Advanced Health Assessment and Diagnostic Reasoning 3rd Edition Rhoads TESTBANK/STUDY SOURCE

Chapter 1: Interview and History Taking Strategies

MULTIPLE CHOICE

1. The nurse is conducting an interview with a woman who has recently learned that she is pregnant and who has come to the clinic today to begin prenatal care. The woman states that she and her husband are excited about the pregnancy but have a few questions. She looks nervously at her hands during the interview and sighs loudly. Considering the concept of communication, which statement does the nurse know to be *most* accurate? The woman is:

a. Excited about her pregnancy but nervous about the labor.

b. Exhibiting verbal and nonverbal behaviors that do not match.

c. Excited about her pregnancy, but her husband is not and this is upsetting to her.

d. Not excited about her pregnancy but believes the nurse will negatively respond to her if she states this.

ANS: B

Communication is all behaviors, conscious and unconscious, verbal and nonverbal. All behaviors have meaning. Her behavior does not imply that she is nervous about labor, upset by her husband, or worried about the nurses response.

2. Receiving is a part of the communication process. Which receiver is most likely to misinterpret a message sent by a health care professional?

a. Well-adjusted adolescent who came in for a sports physical

b. Recovering alcoholic who came in for a basic physical examination

c. Man whose wife has just been diagnosed with lung cancer

d. Man with a hearing impairment who uses sign language to communicate and who has an interpreter with him

ANS: C

The receiver attaches meaning determined by his or her experiences, culture, self-concept, and current physical and emotional states. The man whose wife has just been diagnosed with lung cancer may be experiencing emotions that affect his receiving.

3. The nurse makes which adjustment in the physical environment to promote the success of an interview?

a. Reduces noise by turning off televisions and radios

b. Reduces the distance between the interviewer and the patient to 2 feet or less

c. Provides a dim light that makes the room cozy and helps the patient relax

d. Arranges seating across a desk or table to allow the patient some personal space

ANS: A
The nurse should reduce noise by turning off the television, radio, and other unnecessary equipment, because multiple stimuli are confusing. The interviewer and patient should be approximately 4 to 5 feet apart; the room should be well-lit, enabling the interviewer and patient to see each other clearly. Having a table or desk in between the two people creates the idea of a barrier; equal-status seating, at eye level, is better.
4. In an interview, the nurse may find it necessary to take notes to aid his or her memory later. Which statement is *true*regarding note-taking?

a. Note-taking may impede the nurses observation of the patients nonverbal behaviors.

b. Note-taking allows the patient to continue at his or her own pace as the nurse records what is said.

c. Note-taking allows the nurse to shift attention away from the patient, resulting in an increased comfort level.

d. Note-taking allows the nurse to break eye contact with the patient, which may increase his or her level of comfort.

ANS: A
The use of history forms and note-taking may be unavoidable. However, the nurse must be aware that note-taking during the interview has disadvantages. It breaks eye contact too often and shifts the attention away from the patient, which diminishes his or her sense of importance. Note-taking may also interrupt the patients narrative flow, and it impedes the observation of the patients nonverbal behavior.
5. The nurse asks, I would like to ask you some questions about your health and your usual daily activities so that we can better plan your stay here. This question is found at the _____ phase of the interview process.

a. Summary

b. Closing

c. Body

d. Opening or introduction

ANS: D
When gathering a complete history, the nurse should give the reason for the interview during the opening or introduction phase of the interview, not during or at the end of the interview.
6. A woman has just entered the emergency department after being battered by her husband. The nurse needs to get some information from her to begin treatment. What is the best choice for an opening phase of the interview with this patient?

a. Hello, Nancy, my name is Mrs. C.

b. Hello, Mrs. H., my name is Mrs. C. It sure is cold today!

c. Mrs. H., my name is Mrs. C. How are you?

d. Mrs. H., my name is Mrs. C. Ill need to ask you a few questions about what happened.

ANS: D
Address the person by using his or her surname. The nurse should introduce him or herself and give the reason for the interview. Friendly small talk is not needed to build rapport.

7. During an interview, the nurse states, You mentioned having shortness of breath. Tell me more about that. Which verbal skill is used with this statement?

a. Reflection

b. Facilitation

c. Direct question

d. Open-ended question

ANS: D

The open-ended question asks for narrative information. It states the topic to be discussed but only in general terms. The nurse should use it to begin the interview, to introduce a new section of questions, and whenever the person introduces a new topic.

8. A patient has finished giving the nurse information about the reason he is seeking care. When reviewing the data, the nurse finds that some information about past hospitalizations is missing. At this point, which statement by the nurse would be most appropriate to gather these data?

a. Mr. Y., at your age, surely you have been hospitalized before!

b. Mr. Y., I just need permission to get your medical records from County Medical.

c. Mr. Y., you mentioned that you have been hospitalized on several occasions. Would you tell me more about that?

d. Mr. Y., I just need to get some additional information about your past hospitalizations. When was the last time you were admitted for chest pain?

ANS: D

The nurse should use direct questions after the persons opening narrative to fill in any details he or she left out. The nurse also should use direct questions when specific facts are needed, such as when asking about past health problems or during the review of systems.

9. In using verbal responses to assist the patients narrative, some responses focus on the patients frame of reference and some focus on the health care providers perspective. An example of a verbal response that focuses on the health care providers perspective would be:

a. Empathy.

b. Reflection.

c. Facilitation.

d. Confrontation.

ANS: D

When the health care provider uses the response of confrontation, the frame of reference shifts from the patients perspective to the perspective of the health care provider, and the health care provider starts to express his or her own thoughts and feelings. Empathy, reflection, and facilitation responses focus on the patients frame of reference.

10. When taking a history from a newly admitted patient, the nurse notices that he often pauses and expectantly looks at the nurse. What would be the nurses best response to this behavior?

a. Be silent, and allow him to continue when he is ready.

b. Smile at him and say, Dont worry about all of this. Im sure we can find out why youre having these pains.

c. Lean back in the chair and ask, You are looking at me kind of funny; there isnt anything wrong, is there

d. Stand up and say, I can see that this interview is uncomfortable for you. We can continue it another time.

ANS: A

Silent attentiveness communicates that the person has time to think and to organize what he or she wishes to say without an interruption from the nurse. Health professionals most often interrupt this *thinking silence*. The other responses are not conducive to ideal communication.

11. A woman is discussing the problems she is having with her 2-year-old son. She says, He wont go to sleep at night, and during the day he has several fits. I get so upset when that happens. The nurses best verbal response would be:

a. Go on, Im listening.

b. Fits? Tell me what you mean by this.

c. Yes, it can be upsetting when a child has a fit.

d. Dont be upset when he has a fit; every 2 year old has fits.

ANS: B

The nurse should use clarification when the persons word choice is ambiguous or confusing (e.g., Tell me what you mean by *fits*.). Clarification is also used to summarize the persons words or to simplify the words to make them clearer; the nurse should then ask if he or she is on the right track.

12. A 17-year-old single mother is describing how difficult it is to raise a 3-year-old child by herself. During the course of the interview she states, I cant believe my boyfriend left me to do this by myself! What a terrible thing to do to me! Which of these responses by the nurse uses empathy?

a. You feel alone.

b. You cant believe he left you alone?

c. It must be so hard to face this all alone.

d. I would be angry, too; raising a child alone is no picnic.

