HAP FINAL TEST BANK QUESTIONS: Jarvis 7th Edition

Chapter 01: Evidence-Based Assessment

MULTIPLE CHOICE

1. After completing an initial assessment of a patient, the nurse has charted that his respirations are eupneic and his pulse is 58 beats per minute. These types of data would be:

a. Objective.

b. Reflective.

c. Subjective.

d. Introspective.

ANS: A

Objective data are what the health professional observes by inspecting, percussing, palpating, and auscultating during the physical examination. Subjective data is what the person *says*about him or herself during history taking. The terms *reflective* and *introspective* are not used to describe data.

2. A patient tells the nurse that he is very nervous, is nauseated, and "feels hot." These types of data would be:

a. Objective.

b. Reflective.

c. Subjective.

d. Introspective.

ANS: C

Subjective data are what the person says about him or herself during history taking. Objective data are what the health professional observes by inspecting, percussing, palpating, and auscultating during the physical examination. The terms *reflective* and *introspective* are not used to describe data.

3. The patient's record, laboratory studies, objective data, and subjective data combine to form the:

a. Data base.

b. Admitting data.

c. Financial statement.

d. Discharge summary.

ANS: A

Together with the patient's record and laboratory studies, the objective and subjective data form the data base. The other items are not part of the patient's record, laboratory studies, or data.

4. When listening to a patient's breath sounds, the nurse is unsure of a sound that is heard. The nurse's next action should be to:

a. Immediately notify the patient's physician.

b. Document the sound exactly as it was heard.

c. Validate the data by asking a coworker to listen to the breath sounds.

d. Assess again in 20 minutes to note whether the sound is still present.

ANS: C

When unsure of a sound heard while listening to a patient's breath sounds, the nurse validates the data to ensure accuracy. If the nurse has less experience in an area, then he or she asks an expert to listen.

5. The nurse is conducting a class for new graduate nurses. During the teaching session, the nurse should keep in mind that novice nurses, without a background of skills and experience from which to draw, are more likely to make their decisions using:

a. Intuition.

b. A set of rules.

c. Articles in journals.

d. Advice from supervisors.

ANS: B

Novice nurses operate from a set of defined, structured rules. The expert practitioner uses intuitive links.

6. Expert nurses learn to attend to a pattern of assessment data and act without consciously labeling it. These responses are referred to as:

a. Intuition.

b. The nursing process.

c. Clinical knowledge.

d. Diagnostic reasoning.

ANS: A

Intuition is characterized by pattern recognition—expert nurses learn to attend to a pattern of assessment data and act without consciously labeling it. The other options are not correct.

7. The nurse is reviewing information about evidence-based practice (EBP). Which statement best reflects EBP?

a. EBP relies on tradition for support of best practices.

b. EBP is simply the use of best practice techniques for the treatment of patients.

c. EBP emphasizes the use of best evidence with the clinician's experience.

d. The patient's own preferences are not important with EBP.

ANS: C

EBP is a systematic approach to practice that emphasizes the use of best evidence in combination with the clinician's experience, as well as patient preferences and values, when making decisions about care and treatment. EBP is more than simply using the best practice techniques to treat patients, and questioning tradition is important when no compelling and supportive research evidence exists.

8. The nurse is conducting a class on priority setting for a group of new graduate nurses. Which is an example of a first-level priority problem?

a. Patient with postoperative pain

b. Newly diagnosed patient with diabetes who needs diabetic teaching

c. Individual with a small laceration on the sole of the foot

d. Individual with shortness of breath and respiratory distress

ANS: D

First-level priority problems are those that are emergent, life threatening, and immediate (e.g., establishing an airway, supporting breathing, maintaining circulation, monitoring abnormal vital signs) (see Table 1-1).

9. When considering priority setting of problems, the nurse keeps in mind that second-level priority problems include which of these aspects?

a. Low self-esteem

b. Lack of knowledge

c. Abnormal laboratory values

d. Severely abnormal vital signs

ANS: C

Second-level priority problems are those that require prompt intervention to forestall further deterioration (e.g., mental status change, acute pain, abnormal laboratory values, risks to safety or security) (see Table 1-1).

10. Which critical thinking skill helps the nurse see relationships among the data?

a. Validation

b. Clustering related cues

c. Identifying gaps in data

d. Distinguishing relevant from irrelevant

ANS: B

Clustering related cues helps the nurse see relationships among the data.

11. The nurse knows that developing appropriate nursing interventions for a patient relies on the appropriateness of the _____ diagnosis.

a. Nursing

b. Medical

c. Admission

d. Collaborative

ANS: A

An accurate nursing diagnosis provides the basis for the selection of nursing interventions to achieve outcomes for which the nurse is accountable. The other items do not contribute to the development of appropriate nursing interventions.

12. The nursing process is a sequential method of problem solving that nurses use and includes which steps?

a. Assessment, treatment, planning, evaluation, discharge, and follow-up

b. Admission, assessment, diagnosis, treatment, and discharge planning

c. Admission, diagnosis, treatment, evaluation, and discharge planning

d. Assessment, diagnosis, outcome identification, planning, implementation, and evaluation

ANS: D

The nursing process is a method of problem solving that includes assessment, diagnosis, outcome identification, planning, implementation, and evaluation.

13. A newly admitted patient is in acute pain, has not been sleeping well lately, and is having difficulty breathing. How should the nurse prioritize these problems?

a. Breathing, pain, and sleep

b. Breathing, sleep, and pain

c. Sleep, breathing, and pain

d. Sleep, pain, and breathing

ANS: A

First-level priority problems are immediate priorities, remembering the ABCs (airway, breathing, and circulation), followed by second-level problems, and then third-level problems.

14. Which of these would be formulated by a nurse using diagnostic reasoning?

a. Nursing diagnosis

b. Medical diagnosis

c. Diagnostic hypothesis

d. Diagnostic assessment

ANS: C

Diagnostic reasoning calls for the nurse to formulate a diagnostic hypothesis; the nursing process calls for a nursing diagnosis.

15. Barriers to incorporating EBP include:

a. Nurses' lack of research skills in evaluating the quality of research studies.

b. Lack of significant research studies.

c. Insufficient clinical skills of nurses.

d. Inadequate physical assessment skills.

ANS: A

As individuals, nurses lack research skills in evaluating the quality of research studies, are isolated from other colleagues who are knowledgeable in research, and often lack the time to visit the library to read research. The other responses are not considered barriers.

DIF: Cognitive Level: Understanding (Comprehension) REF: p. 6

MSC: Client Needs: General

16. What step of the nursing process includes data collection by health history, physical examination, and interview?

a. Planning

b. Diagnosis

c. Evaluation

d. Assessment

ANS: D

Data collection, including performing the health history, physical examination, and interview, is the assessment step of the nursing process (see Figure 1-2).

17. During a staff meeting, nurses discuss the problems with accessing research studies to incorporate evidence-based clinical decision making into their practice. Which suggestion by the nurse manager would best help these problems?

a. Form a committee to conduct research studies.

b. Post published research studies on the unit's bulletin boards.

c. Encourage the nurses to visit the library to review studies.

d. Teach the nurses how to conduct electronic searches for research studies.

ANS: D

Facilitating support for EBP would include teaching the nurses how to conduct electronic searches; time to visit the library may not be available for many nurses. Actually conducting research studies may be helpful in the long-run but not an immediate solution to reviewing existing research.

18. When reviewing the concepts of health, the nurse recalls that the components of holistic health include which of these?

a. Disease originates from the external environment.

b. The individual human is a closed system.

c. Nurses are responsible for a patient's health state.

d. Holistic health views the mind, body, and spirit as interdependent.

ANS: D

Consideration of the whole person is the essence of holistic health, which views the mind, body, and spirit as interdependent. The basis of disease originates from both the external environment and from within the person. Both the individual human and the external environment are open systems, continually changing and adapting, and each person is responsible for his or her own personal health state.

19. The nurse recognizes that the concept of prevention in describing health is essential because:

a. Disease can be prevented by treating the external environment.

b. The majority of deaths among Americans under age 65 years are not preventable.

c. Prevention places the emphasis on the link between health and personal behavior.

d. The means to prevention is through treatment provided by primary health care practitioners.

ANS: C

A natural progression to prevention rounds out the present concept of health. Guidelines to prevention place the emphasis on the link between health and personal behavior.

20. The nurse is performing a physical assessment on a newly admitted patient. An example of objective information obtained during the physical assessment includes the:

a. Patient's history of allergies.

b. Patient's use of medications at home.

c. Last menstrual period 1 month ago.

d. 2 ´ 5 cm scar on the right lower forearm.

ANS: D

Objective data are the patient's record, laboratory studies, and condition that the health professional observes by inspecting, percussing, palpating, and auscultating during the physical examination. The other responses reflect subjective data.

21. A visiting nurse is making an initial home visit for a patient who has many chronic medical problems. Which type of data base is most appropriate to collect in this setting?

a. A follow-up data base to evaluate changes at appropriate intervals

b. An episodic data base because of the continuing, complex medical problems of this patient

c. A complete health data base because of the nurse's primary responsibility for monitoring the patient's health

d. An emergency data base because of the need to collect information and make accurate diagnoses rapidly

ANS: C

The complete data base is collected in a primary care setting, such as a pediatric or family practice clinic, independent or group private practice, college health service, women's health care agency, visiting nurse agency, or community health agency. In these settings, the nurse is the first health professional to see the patient and has the primary responsibility for monitoring the person's health care.

22. Which situation is most appropriate during which the nurse performs a focused or problem-centered history?

a. Patient is admitted to a long-term care facility.

b. Patient has a sudden and severe shortness of breath.

c. Patient is admitted to the hospital for surgery the following day.

d. Patient in an outpatient clinic has cold and influenza-like symptoms.

ANS: D

In a focused or problem-centered data base, the nurse collects a “mini” data base, which is smaller in scope than the completed data base. This mini data base primarily concerns one problem, one cue complex, or one body system.

23. A patient is at the clinic to have her blood pressure checked. She has been coming to the clinic weekly since she changed medications 2 months ago. The nurse should:

a. Collect a follow-up data base and then check her blood pressure.

b. Ask her to read her health record and indicate any changes since her last visit.

c. Check only her blood pressure because her complete health history was documented 2 months ago.

d. Obtain a complete health history before checking her blood pressure because much of her history information may have changed.

ANS: A

A follow-up data base is used in all settings to follow up short-term or chronic health problems. The other responses are not appropriate for the situation.

24. A patient is brought by ambulance to the emergency department with multiple traumas received in an automobile accident. He is alert and cooperative, but his injuries are quite severe. How would the nurse proceed with data collection?

a. Collect history information first, then perform the physical examination and institute life-saving measures.

b. Simultaneously ask history questions while performing the examination and initiating life-saving measures.

c. Collect all information on the history form, including social support patterns, strengths, and coping patterns.

d. Perform life-saving measures and delay asking any history questions until the patient is transferred to the intensive care unit.

ANS: B

The emergency data base calls for a rapid collection of the data base, often concurrently compiled with life-saving measures. The other responses are not appropriate for the situation.

25. A 42-year-old patient of Asian descent is being seen at the clinic for an initial examination. The nurse knows that including cultural information in his health assessment is important to:

a. Identify the cause of his illness.

b. Make accurate disease diagnoses.

c. Provide cultural health rights for the individual.

d. Provide culturally sensitive and appropriate care.

ANS: D

The inclusion of cultural considerations in the health assessment is of paramount importance to gathering data that are accurate and meaningful and to intervening with culturally sensitive and appropriate care.

26. In the health promotion model, the focus of the health professional includes:

a. Changing the patient’s perceptions of disease.

b. Identifying biomedical model interventions.

c. Identifying negative health acts of the consumer.

d. Helping the consumer choose a healthier lifestyle.

ANS: D

In the health promotion model, the focus of the health professional is on helping the consumer choose a healthier lifestyle.

27. The nurse has implemented several planned interventions to address the nursing diagnosis of acute pain. Which would be the next appropriate action?

a. Establish priorities.

b. Identify expected outcomes.

c. Evaluate the individual's condition, and compare actual outcomes with expected outcomes.

d. Interpret data, and then identify clusters of cues and make inferences.

ANS: C

Evaluation is the next step after the implementation phase of the nursing process. During this step, the nurse evaluates the individual's condition and compares the actual outcomes with expected outcomes (See Figure 1-2).

28. Which statement *best* describes a proficient nurse? A proficient nurse is one who:

a. Has little experience with a specified population and uses rules to guide performance.

b. Has an intuitive grasp of a clinical situation and quickly identifies the accurate solution.

c. Sees actions in the context of daily plans for patients.

d. Understands a patient situation as a whole rather than a list of tasks and recognizes the long-term goals for the patient.

ANS: D

The proficient nurse, with more time and experience than the novice nurse, is able to understand a patient situation as a whole rather than as a list of tasks. The proficient nurse is able to see how today's nursing actions can apply to the point the nurse wants the patient to reach at a future time.

MULTIPLE RESPONSE

1. The nurse is reviewing data collected after an assessment. Of the data listed below, which would be considered related cues that would be clustered together during data analysis?*Select all that apply*.

a. Inspiratory wheezes noted in left lower lobes

b. Hypoactive bowel sounds

c. Nonproductive cough

d. Edema, +2, noted on left hand

e. Patient reports dyspnea upon exertion

f. Rate of respirations 16 breaths per minute

ANS: A, C, E, F

Clustering related cues help the nurse recognize relationships among the data. The cues related to the patient's respiratory status (e.g., wheezes, cough, report of dyspnea, respiration rate and rhythm) are all related. Cues related to bowels and peripheral edema are not related to the respiratory cues.

MATCHING

Put the following patient situations in order according to the level of priority.

a. A patient newly diagnosed with type 2 diabetes mellitus does not know how to check his own blood glucose levels with a glucometer.

b. A teenager who was stung by a bee during a soccer match is having trouble breathing.

c. An older adult with a urinary tract infection is also showing signs of confusion and agitation.

1. a = First-level priority problem

2. b = Second-level priority problem

3. c = Third-level priority problem

1. ANS: B

NOT: First-level priority problems are immediate priorities, such as trouble breathing (remember the “airway, breathing, circulation” priorities). Second-level priority problems are next in urgency, but not life-threatening. Third-level priorities (e.g., patient education) are important to a patient’s health but can be addressed after more urgent health problems are addressed (see Table 1-1).

2. ANS: C

NOT: First-level priority problems are immediate priorities, such as trouble breathing (remember the “airway, breathing, circulation” priorities). Second-level priority problems are next in urgency, but not life-threatening. Third-level priorities (e.g., patient education) are important to a patient’s health but can be addressed after more urgent health problems are addressed (see Table 1-1).

3. ANS: A

NOT: First-level priority problems are immediate priorities, such as trouble breathing (remember the “airway, breathing, circulation” priorities). Second-level priority problems are next in urgency, but not life-threatening. Third-level priorities (e.g., patient education) are important to a patient’s health but can be addressed after more urgent health problems are addressed (see Table 1-1).

Chapter 02: Cultural Competence

MULTIPLE CHOICE

1. The nurse is reviewing the development of culture. Which statement is *correct* regarding the development of one’s culture? Culture is:

a. Genetically determined on the basis of racial background.

b. Learned through language acquisition and socialization.

c. A nonspecific phenomenon and is adaptive but unnecessary.

d. Biologically determined on the basis of physical characteristics.

ANS: B

Culture is learned from birth through language acquisition and socialization. It is not biologically or genetically determined and is learned by the individual.

2. During a class on the aspects of culture, the nurse shares that culture has four basic characteristics. Which statement correctly reflects one of these characteristics?

a. Cultures are static and unchanging, despite changes around them.

b. Cultures are never specific, which makes them hard to identify.

c. Culture is most clearly reflected in a person’s language and behavior.

d. Culture adapts to specific environmental factors and available natural resources.

ANS: D

Culture has four basic characteristics. Culture adapts to specific conditions related to environmental and technical factors and to the availability of natural resources, and it is dynamic and ever changing. Culture is learned from birth through the process of language acquisition and socialization, but it is not most clearly reflected in one’s language and behavior.

3. During a seminar on cultural aspects of nursing, the nurse recognizes that the definition stating “the specific and distinct knowledge, beliefs, skills, and customs acquired by members of a society” reflects which term?

a. Mores

b. Norms

c. Culture

d. Social learning

ANS: C

The culture that develops in any given society is always specific and distinctive, encompassing all of the knowledge, beliefs, customs, and skills acquired by members of the society. The other terms do not fit the given definition.

4. When discussing the use of the term *subculture*, the nurse recognizes that it is best described as:

a. Fitting as many people into the majority culture as possible.

b. Defining small groups of people who do not want to be identified with the larger culture.

c. Singling out groups of people who suffer differential and unequal treatment as a result of cultural variations.

d. Identifying fairly large groups of people with shared characteristics that are not common to all members of a culture.

ANS: D

Within cultures, groups of people share different beliefs, values, and attitudes. Differences occur because of ethnicity, religion, education, occupation, age, and gender. When such groups function within a large culture, they are referred to as *subcultural groups*.

5. When reviewing the demographics of ethnic groups in the United States, the nurse recalls that the largest and fastest growing population is:

a. Hispanic.

b. Black.

c. Asian.

d. American Indian.

ANS: A

Hispanics are the largest and fastest growing population in the United States, followed by Asians, Blacks, American Indians and Alaska natives, and other groups.

6. During an assessment, the nurse notices that a patient is handling a small charm that is tied to a leather strip around his neck. Which action by the nurse is appropriate?

a. Ask the patient about the item and its significance.

b. Ask the patient to lock the item with other valuables in the hospital's safe.

c. Tell the patient that a family member should take valuables home.

d. No action is necessary.

ANS: A

The nurse should inquire about the amulet's meaning. Amulets, such as charms, are often considered an important means of protection from "evil spirits" by some cultures.

7. The nurse manager is explaining culturally competent care during a staff meeting. Which statement accurately describes the concept of culturally competent care? "The caregiver:

a. Is able to speak the patient's native language."

b. Possesses some basic knowledge of the patient's cultural background."

c. Applies the proper background knowledge of a patient's cultural background to provide the best possible health care."

d. Understands and attends to the total context of the patient's situation."

ANS: D

Culturally competent implies that the caregiver understands and attends to the total context of the individual's situation. This competency includes awareness of immigration status, stress factors, other social factors, and cultural similarities and differences. It does not require the caregiver to speak the patient's native language.

8. The nurse recognizes that an example of a person who is *heritage consistent* would be a:

a. Woman who has adapted her clothing to the clothing style of her new country.

b. Woman who follows the traditions that her mother followed regarding meals.

c. Man who is not sure of his ancestor's country of origin.

d. Child who is not able to speak his parents' native language.

ANS: B

Someone who is heritage consistent lives a lifestyle that reflects his or her traditional heritage, not the norms and customs of the new country.

9. After a class on culture and ethnicity, the new graduate nurse reflects a correct understanding of the concept of ethnicity with which statement?

a. "Ethnicity is dynamic and ever changing."

b. "Ethnicity is the belief in a higher power."

c. "Ethnicity pertains to a social group within the social system that claims shared values and traditions."

d. "Ethnicity is learned from birth through the processes of language acquisition and socialization."

ANS: C

Ethnicity pertains to a social group within the social system that claims to have variable traits, such as a common geographic origin, migratory status, religion, race, language, values, traditions, symbols, or food preferences.*Culture* is dynamic, ever changing, and learned from birth through the processes of language acquisition and socialization. Religion is the belief in a higher power.

10. The nurse is comparing the concepts of religion and spirituality. Which of the following is an appropriate component of one's spirituality?

a. Belief in and the worship of God or gods

b. Attendance at a specific church or place of worship

c. Personal effort made to find purpose and meaning in life

d. Being closely tied to one's ethnic background

ANS: C

Spirituality refers to each person's unique life experiences and his or her personal effort to find purpose and meaning in life. The other responses apply to religion.

11. A woman who has lived in the United States for a year after moving from Europe has learned to speak English and is almost finished with her college studies. She now dresses like her peers and says that her family in Europe would hardly recognize her. This nurse recognizes that this situation illustrates which concept?

a. Assimilation

b. Heritage consistency

c. Biculturalism

d. Acculturation

ANS: A

Assimilation is the process by which a person develops a new cultural identity and becomes like members of the dominant culture. This concept does not reflect heritage consistency. Biculturalism is a dual pattern of identification; acculturation is the process of adapting to and acquiring another culture.

12. The nurse is conducting a heritage assessment. Which question is most appropriate for this assessment?

a. “What is your religion?”

b. “Do you mostly participate in the religious traditions of your family?”

c. “Do you smoke?”

d. “Do you have a history of heart disease?”

ANS: B

Asking questions about participation in the religious traditions of family enables the nurse to assess a person’s heritage. Simply asking about one’s religion, smoking history, or health history does not reflect heritage.

13. In the majority culture of America, coughing, sweating, and diarrhea are symptoms of an illness. For some individuals of Mexican-American origin, however, these symptoms are a normal part of living. The nurse recognizes that this difference is true, probably because Mexican-Americans:

a. Have less efficient immune systems and are often ill.

b. Consider these symptoms part of normal living, not symptoms of ill health.

c. Come from Mexico, and coughing is normal and healthy there.

d. Are usually in a lower socioeconomic group and are more likely to be sick.

ANS: B

The nurse needs to identify the meaning of health to the patient, remembering that concepts are derived, in part, from the way in which members of the cultural group define health.

14. The nurse is reviewing theories of illness. The germ theory, which states that microscopic organisms such as bacteria and viruses are responsible for specific disease conditions, is a basic belief of which theory of illness?

a. Holistic

b. Biomedical

c. Naturalistic

d. Magicoreligious

ANS: B

Among the biomedical explanations for disease is the germ theory, which states that microscopic organisms such as bacteria and viruses are responsible for specific disease conditions. The naturalistic, or holistic, perspective holds that the forces of nature must be kept in natural balance. The magicoreligious perspective holds that supernatural forces dominate and cause illness or health.

15. An Asian-American woman is experiencing diarrhea, which is believed to be “cold” or “yin.” The nurse expects that the woman is likely to try to treat it with:

a. Foods that are “hot” or “yang.”

b. Readings and Eastern medicine meditations.

c. High doses of medicines believed to be “cold.”

d. No treatment is tried because diarrhea is an expected part of life.

ANS: A

Yin foods are cold and yang foods are hot. Cold foods are eaten with a hot illness, and hot foods are eaten with a cold illness. The other explanations do not reflect the yin/yang theory.

16. Many Asians believe in the yin/yang theory, which is rooted in the ancient Chinese philosophy of Tao. Which statement most accurately reflects "health" in an Asian with this belief?

a. A person is able to work and produce.

b. A person is happy, stable, and feels good.

c. All aspects of the person are in perfect balance.

d. A person is able to care for others and function socially.

ANS: C

Many Asians believe in the yin/yang theory, in which health is believed to exist when all aspects of the person are in perfect balance. The other statements do not describe this theory.

17. Illness is considered part of life's rhythmic course and is an outward sign of disharmony within. This statement most accurately reflects the views about illness from which theory?

a. Naturalistic

b. Biomedical

c. Reductionist

d. Magicoreligious

ANS: A

The naturalistic perspective states that the laws of nature create imbalances, chaos, and disease. From the perspective of the Chinese, for example, illness is not considered an introducing agent; rather, illness is considered a part of life's rhythmic course and an outward sign of disharmony within. The other options are not correct.

18. An individual who takes the magicoreligious perspective of illness and disease is likely to believe that his or her illness was caused by:

a. Germs and viruses.

b. Supernatural forces.

c. Eating imbalanced foods.

d. An imbalance within his or her spiritual nature.

ANS: B

The basic premise of the magicoreligious perspective is that the world is seen as an arena in which supernatural forces dominate. The fate of the world and those in it depends on the actions of supernatural forces for good or evil. The other answers do not reflect the magicoreligious perspective.

19. If an American Indian woman has come to the clinic to seek help with regulating her diabetes, then the nurse can expect that she:

a. Will comply with the treatment prescribed.

b. Has obviously given up her belief in naturalistic causes of disease.

c. May also be seeking the assistance of a shaman or medicine man.

d. Will need extra help in dealing with her illness and may be experiencing a crisis of faith.

ANS: C

When self-treatment is unsuccessful, the individual may turn to the lay or folk healing systems, to spiritual or religious healing, or to scientific biomedicine. In addition to seeking help from a biomedical or scientific health care provider, patients may also seek help from folk or religious healers.

20. An older Mexican-American woman with traditional beliefs has been admitted to an inpatient care unit. A culturally sensitive nurse would:

a. Contact the hospital administrator about the best course of action.

b. Automatically get a curandero for her, because requesting one herself is not culturally appropriate.

c. Further assess the patient's cultural beliefs and offer the patient assistance in contacting a curandero or priest if she desires.

d. Ask the family what they would like to do because Mexican-Americans traditionally give control of decision making to their families.

ANS: C

In addition to seeking help from the biomedical or scientific health care provider, patients may also seek help from folk or religious healers. Some people, such as those of Mexican-American or American-Indian origins, may believe that the cure is incomplete unless the body, mind, and spirit are also healed (although the division of the person into parts is a Western concept).

21. A 63-year-old Chinese-American man enters the hospital with complaints of chest pain, shortness of breath, and palpitations. Which statement most accurately reflects the nurse's best course of action?

a. The nurse should focus on performing a full cardiac assessment.

b. The nurse should focus on psychosomatic complaints because the patient has just learned that his wife has cancer.

c. This patient is not in any danger at present; therefore, the nurse should send him home with instructions to contact his physician.

d. It is unclear what is happening with this patient; consequently, the nurse should perform an assessment in both the physical and the psychosocial realms.

ANS: D

Wide cultural variations exist in the manner in which certain symptoms and disease conditions are perceived, diagnosed, labeled, and treated. Chinese-Americans sometimes convert mental experiences or states into bodily symptoms (e.g., complaining of cardiac symptoms because the center of emotion in the Chinese culture is the heart).

22. Symptoms, such as pain, are often influenced by a person's cultural heritage. Which of the following is a *true* statement regarding pain?

a. Nurses' attitudes toward their patients' pain are unrelated to their own experiences with pain.

b. Nurses need to recognize that many cultures practice silent suffering as a response to pain.

c. A nurse's area of clinical practice will most likely determine his or her assessment of a patient's pain.

d. A nurse's years of clinical experience and current position are strong indicators of his or her response to patient pain.

ANS: B

Silent suffering is a potential response to pain in many cultures. The nurse's assessment of pain needs to be embedded in a cultural context. The other responses are not correct.

23. The nurse is reviewing concepts of cultural aspects of pain. Which statement is *true*regarding pain?

a. All patients will behave the same way when in pain.

b. Just as patients vary in their perceptions of pain, so will they vary in their expressions of pain.

c. Cultural norms have very little to do with pain tolerance, because pain tolerance is always biologically determined.

d. A patient's expression of pain is largely dependent on the amount of tissue injury associated with the pain.

ANS: B

In addition to expecting variations in pain perception and tolerance, the nurse should expect variations in the expression of pain. It is well known that individuals turn to their social environment for validation and comparison. The other statements are incorrect.

24. During a class on religion and spirituality, the nurse is asked to define spirituality. Which answer is correct? “Spirituality:

a. Is a personal search to discover a supreme being.”

b. Is an organized system of beliefs concerning the cause, nature, and purpose of the universe.”

c. Is a belief that each person exists forever in some form, such as a belief in reincarnation or the afterlife.”

d. Arises out of each person’s unique life experience and his or her personal effort to find purpose in life.”

ANS: D

Spirituality arises out of each person’s unique life experience and his or her personal effort to find purpose and meaning in life. The other definitions reflect the concept of religion.

25. The nurse recognizes that working with children with a different cultural perspective may be especially difficult because:

a. Children have spiritual needs that are influenced by their stages of development.

b. Children have spiritual needs that are direct reflections of what is occurring in their homes.

c. Religious beliefs rarely affect the parents’ perceptions of the illness.

d. Parents are often the decision makers, and they have no knowledge of their children’s spiritual needs.

ANS: A

Illness during childhood may be an especially difficult clinical situation. Children, as well as adults, have spiritual needs that vary according to the child’s developmental level and the religious climate that exists in the family. The other statements are not correct.

26. A 30-year-old woman has recently moved to the United States with her husband. They are living with the woman’s sister until they can get a home of their own. When company arrives to visit with the woman’s sister, the woman feels suddenly shy and retreats to the back bedroom to hide until the company leaves. She explains that her reaction to guests is simply because she does not know how to speak “perfect English.” This woman could be experiencing:

a. Culture shock.

b. Cultural taboos.

c. Cultural unfamiliarity.

d. Culture disorientation.

ANS: A

Culture shock is a term used to describe the state of disorientation or inability to respond to the behavior of a different cultural group because of its sudden strangeness, unfamiliarity, and incompatibility with the individual’s perceptions and expectations. The other terms are not correct.

27. After a symptom is recognized, the first effort at treatment is often self-care. Which of the following statements about self-care is *true*? “Self-care is:

a. Not recognized as valuable by most health care providers.”

b. Usually ineffective and may delay more effective treatment.”

c. Always less expensive than biomedical alternatives.”

d. Influenced by the accessibility of over-the-counter medicines.”

ANS: D

After a symptom is identified, the first effort at treatment is often self-care. The availability of over-the-counter medications, the relatively high literacy level of Americans, and the influence of the mass media in communicating health-related information to the general population have contributed to the high percentage of cases of self-treatment.

28. The nurse is reviewing the hot/cold theory of health and illness. Which statement best describes the basic tenets of this theory?

a. The causation of illness is based on supernatural forces that influence the humors of the body.

b. Herbs and medicines are classified on their physical characteristics of hot and cold and the humors of the body.

c. The four humors of the body consist of blood, yellow bile, spiritual connectedness, and social aspects of the individual.

d. The treatment of disease consists of adding or subtracting cold, heat, dryness, or wetness to restore the balance of the humors of the body.

ANS: D

The hot/cold theory of health and illness is based on the four humors of the body: blood, phlegm, black bile, and yellow bile. These humors regulate the basic bodily functions, described in terms of temperature, dryness, and moisture. The treatment of disease consists of adding or subtracting cold, heat, dryness, or wetness to restore the balance of the humors. The other statements are not correct.

29. In the hot/cold theory, illnesses are believed to be caused by hot or cold entering the body. Which of these patient conditions is most consistent with a cold condition?

a. Patient with diabetes and renal failure

b. Teenager with an abscessed tooth

c. Child with symptoms of itching and a rash

d. Older man with gastrointestinal discomfort

ANS: D

Illnesses believed to be caused by cold entering the body include earache, chest cramps, gastrointestinal discomfort, rheumatism, and tuberculosis. Those illnesses believed to be caused by heat, or overheating, include sore throats, abscessed teeth, rashes, and kidney disorders.

30. When providing culturally competent care, nurses must incorporate cultural assessments into their health assessments. Which statement is most appropriate to use when initiating an assessment of cultural beliefs with an older American-Indian patient?

a. “Are you of the Christian faith?”

b. “Do you want to see a medicine man?”

c. “How often do you seek help from medical providers?”

d. “What cultural or spiritual beliefs are important to you?”

ANS: D

The nurse needs to assess the cultural beliefs and practices of the patient. American Indians may seek assistance from a medicine man or shaman, but the nurse should not assume this. An open-ended question regarding cultural and spiritual beliefs is best used initially when performing a cultural assessment.

31. During a class on cultural practices, the nurse hears the term *cultural taboo*. Which statement illustrates the concept of a cultural taboo?

a. Believing that illness is a punishment of sin

b. Trying prayer before seeking medical help

c. Refusing to accept blood products as part of treatment

d. Stating that a child’s birth defect is the result of the parents’ sins

ANS: C

Cultural taboos are practices that are to be avoided, such as receiving blood products, eating pork, and consuming caffeine. The other answers do not reflect cultural taboos.

32. The nurse recognizes that categories such as ethnicity, gender, and religion illustrate the concept of:

a. Family.

b. Cultures.

c. Spirituality.

d. Subcultures.

ANS: D

Within cultures, groups of people share different beliefs, values, and attitudes. Differences occur because of ethnicity, religion, education, occupation, age, and gender. When such groups function within a large culture, they are referred to as *subcultural groups*.

33. The nurse is reviewing concepts related to one's heritage and beliefs. The belief in divine or superhuman power(s) to be obeyed and worshipped as the creator(s) and ruler(s) of the universe is known as:

a. Culture.

b. Religion.

c. Ethnicity.

d. Spirituality.

ANS: B

Religion is defined as an organized system of beliefs concerning the cause, nature, and purpose of the universe, especially belief in or the worship of God or gods. Spirituality is born out of each person's unique life experiences and his or her personal efforts to find purpose and meaning in life. Ethnicity pertains to a social group within the social system that claims to possess variable traits, such as a common geographic origin, religion, race, and others.

34. When planning a cultural assessment, the nurse should include which component?

a. Family history

b. Chief complaint

c. Medical history

d. Health-related beliefs

ANS: D

Health-related beliefs and practices are one component of a cultural assessment. The other items reflect other aspects of the patient's history.

35. Which of the following reflects the traditional health and illness beliefs and practices of those of African heritage? Health is:

a. Being rewarded for good behavior.

b. The balance of the body and spirit.

c. Maintained by wearing jade amulets.

d. Being in harmony with nature.

ANS: D

The belief that health is being in harmony with nature reflects the health beliefs of those of African heritages. The other examples represent Iberian and Central and South American heritages, American-Indian heritages, and Asian heritages (See Table 2-3).

MULTIPLE RESPONSE

1. The nurse is reviewing aspects of cultural care. Which statements illustrate proper cultural care? *Select all that apply*.

a. Examine the patient within the context of one's own cultural health and illness practices.

b. Select questions that are not complex.

c. Ask questions rapidly.

d. Touch patients within the cultural boundaries of their heritage.

e. Pace questions throughout the physical examination.

ANS: B, D, E

Patients should be examined within the context of their own cultural health and illness practices. Questions should be simply stated and not rapidly asked.

2. The nurse is asking questions about a patient's health beliefs. Which questions are appropriate? *Select all that apply*.

a. "What is your definition of health?"

b. "Does your family have a history of cancer?"

c. "How do you describe illness?"

d. "What did your mother do to keep you from getting sick?"

e. "Have you ever had any surgeries?"

f. "How do you keep yourself healthy?"

ANS: A, C, D, F

The questions listed are appropriate questions for an assessment of a patient's health beliefs and practices. The questions regarding family history and surgeries are part of the patient's physical history, not the patient's health beliefs.

Chapter 03: The Interview

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 nurse's 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 nurse's observation of the patient's 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 patient's narrative flow, and it impedes the observation of the patient's 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. I'll 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 person’s 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 patient’s narrative, some responses focus on the patient’s frame of reference and some focus on the health care provider’s perspective. An example of a verbal response that focuses on the health care provider’s 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 patient’s 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 patient’s 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 nurse’s best response to this behavior?

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

b. Smile at him and say, “Don’t worry about all of this. I’m sure we can find out why you’re having these pains.”

c. Lean back in the chair and ask, “You are looking at me kind of funny; there isn’t 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 won’t go to sleep at night, and during the day he has several fits. I get so upset when that happens.” The nurse’s best verbal response would be:

a. “Go on, I’m listening.”

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

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

d. “Don’t be upset when he has a fit; every 2 year old has fits.”

