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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.

DIF: Cognitive Level: Understanding (Comprehension)

MSC: Client Needs: Safe and Effective Care Environment: Management of Care

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.

DIF: Cognitive Level: Understanding (Comprehension)

MSC: Client Needs: Safe and Effective Care Environment: Management of Care

3. The patients 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 patients record and laboratory studies, the objective and subjective data form the data base. The other items are not part of the patients record, laboratory studies, or data.

DIF: Cognitive Level: Remembering (Knowledge)

MSC: Client Needs: Safe and Effective Care Environment: Management of Care

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

a. Immediately notify the patients 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 patients 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.

DIF: Cognitive Level: Analyzing (Analysis)

MSC: Client Needs: Safe and Effective Care Environment: Management of Care

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.

DIF: Cognitive Level: Understanding (Comprehension)

MSC: Client Needs: General

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 recognitionexpert nurses learn to attend to a pattern of assessment data and act without consciously labeling it. The other options are not correct.

DIF: Cognitive Level: Understanding (Comprehension)

MSC: Client Needs: General

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 clinicians experience.

d. The patients 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 clinicians 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.

DIF: Cognitive Level: Applying (Application)

MSC: Client Needs: Safe and Effective Care Environment: Management of Care

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).

DIF: Cognitive Level: Understanding (Comprehension)

MSC: Client Needs: Safe and Effective Care Environment: Management of Care

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).

DIF: Cognitive Level: Understanding (Comprehension)

MSC: Client Needs: Safe and Effective Care Environment: Management of Care

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.

DIF: Cognitive Level: Understanding (Comprehension)

MSC: Client Needs: Safe and Effective Care Environment: Management of Care

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.

DIF: Cognitive Level: Understanding (Comprehension)

MSC: Client Needs: Safe and Effective Care Environment: Management of Care

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.

DIF: Cognitive Level: Understanding (Comprehension)

MSC: Client Needs: Safe and Effective Care Environment: Management of Care

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.

DIF: Cognitive Level: Analyzing (Analysis)

MSC: Client Needs: Safe and Effective Care Environment: Management of Care

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.

DIF: Cognitive Level: Understanding (Comprehension)

MSC: Client Needs: General

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)

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.

DIF: Cognitive Level: Remembering (Knowledge)

MSC: Client Needs: General

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 units 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.

DIF: Cognitive Level: Applying (Application)

MSC: Client Needs: Safe and Effective Care Environment: Management of Care

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 patients 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.

DIF: Cognitive Level: Understanding (Comprehension)

MSC: Client Needs: Safe and Effective Care Environment: Management of Care

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.

DIF: Cognitive Level: Understanding (Comprehension)

MSC: Client Needs: General

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. Patients history of allergies.

b. Patients 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 patients 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.

DIF: Cognitive Level: Applying (Application)

MSC: Client Needs: Safe and Effective Care Environment: Management of Care

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 nurses primary responsibility for monitoring the patients 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, womens 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 persons health care.

DIF: Cognitive Level: Applying (Application)

MSC: Client Needs: Safe and Effective Care Environment: Management of 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.

DIF: Cognitive Level: Applying (Application)

MSC: Client Needs: Safe and Effective Care Environment: Management of Care

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.

DIF: Cognitive Level: Applying (Application)

MSC: Client Needs: Safe and Effective Care Environment: Management of Care

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.

DIF: Cognitive Level: Analyzing (Analysis)

MSC: Client Needs: Safe and Effective Care Environment: Management of Care

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.

DIF: Cognitive Level: Understanding (Comprehension)

MSC: Client Needs: Psychosocial Integrity

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

a. Changing the patients 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.

DIF: Cognitive Level: Remembering (Knowledge)

MSC: Client Needs: Health Promotion and Maintenance

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 individuals 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 individuals condition and compares the actual outcomes with expected outcomes.

DIF: Cognitive Level: Applying (Application)

MSC: Client Needs: Safe and Effective Care Environment: Management of Care

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 todays nursing actions can apply to the point the nurse wants the patient to reach at a future time.

DIF: Cognitive Level: Applying (Application)

MSC: Client Needs: General

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 patients 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.

DIF: Cognitive Level: Analyzing (Analysis)

MSC: Client Needs: Safe and Effective Care Environment: Management of Care

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 DIF: Cognitive Level: Analyzing (Analysis)

MSC: Client Needs: Safe and Effective Care Environment: Management of Care

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 patients health but can be addressed after more urgent health problems are addressed.

2. ANS: C DIF: Cognitive Level: Analyzing (Analysis)

MSC: Client Needs: Safe and Effective Care Environment: Management of Care

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3. ANS: A DIF: Cognitive Level: Analyzing (Analysis)

MSC: Client Needs: Safe and Effective Care Environment: Management of Care

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 patients health but can be addressed after more urgent health problems are addressed.

Chapter 02: Cultural Assessment

MULTIPLE CHOICE

1. The nurse is reviewing the development of culture. Which statement is *correct* regarding the development of ones 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.

DIF: Cognitive Level: Understanding (Comprehension)

MSC: Client Needs: Psychosocial Integrity

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 persons 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 ones language and behavior.

DIF: Cognitive Level: Analyzing (Analysis)

MSC: Client Needs: Psychosocial Integrity

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.

DIF: Cognitive Level: Remembering (Knowledge)

MSC: Client Needs: Psychosocial Integrity

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*.

DIF: Cognitive Level: Understanding (Comprehension)

MSC: Client Needs: Psychosocial Integrity

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.

DIF: Cognitive Level: Remembering (Knowledge)

MSC: Client Needs: General

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 hospitals 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 amulets meaning. Amulets, such as charms, are often considered an important means of protection from evil spirits by some cultures.

DIF: Cognitive Level: Applying (Application)

MSC: Client Needs: Psychosocial Integrity

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 patients native language.

b. Possesses some basic knowledge of the patients cultural background.

c. Applies the proper background knowledge of a patients cultural background to provide the best possible health care.

d. Understands and attends to the total context of the patients situation.

ANS: D

Culturally competent implies that the caregiver understands and attends to the total context of the individuals 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 patients native language.

DIF: Cognitive Level: Analyzing (Analysis)

MSC: Client Needs: Psychosocial Integrity

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 ancestors 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.

DIF: Cognitive Level: Understanding (Comprehension)

MSC: Client Needs: Psychosocial Integrity

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.

DIF: Cognitive Level: Applying (Application)

MSC: Client Needs: Psychosocial Integrity

10. The nurse is comparing the concepts of religion and spirituality. Which of the following is an appropriate component of ones 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 ones ethnic background

ANS: C

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

DIF: Cognitive Level: Applying (Application)

MSC: Client Needs: Psychosocial Integrity

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.

DIF: Cognitive Level: Understanding (Comprehension)

MSC: Client Needs: Psychosocial Integrity

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 persons heritage. Simply asking about ones religion, smoking history, or health history does not reflect heritage.

DIF: Cognitive Level: Applying (Application)

MSC: Client Needs: Psychosocial Integrity

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.

DIF: Cognitive Level: Understanding (Comprehension)

MSC: Client Needs: Psychosocial Integrity

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.

DIF: Cognitive Level: Understanding (Comprehension)

MSC: Client Needs: Psychosocial Integrity

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.

DIF: Cognitive Level: Applying (Application)

MSC: Client Needs: Psychosocial Integrity

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.

DIF: Cognitive Level: Analyzing (Analysis)

MSC: Client Needs: Psychosocial Integrity

17. Illness is considered part of lifes 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 lifes rhythmic course and an outward sign of disharmony within. The other options are not correct.

DIF: Cognitive Level: Understanding (Comprehension)

MSC: Client Needs: Psychosocial Integrity

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.

DIF: Cognitive Level: Understanding (Comprehension)

MSC: Client Needs: Psychosocial Integrity

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.

DIF: Cognitive Level: Analyzing (Analysis)

MSC: Client Needs: Psychosocial Integrity

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 patients 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).

DIF: Cognitive Level: Analyzing (Analysis)

MSC: Client Needs: Psychosocial Integrity

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 nurses 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).

DIF: Cognitive Level: Analyzing (Analysis)

MSC: Client Needs: Psychosocial Integrity

22. Symptoms, such as pain, are often influenced by a persons 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 nurses area of clinical practice will most likely determine his or her assessment of a patients pain.

d. A nurses 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 nurses assessment of pain needs to be embedded in a cultural context. The other responses are not correct.

DIF: Cognitive Level: Understanding (Comprehension)

MSC: Client Needs: Psychosocial Integrity

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 patients 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.

DIF: Cognitive Level: Understanding (Comprehension)

MSC: Client Needs: Psychosocial Integrity

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 persons unique life experience and his or her personal effort to find purpose in life.

ANS: D

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

DIF: Cognitive Level: Understanding (Comprehension)

MSC: Client Needs: Psychosocial Integrity

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 childrens 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 childs developmental level and the religious climate that exists in the family. The other statements are not correct.

DIF: Cognitive Level: Applying (Application)

MSC: Client Needs: Psychosocial Integrity

26. A 30-year-old woman has recently moved to the United States with her husband. They are living with the womans sister until they can get a home of their own. When company arrives to visit with the womans 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 individuals perceptions and expectations. The other terms are not correct.

DIF: Cognitive Level: Analyzing (Analysis)

MSC: Client Needs: Psychosocial Integrity

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.

DIF: Cognitive Level: Understanding (Comprehension)

MSC: Client Needs: Psychosocial Integrity

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.

DIF: Cognitive Level: Understanding (Comprehension)

MSC: Client Needs: Psychosocial Integrity

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.

DIF: Cognitive Level: Analyzing (Analysis)

MSC: Client Needs: Psychosocial Integrity

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.

DIF: Cognitive Level: Analyzing (Analysis)

MSC: Client Needs: Psychosocial Integrity

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 childs 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.

DIF: Cognitive Level: Applying (Application)

MSC: Client Needs: Psychosocial Integrity

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*.

DIF: Cognitive Level: Understanding (Comprehension)

MSC: Client Needs: Psychosocial Integrity

33. The nurse is reviewing concepts related to ones 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 persons 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.

DIF: Cognitive Level: Remembering (Knowledge)

MSC: Client Needs: Psychosocial Integrity

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 patients history.

DIF: Cognitive Level: Understanding (Comprehension)

MSC: Client Needs: Psychosocial Integrity

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.

DIF: Cognitive Level: Analyzing (Analysis)

MSC: Client Needs: Psychosocial Integrity

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 ones 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.

DIF: Cognitive Level: Analyzing (Analysis)

MSC: Client Needs: Psychosocial Integrity

2. The nurse is asking questions about a patients 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 patients health beliefs and practices. The questions regarding family history and surgeries are part of the patients physical history, not the patients health beliefs.

DIF: Cognitive Level: Applying (Application)

MSC: Client Needs: Psychosocial Integrity

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 nurses response.

DIF: Cognitive Level: Analyzing (Analysis)

MSC: Client Needs: Psychosocial Integrity

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.

DIF: Cognitive Level: Analyzing (Analysis)

MSC: Client Needs: Psychosocial Integrity

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.

DIF: Cognitive Level: Applying (Application)

MSC: Client Needs: Psychosocial Integrity

4. In an interview, the nurse may find it necessary to take notes to aid his or her memory later. Which statement is *true* regarding note-taking?

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

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

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

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

ANS: A

The use of history forms and note-taking may be unavoidable. However, the nurse must be aware that note-taking during the interview has disadvantages. It breaks eye contact too often and shifts the attention away from the patient, which diminishes his or her sense of importance. Note-taking may also interrupt the patients narrative flow, and it impedes the observation of the patients nonverbal behavior.

DIF: Cognitive Level: Understanding (Comprehension)

MSC: Client Needs: Psychosocial Integrity

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.

DIF: Cognitive Level: Understanding (Comprehension)

MSC: Client Needs: Psychosocial Integrity

6. A woman has just entered the emergency department after being battered by her husband. The nurse needs to get some information from her to begin treatment. What is the best choice for an opening phase of the interview with this patient?

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

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

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

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

ANS: D

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

DIF: Cognitive Level: Applying (Application)

MSC: Client Needs: Psychosocial Integrity

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.

DIF: Cognitive Level: Understanding (Comprehension)

MSC: Client Needs: Psychosocial Integrity

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

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

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

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

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

ANS: D

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

DIF: Cognitive Level: Applying (Application)

MSC: Client Needs: Psychosocial Integrity

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

a. Empathy.

b. Reflection.

c. Facilitation.

d. Confrontation.

ANS: D

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

DIF: Cognitive Level: Remembering (Knowledge)

MSC: Client Needs: Psychosocial Integrity

10. When taking a history from a newly admitted patient, the nurse notices that he often pauses and expectantly

looks at the nurse. What would be the nurses best response to this behavior?

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

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

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

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

ANS: A

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

DIF: Cognitive Level: Applying (Application)

MSC: Client Needs: Psychosocial Integrity

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

a. Go on, Im listening.

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

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

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

ANS: B

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

DIF: Cognitive Level: Applying (Application)

MSC: Client Needs: Psychosocial Integrity

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

a. You feel alone.

b. You cant believe he left you alone?

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

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

ANS: C

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

DIF: Cognitive Level: Applying (Application)

MSC: Client Needs: Psychosocial Integrity

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

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

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

c. Mr. K., I didnt realize your wife had died. It must be difficult for you at this time. Please tell me more about that.

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

ANS: D

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

DIF: Cognitive Level: Applying (Application)

MSC: Client Needs: Psychosocial Integrity

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

a. Apologize, because using interpretation can be demeaning for the patient.

b. Allow time for the patient to confirm or correct the inference.

c. Continue with the interview as though nothing has happened.

d. Immediately restate the nurses conclusion on the basis of the patients nonverbal response.

ANS: B

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

DIF: Cognitive Level: Analyzing (Analysis)

MSC: Client Needs: Psychosocial Integrity

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

a. You are going to leave him?

b. If you are afraid for your children, then why cant you leave?

c. It sounds as if you might be afraid of how your husband will respond.

d. It sounds as though you have made your decision. I think it is a good one.

ANS: C

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

DIF: Cognitive Level: Applying (Application)

MSC: Client Needs: Psychosocial Integrity

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

a. Therapeutic response. By sharing something personal, the nurse gives hope to this woman.

b. Nontherapeutic response. By providing false reassurance, the nurse actually cut off further discussion of the womans fears.

c. Therapeutic response. By providing information about the medications available, the nurse is giving information to the woman.

d. Nontherapeutic response. The nurse is essentially giving the message to the woman that labor cannot be tolerated without medication.

ANS: B

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

DIF: Cognitive Level: Analyzing (Analysis)

MSC: Client Needs: Psychosocial Integrity

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

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

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

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

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

ANS: B

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

DIF: Cognitive Level: Applying (Application)

MSC: Client Needs: Psychosocial Integrity

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

a. Youre afraid you might lose your breast?

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

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

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

ANS: A

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

DIF: Cognitive Level: Applying (Application)

MSC: Client Needs: Psychosocial Integrity

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

a. Talking too much.

b. Using confrontation.

c. Using biased or leading questions.

d. Using blunt language to deal with distasteful topics.

ANS: C

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

DIF: Cognitive Level: Understanding (Comprehension)

MSC: Client Needs: Psychosocial Integrity

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

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

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

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

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

ANS: D

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

DIF: Cognitive Level: Applying (Application)

MSC: Client Needs: Psychosocial Integrity

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

a. Simply changing positions.

b. More comfortable in this position.

c. Tired and needs a break from the interview.

d. Uncomfortable talking about his sons treatment.

ANS: D

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

DIF: Cognitive Level: Analyzing (Analysis)

MSC: Client Needs: Psychosocial Integrity

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.

DIF: Cognitive Level: Applying (Application)

MSC: Client Needs: Psychosocial Integrity

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

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

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

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

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

ANS: D

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

DIF: Cognitive Level: Applying (Application)

MSC: Client Needs: Psychosocial Integrity

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

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

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

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

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

ANS: B

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

DIF: Cognitive Level: Applying (Application)

MSC: Client Needs: Psychosocial Integrity

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.

DIF: Cognitive Level: Understanding (Comprehension)

MSC: Client Needs: Psychosocial Integrity

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

a. Determine the communication method he prefers.

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

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

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

ANS: A

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

DIF: Cognitive Level: Understanding (Comprehension)

MSC: Client Needs: Psychosocial Integrity

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

a. Im so sorry for making you cry!

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

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

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

ANS: B

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

DIF: Cognitive Level: Applying (Application)

MSC: Client Needs: Psychosocial Integrity

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

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

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

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

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

ANS: A

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

DIF: Cognitive Level: Analyzing (Analysis)

MSC: Client Needs: Psychosocial Integrity

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.

DIF: Cognitive Level: Analyzing (Analysis)

MSC: Client Needs: Psychosocial Integrity

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

a. Do you take medicine?

b. Do you sterilize the bottles?

c. Do you have nausea and vomiting?

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

ANS: A

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

DIF: Cognitive Level: Analyzing (Analysis)

MSC: Client Needs: Psychosocial Integrity

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.

DIF: Cognitive Level: Applying (Application)

MSC: Client Needs: Psychosocial Integrity

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

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

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

c. This type of comment promotes dependency and inferiority on the part of the patient and is best

avoided in an interview situation.

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

ANS: C

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

DIF: Cognitive Level: Applying (Application)

MSC: Client Needs: Psychosocial Integrity

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.

DIF: Cognitive Level: Understanding (Comprehension)

MSC: Client Needs: Psychosocial Integrity

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

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

b. This question is an innocent search for information.

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

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

ANS: A

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

DIF: Cognitive Level: Analyzing (Analysis)

MSC: Client Needs: Psychosocial Integrity

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

a. Did we forget something?

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

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

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

ANS: B

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

DIF: Cognitive Level: Understanding (Comprehension)

MSC: Client Needs: Psychosocial Integrity

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.

DIF: Cognitive Level: Remembering (Knowledge)

MSC: Client Needs: Psychosocial Integrity

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.

DIF: Cognitive Level: Understanding (Comprehension)

MSC: Client Needs: Psychosocial Integrity

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

a. Stop that immediately!

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

c. Do you really think I would be interested?

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

ANS: D

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

DIF: Cognitive Level: Analyzing (Analysis)

MSC: Client Needs: Psychosocial Integrity

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.

DIF: Cognitive Level: Applying (Application)

MSC: Client Needs: Psychosocial Integrity

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

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

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

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

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

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

ANS: A, D, E

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

DIF: Cognitive Level: Applying (Application)

MSC: Client Needs: Psychosocial Integrity

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 patients biographic information

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

d. To provide a database of subjective information about the patients past and current health

ANS: D

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

DIF: Cognitive Level: Understanding (Comprehension)

MSC: Client Needs: Safe and Effective Care Environment: Management of Care

2. When the nurse is evaluating the reliability of a patients 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.

DIF: Cognitive Level: Applying (Application)

MSC: Client Needs: Safe and Effective Care Environment: Management of Care

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 persons 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 persons exact words.

DIF: Cognitive Level: Applying (Application)

MSC: Client Needs: Safe and Effective Care Environment: Management of Care

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

a. Can you point to where it hurts?

b. Well 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.

DIF: Cognitive Level: Applying (Application)

MSC: Client Needs: Safe and Effective Care Environment: Management of Care

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

a. How does your family react to your pain?

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

c. Ive 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.

DIF: Cognitive Level: Applying (Application)

MSC: Client Needs: Safe and Effective Care Environment: Management of Care

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 didnt.

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 persons childhood may be unusual today (e.g., measles).

DIF: Cognitive Level: Remembering (Knowledge)

MSC: Client Needs: Safe and Effective Care Environment: Management of Care

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.

DIF: Cognitive Level: Applying (Application)

MSC: Client Needs: Safe and Effective Care Environment: Management of Care

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

a. Are you allergic to any other drugs?

b. How often have you received penicillin?

c. Ill write your allergy on your chart so you wont 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.

DIF: Cognitive Level: Understanding (Comprehension)

MSC: Client Needs: Safe and Effective Care Environment: Management of Care

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.

DIF: Cognitive Level: Remembering (Knowledge)

MSC: Client Needs: Safe and Effective Care Environment: Management of Care

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 patients 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.

DIF: Cognitive Level: Remembering (Knowledge)

MSC: Client Needs: Safe and Effective Care Environment: Management of Care

11. Which of these statements represents subjective data the nurse obtained from the patient regarding the patients 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 datafactors that the person says were or were not present.

DIF: Cognitive Level: Understanding (Comprehension)

MSC: Client Needs: Safe and Effective Care Environment: Management of Care

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.

DIF: Cognitive Level: Understanding (Comprehension)

MSC: Client Needs: Safe and Effective Care Environment: Management of Care

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. Im able to transfer myself from the wheelchair to the bed without help.

ANS: D

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

DIF: Cognitive Level: Applying (Application)

MSC: Client Needs: Safe and Effective Care Environment: Management of Care

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 dont 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 lets 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 ones 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.

DIF: Cognitive Level: Applying (Application)

MSC: Client Needs: Safe and Effective Care Environment: Management of Care

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 patients 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.

DIF: Cognitive Level: Understanding (Comprehension)

MSC: Client Needs: Safe and Effective Care Environment: Management of Care

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 childs 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.

DIF: Cognitive Level: Applying (Application)

MSC: Client Needs: Safe and Effective Care Environment: Management of Care

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

a. List of diseases present in a persons 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 patients family members up to five generations back

d. Description of the health of a persons 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.

DIF: Cognitive Level: Applying (Application)

MSC: Client Needs: Safe and Effective Care Environment: Management of Care

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. Childs birth weight

b. Age at which he crawled

c. Whether the child has had the measles

d. Childs 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.

DIF: Cognitive Level: Analyzing (Analysis)

MSC: Client Needs: Safe and Effective Care Environment: Management of Care

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.

DIF: Cognitive Level: Analyzing (Analysis)

MSC: Client Needs: Safe and Effective Care Environment: Management of Care

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.

DIF: Cognitive Level: Applying (Application)

MSC: Client Needs: Safe and Effective Care Environment: Management of Care

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.

DIF: Cognitive Level: Understanding (Comprehension)

MSC: Client Needs: Safe and Effective Care Environment: Management of 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.

DIF: Cognitive Level: Applying (Application)

MSC: Client Needs: Safe and Effective Care Environment: Management of Care

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 necessarythe 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.

DIF: Cognitive Level: Understanding (Comprehension)

MSC: Client Needs: Safe and Effective Care Environment: Management of Care

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. Dont 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.

DIF: Cognitive Level: Applying (Application)

MSC: Client Needs: Safe and Effective Care Environment: Management of Care

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.

DIF: Cognitive Level: Applying (Application)

MSC: Client Needs: Safe and Effective Care Environment: Management of Care

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.

DIF: Cognitive Level: Remembering (Knowledge)

MSC: Client Needs: Safe and Effective Care Environment: Management of Care

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.

DIF: Cognitive Level: Understanding (Comprehension)

MSC: Client Needs: Safe and Effective Care Environment: Management of Care

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 patients perception of the pain; and describing the sweats and nausea reflects associated factors that occur with the pain.

DIF: Cognitive Level: Analyzing (Analysis)

MSC: Client Needs: Safe and Effective Care Environment: Management of Care

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.

DIF: Cognitive Level: Analyzing (Analysis)

MSC: Client Needs: Safe and Effective Care Environment: Management of Care

30. The nurse is incorporating a persons 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.

DIF: Cognitive Level: Understanding (Comprehension)

MSC: Client Needs: Safe and Effective Care Environment: Management of Care

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.

DIF: Cognitive Level: Analyzing (Analysis)

MSC: Client Needs: Safe and Effective Care Environment: Management of Care

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.

DIF: Cognitive Level: Analyzing (Analysis)

MSC: Client Needs: Psychosocial Integrity

MULTIPLE RESPONSE

1. The nurse is assessing a patients 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 patients 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.

DIF: Cognitive Level: Analyzing (Analysis)

MSC: Client Needs: Safe and Effective Care Environment: Management of Care

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 childrens 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.

DIF: Cognitive Level: Analyzing (Analysis)

MSC: Client Needs: Safe and Effective Care Environment: Management of Care

Chapter 05: Mental Status Assessment

MULTIPLE CHOICE

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

a. Examining the patients 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 patients 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 individuals behaviors, such as consciousness, language, mood and affect, and other aspects.

PTS: 1 DIF: Cognitive Level: Understanding (Comprehension)

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. Childrens mental status is largely a function of their parents level of functioning until the age of 7 years.

d. A childs 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 mothers body. The other statements are not true.

PTS: 1 DIF: Cognitive Level: Understanding (Comprehension)

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.

PTS: 1 DIF: Cognitive Level: Analyzing (Analysis)

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 15) 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.

PTS: 1 DIF: Cognitive Level: Analyzing (Analysis)

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

a. A patients family is the best resource for information about the patients 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 patients 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.

PTS: 1 DIF: Cognitive Level: Applying (Application)

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 nurses 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 persons behavioral changes (e.g., memory loss, inappropriate social interaction) or after trauma, such as a head injury.

PTS: 1 DIF: Cognitive Level: Applying (Application)

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 patients 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.

PTS: 1 DIF: Cognitive Level: Analyzing (Analysis)

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 nurses 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.

PTS: 1 DIF: Cognitive Level: Analyzing (Analysis)

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 notedthe 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 persons economic status or a deliberate fashion trend.

PTS: 1 DIF: Cognitive Level: Applying (Application)

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 todays date? Many hospitalized people have trouble with the exact date but are fully oriented on the remaining items.

PTS: 1 DIF: Cognitive Level: Analyzing (Analysis)

11. During a mental status examination, the nurse wants to assess a patients 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 persons place and condition and should appropriately change with the topics.

PTS: 1 DIF: Cognitive Level: Applying (Application)

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 persons ability to lay down new memories and is a highly sensitive and valid memory test.

PTS: 1 DIF: Cognitive Level: Applying (Application)

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 persons 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.

PTS: 1 DIF: Cognitive Level: Analyzing (Analysis)

14. During a mental status assessment, which question by the nurse would best assess a persons 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 shouldnt 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 persons response to a hypothetical situation (as illustrated in the option with the envelope), the nurse should be more interested in the persons 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.

PTS: 1 DIF: Cognitive Level: Applying (Application)

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.

PTS: 1 DIF: Cognitive Level: Applying (Application)

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 girls 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).

PTS: 1 DIF: Cognitive Level: Applying (Application)

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 couldnt 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 Im at the hospital in Spokane. No, I dont know the date.

d. I know my name is John. I am at the hospital in Spokane. I couldnt tell you what date it is, but I know that it is February of a new year2010.

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.

PTS: 1 DIF: Cognitive Level: Applying (Application)

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 infants 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.

PTS: 1 DIF: Cognitive Level: Applying (Application)

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 patients 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.

PTS: 1 DIF: Cognitive Level: Understanding (Comprehension)

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 patients problem?

a. Global aphasia

b. Brocas aphasia

c. Echolalia

d. Wernickes aphasia

ANS: D

This type of communication illustrates Wernickes 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 persons words or phrases.

PTS: 1 DIF: Cognitive Level: Applying (Application)

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.

PTS: 1 DIF: Cognitive Level: Understanding (Comprehension)

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 babys 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.

PTS: 1 DIF: Cognitive Level: Understanding (Comprehension)

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.

PTS: 1 DIF: Cognitive Level: Applying (Application)

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 persons speech.

PTS: 1 DIF: Cognitive Level: Analyzing (Analysis)

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.

PTS: 1 DIF: Cognitive Level: Remembering (Knowledge)

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 patients:

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.

PTS: 1 DIF: Cognitive Level: Understanding (Comprehension)

27. A patient states, I feel so sad all of the time. I cant feel happy even doing things I used to like to do. He alsc 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.

PTS: 1 DIF: Cognitive Level: Analyzing (Analysis)

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.

PTS: 1 DIF: Cognitive Level: Applying (Application)

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 individuals 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 individuals behaviors. It cannot be directly assessed like the characteristics of the skin or heart sounds.

PTS: 1 DIF: Cognitive Level: Understanding (Comprehension)

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 individuals 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.

PTS: 1 DIF: Cognitive Level: Applying (Application)

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).

PTS: 1 DIF: Cognitive Level: Applying (Application)

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 nurses 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.

PTS: 1 DIF: Cognitive Level: Applying (Application)

33. The nurse is providing instructions to newly hired graduates for the minimental 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.

PTS: 1 DIF: Cognitive Level: Understanding (Comprehension)

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. Brocas

c. Dysphonic

d. Wernickes

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. Dysphonic aphasia is not a valid condition.

PTS: 1 DIF: Cognitive Level: Understanding (Comprehension)

35. A patient repeats, I feel hot. Hot, cot, rot, tot, got. Im 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.

PTS: 1 DIF: Cognitive Level: Understanding (Comprehension)

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.

PTS: 1 DIF: Cognitive Level: Understanding (Comprehension)

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.

PTS: 1 DIF: Cognitive Level: Analyzing (Analysis)

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 anothers words or phrases, often with a mumbling, mocking, or a mechanical tone.

PTS: 1 DIF: Cognitive Level: Applying (Application)

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.

PTS: 1 DIF: Cognitive Level: Applying (Application)

Chapter 06: Substance Use Assessment

MULTIPLE CHOICE

1. A woman has come to the clinic to seek help with a substance abuse problem. She admits to using cocaine just before arriving. Which of these assessment findings would the nurse expect to find when examining this woman?

a. Dilated pupils, pacing, and psychomotor agitation

b. Dilated pupils, unsteady gait, and aggressiveness

c. Pupil constriction, lethargy, apathy, and dysphoria

d. Constricted pupils, euphoria, and decreased temperature

ANS: A

A cocaine users appearance includes pupillary dilation, tachycardia or bradycardia, elevated or lowered blood pressure, sweating, chills, nausea, vomiting, and weight loss. The persons behavior includes euphoria, talkativeness, hypervigilance, pacing, psychomotor agitation, impaired social or occupational functioning, fighting, grandiosity, and visual or tactile hallucinations.

DIF: Cognitive Level: Applying (Application)

MSC: Client Needs: Physiologic Integrity: Physiologic Adaptation

2. The nurse is assessing a patient who has been admitted for cirrhosis of the liver, secondary to chronic alcohol use. During the physical assessment, the nurse looks for cardiac problems that are associated with chronic use of alcohol, such as:

a. Hypertension.

b. Ventricular fibrillation.

c. Bradycardia.

d. Mitral valve prolapse.

ANS: A

Even moderate drinking leads to hypertension and cardiomyopathy, with an increase in left ventricular mass, dilation of ventricles, and wall thinning. Ventricular fibrillation, bradycardia, and mitral valve prolapse are not associated with chronic heavy use of alcohol.

DIF: Cognitive Level: Applying (Application)

MSC: Client Needs: Physiologic Integrity: Physiologic Adaptation

3. The nurse is conducting a class on alcohol and the effects of alcohol on the body. How many standard drinks (each containing 14 grams of alcohol) per day in men are associated with increased deaths from cirrhosis, cancers of the mouth, esophagus, and injuries?

a. 2

b. 4

c. 6

d. 8

ANS: B

In men, alcohol consumption of at least four standard drinks per day is associated with increased deaths from liver cirrhosis, cancers of the mouth, esophagus and other areas, and deaths from injuries and other external causes.

DIF: Cognitive Level: Understanding (Comprehension)

MSC: Client Needs: Physiologic Integrity: Reduction of Risk Potential

4. During a session on substance abuse, the nurse is reviewing statistics with the class. For persons aged 12 years and older, which illicit substance was most commonly used?

a. Crack cocaine

b. Heroin

c. Marijuana

d. Hallucinogens

ANS: C

In persons age 12 years and older who reported using during the past month, marijuana (hashish) was the most commonly used illicit drug reported.

DIF: Cognitive Level: Remembering (Knowledge)

MSC: Client Needs: Physiologic Integrity: Physiologic Adaptation

5. A woman who has just discovered that she is pregnant is in the clinic for her first obstetric visit. She asks the nurse, How many drinks a day is safe for my baby? The nurses best response is:

a. You should limit your drinking to once or twice a week.

b. Its okay to have up to two glasses of wine a day.

c. As long as you avoid getting drunk, you should be safe.

d. No amount of alcohol has been determined to be safe during pregnancy.

ANS: D

No amount of alcohol has been determined to be safe for pregnant women. The potential adverse effects of alcohol use on the fetus are well known; women who are pregnant should be screened for alcohol use, and abstinence should be recommended.

DIF: Cognitive Level: Analyzing (Analysis)

MSC: Client Needs: Safe and Effective Care Environment: Safety and Infection Control

6. When reviewing the use of alcohol by older adults, the nurse notes that older adults have several characteristics that can increase the risk of alcohol use. Which would increase the bioavailability of alcohol in the blood for longer periods in the older adult?

a. Increased muscle mass

b. Decreased liver and kidney functioning

c. Decreased blood pressure

d. Increased cardiac output

ANS: B

Decreased liver and kidney functioning increases the bioavailability of alcohol in the blood for longer periods. Aging people experience decreased muscle mass (not increased), which also increases the alcohol concentration in the blood because the alcohol is distributed to less tissue over time. Blood pressure and cardiac output are not factors regarding bioavailability.

DIF: Cognitive Level: Applying (Application)

MSC: Client Needs: Physiologic Integrity: Physiologic Adaptation

7. During an assessment, the nurse asks a female patient, How many alcoholic drinks do you have a week? Which answer by the patient would indicate *at-risk* drinking?

a. I may have one or two drinks a week.

b. I usually have three or four drinks a week.

c. Ill have a glass or two of wine every now and then.

d. I have seven or eight drinks a week, but I never get drunk.

ANS: D

For women, having seven or more drinks a week or three or more drinks per occasion is considered at-risk drinking, according to the National Institute on Alcohol Abuse and Alcoholism.

DIF: Cognitive Level: Applying (Application)

MSC: Client Needs: Physiologic Integrity: Reduction of Risk Potential

8. The nurse is asking an adolescent about illicit substance abuse. The adolescent answers, Yes, Ive used marijuana at parties with my friends. What is the next question the nurse should ask?

a. Who are these friends?

b. Do your parents know about this?

c. When was the last time you used marijuana?

d. Is this a regular habit?

ANS: C

If a patient admits to the use of illicit substances, then the nurse should ask, When was the last time you used drugs? and How much did you take that time? The other questions may be considered accusatory and are not conducive to gathering information.

DIF: Cognitive Level: Applying (Application)

MSC: Client Needs: Health Promotion and Maintenance

9. The nurse has completed an assessment on a patient who came to the clinic for a leg injury. As a result of the assessment, the nurse has determined that the patient has *at-risk* alcohol use. Which action by the nurse is most appropriate at this time?

a. Record the results of the assessment, and notify the physician on call.

b. State, You are drinking more than is medically safe. I strongly recommend that you quit drinking, and Im willing to help you.

c. State, It appears that you may have a drinking problem. Here is the telephone number of our local Alcoholics Anonymous chapter.

d. Give the patient information about a local rehabilitation clinic.

ANS: B

If an assessment has determined that the patient has at-risk drinking behavior, then the nurse should give a short but clear statement of assistance and concern. Simply giving out a telephone number or referral to agencies may not be enough.

DIF: Cognitive Level: Applying (Application)

MSC: Client Needs: Safe and Effective Care Environment: Safety and Infection Control

10. A patient is brought to the emergency department. He is restless, has dilated pupils, is sweating, has a runny nose and tearing eyes, and complains of muscle and joint pains. His girlfriend thinks he has influenza, but she became concerned when his temperature went up to 39.4 C. She admits that he has been a heavy drug user, but he has been trying to stop on his own. The nurse suspects that the patient is experiencing withdrawal symptoms from which substance?

a. Alcohol

b. Heroin

c. Crack cocaine

d. Sedatives

ANS: B

Withdrawal symptoms of opiates, such as heroin, are similar to the clinical picture of influenza and include symptoms such as dilated pupils, lacrimation, runny nose, tachycardia, fever, restlessness, muscle and joint pains, and other symptoms.

DIF: Cognitive Level: Applying (Application)

MSC: Client Needs: Safe and Effective Care Environment: Safety and Infection Control

11. The nurse is reviewing aspects of substance abuse in preparation for a seminar. Which of these statements illustrates the concept of *tolerance* to an illicit substance? The person:

a. Has a physiologic dependence on a substance.

b. Requires an increased amount of the substance to produce the same effect.

c. Requires daily use of the substance to function and is unable to stop using it.

d. Experiences a syndrome of physiologic symptoms if the substance is not used.

ANS: B

The concept of tolerance to a substance indicates that the person requires an increased amount of the substance to produce the same effect. Abuse indicates that the person needs to use the substance daily to function, and the person is unable to stop using it. Dependence is an actual physiologic dependence on the substance. Withdrawal occurs when cessation of the substance produces a syndrome of physiologic symptoms.

DIF: Cognitive Level: Understanding (Comprehension)

MSC: Client Needs: Physiologic Integrity: Physiologic Adaptation

MULTIPLE RESPONSE

1. A patient with a known history of heavy alcohol use has been admitted to the ICU after he was found unconscious outside a bar. The nurse closely monitors him for symptoms of withdrawal. Which of these symptoms may occur during this time? *Select all that apply.*

a. Bradycardia

b. Coarse tremor of the hands

c. Transient hallucinations

d. Somnolence

e. Sweating

ANS: B, C, E

Symptoms of uncomplicated alcohol withdrawal start shortly after the cessation of drinking, peak at the second day, and improve by the fourth or fifth day. Symptoms include coarse tremors of the hands, tongue, and eyelids; anorexia; nausea and vomiting; autonomic hyperactivity (e.g., tachycardia, sweating, elevated blood pressure); and transient hallucinations, among other symptoms.

DIF: Cognitive Level: Applying (Application)

MSC: Client Needs: Safe and Effective Care Environment: Management of Care

2. A patient visits the clinic to ask about smoking cessation. He has smoked heavily for 30 years and wants to stop cold turkey. He asks the nurse, What symptoms can I expect if I do this? Which of these symptoms should the nurse share with the patient as possible symptoms of nicotine withdrawal? *Select all that apply.*

a. Headaches

b. Hunger

c. Sleepiness

d. Restlessness

e. Nervousness

f. Sweating

ANS: A, B, D, E

Symptoms of nicotine withdrawal include vasodilation, headaches, anger, irritability, frustration, anxiety, nervousness, awakening at night, difficulty concentrating, depression, hunger, impatience, and the desire to smoke.

DIF: Cognitive Level: Applying (Application)

MSC: Client Needs: Physiologic Integrity: Physiologic Adaptation

Chapter 07: Domestic and Family Violence Assessment

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.

DIF: Cognitive Level: Applying (Application)

MSC: Client Needs: Safe and Effective Care Environment: Safety and Infection Control

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*.

DIF: Cognitive Level: Applying (Application)

MSC: Client Needs: Safe and Effective Care Environment: Safety and Infection Control

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.

DIF: Cognitive Level: Applying (Application)

MSC: Client Needs: Safe and Effective Care Environment: Safety and Infection Control

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.

DIF: Cognitive Level: Applying (Application)

MSC: Client Needs: Safe and Effective Care Environment: Safety and Infection Control

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.

DIF: Cognitive Level: Remembering (Knowledge)

MSC: Client Needs: Safe and Effective Care Environment: Safety and Infection Control

6. During an examination, the nurse notices a patterned injury on a patients 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.

DIF: Cognitive Level: Applying (Application)

MSC: Client Needs: Safe and Effective Care Environment: Safety and Infection Control

7. When documenting IPV and elder abuse, the nurse should include:

a. Photographic documentation of the injuries.

b. Summary of the abused patients 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.

DIF: Cognitive Level: Applying (Application)

MSC: Client Needs: Safe and Effective Care Environment: Safety and Infection Control

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.

DIF: Cognitive Level: Understanding (Comprehension)

MSC: Client Needs: Safe and Effective Care Environment: Safety and Infection Control

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 womans understanding of her situation.

d. The higher the number of yes answers, the more serious the danger of the womans situation.

ANS: D

No predetermined cutoff scores exist on the DA. The higher the number yes answers, the more serious the danger of the womans situation. The use of this tool is not limited to law enforcement personnel and is not required in every case of suspected abuse.

DIF: Cognitive Level: Applying (Application)

MSC: Client Needs: Safe and Effective Care Environment: Safety and Infection Control

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.

DIF: Cognitive Level: Understanding (Comprehension)

MSC: Client Needs: Safe and Effective Care Environment: Safety and Infection Control

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 childs 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.

DIF: Cognitive Level: Applying (Application)

MSC: Client Needs: Safe and Effective Care Environment: Management of Care

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.

DIF: Cognitive Level: Analyzing (Analysis)

MSC: Client Needs: Safe and Effective Care Environment: Management of Care

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.

DIF: Cognitive Level: Analyzing (Analysis)

MSC: Client Needs: Safe and Effective Care Environment: Management of Care

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.

DIF: Cognitive Level: Analyzing (Analysis)

MSC: Client Needs: Safe and Effective Care Environment: Management of Care

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.

DIF: Cognitive Level: Remembering (Knowledge)

MSC: Client Needs: Safe and Effective Care Environment: Management of Care

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

a. Usually yields little information.

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

c. May be somewhat uncomfortable for the expert practitioner.

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

ANS: B

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

DIF: Cognitive Level: Understanding (Comprehension)

MSC: Client Needs: Safe and Effective Care Environment: Management of Care

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

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

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

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

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

ANS: B

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

DIF: Cognitive Level: Applying (Application)

MSC: Client Needs: Safe and Effective Care Environment: Management of Care

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.

DIF: Cognitive Level: Remembering (Knowledge)

MSC: Client Needs: Safe and Effective Care Environment: Management of Care

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

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

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

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

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

ANS: D

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

DIF: Cognitive Level: Applying (Application)

MSC: Client Needs: Safe and Effective Care Environment: Management of Care

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.

DIF: Cognitive Level: Applying (Application)

MSC: Client Needs: Safe and Effective Care Environment: Management of Care

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.

DIF: Cognitive Level: Understanding (Comprehension)

MSC: Client Needs: Safe and Effective Care Environment: Management of Care

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.

DIF: Cognitive Level: Applying (Application)

MSC: Client Needs: Safe and Effective Care Environment: Management of Care

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.

DIF: Cognitive Level: Analyzing (Analysis)

MSC: Client Needs: Safe and Effective Care Environment: Management of Care

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

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

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

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

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

ANS: C

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

DIF: Cognitive Level: Applying (Application)

MSC: Client Needs: Safe and Effective Care Environment: Management of Care

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

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

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

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

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

ANS: D

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

DIF: Cognitive Level: Applying (Application)

MSC: Client Needs: Safe and Effective Care Environment: Management of Care

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

a. Count the patients respirations.

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

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

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

ANS: B

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

DIF: Cognitive Level: Analyzing (Analysis)

MSC: Client Needs: Safe and Effective Care Environment: Management of Care

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

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

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

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

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

ANS: B

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

DIF: Cognitive Level: Understanding (Comprehension)

MSC: Client Needs: Safe and Effective Care Environment: Management of Care

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

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

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

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

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

ANS: A

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

DIF: Cognitive Level: Understanding (Comprehension)

MSC: Client Needs: Safe and Effective Care Environment: Management of Care

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

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

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

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

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

ANS: D

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

DIF: Cognitive Level: Applying (Application)

MSC: Client Needs: Safe and Effective Care Environment: Management of Care

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.

DIF: Cognitive Level: Understanding (Comprehension)

MSC: Client Needs: Safe and Effective Care Environment: Management of Care

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.

DIF: Cognitive Level: Remembering (Knowledge)

MSC: Client Needs: Safe and Effective Care Environment: Management of Care

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

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

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

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

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

ANS: D

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

DIF: Cognitive Level: Analyzing (Analysis)

MSC: Client Needs: Safe and Effective Care Environment: Management of Care

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.

DIF: Cognitive Level: Analyzing (Analysis)

MSC: Client Needs: Safe and Effective Care Environment: Management of Care

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

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

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

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

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

ANS: D

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

DIF: Cognitive Level: Applying (Application)

MSC: Client Needs: Safe and Effective Care Environment: Management of Care

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

a. Appear unhurried and confident when examining him.

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

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

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

ANS: A

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

DIF: Cognitive Level: Applying (Application)

MSC: Client Needs: Safe and Effective Care Environment: Management of Care

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

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

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

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

DIF: Cognitive Level: Applying (Application)

MSC: Client Needs: Safe and Effective Care Environment: Safety and Infection Control

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

a. Washing hands, and contacting the physician

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

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

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

ANS: C

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

DIF: Cognitive Level: Analyzing (Analysis)

MSC: Client Needs: Safe and Effective Care Environment: Safety and Infection Control

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

a. Your atrial dysrhythmias are under control.

b. You have pitting edema and mild varicosities.

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

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

ANS: C

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

DIF: Cognitive Level: Analyzing (Analysis)

MSC: Client Needs: Safe and Effective Care Environment: Management of Care

25. The nurse keeps in mind that the most important reason to share information and to offer brief teaching

while performing the physical examination is to help the:

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

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

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

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

ANS: B

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

DIF: Cognitive Level: Understanding (Comprehension)

MSC: Client Needs: Safe and Effective Care Environment: Management of Care

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.

DIF: Cognitive Level: Understanding (Comprehension)

MSC: Client Needs: Safe and Effective Care Environment: Management of Care

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

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

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

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

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

ANS: A

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

DIF: Cognitive Level: Applying (Application)

MSC: Client Needs: Safe and Effective Care Environment: Management of Care

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

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

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

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

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

ANS: A

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

DIF: Cognitive Level: Applying (Application)

MSC: Client Needs: Safe and Effective Care Environment: Management of Care

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

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

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

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

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

ANS: C

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

DIF: Cognitive Level: Applying (Application)

MSC: Client Needs: Safe and Effective Care Environment: Management of Care

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

a. Asking questions enhances the childs autonomy

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

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

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

ANS: D

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

DIF: Cognitive Level: Analyzing (Analysis)

MSC: Client Needs: Safe and Effective Care Environment: Management of Care

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.

DIF: Cognitive Level: Understanding (Comprehension)

MSC: Client Needs: Safe and Effective Care Environment: Management of Care

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

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

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

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

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

ANS: B

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

DIF: Cognitive Level: Understanding (Comprehension)

MSC: Client Needs: Safe and Effective Care Environment: Management of Care

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 teens level of understanding may not match his or her speech.

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

ANS: D

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

DIF: Cognitive Level: Applying (Application)

MSC: Client Needs: Safe and Effective Care Environment: Management of Care

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.

DIF: Cognitive Level: Applying (Application)

MSC: Client Needs: Safe and Effective Care Environment: Management of Care

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.

DIF: Cognitive Level: Understanding (Comprehension)

MSC: Client Needs: Safe and Effective Care Environment: Safety and Infection Control

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

a. Standard Precautions apply to all body fluids, including sweat.

b. Use alcohol-based hand rub if hands are visibly dirty.

c. Standard Precautions are intended for use with all patients, regardless of their risk or presumed infection status.

d. Standard Precautions are to be used only when nonintact skin, excretions containing visible blood, or expected contact with mucous membranes is present.

ANS: C

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

DIF: Cognitive Level: Understanding (Comprehension)

MSC: Client Needs: Safe and Effective Care Environment: Safety and Infection Control

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

a. The patient should lie down to obtain an accurate cardiac, respiratory, and abdominal assessment.

b. A thorough history and physical assessment information should be obtained from the patients family member.

c. A complete history and physical assessment should be immediately performed to obtain baseline information.

d. Body areas appropriate to the problem should be examined and then the assessment completed after the problem has resolved.

ANS: D

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

DIF: Cognitive Level: Applying (Application)

MSC: Client Needs: Safe and Effective Care Environment: Management of Care

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.

DIF: Cognitive Level: Understanding (Comprehension)

MSC: Client Needs: Safe and Effective Care Environment: Management of Care

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

a. Electrocardiogram

b. Bell of the stethoscope

c. Diaphragm of the stethoscope

d. Palpation with the nurses palm of the hand

ANS: B

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

DIF: Cognitive Level: Applying (Application)

MSC: Client Needs: Safe and Effective Care Environment: Management of Care

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

a. Constipation.

b. Air-filled areas.

c. Presence of a tumor.

d. Presence of dense organs.

ANS: B

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

DIF: Cognitive Level: Analyzing (Analysis)

MSC: Client Needs: Safe and Effective Care Environment: Management of Care

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

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

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

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

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

ANS: C

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

DIF: Cognitive Level: Analyzing (Analysis)

MSC: Client Needs: Safe and Effective Care Environment: Management of Care

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

a. Document the findings in the patients record.

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

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

d. Ask another nurse to double check the finding.

ANS: D

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

DIF: Cognitive Level: Analyzing (Analysis)

MSC: Client Needs: Safe and Effective Care Environment: Management of Care

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.

DIF: Cognitive Level: Applying (Application)

MSC: Client Needs: Safe and Effective Care Environment: Management of Care

Chapter 09: General Survey and Measurement

MULTIPLE CHOICE

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

a. Observing the patients body stature and nutritional status

b. Interpreting the subjective information the patient has reported

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

d. Observing specific body systems while performing the physical assessment

ANS: A

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

DIF: Cognitive Level: Understanding (Comprehension)

MSC: Client Needs: Safe and Effective Care Environment: Management of Care

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

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

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

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

DIF: Cognitive Level: Understanding (Comprehension)

MSC: Client Needs: Safe and Effective Care Environment: Management of Care

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

a. General health.

b. Genetic makeup.

c. Nutritional status.

d. Activity and exercise patterns.

ANS: A

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

DIF: Cognitive Level: Remembering (Knowledge)

MSC: Client Needs: Health Promotion and Maintenance

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

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

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

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

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

ANS: B

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

DIF: Cognitive Level: Analyzing (Analysis)

MSC: Client Needs: Health Promotion and Maintenance

5. 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.

DIF: Cognitive Level: Applying (Application)

MSC: Client Needs: Health Promotion and Maintenance

6. 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.

DIF: Cognitive Level: Applying (Application)

MSC: Client Needs: Safe and Effective Care Environment: Management of Care

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

a. Measuring the infants length by using a tape measure

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

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

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

ANS: C

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

DIF: Cognitive Level: Applying (Application)

MSC: Client Needs: Safe and Effective Care Environment: Management of Care

8. 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.

DIF: Cognitive Level: Understanding (Comprehension)

MSC: Client Needs: Safe and Effective Care Environment: Management of Care

9. 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.

DIF: Cognitive Level: Remembering (Knowledge)

MSC: Client Needs: General

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

a. Constipation.

b. Patients emotional state.

c. Diurnal cycle.

d. Nocturnal cycle.

ANS: C

Normal temperature is influenced by the diurnal cycle, exercise, and age. The other responses do not influence

body temperature.

DIF: Cognitive Level: Remembering (Knowledge)

MSC: Client Needs: General

11. When evaluating the temperature of older adults, the nurse should remember which aspect about an older adults body temperature?

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

b. An older adults body temperature is approximately the same as that of a young child.

c. Body temperature depends on the type of thermometer used.

d. In the older adult, the body temperature varies widely because of less effective heat control 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.

DIF: Cognitive Level: Remembering (Knowledge)

MSC: Client Needs: Health Promotion and Maintenance

12. 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.

DIF: Cognitive Level: Analyzing (Analysis)

MSC: Client Needs: Physiologic Integrity: Basic Care and Comfort

13. When assessing a 75-year-old patient who has asthma, the nurse notes that he assumes a tripod position, leaning forward with arms braced on the chair. On the basis of this observation, the nurse should:

a. Assume that the patient is eager and interested in participating in the interview.

b. Evaluate the patient for abdominal pain, which may be exacerbated in the sitting position.

c. Assume that the patient is having difficulty breathing and assist him to a supine position.

d. Recognize that a tripod position is often used when a patient is having respiratory difficulties.

ANS: D

Assuming a tripod positionleaning forward with arms braced on chair armsoccurs with chronic pulmonary disease. The other actions or assumptions are not correct.

DIF: Cognitive Level: Analyzing (Analysis)

MSC: Client Needs: Physiologic Integrity: Basic Care and Comfort

14. 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.

DIF: Cognitive Level: Applying (Application)

MSC: Client Needs: Safe and Effective Care Environment: Management of Care

15. 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.

