Solutions for Nursing Health Assessment 4th Edition by Jensen

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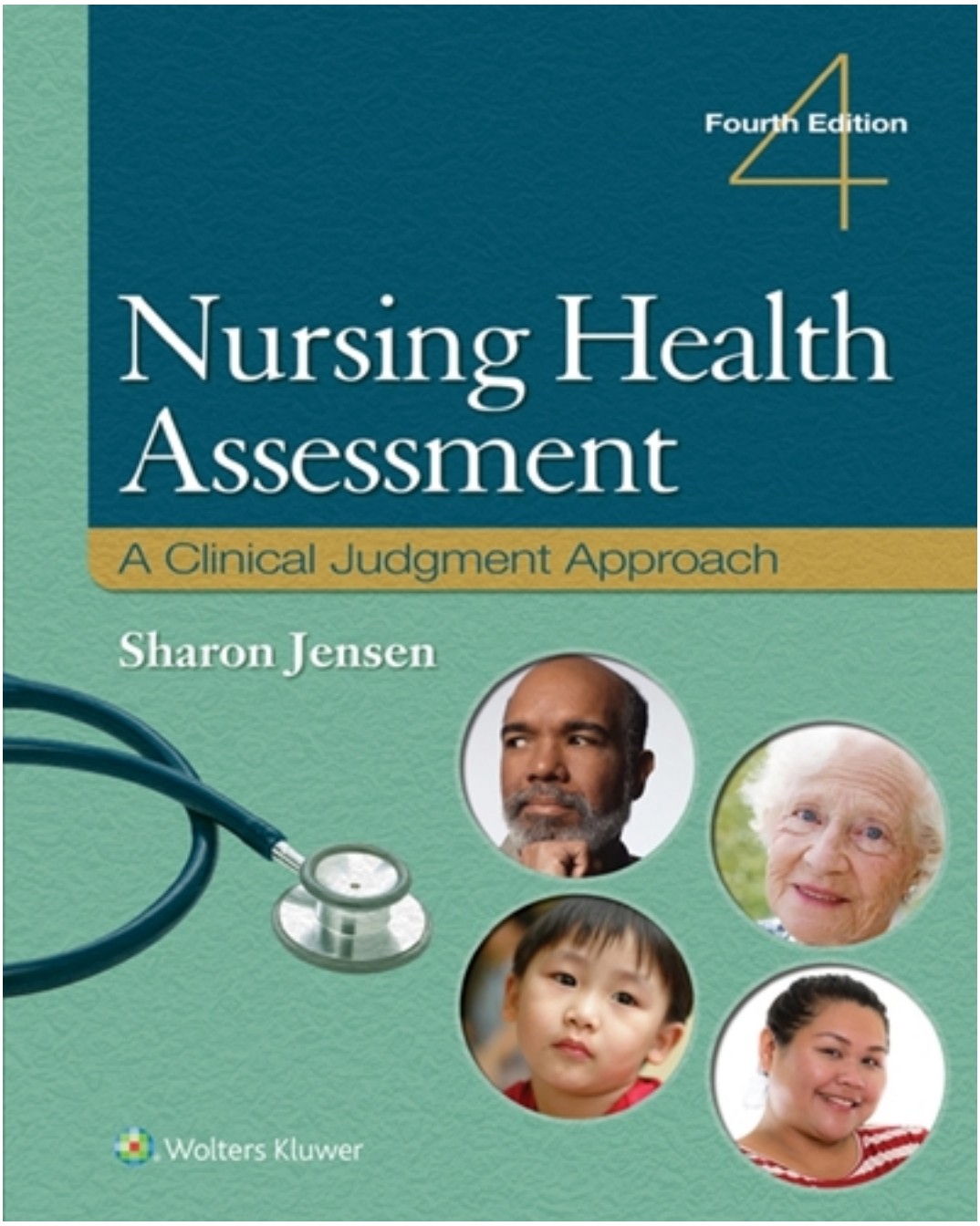

Solutions

Suggested Answers to Assignments, Chapter 2, Nursing Process

Written Assignments	**Learning Objective(s)**
1. Students' answers should include the following: • Information on the nursing process, based on the following: ○ Definition ▪ The nursing process is an organized sequence of problem-solving steps used to identify and manage the health problems of clients. ○ Use ▪ When nursing practice follows the nursing process, clients receive quality care in minimal time with maximal efficiency. ○ Characteristics ▪ Within the legal scope of nursing ▪ Based on knowledge ▪ Planned	1, 2

