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- C. Ignore the client's concern so the assessment is complete
- D. Ask every question now to avoid missing anything

Correct Answer: A

Rationale — Correct Answer: Evidence-based assessment also requires individualized, client-centered care. Prioritizing essential questions respects the client's condition while still allowing the nurse to collect needed data safely.

Rationale — Incorrect Options:

- B. Stopping completely may leave critical gaps in assessment data.
- C. Ignoring the client's concern is not therapeutic and may reduce cooperation.
- D. Completing every question immediately may be unrealistic and increase client distress.

Teaching Point: Good assessment balances evidence with the client's readiness and comfort.

Citation: Jarvis, C., & Eckhardt, A. L. (2024). *Physical examination and health assessment* (9th ed.). Chapter 1: Evidence-Based Assessment.

8. **Reference:** Unit 1. Assessment of the Whole Person — Chapter 1. Evidence-Based Assessment

Stem: During handoff, a nurse says, "The client looks unwell, but I cannot explain why." Another nurse reviews the findings and notices a change in mental status, poor skin turgor, and reduced urine output. What is the best interpretation of these assessment cues?

Options:

- A. The findings require further assessment and clinical interpretation
- B. The findings are unrelated and should be ignored
- C. Only the client's appearance matters in assessment
- D. Evidence-based assessment is not helpful in unclear cases

Correct Answer: A

Rationale — Correct Answer: Evidence-based assessment helps the nurse connect multiple cues to possible clinical problems. Unclear presentations require synthesis of subjective and objective data rather than dismissal of findings.

Rationale — Incorrect Options:

- B. The findings may be related and could indicate a serious problem.

- C. Appearance alone is insufficient for clinical judgment.
- D. Evidence-based assessment is especially useful when data are complex or unclear.

Teaching Point: Combine cues; do not rely on one isolated finding.

Citation: Jarvis, C., & Eckhardt, A. L. (2024). *Physical examination and health assessment* (9th ed.). Chapter 1: Evidence-Based Assessment.

9. **Reference:** Unit 1. Assessment of the Whole Person — Chapter 1. Evidence-Based Assessment

Stem: A nurse is learning how evidence-based assessment improves documentation. The nurse asks what the greatest benefit of using standardized, research-supported assessment language is. Which answer is best?

Options:

- A. It improves communication and consistency across caregivers
- B. It eliminates the need for clinical judgment
- C. It replaces the patient's own report
- D. It guarantees a diagnosis

Correct Answer: A

Rationale — Correct Answer: Standardized, evidence-supported documentation helps the team communicate clearly and compare findings over time. It supports continuity of care and reduces misunderstanding.

Rationale — Incorrect Options:

- B. Clinical judgment remains essential in interpreting assessment data.
- C. Subjective data are still important and cannot be replaced.
- D. Documentation supports diagnosis but does not guarantee it.

Teaching Point: Clear documentation strengthens teamwork and continuity of care.

Citation: Jarvis, C., & Eckhardt, A. L. (2024). *Physical examination and health assessment* (9th ed.). Chapter 1: Evidence-Based Assessment.

10. **Reference:** Unit 1. Assessment of the Whole Person — Chapter 1. Evidence-Based Assessment

Stem: A nurse wants to know whether a new respiratory assessment checklist truly improves patient outcomes on the unit. Which question best reflects evidence-based thinking?

Options:

- A. Does the checklist improve detection, accuracy, or patient outcomes?
- B. Is the checklist newer than the current one?
- C. Does the checklist look more professional?
- D. Do most staff members prefer it?

Correct Answer: A

Rationale — Correct Answer: Evidence-based assessment focuses on whether a tool or process improves meaningful outcomes such as detection, accuracy, and safety. Preference alone is not enough.

Rationale — Incorrect Options:

- B. Newness does not equal effectiveness.
- C. Appearance does not determine clinical value.
- D. Staff preference may matter for adoption, but it is not the main proof of benefit.

Teaching Point: Choose assessment methods that improve outcomes, not just convenience.

