Test Bank for Nursing Interventions and Clinical Skills 6th Edition by Perry

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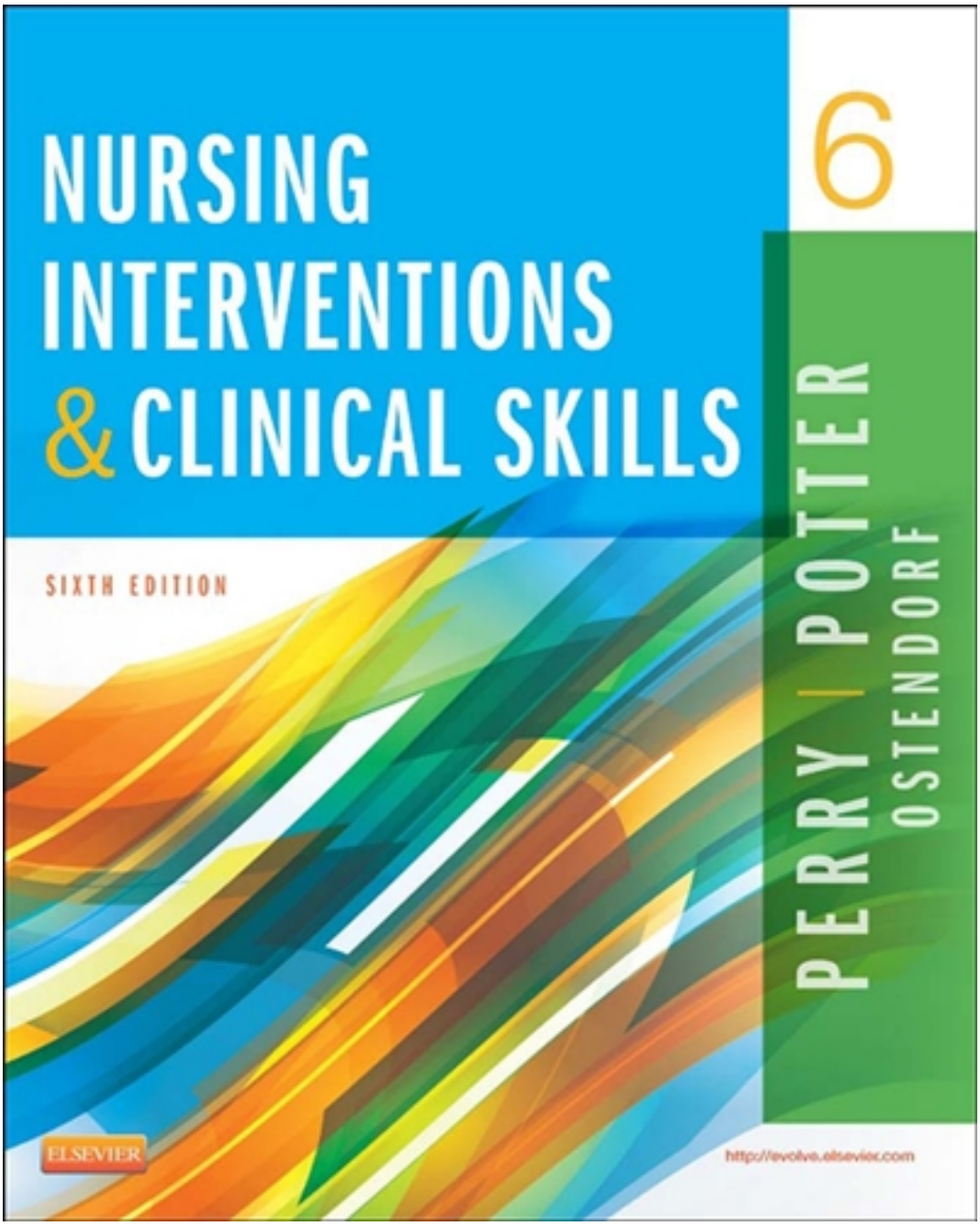

