Chapter 05: Adult Health and Nutritional Assessment

1. A school nurse is teaching a 14-year-old girl of normal weight some of the key factors necessary to maintain good nutrition in this stage of her growth and development. What interventions should the nurse most likely prioritize?

A) Decreasing her calorie intake and encouraging her to maintain her weight to avoid obesity

B) Increasing her BMI, taking a multivitamin, and discussing body image

C) Increasing calcium intake, eating a balanced diet, and discussing eating disorders

D) Obtaining a food diary along with providing close monitoring for anorexia

Ans: C

Feedback:

Adolescent girls are considered to be at high risk for nutritional disorders. Increasing calcium intake and promoting a balanced diet will provide the necessary vitamins and minerals. If adolescents are diagnosed with eating disorders early, the recovery chances are increased. The question presents no information that indicates a need for decreasing her calories. There is no apparent need for an increase in BMI. A food diary is used for assessing eating habits, but the question asks for teaching factors related to good nutrition.

2. A nurse is conducting a health assessment of an adult patient when the patient asks, Why do you need all this health information and who is going to see it? What is the nurses best response?

A) Please do not worry. It is safe and will be used only to help us with your care. Its accessible to a wide variety of people who are invested in your health.

B) It is good you asked and you have a right to know; your information helps us to provide you with the best possible care, and your records are in a secure place.

C) Your health information is placed on secure Web sites to provide easy access to anyone wishing to see your medical records. This ensures continuity of care.

D) Health information becomes the property of the hospital and we will make sure that no one sees it. Then, in 2 years, we destroy all records and the process starts over.

Ans: B

Feedback:

Whenever information is elicited from a person through a health history or physical examination, the person has the right to know why the information is sought and how it will be used. For this reason, it is important to explain what the history and physical examination are, how the information will be obtained, and how it will be used. Medical records allow access to health care providers who need the information to provide patients with the best possible care, and the records are always held in a secure environment. Telling the patient not to worry minimizes the patients concern regarding the safety of his or her health information and a wide variety of people should not have access to patients health information. Health information should not be placed on Web sites and health records are not destroyed every 2 years.

3. The nurse is performing an admission assessment of a 72-year-old female patient who understands minimal English. An interpreter who speaks the patients language is unavailable and no members of the care team speak the language. How should the nurse best perform data collection?

A) Have a family member provide the data.

B) Obtain the data from the old chart and physicians assessment.

C) Obtain the data only from the patient, prioritizing aspects that the patient understands.

D) Collect all possible data from the patient and have the family supplement missing details.

Ans: D

Feedback:

The informant, or the person providing the information, may not always be the patient. The nurse can gain information from the patient and have the family provide any missing details. The nurse should always obtain as much information as possible directly from the patient. In this case, it is not likely possible to get all the information needed only from the patient.

4. You are the nurse assessing a 28-year-old woman who has presented to the emergency department with vague complaints of malaise. You note bruising to the patients upper arm that correspond to the outline of fingers as well as yellow bruising around her left eye. The patient makes minimal eye contact during the assessment. How might you best inquire about the bruising?

A) Is anyone physically hurting you?

B) Tell me about your relationships.

C) Do you want to see a social worker?

D) Is there something you want to tell me?

Ans: A

Feedback:

Few patients will discuss the topic of abuse unless they are directly asked. Therefore, it is important to ask direct questions, such as, Is anyone physically hurting you? The other options are incorrect because they are not the best way to illicit information about possible abuse in a direct and appropriate manner.

5. You are the nurse performing a health assessment of an adult male patient. The man states, The doctor has already asked me all these questions. Why are you asking them all over again? What is your best response?

A) This history helps us determine what your needs may be for nursing care.

B) You are right; this may seem redundant and Im sure that its frustrating for you.

C) I want to make sure your doctor has covered everything thats important for your treatment.

D) I am a member of your health care team and we want to make sure that nothing falls through the cracks.

Ans: A

Feedback:

Regardless of the assessment format used, the focus of nurses during data collection is different from that of physicians and other health team members. Explaining to the patient the purpose of the nursing assessment creates a better understanding of what the nurse does. It also gives the patient an opportunity to add his or her own input into the patients care plan. The nurse should address the patients concerns directly and avoid casting doubt on the thoroughness of the physician.

