1. A nurse is completing the intake assessment of an older adult who has just relocated to a long-term care facility. Which of the following nursing actions would be most important to ensure accurate data when gathering the resident's information?
   A) Documenting the data
   B) Validating the data
   C) Identifying client support systems
   D) Determining client needs

2. A nurse is assessing a female client whose worsening sciatica has prompted her to seek care. Which of the client's following statements would the nurse most likely need to validate?
   A) i don't generally have problems with pain.i
   B) i feel very weak and tired right now.i
   C) i've had two cesarean deliveries.i
   D) iMy mother died of breast cancer in her sixties.i

3. A client who had a mastectomy is being discharged home on postoperative day 1. Knowing that the client lives alone, which data would be most important for the nurse to validate for this client?
   A) If the client has transportation for follow-up appointments
   B) If the client usually functions independently
   C) What support systems are in place to assist the client
   D) If the client has a religious belief regarding illness

4. When describing the importance of documenting initial assessment data to a group of new nurses, which of the following would the nurse emphasize as the primary reason?
   A) Health care institutions have established policies regarding documentation.
   B) Incorrect conclusions may be made without documentation of the nurse's opinions.
   C) It satisfies legal standards established by health care organizations and institutions.
   D) It becomes the foundation for the entire nursing process.

5. A nurse has documented the nursing history and physical examination of a client. This health information is best described as which of the following?
   A) Subjective data and objective data
   B) Interpretation and inference
   C) Observation and inspection
   D) Data and results
6. The nurse is caring for a client with influenza symptoms and is documenting the initial and ongoing assessment database. Which of the following would the nurse emphasize as the major rationale for this action?
A) Reducing the fragmentation of care
B) Maximizing the efficiency of care
C) Promoting communication between disciplines
D) Facilitating achievement of professional standards

7. A nurse has completed a client's initial assessment and is now interpreting and making inferences from the data. The nurse is involved in which phase of the nursing process?
A) Analysis
B) Planning
C) Implementation
D) Evaluation

8. A 54-year-old client is receiving a follow-up assessment in a clinic, following abnormal findings on her recent mammogram. Which of the following statements best reflects appropriate documentation by the nurse?
A) "Client depressed because of fear of breast biopsy"
B) "Client with lower back pain"
C) "Client has unkempt appearance and avoids eye contact"
D) "Client has good lung sounds in right and left lungs"

9. A nurse is working in a health care facility that uses charting by exception. Which of the following would the nurse expect to document?
A) Liver palpation normal
B) No tenderness on palpation
C) Bowel sounds normoactive
D) Decreased range of motion in right shoulder

10. A task force has been established at a hospital with the aim of overhauling the assessment forms that are used throughout the facility. Which of the following options is most likely to help standardize the process of data collection?
A) Open-ended form
B) Integrated cued checklist form
C) Cued or checklist form
D) Nursing minimum data set
11. A nurse is providing in-service training to a group of nurses in a facility that has just begun to use an integrated cued checklist for documentation. Which of the following would the nurse identify as a major advantage of this type of documentation?
   A) It helps nurses to cluster assessment data.
   B) It provides lines for the nurses' comments.
   C) It includes specialized data particular to each client.
   D) It standardizes data collection.

12. A group of nursing students is reviewing the purposes of assessment documentation in preparation for a class discussion. The students demonstrate understanding of the information when they identify which of the following as one of the primary purposes?
   A) It provides a chronologic source of client assessment data.
   B) It creates a database for care that was not rendered to the client.
   C) It replaces the client acuity classification system.
   D) It directly formulates the nursing diagnoses.

13. A nurse is comparing the subjective data and objective data obtained from an assessment of a client who is thought to have hepatitis A. This nurse's comparison will achieve what benefit to this client's care?
   A) Formulation of nursing diagnoses
   B) Identification of missing data
   C) Determination of documentation form to use
   D) Validation of data

14. A nurse is preparing an in-service education program for a group of staff nurses about documentation, including documentation of assessment data. The nurse demonstrates understanding of the significance of documentation by including a discussion of which of the following as playing a role in this area? Select all that apply.
   A) Joint Commission
   B) State nurse practice act
   C) Medicare
   D) Local or city government
   E) Institutional agency

15. A nurse has completed an assessment of a client with cholecystitis and is about to document the findings. Which statement best reflects accurate documentation?
   A) Client appears upset about upcoming surgery.
   B) Client was interviewed about previous history of hypertension.
   C) Skin pale, warm, and dry without evidence of lesions.
   D) Client's oral intake is satisfactory.
16. A nurse is using a nursing minimum data set to document findings following the assessment of a client. This nurse is most likely providing care in which setting?
   A) Acute care facility
   B) Long-term care facility
   C) Urgent care center
   D) Health clinic

17. While performing the initial assessment of a client, the client tells the nurse that this is his first hospitalization and that he has no previous surgeries. The nurse should document which of the following?
   A) Client denies prior hospitalizations and surgeries
   B) Client has not been hospitalized before nor has he had any surgery
   C) Client answered no to previous hospitalizations or surgery
   D) Negative for past hospitalizations