ANS: B

The nurse should use clarification when the person’s word choice is ambiguous or confusing (e.g., “Tell me what you mean by *fits*.”). Clarification is also used to summarize the person’s 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 can’t 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 can’t 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 person’s arm. Simply reflecting the person’s 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 didn’t 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 don’t 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 patient’s 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 patient’s 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 nurse’s conclusion on the basis of the patient’s nonverbal response.

ANS: B

Interpretation is not based on direct observation as is confrontation, but it is based on one's 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 father's violence, but I just can't seem to leave him." Using interpretation, the nurse's best response would be:

a. "You are going to leave him?"

b. "If you are afraid for your children, then why can't 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 one's 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 won't be able to stand it. I know it sounds awful, but I really dread going into labor." The nurse responds by stating, "Oh, don't 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 nurse's 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 of the woman's 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 woman's 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 doesn't understand how hard I've tried. I just don't know the best way to do it. What should I do?" The nurse's most appropriate response in this case would be:

a. "I'd 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? Didn't the doctor give you the information about the smoking cessation program we offer?"

ANS: B

Clarification should be used when the person's word choice is ambiguous or confusing. Clarification is also used to summarize the person's 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 patient's 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, "I'm so afraid of, um, you know." The nurse's most therapeutic response would be to say in a gentle manner:

a. "You're afraid you might lose your breast?"

b. "No, I'm not sure what you are talking about."

c. "I'll 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 patient's words, repeating part of what the person has just said. Reflection can also help express the feelings behind a person's 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 don't 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 don't 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 patient's 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 patient's 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 patient's nonverbal behaviors, because these are often more reflective of a patient's 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 son's 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 son's treatment.

ANS: D

The person's 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 child’s 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 nurse’s 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 one’s attitude, which must be one of respect. Second, communication must be totally honest. An adolescent’s 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 communicate—by 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 nurse's 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 nurse's best response to her crying would be:

a. "I'm so sorry for making you cry!"

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

c. "Why don't I step out for a few minutes until you're feeling better?"

d. "I can see that you feel sad about this; why don't 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 nurse's 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 patient's and the nurse's 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, haven’t 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 nurse’s comment?

a. This comment is inappropriate because it shows the nurse’s 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 haven’t 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 adult's 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. I'll be back."

d. "While I'm here, let's 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 nurse's best reaction would be:

a. "Stop that immediately!"

b. "Oh, you are too funny. Let's 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 nurse’s 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 person’s 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 patient’s 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 patient’s 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 04: The Complete Health History

MULTIPLE CHOICE

1. The nurse is preparing to conduct a health history. Which of these statements best describes the purpose of a health history?

a. To provide an opportunity for interaction between the patient and the nurse

b. To provide a form for obtaining the patient’s biographic information

c. To document the normal and abnormal findings of a physical assessment

d. To provide a database of subjective information about the patient’s past and current health

ANS: D

The purpose of the health history is to collect subjective data—what the person says about him or herself. The other options are not correct.

2. When the nurse is evaluating the reliability of a patient's responses, which of these statements would be *correct*? The patient:

a. Has a history of drug abuse and therefore is not reliable.

b. Provided consistent information and therefore is reliable.

c. Smiled throughout interview and therefore is assumed reliable.

d. Would not answer questions concerning stress and therefore is not reliable.

ANS: B

A reliable person always gives the same answers, even when questions are rephrased or are repeated later in the interview. The other statements are not correct.

3. A 59-year-old patient tells the nurse that he has ulcerative colitis. He has been having "black stools" for the last 24 hours. How would the nurse best document his reason for seeking care?

a. J.M. is a 59-year-old man seeking treatment for ulcerative colitis.

b. J.M. came into the clinic complaining of having black stools for the past 24 hours.

c. J.M. is a 59-year-old man who states that he has ulcerative colitis and wants it checked.

d. J.M. is a 59-year-old man who states that he has been having "black stools" for the past 24 hours.

ANS: D

The reason for seeking care is a brief spontaneous statement in the person's own words that describes the reason for the visit. It states one (possibly two) signs or symptoms and their duration. It is enclosed in quotation marks to indicate the person's exact words.

4. A patient tells the nurse that she has had abdominal pain for the past week. What would be the nurse's best response?

a. "Can you point to where it hurts?"

b. "We'll talk more about that later in the interview."

c. "What have you had to eat in the last 24 hours?"

d. "Have you ever had any surgeries on your abdomen?"

ANS: A

A final summary of any symptom the person has should include, along with seven other critical characteristics, "Location: specific." The person is asked to point to the location.

5. A 29-year-old woman tells the nurse that she has "excruciating pain" in her back. Which would be the nurse's appropriate response to the woman's statement?

a. "How does your family react to your pain?"

b. "The pain must be terrible. You probably pinched a nerve."

c. "I've had back pain myself, and it can be excruciating."

d. "How would you say the pain affects your ability to do your daily activities?"

ANS: D

The symptom of pain is difficult to quantify because of individual interpretation. With pain, adjectives should be avoided and the patient should be asked how the pain affects his or her daily activities. The other responses are not appropriate.

6. In recording the childhood illnesses of a patient who denies having had any, which note by the nurse would be most accurate?

a. Patient denies usual childhood illnesses.

b. Patient states he was a “very healthy” child.

c. Patient states his sister had measles, but he didn’t.

d. Patient denies measles, mumps, rubella, chickenpox, pertussis, and strep throat.

ANS: D

Childhood illnesses include measles, mumps, rubella, chickenpox, pertussis, and strep throat. Avoid recording “usual childhood illnesses” because an illness common in the person’s childhood may be unusual today (e.g., measles).

7. A female patient tells the nurse that she has had six pregnancies, with four live births at term and two spontaneous abortions. Her four children are still living. How would the nurse record this information?

a. P-6, B-4, (S)Ab-2

b. Grav 6, Term 4, (S)Ab-2, Living 4

c. Patient has had four living babies.

d. Patient has been pregnant six times.

ANS: B

Obstetric history includes the number of pregnancies (gravidity), number of deliveries in which the fetus reached term (term), number of preterm pregnancies (preterm), number of incomplete pregnancies (abortions), and number of children living (living). This is recorded: Grav _____ Term _____ Preterm _____ Ab _____ Living _____. For any incomplete pregnancies, the duration is recorded and whether the pregnancy resulted in a spontaneous (S) or an induced (I) abortion.

8. A patient tells the nurse that he is allergic to penicillin. What would be the nurse’s best response to this information?

a. “Are you allergic to any other drugs?”

b. “How often have you received penicillin?”

c. “I’ll write your allergy on your chart so you won’t receive any penicillin.”

d. “Describe what happens to you when you take penicillin.”

ANS: D

Note both the allergen (medication, food, or contact agent, such as fabric or environmental agent) and the reaction (rash, itching, runny nose, watery eyes, or difficulty breathing). With a drug, this symptom should not be a side effect but a true allergic reaction.

9. The nurse is taking a family history. Important diseases or problems about which the patient should be specifically asked include:

a. Emphysema.

b. Head trauma.

c. Mental illness.

d. Fractured bones.

ANS: C

Questions concerning any family history of heart disease, high blood pressure, stroke, diabetes, obesity, blood disorders, breast and ovarian cancers, colon cancer, sickle cell anemia, arthritis, allergies, alcohol or drug addiction, mental illness, suicide, seizure disorder, kidney disease, and tuberculosis should be asked.

10. The review of systems provides the nurse with:

a. Physical findings related to each system.

b. Information regarding health promotion practices.

c. An opportunity to teach the patient medical terms.

d. Information necessary for the nurse to diagnose the patient's medical problem.

ANS: B

The purposes of the review of systems are to: (1) evaluate the past and current health state of each body system, (2) double check facts in case any significant data were omitted in the present illness section, and (3) evaluate health promotion practices.

11. Which of these statements represents subjective data the nurse obtained from the patient regarding the patient's skin?

a. Skin appears dry.

b. No lesions are obvious.

c. Patient denies any color change.

d. Lesion is noted on the lateral aspect of the right arm.

ANS: C

The history should be limited to patient statements or subjective data—factors that the person says were or were not present.

12. The nurse is obtaining a history from a 30-year-old male patient and is concerned about health promotion activities. Which of these questions would be appropriate to use to assess health promotion activities for this patient?

a. "Do you perform testicular self-examinations?"

b. "Have you ever noticed any pain in your testicles?"

c. "Have you had any problems with passing urine?"

d. "Do you have any history of sexually transmitted diseases?"

ANS: A

Health promotion for a man would include the performance of testicular self-examinations. The other questions are asking about possible disease or illness issues.

13. Which of these responses might the nurse expect during a functional assessment of a patient whose leg is in a cast?

a. "I broke my right leg in a car accident 2 weeks ago."

b. "The pain is decreasing, but I still need to take acetaminophen."

c. "I check the color of my toes every evening just like I was taught."

d. "I'm able to transfer myself from the wheelchair to the bed without help."

ANS: D

Functional assessment measures a person's self-care ability in the areas of general physical health or absence of illness. The other statements concern health or illness issues.

14. In response to a question about stress, a 39-year-old woman tells the nurse that her husband and mother both died in the past year. Which response by the nurse is most appropriate?

a. "This has been a difficult year for you."

b. “I don’t know how anyone could handle that much stress in 1 year!”

c. “What did you do to cope with the loss of both your husband and mother?”

d. “That is a lot of stress; now let’s go on to the next section of your history.”

ANS: C

Questions about coping and stress management include questions regarding the kinds of stresses in one’s life, especially in the last year, any changes in lifestyle or any current stress, methods tried to relieve stress, and whether these methods have been helpful.

15. In response to a question regarding the use of alcohol, a patient asks the nurse why the nurse needs to know. What is the reason for needing this information?

a. This information is necessary to determine the patient’s reliability.

b. Alcohol can interact with all medications and can make some diseases worse.

c. The nurse needs to be able to teach the patient about the dangers of alcohol use.

d. This information is not necessary unless a drinking problem is obvious.

ANS: B

Alcohol adversely interacts with all medications and is a factor in many social problems such as child or sexual abuse, automobile accidents, and assaults; alcohol also contributes to many illnesses and disease processes. Therefore, assessing for signs of hazardous alcohol use is important. The other options are not correct.

16. The mother of a 16-month-old toddler tells the nurse that her daughter has an earache. What would be an appropriate response?

a. “Maybe she is just teething.”

b. “I will check her ear for an ear infection.”

c. “Are you sure she is really having pain?”

d. “Describe what she is doing to indicate she is having pain.”

ANS: D

With a very young child, the parent is asked, “How do you know the child is in pain?” A young child pulling at his or her ears should alert parents to the child’s ear pain. Statements about teething and questioning whether the child is really having pain do not explore the symptoms, which should be done before a physical examination.

17. During an assessment of a patient’s family history, the nurse constructs a genogram. Which statement best describes a genogram?

a. List of diseases present in a person’s near relatives

b. Graphic family tree that uses symbols to depict the gender, relationship, and age of immediate family members

c. Drawing that depicts the patient’s family members up to five generations back

d. Description of the health of a person’s children and grandchildren

ANS: B

A genogram (or pedigree) is a graphic family tree that uses symbols to depict the gender, relationship, and age of immediate blood relatives in at least three generations (parents, grandparents, siblings). The other options do not describe a genogram.

18. A 5-year-old boy is being admitted to the hospital to have his tonsils removed. Which information should the nurse collect before this procedure?

a. Child’s birth weight

b. Age at which he crawled

c. Whether the child has had the measles

d. Child’s reactions to previous hospitalizations

ANS: D

How the child reacted to previous hospitalizations and any complications should be assessed. If the child reacted poorly, then he or she may be afraid now and will need special preparation for the examination that is to follow. The other items are not significant for the procedure.

19. As part of the health history of a 6-year-old boy at a clinic for a sports physical examination, the nurse reviews his immunization record and notes that his last measles-mumps-rubella (MMR) vaccination was at 15 months of age. What recommendation should the nurse make?

a. No further MMR immunizations are needed.

b. MMR vaccination needs to be repeated at 4 to 6 years of age.

c. MMR immunization needs to be repeated every 4 years until age 21 years.

d. A recommendation cannot be made until the physician is consulted.

ANS: B

Because of recent outbreaks of measles across the United States, the American Academy of Pediatrics (2006) recommends two doses of the MMR vaccine, one at 12 to 15 months of age and one at age 4 to 6 years.

20. In obtaining a review of systems on a “healthy” 7-year-old girl, the health care provider knows that it would be important to include the:

a. Last glaucoma examination.

b. Frequency of breast self-examinations.

c. Date of her last electrocardiogram.

d. Limitations related to her involvement in sports activities.

ANS: D

When reviewing the cardiovascular system, the health care provider should ask whether any activity is limited or whether the child can keep up with her peers. The other items are not appropriate for a child this age.

21. When the nurse asks for a description of who lives with a child, the method of discipline, and the support system of the child, what part of the assessment is being performed?

a. Family history

b. Review of systems

c. Functional assessment

d. Reason for seeking care

ANS: C

Functional assessment includes interpersonal relationships and home environment. Family history includes illnesses in family members; a review of systems includes questions about the various body systems; and the reason for seeking care is the rationale for requesting health care.

22. The nurse is obtaining a health history on an 87-year-old woman. Which of the following areas of questioning would be most useful at this time?

a. Obstetric history

b. Childhood illnesses

c. General health for the past 20 years

d. Current health promotion activities

ANS: D

It is important for the nurse to recognize positive health measures, such as what the person has been doing to help him or herself stay well and to live to an older age. The other responses are not pertinent to a patient of this age.

23. The nurse is performing a review of systems on a 76-year-old patient. Which of these statements is *correct* for this situation?

a. The questions asked are identical for all ages.

b. The interviewer will start incorporating different questions for patients 70 years of age and older.

c. Questions that are reflective of the normal effects of aging are added.

d. At this age, a review of systems is not necessary—the focus should be on current problems.

ANS: C

The health history includes the same format as that described for the younger adult, as well as some additional questions. These additional questions address ways in which the activities of daily living may have been affected by the normal aging processes or by the effects of chronic illness or disability.

24. A 90-year-old patient tells the nurse that he cannot remember the names of the medications he is taking or for what reason he is taking them. An appropriate response from the nurse would be:

a. “Can you tell me what they look like?”

b. “Don’t worry about it. You are only taking two medications.”

c. “How long have you been taking each of the pills?”

d. “Would you have a family member bring in your medications?”

ANS: D

The person may not know the drug name or purpose. When this occurs, ask the person or a family member to bring in the drug to be identified. The other responses would not help to identify the medications.

25. The nurse is performing a functional assessment on an 82-year-old patient who recently had a stroke. Which of these questions would be most important to ask?

a. “Do you wear glasses?”

b. “Are you able to dress yourself?”

c. “Do you have any thyroid problems?”

d. “How many times a day do you have a bowel movement?”

ANS: B

Functional assessment measures how a person manages day-to-day activities. For the older person, the meaning of health becomes those activities that they can or cannot do. The other responses do not relate to functional assessment.

26. The nurse is preparing to do a functional assessment. Which statement best describes the purpose of a functional assessment?

a. The functional assessment assesses how the individual is coping with life at home.

b. It determines how children are meeting developmental milestones.

c. The functional assessment can identify any problems with memory the individual may be experiencing.

d. It helps determine how a person is managing day-to-day activities.

ANS: D

The functional assessment measures how a person manages day-to-day activities. The other answers do not reflect the purpose of a functional assessment.

27. The nurse is asking a patient for his reason for seeking care and asks about the signs and symptoms he is experiencing. Which of these is an example of a symptom?

a. Chest pain

b. Clammy skin

c. Serum potassium level at 4.2 mEq/L

d. Body temperature of 100° F

ANS: A

A symptom is a subjective sensation (e.g., chest pain) that a person feels from a disorder. A sign is an objective abnormality that the examiner can detect on physical examination or in laboratory reports, as illustrated by the other responses.

28. A patient is describing his symptoms to the nurse. Which of these statements reflects a description of the setting of his symptoms?

a. “It is a sharp, burning pain in my stomach.”

b. “I also have the sweats and nausea when I feel this pain.”

c. “I think this pain is telling me that something bad is wrong with me.”

d. “This pain happens every time I sit down to use the computer.”

ANS: D

The setting describes where the person is or what the person is doing when the symptom starts. Describing the pain as “sharp and burning” reflects the character or quality of the pain; stating that the pain is “telling” the patient that something bad is wrong with him reflects the patient’s perception of the pain; and describing the “sweats and nausea” reflects associated factors that occur with the pain.

29. During an assessment, the nurse uses the CAGE test. The patient answers “yes” to two of the questions. What could this be indicating?

a. The patient is an alcoholic.

b. The patient is annoyed at the questions.

c. The patient should be thoroughly examined for possible alcohol withdrawal symptoms.

d. The nurse should suspect alcohol abuse and continue with a more thorough substance abuse assessment.

ANS: D

The CAGE test is known as the “cut down, annoyed, guilty, and eye-opener” test. If a person answers “yes” to two or more of the four CAGE questions, then the nurse should suspect alcohol abuse and continue with a more complete substance abuse assessment.

30. The nurse is incorporating a person’s spiritual values into the health history. Which of these questions illustrates the “community” portion of the FICA (faith and belief, importance and influence, community, and addressing or applying in care) questions?

a. “Do you believe in God?”

b. “Are you a part of any religious or spiritual congregation?”

c. “Do you consider yourself to be a religious or spiritual person?”

d. “How does your religious faith influence the way you think about your health?”

ANS: B

The “community” is assessed when the nurse asks whether a person is part of a religious or spiritual community or congregation. The other areas assessed are faith, influence, and addressing any religious or spiritual issues or concerns.

31. The nurse is preparing to complete a health assessment on a 16-year-old girl whose parents have brought her to the clinic. Which instruction would be appropriate for the parents before the interview begins?

a. “Please stay during the interview; you can answer for her if she does not know the answer.”

b. “It would help to interview the three of you together.”

c. “While I interview your daughter, will you please stay in the room and complete these family health history questionnaires?”

d. “While I interview your daughter, will you step out to the waiting room and complete these family health history questionnaires?”

ANS: D

The girl should be interviewed alone. The parents can wait outside and fill out the family health history questionnaires.

32. The nurse is assessing a new patient who has recently immigrated to the United States. Which question is appropriate to add to the health history?

a. “Why did you come to the United States?”

b. “When did you come to the United States and from what country?”

c. “What made you leave your native country?”

d. “Are you planning to return to your home?”

ANS: B

Biographic data, such as when the person entered the United States and from what country, are appropriate additions to the health history. The other answers do not reflect appropriate questions.

MULTIPLE RESPONSE

1. The nurse is assessing a patient’s headache pain. Which questions reflect one or more of the critical characteristics of symptoms that should be assessed? *Select all that apply*.

a. “Where is the headache pain?”

b. “Did you have these headaches as a child?”

c. “On a scale of 1 to 10, how bad is the pain?”

d. “How often do the headaches occur?”

e. “What makes the headaches feel better?”

f. “Do you have any family history of headaches?”

ANS: A, C, D, E

The mnemonic PQRSTU may help the nurse remember to address the critical characteristics that need to be assessed: (1) P: provocative or palliative; (2) Q: quality or quantity; (3) R: region or radiation; (4) S: severity scale; (5) T: timing; and (6) U: understand the patient’s perception. Asking, “Where is the pain?” reflects “region.” Asking the patient to rate the pain on a 1 to 10 scale reflects “severity.” Asking “How often…” reflects “timing.” Asking what makes the pain better reflects “provocative.” The other options reflect health history and family history.

2. The nurse is conducting a developmental history on a 5-year-old child. Which questions are appropriate to ask the parents for this part of the assessment? *Select all that apply*.

a. “How much junk food does your child eat?”

b. “How many teeth has he lost, and when did he lose them?”

c. “Is he able to tie his shoelaces?”

d. “Does he take a children’s vitamin?”

e. “Can he tell time?”

f. “Does he have any food allergies?”

ANS: B, C, E

Questions about tooth loss, ability to tell time, and ability to tie shoelaces are appropriate questions for a developmental assessment. Questions about junk food intake and vitamins are part of a nutritional history. Questions about food allergies are not part of a developmental history.

Chapter 05: Mental Status Assessment

MULTIPLE CHOICE

1. During an examination, the nurse can assess mental status by which activity?

a. Examining the patient’s electroencephalogram

b. Observing the patient as he or she performs an intelligence quotient (IQ) test

c. Observing the patient and inferring health or dysfunction

d. Examining the patient’s response to a specific set of questions

ANS: C

Mental status cannot be directly scrutinized like the characteristics of skin or heart sounds. Its functioning is inferred through an assessment of an individual’s behaviors, such as consciousness, language, mood and affect, and other aspects.

2. The nurse is assessing the mental status of a child. Which statement about children and mental status is *true*?

a. All aspects of mental status in children are interdependent.

b. Children are highly labile and unstable until the age of 2 years.

c. Children’s mental status is largely a function of their parents’ level of functioning until the age of 7 years.

d. A child’s mental status is impossible to assess until the child develops the ability to concentrate.

ANS: A

Separating and tracing the development of only one aspect of mental status is difficult. All aspects are interdependent. For example, consciousness is rudimentary at birth because the cerebral cortex is not yet developed. The infant cannot distinguish the self from the mother’s body. The other statements are not true.

3. The nurse is assessing a 75-year-old man. As the nurse begins the mental status portion of the assessment, the nurse expects that this patient:

a. Will have no decrease in any of his abilities, including response time.

b. Will have difficulty on tests of remote memory because this ability typically decreases with age.

c. May take a little longer to respond, but his general knowledge and abilities should not have declined.

d. Will exhibit had a decrease in his response time because of the loss of language and a decrease in general knowledge.

ANS: C

The aging process leaves the parameters of mental status mostly intact. General knowledge does not decrease, and little or no loss in vocabulary occurs. Response time is slower than in a youth. It takes a little longer for the brain to process information and to react to it. Recent memory, which requires some processing, is somewhat decreased with aging, but remote memory is not affected.

4. When assessing aging adults, the nurse knows that one of the first things that should be assessed before making judgments about their mental status is:

a. Presence of phobias

b. General intelligence

c. Presence of irrational thinking patterns

d. Sensory-perceptive abilities

ANS: D

Age-related changes in sensory perception can affect mental status. For example, vision loss (as detailed in Chapter 14) may result in apathy, social isolation, and depression. Hearing changes are common in older adults, which produces frustration, suspicion, and social isolation and makes the person appear confused.

5. The nurse is preparing to conduct a mental status examination. Which statement is *true*regarding the mental status examination?

a. A patient's family is the best resource for information about the patient's coping skills.

b. Gathering mental status information during the health history interview is usually sufficient.

c. Integrating the mental status examination into the health history interview takes an enormous amount of extra time.

d. To get a good idea of the patient's level of functioning, performing a complete mental status examination is usually necessary.

ANS: B

The full mental status examination is a systematic check of emotional and cognitive functioning. The steps described, however, rarely need to be taken in their entirety. Usually, one can assess mental status through the context of the health history interview.

6. A woman brings her husband to the clinic for an examination. She is particularly worried because after a recent fall, he seems to have lost a great deal of his memory of recent events. Which statement reflects the nurse's best course of action?

a. Perform a complete mental status examination.

b. Refer him to a psychometrician.

c. Plan to integrate the mental status examination into the history and physical examination.

d. Reassure his wife that memory loss after a physical shock is normal and will soon subside.

ANS: A

Performing a complete mental status examination is necessary when any abnormality in affect or behavior is discovered or when family members are concerned about a person's behavioral changes (e.g., memory loss, inappropriate social interaction) or after trauma, such as a head injury.

7. The nurse is conducting a patient interview. Which statement made by the patient should the nurse more fully explore during the interview?

a. "I sleep like a baby."

b. "I have no health problems."

c. "I never did too good in school."

d. "I am not currently taking any medications."

ANS: C

In every mental status examination, the following factors from the health history that could affect the findings should be noted: any known illnesses or health problems, such as alcoholism or chronic renal disease; current medications, the side effects of which may cause confusion or depression; the usual educational and behavioral level, noting this level as the patient's normal baseline and not expecting a level of performance on the mental status examination to exceed it; and responses to personal history questions, indicating current stress, social interaction patterns, and sleep habits.

8. A patient is admitted to the unit after an automobile accident. The nurse begins the mental status examination and finds that the patient has dysarthric speech and is lethargic. The nurse's best approach regarding this examination is to:

a. Plan to defer the rest of the mental status examination.

b. Skip the language portion of the examination, and proceed onto assessing mood and affect.

c. Conduct an in-depth speech evaluation, and defer the mental status examination to another time.

d. Proceed with the examination, and assess the patient for suicidal thoughts because dysarthria is often accompanied by severe depression.

ANS: A

In the mental status examination, the sequence of steps forms a hierarchy in which the most basic functions (consciousness, language) are assessed first. The first steps must be accurately assessed to ensure validity of the steps that follow. For example, if consciousness is clouded, then the person cannot be expected to have full attention and to cooperate with new learning. If language is impaired, then a subsequent assessment of new learning or abstract reasoning (anything that requires language functioning) can give erroneous conclusions.

9. A 19-year-old woman comes to the clinic at the insistence of her brother. She is wearing black combat boots and a black lace nightgown over the top of her other clothes. Her hair is dyed pink with black streaks throughout. She has several pierced holes in her nares and ears and is wearing an earring through her eyebrow and heavy black makeup. The nurse concludes that:

a. She probably does not have any problems.

b. She is only trying to shock people and that her dress should be ignored.

c. She has a manic syndrome because of her abnormal dress and grooming.

d. More information should be gathered to decide whether her dress is appropriate.

ANS: D

Grooming and hygiene should be noted—the person is clean and well groomed, hair is neat and clean, women have moderate or no makeup, and men are shaved or their beards or moustaches are well groomed. Care should be taken when interpreting clothing that is disheveled, bizarre, or in poor repair because these sometimes reflect the person's economic status or a deliberate fashion trend.

10. A patient has been in the intensive care unit for 10 days. He has just been moved to the medical-surgical unit, and the admitting nurse is planning to perform a mental status examination. During the tests of cognitive function, the nurse would expect that he:

a. May display some disruption in thought content.

b. Will state, "I am so relieved to be out of intensive care."

c. Will be oriented to place and person, but the patient may not be certain of the date.

d. May show evidence of some clouding of his level of consciousness.

ANS: C

The nurse can discern the orientation of cognitive function through the course of the interview or can directly and tactfully ask, "Some people have trouble keeping up with the dates while in the hospital. Do you know today's date?" Many hospitalized people have trouble with the exact date but are fully oriented on the remaining items.

11. During a mental status examination, the nurse wants to assess a patient's affect. The nurse should ask the patient which question?

a. "How do you feel today?"

b. "Would you please repeat the following words?"

c. "Have these medications had any effect on your pain?"

d. "Has this pain affected your ability to get dressed by yourself?"

ANS: A

Judge mood and affect by body language and facial expression and by directly asking, "How do you feel today?" or "How do you usually feel?" The mood should be appropriate to the person's place and condition and should appropriately change with the topics.

12. The nurse is planning to assess new memory with a patient. The best way for the nurse to do this would be to:

a. Administer the FACT test.

b. Ask him to describe his first job.

c. Give him the Four Unrelated Words Test.

d. Ask him to describe what television show he was watching before coming to the clinic.

ANS: C

Ask questions that can be corroborated, which screens for the occasional person who confabulates or makes up answers to fill in the gaps of memory loss. The Four Unrelated Words Test tests the person's ability to lay down new memories and is a highly sensitive and valid memory test.

13. A 45-year-old woman is at the clinic for a mental status assessment. In giving her the Four Unrelated Words Test, the nurse would be concerned if she could not ____ four unrelated words ____.

a. Invent; within 5 minutes

b. Invent; within 30 seconds

c. Recall; after a 30-minute delay

d. Recall; after a 60-minute delay

ANS: C

The Four Unrelated Words Test tests the person's ability to lay down new memories. It is a highly sensitive and valid memory test. It requires more effort than the recall of personal or historic events. To the person say, "I am going to say four words. I want you to remember them. In a few minutes I will ask you to recall them." After 5 minutes, ask for the four words. The normal response for persons under 60 years is an accurate three- or four-word recall after a 5-, 10-, and 30-minute delay.

14. During a mental status assessment, which question by the nurse would best assess a person's judgment?

a. "Do you feel that you are being watched, followed, or controlled?"

b. "Tell me what you plan to do once you are discharged from the hospital."

c. "What does the statement, 'People in glass houses shouldn't throw stones,' mean to you?"

d. "What would you do if you found a stamped, addressed envelope lying on the sidewalk?"

ANS: B

A person exercises judgment when he or she can compare and evaluate the alternatives in a situation and reach an appropriate course of action. Rather than testing the person's response to a hypothetical situation (as illustrated in the option with the envelope), the nurse should be more interested in the person's judgment about daily or long-term goals, the likelihood of acting in response to delusions or hallucinations, and the capacity for violent or suicidal behavior.

15. Which of these individuals would the nurse consider at highest risk for a suicide attempt?

a. Man who jokes about death

b. Woman who, during a past episode of major depression, attempted suicide

c. Adolescent who just broke up with her boyfriend and states that she would like to kill herself

d. Older adult man who tells the nurse that he is going to "join his wife in heaven" tomorrow and plans to use a gun

ANS: D

When the person expresses feelings of sadness, hopelessness, despair, or grief, assessing any possible risk of physical harm to him or herself is important. The interview should begin with more general questions. If the nurse hears affirmative answers, then he or she should continue with more specific questions. A precise suicide plan to take place in the next 24 to 48 hours with use of a lethal method constitutes high risk.

16. The nurse is performing a mental status assessment on a 5-year-old girl. Her parents are undergoing a bitter divorce and are worried about the effect it is having on their daughter. Which action or statement might lead the nurse to be concerned about the girl's mental status?

a. She clings to her mother whenever the nurse is in the room.

b. She appears angry and will not make eye contact with the nurse.

c. Her mother states that she has begun to ride a tricycle around their yard.

d. Her mother states that her daughter prefers to play with toddlers instead of kids her own age while in daycare.

ANS: D

The mental status assessment of infants and children covers behavioral, cognitive, and psychosocial development and examines how the child is coping with his or her environment. Essentially, the nurse should follow the same Association for Behavioral and Cognitive Therapies (ABCT) guidelines as those for the adult, with special consideration for developmental milestones. The best examination technique arises from a thorough knowledge of the developmental milestones (described in Chapter 2). Abnormalities are often problems of omission (e.g., the child does not achieve a milestone as expected).

17. The nurse is assessing orientation in a 79-year-old patient. Which of these responses would lead the nurse to conclude that this patient is oriented?

a. "I know my name is John. I couldn't tell you where I am. I think it is 2010, though."

b. "I know my name is John, but to tell you the truth, I get kind of confused about the date."

c. "I know my name is John; I guess I'm at the hospital in Spokane. No, I don't know the date."

d. "I know my name is John. I am at the hospital in Spokane. I couldn't tell you what date it is, but I know that it is February of a new year—2010."

ANS: D

Many aging persons experience social isolation, loss of structure without a job, a change in residence, or some short-term memory loss. These factors affect orientation, and the person may not provide the precise date or complete name of the agency. You may consider aging persons oriented if they generally know where they are and the present period. They should be considered oriented to time if the year and month are correctly stated. Orientation to place is accepted with the correct identification of the type of setting (e.g., hospital) and the name of the town.

18. The nurse is performing the Denver II screening test on a 12-month-old infant during a routine well-child visit. The nurse should tell the infant's parents that the Denver II:

a. Tests three areas of development: cognitive, physical, and psychological

b. Will indicate whether the child has a speech disorder so that treatment can begin.

c. Is a screening instrument designed to detect children who are slow in development.

d. Is a test to determine intellectual ability and may indicate whether problems will develop later in school.

ANS: C

The Denver II is a screening instrument designed to detect developmental delays in infants and preschoolers. It tests four functions: gross motor, language, fine motor-adaptive, and personal-social. The Denver II is not an intelligence test; it does not predict current or future intellectual ability. It is not diagnostic; it does not suggest treatment regimens.

19. A patient drifts off to sleep when she is not being stimulated. The nurse can easily arouse her by calling her name, but the patient remains drowsy during the conversation. The best description of this patient's level of consciousness would be:

a. Lethargic

b. Obtunded

c. Stuporous

d. Semialert

ANS: A

Lethargic (or somnolent) is when the person is not fully alert, drifts off to sleep when not stimulated, and can be aroused when called by name in a normal voice but looks drowsy. He or she appropriately responds to questions or commands, but thinking seems slow and fuzzy. He or she is inattentive and loses the train of thought. Spontaneous movements are decreased. (See Table 5-3 for the definitions of the other terms.)

20. A patient has had a cerebrovascular accident (stroke). He is trying very hard to communicate. He seems driven to speak and says, “I buy obie get spirding and take my train.” What is the best description of this patient’s problem?

a. Global aphasia

b. Broca’s aphasia

c. Echolalia

d. Wernicke’s aphasia

ANS: D

This type of communication illustrates Wernicke’s or receptive aphasia. The person can hear sounds and words but cannot relate them to previous experiences. Speech is fluent, effortless, and well articulated, but it has many paraphasias (word substitutions that are malformed or wrong) and neologisms (made-up words) and often lacks substantive words. Speech can be totally incomprehensible. Often, a great urge to speak is present. Repetition, reading, and writing also are impaired. Echolalia is an imitation or the repetition of another person’s words or phrases. (See Table 5-4 for the definitions of the other disorders.)

21. A patient repeatedly seems to have difficulty coming up with a word. He says, “I was on my way to work, and when I got there, the thing that you step into that goes up in the air was so full that I decided to take the stairs.” The nurse will note on his chart that he is using or experiencing:

a. Blocking

b. Neologism

c. Circumlocution

d. Circumstantiality

ANS: C

Circumlocution is a roundabout expression, substituting a phrase when one cannot think of the name of the object.

22. During an examination, the nurse notes that a patient is exhibiting flight of ideas. Which statement by the patient is an example of flight of ideas?

a. “My stomach hurts. Hurts, spurts, burts.”

b. “Kiss, wood, reading, ducks, onto, maybe.”

c. “Take this pill? The pill is red. I see red. Red velvet is soft, soft as a baby’s bottom.”

d. “I wash my hands, wash them, wash them. I usually go to the sink and wash my hands.”

ANS: C

Flight of ideas is demonstrated by an abrupt change, rapid skipping from topic to topic, and practically continuous flow of accelerated speech. Topics usually have recognizable associations or are plays on words.

23. A patient describes feeling an unreasonable, irrational fear of snakes. His fear is so persistent that he can no longer comfortably look at even pictures of snakes and has made an effort to identify all the places he might encounter a snake and avoids them. The nurse recognizes that he:

a. Has a snake phobia.

b. Is a hypochondriac; snakes are usually harmless.

c. Has an obsession with snakes.

d. Has a delusion that snakes are harmful, which must stem from an early traumatic incident involving snakes.

ANS: A

A phobia is a strong, persistent, irrational fear of an object or situation; the person feels driven to avoid it. (See Table 5-7 for the definitions of the other terms.)

24. A patient has been diagnosed with schizophrenia. During a recent interview, he shows the nurse a picture of a man holding a decapitated head. He describes this picture as horrifying but then laughs loudly at the content. This behavior is a display of:

a. Confusion

b. Ambivalence

c. Depersonalization

d. Inappropriate affect

ANS: D

An inappropriate affect is an affect clearly discordant with the content of the person's speech. (See Table 5-5 for the definitions of the other terms.)