Test Bank

Chapter 02: Communication and Collaboration
Perry et al.: Nursing Interventions & Clinical Skills, 6th Edition

MULTIPLE CHOICE

1. The nurse interviews a female patient during admission. Which observation by the nurse identifies congruency in the patient's communication?
   a. Asserts she is eager to answer questions while reading a magazine
   b. States that she wants information while frequently changing the subject
   c. Asks the nurse to explain a surgical procedure while listening intently
   d. Explains that she is relaxed while continuously shifting in her chair

   ANS: C
   The patient demonstrates congruency, or consistency, between her verbal statement asking for an explanation and her nonverbal cue of listening intently. The verbal and nonverbal messages match; each indicates that the nurse's response is important to her. If she is eager to answer questions, the patient should focus on the nurse's questions or note taking; reading a magazine is a distraction and indicates a lack of interest. Changing the subject may indicate discomfort or reluctance to address the issue. Continually shifting position may be an indication of anxiety.

   DIF: Cognitive Level: Apply REF: Page 19
   OBJ: NCLEX: Safe and Effective Care TOP: Nursing Process: Assessment

2. The nurse is interviewing a patient about his health history. Which statement by the nurse is most likely to result in effective patient communication?
   a. "I'm not sure why you're here. Can you explain it to me?"
   b. "Tell me about things and people that are important to you."
   c. "Tell me more about your pain. Where does it start?"
   d. "If you think it's important, I'll try to notify the provider."

   ANS: C
   The nurse communicates effectively by using focused questions. This encourages the patient to give more information about the specific topic of concern. The remaining options are ineffective communication techniques because each impairs the exchange of information between the nurse and the patient. The patient may be unwilling to express concerns openly after the nurse expresses lack of understanding and empathy. The patient will also likely lose confidence in the nurse if the nurse expresses confusion about suitability of the patient's presence. By asking what is important to the patient, the nurse loses focus of the objective of the communication and is likely to confuse the patient.

   DIF: Cognitive Level: Apply REF: Page 14
   OBJ: NCLEX: Safe and Effective Care TOP: Nursing Process: Evaluation

3. After a male patient receives a diagnosis of a fatal disease, he expresses sadness and states that he does not know what to do next. Which is the most effective response by the nurse to facilitate communication?
   a. Ask the patient what he finds comforting in his life.
   b. Reassure the patient that his family will take care of him.
   c. Refer the patient to a church for spiritual counseling.

d. Tell the patient that hospice care is available immediately.

ANS: A
Because of the grim diagnosis, the patient expresses confusion and lacks a clear direction. To reduce anxiety, enhance coping skills, and facilitate communication, the nurse provides a calm atmosphere by redirecting and focusing the patient to identify comforting things. The nurse should use comfort measures, hoping that they will reduce tension so the patient can process information and make decisions. Discussing hospice is premature until end-stage disease and because the patient is not thinking clearly. The patient can benefit from a calming atmosphere and time to process the new information. Besides, informing the patient about hospice implies that end of life is imminent. Assuring the patient of family involvement requires consultation with the family first. Spiritual counseling may not be indicated for this patient if the patient does not wish to participate.

DIF: Cognitive Level: Analyze REF: Page 14| Page 24
OBJ: NCLEX: Safe and Effective Care TOP: Nursing Process: Evaluation

4. A female patient sobs uncontrollably when talking about the recent death of a pet. Which response should the nurse implement to best provide for her immediate needs?
   a. Sit with the patient quietly and allow her to cry.
   b. Provide tissues and promise to come back later.
   c. Ask why the patient is upset over the pet's death.
   d. Encourage her to describe the day she got her pet.