DIF: Cognitive Level: Understanding (Comprehension)

MSC: Client Needs: Safe and Effective Care Environment: Management of Care

16. 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.

DIF: Cognitive Level: Understanding (Comprehension)

MSC: Client Needs: Safe and Effective Care Environment: Management of Care

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

a. When standing, the patients 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 patients height.

ANS: D

When performing the general survey, the patients arm span (fingertip to fingertip) should equal the patients height. An arm span that is greater than the persons 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.

DIF: Cognitive Level: Analyzing (Analysis)

MSC: Client Needs: Physiologic Integrity

Chapter 10: Vital Signs

MULTIPLE CHOICE

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

a. Normal blood pressure

b. Prehypertension

c. Stage 1 hypertension

d. Stage 2 hypertension

ANS: B

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

DIF: Cognitive Level: Understanding (Comprehension)

MSC: Client Needs: Safe and Effective Care Environment: Management of Care

2. 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.

DIF: Cognitive Level: Understanding (Comprehension)

MSC: Client Needs: Health Promotion and Maintenance

3. 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.

DIF: Cognitive Level: Applying (Application)

MSC: Client Needs: Safe and Effective Care Environment: Management of Care

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

a. Force

b. Pallor

c. Capillary refill time

d. Timing in the cardiac cycle

ANS: A

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

DIF: Cognitive Level: Understanding (Comprehension)

MSC: Client Needs: Safe and Effective Care Environment: Management of Care

5. 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 nurses next action would be to:

a. Immediately notify the physician.

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

c. Check the childs 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.

DIF: Cognitive Level: Analyzing (Analysis)

MSC: Client Needs: Health Promotion and Maintenance

6. 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 hearts 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.

DIF: Cognitive Level: Remembering (Knowledge)

MSC: Client Needs: General

7. The nurse is assessing the vital signs of a 20-year-old male marathon runner and documents the following vital signs: temperature36 C; pulse48 beats per minute; respirations14 breaths per minute; blood pressure104/68 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 patients pulse rate is not normalhis 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.

DIF: Cognitive Level: Analyzing (Analysis)

MSC: Client Needs: Health Promotion and Maintenance

8. 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 childs respirations?

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

b. Childs pulse and respirations should be simultaneously checked for 30 seconds.

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

d. Patients 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.

DIF: Cognitive Level: Applying (Application)

MSC: Client Needs: Health Promotion and Maintenance

9. A patients blood pressure is 118/82 mm Hg. He asks the nurse, What do the numbers mean? The nurses 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 patients question and use terms he can understand.

DIF: Cognitive Level: Analyzing (Analysis)

MSC: Client Needs: Safe and Effective Care Environment: Management of Care

10. While measuring a patients 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.

DIF: Cognitive Level: Remembering (Knowledge)

MSC: Client Needs: General

11. 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 teenagers blood pressure reading will be lower than that of an adult.

ANS: B

In the United States, a Black adults 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.

DIF: Cognitive Level: Applying (Application)

MSC: Client Needs: Physiologic Integrity

12. 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.

DIF: Cognitive Level: Applying (Application)

MSC: Client Needs: Safe and Effective Care Environment: Management of Care

13. 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.

DIF: Cognitive Level: Analyzing (Analysis)

MSC: Client Needs: Safe and Effective Care Environment: Management of Care

14. 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.

DIF: Cognitive Level: Understanding (Comprehension)

MSC: Client Needs: Safe and Effective Care Environment: Management of Care

15. 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 patients arm and inflated 30 mm Hg above the patients 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 patients 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.

DIF: Cognitive Level: Analyzing (Analysis)

MSC: Client Needs: Safe and Effective Care Environment: Management of Care

16. The nurse has collected the following information on a patient: palpated blood pressure180 mm Hg; auscultated blood pressure170/100 mm Hg; apical pulse60 beats per minute; radial pulse70 beats per minute. What is the patients 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.

DIF: Cognitive Level: Applying (Application)

MSC: Client Needs: Physiologic Integrity

17. 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 patients 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).

DIF: Cognitive Level: Analyzing (Analysis)

MSC: Client Needs: Safe and Effective Care Environment: Management of Care

18. 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.

DIF: Cognitive Level: Applying (Application)

MSC: Client Needs: Safe and Effective Care Environment: Management of Care

19. 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 patients 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 patients 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.

DIF: Cognitive Level: Analyzing (Analysis)

MSC: Client Needs: Health Promotion and Maintenance

20. The nurse is helping another nurse to take a blood pressure reading on a patients 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.

DIF: Cognitive Level: Understanding (Comprehension)

MSC: Client Needs: Safe and Effective Care Environment: Management of Care

21. 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 infants vital signs?

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

d. The infants 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.

DIF: Cognitive Level: Applying (Application)

MSC: Client Needs: Safe and Effective Care Environment: Management of Care

22. 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 bodys 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.

DIF: Cognitive Level: Understanding (Comprehension)

MSC: Client Needs: Health Promotion and Maintenance

23. 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.

DIF: Cognitive Level: Understanding (Comprehension)

MSC: Client Needs: Safe and Effective Care Environment: Management of Care

24. 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.

DIF: Cognitive Level: Remembering (Knowledge)

MSC: Client Needs: Health Promotion and Maintenance

25. 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.

DIF: Cognitive Level: Understanding (Comprehension)

MSC: Client Needs: Safe and Effective Care Environment: Management of Care

26. 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.

DIF: Cognitive Level: Remembering (Knowledge)

MSC: Client Needs: Safe and Effective Care Environment: Management of Care

27. 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.

DIF: Cognitive Level: Applying (Application)

MSC: Client Needs: Safe and Effective Care Environment: Management of Care

28. Which of these specific measurements is the best index of a childs 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 childs general health.

DIF: Cognitive Level: Understanding (Comprehension)

MSC: Client Needs: Health Promotion and Maintenance

29. 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 childs 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.

DIF: Cognitive Level: Applying (Application)

MSC: Client Needs: Safe and Effective Care Environment: Management of Care

30. The nurse is counting an infants respirations. Which technique is correct?

a. Watching the chest rise and fall

b. Watching the abdomen for movement

c. Placing a hand across the infants chest

d. Using a stethoscope to listen to the breath sounds

ANS: B

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

DIF: Cognitive Level: Analyzing (Analysis)

MSC: Client Needs: Health Promotion and Maintenance

31. 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 persons arm. The length of the bladder should equal 80% of this circumference.

DIF: Cognitive Level: Applying (Application)

MSC: Client Needs: Safe and Effective Care Environment: Management of Care

32. 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.

DIF: Cognitive Level: Applying (Application)

MSC: Client Needs: Safe and Effective Care Environment: Management of Care

33. 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 infants 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.

DIF: Cognitive Level: Applying (Application)

MSC: Client Needs: Safe and Effective Care Environment: Management of Care

MULTIPLE RESPONSE

1. While measuring a patients 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 patients arm held above the level of the heart is one part of the correct technique.

DIF: Cognitive Level: Applying (Application)

MSC: Client Needs: Safe and Effective Care Environment: Management of Care

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.

DIF: Cognitive Level: Analyzing (Analysis)

MSC: Client Needs: Safe and Effective Care Environment: Management of Care

Chapter 11: Pain Assessment

MULTIPLE CHOICE

1. When evaluating a patients 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.

DIF: Cognitive Level: Understanding (Comprehension)

MSC: Client Needs: Physiologic Integrity: Basic Care and Comfort

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.

DIF: Cognitive Level: Applying (Application)

MSC: Client Needs: Physiologic Integrity: Basic Care and Comfort

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 childs pain?

a. Descriptor Scale

b. Numeric rating scale

c. Brief Pain Inventory

d. Faces Pain ScaleRevised (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.

DIF: Cognitive Level: Applying (Application)

MSC: Client Needs: Physiologic Integrity: Basic Care and Comfort

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.

DIF: Cognitive Level: Analyzing (Analysis)

MSC: Client Needs: Physiologic Integrity: Basic Care and Comfort

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. Patients 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.

DIF: Cognitive Level: Understanding (Comprehension)

MSC: Client Needs: Physiologic Integrity: Basic Care and Comfort

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

a. Patients 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.

DIF: Cognitive Level: Understanding (Comprehension)

MSC: Client Needs: Safe and Effective Care Environment: Management of Care

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.

DIF: Cognitive Level: Analyzing (Analysis)

MSC: Client Needs: Safe and Effective Care Environment: Management of Care

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.

DIF: Cognitive Level: Remembering (Knowledge)

MSC: Client Needs: Safe and Effective Care Environment: Management of Care

9. When assessing the quality of a patients 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 persons pain, the patient is asked to describe the pain in his or her own words.

DIF: Cognitive Level: Analyzing (Analysis)

MSC: Client Needs: Safe and Effective Care Environment: Management of Care

10. When assessing a patients 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.

DIF: Cognitive Level: Understanding (Comprehension)

MSC: Client Needs: Safe and Effective Care Environment: Management of Care

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.

DIF: Cognitive Level: Remembering (Knowledge)

MSC: Client Needs: Physiologic Integrity: Basic Care and Comfort

12. When assessing the intensity of a patients 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 patients pain; various intensity scales can be used. Asking what makes ones pain better or worse assesses alleviating or aggravating factors. Asking whether pain limits ones activities assesses the degree of impairment and quality of life. Asking what does your pain feel like assesses the quality of pain.

DIF: Cognitive Level: Analyzing (Analysis)

MSC: Client Needs: Physiologic Integrity: Basic Care and Comfort

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.

DIF: Cognitive Level: Analyzing (Analysis)

MSC: Client Needs: Physiologic Integrity: Basic Care and Comfort

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.

DIF: Cognitive Level: Understanding (Comprehension)

MSC: Client Needs: Physiologic Integrity: Basic Care and Comfort

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.

DIF: Cognitive Level: Applying (Application)

MSC: Client Needs: Physiologic Integrity: Basic Care and Comfort

MULTIPLE RESPONSE

1. During assessment of a patients 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.

DIF: Cognitive Level: Applying (Application)

MSC: Client Needs: Physiologic Integrity: Basic Care and Comfort

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 patients 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 patients 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 the Pain Assessment in Advanced Dementia [PAINAD] scale, which may also be used to assess pain in persons with dementia.)

DIF: Cognitive Level: Applying (Application)

MSC: Client Needs: Physiologic Integrity: Basic Care and Comfort

Chapter 12: Nutrition Assessment

MULTIPLE CHOICE

1. The nurse recognizes which of these persons is at greatest risk for undernutrition?

a. 5-month-old infant

b. 50-year-old woman

c. 20-year-old college student

d. 30-year-old hospital administrator

ANS: A

Vulnerable groups for undernutrition are infants, children, pregnant women, recent immigrants, persons with low incomes, hospitalized people, and aging adults.

DIF: Cognitive Level: Remembering (Knowledge)

MSC: Client Needs: Health Promotion and Maintenance

2. When assessing a patients nutritional status, the nurse recalls that the best definition of optimal nutritional status is sufficient nutrients that:

a. Are in excess of daily body requirements.

b. Provide for the minimum body needs.

c. Provide for daily body requirements but do not support increased metabolic demands.

d. Provide for daily body requirements and support increased metabolic demands.

ANS: D

Optimal nutritional status is achieved when sufficient nutrients are consumed to support day-to-day body needs and any increased metabolic demands resulting from growth, pregnancy, or illness.

DIF: Cognitive Level: Remembering (Knowledge)

MSC: Client Needs: Health Promotion and Maintenance

3. The nurse is providing nutrition information to the mother of a 1-year-old child. Which of these statements represents accurate information for this age group?

a. Maintaining adequate fat and caloric intake is important for a child in this age group.

b. The recommended dietary allowances for an infant are the same as for an adolescent.

c. The babys growth is minimal at this age; therefore, caloric requirements are decreased.

d. The baby should be placed on skim milk to decrease the risk of coronary artery disease when he or she grows older.

ANS: A

Because of rapid growth, especially of the brain, both infants and children younger than 2 years of age should not drink skim or low-fat milk or be placed on low-fat diets. Fats (calories and essential fatty acids) are required for proper growth and central nervous system development.

DIF: Cognitive Level: Applying (Application)

MSC: Client Needs: Health Promotion and Maintenance

4. A pregnant woman is interested in breastfeeding her baby and asks several questions about the topic. Which information is appropriate for the nurse to share with her?

a. Breastfeeding is best when also supplemented with bottle feedings.

b. Babies who are breastfed often require supplemental vitamins.

c. Breastfeeding is recommended for infants for the first 2 years of life.

d. Breast milk provides the nutrients necessary for growth, as well as natural immunity.

ANS: D

Breastfeeding is recommended for full-term infants for the first year of life because breast milk is ideally formulated to promote normal infant growth and development, as well as natural immunity. The other statements are not correct.

DIF: Cognitive Level: Applying (Application)

MSC: Client Needs: Health Promotion and Maintenance

5. A mother and her 13-year-old daughter express their concern related to the daughters recent weight gain and her increase in appetite. Which of these statements represents information the nurse should discuss with them?

a. Dieting and exercising are necessary at this age.

b. Snacks should be high in protein, iron, and calcium.

c. Teenagers who have a weight problem should not be allowed to snack.

d. A low-calorie diet is important to prevent the accumulation of fat.

ANS: B

After a period of slow growth in late childhood, adolescence is characterized by rapid physical growth and

endocrine and hormonal changes. Caloric and protein requirements increase to meet this demand. Because of bone growth and increasing muscle mass (and, in girls, the onset of menarche), calcium and iron requirements also increase.

DIF: Cognitive Level: Applying (Application)

MSC: Client Needs: Health Promotion and Maintenance

6. The nurse is assessing a 30-year-old unemployed immigrant from an underdeveloped country who has been in the United States for 1 month. Which of these problems related to his nutritional status might the nurse expect to find?

a. Obesity

b. Hypotension

c. Osteomalacia (softening of the bones)

d. Coronary artery disease

ANS: C

General undernutrition, hypertension, diarrhea, lactose intolerance, osteomalacia, scurvy, and dental caries are among the more common nutrition-related problems of new immigrants from developing countries.

DIF: Cognitive Level: Applying (Application)

MSC: Client Needs: Health Promotion and Maintenance

7. For the first time, the nurse is seeing a patient who has no history of nutrition-related problems. The initial nutritional screening should include which activity?

a. Calorie count of nutrients

b. Anthropometric measures

c. Complete physical examination

d. Measurement of weight and weight history

ANS: D

Parameters used for nutrition screening typically include weight and weight history, conditions associated with increased nutritional risk, diet information, and routine laboratory data. The other responses reflect a more in-depth assessment rather than a screening.

DIF: Cognitive Level: Applying (Application)

MSC: Client Needs: Health Promotion and Maintenance

8. A patient is asked to indicate on a form how many times he eats a specific food. This method describes which of these tools for obtaining dietary information?

a. Food diary

b. Calorie count

c. 24-hour recall

d. Food-frequency questionnaire

ANS: D

With this tool, information is collected on how many times per day, week, or month the individual eats particular foods, which provides an estimate of usual intake.

DIF: Cognitive Level: Remembering (Knowledge)

MSC: Client Needs: Health Promotion and Maintenance

9. The nurse is providing care for a 68-year-old woman who is complaining of constipation. What concern exists regarding her nutritional status?

a. Absorption of nutrients may be impaired.

b. Constipation may represent a food allergy.

c. The patient may need emergency surgery to correct the problem.

d. Gastrointestinal problems will increase her caloric demand.

ANS: A

Gastrointestinal symptoms such as vomiting, diarrhea, or constipation may interfere with nutrient intake or absorption. The other responses are not correct.

DIF: Cognitive Level: Applying (Application)

MSC: Client Needs: Health Promotion and Maintenance

10. During a nutritional assessment, why is it important for the nurse to ask a patient what medications he or she is taking?

a. Certain drugs can affect the metabolism of nutrients.

b. The nurse needs to assess the patient for allergic reactions.

c. Medications need to be documented in the record for the physicians review.

d. Medications can affect ones memory and ability to identify food eaten in the last 24 hours.

ANS: A

Analgesics, antacids, anticonvulsants, antibiotics, diuretics, laxatives, antineoplastic drugs, steroids, and oral contraceptives are drugs that can interact with nutrients, impairing their digestion, absorption, metabolism, or use. The other responses are not correct.

DIF: Cognitive Level: Understanding (Comprehension)

MSC: Client Needs: Health Promotion and Maintenance

11. A patient tells the nurse that his food simply does not have any taste anymore. The nurses best response would be:

a. That must be really frustrating.

b. When did you first notice this change?

c. My food doesnt always have a lot of taste either.

d. Sometimes that happens, but your taste will come back.

ANS: B

With changes in appetite, taste, smell, or chewing or swallowing, the examiner should ask about the type of change and when the change occurred. These problems interfere with adequate nutrient intake. The other responses are not correct.

DIF: Cognitive Level: Understanding (Comprehension)

MSC: Client Needs: Health Promotion and Maintenance

12. The nurse is performing a nutritional assessment on a 15-year-old girl who tells the nurse that she is so fat. Assessment reveals that she is 5 feet 4 inches and weighs 110 pounds. The nurses appropriate response would be:

a. How much do you think you should weigh?

b. Dont worry about it; youre not that overweight.

c. The best thing for you would be to go on a diet.

d. I used to always think I was fat when I was your age.

ANS: A

Adolescents increased body awareness and self-consciousness may cause eating disorders such as anorexia nervosa or bulimia, conditions in which the real or perceived body image does not favorably compare with an ideal image. The nurse should not belittle the adolescents feelings, provide unsolicited advice, or agree with her.

DIF: Cognitive Level: Applying (Application)

MSC: Client Needs: Health Promotion and Maintenance

13. The nurse is discussing appropriate foods with the mother of a 3-year-old child. Which of these foods are recommended?

a. Foods that the child will eat, no matter what they are

b. Foods easy to hold such as hot dogs, nuts, and grapes

c. Any foods, as long as the rest of the family is also eating them

d. Finger foods and nutritious snacks that cannot cause choking

ANS: D

Small portions, finger foods, simple meals, and nutritious snacks help improve the dietary intake of young children. Foods likely to be aspirated should be avoided (e.g., hot dogs, nuts, grapes, round candies, popcorn).

DIF: Cognitive Level: Applying (Application)

MSC: Client Needs: Health Promotion and Maintenance

14. The nurse is reviewing the nutritional assessment of an 82-year-old patient. Which of these factors will most likely affect the nutritional status of an older adult?

a. Increase in taste and smell

b. Living alone on a fixed income

c. Change in cardiovascular status

d. Increase in gastrointestinal motility and absorption

ANS: B

Socioeconomic conditions frequently affect the nutritional status of the aging adult; these factors should be closely evaluated. Physical limitations, income, and social isolation are frequent problems that interfere with the acquisition of a balanced diet. A decrease in taste and smell and decreased gastrointestinal motility and absorption occur with aging. Cardiovascular status is not a factor that affects an older adults nutritional status.

DIF: Cognitive Level: Understanding (Comprehension)

MSC: Client Needs: Health Promotion and Maintenance

15. When considering a nutritional assessment, the nurse is aware that the most common anthropometric measurements include:

a. Height and weight.

b. Leg circumference.

c. Skinfold thickness of the biceps.

d. Hip and waist measurements.

ANS: A

The most commonly used anthropometric measures are height, weight, triceps skinfold thickness, elbow breadth, and arm and head circumferences.

DIF: Cognitive Level: Remembering (Knowledge)

MSC: Client Needs: Health Promotion and Maintenance

16. If a 29-year-old woman weighs 156 pounds, and the nurse determines her ideal body weight to be 120 pounds, then how would the nurse classify the womans weight?

a. Obese

b. Mildly overweight

c. Suffering from malnutrition

d. Within appropriate range of ideal weight

ANS: A

Obesity, as a result of caloric excess, refers to weight more than 20% above ideal body weight. For this patient, 20% of her ideal body weight would be 24 pounds, and greater than 20% of her body weight would be over 144 pounds. Therefore, having a weight of 156 pounds would be considered obese.

DIF: Cognitive Level: Applying (Application)

MSC: Client Needs: Health Promotion and Maintenance

17. How should the nurse perform a triceps skinfold assessment?

a. After pinching the skin and fat, the calipers are vertically applied to the fat fold.

b. The skin and fat on the front of the patients arm are gently pinched, and then the calipers are applied.

c. After applying the calipers, the nurse waits 3 seconds before taking a reading. After repeating the procedure three times, an average is recorded.

d. The patient is instructed to stand with his or her back to the examiner and arms folded across the chest. The skin on the forearm is pinched.

ANS: C

While holding the skinfold, the lever of the calipers is released. The nurse waits 3 seconds and then takes a

reading. This procedure should be repeated three times, and an average of the three skinfold measurements is then recorded.

DIF: Cognitive Level: Understanding (Comprehension)

MSC: Client Needs: Health Promotion and Maintenance

18. In teaching a patient how to determine total body fat at home, the nurse includes instructions to obtain measurements of:

a. Height and weight.

b. Frame size and weight.

c. Waist and hip circumferences.

d. Mid-upper arm circumference and arm span.

ANS: A

Body mass index, calculated by using height and weight measurements, is a practical marker of optimal weight for height and an indicator of obesity. The other options are not correct.

DIF: Cognitive Level: Understanding (Comprehension)

MSC: Client Needs: Health Promotion and Maintenance

19. The nurse is evaluating patients for obesity-related diseases by calculating the waist-to-hip ratios. Which one of these patients would be at increased risk?

a. 29-year-old woman whose waist measures 33 inches and hips measure 36 inches

b. 32-year-old man whose waist measures 34 inches and hips measure 36 inches

c. 38-year-old man whose waist measures 35 inches and hips measure 38 inches

d. 46-year-old woman whose waist measures 30 inches and hips measure 38 inches

ANS: A

The waist-to-hip ratio assesses body fat distribution as an indicator of health risk. A waist-to-hip ratio of 1.0 or greater in men or 0.8 or greater in women is indicative of android (upper body obesity) and increasing risk for obesity-related disease and early death. The 29-year-old woman has a waist-to-hip ratio of 0.92, which is greater than 0.8. The 32-year-old man has a waist-to-hip ratio of 0.94; the 38-year-old man has a waist-to-hip ratio of 0.92; the 46-year-old woman has a waist-to-hip ratio of 0.78.

DIF: Cognitive Level: Analyzing (Analysis)

MSC: Client Needs: Health Promotion and Maintenance

20. A 50-year-old woman with elevated total cholesterol and triglyceride levels is visiting the clinic to find out about her laboratory results. What would be important for the nurse to include in patient teaching in relation to

these tests?

a. The risks of undernutrition should be included.

b. Offer methods to reduce the stress in her life.

c. Provide information regarding a diet low in saturated fat.

d. This condition is hereditary; she can do nothing to change the levels.

ANS: C

The patient with elevated cholesterol and triglyceride levels should be taught about eating a healthy diet that limits the intake of foods high in saturated fats or trans fats. Reducing dietary fats is part of the treatment for this condition. The other responses are not pertinent to her condition.

DIF: Cognitive Level: Applying (Application)

MSC: Client Needs: Health Promotion and Maintenance

21. In performing an assessment on a 49-year-old woman who has imbalanced nutrition as a result of dysphagia, which data would the nurse expect to find?

a. Increase in hair growth

b. Inadequate nutrient food intake

c. Weight 10% to 20% over ideal

d. Sore, inflamed buccal cavity

ANS: B

Dysphagia, or impaired swallowing, interferes with adequate nutrient intake.

DIF: Cognitive Level: Applying (Application)

MSC: Client Needs: Health Promotion and Maintenance

22. A 21-year-old woman has been on a low-protein liquid diet for the past 2 months. She has had adequate intake of calories and appears well nourished. After further assessment, what would the nurse expect to find?

a. Poor skin turgor

b. Decreased serum albumin

c. Increased lymphocyte count

d. Triceps skinfold less than standard

ANS: B

Kwashiorkor (protein malnutrition) is due to diets that may be high in calories but contain little or no protein (e.g., low-protein liquid diets, fad diets, and long-term use of dextrose-containing intravenous fluids). The serum albumin would be less than 3.5 g/dL.

DIF: Cognitive Level: Analyzing (Analysis)

MSC: Client Needs: Health Promotion and Maintenance

23. The nurse is performing a nutritional assessment on an 80-year-old patient. The nurse knows that physiologic changes can directly affect the nutritional status of the older adult and include:

a. Slowed gastrointestinal motility.

b. Hyperstimulation of the salivary glands.

c. Increased sensitivity to spicy and aromatic foods.

d. Decreased gastrointestinal absorption causing esophageal reflux.

ANS: A

Normal physiologic changes in aging adults that affect nutritional status include slowed gastrointestinal motility, decreased gastrointestinal absorption, diminished olfactory and taste sensitivity, decreased saliva production, decreased visual acuity, and poor dentition.

DIF: Cognitive Level: Remembering (Knowledge)

MSC: Client Needs: Health Promotion and Maintenance

24. Which of these interventions is most appropriate when the nurse is planning nutritional interventions for a healthy, active 74-year-old woman?

a. Decreasing the amount of carbohydrates to prevent lean muscle catabolism

b. Increasing the amount of soy and tofu in her diet to promote bone growth and reverse osteoporosis

c. Decreasing the number of calories she is eating because of the decrease in energy requirements from the loss of lean body mass

d. Increasing the number of calories she is eating because of the increased energy needs of the older adult

ANS: C

Important nutritional features of the older years are a decrease in energy requirements as a result of loss of lean body mass, the most metabolically active tissue, and an increase in fat mass.

DIF: Cognitive Level: Applying (Application)

MSC: Client Needs: Health Promotion and Maintenance

25. A 16-year-old girl is being seen at the clinic for gastrointestinal complaints and weight loss. The nurse determines that many of her complaints may be related to erratic eating patterns, eating predominantly fast foods, and high caffeine intake. In this situation, which is most appropriate when collecting current dietary intake information?

a. Scheduling a time for direct observation of the adolescent during meals

b. Asking the patient for a 24-hour diet recall, and assuming it to be reflective of a typical day for her

c. Having the patient complete a food diary for 3 days, including 2 weekdays and 1 weekend day

d. Using the food frequency questionnaire to identify the amount of intake of specific foods

ANS: C

Food diaries require the individual to write down everything consumed for a certain time period. Because of the erratic eating patterns of this individual, assessing dietary intake over a few days would produce more accurate information regarding eating patterns. Direct observation is best used with young children or older adults.

DIF: Cognitive Level: Analyzing (Analysis)

MSC: Client Needs: Health Promotion and Maintenance

26. The nurse is preparing to measure fat and lean body mass and bone mineral density. Which tool is appropriate?

a. Measuring tape

b. Skinfold calipers

c. Bioelectrical impedance analysis (BIA)

d. Dual-energy x-ray absorptiometry (DEXA)

ANS: D

DEXA measures both bone mineral density and fat and lean body mass. BIA measures fat and lean body mass but not bone mineral density. A measuring tape measures distance or length, and skinfold calipers are used to determine skinfold thickness.

DIF: Cognitive Level: Understanding (Comprehension)

MSC: Client Needs: Health Promotion and Maintenance

27. Which of these conditions is due to an inadequate intake of both protein and calories?

a. Obesity

b. Bulimia

c. Marasmus

d. Kwashiorkor

ANS: C

Marasmus, protein-calorie malnutrition, is due to an inadequate intake of protein and calories or prolonged starvation. Obesity is due to caloric excess; bulimia is an eating disorder. Kwashiorkor is protein malnutrition.

DIF: Cognitive Level: Remembering (Knowledge)

MSC: Client Needs: Physiologic Integrity: Physiologic Adaptation

28. During an assessment of a patient who has been homeless for several years, the nurse notices that his tongue is magenta in color, which is an indication of a deficiency in what mineral and/or vitamin?

a. Iron

b. Riboflavin

c. Vitamin D and calcium

d. Vitamin C

ANS: B

Magenta tongue is a sign of riboflavin deficiency. In contrast, a pale tongue is probably attributable to iron deficiency. Vitamin D and calcium deficiencies cause osteomalacia in adults, and a vitamin C deficiency causes scorbutic gums.

DIF: Cognitive Level: Applying (Application)

MSC: Client Needs: Physiologic Integrity: Physiologic Adaptation

29. A 50-year-old patient has been brought to the emergency department after a housemate found that the patient could not get out of bed alone. He has lived in a group home for years but for several months has not participated in the activities and has stayed in his room. The nurse assesses for signs of undernutrition, and an x-ray study reveals that he has osteomalacia, which is a deficiency of:

a. Iron.

b. Riboflavin.

c. Vitamin D and calcium.

d. Vitamin C.

ANS: C

Osteomalacia results from a deficiency of vitamin D and calcium in adults. Iron deficiency would result in anemia, riboflavin deficiency would result in magenta tongue, and vitamin C deficiency would result in scurvy.

DIF: Cognitive Level: Applying (Application)

MSC: Client Needs: Physiologic Integrity: Physiologic Adaptation

30. An older adult patient in a nursing home has been receiving tube feedings for several months. During an oral examination, the nurse notes that patients gums are swollen, ulcerated, and bleeding in some areas. The nurse suspects that the patient has what condition?

a. Rickets

b. Vitamin A deficiency

c. Linoleic-acid deficiency

d. Vitamin C deficiency

ANS: D

Vitamin C deficiency causes swollen, ulcerated, and bleeding gums, known as *scorbutic gums*. Rickets is a condition related to vitamin D and calcium deficiencies in infants and children. Linoleic-acid deficiency causes eczematous skin. Vitamin A deficiency causes Bitot spots and visual problems.

DIF: Cognitive Level: Applying (Application)

MSC: Client Needs: Physiologic Integrity: Physiologic Adaptation

31. The nurse is assessing the body weight as a percentage of ideal body weight on an adolescent patient who was admitted for suspected anorexia nervosa. The patients usual weight was 125 pounds, but today she weighs 98 pounds. The nurse calculates the patients ideal body weight and concludes that the patient is:

a. Experiencing mild malnutrition.

b. Experiencing moderate malnutrition.

c. Experiencing severe malnutrition.

d. Still within expected parameters with her current weight.

ANS: B

By dividing her current weight by her usual weight and then multiplying by 100, a percentage of 78.4% is obtained, which means that her current weight is 78.4% of her ideal body weight. A current weight of 80% to 90% of ideal weight suggests mild malnutrition; a current weight of 70% to 80% of ideal weight suggests moderate malnutrition; a current weight of less than 70% of ideal weight suggests severe malnutrition.

DIF: Cognitive Level: Analyzing (Analysis)

MSC: Client Needs: Physiologic Integrity: Physiologic Adaptation

MULTIPLE RESPONSE

1. The nurse is assessing a patient who is obese for signs of metabolic syndrome. This condition is diagnosed when three or more certain risk factors are present. Which of these assessment findings are risk factors for metabolic syndrome? *Select all that apply*.

a. Fasting plasma glucose level less than 100 mg/dL

b. Fasting plasma glucose level greater than or equal to 110 mg/dL

c. Blood pressure reading of 140/90 mm Hg

d. Blood pressure reading of 110/80 mm Hg

e. Triglyceride level of 120 mg/dL

ANS: B, C

Metabolic syndrome is diagnosed when three or more of the following risk factors are present: (1) fasting plasma glucose level greater than or equal to 100 mg/dL; (2) blood pressure greater than or equal to 130/85 mm Hg; (3) waist circumference greater than or equal to 40 inches for men and 35 inches for women; (4) high-density lipoprotein cholesterol less than 40 in men and less than 50 in women; and (5) triglyceride levels greater than or equal to 150 mg/dL (ATP III, 2001).

DIF: Cognitive Level: Applying (Application)

MSC: Client Needs: Health Promotion and Maintenance

SHORT ANSWER

1. A patient has been unable to eat solid food for 2 weeks and is in the clinic today complaining of weakness, tiredness, and hair loss. The patient states that her usual weight is 175 pounds, but today she weighs 161 pounds. What is her recent weight change percentage? To calculate recent weight change percentage, use this formula:

Usual weight current weight 100

usual weight

ANS:

8%

175 161 = 14 pounds

14 175 = 0.08

0.08 100 = 8%

DIF: Cognitive Level: Analyzing (Analysis)

MSC: Client Needs: Health Promotion and Maintenance

Chapter 13: 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.

DIF: Cognitive Level: Understanding (Comprehension)

MSC: Client Needs: General

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.

DIF: Cognitive Level: Understanding (Comprehension)

MSC: Client Needs: General

3. The nurse is examining a patient who tells the nurse, I sure sweat a lot, especially on my face and feet but it doesnt 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 patients statement is not related to disorders of the stratum corneum or the stratum germinativum.

DIF: Cognitive Level: Applying (Application)

MSC: Client Needs: Physiologic Integrity: Physiologic Adaptation

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 newborns skin is more permeable than that of the adult.

d. The amount of vernix caseosa dramatically rises in the newborn.

ANS: C

The newborns 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.

DIF: Cognitive Level: Applying (Application)

MSC: Client Needs: Health Promotion and Maintenance

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.

DIF: Cognitive Level: Applying (Application)

MSC: Client Needs: Health Promotion and Maintenance

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.

DIF: Cognitive Level: Understanding (Comprehension)

MSC: Client Needs: Health Promotion and Maintenance

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.

DIF: Cognitive Level: Remembering (Knowledge)

MSC: Client Needs: Health Promotion and Maintenance

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.

DIF: Cognitive Level: Applying (Application)

MSC: Client Needs: Health Promotion and Maintenance

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.

DIF: Cognitive Level: Applying (Application)

MSC: Client Needs: Physiologic Integrity: Reduction of Risk Potential

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.

DIF: Cognitive Level: Understanding (Comprehension)

MSC: Client Needs: Health Promotion and Maintenance

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 persons risk for skin lesions in the feet or ankles. The patient needs to seek a professional for assistance with corn removal.

DIF: Cognitive Level: Applying (Application)

MSC: Client Needs: Physiologic Integrity: Reduction of Risk Potential

12. The nurse keeps in mind that a thorough skin assessment is extremely important because the skin holds information about a persons:

a. Support systems.

b. Circulatory status.

c. Socioeconomic status.

d. Psychological wellness.

ANS: B

The skin holds information about the bodys circulation, nutritional status, and signs of systemic diseases, as well as topical data on the integumentary system itself.

DIF: Cognitive Level: Understanding (Comprehension)

MSC: Client Needs: Safe and Effective Care Environment: Management of Care

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.

DIF: Cognitive Level: Applying (Application)

MSC: Client Needs: Physiologic Integrity: Basic Care and Comfort

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.

DIF: Cognitive Level: Applying (Application)

MSC: Client Needs: Physiologic Integrity: Physiologic Adaptation

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 orificesotherwise, the depigmented skin is normal.

DIF: Cognitive Level: Applying (Application)

MSC: Client Needs: Physiologic Integrity: Physiologic Adaptation

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.

DIF: Cognitive Level: Understanding (Comprehension)

MSC: Client Needs: Health Promotion and Maintenance

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.

DIF: Cognitive Level: Applying (Application)

MSC: Client Needs: Physiologic Integrity: Physiologic Adaptation

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 patients 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.

DIF: Cognitive Level: Analyzing (Analysis)

MSC: Client Needs: Physiologic Integrity: Physiologic Adaptation

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 patients 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.

DIF: Cognitive Level: Analyzing (Analysis)

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.

DIF: Cognitive Level: Applying (Application)

MSC: Client Needs: Physiologic Integrity: Physiologic Adaptation

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.

DIF: Cognitive Level: Applying (Application)

MSC: Client Needs: Physiologic Integrity: Physiologic Adaptation

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.

DIF: Cognitive Level: Analyzing (Analysis)

MSC: Client Needs: Physiologic Integrity: Physiologic Adaptation

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 infants mother also notices the mottling and asks what it is. The nurse knows that this mottling is called:

a. Caf 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 caf 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.

DIF: Cognitive Level: Understanding (Comprehension)

MSC: Client Needs: Physiologic Integrity: Physiologic Adaptation

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.

DIF: Cognitive Level: Analyzing (Analysis)

MSC: Client Needs: Physiologic Integrity: Physiologic Adaptation

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.

DIF: Cognitive Level: Analyzing (Analysis)

MSC: Client Needs: Physiologic Integrity: Physiologic Adaptation

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.

DIF: Cognitive Level: Understanding (Comprehension)

MSC: Client Needs: Physiologic Integrity: Physiologic Adaptation

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.

DIF: Cognitive Level: Understanding (Comprehension)

MSC: Client Needs: Physiologic Integrity: Physiologic Adaptation

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.

DIF: Cognitive Level: Understanding (Comprehension)

MSC: Client Needs: Physiologic Integrity: Physiologic Adaptation

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.

DIF: Cognitive Level: Understanding (Comprehension)

MSC: Client Needs: Physiologic Integrity: Physiologic Adaptation

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.

DIF: Cognitive Level: Understanding (Comprehension)

MSC: Client Needs: Physiologic Integrity: Physiologic Adaptation

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.

DIF: Cognitive Level: Applying (Application)

MSC: Client Needs: Physiologic Integrity: Physiologic Adaptation

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.

DIF: Cognitive Level: Analyzing (Analysis)

MSC: Client Needs: Physiologic Integrity: Physiologic Adaptation

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. Kaposis sarcoma.

c. Angiomas.

d. Herpes zoster.

ANS: B

Kaposis sarcoma is a vascular tumor that, in the early stages, appears as multiple, patchlike, faint pink lesions over the patients 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.

DIF: Cognitive Level: Applying (Application)

MSC: Client Needs: Physiologic Integrity: Physiologic Adaptation

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.

DIF: Cognitive Level: Analyzing (Analysis)

MSC: Client Needs: Physiologic Integrity: Physiologic Adaptation

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.

DIF: Cognitive Level: Applying (Application)

MSC: Client Needs: Physiologic Integrity: Physiologic Adaptation

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.

DIF: Cognitive Level: Understanding (Comprehension)

MSC: Client Needs: Physiologic Integrity: Physiologic Adaptation

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.

DIF: Cognitive Level: Analyzing (Analysis)

MSC: Client Needs: Physiologic Integrity: Physiologic Adaptation

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.

DIF: Cognitive Level: Analyzing (Analysis)

MSC: Client Needs: Physiologic Integrity: Physiologic Adaptation

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.

DIF: Cognitive Level: Understanding (Comprehension)

MSC: Client Needs: Physiologic Integrity: Physiologic Adaptation

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.

DIF: Cognitive Level: Understanding (Comprehension)

MSC: Client Needs: Physiologic Integrity: Physiologic Adaptation

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.

DIF: Cognitive Level: Applying (Application)

MSC: Client Needs: Physiologic Integrity: Physiologic Adaptation

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 bulls 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 bulls 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.

DIF: Cognitive Level: Analyzing (Analysis)

MSC: Client Needs: Physiologic Integrity: Physiologic Adaptation

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.

DIF: Cognitive Level: Applying (Application)

MSC: Client Needs: Physiologic Integrity: Physiologic Adaptation

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 infants:

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.

DIF: Cognitive Level: Analyzing (Analysis)

MSC: Client Needs: Physiologic Integrity: Physiologic Adaptation

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 carbor monoxide poisoning.

DIF: Cognitive Level: Analyzing (Analysis)

MSC: Client Needs: Physiologic Integrity: Physiologic Adaptation

46. A patient has been admitted for severe psoriasis. The nurse expects to see what finding in the patients 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.

DIF: Cognitive Level: Applying (Application)

MSC: Client Needs: Physiologic Integrity: Physiologic Adaptation

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.

DIF: Cognitive Level: Understanding (Comprehension)

MSC: Client Needs: Physiologic Integrity: Physiologic Adaptation

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.

DIF: Cognitive Level: Applying (Application)

MSC: Client Needs: Physiologic Integrity: Physiologic Adaptation

Chapter 14: Head, Face, Neck, and Regional Lymphatics

MULTIPLE CHOICE

1. A physician tells the nurse that a patients 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.

DIF: Cognitive Level: Applying (Application)

MSC: Client Needs: Physiologic Integrity: Physiologic Adaptation

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 nurses 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 babys 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.

DIF: Cognitive Level: Applying (Application)

MSC: Client Needs: Health Promotion and Maintenance

3. The nurse notices that a patients 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).

DIF: Cognitive Level: Applying (Application)

MSC: Client Needs: Physiologic Integrity: Physiologic Adaptation

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.

DIF: Cognitive Level: Applying (Application)

MSC: Client Needs: Physiologic Integrity: Physiologic Adaptation

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.

DIF: Cognitive Level: Understanding (Comprehension)

MSC: Client Needs: Safe and Effective Care Environment: Management of Care

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.

DIF: Cognitive Level: Analyzing (Analysis)

MSC: Client Needs: Safe and Effective Care Environment: Management of Care

7. When examining a patients 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.

DIF: Cognitive Level: Remembering (Knowledge)

MSC: Client Needs: General

8. A patients laboratory data reveal an elevated thyroxine (T_4) 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 T_4 and triiodothyronine (T_3). The other glands do not secrete T_4.

DIF: Cognitive Level: Understanding (Comprehension)

MSC: Client Needs: Safe and Effective Care Environment: Management of Care

9. A patient says that she has recently noticed a lump in the front of her neck below her Adams 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.

DIF: Cognitive Level: Applying (Application)

MSC: Client Needs: Physiologic Integrity: Physiologic Adaptation

10. The nurse notices that a patients submental lymph nodes are enlarged. In an effort to identify the cause of the node enlargement, the nurse would assess the patients:

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.

DIF: Cognitive Level: Analyzing (Analysis)

MSC: Client Needs: Safe and Effective Care Environment: Management of Care

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.

DIF: Cognitive Level: Remembering (Knowledge)

MSC: Client Needs: Safe and Effective Care Environment: Management of Care

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.

DIF: Cognitive Level: Understanding (Comprehension)

MSC: Client Needs: Health Promotion and Maintenance

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.

DIF: Cognitive Level: Understanding (Comprehension)

MSC: Client Needs: Health Promotion and Maintenance

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.

DIF: Cognitive Level: Applying (Application)

MSC: Client Needs: Physiologic Integrity: Physiologic Adaptation

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.

DIF: Cognitive Level: Applying (Application)

MSC: Client Needs: Physiologic Integrity: Physiologic Adaptation

16. A 19-year-old college student is brought to the emergency department with a severe headache he describes as, Like nothing Ive 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.

DIF: Cognitive Level: Analyzing (Analysis)

MSC: Client Needs: Physiologic Integrity: Physiologic Adaptation

17. During a well-baby checkup, the nurse notices that a 1-week-old infants 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 skulls 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.

DIF: Cognitive Level: Applying (Application)

MSC: Client Needs: Health Promotion and Maintenance

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.

DIF: Cognitive Level: Understanding (Comprehension)

MSC: Client Needs: General

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.

DIF: Cognitive Level: Applying (Application)

MSC: Client Needs: Physiologic Integrity: Physiologic Adaptation

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).

DIF: Cognitive Level: Applying (Application)

MSC: Client Needs: Physiologic Integrity: Physiologic Adaptation

21. The nurse suspects that a patient has hyperthyroidism, and the laboratory data indicate that the patients T_4 and T_3 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

T_4 and T_3 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.

DIF: Cognitive Level: Analyzing (Analysis)

MSC: Client Needs: Physiologic Integrity: Physiologic Adaptation

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 nurses hands placed firmly around his neck.

b. The side with the nurses eyes averted toward the ceiling and thumbs on his neck.

c. The front with the nurses thumbs placed on either side of his trachea and his head tilted forward.

d. The front with the nurses thumbs placed on either side of his trachea and his head tilted backward.

ANS: C

Examining this patients 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.

DIF: Cognitive Level: Applying (Application)

MSC: Client Needs: Safe and Effective Care Environment: Management of Care

23. A patients 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.

DIF: Cognitive Level: Understanding (Comprehension)

MSC: Client Needs: Safe and Effective Care Environment: Management of Care

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 babys 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.

DIF: Cognitive Level: Analyzing (Analysis)

MSC: Client Needs: Physiologic Integrity: Physiologic Adaptation

25. A mother brings in her newborn infant for an assessment and tells the nurse that she has noticed that

whenever her newborns 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.

DIF: Cognitive Level: Analyzing (Analysis)

MSC: Client Needs: Health Promotion and Maintenance

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.

DIF: Cognitive Level: Analyzing (Analysis)

MSC: Client Needs: Physiologic Integrity: Physiologic Adaptation

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.

DIF: Cognitive Level: Understanding (Comprehension)

MSC: Client Needs: Physiologic Integrity: Physiologic Adaptation

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.

DIF: Cognitive Level: Applying (Application)

MSC: Client Needs: Physiologic Integrity: Physiologic Adaptation

29. A woman comes to the clinic and states, Ive 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.

DIF: Cognitive Level: Applying (Application)

MSC: Client Needs: Physiologic Integrity: Physiologic Adaptation

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.

DIF: Cognitive Level: Understanding (Comprehension)

MSC: Client Needs: Physiologic Integrity: Physiologic Adaptation

31. The physician reports that a patient with a neck tumor has a tracheal shift. The nurse is aware that this means that the patients 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.

DIF: Cognitive Level: Understanding (Comprehension)

MSC: Client Needs: Physiologic Integrity: Physiologic Adaptation

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 nc effect on the fontanels. Increased intracranial pressure would cause tense or bulging and possibly pulsating fontanels.

DIF: Cognitive Level: Applying (Application)

MSC: Client Needs: Physiologic Integrity: Physiologic Adaptation

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.

DIF: Cognitive Level: Analyzing (Analysis)

MSC: Client Needs: Physiologic Integrity: Physiologic Adaptation

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.

DIF: Cognitive Level: Analyzing (Analysis)

MSC: Client Needs: Health Promotion and Maintenance

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.

DIF: Cognitive Level: Applying (Application)

MSC: Client Needs: Physiologic Integrity: Physiologic Adaptation

36. During an examination of a patient in her third trimester of pregnancy, the nurse notices that the patients 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.

DIF: Cognitive Level: Applying (Application)

MSC: Client Needs: Safe and Effective Care Environment: Management of Care

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 ones 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.

DIF: Cognitive Level: Understanding (Comprehension)

MSC: Client Needs: Safe and Effective Care Environment: Management of Care

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 shouldnt 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.

DIF: Cognitive Level: Analyzing (Analysis)

MSC: Client Needs: Health Promotion and Maintenance

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.

DIF: Cognitive Level: Analyzing (Analysis)

MSC: Client Needs: Health Promotion and Maintenance

40. During an examination, the nurse finds that a patients 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.

DIF: Cognitive Level: Applying (Application)

MSC: Client Needs: Physiologic Integrity: Physiologic Adaptation

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 infants 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.

DIF: Cognitive Level: Applying (Application)

MSC: Client Needs: Health Promotion and Maintenance

Chapter 15: Eyes

MULTIPLE CHOICE

1. When examining the eye, the nurse notices that the patients 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.

DIF: Cognitive Level: Understanding (Comprehension)

MSC: Client Needs: Physiologic Integrity: Physiologic Adaptation

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.

DIF: Cognitive Level: Remembering (Knowledge)

MSC: Client Needs: Physiologic Integrity: Physiologic Adaptation

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.

DIF: Cognitive Level: Understanding (Comprehension)

MSC: Client Needs: Physiologic Integrity: Physiologic Adaptation

4. When examining a patients 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.

DIF: Cognitive Level: Understanding (Comprehension)

MSC: Client Needs: Physiologic Integrity: Physiologic Adaptation

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.

DIF: Cognitive Level: Remembering (Knowledge)

MSC: Client Needs: Physiologic Integrity: Physiologic Adaptation

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.

DIF: Cognitive Level: Remembering (Knowledge)

MSC: Client Needs: Physiologic Integrity: Physiologic Adaptation

7. The nurse is testing a patients 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.

DIF: Cognitive Level: Remembering (Knowledge)

MSC: Client Needs: Physiologic Integrity: Physiologic Adaptation

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.

DIF: Cognitive Level: Understanding (Comprehension)

MSC: Client Needs: Physiologic Integrity: Physiologic Adaptation

9. A mother asks when her newborn infants 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.

DIF: Cognitive Level: Applying (Application)

MSC: Client Needs: Health Promotion and Maintenance

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*.

DIF: Cognitive Level: Understanding (Comprehension)

MSC: Client Needs: Health Promotion and Maintenance

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.

DIF: Cognitive Level: Understanding (Comprehension)

MSC: Client Needs: Safe and Effective Care Environment: Management of Care

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.

DIF: Cognitive Level: Analyzing (Analysis)

MSC: Client Needs: Health Promotion and Maintenance

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 patients 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.

DIF: Cognitive Level: Analyzing (Analysis)

MSC: Client Needs: Safe and Effective Care Environment: Management of Care

14. A patients 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.

DIF: Cognitive Level: Applying (Application)

MSC: Client Needs: Physiologic Integrity: Physiologic Adaptation

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 nurses 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.

DIF: Cognitive Level: Analyzing (Analysis)

MSC: Client Needs: Physiologic Integrity: Physiologic Adaptation

16. A patients 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.

DIF: Cognitive Level: Applying (Application)

MSC: Client Needs: Physiologic Integrity: Physiologic Adaptation

17. When performing the corneal light reflex assessment, the nurse notes that the light is reflected at 2 oclock 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.

DIF: Cognitive Level: Analyzing (Analysis)

MSC: Client Needs: Safe and Effective Care Environment: Management of Care

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.

DIF: Cognitive Level: Applying (Application)

MSC: Client Needs: Safe and Effective Care Environment: Management of Care

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.

DIF: Cognitive Level: Applying (Application)

MSC: Client Needs: Safe and Effective Care Environment: Management of Care

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 individuals 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.

DIF: Cognitive Level: Analyzing (Analysis)

MSC: Client Needs: Health Promotion and Maintenance

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.

DIF: Cognitive Level: Applying (Application)

MSC: Client Needs: Safe and Effective Care Environment: Management of Care

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.

DIF: Cognitive Level: Applying (Application)

MSC: Client Needs: Safe and Effective Care Environment: Management of Care

23. The nurse is assessing a patients 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.

DIF: Cognitive Level: Applying (Application)

MSC: Client Needs: Safe and Effective Care Environment: Management of Care

24. In using the ophthalmoscope to assess a patients eyes, the nurse notices a red glow in the patients 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 persons 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.

DIF: Cognitive Level: Analyzing (Analysis)

MSC: Client Needs: Safe and Effective Care Environment: Management of Care

25. The nurse is examining a patients 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.

DIF: Cognitive Level: Applying (Application)

MSC: Client Needs: Safe and Effective Care Environment: Management of Care

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.

DIF: Cognitive Level: Analyzing (Analysis)

MSC: Client Needs: Health Promotion and Maintenance

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 childs 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.

DIF: Cognitive Level: Applying (Application)

MSC: Client Needs: Health Promotion and Maintenance

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 childs 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.

DIF: Cognitive Level: Applying (Application)

MSC: Client Needs: Health Promotion and Maintenance

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.

DIF: Cognitive Level: Understanding (Comprehension)

MSC: Client Needs: Health Promotion and Maintenance

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.

DIF: Cognitive Level: Analyzing (Analysis)

MSC: Client Needs: Physiologic Integrity: Physiologic Adaptation

31. When a light is directed across the iris of a patients 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.

DIF: Cognitive Level: Applying (Application)

MSC: Client Needs: Safe and Effective Care Environment: Management of Care

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.

DIF: Cognitive Level: Understanding (Comprehension)

MSC: Client Needs: Physiologic Integrity: Physiologic Adaptation

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 cant 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.

DIF: Cognitive Level: Analyzing (Analysis)

MSC: Client Needs: Physiologic Integrity: Physiologic Adaptation

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.

DIF: Cognitive Level: Applying (Application)

MSC: Client Needs: Physiologic Integrity: Physiologic Adaptation

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.

DIF: Cognitive Level: Applying (Application)

MSC: Client Needs: Physiologic Integrity: Physiologic Adaptation

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.

DIF: Cognitive Level: Applying (Application)

MSC: Client Needs: Physiologic Integrity: Physiologic Adaptation

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.

DIF: Cognitive Level: Applying (Application)

MSC: Client Needs: Physiologic Integrity: Physiologic Adaptation

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.