25. During reporting, the nurse hears that a patient is experiencing hallucinations. Which is an example of a hallucination?

a. Man believes that his dead wife is talking to him.

b. Woman hears the doorbell ring and goes to answer it, but no one is there.

c. Child sees a man standing in his closet. When the lights are turned on, it is only a dry cleaning bag.

d. Man believes that the dog has curled up on the bed, but when he gets closer he sees that it is a blanket.

ANS: A

Hallucinations are sensory perceptions for which no external stimuli exist. They may strike any sense: visual, auditory, tactile, olfactory, or gustatory.

26. A 20-year-old construction worker has been brought into the emergency department with heat stroke. He has delirium as a result of a fluid and electrolyte imbalance. For the mental status examination, the nurse should first assess the patient's:

a. Affect and mood

b. Memory and affect

c. Language abilities

d. Level of consciousness and cognitive abilities

ANS: D

Delirium is a disturbance of consciousness (i.e., reduced clarity of awareness of the environment) with reduced ability to focus, sustain, or shift attention. Delirium is not an alteration in mood, affect, or language abilities.

27. A patient states, "I feel so sad all of the time. I can't feel happy even doing things I used to like to do." He also states that he is tired, sleeps poorly, and has no energy. To differentiate between a dysthymic disorder and a major depressive disorder, the nurse should ask which question?

a. "Have you had any weight changes?"

b. "Are you having any thoughts of suicide?"

c. "How long have you been feeling this way?"

d. "Are you having feelings of worthlessness?"

ANS: C

Major depressive disorder is characterized by one or more major depressive episodes, that is, at least 2 weeks of depressed mood or loss of interest accompanied by at least four additional symptoms of depression. Dysthymic disorder is characterized by at least 2 years of depressed mood for more days than not, accompanied by additional depressive symptoms.

28. A 26-year-old woman was robbed and beaten a month ago. She is returning to the clinic today for a follow-up assessment. The nurse will want to ask her which one of these questions?

a. “How are things going with the trial?”

b. “How are things going with your job?”

c. “Tell me about your recent engagement!”

d. “Are you having any disturbing dreams?”

ANS: D

In posttraumatic stress disorder, the person has been exposed to a traumatic event. The traumatic event is persistently reexperienced by recurrent and intrusive, distressing recollections of the event, including images, thoughts, or perceptions; recurrent distressing dreams of the event; and acting or feeling as if the traumatic event were recurring.

29. The nurse is performing a mental status examination. Which statement is *true* regarding the assessment of mental status?

a. Mental status assessment diagnoses specific psychiatric disorders.

b. Mental disorders occur in response to everyday life stressors.

c. Mental status functioning is inferred through the assessment of an individual’s behaviors.

d. Mental status can be directly assessed, similar to other systems of the body (e.g., heart sounds, breath sounds).

ANS: C

Mental status functioning is inferred through the assessment of an individual’s behaviors. It cannot be directly assessed like the characteristics of the skin or heart sounds.

30. A 23-year-old patient in the clinic appears anxious. Her speech is rapid, and she is fidgety and in constant motion. Which of these questions or statements would be most appropriate for the nurse to use in this situation to assess attention span?

a. “How do you usually feel? Is this normal behavior for you?”

b. “I am going to say four words. In a few minutes, I will ask you to recall them.”

c. “Describe the meaning of the phrase, ‘Looking through rose-colored glasses.’”

d. “Pick up the pencil in your left hand, move it to your right hand, and place it on the table.”

ANS: D

Attention span is evaluated by assessing the individual’s ability to concentrate and complete a thought or task without wandering. Giving a series of directions to follow is one method used to assess attention span.

31. The nurse is planning health teaching for a 65-year-old woman who has had a cerebrovascular accident (stroke) and has aphasia. Which of these questions is most important to use when assessing mental status in this patient?

a. “Please count backward from 100 by seven.”

b. “I will name three items and ask you to repeat them in a few minutes.”

c. “Please point to articles in the room and parts of the body as I name them.”

d. “What would you do if you found a stamped, addressed envelope on the sidewalk?”

ANS: C

Additional tests for persons with aphasia include word comprehension (asking the individual to point to articles in the room or parts of the body), reading (asking the person to read available print), and writing (asking the person to make up and write a sentence).

32. A 30-year-old female patient is describing feelings of hopelessness and depression. She has attempted self-mutilation and has a history of suicide attempts. She describes difficulty sleeping at night and has lost 10 pounds in the past month. Which of these statements or questions is the nurse’s best response in this situation?

a. “Do you have a weapon?”

b. “How do other people treat you?”

c. “Are you feeling so hopeless that you feel like hurting yourself now?”

d. “People often feel hopeless, but the feelings resolve within a few weeks.”

ANS: C

When the person expresses feelings of hopelessness, despair, or grief, assessing the risk of physical harm to him or herself is important. This process begins with more general questions. If the answers are affirmative, then the assessment continues with more specific questions.

33. The nurse is providing instructions to newly hired graduates for the mini–mental state examination (MMSE). Which statement best describes this examination?

a. Scores below 30 indicate cognitive impairment.

b. The MMSE is a good tool to evaluate mood and thought processes.

c. This examination is a good tool to detect delirium and dementia and to differentiate these from psychiatric mental illness.

d. The MMSE is useful tool for an initial evaluation of mental status. Additional tools are needed to evaluate cognition changes over time.

ANS: C

The MMSE is a quick, easy test of 11 questions and is used for initial and serial evaluations and can demonstrate a worsening or an improvement of cognition over time and with treatment. It evaluates cognitive functioning, not mood or thought processes. MMSE is a good screening tool to detect dementia and delirium and to differentiate these from psychiatric mental illness.

34. The nurse discovers speech problems in a patient during an assessment. The patient has spontaneous speech, but it is mostly absent or is reduced to a few stereotypical words or sounds. This finding reflects which type of aphasia?

a. Global

b. Broca’s

c. Dysphonic

d. Wernicke’s

ANS: A

Global aphasia is the most common and severe form of aphasia. Spontaneous speech is absent or reduced to a few stereotyped words or sounds, and prognosis for language recovery is poor. (Broca’s aphasia and Wernicke’s aphasia are described in Table 5-4.) Dysphonic aphasia is not a valid condition.

35. A patient repeats, “I feel hot. Hot, cot, rot, tot, got. I’m a spot.” The nurse documents this as an illustration of:

a. Blocking

b. Clanging

c. Echolalia

d. Neologism

ANS: B

Clanging is word choice based on sound, not meaning, and includes nonsense rhymes and puns. (See Table 5-6 for the definitions of the other terms.)

36. During an interview, the nurse notes that the patient gets up several times to wash her hands even though they are not dirty. This behavior is an example of:

a. Social phobia

b. Compulsive disorder

c. Generalized anxiety disorder

d. Posttraumatic stress disorder

ANS: B

Repetitive behaviors, such as handwashing, are behaviors that the person feels driven to perform in response to an obsession. The behaviors are aimed at preventing or reducing distress or preventing some dreaded event or situation.

37. The nurse is administering a Mini-Cog test to an older adult woman. When asked to draw a clock showing the time of 10:45, the patient drew a clock with the numbers out of order and with an incorrect time. This result indicates which finding?

a. Cognitive impairment

b. Amnesia

c. Delirium

d. Attention-deficit disorder

ANS: A

The Mini-Cog is a newer instrument that screens for cognitive impairment, often found with dementia. The result of an abnormal drawing of a clock and time indicates a cognitive impairment.

38. During morning rounds, the nurse asks a patient, “How are you today?” The patient responds, “You today, you today, you today!” and mumbles the words. This speech pattern is an example of:

a. Echolalia

b. Clanging

c. Word salad

d. Perseveration

ANS: A

Echolalia occurs when a person imitates or repeats another’s words or phrases, often with a mumbling, mocking, or a mechanical tone.

MULTIPLE RESPONSE

1. The nurse is assessing a patient who is admitted with possible delirium. Which of these are manifestations of delirium? *Select all that apply*.

a. Develops over a short period.

b. Person is experiencing apraxia.

c. Person is exhibiting memory impairment or deficits.

d. Occurs as a result of a medical condition, such as systemic infection.

e. Person is experiencing agnosia.

ANS: A, C, D

Delirium is a disturbance of consciousness that develops over a short period and may be attributable to a medical condition. Memory deficits may also occur. Apraxia and agnosia occur with dementia.

Chapter 08: Assessment Techniques and Safety in the Clinical Setting

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 patient's 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 patient's skin during an office visit. What part of the hand and technique should be used to best assess the patient's 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 patient's 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 person's 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 child's 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 patient's 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 patient's 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 examiner's 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 person's skin to block out low-pitched sounds.

d. Should be lightly held against the person's 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 person's 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 examiner's 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 patient's 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 patient's anxiety.

c. Follows the same examination sequence, regardless of the patient's 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 examiner's 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 person's 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 one's 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 one 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 patient's 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 patient's body or the examiner's 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. "I'm 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 patient's 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 patient's 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 infant's vital signs.

ANS: A

The parent should always be present to increase the child's 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 infant's 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 child's 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 child's trust has been obtained.

ANS: C

The best place to examine the toddler is on the parent's 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 nurse's technique is *most* accurate?

a. Asking questions enhances the child's 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 child’s 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 wellness.

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 teen’s 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 sweat—regardless 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 patient’s 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 nurse's 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 patient's 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 child's 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 child's head to the toes.

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

a. Document the findings in the patient's 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 09: General Survey, Measurement, Vital Signs

MULTIPLE CHOICE

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

a. Observing the patient's body stature and nutritional status

b. Interpreting the subjective information the patient has reported

c. Measuring the patient's 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 patient's physical appearance, body structure, mobility, and behavior.

2. When measuring a patient's 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 weight.

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 patient's 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 child's:

a. General health.

b. Genetic makeup.

c. Nutritional status.

d. Activity and exercise patterns.

ANS: A

Physical growth is the best index of a child's general health; recording the child's 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 newborn's 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 infant's 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 bones—the 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 patient's body temperature, the nurse keeps in mind that body temperature is influenced by:

a. Constipation.

b. Patient's 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 adult's body temperature?

a. The body temperature of the older adult is lower than that of a younger adult.

b. An older adult's 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 mechanisms.

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 position—leaning forward with arms braced on chair arms—occurs 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 patient’s 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.

21. When assessing the pulse of a 6-year-old boy, the nurse notices that his heart rate varies with his respiratory cycle, speeding up at the peak of inspiration and slowing to normal with expiration. The nurse's next action would be to:

a. Immediately notify the physician.

b. Consider this finding normal in children and young adults.

c. Check the child's blood pressure, and note any variation with respiration.

d. Document that this child has bradycardia, and continue with the assessment.

ANS: B

Sinus arrhythmia is commonly found in children and young adults. During the respiratory cycle, the heart rate varies, speeding up at the peak of inspiration and slowing to normal with expiration.

22. When assessing the force, or strength, of a pulse, the nurse recalls that the pulse:

a. Is usually recorded on a 0- to 2-point scale.

b. Demonstrates elasticity of the vessel wall.

c. Is a reflection of the heart's stroke volume.

d. Reflects the blood volume in the arteries during diastole.

ANS: C

The heart pumps an amount of blood (the stroke volume) into the aorta. The force flares the arterial walls and generates a pressure wave, which is felt in the periphery as the pulse.

23. The nurse is assessing the vital signs of a 20-year-old male marathon runner and documents the following vital signs: temperature–36° C; pulse–48 beats per minute; respirations–14 breaths per minute; blood pressure–104/68 mm Hg. Which statement is *true* concerning these results?

a. The patient is experiencing tachycardia.

b. These are normal vital signs for a healthy, athletic adult.

c. The patient's pulse rate is not normal—his physician should be notified.

d. On the basis of these readings, the patient should return to the clinic in 1 week.

ANS: B

In the adult, a heart rate less than 50 beats per minute is called *bradycardia*, which normally occurs in the well-trained athlete whose heart muscle develops along with the skeletal muscles.

24. The nurse is assessing the vital signs of a 3-year-old patient who appears to have an irregular respiratory pattern. How should the nurse assess this child's respirations?

a. Respirations should be counted for 1 full minute, noticing rate and rhythm.

b. Child's pulse and respirations should be simultaneously checked for 30 seconds.

c. Child's respirations should be checked for a minimum of 5 minutes to identify any variations in his or her respiratory pattern.

d. Patient's respirations should be counted for 15 seconds and then multiplied by 4 to obtain the number of respirations per minute.

ANS: A

Respirations are counted for 1 full minute if an abnormality is suspected. The other responses are not correct actions.

25. A patient's blood pressure is 118/82 mm Hg. He asks the nurse, "What do the numbers mean?" The nurse's best reply is:

a. "The numbers are within the normal range and are nothing to worry about."

b. "The bottom number is the diastolic pressure and reflects the stroke volume of the heart."

c. "The top number is the systolic blood pressure and reflects the pressure of the blood against the arteries when the heart contracts."

d. "The concept of blood pressure is difficult to understand. The primary thing to be concerned about is the top number, or the systolic blood pressure."

ANS: C

The systolic pressure is the maximum pressure felt on the artery during left ventricular contraction, or systole. The diastolic pressure is the elastic recoil, or resting, pressure that the blood constantly exerts in between each contraction. The nurse should answer the patient's question and use terms he can understand.

26. While measuring a patient's blood pressure, the nurse recalls that certain factors, such as _____, help determine blood pressure.

a. Pulse rate

b. Pulse pressure

c. Vascular output

d. Peripheral vascular resistance

ANS: D

The level of blood pressure is determined by five factors: cardiac output, peripheral vascular resistance, volume of circulating blood, viscosity, and elasticity of the vessel walls.

27. A nurse is helping at a health fair at a local mall. When taking blood pressures on a variety of people, the nurse keeps in mind that:

a. After menopause, blood pressure readings in women are usually lower than those taken in men.

b. The blood pressure of a Black adult is usually higher than that of a White adult of the same age.

c. Blood pressure measurements in people who are overweight should be the same as those of people who are at a normal weight.

d. A teenager's blood pressure reading will be lower than that of an adult.

ANS: B

In the United States, a Black adult's blood pressure is usually higher than that of a White adult of the same age. The incidence of hypertension is twice as high in Blacks as it is in Whites. After menopause, blood pressure in women is higher than in men; blood pressure measurements in people who are obese are usually higher than in those who are not overweight. Normally, a gradual rise occurs through childhood and into the adult years.

28. The nurse notices a colleague is preparing to check the blood pressure of a patient who is obese by using a standard-sized blood pressure cuff. The nurse should expect the reading to:

a. Yield a falsely low blood pressure.

b. Yield a falsely high blood pressure.

c. Be the same, regardless of cuff size.

d. Vary as a result of the technique of the person performing the assessment.

ANS: B

Using a cuff that is too narrow yields a falsely high blood pressure because it takes extra pressure to compress the artery.

29. A student is late for his appointment and has rushed across campus to the health clinic. The nurse should:

a. Allow 5 minutes for him to relax and rest before checking his vital signs.

b. Check the blood pressure in both arms, expecting a difference in the readings because of his recent exercise.

c. Immediately monitor his vital signs on his arrival at the clinic and then 5 minutes later, recording any differences.

d. Check his blood pressure in the supine position, which will provide a more accurate reading and will allow him to relax at the same time.

ANS: A

A comfortable, relaxed person yields a valid blood pressure. Many people are anxious at the beginning of an examination; the nurse should allow at least a 5-minute rest period before measuring blood pressure.

30. The nurse will perform a palpated pressure before auscultating blood pressure. The reason for this is to:

a. More clearly hear the Korotkoff sounds.

b. Detect the presence of an auscultatory gap.

c. Avoid missing a falsely elevated blood pressure.

d. More readily identify phase IV of the Korotkoff sounds.

ANS: B

Inflation of the cuff 20 to 30 mm Hg beyond the point at which a palpated pulse disappears will avoid missing an auscultatory gap, which is a period when the Korotkoff sounds disappear during auscultation.

31. The nurse is taking an initial blood pressure reading on a 72-year-old patient with documented hypertension. How should the nurse proceed?

a. Cuff should be placed on the patient’s arm and inflated 30 mm Hg above the patient’s pulse rate.

b. Cuff should be inflated to 200 mm Hg in an attempt to obtain the most accurate systolic reading.

c. Cuff should be inflated 30 mm Hg above the point at which the palpated pulse disappears.

d. After confirming the patient’s previous blood pressure readings, the cuff should be inflated 30 mm Hg above the highest systolic reading recorded.

ANS: C

An auscultatory gap occurs in approximately 5% of the people, most often in those with hypertension. To check for the presence of an auscultatory gap, the cuff should be inflated 20 to 30 mm Hg beyond the point at which the palpated pulse disappears.

32. The nurse has collected the following information on a patient: palpated blood pressure–180 mm Hg; auscultated blood pressure–170/100 mm Hg; apical pulse–60 beats per minute; radial pulse–70 beats per minute. What is the patient’s pulse pressure?

a. 10

b. 70

c. 80

d. 100

ANS: B

Pulse pressure is the difference between systolic and diastolic blood pressure (170 – 100 = 70) and reflects the stroke volume.

33. When auscultating the blood pressure of a 25-year-old patient, the nurse notices the phase I Korotkoff sounds begin at 200 mm Hg. At 100 mm Hg, the Korotkoff sounds muffle. At 92 mm Hg, the Korotkoff sounds disappear. How should the nurse record this patient's blood pressure?

a. 200/92

b. 200/100

c. 100/200/92

d. 200/100/92

ANS: A

In adults, the last audible sound best indicates the diastolic pressure. When a variance is greater than 10 to 12 mm Hg between phases IV and V, both phases should be recorded along with the systolic reading (e.g., 142/98/80).

34. A patient is seen in the clinic for complaints of "fainting episodes that started last week." How should the nurse proceed with the examination?

a. Blood pressure readings are taken in both the arms and the thighs.

b. The patient is assisted to a lying position, and his blood pressure is taken.

c. His blood pressure is recorded in the lying, sitting, and standing positions.

d. His blood pressure is recorded in the lying and sitting positions; these numbers are then averaged to obtain a mean blood pressure.

ANS: C

If the person is known to have hypertension, is taking antihypertensive medications, or reports a history of fainting or syncope, then the blood pressure reading should be taken in three positions: lying, sitting, and standing.

35. A 70-year-old man has a blood pressure of 150/90 mm Hg in a lying position, 130/80 mm Hg in a sitting position, and 100/60 mm Hg in a standing position. How should the nurse evaluate these findings?

a. These readings are a normal response and attributable to changes in the patient's position.

b. The change in blood pressure readings is called *orthostatic hypotension*.

c. The blood pressure reading in the lying position is within normal limits.

d. The change in blood pressure readings is considered within normal limits for the patient's age.

ANS: B

Orthostatic hypotension is a drop in systolic pressure of more than 20 mm Hg, which occurs with a quick change to a standing position. Aging people have the greatest risk of this problem.

36. The nurse is helping another nurse to take a blood pressure reading on a patient's thigh. Which action is *correct* regarding thigh pressure?

a. Either the popliteal or femoral vessels should be auscultated to obtain a thigh pressure.

b. The best position to measure thigh pressure is the supine position with the knee slightly bent.

c. If the blood pressure in the arm is high in an adolescent, then it should be compared with the thigh pressure.

d. The thigh pressure is lower than the pressure in the arm, which is attributable to the distance away from the heart and the size of the popliteal vessels.

ANS: C

When blood pressure measured at the arm is excessively high, particularly in adolescents and young adults, it is compared with thigh pressure to check for coarctation of the aorta. The popliteal artery is auscultated for the reading. Generally, thigh pressure is higher than that of the arm; however, if coarctation of the artery is present, then arm pressures are higher than thigh pressures.

37. The nurse is preparing to measure the vital signs of a 6-month-old infant. Which action by the nurse is *correct*?

a. Respirations are measured; then pulse and temperature.

b. Vital signs should be measured more frequently than in an adult.

c. Procedures are explained to the parent, and the infant is encouraged to handle the equipment.

d. The nurse should first perform the physical examination to allow the infant to become more familiar with her and then measure the infant's vital signs.

ANS: A

With an infant, the order of vital sign measurements is reversed to respiration, pulse, and temperature. Taking the temperature first, especially if it is rectal, may cause the infant to cry, which will increase the respiratory and pulse rate, thus masking the normal resting values. The vital signs are measured with the same purpose and frequency as would be measured in an adult.

38. A 4-month-old child is at the clinic for a well-baby check-up and immunizations. Which of these actions is most appropriate when the nurse is assessing an infant's vital signs?

a. The infant's radial pulse should be palpated, and the nurse should notice any fluctuations resulting from activity or exercise.

b. The nurse should auscultate an apical rate for 1 minute and then assess for any normal irregularities, such as sinus arrhythmia.

c. The infant's blood pressure should be assessed by using a stethoscope with a large diaphragm piece to hear the soft muffled Korotkoff sounds.

d. The infant's chest should be observed and the respiratory rate counted for 1 minute; the respiratory pattern may vary significantly.

ANS: B

The nurse palpates or auscultates an apical rate with infants and toddlers. The pulse should be counted for 1 full minute to account for normal irregularities, such as sinus arrhythmia. Children younger than 3 years of age have such small arm vessels; consequently, hearing Korotkoff sounds with a stethoscope is difficult. The nurse should use either an electronic blood pressure device that uses oscillometry or a Doppler ultrasound device to amplify the sounds.

39. The nurse is conducting a health fair for older adults. Which statement is *true* regarding vital sign measurements in aging adults?

a. The pulse is more difficult to palpate because of the stiffness of the blood vessels.

b. An increased respiratory rate and a shallower inspiratory phase are expected findings.

c. A decreased pulse pressure occurs from changes in the systolic and diastolic blood pressures.

d. Changes in the body's temperature regulatory mechanism leave the older person more likely to develop a fever.

ANS: B

Aging causes a decrease in vital capacity and decreased inspiratory reserve volume. The examiner may notice a shallower inspiratory phase and an increased respiratory rate. An increase in the rigidity of the arterial walls makes the pulse actually easier to palpate. Pulse pressure is widened in older adults, and changes in the body temperature regulatory mechanism leave the older person less likely to have fever but at a greater risk for hypothermia.

40. In a patient with acromegaly, the nurse will expect to discover which assessment findings?

a. Heavy, flattened facial features

b. Growth retardation and a delayed onset of puberty

c. Overgrowth of bone in the face, head, hands, and feet

d. Increased height and weight and delayed sexual development

ANS: C

Excessive secretions of growth hormone in adulthood after normal completion of body growth causes an overgrowth of the bones in the face, head, hands, and feet but no change in height.

41. The nurse is performing a general survey of a patient. Which finding is considered normal?

a. When standing, the patient's base is narrow.

b. The patient appears older than his stated age.

c. Arm span (fingertip to fingertip) is greater than the height.

d. Arm span (fingertip to fingertip) equals the patient's height.

ANS: D

When performing the general survey, the patient's arm span (fingertip to fingertip) should equal the patient's height. An arm span that is greater than the person's height may indicate Marfan syndrome. The base should be wide when the patient is standing, and an older appearance than the stated age may indicate a history of a chronic illness or chronic alcoholism.

42. The nurse is assessing children in a pediatric clinic. Which statement is *true* regarding the measurement of blood pressure in children?

a. Blood pressure guidelines for children are based on age.

b. Phase II Korotkoff sounds are the best indicator of systolic blood pressure in children.

c. Using a Doppler device is recommended for accurate blood pressure measurements until adolescence.

d. The disappearance of phase V Korotkoff sounds can be used for the diastolic reading in children.

ANS: D

The disappearance of phase V Korotkoff sounds can be used for the diastolic reading in children, as well as in adults.

43. What type of blood pressure measurement error is most likely to occur if the nurse does not check for the presence of an auscultatory gap?

a. Diastolic blood pressure may not be heard.

b. Diastolic blood pressure may be falsely low.

c. Systolic blood pressure may be falsely low.

d. Systolic blood pressure may be falsely high.

ANS: C

If an auscultatory gap is undetected, then a falsely low systolic or falsely high diastolic reading may result, which is common in patients with hypertension.

44. When considering the concepts related to blood pressure, the nurse knows that the concept of mean arterial pressure (MAP) is best described by which statement?

a. MAP is the pressure of the arterial pulse.

b. MAP reflects the stroke volume of the heart.

c. MAP is the pressure forcing blood into the tissues, averaged over the cardiac cycle.

d. MAP is an average of the systolic and diastolic blood pressures and reflects tissue perfusion.

ANS: C

MAP is the pressure that forces blood into the tissues, averaged over the cardiac cycle. Stroke volume is reflected by the blood pressure. MAP is not an arithmetic average of systolic and diastolic pressures because diastole lasts longer; rather, it is a value closer to diastolic pressure plus one third of the pulse pressure.

45. A 75-year-old man with a history of hypertension was recently changed to a new antihypertensive drug. He reports feeling dizzy at times. How should the nurse evaluate his blood pressure?

a. Blood pressure and pulse should be recorded in the supine, sitting, and standing positions.

b. The patient should be directed to walk around the room and his blood pressure assessed after this activity.

c. Blood pressure and pulse are assessed at the beginning and at the end of the examination.

d. Blood pressure is taken on the right arm and then 5 minutes later on the left arm.

ANS: A

Orthostatic vital signs should be taken when the person is hypertensive or is taking antihypertensive medications, when the person reports fainting or syncope, or when volume depletion is suspected. The blood pressure and pulse readings are recorded in the supine, sitting, and standing positions.

46. Which of these specific measurements is the best index of a child's general health?

a. Vital signs

b. Height and weight

c. Head circumference

d. Chest circumference

ANS: B

Physical growth, measured by height and weight, is the best index of a child's general health.

47. The nurse is assessing an 8-year-old child whose growth rate measures below the third percentile for a child his age. He appears significantly younger than his stated age and is chubby with infantile facial features. Which condition does this child have?

a. Hypopituitary dwarfism

b. Achondroplastic dwarfism

c. Marfan syndrome

d. Acromegaly

ANS: A

Hypopituitary dwarfism is caused by a deficiency in growth hormone in childhood and results in a retardation of growth below the third percentile, delayed puberty, and other problems. The child's appearance fits this description. Achondroplastic dwarfism is a genetic disorder resulting in characteristic deformities; Marfan syndrome is an inherited connective tissue disorder characterized by a tall, thin stature and other features. Acromegaly is the result of excessive secretion of growth hormone in adulthood. (For more information, see Table 9-5, Abnormalities in Body Height and Proportion.)

48. The nurse is counting an infant's respirations. Which technique is correct?

a. Watching the chest rise and fall

b. Watching the abdomen for movement

c. Placing a hand across the infant's chest

d. Using a stethoscope to listen to the breath sounds

ANS: B

Watching the abdomen for movement is the correct technique because the infant's respirations are normally more diaphragmatic than thoracic. The other responses do not reflect correct techniques.

49. When checking for proper blood pressure cuff size, which guideline is correct?

a. The standard cuff size is appropriate for all sizes.

b. The length of the rubber bladder should equal 80% of the arm circumference.

c. The width of the rubber bladder should equal 80% of the arm circumference.

d. The width of the rubber bladder should equal 40% of the arm circumference.

ANS: D

The width of the rubber bladder should equal 40% of the circumference of the person's arm. The length of the bladder should equal 80% of this circumference.

50. During an examination, the nurse notices that a female patient has a round "moon" face, central trunk obesity, and a cervical hump. Her skin is fragile with bruises. The nurse determines that the patient has which condition?

a. Marfan syndrome

b. Gigantism

c. Cushing syndrome

d. Acromegaly

ANS: C

Cushing syndrome is characterized by weight gain and edema with central trunk and cervical obesity (buffalo hump) and round plethoric face (moon face). Excessive catabolism causes muscle wasting; weakness; thin arms and legs; reduced height; and thin, fragile skin with purple abdominal striae, bruising, and acne. (See Table 9-5, Abnormalities in Body Height and Proportion, for the definitions of the other conditions.)

MULTIPLE RESPONSE

1. While measuring a patient's blood pressure, the nurse uses the proper technique to obtain an accurate reading. Which of these situations will result in a falsely high blood pressure reading? *Select all that apply*.

a. The person supports his or her own arm during the blood pressure reading.

b. The blood pressure cuff is too narrow for the extremity.

c. The arm is held above level of the heart.

d. The cuff is loosely wrapped around the arm.

e. The person is sitting with his or her legs crossed.

f. The nurse does not inflate the cuff high enough.

ANS: A, B, D, E

Several factors can result in blood pressure readings that are too high or too low. Having the patient's arm held above the level of the heart is one part of the correct technique. (Refer to Table 9-5, Common Errors in Blood Pressure Measurement.)

SHORT ANSWER

1. What is the pulse pressure for a patient whose blood pressure is 158/96 mm Hg and whose pulse rate is 72 beats per minute?

ANS:

62

The pulse pressure is the difference between the systolic and diastolic and reflects the stroke volume. The pulse rate is not necessary for pulse pressure calculations.

Chapter 10: Pain Assessment: The Fifth Vital Sign

MULTIPLE CHOICE

1. When evaluating a patient's pain, the nurse knows that an example of acute pain would be:

a. Arthritic pain.

b. Fibromyalgia.

c. Kidney stones.

d. Low back pain.

ANS: C

Acute pain is short-term and dissipates after an injury heals, such as with kidney stones. The other conditions are examples of chronic pain during which the pain continues for 6 months or longer and does not stop when the injury heals.

2. Which statement indicates that the nurse understands the pain experienced by an older adult?

a. “Older adults must learn to tolerate pain.”

b. “Pain is a normal process of aging and is to be expected.”

c. “Pain indicates a pathologic condition or an injury and is not a normal process of aging.”

d. “Older individuals perceive pain to a lesser degree than do younger individuals.”

ANS: C

Pain indicates a pathologic condition or an injury and should never be considered something that an older adult should expect or tolerate. Pain is not a normal process of aging, and no evidence suggests that pain perception is reduced with aging.

3. A 4-year-old boy is brought to the emergency department by his mother. She says he points to his stomach and says, “It hurts so bad.” Which pain assessment tool would be the best choice when assessing this child’s pain?

a. Descriptor Scale

b. Numeric rating scale

c. Brief Pain Inventory

d. Faces Pain Scale—Revised (FPS-R)

ANS: D

Rating scales can be introduced at the age of 4 or 5 years. The FPS-R is designed for use by children and asks the child to choose a face that shows “how much hurt (or pain) you have now.” Young children should not be asked to rate pain by using numbers.

4. A patient states that the pain medication is “not working” and rates his postoperative pain at a 10 on a 1-to-10 scale. Which of these assessment findings indicates an acute pain response to poorly controlled pain?

a. Confusion

b. Hyperventilation

c. Increased blood pressure and pulse

d. Depression

ANS: C

Responses to poorly controlled acute pain include tachycardia, elevated blood pressure, and hypoventilation. Confusion and depression are associated with poorly controlled chronic pain (see Table 10-1).

5. A 60-year-old woman has developed reflexive sympathetic dystrophy after arthroscopic repair of her shoulder. A key feature of this condition is that the:

a. Affected extremity will eventually regain its function.

b. Pain is felt at one site but originates from another location.

c. Patient’s pain will be associated with nausea, pallor, and diaphoresis.

d. Slightest touch, such as a sleeve brushing against her arm, causes severe and intense pain.

ANS: D

A key feature of reflexive sympathetic dystrophy is that a typically innocuous stimulus can create a severe, intensely painful response. The affected extremity becomes less functional over time.

6. The nurse is assessing a patient's pain. The nurse knows that the most reliable indicator of pain would be the:

a. Patient's vital signs.

b. Physical examination.

c. Results of a computerized axial tomographic scan.

d. Subjective report.

ANS: D

The subjective report is the most reliable indicator of pain. Physical examination findings can lend support, but the clinician cannot exclusively base the diagnosis of pain on physical assessment findings.

7. A patient has had arthritic pain in her hips for several years since a hip fracture. She is able to move around in her room and has not offered any complaints so far this morning. However, when asked, she states that her pain is "bad this morning" and rates it at an 8 on a 1-to-10 scale. What does the nurse suspect? The patient:

a. Is addicted to her pain medications and cannot obtain pain relief.

b. Does not want to trouble the nursing staff with her complaints.

c. Is not in pain but rates it high to receive pain medication.

d. Has experienced chronic pain for years and has adapted to it.

ANS: D

Persons with chronic pain typically try to give little indication that they are in pain and, over time, adapt to the pain. As a result, they are at risk for underdetection.

8. The nurse is reviewing the principles of pain. Which type of pain is due to an abnormal processing of the pain impulse through the peripheral or central nervous system?

a. Visceral

b. Referred

c. Cutaneous

d. Neuropathic

ANS: D

Neuropathic pain implies an abnormal processing of the pain message. The other types of pain are named according to their sources.

9. When assessing the quality of a patient's pain, the nurse should ask which question?

a. "When did the pain start?"

b. "Is the pain a stabbing pain?"

c. "Is it a sharp pain or dull pain?"

d. "What does your pain feel like?"

ANS: D

To assess the quality of a person's pain, the patient is asked to describe the pain in his or her own words.

10. When assessing a patient's pain, the nurse knows that an example of visceral pain would be:

a. Hip fracture.

b. Cholecystitis.

c. Second-degree burns.

d. Pain after a leg amputation.

ANS: B

Visceral pain originates from the larger interior organs, such as the gallbladder, liver, or kidneys.

11. The nurse is reviewing the principles of nociception. During which phase of nociception does the conscious awareness of a painful sensation occur?

a. Perception

b. Modulation

c. Transduction

d. Transmission

ANS: A

Perception is the third phase of nociception and indicates the conscious awareness of a painful sensation. During this phase, the sensation is recognized by higher cortical structures and identified as pain.

12. When assessing the intensity of a patient's pain, which question by the nurse is appropriate?

a. "What makes your pain better or worse?"

b. "How much pain do you have now?"

c. "How does pain limit your activities?"

d. "What does your pain feel like?"

ANS: B

Asking the patient "how much pain do you have?" is an assessment of the intensity of a patient's pain; various intensity scales can be used. Asking what makes one's pain better or worse assesses alleviating or aggravating factors. Asking whether pain limits one's activities assesses the degree of impairment and quality of life. Asking "what does your pain feel like" assesses the quality of pain.

13. A patient is complaining of severe knee pain after twisting it during a basketball game and is requesting pain medication. Which action by the nurse is appropriate?

a. Completing the physical examination first and then giving the pain medication

b. Telling the patient that the pain medication must wait until after the x-ray images are completed

c. Evaluating the full range of motion of the knee and then medicating for pain

d. Administering pain medication and then proceeding with the assessment

ANS: D

According to the American Pain Society (1992), “In cases in which the cause of acute pain is uncertain, establishing a diagnosis is a priority, but symptomatic treatment of pain should be given while the investigation is proceeding. With occasional exceptions, (e.g., the *initial*examination of the patient with an acute condition of the abdomen), it is rarely justified to defer analgesia until a diagnosis is made. In fact, a comfortable patient is better able to cooperate with diagnostic procedures.”

14. The nurse knows that which statement is *true* regarding the pain experienced by infants?

a. Pain in infants can only be assessed by physiologic changes, such as an increased heart rate.

b. The FPS-R can be used to assess pain in infants.

c. A procedure that induces pain in adults will also induce pain in the infant.

d. Infants feel pain less than do adults.