6. You are taking a health history on an adult patient who is new to the clinic. While performing your assessment, the patient informs you that her mother has type 1 diabetes. What is the primary significance of this information to the health history?

A) The patient may be at risk for developing diabetes.

B) The patient may need teaching on the effects of diabetes.

C) The patient may need to attend a support group for individuals with diabetes.

D) The patient may benefit from a dietary regimen that tracks glucose intake.

Ans: A

Feedback:

Nurses incorporate a genetics focus into the health assessments of family history to assess for genetics-related risk factors. The information aids the nurse in determining if the patient may be predisposed to diseases that are genetic in origin. The results of diabetes testing would determine whether dietary changes, support groups or health education would be needed.

7. A registered nurse is performing the admission assessment of a 37-year-old man who will be treated for pancreatitis on the medical unit. During the nursing assessment, the nurse asks the patient questions related to his spirituality. What is the primary rationale for this aspect of the nurses assessment?

A) The patients spiritual environment can affect his physical activity.

B) The patients spiritual environment can affect his ability to communicate.

C) The patients spiritual environment can affect his quality of sexual relationships.

D) The patients spiritual environment can affect his response to illness.

Ans: D

Feedback:

Illness may cause a spiritual crisis and can place considerable stresses on a persons internal resources. The term spiritual environment refers to the degree to which a person has contemplated his or her own existence. The other listed options may be right, but they are not the most important reasons for a nurse to assess a patients spiritual environment.

8. A nurse on a medical unit is conducting a spiritual assessment of a patient who is newly admitted. In the course of this assessment, the patient indicates that she does not eat meat. Which of the following is the most likely significance of this patients statement?

A) The patient does not understand the principles of nutrition.

B) This is an aspect of the patients religious practice.

C) This constitutes a nursing diagnosis of Risk for Imbalanced Nutrition.

D) This is an example of the patients coping strategies.

Ans: B

Feedback:

Because this datum was obtained during a spiritual assessment, it could be that this is an aspect of the patients religious practice. It is indeed a personal choice, but this is not the primary significance of the statement. This practice may not be related to health-seeking if it is in fact a religious practice. This does not necessarily constitute a risk for malnutrition or a misunderstanding of nutrition.

9. You are beginning your shift on a medical unit and are performing assessments appropriate to each patients diagnosis and history. When assessing a patient who has an acute staphylococcal infection, what

is the most effective technique for assessing the lymph nodes of the patients neck?

A) Inspection

B) Auscultation

C) Palpation

D) Percussion

Ans: C

Feedback:

Palpation is a part of the assessment that allows the nurse to assess a body part through touch. Many structures of the body (superficial blood vessels, lymph nodes, thyroid gland, organs of the abdomen, pelvis, and rectum), although not visible, may be assessed through the techniques of light and deep palpation. The other options are incorrect because lymph nodes are not assessed through inspection, auscultation, or percussion.

10. In your role as a school nurse, you are working with a female high school junior whose BMI is 31. When planning this girls care, you should identify what goal?

A) Continuation of current diet and activity level

B) Increase in exercise and reduction in calorie intake

C) Possible referral to an eating disorder clinic

D) Increase in daily calorie intake

Ans: B

Feedback:

A BMI of 31 is considered clinically obese; dietary and exercise modifications would be indicated. People who have a BMI lower than 24 (or who are 80% or less of their desirable body weight for height) are at increased risk for problems associated with poor nutritional status. Those who have a BMI of 25 to 29.9 are considered overweight; those with a BMI of 30 or greater are considered to be obese.

11. During your integumentary assessment of an adult female patient, you note that the patient has dry, dull, brittle hair and dry, flaky skin with poor turgor. When planning this patients nursing care, you should prioritize interventions that address what problem?

A) Inadequate physical activity

B) Ineffective personal hygiene

C) Deficient nutritional status

D) Exposure to environmental toxins

Ans: C

Feedback:

Signs of poor nutrition include dry, dull, brittle hair and dry, flaky skin with poor turgor. These findings do not indicate a lack of physical activity, poor personal hygiene, or damage from an environmental cause.

12. A home care nurse is teaching meal-planning to a patients son who is caring for his mother during her recovery from hip replacement surgery. Which of the following meals indicates that the son understands the concept of nutrition, based on the U.S. Department of Agricultures MyPlate?