DIF: Cognitive Level: Analyzing (Analysis)

MSC: Client Needs: Physiologic Integrity: Physiologic Adaptation

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.

DIF: Cognitive Level: Applying (Application)

MSC: Client Needs: Physiologic Integrity: Physiologic Adaptation

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.

DIF: Cognitive Level: Understanding (Comprehension)

MSC: Client Needs: Physiologic Integrity: Physiologic Adaptation

Chapter 16: 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.

DIF: Cognitive Level: Remembering (Knowledge)

MSC: Client Needs: Physiologic Integrity: Physiologic Adaptation

2. The nurse is examining a patients 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)

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.

DIF: Cognitive Level: Remembering (Knowledge)

MSC: Client Needs: Physiologic Integrity: Physiologic Adaptation

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.

DIF: Cognitive Level: Remembering (Knowledge)

MSC: Client Needs: Physiologic Integrity: Physiologic Adaptation

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.

DIF: Cognitive Level: Understanding (Comprehension)

MSC: Client Needs: Physiologic Integrity: Physiologic Adaptation

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.

DIF: Cognitive Level: Remembering (Knowledge)

MSC: Client Needs: Physiologic Integrity: Physiologic Adaptation

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.

DIF: Cognitive Level: Understanding (Comprehension)

MSC: Client Needs: Physiologic Integrity: Physiologic Adaptation

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.

DIF: Cognitive Level: Applying (Application)

MSC: Client Needs: Safe and Effective Care Environment: Management of Care

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*.

DIF: Cognitive Level: Applying (Application)

MSC: Client Needs: Safe and Effective Care Environment: Management of Care

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 infants hearing?

a. Rubella may affect the mothers hearing but not the infants.

b. Rubella can damage the infants 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.

DIF: Cognitive Level: Understanding (Comprehension)

MSC: Client Needs: Physiologic Integrity: Physiologic Adaptation

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 sons eustachian tube is shorter and wider than yours because of his age, which allows for infections to develop more easily.

ANS: D

The infants eustachian tube is relatively shorter and wider than the adults 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.

DIF: Cognitive Level: Applying (Application)

MSC: Client Needs: Health Promotion and Maintenance

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.

DIF: Cognitive Level: Analyzing (Analysis)

MSC: Client Needs: Physiologic Integrity: Physiologic Adaptation

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 cant 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.

DIF: Cognitive Level: Analyzing (Analysis)

MSC: Client Needs: Health Promotion and Maintenance

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.

DIF: Cognitive Level: Applying (Application)

MSC: Client Needs: Safe and Effective Care Environment: Management of Care

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.

DIF: Cognitive Level: Applying (Application)

MSC: Client Needs: Safe and Effective Care Environment: Management of Care

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.

DIF: Cognitive Level: Analyzing (Analysis)

MSC: Client Needs: Safe and Effective Care Environment: Management of Care

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.

DIF: Cognitive Level: Applying (Application)

MSC: Client Needs: Health Promotion and Maintenance

18. The nurse is performing an otoscopic examination on an adult. Which of these actions is *correct*?

a. Tilting the persons 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.

DIF: Cognitive Level: Understanding (Comprehension)

MSC: Client Needs: Safe and Effective Care Environment: Management of Care

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.

DIF: Cognitive Level: Analyzing (Analysis)

MSC: Client Needs: Physiologic Integrity: Physiologic Adaptation

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 patients 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.

DIF: Cognitive Level: Understanding (Comprehension)

MSC: Client Needs: Safe and Effective Care Environment: Management of Care

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.

DIF: Cognitive Level: Analyzing (Analysis)

MSC: Client Needs: Safe and Effective Care Environment: Management of Care

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.

DIF: Cognitive Level: Understanding (Comprehension)

MSC: Client Needs: Health Promotion and Maintenance

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.

DIF: Cognitive Level: Understanding (Comprehension)

MSC: Client Needs: Health Promotion and Maintenance

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.

DIF: Cognitive Level: Applying (Application)

MSC: Client Needs: Health Promotion and Maintenance

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.

DIF: Cognitive Level: Analyzing (Analysis)

MSC: Client Needs: Physiologic Integrity: Physiologic Adaptation

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.

DIF: Cognitive Level: Analyzing (Analysis)

MSC: Client Needs: Physiologic Integrity: Physiologic Adaptation

27. The mother of a 2-year-old toddler is concerned about the upcoming placement of tympanostomy tubes in her sons 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.

DIF: Cognitive Level: Understanding (Comprehension)

MSC: Client Needs: Physiologic Integrity: Physiologic Adaptation

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.

DIF: Cognitive Level: Understanding (Comprehension)

MSC: Client Needs: Physiologic Integrity: Physiologic Adaptation

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.

DIF: Cognitive Level: Analyzing (Analysis)

MSC: Client Needs: Physiologic Integrity: Physiologic Adaptation

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. The other responses are not correct.

DIF: Cognitive Level: Analyzing (Analysis)

MSC: Client Needs: Physiologic Integrity: Physiologic Adaptation

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.

DIF: Cognitive Level: Remembering (Knowledge)

MSC: Client Needs: Safe and Effective Care Environment: Management of Care

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 oclock 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.

DIF: Cognitive Level: Analyzing (Analysis)

MSC: Client Needs: Safe and Effective Care Environment: Management of Care

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 childs 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.

DIF: Cognitive Level: Applying (Application)

MSC: Client Needs: Health Promotion and Maintenance

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.

DIF: Cognitive Level: Understanding (Comprehension)

MSC: Client Needs: Physiologic Integrity: Reduction of Risk Potential

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).

DIF: Cognitive Level: Understanding (Comprehension)

MSC: Client Needs: Physiologic Integrity: Basic Care and Comfort

36. A 17-year-old student is a swimmer on her high schools 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 (swimmers 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.

DIF: Cognitive Level: Analyzing (Analysis)

MSC: Client Needs: Health Promotion and Maintenance

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.

DIF: Cognitive Level: Understanding (Comprehension)

MSC: Client Needs: Physiologic Integrity: Basic Care and Comfort

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.

DIF: Cognitive Level: Applying (Application)

MSC: Client Needs: Physiologic Integrity: Physiologic Adaptation

39. A patient has been admitted after an accident at work. During the assessment, the patient is having trouble hearing and states, I dont know what the matter is. All of a sudden, I cant 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 patients ear.

c. Notify the patients 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 patients health care provider. Hearing loss associated with trauma is often sudden. Irrigating the ear or removing cerumen is not appropriate at this time.

DIF: Cognitive Level: Applying (Application)

MSC: Client Needs: Physiologic Integrity: Basic Care and Comfort

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.

DIF: Cognitive Level: Applying (Application)

MSC: Client Needs: Health Promotion and Maintenance

Chapter 17: 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.

DIF: Cognitive Level: Remembering (Knowledge)

MSC: Client Needs: General

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.

DIF: Cognitive Level: Remembering (Knowledge)

MSC: Client Needs: General

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.

DIF: Cognitive Level: Remembering (Knowledge)

MSC: Client Needs: General

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 tongues dorsal surface.

DIF: Cognitive Level: Remembering (Knowledge)

MSC: Client Needs: General

5. The salivary gland that is the largest and located in the cheek in front of the ear is the _____ gland.

a. Parotid

b. Stensens

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 Stensens 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.

DIF: Cognitive Level: Remembering (Knowledge)

MSC: Client Needs: General

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.

DIF: Cognitive Level: Applying (Application)

MSC: Client Needs: Safe and Effective Care Environment: Management of Care

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 nurses best response would be:

a. Youre 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 hasnt 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.

DIF: Cognitive Level: Understanding (Comprehension)

MSC: Client Needs: Health Promotion and Maintenance

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.

DIF: Cognitive Level: Understanding (Comprehension)

MSC: Client Needs: Health Promotion and Maintenance

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.

DIF: Cognitive Level: Understanding (Comprehension)

MSC: Client Needs: Physiologic Integrity: Physiologic Adaptation

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 nurses 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 dont 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.

DIF: Cognitive Level: Applying (Application)

MSC: Client Needs: Physiologic Integrity: Physiologic Adaptation

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.

DIF: Cognitive Level: Analyzing (Analysis)

MSC: Client Needs: Physiologic Integrity: Physiologic Adaptation

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. Youre right. Bottles make very good pacifiers.

b. Using a bottle as a pacifier is better for the teeth than thumb-sucking.

c. Its 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.

DIF: Cognitive Level: Applying (Application)

MSC: Client Needs: Health Promotion and Maintenance

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.

DIF: Cognitive Level: Applying (Application)

MSC: Client Needs: Physiologic Integrity: Physiologic Adaptation

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.

DIF: Cognitive Level: Understanding (Comprehension)

MSC: Client Needs: Safe and Effective Care Environment: Management of Care

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.

DIF: Cognitive Level: Applying (Application)

MSC: Client Needs: Safe and Effective Care Environment: Management of Care

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).

DIF: Cognitive Level: Remembering (Knowledge)

MSC: Client Needs: Safe and Effective Care Environment: Management of Care

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 patients 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.

DIF: Cognitive Level: Applying (Application)

MSC: Client Needs: Safe and Effective Care Environment: Management of Care

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.

DIF: Cognitive Level: Applying (Application)

MSC: Client Needs: Physiologic Integrity: Physiologic Adaptation

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.

DIF: Cognitive Level: Applying (Application)

MSC: Client Needs: Physiologic Integrity: Physiologic Adaptation

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.

DIF: Cognitive Level: Understanding (Comprehension)

MSC: Client Needs: Physiologic Integrity: Physiologic Adaptation

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.

DIF: Cognitive Level: Analyzing (Analysis)

MSC: Client Needs: Physiologic Integrity: Physiologic Adaptation

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.

DIF: Cognitive Level: Applying (Application)

MSC: Client Needs: Physiologic Integrity: Reduction of Risk Potential

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.

DIF: Cognitive Level: Analyzing (Analysis)

MSC: Client Needs: Physiologic Integrity: Physiologic Adaptation

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.

DIF: Cognitive Level: Analyzing (Analysis)

MSC: Client Needs: Physiologic Integrity: Physiologic Adaptation

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.

DIF: Cognitive Level: Applying (Application)

MSC: Client Needs: Physiologic Integrity: Reduction of Risk Potential

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. Im not sure what causes swollen and bleeding gums, but let me know if its 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.

DIF: Cognitive Level: Applying (Application)

MSC: Client Needs: Physiologic Integrity: Physiologic Adaptation

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.

DIF: Cognitive Level: Applying (Application)

MSC: Client Needs: Physiologic Integrity: Physiologic Adaptation

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.

DIF: Cognitive Level: Analyzing (Analysis)

MSC: Client Needs: Physiologic Integrity: Physiologic Adaptation

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 Kaposis 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.

DIF: Cognitive Level: Understanding (Comprehension)

MSC: Client Needs: Physiologic Integrity: Physiologic Adaptation

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.

DIF: Cognitive Level: Analyzing (Analysis)

MSC: Client Needs: Health Promotion and Maintenance

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 nurses 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 childs 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.

DIF: Cognitive Level: Applying (Application)

MSC: Client Needs: Health Promotion and Maintenance

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.

DIF: Cognitive Level: Remembering (Knowledge)

MSC: Client Needs: Health Promotion and Maintenance

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.

DIF: Cognitive Level: Analyzing (Analysis)

MSC: Client Needs: Physiologic Integrity: Physiologic Adaptation

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.

DIF: Cognitive Level: Understanding (Comprehension)

MSC: Client Needs: Physiologic Integrity: Physiologic Adaptation

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 Stensens 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.

DIF: Cognitive Level: Applying (Application)

MSC: Client Needs: Safe and Effective Care Environment: Management of Care

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.

DIF: Cognitive Level: Understanding (Comprehension)

MSC: Client Needs: Physiologic Integrity: Reduction of Risk Potential

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.

DIF: Cognitive Level: Analyzing (Analysis)

MSC: Client Needs: Physiologic Integrity: Reduction of Risk Potential

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.

DIF: Cognitive Level: Applying (Application)

MSC: Client Needs: Physiologic Integrity: Physiologic Adaptation

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.

DIF: Cognitive Level: Analyzing (Analysis)

MSC: Client Needs: Physiologic Integrity: Physiologic Adaptation

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 patients 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.

DIF: Cognitive Level: Applying (Application)

MSC: Client Needs: Health Promotion and Maintenance

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.

DIF: Cognitive Level: Analyzing (Analysis)

MSC: Client Needs: Health Promotion and Maintenance

2. During an assessment, a patient mentions that I just cant 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

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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.

DIF: Cognitive Level: Applying (Application)

MSC: Client Needs: Physiologic Integrity: Physiologic Adaptation

Chapter 18: Breasts, Axillae, 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.

DIF: Cognitive Level: Remembering (Knowledge)

MSC: Client Needs: General

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.

DIF: Cognitive Level: Applying (Application)

MSC: Client Needs: Safe and Effective Care Environment: Management of Care

3. In performing an assessment of a womans 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.

DIF: Cognitive Level: Applying (Application)

MSC: Client Needs: Safe and Effective Care Environment: Management of Care

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.

DIF: Cognitive Level: Applying (Application)

MSC: Client Needs: Physiologic Integrity: Physiologic Adaptation

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 dont seem to need a bra yet, but I have some friends who do. What if I never get breasts? The nurses best response would be:

a. Dont 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 girls feelings by using statements like dont worry or by sharing personal experiences. The beginning of breast

development precedes menarche by approximately 2 years.

DIF: Cognitive Level: Applying (Application)

MSC: Client Needs: Health Promotion and Maintenance

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 nurses 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 havent 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.

DIF: Cognitive Level: Applying (Application)

MSC: Client Needs: Physiologic Integrity: Physiologic Adaptation

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.

DIF: Cognitive Level: Analyzing (Analysis)

MSC: Client Needs: Health Promotion and Maintenance

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 nurses 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.

DIF: Cognitive Level: Applying (Application)

MSC: Client Needs: Health Promotion and Maintenance

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.

DIF: Cognitive Level: Understanding (Comprehension)

MSC: Client Needs: Physiologic Integrity: Physiologic Adaptation

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.

DIF: Cognitive Level: Applying (Application)

MSC: Client Needs: Physiologic Integrity: Physiologic Adaptation

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.

DIF: Cognitive Level: Understanding (Comprehension)

MSC: Client Needs: Health Promotion and Maintenance

12. In examining a 70-year-old male patient, the nurse notices that he has bilateral gynecomastia. Which of the following describes the nurses 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.

DIF: Cognitive Level: Analyzing (Analysis)

MSC: Client Needs: Safe and Effective Care Environment: Management of Care

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 girls weight and body mass index (BMI).

c. Ask the girls 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.

DIF: Cognitive Level: Analyzing (Analysis)

MSC: Client Needs: Health Promotion and Maintenance

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).

DIF: Cognitive Level: Understanding (Comprehension)

MSC: Client Needs: Physiologic Integrity: Reduction of Risk Potential

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.

DIF: Cognitive Level: Understanding (Comprehension)

MSC: Client Needs: Physiologic Integrity: Reduction of Risk Potential

16. During a breast health interview, a patient states that she has noticed pain in her left breast. The nurses most appropriate response to this would be:

a. Dont 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 patients pain rather than make statements that ignore the patients concerns.

DIF: Cognitive Level: Analyzing (Analysis)

MSC: Client Needs: Safe and Effective Care Environment: Management of Care

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.

DIF: Cognitive Level: Applying (Application)

MSC: Client Needs: Safe and Effective Care Environment: Management of Care

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 appearon 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.

DIF: Cognitive Level: Analyzing (Analysis)

MSC: Client Needs: Physiologic Integrity: Physiologic Adaptation

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 womans 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.

DIF: Cognitive Level: Applying (Application)

MSC: Client Needs: Safe and Effective Care Environment: Management of Care

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 correctmammography 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.

DIF: Cognitive Level: Understanding (Comprehension)

MSC: Client Needs: Physiologic Integrity: Reduction of Risk Potential

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.

DIF: Cognitive Level: Applying (Application)

MSC: Client Needs: Physiologic Integrity: Reduction of Risk Potential

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.

DIF: Cognitive Level: Applying (Application)

MSC: Client Needs: Physiologic Integrity: Reduction of Risk Potential

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.

DIF: Cognitive Level: Analyzing (Analysis)

MSC: Client Needs: Physiologic Integrity: Physiologic Adaptation

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.

DIF: Cognitive Level: Understanding (Comprehension)

MSC: Client Needs: Physiologic Integrity: Physiologic Adaptation

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.

DIF: Cognitive Level: Analyzing (Analysis)

MSC: Client Needs: Physiologic Integrity: Physiologic Adaptation

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.

DIF: Cognitive Level: Applying (Application)

MSC: Client Needs: Safe and Effective Care Environment: Management of Care

27. The nurse is palpating a female patients 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.

DIF: Cognitive Level: Applying (Application)

MSC: Client Needs: Safe and Effective Care Environment: Management of Care

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.

DIF: Cognitive Level: Analyzing (Analysis)

MSC: Client Needs: Safe and Effective Care Environment: Management of Care

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.

DIF: Cognitive Level: Applying (Application)

MSC: Client Needs: Safe and Effective Care Environment: Management of Care

30. The nurse has palpated a lump in a female patients right breast. The nurse documents this as a small, round, firm, distinct, lump located at 2 oclock, 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) sizejudge 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.

DIF: Cognitive Level: Applying (Application)

MSC: Client Needs: Safe and Effective Care Environment: Management of Care

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 monthfor example, her birth date or the day the rent is due.

DIF: Cognitive Level: Applying (Application)

MSC: Client Needs: Physiologic Integrity: Reduction of Risk Potential

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 womans self-care actions.

DIF: Cognitive Level: Applying (Application)

MSC: Client Needs: Physiologic Integrity: Reduction of Risk Potential

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 nurses 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.

DIF: Cognitive Level: Applying (Application)

MSC: Client Needs: Health Promotion and Maintenance

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 oclock, 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.

DIF: Cognitive Level: Analyzing (Analysis)

MSC: Client Needs: Safe and Effective Care Environment: Management of Care

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.

DIF: Cognitive Level: Applying (Application)

MSC: Client Needs: Safe and Effective Care Environment: Management of Care

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.

DIF: Cognitive Level: Understanding (Comprehension)

MSC: Client Needs: Safe and Effective Care Environment: Management of Care

37. While inspecting a patients 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 womans 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.

DIF: Cognitive Level: Analyzing (Analysis)

MSC: Client Needs: Safe and Effective Care Environment: Management of Care

38. During an examination, the nurse notes a supernumerary nipple just under the patients 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 correcta 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.

DIF: Cognitive Level: Analyzing (Analysis)

MSC: Client Needs: Safe and Effective Care Environment: Management of Care

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 dorange.

d. Benign breast disease.

ANS: C

This condition is known as *peau dorange*. 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.

DIF: Cognitive Level: Understanding (Comprehension)

MSC: Client Needs: Physiologic Integrity: Physiologic Adaptation

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.

DIF: Cognitive Level: Applying (Application)

MSC: Client Needs: Physiologic Integrity: Physiologic Adaptation

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.

DIF: Cognitive Level: Understanding (Comprehension)

MSC: Client Needs: Physiologic Integrity: Physiologic Adaptation

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.

DIF: Cognitive Level: Analyzing (Analysis)

MSC: Client Needs: Physiologic Integrity: Physiologic Adaptation

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.

DIF: Cognitive Level: Applying (Application)

MSC: Client Needs: Health Promotion and Maintenance

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.

DIF: Cognitive Level: Analyzing (Analysis)

MSC: Client Needs: Physiologic Integrity: Physiologic Adaptation

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.

DIF: Cognitive Level: Applying (Application)

MSC: Client Needs: Physiologic Integrity: Physiologic Adaptation

Chapter 19: 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.

DIF: Cognitive Level: Remembering (Knowledge)

MSC: Client Needs: General

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.

DIF: Cognitive Level: Understanding (Comprehension)

MSC: Client Needs: Safe and Effective Care Environment: Management of Care

3. When assessing a patients 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.

DIF: Cognitive Level: Remembering (Knowledge)

MSC: Client Needs: General

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.

DIF: Cognitive Level: Remembering (Knowledge)

MSC: Client Needs: General

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.

DIF: Cognitive Level: Remembering (Knowledge)

MSC: Client Needs: Safe and Effective Care Environment: Management of Care

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.

DIF: Cognitive Level: Understanding (Comprehension)

MSC: Client Needs: Safe and Effective Care Environment: Management of Care

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 musclessternomastoid, scaleni, and trapezii muscles. Forced expiration involves the abdominal muscles.

DIF: Cognitive Level: Remembering (Knowledge)

MSC: Client Needs: General

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 patients 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 dyspneabeing awakened from sleep with shortness of breath and the need to be upright to achieve comfort.

DIF: Cognitive Level: Applying (Application)

MSC: Client Needs: Safe and Effective Care Environment: Management of Care

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.

DIF: Cognitive Level: Understanding (Comprehension)

MSC: Client Needs: Safe and Effective Care Environment: Management of Care

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.

DIF: Cognitive Level: Understanding (Comprehension)

MSC: Client Needs: Safe and Effective Care Environment: Management of Care

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.

DIF: Cognitive Level: Understanding (Comprehension)

MSC: Client Needs: General

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.

DIF: Cognitive Level: Understanding (Comprehension)

MSC: Client Needs: Safe and Effective Care Environment: Management of Care

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.

DIF: Cognitive Level: Applying (Application)

MSC: Client Needs: Safe and Effective Care Environment: Management of Care

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.

DIF: Cognitive Level: Understanding (Comprehension)

MSC: Client Needs: Safe and Effective Care Environment: Management of Care

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.

DIF: Cognitive Level: Understanding (Comprehension)

MSC: Client Needs: Physiologic Integrity: Physiologic Adaptation

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.

DIF: Cognitive Level: Understanding (Comprehension)

MSC: Client Needs: Physiologic Integrity: Physiologic Adaptation

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.

DIF: Cognitive Level: Understanding (Comprehension)

MSC: Client Needs: Health Promotion and Maintenance

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 nurses 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 infants feeding is not a priority at this time.

DIF: Cognitive Level: Analyzing (Analysis)

MSC: Client Needs: Physiologic Integrity: Physiologic Adaptation

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 childs 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.

DIF: Cognitive Level: Applying (Application)

MSC: Client Needs: Safe and Effective Care Environment: Management of Care

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 patients level of consciousness and the patients 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.

DIF: Cognitive Level: Understanding (Comprehension)

MSC: Client Needs: Safe and Effective Care Environment: Management of Care

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.

DIF: Cognitive Level: Applying (Application)

MSC: Client Needs: Safe and Effective Care Environment: Management of Care

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.

DIF: Cognitive Level: Understanding (Comprehension)

MSC: Client Needs: Physiologic Integrity: Physiologic Adaptation

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.

DIF: Cognitive Level: Understanding (Comprehension)

MSC: Client Needs: Physiologic Integrity: Physiologic Adaptation

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 posteriorlybetween 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.

DIF: Cognitive Level: Understanding (Comprehension)

MSC: Client Needs: Safe and Effective Care Environment: Management of Care

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.

DIF: Cognitive Level: Understanding (Comprehension)

MSC: Client Needs: Physiologic Integrity: Physiologic Adaptation

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.

DIF: Cognitive Level: Applying (Application)

MSC: Client Needs: Physiologic Integrity: Physiologic Adaptation

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.

DIF: Cognitive Level: Analyzing (Analysis)

MSC: Client Needs: Physiologic Integrity: Physiologic Adaptation

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.

DIF: Cognitive Level: Analyzing (Analysis)

MSC: Client Needs: Physiologic Integrity: Physiologic Adaptation

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.

DIF: Cognitive Level: Understanding (Comprehension)

MSC: Client Needs: Health Promotion and Maintenance

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 nurses 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 mothers 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 mothers body, this increased demand is easily met by the increasing tidal volume (deeper breathing). Little change occurs in the respiratory rate.

DIF: Cognitive Level: Applying (Application)

MSC: Client Needs: Health Promotion and Maintenance

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 nurses 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.

DIF: Cognitive Level: Analyzing (Analysis)

MSC: Client Needs: Physiologic Integrity: Physiologic Adaptation

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.

DIF: Cognitive Level: Applying (Application)

MSC: Client Needs: Physiologic Integrity: Physiologic Adaptation

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.

DIF: Cognitive Level: Applying (Application)

MSC: Client Needs: Physiologic Integrity: Physiologic Adaptation

34. During a morning assessment, the nurse notices that the patients 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.

DIF: Cognitive Level: Understanding (Comprehension)

MSC: Client Needs: Physiologic Integrity: Physiologic Adaptation

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.

DIF: Cognitive Level: Applying (Application)

MSC: Client Needs: Safe and Effective Care Environment: Management of Care

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 (PaO_2) less than 80 mm Hg, diaphoresis, hypotension, crackles, and wheezes.

DIF: Cognitive Level: Analyzing (Analysis)

MSC: Client Needs: Physiologic Integrity: Physiologic Adaptation

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.

DIF: Cognitive Level: Applying (Application)

MSC: Client Needs: Physiologic Integrity: Physiologic Adaptation

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.

DIF: Cognitive Level: Analyzing (Analysis)

MSC: Client Needs: Safe and Effective Care Environment: Management of Care

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.

DIF: Cognitive Level: Analyzing (Analysis)

MSC: Client Needs: Safe and Effective Care Environment: Management of Care

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. Wheezes are associated with diffuse airway obstruction caused by acute asthma or chronic emphysema.

DIF: Cognitive Level: Applying (Application)

MSC: Client Needs: Safe and Effective Care Environment: Management of Care

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.

DIF: Cognitive Level: Applying (Application)

MSC: Client Needs: Safe and Effective Care Environment: Management of Care

Chapter 20: Heart and Neck Vessels

MULTIPLE CHOICE

1. The sac that surrounds and protects the heart is called the:

a. Pericardium.

b. Myocardium.

c. Endocardium.

d. Pleural space.

ANS: A

The pericardium is a tough, fibrous double-walled sac that surrounds and protects the heart. It has two layers that contain a few milliliters of serous pericardial fluid.

DIF: Cognitive Level: Remembering (Knowledge)

MSC: Client Needs: General

2. The direction of blood flow through the heart is best described by which of these?

a. Vena cava right atrium right ventricle lungs pulmonary artery left atrium left ventricle

b. Right atrium right ventricle pulmonary artery lungs pulmonary vein left atrium left ventricle

c. Aorta right atrium right ventricle lungs pulmonary vein left atrium left ventricle vena cava

d. Right atrium right ventricle pulmonary vein lungs pulmonary artery left atrium left ventricle

ANS: B

Returning blood from the body empties into the right atrium and flows into the right ventricle and then goes to the lungs through the pulmonary artery. The lungs oxygenate the blood, and it is then returned to the left atrium through the pulmonary vein. The blood goes from there to the left ventricle and then out to the body through the aorta.

DIF: Cognitive Level: Remembering (Knowledge)

MSC: Client Needs: General

3. The nurse is reviewing the anatomy and physiologic functioning of the heart. Which statement best describes what is meant by *atrial kick*?

a. The atria contract during systole and attempt to push against closed valves.

b. Contraction of the atria at the beginning of diastole can be felt as a palpitation.

c. Atrial kick is the pressure exerted against the atria as the ventricles contract during systole.

d. The atria contract toward the end of diastole and push the remaining blood into the ventricles.

ANS: D

Toward the end of diastole, the atria contract and push the last amount of blood (approximately 25% of stroke volume) into the ventricles. This active filling phase is called *presystole*, or atrial systole, or sometimes the*atrial kick*.

DIF: Cognitive Level: Remembering (Knowledge)

MSC: Client Needs: General

4. When listening to heart sounds, the nurse knows the valve closures that can be heard best at the base of the heart are:

a. Mitral and tricuspid.

b. Tricuspid and aortic.

c. Aortic and pulmonic.

d. Mitral and pulmonic.

ANS: C

The second heart sound (S_2) occurs with the closure of the semilunar (aortic and pulmonic) valves and signals the end of systole. Although it is heard over all the precordium, the S_2 is loudest at the base of the heart.

DIF: Cognitive Level: Understanding (Comprehension)

MSC: Client Needs: General

5. Which of these statements describes the closure of the valves in a normal cardiac cycle?

a. The aortic valve closes slightly before the tricuspid valve.

b. The pulmonic valve closes slightly before the aortic valve.

c. The tricuspid valve closes slightly later than the mitral valve.

d. Both the tricuspid and pulmonic valves close at the same time.

ANS: C

Events occur just slightly later in the right side of the heart because of the route of myocardial depolarization. As a result, two distinct components to each of the heart sounds exist, and sometimes they can be heard separately. In the first heart sound, the mitral component (M1) closes just before the tricuspid component (T1).

DIF: Cognitive Level: Understanding (Comprehension)

MSC: Client Needs: General

6. The component of the conduction system referred to as *the pacemaker of the heart* is the:

a. Atrioventricular (AV) node.

b. Sinoatrial (SA) node.

c. Bundle of His.

d. Bundle branches.

ANS: B

Specialized cells in the SA node near the superior vena cava initiate an electrical impulse. Because the SA node has an intrinsic rhythm, it is called the *pacemaker of the heart.*

DIF: Cognitive Level: Remembering (Knowledge)

MSC: Client Needs: General

7. The electrical stimulus of the cardiac cycle follows which sequence?

a. AV node SA node bundle of His

b. Bundle of His AV node SA node

c. SA node AV node bundle of His bundle branches

d. AV node SA node bundle of His bundle branches

ANS: D

Specialized cells in the SA node near the superior vena cava initiate an electrical impulse. The current flows in an orderly sequence, first across the atria to the AV node low in the atrial septum. There it is delayed slightly, allowing the atria the time to contract before the ventricles are stimulated. Then the impulse travels to the bundle of His, the right and left bundle branches, and then through the ventricles.

DIF: Cognitive Level: Understanding (Comprehension)

MSC: Client Needs: General

8. The findings from an assessment of a 70-year-old patient with swelling in his ankles include jugular venous pulsations 5 cm above the sternal angle when the head of his bed is elevated 45 degrees. The nurse knows that this finding indicates:

a. Decreased fluid volume.

b. Increased cardiac output.

c. Narrowing of jugular veins.

d. Elevated pressure related to heart failure.

ANS: D

Because no cardiac valve exists to separate the superior vena cava from the right atrium, the jugular veins give information about the activity on the right side of the heart. They reflect filling pressures and volume changes. Normal jugular venous pulsation is 2 cm or less above the sternal angle. Elevated pressure is more than 3 cm above the sternal angle at 45 degrees and occurs with heart failure.

DIF: Cognitive Level: Analyzing (Analysis)

MSC: Client Needs: Physiologic Integrity: Physiologic Adaptation

9. When assessing a newborn infant who is 5 minutes old, the nurse knows which of these statements to be *true*?

a. The left ventricle is larger and weighs more than the right ventricle.

b. The circulation of a newborn is identical to that of an adult.

c. Blood can flow into the left side of the heart through an opening in the atrial septum.

d. The foramen ovale closes just minutes before birth, and the ductus arteriosus closes immediately after.

ANS: C

First, approximately two thirds of the blood is shunted through an opening in the atrial septum, the foramen ovale, into the left side of the heart, where it is pumped out through the aorta. The foramen ovale closes within the first hour after birth because the pressure in the right side of the heart is now lower than in the left side.

DIF: Cognitive Level: Applying (Application)

MSC: Client Needs: Health Promotion and Maintenance

10. A 25-year-old woman in her fifth month of pregnancy has a blood pressure of 100/70 mm Hg. In reviewing her previous examination, the nurse notes that her blood pressure in her second month was 124/80 mm Hg. In evaluating this change, what does the nurse know to be *true*?

a. This decline in blood pressure is the result of peripheral vasodilatation and is an expected change.

b. Because of increased cardiac output, the blood pressure should be higher at this time.

c. This change in blood pressure is not an expected finding because it means a decrease in cardiac output.

d. This decline in blood pressure means a decrease in circulating blood volume, which is dangerous for the fetus.

ANS: A

Despite the increased cardiac output, arterial blood pressure decreases in pregnancy because of peripheral vasodilatation. The blood pressure drops to its lowest point during the second trimester and then rises after that.

DIF: Cognitive Level: Analyzing (Analysis)

MSC: Client Needs: Physiologic Integrity: Physiologic Adaptation

11. In assessing a 70-year-old man, the nurse finds the following: blood pressure 140/100 mm Hg; heart rate 104 beats per minute and slightly irregular; and the split S_2 heart sound. Which of these findings can be explained by expected hemodynamic changes related to age?

a. Increase in resting heart rate

b. Increase in systolic blood pressure

c. Decrease in diastolic blood pressure

d. Increase in diastolic blood pressure

ANS: B

With aging, an increase in systolic blood pressure occurs. No significant change in diastolic pressure and no change in the resting heart rate occur with aging. Cardiac output at rest is does not changed with aging.

DIF: Cognitive Level: Analyzing (Analysis)

MSC: Client Needs: Health Promotion and Maintenance

12. A 45-year-old man is in the clinic for a routine physical examination. During the recording of his health history, the patient states that he has been having difficulty sleeping. Ill be sleeping great, and then I wake up and feel like I cant get my breath. The nurses best response to this would be:

a. When was your last electrocardiogram?

b. Its probably because its been so hot at night.

c. Do you have any history of problems with your heart?

d. Have you had a recent sinus infection or upper respiratory infection?

ANS: C

Paroxysmal nocturnal dyspnea (shortness of breath generally occurring at night) occurs with heart failure. Lying down increases the volume of intrathoracic blood, and the weakened heart cannot accommodate the increased load. Classically, the person awakens after 2 hours of sleep, arises, and flings open a window with the perception of needing fresh air.

DIF: Cognitive Level: Applying (Application)

MSC: Client Needs: Physiologic Integrity: Physiologic Adaptation

13. In assessing a patients major risk factors for heart disease, which would the nurse want to include when taking a history?

a. Family history, hypertension, stress, and age

b. Personality type, high cholesterol, diabetes, and smoking

c. Smoking, hypertension, obesity, diabetes, and high cholesterol

d. Alcohol consumption, obesity, diabetes, stress, and high cholesterol

ANS: C

To assess for major risk factors of coronary artery disease, the nurse should collect data regarding elevated serum cholesterol, elevated blood pressure, blood glucose levels above 100 mg/dL or known diabetes mellitus, obesity, any length of hormone replacement therapy for post menopausal women, cigarette smoking, and low activity level.

DIF: Cognitive Level: Applying (Application)

MSC: Client Needs: Physiologic Integrity: Reduction of Risk Potential

14. The mother of a 3-month-old infant states that her baby has not been gaining weight. With further questioning, the nurse finds that the infant falls asleep after nursing and wakes up after a short time, hungry again. What other information would the nurse want to have?

a. Infants sleeping position

b. Sibling history of eating disorders

c. Amount of background noise when eating

d. Presence of dyspnea or diaphoresis when sucking

ANS: D

To screen for heart disease in an infant, the focus should be on feeding. Fatigue during feeding should be noted. An infant with heart failure takes fewer ounces each feeding, becomes dyspneic with sucking, may be diaphoretic, and then falls into exhausted sleep and awakens after a short time hungry again.

DIF: Cognitive Level: Analyzing (Analysis)

MSC: Client Needs: Physiologic Integrity: Physiologic Adaptation

15. In assessing the carotid arteries of an older patient with cardiovascular disease, the nurse would:

a. Palpate the artery in the upper one third of the neck.

b. Listen with the bell of the stethoscope to assess for bruits.

c. Simultaneously palpate both arteries to compare amplitude.

d. Instruct the patient to take slow deep breaths during auscultation.

ANS: B

If cardiovascular disease is suspected, then the nurse should auscultate each carotid artery for the presence of a bruit. The nurse should avoid compressing the artery, which could create an artificial bruit and compromise circulation if the carotid artery is already narrowed by atherosclerosis. Excessive pressure on the carotid sinus area high in the neck should be avoided, and excessive vagal stimulation could slow down the heart rate, especially in older adults. Palpating only one carotid artery at a time will avoid compromising arterial blood to the brain.

DIF: Cognitive Level: Applying (Application)

MSC: Client Needs: Safe and Effective Care Environment: Management of Care

16. During an assessment of a 68-year-old man with a recent onset of right-sided weakness, the nurse hears a blowing, swishing sound with the bell of the stethoscope over the left carotid artery. This finding would indicate:

a. Valvular disorder.

b. Blood flow turbulence.

c. Fluid volume overload.

d. Ventricular hypertrophy.

ANS: B

A bruit is a blowing, swishing sound indicating blood flow turbulence; normally, none is present.

DIF: Cognitive Level: Analyzing (Analysis)

MSC: Client Needs: Safe and Effective Care Environment: Management of Care

17. During an inspection of the precordium of an adult patient, the nurse notices the chest moving in a forceful manner along the sternal border. This finding most likely suggests a(n):

a. Normal heart.

b. Systolic murmur.

c. Enlargement of the left ventricle.

d. Enlargement of the right ventricle.

ANS: D

Normally, the examiner may or may not see an apical impulse; when visible, it occupies the fourth or fifth intercostal space at or inside the midclavicular line. A heave or lift is a sustained forceful thrusting of the ventricle during systole. It occurs with ventricular hypertrophy as a result of increased workload. A right ventricular heave is seen at the sternal border; a left ventricular heave is seen at the apex.

DIF: Cognitive Level: Applying (Application)

MSC: Client Needs: Safe and Effective Care Environment: Management of Care

18. During an assessment of a healthy adult, where would the nurse expect to palpate the apical impulse?

a. Third left intercostal space at the midclavicular line

b. Fourth left intercostal space at the sternal border

c. Fourth left intercostal space at the anterior axillary line

d. Fifth left intercostal space at the midclavicular line

ANS: D

The apical impulse should occupy only one intercostal space, the fourth or fifth, and it should be at or medial to the midclavicular line.

DIF: Cognitive Level: Remembering (Knowledge)

MSC: Client Needs: Safe and Effective Care Environment: Management of Care

19. The nurse is examining a patient who has possible cardiac enlargement. Which statement about percussion of the heart is *true*?

a. Percussion is a useful tool for outlining the hearts borders.

b. Percussion is easier in patients who are obese.

c. Studies show that percussed cardiac borders do not correlate well with the true cardiac border.

d. Only expert health care providers should attempt percussion of the heart.

ANS: C

Numerous comparison studies have shown that the percussed cardiac border correlates *only moderately* with the true cardiac border. Percussion is of limited usefulness with the female breast tissue, in a person who is obese, or in a person with a muscular chest wall. Chest x-ray images or echocardiographic examinations are significantly more accurate in detecting heart enlargement.

DIF: Cognitive Level: Understanding (Comprehension)

MSC: Client Needs: Safe and Effective Care Environment: Management of Care

20. The nurse is preparing to auscultate for heart sounds. Which technique is *correct*?

a. Listening to the sounds at the aortic, tricuspid, pulmonic, and mitral areas

b. Listening by inching the stethoscope in a rough Z pattern, from the base of the heart across and down, then over to the apex

c. Listening to the sounds only at the site where the apical pulse is felt to be the strongest

d. Listening for all possible sounds at a time at each specified area

ANS: B

Auscultation of breath sounds should not be limited to only four locations. Sounds produced by the valves may be heard all over the precordium. The stethoscope should be inched in a rough Z pattern from the base of the heart across and down, then over to the apex; or, starting at the apex, it should be slowly worked up. Listening selectively to one sound at a time is best.

DIF: Cognitive Level: Understanding (Comprehension)

MSC: Client Needs: Safe and Effective Care Environment: Management of Care

21. While counting the apical pulse on a 16-year-old patient, the nurse notices an irregular rhythm. His rate speeds up on inspiration and slows on expiration. What would be the nurses response?

a. Talk with the patient about his intake of caffeine.

b. Perform an electrocardiogram after the examination.

c. No further response is needed because sinus arrhythmia can occur normally.

d. Refer the patient to a cardiologist for further testing.

ANS: C

The rhythm should be regular, although sinus arrhythmia occurs normally in young adults and children. With sinus arrhythmia, the rhythm varies with the persons breathing, increasing at the peak of inspiration and slowing with expiration.

DIF: Cognitive Level: Analyzing (Analysis)

MSC: Client Needs: Health Promotion and Maintenance

22. When listening to heart sounds, the nurse knows that the S_1:

a. Is louder than the S_2 at the base of the heart.

b. Indicates the beginning of diastole.

c. Coincides with the carotid artery pulse.

d. Is caused by the closure of the semilunar valves.

ANS: C

The S_1 coincides with the carotid artery pulse, is the start of systole, and is louder than the S_2 at the apex of the heart; the S_2 is louder than the S_1 at the base. The nurse should gently feel the carotid artery pulse while auscultating at the apex; the sound heard as each pulse is felt is the S_1.

DIF: Cognitive Level: Understanding (Comprehension)

MSC: Client Needs: General

23. During the cardiac auscultation, the nurse hears a sound immediately occurring after the S_2 at the second left intercostal space. To further assess this sound, what should the nurse do?

a. Have the patient turn to the left side while the nurse listens with the bell of the stethoscope.

b. Ask the patient to hold his or her breath while the nurse listens again.

c. No further assessment is needed because the nurse knows this sound is an S_3.

d. Watch the patients respirations while listening for the effect on the sound.

ANS: D

A split S_2 is a normal phenomenon that occurs toward the end of inspiration in some people. A split S_2 is heard only in the pulmonic valve area, the second left interspace. When the split S_2 is first heard, the nurse should not be tempted to ask the person to hold his or her breath so that the nurse can concentrate on the sounds. Breath holding will only equalize ejection times in the right and left sides of the heart and cause the split to go away. Rather, the nurse should concentrate on the split while watching the persons chest rise up and down with breathing.

DIF: Cognitive Level: Analyzing (Analysis)

MSC: Client Needs: Safe and Effective Care Environment: Management of Care

24. Which of these findings would the nurse expect to notice during a cardiac assessment on a 4-year-old child?

a. S_3 when sitting up

b. Persistent tachycardia above 150 beats per minute

c. Murmur at the second left intercostal space when supine

d. Palpable apical impulse in the fifth left intercostal space lateral to midclavicular line

ANS: C

Some murmurs are common in healthy children or adolescents and are termed *innocent* or *functional*. The innocent murmur is heard at the second or third left intercostal space and disappears with sitting, and the young person has no associated signs of cardiac dysfunction.

DIF: Cognitive Level: Applying (Application)

MSC: Client Needs: Health Promotion and Maintenance

25. While auscultating heart sounds on a 7-year-old child for a routine physical examination, the nurse hears an S_3, a soft murmur at the left midsternal border, and a venous hum when the child is standing. What would be a correct interpretation of these findings?

a. S_3 is indicative of heart disease in children.

b. These findings can all be normal in a child.

c. These findings are indicative of congenital problems.

d. The venous hum most likely indicates an aneurysm.

ANS: B

A physiologic S_3 is common in children. A venous hum, caused by turbulence of blood flow in the jugular venous system, is common in healthy children and has no pathologic significance. Heart murmurs that are innocent (or functional) in origin are very common through childhood.

DIF: Cognitive Level: Analyzing (Analysis)

MSC: Client Needs: Health Promotion and Maintenance

26. During the precordial assessment on an patient who is 8 months pregnant, the nurse palpates the apical impulse at the fourth left intercostal space lateral to the midclavicular line. This finding would indicate:

a. Right ventricular hypertrophy.

b. Increased volume and size of the heart as a result of pregnancy.

c. Displacement of the heart from elevation of the diaphragm.

d. Increased blood flow through the internal mammary artery.

ANS: C

Palpation of the apical impulse is higher and more lateral, compared with the normal position, because the enlarging uterus elevates the diaphragm and displaces the heart up and to the left and rotates it on its long axis.

DIF: Cognitive Level: Analyzing (Analysis)

MSC: Client Needs: Health Promotion and Maintenance

27. In assessing for an S_4 heart sound with a stethoscope, the nurse would listen with the:

a. Bell of the stethoscope at the base with the patient leaning forward.

b. Bell of the stethoscope at the apex with the patient in the left lateral position.

c. Diaphragm of the stethoscope in the aortic area with the patient sitting.

d. Diaphragm of the stethoscope in the pulmonic area with the patient supine.

ANS: B

The S_4 is a ventricular filling sound that occurs when the atria contract late in diastole and is heard immediately before the S_1. The S_4 is a very soft sound with a very low pitch. The nurse needs a good bell and must listen for this sound. An S_4 is heard best at the apex, with the person in the left lateral position.

DIF: Cognitive Level: Understanding (Comprehension)

MSC: Client Needs: Safe and Effective Care Environment: Management of Care

28. A 70-year-old patient with a history of hypertension has a blood pressure of 180/100 mm Hg and a heart rate of 90 beats per minute. The nurse hears an extra heart sound at the apex immediately before the S_1. The sound is heard only with the bell of the stethoscope while the patient is in the left lateral position. With these findings and the patients history, the nurse knows that this extra heart sound is most likely a(n):

a. Split S_1.

b. Atrial gallop.

c. Diastolic murmur.

d. Summation sound.

ANS: B

A pathologic S_4 is termed an *atrial gallop* or an *S_4 gallop*. It occurs with decreased compliance of the ventricle and with systolic overload (afterload), including outflow obstruction to the ventricle (aortic stenosis) and systemic hypertension. A left-sided S_4 occurs with these conditions and is heard best at the apex with the patient in the left lateral position.

DIF: Cognitive Level: Analyzing (Analysis)

MSC: Client Needs: Health Promotion and Maintenance

29. The nurse is performing a cardiac assessment on a 65-year-old patient 3 days after her myocardial infarction (MI). Heart sounds are normal when she is supine, but when she is sitting and leaning forward, the nurse hears a high-pitched, scratchy sound with the diaphragm of the stethoscope at the apex. It disappears on inspiration. The nurse suspects:

a. Increased cardiac output.

b. Another MI.

c. Inflammation of the precordium.

d. Ventricular hypertrophy resulting from muscle damage.

ANS: C

Inflammation of the precordium gives rise to a friction rub. The sound is high pitched and scratchy, similar to sandpaper being rubbed. A friction rub is best heard with the diaphragm of the stethoscope, with the person sitting up and leaning forward, and with the breath held in expiration. A friction rub can be heard any place on the precordium. Usually, however, the sound is best heard at the apex and left lower sternal border, which are places where the pericardium comes in close contact with the chest wall.

DIF: Cognitive Level: Analyzing (Analysis)

MSC: Client Needs: Physiologic Integrity: Physiologic Adaptation

30. The mother of a 10-month-old infant tells the nurse that she has noticed that her son becomes blue when he is crying and that the frequency of this is increasing. He is also not crawling yet. During the examination the nurse palpates a thrill at the left lower sternal border and auscultates a loud systolic murmur in the same area. What would be the most likely cause of these findings?

a. Tetralogy of Fallot

b. Atrial septal defect

c. Patent ductus arteriosus

d. Ventricular septal defect

ANS: A

The cause of these findings is tetralogy of Fallot. Its *subjective* findings include: (1) severe cyanosis, not in the first months of life but developing as the infant grows, and right ventricle outflow (i.e., pulmonic) stenosis that gets worse; (2) cyanosis with crying and exertion at first and then at rest; and (3) slowed development. Its *objective* findings include: (1) thrill palpable at the left lower sternal border; (2) the S_1 is normal, the S_2 has a loud A_2, and the P_2 is diminished or absent; and (3) the murmur is systolic, loud, and crescendo-decrescendo.

DIF: Cognitive Level: Analyzing (Analysis)

MSC: Client Needs: Health Promotion and Maintenance

31. A 30-year-old woman with a history of mitral valve problems states that she has been very tired. She has started waking up at night and feels like her heart is pounding. During the assessment, the nurse palpates a thrill and lift at the fifth left intercostal space midclavicular line. In the same area, the nurse also auscultates a blowing, swishing sound right after the S_1. These findings would be most consistent with:

a. Heart failure.

b. Aortic stenosis.

c. Pulmonary edema.

d. Mitral regurgitation.

ANS: D

These findings are consistent with mitral regurgitation. Its *subjective* findings include fatigue, palpitation, and orthopnea, and its *objective* findings are: (1) a thrill in systole at the apex; (2) a lift at the apex; (3) the apical impulse displaced down and to the left; (4) the S_1 is diminished, the S_2 is accentuated, and the S_3 at the apex is often present; and (5) a pansystolic murmur that is often loud, blowing, best heard at the apex, and radiating well to the left axilla.

DIF: Cognitive Level: Analyzing (Analysis)

MSC: Client Needs: Physiologic Integrity: Physiologic Adaptation

32. During a cardiac assessment on a 38-year-old patient in the hospital for chest pain, the nurse finds the following: jugular vein pulsations 4 cm above the sternal angle when the patient is elevated at 45 degrees, blood pressure 98/60 mm Hg, heart rate 130 beats per minute, ankle edema, difficulty breathing when supine, and an S_3 on auscultation. Which of these conditions best explains the cause of these findings?

a. Fluid overload

b. Atrial septal defect

c. MI

d. Heart failure

ANS: D

Heart failure causes decreased cardiac output when the heart fails as a pump and the circulation becomes backed up and congested. Signs and symptoms include dyspnea, orthopnea, paroxysmal nocturnal dyspnea, decreased blood pressure, dependent and pitting edema; anxiety; confusion; jugular vein distention; and fatigue. The S_3 is associated with heart failure and is always abnormal after 35 years of age. The S_3 may be the earliest sign of heart failure.

DIF: Cognitive Level: Analyzing (Analysis)

MSC: Client Needs: Physiologic Integrity: Physiologic Adaptation

33. The nurse knows that normal splitting of the S_2 is associated with:

a. Expiration.

b. Inspiration.

c. Exercise state.

d. Low resting heart rate.

ANS: B

Normal or physiologic splitting of the S_2 is associated with inspiration because of the increased blood return to the right side of the heart, delaying closure of the pulmonic valve.

DIF: Cognitive Level: Understanding (Comprehension)

MSC: Client Needs: Safe and Effective Care Environment: Management of Care

34. During a cardiovascular assessment, the nurse knows that a *thrill* is:

a. Vibration that is palpable.

b. Palpated in the right epigastric area.

c. Associated with ventricular hypertrophy.

d. Murmur auscultated at the third intercostal space.

ANS: A

A *thrill* is a palpable vibration that signifies turbulent blood flow and accompanies loud murmurs. The absence of a thrill does not rule out the presence of a murmur.

DIF: Cognitive Level: Remembering (Knowledge)

MSC: Client Needs: Safe and Effective Care Environment: Management of Care

35. During a cardiovascular assessment, the nurse knows that an S_4 heart sound is:

a. Heard at the onset of atrial diastole.

b. Usually a normal finding in the older adult.

c. Heard at the end of ventricular diastole.

d. Heard best over the second left intercostal space with the individual sitting upright.

ANS: C

An S_4 heart sound is heard at the end of diastole when the atria contract (atrial systole) and when the ventricles are resistant to filling. The S_4 occurs just before the S_1.

DIF: Cognitive Level: Understanding (Comprehension)

MSC: Client Needs: Safe and Effective Care Environment: Management of Care

36. During an assessment, the nurse notes that the patients apical impulse is laterally displaced and is palpable over a wide area. This finding indicates:

a. Systemic hypertension.

b. Pulmonic hypertension.

c. Pressure overload, as in aortic stenosis.

d. Volume overload, as in *heart failure.*

ANS: D

With volume overload, as in heart failure and cardiomyopathy, cardiac enlargement laterally displaces the apical impulse and is palpable over a wider area when left ventricular hypertrophy and dilation are present.

DIF: Cognitive Level: Applying (Application)

MSC: Client Needs: Safe and Effective Care Environment: Management of Care

37. When the nurse is auscultating the carotid artery for bruits, which of these statements reflects the correct technique?

a. While listening with the bell of the stethoscope, the patient is asked to take a deep breath and hold it.

b. While auscultating one side with the bell of the stethoscope, the carotid artery is palpated on the other side to check pulsations.

c. While lightly applying the bell of the stethoscope over the carotid artery and listening, the patient is asked to take a breath, exhale, and briefly hold it.

d. While firmly placing the bell of the stethoscope over the carotid artery and listening, the patient is asked to take a breath, exhale, and briefly hold it.