ANS: C

An empathetic response recognizes the feeling and puts it into words. It names the feeling, allows its expression, and strengthens rapport. Other empathetic responses are, This must be very hard for you, I understand, or simply placing your hand on the persons arm. Simply reflecting the persons words or agreeing with the person is not an empathetic response.

13. A man has been admitted to the observation unit for observation after being treated for a large cut on his forehead. As the nurse works through the interview, one of the standard questions has to do with alcohol, tobacco, and drug use. When the nurse asks him about tobacco use, he states, I quit smoking after my wife died 7 years ago. However, the nurse notices an open pack of cigarettes in his shirt pocket. Using confrontation, the nurse could say:

a. Mr. K., I know that you are lying.

b. Mr. K., come on, tell me how much you smoke.

c. Mr. K., I didnt realize your wife had died. It must be difficult for you at this time.

	Please tell me more about that.
d.	Mr. K., you have said that you dont smoke, but I see that you have an open pack of cigarettes in your pocket.

ANS: D
In the case of confrontation, a certain action, feeling, or statement has been observed, and the nurse now focuses the patients attention on it. The nurse should give honest feedback about what is seen or felt. Confrontation may focus on a discrepancy, or the nurse may confront the patient when parts of the story are inconsistent. The other statements are not appropriate.

14. The nurse has used interpretation regarding a patients statement or actions. After using this technique, it would be best for the nurse to:

a.	Apologize, because using interpretation can be demeaning for the patient.
b.	Allow time for the patient to confirm or correct the inference.
c.	Continue with the interview as though nothing has happened.
d.	Immediately restate the nurses conclusion on the basis of the patients nonverbal response.

ANS: B
Interpretation is not based on direct observation as is confrontation, but it is based on ones inference or conclusion. The nurse risks making the wrong inference. If this is the case, then the patient will correct it. However, even if the inference is correct, interpretation helps prompt further discussion of the topic.

15. During an interview, a woman says, I have decided that I can no longer allow my children to live with their fathers violence, but I just cant seem to leave him. Using interpretation, the nurses best response would be:

a.	You are going to leave him?
b.	If you are afraid for your children, then why cant you leave?
c.	It sounds as if you might be afraid of how your husband will respond.
d.	It sounds as though you have made your decision. I think it is a good one.

ANS: C
This statement is not based on ones inference or conclusion. It links events, makes associations, or implies cause. Interpretation also ascribes feelings and helps the person understand his or her own feelings in relation to the verbal message. The other statements do not reflect interpretation.

16. A pregnant woman states, I just know labor will be so painful that I wont be able to stand it. I know it sounds awful, but I really dread going into labor. The nurse responds by stating, Oh, dont worry about labor so much. I have been through it, and although it is painful, many good medications are available to decrease the pain. Which statement is*true* regarding this response? The nurses reply was a:

a.	Therapeutic response. By sharing something personal, the nurse gives hope to this woman.
b.	Nontherapeutic response. By providing false reassurance, the nurse actually cut off further discussion o the womans fears.
c.	Therapeutic response. By providing information about the medications available, the nurse is giving information to the woman.
d.	Nontherapeutic response. The nurse is essentially giving the message to the woman

that labor cannot be tolerated without medication.

ANS: B

By providing false assurance or reassurance, this *courage builder* relieves the womans anxiety and gives the nurse the false sense of having provided comfort. However, for the woman, providing false assurance or reassurance actually closes off communication, trivializes her anxiety, and effectively denies any further talk of it.

17. During a visit to the clinic, a patient states, The doctor just told me he thought I ought to stop smoking. He doesnt understand how hard Ive tried. I just dont know the best way to do it. What should I do? The nurses most appropriate response in this case would be:

a. Id quit if I were you. The doctor really knows what he is talking about.

b. Would you like some information about the different ways a person can quit smoking?

c. Stopping your dependence on cigarettes can be very difficult. I understand how you feel.

d. Why are you confused? Didnt the doctor give you the information about the smoking cessation program we offer?

ANS: B

Clarification should be used when the persons word choice is ambiguous or confusing. Clarification is also used to summarize the persons words or to simplify the words to make them clearer; the nurse should then ask if he or she is on the right track. The other responses give unwanted advice or do not offer a helpful response.

18. As the nurse enters a patients room, the nurse finds her crying. The patient states that she has just found out that the lump in her breast is cancer and says, Im so afraid of, um, you know. The nurses most therapeutic response would be to say in a gentle manner:

a. Youre afraid you might lose your breast?

b. No, Im not sure what you are talking about.

c. Ill wait here until you get yourself under control, and then we can talk.

d. I can see that you are very upset. Perhaps we should discuss this later.

ANS: A

Reflection echoes the patients words, repeating part of what the person has just said. Reflection can also help express the feelings behind a persons words.

19. A nurse is taking complete health histories on all of the patients attending a wellness workshop. On the history form, one of the written questions asks, You dont smoke, drink, or take drugs, do you? This question is an example of:

a. Talking too much.

b. Using confrontation.

c. Using biased or leading questions.

d. Using blunt language to deal with distasteful topics.

ANS: C

This question is an example of using leading or biased questions. Asking, You dont smoke, do you? implies that one answer is *better* than another. If the person wants to please someone, then he or she is either forced to answer in a way that corresponds to his or her implied values or is made to feel guilty when admitting the other answer.

20. When observing a patients verbal and nonverbal communication, the nurse notices a discrepancy. Which statement is *true* regarding this situation? The nurse should:

a. Ask someone who knows the patient well to help interpret this discrepancy.

b. Focus on the patients verbal message, and try to ignore the nonverbal behaviors.

c. Try to integrate the verbal and nonverbal messages and then interpret them as an average.

d. Focus on the patients nonverbal behaviors, because these are often more reflective of a patients true feelings.

ANS: D

When nonverbal and verbal messages are congruent, the verbal message is reinforced. When they are incongruent, the nonverbal message tends to be the true one because it is under less conscious control. Thus studying the nonverbal messages of the patients and examiners and understanding their meanings are important. The other statements are not true.

21. During an interview, a parent of a hospitalized child is sitting in an open position. As the interviewer begins to discuss his sons treatment, however, he suddenly crosses his arms against his chest and crosses his legs. This changed posture would suggest that the parent is:

a. Simply changing positions.

b. More comfortable in this position.

c. Tired and needs a break from the interview.

d. Uncomfortable talking about his sons treatment.

ANS: D

The persons position is noted. An open position with the extension of large muscle groups shows relaxation, physical comfort, and a willingness to share information. A closed position with the arms and legs crossed tends to look defensive and anxious. Any change in posture should be noted. If a person in a relaxed position suddenly tenses, then this change in posture suggests possible discomfort with the new topic.

22. A mother brings her 28-month-old daughter into the clinic for a well-child visit. At the beginning of the visit, the nurse focuses attention away from the toddler, but as the interview progresses, the toddler begins to warm up and is smiling shyly at the nurse. The nurse will be most successful in interacting with the toddler if which is done next?

a. Tickle the toddler, and get her to laugh.

b. Stoop down to her level, and ask her about the toy she is holding.

c. Continue to ignore her until it is time for the physical examination.

d. Ask the mother to leave during the examination of the toddler, because toddlers often fuss less if their parent is not in view.

ANS: B

Although most of the communication is with the parent, the nurse should not completely ignore the child. Making contact will help ease the toddler later during the physical examination. The nurse should begin by asking about the toys the child is playing with or about a special doll or teddy bear brought from home. Does your doll have a name? or What can your truck do? Stoop down to meet the child at his or her eye level.