A) Cheeseburger, carrot sticks, and mushroom soup with whole wheat crackers

B) Spaghetti and meat sauce with garlic bread and a salad

C) Chicken and pepper stir fry on a bed of rice

D) Ham sandwich with tomato on rye bread with peaches and yogurt

Ans: D

Feedback:

This menu has a choice from each of the food groups identified in MyPlate: grains, vegetables, fruits, dairy, and protein. The other selections are incomplete choices.

13. You are assessing an 80-year-old patient who has presented because of an unintended weight loss of 10 pounds over the past 8 weeks. During the assessment, you learn that the patient has ill-fitting dentures and a limited intake of high-fiber foods. You would be aware that the patient is at risk for what problem?

A) Constipation

B) Deficient fluid volume

C) Malabsorption of nutrients

D) Excessive intake of convenience foods

Ans: A

Feedback:

Patients with ill-fitting dentures are at a potential risk for an inadequate intake of high-fiber foods. The elderly are already at an increased risk for constipation because of other developmental factors and the potential for a decreased activity level. Ill-fitting dentures do not put a patient at risk for dehydration, malabsorption of nutrients, or a reliance on convenience foods.

14. You are teaching a nutrition education class that is being held for a group of older adults at a senior center. When planning your teaching, you should be aware that individuals at this point in the lifespan have which of the following?

A) A decreased need for calcium

B) An increased need for glucose

C) An increased need for sodium

D) A decreased need for calories

Ans: D

Feedback:

The older adult has a decreased metabolism, and absorption of nutrients has decreased. The older adult has an increased need for sound nutrition but a decreased need for calories. The other options are incorrect because there is no decreased need for calcium and no increased need for either glucose or sodium.

15. You are the emergency department nurse obtaining a health history from a patient who has earlier told the triage nurse that she is experiencing intermittent abdominal pain. What question should you ask to elicit the probable reason for the visit and identify her chief complaint?

A) Why do you think your abdomen is painful?

B) Where exactly is your abdominal pain and when did it start?

C) What brings you to the hospital today?

D) What is wrong with you today?

Ans: C

Feedback:

The chief complaint should clearly address what has brought the patient to see the health care provider; an open-ended question best serves this purpose. The question What brings you to the hospital? allows the patient sufficient latitude to provide an answer that expresses the priority issue. Focusing solely on abdominal pain would be too specific to serve as the first question regarding the chief complaint. Asking, What is wrong with you today? is an open-ended question but still directs the patient toward the fact that there is a problem.

16. You are the nurse caring for a patient who is Native American who arrives at the clinic for treatment related to type 2 diabetes. Which question would best provide you with information about the role of food in the patients cultural practices and identify how the patients food preferences could be related to his problem?

A) Do you feel any of your cultural practices have a negative impact on your disease process?

B) What types of foods are served as a part of your cultural practices, and how are they prepared?

C) As a nonnative, I am unaware of your cultural practices. Could you teach me a few practices that may affect your care?

D) Tell me about foods that are important in your culture and how you feel they influence your diabetes.

Ans: D

Feedback:

The beliefs and practices that have been shared from generation to generation are known as cultural or ethnic patterns. Food plays a significant role in both cultural practices and type 2 diabetes. By asking the question, Tell me about the foods that are important in your culture and how you feel they influence your diabetes, the nurse demonstrates a cultural awareness to the client and allows an open-ended discussion of the disease process and its relationship to cultural practice. An overemphasis on negatives can inhibit assessment and communication. Assessing the types and preparation of foods specific to cultural practices without relating it to diabetes is inadequate. The question, As a nonnative, I am unaware of your cultural practices. Could you teach me a few practices that may affect your care? focuses on care and fails to address the significance of food in cultural practice or diabetes.

17. An 89-year-old male patient is wheelchair bound following a hemorrhagic stroke and has been living in a nursing home since leaving the hospital. He returns to the adjacent primary care clinic by wheelchair for follow-up care of hypertension and other health problems. The nurse would modify his health history to include which question?

A) Tell me about your medications: How do you usually get them each day?

B) Tell me about where you live: Do you feel your needs are being met, and do you feel safe?

C) Your wheelchair would seem to limit your ability to move around. How do you deal with that?

D) What limitations are you dealing with related to your health and being in a wheelchair?