ANS: C

If a procedure or disease process causes pain in an adult, then it will also cause pain in an infant. Physiologic changes cannot be exclusively used to confirm or deny pain because other factors, such as medications, fluid status, or stress may cause physiologic changes. The FPS-R can be used starting at age 4 years.

15. A patient has been admitted to the hospital with vertebral fractures related to osteoporosis. She is in extreme pain. This type of pain would be classified as:

a. Referred.

b. Cutaneous.

c. Visceral.

d. Deep somatic.

ANS: D

Deep somatic pain comes from sources such as the blood vessels, joints, tendons, muscles, and bone. Referred pain is felt at one site but originates from another location. Cutaneous pain is derived from the skin surface and subcutaneous tissues. Visceral pain originates from the larger, interior organs.

MULTIPLE RESPONSE

1. During assessment of a patient’s pain, the nurse is aware that certain nonverbal behaviors are associated with chronic pain. Which of these behaviors are associated with chronic pain?*Select all that apply*.

a. Sleeping

b. Moaning

c. Diaphoresis

d. Bracing

e. Restlessness

f. Rubbing

ANS: A, D, F

Behaviors that have been associated with chronic pain include bracing, rubbing, diminished activity, sighing, and changes in appetite. In addition, those with chronic pain may sleep in an attempt at distraction. The other behaviors are associated with acute pain.

2. During an admission assessment of a patient with dementia, the nurse assesses for pain because the patient has recently had several falls. Which of these are appropriate for the nurse to assess in a patient with dementia? *Select all that apply*.

a. Ask the patient, “Do you have pain?”

b. Assess the patient’s breathing independent of vocalization.

c. Note whether the patient is calling out, groaning, or crying.

d. Have the patient rate pain on a 1-to-10 scale.

e. Observe the patient's body language for pacing and agitation.

ANS: B, C, E

Patients with dementia may say "no" when, in reality, they are very uncomfortable because words have lost their meaning. Patients with dementia become less able to identify and describe pain over time, although pain is still present. People with dementia communicate pain through their behaviors. Agitation, pacing, and repetitive yelling may indicate pain and not a worsening of the dementia. (See Figure 10-10 for the Pain Assessment in Advanced Dementia [PAINAD] scale, which may also be used to assess pain in persons with dementia.)

Chapter 07: Domestic and Family Violence Assessments

MULTIPLE CHOICE

1. As a mandatory reporter of elder abuse, which must be present before a nurse should notify the authorities?

a. Statements from the victim

b. Statements from witnesses

c. Proof of abuse and/or neglect

d. Suspicion of elder abuse and/or neglect

ANS: D

Many health care workers are under the erroneous assumption that proof is required before notification of suspected abuse can occur. Only the *suspicion* of elder abuse or neglect is necessary.

2. During a home visit, the nurse notices that an older adult woman is caring for her bedridden husband. The woman states that this is her duty, she does the best she can, and her children come to help when they are in town. Her husband is unable to care for himself, and she appears thin, weak, and exhausted. The nurse notices that several of his prescription medication bottles are empty. This situation is best described by the term:

a. Physical abuse.

b. Financial neglect.

c. Psychological abuse.

d. Unintentional physical neglect.

ANS: D

Unintentional physical neglect may occur, despite good intentions, and is the failure of a family member or caregiver to provide basic goods or services. Physical abuse is defined as*violent acts that result or could result in injury, pain, impairment, or disease*. Financial neglect is defined as *the failure to use the assets of the older person to provide services needed by him or her*. Psychological abuse is defined as *behaviors that result in mental anguish*.

3. The nurse is aware that intimate partner violence (IPV) screening should occur with which situation?

a. When IPV is suspected

b. When a woman has an unexplained injury

c. As a routine part of each health care encounter

d. When a history of abuse in the family is known

ANS: C

Many nursing professional organizations have called for routine, universal screening for IPV to assist women in getting help for the problem.

4. Which statement is *best* for the nurse to use when preparing to administer the Abuse Assessment Screen?

a. "We are required by law to ask these questions."

b. “We need to talk about whether you believe you have been abused.”

c. “We are asking these questions because we suspect that you are being abused.”

d. “We need to ask the following questions because domestic violence is so common in our society.”

ANS: D

Such an introduction alerts the woman that questions about domestic violence are coming and ensures the woman that she is not being singled out for these questions.

5. Which term refers to a wound produced by the tearing or splitting of body tissue, usually from blunt impact over a bony surface?

a. Abrasion

b. Contusion

c. Laceration

d. Hematoma

ANS: C

The term *laceration* refers to a wound produced by the tearing or splitting of body tissue. An abrasion is caused by the rubbing of the skin or mucous membrane. A contusion is injury to tissues without breakage of skin, and a hematoma is a localized collection of extravasated blood.

6. During an examination, the nurse notices a patterned injury on a patient’s back. Which of these would cause such an injury?

a. Blunt force

b. Friction abrasion

c. Stabbing from a kitchen knife

d. Whipping from an extension cord

ANS: D

A patterned injury is an injury caused by an object that leaves a distinct pattern on the skin or organ. The other actions do not cause a patterned injury.

7. When documenting IPV and elder abuse, the nurse should include:

a. Photographic documentation of the injuries.

b. Summary of the abused patient’s statements.

c. Verbatim documentation of every statement made.

d. General description of injuries in the progress notes.

ANS: A

Documentation of IPV and elder abuse must include detailed nonbiased progress notes, the use of injury maps, and photographic documentation. Written documentation needs to be verbatim, within reason. Not every statement can be documented.

8. A female patient has denied any abuse when answering the Abuse Assessment Screen, but the nurse has noticed some other conditions that are associated with IPV. Examples of such conditions include:

a. Asthma.

b. Confusion.

c. Depression.

d. Frequent colds.

ANS: C

Depression is one of the conditions that is particularly associated with IPV. Abused women also have been found to have more chronic health problems, such as neurologic, gastrointestinal, and gynecologic symptoms; chronic pain; and symptoms of suicidality and posttraumatic stress disorder.

9. The nurse is using the danger assessment (DA) tool to evaluate the risk of homicide. Which of these statements best describes its use?

a. The DA tool is to be administered by law enforcement personnel.

b. The DA tool should be used in every assessment of suspected abuse.

c. The number of “yes” answers indicates the woman’s understanding of her situation.

d. The higher the number of “yes” answers, the more serious the danger of the woman’s situation.

ANS: D

No predetermined cutoff scores exist on the DA. The higher the number “yes” answers, the more serious the danger of the woman’s situation. The use of this tool is not limited to law enforcement personnel and is not required in every case of suspected abuse.

10. The nurse is assessing bruising on an injured patient. Which color indicates a new bruise that is less than 2 hours old?

a. Red

b. Purple-blue

c. Greenish-brown

d. Brownish-yellow

ANS: A

A new bruise is usually red and will often develop a purple or purple-blue appearance 12 to 36 hours after blunt-force trauma. The color of bruises (and ecchymoses) generally progresses from purple-blue to bluish-green to greenish-brown to brownish-yellow before fading away.

11. The nurse suspects abuse when a 10-year-old child is taken to the urgent care center for a leg injury. The best way to document the history and physical findings is to:

a. Document what the child’s caregiver tells the nurse.

b. Use the words the child has said to describe how the injury occurred.

c. Record what the nurse observes during the conversation.

d. Rely on photographs of the injuries.

ANS: B

When documenting the history and physical findings of suspected child abuse and neglect, use the words the child has said to describe how his or her injury occurred. Remember, the abuser may be accompanying the child.

12. During an interview, a woman has answered “yes” to two of the Abuse Assessment Screen questions. What should the nurse say next?

a. “I need to report this abuse to the authorities.”

b. “Tell me about this abuse in your relationship.”

c. “So you were abused?”

d. “Do you know what caused this abuse?”

ANS: B

If a woman answers “yes” to any of the Abuse Assessment Screen questions, then the nurse should ask questions designed to assess how recent and how serious the abuse was. Asking the woman an open-ended question, such as “tell me about this abuse in your relationship” is a good way to start.

13. The nurse is examining a 3-year-old child who was brought to the emergency department after a fall. Which bruise, if found, would be of most concern?

a. Bruise on the knee

b. Bruise on the elbow

c. Bruising on the abdomen

d. Bruise on the shin

ANS: C

Studies have shown that children who are walking often have bruises over the bony prominences of the front of their bodies. Other studies have found that bruising in atypical places such as the buttocks, hands, feet, and abdomen were exceedingly rare and should arouse concern.

MULTIPLE RESPONSE

1. The nurse assesses an older woman and suspects physical abuse. Which questions are appropriate for screening for abuse? *Select all that apply*.

a. “Has anyone made you afraid, touched you in ways that you did not want, or hurt you physically?”

b. “Are you being abused?”

c. “Have you relied on people for any of the following: bathing, dressing, shopping, banking, or meals?”

d. “Have you been upset because someone talked to you in a way that made you feel shamed or threatened?”

e. “Have you relied on people for any of the following: bathing, dressing, shopping, banking, or meals?”

ANS: A, C, D, E

Directly asking “Are you being abused?” is not an appropriate screening question for abuse because the woman could easily say “no,” and no further information would be obtained. The other questions are among the questions recommended by the Elder Abuse Suspicion Index (EASI) when screening for elder abuse.

Chapter 12: Skin, Hair, and Nails

MULTIPLE CHOICE

1. The nurse educator is preparing an education module for the nursing staff on the epidermal layer of skin. Which of these statements would be included in the module? The epidermis is:

a. Highly vascular.

b. Thick and tough.

c. Thin and nonstratified.

d. Replaced every 4 weeks.

ANS: D

The epidermis is thin yet tough, replaced every 4 weeks, avascular, and stratified into several zones.

2. The nurse educator is preparing an education module for the nursing staff on the dermis layer of skin. Which of these statements would be included in the module? The dermis:

a. Contains mostly fat cells.

b. Consists mostly of keratin.

c. Is replaced every 4 weeks.

d. Contains sensory receptors.

ANS: D

The dermis consists mostly of collagen, has resilient elastic tissue that allows the skin to stretch, and contains nerves, sensory receptors, blood vessels, and lymphatic vessels. It is not replaced every 4 weeks.

3. The nurse is examining a patient who tells the nurse, “I sure sweat a lot, especially on my face and feet but it doesn’t have an odor.” The nurse knows that this condition could be related to:

a. Eccrine glands.

b. Apocrine glands.

c. Disorder of the stratum corneum.

d. Disorder of the stratum germinativum.

ANS: A

The eccrine glands are coiled tubules that directly open onto the skin surface and produce a dilute saline solution called *sweat*. Apocrine glands are primarily located in the axillae, anogenital area, nipples, and naval area and mix with bacterial flora to produce the characteristic musky body odor. The patient’s statement is not related to disorders of the stratum corneum or the stratum germinativum.

4. A newborn infant is in the clinic for a well-baby checkup. The nurse observes the infant for the possibility of fluid loss because of which of these factors?

a. Subcutaneous fat deposits are high in the newborn.

b. Sebaceous glands are overproductive in the newborn.

c. The newborn’s skin is more permeable than that of the adult.

d. The amount of vernix caseosa dramatically rises in the newborn.

ANS: C

The newborn’s skin is thin, smooth, and elastic and is relatively more permeable than that of the adult; consequently, the infant is at greater risk for fluid loss. The subcutaneous layer in the infant is inefficient, not thick, and the sebaceous glands are present but decrease in size and production. Vernix caseosa is not produced after birth.

5. The nurse is bathing an 80-year-old man and notices that his skin is wrinkled, thin, lax, and dry. This finding would be related to which factor in the older adult?

a. Increased vascularity of the skin

b. Increased numbers of sweat and sebaceous glands

c. An increase in elastin and a decrease in subcutaneous fat

d. An increased loss of elastin and a decrease in subcutaneous fat

ANS: D

An accumulation of factors place the aging person at risk for skin disease and breakdown: the thinning of the skin, a decrease in vascularity and nutrients, the loss of protective cushioning of the subcutaneous layer, a lifetime of environmental trauma to skin, the social changes of aging, a increasingly sedentary lifestyle, and the chance of immobility.

6. During the aging process, the hair can look gray or white and begin to feel thin and fine. The nurse knows that this occurs because of a decrease in the number of functioning:

a. Metrocytes.

b. Fungacytes.

c. Phagocytes.

d. Melanocytes.

ANS: D

In the aging hair matrix, the number of functioning melanocytes decreases; as a result, the hair looks gray or white and feels thin and fine. The other options are not correct.

7. During an examination, the nurse finds that a patient has excessive dryness of the skin. The best term to describe this condition is:

a. Xerosis.

b. Pruritus.

c. Alopecia.

d. Seborrhea.

ANS: A

Xerosis is the term used to describe skin that is excessively dry. Pruritus refers to itching, alopecia refers to hair loss, and seborrhea refers to oily skin.

8. A 22-year-old woman comes to the clinic because of severe sunburn and states, “I was out in the sun for just a couple of minutes.” The nurse begins a medication review with her, paying special attention to which medication class?

a. Nonsteroidal antiinflammatory drugs for pain

b. Tetracyclines for acne

c. Proton pump inhibitors for heartburn

d. Thyroid replacement hormone for hypothyroidism

ANS: B

Drugs that may increase sunlight sensitivity and give a burn response include sulfonamides, thiazide diuretics, oral hypoglycemic agents, and tetracycline.

9. A woman is leaving on a trip to Hawaii and has come in for a checkup. During the examination the nurse learns that she has diabetes and takes oral hypoglycemic agents. The patient needs to be concerned about which possible effect of her medications?

a. Increased possibility of bruising

b. Skin sensitivity as a result of exposure to salt water

c. Lack of availability of glucose-monitoring supplies

d. Importance of sunscreen and avoiding direct sunlight

ANS: D

Drugs that may increase sunlight sensitivity and give a burn response include sulfonamides, thiazide diuretics, oral hypoglycemic agents, and tetracycline.

10. A 13-year-old girl is interested in obtaining information about the cause of her acne. The nurse should share with her that acne:

a. Is contagious.

b. Has no known cause.

c. Is caused by increased sebum production.

d. Has been found to be related to poor hygiene.

ANS: C

Approximately 90% of males and 80% of females will develop acne; causes are increased sebum production and epithelial cells that do not desquamate normally.

11. A 75-year-old woman who has a history of diabetes and peripheral vascular disease has been trying to remove a corn on the bottom of her foot with a pair of scissors. The nurse will encourage her to stop trying to remove the corn with scissors because:

a. The woman could be at increased risk for infection and lesions because of her chronic disease.

b. With her diabetes, she has increased circulation to her foot, and it could cause severe bleeding.

c. She is 75 years old and is unable to see; consequently, she places herself at greater risk for self-injury with the scissors.

d. With her peripheral vascular disease, her range of motion is limited and she may not be able to reach the corn safely.

ANS: A

A personal history of diabetes and peripheral vascular disease increases a person's risk for skin lesions in the feet or ankles. The patient needs to seek a professional for assistance with corn removal.

12. The nurse keeps in mind that a thorough skin assessment is extremely important because the skin holds information about a person's:

a. Support systems.

b. Circulatory status.

c. Socioeconomic status.

d. Psychological wellness.

ANS: B

The skin holds information about the body's circulation, nutritional status, and signs of systemic diseases, as well as topical data on the integumentary system itself.

13. A patient comes in for a physical examination and complains of "freezing to death" while waiting for her examination. The nurse notes that her skin is pale and cool and attributes this finding to:

a. Venous pooling.

b. Peripheral vasodilation.

c. Peripheral vasoconstriction.

d. Decreased arterial perfusion.

ANS: C

A chilly or air-conditioned environment causes vasoconstriction, which results in false pallor and coolness (see Table 12-1).

14. A patient comes to the clinic and tells the nurse that he has been confined to his recliner chair for approximately 3 days with his feet down and he asks the nurse to evaluate his feet. During the assessment, the nurse might expect to find:

a. Pallor

b. Coolness

c. Distended veins

d. Prolonged capillary filling time

ANS: C

Keeping the feet in a dependent position causes venous pooling, resulting in redness, warmth, and distended veins. Prolonged elevation would cause pallor and coolness. Immobilization or prolonged inactivity would cause prolonged capillary filling time (see Table 12-1).

15. A patient is especially worried about an area of skin on her feet that has turned white. The health care provider has told her that her condition is vitiligo. The nurse explains to her that vitiligo is:

a. Caused by an excess of melanin pigment

b. Caused by an excess of apocrine glands in her feet

c. Caused by the complete absence of melanin pigment

d. Related to impetigo and can be treated with an ointment

ANS: C

Vitiligo is the complete absence of melanin pigment in patchy areas of white or light skin on the face, neck, hands, feet, body folds, and around orifices—otherwise, the depigmented skin is normal.

16. A patient tells the nurse that he has noticed that one of his moles has started to burn and bleed. When assessing his skin, the nurse pays special attention to the danger signs for pigmented lesions and is concerned with which additional finding?

a. Color variation

b. Border regularity

c. Symmetry of lesions

d. Diameter of less than 6 mm

ANS: A

Abnormal characteristics of pigmented lesions are summarized in the mnemonic ABCD: asymmetry of pigmented lesion, border irregularity, color variation, and diameter greater than 6 mm.

17. A patient comes to the clinic and states that he has noticed that his skin is redder than normal. The nurse understands that this condition is due to hyperemia and knows that it can be caused by:

a. Decreased amounts of bilirubin in the blood

b. Excess blood in the underlying blood vessels

c. Decreased perfusion to the surrounding tissues

d. Excess blood in the dilated superficial capillaries

ANS: D

Erythema is an intense redness of the skin caused by excess blood (hyperemia) in the dilated superficial capillaries.

18. During a skin assessment, the nurse notices that a Mexican-American patient has skin that is yellowish-brown; however, the skin on the hard and soft palate is pink and the patient's scleras are not yellow. From this finding, the nurse could probably rule out:

a. Pallor

b. Jaundice

c. Cyanosis

d. Iron deficiency

ANS: B

Jaundice is exhibited by a yellow color, which indicates rising levels of bilirubin in the blood. Jaundice is first noticed in the junction of the hard and soft palate in the mouth and in the scleras.

19. A black patient is in the intensive care unit because of impending shock after an accident. The nurse expects to find what characteristics in this patient's skin?

a. Ruddy blue.

b. Generalized pallor.

c. Ashen, gray, or dull.

d. Patchy areas of pallor.

ANS: C

Pallor attributable to shock, with decreased perfusion and vasoconstriction, in black-skinned people will cause the skin to appear ashen, gray, or dull (see Table 12-2).

DIF: Cognitive Level: Analyzing (Analysis) REF: pp. 208-209

MSC: Client Needs: Physiologic Integrity: Physiologic Adaptation

20. An older adult woman is brought to the emergency department after being found lying on the kitchen floor for 2 days; she is extremely dehydrated. What would the nurse expect to see during the examination?

a. Smooth mucous membranes and lips

b. Dry mucous membranes and cracked lips

c. Pale mucous membranes

d. White patches on the mucous membranes

ANS: B

With dehydration, mucous membranes appear dry and the lips look parched and cracked. The other responses are not found in dehydration.

21. A 42-year-old woman complains that she has noticed several small, slightly raised, bright red dots on her chest. On examination, the nurse expects that the spots are probably:

a. Anasarca.

b. Scleroderma.

c. Senile angiomas.

d. Latent myeloma.

ANS: C

Cherry (senile) angiomas are small, smooth, slightly raised bright red dots that commonly appear on the trunk of adults over 30 years old.

22. A 65-year-old man with emphysema and bronchitis has come to the clinic for a follow-up appointment. On assessment, the nurse might expect to see which finding?

a. Anasarca

b. Scleroderma

c. Pedal erythema

d. Clubbing of the nails

ANS: D

Clubbing of the nails occurs with congenital cyanotic heart disease and neoplastic and pulmonary diseases. The other responses are assessment findings not associated with pulmonary diseases.

23. A newborn infant has Down syndrome. During the skin assessment, the nurse notices a transient mottling in the trunk and extremities in response to the cool temperature in the examination room. The infant's mother also notices the mottling and asks what it is. The nurse knows that this mottling is called:

a. Café au lait.

b. Carotenemia.

c. Acrocyanosis.

d. Cutis marmorata.

ANS: D

Persistent or pronounced cutis marmorata occurs with infants born with Down syndrome or those born prematurely and is a transient mottling in the trunk and extremities in response to cool room temperatures. A café au lait spot is a large round or oval patch of light-brown pigmentation. Carotenemia produces a yellow-orange color in light-skinned persons. Acrocyanosis is a bluish color around the lips, hands and fingernails, and feet and toenails.

24. A 35-year-old pregnant woman comes to the clinic for a monthly appointment. During the assessment, the nurse notices that she has a brown patch of hyperpigmentation on her face. The nurse continues the skin assessment aware that another finding may be:

a. Keratoses.

b. Xerosis.

c. Chloasma.

d. Acrochordons.

ANS: C

In pregnancy, skin changes can include striae, linea nigra (a brownish-black line down the midline), chloasma (brown patches of hyperpigmentation), and vascular spiders. Keratoses are raised, thickened areas of pigmentation that look crusted, scaly, and warty. Xerosis is dry skin. Acrochordons, or *skin tags*, occur more often in the aging adult.

25. A man has come in to the clinic for a skin assessment because he is worried he might have skin cancer. During the skin assessment the nurse notices several areas of pigmentation that look greasy, dark, and "stuck on" his skin. Which is the best prediction?

a. Senile lentigines, which do not become cancerous

b. Actinic keratoses, which are precursors to basal cell carcinoma

c. Acrochordons, which are precursors to squamous cell carcinoma

d. Seborrheic keratoses, which do not become cancerous

ANS: D

Seborrheic keratoses appear like dark, greasy, "stuck-on" lesions that primarily develop on the trunk. These lesions do not become cancerous. Senile lentigines are commonly called*liver spots* and are not precancerous. Actinic (senile or solar) keratoses are lesions that are red-tan scaly plaques that increase over the years to become raised and roughened. They may have a silvery-white scale adherent to the plaque. They occur on sun-exposed surfaces and are directly related to sun exposure. They are premalignant and may develop into squamous cell carcinoma. Acrochordons are *skin tags* and are not precancerous.

26. A 70-year-old woman who loves to garden has small, flat, brown macules over her arms and hands. She asks, "What causes these liver spots?" The nurse tells her, "They are:

a. "Signs of decreased hematocrit related to anemia."

b. "Due to the destruction of melanin in your skin from exposure to the sun."

c. "Clusters of melanocytes that appear after extensive sun exposure."

d. "Areas of hyperpigmentation related to decreased perfusion and vasoconstriction."

ANS: C

Liver spots, or senile lentigines, are clusters of melanocytes that appear on the forearms and dorsa of the hands after extensive sun exposure. The other responses are not correct.

27. The nurse notices that a patient has a solid, elevated, circumscribed lesion that is less than 1 cm in diameter. When documenting this finding, the nurse reports this as a:

a. Bulla.

b. Wheal.

c. Nodule.

d. Papule.

ANS: D

A papule is something one can feel, is solid, elevated, circumscribed, less than 1 cm in diameter, and is due to superficial thickening in the epidermis. A bulla is larger than 1 cm, superficial, and thin walled. A wheal is superficial, raised, transient, erythematous, and irregular in shape attributable to edema. A nodule is solid, elevated, hard or soft, and larger than 1 cm.

28. The nurse just noted from the medical record that the patient has a lesion that is confluent in nature. On examination, the nurse expects to find:

a. Lesions that run together.

b. Annular lesions that have grown together.

c. Lesions arranged in a line along a nerve route.

d. Lesions that are grouped or clustered together.

ANS: A

Confluent lesions (as with urticaria [hives]) run together. Grouped lesions are clustered together. Annular lesions are circular in nature. Zosteriform lesions are arranged along a nerve route.

29. A patient has had a “terrible itch” for several months that he has been continuously scratching. On examination, the nurse might expect to find:

a. A keloid.

b. A fissure.

c. Keratosis.

d. Lichenification.

ANS: D

Lichenification results from prolonged, intense scratching that eventually thickens the skin and produces tightly packed sets of papules. A keloid is a hypertrophic scar. A fissure is a linear crack with abrupt edges, which extends into the dermis; it can be dry or moist. Keratoses are lesions that are raised, thickened areas of pigmentation that appear crusted, scaly, and warty.

30. A physician has diagnosed a patient with purpura. After leaving the room, a nursing student asks the nurse what the physician saw that led to that diagnosis. The nurse should say, “The physician is referring to the:

a. “Blue dilation of blood vessels in a star-shaped linear pattern on the legs.”

b. “Fiery red, star-shaped marking on the cheek that has a solid circular center.”

c. “Confluent and extensive patch of petechiae and ecchymoses on the feet.”

d. “Tiny areas of hemorrhage that are less than 2 mm, round, discrete, and dark red in color.”

ANS: C

Purpura is a confluent and extensive patch of petechiae and ecchymoses and a flat macular hemorrhage observed in generalized disorders such as thrombocytopenia and scurvy. The blue dilation of blood vessels in a star-shaped linear pattern on the legs describes a venous lake. The fiery red, star-

shaped marking on the cheek that has a solid circular center describes a spider or star angioma. The tiny areas of hemorrhage that are less than 2 mm, round, discrete, and dark red in color describes petechiae.

31. A mother has noticed that her son, who has been to a new babysitter, has some blisters and scabs on his face and buttocks. On examination, the nurse notices moist, thin-roofed vesicles with a thin erythematous base and suspects:

a. Eczema.

b. Impetigo.

c. Herpes zoster.

d. Diaper dermatitis.

ANS: B

Impetigo is moist, thin-roofed vesicles with a thin erythematous base and is a contagious bacterial infection of the skin and most common in infants and children. Eczema is characterized by erythematous papules and vesicles with weeping, oozing, and crusts. Herpes zoster (i.e., chickenpox or varicella) is characterized by small, tight vesicles that are shiny with an erythematous base. Diaper dermatitis is characterized by red, moist maculopapular patches with poorly defined borders.

32. The nurse notices that a school-aged child has bluish-white, red-based spots in her mouth that are elevated approximately 1 to 3 mm. What other signs would the nurse expect to find in this patient?

a. Pink, papular rash on the face and neck

b. Pruritic vesicles over her trunk and neck

c. Hyperpigmentation on the chest, abdomen, and back of the arms

d. Red-purple, maculopapular, blotchy rash behind the ears and on the face

ANS: D

With measles (rubeola), the examiner assesses a red-purple, blotchy rash on the third or fourth day of illness that appears first behind the ears, spreads over the face, and then over the neck, trunk, arms, and legs. The rash appears coppery and does not blanch. The bluish-white, red-based spots in the mouth are known as Koplik spots.

33. The nurse is assessing the skin of a patient who has acquired immunodeficiency syndrome (AIDS) and notices multiple patchlike lesions on the temple and beard area that are faint pink in color. The nurse recognizes these lesions as:

a. Measles (rubeola).

b. Kaposi’s sarcoma.

c. Angiomas.

d. Herpes zoster.

ANS: B

Kaposi’s sarcoma is a vascular tumor that, in the early stages, appears as multiple, patchlike, faint pink lesions over the patient’s temple and beard areas. Measles is characterized by a red-purple maculopapular blotchy rash that appears on the third or fourth day of illness. The rash is first observed behind the ears, spreads over the face, and then spreads over the neck, trunk, arms, and legs. Cherry (senile) angiomas are small (1 to 5 mm), smooth, slightly raised bright red dots that commonly appear on the trunk in all adults over 30 years old. Herpes zoster causes vesicles up to 1 cm in size that are elevated with a cavity containing clear fluid.

34. A 45-year-old farmer comes in for a skin evaluation and complains of hair loss on his head. His hair seems to be breaking off in patches, and he notices some scaling on his head. The nurse begins the examination suspecting:

a. Tinea capitis.

b. Folliculitis.

c. Toxic alopecia.

d. Seborrheic dermatitis.

ANS: A

Tinea capitis is rounded patchy hair loss on the scalp, leaving broken-off hairs, pustules, and scales on the skin, and is caused by a fungal infection. Lesions are fluorescent under a Wood light and are usually observed in children and farmers; tinea capitis is highly contagious. (See Table 12-12, Abnormal Conditions of Hair, for descriptions of the other terms.)

35. A mother brings her child into the clinic for an examination of the scalp and hair. She states that the child has developed irregularly shaped patches with broken-off, stublike hair in some places; she is worried that this condition could be some form of premature baldness. The nurse tells her that it is:

a. Folliculitis that can be treated with an antibiotic.

b. Traumatic alopecia that can be treated with antifungal medications.

c. Tinea capitis that is highly contagious and needs immediate attention.

d. Trichotillomania; her child probably has a habit of absentmindedly twirling her hair.

ANS: D

Trichotillomania, self-induced hair loss, is usually due to habit. It forms irregularly shaped patches with broken-off, stublike hairs of varying lengths. A person is never completely bald. It occurs as a child absentmindedly rubs or twirls the area while falling asleep, reading, or watching television. (See Table 12-12, Abnormal Conditions of Hair, for descriptions of the other terms.)

36. The nurse has discovered decreased skin turgor in a patient and knows that this finding is expected in which condition?

a. Severe obesity

b. Childhood growth spurts

c. Severe dehydration

d. Connective tissue disorders such as scleroderma

ANS: C

Decreased skin turgor is associated with severe dehydration or extreme weight loss.

37. While performing an assessment of a 65-year-old man with a history of hypertension and coronary artery disease, the nurse notices the presence of bilateral pitting edema in the lower legs. The skin is puffy and tight but normal in color. No increased redness or tenderness is observed over his lower legs, and the peripheral pulses are equal and strong. In this situation, the nurse suspects that the likely cause of the edema is which condition?

a. Heart failure

b. Venous thrombosis

c. Local inflammation

d. Blockage of lymphatic drainage

ANS: A

Bilateral edema or edema that is generalized over the entire body is caused by a central problem such as heart failure or kidney failure. Unilateral edema usually has a local or peripheral cause.

38. A 40-year-old woman reports a change in mole size, accompanied by color changes, itching, burning, and bleeding over the past month. She has a dark complexion and has no family history of skin cancer, but she has had many blistering sunburns in the past. The nurse would:

a. Tell the patient to watch the lesion and report back in 2 months.

b. Refer the patient because of the suggestion of melanoma on the basis of her symptoms.

c. Ask additional questions regarding environmental irritants that may have caused this condition.

d. Tell the patient that these signs suggest a compound nevus, which is very common in young to middle-aged adults.

ANS: B

The ABCD danger signs of melanoma are asymmetry, border irregularity, color variation, and diameter. In addition, individuals may report a change in size, the development of itching, burning, and bleeding, or a new-pigmented lesion. Any one of these signs raises the suggestion of melanoma and warrants immediate referral.

39. The nurse is assessing for clubbing of the fingernails and expects to find:

a. Nail bases that are firm and slightly tender.

b. Curved nails with a convex profile and ridges across the nails.

c. Nail bases that feel spongy with an angle of the nail base of 150 degrees.

d. Nail bases with an angle of 180 degrees or greater and nail bases that feel spongy.

ANS: D

The normal nail is firm at its base and has an angle of 160 degrees. In clubbing, the angle straightens to 180 degrees or greater and the nail base feels spongy.

40. The nurse is assessing a patient who has liver disease for jaundice. Which of these assessment findings is indicative of true jaundice?

a. Yellow patches in the outer sclera

b. Yellow color of the sclera that extends up to the iris

c. Skin that appears yellow when examined under low light

d. Yellow deposits on the palms and soles of the feet where jaundice first appears

ANS: B

The yellow sclera of jaundice extends up to the edge of the iris. Calluses on the palms and soles of the feet often appear yellow but are not classified as jaundice. Scleral jaundice should not be confused with the normal yellow subconjunctival fatty deposits that are common in the outer sclera of dark-skinned persons.

41. The nurse is assessing for inflammation in a dark-skinned person. Which technique is the best?

a. Assessing the skin for cyanosis and swelling

b. Assessing the oral mucosa for generalized erythema

c. Palpating the skin for edema and increased warmth

d. Palpating for tenderness and local areas of ecchymosis

ANS: C

Because inflammation cannot be seen in dark-skinned persons, palpating the skin for increased warmth, for taut or tightly pulled surfaces that may be indicative of edema, and for a hardening of deep tissues or blood vessels is often necessary.

42. A few days after a summer hiking trip, a 25-year-old man comes to the clinic with a rash. On examination, the nurse notes that the rash is red, macular, with a bull’s eye pattern across his midriff and behind his knees. The nurse suspects:

a. Rubeola.

b. Lyme disease.

c. Allergy to mosquito bites.

d. Rocky Mountain spotted fever.

ANS: B

Lyme disease occurs in people who spend time outdoors in May through September. The first disease state exhibits the distinctive bull's eye and a red macular or papular rash that radiates from the site of the tick bite with some central clearing. The rash spreads 5 cm or larger, and is usually in the axilla, midriff, inguinal, or behind the knee, with regional lymphadenopathy.

43. A 52-year-old woman has a papule on her nose that has rounded, pearly borders and a central red ulcer. She said she first noticed it several months ago and that it has slowly grown larger. The nurse suspects which condition?

a. Acne

b. Basal cell carcinoma

c. Melanoma

d. Squamous cell carcinoma

ANS: B

Basal cell carcinoma usually starts as a skin-colored papule that develops rounded, pearly borders with a central red ulcer. It is the most common form of skin cancer and grows slowly. This description does not fit acne lesions. (See Table 12-11 for descriptions of melanoma and squamous cell carcinoma.)

44. A father brings in his 2-month-old infant to the clinic because the infant has had diarrhea for the last 24 hours. He says his baby has not been able to keep any formula down and that the diarrhea has been at least every 2 hours. The nurse suspects dehydration. The nurse should test skin mobility and turgor over the infant's:

a. Sternum.

b. Forehead.

c. Forearms.

d. Abdomen.

ANS: D

Mobility and turgor are tested over the abdomen in an infant. Poor turgor, or *tenting*, indicates dehydration or malnutrition. The other sites are not appropriate for checking skin turgor in an infant.

45. A semiconscious woman is brought to the emergency department after she was found on the floor in her kitchen. Her face, nail beds, lips, and oral mucosa are a bright cherry-red color. The nurse suspects that this coloring is due to:

a. Polycythemia.

b. Carbon monoxide poisoning.

c. Carotenemia.

d. Uremia.

ANS: B

A bright cherry-red coloring in the face, upper torso, nail beds, lips, and oral mucosa appears in cases of carbon monoxide poisoning.

46. A patient has been admitted for severe psoriasis. The nurse expects to see what finding in the patient's fingernails?

a. Splinter hemorrhages

b. Paronychia

c. Pitting

d. Beau lines

ANS: C

Sharply defined pitting and crumbling of the nails, each with distal detachment characterize pitting nails and are associated with psoriasis. (See Table 12-13 for descriptions of the other terms.)