23. During an examination of a 3-year-old child, the nurse will need to take her blood pressure. What might the nurse do to try to gain the childs full cooperation?

a. Tell the child that the blood pressure cuff is going to give her arm a big hug.

b. Tell the child that the blood pressure cuff is asleep and cannot wake up.

c. Give the blood pressure cuff a name and refer to it by this name during the assessment.

d. Tell the child that by using the blood pressure cuff, we can see how strong her muscles are.

ANS: D

Take the time to give a short, simple explanation with a concrete explanation for any unfamiliar equipment that will be used on the child. Preschoolers are animistic; they imagine inanimate objects can come alive and have human characteristics. Thus a blood pressure cuff can wake up and bite or pinch.

24. A 16-year-old boy has just been admitted to the unit for overnight observation after being in an automobile accident. What is the nurses best approach to communicating with him?

a. Use periods of silence to communicate respect for him.

b. Be totally honest with him, even if the information is unpleasant.

c. Tell him that everything that is discussed will be kept totally confidential.

d. Use slang language when possible to help him open up.

ANS: B

Successful communication with an adolescent is possible and can be rewarding. The guidelines are simple. The first consideration is ones attitude, which must be one of respect. Second, communication must be totally honest. An adolescents intuition is highly tuned and can detect phoniness or the withholding of information. Always tell him or her the truth.

25. A 75-year-old woman is at the office for a preoperative interview. The nurse is aware that the interview may take longer than interviews with younger persons. What is the reason for this?

a. An aged person has a longer story to tell.

b. An aged person is usually lonely and likes to have someone with whom to talk.

c. Aged persons lose much of their mental abilities and require longer time to complete an interview.

d. As a person ages, he or she is unable to hear; thus the interviewer usually needs to repeat much of what is said.

ANS: A

The interview usually takes longer with older adults because they have a longer story to tell. It is not necessarily true that all older adults are lonely, have lost mental abilities, or are hard of hearing.

26. The nurse is interviewing a male patient who has a hearing impairment. What techniques would be most beneficial in communicating with this patient?

a. Determine the communication method he prefers.

b. Avoid using facial and hand gestures because most hearing-impaired people find this degrading.

c. Request a sign language interpreter before meeting with him to help facilitate the communication.

d. Speak loudly and with exaggerated facial movement when talking with him because doing so will help him lip read.

ANS: A

The nurse should ask the deaf person the preferred way to communicateby signing, lip reading, or writing. If the person prefers lip reading, then the nurse should be sure to face him squarely and have good lighting on the nurses face. The nurse should not exaggerate lip movements because this distorts words. Similarly, shouting distorts the reception of a hearing aid the person may wear. The nurse should speak slowly and supplement his or her voice with appropriate hand gestures or pantomime.

27. During a prenatal check, a patient begins to cry as the nurse asks her about previous pregnancies. She states that she is remembering her last pregnancy, which ended in miscarriage. The nurses best response to her crying would be:

a. Im so sorry for making you cry!

b. I can see that you are sad remembering this. It is all right to cry.

c. Why dont I step out for a few minutes until youre feeling better?

d. I can see that you feel sad about this; why dont we talk about something else?

ANS: B

A beginning examiner usually feels horrified when the patient starts crying. When the nurse says something that makes the person cry, the nurse should not think he or she has hurt the person. The nurse has simply hit on an important topic; therefore, moving on to a new topic is essential. The nurse should allow the person to cry and to express his or her feelings fully. The nurse can offer a tissue and wait until the crying subsides to talk.

28. A female nurse is interviewing a man who has recently immigrated. During the course of the interview, he leans forward and then finally moves his chair close enough that his knees are nearly touching the nurses knees. The nurse begins to feel uncomfortable with his proximity. Which statement most closely reflects what the nurse should do next?

a. The nurse should try to relax; these behaviors are culturally appropriate for this person.

b. The nurse should discreetly move his or her chair back until the distance is more comfortable, and then continue with the interview.

c. These behaviors are indicative of sexual aggression, and the nurse should confront this person about his behaviors.

d. The nurse should laugh but tell him that he or she is uncomfortable with his proximity and ask him to move away.

ANS: A

Both the patients and the nurses sense of spatial distance are significant throughout the interview and physical examination, with culturally appropriate distance zones varying widely. Some cultural groups value close physical proximity and may perceive a health care provider who is distancing him or herself as being aloof and unfriendly.

29. A female American Indian has come to the clinic for follow-up diabetic teaching. During the interview, the nurse notices that she never makes eye contact and speaks mostly to the floor. Which statement is *true* regarding this situation?

a. The woman is nervous and embarrassed.

b. She has something to hide and is ashamed.

c. The woman is showing inconsistent verbal and nonverbal behaviors.

d. She is showing that she is carefully listening to what the nurse is saying.

ANS: D
Eye contact is perhaps among the most culturally variable nonverbal behaviors. Asian, American Indian, Indochinese, Arabian, and Appalachian people may consider direct eye contact impolite or aggressive, and they may avert their eyes during the interview. American Indians often stare at the floor during the interview, which is a culturally appropriate behavior, indicating that the listener is paying close attention to the speaker.

30. The nurse is performing a health interview on a patient who has a language barrier, and no interpreter is available. Which is the best example of an appropriate question for the nurse to ask in this situation?

a. Do you take medicine?

b. Do you sterilize the bottles?

c. Do you have nausea and vomiting?

d. You have been taking your medicine, havent you?

ANS: A
In a situation during which a language barrier exists and no interpreter is available, simple words should be used, avoiding medical jargon. The use of contractions and pronouns should also be avoided. Nouns should be repeatedly used, and one topic at a time should be discussed.

31. A man arrives at the clinic for his annual wellness physical. He is experiencing no acute health problems. Which question or statement by the nurse is most appropriate when beginning the interview?

a. How is your family?

b. How is your job?

c. Tell me about your hypertension.

d. How has your health been since your last visit?

ANS: D
Open-ended questions are used for gathering narrative information. This type of questioning should be used to begin the interview, to introduce a new section of questions, and whenever the person introduces a new topic.

32. The nurse makes this comment to a patient, I know it may be hard, but you should do what the doctor ordered because she is the expert in this field. Which statement is correct about the nurses comment?

a. This comment is inappropriate because it shows the nurses bias.

b. This comment is appropriate because members of the health care team are experts in their area of patient care.

c. This type of comment promotes dependency and inferiority on the part of the patient and is best avoided in an interview situation.

d. Using authority statements when dealing with patients, especially when they are undecided about an issue, is necessary at times.

ANS: C
Using authority responses promotes dependency and inferiority. Avoiding the use of authority is best. Although the health care provider and patient do not have equal professional knowledge, both have equally worthy roles in the health process. The other statements are not correct.

33. A female patient does not speak English well, and the nurse needs to choose an interpreter. Which of the following would be the most appropriate choice?

a. Trained interpreter

b. Male family member

c. Female family member

d. Volunteer college student from the foreign language studies department

ANS: A

Whenever possible, the nurse should use a trained interpreter, preferably one who knows medical terminology. In general, an older, more mature interpreter is preferred to a younger, less experienced one, and the same gender is preferred when possible.