Ans: B

Feedback:

The question, Tell me about where you live: Do you feel your needs are being met and do you feel safe? seeks to explore the specific issue of the safety in the home environment. People who are older, have a disability, and live in the community setting are at a greater risk for abuse. An explicit focus on limitations may be counterproductive.

18. A 30-year-old man is in the clinic for a yearly physical. He states, I found out that two of my uncles had heart attacks when they were young. This alerts the nurse to complete a genetic-specific assessment. What component should the nurse include in this assessment?

A) A complete health history, including genogram along with any history of cholesterol testing or screening and a complete physical exam

B) A limited health history along with a complete physical assessment with an emphasis on genetic abnormalities

C) A limited health history and focused physical exam followed by safety-related education

D) A family history focused on the paternal family with focused physical exam and genetic profile

Ans: A

Feedback:

A genetic-specific exam in this case would include a complete health history, genogram, a history of cholesterol testing or screening, and a complete physical exam. A broad examination is warranted and safety education is not directly relevant.

19. A patient has a newly diagnosed heart murmur. During the nurses subsequent health education, he asks if he can listen to it. What would be the nurses best response?

A) Listening to the body is called auscultation. It is done with the diaphragm, and it requires a trained ear to hear a murmur.

B) Listening is called palpation, and I would be glad to help you to palpate your murmur.

C) Heart murmurs are pathologic and may require surgery. If you would like to listen to your murmur, I can provide you with instruction.

D) If you would like to listen to your murmur, Id be glad to help you and to show you how to use a stethoscope.

Ans: D

Feedback:

Listening with a stethoscope is auscultation and it is done with both the bell and diaphragm. The diaphragm is used to assess high-frequency sounds such as systolic heart murmurs, whereas the bell is used to assess low-frequency sounds such as diastolic heart murmurs. It is also important to provide education whenever possible and actively include the patient in the plan of care. Teaching an interested patient how to listen to a murmur should be encouraged. Many heart murmurs are benign and do not require surgery.

20. In your role as a school nurse, you are performing a sports physical on a healthy adolescent girl who is planning to try out for the volleyball team. When it comes time to listen to the students heart and lungs, what is your best nursing action?

A) Perform auscultation with the stethoscope placed firmly over her clothing to protect her privacy.

B) Perform auscultation by holding the diaphragm lightly on her clothing to eliminate the scratchy noise.

C) Perform auscultation with the diaphragm placed firmly on her skin to minimize extra noise.

D) Defer the exam because the girl is known to be healthy and chest auscultation may cause her anxiety.

Ans: C

Feedback:

Auscultation should always be performed with the diaphragm placed firmly on the skin to minimize extra noise and with the bell lightly placed on the skin to reduce distortion caused by vibration. Placing a stethoscope over clothing limits the conduction of sound. Performing auscultation is an important part of a sports physical and should never be deferred.

21. A nurse who provides care in a campus medical clinic is performing an assessment of a 21-year-old student who has presented for care. After assessment, the nurse determines that the patient has a BMI of 45. What does this indicate?

A) The patient is a normal weight.

B) The patient is extremely obese.

C) The patient is overweight.

D) The patient is mildly obese.

Ans: B

Feedback:

Individuals who have a BMI between 25 and 29.9 are considered overweight. Obesity is defined as a BMI of greater than 30 (WHO, 2011). A BMI of 45 would indicate extreme obesity.

22. A nurse is conducting a home visit as part of the community health assessment of a patient who will receive scheduled wound care. During assessment, the nurse should prioritize which of the following variables?

A) Availability of home health care, current Medicare rules, and family support

B) The community and home environment, support systems or family care, and the availability of needed resources

C) The future health status of the individual, and community and hospital resources

D) The characteristics of the neighborhood, and the patients socioeconomic status and insurance coverage

Ans: B

Feedback:

The community or home environment, support systems or family care, and the availability of needed resources are the key factors that distinguish community assessment from assessments in the acute-care setting. The other options fail to address the specifics of either the community or home environment.

23. You are performing the admission assessment of a patient who is being admitted to the postsurgical unit following knee arthroplasty. The patient states, Youve got more information on me now than my own family has. How do you manage to keep it all private? What is your best response to this patients concern?

A) Your information is maintained in a secure place and only those health care professionals directly involved in your care can see it.

B) Your information is available only to people who currently work in patient care here in the hospital.

C) Your information is kept electronically on a secure server and anyone who gets permission from you can see it.