ANS: A
Sitting with the patient demonstrates acceptance, caring, and value for the patient's experience as she expresses her grief. This is more likely to promote effective communication later because the nurse establishes a foundation of trust by respecting, caring, and staying with her. Providing tissues is indicated; however, leaving the room indicates that the nurse does not value what the patient is experiencing, the nurse does not care, or the nurse is uncomfortable with crying. Questions beginning with "why" ask the patient to justify feelings or actions and thereby can inhibit effective communication as she assumes a defensive position. The patient needs to be able to experience the grief. She will talk when she is ready.

DIF: Cognitive Level: Apply REF: Page 14| Page 17| Page 19| Page 24
OBJ: NCLEX: Safe and Effective Care TOP: Nursing Process: Implementation

5. The nurse is preparing to begin the patient hand-off procedure for five patients. Who should the nurse include in this process?
   a. Only the licensed nurses
   b. The unit health care personnel
   c. The entire interdisciplinary team
   d. The nurses and healthcare provider

ANS: B
All the healthcare personnel on the unit who will be interacting with this group of patients should actively participate in the patient hand-off. This would include nursing assistive personnel (NAP) and the nurses. An interdisciplinary team usually meets when there is a problem with a patient and all the team members need to discuss approaches and plans with and for a patient. The healthcare provider does not participate in the patient hand-off procedure. The provider makes rounds on a specific group of patients.

DIF: Cognitive Level: Remember REF: Page 27-28
OBJ: NCLEX: Safe and Effective Care TOP: Nursing Process: Planning

6. The nurse brings the patient's medications into the room, and the patient shouts, "You don't care if I take these, so get out of my room!" Which response by the nurse is most likely to diminish the patient's anger?
   a. "Who misinformed you about my feelings?"
   b. "You seem very angry about the medications."
   c. "We know each other; why are you saying this?"
   d. "I cannot leave until you take these medications."

   ANS: B
   To neutralize the situation, the nurse seeks to confirm an impression by sharing an observation about the patient's actions and encourages the patient to communicate about the anger to help keep him or her in control and elicit more discussion about his or her emotional state. The nurse's statement also expresses caring and respect for the patient. Questions beginning with "why" are confrontational and not likely to diminish anger. Confronting the patient with questions is more likely to escalate anger and force the patient to justify statements. When the nurse attempts to control the patient by stating that the medications must be administered before the nurse can leave the room, the nurse may succeed in administering the medications; however, controlling behavior is confrontational because the nurse engages the patient in a power struggle and misses an opportunity to explore the patient's anger. Forcing the patient in this manner is unlikely to elicit patient cooperation in the future because the nurse has displayed a lack of caring and respect.

   DIF: Cognitive Level: Analyze REF: Page 22| Page 24-26
   OBJ: NCLEX: Safe and Effective Care TOP: Nursing Process: Evaluation

7. The patient shouts at the nurse, "No one answered my call bell all night!" Which response should the nurse use with this patient to restore therapeutic communication?
   a. "Shouting is going to disturb other patients."
   b. "I see how that would make you very angry."
   c. "Are you sure the nurses were avoiding you?"
   d. "The unit has many very sick patients right now."

   ANS: B
   Regardless of whether the nurses answered the patient's call bell during the night, the patient felt ignored. By empathizing with the patient's distress and reflecting feelings, the nurse displays respect and understanding of his or her experience. Reprimanding the patient is humiliating and conveys the nurse's lack of regard for the patient's feelings. Quieting the patient is achievable by displaying empathy, caring, respect, and willingness to hear his or her complaints. Questioning the patient's perception is demeaning and forces the patient to justify feelings, similar to asking a "why" question. Stating that the unit has very sick patients implies that the patient is not as important as the others are, potentially leads to patient feelings of guilt and shame, and is likely to impair therapeutic communication for making an issue of a lack of attention.

   DIF: Cognitive Level: Analyze REF: Page 17
   OBJ: NCLEX: Safe and Effective Care TOP: Nursing Process: Planning

8. A male patient with a history of violence directed toward others becomes very excited and agitated during the nurse's interview. Which intervention should the nurse implement to foster therapeutic communication?
   a. Call the security staff for assistance.
   b. Ask the patient if he will use self-control.
   c. Lean forward and touch the patient's arm.
   d. Assume an open, nonthreatening posture.