34. During a follow-up visit, the nurse discovers that a patient has not been taking his insulin on a regular basis. The nurse asks, Why havent you taken your insulin? Which statement is an appropriate evaluation of this question?

a. This question may place the patient on the defensive.

b. This question is an innocent search for information.

c. Discussing his behavior with his wife would have been better.

d. A direct question is the best way to discover the reasons for his behavior.

ANS: A

The adults use of why questions usually implies blame and condemnation and places the person on the defensive. The other statements are not correct.

35. The nurse is nearing the end of an interview. Which statement is appropriate at this time?

a. Did we forget something?

b. Is there anything else you would like to mention?

c. I need to go on to the next patient. Ill be back.

d. While Im here, lets talk about your upcoming surgery.

ANS: B

This question offers the person a final opportunity for self-expression. No new topic should be introduced. The other questions are not appropriate.

36. During the interview portion of data collection, the nurse collects _____ data.

a. Physical

b. Historical

c. Objective

d. Subjective

ANS: D

The interview is the first, and really the most important, part of data collection. During the interview, the nurse collects subjective data; that is, what the person says about him or herself.

37. During an interview, the nurse would expect that most of the interview will take place at what distance?

a. Intimate zone

b. Personal distance

c. Social distance

d. Public distance

ANS: C

Social distance, 4 to 12 feet, is usually the distance category for most of the interview. Public distance, over 12 feet, is too much distance; the intimate zone is inappropriate, and the personal distance will be used for the physical assessment.

38. A female nurse is interviewing a male patient who is near the same age as the nurse. During the interview, the patient makes an overtly sexual comment. The nurses best reaction would be:

a. Stop that immediately!

b. Oh, you are too funny. Lets keep going with the interview.

c. Do you really think I would be interested?

d. It makes me uncomfortable when you talk that way. Please stop.

ANS: D

The nurses response must make it clear that she is a health professional who can best care for the person by maintaining a professional relationship. At the same time, the nurse should communicate that he or she accepts the person and understands the persons need to be self-assertive but that sexual advances cannot be tolerated.

MULTIPLE RESPONSE

1. The nurse is conducting an interview. Which of these statements is *true* regarding open-ended questions? *Select all that apply*.

a. Open-ended questions elicit cold facts.

b. They allow for self-expression.

c. Open-ended questions build and enhance rapport.

d. They leave interactions neutral.

e. Open-ended questions call for short one- to two-word answers.

f. They are used when narrative information is needed.

ANS: B, C, F

Open-ended questions allow for self-expression, build and enhance rapport, and obtain narrative information. These features enhance communication during an interview. The other statements are appropriate for closed or direct questions.

2. The nurse is conducting an interview in an outpatient clinic and is using a computer to record data. Which are the*best* uses of the computer in this situation? *Select all that apply*.

a. Collect the patients data in a direct, face-to-face manner.

b. Enter all the data as the patient states them.

c. Ask the patient to wait as the nurse enters the data.

d. Type the data into the computer after the narrative is fully explored.

e. Allow the patient to see the monitor during typing.

ANS: A, D, E
The use of a computer can become a barrier. The nurse should begin the interview as usual by greeting the patient, establishing rapport, and collecting the patients narrative story in a direct, face-to-face manner. Only after the narrative is fully explored should the nurse type data into the computer. When typing, the nurse should position the monitor so that the patient can see it.

Chapter 2 Physical Examination Strategies
MULTIPLE CHOICE
1. When performing a physical assessment, the first technique the nurse will always use is:

a. Palpation.

b. Inspection.

c. Percussion.

d. Auscultation.

ANS: B

The skills requisite for the physical examination are inspection, palpation, percussion, and auscultation. The skills are performed one at a time and in this order (with the exception of the abdominal assessment, during which auscultation takes place before palpation and percussion). The assessment of each body system begins with inspection. A focused inspection takes time and yields a surprising amount of information.

2. The nurse is preparing to perform a physical assessment. Which statement is *true* about the physical assessment? The inspection phase:

a. Usually yields little information.

b. Takes time and reveals a surprising amount of information.

c. May be somewhat uncomfortable for the expert practitioner.

d. Requires a quick glance at the patients body systems before proceeding with palpation.

ANS: B

A focused inspection takes time and yields a surprising amount of information. Initially, the examiner may feel uncomfortable, *staring* at the person without also *doing something*. A focused assessment is significantly more than a quick glance.

3. The nurse is assessing a patients skin during an office visit. What part of the hand and technique should be used to best assess the patients skin temperature?

a. Fingertips; they are more sensitive to small changes in temperature.

b. Dorsal surface of the hand; the skin is thinner on this surface than on the palms.

c. Ulnar portion of the hand; increased blood supply in this area enhances temperature sensitivity.

d. Palmar surface of the hand; this surface is the most sensitive to temperature variations because of its increased nerve supply in this area.

ANS: B

The dorsa (backs) of the hands and fingers are best for determining temperature because the skin is thinner on the dorsal surfaces than on the palms. Fingertips are best for fine, tactile discrimination. The other responses are not useful for palpation.

4. Which of these techniques uses the sense of touch to assess texture, temperature, moisture, and swelling when the nurse is assessing a patient?

a. Palpation

b. Inspection

c. Percussion

d. Auscultation

ANS: A

Palpation uses the sense of touch to assess the patient for these factors. Inspection involves vision; percussion assesses through the use of palpable vibrations and audible sounds; and auscultation uses the sense of hearing.

5. The nurse is preparing to assess a patients abdomen by palpation. How should the nurse proceed?

a. Palpation of reportedly tender areas are avoided because palpation in these areas may cause pain.

b. Palpating a tender area is quickly performed to avoid any discomfort that the patient may experience.

c. The assessment begins with deep palpation, while encouraging the patient to relax and to take deep breaths.

d. The assessment begins with light palpation to detect surface characteristics and to accustom the patient to being touched.

ANS: D

Light palpation is initially performed to detect any surface characteristics and to accustom the person to being touched. Tender areas should be palpated last, not first.

6. The nurse would use bimanual palpation technique in which situation?

a. Palpating the thorax of an infant

b. Palpating the kidneys and uterus

c. Assessing pulsations and vibrations

d. Assessing the presence of tenderness and pain

ANS: B

Bimanual palpation requires the use of both hands to envelop or capture certain body parts or organs such as the kidneys, uterus, or adnexa. The other situations are not appropriate for bimanual palpation.

7. The nurse is preparing to percuss the abdomen of a patient. The purpose of the percussion is to assess the _____ of the underlying tissue.

a. Turgor

b. Texture

c. Density

d. Consistency

ANS: C

Percussion yields a sound that depicts the location, size, and density of the underlying organ. Turgor and texture are assessed with palpation.

8. The nurse is reviewing percussion techniques with a newly graduated nurse. Which technique, if used by the new nurse, indicates that more review is needed?

a. Percussing once over each area

b. Quickly lifting the striking finger after each stroke

c. Striking with the fingertip, not the finger pad

d. Using the wrist to make the strikes, not the arm

ANS: A

For percussion, the nurse should percuss two times over each location. The striking finger should be quickly lifted because a resting finger damps off vibrations. The tip of the striking finger should make contact, not the pad of the finger. The wrist must be relaxed and is used to make the strikes, not the arm.

9. When percussing over the liver of a patient, the nurse notices a dull sound. The nurse should:

a. Consider this a normal finding.

b. Palpate this area for an underlying mass.

c. Reposition the hands, and attempt to percuss in this area again.

d. Consider this finding as abnormal, and refer the patient for additional treatment.

