inspecting, percussing, palpating, and auscultating during the physical examination. Subjective data is what the person says about him or herself during history taking. The terms reflective and introspective are not used to describe data.

DIF: Cognitive Level: Understanding (Comprehension)

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

2. A patient tells the nurse that he is very nervous, nauseous, and "feels hot." What type of assessment data is this?

a. Objective

b. Reflective

c. Subjective

d. Introspective

ANS: C

Subjective data is what the person says about him or herself during history taking. Objective data is what the health professional observes by inspecting, percussing, palpating, and auscultating during the physical examination. The terms reflective and introspective are not used to describe data.

DIF: Cognitive Level: Understanding (Comprehension)

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

3. What do the patient's record, laboratory studies, objective data, and subjective data combine to form?

a. Database

b. Admitting data

c. Financial statement

d. Discharge summary

ANS: A

Together with the patient's record and laboratory studies, the objective and subjective data form the database. The other items are not part of the patient's record, laboratory studies, or data.

DIF: Cognitive Level: Remembering (Knowledge)

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

4. When listening to a patient's breath sounds, the nurse is unsure of a sound that is heard. Which action should the nurse take next?

a. Notify the patient's physician.

b. Document the sound exactly as it was heard.

c. Validate the data by asking another nurse to listen to the breath sounds.

d. Assess again in 20 minutes to note whether the sound is still present.

ANS: C

When unsure of a sound heard while listening to a patient's breath sounds, the nurse validates the data to ensure accuracy by either repeating the assessment themselves or asking another nurse to assess the breath sounds. If the nurse has less experience analyzing breath sounds, then he or she should ask an expert to listen. When unsure of a sound heard while listening to a patient's breath sounds, the nurse should validate the data before documenting to ensure accuracy and before notifying the patient's physician. To validate that data, the nurse either repeats the assessment himself or herself or asks another nurse to assess the breath sounds.

DIF: Cognitive Level: Analyzing (Analysis)

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