Chapter 3. Nursing Process: Assessment

MULTIPLE CHOICE

1. Which of the following is an example of data that should be validated?
   a) The client's weight measures 185 lb at the clinic.
   b) The client's liver function test results are elevated.
   c) The client's blood pressure reading is 160/94 mm Hg; he states that is typical for him.
   d) The client states she eats a low-sodium diet; she reports eating processed food.

   ANS: D
   Validation should be done when the client's statements are inconsistent (processed foods are generally high in sodium). Validation is not necessary for laboratory data when you suspect an error has been made in the results. Personal information that patients might be embarrassed about, such as weight, is best validated with a scale.

   Difficulty: Moderate
   Nursing Process: Assessment
   Client Need: PHSI
   Cognitive Level: Application

   PTS: 1

2. Which of the following examples includes both objective and subjective data?
   a) The client's blood pressure reading is 132/68 mm Hg and heart rate is 88 beats/min.
   b) The client's cholesterol is elevated, and he states he likes fried food.
   c) The client states she has trouble sleeping and that she drinks coffee in the evening.
   d) The client states he gets frequent headaches and that he takes aspirin for the pain.

   ANS: B
   Elevated cholesterol is objective and "states he likes fried food" is subjective. Objective data can be observed by someone other than the patient (e.g., from physical assessments or laboratory and diagnostic tests). Subjective data are information given by the client. Blood pressure and heart rate measurements are both objective. "States . . . trouble sleeping and . . . drinks coffee . . ." are both subjective. States ". . . frequent headaches and . . . takes aspirin . . ." are both subjective.

   Difficulty: Moderate
   Nursing Process: Assessment
   Client Need: PHSI
   Cognitive level: Analysis

   PTS: 1

3. The Joint Commission requires which type of assessment to be performed on all patients?
   a) Functional ability
   b) Pain
   c) Cultural

d) Wellness

ANS: B
The Joint Commission requires that pain and nutrition assessment be performed on all patients. Other special needs assessments should be performed when cues indicate there are risk factors.

Difficulty: Moderate
Nursing Process: Assessment
Client Need: PHSI
Cognitive Level: Analysis

PTS: 1

4. Which of the following is an example of an ongoing assessment?
   a) Taking the patient's temperature 1 hour after giving acetaminophen (Tylenol)
   b) Examining the patient's mouth at the time she complains of a sore throat
   c) Requesting the patient to rate intensity on a pain scale at the first perception of pain
   d) Asking the patient in detail how he will return to his normal exercise activities

   ANS: A
   An ongoing assessment occurs when a previously identified problem is being reassessed—for example, taking an hourly temperature when a patient has a fever. Examining the mouth is a focused assessment to explore the patient's complaint of sore throat. Asking for a pain rating is a focused assessment at the first complaint of pain. A detailed interview about exercise is a special needs assessment; there is no way to know whether it is initial or ongoing.

   Difficulty: Moderate
   Nursing Process: Assessment
   Client Need: PHSI
   Cognitive Level: Application

   PTS: 1

5. When should the nurse make systematic observations about a patient?
   a) When the patient has specific complaints
   b) With the first assessment of the shift
   c) Each time the nurse gives medications to the patient
   d) Each time the nurse interacts with the patient

   ANS: D
   The nurse should make observations about the patient each time she enters the room or interacts with the patient to gain ongoing data about the patient.

   Difficulty: Easy
   Nursing Process: Assessment
   Client Need: Safe and Effective Nursing Care
   Cognitive Level: Application

   PTS: 1

6. Which of the following is an example of an open-ended question?
   a) Have you had surgery before?
   b) When was your last menstrual period?
   c) What happens when you have a headache?
   d) Do you have a family history of heart disease?

   ANS: C
   Open-ended questions, such as "What happens when you have a headache?" are broadly worded to encourage the patient to elaborate. The questions about surgery, menstrual period, and family history can all be answered with a "yes," "no," or short, specific answer (e.g., a date).

   Difficulty: Moderate
   Nursing Process: Assessment
   Client Need: Safe and Effective Nursing Care
   Cognitive Level: Application

   PTS: 1

7. Of the following recommended interviewing techniques, which one is the *most* basic? (That is, without the intervention, the others will all be less effective.)
   a) Beginning with neutral topics
   b) Individualizing your approach
   c) Minimizing note taking
   d) Using active listening

   ANS: D
   All are important techniques, but active listening focuses the attention on the patient and lets her know you are trying to understand her needs. The interviewer is more likely to get the patient to open up. Patients will forgive you for most errors in technique, but if they think you are not listening, that can negatively affect your relationship.