ANS: A

Percussion over relatively dense organs, such as the liver or spleen, will produce a dull sound. The other responses are not correct.

10. The nurse is unable to identify any changes in sound when percussing over the abdomen of an obese patient. What should the nurse do next?

a. Ask the patient to take deep breaths to relax the abdominal musculature.

b. Consider this finding as normal, and proceed with the abdominal assessment.

c. Increase the amount of strength used when attempting to percuss over the abdomen.

d. Decrease the amount of strength used when attempting to percuss over the abdomen.

ANS: C

The thickness of the persons body wall will be a factor. The nurse needs a stronger percussion stroke for persons with obese or very muscular body walls. The force of the blow determines the loudness of the note. The other actions are not correct.

11. The nurse hears bilateral loud, long, and low tones when percussing over the lungs of a 4-year-old child. The nurse should:

a. Palpate over the area for increased pain and tenderness.

b. Ask the child to take shallow breaths, and percuss over the area again.

c. Immediately refer the child because of an increased amount of air in the lungs.

d. Consider this finding as normal for a child this age, and proceed with the examination.

ANS: D

Percussion notes that are loud in amplitude, low in pitch, of a booming quality, and long in duration are normal over a childs lung.

12. A patient has suddenly developed shortness of breath and appears to be in significant respiratory distress. After calling the physician and placing the patient on oxygen, which of these actions is the best for the nurse to take when further assessing the patient?

a. Count the patients respirations.

b. Bilaterally percuss the thorax, noting any differences in percussion tones.

c. Call for a chest x-ray study, and wait for the results before beginning an assessment.

d. Inspect the thorax for any new masses and bleeding associated with respirations.

ANS: B

Percussion is always available, portable, and offers instant feedback regarding changes in underlying tissue density, which may yield clues of the patients physical status.

13. The nurse is teaching a class on basic assessment skills. Which of these statements is *true* regarding the stethoscope and its use?

a. Slope of the earpieces should point posteriorly (toward the occiput).

b. Although the stethoscope does not magnify sound, it does block out extraneous room noise.

c. Fit and quality of the stethoscope are not as important as its ability to magnify sound.

d. Ideal tubing length should be 22 inches to dampen the distortion of sound.

ANS: B

The stethoscope does not magnify sound, but it does block out extraneous room sounds. The slope of the earpieces should point forward toward the examiners nose. Long tubing will distort sound. The fit and quality of the stethoscope are both important.

14. The nurse is preparing to use a stethoscope for auscultation. Which statement is *true* regarding the diaphragm of the stethoscope? The diaphragm:

a. Is used to listen for high-pitched sounds.

b. Is used to listen for low-pitched sounds.

c. Should be lightly held against the persons skin to block out low-pitched sounds.

d. Should be lightly held against the persons skin to listen for extra heart sounds and murmurs.

ANS: A

The diaphragm of the stethoscope is best for listening to high-pitched sounds such as breath, bowel, and normal heart sounds. It should be firmly held against the persons skin, firmly enough to leave a ring. The bell of the stethoscope is best for soft, low-pitched sounds such as extra heart sounds or murmurs.

15. Before auscultating the abdomen for the presence of bowel sounds on a patient, the nurse should:

a. Warm the endpiece of the stethoscope by placing it in warm water.

b. Leave the gown on the patient to ensure that he or she does not get chilled during the examination.

c. Ensure that the bell side of the stethoscope is turned to the on position.

d. Check the temperature of the room, and offer blankets to the patient if he or she feels cold.

ANS: D

The examination room should be warm. If the patient shivers, then the involuntary muscle contractions can make it difficult to hear the underlying sounds. The end of the stethoscope should be warmed between the examiners hands, not with water. The nurse should never listen through a gown. The diaphragm of the stethoscope should be used to auscultate for bowel sounds.

16. The nurse will use which technique of assessment to determine the presence of crepitus, swelling, and pulsations?

a. Palpation

b. Inspection

c. Percussion

d. Auscultation

ANS: A

Palpation applies the sense of touch to assess texture, temperature, moisture, organ location and size, as well as any swelling, vibration or pulsation, rigidity or spasticity, crepitation, presence of lumps or masses, and the presence of tenderness or pain.

17. The nurse is preparing to use an otoscope for an examination. Which statement is *true* regarding the otoscope? The otoscope:

a. Is often used to direct light onto the sinuses.

b. Uses a short, broad speculum to help visualize the ear.

c. Is used to examine the structures of the internal ear.

d. Directs light into the ear canal and onto the tympanic membrane.

ANS: D

The otoscope directs light into the ear canal and onto the tympanic membrane that divides the external and middle ear. A short, broad speculum is used to visualize the nares.

18. An examiner is using an ophthalmoscope to examine a patients eyes. The patient has astigmatism and is nearsighted. The use of which of these techniques would indicate that the examination is being correctly performed?

a. Using the large full circle of light when assessing pupils that are not dilated

b. Rotating the lens selector dial to the black numbers to compensate for astigmatism

c. Using the grid on the lens aperture dial to visualize the external structures of the eye

d. Rotating the lens selector dial to bring the object into focus

ANS: D

The ophthalmoscope is used to examine the internal eye structures. It can compensate for nearsightedness or farsightedness, but it will not correct for astigmatism. The grid is used to assess size and location of lesions on the fundus. The large full spot of light is used to assess dilated pupils. Rotating the lens selector dial brings the object into focus.

19. The nurse is unable to palpate the right radial pulse on a patient. The best action would be to:

a. Auscultate over the area with a fetoscope.

b. Use a goniometer to measure the pulsations.

c. Use a Doppler device to check for pulsations over the area.

d. Check for the presence of pulsations with a stethoscope.

ANS: C

Doppler devices are used to augment pulse or blood pressure measurements. Goniometers measure joint range of motion. A fetoscope is used to auscultate fetal heart tones. Stethoscopes are used to auscultate breath, bowel, and heart sounds.

20. The nurse is preparing to perform a physical assessment. The correct action by the nurse is reflected by which statement? The nurse:

a. Performs the examination from the left side of the bed.

b. Examines tender or painful areas first to help relieve the patients anxiety.

c. Follows the same examination sequence, regardless of the patients age or condition.

d. Organizes the assessment to ensure that the patient does not change positions too often.

ANS: D

The steps of the assessment should be organized to ensure that the patient does not change positions too often. The sequence of the steps of the assessment may differ, depending on the age of the person and the examiners preference. Tender or painful areas should be assessed last.

21. A man is at the clinic for a physical examination. He states that he is very anxious about the physical examination. What steps can the nurse take to make him more comfortable?

a. Appear unhurried and confident when examining him.

b. Stay in the room when he undresses in case he needs assistance.

c. Ask him to change into an examining gown and to take off his undergarments.

d. Defer measuring vital signs until the end of the examination, which allows him time to become comfortable.

ANS: A

Anxiety can be reduced by an examiner who is confident, self-assured, considerate, and unhurried. Familiar and relatively nonthreatening actions, such as measuring the persons vital signs, will gradually accustom the person to the examination.

22. When performing a physical examination, safety must be considered to protect the examiner and the patient against the spread of infection. Which of these statements describes the most appropriate action the nurse should take when performing a physical examination?

a. Washing ones hands after removing gloves is not necessary, as long as the gloves are still intact.

b. Hands are washed before and after every physical patient encounter.

c. Hands are washed before the examination of each body system to prevent the spread of bacteria from o part of the body to another.

d. Gloves are worn throughout the entire examination to demonstrate to the patient concern regarding the spread of infectious diseases.