Citation: Jarvis, C., & Eckhardt, A. L. (2024). *Physical examination and health assessment* (9th ed.). Chapter 1: Evidence-Based Assessment.

11. Reference: Unit 1. Assessment of the Whole Person — Chapter 1. Evidence-Based Assessment

Stem: A student nurse records “patient seems anxious” after interviewing a client before surgery. The instructor asks for stronger documentation. Which note is best supported by evidence-based assessment principles?

Options:

- A. “Client wringing hands, speaking rapidly, and states, ‘I am scared about the surgery.’”
- B. “Client is dramatic and nervous.”
- C. “Client probably has anxiety disorder.”
- D. “Client is fine but may be overreacting.”

Correct Answer: A

14. Reference

Chapter 2 — Cultural Assessment: Interpreting Silence

Stem:

A patient pauses for a long time before answering questions about a new cancer diagnosis. The nurse feels uncomfortable with the silence and considers filling every pause with more questions. The patient's facial expression suggests the news is emotionally difficult.

Options:

- A. Interrupt the silence quickly to reduce the patient's distress.
- B. Allow silence and remain present while the patient processes the information.
- C. Ask another family member to answer because the patient is too emotional.
- D. Move on to the next topic to keep the conversation efficient.

Correct Answer: B

Rationale — Correct Answer:

Silence can be a respectful and necessary communication style that allows reflection and emotional processing. The nurse should not assume the pause means confusion, disinterest, or refusal.

Rationale — Incorrect Options:

- A. Interrupting may shut down communication and increase anxiety.
- C. The patient should be given time to respond unless unable to participate.
- D. Efficiency should not replace emotional support during serious health discussions.

Teaching Point:

Silence can be therapeutic and culturally appropriate.

Citation:

Jarvis, C., & Eckhardt, A. L. (2024). *Physical Examination and Health Assessment* (9th ed.). Chapter 2, Cultural Assessment and Developmental Competence.

15. Reference

Chapter 2 — Cultural Assessment: Spiritual Practices

Stem:

A hospitalized patient asks whether the unit can accommodate daily prayer times and objects used in worship. The nurse is unsure whether this request matters clinically and

Citation Jarvis, C., & Eckhardt, A. L. (2024). *Physical Examination and Health Assessment* (9th ed.). Chapter 3: The Interview.

4. Reference Chapter 3: The Interview — Developmental Competence (School-Age Children)

Clinical Stem A 10-year-old child is interviewed about headaches. The child provides detailed information but frequently looks at the parent for approval. The best nursing action is to:

Options A. Ask the parent to leave the room. B. Direct questions to the child while welcoming input from both child and parent. C. Rely solely on the parent's report. D. Use only written questionnaires.

Correct Answer: B

 **Correct Answer Rationale** School-age children are concrete thinkers, can provide reliable histories, and benefit from inclusion. Validating both child and parent builds trust and improves accuracy of subjective data.

 **Incorrect Options** A. Abrupt separation may reduce openness. C. Excluding the child misses valuable perspective. D. Questionnaires supplement but do not replace interaction.

Teaching Point Include school-age children directly; they give reliable information when supported by parents.

Citation Jarvis, C., & Eckhardt, A. L. (2024). *Physical Examination and Health Assessment* (9th ed.). Chapter 3: The Interview.

5. Reference Chapter 3: The Interview — Developmental Competence (Adolescents)

Clinical Stem A 15-year-old is brought in by a parent for a routine check-up. When sensitive topics such as sexual activity arise, the teen becomes quiet. The nurse's most developmentally appropriate action is:

Options A. Continue the interview with the parent present. B. Spend private time alone with the adolescent after explaining confidentiality limits. C. Tell the teen everything must be shared with the parent. D. Skip sensitive topics to maintain rapport.