   ANS: D
   The nurse should use neutralizing skills and assume an open, nonthreatening posture that conveys respect and acceptance, creating an atmosphere in which the patient can communicate without feeling threatened or defensive. Depending on the extent of this nurse-patient relationship, the patient can be posturing as they get to know one another; however, before entering the room in the future, the nurse should plan for personal safety by keeping the door open and letting others know that he or she is with the potentially violent patient. Calling security in the patient's presence is likely to aggravate the patient and escalate the potential for violence because it is humiliating, conveys the nurse's rejection of the patient, and threatens to take all control away from him. Asking the patient if he will use self-control is reprimanding him, humiliating, and conveys rejection and lack of respect by the nurse. The patient can perceive leaning and touching as threatening.

   DIF: Cognitive Level: Apply REF: Page 22| Page 24-26
   OBJ: NCLEX: Safe and Effective Care TOP: Nursing Process: Planning

9. The nurse admits a patient who is complaining of severe abdominal pain and vomiting who is nonverbal. What can the nurse do to communicate effectively with the patient?
   a. Use a communication aid
   b. Wait for family to arrive
   c. Call interpreter services
   d. Treat the pain

   ANS: A
   Patients with sensory losses require communication techniques that maximize existing sensory and motor functions. Some patients are unable to speak because of physical or neurological alterations such as paralysis; a tube in the trachea to facilitate breathing; or a stroke resulting in aphasia, difficulty understanding, or verbalizing. Many types of communication aids are available for use, including writing boards, flash cards, and picture boards. The nurse needs to determine what will work for the patient. Waiting for family is unacceptable because the patient is in pain. Interpreter services are for patients who do not speak the language. The nurse should not just treat the pain without assessing the patient.

   DIF: Cognitive Level: Apply REF: Page 15-16
   OBJ: NCLEX: Safe and Effective Care TOP: Nursing Process: Assessment

10. The nurse is teaching the patient about weight management, and the patient wants to know how the nurse manages to stay "so thin." Which response should the nurse use to maintain therapeutic communication?
    a. State that nurses cannot discuss personal information with patients.
    b. Describe a daily routine of walking the family dog to the local park.
    c. Recognize the question and redirect the discussion to weight management.
    d. Explain that the patient needs a background in health care to use the nurse's plan.

ANS: C
After acknowledging the patient's question, the nurse redirects the conversation to weight management because therapeutic communication is patient centered and goal oriented; however, the communication and the goal do not involve personal details about the nurse because therapeutic communication is not social conversation. Describing a daily routine reveals personal information that belies the nurse-patient relationship. Telling the patient that a healthcare background is needed to implement the nurse's plan is condescending and conveys a lack of respect.

DIF: Cognitive Level: Apply REF: Page 13
OBJ: NCLEX: Safe and Effective Care TOP: Nursing Process: Planning

11. A patient's mother died several days ago. The patient begins to cry and states, "The pain of her death is impossible to bear." Which statement by the nurse is the most effective response?
    a. "I was depressed last year when my mother died, too."
    b. "I know things seem bleak, but you are doing so well."
    c. "I can see this is a very difficult time for you right now."
    d. "Should I cancel your appointment with the cardiologist?"

    ANS: C
    The nurse conveys empathy and respect by acknowledging the patient's grief. This is an effective response and is likely to enhance the nurse-patient relationship because it is patient centered, displays caring and respect, and helps to make the patient feel accepted. Relating personal details about the nurse's life redirects the focus of the communication to the nurse and fails to support the objectives of the nurse-patient relationship. Responding with a comment about the patient's progress and asking about the cardiologist's appointment ignores the patient's grief and conveys a lack of respect and consideration.