ANS: B

The nurse should wash his or her hands before and after every physical patient encounter; after contact with blood, body fluids, secretions, and excretions; after contact with any equipment contaminated with body fluids; and after removing gloves. Hands should be washed after gloves have been removed, even if the gloves appear to be intact. Gloves should be worn when potential contact with any body fluids is present.

23. The nurse is examining a patients lower leg and notices a draining ulceration. Which of these actions is most appropriate in this situation?

a. Washing hands, and contacting the physician

b. Continuing to examine the ulceration, and then washing hands

c. Washing hands, putting on gloves, and continuing with the examination of the ulceration

d. Washing hands, proceeding with rest of the physical examination, and then continuing with the examination of the leg ulceration

ANS: C

The examiner should wear gloves when the potential contact with any body fluids is present. In this situation, the nurse should wash his or her hands, put on gloves, and continue examining the ulceration.

24. During the examination, offering some brief teaching about the patients body or the examiners findings is often appropriate. Which one of these statements by the nurse is most appropriate?

a. Your atrial dysrhythmias are under control.

b. You have pitting edema and mild varicosities.

c. Your pulse is 80 beats per minute, which is within the normal range.

d. Im using my stethoscope to listen for any crackles, wheezes, or rubs.

ANS: C

The sharing of some information builds rapport, as long as the patient is able to understand the terminology.

25. The nurse keeps in mind that the most important reason to share information and to offer brief teaching while performing the physical examination is to help the:

a. Examiner feel more comfortable and to gain control of the situation.

b. Examiner to build rapport and to increase the patients confidence in him or her.

c. Patient understand his or her disease process and treatment modalities.

d. Patient identify questions about his or her disease and the potential areas of patient education.

ANS: B

Sharing information builds rapport and increases the patients confidence in the examiner. It also gives the patient a little more control in a situation during which feeling completely helpless is often present.

26. The nurse is examining an infant and prepares to elicit the Moro reflex at which time during the examination?

a. When the infant is sleeping

b. At the end of the examination

c. Before auscultation of the thorax

d. Halfway through the examination

ANS: B

The Moro or startle reflex is elicited at the end of the examination because it may cause the infant to cry.

27. When preparing to perform a physical examination on an infant, the nurse should:

a. Have the parent remove all clothing except the diaper on a boy.

b. Instruct the parent to feed the infant immediately before the examination.

c. Encourage the infant to suck on a pacifier during the abdominal examination.

d. Ask the parent to leave the room briefly when assessing the infants vital signs.

ANS: A

The parent should always be present to increase the childs feeling of security and to understand normal growth and development. The timing of the examination should be 1 to 2 hours after feeding when the baby is neither too drowsy nor too hungry. Infants do not object to being nude; clothing should be removed, but a diaper should be left on a boy.

28. A 6-month-old infant has been brought to the well-child clinic for a check-up. She is currently sleeping. What should the nurse do first when beginning the examination?

a. Auscultate the lungs and heart while the infant is still sleeping.

b. Examine the infants hips, because this procedure is uncomfortable.

c. Begin with the assessment of the eye, and continue with the remainder of the examination in a head-to-toe approach.

d. Wake the infant before beginning any portion of the examination to obtain the most accurate assessment of body systems.

ANS: A

When the infant is quiet or sleeping is an ideal time to assess the cardiac, respiratory, and abdominal systems. Assessment of the eye, ear, nose, and throat are invasive procedures that should be performed at the end of the examination.

29. A 2-year-old child has been brought to the clinic for a well-child checkup. The best way for the nurse to begin the assessment is to:

a. Ask the parent to place the child on the examining table.

b. Have the parent remove all of the childs clothing before the examination.

c. Allow the child to keep a security object such as a toy or blanket during the examination.

d. Initially focus the interactions on the child, essentially ignoring the parent until the childs trust has been obtained.

ANS: C

The best place to examine the toddler is on the parents lap. Toddlers understand symbols; therefore, a security object is helpful. Initially, the focus is more on the parent, which allows the child to adjust gradually and to become familiar with you. A 2-year-old child does not like to take off his or her clothes. Therefore, ask the parent to undress one body part at a time.

30. The nurse is examining a 2-year-old child and asks, May I listen to your heart now? Which critique of the nurses technique is *most* accurate?

a. Asking questions enhances the childs autonomy

b. Asking the child for permission helps develop a sense of trust

c. This question is an appropriate statement because children at this age like to have choices

d. Children at this age like to say, No. The examiner should not offer a choice when no choice is available

ANS: D

Children at this age like to say, No. Choices should not be offered when no choice is really available. If the child says, No and the nurse does it anyway, then the nurse loses trust. Autonomy is enhanced by offering a limited option, Shall I listen to your heart next or your tummy?

31. With which of these patients would it be most appropriate for the nurse to use games during the assessment, such as having the patient blow out the light on the penlight?

a. Infant

b. Preschool child

c. School-age child

d. Adolescent

ANS: B

When assessing preschool children, using games or allowing them to play with the equipment to reduce their fears can be helpful. Such games are not appropriate for the other age groups.

32. The nurse is preparing to examine a 4-year-old child. Which action is appropriate for this age group?

a. Explain the procedures in detail to alleviate the childs anxiety.

b. Give the child feedback and reassurance during the examination.

c. Do not ask the child to remove his or her clothes because children at this age are usually very private.

d. Perform an examination of the ear, nose, and throat first, and then examine the thorax and abdomen.

ANS: B

With preschool children, short, simple explanations should be used. Children at this age are usually willing to undress. An examination of the head should be performed last. During the examination, needed feedback and reassurance should be given to the preschooler.

33. When examining a 16-year-old male teenager, the nurse should:

a. Discuss health teaching with the parent because the teen is unlikely to be interested in promoting welln

b. Ask his parent to stay in the room during the history and physical examination to answer any questions and to alleviate his anxiety.

c. Talk to him the same manner as one would talk to a younger child because a teens level of understanding may not match his or her speech.

d. Provide feedback that his body is developing normally, and discuss the wide variation among teenagers on the rate of growth and development.

ANS: D

During the examination, the adolescent needs feedback that his or her body is healthy and developing normally. The adolescent has a keen awareness of body image and often compares him or herself with peers. Apprise the adolescent of the wide variation among teenagers on the rate of growth and development.

34. When examining an older adult, the nurse should use which technique?

a. Avoid touching the patient too much.

b. Attempt to perform the entire physical examination during one visit.

c. Speak loudly and slowly because most aging adults have hearing deficits.

d. Arrange the sequence of the examination to allow as few position changes as possible.

ANS: D
When examining the older adult, arranging the sequence of the examination to allow as few position changes as possible is best. Physical touch is especially important with the older person because other senses may be diminished.

35. The most important step that the nurse can take to prevent the transmission of microorganisms in the hospital setting is to:

a. Wear protective eye wear at all times.
b. Wear gloves during any and all contact with patients.
c. Wash hands before and after contact with each patient.
d. Clean the stethoscope with an alcohol swab between patients.

ANS: C
The most important step to decrease the risk of microorganism transmission is to wash hands promptly and thoroughly before and after physical contact with each patient. Stethoscopes should also be cleansed with an alcohol swab before and after each patient contact. The best routine is to combine stethoscope rubbing with hand hygiene each time hand hygiene is performed.