ANS: C

The correct technique for auscultating the carotid artery for bruits involves the nurse lightly applying the bell of the stethoscope over the carotid artery at three levels. While listening, the nurse asks the patient take a breath, exhale, and briefly hold it. Holding the breath on inhalation will also tense the levator scapulae muscles, which makes it hard to hear the carotid arteries. Examining only one carotid artery at a time will avoid compromising arterial blood flow to the brain. Pressure over the carotid sinus, which may lead to decreased heart rate, decreased blood pressure, and cerebral ischemia with syncope, should be avoided.

DIF: Cognitive Level: Applying (Application)

MSC: Client Needs: Safe and Effective Care Environment: Management of Care

38. The nurse is preparing for a class on risk factors for hypertension and reviews recent statistics. Which racial group has the highest prevalence of hypertension in the world?

a. Blacks

b. Whites

c. American Indians

d. Hispanics

ANS: A

According to the American Heart Association, the prevalence of hypertension is higher among Blacks than in other racial groups.

DIF: Cognitive Level: Understanding (Comprehension)

MSC: Client Needs: Physiologic Integrity: Reduction of Risk Potential

39. The nurse is assessing a patient with possible cardiomyopathy and assesses the hepatojugular reflux. If heart failure is present, then the nurse should recognize which finding while pushing on the right upper quadrant of the patients abdomen, just below the rib cage?

a. The jugular veins will rise for a few seconds and then recede back to the previous level if the heart is properly working.

b. The jugular veins will remain elevated as long as pressure on the abdomen is maintained.

c. An impulse will be visible at the fourth or fifth intercostal space at or inside the midclavicular line.

d. The jugular veins will not be detected during this maneuver.

ANS: B

When performing hepatojugular reflux, the jugular veins will rise for a few seconds and then recede back to the previous level if the heart is able to pump the additional volume created by the pushing. However, with heart failure, the jugular veins remain elevated as long as pressure on the abdomen is maintained.

DIF: Cognitive Level: Analyzing (Analysis)

MSC: Client Needs: Safe and Effective Care Environment: Management of Care

40. The nurse is assessing the apical pulse of a 3-month-old infant and finds that the heart rate is 135 beats per minute. The nurse interprets this result as:

a. Normal for this age.

b. Lower than expected.

c. Higher than expected, probably as a result of crying.

d. Higher than expected, reflecting persistent tachycardia.

ANS: A

The heart rate may range from 100 to 180 beats per minute immediately after birth and then stabilize to an average of 120 to 140 beats per minute. Infants normally have wide fluctuations with activity, from 170 beats per minute or more with crying or being active to 70 to 90 beats per minute with sleeping. Persistent tachycardia is greater than 200 beats per minute in newborns or greater than 150 beats per minute in infants.

DIF: Cognitive Level: Analyzing (Analysis)

MSC: Client Needs: Safe and Effective Care Environment: Management of Care

MULTIPLE RESPONSE

1. The nurse is presenting a class on risk factors for cardiovascular disease. Which of these are considered modifiable risk factors for MI? *Select all that apply*.

a. Ethnicity

b. Abnormal lipids

c. Smoking

d. Gender

e. Hypertension

f. Diabetes

g. Family history

ANS: B, C, E, F

Nine modifiable risk factors for MI, as identified by a recent study, include abnormal lipids, smoking, hypertension, diabetes, abdominal obesity, psychosocial factors, consumption of fruits and vegetables, alcohol use, and regular physical activity.

DIF: Cognitive Level: Applying (Application)

MSC: Client Needs: Health Promotion and Maintenance

SHORT ANSWER

1. The nurse is assessing a patients pulses and notices a difference between the patients apical pulse and radial pulse. The apical pulse was 118 beats per minute, and the radial pulse was 105 beats per minute. What is the pulse deficit?

ANS:

13

The nurse should count a serial measurement (one after the other) of the apical pulse and then the radial pulse. Normally, every beat heard at the apex should perfuse to the periphery and be palpable. The two counts should be identical. If they are different, then the nurse should subtract the radial rate from the apical pulse and record the remainder as the pulse deficit.

DIF: Cognitive Level: Analyzing (Analysis)

MSC: Client Needs: Safe and Effective Care Environment: Management of Care

Chapter 21: Peripheral Vascular System and Lymphatic System

MULTIPLE CHOICE

1. Which statement is *true* regarding the arterial system?

a. Arteries are large-diameter vessels.

b. The arterial system is a high-pressure system.

c. The walls of arteries are thinner than those of the veins.

d. Arteries can greatly expand to accommodate a large blood volume increase.

ANS: B

The pumping heart makes the arterial system a high-pressure system.

DIF: Cognitive Level: Remembering (Knowledge)

MSC: Client Needs: General

2. The nurse is reviewing the blood supply to the arm. The major artery supplying the arm is the _____ artery.

a. Ulnar

b. Radial

c. Brachial

d. Deep palmar

ANS: C

The major artery supplying the arm is the brachial artery. The brachial artery bifurcates into the ulnar and radial arteries immediately below the elbow. In the hand, the ulnar and radial arteries form two arches known as the superficial and deep palmar arches.

DIF: Cognitive Level: Remembering (Knowledge)

MSC: Client Needs: General

3. The nurse is preparing to assess the dorsalis pedis artery. Where is the correct location for palpation?

a. Behind the knee

b. Over the lateral malleolus

c. In the groove behind the medial malleolus

d. Lateral to the extensor tendon of the great toe

ANS: D

The dorsalis pedis artery is located on the dorsum of the foot. The nurse should palpate just lateral to and parallel with the extensor tendon of the big toe. The popliteal artery is palpated behind the knee. The posterior tibial pulse is palpated in the groove between the malleolus and the Achilles tendon. No pulse is palpated at the lateral malleolus.

DIF: Cognitive Level: Understanding (Comprehension)

MSC: Client Needs: General

4. A 65-year-old patient is experiencing pain in his left calf when he exercises that disappears after resting for a few minutes. The nurse recognizes that this description is most consistent with _____ the left leg.

a. Venous obstruction of

b. Claudication due to venous abnormalities in

c. Ischemia caused by a partial blockage of an artery supplying

d. Ischemia caused by the complete blockage of an artery supplying

ANS: C

Ischemia is a deficient supply of oxygenated arterial blood to a tissue. A partial blockage creates an insufficient supply, and the ischemia may be apparent only during exercise when oxygen needs increase.

DIF: Cognitive Level: Analyzing (Analysis)

MSC: Client Needs: Physiologic Integrity: Physiologic Adaptation

5. The nurse is reviewing venous blood flow patterns. Which of these statements best describes the mechanism(s) by which venous blood returns to the heart?

a. Intraluminal valves ensure unidirectional flow toward the heart.

b. Contracting skeletal muscles milk blood distally toward the veins.

c. High-pressure system of the heart helps facilitate venous return.

d. Increased thoracic pressure and decreased abdominal pressure facilitate venous return to the heart.

ANS: A

Blood moves through the veins by (1) contracting skeletal muscles that proximally milk the blood; (2) pressure gradients caused by breathing, during which inspiration makes the thoracic pressure decrease and the abdominal pressure increase; and (3) the intraluminal valves, which ensure unidirectional flow toward the heart.

DIF: Cognitive Level: Understanding (Comprehension)

MSC: Client Needs: General

6. Which vein(s) is(are) responsible for most of the venous return in the arm?

a. Deep

b. Ulnar

c. Subclavian

d. Superficial

ANS: D

The superficial veins of the arms are in the subcutaneous tissue and are responsible for most of the venous return.

DIF: Cognitive Level: Remembering (Knowledge)

MSC: Client Needs: General

7. A 70-year-old patient is scheduled for open-heart surgery. The surgeon plans to use the great saphenous vein for the coronary bypass grafts. The patient asks, What happens to my circulation when this vein is removed? The nurse should reply:

a. Venous insufficiency is a common problem after this type of surgery.

b. Oh, you have lots of veinsyou wont even notice that it has been removed.

c. You will probably experience decreased circulation after the vein is removed.

d. This vein can be removed without harming your circulation because the deeper veins in your leg are in good condition.

ANS: D

As long as the femoral and popliteal veins remain intact, the superficial veins can be excised without harming circulation. The other responses are not correct.

DIF: Cognitive Level: Analyzing (Analysis)

MSC: Client Needs: Physiologic Integrity: Physiologic Adaptation

8. The nurse is reviewing the risk factors for venous disease. Which of these situations best describes a person at highest risk for the development of venous disease?

a. Woman in her second month of pregnancy

b. Person who has been on bed rest for 4 days

c. Person with a 30-year, 1 pack per day smoking habit

d. Older adult taking anticoagulant medication

ANS: B

People who undergo prolonged standing, sitting, or bed rest are at risk for venous disease. Hypercoagulable (not anticoagulated) states and vein-wall trauma also place the person at risk for venous disease. Obesity and the late months of pregnancy are also risk factors.

DIF: Cognitive Level: Applying (Application)

MSC: Client Needs: Physiologic Integrity: Reduction of Risk Potential

9. The nurse is teaching a review class on the lymphatic system. A participant shows correct understanding of the material with which statement?

a. Lymph flow is propelled by the contraction of the heart.

b. The flow of lymph is slow, compared with that of the blood.

c. One of the functions of the lymph is to absorb lipids from the biliary tract.

d. Lymph vessels have no valves; therefore, lymph fluid flows freely from the tissue spaces into the bloodstream.

ANS: B

The flow of lymph is slow, compared with flow of the blood. Lymph flow is not propelled by the heart but rather by contracting skeletal muscles, pressure changes secondary to breathing, and contraction of the vessel walls. Lymph does not absorb lipids from the biliary tract. The vessels do have valves; therefore, flow is one way from the tissue spaces to the bloodstream.

DIF: Cognitive Level: Understanding (Comprehension)

MSC: Client Needs: Physiologic Integrity: Physiologic Adaptation

10. When performing an assessment of a patient, the nurse notices the presence of an enlarged right epitrochlear lymph node. What should the nurse do next?

a. Assess the patients abdomen, and notice any tenderness.

b. Carefully assess the cervical lymph nodes, and check for any enlargement.

c. Ask additional health history questions regarding any recent ear infections or sore throats.

d. Examine the patients lower arm and hand, and check for the presence of infection or lesions.

ANS: D

The epitrochlear nodes are located in the antecubital fossa and drain the hand and lower arm. The other actions are not correct for this assessment finding.

DIF: Cognitive Level: Applying (Application)

MSC: Client Needs: Safe and Effective Care Environment: Management of Care

11. A 35-year-old man is seen in the clinic for an infection in his left foot. Which of these findings should the nurse expect to see during an assessment of this patient?

a. Hard and fixed cervical nodes

b. Enlarged and tender inguinal nodes

c. Bilateral enlargement of the popliteal nodes

d. Pelletlike nodes in the supraclavicular region

ANS: B

The inguinal nodes in the groin drain most of the lymph of the lower extremities. With local inflammation, the nodes in that area become swollen and tender.

DIF: Cognitive Level: Applying (Application)

MSC: Client Needs: Physiologic Integrity: Physiologic Adaptation

12. The nurse is examining the lymphatic system of a healthy 3-year-old child. Which finding should the nurse expect?

a. Excessive swelling of the lymph nodes

b. Presence of palpable lymph nodes

c. No palpable nodes because of the immature immune system of a child

d. Fewer numbers and a smaller size of lymph nodes compared with those of an adult

ANS: B

Lymph nodes are relatively large in children, and the superficial ones are often palpable even when the child is healthy.

DIF: Cognitive Level: Applying (Application)

MSC: Client Needs: Health Promotion and Maintenance

13. During an assessment of an older adult, the nurse should expect to notice which finding as a normal physiologic change associated with the aging process?

a. Hormonal changes causing vasodilation and a resulting drop in blood pressure

b. Progressive atrophy of the intramuscular calf veins, causing venous insufficiency

c. Peripheral blood vessels growing more rigid with age, producing a rise in systolic blood pressure

d. Narrowing of the inferior vena cava, causing low blood flow and increases in venous pressure resulting in varicosities

ANS: C

Peripheral blood vessels grow more rigid with age, resulting in a rise in systolic blood pressure. Aging produces progressive enlargement of the intramuscular calf veins, not atrophy. The other options are not correct.

DIF: Cognitive Level: Understanding (Comprehension)

MSC: Client Needs: Health Promotion and Maintenance

14. A 67-year-old patient states that he recently began to have pain in his left calf when climbing the 10 stairs to his apartment. This pain is relieved by sitting for approximately 2 minutes; then he is able to resume his activities. The nurse interprets that this patient is most likely experiencing:

a. Claudication.

b. Sore muscles.

c. Muscle cramps.

d. Venous insufficiency.

ANS: A

Intermittent claudication feels like a cramp and is usually relieved by rest within 2 minutes. The other responses are not correct.

DIF: Cognitive Level: Analyzing (Analysis)

MSC: Client Needs: Physiologic Integrity: Physiologic Adaptation

15. A patient complains of leg pain that wakes him at night. He states that he has been having problems with his legs. He has pain in his legs when they are elevated that disappears when he dangles them. He recently noticed a sore on the inner aspect of the right ankle. On the basis of this health history information, the nurse interprets that the patient is most likely experiencing:

a. Pain related to lymphatic abnormalities.

b. Problems related to arterial insufficiency.

c. Problems related to venous insufficiency.

d. Pain related to musculoskeletal abnormalities.

ANS: B

Night leg pain is common in aging adults and may indicate the ischemic rest pain of peripheral vascular disease. Alterations in arterial circulation cause pain that becomes worse with leg elevation and is eased when the extremity is dangled.

DIF: Cognitive Level: Analyzing (Analysis)

MSC: Client Needs: Physiologic Integrity: Physiologic Adaptation

16. During an assessment, the nurse uses the *profile sign* to detect:

a. Pitting edema.

b. Early clubbing.

c. Symmetry of the fingers.

d. Insufficient capillary refill.

ANS: B

The nurse should use the profile sign (viewing the finger from the side) to detect early clubbing.

DIF: Cognitive Level: Understanding (Comprehension)

MSC: Client Needs: Physiologic Integrity: Physiologic Adaptation

17. The nurse is performing an assessment on an adult. The adults vital signs are normal, and capillary refill time is 5 seconds. What should the nurse do next?

a. Ask the patient about a history of frostbite.

b. Suspect that the patient has venous insufficiency.

c. Consider this a delayed capillary refill time, and investigate further.

d. Consider this a normal capillary refill time that requires no further assessment.

ANS: C

Normal capillary refill time is less than 1 to 2 seconds. The following conditions can skew the findings: a cool room, decreased body temperature, cigarette smoking, peripheral edema, and anemia.

DIF: Cognitive Level: Analyzing (Analysis)

MSC: Client Needs: Health Promotion and Maintenance

18. When assessing a patient, the nurse notes that the left femoral pulse as diminished, 1+/4+. What should the nurse do next?

a. Document the finding.

b. Auscultate the site for a bruit.

c. Check for calf pain.

d. Check capillary refill in the toes.

ANS: B

If a pulse is weak or diminished at the femoral site, then the nurse should auscultate for a bruit. The presence of a bruit, or turbulent blood flow, indicates partial occlusion. The other responses are not correct.

DIF: Cognitive Level: Analyzing (Analysis)

MSC: Client Needs: Safe and Effective Care Environment: Management of Care

19. When performing a peripheral vascular assessment on a patient, the nurse is unable to palpate the ulnar pulses. The patients skin is warm and capillary refill time is normal. Next, the nurse should:

a. Check for the presence of claudication.

b. Refer the individual for further evaluation.

c. Consider this finding as normal, and proceed with the peripheral vascular evaluation.

d. Ask the patient if he or she has experienced any unusual cramping or tingling in the arm.

ANS: C

Palpating the ulnar pulses is not usually necessary. The ulnar pulses are not often palpable in the normal person. The other responses are not correct.

DIF: Cognitive Level: Analyzing (Analysis)

MSC: Client Needs: Safe and Effective Care Environment: Management of Care

20. The nurse is assessing the pulses of a patient who has been admitted for untreated hyperthyroidism. The nurse should expect to find a(n) _____ pulse.

a. Normal

b. Absent

c. Bounding

d. Weak, thready

ANS: C

A full, bounding pulse occurs with hyperkinetic states (e.g., exercise, anxiety, fever), anemia, and hyperthyroidism. An absent pulse occurs with occlusion. Weak, thready pulses occur with shock and peripheral artery disease.

DIF: Cognitive Level: Understanding (Comprehension)

MSC: Client Needs: Physiologic Integrity: Physiologic Adaptation

21. The nurse is preparing to perform a modified Allen test. Which is an appropriate reason for this test?

a. To measure the rate of lymphatic drainage

b. To evaluate the adequacy of capillary patency before venous blood draws

c. To evaluate the adequacy of collateral circulation before cannulating the radial artery

d. To evaluate the venous refill rate that occurs after the ulnar and radial arteries are temporarily occluded

ANS: C

A modified Allen test is used to evaluate the adequacy of collateral circulation before the radial artery is cannulated. The other responses are not reasons for a modified Allen test.

DIF: Cognitive Level: Understanding (Comprehension)

MSC: Client Needs: Physiologic Integrity: Physiologic Adaptation

22. A patient has been diagnosed with venous stasis. Which of these findings would the nurse most likely observe?

a. Unilateral cool foot

b. Thin, shiny, atrophic skin

c. Pallor of the toes and cyanosis of the nail beds

d. Brownish discoloration to the skin of the lower leg

ANS: D

A brown discoloration occurs with chronic venous stasis as a result of hemosiderin deposits (a by-product of red blood cell degradation). Pallor, cyanosis, atrophic skin, and unilateral coolness are all signs associated with arterial problems.

DIF: Cognitive Level: Applying (Application)

MSC: Client Needs: Physiologic Integrity: Physiologic Adaptation

23. The nurse is attempting to assess the femoral pulse in a patient who is obese. Which of these actions would be most appropriate?

a. The patient is asked to assume a prone position.

b. The patient is asked to bend his or her knees to the side in a froglike position.

c. The nurse firmly presses against the bone with the patient in a semi-Fowler position.

d. The nurse listens with a stethoscope for pulsations; palpating the pulse in an obese person is extremely difficult.

ANS: B

To help expose the femoral area, particularly in obese people, the nurse should ask the person to bend his or her knees to the side in a froglike position.

DIF: Cognitive Level: Applying (Application)

MSC: Client Needs: Safe and Effective Care Environment: Management of Care

24. When auscultating over a patients femoral arteries, the nurse notices the presence of a bruit on the left side. The nurse knows that bruits:

a. Are often associated with venous disease.

b. Occur in the presence of lymphadenopathy.

c. In the femoral arteries are caused by hypermetabolic states.

d. Occur with turbulent blood flow, indicating partial occlusion.

ANS: D

A bruit occurs with turbulent blood flow and indicates partial occlusion of the artery. The other responses are not correct.

DIF: Cognitive Level: Understanding (Comprehension)

MSC: Client Needs: Safe and Effective Care Environment: Management of Care

25. How should the nurse document mild, slight pitting edema the ankles of a pregnant patient?

a. 1+/0-4+

b. 3+/0-4+

c. 4+/0-4+

d. Brawny edema

ANS: A

If pitting edema is present, then the nurse should grade it on a scale of 1+ (mild) to 4+ (severe). Brawny edema appears as nonpitting edema and feels hard to the touch.

DIF: Cognitive Level: Applying (Application)

MSC: Client Needs: Safe and Effective Care Environment: Management of Care

26. A patient has hard, nonpitting edema of the left lower leg and ankle. The right leg has no edema. Based on these findings, the nurse recalls that:

a. Nonpitting, hard edema occurs with lymphatic obstruction.

b. Alterations in arterial function will cause edema.

c. Phlebitis of a superficial vein will cause bilateral edema.

d. Long-standing arterial obstruction will cause pitting edema.

ANS: A

Unilateral edema occurs with occlusion of a deep vein and with unilateral lymphatic obstruction. With these factors, the edema is nonpitting and feels hard to the touch (brawny edema).

DIF: Cognitive Level: Applying (Application)

MSC: Client Needs: Physiologic Integrity: Physiologic Adaptation

27. When assessing a patients pulse, the nurse notes that the amplitude is weaker during inspiration and stronger during expiration. When the nurse measures the blood pressure, the reading decreases 20 mm Hg during inspiration and increases with expiration. This patient is experiencing pulsus:

a. Alternans.

b. Bisferiens.

c. Bigeminus.

d. Paradoxus.

ANS: D

In pulsus paradoxus, beats have weaker amplitude with inspiration and stronger amplitude with expiration and is best determined during blood pressure measurement; reading decreases (>10 mm Hg) during inspiration and increases with expiration.

DIF: Cognitive Level: Analyzing (Analysis)

MSC: Client Needs: Safe and Effective Care Environment: Management of Care

28. During an assessment, the nurse has elevated a patients legs 12 inches off the table and has had him wag his feet to drain off venous blood. After helping him sit up and dangle his legs over the side of the table, the nurse should expect that a normal finding at this point would be:

a. Significant elevational pallor.

b. Venous filling within 15 seconds.

c. No change in the coloration of the skin.

d. Color returning to the feet within 20 seconds of assuming a sitting position.

ANS: B

In this test, it normally takes 10 seconds or less for the color to return to the feet and 15 seconds for the veins of the feet to fill. Significant elevational pallor, as well as delayed venous filling, occurs with arterial insufficiency.

DIF: Cognitive Level: Applying (Application)

MSC: Client Needs: Safe and Effective Care Environment: Management of Care

29. During a visit to the clinic, a woman in her seventh month of pregnancy complains that her legs feel heavy in the calf and that she often has foot cramps at night. The nurse notices that the patient has dilated, tortuous veins apparent in her lower legs. Which condition is reflected by these findings?

a. Deep-vein thrombophlebitis

b. Varicose veins

c. Lymphedema

d. Raynaud phenomenon

ANS: B

Superficial varicose veins are caused by incompetent distant valves in the veins, which results in the reflux of blood, producing dilated, tortuous veins. Varicose veins are more common in women, and pregnancy can also be a cause. Symptoms include aching, heaviness in the calf, easy fatigability, and night leg or foot cramps. Dilated, tortuous veins are observed on assessment.

DIF: Cognitive Level: Applying (Application)

MSC: Client Needs: Physiologic Integrity: Physiologic Adaptation

30. During an assessment, the nurse notices that a patients left arm is swollen from the shoulder down to the fingers, with nonpitting brawny edema. The right arm is normal. The patient had a left-sided mastectomy 1 year ago. The nurse suspects which problem?

a. Venous stasis

b. Lymphedema

c. Arteriosclerosis

d. Deep-vein thrombosis

ANS: B

Lymphedema after breast cancer causes unilateral swelling and nonpitting brawny edema, with overlying skin indurated. It is caused by the removal of lymph nodes with breast surgery or damage to lymph nodes and channels with radiation therapy for breast cancer, and lymphedema can impede drainage of lymph. The other responses are not correct.

DIF: Cognitive Level: Applying (Application)

MSC: Client Needs: Safe and Effective Care Environment: Management of Care

31. The nurse is preparing to assess the ankle-brachial index (ABI) of a patient. Which statement about the ABI is *true*?

a. Normal ABI indices are from 0.5 to 1.0.

b. Normal ankle pressure is slightly lower than the brachial pressure.

c. The ABI is a reliable measurement of peripheral vascular disease in individuals with diabetes.

d. An ABI of 0.9 to 0.7 indicates the presence of peripheral vascular disease and mild claudication.

ANS: D

Use of the Doppler stethoscope is a noninvasive way to determine the extent of peripheral vascular disease. The normal ankle pressure is slightly greater than or equal to the brachial pressure. An ABI of 0.9 to 0.7 indicates the presence of peripheral vascular disease and mild claudication. The ABI is less reliable in patients with diabetes mellitus because of claudication, which makes the arteries noncompressible and may give a false high-ankle pressure.

DIF: Cognitive Level: Applying (Application)

MSC: Client Needs: Safe and Effective Care Environment: Management of Care

32. The nurse is performing a well-child checkup on a 5-year-old boy. He has no current condition that would lead the nurse to suspect an illness. His health history is unremarkable, and he received immunizations 1 week ago. Which of these findings should be considered normal in this patient?

a. Enlarged, warm, and tender nodes

b. Lymphadenopathy of the cervical nodes

c. Palpable firm, small, shotty, mobile, and nontender lymph nodes

d. Firm, rubbery, and large nodes, somewhat fixed to the underlying tissue

ANS: C

Palpable lymph nodes are often normal in children and infants. They are small, firm, shotty, mobile, and nontender. Vaccinations can produce lymphadenopathy. Enlarged, warm, and tender nodes indicate a current infection.

DIF: Cognitive Level: Analyzing (Analysis)

MSC: Client Needs: Health Promotion and Maintenance

33. When using a Doppler ultrasonic stethoscope, the nurse recognizes venous flow when which sound is heard?

a. Low humming sound

b. Regular lub, dub pattern

c. Swishing, whooshing sound

d. Steady, even, flowing sound

ANS: C

When using the Doppler ultrasonic stethoscope, the pulse site is found when one hears a swishing, whooshing sound.

DIF: Cognitive Level: Understanding (Comprehension)

MSC: Client Needs: Safe and Effective Care Environment: Management of Care

34. The nurse is describing a weak, thready pulse on the documentation flow sheet. Which statement is *correct*?

a. Is easily palpable; pounds under the fingertips.

b. Has greater than normal force, then suddenly collapses.

c. Is hard to palpate, may fade in and out, and is easily obliterated by pressure.

d. Rhythm is regular, but force varies with alternating beats of large and small amplitude.

ANS: C

A weak, thready pulse is hard to palpate, may fade in and out, and is easily obliterated by pressure. It is associated with decreased cardiac output and peripheral arterial disease.

DIF: Cognitive Level: Understanding (Comprehension)

MSC: Client Needs: Safe and Effective Care Environment: Management of Care

35. During an assessment, a patient tells the nurse that her fingers often change color when she goes out in cold weather. She describes these episodes as her fingers first turning white, then blue, then red with a burning, throbbing pain. The nurse suspects that she is experiencing:

a. Lymphedema.

b. Raynaud disease.

c. Deep-vein thrombosis.

d. Chronic arterial insufficiency.

ANS: B

The condition with episodes of abrupt, progressive tricolor changes of the fingers in response to cold, vibration, or stress is known as Raynaud disease.

DIF: Cognitive Level: Analyzing (Analysis)

MSC: Client Needs: Physiologic Integrity: Physiologic Adaptation

36. During a routine office visit, a patient takes off his shoes and shows the nurse this awful sore that wont heal. On inspection, the nurse notes a 3-cm round ulcer on the left great toe, with a pale ischemic base, well-defined edges, and no drainage. The nurse should assess for other signs and symptoms of:

a. Varicosities.

b. Venous stasis ulcer.

c. Arterial ischemic ulcer.

d. Deep-vein thrombophlebitis.

ANS: C

Arterial ischemic ulcers occur at the toes, metatarsal heads, heels, and lateral ankle and are characterized by a pale ischemic base, well-defined edges, and no bleeding.

DIF: Cognitive Level: Analyzing (Analysis)

MSC: Client Needs: Physiologic Integrity: Physiologic Adaptation

37. The nurse is reviewing an assessment of a patients peripheral pulses and notices that the documentation states that the radial pulses are 2+. The nurse recognizes that this reading indicates what type of pulse?

a. Bounding

b. Normal

c. Weak

d. Absent

ANS: B

When documenting the force, or amplitude, of pulses, 3+ indicates an increased, full, or bounding pulse, 2+ indicates a normal pulse, 1+ indicates a weak pulse, and 0 indicates an absent pulse.

DIF: Cognitive Level: Applying (Application)

MSC: Client Needs: Safe and Effective Care Environment: Management of Care

MULTIPLE RESPONSE

1. A patient is recovering from several hours of orthopedic surgery. During an assessment of the patients lower legs, the nurse will monitor for signs of acute venous symptoms. Signs of acute venous symptoms include which of the following? *Select all that apply.*

a. Intense, sharp pain, with the deep muscle tender to the touch

b. Aching, tired pain, with a feeling of fullness

c. Pain that is worse at the end of the day

d. Sudden onset

e. Warm, red, and swollen calf

f. Pain that is relieved with elevation of the leg

ANS: A, D, E

Signs and symptoms of acute venous problems include pain in the calf that has a sudden onset and that is intense and sharp with tenderness in the deep muscle when touched. The calf is warm, red, and swollen. The other options are symptoms of chronic venous problems.

DIF: Cognitive Level: Analyzing (Analysis)

MSC: Client Needs: Physiologic Integrity: Reduction of Risk Potential

2. A patient has been admitted with chronic arterial symptoms. During the assessment, the nurse should expect which findings? *Select all that apply.*

a. Patient has a history of diabetes and cigarette smoking.

b. Skin of the patient is pale and cool.

c. His ankles have two small, weeping ulcers.

d. Patient works long hours sitting at a computer desk.

e. He states that the pain gets worse when walking.

f. Patient states that the pain is worse at the end of the day.

ANS: A, B, E

Patients with chronic arterial symptoms often have a history of smoking and diabetes (among other risk factors). The pain has a gradual onset with exertion and is relieved with rest or dangling. The skin appears cool and pale. The other responses reflect chronic venous problems.

DIF: Cognitive Level: Analyzing (Analysis)

MSC: Client Needs: Physiologic Integrity: Reduction of Risk Potential

Chapter 22: Abdomen

MULTIPLE CHOICE

1. The nurse is percussing the seventh right intercostal space at the midclavicular line over the liver. Which sound should the nurse expect to hear?

a. Dullness

b. Tympany

c. Resonance

d. Hyperresonance

ANS: A

The liver is located in the right upper quadrant and would elicit a dull percussion note.

DIF: Cognitive Level: Understanding (Comprehension)

MSC: Client Needs: Safe and Effective Care Environment: Management of Care

2. Which structure is located in the left lower quadrant of the abdomen?

a. Liver

b. Duodenum

c. Gallbladder

d. Sigmoid colon

ANS: D

The sigmoid colon is located in the left lower quadrant of the abdomen.

DIF: Cognitive Level: Remembering (Knowledge)

MSC: Client Needs: General

3. A patient is having difficulty swallowing medications and food. The nurse would document that this patient has:

a. Aphasia.

b. Dysphasia.

c. Dysphagia.

d. Anorexia.

ANS: C

Dysphagia is a condition that occurs with disorders of the throat or esophagus and results in difficulty swallowing. Aphasia and dysphasia are speech disorders. Anorexia is a loss of appetite.

DIF: Cognitive Level: Applying (Application)

MSC: Client Needs: Safe and Effective Care Environment: Management of Care

4. The nurse suspects that a patient has a distended bladder. How should the nurse assess for this condition?

a. Percuss and palpate in the lumbar region.

b. Inspect and palpate in the epigastric region.

c. Auscultate and percuss in the inguinal region.

d. Percuss and palpate the midline area above the suprapubic bone.

ANS: D

Dull percussion sounds would be elicited over a distended bladder, and the hypogastric area would seem firm to palpation.

DIF: Cognitive Level: Applying (Application)

MSC: Client Needs: Safe and Effective Care Environment: Management of Care

5. The nurse is aware that one change that may occur in the gastrointestinal system of an aging adult is:

a. Increased salivation.

b. Increased liver size.

c. Increased esophageal emptying.

d. Decreased gastric acid secretion.

ANS: D

Gastric acid secretion decreases with aging. As one ages, salivation decreases, esophageal emptying is delayed, and liver size decreases.

DIF: Cognitive Level: Understanding (Comprehension)

MSC: Client Needs: Health Promotion and Maintenance

6. A 22-year-old man comes to the clinic for an examination after falling off his motorcycle and landing on his left side on the handle bars. The nurse suspects that he may have injured his spleen. Which of these statements

is *true*regarding assessment of the spleen in this situation?

a. The spleen can be enlarged as a result of trauma.

b. The spleen is normally felt on routine palpation.

c. If an enlarged spleen is noted, then the nurse should thoroughly palpate to determine its size.

d. An enlarged spleen should not be palpated because it can easily rupture.

ANS: D

If an enlarged spleen is felt, then the nurse should refer the person and should not continue to palpate it. An enlarged spleen is friable and can easily rupture with overpalpation.

DIF: Cognitive Level: Applying (Application)

MSC: Client Needs: Physiologic Integrity: Physiologic Adaptation

7. A patients abdomen is bulging and stretched in appearance. The nurse should describe this finding as:

a. Obese.

b. Herniated.

c. Scaphoid.

d. Protuberant.

ANS: D

A protuberant abdomen is rounded, bulging, and stretched. A scaphoid abdomen caves inward.

DIF: Cognitive Level: Remembering (Knowledge)

MSC: Client Needs: Physiologic Integrity: Physiologic Adaptation

8. The nurse is describing a scaphoid abdomen. To the horizontal plane, a scaphoid contour of the abdomen depicts a _____ profile.

a. Flat

b. Convex

c. Bulging

d. Concave

ANS: D

Contour describes the profile of the abdomen from the rib margin to the pubic bone; a scaphoid contour is one that is concave from a horizontal plane.

DIF: Cognitive Level: Understanding (Comprehension)

MSC: Client Needs: Physiologic Integrity: Physiologic Adaptation

9. While examining a patient, the nurse observes abdominal pulsations between the xiphoid process and umbilicus. The nurse would suspect that these are:

a. Pulsations of the renal arteries.

b. Pulsations of the inferior vena cava.

c. Normal abdominal aortic pulsations.

d. Increased peristalsis from a bowel obstruction.

ANS: C

Normally, the pulsations from the aorta are observed beneath the skin in the epigastric area, particularly in thin persons who have good muscle wall relaxation.

DIF: Cognitive Level: Applying (Application)

MSC: Client Needs: Safe and Effective Care Environment: Management of Care

10. A patient has hypoactive bowel sounds. The nurse knows that a potential cause of hypoactive bowel sounds is:

a. Diarrhea.

b. Peritonitis.

c. Laxative use.

d. Gastroenteritis.

ANS: B

Diminished or absent bowel sounds signal decreased motility from inflammation as exhibited with peritonitis, with paralytic ileus after abdominal surgery, or with late bowel obstruction.

DIF: Cognitive Level: Understanding (Comprehension)

MSC: Client Needs: Physiologic Integrity: Physiologic Adaptation

11. The nurse is watching a new graduate nurse perform auscultation of a patients abdomen. Which statement by the new graduate shows a *correct* understanding of the reason auscultation precedes percussion and palpation of the abdomen?

a. We need to determine the areas of tenderness before using percussion and palpation.

b. Auscultation prevents distortion of bowel sounds that might occur after percussion and palpation.

c. Auscultation allows the patient more time to relax and therefore be more comfortable with the physical examination.

d. Auscultation prevents distortion of vascular sounds, such as bruits and hums, that might occur after percussion and palpation.

ANS: B

Auscultation is performed first (after inspection) because percussion and palpation can increase peristalsis, which would give a false interpretation of bowel sounds.

DIF: Cognitive Level: Applying (Application)

MSC: Client Needs: Safe and Effective Care Environment: Management of Care

12. The nurse is listening to bowel sounds. Which of these statements is *true* of bowel sounds? Bowel sounds:

a. Are usually loud, high-pitched, rushing, and tinkling sounds.

b. Are usually high-pitched, gurgling, and irregular sounds.

c. Sound like two pieces of leather being rubbed together.

d. Originate from the movement of air and fluid through the large intestine.

ANS: B

Bowel sounds are high-pitched, gurgling, and cascading sounds that irregularly occur from 5 to 30 times per minute. They originate from the movement of air and fluid through the small intestine.

DIF: Cognitive Level: Understanding (Comprehension)

MSC: Client Needs: Safe and Effective Care Environment: Management of Care

13. The physician comments that a patient has abdominal borborygmi. The nurse knows that this term refers to:

a. Loud continual hum.

b. Peritoneal friction rub.

c. Hypoactive bowel sounds.

d. Hyperactive bowel sounds.

ANS: D

Borborygmi is the term used for hyperperistalsis when the person actually feels his or her stomach growling.

DIF: Cognitive Level: Understanding (Comprehension)

MSC: Client Needs: Safe and Effective Care Environment: Management of Care

14. During an abdominal assessment, the nurse would consider which of these findings as normal?

a. Presence of a bruit in the femoral area

b. Tympanic percussion note in the umbilical region

c. Palpable spleen between the ninth and eleventh ribs in the left midaxillary line

d. Dull percussion note in the left upper quadrant at the midclavicular line

ANS: B

Tympany should predominate in all four quadrants of the abdomen because air in the intestines rises to the surface when the person is supine. Vascular bruits are not usually present. Normally, the spleen is not palpable. Dullness would not be found in the area of lung resonance (left upper quadrant at the midclavicular line).

DIF: Cognitive Level: Understanding (Comprehension)

MSC: Client Needs: Safe and Effective Care Environment: Management of Care

15. The nurse is assessing the abdomen of a pregnant woman who is complaining of having acid indigestion all the time. The nurse knows that esophageal reflux during pregnancy can cause:

a. Diarrhea.

b. Pyrosis.

c. Dysphagia.

d. Constipation.

ANS: B

Pyrosis, or heartburn, is caused by esophageal reflux during pregnancy. The other options are not correct.

DIF: Cognitive Level: Applying (Application)

MSC: Client Needs: Physiologic Integrity: Physiologic Adaptation

16. The nurse is performing percussion during an abdominal assessment. Percussion notes heard during the abdominal assessment may include:

a. Flatness, resonance, and dullness.

b. Resonance, dullness, and tympany.

c. Tympany, hyperresonance, and dullness.

d. Resonance, hyperresonance, and flatness.

ANS: C

Percussion notes normally heard during the abdominal assessment may include tympany, which should predominate because air in the intestines rises to the surface when the person is supine; hyperresonance, which may be present with gaseous distention; and dullness, which may be found over a distended bladder, adipose tissue, fluid, or a mass.

DIF: Cognitive Level: Understanding (Comprehension)

MSC: Client Needs: Safe and Effective Care Environment: Management of Care

17. An older patient has been diagnosed with pernicious anemia. The nurse knows that this condition could be related to:

a. Increased gastric acid secretion.

b. Decreased gastric acid secretion.

c. Delayed gastrointestinal emptying time.

d. Increased gastrointestinal emptying time.

ANS: B

Gastric acid secretion decreases with aging and may cause pernicious anemia (because it interferes with vitamin B_{12} absorption), iron-deficiency anemia, and malabsorption of calcium.

DIF: Cognitive Level: Applying (Application)

MSC: Client Needs: Physiologic Integrity: Physiologic Adaptation

18. A patient is complaining of a sharp pain along the costovertebral angles. The nurse is aware that this symptom is most often indicative of:

a. Ovary infection.

b. Liver enlargement.

c. Kidney inflammation.

d. Spleen enlargement.

ANS: C

Sharp pain along the costovertebral angles occurs with inflammation of the kidney or paranephric area. The other options are not correct.

DIF: Cognitive Level: Applying (Application)

MSC: Client Needs: Physiologic Integrity: Physiologic Adaptation

19. A nurse notices that a patient has ascites, which indicates the presence of:

a. Fluid.

b. Feces.

c. Flatus.

d. Fibroid tumors.

ANS: A

Ascites is free fluid in the peritoneal cavity and occurs with heart failure, portal hypertension, cirrhosis, hepatitis, pancreatitis, and cancer.

DIF: Cognitive Level: Understanding (Comprehension)

MSC: Client Needs: Physiologic Integrity: Physiologic Adaptation

20. The nurse knows that during an abdominal assessment, deep palpation is used to determine:

a. Bowel motility.

b. Enlarged organs.

c. Superficial tenderness.

d. Overall impression of skin surface and superficial musculature.

ANS: B

With deep palpation, the nurse should notice the location, size, consistency, and mobility of any palpable organs and the presence of any abnormal enlargement, tenderness, or masses.

DIF: Cognitive Level: Understanding (Comprehension)

MSC: Client Needs: Safe and Effective Care Environment: Management of Care

21. The nurse notices that a patient has had a black, tarry stool and recalls that a possible cause would be:

a. Gallbladder disease.

b. Overuse of laxatives.

c. Gastrointestinal bleeding.

d. Localized bleeding around the anus.

ANS: C

Black stools may be tarry as a result of occult blood (melena) from gastrointestinal bleeding. Red blood in stools occurs with localized bleeding around the anus.

DIF: Cognitive Level: Understanding (Comprehension)

MSC: Client Needs: Physiologic Integrity: Physiologic Adaptation

22. During an abdominal assessment, the nurse elicits tenderness on light palpation in the right lower quadrant. The nurse interprets that this finding could indicate a disorder of which of these structures?

a. Spleen

b. Sigmoid

c. Appendix

d. Gallbladder

ANS: C

The appendix is located in the right lower quadrant. When the iliopsoas muscle is inflamed, which occurs with an inflamed or perforated appendix, pain is felt in the right lower quadrant.

DIF: Cognitive Level: Applying (Application)

MSC: Client Needs: Physiologic Integrity: Physiologic Adaptation

23. The nurse is assessing the abdomen of an older adult. Which statement regarding the older adult and abdominal assessment is *true*?

a. Abdominal tone is increased.

b. Abdominal musculature is thinner.

c. Abdominal rigidity with an acute abdominal condition is more common.

d. The older adult with an acute abdominal condition complains more about pain than the younger person.

ANS: B

In the older adult, the abdominal musculature is thinner and has less tone than that of the younger adult, and abdominal rigidity with an acute abdominal condition is less common in the aging person. The older adult with

an acute abdominal condition often complains less about pain than the younger person.

DIF: Cognitive Level: Applying (Application)

MSC: Client Needs: Health Promotion and Maintenance

24. During an assessment of a newborn infant, the nurse recalls that pyloric stenosis would be exhibited by:

a. Projectile vomiting.

b. Hypoactive bowel activity.

c. Palpable olive-sized mass in the right lower quadrant.

d. Pronounced peristaltic waves crossing from right to left.

ANS: A

Significant peristalsis, together with projectile vomiting, in the newborn suggests pyloric stenosis. After feeding, pronounced peristaltic waves cross from *left to right*, leading to projectile vomiting. One can also palpate an olive-sized mass in the right *upper* quadrant.

DIF: Cognitive Level: Applying (Application)

MSC: Client Needs: Health Promotion and Maintenance

25. The nurse is reviewing the assessment of an aortic aneurysm. Which of these statements is *true* regarding an aortic aneurysm?

a. A bruit is absent.

b. Femoral pulses are increased.

c. A pulsating mass is usually present.

d. Most are located below the umbilicus.

ANS: C

Most aortic aneurysms are palpable during routine examination and feel like a pulsating mass. A bruit will be audible, and femoral pulses are present but decreased. Such aneurysms are located in the upper abdomen just to the left of midline.

DIF: Cognitive Level: Understanding (Comprehension)

MSC: Client Needs: Physiologic Integrity: Physiologic Adaptation

26. During an abdominal assessment, the nurse is unable to hear bowel sounds in a patients abdomen. Before reporting this finding as *silent bowel sounds*, the nurse should listen for at least:

a. 1 minute.

b. 5 minutes.

c. 10 minutes.

d. 2 minutes in each quadrant.

ANS: B

Absent bowel sounds are rare. The nurse must listen for 5 minutes before deciding that bowel sounds are completely absent.

DIF: Cognitive Level: Applying (Application)

MSC: Client Needs: Safe and Effective Care Environment: Management of Care

27. A patient is suspected of having inflammation of the gallbladder, or cholecystitis. The nurse should conduct which of these techniques to assess for this condition?

a. Obturator test

b. Test for Murphy sign

c. Assess for rebound tenderness

d. Iliopsoas muscle test

ANS: B

Normally, palpating the liver causes no pain. In a person with inflammation of the gallbladder, or cholecystitis, pain occurs as the descending liver pushes the inflamed gallbladder onto the examining hand during inspiration (Murphy test). The person feels sharp pain and abruptly stops midway during inspiration.

DIF: Cognitive Level: Understanding (Comprehension)

MSC: Client Needs: Physiologic Integrity: Physiologic Adaptation

28. Just before going home, a new mother asks the nurse about the infants umbilical cord. Which of these statements is *correct*?

a. It should fall off in 10 to 14 days.

b. It will soften before it falls off.

c. It contains two veins and one artery.

d. Skin will cover the area within 1 week.

ANS: A

At birth, the umbilical cord is white and contains two umbilical arteries and one vein inside the Wharton jelly. The umbilical stump dries within a week, hardens, and falls off in 10 to 14 days. Skin will cover the area in 3 to 4 weeks.

DIF: Cognitive Level: Applying (Application)

MSC: Client Needs: Health Promotion and Maintenance

29. Which of these percussion findings would the nurse expect to find in a patient with a large amount of ascites?

a. Dullness across the abdomen

b. Flatness in the right upper quadrant

c. Hyperresonance in the left upper quadrant

d. Tympany in the right and left lower quadrants

ANS: A

A large amount of ascitic fluid produces a dull sound to percussion.

DIF: Cognitive Level: Understanding (Comprehension)

MSC: Client Needs: Physiologic Integrity: Physiologic Adaptation

30. A 40-year-old man states that his physician told him that he has a hernia. He asks the nurse to explain what a hernia is. Which response by the nurse is appropriate?

a. No need to worry. Most men your age develop hernias.

b. A hernia is a loop of bowel protruding through a weak spot in the abdominal muscles.

c. A hernia is the result of prenatal growth abnormalities that are just now causing problems.

d. Ill have to have your physician explain this to you.

ANS: B

The nurse should explain that a hernia is a protrusion of the abdominal viscera through an abnormal opening in the muscle wall.

DIF: Cognitive Level: Applying (Application)

MSC: Client Needs: Physiologic Integrity: Physiologic Adaptation

31. A 45-year-old man is in the clinic for a physical examination. During the abdominal assessment, the nurse percusses the abdomen and notices an area of dullness above the right costal margin of approximately 11 cm. The nurse should:

a. Document the presence of hepatomegaly.

b. Ask additional health history questions regarding his alcohol intake.

c. Describe this dullness as indicative of an enlarged liver, and refer him to a physician.

d. Consider this finding as normal, and proceed with the examination.

ANS: D

A liver span of 10.5 cm is the mean for males and 7 cm for females. Men and taller individuals are at the upper end of this range. Women and shorter individuals are at the lower end of this range. A liver span of 11 cm is within normal limits for this individual.

DIF: Cognitive Level: Analyzing (Analysis)

MSC: Client Needs: Safe and Effective Care Environment: Management of Care

32. When palpating the abdomen of a 20-year-old patient, the nurse notices the presence of tenderness in the left upper quadrant with deep palpation. Which of these structures is most likely to be involved?

a. Spleen

b. Sigmoid colon

c. Appendix

d. Gallbladder

ANS: A

The spleen is located in the left upper quadrant of the abdomen. The gallbladder is in the right upper quadrant, the sigmoid colon is in the left lower quadrant, and the appendix is in the right lower quadrant.

DIF: Cognitive Level: Applying (Application)

MSC: Client Needs: Physiologic Integrity: Physiologic Adaptation

33. The nurse is reviewing statistics for lactose intolerance. In the United States, the incidence of lactose intolerance is higher in adults of which ethnic group?

a. Blacks

b. Hispanics

c. Whites

d. Asians

ANS: A

A recent study found estimates of lactose-intolerance prevalence as follows: 19.5% for Blacks, 10% for Hispanics, and 7.72% for Whites.

DIF: Cognitive Level: Understanding (Comprehension)

MSC: Client Needs: Health Promotion and Maintenance

34. The nurse is assessing a patient for possible peptic ulcer disease. Which condition or history often causes this problem?

a. Hypertension

b. Streptococcal infections

c. Recurrent constipation with frequent laxative use

d. Frequent use of nonsteroidal antiinflammatory drugs

ANS: D

Peptic ulcer disease occurs with the frequent use of nonsteroidal antiinflammatory drugs, alcohol use, smoking, and *Helicobacter pylori* infection.

DIF: Cognitive Level: Applying (Application)

MSC: Client Needs: Physiologic Integrity: Reduction of Risk Potential

35. During reporting, the student nurse hears that a patient has *hepatomegaly* and recognizes that this term refers to:

a. Enlarged liver.

b. Enlarged spleen.

c. Distended bowel.

d. Excessive diarrhea.

ANS: A

The term *hepatomegaly* refers to an enlarged liver. The term *splenomegaly* refers to an enlarged spleen. The other responses are not correct.

DIF: Cognitive Level: Remembering (Knowledge)

MSC: Client Needs: Physiologic Integrity: Physiologic Adaptation

36. During an assessment, the nurse notices that a patients umbilicus is enlarged and everted. It is positioned midline with no change in skin color. The nurse recognizes that the patient may have which condition?

a. Intra-abdominal bleeding

b. Constipation

c. Umbilical hernia

d. Abdominal tumor

ANS: C

The umbilicus is normally midline and inverted with no signs of discoloration. With an umbilical hernia, the mass is enlarged and everted. The other responses are incorrect.

DIF: Cognitive Level: Applying (Application)

MSC: Client Needs: Physiologic Integrity: Physiologic Adaptation

37. During an abdominal assessment, the nurse tests for a fluid wave. A positive fluid wave test occurs with:

a. Splenomegaly.

b. Distended bladder.

c. Constipation.

d. Ascites.

ANS: D

If ascites (fluid in the abdomen) is present, then the examiner will feel a fluid wave when assessing the abdomen. A fluid wave is not present with splenomegaly, a distended bladder, or constipation.

DIF: Cognitive Level: Applying (Application)

MSC: Client Needs: Physiologic Integrity: Physiologic Adaptation

38. The nurse is preparing to examine a patient who has been complaining of right lower quadrant pain. Which technique is *correct* during the assessment?

The nurse should:

a. Examine the tender area first.

b. Examine the tender area last.

c. Avoid palpating the tender area.

d. Palpate the tender area first, and then auscultate for bowel sounds.

ANS: B

The nurse should save the examination of any identified tender areas until last. This method avoids pain and the resulting muscle rigidity that would obscure deep palpation later in the examination. Auscultation is performed before percussion and palpation because percussion and palpation can increase peristalsis, which would give a false interpretation of bowel sounds.

DIF: Cognitive Level: Analyzing (Analysis)

MSC: Client Needs: Safe and Effective Care Environment: Management of Care

39. During a health history, the patient tells the nurse, I have pain all the time in my stomach. Its worse 2 hours after I eat, but it gets better if I eat again! Based on these symptoms, the nurse suspects that the patient has which condition?

a. Appendicitis

b. Gastric ulcer

c. Duodenal ulcer

d. Cholecystitis

ANS: C

Pain associated with duodenal ulcers occurs 2 to 3 hours after a meal; it may relieved by more food. Chronic pain associated with gastric ulcers usually occurs on an empty stomach. Severe, acute pain would occur with appendicitis and cholecystitis.

DIF: Cognitive Level: Applying (Application)

MSC: Client Needs: Safe and Effective Care Environment: Management of Care

MULTIPLE RESPONSE

1. The nurse suspects that a patient has appendicitis. Which of these procedures are appropriate for use when assessing for appendicitis or a perforated appendix? *Select all that apply*.

a. Test for the Murphy sign

b. Test for the Blumberg sign

c. Test for shifting dullness

d. Perform the iliopsoas muscle test

e. Test for fluid wave

ANS: B, D

Testing for the Blumberg sign (rebound tenderness) and performing the iliopsoas muscle test should be used when assessing for appendicitis. The Murphy sign is used when assessing for an inflamed gallbladder or cholecystitis. Testing for a fluid wave and shifting dullness is performed when assessing for ascites.

DIF: Cognitive Level: Applying (Application)

MSC: Client Needs: Physiologic Integrity: Physiologic Adaptation

Chapter 23: Musculoskeletal System

MULTIPLE CHOICE

1. A patient is being assessed for range-of-joint movement. The nurse asks him to move his arm in toward the center of his body. This movement is called:

a. Flexion.

b. Abduction.

c. Adduction.

d. Extension.

ANS: C

Moving a limb toward the midline of the body is called *adduction*; moving a limb away from the midline of the body is called *abduction*. *Flexion* is bending a limb at a joint; and *extension* is straightening a limb at a joint.