Correct Answer: B

2) Reference: Mental Status Assessment — Developmental Competence

A 4-year-old child is examined in a pediatric clinic. The child briefly clings to the parent at the start of the visit, then begins to play with a toy and answers simple questions with short phrases. The parent asks whether this behavior means the child is “overly anxious.” What is the nurse’s best interpretation?

- A. This is expected age-appropriate behavior.
- B. This indicates severe separation anxiety disorder.
- C. This is evidence of delayed language development.
- D. This behavior is abnormal and requires immediate psychiatric evaluation.

Correct Answer: A

Rationale — Correct Answer:

Brief separation anxiety at the start of a visit is expected in young children and usually decreases as they become comfortable. Short, simple responses are also consistent with developmental stage. The nurse should interpret the behavior in the context of age and setting.

Rationale — Incorrect Options:

- B. The scenario shows transient and appropriate clinginess, not a disorder.
- C. Short phrases can be normal for a preschooler; more data would be needed before labeling delay.
- D. The behavior is not abnormal enough to justify immediate psychiatric evaluation.

Teaching Point: Interpret mental status through the lens of development.

Citation: Jarvis, C., & Eckhardt, A. L. (2024). *Physical Examination and Health Assessment* (9th ed.). Chapter 5: Mental Status Assessment.

3) Reference: Mental Status Assessment — Genetics and Environment

A 39-year-old client reports increasing sadness after losing a job, sleeping poorly, and worrying constantly about finances. The client also says, “My mother had depression, so I think I might be headed that way too.” Which nursing action is most appropriate?

- A. Reassure the client that depression is unlikely without a formal diagnosis.
- B. Document the family history and assess for depressive symptoms and suicidal ideation.
- C. Tell the client to avoid discussing family history because it may increase anxiety.
- D. Conclude that the client has major depressive disorder.

Rationale — Correct Answer:

The first priority is privacy and immediate safety, because several trafficking indicators are present. Trauma-informed guidance recommends a secure environment and careful assessment before any confrontation or referral discussion.

Rationale — Incorrect Options:

A gives the companion more control. C may escalate danger. D is insufficient for a potentially unsafe situation.

Teaching Point: Safety and privacy come before confrontation.

18) Pediatric bruising patterns

Reference: Objective Data — Child Abuse

A 4-year-old has bruises on the ears, neck, and torso. The caregiver says the child “just bruises easily.” Which finding makes the nurse most concerned?

- A. Bruises over bony prominences only
- B. Bruises on the ears, neck, and torso
- C. A minor scrape on the knee
- D. A runny nose and low-grade fever

Correct Answer: B

Rationale — Correct Answer:

Bruising in atypical locations such as the ears, neck, and torso is concerning for inflicted trauma rather than routine childhood play. Child maltreatment should be considered when injuries do not match the explanation.

Rationale — Incorrect Options:

A is more typical of accidental bruising. C is a common minor injury. D is unrelated to abuse screening.

Teaching Point: Bruises on ears, neck, or torso are concerning.

19) Elder sexual abuse concern

Reference: Abnormal Findings — Elder Abuse

Correct Answer: B

Rationale:

Correct: Clean gloves protect the nurse and client during contact with mucous membranes. Standard precautions apply even without visible bleeding.

A: Bare hands are not appropriate for mucosal contact.

C: The assessment should not be delayed without a valid reason.

D: Sterile gloves are not required for routine oral inspection.

Teaching Point:

Use clean gloves for mucous membrane assessment.

Citation: Jarvis, C., & Eckhardt, A. L. (n.d.). *Physical Examination and Health Assessment* (9th ed.), Chapter 8: Assessment Techniques and Safety in the Clinical Setting.

12. Reference: Chapter 8 — Developmental Competence: School-Age Child Assessment

Stem:

A 9-year-old child is anxious before a routine exam and asks, “Will it hurt?” The parent is present, and the child watches every movement of the nurse. The nurse wants to support cooperation and reduce fear.

Which action is best?