36. Which of these statements is *true* regarding the use of Standard Precautions in the health care setting?

a. Standard Precautions apply to all body fluids, including sweat.
b. Use alcohol-based hand rub if hands are visibly dirty.
c. Standard Precautions are intended for use with all patients, regardless of their risk or presumed infection status.
d. Standard Precautions are to be used only when nonintact skin, excretions containing visible blood, or expected contact with mucous membranes is present.

ANS: C
Standard Precautions are designed to reduce the risk of transmission of microorganisms from both recognized and unrecognized sources and are intended for use for all patients, regardless of their risk or presumed infection status. Standard Precautions apply to blood and all other body fluids, secretions and excretions except sweatregardless of whether they contain visible blood, nonintact skin, or mucous membranes. Hands should be washed with soap and water if visibly soiled with blood or body fluids. Alcohol-based hand rubs can be used if hands are not visibly soiled.

37. The nurse is preparing to assess a hospitalized patient who is experiencing significant shortness of breath. How should the nurse proceed with the assessment?

a. The patient should lie down to obtain an accurate cardiac, respiratory, and abdominal assessment.
b. A thorough history and physical assessment information should be obtained from the patients family member.
c. A complete history and physical assessment should be immediately performed to obtain baseline information.
d. Body areas appropriate to the problem should be examined and then the assessment completed after the problem has resolved.

ANS: D

Both altering the position of the patient during the examination and collecting a mini database by examining the body areas appropriate to the problem may be necessary in this situation. An assessment may be completed later after the distress is resolved.

38. When examining an infant, the nurse should examine which area first?

a. Ear

b. Nose

c. Throat

d. Abdomen

ANS: D

The least-distressing steps are performed first, saving the invasive steps of the examination of the eye, ear, nose, and throat until last.

39. While auscultating heart sounds, the nurse hears a murmur. Which of these instruments should be used to assess this murmur?

a. Electrocardiogram

b. Bell of the stethoscope

c. Diaphragm of the stethoscope

d. Palpation with the nurses palm of the hand

ANS: B

The bell of the stethoscope is best for soft, low-pitched sounds such as extra heart sounds or murmurs. The diaphragm of the stethoscope is best used for high-pitched sounds such as breath, bowel, and normal heart sounds.

40. During an examination of a patients abdomen, the nurse notes that the abdomen is rounded and firm to the touch. During percussion, the nurse notes a drumlike quality of the sounds across the quadrants. This type of sound indicates:

a. Constipation.

b. Air-filled areas.

c. Presence of a tumor.

d. Presence of dense organs.

ANS: B

A musical or drumlike sound (tympany) is heard when percussion occurs over an air-filled viscus, such as the stomach or intestines.

41. The nurse is preparing to examine a 6-year-old child. Which action is most appropriate?

a. The thorax, abdomen, and genitalia are examined before the head.

b. Talking about the equipment being used is avoided because doing so may increase the childs anxiety.

c. The nurse should keep in mind that a child at this age will have a sense of modesty.

d. The child is asked to undress from the waist up.

ANS: C

A 6-year-old child has a sense of modesty. The child should undress him or herself, leaving underpants on and using a gown or drape. A school-age child is curious to know how equipment works, and the sequence should progress from the childs head to the toes.

42. During auscultation of a patients heart sounds, the nurse hears an unfamiliar sound. The nurse should:

a. Document the findings in the patients record.

b. Wait 10 minutes, and auscultate the sound again.

c. Ask the patient how he or she is feeling.

d. Ask another nurse to double check the finding.

ANS: D

If an abnormal finding is not familiar, then the nurse may ask another examiner to double check the finding. The other responses do not help identify the unfamiliar sound.

MULTIPLE RESPONSE

1. The nurse is preparing to palpate the thorax and abdomen of a patient. Which of these statements describes the correct technique for this procedure? *Select all that apply*.

a. Warm the hands first before touching the patient.

b. For deep palpation, use one long continuous palpation when assessing the liver.

c. Start with light palpation to detect surface characteristics.

d. Use the fingertips to examine skin texture, swelling, pulsation, and presence of lumps.

e. Identify any tender areas, and palpate them last.

f. Use the palms of the hands to assess temperature of the skin.

ANS: A, C, D, E

The hands should always be warmed before beginning palpation. Intermittent pressure rather than one long continuous palpation is used; any tender areas are identified and palpated last. Fingertips are used to examine skin texture, swelling, pulsation, and the presence of lumps. The dorsa (backs) of the hands are used to assess skin temperature because the skin on the dorsa is thinner than on the palms.

Chapter 3 Documentation Strategies

MULTIPLE CHOICE

1. The nurse is performing a general survey. Which action is a component of the general survey?

a. Observing the patients body stature and nutritional status

b. Interpreting the subjective information the patient has reported

c. Measuring the patients temperature, pulse, respirations, and blood pressure

d. Observing specific body systems while performing the physical assessment

ANS: A

The general survey is a study of the whole person that includes observing the patients physical appearance, body structure, mobility, and behavior.

2. When measuring a patients weight, the nurse is aware of which of these guidelines?

a. The patient is always weighed wearing only his or her undergarments.

b. The type of scale does not matter, as long as the weights are similar from day to day.

c. The patient may leave on his or her jacket and shoes as long as these are documented next to the weigh

d. Attempts should be made to weigh the patient at approximately the same time of day, if a sequence of weights is necessary.

ANS: D

A standardized balance scale is used to measure weight. The patient should remove his or her shoes and heavy outer clothing. If a sequence of repeated weights is necessary, then the nurse should attempt to weigh the patient at approximately the same time of day and with the same types of clothing worn each time.

3. A patients weekly blood pressure readings for 2 months have ranged between 124/84 mm Hg and 136/88 mm Hg, with an average reading of 126/86 mm Hg. The nurse knows that this blood pressure falls within which blood pressure category?

a. Normal blood pressure

b. Prehypertension

c. Stage 1 hypertension

d. Stage 2 hypertension

ANS: B

According to the Seventh Report of the Joint National Committee (JNC 7) guidelines, prehypertension blood pressure readings are systolic readings of 120 to 139 mm Hg or diastolic readings of 50 to 89 mm Hg.

4. During an examination of a child, the nurse considers that physical growth is the best index of a childs:

a. General health.

b. Genetic makeup.

c. Nutritional status.

d. Activity and exercise patterns.

ANS: A

Physical growth is the best index of a childs general health; recording the childs height and weight helps determine normal growth patterns.

5. A 1-month-old infant has a head measurement of 34 cm and has a chest circumference of 32 cm. Based on the interpretation of these findings, the nurse would:

a. Refer the infant to a physician for further evaluation.

b. Consider these findings normal for a 1-month-old infant.

c. Expect the chest circumference to be greater than the head circumference.

d. Ask the parent to return in 2 weeks to re-evaluate the head and chest circumferences.

ANS: B

The newborns head measures approximately 32 to 38 cm and is approximately 2 cm larger than the chest circumference. Between 6 months and 2 years, both measurements are approximately the same, and after age 2 years, the chest circumference is greater than the head circumference.

