

Answer Key

Chapter 1 Health Assessment

Anatomic Planes Terminology

- | | |
|------|-------|
| 1. j | 9. m |
| 2. d | 10. g |
| 3. k | 11. a |
| 4. c | 12. e |
| 5. i | 13. f |
| 6. l | 14. b |
| 7. n | 15. p |
| 8. o | 16. h |

Defining Health

- One's definition of "health" is highly individualized. There is no right or wrong answer here.

Healthy People 2020

Subjective to learner's findings.

Health Assessment

Health History

- | | |
|------|-------|
| 1. e | 6. c |
| 2. b | 7. d |
| 3. f | 8. c |
| 4. a | 9. c |
| 5. g | 10. f |

Data

- | | |
|---------|----------|
| 1. O-PA | 6. S-HH |
| 2. S-HH | 7. O-PA |
| 3. O-PA | 8. O-PA |
| 4. O-PA | 9. S-HH |
| 5. S-HH | 10. O-PA |

Confidentiality

A check (✓) belongs next to 1, 3, 4, 5, 6, 9, 10.

Documentation

- Dx = diagnosis
- Hx = history
- Wt = weight
- ADL = activities of daily living
- BP = blood pressure
- CBC = complete blood count

- abd = abdomen
- LMP = last menstrual period
- CVA = cerebral vascular accident
- VS = vital signs
- WBC = white blood cell
- CNS = central nervous system

Charting

1. APIE

Assessment:

Client states weakness and a rapid heartbeat. "I was gardening all day in the church courtyard and never took a break to eat or drink." Cannot recall last void.

VS: BP 86/40, HR 119 bpm

Mucous membranes are dry

Problem:

Dehydration

Intervention:

1 liter of intravenous fluids administered over 2 hours

Evaluation:

VS: BP 109/62, HR 88 bpm

Able to void 475 ml clear amber urine

2. SOAP

Subjective:

Client states weakness and a rapid heartbeat. "I was gardening all day in the church courtyard and never took a break to eat or drink." Cannot recall last void.

Objective:

VS-BP-86/40, HR-119 bpm

Mucous membranes are dry

Assessment:

Dehydration

Plan:

Administer 1 liter intravenous fluids over 2 hours and collect a urine sample

3. Narrative Note

The nursing narrative provided is incomplete because it lacks the following: data that support dehydration, details about the type of intravenous fluids provided, specific data to support an improvement in vital signs.

The Nursing Process and Critical Thinking

- Assessment**—25-year-old female status post-hysterectomy complaining of intermittent sharp pains in the lower abdomen scaled 8/10 on a numeric scale

Diagnosis—Select a NANDA-approved nursing diagnosis related to pain

Planning—The relief of pain/ administer analgesics to relieve the pain

Implementation—Administer morphine 4 mg subcutaneous injection

Evaluation—The client's pain decreased to a 2/10 on a numeric scale

- Normal findings: energetic, good appetite. Abnormal findings: dry mouth and frequent headaches
 - Dry mouth related to side effects of medication, headaches related to side effects of medication, knowledge deficit related to side effects of medication would all be appropriate for this scenario.
 - Planning involves setting goals and priorities for the client. Outcomes should be determined and interventions should be selected that are necessary to meet each

outcome. Implementation means the nurse puts the plan into action. The plan of care is carried out.

Critical Thinking

Essential Elements of Critical Thinking

1. Collection of information
2. Analysis of the situation
3. Generation of alternatives
4. Selection of alternatives
5. Evaluation

Application of the Critical Thinking Process

Answers are provided in shaded areas of scenario.

Role of the Professional Nurse in Health Assessment

- | | |
|------|------|
| 1. D | 5. A |
| 2. E | 6. C |
| 3. C | 7. A |
| 4. E | 8. B |

Teaching Plans

Objectives

- | | |
|------|------|
| 1. C | 5. A |
| 2. P | 6. C |
| 3. A | 7. C |
| 4. P | 8. C |

Teaching Methods

1. Lecture
2. Demonstration
3. Practice
4. Demonstration
5. Printed material
6. Group discussion
7. Demonstration
8. Explanation

Teaching Scenario

1. The client requires both short- and long-term goals. Short-term goals would be to restore respiratory function due to the exacerbation of asthma. Long-term goals should focus on smoking cessation.
2. Example goal: The client will stop smoking within 2 months.
3. Example objectives: The client will be able to list three benefits to stopping smoking. The client will be able to discuss three methods to assist in smoking cessation.

The client will be able to demonstrate the correct method of applying a nicotine patch.

4. Subjective to learner's findings.
5. A return demonstration is the best way to confirm that learning has taken place.

NCLEX®-Style Review Questions

1. **4. Rationale:** The letters in SOAP charting stand for the following: Subjective, Objective, Assessment, and Planning. Subjective data is collected from the client or a reliable source. Objective data is what the nurse observes or collects. Objective data could be collected from the nursing physical assessment, laboratory tests, diagnostic tests, and patient records. Assessment is what is drawn from both the subjective and objective data. Planning is where the nurse would record the plan of action to resolve any concerns, issues, or needs of the client.