   Difficulty: Difficult
   Nursing Process: Assessment
   Client Need: PHSI
   Cognitive Level: Application

   PTS: 1

8. Which of the following is an example of the most basic motivation in Maslow's Hierarchy of Needs?
   a) Experiencing loving relationships
   b) Having adequate housing
   c) Receiving education
   d) Living in a crime-free neighborhood

   ANS: B

The most basic needs are centered on physiological survival—shelter (housing), food, and water. All other options are for higher needs. The order from most basic to highest level is physiological; safety and security; love and belonging; esteem; and self-actualization. Loving relationships fall under the love and belonging category. Education is a form of self-actualization. Living in a crime-free neighborhood meets the need for safety and security.

Difficulty: Moderate
Nursing Process: Assessment
Client Need: PHSI
Cognitive Level: Application

PTS: 1

9. What makes a nursing history different from a medical history?
   a) A nursing history focuses on the patient's responses to the health problem.
   b) The same information is gathered in both; the difference is in who obtains the information.
   c) A nursing history is gathered using a specific format.
   d) A medical history collects more in-depth information.

   ANS: A
   A medical history focuses on the patient's current and past medical/surgical problems. A nursing history focuses on the patient's responses to and perception of the illness/injury or health problem, his coping ability, and resources and support. Nursing history formats vary depending on the patient, the agency, and the patient's needs. Both nursing and medical histories typically use a specific format. A medical history does not necessarily contain more in-depth information. A nursing history can be thorough, covering a wide range of topics, including biographical data, reason(s) patient is seeking healthcare, history of present illness, patient's perception of health status and expectations for care, past medical history, medical history, use of complementary modalities, and review of functional ability associated with activities of daily living. Other topics might deal with nutrition, psychosocial needs, pain assessment, or other special needs topics.

   Difficulty: Easy
   Nursing Process: Assessment
   Client Need: Safe and Effective Nursing Care
   Cognitive Level: Comprehension

   PTS: 1

10. Why is it important to obtain information about nutritional and herbal supplements as well as about complementary and alternative therapies?
    a) To determine what type of therapies are acceptable to the client
    b) To identify whether the client has a nutrition deficiency
    c) To help you to understand cultural and spiritual beliefs
    d) To identify potential interaction with prescribed medication and therapies

    ANS: D

Herbs and nutritional supplements can interact with prescription medications, and complementary and alternative treatments can interfere with conventional therapies. Physical assessment and laboratory tests are needed to assess a nutritional deficiency. To identify cultural and spiritual beliefs and well as what therapies are acceptable to the client, you need more than just information about nutritional and herbal supplements.

Difficulty: Difficult
Nursing Process: Assessment
Client Need: HPM
Cognitive Level: Application

PTS: 1

11. What do the nursing assessment models have in common?
    a) They assess and cluster data into model categories.
    b) They organize assessment data according to body systems.
    c) They specify use of the nursing process to collect data.
    d) They are based on the ANA Standards of Care.

ANS: A
All the models categorize or cluster data into functional health patterns, domains, or categories. None of the assessment models clusters data according to body system. Assessment is the first step of the nursing process; the nurse does not use the entire nursing process in data collection. The ANA Standards of Care describe a competent level of clinical nursing practice based on the nursing process; nursing models are not based on the ANA Standards of Care.

Difficulty: Difficult
Nursing Process: Assessment
Client Need: Safe and Effective Nursing Care
Cognitive Level: Analysis

PTS: 1

12. Nondirective interviewing is a useful technique because it:
    a) Allows the nurse to have control of the interview
    b) Is an efficient way to interview a patient
    c) Facilitates open communication
    d) Helps focus patients who are anxious

ANS: C
Nondirective interviewing helps build rapport and facilitates open communication. Because it puts the patient in control, it can be very time consuming (inefficient) and produce information that is not relevant. Directive interviewing should be used to focus anxious patients.

Difficulty: Easy
Nursing Process: Assessment
Client Need: PSI
Cognitive Level: Knowledge

PTS: 1

13. A nursing instructor is guiding nursing students on best practices for interviewing patients. Which of the following comments by a student would indicate the need for further instruction?
    a) "My patient is a young adult, so I plan to talk to her without her parents in the room."
    b) "Because my patient is old enough to be my grandfather, I will call him Mr."
    c) "When reading my patient's health record, I thought of a few questions to ask."
    d) "When I give my patient his pain medication, I will have time to ask questions."