DIF: Cognitive Level: Understanding (Comprehension)

MSC: Client Needs: Physiologic Integrity: Physiologic Adaptation

2. A patient tells the nurse that she is having a hard time bringing her hand to her mouth when she eats or tries to brush her teeth. The nurse knows that for her to move her hand to her mouth, she must perform which movement?

a. Flexion

b. Abduction

c. Adduction

d. Extension

ANS: A

Flexion, or bending a limb at a joint, is required to move the hand to the mouth. *Extension* is straightening a limb at a joint. Moving a limb toward the midline of the body is called *adduction*; *abduction* is moving a limb away from the midline of the body.

DIF: Cognitive Level: Understanding (Comprehension)

MSC: Client Needs: Physiologic Integrity: Physiologic Adaptation

3. The functional units of the musculoskeletal system are the:

a. Joints.

b. Bones.

c. Muscles.

d. Tendons.

ANS: A

Joints are the functional units of the musculoskeletal system because they permit the mobility needed to perform the activities of daily living. The skeleton (bones) is the framework of the body. The other options are not correct.

DIF: Cognitive Level: Remembering (Knowledge)

MSC: Client Needs: General

4. When reviewing the musculoskeletal system, the nurse recalls that hematopoiesis takes place in the:

a. Liver.

b. Spleen.

c. Kidneys.

d. Bone marrow.

ANS: D

The musculoskeletal system functions to encase and protect the inner vital organs, to support the body, to produce red blood cells in the bone marrow (hematopoiesis), and to store minerals. The other options are not correct.

DIF: Cognitive Level: Remembering (Knowledge)

MSC: Client Needs: General

5. Fibrous bands running directly from one bone to another that strengthen the joint and help prevent movement in undesirable directions are called:

a. Bursa.

b. Tendons.

c. Cartilage.

d. Ligaments.

ANS: D

Fibrous bands running directly from one bone to another that strengthen the joint and help prevent movement

in undesirable directions are called *ligaments*. The other options are not correct.

DIF: Cognitive Level: Remembering (Knowledge)

MSC: Client Needs: General

6. The nurse notices that a woman in an exercise class is unable to jump rope. The nurse is aware that to jump rope, ones shoulder has to be capable of:

a. Inversion.

b. Supination.

c. Protraction.

d. Circumduction.

ANS: D

Circumduction is defined as moving the arm in a circle around the shoulder. The other options are not correct.

DIF: Cognitive Level: Applying (Application)

MSC: Client Needs: Physiologic Integrity: Physiologic Adaptation

7. The articulation of the mandible and the temporal bone is known as the:

a. Intervertebral foramen.

b. Condyle of the mandible.

c. Temporomandibular joint.

d. Zygomatic arch of the temporal bone.

ANS: C

The articulation of the mandible and the temporal bone is the temporomandibular joint. The other responses are not correct.

DIF: Cognitive Level: Remembering (Knowledge)

MSC: Client Needs: General

8. To palpate the temporomandibular joint, the nurses fingers should be placed in the depression _____ of the ear.

a. Distal to the helix

b. Proximal to the helix

c. Anterior to the tragus

d. Posterior to the tragus

ANS: C

The temporomandibular joint can be felt in the depression anterior to the tragus of the ear. The other locations are not correct.

DIF: Cognitive Level: Understanding (Comprehension)

MSC: Client Needs: Safe and Effective Care Environment: Management of Care

9. Of the 33 vertebrae in the spinal column, there are:

a. 5 lumbar.

b. 5 thoracic.

c. 7 sacral.

d. 12 cervical.

ANS: A

There are 7 cervical, 12 thoracic, 5 lumbar, 5 sacral, and 3 to 4 coccygeal vertebrae in the spinal column.

DIF: Cognitive Level: Remembering (Knowledge)

MSC: Client Needs: General

10. An imaginary line connecting the highest point on each iliac crest would cross the _____ vertebra.

a. First sacral

b. Fourth lumbar

c. Seventh cervical

d. Twelfth thoracic

ANS: B

An imaginary line connecting the highest point on each iliac crest crosses the fourth lumbar vertebra. The other options are not correct.

DIF: Cognitive Level: Remembering (Knowledge)

MSC: Client Needs: General

11. The nurse is explaining to a patient that there are *shock absorbers* in his back to cushion the spine and to

help it move. The nurse is referring to his:

a. Vertebral column.

b. Nucleus pulposus.

c. Vertebral foramen.

d. Intervertebral disks.

ANS: D

Intervertebral disks are elastic fibrocartilaginous plates that cushion the spine similar to shock absorbers and help it move. The vertebral column is the spinal column itself. The nucleus pulposus is located in the center of each disk. The vertebral foramen is the channel, or opening, for the spinal cord in the vertebrae.

DIF: Cognitive Level: Understanding (Comprehension)

MSC: Client Needs: Physiologic Integrity: Physiologic Adaptation

12. The nurse is providing patient education for a man who has been diagnosed with a rotator cuff injury. The nurse knows that a rotator cuff injury involves the:

a. Nucleus pulposus.

b. Articular processes.

c. Medial epicondyle.

d. Glenohumeral joint.

ANS: D

A rotator cuff injury involves the glenohumeral joint, which is enclosed by a group of four powerful muscles and tendons that support and stabilize it. The nucleus pulposus is located in the center of each intervertebral disk. The articular processes are projections in each vertebral disk that lock onto the next vertebra, thereby stabilizing the spinal column. The medial epicondyle is located at the elbow.

DIF: Cognitive Level: Applying (Application)

MSC: Client Needs: Physiologic Integrity: Physiologic Adaptation

13. During an interview the patient states, I can feel this bump on the top of both of my shouldersit doesnt hurt but I am curious about what it might be. The nurse should tell the patient that it is his:

a. Subacromial bursa.

b. Acromion process.

c. Glenohumeral joint.

d. Greater tubercle of the humerus.

ANS: B

The bump of the scapulas acromion process is felt at the very top of the shoulder. The other options are not correct.

DIF: Cognitive Level: Applying (Application)

MSC: Client Needs: Physiologic Integrity: Physiologic Adaptation

14. The nurse is checking the range of motion in a patients knee and knows that the knee is capable of which movement(s)?

a. Flexion and extension

b. Supination and pronation

c. Circumduction

d. Inversion and eversion

ANS: A

The knee is a hinge joint, permitting flexion and extension of the lower leg on a single plane. The knee is not capable of the other movements listed.

DIF: Cognitive Level: Understanding (Comprehension)

MSC: Client Needs: Physiologic Integrity: Physiologic Adaptation

15. A patient is visiting the clinic for an evaluation of a swollen, painful knuckle. The nurse notices that the knuckle above his ring on the left hand is swollen and that he is unable to remove his wedding ring. This joint is called the _____ joint.

a. Interphalangeal

b. Tarsometatarsal

c. Metacarpophalangeal

d. Tibiotalar

ANS: C

The joint located just above the ring on the finger is the metacarpophalangeal joint. The interphalangeal joint is located distal to the metacarpophalangeal joint. The tarsometatarsal and tibiotalar joints are found in the foot and ankle.

DIF: Cognitive Level: Understanding (Comprehension)

MSC: Client Needs: Physiologic Integrity: Physiologic Adaptation

16. The nurse is assessing a patients ischial tuberosity. To palpate the ischial tuberosity, the nurse knows that it is best to have the patient:

a. Standing.

b. Flexing the hip.

c. Flexing the knee.

d. Lying in the supine position.

ANS: B

The ischial tuberosity lies under the gluteus maximus muscle and is palpable when the hip is flexed. The other options are not correct.

DIF: Cognitive Level: Understanding (Comprehension)

MSC: Client Needs: Safe and Effective Care Environment: Management of Care

17. The nurse is examining the hip area of a patient and palpates a flat depression on the upper, lateral side of the thigh when the patient is standing. The nurse interprets this finding as the:

a. Ischial tuberosity.

b. Greater trochanter.

c. Iliac crest.

d. Gluteus maximus muscle.

ANS: B

The greater trochanter of the femur is palpated when the person is standing, and it appears as a flat depression on the upper lateral side of the thigh. The iliac crest is the upper part of the hip bone; the ischial tuberosity lies under the gluteus maximus muscle and is palpable when the hip is flexed; and the gluteus muscle is part of the buttocks.

DIF: Cognitive Level: Understanding (Comprehension)

MSC: Client Needs: Physiologic Integrity: Physiologic Adaptation

18. The ankle joint is the articulation of the tibia, fibula, and:

a. Talus.

b. Cuboid.

c. Calcaneus.

d. Cuneiform bones.

ANS: A

The ankle or tibiotalar joint is the articulation of the tibia, fibula, and talus. The other bones listed are foot bones and not part of the ankle joint.

DIF: Cognitive Level: Remembering (Knowledge)

MSC: Client Needs: General

19. The nurse is explaining the mechanism of the growth of long bones to a mother of a toddler. Where does lengthening of the bones occur?

a. Bursa

b. Calcaneus

c. Epiphyses

d. Tuberosities

ANS: C

Lengthening occurs at the epiphyses, or growth plates. The other options are not correct.

DIF: Cognitive Level: Understanding (Comprehension)

MSC: Client Needs: Health Promotion and Maintenance

20. A woman who is 8 months pregnant comments that she has noticed a change in her posture and is having lower back pain. The nurse tells her that during pregnancy, women have a posture shift to compensate for the enlarging fetus. This shift in posture is known as:

a. Lordosis.

b. Scoliosis.

c. Ankylosis.

d. Kyphosis.

ANS: A

Lordosis compensates for the enlarging fetus, which would shift the center of balance forward. This shift in balance, in turn, creates a strain on the low back muscles, felt as low back pain during late pregnancy by some women. Scoliosis is lateral curvature of portions of the spine; ankylosis is extreme flexion of the wrist, as observed with severe rheumatoid arthritis; and kyphosis is an enhanced thoracic curvature of the spine.

DIF: Cognitive Level: Understanding (Comprehension)

MSC: Client Needs: Health Promotion and Maintenance

21. An 85-year-old patient comments during his annual physical examination that he seems to be getting shorter as he ages. The nurse should explain that decreased height occurs with aging because:

a. Long bones tend to shorten with age.

b. The vertebral column shortens.

c. A significant loss of subcutaneous fat occurs.

d. A thickening of the intervertebral disks develops.

ANS: B

Postural changes are evident with aging; decreased height is most noticeable and is due to shortening of the vertebral column. Long bones do not shorten with age. Intervertebral disks actually get thinner with age. Subcutaneous fat is not lost but is redistributed to the abdomen and hips.

DIF: Cognitive Level: Applying (Application)

MSC: Client Needs: Health Promotion and Maintenance

22. A patient has been diagnosed with osteoporosis and asks the nurse, What is osteoporosis? The nurse explains that osteoporosis is defined as:

a. Increased bone matrix.

b. Loss of bone density.

c. New, weaker bone growth.

d. Increased phagocytic activity.

ANS: B

After age 40 years, a loss of bone matrix (resorption) occurs more rapidly than new bone formation. The net effect is a gradual loss of bone density, or osteoporosis. The other options are not correct.

DIF: Cognitive Level: Remembering (Knowledge)

MSC: Client Needs: Physiologic Integrity: Physiologic Adaptation

23. The nurse is teaching a class on preventing osteoporosis to a group of perimenopausal women. Which of these actions is the *best* way to prevent or delay bone loss in this group?

a. Taking calcium and vitamin D supplements

b. Taking medications to prevent osteoporosis

c. Performing physical activity, such as fast walking

d. Assessing bone density annually

ANS: C

Physical activity, such as fast walking, delays or prevents bone loss in perimenopausal women. The faster the pace of walking, the higher the preventive effect is on the risk of hip fracture. The other options are not correct.

DIF: Cognitive Level: Applying (Application)

MSC: Client Needs: Health Promotion and Maintenance

24. A teenage girl has arrived complaining of pain in her left wrist. She was playing basketball when she fell and landed on her left hand. The nurse examines her hand and would expect a fracture if the girl complains of a:

a. Dull ache.

b. Deep pain in her wrist.

c. Sharp pain that increases with movement.

d. Dull throbbing pain that increases with rest.

ANS: C

A fracture causes sharp pain that increases with movement. The other types of pain do not occur with a fracture.

DIF: Cognitive Level: Analyzing (Analysis)

MSC: Client Needs: Physiologic Integrity: Physiologic Adaptation

25. A patient is complaining of pain in his joints that is worse in the morning, better after he moves around for a while, and then gets worse again if he sits for long periods. The nurse should assess for other signs of what problem?

a. Tendinitis

b. Osteoarthritis

c. Rheumatoid arthritis

d. Intermittent claudication

ANS: C

Rheumatoid arthritis is worse in the morning when a person arises. Movement increases most joint pain, except

the pain with rheumatoid arthritis, which decreases with movement. The other options are not correct.

DIF: Cognitive Level: Analyzing (Analysis)

MSC: Client Needs: Physiologic Integrity: Physiologic Adaptation

26. A patient states, I can hear a crunching or grating sound when I kneel. She also states that it is very difficult to get out of bed in the morning because of stiffness and pain in my joints. The nurse should assess for signs of what problem?

a. Crepitation

b. Bone spur

c. Loose tendon

d. Fluid in the knee joint

ANS: A

Crepitation is an audible and palpable crunching or grating that accompanies movement and occurs when articular surfaces in the joints are roughened, as with rheumatoid arthritis. The other options are not correct.

DIF: Cognitive Level: Analyzing (Analysis)

MSC: Client Needs: Physiologic Integrity: Physiologic Adaptation

27. A patient is able to flex his right arm forward without difficulty or pain but is unable to abduct his arm because of pain and muscle spasms. The nurse should suspect:

a. Crepitation.

b. Rotator cuff lesions.

c. Dislocated shoulder.

d. Rheumatoid arthritis.

ANS: B

Rotator cuff lesions may limit range of motion and cause pain and muscle spasms during abduction, whereas forward flexion remains fairly normal. The other options are not correct.

DIF: Cognitive Level: Analyzing (Analysis)

MSC: Client Needs: Physiologic Integrity: Physiologic Adaptation

28. A professional tennis player comes into the clinic complaining of a sore elbow. The nurse will assess for tenderness at the:

a. Olecranon bursa.

b. Annular ligament.

c. Base of the radius.

d. Medial and lateral epicondyle.

ANS: D

The epicondyles, the head of the radius, and the tendons are common sites of inflammation and local tenderness, commonly referred to as *tennis elbow*. The other locations are not affected.

DIF: Cognitive Level: Analyzing (Analysis)

MSC: Client Needs: Physiologic Integrity: Physiologic Adaptation

29. The nurse suspects that a patient has carpal tunnel syndrome and wants to perform the Phalen test. To perform this test, the nurse should instruct the patient to:

a. Dorsiflex the foot.

b. Plantarflex the foot.

c. Hold both hands back to back while flexing the wrists 90 degrees for 60 seconds.

d. Hyperextend the wrists with the palmar surface of both hands touching, and wait for 60 seconds.

ANS: C

For the Phalen test, the nurse should ask the person to hold both hands back to back while flexing the wrists 90 degrees. Acute flexion of the wrist for 60 seconds produces no symptoms in the normal hand. The Phalen test reproduces numbness and burning in a person with carpal tunnel syndrome. The other actions are not correct when testing for carpal tunnel syndrome.

DIF: Cognitive Level: Applying (Application)

MSC: Client Needs: Physiologic Integrity: Physiologic Adaptation

30. An 80-year-old woman is visiting the clinic for a checkup. She states, I cant walk as much as I used to. The nurse is observing for motor dysfunction in her hip and should ask her to:

a. Internally rotate her hip while she is sitting.

b. Abduct her hip while she is lying on her back.

c. Adduct her hip while she is lying on her back.

d. Externally rotate her hip while she is standing.

ANS: B

Limited abduction of the hip while supine is the most common motion dysfunction found in hip disease. The other options are not correct.

DIF: Cognitive Level: Analyzing (Analysis)

MSC: Client Needs: Physiologic Integrity: Physiologic Adaptation

31. The nurse has completed the musculoskeletal examination of a patients knee and has found a positive bulge sign. The nurse interprets this finding to indicate:

a. Irregular bony margins.

b. Soft-tissue swelling in the joint.

c. Swelling from fluid in the epicondyle.

d. Swelling from fluid in the suprapatellar pouch.

ANS: D

A positive bulge sign confirms the presence of swelling caused by fluid in the suprapatellar pouch. The other options are not correct.

DIF: Cognitive Level: Analyzing (Analysis)

MSC: Client Needs: Physiologic Integrity: Physiologic Adaptation

32. During an examination, the nurse asks a patient to bend forward from the waist and notices that the patient has lateral tilting. When his leg is raised straight up, the patient complains of a pain going down his buttock into his leg. The nurse suspects:

a. Scoliosis.

b. Meniscus tear.

c. Herniated nucleus pulposus.

d. Spasm of paravertebral muscles.

ANS: C

Lateral tilting and sciatic pain with straight leg raising are findings that occur with a herniated nucleus pulposus. The other options are not correct.

DIF: Cognitive Level: Analyzing (Analysis)

MSC: Client Needs: Physiologic Integrity: Physiologic Adaptation

33. The nurse is examining a 3-month-old infant. While the nurse holds his or her thumbs on the infants inner mid thighs and the fingers on the outside of the infants hips, touching the greater trochanter, the nurse adducts the legs until the his or her thumbs touch and then abducts the legs until the infants knees touch the table. The nurse does not notice any clunking sounds and is confident to record a:

a. Positive Allis test.

b. Negative Allis test.

c. Positive Ortolani sign.

d. Negative Ortolani sign.

ANS: D

Normally, this maneuver feels smooth and has no sound. With a positive Ortolani sign, however, the nurse will feel and hear a clunk, as the head of the femur pops back into place. A positive Ortolani sign also reflects hip instability. The Allis test also tests for hip dislocation but is performed by comparing leg lengths.

DIF: Cognitive Level: Analyzing (Analysis)

MSC: Client Needs: Physiologic Integrity: Physiologic Adaptation

34. During a neonatal examination, the nurse notices that the newborn infant has six toes. This finding is documented as:

a. Unidactyly.

b. Syndactyly.

c. Polydactyly.

d. Multidactyly.

ANS: C

Polydactyly is the presence of extra fingers or toes. *Syndactyly* is webbing between adjacent fingers or toes. The other terms are not correct.

DIF: Cognitive Level: Understanding (Comprehension)

MSC: Client Needs: Physiologic Integrity: Physiologic Adaptation

35. A mother brings her newborn baby boy in for a checkup; she tells the nurse that he does not seem to be moving his right arm as much as his left and that he seems to have pain when she lifts him up under the arms. The nurse suspects a fractured clavicle and would observe for:

a. Negative Allis test.

b. Positive Ortolani sign.

c. Limited range of motion during the Moro reflex.

d. Limited range of motion during Lasgue test.

ANS: C

For a fractured clavicle, the nurse should observe for limited arm range of motion and unilateral response to the Moro reflex. The other tests are not appropriate for this type of fracture.

DIF: Cognitive Level: Analyzing (Analysis)

MSC: Client Needs: Health Promotion and Maintenance

36. A 40-year-old man has come into the clinic with complaints of extreme pain in his toes. The nurse notices that his toes are slightly swollen, reddened, and warm to the touch. His complaints would suggest:

a. Osteoporosis.

b. Acute gout.

c. Ankylosing spondylitis.

d. Degenerative joint disease.

ANS: B

Clinical findings for acute gout consist of redness, swelling, heat, and extreme pain like a continuous throbbing. Gout is a metabolic disorder of disturbed purine metabolism, associated with elevated serum uric acid.

DIF: Cognitive Level: Analyzing (Analysis)

MSC: Client Needs: Physiologic Integrity: Physiologic Adaptation

37. A young swimmer comes to the sports clinic complaining of a very sore shoulder. He was running at the pool, slipped on some wet concrete, and tried to catch himself with his outstretched hand. He landed on his outstretched hand and has not been able to move his shoulder since. The nurse suspects:

a. Joint effusion.

b. Tear of rotator cuff.

c. Adhesive capsulitis.

d. Dislocated shoulder.

ANS: D

A dislocated shoulder occurs with trauma involving abduction, extension, and external rotation (e.g., falling on an outstretched arm or diving into a pool).

DIF: Cognitive Level: Analyzing (Analysis)

MSC: Client Needs: Physiologic Integrity: Physiologic Adaptation

38. A 68-year-old woman has come in for an assessment of her rheumatoid arthritis, and the nurse notices raised, firm, nontender nodules at the olecranon bursa and along the ulna. These nodules are most commonly diagnosed as:

a. Epicondylitis.

b. Gouty arthritis.

c. Olecranon bursitis.

d. Subcutaneous nodules.

ANS: D

Subcutaneous nodules are raised, firm, and nontender and occur with rheumatoid arthritis in the olecranon bursa and along the extensor surface of the ulna.

DIF: Cognitive Level: Analyzing (Analysis)

MSC: Client Needs: Physiologic Integrity: Physiologic Adaptation

39. A woman who has had rheumatoid arthritis for years is starting to notice that her fingers are drifting to the side. The nurse knows that this condition is commonly referred to as:

a. Radial drift.

b. Ulnar deviation.

c. Swan-neck deformity.

d. Dupuytren contracture.

ANS: B

Fingers drift to the ulnar side because of stretching of the articular capsule and muscle imbalance caused by chronic rheumatoid arthritis. A radial drift is not observed.

DIF: Cognitive Level: Applying (Application)

MSC: Client Needs: Physiologic Integrity: Physiologic Adaptation

40. A patient who has had rheumatoid arthritis for years comes to the clinic to ask about changes in her fingers. The nurse will assess for signs of what problems?

a. Heberden nodes

b. Bouchard nodules

c. Swan-neck deformities

d. Dupuytren contractures

ANS: C

Changes in the fingers caused by chronic rheumatoid arthritis include swan-neck and boutonniere deformities. Heberden nodes and Bouchard nodules are associated with osteoarthritis. Dupuytren contractures of the digits occur because of chronic hyperplasia of the palmar fascia.

DIF: Cognitive Level: Applying (Application)

MSC: Client Needs: Physiologic Integrity: Physiologic Adaptation

41. A patients annual physical examination reveals a lateral curvature of the thoracic and lumbar segments of his spine; however, this curvature disappears with forward bending. The nurse knows that this abnormality of the spine is called:

a. Structural scoliosis.

b. Functional scoliosis.

c. Herniated nucleus pulposus.

d. Dislocated hip.

ANS: B

Functional scoliosis is flexible and apparent with standing but disappears with forward bending. Structural scoliosis is fixed; the curvature shows both when standing and when bending forward. These findings are not indicative of a dislocated hip.

DIF: Cognitive Level: Analyzing (Analysis)

MSC: Client Needs: Physiologic Integrity: Physiologic Adaptation

42. A 14-year-old boy who has been diagnosed with Osgood-Schlatter disease reports painful swelling just below the knee for the past 5 months. Which response by the nurse is appropriate?

a. If these symptoms persist, you may need arthroscopic surgery.

b. You are experiencing degeneration of your knee, which may not resolve.

c. Your disease is due to repeated stress on the patellar tendon. It is usually self-limited, and your symptoms should resolve with rest.

d. Increasing your activity and performing knee-strengthening exercises will help decrease the inflammation and maintain mobility in the knee.

ANS: C

Osgood-Schlatter disease is a painful swelling of the tibial tubercle just below the knee and most likely due to repeated stress on the patellar tendon. It is usually self-limited, occurring during rapid growth and most often

in boys. The symptoms resolve with rest. The other responses are not appropriate.

DIF: Cognitive Level: Applying (Application)

MSC: Client Needs: Physiologic Integrity: Physiologic Adaptation

43. When assessing muscle strength, the nurse observes that a patient has complete range of motion against gravity with full resistance. What grade of muscle strength should the nurse record using a 0- to 5-point scale?

a. 2

b. 3

c. 4

d. 5

ANS: D

Complete range of motion against gravity is normal muscle strength and is recorded as grade 5 muscle strength. The other options are not correct.

DIF: Cognitive Level: Applying (Application)

MSC: Client Needs: Physiologic Integrity: Physiologic Adaptation

44. The nurse is examining a 6-month-old infant and places the infants feet flat on the table and flexes his knees up. The nurse notes that the right knee is significantly lower than the left. Which of these statements is *true* of this finding?

a. This finding is a positive Allis sign and suggests hip dislocation.

b. The infant probably has a dislocated patella on the right knee.

c. This finding is a negative Allis sign and normal for an infant of this age.

d. The infant should return to the clinic in 2 weeks to see if his condition has changed.

ANS: A

Finding one knee significantly lower than the other is a positive Allis sign and suggests hip dislocation. Normally, the tops of the knees are at the same elevation. The other statements are not correct.

DIF: Cognitive Level: Analyzing (Analysis)

MSC: Client Needs: Health Promotion and Maintenance

45. The nurse is assessing a 1-week-old infant and is testing his muscle strength. The nurse lifts the infant with hands under the axillae and notices that the infant starts to slip between the hands. The nurse should:

a. Suspect a fractured clavicle.

b. Suspect that the infant may have a deformity of the spine.

c. Suspect that the infant may have weakness of the shoulder muscles.

d. Conclude that this is a normal finding because the musculature of an infant at this age is undeveloped.

ANS: C

An infant who starts to slip between the nurses hands shows weakness of the shoulder muscles. An infant with normal muscle strength wedges securely between the nurses hands. The other responses are not correct.

DIF: Cognitive Level: Analyzing (Analysis)

MSC: Client Needs: Health Promotion and Maintenance

46. The nurse is examining a 2-month-old infant and notices asymmetry of the infants gluteal folds. The nurse should assess for other signs of what disorder?

a. Fractured clavicle

b. Down syndrome

c. Spina bifida

d. Hip dislocation

ANS: D

Unequal gluteal folds may accompany hip dislocation after 2 to 3 months of age, but some asymmetry may occur in healthy children. Further assessment is needed. The other responses are not correct.

DIF: Cognitive Level: Applying (Application)

MSC: Client Needs: Safe and Effective Care Environment: Management of Care

47. The nurse should use which test to check for large amounts of fluid around the patella?

a. Ballottement

b. Tinel sign

c. Phalen test

d. McMurray test

ANS: A

Ballottement of the patella is reliable when large amounts of fluid are present. The Tinel sign and the Phalen test are used to check for carpal tunnel syndrome. The McMurray test is used to test the knee for a torn

meniscus.

DIF: Cognitive Level: Understanding (Comprehension)

MSC: Client Needs: Safe and Effective Care Environment: Management of Care

48. A patient tells the nurse that, All my life Ive been called knock knees. The nurse knows that another term for knock knees is:

a. Genu varum.

b. Genu valgum.

c. Pes planus.

d. Metatarsus adductus.

ANS: B

Genu valgum is also known as *knock knees* and is present when more than 2.5 cm is between the medial malleoli when the knees are together.

DIF: Cognitive Level: Understanding (Comprehension)

MSC: Client Needs: Physiologic Integrity: Physiologic Adaptation

49. A man who has had gout for several years comes to the clinic with a problem with his toe. On examination, the nurse notices the presence of hard, painless nodules over the great toe; one has burst open with a chalky discharge. This finding is known as:

a. Callus.

b. Plantar wart.

c. Bunion.

d. Tophi.

ANS: D

Tophi are collections of monosodium urate crystals resulting from chronic gout in and around the joint that cause extreme swelling and joint deformity. They appear as hard, painless nodules (tophi) over the metatarsophalangeal joint of the first toe and they sometimes burst with a chalky discharge.

DIF: Cognitive Level: Applying (Application)

MSC: Client Needs: Physiologic Integrity: Physiologic Adaptation

50. When performing a musculoskeletal assessment, the nurse knows that the correct approach for the examination should be:

a. Proximal to distal.

b. Distal to proximal.

c. Posterior to anterior.

d. Anterior to posterior.

ANS: A

The musculoskeletal assessment should be performed in an orderly approach, head to toe, proximal to distal, from the midline outward. The other options are not correct.

DIF: Cognitive Level: Applying (Application)

MSC: Client Needs: Safe and Effective Care Environment: Management of Care

MULTIPLE RESPONSE

1. The nurse is assessing the joints of a woman who has stated, I have a long family history of arthritis, and my joints hurt. The nurse suspects that she has osteoarthritis. Which of these are symptoms of osteoarthritis? *Select all that apply*.

a. Symmetric joint involvement

b. Asymmetric joint involvement

c. Pain with motion of affected joints

d. Affected joints are swollen with hard, bony protuberances

e. Affected joints may have heat, redness, and swelling

ANS: B, C, D

In osteoarthritis, asymmetric joint involvement commonly affects hands, knees, hips, and lumbar and cervical segments of the spine. Affected joints have stiffness, swelling with hard bony protuberances, pain with motion, and limitation of motion. The other options reflect the signs of rheumatoid arthritis.

DIF: Cognitive Level: Applying (Application)

MSC: Client Needs: Physiologic Integrity: Physiologic Adaptation

Chapter 24: Neurologic System

MULTIPLE CHOICE

1. The two parts of the nervous system are the:

a. Motor and sensory.

b. Central and peripheral.

c. Peripheral and autonomic.

d. Hypothalamus and cerebral.

ANS: B

The nervous system can be divided into two partscentral and peripheral. The central nervous system includes the brain and spinal cord. The peripheral nervous system includes the 12 pairs of cranial nerves (CNs), the 31 pairs of spinal nerves, and all of their branches.

DIF: Cognitive Level: Remembering (Knowledge)

MSC: Client Needs: General

2. The wife of a 65-year-old man tells the nurse that she is concerned because she has noticed a change in her husbands personality and ability to understand. He also cries very easily and becomes angry. The nurse recalls that the cerebral lobe responsible for these behaviors is the _____ lobe.

a. Frontal

b. Parietal

c. Occipital

d. Temporal

ANS: A

The frontal lobe has areas responsible for personality, behavior, emotions, and intellectual function. The parietal lobe has areas responsible for sensation; the occipital lobe is responsible for visual reception; and the temporal lobe is responsible for hearing, taste, and smell.

DIF: Cognitive Level: Understanding (Comprehension)

MSC: Client Needs: Physiologic Integrity: Physiologic Adaptation

3. Which statement concerning the areas of the brain is *true*?

a. The cerebellum is the center for speech and emotions.

b. The hypothalamus controls body temperature and regulates sleep.

c. The basal ganglia are responsible for controlling voluntary movements.

d. Motor pathways of the spinal cord and brainstem synapse in the thalamus.

ANS: B

The hypothalamus is a vital area with many important functions: body temperature controller, sleep center, anterior and posterior pituitary gland regulator, and coordinator of autonomic nervous system activity and emotional status. The cerebellum controls motor coordination, equilibrium, and balance. The basal ganglia control autonomic movements of the body. The motor pathways of the spinal cord synapse in various areas of the spinal cord, not in the thalamus.

DIF: Cognitive Level: Understanding (Comprehension)

MSC: Client Needs: General

4. The area of the nervous system that is responsible for mediating reflexes is the:

a. Medulla.

b. Cerebellum.

c. Spinal cord.

d. Cerebral cortex.

ANS: C

The spinal cord is the main highway for ascending and descending fiber tracts that connect the brain to the spinal nerves; it is responsible for mediating reflexes.

DIF: Cognitive Level: Remembering (Knowledge)

MSC: Client Needs: General

5. While gathering equipment after an injection, a nurse accidentally received a prick from an improperly capped needle. To interpret this sensation, which of these areas must be intact?

a. Corticospinal tract, medulla, and basal ganglia

b. Pyramidal tract, hypothalamus, and sensory cortex

c. Lateral spinothalamic tract, thalamus, and sensory cortex

d. Anterior spinothalamic tract, basal ganglia, and sensory cortex

ANS: C

The spinothalamic tract contains sensory fibers that transmit the sensations of pain, temperature, and crude or light touch. Fibers carrying pain and temperature sensations ascend the lateral spinothalamic tract, whereas the sensations of crude touch form the anterior spinothalamic tract. At the thalamus, the fibers synapse with another sensory neuron, which carries the message to the sensory cortex for full interpretation. The other options are not correct.

DIF: Cognitive Level: Applying (Application)

MSC: Client Needs: General

6. A patient with a lack of oxygen to his heart will have pain in his chest and possibly in the shoulder, arms, or jaw. The nurse knows that the *best* explanation why this occurs is which one of these statements?

a. A problem exists with the sensory cortex and its ability to discriminate the location.

b. The lack of oxygen in his heart has resulted in decreased amount of oxygen to the areas experiencing the pain.

c. The sensory cortex does not have the ability to localize pain in the heart; consequently, the pain is felt elsewhere.

d. A lesion has developed in the dorsal root, which is preventing the sensation from being transmitted normally.

ANS: C

The sensory cortex is arranged in a specific pattern, forming a corresponding map of the body. Pain in the right hand is perceived at a specific spot on the map. Some organs, such as the heart, liver, and spleen, are absent from the brain map. Pain originating in these organs is referred because no felt image exists in which to have pain. Pain is felt *by proxy*, that is, by another body part that does have a felt image. The other responses are not correct explanations.

DIF: Cognitive Level: Understanding (Comprehension)

MSC: Client Needs: Physiologic Integrity: Basic Care and Comfort

7. The ability that humans have to perform very skilled movements such as writing is controlled by the:

a. Basal ganglia.

b. Corticospinal tract.

c. Spinothalamic tract.

d. Extrapyramidal tract.

ANS: B

Corticospinal fibers mediate voluntary movement, particularly very skilled, discrete, and purposeful movements, such as writing. The corticospinal tract, also known as the *pyramidal tract*, is a newer, higher motor system that humans have that permits very skilled and purposeful movements. The other responses are not related to skilled movements.

DIF: Cognitive Level: Understanding (Comprehension)

MSC: Client Needs: General

8. A 30-year-old woman tells the nurse that she has been very unsteady and has had difficulty in maintaining her balance. Which area of the brain that is related to these findings would concern the nurse?

a. Thalamus

b. Brainstem

c. Cerebellum

d. Extrapyramidal tract

ANS: C

The cerebellar system coordinates movement, maintains equilibrium, and helps maintain posture. The thalamus is the primary relay station where sensory pathways of the spinal cord, cerebellum, and brainstem form synapses on their way to the cerebral cortex. The brainstem consists of the midbrain, pons, and medulla and has various functions, especially concerning autonomic centers. The extrapyramidal tract maintains muscle tone for gross automatic movements, such as walking.

DIF: Cognitive Level: Understanding (Comprehension)

MSC: Client Needs: Physiologic Integrity: Physiologic Adaptation

9. Which of these statements about the peripheral nervous system is *correct*?

a. The CNs enter the brain through the spinal cord.

b. Efferent fibers carry sensory input to the central nervous system through the spinal cord.

c. The peripheral nerves are inside the central nervous system and carry impulses through their motor fibers.

d. The peripheral nerves carry input to the central nervous system by afferent fibers and away from the central nervous system by efferent fibers.

ANS: D

A nerve is a bundle of fibers outside of the central nervous system. The peripheral nerves carry input to the central nervous system by their sensory afferent fibers and deliver output from the central nervous system by their efferent fibers. The other responses are not related to the peripheral nervous system.

DIF: Cognitive Level: Remembering (Knowledge)

MSC: Client Needs: General

10. A patient has a severed spinal nerve as a result of trauma. Which statement is *true* in this situation?

a. Because there are 31 pairs of spinal nerves, no effect results if only one nerve is severed.

b. The dermatome served by this nerve will no longer experience any sensation.

c. The adjacent spinal nerves will continue to carry sensations for the dermatome served by the severed nerve.

d. A severed spinal nerve will only affect motor function of the patient because spinal nerves have no sensory component.

ANS: C

A dermatome is a circumscribed skin area that is primarily supplied from one spinal cord segment through a particular spinal nerve. The dermatomes overlap, which is a form of biologic insurance; that is, if one nerve is severed, then most of the sensations can be transmitted by the spinal nerve above and the spinal nerve below the severed nerve.

DIF: Cognitive Level: Applying (Application)

MSC: Client Needs: Physiologic Integrity: Physiologic Adaptation

11. A 21-year-old patient has a head injury resulting from trauma and is unconscious. There are no other injuries. During the assessment what would the nurse expect to find when testing the patients deep tendon reflexes?

a. Reflexes will be normal.

b. Reflexes cannot be elicited.

c. All reflexes will be diminished but present.

d. Some reflexes will be present, depending on the area of injury.

ANS: A

A reflex is a defense mechanism of the nervous system. It operates below the level of conscious control and permits a quick reaction to potentially painful or damaging situations.

DIF: Cognitive Level: Applying (Application)

MSC: Client Needs: Safe and Effective Care Environment: Management of Care

12. A mother of a 1-month-old infant asks the nurse why it takes so long for infants to learn to roll over. The nurse knows that the reason for this is:

a. A demyelinating process must be occurring with her infant.

b. Myelin is needed to conduct the impulses, and the neurons of a newborn are not yet myelinated.

c. The cerebral cortex is not fully developed; therefore, control over motor function gradually occurs.

d. The spinal cord is controlling the movement because the cerebellum is not yet fully developed.

ANS: B

The infants sensory and motor development proceeds along with the gradual acquisition of myelin, which is needed to conduct most impulses. Very little cortical control exists, and the neurons are not yet myelinated. The other responses are not correct.

DIF: Cognitive Level: Applying (Application)

MSC: Client Needs: Health Promotion and Maintenance

13. During an assessment of an 80-year-old patient, the nurse notices the following: an inability to identify vibrations at her ankle and to identify the position of her big toe, a slower and more deliberate gait, and a slightly impaired tactile sensation. All other neurologic findings are normal. The nurse should interpret that these findings indicate:

a. CN dysfunction.

b. Lesion in the cerebral cortex.

c. Normal changes attributable to aging.

d. Demyelination of nerves attributable to a lesion.

ANS: C

Some aging adults show a slower response to requests, especially for those calling for coordination of movements. The findings listed are normal in the absence of other significant abnormal findings. The other responses are incorrect.

DIF: Cognitive Level: Analyzing (Analysis)

MSC: Client Needs: Health Promotion and Maintenance

14. A 70-year-old woman tells the nurse that every time she gets up in the morning or after shes been sitting, she gets really dizzy and feels like she is going to fall over. The nurses best response would be:

a. Have you been extremely tired lately?

b. You probably just need to drink more liquids.

c. Ill refer you for a complete neurologic examination.

d. You need to get up slowly when youve been lying down or sitting.

ANS: D

Aging is accompanied by a progressive decrease in cerebral blood flow. In some people, this decrease causes dizziness and a loss of balance with a position change. These individuals need to be taught to get up slowly. The other responses are incorrect.

DIF: Cognitive Level: Analyzing (Analysis)

MSC: Client Needs: Health Promotion and Maintenance

15. During the taking of the health history, a patient tells the nurse that it feels like the room is spinning around me. The nurse would document this finding as:

a. Vertigo.

b. Syncope.

c. Dizziness.

d. Seizure activity.

ANS: A

True vertigo is rotational spinning caused by a neurologic dysfunction or a problem in the vestibular apparatus or the vestibular nuclei in the brainstem. Syncope is a sudden loss of strength or a temporary loss of consciousness. Dizziness is a lightheaded, swimming sensation. Seizure activity is characterized by altered or loss of consciousness, involuntary muscle movements, and sensory disturbances.

DIF: Cognitive Level: Applying (Application)

MSC: Client Needs: Physiologic Integrity: Physiologic Adaptation

16. When taking the health history on a patient with a seizure disorder, the nurse assesses whether the patient has an aura. Which of these would be the best question for obtaining this information?

a. Does your muscle tone seem tense or limp?

b. After the seizure, do you spend a lot of time sleeping?

c. Do you have any warning sign before your seizure starts?

d. Do you experience any color change or incontinence during the seizure?

ANS: C

Aura is a subjective sensation that precedes a seizure; it could be auditory, visual, or motor. The other questions do not solicit information about an aura.

DIF: Cognitive Level: Applying (Application)

MSC: Client Needs: Physiologic Integrity: Physiologic Adaptation

17. While obtaining a health history of a 3-month-old infant from the mother, the nurse asks about the infants ability to suck and grasp the mothers finger. What is the nurse assessing?

a. Reflexes

b. Intelligence

c. CNs

d. Cerebral cortex function

ANS: A

Questions regarding reflexes include such questions as, What have you noticed about the infants behavior, Are the infants sucking and swallowing seem coordinated, and Does the infant grasp your finger? The other responses are incorrect.

DIF: Cognitive Level: Understanding (Comprehension)

MSC: Client Needs: Health Promotion and Maintenance

18. In obtaining a health history on a 74-year-old patient, the nurse notes that he drinks alcohol daily and that he has noticed a tremor in his hands that affects his ability to hold things. With this information, what response should the nurse make?

a. Does your family know you are drinking every day?

b. Does the tremor change when you drink alcohol?

c. Well do some tests to see what is causing the tremor.

d. You really shouldnt drink so much alcohol; it may be causing your tremor.

ANS: B

Senile tremor is relieved by alcohol, although not a recommended treatment. The nurse should assess whether the person is abusing alcohol in an effort to relieve the tremor.

DIF: Cognitive Level: Analyzing (Analysis)

MSC: Client Needs: Health Promotion and Maintenance

19. A 50-year-old woman is in the clinic for weakness in her left arm and leg that she has noticed for the past week. The nurse should perform which type of neurologic examination?

a. Glasgow Coma Scale

b. Neurologic recheck examination

c. Screening neurologic examination

d. Complete neurologic examination

ANS: D

The nurse should perform a complete neurologic examination on an individual who has neurologic concerns (e.g., headache, weakness, loss of coordination) or who is showing signs of neurologic dysfunction. The Glasgow Coma Scale is used to define a persons level of consciousness. The neurologic recheck examination is appropriate for those who are demonstrating neurologic deficits. The screening neurologic examination is performed on seemingly well individuals who have no significant subjective findings from the health history.

DIF: Cognitive Level: Applying (Application)

MSC: Client Needs: Health Promotion and Maintenance

20. During an assessment of the CNs, the nurse finds the following: asymmetry when the patient smiles or frowns, uneven lifting of the eyebrows, sagging of the lower eyelids, and escape of air when the nurse presses against the right puffed cheek. This would indicate dysfunction of which of these CNs?

a. Motor component of CN IV

b. Motor component of CN VII

c. Motor and sensory components of CN XI

d. Motor component of CN X and sensory component of CN VII

ANS: B

The findings listed reflect a dysfunction of the motor component of the facial nerve (CN VII).

DIF: Cognitive Level: Analyzing (Analysis)

MSC: Client Needs: Health Promotion and Maintenance

21. The nurse is testing the function of CN XI. Which statement *best* describes the response the nurse should expect if this nerve is intact? The patient:

a. Demonstrates the ability to hear normal conversation.

b. Sticks out the tongue midline without tremors or deviation.

c. Follows an object with his or her eyes without nystagmus or strabismus.

d. Moves the head and shoulders against resistance with equal strength.

ANS: D

The following normal findings are expected when testing the spinal accessory nerve (CN XI): The patients sternomastoid and trapezius muscles are equal in size; the person can forcibly rotate the head both ways against resistance applied to the side of the chin with equal strength; and the patient can shrug the shoulders against resistance with equal strength on both sides. Checking the patients ability to hear normal conversation checks the function of CN VIII. Having the patient stick out the tongue checks the function of CN XII. Testing the eyes for nystagmus or strabismus is performed to check CNs III, IV, and VI.

DIF: Cognitive Level: Applying (Application)

MSC: Client Needs: Health Promotion and Maintenance

22. During the neurologic assessment of a healthy 35-year-old patient, the nurse asks him to relax his muscles completely. The nurse then moves each extremity through full range of motion. Which of these results would the nurse expect to find?

a. Firm, rigid resistance to movement

b. Mild, even resistance to movement

c. Hypotonic muscles as a result of total relaxation

d. Slight pain with some directions of movement

ANS: B

Tone is the normal degree of tension (contraction) in voluntarily relaxed muscles. It shows a mild resistance to passive stretching. Normally, the nurse will notice a mild, even resistance to movement. The other responses are not correct.

DIF: Cognitive Level: Applying (Application)

MSC: Client Needs: Health Promotion and Maintenance

23. When the nurse asks a 68-year-old patient to stand with his feet together and arms at his side with his eyes closed, he starts to sway and moves his feet farther apart. The nurse would document this finding as:

a. Ataxia.

b. Lack of coordination.

c. Negative Homans sign.

d. Positive Romberg sign.

ANS: D

Abnormal findings for the Romberg test include swaying, falling, and a widening base of the feet to avoid falling. A positive Romberg sign is a loss of balance that is increased by the closing of the eyes. Ataxia is an uncoordinated or unsteady gait. Homans sign is used to test the legs for deep-vein thrombosis.

DIF: Cognitive Level: Analyzing (Analysis)

MSC: Client Needs: Health Promotion and Maintenance

24. The nurse is performing an assessment on a 29-year-old woman who visits the clinic complaining of always dropping things and falling down. While testing rapid alternating movements, the nurse notices that the woman is unable to pat both of her knees. Her response is extremely slow and she frequently misses. What should the nurse suspect?

a. Vestibular disease

b. Lesion of CN IX

c. Dysfunction of the cerebellum

d. Inability to understand directions

ANS: C

When a person tries to perform rapid, alternating movements, responses that are slow, clumsy, and sloppy are indicative of cerebellar disease. The other responses are incorrect.

DIF: Cognitive Level: Analyzing (Analysis)

MSC: Client Needs: Physiologic Integrity: Physiologic Adaptation

25. During the taking of the health history of a 78-year-old man, his wife states that he occasionally has problems with short-term memory loss and confusion: He cant even remember how to button his shirt. When assessing his sensory system, which action by the nurse is *most* appropriate?

a. The nurse would not test the sensory system as part of the examination because the results would not be valid.

b. The nurse would perform the tests, knowing that mental status does not affect sensory ability.

c. The nurse would proceed with an explanation of each test, making certain that the wife understands.

d. Before testing, the nurse would assess the patients mental status and ability to follow directions.

ANS: D

The nurse should ensure the validity of the sensory system testing by making certain that the patient is alert, cooperative, comfortable, and has an adequate attention span. Otherwise, the nurse may obtain misleading and invalid results.

DIF: Cognitive Level: Analyzing (Analysis)

MSC: Client Needs: Health Promotion and Maintenance

26. The assessment of a 60-year-old patient has taken longer than anticipated. In testing his pain perception, the nurse decides to complete the test as quickly as possible. When the nurse applies the sharp point of the pin on his arm several times, he is only able to identify these as one very sharp prick. What would be the *most* accurate explanation for this?

a. The patient has hyperesthesia as a result of the aging process.

b. This response is most likely the result of the summation effect.

c. The nurse was probably not poking hard enough with the pin in the other areas.

d. The patient most likely has analgesia in some areas of arm and hyperalgesia in others.

ANS: B

At least 2 seconds should be allowed to elapse between each stimulus to avoid summation. With summation, frequent consecutive stimuli are perceived as one strong stimulus. The other responses are incorrect.

DIF: Cognitive Level: Analyzing (Analysis)

MSC: Client Needs: Safe and Effective Care Environment: Management of Care

27. The nurse is performing a neurologic assessment on a 41-year-old woman with a history of diabetes. When testing her ability to feel the vibrations of a tuning fork, the nurse notices that the patient is unable to feel vibrations on the great toe or ankle bilaterally, but she is able to feel vibrations on both patellae. Given this information, what would the nurse suspect?

a. Hyperalgesia

b. Hyperesthesia

c. Peripheral neuropathy

d. Lesion of sensory cortex

ANS: C

Loss of vibration sense occurs with peripheral neuropathy (e.g., diabetes and alcoholism). Peripheral neuropathy is worse at the feet and gradually improves as the examiner moves up the leg, as opposed to a specific nerve lesion, which has a clear zone of deficit for its dermatome. The other responses are incorrect.

DIF: Cognitive Level: Analyzing (Analysis)

MSC: Client Needs: Physiologic Integrity: Physiologic Adaptation

28. The nurse places a key in the hand of a patient and he identifies it as a penny. What term would the nurse use to describe this finding?

a. Extinction

b. Astereognosis

c. Graphesthesia

d. Tactile discrimination

ANS: B

Stereognosis is the persons ability to recognize objects by feeling their forms, sizes, and weights. Astereognosis is an inability to identify objects correctly, and it occurs in sensory cortex lesions. Tactile discrimination tests fine touch. Extinction tests the persons ability to feel sensations on both sides of the body at the same point.

DIF: Cognitive Level: Applying (Application)

MSC: Client Needs: Physiologic Integrity: Physiologic Adaptation

29. The nurse is testing the deep tendon reflexes of a 30-year-old woman who is in the clinic for an annual physical examination. When striking the Achilles heel and quadriceps muscle, the nurse is unable to elicit a reflex. The nurses next response should be to:

a. Ask the patient to lock her fingers and pull.

b. Complete the examination, and then test these reflexes again.

c. Refer the patient to a specialist for further testing.

d. Document these reflexes as 0 on a scale of 0 to 4+.

ANS: A

Sometimes the reflex response fails to appear. Documenting the reflexes as *absent* is inappropriate this soon in the examination. The nurse should try to further encourage relaxation, varying the persons position or increasing the strength of the blow. Reinforcement is another technique to relax the muscles and enhance the response. The person should be asked to perform an isometric exercise in a muscle group somewhat away from the one being tested. For example, to enhance a patellar reflex, the person should be asked to lock the fingers together and pull.

DIF: Cognitive Level: Applying (Application)

MSC: Client Needs: Health Promotion and Maintenance

30. In assessing a 70-year-old patient who has had a recent cerebrovascular accident, the nurse notices right-sided weakness. What might the nurse expect to find when testing his reflexes on the right side?

a. Lack of reflexes

b. Normal reflexes

c. Diminished reflexes

d. Hyperactive reflexes

ANS: D

Hyperreflexia is the exaggerated reflex observed when the monosynaptic reflex arc is released from the influence of higher cortical levels. This response occurs with upper motor neuron lesions (e.g., a cerebrovascular accident). The other responses are incorrect.

DIF: Cognitive Level: Applying (Application)

MSC: Client Needs: Physiologic Integrity: Physiologic Adaptation

31. When the nurse is testing the triceps reflex, what is the expected response?

a. Flexion of the hand

b. Pronation of the hand

c. Extension of the forearm

d. Flexion of the forearm

ANS: C

The normal response of the triceps reflex is extension of the forearm. The normal response of the biceps reflex causes flexion of the forearm. The other responses are incorrect.

DIF: Cognitive Level: Remembering (Knowledge)

MSC: Client Needs: Safe and Effective Care Environment: Management of Care

32. The nurse is testing superficial reflexes on an adult patient. When stroking up the lateral side of the sole and across the ball of the foot, the nurse notices the plantar flexion of the toes. How should the nurse document this finding?

a. Positive Babinski sign

b. Plantar reflex abnormal

c. Plantar reflex present

d. Plantar reflex 2+ on a scale from 0 to 4+

ANS: C

With the same instrument, the nurse should draw a light stroke up the lateral side of the sole of the foot and across the ball of the foot, similar to an upside-down J. The normal response is plantar flexion of the toes and sometimes of the entire foot. A positive Babinski sign is abnormal and occurs with the response of dorsiflexion of the big toe and fanning of all toes. The plantar reflex is not graded on a 0 to 4+ scale.

DIF: Cognitive Level: Analyzing (Analysis)

MSC: Client Needs: Safe and Effective Care Environment: Management of Care

33. In the assessment of a 1-month-old infant, the nurse notices a lack of response to noise or stimulation. The mother reports that in the last week he has been sleeping all of the time, and when he is awake all he does is cry. The nurse hears that the infants cries are very high pitched and shrill. What should be the nurses appropriate response to these findings?

a. Refer the infant for further testing.

b. Talk with the mother about eating habits.

c. Do nothing; these are expected findings for an infant this age.

d. Tell the mother to bring the baby back in 1 week for a recheck.

ANS: A

A high-pitched, shrill cry or cat-sounding screech occurs with central nervous system damage. Lethargy, hyporeactivity, and hyperirritability, as well as the parents report of significant changes in behavior all warrant referral. The other options are not correct responses.