2. **1, 2. Rationale:** Charting by exception is an example of documentation in which recording of information is limited to exceptions from preestablished norms or significant findings. Charting by exception eliminates repetitive charting of data and findings that are within defined parameters. Charting by exception is not based on a computer program, but could be based on electronic charting format. Charting by exception is not based on the use of phrases and sentences or on the frequent use of scales.

3. **2. Rationale:** The purpose of the health history is to obtain information about the client's health in the client's own words and based on the client's own perceptions. The information obtained provides cues and guides for further data collection. It does not eliminate the need for a full physical assessment because the data gathered from the client is subjective in nature. The physical assessment gathers objective data. The health history does not save

the nurse time. The health history is a part of, but not the basis for, formulating the nursing diagnosis. The full physical assessment would be the basis of the formulation of the nursing diagnosis.

4. **1. Rationale:** Data is either constant or variable in nature. Constant data is information that does not change over time, such as gender, ethnicity, or blood type. Variable data may change within minutes, hours, or days. Blood pressure, pulse rate, blood counts, and age are examples of variable data.

5. **1, 2, 3. Rationale:** The nurse educator, a nurse with an advanced degree, could teach in a nursing program or work in staff development in a clinical agency. The options that are correct all focus on the nurse educator in the staff development setting. The nurse educator would be responsible for teaching a new graduate how to use an IV pump. The nurse educator would also coordinate a workshop for critical care nurses and provide staff nurses with information about a new medication. A nurse researcher would possibly write a grant for funds to conduct research. A clinical nurse specialist would be an advanced practice nurse who could be providing direct patient care, directing and teaching other team members providing care, and conducting nursing research. A clinical nurse specialist would possibly be assessing the client's daily intake of food.

6. **2. Rationale:** After the nurse obtained the history of past illness, the next step would be to continue with a family history and review of systems. The nurse could continue collecting subjective data prior to moving to the physical assessment phase of the health assessment. The nurse would collect the client's BP and possibly a fingerstick during the physical assessment phase of the health assessment. After all subjective and objective data

are collected, the nurse would develop a plan of care, including interventions. An example of an intervention would be to educate the client about the proper diet and possibly discuss a referral to a cardiologist.

7. **3. Rationale:** An objective in the psychomotor domain would focus on the client performing an action to learn information. This could be in the realm of practicing, demonstrating, or using computer-assisted instruction. Completing a case study would be more in the area of the cognitive or affective domain, depending on the focus of the case study. The case study would be designed to either increase knowledge (cognitive), or impact attitudes, feelings, values, or opinions (affective).

8. **3. Rationale:** A cluster is the analysis of assessment data and grouping it into related pieces of information. From the information given, the cluster with the poorest relationship would be diarrhea, swelling of the ankles, and exercises three times a day. One item has to do with fluid loss, one has to do with fluid retention, and one has to do with exercise habits. It is difficult to see a relationship with these three factors. The other three options all show a relationship or possible relationship between the three factors. Since the question asks to identify which cluster has the poorest relationship, it would be the ones noted above.

9. **3. Rationale:** The scenario notes both subjective and objective data gathered from the client. The question asks which behaviors the nurse should interpret as abnormal. The client attending church services and a support group would both be positive behaviors. Since the support group is identified as a positive factor, including it with another option such as skipping meals would not make that option abnormal, since both factors

are not identified as abnormal. Weight loss and living alone are distractors. Yes, living alone can possibly impact weight loss, but living alone is not the key problem to be identified. "Skipping meals and weight loss" is the correct answer.

10. **2. Rationale:** The nurse's next step in the scenario is to gather more information. Assessment is the first step of the nursing process. The nurse would ask the client if he has ever had surgery before. The other options listed are not assessment steps; rather, they are interventions and are incorrect options.

Chapter 2 Human Development Across the Life Span

Developmental Milestones

- 8 months
- 3 years
- 2 months
- 3 ½ months
- 4 months
- 12 months
- 5 years
- 10 months
- 11 months
- 6 months
- 7 months
- 10 months

Stages of Development

- | | |
|-------|-------|
| 1. T | 11. I |
| 2. O | 12. S |
| 3. M | 13. P |
| 4. Y | 14. A |
| 5. M | 15. T |
| 6. O | 16. P |
| 7. S | 17. S |
| 8. P | 18. A |
| 9. T | 19. Y |
| 10. I | 20. M |

Psychosocial Theory

- Trust vs. mistrust—no
- Integrity vs. despair—yes; losing interest in everyday life can be a sign of despair
- Intimacy vs. isolation—no
- Generativity vs. stagnation—no
- Initiative vs. guilt—no

- Autonomy vs. shame and doubt—no
- Identity vs. role diffusion—no
- Industry vs. inferiority—yes; he feels hopeless and is giving up