    DIF: Cognitive Level: Apply REF: Page 17
    OBJ: NCLEX: Safe and Effective Care TOP: Nursing Process: Evaluation

12. A male patient who says that his parents died of heart disease early in life is waiting for diagnostic testing results. He is biting his nails and pacing around the room. Which statement should the nurse use to clarify patient information?
    a. "I can see that you are anxious about dying."
    b. "Tell me more about your family's history."
    c. "Do you have your parents' medical records?"
    d. "I'm not sure that I understand what you mean."

    ANS: B
    Asking for more information about the family's history directs the patient to expand on a specific, pertinent topic and relate key details before moving to another topic. "Early in life" and "heart disease" need to be defined by the patient; "early in life" can indicate a wide range of ages, depending on the definition of "early," and "heart disease" can mean conditions such as heart failure, coronary artery disease, valve disease, and arrhythmias. Until the patient discusses his particular concerns, the nurse cannot be sure about the source of his anxiety. Asking for the records can display a lack of respect by implying that the patient is an unreliable source for information. Stating that the nurse is not sure what the patient means is vague, leaving the patient to guess what the nurse wants to know.

DIF: Cognitive Level: Apply REF: Page 14
OBJ: NCLEX: Safe and Effective Care TOP: Nursing Process: Planning

13. You are working with a patient who is cognitively impaired and you need to provide some information to them. Which should the nurse implement in response to the patient's condition?
    a. Present the interview in written form.
    b. Repeat the information.
    c. Have another person finish the interview.
    d. Focus on the patient's physical complaints.

    ANS: B
    Use clear and concise verbal techniques to respond to the patient. Use simple language and speak slowly; use short, simple sentences. Ask yes or no questions, ask one question at a time, and repeat the information. The patient is unable to clearly communicate needs or concerns in the present state because he or she needs comfort and support in a threatening situation. Having another person complete the interview may convey a lack of respect and lead to patient confusion if the other person does not make sure that the patient understands all the information.

    DIF: Cognitive Level: Apply REF: Page 26
    OBJ: NCLEX: Safe and Effective Care TOP: Nursing Process: Planning

14. The patient tells the nurse, "I must be very sick because so many tests are being performed." Which statement does the nurse use to reflect the patient's message?
    a. "I sense that you are very worried."
    b. "You mention this so frequently."
    c. "We should talk about this more."
    d. "You think you must be very sick."

    ANS: D
    The nurse reflects the patient's message by focusing on the feelings the patient identifies, including nonverbal cues, and then clarifying the nurse's perception with the patient. The nurse follows this statement by encouraging the patient to confirm the perception. Pointing out that the patient has stated this before can be misinterpreted to mean that the patient is forgetful or annoying. Stating that the nurse feels that the patient is worried is a suitable response but does not reflect what the patient actually said. Exploring the topic with the patient is a suitable response but does not reflect the patient's actual statement.

    DIF: Cognitive Level: Apply REF: Page 14
    OBJ: NCLEX: Safe and Effective Care TOP: Nursing Process: Implementation

15. The patient tells the nurse, "I want to die." Which is the best response by the nurse to facilitate therapeutic communication?
    a. "Now why would you say a thing like that?"
    b. "Tell me more about how you're feeling."
    c. "We need to tell the provider how you feel."
    d. "You have too much to live for to say that."

    ANS: B

The patient's statement warrants further investigation to determine how serious the patient is about dying and whether he or she has a plan. Research on suicide supports the claim that patients with well-established suicide plans are more likely to carry out the plan; thus details about the patient's feelings on dying and suicide plans are important for preventing self-injury and planning medical therapy, nursing care, and patient safety. To elicit more information from the patient, the nurse allows the patient to expand on the statement, "I want to die" by stating, "Tell me more." The statement displays concern for and value of the patient by acknowledging the patient's message and encouraging him or her to continue. Safety is a major concern when a patient wants to die, and the remaining options are unlikely to further the discussion, keep the patient safe, or facilitate therapeutic communication.