DIF: Cognitive Level: Analyzing (Analysis)

MSC: Client Needs: Health Promotion and Maintenance

34. Which of these tests would the nurse use to check the motor coordination of an 11-month-old infant?

a. Denver II

b. Stereognosis

c. Deep tendon reflexes

d. Rapid alternating movements

ANS: A

To screen gross and fine motor coordination, the nurse should use the Denver II with its age-specific developmental milestones. Stereognosis tests a persons ability to recognize objects by feeling them and is not appropriate for an 11-month-old infant. Testing the deep tendon reflexes is not appropriate for checking motor coordination. Testing rapid alternating movements is appropriate for testing coordination in adults.

DIF: Cognitive Level: Understanding (Comprehension)

MSC: Client Needs: Health Promotion and Maintenance

35. To assess the head control of a 4-month-old infant, the nurse lifts up the infant in a prone position while supporting his chest. The nurse looks for what normal response? The infant:

a. Raises the head, and arches the back.

b. Extends the arms, and drops down the head.

c. Flexes the knees and elbows with the back straight.

d. Holds the head at 45 degrees, and keeps the back straight.

ANS: A

At 3 months of age, the infant raises the head and arches the back as if in a swan dive. This response is the Landau reflex, which persists until 1 years of age. The other responses are incorrect.

DIF: Cognitive Level: Applying (Application)

MSC: Client Needs: Health Promotion and Maintenance

36. While assessing a 7-month-old infant, the nurse makes a loud noise and notices the following response: abduction and flexion of the arms and legs; fanning of the fingers, and curling of the index finger and thumb in a C position, followed by the infant bringing in the arms and legs to the body. What does the nurse know about this response?

a. This response could indicate brachial nerve palsy.

b. This reaction is an expected startle response at this age.

c. This reflex should have disappeared between 1 and 4 months of age.

d. This response is normal as long as the movements are bilaterally symmetric.

ANS: C

The Moro reflex is present at birth and usually disappears at 1 to 4 months. Absence of the Moro reflex in the newborn or its persistence after 5 months of age indicates severe central nervous system injury. The other responses are incorrect.

DIF: Cognitive Level: Analyzing (Analysis)

MSC: Client Needs: Health Promotion and Maintenance

37. To test for gross motor skill and coordination of a 6-year-old child, which of these techniques would be appropriate? Ask the child to:

a. Hop on one foot.

b. Stand on his head.

c. Touch his finger to his nose.

d. Make funny faces at the nurse.

ANS: A

Normally, a child can hop on one foot and can balance on one foot for approximately 5 seconds by 4 years of age and can balance on one foot for 8 to 10 seconds at 5 years of age. Children enjoy performing these tests. Failure to hop after 5 years of age indicates incoordination of gross motor skills. Asking the child to touch his or her finger to the nose checks fine motor coordination; and asking the child to make funny faces tests CN VII. Asking a child to stand on his or her head is not appropriate.

DIF: Cognitive Level: Applying (Application)

MSC: Client Needs: Health Promotion and Maintenance

38. During the assessment of an 80-year-old patient, the nurse notices that his hands show tremors when he reaches for something and his head is always nodding. No associated rigidity is observed with movement. Which of these statements is *most* accurate?

a. These findings are normal, resulting from aging.

b. These findings could be related to hyperthyroidism.

c. These findings are the result of Parkinson disease.

d. This patient should be evaluated for a cerebellar lesion.

ANS: A

Senile tremors occasionally occur. These benign tremors include an intention tremor of the hands, head nodding (as if saying yes or no), and tongue protrusion. Tremors associated with Parkinson disease include rigidity, slowness, and a weakness of voluntary movement. The other responses are incorrect.

DIF: Cognitive Level: Analyzing (Analysis)

MSC: Client Needs: Health Promotion and Maintenance

39. While the nurse is taking the history of a 68-year-old patient who sustained a head injury 3 days earlier, he tells the nurse that he is on a cruise ship and is 30 years old. The nurse knows that this finding is indicative of a(n):

a. Great sense of humor.

b. Uncooperative behavior.

c. Inability to understand questions.

d. Decreased level of consciousness.

ANS: D

A change in consciousness may be subtle. The nurse should notice any decreasing level of consciousness, disorientation, memory loss, uncooperative behavior, or even complacency in a previously combative person. The other responses are incorrect.

DIF: Cognitive Level: Applying (Application)

MSC: Client Needs: Physiologic Integrity: Physiologic Adaptation

40. The nurse is caring for a patient who has just had neurosurgery. To assess for increased intracranial pressure, what would the nurse include in the assessment?

a. CNs, motor function, and sensory function

b. Deep tendon reflexes, vital signs, and coordinated movements

c. Level of consciousness, motor function, pupillary response, and vital signs

d. Mental status, deep tendon reflexes, sensory function, and pupillary response

ANS: C

Some hospitalized persons have head trauma or a neurologic deficit from a systemic disease process. These people must be closely monitored for any improvement or deterioration in neurologic status and for any indication of increasing intracranial pressure. The nurse should use an abbreviation of the neurologic examination in the following sequence: level of consciousness, motor function, pupillary response, and vital signs.

DIF: Cognitive Level: Applying (Application)

MSC: Client Needs: Physiologic Integrity: Physiologic Adaptation

41. During an assessment of a 22-year-old woman who sustained a head injury from an automobile accident 4 hours earlier, the nurse notices the following changes: pupils were equal, but now the right pupil is fully dilated and nonreactive, and the left pupil is 4 mm and reacts to light. What do these findings suggest?

a. Injury to the right eye

b. Increased intracranial pressure

c. Test inaccurately performed

d. Normal response after a head injury

ANS: B

In a person with a brain injury, a sudden, unilateral, dilated, and nonreactive pupil is ominous. CN III runs parallel to the brainstem. When increasing intracranial pressure pushes down the brainstem (uncal herniation), it puts pressure on CN III, causing pupil dilation. The other responses are incorrect.

DIF: Cognitive Level: Analyzing (Analysis)

MSC: Client Needs: Physiologic Integrity: Physiologic Adaptation

42. A 32-year-old woman tells the nurse that she has noticed very sudden, jerky movements mainly in her hands and arms. She says, They seem to come and go, primarily when I am trying to do something. I havent noticed them when Im sleeping. This description suggests:

a. Tics.

b. Athetosis.

c. Myoclonus.

d. Chorea.

ANS: D

Chorea is characterized by sudden, rapid, jerky, purposeless movements that involve the limbs, trunk, or face. Chorea occurs at irregular intervals, and the movements are all accentuated by voluntary actions.

DIF: Cognitive Level: Analyzing (Analysis)

MSC: Client Needs: Physiologic Integrity: Physiologic Adaptation

43. During an assessment of a 62-year-old man, the nurse notices the patient has a stooped posture, shuffling walk with short steps, flat facial expression, and pill-rolling finger movements. These findings would be consistent with:

a. Parkinsonism.

b. Cerebral palsy.

c. Cerebellar ataxia.

d. Muscular dystrophy.

ANS: A

The stooped posture, shuffling walk, short steps, flat facial expression, and pill-rolling finger movements are all found in parkinsonism.

DIF: Cognitive Level: Analyzing (Analysis)

MSC: Client Needs: Physiologic Integrity: Physiologic Adaptation

44. During an assessment of a 32-year-old patient with a recent head injury, the nurse notices that the patient responds to pain by extending, adducting, and internally rotating his arms. His palms pronate, and his lower extremities extend with plantar flexion. Which statement concerning these findings is *most* accurate? This patients response:

a. Indicates a lesion of the cerebral cortex.

b. Indicates a completely nonfunctional brainstem.

c. Is normal and will go away in 24 to 48 hours.

d. Is a very ominous sign and may indicate brainstem injury.

ANS: D

These findings are all indicative of decerebrate rigidity, which is a very ominous condition and may indicate a brainstem injury.

DIF: Cognitive Level: Analyzing (Analysis)

MSC: Client Needs: Physiologic Integrity: Physiologic Adaptation

45. A 78-year-old man has a history of a cerebrovascular accident. The nurse notes that when he walks, his left arm is immobile against the body with flexion of the shoulder, elbow, wrist, and fingers and adduction of the shoulder. His left leg is stiff and extended and circumducts with each step. What type of gait disturbance is this individual experiencing?

a. Scissors gait

b. Cerebellar ataxia

c. Parkinsonian gait

d. Spastic hemiparesis

ANS: D

With spastic hemiparesis, the arm is immobile against the body. Flexion of the shoulder, elbow, wrist, and fingers occurs, and adduction of the shoulder, which does not swing freely, is observed. The leg is stiff and extended and circumducts with each step. Causes of this type of gait include cerebrovascular accident.

DIF: Cognitive Level: Analyzing (Analysis)

MSC: Client Needs: Physiologic Integrity: Physiologic Adaptation

46. In a person with an upper motor neuron lesion such as a cerebrovascular accident, which of these physical assessment findings should the nurse expect?

a. Hyperreflexia

b. Fasciculations

c. Loss of muscle tone and flaccidity

d. Atrophy and wasting of the muscles

ANS: A

Hyperreflexia, diminished or absent superficial reflexes, and increased muscle tone or spasticity can be expected with upper motor neuron lesions. The other options reflect a lesion of lower motor neurons.

DIF: Cognitive Level: Applying (Application)

MSC: Client Needs: Physiologic Integrity: Physiologic Adaptation

47. A 59-year-old patient has a herniated intervertebral disk. Which of the following findings should the nurse expect to see on physical assessment of this individual?

a. Hyporeflexia

b. Increased muscle tone

c. Positive Babinski sign

d. Presence of pathologic reflexes

ANS: A

With a herniated intervertebral disk or lower motor neuron lesion, loss of tone, flaccidity, atrophy, fasciculations, and hyporeflexia or areflexia are demonstrated. No Babinski sign or pathologic reflexes would be observed. The other options reflect a lesion of upper motor neurons.

DIF: Cognitive Level: Applying (Application)

MSC: Client Needs: Physiologic Integrity: Physiologic Adaptation

48. A patient is unable to perform rapid alternating movements such as rapidly patting her knees. The nurse should document this inability as:

a. Ataxia.

b. Astereognosis.

c. Presence of dysdiadochokinesia.

d. Loss of kinesthesia.

ANS: C

Slow clumsy movements and the inability to perform rapid alternating movements occur with cerebellar disease. The condition is termed *dysdiadochokinesia*. Ataxia is an uncoordinated or unsteady gait. Astereognosis is the inability to identify an object by feeling it. Kinesthesia is the persons ability to perceive passive movement of the extremities or the loss of position sense.

DIF: Cognitive Level: Applying (Application)

MSC: Client Needs: Physiologic Integrity: Physiologic Adaptation

49. The nurse knows that determining whether a person is oriented to his or her surroundings will test the functioning of which structure(s)?

a. Cerebrum

b. Cerebellum

c. CNs

d. Medulla oblongata

ANS: A

The cerebral cortex is responsible for thought, memory, reasoning, sensation, and voluntary movement. The other structures are not responsible for a persons level of consciousness.

DIF: Cognitive Level: Understanding (Comprehension)

MSC: Client Needs: Safe and Effective Care Environment: Management of Care

50. During an examination, the nurse notices severe nystagmus in both eyes of a patient. Which conclusion by the nurse is *correct*? Severe nystagmus in both eyes:

a. Is a normal occurrence.

b. May indicate disease of the cerebellum or brainstem.

c. Is a sign that the patient is nervous about the examination.

d. Indicates a visual problem, and a referral to an ophthalmologist is indicated.

ANS: B

End-point nystagmus at an extreme lateral gaze normally occurs; however, the nurse should carefully assess any other nystagmuses. Severe nystagmus occurs with disease of the vestibular system, cerebellum, or brainstem.

DIF: Cognitive Level: Analyzing (Analysis)

MSC: Client Needs: Health Promotion and Maintenance

51. The nurse knows that testing kinesthesia is a test of a persons:

a. Fine touch.

b. Position sense.

c. Motor coordination.

d. Perception of vibration.

ANS: B

Kinesthesia, or position sense, is the persons ability to perceive passive movements of the extremities. The other options are incorrect.

DIF: Cognitive Level: Understanding (Comprehension)

MSC: Client Needs: Safe and Effective Care Environment: Management of Care

52. The nurse is reviewing a patients medical record and notes that he is in a coma. Using the Glasgow Coma Scale, which number indicates that the patient is in a coma?

a. 6

b. 12

c. 15

d. 24

ANS: A

A fully alert, normal person has a score of 15, whereas a score of 7 or less reflects coma on the Glasgow Coma Scale.

DIF: Cognitive Level: Applying (Application)

MSC: Client Needs: Physiologic Integrity: Physiologic Adaptation

53. A man who was found wandering in a park at 2 AM has been brought to the emergency department for an examination; he said he fell and hit his head. During the examination, the nurse asks him to use his index finger to touch the nurses finger, then his own nose, then the nurses finger again (which has been moved to a different location). The patient is clumsy, unable to follow the instructions, and overshoots the mark, missing the finger. The nurse should suspect which of the following?

a. Cerebral injury

b. Cerebrovascular accident

c. Acute alcohol intoxication

d. Peripheral neuropathy

ANS: C

During the finger-to-finger test, if the person has clumsy movement with overshooting the mark, either a cerebellar disorder or acute alcohol intoxication should be suspected. The persons movements should be smooth and accurate. The other options are not correct.

DIF: Cognitive Level: Analyzing (Analysis)

MSC: Client Needs: Physiologic Integrity: Physiologic Adaptation

54. The nurse is assessing the neurologic status of a patient who has a late-stage brain tumor. With the reflex hammer, the nurse draws a light stroke up the lateral side of the sole of the foot and inward, across the ball of the foot. In response, the patients toes fan out, and the big toe shows dorsiflexion. The nurse interprets this result as:

a. Negative Babinski sign, which is normal for adults.

b. Positive Babinski sign, which is abnormal for adults.

c. Clonus, which is a hyperactive response.

d. Achilles reflex, which is an expected response.

ANS: B

Dorsiflexion of the big toe and fanning of all toes is a positive Babinski sign, also called *up-going toes*. This

response occurs with upper motor neuron disease of the corticospinal (or pyramidal) tract and is an abnormal finding for adults.

DIF: Cognitive Level: Analyzing (Analysis)

MSC: Client Needs: Physiologic Integrity: Physiologic Adaptation

MULTIPLE RESPONSE

1. A 69-year-old patient has been admitted to an adult psychiatric unit because his wife thinks he is getting more and more confused. He laughs when he is found to be forgetful, saying Im just getting old! After the nurse completes a thorough neurologic assessment, which findings would be indicative of Alzheimer disease? *Select all that apply*.

a. Occasionally forgetting names or appointments

b. Difficulty performing familiar tasks, such as placing a telephone call

c. Misplacing items, such as putting dish soap in the refrigerator

d. Sometimes having trouble finding the right word

e. Rapid mood swings, from calm to tears, for no apparent reason

f. Getting lost in ones own neighborhood

ANS: B, C, E, F

Difficulty performing familiar tasks, misplacing items, rapid mood swings, and getting lost in ones own neighborhood can be warning signs of Alzheimer disease. Occasionally forgetting names or appointments, and sometimes having trouble finding the right word are part of normal aging.

DIF: Cognitive Level: Applying (Application)

MSC: Client Needs: Physiologic Integrity: Physiologic Adaptation

SHORT ANSWER

1. During the assessment of deep tendon reflexes, the nurse finds that a patients responses are bilaterally normal. What number is used to indicate *normal* deep tendon reflexes when the documenting this finding?
____+

ANS:

2

Responses to assessment of deep tendon reflexes are graded on a 4-point scale. A rating of 2+ indicates normal or average response. A rating of 0 indicates no response, and a rating of 4+ indicates very brisk, hyperactive response with clonus, which is indicative of disease.

DIF: Cognitive Level: Applying (Application)

MSC: Client Needs: Physiologic Integrity: Physiologic Adaptation

Chapter 25: Male Genitourinary System

MULTIPLE CHOICE

1. The external male genital structures include the:

a. Testis.

b. Scrotum.

c. Epididymis.

d. Vas deferens.

ANS: B

The external male genital structures include the penis and scrotum. The testis, epididymis, and vas deferens are internal structures.

DIF: Cognitive Level: Remembering (Knowledge)

MSC: Client Needs: General

2. An accessory glandular structure for the male genital organs is the:

a. Testis.

b. Scrotum.

c. Prostate.

d. Vas deferens.

ANS: C

Glandular structures accessory to the male genital organs are the prostate, seminal vesicles, and bulbourethral glands.

DIF: Cognitive Level: Remembering (Knowledge)

MSC: Client Needs: General

3. Which of these statements is *true* regarding the penis?

a. The urethral meatus is located on the ventral side of the penis.

b. The prepuce is the fold of foreskin covering the shaft of the penis.

c. The penis is made up of two cylindrical columns of erectile tissue.

d. The corpus spongiosum expands into a cone of erectile tissue called the *glans*.

ANS: D

At the distal end of the shaft, the corpus spongiosum expands into a cone of erectile tissue, the glans. The penis is made up of three cylindrical columns of erectile tissue. The skin that covers the glans of the penis is the prepuce. The urethral meatus forms at the tip of the glans.

DIF: Cognitive Level: Remembering (Knowledge)

MSC: Client Needs: General

4. When performing a genital examination on a 25-year-old man, the nurse notices deeply pigmented, wrinkled scrotal skin with large sebaceous follicles. On the basis of this information, the nurse would:

a. Squeeze the glans to check for the presence of discharge.

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

c. Assess the testicles for the presence of masses or painless lumps.

d. Obtain a more detailed history, focusing on any scrotal abnormalities the patient has noticed.

ANS: B

After adolescence, the scrotal skin is deeply pigmented and has large sebaceous follicles and appears corrugated.

DIF: Cognitive Level: Applying (Application)

MSC: Client Needs: Health Promotion and Maintenance

5. Which statement concerning the testes is *true*?

a. The lymphatic vessels of the testes drain into the abdominal lymph nodes.

b. The vas deferens is located along the inferior portion of each testis.

c. The right testis is lower than the left because the right spermatic cord is longer.

d. The cremaster muscle contracts in response to cold and draws the testicles closer to the body.

ANS: D

When it is cold, the cremaster muscle contracts, which raises the scrotal sac and brings the testes closer to the body to absorb heat necessary for sperm viability. The lymphatic vessels of the testes drain into the inguinal lymph nodes. The vas deferens is located along the upper portion of each testis. The left testis is lower than the right because the left spermatic cord is longer.

DIF: Cognitive Level: Remembering (Knowledge)

MSC: Client Needs: General

6. A male patient with possible fertility problems asks the nurse where sperm is produced. The nurse knows that sperm production occurs in the:

a. Testes.

b. Prostate.

c. Epididymis.

d. Vas deferens.

ANS: A

Sperm production occurs in the testes, not in the other structures listed.

DIF: Cognitive Level: Remembering (Knowledge)

MSC: Client Needs: Physiologic Integrity

7. A 62-year-old man states that his physician told him that he has an inguinal hernia. He asks the nurse to explain what a hernia is. The nurse should:

a. Tell him not to worry and that most men his age develop hernias.

b. Explain that a hernia is often the result of prenatal growth abnormalities.

c. Refer him to his physician for additional consultation because the physician made the initial diagnosis.

d. Explain that a hernia is a loop of bowel protruding through a weak spot in the abdominal muscles.

ANS: D

A hernia is a loop of bowel protruding through a weak spot in the musculature. The other options are not correct responses to the patients question.

DIF: Cognitive Level: Applying (Application)

MSC: Client Needs: Physiologic Integrity

8. The mother of a 10-year-old boy asks the nurse to discuss the recognition of puberty. The nurse should reply by saying:

a. Puberty usually begins around 15 years of age.

b. The first sign of puberty is an enlargement of the testes.

c. The penis size does not increase until about 16 years of age.

d. The development of pubic hair precedes testicular or penis enlargement.

ANS: B

Puberty begins sometime between age 9 for African Americans and age 10 for Caucasians and Hispanics. The first sign is an enlargement of the testes. Pubic hair appears next, and then penis size increases.

DIF: Cognitive Level: Applying (Application)

MSC: Client Needs: Health Promotion and Maintenance

9. During an examination of an aging man, the nurse recognizes that normal changes to expect would be:

a. Enlarged scrotal sac.

b. Increased pubic hair.

c. Decreased penis size.

d. Increased rugae over the scrotum.

ANS: C

In the aging man, the amount of pubic hair decreases, the penis size decreases, and the rugae over the scrotal sac decreases. The scrotal sac does not enlarge.

DIF: Cognitive Level: Understanding (Comprehension)

MSC: Client Needs: Health Promotion and Maintenance

10. An older man is concerned about his sexual performance. The nurse knows that in the absence of disease, a withdrawal from sexual activity later in life may be attributable to:

a. Side effects of medications.

b. Decreased libido with aging.

c. Decreased sperm production.

d. Decreased pleasure from sexual intercourse.

ANS: A

In the absence of disease, a withdrawal from sexual activity may be attributable to side effects of medications such as antihypertensives, antidepressants, sedatives, psychotropics, antispasmotics, tranquilizers or narcotics, and estrogens. The other options are not correct.

DIF: Cognitive Level: Understanding (Comprehension)

MSC: Client Needs: Health Promotion and Maintenance

11. A 59-year-old patient has been diagnosed with prostatitis and is being seen at the clinic for complaints of burning and pain during urination. He is experiencing:

a. Dysuria.

b. Nocturia.

c. Polyuria.

d. Hematuria.

ANS: A

Dysuria (burning with urination) is common with acute cystitis, prostatitis, and urethritis. Nocturia is voiding during the night. Polyuria is voiding in excessive quantities. Hematuria is voiding with blood in the urine.

DIF: Cognitive Level: Applying (Application)

MSC: Client Needs: Physiologic Integrity: Physiologic Adaptation

12. A 45-year-old mother of two children is seen at the clinic for complaints of losing my urine when I sneeze. The nurse documents that she is experiencing:

a. Urinary frequency.

b. Enuresis.

c. Stress incontinence.

d. Urge incontinence.

ANS: C

Stress incontinence is involuntary urine loss with physical strain, sneezing, or coughing that occurs as a result to weakness of the pelvic floor. Urinary frequency is urinating more times than usual (more than five to six times per day). Enuresis is involuntary passage of urine at night after age 5 to 6 years (bed wetting). Urge incontinence is involuntary urine loss from overactive detrusor muscle in the bladder. It contracts, causing an urgent need to void.

DIF: Cognitive Level: Applying (Application)

MSC: Client Needs: Physiologic Integrity: Physiologic Adaptation

13. When the nurse is conducting sexual history from a male adolescent, which statement would be most appropriate to use at the beginning of the interview?

a. Do you use condoms?

b. You dont masturbate, do you?

c. Have you had sex in the last 6 months?

d. Often adolescents your age have questions about sexual activity.

ANS: D

The interview should begin with a permission statement, which conveys that it is normal and acceptable to think or feel a certain way. Sounding judgmental should be avoided.

DIF: Cognitive Level: Analyzing (Analysis)

MSC: Client Needs: Health Promotion and Maintenance

14. Which of these statements is most appropriate when the nurse is obtaining a genitourinary history from an older man?

a. Do you need to get up at night to urinate?

b. Do you experience nocturnal emissions, or wet dreams?

c. Do you know how to perform a testicular self-examination?

d. Has anyone ever touched your genitals when you did not want them to?

ANS: A

The older male patient should be asked about the presence of nocturia. Awaking at night to urinate may be attributable to a diuretic medication, fluid retention from mild heart failure or varicose veins, or fluid ingestion 3 hours before bedtime, especially coffee and alcohol. The other questions are more appropriate for younger men.

DIF: Cognitive Level: Analyzing (Analysis)

MSC: Client Needs: Health Promotion and Maintenance

15. When the nurse is performing a genital examination on a male patient, the patient has an erection. The nurses most appropriate action or response is to:

a. Ask the patient if he would like someone else to examine him.

b. Continue with the examination as though nothing has happened.

c. Stop the examination, leave the room while stating that the examination will resume at a later time.

d. Reassure the patient that this is a normal response and continue with the examination.

ANS: D

When the male patient has an erection, the nurse should reassure the patient that this is a normal physiologic response to touch and proceed with the rest of the examination. The other responses are not correct and may be

perceived as judgmental.

DIF: Cognitive Level: Applying (Application)

MSC: Client Needs: Psychosocial Integrity

16. The nurse is examining the glans and knows which finding is normal for this area?

a. The meatus may have a slight discharge when the glans is compressed.

b. Hair is without pest inhabitants.

c. The skin is wrinkled and without lesions.

d. Smegma may be present under the foreskin of an uncircumcised male.

ANS: D

The glans looks smooth and without lesions and does not have hair. The meatus should not have any discharge when the glans is compressed. Some cheesy smegma may have collected under the foreskin of an uncircumcised male.

DIF: Cognitive Level: Understanding (Comprehension)

MSC: Client Needs: Safe and Effective Care Environment: Management of Care

17. When performing a genitourinary assessment, the nurse notices that the urethral meatus is ventrally positioned. This finding is:

a. Called hypospadias.

b. A result of phimosis.

c. Probably due to a stricture.

d. Often associated with aging.

ANS: A

Normally, the urethral meatus is positioned just about centrally. Hypospadias is the ventral location of the urethral meatus. The position of the meatus does not change with aging. Phimosis is the inability to retract the foreskin. A stricture is a narrow opening of the meatus.

DIF: Cognitive Level: Applying (Application)

MSC: Client Needs: Safe and Effective Care Environment: Management of Care

18. The nurse is performing a genital examination on a male patient and notices urethral drainage. When collecting urethral discharge for microscopic examination and culture, the nurse should:

a. Ask the patient to urinate into a sterile cup.

b. Ask the patient to obtain a specimen of semen.

c. Insert a cotton-tipped applicator into the urethra.

d. Compress the glans between the examiners thumb and forefinger, and collect any discharge.

ANS: D

If urethral discharge is noticed, then the examiner should collect a smear for microscopic examination and culture by compressing the glans anteroposteriorly between the thumb and forefinger. The other options are not correct actions.

DIF: Cognitive Level: Applying (Application)

MSC: Client Needs: Safe and Effective Care Environment: Management of Care

19. When assessing the scrotum of a male patient, the nurse notices the presence of multiple firm, nontender, yellow 1-cm nodules. The nurse knows that these nodules are most likely:

a. From urethritis.

b. Sebaceous cysts.

c. Subcutaneous plaques.

d. From an inflammation of the epididymis.

ANS: B

Sebaceous cysts are commonly found on the scrotum. These yellowish 1-cm nodules are firm, nontender, and often multiple. The other options are not correct.

DIF: Cognitive Level: Analyzing (Analysis)

MSC: Client Needs: Physiologic Integrity: Physiologic Adaptation

20. When performing a scrotal assessment, the nurse notices that the scrotal contents show a red glow with transillumination. On the basis of this finding the nurse would:

a. Assess the patient for the presence of a hernia.

b. Suspect the presence of serous fluid in the scrotum.

c. Consider this finding normal, and proceed with the examination.

d. Refer the patient for evaluation of a mass in the scrotum.

ANS: B

Normal scrotal contents do not allow light to pass through the scrotum. However, serous fluid does

transilluminate and shows as a red glow. Neither a mass nor a hernia would transilluminate.

DIF: Cognitive Level: Analyzing (Analysis)

MSC: Client Needs: Physiologic Integrity: Physiologic Adaptation

21. When the nurse is performing a genital examination on a male patient, which action is *correct*?

a. Auscultating for the presence of a bruit over the scrotum

b. Palpating for the vertical chain of lymph nodes along the groin, inferior to the inguinal ligament

c. Palpating the inguinal canal only if a bulge is present in the inguinal region during inspection

d. Having the patient shift his weight onto the left (unexamined) leg when palpating for a hernia on the right side

ANS: D

When palpating for the presence of a hernia on the right side, the male patient is asked to shift his weight onto the left (unexamined) leg. Auscultating for a bruit over the scrotum is not appropriate. When palpating for lymph nodes, the horizontal chain is palpated. The inguinal canal should be palpated whether a bulge is present or not.

DIF: Cognitive Level: Applying (Application)

MSC: Client Needs: Safe and Effective Care Environment: Management of Care

22. The nurse is aware of which statement to be *true* regarding the incidence of testicular cancer?

a. Testicular cancer is the most common cancer in men aged 30 to 50 years.

b. The early symptoms of testicular cancer are pain and induration.

c. Men with a history of cryptorchidism are at the greatest risk for the development of testicular cancer.

d. The cure rate for testicular cancer is low.

ANS: C

Men with undescended testicles (cryptorchidism) are at the greatest risk for the development of testicular cancer. The overall incidence of testicular cancer is rare. Although testicular cancer has no early symptoms, when detected early and treated before metastasizing, the cure rate is almost 100%.

DIF: Cognitive Level: Understanding (Comprehension)

MSC: Client Needs: Health Promotion and Maintenance

23. The nurse is describing how to perform a testicular self-examination to a patient. Which statement is *most* appropriate?

a. A good time to examine your testicles is just before you take a shower.

b. If you notice an enlarged testicle or a painless lump, call your health care provider.

c. The testicle is egg shaped and movable. It feels firm and has a lumpy consistency.

d. Perform a testicular examination at least once a week to detect the early stages of testicular cancer.

ANS: B

If the patient notices a firm painless lump, a hard area, or an overall enlarged testicle, then he should call his health care provider for further evaluation. The testicle normally feels rubbery with a smooth surface. A good time to examine the testicles is during the shower or bath, when ones hands are warm and soapy and the scrotum is warm. Testicular self-examination should be performed once a month.

DIF: Cognitive Level: Applying (Application)

MSC: Client Needs: Health Promotion and Maintenance

24. A 2-month-old uncircumcised infant has been brought to the clinic for a well-baby checkup. How would the nurse proceed with the genital examination?

a. Eliciting the cremasteric reflex is recommended.

b. The glans is assessed for redness or lesions.

c. Retracting the foreskin should be avoided until the infant is 3 months old.

d. Any dirt or smegma that has collected under the foreskin should be noted.

ANS: C

If uncircumcised, then the foreskin is normally tight during the first 3 months and should not be retracted because of the risk of tearing the membrane attaching the foreskin to the shaft. The other options are not correct.

DIF: Cognitive Level: Applying (Application)

MSC: Client Needs: Safe and Effective Care Environment: Management of Care

25. A 2-year-old boy has been diagnosed with physiologic cryptorchidism. Considering this diagnosis, during assessment the nurse will most likely observe:

a. Testes that are hard and painful to palpation.

b. Atrophic scrotum and a bilateral absence of the testis.

c. Absence of the testis in the scrotum, but the testis can be milked down.

d. Testes that migrate into the abdomen when the child squats or sits cross-legged.

ANS: C

Migratory testes (physiologic cryptorchidism) are common because of the strength of the cremasteric reflex and the small mass of the prepubertal testes. The affected side has a normally developed scrotum and the testis can be milked down. The other responses are not correct.

DIF: Cognitive Level: Applying (Application)

MSC: Client Needs: Physiologic Integrity: Physiologic Adaptation

26. The nurse knows that a common assessment finding in a boy younger than 2 years old is:

a. Inflamed and tender spermatic cord.

b. Presence of a hernia in the scrotum.

c. Penis that looks large in relation to the scrotum.

d. Presence of a hydrocele, or fluid in the scrotum.

ANS: D

A common scrotal finding in boys younger than 2 years of age is a hydrocele, or fluid in the scrotum. The other options are not correct.

DIF: Cognitive Level: Applying (Application)

MSC: Client Needs: Health Promotion and Maintenance

27. During an examination of an aging man, the nurse recognizes that normal changes to expect would be:

a. Change in scrotal color.

b. Decrease in the size of the penis.

c. Enlargement of the testes and scrotum.

d. Increase in the number of rugae over the scrotal sac.

ANS: B

When assessing the genitals of an older man, the nurse may notice thinner, graying pubic hair and a decrease in the size of the penis. The size of the testes may be decreased, they may feel less firm, and the scrotal sac is pendulous with less rugae. No change in scrotal color is observed.

DIF: Cognitive Level: Applying (Application)

MSC: Client Needs: Health Promotion and Maintenance

28. When performing a genital assessment on a middle-aged man, the nurse notices multiple soft, moist, painless papules in the shape of cauliflower-like patches scattered across the shaft of the penis. These lesions

are characteristic of:

a. Carcinoma.

b. Syphilitic chancres.

c. Genital herpes.

d. Genital warts.

ANS: D

The lesions of genital warts are soft, pointed, moist, fleshy, painless papules that may be single or multiple in a cauliflower-like patch. They occur on the shaft of the penis, behind the corona, or around the anus, where they may grow into large grapelike clusters.

DIF: Cognitive Level: Analyzing (Analysis)

MSC: Client Needs: Physiologic Integrity: Physiologic Adaptation

29. A 15-year-old boy is seen in the clinic for complaints of dull pain and pulling in the scrotal area. On examination, the nurse palpates a soft, irregular mass posterior to and above the testis on the left. This mass collapses when the patient is supine and refills when he is upright. This description is consistent with:

a. Epididymitis.

b. Spermatocele.

c. Testicular torsion.

d. Varicocele.

ANS: D

A varicocele consists of dilated, tortuous varicose veins in the spermatic cord caused by incompetent valves within the vein. Symptoms include dull pain or a constant pulling or dragging feeling, or the individual may be asymptomatic. When palpating the mass, the examiner will feel a soft, irregular mass posterior to and above the testis that collapses when the individual is supine and refills when the individual is upright.

DIF: Cognitive Level: Analyzing (Analysis)

MSC: Client Needs: Physiologic Integrity: Physiologic Adaptation

30. When performing a genitourinary assessment on a 16-year-old male adolescent, the nurse notices a swelling in the scrotum that increases with increased intra-abdominal pressure and decreases when he is lying down. The patient complains of pain when straining. The nurse knows that this description is most consistent with a(n) _____ hernia.

a. Femoral

b. Incisional

c. Direct inguinal

d. Indirect inguinal

ANS: D

With indirect inguinal hernias, pain occurs with straining and a soft swelling increases with increased intra-abdominal pressure, which may decrease when the patient lies down. These findings do not describe the other hernias.

DIF: Cognitive Level: Analyzing (Analysis)

MSC: Client Needs: Physiologic Integrity: Physiologic Adaptation

31. When the nurse is performing a testicular examination on a 25-year-old man, which finding is considered normal?

a. Nontender subcutaneous plaques

b. Scrotal area that is dry, scaly, and nodular

c. Testes that feel oval and movable and are slightly sensitive to compression

d. Single, hard, circumscribed, movable mass, less than 1 cm under the surface of the testes

ANS: C

Testes normally feel oval, firm and rubbery, smooth, and bilaterally equal and are freely movable and slightly tender to moderate pressure. The scrotal skin should not be dry, scaly, or nodular or contain subcutaneous plaques. Any mass would be an abnormal finding.

DIF: Cognitive Level: Applying (Application)

MSC: Client Needs: Safe and Effective Care Environment: Management of Care

32. The nurse is inspecting the scrotum and testes of a 43-year-old man. Which finding would require additional follow-up and evaluation?

a. Skin on the scrotum is taut.

b. Left testicle hangs lower than the right testicle.

c. Scrotal skin has yellowish 1-cm nodules that are firm and nontender.

d. Testes move closer to the body in response to cold temperatures.

ANS: A

Scrotal swelling may cause the skin to be taut and to display pitting edema. Normal scrotal skin is rugae, and

asymmetry is normal with the left scrotal half usually lower than the right. The testes may move closer to the body in response to cold temperatures.

DIF: Cognitive Level: Analyzing (Analysis)

MSC: Client Needs: Physiologic Integrity: Physiologic Adaptation

33. A 55-year-old man is experiencing severe pain of sudden onset in the scrotal area. It is somewhat relieved by elevation. On examination the nurse notices an enlarged, red scrotum that is very tender to palpation. Distinguishing the epididymis from the testis is difficult, and the scrotal skin is thick and edematous. This description is consistent with which of these?

a. Varicocele

b. Epididymitis

c. Spermatocele

d. Testicular torsion

ANS: B

Epididymitis presents as severe pain of sudden onset in the scrotum that is somewhat relieved by elevation. On examination, the scrotum is enlarged, reddened, and exquisitely tender. The epididymis is enlarged and indurated and may be hard to distinguish from the testis. The overlying scrotal skin may be thick and edematous.

DIF: Cognitive Level: Analyzing (Analysis)

MSC: Client Needs: Physiologic Integrity: Physiologic Adaptation

34. The nurse is performing a genitourinary assessment on a 50-year-old obese male laborer. On examination, the nurse notices a painless round swelling close to the pubis in the area of the internal inguinal ring that is easily reduced when the individual is supine. These findings are most consistent with a(n) _____ hernia.

a. Scrotal

b. Femoral

c. Direct inguinal

d. Indirect inguinal

ANS: C

Direct inguinal hernias occur most often in men over the age of 40 years. It is an acquired weakness brought on by heavy lifting, obesity, chronic cough, or ascites. The direct inguinal hernia is usually a painless, round swelling close to the pubis in the area of the internal inguinal ring that is easily reduced when the individual is supine.

DIF: Cognitive Level: Analyzing (Analysis)

MSC: Client Needs: Physiologic Integrity: Physiologic Adaptation

35. The nurse is providing patient teaching about an erectile dysfunction drug. One of the drugs potential side effects is prolonged, painful erection of the penis without sexual stimulation, which is known as:

a. Orchitis.

b. Stricture.

c. Phimosis.

d. Priapism.

ANS: D

Priapism is prolonged, painful erection of the penis without sexual desire. Orchitis is inflammation of the testes. Stricture is a narrowing of the opening of the urethral meatus. Phimosis is the inability to retract the foreskin.

DIF: Cognitive Level: Remembering (Knowledge)

MSC: Client Needs: Physiologic Integrity: Physiologic Adaptation

36. During an examination, the nurse notices that a male patient has a red, round, superficial ulcer with a yellowish serous discharge on his penis. On palpation, the nurse finds a nontender base that feels like a small button between the thumb and fingers. At this point the nurse suspects that this patient has:

a. Genital warts.

b. Herpes infection.

c. Syphilitic chancre.

d. Carcinoma lesion.

ANS: C

This lesion indicates syphilitic chancre, which begins within 2 to 4 weeks of infection.

DIF: Cognitive Level: Analyzing (Analysis)

MSC: Client Needs: Physiologic Integrity: Physiologic Adaptation

37. During a health history, a patient tells the nurse that he has trouble in starting his urine stream. This problem is known as:

a. Urgency.

b. Dribbling.

c. Frequency.

d. Hesitancy.

ANS: D

Hesitancy is trouble in starting the urine stream. Urgency is the feeling that one cannot wait to urinate. Dribbling is the last of the urine before or after the main act of urination. Frequency is urinating more often than usual.

DIF: Cognitive Level: Understanding (Comprehension)

MSC: Client Needs: Physiologic Integrity: Physiologic Adaptation

38. During a genital examination, the nurse notices that a male patient has clusters of small vesicles on the glans, surrounded by erythema. The nurse recognizes that these lesions are:

a. Peyronie disease.

b. Genital warts.

c. Genital herpes.

d. Syphilitic cancer.

ANS: C

Genital herpes, or herpes simplex virus 2 (HSV-2), infections are indicated with clusters of small vesicles with surrounding erythema, which are often painful and erupt on the glans or foreskin.

DIF: Cognitive Level: Applying (Application)

MSC: Client Needs: Physiologic Integrity: Physiologic Adaptation

39. During a physical examination, the nurse finds that a male patients foreskin is fixed and tight and will not retract over the glans. The nurse recognizes that this condition is:

a. Phimosis.

b. Epispadias.

c. Urethral stricture.

d. Peyronie disease.

ANS: A

With phimosis, the foreskin is nonretractable, forming a pointy tip of the penis with a tiny orifice at the end of the glans. The foreskin is advanced and so tight that it is impossible to retract over the glans. This condition may be congenital or acquired from adhesions related to infection.

DIF: Cognitive Level: Applying (Application)

MSC: Client Needs: Physiologic Integrity: Physiologic Adaptation

MULTIPLE RESPONSE

1. A 55-year-old man is in the clinic for a yearly checkup. He is worried because his father died of prostate cancer. The nurse knows which tests should be performed at this time? *Select all that apply*.

a. Blood test for prostate-specific antigen (PSA)

b. Urinalysis

c. Transrectal ultrasound

d. Digital rectal examination (DRE)

e. Prostate biopsy

ANS: A, D

Prostate cancer is typically detected by testing the blood for PSA or by a DRE. It is recommended that *both* PSA and DRE be offered to men annually, beginning at age 50 years. If the PSA is elevated, then further laboratory work or a transrectal ultrasound (TRUS) and biopsy may be recommended.

DIF: Cognitive Level: Applying (Application)

MSC: Client Needs: Health Promotion and Maintenance

2. A 16-year-old boy is brought to the clinic for a problem that he refused to let his mother see. The nurse examines him, and finds that he has scrotal swelling on the left side. He had the mumps the previous week, and the nurse suspects that he has orchitis. Which of the following assessment findings support this diagnosis? *Select all that apply*.

a. Swollen testis

b. Mass that transilluminates

c. Mass that does not transilluminate

d. Scrotum that is nontender upon palpation

e. Scrotum that is tender upon palpation

f. Scrotal skin that is reddened

ANS: A, C, E, F

With orchitis, the testis is swollen, with a feeling of weight, and is tender or painful. The mass does not transilluminate, and the scrotal skin is reddened. Transillumination of a mass occurs with a hydrocele, not

orchitis.

DIF: Cognitive Level: Applying (Application)

MSC: Client Needs: Health Promotion and Maintenance

Chapter 26: Anus, Rectum, and Prostate

MULTIPLE CHOICE

1. Which statement concerning the anal canal is *true*? The anal canal:

a. Is approximately 2 cm long in the adult.

b. Slants backward toward the sacrum.

c. Contains hair and sebaceous glands.

d. Is the outlet for the gastrointestinal tract.

ANS: D

The anal canal is the outlet for the gastrointestinal tract and is approximately 3.8 cm long in the adult. It is lined with a modified skin that does not contain hair or sebaceous glands, and it slants forward toward the umbilicus.

DIF: Cognitive Level: Remembering (Knowledge)

MSC: Client Needs: General

2. Which statement concerning the sphincters is *correct*?

a. The internal sphincter is under voluntary control.

b. The external sphincter is under voluntary control.

c. Both sphincters remain slightly relaxed at all times.

d. The internal sphincter surrounds the external sphincter.

ANS: B

The external sphincter surrounds the internal sphincter but also has a small section overriding the tip of the internal sphincter at the opening. The external sphincter is under voluntary control. Except for the passing of feces and gas, the sphincters keep the anal canal tightly closed.

DIF: Cognitive Level: Remembering (Knowledge)

MSC: Client Needs: General

3. The nurse is performing an examination of the anus and rectum. Which of these statements is *correct* and important to remember during this examination?

a. The rectum is approximately 8 cm long.

b. The anorectal junction cannot be palpated.

c. Above the anal canal, the rectum turns anteriorly.

d. No sensory nerves are in the anal canal or rectum.

ANS: B

The anal columns are folds of mucosa that extend vertically down from the rectum and end in the anorectal junction. This junction is not palpable but is visible on proctoscopy. The rectum is 12 cm long; just above the anal canal, the rectum dilates and turns posteriorly.

DIF: Cognitive Level: Remembering (Knowledge)

MSC: Client Needs: Safe and Effective Care Environment: Management of Care

4. The structure that secretes a thin, milky alkaline fluid to enhance the viability of sperm is the:

a. Cowper gland.

b. Prostate gland.

c. Median sulcus.

d. Bulbourethral gland.

ANS: B

In men, the prostate gland secretes a thin milky alkaline fluid that enhances sperm viability. The Cowper glands (also known as *bulbourethral glands*) secrete a clear, viscid mucus. The median sulcus is a groove that divides the lobes of the prostate gland and does not secrete fluid.

DIF: Cognitive Level: Remembering (Knowledge)

MSC: Client Needs: General

5. A 46-year-old man requires an assessment of his sigmoid colon. Which instrument or technique is *most* appropriate for this examination?

a. Proctoscope

b. Ultrasound

c. Colonoscope

d. Rectal examination with an examining finger

ANS: C

The sigmoid colon is 40 cm long, and the nurse knows that it is accessible to examination only with the colonoscope. The other responses are not appropriate for an examination of the entire sigmoid colon.

DIF: Cognitive Level: Understanding (Comprehension)

MSC: Client Needs: Safe and Effective Care Environment: Management of Care

6. The nurse is caring for a newborn infant. Thirty hours after birth, the infant passes a dark green meconium stool. The nurse recognizes this is important because the:

a. Stool indicates anal patency.

b. Dark green color indicates occult blood in the stool.

c. Meconium stool can be reflective of distress in the newborn.

d. Newborn should have passed the first stool within 12 hours after birth.

ANS: A

The first stool passed by the newborn is dark green meconium and occurs within 24 to 48 hours of birth, indicating anal patency. The other responses are not correct.

DIF: Cognitive Level: Understanding (Comprehension)

MSC: Client Needs: Health Promotion and Maintenance

7. During the assessment of an 18-month-old infant, the mother expresses concern to the nurse about the infants inability to toilet train. What would be the nurses best response?

a. Some children are just more difficult to train, so I wouldnt worry about it yet.

b. Have you considered reading any of the books on toilet training? They can be very helpful.

c. This could mean that there is a problem in your babys development. Well watch her closely for the next few months.

d. The nerves that will allow your baby to have control over the passing of stools are not developed until at least 18 to 24 months of age.

ANS: D

The infant passes stools by reflex. Voluntary control of the external anal sphincter cannot occur until the nerves supplying the area have become fully myelinated, usually around 1 to 2 years of age. Toilet training usually starts after the age of 2 years.

DIF: Cognitive Level: Applying (Application)

MSC: Client Needs: Health Promotion and Maintenance

8. A 60-year-old man has just been told that he has benign prostatic hypertrophy (BPH). He has a friend who just died from cancer of the prostate. He is concerned this will happen to him. How should the nurse respond?

a. The swelling in your prostate is only temporary and will go away.

b. We will treat you with chemotherapy so we can control the cancer.

c. It would be very unusual for a man your age to have cancer of the prostate.

d. The enlargement of your prostate is caused by hormonal changes, and not cancer.

ANS: D

The prostate gland commonly starts to enlarge during the middle adult years. BPH is present in 1 in 10 men at the age of 40 years and increases with age. It is believed that the hypertrophy is caused by hormonal imbalance that leads to the proliferation of benign adenomas. The other responses are not appropriate.

DIF: Cognitive Level: Applying (Application)

MSC: Client Needs: Health Promotion and Maintenance

9. A 30-year-old woman is visiting the clinic because of pain in my bottom when I have a bowel movement. The nurse should assess for which problem?

a. Pinworms

b. Hemorrhoids

c. Colon cancer

d. Fecal incontinence

ANS: B

Having painful bowel movements, known as *dyschezia*, may be attributable to a local condition (hemorrhoid or fissure) or constipation. The other responses are not correct.

DIF: Cognitive Level: Applying (Application)

MSC: Client Needs: Physiologic Integrity: Physiologic Adaptation

10. A patient who is visiting the clinic complains of having stomach pains for 2 weeks and describes his stools as being soft and black for approximately the last 10 days. He denies taking any medications. The nurse is aware that these symptoms are mostly indicative of:

a. Excessive fat caused by malabsorption.

b. Increased iron intake, resulting from a change in diet.

c. Occult blood, resulting from gastrointestinal bleeding.

d. Absent bile pigment from liver problems.

ANS: C

Black stools may be tarry as a result of occult blood (melena) from gastrointestinal bleeding or nontarry from ingestion of iron medications (not diet). Excessive fat causes the stool to become frothy. The absence of bile pigment causes clay-colored stools.

DIF: Cognitive Level: Analyzing (Analysis)

MSC: Client Needs: Physiologic Integrity: Physiologic Adaptation

11. After completing an assessment of a 60-year-old man with a family history of colon cancer, the nurse discusses with him early detection measures for colon cancer. The nurse should mention the need for a(n):

a. Annual proctoscopy.

b. Colonoscopy every 10 years.

c. Fecal test for blood every 6 months.

d. DREs every 2 years.

ANS: B

Early detection measures for colon cancer include a DRE performed annually after age 50 years, an annual fecal occult blood test after age 50 years, a sigmoidoscopic examination every 5 years or a colonoscopy every 10 years after age 50 years, and a PSA blood test annually for men over 50 years old, except beginning at age 45 years for black men (American Cancer Society, 2006).

DIF: Cognitive Level: Applying (Application)

MSC: Client Needs: Health Promotion and Maintenance

12. The mother of a 5-year-old girl tells the nurse that she has noticed her daughter scratching at her bottom a lot the last few days. During the assessment, the nurse finds redness and raised skin in the anal area. This finding most likely indicates:

a. Pinworms.

b. Chickenpox.

c. Constipation.

d. Bacterial infection.

ANS: A

In children, pinworms are a common cause of intense itching and irritated anal skin. The other options are not correct.

DIF: Cognitive Level: Analyzing (Analysis)

MSC: Client Needs: Physiologic Integrity: Physiologic Adaptation

13. The nurse is examining only the rectal area of a woman and should place the woman in what position?

a. Lithotomy

b. Prone

c. Left lateral decubitus

d. Bending over the table while standing

ANS: C

The nurse should place the female patient in the lithotomy position if the genitalia are being examined as well. The left lateral decubitus position is used for the rectal area alone.

DIF: Cognitive Level: Understanding (Comprehension)

MSC: Client Needs: Safe and Effective Care Environment: Management of Care

14. While performing an assessment of the perianal area of a patient, the nurse notices that the pigmentation of anus is darker than the surrounding skin, the anal opening is closed, and a skin sac that is shiny and blue is noted. The patient mentioned that he has had pain with bowel movements and has occasionally noted some spots of blood. What would this assessment and history *most* likely indicate?

a. Anal fistula

b. Pilonidal cyst

c. Rectal prolapse

d. Thrombosed hemorrhoid

ANS: D

The anus normally looks moist and hairless, with coarse folded skin that is more pigmented than the perianal skin, and the anal opening is tightly closed. The shiny blue skin sac indicates a thrombosed hemorrhoid.

DIF: Cognitive Level: Analyzing (Analysis)

MSC: Client Needs: Physiologic Integrity: Physiologic Adaptation

15. The nurse is preparing to palpate the rectum and should use which of these techniques? The nurse should:

a. Flex the finger, and slowly insert it toward the umbilicus.

b. First instruct the patient that this procedure will be painful.

c. Insert an extended index finger at a right angle to the anus.

d. Place the finger directly into the anus to overcome the tight sphincter.

ANS: A

The nurse should gently place the pad of the index finger against the anal verge. The nurse will feel the sphincter tighten and then relax. As it relaxes, the nurse should flex the tip of the finger and slowly insert it into the anal canal in a direction toward the umbilicus. The nurse should never approach the anus at right angles with the index finger extended; doing so would cause pain. The nurse should instruct the patient that palpation is not painful but may feel like needing to move the bowels.

DIF: Cognitive Level: Understanding (Comprehension)

MSC: Client Needs: Safe and Effective Care Environment: Management of Care

16. While performing a rectal examination, the nurse notices a firm, irregularly shaped mass. What should the nurse do next?

a. Continue with the examination, and document the finding in the chart.

b. Instruct the patient to return for a repeat assessment in 1 month.

c. Tell the patient that a mass was felt, but it is nothing to worry about.

d. Report the finding, and refer the patient to a specialist for further examination.

ANS: D

A firm or hard mass with an irregular shape or rolled edges may signify carcinoma. Any mass that is discovered should be promptly reported for further examination. The other responses are not correct.

DIF: Cognitive Level: Applying (Application)

MSC: Client Needs: Health Promotion and Maintenance

17. During an assessment of the newborn, the nurse expects to see which finding when the anal area is slightly stroked?

a. Jerking of the legs

b. Flexion of the knees

c. Quick contraction of the sphincter

d. Relaxation of the external sphincter

ANS: C

To assess sphincter tone, the nurse should check the anal reflex by gently stroking the anal area and noticing a quick contraction of the sphincter. The other responses are not correct.