Assessment Findings

- Normal
- Normal
- Abnormal
- Abnormal
- Normal
- Normal
- Normal
- Normal
- Abnormal
- Abnormal

Application of the Critical Thinking Process

- Integrity vs. despair
- Questions related to Janie's plan for retirement, her feelings about leaving the workforce, and/or support systems would all be appropriate.
- Integrity
- This is a positive response because her planned postretirement activities will help her maintain her self-worth and usefulness.
- Lactose intolerance may lead to a decreased calcium intake, which is a risk factor for osteoporosis. Also, heart disease is the leading cause of death among women in this age group. Therefore, a cholesterol screening would be necessary.
- Questions related to her plan of care for her father, support systems she may have when her sister is not available, and coping mechanisms/stress relief measures.
- Example of a community resource would be Meals-on-Wheels. Meals-on-Wheels is offered in many communities across the country and provides one cold and one hot meal per day delivered to a client's home.

NCLEX®-Style Review Questions

- 3. Rationale:** The major systems of the body decline

in effectiveness as one ages. An older adult would demonstrate an increase in peripheral vascular resistance due to the inelasticity of the arteries. The older adult would evidence decreased vital capacity, decreased filling and emptying ability of the heart valves, and decreased filtering abilities of the kidneys.

2. **1. *Rationale:*** The teaching topic that would be most appropriate for an adolescent would be seat belt safety. Adolescents exhibit acting-out and risk-taking behaviors, placing the adolescent at risk for serious injury from all accidents, including car crashes. Because of this risk-taking behavior, seat belt safety education would be beneficial. Adolescents are not an appropriate group for prostate screenings or teaching designed for adjusting to aging parents. This would be appropriate for middle-age adults. Although the influenza vaccination is important to all age groups, teaching would be most appropriate for the older adult population.
3. **2. *Rationale:*** Myelination in the spinal cord is almost complete by 2 years of age. This event corresponds to the increase in gross motor skills. All of the other distractors are incorrect.
4. **3. *Rationale:*** Socioeconomic status has a major influence on growth and development. Children of low socioeconomic status may have an impaired ability to meet their nutritional needs. Children of low socioeconomic status have been found to have lower height and weight than those in other economic groups. Children of low socioeconomic status are less likely to have fresh fruits, vegetables, and lean meats in their diet. Children of low socioeconomic status are more likely to be exposed to environmental

elements that influence physical health and well-being.

5. **3. *Rationale:*** An appropriate age to give a child a tricycle for a birthday present would be 3 years. All of the other listed distractors are incorrect.
6. **3. *Rationale:*** An appropriate sentence for a 3-year-old would be more complex in nature and include more parts of speech. The appropriate response would be "Can I color now?" The response "Mama, Mama" would be appropriate for a 1-year-old. The response "Juice please" would be appropriate for a 2-year-old. The response "Will we be going to the movies today?" would be appropriate for a child older than 3 years.
7. **3. *Rationale:*** The nurse is aware that according to Freud's stages of psychosexual development, the mother refusing to offer a pacifier to her newborn baby affects the oral phase. This phase in Freud's theory occurs during the first year of life when the mouth is the center of pleasure. The anal phase follows the oral phase and continues through about 3 years of age. At this time the anus becomes the focus of gratification, and the functions of elimination take on new importance. The phallic phase occurs during years 4 to 5 or 6, when the focus of pleasure shifts to the genital area. Conflict occurs as the child feels possessive toward the parent of the opposite sex and rivalry toward the parent of the same sex. The latency phase occurs from 5 or 6 years of age to puberty. This is a time of relative quiet as previous conflicts are resolved and aggressiveness becomes latent.
8. **1. *Rationale:*** The nurse's next action should be to sit down and speak with the student to obtain more information about his home situation. The application of the nursing process is important in this

question. The nurse would not implement an intervention without gathering information from the student to develop an action plan or interventions. The three options that are listed are all interventions and would not be the appropriate answer for a question asking for the next action that should be taken by the nurse.

9. **3. *Rationale:*** A 3-year-old would fall in the area between a toddler and preschool child. It would be important for the nurse to explain in simple terms the procedure that is going to be performed. The child would not know what the procedure is called, so saying "Let me take your blood pressure" or "I'm going to assess your blood pressure" would not be correct. The nurse would not want to distract the child to do the procedure without saying anything because that could interfere with building trust between the nurse and the child.
10. **1, 2, 3, 4. *Rationale:*** The nurse would need to further assess several of the clients. The nurse would further assess a 43-year-old male who lives in the same home he grew up in as a child with his elderly parents and can't keep a job. A middle-age adult is in a time of evaluation and adjustment, and one of the tasks is reviewing and redirecting career goals. Not being able to keep a job is an area of concern and would indicate a need for further assessment by the nurse. Adjusting to aging parents is one of the tasks of middle adulthood. A female client who is 15 years old and who is unsure of how many sexual partners she has had would require further assessment by the nurse. Tasks of this period do include developing a sexual identity, but the client is involved in sexual practices that are dangerous to her health. The 48-year-old female