    ANS: D
    A patient should be comfortable when interviewing. The pain medication should have time to work before the nurse would consider interviewing the patient, so asking questions when giving the medication is not a good idea. It is appropriate to interview patients without family/friends around. In nearly every culture, calling a patient Mr. or Mrs. shows respect and is, therefore, correct. Reading the patient's health record is appropriate preparation for an interview.

    Difficulty: Moderate
    Nursing Process: Evaluation
    Client Need: Safe and Effective Nursing Care
    Cognitive Level: Application

    PTS: 1

14. A patient comes to the urgent care clinic because he stepped on a rusty nail. What type of assessment would the nurse perform?
    a) Comprehensive
    b) Ongoing
    c) Initial focused
    d) Special needs

    ANS: C
    An initial focused assessment is performed during a first examination for specific abnormal findings. A comprehensive assessment is holistic and is usually done on admission to a healthcare facility. An ongoing assessment follows up after an initial database is completed or a problem is identified. A special needs assessment is performed when there are cues that more in-depth assessment is needed.

    Difficulty: Moderate
    Nursing Process: Assessment
    Client Need: PHSI
    Cognitive Level: Application

    PTS: 1

15. A patient has left-sided weakness because of a recent stroke. Which type of special needs assessment would be most important to perform?
    a) Family
    b) Functional

c) Community
d) Psychosocial

ANS: B
A functional assessment is most important because of discharge needs (e.g., self-care ability at home) and patient safety. A family and community assessment would be helpful to evaluate support systems, and a psychosocial assessment would be helpful to evaluate a patient's understanding of and coping with his recent stroke. Remember that special needs assessments are lengthy and time consuming, so they should be used only when in-depth information is needed about a topic.

Difficulty: Moderate
Nursing Process: Assessment
Client Need: Safe and Effective Nursing Care
Cognitive Level: Analysis

PTS: 1

16. The nurse is interviewing a patient who has a recent onset of migraine headaches. The patient is very anxious and cannot seem to focus on what the nurse is saying. Which of the following would be best for the nurse to say to *begin* gathering data about the headaches?
a) "When did your migraines begin?"
b) "Tell me about your family history of migraines."
c) "What are the types of things that trigger your headaches?"
d) "Describe what your headaches feel like."

ANS: A
For someone who is anxious, it is best to use closed questions. ("When did your migraines begin?") A closed question can be answered in one or very few words and has a very specific answer. The others require an open-ended response.

Difficulty: Moderate
Nursing Process: Assessment
Client Need: PSI
Cognitive Level: Application

PTS: 1

17. Which of the following is an example of an active listening behavior?
a) Taking frequent notes
b) Asking for more details
c) Leaning toward the patient
d) Sitting comfortably with legs crossed

ANS: C
Active listening behaviors include leaning toward the patient; facing the patient; exhibiting an open, relaxed posture without crossing arms or legs; and maintaining eye contact. Taking frequent notes makes it difficult to keep eye contact. Asking for more details may seem like idle curiosity. Sitting with legs crossed may indicate to the patient that you are not open to her.

Difficulty: Easy
Nursing Process: Assessment
Client Need: Safe and Effective Nursing Care
Cognitive Level: Comprehension

PTS: 1

18. A nursing instructor asked his nursing students to discuss their experiences with charting assessment data. Which comment by the student indicates the need for further teaching?
    a) "I find it difficult to avoid using phrases like 'the patient tolerated the procedure well.'"
    b) "It's confusing to have to remember which abbreviations this hospital allows."
    c) "I need to work on charting assessments and interventions right after they are done."
    d) "My patient was really quiet and didn't say much, so I charted that he acted depressed."

    ANS: D
    When charting data, chart only what was observed, not what it meant. Inferences should not be made about a patient's behavior during data collection ("he acted depressed"), so that response reflects the student's lack of knowledge and need for teaching. Chart specific data, not vague phrases; the student is acknowledging the importance of this. There are no universally accepted phrases, just agency-approved abbreviations; the student is acknowledging the need to use agency-approved abbreviations. The student is correct that charting should be completed as soon after data collection as possible.