DIF: Cognitive Level: Understanding (Comprehension)

MSC: Client Needs: Health Promotion and Maintenance

18. A 13-year-old girl is visiting the clinic for a sports physical examination. The nurse should remember to include which of these tests in the examination?

a. Testing for occult blood

b. Valsalva maneuver

c. Internal palpation of the anus

d. Inspection of the perianal area

ANS: D

The perianal region of the school-aged child and adolescent should be inspected during the examination of the genitalia. Internal palpation is not routinely performed at this age. Testing for occult blood and performing the Valsalva maneuver are also not necessary.

DIF: Cognitive Level: Applying (Application)

MSC: Client Needs: Health Promotion and Maintenance

19. During an assessment of a 20-year-old man, the nurse finds a small palpable lesion with a tuft of hair located directly over the coccyx. The nurse knows that this lesion would most likely be a:

a. Rectal polyp.

b. Pruritus ani.

c. Carcinoma.

d. Pilonidal cyst.

ANS: D

A pilonidal cyst or sinus is a hair-containing cyst or sinus located in the midline over the coccyx or lower sacrum. It often opens as a dimple with a visible tuft of hair and, possibly, an erythematous halo.

DIF: Cognitive Level: Applying (Application)

MSC: Client Needs: Physiologic Integrity: Physiologic Adaptation

20. During an examination, the nurse asks the patient to perform the Valsalva maneuver and notices that the patient has a moist, red, doughnut-shaped protrusion from the anus. The nurse knows that this finding is consistent with a:

a. Rectal polyp.

b. Hemorrhoid.

c. Rectal fissure.

d. Rectal prolapse.

ANS: D

In rectal prolapse, the rectal mucous membrane protrudes through the anus, appearing as a moist red doughnut with radiating lines. It occurs after a Valsalva maneuver, such as straining at passing stool or with exercising.

DIF: Cognitive Level: Understanding (Comprehension)

MSC: Client Needs: Physiologic Integrity: Physiologic Adaptation

21. A 70-year-old man is visiting the clinic for difficulty in passing urine. In the health history, he indicates that he has to urinate frequently, especially at night. He has burning when he urinates and has noticed pain in his back. Considering this history, what might the nurse expect to find during the physical assessment?

a. Asymmetric, hard, and fixed prostate gland

b. Occult blood and perianal pain to palpation

c. Symmetrically enlarged, soft prostate gland

d. Soft nodule protruding from the rectal mucosa

ANS: A

Subjective symptoms of carcinoma of the prostate include frequency, nocturia, hematuria, weak stream, hesitancy, pain or burning on urination, and continuous pain in lower back, pelvis, and thighs. Objective symptoms of carcinoma of the prostate include a malignant neoplasm that often starts as a single hard nodule on the posterior surface, producing asymmetry and a change in consistency. As it invades normal tissue, multiple hard nodules appear, or the entire gland feels stone hard and fixed.

DIF: Cognitive Level: Analyzing (Analysis)

MSC: Client Needs: Physiologic Integrity: Physiologic Adaptation

22. A 40-year-old black man is in the office for his annual physical examination. Which statement regarding the PSA blood test is *true*, according to the American Cancer Society? The PSA:

a. Should be performed with this visit.

b. Should be performed at age 45 years.

c. Should be performed at age 50 years.

d. Is only necessary if a family history of prostate cancer exists.

ANS: B

According to the American Cancer Society (2006), the PSA blood test should be performed annually for black men beginning at age 45 years and annually for all other men over age 50 years.

DIF: Cognitive Level: Applying (Application)

MSC: Client Needs: Health Promotion and Maintenance

23. A 62-year-old man is experiencing fever, chills, malaise, urinary frequency, and urgency. He also reports urethral discharge and a dull aching pain in the perineal and rectal area. These symptoms are most consistent with which condition?

a. Prostatitis

b. Polyps

c. Carcinoma of the prostate

d. BPH

ANS: A

The common presenting symptoms of prostatitis are fever, chills, malaise, and urinary frequency and urgency. The individual may also have dysuria, urethral discharge, and a dull aching pain in the perineal and rectal area. These symptoms are not consistent with polyps.

DIF: Cognitive Level: Analyzing (Analysis)

MSC: Client Needs: Physiologic Integrity: Physiologic Adaptation

24. During a discussion for a mens health group, the nurse relates that the group with the highest incidence of prostate cancer is:

a. Asian Americans.

b. Blacks.

c. American Indians.

d. Hispanics.

ANS: B

According to the American Cancer Society (2010), black men have a higher rate of prostate cancer than other racial groups.

DIF: Cognitive Level: Remembering (Knowledge)

MSC: Client Needs: Physiologic Integrity: Reduction of Risk Potential

25. Which characteristic of the prostate gland would the nurse recognize as an abnormal finding while palpating the prostate gland through the rectum?

a. Palpable central groove

b. Tenderness to palpation

c. Heart shaped

d. Elastic and rubbery consistency

ANS: B

The normal prostate gland should feel smooth, elastic, and rubbery; slightly movable; heart-shaped with a palpable central groove; and not be tender to palpation.

DIF: Cognitive Level: Analyzing (Analysis)

MSC: Client Needs: Health Promotion and Maintenance

26. The nurse notices that a patient has had a pale, yellow, greasy stool, or steatorrhea, and recalls that this is caused by:

a. Occult bleeding.

b. Absent bile pigment.

c. Increased fat content.

d. Ingestion of bismuth preparations.

ANS: C

Steatorrhea (pale, yellow, greasy stool) is caused by increased fat content in the stools, as in malabsorption syndrome. Occult bleeding and ingestion of bismuth products cause a black stool, and absent bile pigment causes a gray-tan stool.

DIF: Cognitive Level: Understanding (Comprehension)

MSC: Client Needs: Physiologic Integrity: Physiologic Adaptation

27. During a health history of a patient who complains of chronic constipation, the patient asks the nurse about high-fiber foods. The nurse relates that an example of a high-fiber food would be:

a. Broccoli.

b. Hamburger.

c. Iceberg lettuce.

d. Yogurt.

ANS: A

High-fiber foods are either soluble type (e.g., beans, prunes, barley, broccoli) or insoluble type (e.g., cereals,

wheat germ). The other examples are not considered high-fiber foods.

DIF: Cognitive Level: Understanding (Comprehension)

MSC: Client Needs: Health Promotion and Maintenance

28. While assessing a patient who is hospitalized and bedridden, the nurse notices that the patient has been incontinent of stool. The stool is loose and gray-tan in color. The nurse recognizes that this finding indicates which of the following?

a. Occult blood

b. Inflammation

c. Absent bile pigment

d. Ingestion of iron preparations

ANS: C

The presence of gray-tan stool indicates absent bile pigment, which can occur with obstructive jaundice. The ingestion of iron preparations and the presence of occult blood turns the stools to a black color. Jellylike mucus shreds mixed in the stool would indicate inflammation.

DIF: Cognitive Level: Applying (Application)

MSC: Client Needs: Physiologic Integrity: Physiologic Adaptation

29. During a digital examination of the rectum, the nurse notices that the patient has hard feces in the rectum. The patient complains of feeling full, has a distended abdomen, and states that she has not had a bowel movement for several days. The nurse suspects which condition?

a. Rectal polyp

b. Fecal impaction

c. Rectal abscess

d. Rectal prolapse

ANS: B

A fecal impaction is a collection of hard, desiccated feces in the rectum. The obstruction often results from decreased bowel motility, in which more water is reabsorbed from the stool.

DIF: Cognitive Level: Applying (Application)

MSC: Client Needs: Physiologic Integrity: Physiologic Adaptation

30. During the taking of a health history, the patient states, It really hurts back there, and sometimes it itches, too. I have even seen blood on the tissue when I have a bowel movement. Is there something there? The nurse should expect to see which of these upon examination of the anus?

a. Rectal prolapse

b. Internal hemorrhoid

c. External hemorrhoid that has resolved

d. External hemorrhoid that is thrombosed

ANS: D

These symptoms are consistent with an external hemorrhoid. An external hemorrhoid, when thrombosed, contains clotted blood and becomes a painful, swollen, shiny blue mass that itches and bleeds with defecation. When the external hemorrhoid resolves, it leaves a flabby, painless skin sac around the anal orifice. An internal hemorrhoid is not palpable but may appear as a red mucosal mass when the person performs a Valsalva maneuver. A rectal prolapse appears as a moist, red doughnut with radiating lines.

DIF: Cognitive Level: Applying (Application)

MSC: Client Needs: Physiologic Integrity: Physiologic Adaptation

MULTIPLE RESPONSE

1. The nurse is performing a digital examination of a patients prostate gland and notices that a normal prostate gland includes which of the following characteristics? *Select all that apply*.

a. 1 cm protrusion into the rectum

b. Heart-shaped with a palpable central groove

c. Flat shape with no palpable groove

d. Boggy with a soft consistency

e. Smooth surface, elastic, and rubbery consistency

f. Fixed mobility

ANS: A, B, E

The size of a normal prostate gland should be 2.5 cm long by 4 cm wide and should not protrude more than 1 cm into the rectum. The prostate should be heart-shaped, with a palpable central groove, a smooth surface, and elastic with a rubbery consistency. Abnormal findings include a flat shape with no palpable groove, boggy with a soft consistency, and fixed mobility.

DIF: Cognitive Level: Analyzing (Analysis)

MSC: Client Needs: Health Promotion and Maintenance

Chapter 27: Female Genitourinary System

MULTIPLE CHOICE

1. During a health history, a 22-year old woman asks, Can I get that vaccine for human papilloma virus (HPV)? I have genital warts and Id like them to go away! What is the nurses best response?

a. The HPV vaccine is for girls and women ages 9 to 26 years, so we can start that today.

b. This vaccine is only for girls who have not yet started to become sexually active.

c. Lets check with the physician to see if you are a candidate for this vaccine.

d. The vaccine cannot protect you if you already have an HPV infection.

ANS: D

The HPV vaccine is appropriate for girls and women age 9 to 26 years and is administered to prevent cervical cancer by preventing HPV infections before girls become sexually active. However, it cannot protect the woman if an HPV infection is already present.

DIF: Cognitive Level: Analyzing (Analysis)

MSC: Client Needs: General

2. During an examination, the nurse observes a female patients vestibule and expects to see the:

a. Urethral meatus and vaginal orifice.

b. Vaginal orifice and vestibular (Bartholin) glands.

c. Urethral meatus and paraurethral (Skene) glands.

d. Paraurethral (Skene) and vestibular (Bartholin) glands.

ANS: A

The labial structures encircle a boat-shaped space, or cleft, termed the *vestibule*. Within the vestibule are numerous openings. The urethral meatus and vaginal orifice are visible. The ducts of the paraurethral (Skene) glands and the vestibular (Bartholin) glands are present but not visible.

DIF: Cognitive Level: Understanding (Comprehension)

MSC: Client Needs: Physiologic Integrity: Physiologic Adaptation

3. During a speculum inspection of the vagina, the nurse would expect to see what at the end of the vaginal canal?

a. Cervix

b. Uterus

c. Ovaries

d. Fallopian tubes

ANS: A

At the end of the canal, the uterine cervix projects into the vagina.

DIF: Cognitive Level: Remembering (Knowledge)

MSC: Client Needs: Physiologic Integrity: Physiologic Adaptation

4. The uterus is usually positioned tilting forward and superior to the bladder. This position is known as:

a. Anteverted and anteflexed.

b. Retroverted and anteflexed.

c. Retroverted and retroflexed.

d. Superiorverted and anteflexed.

ANS: A

The uterus is freely movable, not fixed, and usually tilts forward and superior to the bladder (a position labeled as *anteverted and anteflexed*).

DIF: Cognitive Level: Remembering (Knowledge)

MSC: Client Needs: General

5. An 11-year-old girl is in the clinic for a sports physical examination. The nurse notices that she has begun to develop breasts, and during the conversation the girl reveals that she is worried about her development. The nurse should use which of these techniques to best assist the young girl in understanding the expected sequence for development? The nurse should:

a. Use the Tanner scale on the five stages of sexual development.

b. Describe her development and compare it with that of other girls her age.

c. Use the Jacobsen table on expected development on the basis of height and weight data.

d. Reassure her that her development is within normal limits and tell her not to worry about the next step.

ANS: A

The Tanner scale on the five stages of pubic hair development is helpful in teaching girls the expected

sequence of sexual development. The other responses are not appropriate.

DIF: Cognitive Level: Applying (Application)

MSC: Client Needs: Health Promotion and Maintenance

6. A woman who is 8 weeks pregnant is in the clinic for a checkup. The nurse reads on her chart that her cervix is softened and looks cyanotic. The nurse knows that the woman is exhibiting _____ sign and _____ sign.

a. Tanner; Hegar

b. Hegar; Goodell

c. Chadwick; Hegar

d. Goodell; Chadwick

ANS: D

Shortly after the first missed menstrual period, the female genitalia show signs of the growing fetus. The cervix softens (Goodell sign) at 4 to 6 weeks, and the vaginal mucosa and cervix look cyanotic (Chadwick sign) at 8 to 12 weeks. These changes occur because of increased vascularity and edema of the cervix and hypertrophy and hyperplasia of the cervical glands. Hegar sign occurs when the isthmus of the uterus softens at 6 to 8 weeks. Tanner sign is not a correct response.

DIF: Cognitive Level: Understanding (Comprehension)

MSC: Client Needs: Health Promotion and Maintenance

7. Generally, the changes normally associated with menopause occur because the cells in the reproductive tract are:

a. Aging.

b. Becoming fibrous.

c. Estrogen dependent.

d. Able to respond to estrogen.

ANS: C

Because cells in the reproductive tract are estrogen dependent, decreased estrogen levels during menopause bring dramatic physical changes. The other options are not correct.

DIF: Cognitive Level: Remembering (Knowledge)

MSC: Client Needs: Health Promotion and Maintenance

8. The nurse is reviewing the changes that occur with menopause. Which changes are associated with menopause?

a. Uterine and ovarian atrophy, along with a thinning of the vaginal epithelium

b. Ovarian atrophy, increased vaginal secretions, and increasing clitoral size

c. Cervical hypertrophy, ovarian atrophy, and increased acidity of vaginal secretions

d. Vaginal mucosa fragility, increased acidity of vaginal secretions, and uterine hypertrophy

ANS: A

The uterus shrinks because of its decreased myometrium. The ovaries atrophy to 1 to 2 cm and are not palpable after menopause. The sacral ligaments relax, and the pelvic musculature weakens; consequently, the uterus droops. The cervix shrinks and looks paler with a thick glistening epithelium. The vaginal epithelium atrophies, becoming thinner, drier, and itchy. The vaginal pH becomes more alkaline, and secretions are decreased, which results in a fragile mucosal surface that is at risk for vaginitis.

DIF: Cognitive Level: Understanding (Comprehension)

MSC: Client Needs: Health Promotion and Maintenance

9. A 54-year-old woman who has just completed menopause is in the clinic today for a yearly physical examination. Which of these statements should the nurse include in patient education? A postmenopausal woman:

a. Is not at any greater risk for heart disease than a younger woman.

b. Should be aware that she is at increased risk for dyspareunia because of decreased vaginal secretions.

c. Has only stopped menstruating; there really are no other significant changes with which she should be concerned.

d. Is likely to have difficulty with sexual pleasure as a result of drastic changes in the female sexual response cycle.

ANS: B

Decreased vaginal secretions leave the vagina dry and at risk for irritation and pain with intercourse (dyspareunia). The other statements are incorrect.

DIF: Cognitive Level: Applying (Application)

MSC: Client Needs: Health Promotion and Maintenance

10. A woman is in the clinic for an annual gynecologic examination. The nurse should plan to begin the interview with the:

a. Menstrual history, because it is generally nonthreatening.

b. Obstetric history, because it includes the most important information.

c. Urinary system history, because problems may develop in this area as well.

d. Sexual history, because discussing it first will build rapport.

ANS: A

Menstrual history is usually nonthreatening and therefore a good topic with which to begin the interview. Obstetric, urinary, and sexual histories are also part of the interview but not necessarily the best topics with which to start.

DIF: Cognitive Level: Applying (Application)

MSC: Client Needs: Safe and Effective Care Environment: Management of Care

11. A patient has had three pregnancies and two live births. The nurse would record this information as grav _____, para _____, AB _____.

a. 2; 2; 1

b. 3; 2; 0

c. 3; 2; 1

d. 3; 3; 1

ANS: C

Gravida (grav) is the number of pregnancies. Para is the number of births. Abortions are interrupted pregnancies, including elective abortions and spontaneous miscarriages.

DIF: Cognitive Level: Applying (Application)

MSC: Client Needs: Safe and Effective Care Environment: Management of Care

12. During the interview with a female patient, the nurse gathers data that indicate the patient is perimenopausal. Which of these statements made by this patient leads to this conclusion?

a. I have noticed that my muscles ache at night when I go to bed.

b. I will be very happy when I can stop worrying about having a period.

c. I have been noticing that I sweat a lot more than I used to, especially at night.

d. I have only been pregnant twice, but both times I had breast tenderness as my first symptom.

ANS: C

Hormone shifts occur during the perimenopausal period, and associated symptoms of menopause may occur, such as hot flashes, night sweats, numbness and tingling, headache, palpitations, drenching sweats, mood swings, vaginal dryness, and itching. The other responses are not correct.

DIF: Cognitive Level: Analyzing (Analysis)

MSC: Client Needs: Health Promotion and Maintenance

13. A 50-year-old woman calls the clinic because she has noticed some changes in her body and breasts and wonders if these changes could be attributable to the hormone replacement therapy (HRT) she started 3 months earlier. The nurse should tell her:

a. HRT is at such a low dose that side effects are very unusual.

b. HRT has several side effects, including fluid retention, breast tenderness, and vaginal bleeding.

c. Vaginal bleeding with HRT is very unusual; I suggest you come into the clinic immediately to have this evaluated.

d. It sounds as if your dose of estrogen is too high; I think you may need to decrease the amount you are taking and then call back in a week.

ANS: B

Side effects of HRT include fluid retention, breast pain, and vaginal bleeding. The other responses are not correct.

DIF: Cognitive Level: Applying (Application)

MSC: Client Needs: Physiologic Integrity: Pharmacologic and Parenteral Therapies

14. A 52-year-old patient states that when she sneezes or coughs she wets herself a little. She is very concerned that something may be wrong with her. The nurse suspects that the problem is:

a. Dysuria.

b. Stress incontinence.

c. Hematuria.

d. Urge incontinence.

ANS: B

Stress incontinence is involuntary urine loss with physical strain, sneezing, or coughing. Dysuria is pain or burning with urination. Hematuria is bleeding with urination. Urge incontinence is involuntary urine loss that occurs as a result of an overactive detrusor muscle in the bladder that contracts and causes an urgent need to void.

DIF: Cognitive Level: Understanding (Comprehension)

MSC: Client Needs: Physiologic Integrity: Physiologic Adaptation

15. During the interview, a patient reveals that she has some vaginal discharge. She is worried that it may be a sexually transmitted infection. The nurses most appropriate response to this would be:

a. Oh, dont worry. Some cyclic vaginal discharge is normal.

b. Have you been engaging in unprotected sexual intercourse?

c. Id like some information about the discharge. What color is it?

d. Have you had any urinary incontinence associated with the discharge?

ANS: C

Questions that help the patient reveal more information about her symptoms should be asked in a nonthreatening manner. Asking about the amount, color, and odor of the vaginal discharge provides the opportunity for further assessment. Normal vaginal discharge is small, clear or cloudy, and always nonirritating.

DIF: Cognitive Level: Analyzing (Analysis)

MSC: Client Needs: Physiologic Integrity: Physiologic Adaptation

16. A woman states that 2 weeks ago she had a urinary tract infection that was treated with an antibiotic. As a part of the interview, the nurse should ask, Have you noticed any:

a. Changes in your urination patterns?

b. Excessive vaginal bleeding?

c. Unusual vaginal discharge or itching?

d. Changes in your desire for intercourse?

ANS: C

Several medications may increase the risk of vaginitis. Broad-spectrum antibiotics alter the balance of normal flora, which may lead to the development of vaginitis. The other questions are not appropriate.

DIF: Cognitive Level: Applying (Application)

MSC: Client Needs: Physiologic Integrity: Pharmacologic and Parenteral Therapies

17. Which statement would be *most* appropriate when the nurse is introducing the topic of sexual relationships during an interview?

a. Now, it is time to talk about your sexual history. When did you first have intercourse?

b. Women often feel dissatisfied with their sexual relationships. Would it be okay to discuss this now?

c. Women often have questions about their sexual relationship and how it affects their health. Do you have any questions?

d. Most women your age have had more than one sexual partner. How many would you say you have had?

ANS: C

The nurse should begin with an open-ended question to assess individual needs. The nurse should include appropriate questions as a routine part of the health history, because doing so communicates that the nurse accepts the individuals sexual activity and believes it is important. The nurses comfort with the discussion prompts the patients interest and, possibly, relief that the topic has been introduced. The initial discussion establishes a database for comparison with any future sexual activities and provides an opportunity to screen sexual problems.

DIF: Cognitive Level: Applying (Application)

MSC: Client Needs: Psychosocial Integrity

18. A 22-year-old woman has been considering using oral contraceptives. As a part of her health history, the nurse should ask:

a. Do you have a history of heart murmurs?

b. Will you be in a monogamous relationship?

c. Have you carefully thought this choice through?

d. If you smoke, how many cigarettes do you smoke per day?

ANS: D

Oral contraceptives, together with cigarette smoking, increase the risk for cardiovascular side effects. If cigarettes are used, then the nurse should assess the patients smoking history. The other questions are not appropriate.

DIF: Cognitive Level: Applying (Application)

MSC: Client Needs: Physiologic Integrity: Pharmacologic and Parenteral Therapies

19. A married couple has come to the clinic seeking advice on pregnancy. They have been trying to conceive for 4 months and have not been successful. What should the nurse do first?

a. Ascertain whether either of them has been using broad-spectrum antibiotics.

b. Explain that couples are considered infertile after 1 year of unprotected intercourse.

c. Immediately refer the woman to an expert in pelvic inflammatory diseasethe most common cause of infertility.

d. Explain that couples are considered infertile after 3 months of engaging in unprotected intercourse and that they will need a referral to a fertility expert.

ANS: B

Infertility is considered after 1 year of engaging in unprotected sexual intercourse without conceiving. The other actions are not appropriate.

DIF: Cognitive Level: Applying (Application)

MSC: Client Needs: Psychosocial Integrity

20. A nurse is assessing a patients risk of contracting a sexually transmitted infection (STI). An appropriate question to ask would be:

a. You know that its important to use condoms for protection, right?

b. Do you use a condom with each episode of sexual intercourse?

c. Do you have a sexually transmitted infection?

d. You are aware of the dangers of unprotected sex, arent you?

ANS: B

In reviewing a patients risk for STIs, the nurse should ask in a nonconfrontational manner whether condoms are being used during each episode of sexual intercourse. Asking a person whether he or she has an infection does not address the risk.

DIF: Cognitive Level: Understanding (Comprehension)

MSC: Client Needs: Physiologic Integrity: Reduction of Risk Potential

21. When the nurse is interviewing a preadolescent girl, which opening question would be least threatening?

a. Do you have any questions about growing up?

b. What has your mother told you about growing up?

c. When did you notice that your body was changing?

d. I remember being very scared when I got my period. How do you think youll feel?

ANS: C

Open-ended questions such as, When did you ? rather than Do you ? should be asked. Open-ended questions are less threatening because they imply that the topic is normal and unexceptional.

DIF: Cognitive Level: Understanding (Comprehension)

MSC: Client Needs: Psychosocial Integrity

22. When the nurse is discussing sexuality and sexual issues with an adolescent, a permission statement helps convey that it is normal to think or feel a certain way. Which statement is the best example of a permission statement?

a. It is okay that you have become sexually active.

b. Girls your age often have questions about sexual activity. Do you have any questions?

c. If it is okay with you, Id like to ask you some questions about your sexual history.

d. Girls your age often engage in sexual activities. It is okay to tell me if you have had intercourse.

ANS: B

The examiner should start with a permission statement such as, Girls your age often experience A permission statement conveys the idea that it is normal to think or feel a certain way, and implying that the topic is normal and unexceptional is important.

DIF: Cognitive Level: Understanding (Comprehension)

MSC: Client Needs: Psychosocial Integrity

23. The nurse is preparing to interview a postmenopausal woman. Which of these statements is *true* as it applies to obtaining the health history of a postmenopausal woman?

a. The nurse should ask a postmenopausal woman if she has ever had vaginal bleeding.

b. Once a woman reaches menopause, the nurse does not need to ask any history questions.

c. The nurse should screen for monthly breast tenderness.

d. Postmenopausal women are not at risk for contracting STIs; therefore, these questions can be omitted.

ANS: A

Postmenopausal bleeding warrants further workup and referral. The other statements are not true.

DIF: Cognitive Level: Understanding (Comprehension)

MSC: Client Needs: Physiologic Integrity: Reduction of Risk Potential

24. During the examination portion of a patients visit, she will be in lithotomy position. Which statement reflects some things that the nurse can do to make this position more comfortable for her?

a. Ask her to place her hands and arms over her head.

b. Elevate her head and shoulders to maintain eye contact.

c. Allow her to choose to have her feet in the stirrups or have them resting side by side on the edge of the table.

d. Allow her to keep her buttocks approximately 6 inches from the edge of the table to prevent her from feeling as if she will fall off.

ANS: B

The nurse should elevate her head and shoulders to maintain eye contact. The patients arms should be placed at her sides or across the chest. Placing her hands and arms over her head only tightens the abdominal muscles. The feet should be placed into the stirrups, knees apart, and buttocks at the edge of the examining table. The stirrups are placed so that the legs are not abducted too far.

DIF: Cognitive Level: Applying (Application)

MSC: Client Needs: Safe and Effective Care Environment: Management of Care

25. An 18-year-old patient is having her first pelvic examination. Which action by the nurse is appropriate?

a. Inviting her mother to be present during the examination

b. Avoiding the lithotomy position for this first time because it can be uncomfortable and embarrassing

c. Raising the head of the examination table and giving her a mirror so that she can view the examination

d. Fully draping her, leaving the drape between her legs elevated to avoid embarrassing her with eye contact

ANS: C

The techniques of the educational or mirror pelvic examination should be used. This is a routine examination with some modifications in attitude, position, and communication. First, the woman is considered an active participant, one who is interested in learning and in sharing decisions about her own health care. The woman props herself up on one elbow, or the head of the table is raised. Her other hand holds a mirror between her legs, above the examiners hands. The young woman can see all that the examiner is doing and has a full view of her genitalia. The mirror works well for teaching normal anatomy and its relationship to sexual behavior. The examiner can ask her if she would like to have a family member, friend, or chaperone present for the examination. The drape should be pushed down between the patients legs so that the nurse can see her face.

DIF: Cognitive Level: Applying (Application)

MSC: Client Needs: Safe and Effective Care Environment: Management of Care

26. The nurse has just completed an inspection of a nulliparous womans external genitalia. Which of these would be a description of a finding within normal limits?

a. Redness of the labia majora

b. Multiple nontender sebaceous cysts

c. Discharge that is foul smelling and irritating

d. Gaping and slightly shriveled labia majora

ANS: B

No lesions should be noted, except for the occasional sebaceous cysts, which are yellowish 1-cm nodules that are firm, nontender, and often multiple. The labia majora are dark pink, moist, and symmetric; redness indicates inflammation or lesions. Discharge that is foul smelling and irritating may indicate infection. In the nulliparous woman, the labia majora meet in the midline, are symmetric and plump.

DIF: Cognitive Level: Applying (Application)

MSC: Client Needs: Safe and Effective Care Environment: Management of Care

27. The nurse is preparing for an internal genitalia examination of a woman. Which order of the examination is correct?

a. Bimanual, speculum, and rectovaginal

b. Speculum, rectovaginal, and bimanual

c. Speculum, bimanual, and rectovaginal

d. Rectovaginal, bimanual, and speculum

ANS: C

The correct sequence is speculum examination, then bimanual examination after removing the speculum, and then rectovaginal examination. The examiner should change gloves before performing the rectovaginal examination to avoid spreading any possible infection.

DIF: Cognitive Level: Analyzing (Analysis)

MSC: Client Needs: Safe and Effective Care Environment: Management of Care

28. During an internal examination of a womans genitalia, the nurse will use which technique for proper insertion of the speculum?

a. The woman is instructed to bear down, the speculum blades are opened and applied in a swift, upward movement.

b. The blades of the speculum are inserted on a horizontal plane, turning them to a 30-degree angle while continuing to insert them. The woman is asked to bear down after the speculum is inserted.

c. The woman is instructed to bear down, the width of the blades are horizontally turned, and the speculum is inserted downward at a 45-degree angle toward the small of the womans back.

d. The blades are locked open by turning the thumbscrew. Once the blades are open, pressure is applied to the introitus and the blades are inserted downward at a 45-degree angle to bring the cervix into view.

ANS: C

The examiner should instruct the woman to bear down, turn the width of the blades horizontally, and insert the speculum at a 45-degree angle downward toward the small of the womans back. (See the text under Speculum Examination for more detail.)

DIF: Cognitive Level: Applying (Application)

MSC: Client Needs: Safe and Effective Care Environment: Management of Care

29. The nurse is examining a 35-year-old female patient. During the health history, the nurse notices that she has had two term pregnancies, and both babies were delivered vaginally. During the internal examination, the nurse observes that the cervical os is a horizontal slit with some healed lacerations and that the cervix has some nabothian cysts that are small, smooth, and yellow. In addition, the nurse notices that the cervical surface is granular and red, especially around the os. Finally, the nurse notices the presence of stringy, opaque, odorless secretions. Which of these findings are abnormal?

a. Nabothian cysts are present.

b. The cervical os is a horizontal slit.

c. The cervical surface is granular and red.

d. Stringy and opaque secretions are present.

ANS: C

Normal findings: Nabothian cysts may be present on the cervix after childbirth. The cervical os is a horizontal, irregular slit in the parous woman. Secretions vary according to the day of the menstrual cycle, and may be clear and thin or thick, opaque, and stringy. The surface is normally smooth, but cervical eversion, or ectropion, may occur where the endocervical canal is *rolled out*. Abnormal finding: The cervical surface should not be reddened or granular, which may indicate a lesion.

DIF: Cognitive Level: Analyzing (Analysis)

MSC: Client Needs: Health Promotion and Maintenance

30. A patient calls the clinic for instructions before having a Papanicolaou (Pap) smear. The most appropriate instructions from the nurse are:

a. If you are menstruating, please use pads to avoid placing anything into the vagina.

b. Avoid intercourse, inserting anything into the vagina, or douching within 24 hours of your appointment.

c. If you suspect that you have a vaginal infection, please gather a sample of the discharge to bring with you.

d. We would like you to use a mild saline douche before your examination. You may pick this up in our office.

ANS: B

When instructing a patient before Pap smear is obtained, the nurse should follow these guidelines: Do not obtain during the womans menses or if a heavy infectious discharge is present. Instruct the woman not to douche, have intercourse, or put anything into the vagina within 24 hours before collecting the specimens. Any specimens will be obtained during the visit, not beforehand.

DIF: Cognitive Level: Applying (Application)

MSC: Client Needs: Health Promotion and Maintenance

31. During an examination, which tests will the nurse collect to screen for cervical cancer?

a. Endocervical specimen, cervical scrape, and vaginal pool

b. Endocervical specimen, vaginal pool, and acetic acid wash

c. Endocervical specimen, potassium hydroxide (KOH) preparation, and acetic acid wash

d. Cervical scrape, acetic acid wash, saline mount (wet prep)

ANS: A

Laboratories may vary in method, but usually the test consists of three specimens: endocervical specimen, cervical scrape, and vaginal pool. The other tests (acetic acid wash, KOH preparation, and saline mount) are used to test for sexually transmitted infections.

DIF: Cognitive Level: Understanding (Comprehension)

MSC: Client Needs: Safe and Effective Care Environment: Management of Care

32. When performing the bimanual examination, the nurse notices that the cervix feels smooth and firm, is round, and is fixed in place (does not move). When cervical palpation is performed, the patient complains of some pain. The nurses interpretation of these results should be which of these?

a. These findings are all within normal limits.

b. Cervical consistency should be soft and velvetynot firm.

c. The cervix should move when palpated; an immobile cervix may indicate malignancy.

d. Pain may occur during palpation of the cervix.

ANS: C

Normally, the cervix feels smooth and firm, similar to the consistency of the tip of the nose. It softens and feels velvety at 5 to 6 weeks of pregnancy (Goodell sign). The cervix should be evenly rounded. With a finger on either side, the examiner should be able to move the cervix gently from side to side, and doing so should produce no pain for the patient. Hardness of the cervix may occur with malignancy. Immobility may occur with malignancy, and pain may occur with inflammation or ectopic pregnancy.

DIF: Cognitive Level: Analyzing (Analysis)

MSC: Client Needs: Health Promotion and Maintenance

33. The nurse is palpating a female patients adnexa. The findings include a firm, smooth uterine wall; the ovaries are palpable and feel smooth and firm. The fallopian tube is firm and pulsating. The nurses most appropriate course of action would be to:

a. Tell the patient that her examination is normal.

b. Give her an immediate referral to a gynecologist.

c. Suggest that she return in a month for a recheck to verify the findings.

d. Tell the patient that she may have an ovarian cyst that should be evaluated further.

ANS: B

Normally, the uterine wall feels firm and smooth, with the contour of the fundus rounded. Ovaries are not often palpable, but when they are, they normally feel smooth, firm, and almond shaped and are highly movable, sliding through the fingers. The fallopian tube is not normally palpable. No other mass or pulsation should be felt. Pulsation or palpable fallopian tube suggests ectopic pregnancy, which warrants immediate referral.

DIF: Cognitive Level: Applying (Application)

MSC: Client Needs: Health Promotion and Maintenance

34. A 65-year-old woman is in the office for routine gynecologic care. She had a complete hysterectomy 3 months ago after cervical cancer was detected. Which statement does the nurse know to be *true* regarding this visit?

a. Her cervical mucosa will be red and dry looking.

b. She will not need to have a Pap smear performed.

c. The nurse can expect to find that her uterus will be somewhat enlarged and her ovaries small and hard.

d. The nurse should plan to lubricate the instruments and the examining hand adequately to avoid a painful examination.

ANS: D

In the aging adult woman, natural lubrication is decreased; therefore, to avoid a painful examination, the nurse should take care to lubricate the instruments and the examining hand adequately. Menopause, with the resulting decrease in estrogen production, shows numerous physical changes. The cervix shrinks and looks pale and glistening. With the bimanual examination, the uterus feels smaller and firmer and the ovaries are not normally palpable. Women should continue cervical cancer screening up to age 65 years if they have an intact cervix and are in good health. Women who have had a total hysterectomy do not need cervical cancer screening if they have 3 consecutive negative Pap tests or 2 or more consecutive negative HIV and Pap tests within the last 10 years.

DIF: Cognitive Level: Applying (Application)

MSC: Client Needs: Health Promotion and Maintenance

35. The nurse is preparing to examine the external genitalia of a school-age girl. Which position would be most appropriate in this situation?

a. In the parents lap

b. In a frog-leg position on the examining table

c. In the lithotomy position with the feet in stirrups

d. Lying flat on the examining table with legs extended

ANS: B

For school-age children, placing them on the examining table in a frog-leg position is best. With toddlers and preschoolers, having the child on the parents lap in a frog-leg position is best.

DIF: Cognitive Level: Applying (Application)

MSC: Client Needs: Health Promotion and Maintenance

36. When assessing a newborn infants genitalia, the nurse notices that the genitalia are somewhat engorged. The labia majora are swollen, the clitoris looks large, and the hymen is thick. The vaginal opening is difficult to visualize. The infants mother states that she is worried about the labia being swollen. The nurse should reply:

a. This is a normal finding in newborns and should resolve within a few weeks.

b. This finding could indicate an abnormality and may need to be evaluated by a physician.

c. We will need to have estrogen levels evaluated to ensure that they are within normal limits.

d. We will need to keep close watch over the next few days to see if the genitalia decrease in size.

ANS: A

It is normal for a newborns genitalia to be somewhat engorged. A sanguineous vaginal discharge or leukorrhea is normal during the first few weeks because of the maternal estrogen effect. During the early weeks, the genital engorgement resolves, and the labia minora atrophy and remain small until puberty.

DIF: Cognitive Level: Applying (Application)

MSC: Client Needs: Health Promotion and Maintenance

37. During a vaginal examination of a 38-year-old woman, the nurse notices that the vulva and vagina are erythematous and edematous with thick, white, curdlike discharge adhering to the vaginal walls. The woman reports intense pruritus and thick white discharge from her vagina. The nurse knows that these history and physical examination findings are most consistent with which condition?

a. Candidiasis

b. Trichomoniasis

c. Atrophic vaginitis

d. Bacterial vaginosis

ANS: A

The woman with candidiasis often reports intense pruritus and thick white discharge. The vulva and vagina are erythematous and edematous. The discharge is usually thick, white, and curdlike. Infection with trichomoniasis causes a profuse, watery, gray-green, and frothy discharge. Bacterial vaginosis causes a profuse discharge that has a foul, fishy, rotten odor. Atrophic vaginitis may have a mucoid discharge.

DIF: Cognitive Level: Analyzing (Analysis)

MSC: Client Needs: Physiologic Integrity: Physiologic Adaptation

38. A 22-year-old woman is being seen at the clinic for problems with vulvar pain, dysuria, and fever. On physical examination, the nurse notices clusters of small, shallow vesicles with surrounding erythema on the labia. Inguinal lymphadenopathy present is also present. The most likely cause of these lesions is:

a. Pediculosis pubis.

b. Contact dermatitis.

c. HPV.

d. Herpes simplex virus type 2.

ANS: D

Herpes simplex virus type 2 exhibits clusters of small, shallow vesicles with surrounding erythema that erupt on the genital areas. Inguinal lymphadenopathy is also present. The woman reports local pain, dysuria, and fever.

DIF: Cognitive Level: Analyzing (Analysis)

MSC: Client Needs: Physiologic Integrity: Physiologic Adaptation

39. When performing an external genitalia examination of a 10-year-old girl, the nurse notices that no pubic hair has grown in and the mons and the labia are covered with fine vellus hair. These findings are consistent with stage _____ of sexual maturity, according to the Sexual Maturity Rating scale.

a. 1

b. 2

c. 3

d. 4

ANS: A

Sexual Maturity Rating stage 1 is the preadolescent stage. There is no pubic hair, and the mons and labia are covered with fine, vellus hair as on the abdomen.

DIF: Cognitive Level: Applying (Application)

MSC: Client Needs: Health Promotion and Maintenance

40. A 46-year-old woman is in the clinic for her annual gynecologic examination. She voices a concern about ovarian cancer because her mother and sister died of it. Which statement does the nurse know to be *correct* regarding ovarian cancer?

a. Ovarian cancer rarely has any symptoms.

b. The Pap smear detects the presence of ovarian cancer.

c. Women at high risk for ovarian cancer should have annual transvaginal ultrasonography for screening.

d. Women over age 40 years should have a thorough pelvic examination every 3 years.

ANS: C

With ovarian cancer, the patient may have abdominal pain, pelvic pain, increased abdominal size, bloating, and nonspecific gastrointestinal symptoms; or she may be asymptomatic. The Pap smear does not detect the presence of ovarian cancer. Annual transvaginal ultrasonography may detect ovarian cancer at an earlier stage in women who are at high risk for developing it.

DIF: Cognitive Level: Applying (Application)

MSC: Client Needs: Health Promotion and Maintenance

41. During a bimanual examination, the nurse detects a solid tumor on the ovary that is heavy and fixed, with a poorly defined mass. This finding is suggestive of:

a. Ovarian cyst.

b. Endometriosis.

c. Ovarian cancer.

d. Ectopic pregnancy.

ANS: C

Ovarian tumors that are solid, heavy, and fixed, with poorly defined mass are suggestive of malignancy. Benign masses may feel mobile and solid. An ovarian cyst may feel smooth, round, fluctuant, mobile, and nontender. With an ectopic pregnancy, the examiner may feel a palpable, tender pelvic mass that is solid, mobile, and unilateral. Endometriosis may have masses (in various locations in the pelvic area) that are small, firm, nodular, and tender to palpation, with enlarged ovaries.

DIF: Cognitive Level: Applying (Application)

MSC: Client Needs: Physiologic Integrity: Physiologic Adaptation

42. A 25-year-old woman comes to the emergency department with a sudden fever of 38.3 C and abdominal

pain. Upon examination, the nurse notices that she has rigid, boardlike lower abdominal musculature. When the nurse tries to perform a vaginal examination, the patient has severe pain when the uterus and cervix are moved. The nurse knows that these signs and symptoms are suggestive of:

a. Endometriosis.

b. Uterine fibroids.

c. Ectopic pregnancy.

d. Pelvic inflammatory disease.

ANS: D

These signs and symptoms are suggestive of acute pelvic inflammatory disease, also known as *acute salpingitis*.

DIF: Cognitive Level: Analyzing (Analysis)

MSC: Client Needs: Physiologic Integrity: Physiologic Adaptation

43. During an external genitalia examination of a woman, the nurse notices several lesions around the vulva. The lesions are pink, moist, soft, and pointed papules. The patient states that she is not aware of any problems in that area. The nurse recognizes that these lesions may be:

a. Syphilitic chancre.

b. Herpes simplex virus type 2 (herpes genitalis).

c. HPV or genital warts.

d. Pediculosis pubis (crab lice).

ANS: C

HPV lesions are painless, warty growths that the woman may not notice. Lesions are pink or flesh colored, soft, pointed, moist, warty papules that occur in single or multiple cauliflower-like patches around the vulva, introitus, anus, vagina, or cervix. Herpetic lesions are painful clusters of small, shallow vesicles with surrounding erythema. Syphilitic chancres begin as a solitary silvery papule that erodes into a red, round or oval superficial ulcer with a yellowish discharge. Pediculosis pubis causes severe perineal itching and excoriations and erythematous areas.

DIF: Cognitive Level: Analyzing (Analysis)

MSC: Client Needs: Physiologic Integrity: Physiologic Adaptation

44. During an examination, the nurse would expect the cervical os of a woman who has never had children to appear:

a. Stellate.

b. Small and round.

c. As a horizontal irregular slit.

d. Everted.

ANS: B

The cervical os in a nulliparous woman is small and round. In the parous woman, it is a horizontal, irregular slit that also may show healed lacerations on the sides.

DIF: Cognitive Level: Understanding (Comprehension)

MSC: Client Needs: Health Promotion and Maintenance

45. A woman has just been diagnosed with HPV or genital warts. The nurse should counsel her to receive regular examinations because this virus makes her at a higher risk for _____ cancer.

a. Uterine

b. Cervical

c. Ovarian

d. Endometrial

ANS: B

HPV is the virus responsible for most cases of cervical cancer, not the other options.

DIF: Cognitive Level: Applying (Application)

MSC: Client Needs: Health Promotion and Maintenance

46. During an internal examination, the nurse notices that the cervix bulges outside the introitus when the patient is asked to strain. The nurse will document this as:

a. Uterine prolapse, graded first degree.

b. Uterine prolapse, graded second degree.

c. Uterine prolapse, graded third degree.

d. A normal finding.

ANS: B

The cervix should not be found to bulge into the vagina. Uterine prolapse is graded as follows: first degreethe cervix appears at the introitus with straining; second degreethe cervix bulges outside the introitus with straining; and third degreethe whole uterus protrudes, even without straining (essentially, the uterus is inside

out).

DIF: Cognitive Level: Applying (Application)

MSC: Client Needs: Physiologic Integrity: Physiologic Adaptation

47. A 35-year-old woman is at the clinic for a gynecologic examination. During the examination, she asks the nurse, How often do I need to have this Pap test done? Which reply by the nurse is *correct*?

a. It depends. Do you smoke?

b. A Pap test needs to be performed annually until you are 65 years of age.

c. If you have two consecutive normal Pap tests, then you can wait 5 years between tests.

d. After age 30 years, if you have three consecutive normal Pap tests, then you may be screened every 2 to 3 years.

ANS: D

Cervical cancer screening with the Pap test continues annually until age 30 years. After age 21, regardless of sexual history or activity, women should be screened every 3 years until age 30, then every 5 years until age 65.

DIF: Cognitive Level: Applying (Application)

MSC: Client Needs: Health Promotion and Maintenance

MULTIPLE RESPONSE

1. The nurse is palpating an ovarian mass during an internal examination of a 63-year-old woman. Which findings of the masss characteristics would suggest the presence of an ovarian cyst? *Select all that apply*.

a. Heavy and solid

b. Mobile and fluctuant

c. Mobile and solid

d. Fixed

e. Smooth and round

f. Poorly defined

ANS: B, E

An ovarian cyst (fluctuant ovarian mass) is usually asymptomatic and would feel like a smooth, round, fluctuant, mobile, nontender mass on the ovary. A mass that is heavy, solid, fixed, and poorly defined suggests malignancy. A benign mass may feel mobile and solid.

DIF: Cognitive Level: Applying (Application)

MSC: Client Needs: Physiologic Integrity: Physiologic Adaptation

Chapter 28: The Complete Health Assessment: Adult

MULTIPLE CHOICE

1. An 85-year-old man has come in for a physical examination, and the nurse notices that he uses a cane. When documenting general appearance, the nurse should document this information under the section that covers:

a. Posture.

b. Mobility.

c. Mood and affect.

d. Physical deformity.

ANS: B

Use of assistive devices would be documented under the mobility section. The other responses are all other categories of the general appearance section of the health history.

DIF: Cognitive Level: Remembering (Knowledge)

MSC: Client Needs: Safe and Effective Care Environment: Management of Care

2. The nurse is performing a vision examination. Which of these charts is most widely used for vision examinations?

a. Snellen

b. Shetllen

c. Smoollen

d. Schwellon

ANS: A

The Snellen eye chart is most widely used for vision examinations. The other options are not tests for vision examinations.

DIF: Cognitive Level: Remembering (Knowledge)

MSC: Client Needs: Safe and Effective Care Environment: Management of Care

3. After the health history has been obtained and before beginning the physical examination, the nurse should first ask the patient to:

a. Empty the bladder.

b. Completely disrobe.

c. Lie on the examination table.

d. Walk around the room.

ANS: A

Before beginning the examination, the nurse should ask the person to empty the bladder (save the specimen if needed), disrobe except for underpants, put on a gown, and sit with the legs dangling off side of the bed or table.

DIF: Cognitive Level: Remembering (Knowledge)

MSC: Client Needs: Safe and Effective Care Environment: Management of Care

4. During a complete health assessment, how would the nurse test the patients hearing?

a. Observing how the patient participates in normal conversation

b. Using the whispered voice test

c. Using the Weber and Rinne tests

d. Testing with an audiometer

ANS: B

During the complete health assessment, the nurse should test hearing with the whispered voice test. The other options are not correct.

DIF: Cognitive Level: Applying (Application)

MSC: Client Needs: Safe and Effective Care Environment: Management of Care

5. A patient states, Whenever I open my mouth real wide, I feel this popping sensation in front of my ears. To further examine this, the nurse would:

a. Place the stethoscope over the temporomandibular joint, and listen for bruits.

b. Place the hands over his ears, and ask him to open his mouth really wide.

c. Place one hand on his forehead and the other on his jaw, and ask him to try to open his mouth.

d. Place a finger on his temporomandibular joint, and ask him to open and close his mouth.

ANS: D

The nurse should palpate the temporomandibular joint by placing his or her fingers over the joint as the person opens and closes the mouth.

DIF: Cognitive Level: Applying (Application)

MSC: Client Needs: Safe and Effective Care Environment: Management of Care

6. The nurse has just completed an examination of a patients extraocular muscles. When documenting the findings, the nurse should document the assessment of which cranial nerves?

a. II, III, and VI

b. II, IV, and V

c. III, IV, and V

d. III, IV, and VI

ANS: D

Extraocular muscles are innervated by cranial nerves III, IV, and VI.

DIF: Cognitive Level: Applying (Application)

MSC: Client Needs: Safe and Effective Care Environment: Management of Care

7. A patients uvula raises midline when she says ahh, and she has a positive gag reflex. The nurse has just tested which cranial nerves?

a. IX and X

b. IX and XII

c. X and XII

d. XI and XII

ANS: A

Cranial nerves IX and X are being tested by having the patient say ahh, noting the mobility of the uvula, and when assessing the patients gag reflex.

DIF: Cognitive Level: Applying (Application)

MSC: Client Needs: Safe and Effective Care Environment: Management of Care

8. During an examination, the nurse notices that a patient is unable to stick out his tongue. Which cranial nerve is involved with the successful performance of this action?

a. I

b. V

c. XI

d. XII

ANS: D

Cranial nerve XII enables the person to stick out his or her tongue.

DIF: Cognitive Level: Understanding (Comprehension)

MSC: Client Needs: Safe and Effective Care Environment: Management of Care

9. A patient is unable to shrug her shoulders against the nurses resistant hands. What cranial nerve is involved with successful shoulder shrugging?

a. VII

b. IX

c. XI

d. XII

ANS: C

Cranial nerve XI enables the patient to shrug her shoulders against resistance.

DIF: Cognitive Level: Understanding (Comprehension)

MSC: Client Needs: Safe and Effective Care Environment: Management of Care

10. During an examination, a patient has just successfully completed the finger-to-nose and the rapid-alternating-movements tests and is able to run each heel down the opposite shin. The nurse will conclude that the patients _____ function is intact.

a. Occipital

b. Cerebral

c. Temporal

d. Cerebellar

ANS: D

The nurse should test cerebellar function of the upper extremities by using the finger-to-nose test or rapid-alternating-movements test. The nurse should test cerebellar function of the lower extremities by asking the person to run each heel down the opposite shin.

DIF: Cognitive Level: Applying (Application)

MSC: Client Needs: Safe and Effective Care Environment: Management of Care

11. When the nurse performs the confrontation test, the nurse has assessed:

a. Extraocular eye muscles (EOMs).

b. Pupils (pupils equal, round, reactive to light, and accommodation [PERRLA]).

c. Near vision.

d. Visual fields.

ANS: D

The confrontation test assesses visual fields. The other options are not tested with the confrontation test.

DIF: Cognitive Level: Applying (Application)

MSC: Client Needs: Safe and Effective Care Environment: Management of Care

12. Which statement is *true* regarding the complete physical assessment?

a. The male genitalia should be examined in the supine position.

b. The patient should be in the sitting position for examination of the head and neck.

c. The vital signs, height, and weight should be obtained at the end of the examination.

d. To promote consistency between patients, the examiner should not vary the order of the assessment.

ANS: B

The head and neck should be examined in the sitting position to best palpate the thyroid and lymph nodes. The male patient should stand during an examination of the genitalia. Vital signs are measured early in the assessment. The sequence of the assessment may need to vary according to different patient situations.

DIF: Cognitive Level: Remembering (Knowledge)

MSC: Client Needs: Safe and Effective Care Environment: Management of Care

13. Which of these is included in an assessment of general appearance?

a. Height

b. Weight

c. Skin color

d. Vital signs

ANS: C

General appearance includes items such as level of consciousness, skin color, nutritional status, posture, mobility, facial expression, mood and affect, speech, hearing, and personal hygiene. Height, weight, and vital signs are considered measurements.

DIF: Cognitive Level: Remembering (Knowledge)

MSC: Client Needs: Safe and Effective Care Environment: Management of Care

14. The nurse should wear gloves for which of these examinations?

a. Measuring vital signs

b. Palpation of the sinuses

c. Palpation of the mouth and tongue

d. Inspection of the eye with an ophthalmoscope

ANS: C

Gloves should be worn when the examiner is exposed to the patients body fluids.

DIF: Cognitive Level: Applying (Application)

MSC: Client Needs: Safe and Effective Care Environment: Safety and Infection Control

15. The nurse should use which location for eliciting deep tendon reflexes?

a. Achilles

b. Femoral

c. Scapular

d. Abdominal

ANS: A

Deep tendon reflexes are elicited in the biceps, triceps, brachioradialis, patella, and Achilles heel.