D) Your information is only available to professionals who care for you and representatives of your insurance company.

Ans: A

Feedback:

This written record of the patients history and physical examination findings is then maintained in a secure place and made available only to those health professionals directly involved in the care of the patient. Only those caring for the patient have access to the health record. Insurance companies have the right to know the patients coded diagnoses so that bills may be paid; they are not privy to the health record.

24. You are admitting an elderly woman who is accompanied by her husband. The husband wants to know where the information you are obtaining is going to be kept and you follow up by describing the system of electronic health records. The husband states, I sure am not comfortable with that. It is too easy for someone to break into computer records these days. What is your best response?

A) The Institute of Medicine has called for the implementation of the computerized health record so all hospitals are doing it.

B) Weve been doing this for several years with good success, so I can assure you that our records are very safe.

C) This hospital is as concerned as you are about keeping our patients records private. So we take special precautions to make sure no one can break into our patients medical records.

D) Your wifes records will be safe, because only people who work in the hospital have the credentials to access them.

Ans: C

Feedback:

Nurses must be sensitive to the needs of the older adults and others who may not be comfortable with computer technology. Special precautions are indeed taken. Not every hospital employee has access and referencing the IOM may not provide reassurance.

25. A family whose religion limits the use of some forms of technology is admitting their grandfather to your unit. They express skepticism about the fact that you are recording the admission data on a laptop computer. What would be your best response to their concerns?

A) Its been found that using computers improves our patients care and reduces their health care costs.

B) We have found that it is easier to keep track of our patients information this way rather than with pen and paper.

C) Youll find that all the hospitals are doing this now, and that writing information with a pen is rare.

D) The government is telling us we have to do this, even though most people, like yourselves, are opposed to it.

Ans: A

Feedback:

Electronic health records are thought to improve the quality of care, reduce medical errors, and help reduce health care costs; therefore, their implementation is moving forward on a global scale. Electronic documentation is not always easier and most people are not opposed to it. Stating that all hospitals do this does not directly address their reluctance or state the benefits. The use of technology in health care settings is not specifically mandated by legislation.

26. You are performing a dietary assessment with a patient who has been admitted to the medical unit with community-acquired pneumonia. The patient wants to know why the hospital needs all this information about the way he eats, asking you, Are you asking me all these questions because I am Middle Eastern? What is your best response to this patient?

A) We always try to abide by foreign-born patients dietary preferences in order to make them comfortable.

B) We know that some cultural and religious practices include dietary guidelines, and we do not want to violate these.

C) We wouldnt want to feed you anything you only eat on certain holidays.

D) We know that patients who grew up in other countries often have unusual diets, and we want to accommodate this.

Ans: B

Feedback:

Culture and religious practices together often determine whether certain foods are prohibited and whether certain foods and spices are eaten on certain holidays or at specific family gatherings. A specific focus on holidays, however, does not convey the overall intent of the dietary interview. Dietary planning addresses all patients needs, not only those who are born outside the United States. It is inappropriate to characterize a patients diet as unusual.

27. You are orienting a new nursing graduate to your medical unit. The new nurse has been assisting an elderly woman, who is Greek, to fill out her menu for the next day. To what resource should you refer your colleague to obtain appropriate dietary recommendations for this patient?

A) The U.S. Department of Agricultures MyPlate

B) Evidence-based resources on nutritional assessment

C) Culturally sensitive materials, such as the Mediterranean Pyramid

D) A Greek cookbook that contains academic references

Ans: C

Feedback:

Culturally sensitive materials, such as the food pagoda and the Mediterranean Pyramid, are available for making appropriate dietary recommendations. MyPlate is not explicitly culturally sensitive. Nursing resource books do not usually have culturally sensitive dietary specific material. A Greek cookbook would not be an appropriate clinical resource.

28. In the course of performing an admission assessment, the nurse has asked questions about the patients first- and second-order relatives. What is the primary rationale for the nurses line of questioning?

A) To determine how many living relatives the patient has

B) To identify the familys level of health literacy

C) To identify potential sources of social support

D) To identify diseases that may be genetic

Ans: D

Feedback:

To identify diseases that may be genetic, communicable, or possibly environmental in origin, the interviewer asks about the age and health status, or the age and cause of death, of first-order relatives (parents, siblings, spouse, children) and second-order relatives (grandparents, cousins). This is a priority over the number of living relatives, sources of support, or health literacy, though each of these may be relevant.