- A. Give a detailed technical explanation to show honesty
- B. Explain each step in simple terms and allow the child to ask questions
- C. Ignore the question to avoid increasing anxiety
- D. Tell the child that good children never cry during exams

Correct Answer: B

Rationale:

Correct: School-age children benefit from concrete explanations and a chance to ask questions. Clear, honest communication helps the child feel more in control.

A: Technical language may confuse and increase anxiety.

C: Ignoring the child’s concern weakens trust.

D: Shaming language is inappropriate and harmful.

Teaching Point:

School-age children need clear explanations and reassurance without shame.

Clinical stem:

A client with vomiting and poor oral intake has weak, thready radial pulses and cool extremities. Blood pressure is 88/54 mm Hg, and urine output has decreased. Which interpretation is most appropriate?

Options:

- A. The findings suggest decreased circulating volume
- B. The pulse is normal for dehydration
- C. The client likely has improved perfusion
- D. The weak pulse is unrelated to blood pressure

Correct answer: A

Rationale — Correct answer:

Weak, thready pulses along with hypotension and decreased urine output suggest poor perfusion and possible fluid volume deficit. The nurse should recognize the pattern rather than isolate each finding. These data require prompt follow-up.

Rationales — Incorrect options:

- B. Weak pulses are not a normal finding in dehydration; they are a warning sign.
- C. The findings indicate impaired, not improved, perfusion.
- D. Pulse quality often reflects circulatory status and blood pressure.

Teaching point:

Weak pulses with hypotension often reflect low circulating volume.

Citation:

Jarvis, C., & Eckhardt, A. L. (2024). *Physical Examination and Health Assessment* (9th ed.). Chapter 10: Vital Signs.

12) Temperature and environmental influence

Reference: Chapter 10 — Vital Signs: Temperature Measurement

Clinical stem:

A child arrives from outside on a hot day wearing a heavy coat. An axillary temperature is 38.0°C (100.4°F). The child is otherwise alert and playful. Which action is best?

Options:

- A. Record the temperature as definitive evidence of fever
- B. Reassess after the child has rested in a comfortable environment

Teaching point:

Vital sign trends are often more important than one isolated reading.

Citation:

Jarvis, C., & Eckhardt, A. L. (2024). *Physical Examination and Health Assessment* (9th ed.). Chapter 10: Vital Signs.

15) Pulse irregularity

Reference: Chapter 10 — Vital Signs: Pulse Rhythm

Clinical stem:

A nurse palpates a client's radial pulse and notes a regular pattern interrupted by occasional skipped beats. The client denies chest pain but says, "My heart feels funny sometimes." What is the nurse's best next action?

Options:

- A. Document the pulse as normal because the rate is within range
- B. Reassess pulse apically and further evaluate rhythm irregularity
- C. Ask the client to walk to see whether the rhythm corrects
- D. Ignore the finding unless the client becomes symptomatic

Correct answer: B

Rationale — Correct answer:

An irregular pulse should be assessed more carefully, including an apical pulse and rhythm evaluation. Even when the rate is acceptable, rhythm abnormalities may indicate dysrhythmia or other cardiac issues. The finding should not be ignored.

Rationales — Incorrect options:

- A. A normal rate does not rule out an abnormal rhythm.
- C. Exercise is not the first response to irregular pulse.
- D. Asymptomatic rhythm changes still warrant assessment.

Teaching point:

Irregular pulse rhythm requires apical reassessment and clinical judgment.

Citation:

Jarvis, C., & Eckhardt, A. L. (2024). *Physical Examination and Health Assessment* (9th ed.). Chapter 10: Vital Signs.

Rationales:

Correct Answer: Infants cannot reliably self-report, so behavioral cues are essential for pain assessment. Crying, facial expression, and body tension are meaningful clinical data.

A: A numeric rating scale is not developmentally appropriate for an infant.

C: Infants cannot maintain a written diary.

D: A visual analog line is not appropriate for this developmental stage.

Teaching Point: Infants require behavioral pain assessment, not self-report scales.

Citation: Jarvis, C., & Eckhardt, A. L. *Physical Examination and Health Assessment* (9th ed.). Chapter 11: Pain Assessment.