DIF: Cognitive Level: Analyze REF: Page 25
OBJ: NCLEX: Safe and Effective Care TOP: Nursing Process: Planning

16. The nurse is explaining a procedure to a 3-year-old female patient. Which strategy should the nurse use for patient teaching?
    a. Ask the patient to draw her feelings.
    b. Show needles, syringes, and bandages.
    c. Tell the patient about postoperative pain.
    d. Use dolls and stories to explain surgery.

ANS: D
Using dolls, stuffed animals, or puppets with stories is a suitable way to explain surgery to the 3-year-old patient because storytelling is a familiar communication method for the toddler's developmental stage. A 3-year-old child is unlikely to understand an explanation about the surgery suited for an adult, and the discussion can frighten the child and upset the family or guardian. A 3-year-old child lacks the fine motor and cognitive skills to draw an abstract concept. Needles, syringes, and bandages usually are not shown to patients of any developmental level because many people at various ages are fearful of needles and pain. A toddler is unlikely to understand and probably would be frightened by a discussion about postoperative pain.

DIF: Cognitive Level: Apply REF: Page 22
OBJ: NCLEX: Safe and Effective Care TOP: Nursing Process: Planning

17. The nurse is caring for a patient who states, "I don't feel well today." Which is the best follow-up action to the patient's statement for the nurse to implement?
    a. Ask the patient to continue to describe the feeling.
    b. Measure the blood pressure and temperature.
    c. State that the patient's diagnostic testing had normal results.
    d. Compare recent laboratory results with the prior results.

ANS: A
Because the patient's statement is too vague, the nurse asks him or her to continue describing, "I don't feel well today," because many disorders begin with nonspecific complaints. Depending on the details the patient shares, the nurse plans and implements nursing care individualized to his or her description. This is a better choice than taking vital signs or checking test results because principles of diagnostics mandate completing the patient history before objective data; a good diagnostician should be able to formulate a reasonable prognostication about the patient's actual health alteration with the history alone.

DIF: Cognitive Level: Analyze REF: Page 14
OBJ: NCLEX: Safe and Effective Care TOP: Nursing Process: Implementation

18. The nurse is assessing a patient for pain. Which question is best for the nurse to ask when determining aggravating factors for a patient's pain?
    a. How long has the patient had pain?
    b. What increases the intensity of the pain?
    c. Where is the pain located specifically?
    d. What is the pain level on a scale of 0 to 10?

    ANS: B
    Aggravating factors make the pain worse or increase its severity, so the nurse asks about what increases the intensity of the pain to determine aggravating factors. The nurse asks the patient about the duration of the pain when asking how long the patient has had it. This is important to know but doesn't explain any of the factors that either trigger the pain or make it worse. Asking the patient to identify a specific spot for the pain determines its location but does not identify aggregating factors. Rating the pain on a scale transforms the patient complaint into objective data that are helpful in establishing trends and response to therapy.

    DIF: Cognitive Level: Comprehend REF: Page 21
    OBJ: NCLEX: Safe and Effective Care TOP: Nursing Process: Planning

19. The nurse is caring for a patient who refuses to participate in physical therapy (PT) and states, "I really don't like to exercise." Which response by the nurse is most likely to help engage the patient in PT?
    a. "It makes the pain worse, doesn't it?"
    b. "What don't you like about exercise?"
    c. "You really should do these exercises."
    d. "Do you like to do any other activities?"

    ANS: B
    The nurse asks an open-ended question using the patient's words to uncover information about the patient's refusal to participate in PT by asking what the patient dislikes about exercise. Using the patient's words conveys acceptance and value because the nurse listened closely enough to repeat what the patient said; in addition, the nurse is asking the patient to continue describing his or her pain to uncover factors that can be resolved or other issues requiring follow-up care and ultimately result in patient participation. Asking the patient a yes-or-no question such as, "It makes the pain worse, doesn't it?" is unlikely to promote further discussion. Telling the patient to do the exercises is giving advice; rather the nurse can tell the patient the reason for the therapy and the benefits of doing it or the risks of not doing it. Asking about other activities moves the focus away from the patient's need for physical therapy.