MULTIPLE RESPONSE

1. The nurse is preparing for a certification course in skin care and needs to be familiar with the various lesions that may be identified on assessment of the skin. Which of the following definitions are correct? *Select all that apply*.

a. Petechiae: Tiny punctate hemorrhages, 1 to 3 mm, round and discrete, dark red, purple, or brown in color

b. Bulla: Elevated, circumscribed lesion filled with turbid fluid (pus)

c. Papule: Hypertrophic scar

d. Vesicle: Known as a friction blister

e. Nodule: Solid, elevated, and hard or soft growth that is larger than 1 cm

ANS: A, D, E

A pustule is an elevated, circumscribed lesion filled with turbid fluid (pus). A hypertrophic scar is a keloid. A bulla is larger than 1 cm and contains clear fluid. A papule is solid and elevated but measures less than 1 cm.

2. A patient has been admitted to a hospital after the staff in the nursing home noticed a pressure ulcer in his sacral area. The nurse examines the pressure ulcer and determines that it is a stage II ulcer. Which of these findings are characteristic of a stage II pressure ulcer?*Select all that apply*.

a. Intact skin appears red but is not broken.

b. Partial thickness skin erosion is observed with a loss of epidermis or dermis.

c. Ulcer extends into the subcutaneous tissue.

d. Localized redness in light skin will blanch with fingertip pressure.

e. Open blister areas have a red-pink wound bed.

f. Patches of eschar cover parts of the wound.

ANS: B, E

Stage I pressure ulcers have intact skin that appears red but is not broken, and localized redness in intact skin will blanche with fingertip pressure. Stage II pressure ulcers have partial thickness skin erosion with a loss of epidermis or also the dermis; open blisters have a red-pink wound bed. Stage III pressure ulcers are full thickness, extending into the subcutaneous tissue; subcutaneous fat may be seen but not muscle, bone, or tendon. Stage IV pressure ulcers involve all skin layers and extend into supporting tissue, exposing muscle, bone, and tendon. Slough (stringy matter attached to the wound bed) or eschar (black or brown necrotic tissue) may be present.

Chapter 13: Head, Face, and Neck, Including Regional Lymphatics

MULTIPLE CHOICE

1. A physician tells the nurse that a patient's vertebra prominens is tender and asks the nurse to reevaluate the area in 1 hour. The area of the body the nurse will assess is:

a. Just above the diaphragm.

b. Just lateral to the knee cap.

c. At the level of the C7 vertebra.

d. At the level of the T11 vertebra.

ANS: C

The C7 vertebra has a long spinous process, called the *vertebra prominens*, which is palpable when the head is flexed.

2. A mother brings her 2-month-old daughter in for an examination and says, "My daughter rolled over against the wall, and now I have noticed that she has this spot that is soft on the top of her head. Is something terribly wrong?" The nurse's best response would be:

a. “Perhaps that could be a result of your dietary intake during pregnancy.”

b. “Your baby may have craniosynostosis, a disease of the sutures of the brain.”

c. “That ‘soft spot’ may be an indication of cretinism or congenital hypothyroidism.”

d. “That ‘soft spot’ is normal, and actually allows for growth of the brain during the first year of your baby’s life.”

ANS: D

Membrane-covered “soft spots” allow for growth of the brain during the first year of life. They gradually ossify; the triangular-shaped posterior fontanel is closed by 1 to 2 months, and the diamond-shaped anterior fontanel closes between 9 months and 2 years.

3. The nurse notices that a patient’s palpebral fissures are not symmetric. On examination, the nurse may find that damage has occurred to which cranial nerve (CN)?

a. III

b. V

c. VII

d. VIII

ANS: C

Facial muscles are mediated by CN VII; asymmetry of palpebral fissures may be attributable to damage to CN VII (Bell palsy).

4. A patient is unable to differentiate between sharp and dull stimulation to both sides of her face. The nurse suspects:

a. Bell palsy.

b. Damage to the trigeminal nerve.

c. Frostbite with resultant paresthesia to the cheeks.

d. Scleroderma.

ANS: B

Facial sensations of pain or touch are mediated by CN V, which is the trigeminal nerve. Bell palsy is associated with CN VII damage. Frostbite and scleroderma are not associated with this problem.

5. When examining the face of a patient, the nurse is aware that the two pairs of salivary glands that are accessible to examination are the _____ and _____ glands.

a. Occipital; submental

b. Parotid; jugulodigastric

c. Parotid; submandibular

d. Submandibular; occipital

ANS: C

Two pairs of salivary glands accessible to examination on the face are the parotid glands, which are in the cheeks over the mandible, anterior to and below the ear; and the submandibular glands, which are beneath the mandible at the angle of the jaw. The parotid glands are normally nonpalpable.

6. A patient comes to the clinic complaining of neck and shoulder pain and is unable to turn her head. The nurse suspects damage to CN _____ and proceeds with the examination by _____.

a. XI; palpating the anterior and posterior triangles

b. XI; asking the patient to shrug her shoulders against resistance

c. XII; percussing the sternomastoid and submandibular neck muscles

d. XII; assessing for a positive Romberg sign

ANS: B

The major neck muscles are the sternomastoid and the trapezius. They are innervated by CN XI, the spinal accessory. The innervated muscles assist with head rotation and head flexion, movement of the shoulders, and extension and turning of the head.

7. When examining a patient's CN function, the nurse remembers that the muscles in the neck that are innervated by CN XI are the:

a. Sternomastoid and trapezius.

b. Spinal accessory and omohyoid.

c. Trapezius and sternomandibular.

d. Sternomandibular and spinal accessory.

ANS: A

The major neck muscles are the sternomastoid and the trapezius. They are innervated by CN XI, the spinal accessory.

8. A patient's laboratory data reveal an elevated thyroxine (T4) level. The nurse would proceed with an examination of the _____ gland.

a. Thyroid

b. Parotid

c. Adrenal

d. Parathyroid

ANS: A

The thyroid gland is a highly vascular endocrine gland that secretes T4 and triiodothyronine (T3). The other glands do not secrete T4.

9. A patient says that she has recently noticed a lump in the front of her neck below her "Adam's apple" that seems to be getting bigger. During the assessment, the finding that leads the nurse to suspect that this may not be a cancerous thyroid nodule is that the lump (nodule):

a. Is tender.

b. Is mobile and not hard.

c. Disappears when the patient smiles.

d. Is hard and fixed to the surrounding structures.

ANS: B

Painless, rapidly growing nodules may be cancerous, especially the appearance of a single nodule in a young person. However, cancerous nodules tend to be hard and fixed to surrounding structures, not mobile.

10. The nurse notices that a patient's submental lymph nodes are enlarged. In an effort to identify the cause of the node enlargement, the nurse would assess the patient's:

a. Infraclavicular area.

b. Supraclavicular area.

c. Area distal to the enlarged node.

d. Area proximal to the enlarged node.

ANS: D

When nodes are abnormal, the nurse should check the area into which they drain for the source of the problem. The area proximal (upstream) to the location of the abnormal node should be explored.

11. The nurse is aware that the four areas in the body where lymph nodes are accessible are the:

a. Head, breasts, groin, and abdomen.

b. Arms, breasts, inguinal area, and legs.

c. Head and neck, arms, breasts, and axillae.

d. Head and neck, arms, inguinal area, and axillae.

ANS: D

Nodes are located throughout the body, but they are accessible to examination only in four areas: head and neck, arms, inguinal region, and axillae.

12. A mother brings her newborn in for an assessment and asks, “Is there something wrong with my baby? His head seems so big.” Which statement is *true* regarding the relative proportions of the head and trunk of the newborn?

a. At birth, the head is one fifth the total length.

b. Head circumference should be greater than chest circumference at birth.

c. The head size reaches 90% of its final size when the child is 3 years old.

d. When the anterior fontanel closes at 2 months, the head will be more proportioned to the body.

ANS: B

The nurse recognizes that during the fetal period, head growth predominates. Head size is greater than chest circumference at birth, and the head size grows during childhood, reaching 90% of its final size when the child is age 6 years.

13. A patient, an 85-year-old woman, is complaining about the fact that the bones in her face have become more noticeable. What explanation should the nurse give her?

a. Diets low in protein and high in carbohydrates may cause enhanced facial bones.

b. Bones can become more noticeable if the person does not use a dermatologically approved moisturizer.

c. More noticeable facial bones are probably due to a combination of factors related to aging, such as decreased elasticity, subcutaneous fat, and moisture in her skin.

d. Facial skin becomes more elastic with age. This increased elasticity causes the skin to be more taught, drawing attention to the facial bones.

ANS: C

The facial bones and orbits appear more prominent in the aging adult, and the facial skin sags, which is attributable to decreased elasticity, decreased subcutaneous fat, and decreased moisture in the skin.

14. A patient reports excruciating headache pain on one side of his head, especially around his eye, forehead, and cheek that has lasted approximately

to 2 hours, occurring once or twice each day. The nurse should suspect:

a. Hypertension.

b. Cluster headaches.

c. Tension headaches.

d. Migraine headaches.

ANS: B

Cluster headaches produce pain around the eye, temple, forehead, and cheek and are unilateral and always on the same side of the head. They are excruciating and occur once or twice per day and last to 2 hours each.

15. A patient complains that while studying for an examination he began to notice a severe headache in the frontotemporal area of his head that is throbbing and is somewhat relieved when he lies down. He tells the nurse that his mother also had these headaches. The nurse suspects that he may be suffering from:

a. Hypertension.

b. Cluster headaches.

c. Tension headaches.

d. Migraine headaches.

ANS: D

Migraine headaches tend to be supraorbital, retroorbital, or frontotemporal with a throbbing quality. They are severe in quality and are relieved by lying down. Migraines are associated with a family history of migraine headaches.

16. A 19-year-old college student is brought to the emergency department with a severe headache he describes as, “Like nothing I’ve ever had before.” His temperature is 40° C, and he has a stiff neck. The nurse looks for other signs and symptoms of which problem?

a. Head injury

b. Cluster headache

c. Migraine headache

d. Meningeal inflammation

ANS: D

The acute onset of neck stiffness and pain along with headache and fever occurs with meningeal inflammation. A severe headache in an adult or child who has never had it before is a *red flag*. Head injury and cluster or migraine headaches are not associated with a fever or stiff neck.

17. During a well-baby checkup, the nurse notices that a 1-week-old infant’s face looks small compared with his cranium, which seems enlarged. On further examination, the nurse also notices dilated scalp veins and downcast or “setting sun” eyes. The nurse suspects which condition?

a. Craniotabes

b. Microcephaly

c. Hydrocephalus

d. Caput succedaneum

ANS: C

Hydrocephalus occurs with the obstruction of drainage of cerebrospinal fluid that results in excessive accumulation, increasing intracranial pressure, and an enlargement of the head. The face looks small, compared with the enlarged cranium, and dilated scalp veins and downcast or “setting sun” eyes are noted. Craniotabes is a softening of the skull’s outer layer. Microcephaly is an abnormally small head. A caput succedaneum is edematous swelling and ecchymosis of the presenting part of the head caused by birth trauma.

18. The nurse needs to palpate the temporomandibular joint for crepitation. This joint is located just below the temporal artery and anterior to the:

a. Hyoid bone.

b. Vagus nerve.

c. Tragus.

d. Mandible.

ANS: C

The temporomandibular joint is just below the temporal artery and anterior to the tragus.

19. A patient has come in for an examination and states, “I have this spot in front of my ear lobe on my cheek that seems to be getting bigger and is tender. What do you think it is?” The nurse notes swelling below the angle of the jaw and suspects that it could be an inflammation of his:

a. Thyroid gland.

b. Parotid gland.

c. Occipital lymph node.

d. Submental lymph node.

ANS: B

Swelling of the parotid gland is evident below the angle of the jaw and is most visible when the head is extended. Painful inflammation occurs with mumps, and swelling also occurs with abscesses or tumors. Swelling occurs anterior to the lower ear lobe.

20. A male patient with a history of acquired immunodeficiency syndrome (AIDS) has come in for an examination and he states, “I think that I have the mumps.” The nurse would begin by examining the:

a. Thyroid gland.

b. Parotid gland.

c. Cervical lymph nodes.

d. Mouth and skin for lesions.

ANS: B

The parotid gland may become swollen with the onset of mumps, and parotid enlargement has been found with human immunodeficiency virus (HIV).

21. The nurse suspects that a patient has hyperthyroidism, and the laboratory data indicate that the patient’s T4 and T3 hormone levels are elevated. Which of these findings would the nurse most likely find on examination?

a. Tachycardia

b. Constipation

c. Rapid dyspnea

d. Atrophied nodular thyroid gland

ANS: A

T4 and T3 are thyroid hormones that stimulate the rate of cellular metabolism, resulting in tachycardia. With an enlarged thyroid gland as in hyperthyroidism, the nurse might expect to find diffuse enlargement (goiter) or a nodular lump but not an atrophied gland. Dyspnea and constipation are not findings associated with hyperthyroidism.

22. A visitor from Poland who does not speak English seems to be somewhat apprehensive about the nurse examining his neck. He would probably be more comfortable with the nurse examining his thyroid gland from:

a. Behind with the nurse’s hands placed firmly around his neck.

b. The side with the nurse’s eyes averted toward the ceiling and thumbs on his neck.

c. The front with the nurse’s thumbs placed on either side of his trachea and his head tilted forward.

d. The front with the nurse’s thumbs placed on either side of his trachea and his head tilted backward.

ANS: C

Examining this patient's thyroid gland from the back may be unsettling for him. It would be best to examine his thyroid gland using the anterior approach, asking him to tip his head forward and to the right and then to the left.

23. A patient's thyroid gland is enlarged, and the nurse is preparing to auscultate the thyroid gland for the presence of a bruit. A bruit is a _____ sound that is heard best with the _____ of the stethoscope.

a. Low gurgling; diaphragm

b. Loud, whooshing, blowing; bell

c. Soft, whooshing, pulsatile; bell

d. High-pitched tinkling; diaphragm

ANS: C

If the thyroid gland is enlarged, then the nurse should auscultate it for the presence of a bruit, which is a soft, pulsatile, whooshing, blowing sound heard best with the bell of the stethoscope.

24. The nurse notices that an infant has a large, soft lump on the side of his head and that his mother is very concerned. She tells the nurse that she noticed the lump approximately 8 hours after her baby's birth and that it seems to be getting bigger. One possible explanation for this is:

a. Hydrocephalus.

b. Craniosynostosis.

c. Cephalhematoma.

d. Caput succedaneum.

ANS: C

A cephalhematoma is a subperiosteal hemorrhage that is the result of birth trauma. It is soft, fluctuant, and well defined over one cranial bone. It appears several hours after birth and gradually increases in size.

25. A mother brings in her newborn infant for an assessment and tells the nurse that she has noticed that whenever her newborn's head is turned to the right side, she straightens out the arm and leg on the same side and flexes the opposite arm and leg. After observing this on examination, the nurse tells her that this reflex is:

a. Abnormal and is called the *atonic neck reflex*.

b. Normal and should disappear by the first year of life.

c. Normal and is called the *tonic neck reflex*, which should disappear between 3 and 4 months of age.

d. Abnormal. The baby should be flexing the arm and leg on the right side of his body when the head is turned to the right.

ANS: C

By 2 weeks, the infant shows the tonic neck reflex when supine and the head is turned to one side (extension of same arm and leg, flexion of opposite arm and leg). The tonic neck reflex disappears between 3 and 4 months of age.

26. During an admission assessment, the nurse notices that a male patient has an enlarged and rather thick skull. The nurse suspects acromegaly and would further assess for:

a. Exophthalmos.

b. Bowed long bones.

c. Coarse facial features.

d. Acorn-shaped cranium.

ANS: C

Acromegaly is excessive secretion of growth hormone that creates an enlarged skull and thickened cranial bones. Patients will have elongated heads, massive faces, prominent noses and lower jaws, heavy eyebrow ridges, and coarse facial features. Exophthalmos is associated with hyperthyroidism. Bowed long bones and an acorn-shaped cranium result from Paget disease.

27. When examining children affected with Down syndrome (trisomy 21), the nurse looks for the possible presence of:

a. Ear dysplasia.

b. Long, thin neck.

c. Protruding thin tongue.

d. Narrow and raised nasal bridge.

ANS: A

With the chromosomal aberration trisomy 21, also known as *Down syndrome*, head and face characteristics may include upslanting eyes with inner epicanthal folds, a flat nasal bridge, a small broad flat nose, a protruding thick tongue, ear dysplasia, a short broad neck with webbing, and small hands with a single palmar crease.

28. A patient visits the clinic because he has recently noticed that the left side of his mouth is paralyzed. He states that he cannot raise his eyebrow or whistle. The nurse suspects that he has:

a. Cushing syndrome.

b. Parkinson disease.

c. Bell palsy.

d. Experienced a cerebrovascular accident (CVA) or stroke.

ANS: D

With an upper motor neuron lesion, as with a CVA, the patient will have paralysis of lower facial muscles, but the upper half of the face will not be affected owing to the intact nerve from the unaffected hemisphere. The person is still able to wrinkle the forehead and close the eyes. (See Table 13-4, Abnormal Facial Appearances with Chronic Illnesses, for descriptions of the other responses.)

29. A woman comes to the clinic and states, “I’ve been sick for so long! My eyes have gotten so puffy, and my eyebrows and hair have become coarse and dry.” The nurse will assess for other signs and symptoms of:

a. Cachexia.

b. Parkinson syndrome.

c. Myxedema.

d. Scleroderma.

ANS: C

Myxedema (hypothyroidism) is a deficiency of thyroid hormone that, when severe, causes a nonpitting edema or myxedema. The patient will have a puffy edematous face, especially around the eyes (periorbital edema); coarse facial features; dry skin; and dry, coarse hair and eyebrows. (See Table 13-4, Abnormal Facial Appearances with Chronic Illnesses, for descriptions of the other responses.)

30. During an examination of a female patient, the nurse notes lymphadenopathy and suspects an acute infection. Acutely infected lymph nodes would be:

a. Clumped.

b. Unilateral.

c. Firm but freely movable.

d. Firm and nontender.

ANS: C

Acutely infected lymph nodes are bilateral, enlarged, warm, tender, and firm but freely movable. Unilaterally enlarged nodes that are firm and nontender may indicate cancer.

31. The physician reports that a patient with a neck tumor has a tracheal shift. The nurse is aware that this means that the patient's trachea is:

a. Pulled to the affected side.

b. Pushed to the unaffected side.

c. Pulled downward.

d. Pulled downward in a rhythmic pattern.

ANS: B

The trachea is pushed to the unaffected side with an aortic aneurysm, a tumor, unilateral thyroid lobe enlargement, or a pneumothorax. The trachea is pulled to the affected side with large atelectasis, pleural adhesions, or fibrosis. Tracheal tug is a rhythmic downward pull that is synchronous with systole and occurs with aortic arch aneurysm.

32. During an assessment of an infant, the nurse notes that the fontanels are depressed and sunken. The nurse suspects which condition?

a. Rickets

b. Dehydration

c. Mental retardation

d. Increased intracranial pressure

ANS: B

Depressed and sunken fontanels occur with dehydration or malnutrition. Mental retardation and rickets have no effect on the fontanels. Increased intracranial pressure would cause tense or bulging and possibly pulsating fontanels.

33. The nurse is performing an assessment on a 7-year-old child who has symptoms of chronic watery eyes, sneezing, and clear nasal drainage. The nurse notices the presence of a transverse line across the bridge of the nose, dark blue shadows below the eyes, and a double crease on the lower eyelids. These findings are characteristic of:

a. Allergies.

b. Sinus infection.

c. Nasal congestion.

d. Upper respiratory infection.

ANS: A

Chronic allergies often develop chronic facial characteristics and include blue shadows below the eyes, a double or single crease on the lower eyelids, open-mouth breathing, and a transverse line on the nose.

34. While performing a well-child assessment on a 5 year old, the nurse notes the presence of palpable, bilateral, cervical, and inguinal lymph nodes. They are approximately 0.5 cm in size, round, mobile, and nontender. The nurse suspects that this child:

a. Has chronic allergies.

b. May have an infection.

c. Is exhibiting a normal finding for a well child of this age.

d. Should be referred for additional evaluation.

ANS: C

Palpable lymph nodes are normal in children until puberty when the lymphoid tissue begins to atrophy. Lymph nodes may be up to 1 cm in size in the cervical and inguinal areas but are discrete, movable, and nontender.

35. The nurse has just completed a lymph node assessment on a 60-year-old healthy female patient. The nurse knows that most lymph nodes in healthy adults are normally:

a. Shotty.

b. Nonpalpable.

c. Large, firm, and fixed to the tissue.

d. Rubbery, discrete, and mobile.

ANS: B

Most lymph nodes are nonpalpable in adults. The palpability of lymph nodes decreases with age. Normal nodes feel movable, discrete, soft, and nontender.

36. During an examination of a patient in her third trimester of pregnancy, the nurse notices that the patient's thyroid gland is slightly enlarged. No enlargement had been previously noticed. The nurse suspects that the patient:

a. Has an iodine deficiency.

b. Is exhibiting early signs of goiter.

c. Is exhibiting a normal enlargement of the thyroid gland during pregnancy.

d. Needs further testing for possible thyroid cancer.

ANS: C

The thyroid gland enlarges slightly during pregnancy because of hyperplasia of the tissue and increased vascularity.

37. During an examination, the nurse knows that the best way to palpate the lymph nodes in the neck is described by which statement?

a. Using gentle pressure, palpate with both hands to compare the two sides.

b. Using strong pressure, palpate with both hands to compare the two sides.

c. Gently pinch each node between one's thumb and forefinger, and then move down the neck muscle.

d. Using the index and middle fingers, gently palpate by applying pressure in a rotating pattern.

ANS: A

Using gentle pressure is recommended because strong pressure can push the nodes into the neck muscles. Palpating with both hands to compare the two sides symmetrically is usually most efficient.

38. During a well-baby checkup, a mother is concerned because her 2-month-old infant cannot hold her head up when she is pulled to a sitting position. Which response by the nurse is appropriate?

a. "Head control is usually achieved by 4 months of age."

b. "You shouldn't be trying to pull your baby up like that until she is older."

c. "Head control should be achieved by this time."

d. "This inability indicates possible nerve damage to the neck muscles."

ANS: A

Head control is achieved by 4 months when the baby can hold the head erect and steady when pulled to a vertical position. The other responses are not appropriate.

39. During an examination of a 3-year-old child, the nurse notices a bruit over the left temporal area. The nurse should:

a. Continue the examination because a bruit is a normal finding for this age.

b. Check for the bruit again in 1 hour.

c. Notify the parents that a bruit has been detected in their child.

d. Stop the examination, and notify the physician.

ANS: A

Bruits are common in the skull in children under 4 or 5 years of age and in children with anemia. They are systolic or continuous and are heard over the temporal area.

40. During an examination, the nurse finds that a patient's left temporal artery is tortuous and feels hardened and tender, compared with the right temporal artery. The nurse suspects which condition?

a. Crepitation

b. Mastoiditis

c. Temporal arteritis

d. Bell palsy

ANS: C

With temporal arteritis, the artery appears more tortuous and feels hardened and tender. These assessment findings are not consistent with the other responses.

MULTIPLE RESPONSE

1. The nurse is assessing a 1-month-old infant at his well-baby checkup. Which assessment findings are appropriate for this age? *Select all that apply*.

a. Head circumference equal to chest circumference

b. Head circumference greater than chest circumference

c. Head circumference less than chest circumference

d. Fontanels firm and slightly concave

e. Absent tonic neck reflex

f. Nonpalpable cervical lymph nodes

ANS: B, D, F

An infant's head circumference is larger than the chest circumference. At age 2 years, both measurements are the same. During childhood, the chest circumference grows to exceed the head circumference by 5 to 7 cm. The fontanels should feel firm and slightly concave in the infant, and they should close by age 9 months. The tonic neck reflex is present until between 3 and 4 months of age, and cervical lymph nodes are normally nonpalpable in an infant.

Chapter 14: Eyes

MULTIPLE CHOICE

1. When examining the eye, the nurse notices that the patient's eyelid margins approximate completely. The nurse recognizes that this assessment finding:

a. Is expected.

b. May indicate a problem with extraocular muscles.

c. May result in problems with tearing.

d. Indicates increased intraocular pressure.

ANS: A

The palpebral fissure is the elliptical open space between the eyelids, and, when closed, the lid margins approximate completely, which is a normal finding.

2. During ocular examinations, the nurse keeps in mind that movement of the extraocular muscles is:

a. Decreased in the older adult.

b. Impaired in a patient with cataracts.

c. Stimulated by cranial nerves (CNs) I and II.

d. Stimulated by CNs III, IV, and VI.

ANS: D

Movement of the extraocular muscles is stimulated by three CNs: III, IV, and VI.

3. The nurse is performing an external eye examination. Which statement regarding the outer layer of the eye is *true*?

a. The outer layer of the eye is very sensitive to touch.

b. The outer layer of the eye is darkly pigmented to prevent light from reflecting internally.

c. The trigeminal nerve (CN V) and the trochlear nerve (CN IV) are stimulated when the outer surface of the eye is stimulated.

d. The visual receptive layer of the eye in which light waves are changed into nerve impulses is located in the outer layer of the eye.

ANS: A

The cornea and the sclera make up the outer layer of the eye. The cornea is very sensitive to touch. The middle layer, the choroid, has dark pigmentation to prevent light from reflecting internally. The trigeminal nerve (CN V) and the facial nerve (CN VII) are stimulated when the outer surface of the eye is stimulated. The retina, in the inner layer of the eye, is where light waves are changed into nerve impulses.

4. When examining a patient's eyes, the nurse recalls that stimulation of the sympathetic branch of the autonomic nervous system:

a. Causes pupillary constriction.

b. Adjusts the eye for near vision.

c. Elevates the eyelid and dilates the pupil.

d. Causes contraction of the ciliary body.

ANS: C

Stimulation of the sympathetic branch of the autonomic nervous system dilates the pupil and elevates the eyelid. Parasympathetic nervous system stimulation causes the pupil to constrict. The muscle fibers of the iris contract the pupil in bright light to accommodate for near vision. The ciliary body controls the thickness of the lens.

5. The nurse is reviewing causes of increased intraocular pressure. Which of these factors determines intraocular pressure?

a. Thickness or bulging of the lens

b. Posterior chamber as it accommodates increased fluid

c. Contraction of the ciliary body in response to the aqueous within the eye

d. Amount of aqueous produced and resistance to its outflow at the angle of the anterior chamber

ANS: D

Intraocular pressure is determined by a balance between the amount of aqueous produced and the resistance to its outflow at the angle of the anterior chamber. The other responses are incorrect.

6. The nurse is conducting a visual examination. Which of these statements regarding visual pathways and visual fields is *true*?

a. The right side of the brain interprets the vision for the right eye.

b. The image formed on the retina is upside down and reversed from its actual appearance in the outside world.

c. Light rays are refracted through the transparent media of the eye before striking the pupil.

d. Light impulses are conducted through the optic nerve to the temporal lobes of the brain.

ANS: B

The image formed on the retina is upside down and reversed from its actual appearance in the outside world. The light rays are refracted through the transparent media of the eye before striking the retina, and the nerve impulses are conducted through the optic nerve tract to the visual cortex of the occipital lobe of the brain. The left side of the brain interprets vision for the right eye.

7. The nurse is testing a patient's visual accommodation, which refers to which action?

a. Pupillary constriction when looking at a near object

b. Pupillary dilation when looking at a far object

c. Changes in peripheral vision in response to light

d. Involuntary blinking in the presence of bright light

ANS: A

The muscle fibers of the iris contract the pupil in bright light and accommodate for near vision, which also results in pupil constriction. The other responses are not correct.

8. A patient has a normal pupillary light reflex. The nurse recognizes that this reflex indicates that:

a. The eyes converge to focus on the light.

b. Light is reflected at the same spot in both eyes.

c. The eye focuses the image in the center of the pupil.

d. Constriction of both pupils occurs in response to bright light.

ANS: D

The pupillary light reflex is the normal constriction of the pupils when bright light shines on the retina. The other responses are not correct.

9. A mother asks when her newborn infant's eyesight will be developed. The nurse should reply:

a. "Vision is not totally developed until 2 years of age."

b. "Infants develop the ability to focus on an object at approximately 8 months of age."

c. "By approximately 3 months of age, infants develop more coordinated eye movements and can fixate on an object."

d. "Most infants have uncoordinated eye movements for the first year of life."

ANS: C

Eye movements may be poorly coordinated at birth, but by 3 to 4 months of age, the infant should establish binocularity and should be able to fixate simultaneously on a single image with both eyes.

10. The nurse is reviewing in age-related changes in the eye for a class. Which of these physiologic changes is responsible for presbyopia?

a. Degeneration of the cornea

b. Loss of lens elasticity

c. Decreased adaptation to darkness

d. Decreased distance vision abilities

ANS: B

The lens loses elasticity and decreases its ability to change shape to accommodate for near vision. This condition is called *presbyopia*.

11. Which of these assessment findings would the nurse expect to see when examining the eyes of a black patient?

a. Increased night vision

b. Dark retinal background

c. Increased photosensitivity

d. Narrowed palpebral fissures

ANS: B

An ethnically based variability in the color of the iris and in retinal pigmentation exists, with darker irides having darker retinas behind them.

12. A 52-year-old patient describes the presence of occasional *floaters* or *spots* moving in front of his eyes. The nurse should:

a. Examine the retina to determine the number of floaters.

b. Presume the patient has glaucoma and refer him for further testing.

c. Consider these to be abnormal findings, and refer him to an ophthalmologist.

d. Know that floaters are usually insignificant and are caused by condensed vitreous fibers.

ANS: D

Floaters are a common sensation with myopia or after middle age and are attributable to condensed vitreous fibers. Floaters or spots are not usually significant, but the acute onset of floaters may occur with retinal detachment.

13. The nurse is preparing to assess the visual acuity of a 16-year-old patient. How should the nurse proceed?

a. Perform the confrontation test.

b. Ask the patient to read the print on a handheld Jaeger card.

c. Use the Snellen chart positioned 20 feet away from the patient.

d. Determine the patient's ability to read newsprint at a distance of 12 to 14 inches.

ANS: C

The Snellen alphabet chart is the most commonly used and most accurate measure of visual acuity. The confrontation test is a gross measure of peripheral vision. The Jaeger card or newspaper tests are used to test near vision.

14. A patient's vision is recorded as 20/30 when the Snellen eye chart is used. The nurse interprets these results to indicate that:

a. At 30 feet the patient can read the entire chart.

b. The patient can read at 20 feet what a person with normal vision can read at 30 feet.

c. The patient can read the chart from 20 feet in the left eye and 30 feet in the right eye.

d. The patient can read from 30 feet what a person with normal vision can read from 20 feet.

ANS: B

The top number indicates the distance the person is standing from the chart; the denominator gives the distance at which a normal eye can see.

15. A patient is unable to read even the largest letters on the Snellen chart. The nurse should take which action next?

a. Refer the patient to an ophthalmologist or optometrist for further evaluation.

b. Assess whether the patient can count the nurse's fingers when they are placed in front of his or her eyes.

c. Ask the patient to put on his or her reading glasses and attempt to read the Snellen chart again.

d. Shorten the distance between the patient and the chart until the letters are seen, and record that distance.

ANS: D

If the person is unable to see even the largest letters when standing 20 feet from the chart, then the nurse should shorten the distance to the chart until the letters are seen, and record that distance (e.g., "10/200"). If visual acuity is even lower, then the nurse should assess whether the person can count fingers when they are spread in front of the eyes or can distinguish light perception from a penlight. If vision is poorer than 20/30, then a referral to an ophthalmologist or optometrist is necessary, but the nurse must first assess the visual acuity.

16. A patient's vision is recorded as 20/80 in each eye. The nurse interprets this finding to mean that the patient:

a. Has poor vision.

b. Has acute vision.

c. Has normal vision.

d. Is presbyopic.

ANS: A

Normal visual acuity is 20/20 in each eye; the larger the denominator, the poorer the vision.

17. When performing the corneal light reflex assessment, the nurse notes that the light is reflected at 2 o'clock in each eye. The nurse should:

a. Consider this a normal finding.

b. Refer the individual for further evaluation.

c. Document this finding as an asymmetric light reflex.

d. Perform the confrontation test to validate the findings.

ANS: A

Reflection of the light on the corneas should be in exactly the same spot on each eye, or symmetric. If asymmetry is noted, then the nurse should administer the cover test.

18. The nurse is performing the diagnostic positions test. Normal findings would be which of these results?

a. Convergence of the eyes

b. Parallel movement of both eyes

c. Nystagmus in extreme superior gaze

d. Slight amount of lid lag when moving the eyes from a superior to an inferior position

ANS: B

A normal response for the diagnostic positions test is parallel tracking of the object with both eyes. Eye movement that is not parallel indicates a weakness of an extraocular muscle or dysfunction of the CN that innervates it.

19. During an assessment of the sclera of a black patient, the nurse would consider which of these an expected finding?

a. Yellow fatty deposits over the cornea

b. Pallor near the outer canthus of the lower lid

c. Yellow color of the sclera that extends up to the iris

d. Presence of small brown macules on the sclera

ANS: D

Normally in dark-skinned people, small brown macules may be observed in the sclera.

20. A 60-year-old man is at the clinic for an eye examination. The nurse suspects that he has ptosis of one eye. How should the nurse check for this?

a. Perform the confrontation test.

b. Assess the individual's near vision.

c. Observe the distance between the palpebral fissures.

d. Perform the corneal light test, and look for symmetry of the light reflex.

ANS: C

Ptosis is a drooping of the upper eyelid that would be apparent by observing the distance between the upper and lower eyelids. The confrontation test measures peripheral vision. Measuring near vision or the corneal light test does not check for ptosis.

21. During an examination of the eye, the nurse would expect what normal finding when assessing the lacrimal apparatus?

a. Presence of tears along the inner canthus

b. Blocked nasolacrimal duct in a newborn infant

c. Slight swelling over the upper lid and along the bony orbit if the individual has a cold

d. Absence of drainage from the puncta when pressing against the inner orbital rim

ANS: D

No swelling, redness, or drainage from the puncta should be observed when it is pressed. Regurgitation of fluid from the puncta, when pressed, indicates duct blockage. The lacrimal glands are not functional at birth.

22. When assessing the pupillary light reflex, the nurse should use which technique?

a. Shine a penlight from directly in front of the patient, and inspect for pupillary constriction.

b. Ask the patient to follow the penlight in eight directions, and observe for bilateral pupil constriction.

c. Shine a light across the pupil from the side, and observe for direct and consensual pupillary constriction.

d. Ask the patient to focus on a distant object. Then ask the patient to follow the penlight to approximately 7 cm from the nose.

ANS: C

To test the pupillary light reflex, the nurse should advance a light in from the side and note the direct and consensual pupillary constriction.

23. The nurse is assessing a patient's eyes for the accommodation response and would expect to see which normal finding?

a. Dilation of the pupils

b. Consensual light reflex

c. Conjugate movement of the eyes

d. Convergence of the axes of the eyes

ANS: D

The accommodation reaction includes pupillary constriction and convergence of the axes of the eyes. The other responses are not correct.

24. In using the ophthalmoscope to assess a patient's eyes, the nurse notices a red glow in the patient's pupils. On the basis of this finding, the nurse would:

a. Suspect that an opacity is present in the lens or cornea.

b. Check the light source of the ophthalmoscope to verify that it is functioning.

c. Consider the red glow a normal reflection of the ophthalmoscope light off the inner retina.

d. Continue with the ophthalmoscopic examination, and refer the patient for further evaluation.

ANS: C

The red glow filling the person's pupil is the red reflex and is a normal finding caused by the reflection of the ophthalmoscope light off the inner retina. The other responses are not correct.