    Difficulty: Moderate
    Nursing Process: Evaluation
    Client Need: SECE
    Cognitive Level: Application

    PTS: 1

19. For which of the following purposes is a graphic flowsheet superior to other methods of recording data?
    a) Providing easy documentation of routine vital signs
    b) Seeing the patterns of a patient's fever
    c) Describing the symptoms accompanying a rising temperature
    d) Checking to make sure vitals signs were taken

    ANS: B
    All are benefits of the graphic flowsheet, but to easily and graphically see trends over time, the graphic flowsheet is superior to other methods of documentation. For the other options, other kinds of flowsheets would be equally effective.

    Difficulty: Moderate
    Client Need: SECE
    Cognitive Level: Analysis

    PTS: 1

20. The most obvious reason for using a framework when assessing a patient is to:
    a) Prioritize assessment data
    b) Organize and cluster data
    c) Separate subjective data from objective data
    d) Identify both primary and secondary data

    ANS: B
    A framework is used to organize and cluster data to find patterns. During the assessment phase, the nurse is collecting and recording data, not prioritizing the data. A framework includes subjective and objective data as well as primary and secondary data; it does not help you to separate them.

    Difficulty: Moderate
    Nursing Process: Assessment
    Client Need: Safe and Effective Nursing Care
    Cognitive Level: Knowledge

    PTS: 1

21. Which situation is the most conducive to conducting a successful interview of an elderly woman whose husband and two children are in the hospital room visiting and watching television? The woman is alert and oriented.
    a) Provide enough chairs so the family and you are able to sit facing the client.
    b) Introduce yourself and ask, "Dear, what name do you prefer to go by?" before asking any further questions.
    c) After the family leaves, ask the client whether she is comfortable and willing to answer a few questions.
    d) Ask the client whether you can talk with her while her family is watching the television.

    ANS: C
    The interview should be done when the client is comfortable and there are no distractions. Endearing terms are inappropriate unless the client prefers them. Family members may offer information that may or may not be pertinent, and may distract from the interview. The presence of family members may also inhibit full disclosure of information by the client.

    Difficulty: Difficult
    Nursing Process: Assessment
    Client Need: PSI
    Cognitive Level: Application

    PTS: 1

22. The nurse obtains the following information from the patient: Alert and oriented, is married, and has a history of heart disease. This is an example of:
    a) Collecting data
    b) Analyzing data
    c) Categorizing data
    d) Making a comprehensive physical assessment

    ANS: A

The nurse is collecting data on this patient. Once the complete data are collected, they can then be categorized and analyzed to formulate nursing diagnoses and plan for care. Using the information given in the question, a comprehensive physical assessment has not been completed.

Difficulty: Easy
Nursing Process: Assessment
Client Need: PHSI
Cognitive Level: Comprehension

PTS: 1

23. The certified nursing assistant (CNA) tells the nurse: "I can help you with your assessment." What is the most appropriate response by the nurse?
    a) "Thank you. I am having a busy day and I can use your help."
    b) "I'm sorry, but nurses are responsible for all patient assessment."
    c) "How long have you been a CNA?"
    d) "If you will obtain the vital signs and place them in the chart then that would be a big help."

    ANS: D
    In making decisions about which parts of an assessment can be delegated to the CNA, the nurse must consider agency policies and the regulations of the state board of nursing. The length of time one has been a CNA does not determine scope of practice or which parts of assessment can be delegated, but the nurse must consider the CNA's competence and the patient's conditions. In most states, the CNA can obtain vital signs and record them in the patient's chart; however, these must first be validated by the nurse.

    Difficulty: Moderate
    Nursing Process: Assessment
    Client Need: PHSI
    Cognitive Level: Application

    PTS: 1

24. During the assessment process the patient states, "I am having numbness and tingling in my right arm." Which of the following best describes the patient's statement?
    a) Subjective data
    b) Objective data
    c) Secondary data
    d) Focused assessment

    ANS: A
    The patient statement of experiencing numbness and tingling down the right arm is an example of subjective data, as the statement is in the patient's own words. Objective data are overt and gathered by the nurse, either through physical assessment, laboratory findings, or diagnostic testing results. Secondary data are obtained through a source other than the patient, such as a family member. There is not enough information in the patient statement's to categorize it as comprehensive data, as the nurse would have to complete a physical assessment and obtain all data.

Difficulty: Easy
Nursing Process: Assessment
Client Need: PHSI
Cognitive Level: Analysis

PTS: 1

25. The nurse is performing an initial interview on a 75-year-old male. Which of the following statements by this patient indicates the need to perform a special needs assessment?
    a) "I don't go to church as much as I used to but I watch the services on TV."
    b) "I have fallen twice at home in the past 6 months, so my wife thinks I need a walker."
    c) "I don't eat much red meat anymore but I get my protein from other foods."
    d) "I had a toothache but I already saw the dentist."