29. The nurse is completing a family history for a patient who is admitted for exacerbation of chronic obstructive pulmonary disease (COPD). The nurse should include questions that address which of the following health problems? Select all that apply.

A) Allergies

B) Alcoholism

C) Psoriasis

D) Hypervitaminosis

E) Obesity

Ans: A, B, E

Feedback:

In general, the following conditions are included in a family history: cancer, hypertension, heart disease, diabetes, epilepsy, mental illness, tuberculosis, kidney disease, arthritis, allergies, asthma, alcoholism, and obesity. Psoriasis and hypervitaminosis do not have genetic etiologies.

30. The admitting nurse has just met a new patient who has been admitted from the emergency department. As the nurse introduces himself, he begins the process of inspection. What nursing action should the nurse include during this phase of assessment?

A) Gather as many psychosocial details as possible.

B) Pay attention to the details while observing.

C) Write down as many details as possible during the observation.

D) Do not let the patient know he is being assessed.

Ans: B

Feedback:

It is essential to pay attention to the details in observation. Vague, general statements are not a substitute for specific descriptions based on careful observation. It is specific information, not general information, that is being gathered. Writing while observing can be a conflict for the nurse. It is not necessary or appropriate to keep the patient from knowing he is being assessed.

31. During a comprehensive health assessment, which of the following structures can the nurse best assess by palpation?

A) Intestines

B) Gall bladder

C) Thyroid gland

D) Pancreas

Ans: C

Feedback:

Many structures of the body, although not visible, may be assessed through the techniques of light and deep palpation. Examples include the superficial blood vessels, lymph nodes, thyroid gland, organs of the abdomen and pelvis, and rectum. The intestines, muscles, and pancreas cannot be assessed through palpation.

32. During a health assessment of an older adult with multiple chronic health problems, the nurse practitioner is utilizing multiple assessment techniques, including percussion. What is the essential principle of percussion?

A) To assess the sound created by the body

B) To strike the abdominal wall with a soft object

C) To create sound over dead spaces in the body

D) To create vibration in a body wall

Ans: D

Feedback:

The principle of percussion is to set the chest wall or abdominal wall into vibration by striking it with a firm object. Percussion is not limited to dead spaces or the abdomen. The body does not create the sounds resulting from percussion; sound is referred from striking the surface of the body.

33. A nurse practitioners assessment of a new patient includes each of the four basic assessment techniques. When using percussion, which of the following is the nurse able to assess?

A) Borders of the patients heart

B) Movement of the patients diaphragm during expiration

C) Borders of the patients liver

D) The presence of rectal distension

Ans: A

Feedback:

Percussion allows the examiner to assess such normal anatomic details as the borders of the heart and the movement of the diaphragm during inspiration. Movement of the diaphragm, delineation of the liver and the presence of rectal distention cannot be assessed by percussion.

34. A 51-year-old womans recent complaints of fatigue are thought to be attributable to iron-deficiency anemia. The patients subsequent diagnostic testing includes quantification of her transferrin levels. This biochemical assessment would be performed by assessing which of the following?

A) The patients urine

B) The patients serum

C) The patients cerebrospinal fluid

D) The patients synovial fluid

Ans: B

Feedback:

Biochemical assessments are made from studies of serum (albumin, transferrin, retinol-binding protein, electrolytes, hemoglobin, vitamin A, carotene, vitamin C, and total lymphocyte count) and studies of urine (creatinine, thiamine, riboflavin, niacin, and iodine). Transferrin is found in serum, not urine, CSF, or synovial fluid.

35. An older adults unexplained weight loss of 15 pounds over the past 3 months has prompted a thorough diagnostic workup. What is the nurses rationale for prioritizing biochemical assessment when appraising a persons nutritional status?

A) It identifies abnormalities in the chemical structure of nutrients.

B) It predicts abnormal utilization of nutrients.

C) It reflects the tissue level of a given nutrient.

D) It predicts metabolic abnormalities in nutritional intake.

Ans: C

Feedback:

Biochemical assessment reflects both the tissue level of a given nutrient and any abnormality of metabolism in the utilization of nutrients. It does not focus on abnormalities in the chemical structure of nutrients. Biochemical assessment is not predictive.