25. The nurse is examining a patient's retina with an ophthalmoscope. Which finding is considered normal?

a. Optic disc that is a yellow-orange color

b. Optic disc margins that are blurred around the edges

c. Presence of pigmented crescents in the macular area

d. Presence of the macula located on the nasal side of the retina

ANS: A

The optic disc is located on the nasal side of the retina. Its color is a creamy yellow-orange to a pink, and the edges are distinct and sharply demarcated, not blurred. A pigmented crescent is black and is due to the accumulation of pigment in the choroid.

26. A 2-week-old infant can fixate on an object but cannot follow a light or bright toy. The nurse would:

a. Consider this a normal finding.

b. Assess the pupillary light reflex for possible blindness.

c. Continue with the examination, and assess visual fields.

d. Expect that a 2-week-old infant should be able to fixate and follow an object.

ANS: A

By 2 to 4 weeks an infant can fixate on an object. By the age of 1 month, the infant should fixate and follow a bright light or toy.

27. The nurse is assessing color vision of a male child. Which statement is correct? The nurse should:

a. Check color vision annually until the age of 18 years.

b. Ask the child to identify the color of his or her clothing.

c. Test for color vision once between the ages of 4 and 8 years.

d. Begin color vision screening at the child's 2-year checkup.

ANS: C

Test boys only once for color vision between the ages of 4 and 8 years. Color vision is not tested in girls because it is rare in girls. Testing is performed with the Ishihara test, which is a series of polychromatic cards.

28. The nurse is performing an eye-screening clinic at a daycare center. When examining a 2-year-old child, the nurse suspects that the child has a "lazy eye" and should:

a. Examine the external structures of the eye.

b. Assess visual acuity with the Snellen eye chart.

c. Assess the child's visual fields with the confrontation test.

d. Test for strabismus by performing the corneal light reflex test.

ANS: D

Testing for strabismus is done by performing the corneal light reflex test and the cover test. The Snellen eye chart and confrontation test are not used to test for strabismus.

29. The nurse is performing an eye assessment on an 80-year-old patient. Which of these findings is considered abnormal?

a. Decrease in tear production

b. Unequal pupillary constriction in response to light

c. Presence of arcus senilis observed around the cornea

d. Loss of the outer hair on the eyebrows attributable to a decrease in hair follicles

ANS: B

Pupils are small in the older adult, and the pupillary light reflex may be slowed, but pupillary constriction should be symmetric. The assessment findings in the other responses are considered normal in older persons.

30. The nurse notices the presence of periorbital edema when performing an eye assessment on a 70-year-old patient. The nurse should:

a. Check for the presence of exophthalmos.

b. Suspect that the patient has hyperthyroidism.

c. Ask the patient if he or she has a history of heart failure.

d. Assess for blepharitis, which is often associated with periorbital edema.

ANS: C

Periorbital edema occurs with local infections, crying, and systemic conditions such as heart failure, renal failure, allergy, and hypothyroidism. Periorbital edema is not associated with blepharitis.

31. When a light is directed across the iris of a patient's eye from the temporal side, the nurse is assessing for:

a. Drainage from dacryocystitis.

b. Presence of conjunctivitis over the iris.

c. Presence of shadows, which may indicate glaucoma.

d. Scattered light reflex, which may be indicative of cataracts.

ANS: C

The presence of shadows in the anterior chamber may be a sign of acute angle-closure glaucoma. The normal iris is flat and creates no shadows. This method is not correct for the assessment of dacryocystitis, conjunctivitis, or cataracts.

32. In a patient who has anisocoria, the nurse would expect to observe:

a. Dilated pupils.

b. Excessive tearing.

c. Pupils of unequal size.

d. Uneven curvature of the lens.

ANS: C

Unequal pupil size is termed *anisocoria*. It normally exists in 5% of the population but may also be indicative of central nervous system disease.

33. A patient comes to the emergency department after a boxing match, and his left eye is swollen almost shut. He has bruises on his face and neck. He says he is worried because he “can’t see well” from his left eye. The physician suspects retinal damage. The nurse recognizes that signs of retinal detachment include:

a. Loss of central vision.

b. Shadow or diminished vision in one quadrant or one half of the visual field.

c. Loss of peripheral vision.

d. Sudden loss of pupillary constriction and accommodation.

ANS: B

With retinal detachment, the person has shadows or diminished vision in one quadrant or one half of the visual field. The other responses are not signs of retinal detachment.

34. A patient comes into the clinic complaining of pain in her right eye. On examination, the nurse sees a pustule at the lid margin that is painful to touch, red, and swollen. The nurse recognizes that this is a:

a. Chalazion.

b. Hordeolum (stye).

c. Dacryocystitis.

d. Blepharitis.

ANS: B

A hordeolum, or stye, is a painful, red, and swollen pustule at the lid margin. A chalazion is a nodule protruding on the lid, toward the inside, and is nontender, firm, with discrete swelling. Dacryocystitis is an inflammation of the lacrimal sac. Blepharitis is inflammation of the eyelids (see Table 14-3).

35. A 68-year-old woman is in the eye clinic for a checkup. She tells the nurse that she has been having trouble reading the paper, sewing, and even seeing the faces of her grandchildren. On examination, the nurse notes that she has some loss of central vision but her peripheral vision is normal. These findings suggest that she may have:

a. Macular degeneration.

b. Vision that is normal for someone her age.

c. The beginning stages of cataract formation.

d. Increased intraocular pressure or glaucoma.

ANS: A

Macular degeneration is the most common cause of blindness. It is characterized by the loss of central vision. Cataracts would show lens opacity. Chronic open-angle glaucoma, the most common type of glaucoma, involves a gradual loss of peripheral vision. These findings are not consistent with vision that is considered normal at any age.

36. A patient comes into the emergency department after an accident at work. A machine blew dust into his eyes, and he was not wearing safety glasses. The nurse examines his corneas by shining a light from the side across the cornea. What findings would suggest that he has suffered a corneal abrasion?

a. Smooth and clear corneas

b. Opacity of the lens behind the cornea

c. Bleeding from the areas across the cornea

d. Shattered look to the light rays reflecting off the cornea

ANS: D

A corneal abrasion causes irregular ridges in reflected light, which produce a shattered appearance to light rays. No opacities should be observed in the cornea. The other responses are not correct.

37. An ophthalmic examination reveals papilledema. The nurse is aware that this finding indicates:

a. Retinal detachment.

b. Diabetic retinopathy.

c. Acute-angle glaucoma.

d. Increased intracranial pressure.

ANS: D

Papilledema, or choked disk, is a serious sign of increased intracranial pressure, which is caused by a space-occupying mass such as a brain tumor or hematoma. This pressure causes venous stasis in the globe, showing redness, congestion, and elevation of the optic disc, blurred margins, hemorrhages, and absent venous pulsations. Papilledema is not associated with the conditions in the other responses.

38. During a physical education class, a student is hit in the eye with the end of a baseball bat. When examined in the emergency department, the nurse notices the presence of blood in the anterior chamber of the eye. This finding indicates the presence of:

a. Hypopyon.

b. Hyphema.

c. Corneal abrasion.

d. Pterygium.

ANS: B

Hyphema is the term for blood in the anterior chamber and is a serious result of blunt trauma (a fist or a baseball) or spontaneous hemorrhage and may indicate scleral rupture or major intraocular trauma. (See Table 14-7 for descriptions of the other terms.)

39. During an assessment, the nurse notices that an older adult patient has tears rolling down his face from his left eye. Closer examination shows that the lower lid is loose and rolling outward. The patient complains of his eye feeling “dry and itchy.” Which action by the nurse is *correct*?

a. Assessing the eye for a possible foreign body

b. Documenting the finding as ptosis

c. Assessing for other signs of ectropion

d. Contacting the prescriber; these are signs of basal cell carcinoma

ANS: C

The condition described is known as *ectropion*, and it occurs in older adults and is attributable to atrophy of the elastic and fibrous tissues. The lower lid does not approximate to the eyeball, and, as a result, the puncta cannot effectively siphon tears; excessive tearing results. Ptosis is a drooping of the upper eyelid. These signs do not suggest the presence of a foreign body in the eye or basal cell carcinoma.

MULTIPLE RESPONSE

1. During an examination, a patient states that she was diagnosed with open-angle glaucoma 2 years ago. The nurse assesses for characteristics of open-angle glaucoma. Which of these are characteristics of open-angle glaucoma?*Select all that apply*.

a. Patient may experience sensitivity to light, nausea, and halos around lights.

b. Patient experiences tunnel vision in the late stages.

c. Immediate treatment is needed.

d. Vision loss begins with peripheral vision.

e. Open-angle glaucoma causes sudden attacks of increased pressure that cause blurred vision.

f. Virtually no symptoms are exhibited.

ANS: B, D, F

Open-angle glaucoma is the most common type of glaucoma; virtually no symptoms are exhibited. Vision loss begins with the peripheral vision, which often goes unnoticed because individuals learn to compensate intuitively by turning their heads. The other characteristics are those of closed-angle glaucoma.

Chapter 15: Ears

MULTIPLE CHOICE

1. The nurse needs to pull the portion of the ear that consists of movable cartilage and skin down and back when administering eardrops. This portion of the ear is called the:

a. Auricle.

b. Concha.

c. Outer meatus.

d. Mastoid process.

ANS: A

The external ear is called the *auricle* or *pinna* and consists of movable cartilage and skin.

2. The nurse is examining a patient's ears and notices cerumen in the external canal. Which of these statements about cerumen is *correct*?

a. Sticky honey-colored cerumen is a sign of infection.

b. The presence of cerumen is indicative of poor hygiene.

c. The purpose of cerumen is to protect and lubricate the ear.

d. Cerumen is necessary for transmitting sound through the auditory canal.

ANS: C

The ear is lined with glands that secrete cerumen, which is a yellow waxy material that lubricates and protects the ear.

DIF: Cognitive Level: Remembering (Knowledge) REF: p. 325

MSC: Client Needs: Physiologic Integrity: Physiologic Adaptation

3. When examining the ear with an otoscope, the nurse notes that the tympanic membrane should appear:

a. Light pink with a slight bulge.

b. Pearly gray and slightly concave.

c. Pulled in at the base of the cone of light.

d. Whitish with a small fleck of light in the superior portion.

ANS: B

The tympanic membrane is a translucent membrane with a pearly gray color and a prominent cone of light in the anteroinferior quadrant, which is the reflection of the otoscope light. The tympanic membrane is oval and slightly concave, pulled in at its center by the malleus, which is one of the middle ear ossicles.

4. The nurse is reviewing the structures of the ear. Which of these statements concerning the eustachian tube is *true*?

a. The eustachian tube is responsible for the production of cerumen.

b. It remains open except when swallowing or yawning.

c. The eustachian tube allows passage of air between the middle and outer ear.

d. It helps equalize air pressure on both sides of the tympanic membrane.

ANS: D

The eustachian tube allows an equalization of air pressure on each side of the tympanic membrane so that the membrane does not rupture during, for example, altitude changes in an airplane. The tube is normally closed, but it opens with swallowing or yawning.

5. A patient with a middle ear infection asks the nurse, “What does the middle ear do?” The nurse responds by telling the patient that the middle ear functions to:

a. Maintain balance.

b. Interpret sounds as they enter the ear.

c. Conduct vibrations of sounds to the inner ear.

d. Increase amplitude of sound for the inner ear to function.

ANS: C

Among its other functions, the middle ear conducts sound vibrations from the outer ear to the central hearing apparatus in the inner ear. The other responses are not functions of the middle ear.

6. The nurse is reviewing the function of the cranial nerves (CNs). Which CN is responsible for conducting nerve impulses to the brain from the organ of Corti?

a. I

b. III

c. VIII

d. XI

ANS: C

The nerve impulses are conducted by the auditory portion of CN VIII to the brain.

7. The nurse is assessing a patient who may have hearing loss. Which of these statements is*true* concerning air conduction?

a. Air conduction is the normal pathway for hearing.

b. Vibrations of the bones in the skull cause air conduction.

c. Amplitude of sound determines the pitch that is heard.

d. Loss of air conduction is called *a conductive hearing loss*.

ANS: A

The normal pathway of hearing is air conduction, which starts when sound waves produce vibrations on the tympanic membrane. Conductive hearing loss results from a mechanical dysfunction of the external or middle ear. The other statements are not true concerning air conduction.

8. A patient has been shown to have a sensorineural hearing loss. During the assessment, it would be important for the nurse to:

a. Speak loudly so the patient can hear the questions.

b. Assess for middle ear infection as a possible cause.

c. Ask the patient what medications he is currently taking.

d. Look for the source of the obstruction in the external ear.

ANS: C

A simple increase in amplitude may not enable the person to understand spoken words. Sensorineural hearing loss may be caused by presbycusis, which is a gradual nerve degeneration that occurs with aging and by ototoxic drugs, which affect the hair cells in the cochlea.

9. During an interview, the patient states he has the sensation that “everything around him is spinning.” The nurse recognizes that the portion of the ear responsible for this sensation is the:

a. Cochlea.

b. CN VIII.

c. Organ of Corti.

d. Labyrinth.

ANS: D

If the labyrinth ever becomes inflamed, then it feeds the wrong information to the brain, creating a staggering gait and a strong, spinning, whirling sensation called *vertigo*.

10. A patient in her first trimester of pregnancy is diagnosed with rubella. Which of these statements is *correct* regarding the significance of this in relation to the infant’s hearing?

a. Rubella may affect the mother’s hearing but not the infant’s.

b. Rubella can damage the infant’s organ of Corti, which will impair hearing.

c. Rubella is only dangerous to the infant in the second trimester of pregnancy.

d. Rubella can impair the development of CN VIII and thus affect hearing.

ANS: B

If maternal rubella infection occurs during the first trimester, then it can damage the organ of Corti and impair hearing.

11. The mother of a 2-year-old is concerned because her son has had three ear infections in the past year. What would be an appropriate response by the nurse?

a. “It is unusual for a small child to have frequent ear infections unless something else is wrong.”

b. “We need to check the immune system of your son to determine why he is having so many ear infections.”

c. “Ear infections are not uncommon in infants and toddlers because they tend to have more cerumen in the external ear.”

d. “Your son’s eustachian tube is shorter and wider than yours because of his age, which allows for infections to develop more easily.”

ANS: D

The infant’s eustachian tube is relatively shorter and wider than the adult’s eustachian tube, and its position is more horizontal; consequently, pathogens from the nasopharynx can more easily migrate through to the middle ear. The other responses are not appropriate.

12. A 31-year-old patient tells the nurse that he has noticed a progressive loss in his hearing. He says that it does seem to help when people speak louder or if he turns up the volume of a television or radio. The most likely cause of his hearing loss is:

a. Otosclerosis.

b. Presbycusis.

c. Trauma to the bones.

d. Frequent ear infections.

ANS: A

Otosclerosis is a common cause of conductive hearing loss in young adults between the ages of 20 and 40 years. Presbycusis is a type of hearing loss that occurs with aging. Trauma and frequent ear infections are not a likely cause of his hearing loss.

13. A 70-year-old patient tells the nurse that he has noticed that he is having trouble hearing, especially in large groups. He says that he “can’t always tell where the sound is coming from” and the words often sound “mixed up.” What might the nurse suspect as the cause for this change?

a. Atrophy of the apocrine glands

b. Cilia becoming coarse and stiff

c. Nerve degeneration in the inner ear

d. Scarring of the tympanic membrane

ANS: C

Presbycusis is a type of hearing loss that occurs in 60% of those older than 65 years of age, even in those living in a quiet environment. This sensorineural loss is gradual and caused by nerve degeneration in the inner ear. Words sound garbled, and the ability to localize sound is also impaired. This communication dysfunction is accentuated when background noise is present.

14. During an assessment of a 20-year-old Asian patient, the nurse notices that he has dry, flaky cerumen in his canal. What is the significance of this finding? This finding:

a. Is probably the result of lesions from eczema in his ear.

b. Represents poor hygiene.

c. Is a normal finding, and no further follow-up is necessary.

d. Could be indicative of change in cilia; the nurse should assess for hearing loss.

ANS: C

Asians and Native Americans are more likely to have dry cerumen, whereas Blacks and Whites usually have wet cerumen.

15. The nurse is taking the history of a patient who may have a perforated eardrum. What would be an important question in this situation?

a. “Do you ever notice ringing or crackling in your ears?”

b. “When was the last time you had your hearing checked?”

c. “Have you ever been told that you have any type of hearing loss?”

d. “Is there any relationship between the ear pain and the discharge you mentioned?”

ANS: D

Typically with perforation, ear pain occurs first, stopping with a popping sensation, and then drainage occurs.

16. A 31-year-old patient tells the nurse that he has noticed pain in his left ear when people speak loudly to him. The nurse knows that this finding:

a. Is normal for people of his age.

b. Is a characteristic of recruitment.

c. May indicate a middle ear infection.

d. Indicates that the patient has a cerumen impaction.

ANS: B

Recruitment is significant hearing loss occurring when speech is at low intensity, but sound actually becomes painful when the speaker repeats at a louder volume. The other responses are not correct.

17. While discussing the history of a 6-month-old infant, the mother tells the nurse that she took a significant amount of aspirin while she was pregnant. What question would the nurse want to include in the history?

a. "Does your baby seem to startle with loud noises?"

b. "Has your baby had any surgeries on her ears?"

c. "Have you noticed any drainage from her ears?"

d. "How many ear infections has your baby had since birth?"

ANS: A

Children at risk for a hearing deficit include those exposed in utero to a variety of conditions, such as maternal rubella or to maternal ototoxic drugs.

18. The nurse is performing an otoscopic examination on an adult. Which of these actions is*correct*?

a. Tilting the person's head forward during the examination

b. Once the speculum is in the ear, releasing the traction

c. Pulling the pinna up and back before inserting the speculum

d. Using the smallest speculum to decrease the amount of discomfort

ANS: C

The pinna is pulled up and back on an adult or older child, which helps straighten the S-shape of the canal. Traction should not be released on the ear until the examination is completed and the otoscope is removed.

19. The nurse is assessing a 16-year-old patient who has suffered head injuries from a recent motor vehicle accident. Which of these statements indicates the most important reason for assessing for any drainage from the ear canal?

a. If the drum has ruptured, then purulent drainage will result.

b. Bloody or clear watery drainage can indicate a basal skull fracture.

c. The auditory canal many be occluded from increased cerumen.

d. Foreign bodies from the accident may cause occlusion of the canal.

ANS: B

Frank blood or clear watery drainage (cerebrospinal leak) after a trauma suggests a basal skull fracture and warrants immediate referral. Purulent drainage indicates otitis externa or otitis media.

20. In performing a voice test to assess hearing, which of these actions would the nurse perform?

a. Shield the lips so that the sound is muffled.

b. Whisper a set of random numbers and letters, and then ask the patient to repeat them.

c. Ask the patient to place his finger in his ear to occlude outside noise.

d. Stand approximately 4 feet away to ensure that the patient can really hear at this distance.

ANS: B

With the head 30 to 60 cm (1 to 2 feet) from the patient's ear, the examiner exhales and slowly whispers a set of random numbers and letters, such as "5, B, 6." Normally, the patient is asked to repeat each number and letter correctly after hearing the examiner say them.

21. In performing an examination of a 3-year-old child with a suspected ear infection, the nurse would:

a. Omit the otoscopic examination if the child has a fever.

b. Pull the ear up and back before inserting the speculum.

c. Ask the mother to leave the room while examining the child.

d. Perform the otoscopic examination at the end of the assessment.

ANS: D

In addition to its place in the complete examination, eardrum assessment is mandatory for any infant or child requiring care for an illness or fever. For the infant or young child, the timing of the otoscopic examination is best toward the end of the complete examination.

22. The nurse is preparing to perform an otoscopic examination of a newborn infant. Which statement is *true* regarding this examination?

a. Immobility of the drum is a normal finding.

b. An injected membrane would indicate an infection.

c. The normal membrane may appear thick and opaque.

d. The appearance of the membrane is identical to that of an adult.

ANS: C

During the first few days after the birth, the tympanic membrane of a newborn often appears thickened and opaque. It may look *injected* and have a mild redness from increased vascularity. The other statements are not correct.

23. The nurse assesses the hearing of a 7-month-old by clapping hands. What is the expected response? The infant:

a. Turns his or her head to localize the sound.

b. Shows no obvious response to the noise.

c. Shows a startle and acoustic blink reflex.

d. Stops any movement, and appears to listen for the sound.

ANS: A

With a loud sudden noise, the nurse should notice the infant turning his or her head to localize the sound and to respond to his or her own name. A startle reflex and acoustic blink reflex is expected in newborns; at age 3 to 4 months, the infant stops any movement and appears to listen.

24. The nurse is performing an ear examination of an 80-year-old patient. Which of these findings would be considered normal?

a. High-tone frequency loss

b. Increased elasticity of the pinna

c. Thin, translucent membrane

d. Shiny, pink tympanic membrane

ANS: A

A high-tone frequency hearing loss is apparent for those affected with presbycusis, the hearing loss that occurs with aging. The pinna loses elasticity, causing earlobes to be pendulous. The eardrum may be whiter in color and more opaque and duller in the older person than in the younger adult.

25. An assessment of a 23-year-old patient reveals the following: an auricle that is tender and reddish-blue in color with small vesicles. The nurse would need to know additional information that includes which of these?

a. Any change in the ability to hear

b. Any recent drainage from the ear

c. Recent history of trauma to the ear

d. Any prolonged exposure to extreme cold

ANS: D

Frostbite causes reddish-blue discoloration and swelling of the auricle after exposure to extreme cold. Vesicles or bullae may develop, and the person feels pain and tenderness.

26. While performing the otoscopic examination of a 3-year-old boy who has been pulling on his left ear, the nurse finds that his left tympanic membrane is bright red and that the light reflex is not visible. The nurse interprets these findings to indicate a(n):

a. Fungal infection.

b. Acute otitis media.

c. Perforation of the eardrum.

d. Cholesteatoma.

ANS: B

Absent or distorted light reflex and a bright red color of the eardrum are indicative of acute otitis media. (See Table 15-5 for descriptions of the other conditions.)

27. The mother of a 2-year-old toddler is concerned about the upcoming placement of tympanostomy tubes in her son's ears. The nurse would include which of these statements in the teaching plan?

a. The tubes are placed in the inner ear.

b. The tubes are used in children with sensorineural loss.

c. The tubes are permanently inserted during a surgical procedure.

d. The purpose of the tubes is to decrease the pressure and allow for drainage.

ANS: D

Polyethylene tubes are surgically inserted into the eardrum to relieve middle ear pressure and to promote drainage of chronic or recurrent middle ear infections. Tubes spontaneously extrude in 6 months to 1 year.

28. In an individual with otitis externa, which of these signs would the nurse expect to find on assessment?

a. Rhinorrhea

b. Periorbital edema

c. Pain over the maxillary sinuses

d. Enlarged superficial cervical nodes

ANS: D

The lymphatic drainage of the external ear flows to the parotid, mastoid, and superficial cervical nodes. The signs are severe swelling of the canal, inflammation, and tenderness. Rhinorrhea, periorbital edema, and pain over the maxillary sinuses do not occur with otitis externa.

29. When performing an otoscopic examination of a 5-year-old child with a history of chronic ear infections, the nurse sees that his right tympanic membrane is amber-yellow in color and that air bubbles are visible behind the tympanic membrane. The child reports occasional hearing loss and a popping sound with swallowing. The preliminary analysis based on this information is that the child:

a. Most likely has serous otitis media.

b. Has an acute purulent otitis media.

c. Has evidence of a resolving cholesteatoma.

d. Is experiencing the early stages of perforation.

ANS: A

An amber-yellow color to the tympanic membrane suggests serum or pus in the middle ear. Air or fluid or bubbles behind the tympanic membrane are often visible. The patient may have feelings of fullness, transient hearing loss, and a popping sound with swallowing. These findings most likely suggest that the child has serous otitis media. The other responses are not correct.

30. The nurse is performing an assessment on a 65-year-old man. He reports a crusty nodule behind the pinna. It intermittently bleeds and has not healed over the past 6 months. On physical assessment, the nurse finds an ulcerated crusted nodule with an indurated base. The preliminary analysis in this situation is that this:

a. Is most likely a benign sebaceous cyst.

b. Is most likely a keloid.

c. Could be a potential carcinoma, and the patient should be referred for a biopsy.

d. Is a tophus, which is common in the older adult and is a sign of gout.

ANS: C

An ulcerated crusted nodule with an indurated base that fails to heal is characteristic of a carcinoma. These lesions fail to heal and intermittently bleed. Individuals with such symptoms should be referred for a biopsy (see Table 15-2). The other responses are not correct.

31. The nurse suspects that a patient has otitis media. Early signs of otitis media include which of these findings of the tympanic membrane?

a. Red and bulging

b. Hypomobility

c. Retraction with landmarks clearly visible

d. Flat, slightly pulled in at the center, and moves with insufflation

ANS: B

An early sign of otitis media is hypomobility of the tympanic membrane. As pressure increases, the tympanic membrane begins to bulge.

32. The nurse is performing a middle ear assessment on a 15-year-old patient who has had a history of chronic ear infections. When examining the right tympanic membrane, the nurse sees the presence of dense white patches. The tympanic membrane is otherwise unremarkable. It is pearly, with the light reflex at 5 o’clock and landmarks visible. The nurse should:

a. Refer the patient for the possibility of a fungal infection.

b. Know that these are scars caused from frequent ear infections.

c. Consider that these findings may represent the presence of blood in the middle ear.

d. Be concerned about the ability to hear because of this abnormality on the tympanic membrane.

ANS: B

Dense white patches on the tympanic membrane are sequelae of repeated ear infections. They do not necessarily affect hearing.

33. The nurse is preparing to do an otoscopic examination on a 2-year-old child. Which one of these reflects the *correct* procedure?

a. Pulling the pinna down

b. Pulling the pinna up and back

c. Slightly tilting the child’s head toward the examiner

d. Instructing the child to touch his chin to his chest

ANS: A

For an otoscopic examination on an infant or on a child under 3 years of age, the pinna is pulled down. The other responses are not part of the correct procedure.

34. The nurse is conducting a child safety class for new mothers. Which factor places young children at risk for ear infections?

a. Family history

b. Air conditioning

c. Excessive cerumen

d. Passive cigarette smoke

ANS: D

Exposure to passive and gestational smoke is a risk factor for ear infections in infants and children.

35. During an otoscopic examination, the nurse notices an area of black and white dots on the tympanic membrane and the ear canal wall. What does this finding suggest?

a. Malignancy

b. Viral infection

c. Blood in the middle ear

d. Yeast or fungal infection

ANS: D

A colony of black or white dots on the drum or canal wall suggests a yeast or fungal infection (otomycosis).

36. A 17-year-old student is a swimmer on her high school's swim team. She has had three bouts of otitis externa this season and wants to know what to do to prevent it. The nurse instructs her to:

a. Use a cotton-tipped swab to dry the ear canals thoroughly after each swim.

b. Use rubbing alcohol or 2% acetic acid eardrops after every swim.

c. Irrigate the ears with warm water and a bulb syringe after each swim.

d. Rinse the ears with a warmed solution of mineral oil and hydrogen peroxide.

ANS: B

With otitis externa (swimmer's ear), swimming causes the external canal to become waterlogged and swell; skinfolds are set up for infection. Otitis externa can be prevented by using rubbing alcohol or 2% acetic acid eardrops after every swim.

37. During an examination, the patient states he is hearing a buzzing sound and says that it is "driving me crazy!" The nurse recognizes that this symptom indicates:

a. Vertigo.

b. Pruritus.

c. Tinnitus.

d. Cholesteatoma.

ANS: C

Tinnitus is a sound that comes from within a person; it can be a ringing, crackling, or buzzing sound. It accompanies some hearing or ear disorders.

38. During an examination, the nurse notices that the patient stumbles a little while walking, and, when she sits down, she holds on to the sides of the chair. The patient states, "It feels like the room is spinning!" The nurse notices that the patient is experiencing:

a. Objective vertigo.

b. Subjective vertigo.

c. Tinnitus.

d. Dizziness.

ANS: A

With objective vertigo, the patient feels like the room spins; with subjective vertigo, the person feels like he or she is spinning. Tinnitus is a sound that comes from within a person; it can be a ringing, crackling, or buzzing sound. It accompanies some hearing or ear disorders. Dizziness is not the same as true vertigo; the person who is dizzy may feel unsteady and lightheaded.

39. A patient has been admitted after an accident at work. During the assessment, the patient is having trouble hearing and states, “I don’t know what the matter is. All of a sudden, I can’t hear you out of my left ear!” What should the nurse do next?

a. Make note of this finding for the report to the next shift.

b. Prepare to remove cerumen from the patient’s ear.

c. Notify the patient’s health care provider.

d. Irrigate the ear with rubbing alcohol.

ANS: C

Any sudden loss of hearing in one or both ears that is not associated with an upper respiratory infection needs to be reported at once to the patient’s health care provider. Hearing loss associated with trauma is often sudden. Irrigating the ear or removing cerumen is not appropriate at this time.

MULTIPLE RESPONSE

1. The nurse is testing the hearing of a 78-year-old man and is reminded of the changes in hearing that occur with aging that include which of the following? *Select all that apply*.

a. Hearing loss related to aging begins in the mid 40s.

b. Progression of hearing loss is slow.

c. The aging person has low-frequency tone loss.

d. The aging person may find it harder to hear consonants than vowels.

e. Sounds may be garbled and difficult to localize.

f. Hearing loss reflects nerve degeneration of the middle ear.

ANS: B, D, E

Presbycusis is a type of hearing loss that occurs with aging and is found in 60% of those older than 65 years. It is a gradual sensorineural loss caused by nerve degeneration in the inner ear or auditory nerve, and it slowly progresses after the age of 50 years. The person first notices a high-frequency tone loss; it is harder to hear consonants (high-pitched components of speech) than vowels, which makes words sound garbled. The ability to localize sound is also impaired.

Chapter 16: Nose, Mouth, and Throat

MULTIPLE CHOICE

1. The primary purpose of the ciliated mucous membrane in the nose is to:

a. Warm the inhaled air.

b. Filter out dust and bacteria.

c. Filter coarse particles from inhaled air.

d. Facilitate the movement of air through the nares.

ANS: B

The nasal hairs filter the coarsest matter from inhaled air, whereas the mucous blanket filters out dust and bacteria. The rich blood supply of the nasal mucosa warms the inhaled air.

2. The projections in the nasal cavity that increase the surface area are called the:

a. Meatus.

b. Septum.

c. Turbinates.

d. Kiesselbach plexus.

ANS: C

The lateral walls of each nasal cavity contain three parallel bony projections: the superior, middle, and inferior turbinates. These increase the surface area, making more blood vessels and mucous membrane available to warm, humidify, and filter the inhaled air.

3. The nurse is reviewing the development of the newborn infant. Regarding the sinuses, which statement is *true* in relation to a newborn infant?

a. Sphenoid sinuses are full size at birth.

b. Maxillary sinuses reach full size after puberty.

c. Frontal sinuses are fairly well developed at birth.

d. Maxillary and ethmoid sinuses are the only sinuses present at birth.

ANS: D

Only the maxillary and ethmoid sinuses are present at birth. The sphenoid sinuses are minute at birth and develop after puberty. The frontal sinuses are absent at birth, are fairly well developed at age 7 to 8 years, and reach full size after puberty.

4. The tissue that connects the tongue to the floor of the mouth is the:

a. Uvula.

b. Palate.

c. Papillae.

d. Frenulum.

ANS: D

The frenulum is a midline fold of tissue that connects the tongue to the floor of the mouth. The uvula is the free projection hanging down from the middle of the soft palate. The palate is the arching roof of the mouth. Papillae are the rough, bumpy elevations on the tongue's dorsal surface.

5. The salivary gland that is the largest and located in the cheek in front of the ear is the _____ gland.

a. Parotid

b. Stensen's

c. Sublingual

d. Submandibular

ANS: A

The mouth contains three pairs of salivary glands. The largest, the parotid gland, lies within the cheeks in front of the ear extending from the zygomatic arch down to the angle of the jaw. The Stensen's duct (not gland) drains the parotid gland onto the buccal mucosa opposite the second molar. The sublingual gland is located within the floor of the mouth under the tongue. The submandibular gland lies beneath the mandible at the angle of the jaw.

6. In assessing the tonsils of a 30 year old, the nurse notices that they are involuted, granular in appearance, and appear to have deep crypts. What is correct response to these findings?

a. Refer the patient to a throat specialist.

b. No response is needed; this appearance is normal for the tonsils.

c. Continue with the assessment, looking for any other abnormal findings.

d. Obtain a throat culture on the patient for possible streptococcal (strep) infection.

ANS: B

The tonsils are the same color as the surrounding mucous membrane, although they look more granular and their surface shows deep crypts. Tonsillar tissue enlarges during childhood until puberty and then involutes.

7. The nurse is obtaining a health history on a 3-month-old infant. During the interview, the mother states, "I think she is getting her first tooth because she has started drooling a lot." The nurse's best response would be:

a. "You're right, drooling is usually a sign of the first tooth."

b. "It would be unusual for a 3 month old to be getting her first tooth."

c. "This could be the sign of a problem with the salivary glands."

d. "She is just starting to salivate and hasn't learned to swallow the saliva."

ANS: D

In the infant, salivation starts at 3 months. The baby will drool for a few months before learning to swallow the saliva. This drooling does not herald the eruption of the first tooth, although many parents think it does.

8. The nurse is assessing an 80-year-old patient. Which of these findings would be expected for this patient?

a. Hypertrophy of the gums

b. Increased production of saliva

c. Decreased ability to identify odors

d. Finer and less prominent nasal hair

ANS: C

The sense of smell may be reduced because of a decrease in the number of olfactory nerve fibers. Nasal hairs grow coarser and stiffer with aging. The gums may recede with aging, not hypertrophy, and saliva production decreases.

9. The nurse is performing an oral assessment on a 40-year-old Black patient and notices the presence of a 1 cm, nontender, grayish-white lesion on the left buccal mucosa. Which one of these statements is *true*? This lesion is:

a. Leukoedema and is common in dark-pigmented persons.

b. The result of hyperpigmentation and is normal.

c. Torus palatinus and would normally be found only in smokers.

d. Indicative of cancer and should be immediately tested.

ANS: A

Leukoedema, a grayish-white benign lesion occurring on the buccal mucosa, is most often observed in Blacks.

10. While obtaining a health history, a patient tells the nurse that he has frequent nosebleeds and asks the best way to get them to stop. What would be the nurse's best response?

a. "While sitting up, place a cold compress over your nose."

b. "Sit up with your head tilted forward and pinch your nose."

c. "Just allow the bleeding to stop on its own, but don't blow your nose."

d. "Lie on your back with your head tilted back and pinch your nose."

ANS: B

With a nosebleed, the person should sit up with the head tilted forward and pinch the nose between the thumb and forefinger for 5 to 15 minutes.

11. A 92-year-old patient has had a stroke. The right side of his face is drooping. The nurse might also suspect which of these assessment findings?

a. Epistaxis

b. Rhinorrhea

c. Dysphagia

d. Xerostomia

ANS: C

Dysphagia is difficulty with swallowing and may occur with a variety of disorders, including stroke and other neurologic diseases. Rhinorrhea is a runny nose, epistaxis is a bloody nose, and xerostomia is a dry mouth.