Written Assignments	**Learning Objective(s)**
▪ Client centered ▪ Goal directed ▪ Prioritized ▪ Dynamic	
2. Students' answers should include the following: • A comparative chart differentiating between database assessment, focus assessment, and functional assessment based on the following points: ○ Purpose of the assessment ○ When the assessment is conducted ○ Information obtained ○ Frequency • A database assessment (initial information about the client's physical, emotional, social, and spiritual health) is lengthy and comprehensive. The nurse obtains database information during the admission interview and physical examination. Information obtained serves as a reference for comparing all future data and provides the evidence used to identify the client's initial	5

Written Assignments	Learning Objective(s)
problems. • A focus assessment is information that provides more details about specific problems and expands the original database. Focus assessments are generally repeated frequently or on a scheduled basis to determine trends in a client's condition and responses to therapeutic interventions. • A functional assessment is a comprehensive evaluation of a client's physical strengths and weaknesses in areas such as (1) the performance of activities of daily living, (2) cognitive abilities, and (3) social functioning. The results of the functional assessment help formulate an individualized plan for care that identifies specific interventions for achieving the maximum possible functioning to ensure a better quality of life. Currently, the performance of a functional assessment is being promoted by The Joint Commission in all general health care settings.	

Group Assignment	**Learning Objective(s)**
1. Students' answers should include the following: • Resources for assessment data, distinguishing between a nursing diagnosis and a collaborative problem, the rationale for setting priorities, and examples of outcomes that result from evaluation, for each group's assigned step of the nursing process: ○ Assessment ○ Diagnosis ○ Planning ○ Implementation ○ Evaluation	3, 4, 6, 8, 12

Clinical Assignments	**Learning Objective(s)**
1. Students' answers should include the following: • The different parts of the diagnostic statement • Name of the health-related issue or problem as identified in the NANDA list	7

Clinical Assignments	**Learning Objective(s)**
• Etiology (the problem's cause) • Signs and symptoms, also called defining characteristics	

2. Students' answers should include the following:
• The reasons for establishing goals
• Examples of different types of goals:
  ○ Short-term goals
  ○ Long-term goals
  ○ An example of a goal for collaborative problems
	9

3. Students' answers should include the following: • The ways that the plan of care is documented • Specific information that is documented in reference to the plan of care	10, 11

Web Assignment	**Learning Objective**
1. Students could visit the following website for information: • http://www.udel.edu/chem/white/teaching/ConceptMap.html	13

Suggested Answers to Case Study, Chapter 2, Nursing Process

The nurse is caring for a client who has lost function of both legs due to a stroke to the brainstem. The client is unable to walk or maintain balance while standing.

The client is unable to perform activities of daily living without assistance. Additionally, the client has difficulty in chewing and swallowing food. This, coupled with a speech impairment, has resulted in frustration, irritability, and limited food intake. (Learning Objectives 4, 10, and 11)

a. What objective data can the nurse include in the electronic medical record admission database, based on the information available about the client?
b. What should the nurse include in preparing the plan of care for the client?
c. What should the nurse keep in mind when selecting nursing interventions for the client?

a. The nurse can include the following objective data about the client in the electronic medical record admission database, based on the available information:

- Stroke to the brainstem
- Loss of function of both legs
- Unable to walk or maintain balance while standing
- Unable to perform activities of daily living
- Difficulty chewing and swallowing food
- Limited food intake
- Speech impairment

b. The nurse should include the following when preparing the plan of care for the client:

- Set realistic goals, such as:
  - Improving food intake
  - Overcoming frustration caused by disabilities
- Help the client in achieving these goals
- Teach and assist the client in performing activities of daily living
- Help the client improve his or her speech
- Allow the client to express feelings without disagreeing or interrupting

c. When selecting nursing interventions for this client, the nurse should keep in mind that the selected nursing intervention is:

- safe.
- within the legal scope of nursing practice.
- compatible with medical orders.

Suggested Answers for Discussion Topics, Chapter 2, Nursing Process

Suggested Answers for Discussion Topics	**Learning Objective(s)**
1a. Students' answers should include the following: • The nurse can collect database assessment data from the client in the following ways: ○ The nurse can conduct a physical examination of the client to obtain data, such as her blood pressure. ○ Because the client is in an unconscious state, the nurse can gather further information from her family—in this case, her husband—and refer to her current and past medical records and to other health care providers. 1b. Students' answers should include the following: • The nurse can collect more specific information from the client in the following ways: ○ By interviewing the client, once she	4, 5