    ANS: B
    An older adult who has fallen twice in 6 months has a safety risk. Although the wife thinks the patient needs a walker, there is no indication that a walker has been obtained. Falling and risk for falls requires the nurse to perform a special needs assessment most likely related to functional status. The patient verbalizes he misses church but follows by saying how he is able to view services on TV. He also verbalizes eating less red meat but adds that he obtains protein from other sources. The client verbalizes a physiological concern in his toothache but he has addressed this by seeing his dentist.

    Difficulty: Moderate
    Nursing Process: Assessment
    Client Need: Safe and Effective Nursing Care
    Cognitive Level: Analysis

    PTS: 1

26. A patient is not feeling well at home and comes to the emergency department to be evaluated. In the initial nursing interview, what is the first question the nurse would ask?
    a) "Do you live alone?"
    b) "Are you having any pain?"
    c) "What is your past medical history?"
    d) "Why did you come to the hospital today?"

    ANS: D
    The nurse should first ask in the initial interview why the patient is seeking nursing or medical assistance. This broad question will elicit the most information because it is open ended. It is important to ask the patient about pain, medical history, and home situation; however, these questions can all be addressed later on when taking the health history and physical assessment, as the nurse follows the patient's leads.

    Difficulty: Moderate
    Nursing Process: Assessment
    Client Need: PHSI
    Cognitive Level: Application

    PTS: 1

27. The patient comes to the emergency department complaining of chest pain. What question by the nurse will encourage the patient to provide the most details about the pain?
    a) "When did your chest pain begin?"
    b) "On a scale of 0 to 10, what is your pain level?"
    c) "Would you please tell me more about the pain you are having?"
    d) "Have you taken any medication for your pain?"

    ANS: C
    The most information is gained by asking the patient to tell the nurse more about the pain. This is an open-ended question and will give the nurse more information about pain. All other questions are closed questions and will only elicit short answers specific to that question. Each question is asked in pain assessment; however, the question that will elicit the most information the one that asks the patient to tell the nurse more.

    Difficulty: Moderate
    Nursing Process: Assessment
    Client Need: PHSI
    Cognitive Level: Application

    PTS: 1

28. Which statement below is the best example of high-quality nursing documentation?
    a) Patient breathing is normal, no pain noted, urine output is adequate at this time.
    b) Good strength in both lower extremities. Ambulating with walker down hall.
    c) Started on solid foods. Ate 75% of dinner. No complaints of any nausea or vomiting.
    d) Patient seems upset with wife visiting in room; will perform physical assessment at a later time.

    ANS: C
    "Started on solid foods. Ate 75% of dinner. No complaints of nausea or vomiting" is clear, concrete, and specific. Noting that patient breathing is normal and urine output is adequate does not give enough information about breathing or urine output. These statements contain vague and subjective words. "Good strength in both lower extremities" is vague as the word *good* is subjective. "Patient seems upset" does not give enough information nor is it specific.

    Difficulty: Moderate
    Nursing Process: Assessment
    Client Need: PHSI
    Cognitive Level: Application

    PTS: 1

MULTIPLE RESPONSE

1. Which of the following questions would be effective for obtaining information from a patient? Select all that apply.
    a) How did this happen to you?
    b) What was your first symptom?

c) Why didn't you seek healthcare earlier?
d) When did you start having symptoms?

ANS: A, B, D
How, what, and when are acceptable lines of questioning. Asking "why" can put the patient on the defensive and may suggest disapproval, limiting the amount of information the patient is willing give.

Difficulty: Moderate
Nursing Process: Assessment
Client Need: Safe and Effective Nursing Care
Cognitive Level: Application

PTS: 1

2. A nurse with a large caseload of patients needs to delegate some assessment tasks to other members of the health team. The nurse is unsure which tasks can be delegated to nursing assistive personnel (NAP) and which are appropriate for a licensed practical nurse (LPN) or a registered nurse (RN). To which sources should the nurse turn find out to whom to delegate which tasks? Select all that apply.
   a) Nurse practice act of his state
   b) American Medical Association guidelines
   c) Code of Ethics for Nurses
   d) ANA *Scope and Standards of Practice*

   ANS: A, D
   State nurse practice acts specify which portions of the assessment can legally be completed by individuals with different credentials. The ANA *Scope and Standards of Practice* provides a guide for determining who is ultimately responsible and qualified to collect assessment data. The American Medical Association provides guidelines and standards for physicians, not nurses. The Code of Ethics for Nurses says merely that the nurse should delegate tasks appropriately; it does not speak to credentials of personnel.