6. The nurse is assessing an 80-year-old male patient. Which assessment findings would be considered normal?

a. Increase in body weight from his younger years

b. Additional deposits of fat on the thighs and lower legs

c. Presence of kyphosis and flexion in the knees and hips

d. Change in overall body proportion, including a longer trunk and shorter extremities

ANS: C

Changes that occur in the aging person include more prominent bony landmarks, decreased body weight (especially in men), a decrease in subcutaneous fat from the face and periphery, and additional fat deposited on the abdomen and hips. Postural changes of kyphosis and slight flexion in the knees and hips also occur.

7. The nurse should measure rectal temperatures in which of these patients?

a. School-age child

b. Older adult

c. Comatose adult

d. Patient receiving oxygen by nasal cannula

ANS: C

Rectal temperatures should be taken when the other routes are impractical, such as for comatose or confused persons, for those in shock, or for those who cannot close the mouth because of breathing or oxygen tubes, a wired mandible, or other facial dysfunctions.

8. The nurse is preparing to measure the length, weight, chest, and head circumference of a 6-month-old infant. Which measurement technique is correct?

a. Measuring the infants length by using a tape measure

b. Weighing the infant by placing him or her on an electronic standing scale

c. Measuring the chest circumference at the nipple line with a tape measure

d. Measuring the head circumference by wrapping the tape measure over the nose and cheekbones

ANS: C

To measure the chest circumference, the tape is encircled around the chest at the nipple line. The length should be measured on a horizontal measuring board. Weight should be measured on a platform-type balance scale. Head circumference is measured with the tape around the head, aligned at the eyebrows, and at the prominent frontal and occipital bonesthe widest span is correct.

9. The nurse knows that one advantage of the tympanic membrane thermometer (TMT) is that:

a. Rapid measurement is useful for uncooperative younger children.

b. Using the TMT is the most accurate method for measuring body temperature in newborn infants.

c. Measuring temperature using the TMT is inexpensive.

d. Studies strongly support the use of the TMT in children under the age 6 years.

ANS: A

The TMT is useful for young children who may not cooperate for oral temperatures and fear rectal temperatures. However, the use a TMT with newborn infants and young children is conflicting.

10. When assessing an older adult, which vital sign changes occur with aging?

a. Increase in pulse rate

b. Widened pulse pressure

c. Increase in body temperature

d. Decrease in diastolic blood pressure

ANS: B

With aging, the nurse keeps in mind that the systolic blood pressure increases, leading to widened pulse pressure. With many older people, both the systolic and diastolic pressures increase. The pulse rate and temperature do not increase.

11. The nurse is examining a patient who is complaining of feeling cold. Which is a mechanism of heat loss in the body?

a. Exercise

b. Radiation

c. Metabolism

d. Food digestion

ANS: B

The body maintains a steady temperature through a thermostat or feedback mechanism, which is regulated in the hypothalamus of the brain. The hypothalamus regulates heat production from metabolism, exercise, food digestion, and external factors with heat loss through radiation, evaporation of sweat, convection, and conduction.

12. When measuring a patients body temperature, the nurse keeps in mind that body temperature is influenced by:

a. Constipation.

b. Patients emotional state.

c. Diurnal cycle.

d. Nocturnal cycle.

ANS: C
Normal temperature is influenced by the diurnal cycle, exercise, and age. The other responses do not influence body temperature.
13. When evaluating the temperature of older adults, the nurse should remember which aspect about an older adults body temperature?

a. The body temperature of the older adult is lower than that of a younger adult.
b. An older adults body temperature is approximately the same as that of a young child.
c. Body temperature depends on the type of thermometer used.
d. In the older adult, the body temperature varies widely because of less effective heat control mechanism

ANS: A
In older adults, the body temperature is usually lower than in other age groups, with a mean temperature of 36.2 C.
14. A 60-year-old male patient has been treated for pneumonia for the past 6 weeks. He is seen today in the clinic for an unexplained weight loss of 10 pounds over the last 6 weeks. The nurse knows that:

a. Weight loss is probably the result of unhealthy eating habits.
b. Chronic diseases such as hypertension cause weight loss.
c. Unexplained weight loss often accompanies short-term illnesses.
d. Weight loss is probably the result of a mental health dysfunction.

ANS: C
An unexplained weight loss may be a sign of a short-term illness or a chronic illness such as endocrine disease, malignancy, depression, anorexia nervosa, or bulimia.
15. When assessing a 75-year-old patient who has asthma, the nurse notes that he assumes a tripod position, leaning forward with arms braced on the chair. On the basis of this observation, the nurse should:

a. Assume that the patient is eager and interested in participating in the interview.
b. Evaluate the patient for abdominal pain, which may be exacerbated in the sitting position.
c. Assume that the patient is having difficulty breathing and assist him to a supine position.
d. Recognize that a tripod position is often used when a patient is having respiratory difficulties.

ANS: D
Assuming a tripod positionleaning forward with arms braced on chair armsoccurs with chronic pulmonary disease. The other actions or assumptions are not correct.
16. Which of these actions illustrates the correct technique the nurse should use when assessing oral temperature with a mercury thermometer?

a. Wait 30 minutes if the patient has ingested hot or iced liquids.
b. Leave the thermometer in place 3 to 4 minutes if the patient is afebrile.
c. Place the thermometer in front of the tongue, and ask the patient to close his or her lips.
d. Shake the mercury-in-glass thermometer down to below 36.6 C before taking the temperature.

ANS: B

The thermometer should be left in place 3 to 4 minutes if the person is afebrile and up to 8 minutes if the person is febrile. The nurse should wait 15 minutes if the person has just ingested hot or iced liquids and 2 minutes if he or she has just smoked.

17. The nurse is taking temperatures in a clinic with a TMT. Which statement is *true* regarding use of the TMT?

a. A tympanic temperature is more time consuming than a rectal temperature.

b. The tympanic method is more invasive and uncomfortable than the oral method.

c. The risk of cross-contamination is reduced, compared with the rectal route.

d. The tympanic membrane most accurately reflects the temperature in the ophthalmic artery.

ANS: C

The TMT is a noninvasive, nontraumatic device that is extremely quick and efficient. The chance of cross-contamination with the TMT is minimal because the ear canal is lined with skin, not mucous membranes.

18. To assess a rectal temperature accurately in an adult, the nurse would:

a. Use a lubricated blunt tip thermometer.

b. Insert the thermometer 2 to 3 inches into the rectum.

c. Leave the thermometer in place up to 8 minutes if the patient is febrile.

d. Wait 2 to 3 minutes if the patient has recently smoked a cigarette.

ANS: A

A lubricated rectal thermometer (with a short, blunt tip) is inserted only 2 to 3 cm (1 inch) into the adult rectum and left in place for 2 minutes. Cigarette smoking does not alter rectal temperatures.

19. Which technique is correct when the nurse is assessing the radial pulse of a patient? The pulse is counted for:

a. 1 minute, if the rhythm is irregular.

b. 15 seconds and then multiplied by 4, if the rhythm is regular.

c. 2 full minutes to detect any variation in amplitude.

d. 10 seconds and then multiplied by 6, if the patient has no history of cardiac abnormalities.

ANS: A

Recent research suggests that the 30-second interval multiplied by 2 is the most accurate and efficient technique when heart rates are normal or rapid and when rhythms are regular. If the rhythm is irregular, then the pulse is counted for 1 full minute.

20. When assessing a patients pulse, the nurse should also notice which of these characteristics?

a. Force

b. Pallor

c. Capillary refill time

d. Timing in the cardiac cycle

ANS: A

The pulse is assessed for rate, rhythm, and force.