18 Reference: Pain Assessment — Documentation and Critical Thinking

Stem: A client with cancer describes “breakthrough pain” that occurs during transfers even though baseline pain is controlled at rest. The nurse is documenting the pattern. Which note is most clinically useful?

Options:

A. “Pain is present.”

B. “Pain has improved.”

C. “Reports sudden pain spikes with movement despite resting comfort; further assessment of triggers needed.”

D. “Client is asking for medication too often.”

Correct Answer: C

Rationales:

Correct Answer: This note captures the pattern, trigger, and need for follow-up assessment. It supports clinical reasoning and future care planning.

A: This is too nonspecific to guide treatment.

B: Improvement alone does not describe the breakthrough pattern.

D: This is judgmental and does not describe the assessment accurately.

Teaching Point: Document pain patterns and triggers, not vague impressions.

Citation: Jarvis, C., & Eckhardt, A. L. *Physical Examination and Health Assessment* (9th ed.). Chapter 11: Pain Assessment.

19 Reference: Pain Assessment — Genetic and Environmental Influences

Stem: A client says, “My sister always had terrible pain after surgery, so I probably will too.” The nurse wants to respond using clinical judgment rather than prediction. What is the best response?

Options:

A. “You will probably have the same pain pattern.”

B. “Family history can matter, but I need to assess your own pain experience.”

C. “That means your pain is likely exaggerated.”

D. “Pain is mostly random, so family history never matters.”

9 **Reference:** Chapter 16 — Ears: Objective Data

Stem:

A patient with severe ear pain has redness and swelling of the external auditory canal and reports pain when the auricle is pulled. Which finding is most consistent with otitis externa?

- A. Tenderness with manipulation of the ear
- B. Bulging tympanic membrane with no canal pain
- C. Bilateral painless hearing loss only
- D. Clear ear canal without erythema

Correct Answer: A

Rationale — Correct:

Pain with movement of the external ear is a classic sign of **otitis externa**. The inflammation involves the canal and makes manipulation painful.

Rationales — Incorrect:

- B. A bulging tympanic membrane points more toward otitis media.
- C. Hearing loss alone is not enough to identify otitis externa.
- D. A normal-appearing canal does not fit this presentation.

Teaching Point:

Pain on auricle movement strongly suggests otitis externa.

Citation:

Jarvis, C., & Eckhardt, A. L. (2024). *Physical Examination and Health Assessment* (9th ed.). Chapter 16: Ears.

10 **Reference:** Chapter 16 — Ears: Objective Data

Stem:

A child in the clinic is irritable and has a fever and tugging at the ear. Otoscopic examination shows a cloudy, bulging tympanic membrane. Which nursing interpretation is best?

- A. Findings are consistent with acute otitis media.
- B. Findings are expected after normal cerumen production.
- C. Findings confirm sensorineural hearing loss.
- D. Findings indicate a foreign body in the ear canal.

Rationale — Correct: Needing the arms to rise from a chair suggests weakness in the large proximal muscle groups, especially the hips and thighs. The nurse should continue the assessment and consider how the weakness affects function and safety.

Rationale — Incorrect:

- A. Normal proximal strength would allow standing with little or no arm assistance.
- C. This is not a gait assessment finding.
- D. Pushing off the thighs is compensation for weakness, not joint protection.

Teaching Point: Using the arms to stand often signals proximal weakness.

Citation: Jarvis, C., & Eckhardt, A. L. (2024). *Physical Examination and Health Assessment* (9th ed.). Chapter 23: Musculoskeletal System.

18) Reference: Musculoskeletal System — Abnormal Findings for Advanced Practice

Stem: A client reports localized tenderness over the shoulder and pain when the area is pressed, but the joint itself moves through full range of motion. The nurse suspects inflammation of a structure around the joint rather than the joint itself. Which finding best supports that interpretation?