   Difficulty: Moderate
   Nursing Process: Assessment
   Client Need: Safe and Effective Nursing Care
   Cognitive Level: Comprehension

   PTS: 1

3. Which of the following are cues rather than inferences? Select all that apply.
   a) Ate 50% of his meal.
   b) Patient feels better today.
   c) States, "I slept well."
   d) White blood cell count is 15,000/mm^3.

   ANS: A, C, D
   Cues are what the client says and what you observe: "just the facts." The only inference in the list is "feels better." What did the nurse observe to tell her the client feels better? Those would be cues. States, "I slept well" is a cue because it is a fact—that is what the client stated.

Difficulty: Moderate
Nursing Process: Assessment
Client Need: Safe and Effective Nursing Care
Cognitive Level: Comprehension

PTS: 1

4. Which of the following statements are true regarding professional standards of nursing assessment? Select all that apply.
   a) Assessment is a professional nursing responsibility.
   b) Assessment helps the nurse identify problems and assign priorities for patient care.
   c) Assessment helps the nurse formulate the medical diagnosis.
   d) Only patients complaining of pain need to be assessed for pain.
   e) Parts of nursing assessments can be delegated according to state practice acts and agency policies.

   ANS: A, B, E
   Assessment is a professional responsibility and assists the nurse to identify problems and prioritize care. Parts of the assessment may be delegated depending on state boards of nursing and agency policies. Assessment helps the nurse formulate a nursing diagnosis; a medical diagnosis is not within the nurse's scope of practice. All patients are assessed for pain.

   Difficulty: Moderate
   Nursing Process: Assessment
   Client Need: PHSI
   Cognitive Level: Comprehension

   PTS: 1

5. Which of the following are examples of objective data? Select all that apply.
   a) Blood pressure reading 120/80 mm Hg
   b) Pain rated as 6 on a pain scale of 0 to 10
   c) Moderate amount of yellow drainage from right ear
   d) Wife states, "He has not been sleeping well at night."
   e) Patient states, "I have a stomach ache."

   ANS: A, C
   Blood pressure and yellow ear drainage are examples of objective data. These data are obtained by the nurse through assessment. Patient statements are subjective data. The wife's statement constitutes secondary data and is vague and subjective.

   Difficulty: Moderate
   Nursing Process: Assessment
   Client Need: PHSI
   Cognitive Level: Comprehension

   PTS: 1

6. Which of the following are examples of high-quality nursing documentation? Select all that apply.
   a) Patient states, "When I get up in the morning, I feel dizzy."

b) Patient is alert and oriented to person, place, time, and surroundings.
c) Drainage from midline abdominal incision appears normal.
d) Patient is angry with wife over arriving late for Dr. appointment.
e) Patent has no complaints of pain at this time.

ANS: A, B, E
Patient statements using the patient's own words, documentation of patient level of consciousness, and documentation of patient denial of pain are all examples of high-quality documentation. These statements are not subjective or vague. The statement regarding the patient's incision is vague as what is considered *normal* cannot be measured. Noting that the patient is angry is subjective and unclear.

Difficulty: Moderate
Nursing Process: Assessment
Client Need: PHSI
Cognitive Level: Analysis

PTS: 1

7. When conducting the patient interview, which of the following statements by the nurse are appropriate? Select all that apply.
   a) "You shouldn't be smoking cigarettes; you have already had one heart attack."
   b) "Why don't you take your blood pressure medications? You need them to keep your blood pressure normal."
   c) "I can see that you are in pain right now. Would you like your pain medication and then I can complete the interview a little later?"
   d) "I am going to be completing your interview now. Is this a good time for you?"
   e) "Have you noticed any changes in your pattern of sleeping?"

   ANS: C, D, E
   Observing that the patient is in pain, offering pain medication, postponing the interview, and asking about sleeping patterns are all appropriate actions when performing the nursing interview. Patients should be comfortable and pain free during the process. Asking the patient about time of interview is appropriate and accommodating. Statements in which nurses give advice or use "why" questions may often offend patients.

   Nursing Process: Assessment
   Client Need: PHSI
   Cognitive Level: Analysis

   PTS: 1