12. While obtaining a health history from the mother of a 1-year-old child, the nurse notices that the baby has had a bottle in his mouth the entire time. The mother states, "It makes a great pacifier." The best response by the nurse would be:

a. "You're right. Bottles make very good pacifiers."

b. "Using a bottle as a pacifier is better for the teeth than thumb-sucking."

c. "It's okay to use a bottle as long as it contains milk and not juice."

d. "Prolonged use of a bottle can increase the risk for tooth decay and ear infections."

ANS: D

Prolonged bottle use during the day or when going to sleep places the infant at risk for tooth decay and middle ear infections.

13. A 72-year-old patient has a history of hypertension and chronic lung disease. An important question for the nurse to include in the health history would be:

a. "Do you use a fluoride supplement?"

b. "Have you had tonsillitis in the last year?"

c. "At what age did you get your first tooth?"

d. "Have you noticed any dryness in your mouth?"

ANS: D

Xerostomia (dry mouth) is a side effect of many drugs taken by older people, including antidepressants, anticholinergics, antispasmodics, antihypertensives, antipsychotics, and bronchodilators.

14. The nurse is using an otoscope to assess the nasal cavity. Which of these techniques is *correct*?

a. Inserting the speculum at least 3 cm into the vestibule

b. Avoiding touching the nasal septum with the speculum

c. Gently displacing the nose to the side that is being examined

d. Keeping the speculum tip medial to avoid touching the floor of the nares

ANS: B

The correct technique for using an otoscope is to insert the apparatus into the nasal vestibule, avoiding pressure on the sensitive nasal septum. The tip of the nose should be lifted up before inserting the speculum.

15. The nurse is performing an assessment on a 21-year-old patient and notices that his nasal mucosa appears pale, gray, and swollen. What would be the most appropriate question to ask the patient?

a. “Are you aware of having any allergies?”

b. “Do you have an elevated temperature?”

c. “Have you had any symptoms of a cold?”

d. “Have you been having frequent nosebleeds?”

ANS: A

With chronic allergies, the mucosa looks swollen, boggy, pale, and gray. Elevated body temperature, colds, and nosebleeds do not cause these mucosal changes.

16. The nurse is palpating the sinus areas. If the findings are normal, then the patient should report which sensation?

a. No sensation

b. Firm pressure

c. Pain during palpation

d. Pain sensation behind eyes

ANS: B

The person should feel firm pressure but no pain. Sinus areas are tender to palpation in persons with chronic allergies or an acute infection (sinusitis).

17. During an oral assessment of a 30-year-old Black patient, the nurse notices bluish lips and a dark line along the gingival margin. What action would the nurse perform in response to this finding?

a. Check the patient’s hemoglobin for anemia.

b. Assess for other signs of insufficient oxygen supply.

c. Proceed with the assessment, knowing that this appearance is a normal finding.

d. Ask if he has been exposed to an excessive amount of carbon monoxide.

ANS: C

Some Blacks may have bluish lips and a dark line on the gingival margin; this appearance is a normal finding.

18. During an assessment of a 20-year-old patient with a 3-day history of nausea and vomiting, the nurse notices dry mucosa and deep vertical fissures in the tongue. These findings are reflective of:

a. Dehydration.

b. Irritation by gastric juices.

c. A normal oral assessment.

d. Side effects from nausea medication.

ANS: A

Dry mouth occurs with dehydration or fever. The tongue has deep vertical fissures.

19. A 32-year-old woman is at the clinic for “little white bumps in my mouth.” During the assessment, the nurse notes that she has a 0.5 cm white, nontender papule under her tongue and one on the mucosa of her right cheek. What would the nurse tell the patient?

a. “These spots indicate an infection such as strep throat.”

b. “These bumps could be indicative of a serious lesion, so I will refer you to a specialist.”

c. “This condition is called leukoplakia and can be caused by chronic irritation such as with smoking.”

d. “These bumps are Fordyce granules, which are sebaceous cysts and are not a serious condition.”

ANS: D

Fordyce granules are small, isolated white or yellow papules on the mucosa of the cheek, tongue, and lips. These little sebaceous cysts are painless and are not significant. Chalky, white raised patches would indicate leukoplakia. In strep throat, the examiner would see tonsils that are bright red, swollen, and may have exudates or white spots.

20. A 10 year old is at the clinic for “a sore throat that has lasted 6 days.” Which of these findings would be consistent with an acute infection?

a. Tonsils 1+/1-4+ and pink; the same color as the oral mucosa

b. Tonsils 2+/1-4+ with small plugs of white debris

c. Tonsils 3+/1-4+ with large white spots

d. Tonsils 3+/1-4+ with pale coloring

ANS: C

With an acute infection, tonsils are bright red and swollen and may have exudate or large white spots. Tonsils are enlarged to 2+, 3+, or 4+ with an acute infection.

21. Immediately after birth, the nurse is unable to suction the nares of a newborn. An attempt is made to pass a catheter through both nasal cavities with no success. What should the nurse do next?

a. Attempt to suction again with a bulb syringe.

b. Wait a few minutes, and try again once the infant stops crying.

c. Recognize that this situation requires immediate intervention.

d. Contact the physician to schedule an appointment for the infant at his or her next hospital visit.

ANS: C

Determining the patency of the nares in the immediate newborn period is essential because most newborns are obligate nose breathers. Nares blocked with amniotic fluid are gently suctioned with a bulb syringe. If obstruction is suspected, then a small lumen (5 to 10 Fr) catheter is passed down each naris to confirm patency. The inability to pass a catheter through the nasal cavity indicates choanal atresia, which requires immediate intervention.

22. The nurse notices that the mother of a 2-year-old boy brings him into the clinic quite frequently for various injuries and suspects there may be some child abuse involved. During an inspection of his mouth, the nurse should look for:

a. Swollen, red tonsils.

b. Ulcerations on the hard palate.

c. Bruising on the buccal mucosa or gums.

d. Small yellow papules along the hard palate.

ANS: C

The nurse should notice any bruising or laceration on the buccal mucosa or gums of an infant or young child. Trauma may indicate child abuse from a forced feeding of a bottle or spoon.

23. The nurse is assessing a 3 year old for “drainage from the nose.” On assessment, a purulent drainage that has a very foul odor is noted from the left naris and no drainage is observed from the right naris. The child is afebrile with no other symptoms. What should the nurse do next?

a. Refer to the physician for an antibiotic order.

b. Have the mother bring the child back in 1 week.

c. Perform an otoscopic examination of the left nares.

d. Tell the mother that this drainage is normal for a child of this age.

ANS: C

Children are prone to put an object up the nose, producing unilateral purulent drainage with a foul odor. Because some risk for aspiration exists, removal should be prompt.

24. During an assessment of a 26 year old at the clinic for “a spot on my lip I think is cancer,” the nurse notices a group of clear vesicles with an erythematous base around them located at the lip-skin border. The patient mentions that she just returned from Hawaii. What would be the most appropriate response by the nurse?

a. Tell the patient she needs to see a skin specialist.

b. Discuss the benefits of having a biopsy performed on any unusual lesion.

c. Tell the patient that these vesicles are indicative of herpes simplex I or cold sores and that they will heal in 4 to 10 days.

d. Tell the patient that these vesicles are most likely the result of a riboflavin deficiency and discuss nutrition.

ANS: C

Cold sores are groups of clear vesicles with a surrounding erythematous base. These evolve into pustules or crusts and heal in 4 to 10 days. The most likely site is the lip-skin junction. Infection often recurs in the same site. Recurrent herpes infections may be precipitated by sunlight, fever, colds, or allergy.

25. While performing an assessment of the mouth, the nurse notices that the patient has a 1-cm ulceration that is crusted with an elevated border and located on the outer third of the lower lip. What other information would be most important for the nurse to assess?

a. Nutritional status

b. When the patient first noticed the lesion

c. Whether the patient has had a recent cold

d. Whether the patient has had any recent exposure to sick animals

ANS: B

With carcinoma, the initial lesion is round and indurated, but then it becomes crusted and ulcerated with an elevated border. Most cancers occur between the outer and middle thirds of the lip. Any lesion that is still unhealed after 2 weeks should be referred.

26. A pregnant woman states that she is concerned about her gums because she has noticed they are swollen and have started bleeding. What would be an appropriate response by the nurse?

a. “Your condition is probably due to a vitamin C deficiency.”

b. “I’m not sure what causes swollen and bleeding gums, but let me know if it’s not better in a few weeks.”

c. “You need to make an appointment with your dentist as soon as possible to have this checked.”

d. “Swollen and bleeding gums can be caused by the change in hormonal balance in your system during pregnancy.”

ANS: D

Gum margins are red and swollen and easily bleed with gingivitis. A changing hormonal balance may cause this condition to occur in pregnancy and puberty.

27. A 40-year-old patient who has just finished chemotherapy for breast cancer tells the nurse that she is concerned about her mouth. During the assessment the nurse finds areas of buccal mucosa that are raw and red with some bleeding, as well as other areas that have a white, cheesy coating. The nurse recognizes that this abnormality is:

a. Aphthous ulcers.

b. Candidiasis.

c. Leukoplakia.

d. Koplik spots.

ANS: B

Candidiasis is a white, cheesy, curdlike patch on the buccal mucosa and tongue. It scrapes off, leaving a raw, red surface that easily bleeds. It also occurs after the use of antibiotics or corticosteroids and in persons who are immunosuppressed. (See Table 16-4 for descriptions of the other lesions.)

28. The nurse is assessing a patient in the hospital who has received numerous antibiotics and notices that his tongue appears to be black and hairy. In response to his concern, what would the nurse say?

a. “We will need to get a biopsy to determine the cause.”

b. “This is an overgrowth of hair and will go away in a few days.”

c. “Black, hairy tongue is a fungal infection caused by all the antibiotics you have received.”

d. “This is probably caused by the same bacteria you had in your lungs.”

ANS: C

A black, hairy tongue is not really hair but the elongation of filiform papillae and painless overgrowth of mycelial threads of fungus infection on the tongue. It occurs after the use of antibiotics, which inhibit normal bacteria and allow a proliferation of fungus.

29. The nurse is assessing a patient with a history of intravenous drug abuse. In assessing his mouth, the nurse notices a dark red confluent macule on the hard palate. This could be an early sign of:

a. Acquired immunodeficiency syndrome (AIDS).

b. Measles.

c. Leukemia.

d. Carcinoma.

ANS: A

Oral Kaposi’s sarcoma is a bruiselike, dark red or violet, confluent macule that usually occurs on the hard palate. It may appear on the soft palate or gingival margin. Oral lesions may be among the earliest lesions to develop with AIDS.

30. A mother brings her 4-month-old infant to the clinic with concerns regarding a small pad in the middle of the upper lip that has been there since 1 month of age. The infant has no health problems. On physical examination, the nurse notices a 0.5-cm, fleshy, elevated area in the middle of the upper lip. No evidence of inflammation or drainage is observed. What would the nurse tell this mother?

a. “This area of irritation is caused from teething and is nothing to worry about.”

b. “This finding is abnormal and should be evaluated by another health care provider.”

c. “This area of irritation is the result of chronic drooling and should resolve within the next month or two.”

d. “This elevated area is a sucking tubercle caused from the friction of breastfeeding or bottle-feeding and is normal.”

ANS: D

A normal finding in infants is the sucking tubercle, a small pad in the middle of the upper lip from the friction of breastfeeding or bottle-feeding. This condition is not caused by irritation, teething, or excessive drooling, and evaluation by another health care provider is not warranted.

31. A mother is concerned because her 18-month-old toddler has 12 teeth. She is wondering if this is normal for a child of this age. The nurse's best response would be:

a. "How many teeth did you have at this age?"

b. "All 20 deciduous teeth are expected to erupt by age 4 years."

c. "This is a normal number of teeth for an 18 month old."

d. "Normally, by age 2 years, 16 deciduous teeth are expected."

ANS: C

The guidelines for the number of teeth for children younger than 2 years old are as follows: the child's age in months minus the number 6 should be equal to the expected number of deciduous teeth. Normally, all 20 teeth are in by 2 years old. In this instance, the child is 18 months old, minus 6, equals 12 deciduous teeth expected.

32. When examining the mouth of an older patient, the nurse recognizes which finding is due to the aging process?

a. Teeth appearing shorter

b. Tongue that looks smoother in appearance

c. Buccal mucosa that is beefy red in appearance

d. Small, painless lump on the dorsum of the tongue

ANS: B

In the aging adult, the tongue looks smoother because of papillary atrophy. The teeth are slightly yellowed and appear longer because of the recession of gingival margins.

33. When examining the nares of a 45-year-old patient who has complaints of rhinorrhea, itching of the nose and eyes, and sneezing, the nurse notices the following: pale turbinates, swelling of the turbinates, and clear rhinorrhea. Which of these conditions is most likely the cause?

a. Nasal polyps

b. Acute sinusitis

c. Allergic rhinitis

d. Acute rhinitis

ANS: C

Rhinorrhea, itching of the nose and eyes, and sneezing are present with allergic rhinitis. On physical examination, serous edema is noted, and the turbinates usually appear pale with a smooth, glistening surface. (See Table 16-1 for descriptions of the other conditions.)

34. When assessing the tongue of an adult, the nurse knows that an abnormal finding would be:

a. Smooth glossy dorsal surface.

b. Thin white coating over the tongue.

c. Raised papillae on the dorsal surface.

d. Visible venous patterns on the ventral surface.

ANS: A

The dorsal surface of the tongue is normally roughened from papillae. A thin white coating may be present. The ventral surface may show veins. Smooth, glossy areas may indicate atrophic glossitis (see Table 16-5).

35. The nurse is performing an assessment. Which of these findings would cause the greatest concern?

a. Painful vesicle inside the cheek for 2 days

b. Presence of moist, nontender Stensen's ducts

c. Stippled gingival margins that snugly adhere to the teeth

d. Ulceration on the side of the tongue with rolled edges

ANS: D

Ulceration on the side or base of the tongue or under the tongue raises the suspicion of cancer and must be investigated. The risk of early metastasis is present because of rich lymphatic drainage. The vesicle may be an aphthous ulcer, which is painful but not dangerous. The other responses are normal findings.

36. A patient has been diagnosed with strep throat. The nurse is aware that without treatment, which complication may occur?

a. Rubella

b. Leukoplakia

c. Rheumatic fever

d. Scarlet fever

ANS: C

Untreated strep throat may lead to rheumatic fever. When performing a health history, the patient should be asked whether his or her sore throat has been documented as streptococcal.

37. During a checkup, a 22-year-old woman tells the nurse that she uses an over-the-counter nasal spray because of her allergies. She also states that it does not work as well as it used to when she first started using it. The best response by the nurse would be:

a. "You should never use over-the-counter nasal sprays because of the risk of addiction."

b. "You should try switching to another brand of medication to prevent this problem."

c. "Continuing to use this spray is important to keep your allergies under control."

d. "Using these nasal medications irritates the lining of the nose and may cause rebound swelling."

ANS: D

The misuse of over-the-counter nasal medications irritates the mucosa, causing rebound swelling, which is a common problem.

38. During an oral examination of a 4-year-old Native-American child, the nurse notices that her uvula is partially split. Which of these statements is accurate?

a. This condition is a cleft palate and is common in Native Americans.

b. A bifid uvula may occur in some Native-American groups.

c. This condition is due to an injury and should be reported to the authorities.

d. A bifid uvula is palatinus, which frequently occurs in Native Americans.

ANS: B

Bifid uvula, a condition in which the uvula is split either completely or partially, occurs in some Native-American groups.

39. A patient comes into the clinic complaining of facial pain, fever, and malaise. On examination, the nurse notes swollen turbinates and purulent discharge from the nose. The patient also complains of a dull, throbbing pain in his cheeks and teeth on the right side and pain when the nurse palpates the areas. The nurse recognizes that this patient has:

a. Posterior epistaxis.

b. Frontal sinusitis.

c. Maxillary sinusitis.

d. Nasal polyps.

ANS: C

Signs of maxillary sinusitis include facial pain after upper respiratory infection, red swollen nasal mucosa, swollen turbinates, and purulent discharge. The person also has fever, chills, and malaise. With maxillary sinusitis, dull throbbing pain occurs in the cheeks and teeth on the same side, and pain with palpation is present. With frontal sinusitis, pain is above the supraorbital ridge.

40. A woman who is in the second trimester of pregnancy mentions that she has had "more nosebleeds than ever" since she became pregnant. The nurse recognizes that this is a result of:

a. A problem with the patient's coagulation system.

b. Increased vascularity in the upper respiratory tract as a result of the pregnancy.

c. Increased susceptibility to colds and nasal irritation.

d. Inappropriate use of nasal sprays.

ANS: B

Nasal stuffiness and epistaxis may occur during pregnancy as a result of increased vascularity in the upper respiratory tract.

MULTIPLE RESPONSE

1. The nurse is teaching a health class to high-school boys. When discussing the topic of using smokeless tobacco (SLT), which of these statements are accurate? *Select all that apply*.

a. One pinch of SLT in the mouth for 30 minutes delivers the equivalent of one cigarette.

b. Using SLT has been associated with a greater risk of oral cancer than smoking.

c. Pain is an early sign of oral cancer.

d. Pain is rarely an early sign of oral cancer.

e. Tooth decay is another risk of SLT because of the use of sugar as a sweetener.

f. SLT is considered a healthy alternative to smoking.

ANS: B, D, E

One pinch of SLT in the mouth for 30 minutes delivers the equivalent of three cigarettes. Pain is rarely an early sign of oral cancer. Many brands of SLT are sweetened with sugars, which promotes tooth decay. SLT is not considered a healthy alternative to smoking, and the use of SLT has been associated with a greater risk of oral cancer than smoking.

2. During an assessment, a patient mentions that "I just can't smell like I used to. I can barely smell the roses in my garden. Why is that?" For which possible causes of changes in the sense of smell will the nurse assess? *Select all that apply*.

a. Chronic alcohol use

b. Cigarette smoking

c. Frequent episodes of strep throat

d. Chronic allergies

e. Aging

f. Herpes simplex virus I

ANS: B, D, E

Sen

The sense of smell diminishes with cigarette smoking, chronic allergies, and aging. Chronic alcohol use, a history of strep throat, and herpes simplex virus I are not associated with changes in the sense of smell.

Chapter 17: Breasts and Regional Lymphatics

MULTIPLE CHOICE

1. Which of the following statements is *true* regarding the internal structures of the breast? The breast is made up of:

a. Primarily muscle with very little fibrous tissue.

b. Fibrous, glandular, and adipose tissues.

c. Primarily milk ducts, known as *lactiferous ducts.*

d. Glandular tissue, which supports the breast by attaching to the chest wall.

ANS: B

The breast is made up of glandular, fibrous (including the suspensory ligaments), and adipose tissues.

2. In performing a breast examination, the nurse knows that examining the upper outer quadrant of the breast is especially important. The reason for this is that the upper outer quadrant is:

a. The largest quadrant of the breast.

b. The location of most breast tumors.

c. Where most of the suspensory ligaments attach.

d. More prone to injury and calcifications than other locations in the breast.

ANS: B

The upper outer quadrant is the site of most breast tumors. In the upper outer quadrant, the nurse should notice the axillary tail of Spence, the cone-shaped breast tissue that projects up into the axilla, close to the pectoral group of axillary lymph nodes.

3. In performing an assessment of a woman’s axillary lymph system, the nurse should assess which of these nodes?

a. Central, axillary, lateral, and sternal

b. Pectoral, lateral, anterior, and sternal

c. Central, lateral, pectoral, and subscapular

d. Lateral, pectoral, axillary, and suprascapular

ANS: C

The breast has extensive lymphatic drainage. Four groups of axillary nodes are present: (1) central, (2) pectoral (anterior), (3) subscapular (posterior), and (4) lateral.

4. If a patient reports a recent breast infection, then the nurse should expect to find _____ node enlargement.

a. Nonspecific

b. Ipsilateral axillary

c. Contralateral axillary

d. Inguinal and cervical

ANS: B

The breast has extensive lymphatic drainage. Most of the lymph, more than 75%, drains into the ipsilateral, or same side, axillary nodes.

5. A 9-year-old girl is in the clinic for a sport physical examination. After some initial shyness she finally asks, “Am I normal? I don’t seem to need a bra yet, but I have some friends who do. What if I never get breasts?” The nurse’s best response would be:

a. “Don’t worry, you still have plenty of time to develop.”

b. “I know just how you feel, I was a late bloomer myself. Just be patient, and they will grow.”

c. “You will probably get your periods before you notice any significant growth in your breasts.”

d. “I understand that it is hard to feel different from your friends. Breasts usually develop between 8 and 10 years of age.”

ANS: D

Adolescent breast development usually begins between 8 and 10 years of age. The nurse should not belittle the girl’s feelings by using statements like “don’t worry” or by sharing personal experiences. The beginning of breast development precedes menarche by approximately 2 years.

6. A patient contacts the office and tells the nurse that she is worried about her 10-year-old daughter having breast cancer. She describes a unilateral enlargement of the right breast with associated tenderness. She is worried because the left breast is not enlarged. What would be the nurse’s best response? Tell the mother that:

a. Breast development is usually fairly symmetric and that the daughter should be examined right away.

b. She should bring in her daughter right away because breast cancer is fairly common in preadolescent girls.

c. Although an examination of her daughter would rule out a problem, her breast development is most likely normal.

d. It is unusual for breasts that are first developing to feel tender because they haven’t developed much fibrous tissue.

ANS: C

Occasionally, one breast may grow faster than the other, producing a temporary asymmetry, which may cause some distress; reassurance is necessary. Tenderness is also common.

7. A 14-year-old girl is anxious about not having reached menarche. When taking the health history, the nurse should ascertain which of the following? The age that:

a. The girl began to develop breasts.

b. Her mother developed breasts.

c. She began to develop pubic hair.

d. She began to develop axillary hair.

ANS: A

Full development from stage 2 to stage 5 takes an average of 3 years, although the range is 1 to 6 years. Pubic hair develops during this time, and

axillary hair appears 2 years after the onset of pubic hair. The beginning of breast development precedes menarche by approximately 2 years. Menarche occurs in breast development stage 3 or 4, usually just after the peak of the adolescent growth spurt, which occurs around age 12 years (see Figure 17-6).

8. A woman is in the family planning clinic seeking birth control information. She states that her breasts “change all month long” and that she is worried that this is unusual. What is the nurse’s best response? The nurse should tell her that:

a. Continual changes in her breasts are unusual. The breasts of nonpregnant women usually stay pretty much the same all month long.

b. Breast changes in response to stress are very common and that she should assess her life for stressful events.

c. Because of the changing hormones during the monthly menstrual cycle, cyclic breast changes are common.

d. Breast changes normally occur only during pregnancy and that a pregnancy test is needed at this time.

ANS: C

Breasts of the nonpregnant woman change with the ebb and flow of hormones during the monthly menstrual cycle. During the 3 to 4 days before menstruation, the breasts feel full, tight, heavy, and occasionally sore. The breast volume is smallest on days 4 to 7 of the menstrual cycle.

9. A woman has just learned that she is pregnant. What are some things the nurse should teach her about her breasts?

a. She can expect her areolae to become larger and darker in color.

b. Breasts may begin secreting milk after the fourth month of pregnancy.

c. She should inspect her breasts for visible veins and immediately report these.

d. During pregnancy, breast changes are fairly uncommon; most of the changes occur after the birth.

ANS: A

The areolae become larger and grow a darker brown as pregnancy progresses, and the tubercles become more prominent. (The brown color fades after lactation, but the areolae never return to their original color). A venous pattern is an expected finding and prominent over the skin surface and does not need to be reported. After the fourth month of pregnancy, colostrum, a thick, yellow fluid (precursor to milk), may be expressed from the breasts.

10. The nurse is teaching a pregnant woman about breast milk. Which statement by the nurse is *correct*?

a. “Your breast milk is immediately present after the delivery of your baby.”

b. “Breast milk is rich in protein and sugars (lactose) but has very little fat.”

c. “The colostrum, which is present right after birth, does not contain the same nutrients as breast milk.”

d. “You may notice a thick, yellow fluid expressed from your breasts as early as the fourth month of pregnancy.”

ANS: D

After the fourth month, colostrum may be expressed. This thick yellow fluid is the precursor of milk, and it contains the same amount of protein and lactose but practically no fat. The breasts produce colostrum for the first few days after delivery. It is rich with antibodies that protect the newborn against infection; therefore, breastfeeding is important.

11. A 65-year-old patient remarks that she just cannot believe that her breasts “sag so much.” She states it must be from a lack of exercise. What explanation should the nurse offer her? After menopause:

a. Only women with large breasts experience sagging.

b. Sagging is usually due to decreased muscle mass within the breast.

c. A diet that is high in protein will help maintain muscle mass, which keeps the breasts from sagging.

d. The glandular and fat tissue atrophies, causing breast size and elasticity to diminish, resulting in breasts that sag.

ANS: D

After menopause, the glandular tissue atrophies and is replaced with connective tissue. The fat envelope also atrophies, beginning in the middle years and becoming significant in the eighth and ninth decades of life. These changes decrease breast size and elasticity; consequently, the breasts droop and sag, looking flattened and flabby.

12. In examining a 70-year-old male patient, the nurse notices that he has bilateral gynecomastia. Which of the following describes the nurse’s best course of action?

a. Recommend that he make an appointment with his physician for a mammogram.

b. Ignore it. Benign breast enlargement in men is not unusual.

c. Explain that this condition may be the result of hormonal changes, and recommend that he see his physician.

d. Explain that gynecomastia in men is usually associated with prostate enlargement and recommend that he be thoroughly screened.

ANS: C

Gynecomastia may reappear in the aging man and may be attributable to a testosterone deficiency.

13. During an examination of a 7-year-old girl, the nurse notices that the girl is showing breast budding. What should the nurse do next?

a. Ask the young girl if her periods have started.

b. Assess the girl's weight and body mass index (BMI).

c. Ask the girl's mother at what age she started to develop breasts.

d. Nothing; breast budding is a normal finding.

ANS: B

Research has shown that girls with overweight or obese BMI levels have a higher occurrence of early onset of breast budding (before age 8 years for black girls and age 10 years for white girls) and early menarche.

14. The nurse is reviewing statistics regarding breast cancer. Which woman, aged 40 years in the United States, has the highest risk for developing breast cancer?

a. Black

b. White

c. Asian

d. American Indian

ANS: A

The incidence of breast cancer varies within different cultural groups. White women have a higher incidence of breast cancer than black women starting at age 45 years; but black women have a higher incidence before age 45 years. Asian, Hispanic, and American Indian women have a lower risk for development of breast cancer (American Cancer Society, 2009-2010).

15. The nurse is preparing for a class in early detection of breast cancer. Which statement is*true* with regard to breast cancer in black women in the United States?

a. Breast cancer is not a threat to black women.

b. Black women have a lower incidence of regional or distant breast cancer than white women.

c. Black women are more likely to die of breast cancer at any age.

d. Breast cancer incidence in black women is higher than that of white women after age 45.

ANS: C

Black women have a higher incidence of breast cancer before age 45 years than white women and are more likely to die of their disease. In addition, black women are significantly more likely to be diagnosed with regional or distant breast cancer than are white women. These racial differences in mortality rates may be related to an insufficient use of screening measures and a lack of access to health care.

16. During a breast health interview, a patient states that she has noticed pain in her left breast. The nurse's most appropriate response to this would be:

a. "Don't worry about the pain; breast cancer is not painful."

b. "I would like some more information about the pain in your left breast."

c. "Oh, I had pain like that after my son was born; it turned out to be a blocked milk duct."

d. “Breast pain is almost always the result of benign breast disease.”

ANS: B

Breast pain occurs with trauma, inflammation, infection, or benign breast disease. The nurse will need to gather more information about the patient’s pain rather than make statements that ignore the patient’s concerns.

17. During a health history interview, a female patient states that she has noticed a few drops of clear discharge from her right nipple. What should the nurse do next?

a. Immediately contact the physician to report the discharge.

b. Ask her if she is possibly pregnant.

c. Ask the patient some additional questions about the medications she is taking.

d. Immediately obtain a sample for culture and sensitivity testing.

ANS: C

The use of some medications, such as oral contraceptives, phenothiazines, diuretics, digitalis, steroids, methyldopa, and calcium channel blockers, may cause clear nipple discharge. Bloody or blood-tinged discharge from the nipple, not clear, is significant, especially if a lump is also present. In the pregnant female, colostrum would be a thick, yellowish liquid, and it would be normally expressed after the fourth month of pregnancy.

18. During a physical examination, a 45-year-old woman states that she has had a crusty, itchy rash on her breast for approximately 2 weeks. In trying to find the cause of the rash, which question would be important for the nurse to ask?

a. “Is the rash raised and red?”

b. “Does it appear to be cyclic?”

c. “Where did the rash first appear—on the nipple, the areola, or the surrounding skin?”

d. “What was she doing when she first noticed the rash, and do her actions make it worse?”

ANS: C

The location where the rash first appeared is important for the nurse to determine. Paget disease starts with a small crust on the nipple apex and then spreads to the areola. Eczema or other dermatitis rarely starts at the nipple unless it is a result of breastfeeding. It usually starts on the areola or surrounding skin and then spreads to the nipple (see Table 17-6).

19. A patient is newly diagnosed with benign breast disease. The nurse recognizes which statement about benign breast disease to be *true*? The presence of benign breast disease:

a. Makes it hard to examine the breasts.

b. Frequently turns into cancer in a woman’s later years.

c. Is easily reduced with hormone replacement therapy.

d. Is usually diagnosed before a woman reaches childbearing age.

ANS: A

The presence of benign breast disease (formerly fibrocystic breast disease) makes it hard to examine the breasts; the general lumpiness of the breast conceals a new lump. The other statements are not true.

20. During an annual physical examination, a 43-year-old patient states that she does not perform monthly breast self-examinations (BSEs). She tells the nurse that she believes that mammograms “do a much better job than I ever could to find a lump.” The nurse should explain to her that:

a. BSEs may detect lumps that appear between mammograms.

b. BSEs are unnecessary until the age of 50 years.

c. She is correct—mammography is a good replacement for BSE.

d. She does not need to perform BSEs as long as a physician checks her breasts annually.

ANS: A

The monthly practice of BSE, along with clinical breast examination and mammograms, are complementary screening measures. Mammography can reveal cancers too small to be detected by the woman or by the most experienced examiner. However, interval lumps may become palpable between mammograms.

21. During an interview, a patient reveals that she is pregnant. She states that she is not sure whether she will breastfeed her baby and asks for some information about this. Which of these statements by the nurse is *accurate*?

a. “Breastfed babies tend to be more colicky.”

b. “Breastfeeding provides the perfect food and antibodies for your baby.”

c. “Breastfed babies eat more often than infants on formula.”

d. “Breastfeeding is second nature, and every woman can do it.”

ANS: B

Exclusively breastfeeding for 6 months provides the perfect food and antibodies for the baby, decreases the risk of ear infections, promotes bonding, and provides relaxation.

22. The nurse is reviewing risk factors for breast cancer. Which of these women have risk factors that place them at a higher risk for breast cancer?

a. 37 year old who is slightly overweight

b. 42 year old who has had ovarian cancer

c. 45 year old who has never been pregnant

d. 65 year old whose mother had breast cancer

ANS: D

Risk factors for breast cancer include having a first-degree relative with breast cancer (mother, sister, or daughter) and being older than 50 years of age. (Refer to Table 17- 2 for other risk factors.)

23. During an examination of a woman, the nurse notices that her left breast is slightly larger than her right breast. Which of these statements is *true* about this finding?

a. Breasts should always be symmetric.

b. Asymmetry of breast size and shape is probably due to breastfeeding and is nothing to worry about.

c. Asymmetry is not unusual, but the nurse should verify that this change is not new.

d. Asymmetry of breast size and shape is very unusual and means she may have an inflammation or growth.

ANS: C

The nurse should notice symmetry of size and shape. It is common to have a slight asymmetry in size; often the left breast is slightly larger than the right. A sudden increase in the size of one breast signifies inflammation or new growth.

24. The nurse is assisting with a BSE clinic. Which of these women reflect abnormal findings during the inspection phase of breast examination?

a. Woman whose nipples are in different planes (deviated).

b. Woman whose left breast is slightly larger than her right.

c. Nonpregnant woman whose skin is marked with linear striae.

d. Pregnant woman whose breasts have a fine blue network of veins visible under the skin.

ANS: A

The nipples should be symmetrically placed on the same plane on the two breasts. With deviation in pointing, an underlying cancer may cause fibrosis in the mammary ducts, which pulls the nipple angle toward it. The other examples are normal findings (see Table 17-3).

25. During the physical examination, the nurse notices that a female patient has an inverted left nipple. Which statement regarding this is *most* accurate?

a. Normal nipple inversion is usually bilateral.

b. Unilateral inversion of a nipple is always a serious sign.

c. Whether the inversion is a recent change should be determined.

d. Nipple inversion is not significant unless accompanied by an underlying palpable mass.

ANS: C

The nurse should distinguish between a recently retracted nipple from one that has been inverted for many years or since puberty. Normal nipple inversion may be unilateral or bilateral and usually can be pulled out; that is, if it is not fixed. Recent nipple retraction signifies acquired disease (see Table 17-3).

26. The nurse is performing a breast examination. Which of these statements best describes the correct procedure to use when screening for nipple and skin retraction during a breast examination? Have the woman:

a. Bend over and touch her toes.

b. Lie down on her left side and notice any retraction.

c. Shift from a supine position to a standing position, and note any lag or retraction.

d. Slowly lift her arms above her head, and note any retraction or lag in movement.

ANS: D

The woman should be directed to change position while checking the breasts for signs of skin retraction. Initially, she should be asked to lift her arms slowly over her head. Both breasts should move up symmetrically. Retraction signs are due to fibrosis in the breast tissue, usually caused by growing neoplasms. The nurse should notice whether movement of one breast is lagging.

27. The nurse is palpating a female patient's breasts during an examination. Which of these positions is most likely to make significant lumps more distinct during breast palpation?

a. Supine with the arms raised over her head

b. Sitting with the arms relaxed at her sides

c. Supine with the arms relaxed at her sides

d. Sitting with the arms flexed and fingertips touching her shoulders

ANS: A

The nurse should help the woman to a supine position, tuck a small pad under the side to be palpated, and help the woman raise her arm over her head. These maneuvers will flatten the breast tissue and medially displace it. Any significant lumps will then feel more distinct.

28. Which of these clinical situations would the nurse consider to be outside normal limits?

a. A patient has had one pregnancy and states that she believes she may be entering menopause. Her breast examination reveals breasts that are soft and slightly sagging.

b. A patient has never been pregnant. Her breast examination reveals large pendulous breasts that have a firm, transverse ridge along the lower quadrant in both breasts.

c. A patient has never been pregnant and reports that she should begin her period tomorrow. Her breast examination reveals breast tissue that is nodular and somewhat engorged. She states that the examination was slightly painful.

d. A patient has had two pregnancies, and she breastfed both of her children. Her youngest child is now 10 years old. Her breast examination reveals breast tissue that is somewhat soft, and she has a small amount of thick yellow discharge from both nipples.

ANS: D

If any discharge appears, the nurse should note its color and consistency. Except in pregnancy and lactation, any discharge is abnormal. In nulliparous women, normal breast tissue feels firm, smooth, and elastic; after pregnancy, the tissue feels soft and loose. Premenstrual engorgement is normal, and consists of a slight enlargement, tenderness to palpation, and a generalized nodularity. A firm, transverse ridge of compressed tissue in the lower quadrants, known as the inframammary ridge, is especially noticeable in large breasts.