Suggested Answers for Discussion Topics	**Learning Objective(s)**
gains consciousness, about her blood pressure ○ By repeating the assessment on a frequent or scheduled basis to determine the trend in the client's condition ○ By interviewing the family about the patient's low blood pressure and its history, onset, prior treatments, etc.	
2a. Students' answers should include the following: • The possible short-term goals the nurse could set with the client: ○ To increase client's food intake ○ To maximize the client's independence related to ADLs 2b. Students' answers should include the following: • A possible long-term goal the nurse could set with the client would be for the client to report a decrease in the severity of his depression.	9
3a. Students' answers should include the following: • The possible plan of care that the nurse	11

Suggested Answers for Discussion Topics	**Learning Objective(s)**
should create to help the client overcome situational low self-esteem is ○ Allow the client to express his feeling without disagreeing or interrupting ○ Facilitate the client accomplishing his own ADLs whenever possible ○ Help to set and accomplish one realistic goal daily	

Assignments, Chapter 2, Nursing Process

Written Assignments	**Learning Objective(s)**
1. Prepare a report on the nursing process, based on the following: a. Definition b. Use c. Seven characteristics	1, 2
2. Prepare a comparative chart differentiating between the following types of assessment: a. Database assessment b. Focus assessment c. Functional assessment	5

Group Assignment	**Learning Objective(s)**
1. Divide into five groups; each group should talk about one of the following steps of the nursing process: a. Assessment b. Diagnosis c. Planning d. Implementation e. Evaluation The discussion needs to include resources for assessment	3, 4, 6, 8, 12

Group Assignment	Learning Objective(s)
data, distinguishing between a nursing diagnosis and a collaborative problem, the rationale for setting priorities, and examples of outcomes that result from evaluation.	

Clinical Assignments	Learning Objective(s)
1. During your clinical rotation, assist a registered nurse in identifying the health-related problems of a client, based on the data collected from the client. a. Identify the different parts of the diagnostic statement created by the nurse. b. Identify what parts of the nursing diagnostic statement are not used by the registered nurse, and generate ideas on how the missing steps can be incorporated into a three-part nursing diagnostic statement.	7
2. During your clinical rotation, assist a registered nurse in creating goals for a client with constipation. Prepare a short report on the following: a. The reasons for establishing goals b. An example of a short-term goal and a long-term goal, including the appropriate circumstances in which each type of goal is used c. An example of a goal for collaborative problems	9

Clinical Assignments	**Learning Objective(s)**
3. During your clinical rotation, assist a registered nurse in creating a plan of care for a client. Prepare a short report on the following: a. The ways that the plan of care is documented b. Specific information that is documented in reference to the plan of care	10, 11

Web Assignment	**Learning Objective**
1. Conduct online research on concept mapping in the nursing process using this website: a. http://www.udel.edu/chem/white/teaching/ConceptMap.html Create a short report on the various formats used and the benefits of concept mapping.	13

Case Study, Chapter 2, Nursing Process

The nurse is caring for a client who has lost function of both legs due to a stroke to the brainstem. The client is unable to walk or maintain balance while standing.

The client is unable to perform activities of daily living without assistance. Additionally, the client has difficulty in chewing and swallowing food. This, coupled with a speech impairment, has resulted in frustration, irritability, and limited food intake. (Learning Objectives 4, 10, and 11)

a. What objective data can the nurse include in the electronic medical record admission database, based on the information available about the client?
b. What should the nurse include in preparing the plan of care for the client?
c. What should the nurse keep in mind when selecting nursing interventions for the client?

Discussion Topics, Chapter 2, Nursing Process

Discussion Topics	Learning Objective(s)
1. A 52-year-old female client, accompanied by her husband, is brought to the health care facility in an unconscious state. The client was previously admitted to the health care facility for treatment of hypotension. a. How will the nurse collect the database assessment data during admission? b. If during the initial examination and interview it is discovered that low blood pressure led to the client's loss of consciousness, how should the nurse gain more specific information about the client's hypotension?	4, 5
2. A 24-year-old male client is being treated for spinal cord injury experienced in a motor vehicle accident. He has lost function of both legs due to the spinal cord injury and is unable to walk. In addition, his food intake has diminished because of a lack of appetite and also from possible depression attributable to his inability to walk. a. What are the possible short-term goals that the nurse could set with the client? b. What are the possible long-term goals that the	9

Discussion Topics	Learning Objective(s)
nurse could set with the client?	
3. A 65-year-old male client is being treated for left-sided weakness at a health care facility. Due to impaired mobility, he is unable to perform his normal daily activities without assistance; as a result, he has low self-esteem. He is often heard complaining to the nurses assisting him that he feels like a baby because he needs so much help. He states that he feels useless and is embarrassed about being so dependent on others. a. What possible plan of care could the nurse prepare for the client that would help him overcome his situational low self-esteem?	11