... NR442 Community Health Nursing: Clinical

Judgment Practice Questions

Week 4: Nursing Care in Community Settings

Question 1

A school health nurse is implementing Healthy People 2030 initiatives. Which intervention best demonstrates the nurse's role in health promotion at the school level?

1. Providing first aid for injuries during physical education class
2. Developing a comprehensive nutrition and physical activity program for all students
3. Administering medications to students with chronic conditions
4. Screening students annually for vision and hearing problems

Answer: 2

Rationale: While all options represent school nursing functions, developing comprehensive health promotion programs aligns with Healthy People 2030 initiatives and the nurse's leadership role. This addresses priority areas including physical activity and nutrition, demonstrating primary prevention and population-level intervention. Options 1 and 3 are reactive care, and option 4 is secondary prevention only.

Question 2

An occupational health nurse identifies that an employee recently returned from the hospital after a myocardial infarction. What is the nurse's priority action?

1. Plan a welcome-back celebration for the employee
2. Immediately develop an exercise program for the employee
3. Assess the employee's work capacity and develop appropriate transitional duties
4. Advocate for healthier vending machine options

Answer: 3

Rationale: The priority is assessing individual needs and planning appropriate accommodations to facilitate safe return to work. This demonstrates tertiary prevention and care coordination. While options 2 and 4 address prevention, they don't prioritize the immediate needs of this specific employee. Option 1 doesn't address health needs.

Question 3

A home health nurse arrives for an initial visit with an 80-year-old client who has dementia, impaired mobility, and dysphagia. The nurse observes multiple bruises of various colors, soiled dressings on stage II pressure ulcers, and an emaciated appearance. What is the nurse's priority action?

1. Document findings and plan to discuss at the next team meeting
2. Teach the son proper wound care techniques
3. Report suspected elder abuse to adult protective services immediately
4. Arrange for home health aide services to assist with bathing

Answer: 3

Rationale: The assessment findings (multiple bruises of various colors, poor hygiene, malnutrition, untreated pressure ulcers, and missed medications for 2 months) indicate neglect and possible physical abuse. Nurses are mandated reporters and must report immediately to protect the vulnerable adult. While other options may eventually be needed, reporting abuse is the priority to ensure client safety.

Question 4

A forensic nurse is called to the emergency department for a sexual assault victim. What is the nurse's primary responsibility?

1. Discuss the case details with police officers
2. Collect, preserve, and document chain of custody for evidence
3. Serve as a chaperone during the physical examination
4. Provide emotional support to the victim

Answer: 2

Rationale: While emotional support is important, the forensic nurse's primary and unique responsibility is proper evidence collection, preservation, and documentation of chain of custody. This specialized skill ensures evidence integrity for legal proceedings. Option 4 is important but can be provided by any nurse. Options 1 and 3 are not primary forensic nursing responsibilities.

Question 5

During a home health visit, the nurse teaches a caregiver about medication administration and wound care. What is most important for the nurse to assess before leaving?

1. The client's response to the procedures
2. Whether the client believes goals are being achieved
3. If the caregiver retained all information provided
4. The caregiver's skill level and comfort with performing procedures

Answer: 4

Rationale: Assessing the caregiver's competence and comfort level is critical for ensuring safe, effective care continuation and preventing complications. This demonstrates evaluation of teaching effectiveness through return demonstration. While option 1 is important, the caregiver will be performing the care. Options 2 and 3 don't assess actual skill performance.

Question 6

A hospice nurse is caring for a client with terminal brain cancer in the home setting. What should be the primary goal of nursing care?

1. Prevention of complications related to immobility
2. Maintenance of ambulatory function as long as possible
3. Control of pain related to tumor growth
4. Provision of support necessary for a peaceful home death

Answer: 3

Rationale: Pain control is the primary goal in hospice care, focusing on comfort and quality of life in terminal illness. While option 4 mentions support for home death (a hospice goal), pain management is the priority nursing intervention. Options 1 and 2 focus on cure or prolonging life rather than comfort, which contradicts hospice philosophy.

Week 5: Vulnerable Populations

Question 7

A community health nurse is assessing health disparities in a predominantly minority neighborhood. Which factor most significantly contributes to health inequities?

1. Genetic predisposition to certain diseases
2. Personal lifestyle choices
3. Limited access to healthcare services and health insurance
4. Cultural beliefs about traditional medicine

Answer: 3

Rationale: While all factors may play a role, systemic barriers like limited healthcare access, lack of insurance, discrimination, and socioeconomic factors are primary drivers of health disparities among vulnerable populations. This aligns with social determinants of health. Options 1, 2, and 4 don't address structural inequities that create disparities.

Question 8

During a home visit, the nurse notes a Mexican-American client appears passive during health teaching and avoids eye contact. What should the nurse conclude?

1. The client probably doesn't understand English
2. The client is not interested in the teaching
3. Cultural factors may explain the client's behavior
4. The client is uncomfortable with the home visit

Answer: 3

Rationale: Cultural assessment is essential before making assumptions. In some cultures, passivity and avoiding direct eye contact with authority figures demonstrates respect, not disinterest or lack of understanding. The nurse should use cultural competence and assess further rather than making assumptions (options 1, 2, or 4).