18. An instructor is describing various ways that a nurse can validate data to a group of nursing students. The instructor determines that additional teaching is necessary when the students identify which of the following as a reliable method?
   A) Repeating the assessment
   B) Asking additional questions
   C) Having the client repeat what was said
   D) Checking findings with another health care professional

19. A nurse is working on an acute neurological unit. Which assessment form would the nurse most likely use to document assessment data?
   A) Open-ended form
   B) Focused assessment form
   C) Frequent assessment form
   D) Ongoing assessment form

20. A group of students is reviewing information from class about the purposes of assessment documentation. The students demonstrate understanding of the material when they state which of the following?
   A) “Documentation helps support reimbursement but gives little epidemiologic data.”
   B) “Documentation provides a permanent legal record of care given and not given.”
   C) “Documentation is a viable means of communication but is repetitious.”
   D) “Documentation helps determine client education needs but not staff mix.”
21. A nurse is providing a verbal update to a client's primary care provider because of the client's worsening nausea. When using an SBAR format to provide a report, the nurse should complete the report with which of the following statements?
A) "What would you like to do to address this client's nausea?"
B) "I think this client would benefit from an antiemetic."
C) "This client has no recent history of any nausea or vomiting."
D) "This client rates his nausea as seven out of ten."

22. A surgical client's pain has become increasingly severe overnight, and she has received her maximum current doses of analgesics. The nurse has consequently phoned the surgeon to obtain a new order for analgesia. After the surgeon tells the nurse the new order, how should the nurse best validate this information?
A) Read the order back to the surgeon for confirmation.
B) Compare the order with the standard timing and dosage of the analgesic.
C) Compare the order to the client's existing medication administration record (MAR).
D) Have another nurse read the order that the nurse has transcribed.

23. An audit of a hospital unit's incident reports reveals that several errors have resulted from incomplete or inaccurate information during change-of-shift handoff. In order to prevent such errors, what practice should be encouraged on the unit?
A) Delegate handoff reports to unlicensed care providers who have fewer demands on their time.
B) Use an intermediary to receive report from the first nurse and then provide the handoff report to the second nurse.
C) Involve as few people as possible in the verbal report.
D) Encourage nurses to perform handoff as quickly as possible.

24. A client has illuminated his call light and tells the nurse that he is having "ten out of ten" pain. The nurse's initial inspection reveals that the client is watching videos on his tablet computer and appears to be at ease physically and emotionally. How should the nurse validate the client's subjective complaint of pain?
A) Ask the client to repeat his rating of his pain.
B) Observe the client for several seconds to see if his demeanor or his behavior changes.
C) Consult the client's medication administration record (MAR) to check for recent analgesic use.
D) Perform further assessments addressing various aspects of the client's pain.
25. A hospital nurse is admitting a client with a documented history of acute pancreatitis, liver cirrhosis, malnutrition, and frequent traumatic injuries. What assessment finding would most clearly warrant validation?
   A) The client's blood pressure is 148/88 mm Hg.
   B) The client is oriented to person and place but not to time.
   C) The client states that she only drinks alcohol on a social basis.
   D) The client states, "My skin's kind of yellow because of my liver."

26. A small, rural hospital is revising the policies and procedures surrounding documentation in an effort to align practices with the Health Information Technology for Economic and Clinical Health (HITECH) Act. How can the requirements of this legislation best be met?
   A) Expand the use of the Nursing Minimum Data Set.
   B) Eliminate the use of verbal handoffs between nurses.
   C) Increase interdisciplinary collaboration in the hospital.
   D) Increase the use of electronic health records (EHRs) in the hospital.

27. The nurse is reviewing and analyzing data from the initial assessment of a newly admitted client who is a 79-year-old man. What assessment finding most clearly indicates a need for further data?
   A) The man has male pattern baldness.
   B) The man has a diffuse rash on his torso.
   C) The man's heart rate is 63 beats per minute.

28. There has been some resistance to the planned transition to electronic health records (EHRs) in a hospital system, with many caregivers questioning the rationale for this change in practice. What potential advantage of EHRs should administrators cite?
   A) Increased influence for the nursing profession
   B) Elimination of documentation
   C) Improved continuity of care
   D) Reduced nursing workload

29. While assisting an older adult with morning hygiene, the nurse notes a lesion on the client's coccyx region. How should the nurse best document this objective assessment finding?
   A) "Possible pressure ulcer observed over client's coccyx region."
   B) "Reddened area noted on skin surface superficial to client's coccyx."
   C) "Area of nonblanching erythema noted over client's coccyx, 2 cm x 2 cm."
   D) "Impaired Skin Integrity related to decreased mobility."
30. A nurse is conscientious in adhering to the requirements of the Health Insurance Portability and Accountability Act (HIPAA) when providing care for clients. What action best meets these legal requirements for care?
   A) Having a colleague audit the nurse's documentation to ensure objectivity
   B) Maintaining the privacy and confidentiality of clients' medical records
   C) Using electronic records whenever possible, rather than paper-based records
   D) Collaborating with the client and his or her family prior to documenting
Answer Key

1. B
2. A
3. C
4. D
5. A
6. C
7. A
8. C
9. D
10. C
11. A
12. A
13. D
15. C
16. B
17. A
18. C
19. B
20. B
21. B
22. A
23. C
24. D
25. C
26. D
27. B
28. C
29. C
30. B