    DIF: Cognitive Level: Application REF: Page 14| Page 17
    OBJ: NCLEX: Safe and Effective Care TOP: Nursing Process: Implementation

20. The nursing staff is using the SBAR communication technique during patient hand-off communication. The circumstances leading up to the current status would be explained by the nurses during which step of the technique?
    a. Situation
    b. Background

c. Assessment
d. Recommendations

ANS: B
The background explains circumstances leading up to the situation. The situation explains what is happening at the present time. The assessment phase identifies what the problem is thought to be. The recommendations explain how to correct the problem.

DIF: Cognitive Level: Remember REF: Page 28-29
OBJ: NCLEX: Safe and Effective Care TOP: Nursing Process: Planning

21. The nursing staff is working with a postoperative patient from another culture who does not understand or speak the English language well. Which approach by the nurse would be best?
a. Act out what the patient needs to do.
b. Obtain a medical interpreter.
c. Assess how much the patient is able to communicate in his native language.
d. Talk slowly when instructions are given.

ANS: B
A medical interpreter would be most helpful for effective communication. A translator restates the words from one language to another, whereas an interpreter decodes a patient's words and provides meaning behind the message. Acting out what the patient needs to do is ineffective and may be embarrassing to both the patient and the nurse. Since the patient and nurse do not speak a common language, defining the patient's ability to speak in his native language does not solve the communication problem. Talking slowly will not improve the patient's ability to understand an unfamiliar language.

DIF: Cognitive Level: Remember REF: Page 15
OBJ: NCLEX: Safe and Effective Care TOP: Nursing Process: Planning

22. The following statement best describes which phase of the nurse-patient relationship: "Mr. James, we have reviewed the changes in your diet and insulin dosage to help you improve your HgA1c levels. I would like to see you back in 4 weeks."
a. Orientation phase
b. Termination phase
c. Interim phase
d. Working phase

ANS: B
In the termination phase, the nurse summarizes with the patient what they have discussed during interaction and/or interview, including goal and achievement. The orientation phase occurs at the beginning and creates the climate of trust. The working phase is where the information is gathered. There is no interim phase.

DIF: Cognitive Level: Apply REF: Page 20-21
OBJ: NCLEX: Safe and Effective Care TOP: Nursing Process: Assessment

23. The nurse is working toward discharging a patient. Which of following demonstrates patient engagement during the discharge process?
a. Teaching the patient how to use his equipment
b. Having the patient establish daily goals
c. Reviewing the discharge instructions with the patient

d. Including the family in the discharge planning

ANS: B
All of the answers are important to the discharge process but having the patient set his own daily goals establishes true patient engagement. The other interventions are aimed at the patient and are not really engaging the patient but rather the nurse focusing interventions at the patient. Patient engagement requires that the patient's preferences be incorporated.

DIF: Cognitive Level: Apply REF: Page 29-30
OBJ: NCLEX: Safe and Effective Care TOP: Nursing Process: Planning

MULTIPLE RESPONSE

1. During a home care visit, the patient experiences an angry outburst and hits the nurse on the thigh and yells at her. The patient continues to be threatening. What are the appropriate initial actions by the nurse? *(Select all that apply.)*
   a. Call for a family member who lives down the street.
   b. Call law enforcement to take the patient to the hospital.
   c. Tie the patient to the bed.
   d. Yell at the patient to stop being threatening.
   e. Call the nursing agency.
   f. Use a calm, quiet voice when talking with the patient.

   ANS: A, E, F
   A nearby family member may be able to calm the patient. Notifying the nurse's employing agency is essential. The agency needs to know the situation and can give some guidance. Using a calm, quiet voice requires the patient to be quieter to hear what the nurse is saying. It also denotes to the patient that the nurse is not a threat. The other actions are not appropriate yet. More assessment and intervention should be tried first. Restraining the patient without orders is never appropriate.