29. A patient states during the interview that she noticed a new lump in the shower a few days ago. It was on her left breast near her axilla. The nurse should plan to:

a. Palpate the lump first.

b. Palpate the unaffected breast first.

c. Avoid palpating the lump because it could be a cyst, which might rupture.

d. Palpate the breast with the lump first but plan to palpate the axilla last.

ANS: B

If the woman mentions a breast lump she has discovered herself, then the nurse should examine the unaffected breast first to learn a baseline of normal consistency for this individual.

30. The nurse has palpated a lump in a female patient's right breast. The nurse documents this as a small, round, firm, distinct, lump located at 2 o'clock, 2 cm from the nipple. It is nontender and fixed. No associated retraction of the skin or nipple, no erythema, and no axillary lymphadenopathy are observed. What information is missing from the documentation?

a. Shape of the lump

b. Consistency of the lump

c. Size of the lump

d. Whether the lump is solitary or multiple

ANS: C

If the nurse feels a lump or mass, then he or she should note these characteristics: (1) location, (2) size—judge in centimeters in three dimensions: width ´ length ´ thickness, (3) shape, (4) consistency, (5) motility, (6) distinctness, (7) nipple, (8) the skin over the lump, (9) tenderness, and (10) lymphadenopathy.

31. The nurse is conducting a class on BSE. Which of these statements indicates the proper BSE technique?

a. The best time to perform BSE is in the middle of the menstrual cycle.

b. The woman needs to perform BSE only bimonthly unless she has fibrocystic breast tissue.

c. The best time to perform a BSE is 4 to 7 days after the first day of the menstrual period.

d. If she suspects that she is pregnant, then the woman should not perform a BSE until her baby is born.

ANS: C

The nurse should help each woman establish a regular schedule of self-care. The best time to conduct a BSE is right after the menstrual period, or the fourth through seventh day of the menstrual cycle, when the breasts are the smallest and least congested. The pregnant or menopausal woman who is not having menstrual periods should be advised to select a familiar date to examine her breasts each month—for example, her birth date or the day the rent is due.

32. The nurse is preparing to teach a woman about BSE. Which statement by the nurse is correct?

a. "BSE is more important than ever for you because you have never had any children."

b. "BSE is so important because one out of nine women will develop breast cancer in her lifetime."

c. "BSE on a monthly basis will help you become familiar with your own breasts and feel their normal variations."

d. "BSE will save your life because you are likely to find a cancerous lump between mammograms."

ANS: C

The nurse should stress that a regular monthly BSE will familiarize the woman with her own breasts and their normal variations. BSE is a positive step that will reassure her of her healthy state. While teaching, the nurse should focus on the positive aspects of BSE and avoid citing frightening mortality statistics about breast cancer, which may generate excessive fear and denial that can obstruct a woman's self-care actions.

33. A 55-year-old postmenopausal woman is being seen in the clinic for her annual examination. She is concerned about changes in her breasts that she has noticed over the past 5 years. She states that her breasts have decreased in size and that the elasticity has changed so that her breasts seem "flat and flabby." The nurse's best reply would be:

a. "This change occurs most often because of long-term use of bras that do not provide enough support to the breast tissues."

b. "This is a normal change that occurs as women get older and is due to the increased levels of progesterone during the aging process."

c. "Decreases in hormones after menopause causes atrophy of the glandular tissue in the breast and is a normal process of aging."

d. "Postural changes in the spine make it appear that your breasts have changed in shape. Exercises to strengthen the muscles of the upper back and chest wall will help prevent the changes in elasticity and size."

ANS: C

The hormonal changes of menopause cause the breast glandular tissue to atrophy, making the breasts more pendulous, flattened, and sagging.

34. A 43-year-old woman is at the clinic for a routine examination. She reports that she has had a breast lump in her right breast for years. Recently, it has begun to change in consistency and is becoming harder. She reports that 5 years ago her physician evaluated the lump and determined that it "was nothing to worry about." The examination validates the presence of a mass in the right upper outer quadrant at 1 o'clock, approximately 5 cm from the nipple. It is firm, mobile, and nontender, with borders that are not well defined. The nurse replies:

a. "Because of the change in consistency of the lump, it should be further evaluated by a physician."

b. "The changes could be related to your menstrual cycles. Keep track of the changes in the mass each month."

c. "The lump is probably nothing to worry about because it has been present for years and was determined to be noncancerous 5 years ago."

d. "Because you are experiencing no pain and the size has not changed, you should continue to monitor the lump and return to the clinic in 3 months."

ANS: A

A lump that has been present for years and is not exhibiting changes may not be serious but should still be explored. Any recent change or a new lump should be evaluated. The other responses are not correct.

35. During a discussion about BSEs with a 30-year-old woman, which of these statements by the nurse is most appropriate?

a. "The best time to examine your breasts is during ovulation."

b. "Examine your breasts every month on the same day of the month."

c. "Examine your breasts shortly after your menstrual period each month."

d. "The best time to examine your breasts is immediately before menstruation."

ANS: C

The best time to conduct a BSE is shortly after the menstrual period when the breasts are the smallest and least congested.

36. The nurse is discussing BSEs with a postmenopausal woman. The best time for postmenopausal women to perform BSEs is:

a. On the same day every month.

b. Daily, during the shower or bath.

c. One week after her menstrual period.

d. Every year with her annual gynecologic examination.

ANS: A

Postmenopausal women are no longer experiencing regular menstrual cycles but need to continue to perform BSEs on a monthly basis. Choosing the same day of the month is a helpful reminder to perform the examination.

37. While inspecting a patient's breasts, the nurse finds that the left breast is slightly larger than the right with the bilateral presence of Montgomery glands. The nurse should:

a. Palpate over the Montgomery glands, checking for drainage.

b. Consider these findings as normal, and proceed with the examination.

c. Ask extensive health history questions regarding the woman's breast asymmetry.

d. Continue with the examination, and then refer the patient for further evaluation of the Montgomery glands.

ANS: B

Normal findings of the breast include one breast (most often the left) slightly larger than the other and the presence of Montgomery glands across the areola.

38. During an examination, the nurse notes a supernumerary nipple just under the patient's left breast. The patient tells the nurse that she always thought it was a mole. Which statement about this finding is *correct*?

a. This variation is normal and not a significant finding.

b. This finding is significant and needs further investigation.

c. A supernumerary nipple also contains glandular tissue and may leak milk during pregnancy and lactation.

d. The patient is correct—a supernumerary nipple is actually a mole that happens to be located under the breast.

ANS: A

A supernumerary nipple looks like a mole, but close examination reveals a tiny nipple and areola; it is not a significant finding.

39. While examining a 75-year-old woman, the nurse notices that the skin over her right breast is thickened and the hair follicles are exaggerated. This condition is known as:

a. Dimpling.

b. Retraction.

c. Peau d'orange.

d. Benign breast disease.

ANS: C

This condition is known as *peau d'orange*. Lymphatic obstruction produces edema, which thickens the skin and exaggerates the hair follicles. The skin has a pig-skin or orange-peel appearance, and this condition suggests cancer.

40. When a breastfeeding mother is diagnosed with a breast abscess, which of these instructions from the nurse is *correct*? The mother needs to:

a. Continue to nurse on both sides to encourage milk flow.

b. Immediately discontinue nursing to allow for healing.

c. Temporarily discontinue nursing on the affected breast, and manually express milk and discard it.

d. Temporarily discontinue nursing on affected breast, but manually express milk and give it to the baby.

ANS: C

With a breast abscess, the patient must temporarily discontinue nursing on the affected breast, manually express the milk, and then discard it. Nursing can continue on the unaffected side.

41. A new mother calls the clinic to report that part of her left breast is red, swollen, tender, very hot, and hard. She has a fever of 38.3° C. She also has had symptoms of influenza, such as chills, sweating, and feeling tired. The nurse notices that she has been breastfeeding for 1 month. From her description, what condition does the nurse suspect?

a. Mastitis

b. Paget disease

c. Plugged milk duct

d. Mammary duct ectasia

ANS: A

The symptoms describe mastitis, which stems from an infection or stasis caused by a plugged duct. A plugged duct does not have infection present (see Table 17-7). (Refer to Table 17-6 for descriptions of Paget disease and mammary duct ectasia.)

42. During a breast examination on a female patient, the nurse notices that the nipple is flat, broad, and fixed. The patient states it "started doing that a few months ago." This finding suggests:

a. Dimpling.

b. Retracted nipple.

c. Nipple inversion.

d. Deviation in nipple pointing.

ANS: B

The retracted nipple looks flatter and broader, similar to an underlying crater. A recent retraction suggests cancer, which causes fibrosis of the whole duct system and pulls in the nipple. It also may occur with benign lesions such as ectasia of the ducts. The nurse should not confuse retraction with the normal long-standing type of nipple inversion, which has no broadening and is not fixed.

43. A 54-year-old man comes to the clinic with a "horrible problem." He tells the nurse that he has just discovered a lump on his breast and is fearful of cancer. The nurse knows which statement about breast cancer in men is *true*?

a. Breast masses in men are difficult to detect because of minimal breast tissue.

b. Breast cancer in men rarely spreads to the lymph nodes.

c. One percent of all breast cancers occurs in men.

d. Most breast masses in men are diagnosed as gynecomastia.

ANS: C

One percent of all breast cancers occurs in men. The early spreading to axillary lymph nodes is attributable to minimal breast tissue.

MULTIPLE RESPONSE

1. The nurse is assessing the breasts of a 68-year-old woman and discovers a mass in the upper outer quadrant of the left breast. When assessing this mass, the nurse is aware that characteristics of a cancerous mass include which of the following? *Select all that apply*.

a. Nontender mass

b. Dull, heavy pain on palpation

c. Rubbery texture and mobile

d. Hard, dense, and immobile

e. Regular border

f. Irregular, poorly delineated border

ANS: A, D, F

Cancerous breast masses are solitary, unilateral, and nontender. They are solid, hard, dense, and fixed to underlying tissues or skin as cancer becomes invasive. Their borders are irregular and poorly delineated. They are often painless, although the person may experience pain. They are most common in the upper outer quadrant. A dull, heavy pain on palpation and a mass with a rubbery texture and a regular border are characteristics of benign breast disease.

2. The nurse is examining a 62-year-old man and notes that he has bilateral gynecomastia. The nurse should explore his health history for which related conditions? *Select all that apply*.

a. Malnutrition

b. Hyperthyroidism

c. Type 2 diabetes mellitus

d. Liver disease

e. History of alcohol abuse

ANS: B, D, E

Gynecomastia occurs with Cushing syndrome, liver cirrhosis, adrenal disease, hyperthyroidism, and numerous drugs, such as alcohol and marijuana use, estrogen treatment for prostate cancer, antibiotics (metronidazole, isoniazid), digoxin, angiotensin-converting enzyme (ACE) inhibitors, diazepam, and tricyclic antidepressants.

Chapter 18: Thorax and Lungs

MULTIPLE CHOICE

1. Which of these statements is *true* regarding the vertebra prominens? The vertebra prominens is:

a. The spinous process of C7.

b. Usually nonpalpable in most individuals.

c. Opposite the interior border of the scapula.

d. Located next to the manubrium of the sternum.

ANS: A

The spinous process of C7 is the vertebra prominens and is the most prominent bony spur protruding at the base of the neck. Counting ribs and intercostal spaces on the posterior thorax is difficult because of the muscles and soft tissue. The vertebra prominens is easier to identify and is used as a starting point in counting thoracic processes and identifying landmarks on the posterior chest.

2. When performing a respiratory assessment on a patient, the nurse notices a costal angle of approximately 90 degrees. This characteristic is:

a. Observed in patients with kyphosis.

b. Indicative of pectus excavatum.

c. A normal finding in a healthy adult.

d. An expected finding in a patient with a barrel chest.

ANS: C

The right and left costal margins form an angle where they meet at the xiphoid process. Usually, this angle is 90 degrees or less. The angle increases when the rib cage is chronically overinflated, as in emphysema.

3. When assessing a patient’s lungs, the nurse recalls that the left lung:

a. Consists of two lobes.

b. Is divided by the horizontal fissure.

c. Primarily consists of an upper lobe on the posterior chest.

d. Is shorter than the right lung because of the underlying stomach.

ANS: A

The left lung has two lobes, and the right lung has three lobes. The right lung is shorter than the left lung because of the underlying liver. The left lung is narrower than the right lung because the heart bulges to the left. The posterior chest is almost all lower lobes.

4. Which statement about the apices of the lungs is *true*? The apices of the lungs:

a. Are at the level of the second rib anteriorly.

b. Extend 3 to 4 cm above the inner third of the clavicles.

c. Are located at the sixth rib anteriorly and the eighth rib laterally.

d. Rest on the diaphragm at the fifth intercostal space in the midclavicular line (MCL).

ANS: B

The apex of the lung on the anterior chest is 3 to 4 cm above the inner third of the clavicles. On the posterior chest, the apices are at the level of C7.

5. During an examination of the anterior thorax, the nurse is aware that the trachea bifurcates anteriorly at the:

a. Costal angle.

b. Sternal angle.

c. Xiphoid process.

d. Suprasternal notch.

ANS: B

The sternal angle marks the site of tracheal bifurcation into the right and left main bronchi; it corresponds with the upper borders of the atria of the heart, and it lies above the fourth thoracic vertebra on the back.

6. During an assessment, the nurse knows that expected assessment findings in the normal adult lung include the presence of:

a. Adventitious sounds and limited chest expansion.

b. Increased tactile fremitus and dull percussion tones.

c. Muffled voice sounds and symmetric tactile fremitus.

d. Absent voice sounds and hyperresonant percussion tones.

ANS: C

Normal lung findings include symmetric chest expansion, resonant percussion tones, vesicular breath sounds over the peripheral lung fields, muffled voice sounds, and no adventitious sounds.

7. The primary muscles of respiration include the:

a. Diaphragm and intercostals.

b. Sternomastoids and scaleni.

c. Trapezii and rectus abdominis.

d. External obliques and pectoralis major.

ANS: A

The major muscle of respiration is the diaphragm. The intercostal muscles lift the sternum and elevate the ribs during inspiration, increasing the anteroposterior diameter. Expiration is primarily passive. Forced inspiration involves the use of other muscles, such as the accessory neck muscles—sternomastoid, scaleni, and trapezii muscles. Forced expiration involves the abdominal muscles.

8. A 65-year-old patient with a history of heart failure comes to the clinic with complaints of “being awakened from sleep with shortness of breath.” Which action by the nurse is most appropriate?

a. Obtaining a detailed health history of the patient’s allergies and a history of asthma

b. Telling the patient to sleep on his or her right side to facilitate ease of respirations

c. Assessing for other signs and symptoms of paroxysmal nocturnal dyspnea

d. Assuring the patient that paroxysmal nocturnal dyspnea is normal and will probably resolve within the next week

ANS: C

The patient is experiencing paroxysmal nocturnal dyspnea—being awakened from sleep with shortness of breath and the need to be upright to achieve comfort.

9. When assessing tactile fremitus, the nurse recalls that it is normal to feel tactile fremitus most intensely over which location?

a. Between the scapulae

b. Third intercostal space, MCL

c. Fifth intercostal space, midaxillary line (MAL)

d. Over the lower lobes, posterior side

ANS: A

Normally, fremitus is most prominent between the scapulae and around the sternum. These sites are where the major bronchi are closest to the chest wall. Fremitus normally decreases as one progresses down the chest because more tissue impedes sound transmission.

10. The nurse is reviewing the technique of palpating for tactile fremitus with a new graduate. Which statement by the graduate nurse reflects a *correct* understanding of tactile fremitus? “Tactile fremitus:

a. “Is caused by moisture in the alveoli.”

b. “Indicates that air is present in the subcutaneous tissues.”

c. “Is caused by sounds generated from the larynx.”

d. “Reflects the blood flow through the pulmonary arteries.”

ANS: C

Fremitus is a palpable vibration. Sounds generated from the larynx are transmitted through patent bronchi and the lung parenchyma to the chest wall where they are felt as vibrations.*Crepitus* is the term for air in the subcutaneous tissues.

11. During percussion, the nurse knows that a dull percussion note elicited over a lung lobe most likely results from:

a. Shallow breathing.

b. Normal lung tissue.

c. Decreased adipose tissue.

d. Increased density of lung tissue.

ANS: D

A dull percussion note indicates an abnormal density in the lungs, as with pneumonia, pleural effusion, atelectasis, or a tumor. Resonance is the expected finding in normal lung tissue.

12. The nurse is observing the auscultation technique of another nurse. The correct method to use when progressing from one auscultatory site on the thorax to another is _____ comparison.

a. Side-to-side

b. Top-to-bottom

c. Posterior-to-anterior

d. Interspace-by-interspace

ANS: A

Side-to-side comparison is most important when auscultating the chest. The nurse should listen to at least one full respiration in each location. The other techniques are not correct.

13. When auscultating the lungs of an adult patient, the nurse notes that low-pitched, soft breath sounds are heard over the posterior lower lobes, with inspiration being longer than expiration. The nurse interprets that these sounds are:

a. Normally auscultated over the trachea.

b. Bronchial breath sounds and normal in that location.

c. Vesicular breath sounds and normal in that location.

d. Bronchovesicular breath sounds and normal in that location.

ANS: C

Vesicular breath sounds are low-pitched, soft sounds with inspiration being longer than expiration. These breath sounds are expected over the peripheral lung fields where air flows through smaller bronchioles and alveoli.

14. The nurse is auscultating the chest in an adult. Which technique is *correct*?

a. Instructing the patient to take deep, rapid breaths

b. Instructing the patient to breathe in and out through his or her nose

c. Firmly holding the diaphragm of the stethoscope against the chest

d. Lightly holding the bell of the stethoscope against the chest to avoid friction

ANS: C

Firmly holding the diaphragm of the stethoscope against the chest is the correct way to auscultate breath sounds. The patient should be instructed to breathe through his or her mouth, a little deeper than usual, but not to hyperventilate.

15. The nurse is percussing over the lungs of a patient with pneumonia. The nurse knows that percussion over an area of atelectasis in the lungs will reveal:

a. Dullness.

b. Tympany.

c. Resonance.

d. Hyperresonance.

ANS: A

A dull percussion note signals an abnormal density in the lungs, as with pneumonia, pleural effusion, atelectasis, or a tumor.

16. During auscultation of the lungs, the nurse expects decreased breath sounds to be heard in which situation?

a. When the bronchial tree is obstructed

b. When adventitious sounds are present

c. In conjunction with whispered pectoriloquy

d. In conditions of consolidation, such as pneumonia

ANS: A

Decreased or absent breath sounds occur when the bronchial tree is obstructed, as in emphysema, and when sound transmission is obstructed, as in pleurisy, pneumothorax, or pleural effusion.

17. The nurse knows that a normal finding when assessing the respiratory system of an older adult is:

a. Increased thoracic expansion.

b. Decreased mobility of the thorax.

c. Decreased anteroposterior diameter.

d. Bronchovesicular breath sounds throughout the lungs.

ANS: B

The costal cartilages become calcified with aging, resulting in a less mobile thorax. Chest expansion may be somewhat decreased, and the chest cage commonly shows an increased anteroposterior diameter.

18. A mother brings her 3-month-old infant to the clinic for evaluation of a cold. She tells the nurse that he has had “a runny nose for a week.” When performing the physical assessment, the nurse notes that the child has nasal flaring and sternal and intercostal retractions. The nurse’s next action should be to:

a. Assure the mother that these signs are normal symptoms of a cold.

b. Recognize that these are serious signs, and contact the physician.

c. Ask the mother if the infant has had trouble with feedings.

d. Perform a complete cardiac assessment because these signs are probably indicative of early heart failure.

ANS: B

The infant is an obligatory nose breather until the age of 3 months. Normally, no flaring of the nostrils and no sternal or intercostal retraction occurs. Significant retractions of the sternum and intercostal muscles and nasal flaring indicate increased inspiratory effort, as in pneumonia, acute airway obstruction, asthma, and atelectasis; therefore, immediate referral to the physician is warranted. These signs do not indicate heart failure, and an assessment of the infant’s feeding is not a priority at this time.

19. When assessing the respiratory system of a 4-year-old child, which of these findings would the nurse expect?

a. Crepitus palpated at the costochondral junctions

b. No diaphragmatic excursion as a result of a child’s decreased inspiratory volume

c. Presence of bronchovesicular breath sounds in the peripheral lung fields

d. Irregular respiratory pattern and a respiratory rate of 40 breaths per minute at rest

ANS: C

Bronchovesicular breath sounds in the peripheral lung fields of the infant and young child up to age 5 or 6 years are normal findings. Their thin chest walls with underdeveloped musculature do not dampen the sound, as do the thicker chest walls of adults; therefore, breath sounds are loud and harsh.

20. When inspecting the anterior chest of an adult, the nurse should include which assessment?

a. Diaphragmatic excursion

b. Symmetric chest expansion

c. Presence of breath sounds

d. Shape and configuration of the chest wall

ANS: D

Inspection of the anterior chest includes shape and configuration of the chest wall; assessment of the patient's level of consciousness and the patient's skin color and condition; quality of respirations; presence or absence of retraction and bulging of the intercostal spaces; and use of accessory muscles. Symmetric chest expansion is assessed by palpation. Diaphragmatic excursion is assessed by percussion of the posterior chest. Breath sounds are assessed by auscultation.

21. The nurse knows that auscultation of fine crackles would most likely be noticed in:

a. A healthy 5-year-old child.

b. A pregnant woman.

c. The immediate newborn period.

d. Association with a pneumothorax.

ANS: C

Fine crackles are commonly heard in the immediate newborn period as a result of the opening of the airways and a clearing of fluid. Persistent fine crackles would be noticed with pneumonia, bronchiolitis, or atelectasis.

22. During an assessment of an adult, the nurse has noted unequal chest expansion and recognizes that this occurs in which situation?

a. In an obese patient

b. When part of the lung is obstructed or collapsed

c. When bulging of the intercostal spaces is present

d. When accessory muscles are used to augment respiratory effort

ANS: B

Unequal chest expansion occurs when part of the lung is obstructed or collapsed, as with pneumonia, or when guarding to avoid postoperative incisional pain.

23. During auscultation of the lungs of an adult patient, the nurse notices the presence of bronchophony. The nurse should assess for signs of which condition?

a. Airway obstruction

b. Emphysema

c. Pulmonary consolidation

d. Asthma

ANS: C

Pathologic conditions that increase lung density, such as pulmonary consolidation, will enhance the transmission of voice sounds, such as bronchophony (see Table 18-7).

24. The nurse is reviewing the characteristics of breath sounds. Which statement about bronchovesicular breath sounds is *true*? Bronchovesicular breath sounds are:

a. Musical in quality.

b. Usually caused by a pathologic disease.

c. Expected near the major airways.

d. Similar to bronchial sounds except shorter in duration.

ANS: C

Bronchovesicular breath sounds are heard over major bronchi where fewer alveoli are located posteriorly—between the scapulae, especially on the right; and anteriorly, around the upper sternum in the first and second intercostal spaces. The other responses are not correct.

25. The nurse is listening to the breath sounds of a patient with severe asthma. Air passing through narrowed bronchioles would produce which of these adventitious sounds?

a. Wheezes

b. Bronchial sounds

c. Bronchophony

d. Whispered pectoriloquy

ANS: A

Wheezes are caused by air squeezed or compressed through passageways narrowed almost to closure by collapsing, swelling, secretions, or tumors, such as with acute asthma or chronic emphysema.

26. A patient has a long history of chronic obstructive pulmonary disease (COPD). During the assessment, the nurse will most likely observe which of these?

a. Unequal chest expansion

b. Increased tactile fremitus

c. Atrophied neck and trapezius muscles

d. Anteroposterior-to-transverse diameter ratio of 1:1

ANS: D

An anteroposterior-to-transverse diameter ratio of 1:1 or *barrel chest* is observed in individuals with COPD because of hyperinflation of the lungs. The ribs are more horizontal, and the chest appears as if held in continuous inspiration. Neck muscles are hypertrophied from aiding in forced respiration. Chest expansion may be decreased but symmetric. Decreased tactile fremitus occurs from decreased transmission of vibrations.

27. A teenage patient comes to the emergency department with complaints of an inability to breathe and a sharp pain in the left side of his chest. The assessment findings include cyanosis, tachypnea, tracheal deviation to the right, decreased tactile fremitus on the left, hyperresonance on the left, and decreased breath sounds on the left. The nurse interprets that these assessment findings are consistent with:

a. Bronchitis.

b. Pneumothorax.

c. Acute pneumonia.

d. Asthmatic attack.

ANS: B

With a pneumothorax, free air in the pleural space causes partial or complete lung collapse. If the pneumothorax is large, then tachypnea and cyanosis are evident. Unequal chest expansion, decreased or absent tactile fremitus, tracheal deviation to the unaffected side, decreased chest expansion, hyperresonant percussion tones, and decreased or absent breath sounds are found with the presence of pneumothorax. (See Table 18-8 for descriptions of the other conditions.)

28. An adult patient with a history of allergies comes to the clinic complaining of wheezing and difficulty in breathing when working in his yard. The assessment findings include tachypnea, the use of accessory neck muscles, prolonged expiration, intercostal retractions, decreased breath sounds, and expiratory wheezes. The nurse interprets that these assessment findings are consistent with:

a. Asthma.

b. Atelectasis.

c. Lobar pneumonia.

d. Heart failure.

ANS: A

Asthma is allergic hypersensitivity to certain inhaled particles that produces inflammation and a reaction of bronchospasm, which increases airway resistance, especially during expiration. An increased respiratory rate, the use of accessory muscles, a retraction of the intercostal muscles, prolonged expiration, decreased breath sounds, and expiratory wheezing are all characteristics of asthma. (See Table 18-8 for descriptions of the other conditions.)

29. The nurse is assessing the lungs of an older adult. Which of these changes are normal in the respiratory system of the older adult?

a. Severe dyspnea is experienced on exertion, resulting from changes in the lungs.

b. Respiratory muscle strength increases to compensate for a decreased vital capacity.

c. Decrease in small airway closure occurs, leading to problems with atelectasis.

d. Lungs are less elastic and distensible, which decreases their ability to collapse and recoil.

ANS: D

In the aging adult, the lungs are less elastic and distensible, which decreases their ability to collapse and recoil. Vital capacity is decreased, and a loss of intra-alveolar septa occurs, causing less surface area for gas exchange. The lung bases become less ventilated, and the older person is at risk for dyspnea with exertion beyond his or her usual workload.

30. A woman in her 26th week of pregnancy states that she is “not really short of breath” but feels that she is aware of her breathing and the need to breathe. What is the nurse’s best reply?

a. “The diaphragm becomes fixed during pregnancy, making it difficult to take in a deep breath.”

b. “The increase in estrogen levels during pregnancy often causes a decrease in the diameter of the rib cage and makes it difficult to breathe.”

c. “What you are experiencing is normal. Some women may interpret this as shortness of breath, but it is a normal finding and nothing is wrong.”

d. “This increased awareness of the need to breathe is normal as the fetus grows because of the increased oxygen demand on the mother’s body, which results in an increased respiratory rate.”

ANS: C

During pregnancy, the woman may develop an increased awareness of the need to breathe. Some women may interpret this as dyspnea, although structurally nothing is wrong. Increases in estrogen relax the chest cage ligaments, causing an increase in the transverse diameter. Although the growing fetus increases the oxygen demand on the mother’s body, this increased demand is easily met by the increasing tidal volume (deeper breathing). Little change occurs in the respiratory rate.

31. A 35-year-old recent immigrant is being seen in the clinic for complaints of a cough that is associated with rust-colored sputum, low-grade afternoon fevers, and night sweats for the past 2 months. The nurse’s preliminary analysis, based on this history, is that this patient may be suffering from:

a. Bronchitis.

b. Pneumonia.

c. Tuberculosis.

d. Pulmonary edema.

ANS: C

Sputum is not diagnostic alone, but some conditions have characteristic sputum production. Tuberculosis often produces rust-colored sputum in addition to other symptoms of night sweats and low-grade afternoon fevers (see Table 18-8).

32. A 70-year-old patient is being seen in the clinic for severe exacerbation of his heart failure. Which of these findings is the nurse most likely to observe in this patient?

a. Shortness of breath, orthopnea, paroxysmal nocturnal dyspnea, and ankle edema

b. Rasping cough, thick mucoid sputum, wheezing, and bronchitis

c. Productive cough, dyspnea, weight loss, anorexia, and tuberculosis

d. Fever, dry nonproductive cough, and diminished breath sounds

ANS: A

A person with heart failure often exhibits increased respiratory rate, shortness of breath on exertion, orthopnea, paroxysmal nocturnal dyspnea, nocturia, ankle edema, and pallor in light-skinned individuals. A patient with rasping cough, thick mucoid sputum, and wheezing may have bronchitis. Productive cough, dyspnea, weight loss, and dyspnea indicate tuberculosis; fever, dry nonproductive cough, and diminished breath sounds may indicate *Pneumocystis jiroveci* (*P. carinii*) pneumonia (see Table 18-8).

33. A patient comes to the clinic complaining of a cough that is worse at night but not as bad during the day. The nurse recognizes that this cough may indicate:

a. Pneumonia.

b. Postnasal drip or sinusitis.

c. Exposure to irritants at work.

d. Chronic bronchial irritation from smoking.

ANS: B

A cough that primarily occurs at night may indicate postnasal drip or sinusitis. Exposure to irritants at work causes an afternoon or evening cough. Smokers experience early morning coughing. Coughing associated with acute illnesses such as pneumonia is continuous throughout the day.

34. During a morning assessment, the nurse notices that the patient's sputum is frothy and pink. Which condition could this finding indicate?

a. Croup

b. Tuberculosis

c. Viral infection

d. Pulmonary edema

ANS: D

Sputum, alone, is not diagnostic, but some conditions have characteristic sputum production. Pink, frothy sputum indicates pulmonary edema or it may be a side effect of sympathomimetic medications. Croup is associated with a *barking* cough, not sputum production. Tuberculosis may produce rust-colored sputum. Viral infections may produce white or clear mucoid sputum.

35. During auscultation of breath sounds, the nurse should correctly use the stethoscope in which of the following ways?

a. Listening to at least one full respiration in each location

b. Listening as the patient inhales and then going to the next site during exhalation

c. Instructing the patient to breathe in and out rapidly while listening to the breath sounds

d. If the patient is modest, listening to sounds over his or her clothing or hospital gown

ANS: A

During auscultation of breath sounds with a stethoscope, listening to one full respiration in each location is important. During the examination, the nurse should monitor the breathing and offer times for the person to breathe normally to prevent possible dizziness.

36. A patient has been admitted to the emergency department with a possible medical diagnosis of pulmonary embolism. The nurse expects to see which assessment findings related to this condition?

a. Absent or decreased breath sounds

b. Productive cough with thin, frothy sputum

c. Chest pain that is worse on deep inspiration and dyspnea

d. Diffuse infiltrates with areas of dullness upon percussion

ANS: C

Findings for pulmonary embolism include chest pain that is worse on deep inspiration, dyspnea, apprehension, anxiety, restlessness, partial arterial pressure of oxygen (PaO2) less than 80 mm Hg, diaphoresis, hypotension, crackles, and wheezes.

37. During palpation of the anterior chest wall, the nurse notices a coarse, crackling sensation over the skin surface. On the basis of these findings, the nurse suspects:

a. Tactile fremitus.

b. Crepitus.

c. Friction rub.

d. Adventitious sounds.

ANS: B

Crepitus is a coarse, crackling sensation palpable over the skin surface. It occurs in subcutaneous emphysema when air escapes from the lung and enters the subcutaneous tissue, such as after open thoracic injury or surgery.

38. The nurse is auscultating the lungs of a patient who had been sleeping and notices short, popping, crackling sounds that stop after a few breaths. The nurse recognizes that these breath sounds are:

a. Atelectatic crackles that do not have a pathologic cause.

b. Fine crackles and may be a sign of pneumonia.

c. Vesicular breath sounds.

d. Fine wheezes.

ANS: A

One type of adventitious sound, atelectatic crackles, does not have a pathologic cause. They are short, popping, crackling sounds that sound similar to fine crackles but do not last beyond a few breaths. When sections of alveoli are not fully aerated (as in people who are asleep or in older adults), they deflate slightly and accumulate secretions. Crackles are heard when these sections are expanded by a few deep breaths. Atelectatic crackles are heard only in the periphery, usually in dependent portions of the lungs, and disappear after the first few breaths or after a cough.

39. A patient has been admitted to the emergency department for a suspected drug overdose. His respirations are shallow, with an irregular pattern, with a rate of 12 respirations per minute. The nurse interprets this respiration pattern as which of the following?

a. Bradypnea

b. Cheyne-Stokes respirations

c. Hypoventilation

d. Chronic obstructive breathing

ANS: C

Hypoventilation is characterized by an irregular, shallow pattern, and can be caused by an overdose of narcotics or anesthetics. Bradypnea is slow breathing, with a rate less than 10 respirations per minute. (See Table 18-4 for descriptions of Cheyne-Stokes respirations and chronic obstructive breathing.)

40. A patient with pleuritis has been admitted to the hospital and complains of pain with breathing. What other key assessment finding would the nurse expect to find upon auscultation?

a.	Stridor
b.	Friction rub
c.	Crackles
d.	Wheezing

ANS: B

A patient with pleuritis will exhibit a pleural friction rub upon auscultation. This sound is made when the pleurae become inflamed and rub together during respiration. The sound is superficial, coarse, and low-pitched, as if two pieces of leather are being rubbed together. Stridor is associated with croup, acute epiglottitis in children, and foreign body inhalation. Crackles are associated with pneumonia, heart failure, chronic bronchitis, and other diseases (see Table 18-6). Wheezes are associated with diffuse airway obstruction caused by acute asthma or chronic emphysema.

MULTIPLE RESPONSE

1. The nurse is assessing voice sounds during a respiratory assessment. Which of these findings indicates a normal assessment? *Select all that apply*.

a.	Voice sounds are faint, muffled, and almost inaudible when the patient whispers “one, two, three” in a very soft voice.
b.	As the patient repeatedly says “ninety-nine,” the examiner clearly hears the words “ninety-nine.”
c.	When the patient speaks in a normal voice, the examiner can hear a sound but cannot exactly distinguish what is being said.
d.	As the patient says a long “ee-ee-ee” sound, the examiner also hears a long “ee-ee-ee” sound.
e.	As the patient says a long “ee-ee-ee” sound, the examiner hears a long “aaaaaa” sound.

ANS: A, C, D

As a patient repeatedly says “ninety-nine,” normally the examiner hears voice sounds but cannot distinguish what is being said. If a clear “ninety-nine” is auscultated, then it could indicate increased lung density, which enhances the transmission of voice sounds, which is a measure of bronchophony. When a patient says a long “ee-ee-ee” sound, normally the examiner also hears a long “ee-ee-ee” sound through auscultation, which is a measure of egophony. If the examiner hears a long “aaaaaa” sound instead, this sound could indicate areas of consolidation or compression. With whispered pectoriloquy, as when a patient whispers a phrase such as “one-two-three,” the normal response when auscultating voice sounds is to hear sounds that are faint, muffled, and almost inaudible. If the examiner clearly hears the whispered voice, as if the patient is speaking through the stethoscope, then consolidation of the lung fields may exist.