36. A school nurse at a middle school is planning a health promotion initiative for girls. The nurse has identified a need for nutritional teaching. What problem is most likely to relate to nutritional problems in girls of this age?

A) Protein intake in this age group often falls below recommended levels.

B) Total calorie intake is often insufficient at this age.

C) Calcium intake is above the recommended levels.

D) Folate intake is below the recommended levels in this age group.

Ans: D

Feedback:

Adolescent girls are at particular nutritional risk, because iron, folate, and calcium intakes are below recommended levels, and they are a less physically active group compared to adolescent males. Protein and calorie intake is most often sufficient.

37. A team of community health nurses has partnered with the staff at a youth drop-in center to address some of the health promotion needs of teenagers. The nurses have identified a need to address nutritional assessment and intervention. Which of the following most often occurs during the teen years?

A) Lifelong eating habits are acquired.

B) Peer pressure influences growth.

C) BMI is determined.

D) Culture begins to influence diet.

Ans: A

Feedback:

Adolescence is a time of critical growth and acquisition of lifelong eating habits, and, therefore, nutritional assessment, analysis, and intervention are critical. Peer pressure does not influence growth. Cultural influences tend to become less important during the teen years; they do not emerge for the first time at this age. BMI can be assessed at any age.

38. A newly admitted patient has gained weight steadily over the past 2 years and the nurse recognizes the need for a nutritional assessment. What assessment parameters are included when assessing a patients nutritional status? Select all that apply.

A) Ethnic mores

B) BMI

C) Clinical examination findings

D) Wrist circumference

E) Dietary data

Ans: B, C, E

Feedback:

The sequence of assessment of parameters may vary, but evaluation of nutritional status includes one or more of the following methods: measurement of BMI and waist circumference, biochemical measurements, clinical examination findings, and dietary data. Ethnic mores and wrist circumference are not assessment parameters for nutritional status.

39. The segment of the population who has a BMI lower than 24 has been found to be at increased risk for poor nutritional status and its resultant problems. What else is a low BMI associated with in the community-dwelling elderly?

A) High risk of diabetes

B) Increased incidence of falls

C) Higher mortality rate

D) Low risk of chronic disease

Ans: C

Feedback:

People who have a BMI lower than 24 (or who are 80% or less of their desirable body weight for height) are at increased risk for problems associated with poor nutritional status. In addition, a low BMI is associated with a higher mortality rate among hospitalized patients and community-dwelling elderly. Low BMI is not directly linked to an increased risk for falls or diabetes. Excessively low BMI does not result in a decreased incidence of overall chronic disease.

40. Imbalanced nutrition can be characterized by excessive or deficient food intake. What potential effect of imbalanced nutrition should the nurse be aware of when assessing patients?

A) Masking the symptoms of acute infection

B) Decreasing wound healing time

C) Contributing to shorter hospital stays

D) Prolonging confinement to bed

Ans: D

Feedback:

Malnutrition interferes with wound healing, increases susceptibility to infection, and contributes to an increased incidence of complications, longer hospital stays, and prolonged confinement of patients to bed. Malnutrition does not mask the signs and symptoms of acute infection.

41. A nurse who has practiced in the hospital setting for several years will now transition to a new role in the community. How does a physical assessment in the community vary in technique from physical assessment in the hospital?

A) A physical assessment in the community consists of largely the same techniques as are used in the hospital.

B) A physical assessment made in the community does not require the privacy that a physical assessment made in the hospital setting requires.

C) A physical assessment made in the community requires that the patient be made more comfortable than would be necessary in the hospital setting.

D) A physical assessment made in the community varies in technique from that conducted in the hospital setting by being less structured.

Ans: A

Feedback:

The physical assessment in the community and home consists of the same techniques used in the hospital, outpatient clinic, or office setting. Privacy is provided, and the person is made as comfortable as possible. The importance of comfort, privacy and structure are similar in both settings.

42. You are conducting an assessment of a patient in her home setting. Your patient is a 91-year-old woman who lives alone and has no family members living close by. What would you need to be aware of to aid in providing care to this patient?

A) Where the closest relative lives

B) What resources are available to the patient

C) What the patients financial status is

D) How many children this patient has

Ans: B

Feedback:

The nurse must be aware of resources available in the community and methods of obtaining those resources for the patient. The other data would be nice to know, but are not prerequisites to providing care to this patient.