Question 9

A nurse conducts a home visit for a child with physical and intellectual disabilities. Which complications should the nurse discuss with the family? (Select all that apply)

1. Constipation
2. Aspiration
3. Dehydration
4. Seizures
5. Obesity

Answer: 1, 2, 3, 4, 5

Rationale: All options are common complications for children with physical and intellectual disabilities. Constipation occurs due to immobility and medications; aspiration from dysphagia; dehydration from inadequate fluid intake or difficulty swallowing; seizures from neurological involvement; and obesity from decreased mobility and difficulty with portion control. Comprehensive teaching addresses all potential complications.

Question 10

A home health nurse observes that a client's 22-year-old pregnant daughter has bruising on her left leg and is guarding her right hand. The daughter states she "tripped and fell." Two months ago, she mentioned her partner's anger. What should the nurse do next?

1. Accept the explanation and document the fall
2. Screen for intimate partner violence using a validated tool
3. Confront the partner about the suspected abuse

4. Wait until more obvious signs of abuse are present

Answer: 2

Rationale: Risk factors are present (pregnancy, young age, new relationship, previous concerning behavior, history of partner's anger), and injuries are inconsistent with explanation. The nurse should screen using a validated intimate partner violence screening tool in private. Option 1 ignores red flags, option 3 could endanger the victim, and option 4 delays necessary intervention.

Question 11

A population health nurse works with rural community members. Which factors are characteristic of this population? (Select all that apply)

1. Higher rates of diabetes mellitus and obesity
2. Lower rates of occupational-related injuries
3. Increased likelihood of seeking preventive care
4. Higher risk for skin cancer
5. Inability to pay for care due to being underinsured or uninsured

Answer: 1, 4, 5

Rationale: Rural populations have higher rates of chronic diseases (diabetes, obesity), skin cancer (agricultural work/sun exposure), and financial barriers to care. They have HIGHER rates of occupational injuries (option 2) and are LESS likely to seek preventive care (option 3) due to distance, transportation issues, and healthcare provider shortages.

Question 12

A nurse identifies health restoration activities for older community members. Which areas are appropriate for this population? (Select all that apply)

1. Minimizing medication use
2. Palliative care
3. End-of-life care

4. Attaining maximum function
5. Providing rehabilitation

Answer: 2, 3, 4, 5

Rationale: Health restoration focuses on tertiary prevention: rehabilitation, maximizing function, palliative care, and end-of-life care. Option 1 (minimizing medications) may be appropriate but isn't specifically a restoration activity and could be harmful if needed medications are discontinued. Options 2-5 directly address restoration and quality of life.

Question 13

A nurse implements approaches to address homelessness in the community. What is the first step?

1. Assess and diagnose community factors leading to homelessness
2. Diagnose and implement community programs addressing homelessness
3. Implement and evaluate community programs addressing homelessness
4. Evaluate community factors leading to homelessness

Answer: 1

Rationale: The nursing process begins with assessment. The nurse must first assess community factors (insufficient income, lack of affordable housing, absence of support services) before diagnosing, planning, implementing, or evaluating interventions. This follows the systematic approach of ADPIE.

Question 14

Families in a shelter fear their children may be subject to abuse from other residents. What solution should the nurse recommend?

1. Restrict who uses the shelter
2. Create a separate family area in the shelter
3. Search everyone entering the shelter

4. Require children to stay with parents at all times

Answer: 2

Rationale: Providing a separate family area addresses safety concerns while maintaining shelter accessibility. This balances protection with the shelter's mission. Option 1 contradicts the purpose of shelters, option 3 may not be feasible and could deter people from seeking help, and option 4 is unrealistic and restrictive.

Question 15

A veteran reports difficulty sleeping, hypervigilance, and recurring nightmares about combat experiences. Which condition should the nurse suspect?

1. Major depressive disorder
2. General anxiety disorder
3. Post-traumatic stress disorder (PTSD)
4. Traumatic brain injury

Answer: 3

Rationale: The classic PTSD triad includes re-experiencing (nightmares/flashbacks), avoidance, and hyperarousal (hypervigilance, sleep disturbance). Veterans are at high risk for PTSD due to combat exposure. While depression (option 1) and anxiety (option 2) may co-occur, the specific symptoms described indicate PTSD. TBI (option 4) presents differently.

Question 16

A nurse provides care to LGBTQ+ adolescents at a community health center. Which health risks should the nurse prioritize? (Select all that apply)

1. Bullying and violence
2. Suicide attempts
3. Risky sexual behaviors
4. Substance use

5. HIV infection

Answer: 1, 2, 3, 4, 5

Rationale: LGBTQ+ youth face disproportionate risks for all listed issues due to discrimination, stigma, social isolation, and minority stress. Research shows higher rates of bullying, suicide, risky behaviors, substance use, and HIV. Comprehensive care must address all these risks through screening, education, and support services.

Question 17

A nurse assesses a homeless youth at a drop-in center. Which health issues are most common in this population? (Select all that apply)

1. Sexually transmitted infections
2. Physical and sexual abuse
3. Skin disorders
4. Anemia
5. Unintentional injuries

Answer: 1, 2, 3, 4, 5

Rationale: Homeless youth experience multiple health issues due to survival sex, exposure to violence, poor hygiene, inadequate nutrition, and dangerous living conditions. All options represent common problems requiring screening and intervention. Many identify as LGBTQ+ after family rejection, compounding vulnerabilities.

Question 18

A migrant farmworker presents with symptoms of pesticide exposure. What is the nurse's priority intervention?

1. Educate about protective equipment use
2. Remove contaminated clothing and decontaminate skin
3. Document the exposure for workers' compensation
4. Refer for long-term neurological evaluation