   DIF: Cognitive Level: Analyze REF: Page 24
   OBJ: NCLEX: Safe and Effective Care TOP: Nursing Process: Planning

2. The female patient scheduled for an invasive procedure the next day complains of headache and nausea and knocks over a glass of water. Which intervention(s) should the nurse implement for therapeutic communication? *(Select all that apply.)*
   a. Explain the procedure briefly.
   b. Teach with the patient's partner present.
   c. Give the patient written information.
   d. Tell the patient that she seems overwhelmed.
   e. Ask if this is her first hospitalization.
   f. State that the procedure can be cancelled.

   ANS: A, B, C, D

To manage the situation, the nurse can provide a brief explanation of the procedure and build on the information later. The patient seems very anxious about the procedure, as demonstrated by knocking over the glass, but the nurse must confirm that suspicion because a migraine headache can be developing and the water can be a simple accident. Teaching with another person present is usually a good idea, lending emotional support to the patient and, together with the patient, listening to instructions and explanations. Providing written information is suitable as long as it is not the only information shared with the patient. To confirm any suspicions, the nurse validates conclusions before acting on assumptions. The other responses show a lack of respect for the patient and do not address her needs.

DIF: Cognitive Level: Apply REF: Page 14
OBJ: NCLEX: Safe and Effective Care TOP: Nursing Process: Planning

3. Which of the following pieces of information should be included in a hand-off to ensure patient safety? *(Select all that apply.)*
   a. Code status
   b. Recent changes in patient condition
   c. Age
   d. Family visitation
   e. Use of oxygen

ANS: A, B, E
It is important to include information on a patient's background, assessment, nursing diagnosis, interventions (including the patient's response), family information, discharge plans, and current priorities when handing off your patient to another unit or area. However, only code status, recent changes in patient condition, and use of oxygen directly impact patient safety.

DIF: Cognitive Level: Apply REF: Page 28
OBJ: NCLEX: Safe and Effective Care TOP: Nursing Process: Intervention

MATCHING

When interviewing a patient, it is important to determine additional information about each symptom the patient reports. Match the dimension of the symptom with the corresponding question to ask.

a. Location
b. Quality
c. Severity
d. Timing
e. Setting
f. Aggravating or alleviating factors

1. "What is the worst it has been?"
2. "Does it occur in a particular place or under certain circumstances?"
3. "When does it change?"
4. "Does it move around?"
5. "What is it like? Sharp, dull, stabbing, aching?"
6. "How often does it happen?"

1. ANS: C DIF: Cognitive Level: Apply REF: Page 21
   OBJ: NCLEX: Safe and Effective Care TOP: Nursing Process: Assessment
   MSC: This question evaluates severity.
2. ANS: E DIF: Cognitive Level: Apply REF: Page 21
   OBJ: NCLEX: Safe and Effective Care TOP: Nursing Process: Assessment
   MSC: This question asks in what setting the symptom occurs.
3. ANS: F DIF: Cognitive Level: Apply REF: Page 21
   OBJ: NCLEX: Safe and Effective Care TOP: Nursing Process: Assessment
   MSC: This question addresses what makes it better or worse.
4. ANS: A DIF: Cognitive Level: Apply REF: Page 21
   OBJ: NCLEX: Safe and Effective Care TOP: Nursing Process: Assessment
   MSC: This question identifies the location of the symptom.
5. ANS: B DIF: Cognitive Level: Apply REF: Page 21
   OBJ: NCLEX: Safe and Effective Care TOP: Nursing Process: Assessment
   MSC: This question asks about the quality of the symptom.
6. ANS: D DIF: Cognitive Level: Apply REF: Page 21
   OBJ: NCLEX: Safe and Effective Care TOP: Nursing Process: Assessment
   MSC: This question asks when it occurs.