- A. Pain localized over a bursa with preserved joint ROM
- B. Hard nodules in the finger joints
- C. Bilateral morning stiffness lasting 2 hours
- D. Marked loss of strength in both legs

Correct Answer: A

Rationale — Correct: Pain focused over a bursal area with preserved ROM suggests a periarticular problem rather than joint destruction. The nurse is using the pattern of findings to interpret where the problem is most likely located.

Rationale — Incorrect:

- B. Finger nodules point more toward osteoarthritis in the DIP joints.
- C. Prolonged bilateral morning stiffness suggests inflammatory arthritis.
- D. Bilateral leg weakness suggests a broader functional or neurologic problem, not isolated shoulder bursitis.

Teaching Point: Full ROM with localized tenderness often points to tissue around the joint.

Citation: Jarvis, C., & Eckhardt, A. L. (2024). *Physical Examination and Health Assessment* (9th ed.). Chapter 23: Musculoskeletal System.

C: Deferring assessment may miss a significant symptom.

D: Interpreting without clarification can delay recognition of a cardiac or pulmonary problem.

Teaching Point: Clarify vague patient statements before interpreting them.

Citation: Jarvis, C., & Eckhardt, A. L. (2024). *Physical Examination and Health Assessment* (9th ed.). Chapter 28: The Complete Health Assessment: Adult — Documentation and Critical Thinking.

9) Identifying a priority abnormal skin finding

Reference: Chapter 28 — Documentation and Critical Thinking

Stem:

During a complete adult assessment, the nurse notes a large dark purple area on the sacrum that is nonblanchable and intact. The patient denies pain. What is the best nursing interpretation?

- A. This is a normal pressure-related change.
- B. This finding is consistent with possible deep tissue injury and requires action.
- C. The patient should be reassured because the skin is intact.
- D. This is likely a minor bruise with no clinical significance.

Correct Answer: B

Rationale:

Correct Answer: Nonblanchable purple discoloration over a bony area is concerning for pressure-related tissue injury, even if intact and painless.

A: This is not a normal finding.

C: Intact skin does not rule out significant injury.

D: This finding requires follow-up, not dismissal.

Teaching Point: Nonblanchable pressure-related discoloration is an urgent skin finding.

Citation: Jarvis, C., & Eckhardt, A. L. (2024). *Physical Examination and Health Assessment* (9th ed.). Chapter 28: The Complete Health Assessment: Adult — Documentation and Critical Thinking.

- C. Placenta previa is associated with painless bleeding, not a normal fundal height.
- D. Preeclampsia is associated with blood pressure and proteinuria findings, not fundal height alone.

Teaching Point: Fundal height usually matches gestational age after 20 weeks.

Citation: Jarvis, C., & Eckhardt, A. L. (2024). *Physical Examination and Health Assessment* (9th ed.). Chapter 31: Pregnancy.

5) Leopold maneuvers

Reference: Chapter 31. Pregnancy — Objective Data

Stem: A nurse is preparing to auscultate fetal heart tones on a client in the third trimester. After performing Leopold maneuvers, the nurse locates the fetal back in the mother's left upper quadrant. Why is this information important?

- A. It identifies the safest time to obtain a urine specimen
- B. It helps determine where fetal heart tones will be heard best
- C. It confirms the placenta is in the left upper quadrant
- D. It proves the client is in active labor

Correct Answer: B. It helps determine where fetal heart tones will be heard best

Rationale — Correct Answer:

Leopold maneuvers help the nurse identify fetal lie, presentation, and position. Locating the fetal back helps the nurse place the Doppler over the area where heart tones are heard best.

Rationale — Incorrect Options:

- A. Leopold maneuvers are not used to time urine collection.
- C. The fetal back does not identify placental location.
- D. Leopold maneuvers do not determine labor status.

Teaching Point: Use Leopold maneuvers to find fetal position before auscultating heart tones.

Citation: Jarvis, C., & Eckhardt, A. L. (2024). *Physical Examination and Health Assessment* (9th ed.). Chapter 31: Pregnancy.