DIF: Cognitive Level: Understanding (Comprehension)

MSC: Client Needs: Safe and Effective Care Environment: Management of Care

16. During an inspection of a patients face, the nurse notices that the facial features are symmetric. This finding indicates which cranial nerve is intact?

a. VII

b. IX

c. XI

d. XII

ANS: A

Cranial nerve VII is responsible for facial symmetry.

DIF: Cognitive Level: Understanding (Comprehension)

MSC: Client Needs: Safe and Effective Care Environment: Management of Care

17. During inspection of the posterior chest, the nurse should assess for:

a. Symmetric expansion.

b. Symmetry of shoulders and muscles.

c. Tactile fremitus.

d. Diaphragmatic excursion.

ANS: B

During an inspection of the posterior chest, the nurse should inspect for symmetry of shoulders and muscles, configuration of the thoracic cage, and skin characteristics. Symmetric expansion and tactile fremitus are assessed with palpation; diaphragmatic excursion is assessed with percussion.

DIF: Cognitive Level: Understanding (Comprehension)

MSC: Client Needs: Safe and Effective Care Environment: Management of Care

18. During an examination, the patient tells the nurse that she sometimes feels as if objects are spinning around her. The nurse would document that she occasionally experiences:

a. Vertigo.

b. Tinnitus.

c. Syncope.

d. Dizziness.

ANS: A

Vertigo is the sensation of a person moving around in space (subjective) or of the person sensing objects moving around him or her (objective) and is a result of a disturbance of equilibratory apparatus (see Chapter 24).

DIF: Cognitive Level: Applying (Application)

MSC: Client Needs: Safe and Effective Care Environment: Management of Care

19. A patient tells the nurse, Sometimes I wake up at night and I have real trouble breathing. I have to sit up in bed to get a good breath. When documenting this information, the nurse would note:

a. Orthopnea.

b. Acute emphysema.

c. Paroxysmal nocturnal dyspnea.

d. Acute shortness of breath episode.

ANS: C

Paroxysmal nocturnal dyspnea occurs when the patient awakens from sleep with shortness of breath and needs to be upright to achieve comfort (see Chapter 19).

DIF: Cognitive Level: Analyzing (Analysis)

MSC: Client Needs: Safe and Effective Care Environment: Management of Care

20. During the examination of a patient, the nurse notices that the patient has several small, flat macules on the posterior portion of her thorax. These macules are less than 1 cm wide. Another name for these macules is:

a. Warts.

b. Bullae.

c. Freckles.

d. Papules.

ANS: C

A macule is solely a lesion with color change, flat and circumscribed, less than 1 cm. Macules are also known as *freckles* (see Chapter 13).

DIF: Cognitive Level: Understanding (Comprehension)

MSC: Client Needs: Safe and Effective Care Environment: Management of Care

21. During an examination, the nurse notices that a patients legs turn white when they are raised above the patients head. The nurse should suspect:

a. Lymphedema.

b. Raynaud disease.

c. Chronic arterial insufficiency.

d. Chronic venous insufficiency.

ANS: C

Elevational pallor (striking) indicates arterial insufficiency (see Chapter 21).

DIF: Cognitive Level: Analyzing (Analysis)

MSC: Client Needs: Safe and Effective Care Environment: Management of Care

22. The nurse documents that a patient has coarse, thickened skin and brown discoloration over the lower legs. Pulses are present. This finding is probably the result of:

a. Lymphedema.

b. Raynaud disease.

c. Chronic arterial insufficiency.

d. Chronic venous insufficiency.

ANS: D

Chronic venous insufficiency would exhibit firm brawny edema, coarse thickened skin, normal pulses, and brown discoloration (see Chapter 21).

DIF: Cognitive Level: Analyzing (Analysis)

MSC: Client Needs: Safe and Effective Care Environment: Management of Care

23. The nurse notices that a patient has ulcerations on the tips of the toes and on the lateral aspect of the ankles. This finding indicates:

a. Lymphedema.

b. Raynaud disease.

c. Arterial insufficiency.

d. Venous insufficiency.

ANS: C

Ulcerations on the tips of the toes and lateral aspect of the ankles are indicative of arterial insufficiency (see Chapter 21).

DIF: Cognitive Level: Analyzing (Analysis)

MSC: Client Needs: Safe and Effective Care Environment: Management of Care

24. The nurse has just recorded a positive iliopsoas test on a patient who has abdominal pain. This test is used to confirm a(n):

a. Inflamed liver.

b. Perforated spleen.

c. Perforated appendix.

d. Enlarged gallbladder.

ANS: C

An inflamed or perforated appendix irritates the iliopsoas muscle, producing pain in the RLQ.

DIF: Cognitive Level: Applying (Application)

MSC: Client Needs: Safe and Effective Care Environment: Management of Care

25. The nurse will measure a patients near vision with which tool?

a. Snellen eye chart with letters

b. Snellen E chart

c. Jaeger card

d. Ophthalmoscope

ANS: C

The Jaeger card is used to measure near vision (see Chapter 15).

DIF: Cognitive Level: Applying (Application)

MSC: Client Needs: Safe and Effective Care Environment: Management of Care

26. If the nurse records the results to the Hirschberg test, the nurse has:

a. Tested the patellar reflex.

b. Assessed for appendicitis.

c. Tested the corneal light reflex.

d. Assessed for thrombophlebitis.

ANS: C

The Hirschberg test assesses the corneal light reflex (see Chapter 15).

DIF: Cognitive Level: Applying (Application)

MSC: Client Needs: Safe and Effective Care Environment: Management of Care

27. During the examination of a patients mouth, the nurse observes a nodular bony ridge down the middle of the hard palate. The nurse would chart this finding as:

a. Cheilosis.

b. Leukoplakia.

c. Ankyloglossia.

d. Torus palatinus.

ANS: D

A normal variation of the hard palate is a nodular bony ridge down the middle of the hard palate; this variation is termed *torus palatinus* (see Chapter 17).

DIF: Cognitive Level: Applying (Application)

MSC: Client Needs: Safe and Effective Care Environment: Management of Care

28. During examination, the nurse finds that a patient is unable to distinguish objects placed in his hand. The nurse would document:

a. Stereognosis.

b. Astereognosis.

c. Graphesthesia.

d. Agraphesthesia.

ANS: B

Astereognosis is the inability to identify correctly an object placed in the hand (see Chapter 24).

DIF: Cognitive Level: Applying (Application)

MSC: Client Needs: Safe and Effective Care Environment: Management of Care

29. After the examination of an infant, the nurse documents opisthotonos. The nurse recognizes that this finding often occurs with:

a. Cerebral palsy.

b. Meningeal irritation.

c. Lower motor neuron lesion.

d. Upper motor neuron lesion.

ANS: B

Opisthotonos is a form of spasm in which the head is arched back, and a stiffness of the neck and an extension of the arms and legs are observed. Opisthotonus occurs with meningeal or brainstem irritation (see Chapter 23).

DIF: Cognitive Level: Analyzing (Analysis)

MSC: Client Needs: Safe and Effective Care Environment: Management of Care

30. After assessing a female patient, the nurse notices flesh-colored, soft, pointed, moist, papules in a cauliflower-like patch around her introitus. This finding is most likely:

a. Urethral caruncle.

b. Syphilitic chancre.

c. Herpes simplex virus.

d. Human papillomavirus.

ANS: D

Human papillomavirus appears in a flesh-colored, soft, moist, cauliflower-like patch of papules (see Chapter 27).

DIF: Cognitive Level: Analyzing (Analysis)

MSC: Client Needs: Safe and Effective Care Environment: Management of Care

31. While recording in a patients medical record, the nurse notices that a patients Hematest results are positive. This finding means that there is(are):

a. Crystals in his urine.

b. Parasites in his stool.

c. Occult blood in his stool.

d. Bacteria in his sputum.

ANS: C

If a stool is Hematest positive, then it indicates the presence of occult blood (see Chapter 22).

DIF: Cognitive Level: Analyzing (Analysis)

MSC: Client Needs: Safe and Effective Care Environment: Management of Care

32. While examining a 48-year-old patients eyes, the nurse notices that he had to move the handheld vision screener farther away from his face. The nurse would suspect:

a. Myopia.

b. Omniopia.

c. Hyperopia.

d. Presbyopia.

ANS: D

Presbyopia, the decrease in power of accommodation with aging, is suggested when the handheld vision screener card is moved farther away (see Chapter 15).

DIF: Cognitive Level: Analyzing (Analysis)

MSC: Client Needs: Safe and Effective Care Environment: Management of Care

Chapter 29: The Complete Physical Assessment: Infant, Child, and Adolescent

MULTIPLE CHOICE

1. A 5-year-old child is in the clinic for a checkup. The nurse would expect him to:

a. Need to be held on his mothers lap.

b. Be able to sit on the examination table.

c. Be able to stand on the floor for the examination.

d. Be able to remain alone in the examination room.

ANS: B

At 4 or 5 years old, a child usually feels comfortable on the examination table. Older infants and young children aged 6 months to 2 or 3 years should be positioned in the parents lap.

DIF: Cognitive Level: Understanding (Comprehension)

MSC: Client Needs: Safe and Effective Care Environment: Management of Care

2. Which statement is *true* regarding the recording of data from the history and physical examination?

a. Use long, descriptive sentences to document findings.

b. Record the data as soon as possible after the interview and physical examination.

c. If the information is not documented, then it can be assumed that it was done as a standard of care.

d. The examiner should avoid taking any notes during the history and examination because of the possibility of decreasing the rapport with the patient.

ANS: B

The data from the history and physical examination should be recorded as soon after the event as possible. From a legal perspective, if it is not documented, then it was not done. Brief notes should be taken during the examination. When documenting, the nurse should use short, clear phrases and avoid redundant phrases and descriptions.

DIF: Cognitive Level: Applying (Application)

MSC: Client Needs: Safe and Effective Care Environment: Management of Care

3. When assessing the neonate, the nurse should test for hip stability with which method?

a. Eliciting the Moro reflex

b. Performing the Romberg test

c. Checking for the Ortolani sign

d. Assessing the stepping reflex

ANS: C

The nurse should test for hip stability in the neonate by testing for the Ortolani sign. The other tests are not appropriate for testing hip stability.

DIF: Cognitive Level: Applying (Application)

MSC: Client Needs: Health Promotion and Maintenance

4. A female patient tells the nurse that she has four children and has had three pregnancies. How should the nurse document this?

a. Gravida 3, para 4

b. Gravida 4, para 3

c. This information cannot be documented using the terms *gravida* and *para*.

d. The patient seems to be confused about how many times she has been pregnant.

ANS: A

Gravida refers to the number of pregnancies, and *para* refers to the number of children. One pregnancy was with twins.

DIF: Cognitive Level: Applying (Application)

MSC: Client Needs: Safe and Effective Care Environment: Management of Care

5. The nurse is documenting the assessment of an infant. During the abdominal assessment, the nurse noticed a very loud splash auscultated over the upper abdomen when the nurse rocked her from side to side. This finding would indicate:

a. Epigastric hernia.

b. Pyloric obstruction.

c. Hypoactive bowel sounds.

d. Hyperactive bowel sounds.

ANS: D

A succussion splash, which is unrelated to peristalsis, is a very loud splash auscultated over the upper abdomen

when the infant is rocked side to side. It indicates increased air and fluid in the stomach as observed with pyloric obstruction or large hiatus hernia (see Chapter 21).

DIF: Cognitive Level: Analyzing (Analysis)

MSC: Client Needs: Safe and Effective Care Environment: Management of Care

6. Which of these actions is most appropriate to perform on a 9-month-old infant at a well-child checkup?

a. Testing for Ortolani sign

b. Assessment for stereognosis

c. Blood pressure measurement

d. Assessment for the presence of the startle reflex

ANS: A

Until the age of 12 months, the infant should be assessed for Ortolani sign. If Ortolani sign is present, then it could indicate the presence of a dislocated hip. The other tests are not appropriate for a 9-month-old child.

DIF: Cognitive Level: Applying (Application)

MSC: Client Needs: Safe and Effective Care Environment: Management of Care

Chapter 30: Bedside Assessment and Electronic Documentation

MULTIPLE CHOICE

1. At the beginning of rounds when entering the room, what should the nurse do first?

a. Check the intravenous (IV) infusion site for swelling or redness.

b. Check the infusion pump settings for accuracy.

c. Make eye contact with the patient, and introduce him or herself as the patients nurse.

d. Offer the patient something to drink.

ANS: C

When entering a patients room, the nurse should make direct eye contact, without being distracted by IV pumps and other equipment, and introduce him or herself as the patients nurse.

DIF: Cognitive Level: Analyzing (Analysis)

MSC: Client Needs: Safe and Effective Care Environment: Management of Care

2. During an assessment, the nurse is unable to palpate pulses in the left lower leg. What should the nurse do next?

a. Document that the pulses are nonpalpable.

b. Reassess the pulses in 1 hour.

c. Ask the patient turn to the side, and then palpate for the pulses again.

d. Use a Doppler device to assess the pulses.

ANS: D

The nurse should be prepared to assess pulses in the lower extremities by Doppler measurement if they cannot be detected by palpation.

DIF: Cognitive Level: Applying (Application)

MSC: Client Needs: Safe and Effective Care Environment: Management of Care

3. During a morning assessment, the nurse notices that a patients urine output is below the expected amount. What should the nurse do next?

a. Obtain an order for a Foley catheter.

b. Obtain an order for a straight catheter.

c. Perform a bladder scan test.

d. Refer the patient to an urologist.

ANS: C

If urine output is below the expected value, then the nurse should perform a bladder scan according to institutional policy to check for retention.

DIF: Cognitive Level: Applying (Application)

MSC: Client Needs: Safe and Effective Care Environment: Management of Care

4. What should the nurse assess before entering the patients room on morning rounds?

a. Posted conditions, such as isolation precautions

b. Patients input and output chart from the previous shift

c. Patients general appearance

d. Presence of any visitors in the room

ANS: A

On the way to the patients room, the nurse should assess the presence of conditions such as isolation precautions, latex allergies, or fall precautions.

DIF: Cognitive Level: Applying (Application)

MSC: Client Needs: Safe and Effective Care Environment: Safety and Infection Control

5. The nurse has administered a pain medication to a patient by an IV infusion. The nurse should reassess the patients response to the pain medication within _____ minutes.

a. 5

b. 15

c. 30

d. 60

ANS: B

If pain medication is given, then the nurse should reassess the patients response in 15 minutes for IV administration or 1 hour for oral administration.

DIF: Cognitive Level: Applying (Application)

MSC: Client Needs: Physiologic Integrity: Pharmacologic and Parenteral Therapies

6. During an assessment of a hospitalized patient, the nurse pinches a fold of skin under the clavicle or on the forearm to test the:

a. Mobility and turgor.

b. Patients response to pain.

c. Percentage of the patients fat-to-muscle ratio.

d. Presence of edema.

ANS: A

Pinching a fold of skin under the clavicle or on the forearm is done by the nurse to determine mobility and turgor.

DIF: Cognitive Level: Applying (Application)

MSC: Client Needs: Safe and Effective Care Environment: Management of Care

7. When assessing the neurologic system of a hospitalized patient during morning rounds, the nurse should include which of these during the assessment?

a. Blood pressure

b. Patients rating of pain on a scale of 1 to 10

c. Patients ability to communicate

d. Patients personal hygiene level

ANS: C

Assessment of a patients ability to communicate is part of the neurologic assessment. Blood pressure and pain rating are measurements, and personal hygiene is assessed under general appearance.

DIF: Cognitive Level: Applying (Application)

MSC: Client Needs: Safe and Effective Care Environment: Management of Care

8. When assessing a patients general appearance, the nurse should include which question?

a. Is the patients muscle strength equal in both arms?

b. Is ptosis or facial droop present?

c. Does the patient appropriately respond to questions?

d. Are the pupils equal in reaction and size?

ANS: C

Assessing whether the patient appropriately responds to questions is a component of an assessment of the patients general appearance. The other answers reflect components of the neurologic examination.

DIF: Cognitive Level: Applying (Application)

MSC: Client Needs: Safe and Effective Care Environment: Management of Care

9. When assessing a patient in the hospital setting, the nurse knows which statement to be *true*?

a. The patient will need a brief assessment at least every 4 hours.

b. The patient will need a consistent, specialized examination every 8 hours that focuses on certain parameters.

c. The patient will need a complete head-to-toe physical examination every 24 hours.

d. Most patients require a minimal examination each shift unless they are in critical condition.

ANS: B

In a hospital setting, the patient does not require a complete head-to-toe physical examination during every 24-hour stay. The patient does, however, require a consistent specialized examination every 8 hours that focuses on certain parameters.

DIF: Cognitive Level: Applying (Application)

MSC: Client Needs: Safe and Effective Care Environment: Management of Care

10. The nurse is giving report to the next shift and is using the situation, background, assessment, recommendation (SBAR) framework for communication. Which of these statements reflects the Background portion of the report?

a. Im worried that his gastrointestinal bleeding is getting worse.

b. We need an order for oxygen.

c. My name is Ms. Smith, and Im giving the report on Mrs. X in room 1104.

d. He is 4 days postoperative, and his incision is open to air.

ANS: D

During the Background portion, the nurse should state data pertinent to the moments problem such as the condition of the patients incision. During the Situation portion, the nurse provides his or her name and the patients name. During the Assessment portion, the nurse states what he or she thinks is happening (e.g., gastrointestinal bleeding). During the Recommendation portion, the nurse should offer probable solutions or orders that may be implemented.

DIF: Cognitive Level: Analyzing (Analysis)

MSC: Client Needs: Safe and Effective Care Environment: Safety and Infection Control

MULTIPLE RESPONSE

1. The nurse is assessing the IV infusion at the beginning of the shift. Which factors should be included in the assessment of the infusion? *Select all that apply*.

a. Proper IV solution is infusing, according to the physicians orders.

b. The IV solution is infusing at the proper rate, according to physicians orders.

c. The infusion is proper, according to the nurses assessment of the patients needs.

d. Capillary refill in the fingers is checked and noted.

e. The IV site date is noted.

f. Whether the patient is sufficiently voiding is noted.

ANS: A, B, C, E

The nurse should verify that the proper IV solution is hanging and is flowing at the proper rate according to the physicians orders and the nurses own assessment of the patients needs. In addition, the nurse should note the date of the IV site and surrounding skin condition. Checking capillary refill is part of the cardiovascular assessment; checking the patients voiding is part of the genitourinary assessment.

DIF: Cognitive Level: Applying (Application)

MSC: Client Needs: Physiologic Integrity: Pharmacologic and Parenteral Therapies

2. The nurse is completing an assessment on a patient who was just admitted from the emergency department. Which assessment findings would require immediate attention? *Select all that apply*.

a. Temperature: 38.6 C

b. Systolic blood pressure: 150 mm Hg

c. Respiratory rate: 22 breaths per minute

d. Heart rate: 130 beats per minute

e. Oxygen saturation: 95%

f. Sudden restlessness

ANS: A, D, F

The following examination findings require immediate attention:

High or low temperature: (36.1 C or 37.8 C)

High or low blood pressure: (systolic pressure 90 mm Hg or 160 mm Hg)

High or low number of respirations: (12 or 28 breaths per minute)

High or low heart rate: (60 or 90 beats per minute)

Oxygen saturation: 92%

Sudden restlessness or anxiety, altered level of consciousness, confusion, or difficulty in arousing

DIF: Cognitive Level: Applying (Application)

MSC: Client Needs: Physiologic Integrity: Physiologic Adaptation

Chapter 31: The Pregnant Woman

MULTIPLE CHOICE

1. Which of these statements *best* describes the action of the hormone progesterone during pregnancy?

a. Progesterone produces the hormone human chorionic gonadotropin.

b. Duct formation in the breast is stimulated by progesterone.

c. Progesterone promotes sloughing of the endometrial wall.

d. Progesterone maintains the endometrium around the fetus.

ANS: D

Progesterone prevents the sloughing of the endometrial wall and maintains the endometrium around the fetus. Progesterone increases the alveoli in the breast and keeps the uterus in a quiescent state. The other options are not correct.

DIF: Cognitive Level: Remembering (Knowledge)

MSC: Client Needs: General

2. A female patient has nausea, breast tenderness, fatigue, and amenorrhea. Her last menstrual period was 6 weeks ago. The nurse interprets that this patient is experiencing _____ signs of pregnancy.

a. Positive

b. Possible

c. Probable

d. Presumptive

ANS: D

Presumptive signs of pregnancy are those that the woman experiences and include amenorrhea, breast tenderness, fatigue, nausea, and increased urinary frequency. Probable signs are those that are detected by the examiner, such as an enlarged uterus or changes in the cervix. Positive signs of pregnancy are those that document direct evidence of the fetus such as fetal heart tones or positive cardiac activity on ultrasound.

DIF: Cognitive Level: Applying (Application)

MSC: Client Needs: Health Promotion and Maintenance

3. A woman who is 8 weeks pregnant is visiting the clinic for a checkup. Her systolic blood pressure is 30 mm Hg higher than her prepregnancy systolic blood pressure. The nurse should:

a. Consider this a normal finding.

b. Expect the blood pressure to decrease as the estrogen levels increase throughout the pregnancy.

c. Consider this an abnormal finding because blood pressure is typically lower at this point in the pregnancy.

d. Recommend that she decrease her salt intake in an attempt to decrease her peripheral vascular resistance.

ANS: C

During the seventh gestational week, blood pressure begins to drop as a result of falling peripheral vascular resistance. Early in the first trimester, blood pressure values are similar to those of prepregnancy measurements. In this case, the womans blood pressure is higher than it should be.

DIF: Cognitive Level: Analyzing (Analysis)

MSC: Client Needs: Health Promotion and Maintenance

4. A patient is being seen at the clinic for her 10-week prenatal visit. She asks when she will be able to hear the babys heartbeat. The nurse should reply:

a. The babys heartbeat is not usually heard until the second trimester.

b. The babys heartbeat may be heard anywhere from the ninth to the twelfth week.

c. It is often difficult to hear the heartbeat at this point, but we can try.

d. It is normal to hear the heartbeat at 6 weeks. We may be able to hear it today.

ANS: B

Fetal heart tones can be heard with the use of the Doppler device between 9 and 12 weeks. The other responses are incorrect.

DIF: Cognitive Level: Applying (Application)

MSC: Client Needs: Health Promotion and Maintenance

5. A patient who is in her first trimester of pregnancy tells the nurse that she is experiencing significant nausea and vomiting and asks when it will improve. The nurse should reply:

a. Did your mother have significant nausea and vomiting?

b. Many women experience nausea and vomiting until the third trimester.

c. Usually, by the beginning of the second trimester, the nausea and vomiting improve.

d. At approximately the time you begin to feel the baby move, the nausea and vomiting will subside.

ANS: C

The nausea, vomiting, and fatigue of pregnancy improve by the 12th week. Quickening, when the mother recognizes fetal movement, occurs at approximately 18 to 20 weeks.

DIF: Cognitive Level: Analyzing (Analysis)

MSC: Client Needs: Physiologic Integrity: Physiologic Adaptation

6. During the examination of a woman in her second trimester of pregnancy, the nurse notices the presence of a small amount of yellow drainage from the nipples. The nurse knows that this is:

a. An indication that the womans milk is coming in.

b. A sign of possible breast cancer in a pregnant woman.

c. Most likely colostrum and considered a normal finding at this stage of the pregnancy.

d. Too early in the pregnancy for lactation to begin and refers the woman to a specialist.

ANS: C

During the second trimester, colostrum, the precursor of milk, may be expressed from the nipples. Colostrum is yellow and contains more minerals and protein but less sugar and fat than mature milk. The other options are incorrect.

DIF: Cognitive Level: Analyzing (Analysis)

MSC: Client Needs: Health Promotion and Maintenance

7. A woman in her second trimester of pregnancy complains of heartburn and indigestion. When discussing this with the woman, the nurse considers which explanation for these problems?

a. Tone and motility of the gastrointestinal tract increase during the second trimester.

b. Sluggish emptying of the gallbladder, resulting from the effects of progesterone, often causes heartburn.

c. Lower blood pressure at this time decreases blood flow to the stomach and gastrointestinal tract.

d. Enlarging uterus and altered esophageal sphincter tone predispose the woman to have heartburn.

ANS: D

Stomach displacement from the enlarging uterus plus altered esophageal sphincter and gastric tone as a result of progesterone predispose the woman to heartburn. The tone and motility of the gastrointestinal tract are decreased, not increased, during pregnancy. Emptying of the gallbladder may become more sluggish during pregnancy but is not related to indigestion. Rather, some women are predisposed to gallstone formation. A lower blood pressure may occur during the second semester, but it does not affect digestion.

DIF: Cognitive Level: Understanding (Comprehension)

MSC: Client Needs: Physiologic Integrity: Physiologic Adaptation

8. A patient who is 20 weeks pregnant tells the nurse that she feels more shortness of breath as her pregnancy progresses. The nurse recognizes which statement to be *true*?

a. High levels of estrogen cause shortness of breath.

b. Feelings of shortness of breath are abnormal during pregnancy.

c. Hormones of pregnancy cause an increased respiratory effort.

d. The patient should get more exercise in an attempt to increase her respiratory reserve.

ANS: C

Progesterone and estrogen cause an increase in respiratory effort during pregnancy by increasing tidal volume. Increased tidal volume causes a slight drop in partial pressure of arterial carbon dioxide ($PaCO_2$), causing the woman to have dyspnea occasionally. The other options are not correct.

DIF: Cognitive Level: Understanding (Comprehension)

MSC: Client Needs: Physiologic Integrity: Physiologic Adaptation

9. The nurse auscultates a functional systolic murmur, grade II/IV, on a woman in week 30 of her pregnancy. The remainder of her physical assessment is within normal limits. The nurse would:

a. Consider this finding abnormal, and refer her for additional consultation.

b. Ask the woman to run briefly in place and then assess for an increase in intensity of the murmur.

c. Know that this finding is normal and is a result of the increase in blood volume during pregnancy.

d. Ask the woman to restrict her activities and return to the clinic in 1 week for re-evaluation.

ANS: C

Because of the increase in blood volume, a functional systolic murmur, grade II/IV or less, can be heard in 95% of pregnant women. The other actions are not appropriate.

DIF: Cognitive Level: Analyzing (Analysis)

MSC: Client Needs: Health Promotion and Maintenance

10. A woman who is 28 weeks pregnant has bilateral edema in her lower legs after working 8 hours a day as a cashier at a local grocery store. She is worried about her legs. What is the nurses best response?

a. You will be at risk for development of varicose veins when your legs are edematous.

b. I would like to listen to your heart sounds. Edema can indicate a problem with your heart.

c. Edema is usually the result of too much salt and fluids in your diet. You may need to cut down on salty foods.

d. As your baby grows, it slows blood return from your legs, causing the swelling. This often occurs with prolonged standing.

ANS: D

Edema of the lower extremities occurs because of the enlarging fetus, which impairs venous return. Prolonged standing worsens the edema. Typically, the bilateral, dependent edema experienced with pregnancy is not the result of a cardiac pathologic condition.

DIF: Cognitive Level: Applying (Application)

MSC: Client Needs: Health Promotion and Maintenance

11. When assessing a woman who is in her third trimester of pregnancy, the nurse looks for the classic symptoms associated with preeclampsia, which include:

a. Edema, headaches, and seizures.

b. Elevated blood pressure and proteinuria.

c. Elevated liver enzymes and high platelet counts.

d. Decreased blood pressure and edema.

ANS: B

The classic symptoms of preeclampsia are hypertension and proteinuria. Headaches may occur with worsening symptoms, and seizures may occur if preeclampsia is left untreated and leads to eclampsia. A serious variant of preeclampsia, the hemolysis, elevated liver enzymes, low platelet count (HELLP) syndrome, is an ominous picture. Edema is a common occurrence in pregnancy.

DIF: Cognitive Level: Remembering (Knowledge)

MSC: Client Needs: Physiologic Integrity: Physiologic Adaptation

12. The nurse knows that the best time to assess a womans blood pressure during an initial prenatal visit is:

a. At the end of the examination when she will be the most relaxed.

b. At the beginning of the interview as a nonthreatening method of gaining rapport.

c. During the middle of the physical examination when she is the most comfortable.

d. Before beginning the pelvic examination because her blood pressure will be higher after the pelvic examination.

ANS: A

Assessing the womans blood pressure at the end of the examination, when it is hoped that she will be most relaxed, is the best time to assess blood pressure. The other options are not correct.

DIF: Cognitive Level: Applying (Application)

MSC: Client Needs: Safe and Effective Care Environment: Management of Care

13. When examining the face of a woman who is 28 weeks pregnant, the nurse notices the presence of a butterfly-shaped increase in pigmentation on the face. The proper term for this finding in the documentation is:

a. Striae.

b. Chloasma.

c. Linea nigra.

d. Mask of pregnancy.

ANS: B

Chloasma is a butterfly-shaped increase in pigmentation on the face. It is known as the mask of pregnancy, but when documenting, the nurse should use the correct medical term, *chloasma*. *Striae* is the term for stretch marks. The *linea nigra* is a hyperpigmented line that begins at the sternal notch and extends down the abdomen through the umbilicus to the pubis.

DIF: Cognitive Level: Applying (Application)

MSC: Client Needs: Safe and Effective Care Environment: Management of Care

14. Which finding is considered normal and expected when the nurse is performing a physical examination on a pregnant woman?

a. Palpable, full thyroid

b. Edema in one lower leg

c. Significant diffuse enlargement of the thyroid

d. Pale mucous membranes of the mouth

ANS: A

The thyroid may be palpable during pregnancy. It should feel full, but smooth. Significant diffuse enlargement occurs with hyperthyroidism, thyroiditis, and hypothyroidism. Pale mucous membranes may indicate anemia. Bilateral lower extremity edema is common in pregnancy, but edema with pain in only one leg occurs with deep vein thrombosis.

DIF: Cognitive Level: Applying (Application)

MSC: Client Needs: Health Promotion and Maintenance

15. When auscultating the anterior thorax of a pregnant woman, the nurse notices the presence of a murmur over the second, third, and fourth intercostal spaces. The murmur is continuous but can be obliterated by pressure with the stethoscope or finger on the thorax just lateral to the murmur. The nurse interprets this finding to be:

a. Murmur of aortic stenosis.

b. Most likely a mammary souffle.

c. Associated with aortic insufficiency.

d. Indication of a patent ductus arteriosus.

ANS: B

Blood flow through the blood vessels, specifically the internal mammary artery, can often be heard over the second, third, and fourth intercostal spaces. This finding is called a *mammary souffle*, but it may be mistaken for a cardiac murmur. The other options are incorrect.

DIF: Cognitive Level: Analyzing (Analysis)

MSC: Client Needs: Health Promotion and Maintenance

16. When the nurse is assessing the deep tendon reflexes (DTRs) on a woman who is 32 weeks pregnant, which of these would be considered a normal finding on a 0 to 4+ scale?

a. Absent DTRs

b. 2+

c. 4+

d. Brisk reflexes and the presence of clonus

ANS: B

Normally during pregnancy, the DTRs are 1+ to 2+ and bilaterally equal. Brisk or greater than 2+ DTRs and the presence of clonus are abnormal and may be associated with an elevated blood pressure and cerebral edema in the preeclamptic woman.

DIF: Cognitive Level: Applying (Application)

MSC: Client Needs: Health Promotion and Maintenance

17. When performing an examination of a woman who is 34 weeks pregnant, the nurse notices a midline linear protrusion in the abdomen over the area of the rectus abdominis muscles as the woman raises her head and shoulders off of the bed. Which response by the nurse is *correct*?

a. The presence of diastasis recti should be documented.

b. This condition should be discussed with the physician because it will most likely need to be surgically repaired.

c. The possibility that the woman has a hernia attributable to the increased pressure within the abdomen from the pregnancy should be suspected.

d. The woman should be told that she may have a difficult time with delivery because of the weakness in her abdominal muscles.

ANS: A

The separation of the abdominal muscles is called *diastasis recti* and frequently occurs during pregnancy. The rectus abdominis muscles will return together after pregnancy with abdominal exercise. This condition is not a true hernia.

DIF: Cognitive Level: Applying (Application)

MSC: Client Needs: Health Promotion and Maintenance

18. The nurse is palpating the fundus of a pregnant woman. Which statement about palpation of the fundus is *true*?

a. The fundus should be hard and slightly tender to palpation during the first trimester.

b. Fetal movement may not be felt by the examiner until the end of the second trimester.

c. After 20 weeks gestation, the number of centimeters should approximate the number of weeks gestation.

d. Fundal height is usually less than the number of weeks gestation, unless an abnormal condition such as excessive amniotic fluid is present.

ANS: C

After 20 weeks gestation, the number of centimeters should approximate the number of weeks gestation. In addition, at 20 weeks gestation, the examiner may be able to feel fetal movement and the head can be balloted.

DIF: Cognitive Level: Understanding (Comprehension)

MSC: Client Needs: Health Promotion and Maintenance

19. The nurse is palpating the abdomen of a woman who is 35 weeks pregnant and notices that the fetal head is facing downward toward the pelvis. The nurse would document this as fetal:

a. Lie.

b. Variety.

c. Attitude.

d. Presentation.

ANS: D

Fetal presentation describes the part of the fetus that is entering the pelvis first. *Fetal lie* is orientation of the fetal spine to the maternal spine. *Fetal attitude* is the position of fetal parts in relation to each other, and *fetal*

variety is the location of the fetal back to the maternal pelvis.

DIF: Cognitive Level: Applying (Application)

MSC: Client Needs: Health Promotion and Maintenance

20. The nurse is palpating the uterus of a woman who is 8 weeks pregnant. Which finding would be considered to be most consistent with this stage of pregnancy?

a. The uterus seems slightly enlarged and softened.

b. It reaches the pelvic brim and is approximately the size of a grapefruit.

c. The uterus rises above the pelvic brim and is approximately the size of a cantaloupe.

d. It is about the size of an avocado, approximately 8 cm across the fundus.

ANS: D

The 8-week pregnant uterus is approximately the size of an avocado, 7 to 8 cm across the fundus. The 6-week pregnant uterus is slightly enlarged and softened. The 10-week pregnant uterus is approximately the size of a grapefruit and may reach the pelvic brim. The 12-week pregnant uterus will fill the pelvis. At 12 weeks, the uterus is sized from the abdomen.

DIF: Cognitive Level: Understanding (Comprehension)

MSC: Client Needs: Health Promotion and Maintenance

21. Which of these correctly describes the average length of pregnancy?

a. 38 weeks

b. 9 lunar months

c. 280 days from the last day of the last menstrual period

d. 280 days from the first day of the last menstrual period

ANS: D

The average length of pregnancy is 280 days from the first day of the last menstrual period, which is equal to 40 weeks, 10 lunar months, or roughly 9 calendar months.

DIF: Cognitive Level: Remembering (Knowledge)

MSC: Client Needs: Physiologic Integrity: Physiologic Adaptation

22. A patients pregnancy test is positive, and she wants to know when the baby is due. The first day of her last menstrual period was June 14, and that period ended June 20. Using the Ngele rule, what is her expected date of delivery?

a. March 7

b. March 14

c. March 21

d. March 27

ANS: C

To determine the expected date of delivery using the Ngele rule, 7 days are added to the first day of the last menstrual period; then 3 months are subtracted. Therefore, adding 7 days to June 14 would be June 21 and subtracting 3 months would make the expected delivery date March 21.

DIF: Cognitive Level: Analyzing (Analysis)

MSC: Client Needs: Safe and Effective Care Environment: Management of Care

23. During the assessment of a woman in her 22nd week of pregnancy, the nurse is unable to hear fetal heart tones with the fetoscope. The nurse should:

a. Immediately notify the physician, then wait 10 minutes and try again.

b. Ask the woman if she has felt the baby move today.

c. Wait 10 minutes, and try again.

d. Use ultrasound to verify cardiac activity.

ANS: D

If no fetal heart tones are heard during auscultation with a fetoscope, then the nurse should verify cardiac activity using ultrasonography. An ultrasound should be immediately done and before notifying the physician or causing the woman distress by asking about fetal movement.

DIF: Cognitive Level: Analyzing (Analysis)

MSC: Client Needs: Physiologic Integrity: Physiologic Adaptation

24. A patient who is 24 weeks pregnant asks about wearing a seat belt while driving. Which response by the nurse is correct?

a. Seat belts should not be worn during pregnancy.

b. Place the lap belt below the uterus and use the shoulder strap at the same time.

c. Place the lap belt below the uterus but omit the shoulder strap during pregnancy.

d. Place the lap belt at your waist above the uterus and use the shoulder strap at the same time.

ANS: B

For maternal and fetal safety, the nurse should instruct the woman to place the lap belt below the uterus and to use the shoulder strap. The other instructions are incorrect.

DIF: Cognitive Level: Applying (Application)

MSC: Client Needs: Physiologic Integrity: Reduction of Risk Potential

25. During a health history interview, a 38-year-old woman shares that she is thinking about having another baby. The nurse knows which statement to be *true* regarding pregnancy after 35 years of age?

a. Fertility does not start to decline until age 40 years.

b. Occurrence of Down syndrome is significantly more frequent after the age of 35 years.

c. Genetic counseling and prenatal screening are not routine until after age 40 years.

d. Women older than 35 years who are pregnant have the same rate of pregnancy-related complications as those who are younger than 35 years.

ANS: B

The risk of Down syndrome increases as the woman ages, from approximately 1 in 1250 at age 25 years to 1 in 400 at age 35 years. Fertility declines with advancing maternal age. Women 35 years and older or with a history of a genetic abnormality are offered genetic counseling and the options of prenatal diagnostic screening tests. Because the incidence of chronic diseases increases with age, women older than 35 years who are pregnant more often have medical complications such as diabetes, obesity, and hypertension.

DIF: Cognitive Level: Understanding (Comprehension)

MSC: Client Needs: Physiologic Integrity: Reduction of Risk Potential

26. A 25-year-old woman is in the clinic for her first prenatal visit. The nurse will prepare to obtain which laboratory screening test at this time?

a. Urine toxicology

b. Complete blood cell count

c. Alpha-fetoprotein

d. Carrier screening for cystic fibrosis

ANS: B

At the onset of pregnancy, a routine prenatal panel usually includes a complete blood cell count, serologic testing, rubella antibodies, hepatitis B screening, blood type and Rhesus factor, and antibody screen. A clean-catch urine sample is collected for urinalysis to rule out cystitis. Urine toxicology, although beneficial for women if active substance abuse is suspected or known, is not routinely performed. In the second trimester, maternal serum is analyzed for alpha-fetoprotein. Carrier screening for cystic fibrosis is offered to check whether a person carries the abnormal gene that causes cystic fibrosis but is not part of routine testing.

DIF: Cognitive Level: Applying (Application)

MSC: Client Needs: Safe and Effective Care Environment: Management of Care

27. A woman at 25 weeks gestation comes to the clinic for her prenatal visit. The nurse notices that her face and lower extremities are swollen, and her blood pressure is 154/94 mm Hg. The woman states that she has had headaches and blurry vision but thought she was just tired. What should the nurse suspect?

a. Eclampsia

b. Preeclampsia

c. Diabetes type 1

d. Preterm labor

ANS: B

Classic symptoms of preeclampsia include elevated blood pressure (greater than 140 mm Hg systolic or 90 mm Hg diastolic in a woman with previously normal blood pressure) and proteinuria. Onset and worsening symptoms may be sudden, and subjective signs include headaches and visual changes. Eclampsia is manifested by generalized tonic-clonic seizures. These symptoms are not indicative of diabetes mellitus (type 1 or 2) or preterm labor.

DIF: Cognitive Level: Applying (Application)

MSC: Client Needs: Safe and Effective Care Environment: Management of Care

28. During auscultation of fetal heart tones (FHTs), the nurse determines that the heart rate is 136 beats per minute. The nurses next action should be to:

a. Document the results, which are within normal range.

b. Take the maternal pulse to verify these findings as the uterine souffle.

c. Have the patient change positions and count the FHTs again.

d. Immediately notify the physician for possible fetal distress.

ANS: A

The normal fetal heart rate is between 110 and 160 beats per minute. The nurse should document the results as within the normal range. The other options are not correct.

DIF: Cognitive Level: Analyzing (Analysis)

MSC: Client Needs: Safe and Effective Care Environment: Management of Care

29. During a womans 34th week of pregnancy, she is told that she has preeclampsia. The nurse knows which statement concerning preeclampsia is *true*?

a. Preeclampsia has little effect on the fetus.

b. Edema is one of the main indications of preeclampsia.

c. Eclampsia only occurs before delivery of the baby.

d. Untreated preeclampsia may contribute to restriction of fetal growth.

ANS: D

Untreated preeclampsia may progress to eclampsia, which is manifested by generalized tonic-clonic seizures. Eclampsia may develop as late as 10 days postpartum. Before the syndrome becomes clinically manifested, it is affecting the placenta through vasospasm and a series of small infarctions. The placentas capacity to deliver oxygen and nutrients may be seriously diminished, and fetal growth may be restricted. Edema is common in pregnancy and is not an indicator of preeclampsia.

DIF: Cognitive Level: Applying (Application)

MSC: Client Needs: Physiologic Integrity: Physiologic Adaptation

MULTIPLE RESPONSE

1. During a group prenatal teaching session, the nurse teaches Kegel exercises. Which statements would be appropriate for this teaching session? *Select all that apply*.

a. Kegel exercises help keep your uterus strong during the pregnancy.

b. Kegel exercises should be performed twice a day.

c. Kegel exercises should be performed 50 to 100 times a day.

d. To perform Kegel exercises, slowly squeeze to a peak at the count of eight, and then slowly release to a count of eight.

e. To perform Kegel exercises, rapidly perform alternating squeeze-release exercises up to the count of eight.

ANS: C, D

Kegel exercises can be performed to prepare for and to recover from birth. The nurse should direct the woman to squeeze slowly to a peak at the count of eight and then to release slowly to the count of eight. The nurse can prescribe this exercise to be performed 50 to 100 times a day.

DIF: Cognitive Level: Applying (Application)

MSC: Client Needs: Health Promotion and Maintenance

Chapter 32: Functional Assessment of the Older Adult

MULTIPLE CHOICE

1. The nurse is assessing an older adults functional ability. Which definition correctly describes ones functional ability? Functional ability:

a. Is the measure of the expected changes of aging that one is experiencing.

b. Refers to the individuals motivation to live independently.

c. Refers to the level of cognition present in an older person.

d. Refers to ones ability to perform activities necessary to live in modern society.

ANS: D

Functional ability refers to ones ability to perform activities necessary to live in modern society and can include driving, using the telephone, or performing personal tasks such as bathing and toileting.

DIF: Cognitive Level: Understanding (Comprehension)

MSC: Client Needs: Health Promotion and Maintenance

2. The nurse is preparing to perform a functional assessment of an older patient and knows that a good approach would be to:

a. Observe the patients ability to perform the tasks.

b. Ask the patients wife how he does when performing tasks.

c. Review the medical record for information on the patients abilities.

d. Ask the patients physician for information on the patients abilities.

ANS: A

Two approaches are used to perform a functional assessment: (1) asking individuals about their ability to perform the tasks (self-reports), or (2) actually observing their ability to perform the tasks. For persons with memory problems, the use of surrogate reporters (proxy reports), such as family members or caregivers, may be necessary, keeping in mind that they may either overestimate or underestimate the persons actual abilities.

DIF: Cognitive Level: Applying (Application)

MSC: Client Needs: Safe and Effective Care Environment: Management of Care

3. The nurse needs to assess a patients ability to perform activities of daily living (ADLs) and should choose which tool for this assessment?

a. Direct Assessment of Functional Abilities (DAFA)

b. Lawton Instrumental Activities of Daily Living (IADL) scale

c. Barthel Index

d. Older Americans Resources and Services Multidimensional Functional Assessment QuestionnaireIADL (OMFAQ-IADL)

ANS: C

The Barthel Index is used to assess ADLs. The other options are used to measure IADLs.

DIF: Cognitive Level: Understanding (Comprehension)

MSC: Client Needs: Health Promotion and Maintenance

4. The nurse is preparing to use the Lawton IADL instrument as part of an assessment. Which statement about the Lawton IADL instrument is *true*?

a. The nurse uses direct observation to implement this tool.

b. The Lawton IADL instrument is designed as a self-report measure of performance rather than ability.

c. This instrument is not useful in the acute hospital setting.

d. This tool is best used for those residing in an institutional setting.

ANS: B

The Lawton IADL instrument is designed as a self-report measure of performance rather than ability. Direct testing is often not feasible, such as demonstrating the ability to prepare food while a hospital inpatient. Attention to the final score is less important than identifying a persons strengths and areas where assistance is needed. The instrument is useful in acute hospital settings for discharge planning and continuously in outpatient settings. It would not be useful for those residing in institutional settings because many of these tasks are already being managed for the resident.

DIF: Cognitive Level: Applying (Application)

MSC: Client Needs: Safe and Effective Care Environment: Management of Care

5. The nurse is assessing an older adults advanced activities of daily living (AADLs), which would include:

a. Recreational activities.

b. Meal preparation.

c. Balancing the checkbook.

d. Self-grooming activities.

ANS: A

AADLs are activities that an older adult performs such as occupational and recreational activities. Self-grooming activities are basic ADLs; meal preparation and balancing the checkbook are considered IADLs.

DIF: Cognitive Level: Applying (Application)

MSC: Client Needs: Health Promotion and Maintenance

6. When using the various instruments to assess an older persons ADLs, the nurse needs to remember that a disadvantage of these instruments includes:

a. Reliability of the tools.

b. Self or proxy reporting of functional activities.

c. Lack of confidentiality during the assessment.

d. Insufficient details concerning the deficiencies identified.

ANS: B

A disadvantage of many of the ADL and IADL instruments is the self or proxy reporting of functional activities. The other responses are not correct.

DIF: Cognitive Level: Understanding (Comprehension)

MSC: Client Needs: Health Promotion and Maintenance

7. A patient will be ready to be discharged from the hospital soon, and the patients family members are concerned about whether the patient is able to walk safely outside alone. The nurse will perform which test to assess this?

a. Get Up and Go Test

b. Performance ADLs

c. Physical Performance Test

d. Tinetti Gait and Balance Evaluation

ANS: A

The Get Up and Go Test is a reliable and valid test to quantify functional mobility. The test is quick, requires little training and no special equipment, and is appropriate to use in many settings including hospitals and clinics. This instrument has been shown to predict a persons ability to go safely outside alone. The Performance of ADLs test has a trained observer actually observing as a patient performs various ADLs. The Physical Performance Test assesses upper body fine motor and coarse motor activities, as well as balance, mobility, coordination, and endurance. The Tinetti Gait and Balance Evaluation assesses gait and balance and provides information about fall risk.

DIF: Cognitive Level: Understanding (Comprehension)

MSC: Client Needs: Health Promotion and Maintenance

8. The nurse is assessing the forms of support an older patient has before she is discharged. Which of these examples is an informal source of support?

a. Local senior center

b. Patients Medicare check

c. Meals on Wheels meal delivery service

d. Patients neighbor, who visits with her daily

ANS: D

Informal support includes family and close, long-time friends and is usually provided free of charge. Formal supports include programs such as social welfare and other social service and health care delivery agencies such as home health care.

DIF: Cognitive Level: Applying (Application)

MSC: Client Needs: Psychosocial Integrity

9. An 85-year-old man has been hospitalized after a fall at home, and his 86-year-old wife is at his bedside. She tells the nurse that she is his primary caregiver. The nurse should assess the caregiver for signs of possible caregiver burnout, such as:

a. Depression.

b. Weight gain.

c. Hypertension.

d. Social phobias.

ANS: A

Caregiver burden is the perceived strain by the person who cares for an older adult or for a person who is chronically ill or disabled. Caregiver burnout is linked to the caregivers ability to cope and handle stress. Signs of possible caregiver burnout include multiple somatic complaints, increased stress and anxiety, social isolation, depression, and weight loss. Screening caregivers for depression may also be appropriate.

DIF: Cognitive Level: Applying (Application)

MSC: Client Needs: Psychosocial Integrity

10. During a morning assessment, the nurse notices that an older patient is less attentive and is unable to recall yesterdays events. Which test is appropriate for assessing the patients mental status?

a. Geriatric Depression Scale, short form

b. Rapid Disability Rating Scale-2

c. Mini-Cog

d. Get Up and Go Test

ANS: C

For nurses in various settings, cognitive assessments provide continuing comparisons to the individuals baseline to detect any acute changes in mental status. The Mini-Cog is a mental status test that tests immediate and delayed recall and visuospatial abilities. The Geriatric Depression Scale, short form, assesses for depression and changes in the level of depression, not mental status. The Rapid Disability Rating Scale-2 measures what the person can *actually do* versus what he or she could do, but not mental status. The Get Up and Go Test assesses functional mobility, not mental status.

DIF: Cognitive Level: Applying (Application)

MSC: Client Needs: Psychosocial Integrity

11. An older patient has been admitted to the intensive care unit (ICU) after falling at home. Within 8 hours, his condition has stabilized and he is transferred to a medical unit. The family is wondering whether he will be able to go back home. Which assessment instrument is most appropriate for the nurse to choose at this time?

a. Lawton IADL instrument

b. Hospital Admission Risk Profile (HARP)

c. Mini-Cog

d. NEECHAM Confusion Scale

ANS: B

Hospital-acquired functional decline may occur within 2 days of a hospital admission. The HARP helps identify older adults who are at greatest risk of losing their ability to perform ADLs or mobility at this critical time. The Lawton IADL measures instrumental activities of daily living, which may be difficult to observe in the hospital setting. The Mini-Cog is an assessment of mental status. The NEECHAM Confusion Scale is used to assess for delirium.

DIF: Cognitive Level: Applying (Application)

MSC: Client Needs: Psychosocial Integrity

12. During a functional assessment of an older persons home environment, which statement or question by the nurse is most appropriate regarding common environmental hazards?

a. These low toilet seats are safe because they are nearer to the ground in case of falls.

b. Do you have a relative or friend who can help to install grab bars in your shower?

c. These small rugs are ideal for preventing you from slipping on the hard floor.

d. It would be safer to keep the lighting low in this room to avoid glare in your eyes.

ANS: B

Environmental hazards within the home can be a potential constraint on the older persons day-to-day functioning. Common environmental hazards, including inadequate lighting, loose throw rugs, curled carpet edges, obstructed hallways, cords in walkways, lack of grab bars in tub and shower, and low and loose toilet seats, are hazards that could lead to an increased risk of falls and fractures. Environmental modifications can promote mobility and reduce the likelihood of the older adult falling.

DIF: Cognitive Level: Analyzing (Analysis)

MSC: Client Needs: Safe and Effective Care Environment: Safety and Infection Control

13. When beginning to assess a persons spirituality, which question by the nurse would be most appropriate?

a. Do you believe in God?

b. How does your spirituality relate to your health care decisions?

c. What religious faith do you follow?

d. Do you believe in the power of prayer?

ANS: B

Open-ended questions provide a foundation for future discussions. The other responses are easily answered by one-word replies and are closed questions.

DIF: Cognitive Level: Analyzing (Analysis)

MSC: Client Needs: Psychosocial Integrity

14. The nurse is preparing to assess an older adult and discovers that the older adult is in severe pain. Which statement about pain and the older adult is *true*?

a. Pain is inevitable with aging.

b. Older adults with cognitive impairments feel less pain.

c. Alleviating pain should be a priority over other aspects of the assessment.

d. The assessment should take priority so that care decisions can be made.

ANS: C

If the older adult is experiencing pain or discomfort, then the depth of knowledge gathered through the assessments will suffer. Alleviating pain should be a priority over other aspects of the assessment. Remembering that older adults with cognitive impairment do *not* feel less pain is paramount.

DIF: Cognitive Level: Analyzing (Analysis)

MSC: Client Needs: Physiologic Integrity: Basic Care and Comfort

MULTIPLE RESPONSE

1. The nurse is assessing the abilities of an older adult. Which activities are considered IADLs? *Select all that apply*.

a. Feeding oneself

b. Preparing a meal

c. Balancing a checkbook

d. Walking

e. Toileting

f. Grocery shopping

ANS: B, C, F

Typically, IADL tasks include shopping, meal preparation, housekeeping, laundry, managing finances, taking medications, and using transportation. The other options listed are ADLs related to self-care.

DIF: Cognitive Level: Applying (Application)

MSC: Client Needs: Health Promotion and Maintenance