D'Amico/Barbarito *Health & Physical Assessment in Nursing*, 3/e
Chapter 2
Question 1
Type: MCMA
The nurse is conducting a prenatal class to expectant parents and is asked how children grow. When explaining growth and development to the expectant parents, which descriptions are appropriate for the nurse to use in the response?
Standard Text: Select all that apply.
1. Cephalocaudal direction.
2. Simple to complex.
3. Distal to proximal direction.
4. Generalized response to specific response.
5. Anterior to posterior.
Correct Answer: 1, 2, 4
Rationale 1: Growth and development occurs in a cephalocaudal direction; from head to toe.
Rationale 2: Growth and development proceeds from simple to complex; an infant will reach out for an object before actually being able to grasp the object.
Rationale 3: Growth and development does not proceed from distal to proximal but rather from proximal to distal; i.e., from the center of the body outward.
Rationale 4: Growth and development progresses from general to specific responses; an infant responds to stimuli with the entire body, and older child will respond more specifically, for example, with a smile.
Rationale 5: Anterior to posterior does not describe a pattern of normal growth and development.
Global Rationale: Growth and development (G and D) occurs in a cephalocaudal direction; from head to toe. G and D proceeds from simple to complex; an infant will reach out for an object before actually being able to grasp the object. G and D progresses from general to specific responses; an infant responds to stimuli with the entire body, and older child will respond more specifically, for example with a smile. G and D does not proceed from distal to proximal but rather from proximal to distal; i.e., from the center of the body outward. Anterior to posterior does not describe a pattern of normal growth and development.
Cognitive Level: Understanding
Client Need: Health Promotion and Maintenance
Client Need Sub:
QSEN Competencies: I.B.3. Provide patient-centered care with sensitivity and respect for the diversity of human experience.
AACN Essentials Competencies: I.1. Integrate theories and concepts from liberal education into nursing practice.
NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care.
Nursing/Integrated Concepts: Nursing Process: Implementation
Learning Outcome: 2.1: Relate the principles of growth and development to the nursing process.
MNL Learning Outcome:
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Question 2
Type: MCMA
When reviewing a pediatric client's medical record, which are considered environmental factors that influence growth and development?
Standard Text: Select all that apply.
1. Nutrition.
2. Climate.
3. Heredity.
4. Culture.
5. Religion.
Correct Answer: 1, 2, 4, 5
Rationale 1: Nutrition is an environmental factor that can affect the growth and development of an individual.
Rationale 2: Climate is an environmental factor that can affect the growth and development of an individual.
Rationale 3: Heredity drives the physical attributes of growth and development such as stature, gender, and race.
Rationale 4: Culture is an environmental factor that can affect the growth and development of an individual.
Rationale 5: Religion is an environmental factor that can affect the growth and development of an individual.
Global Rationale: Nutrition, climate, culture, and religion are all external, environmental factors that can affect how an individual grows and develops over time. Heredity drives the physical attributes of growth and development such as stature, gender, and race.
Cognitive Level: Understanding
Client Need: Health Promotion and Maintenance
Client Need Sub:
QSEN Competencies: I.B.3. Provide patient-centered care with sensitivity and respect for the diversity of human experience.
AACN Essentials Competencies: I.1. Integrate theories and concepts from liberal education into nursing practice.
NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care.
Nursing/Integrated Concepts: Nursing Process: Assessment
Learning Outcome: 2.1: Relate the principles of growth and development to the nursing process.
MNL Learning Outcome:
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Question 3
Type: MCSA
The nurse is teaching the parents of a child who is in Piaget's sensorimotor stage of development. Which parental statement indicates appropriate behavior to help the child accomplish developmental tasks of this stage?
1. "We have started buying more colorful toys."
2. "We play with water toys in the bathtub."

3. "We bought some blocks with numbers."
4. "We have been playing peek-a-boo."
Correct Answer: 4
Rationale 1: Buying more colorful toys fosters visual stimulation as the child experiences physiologic growth and development (nervous system), but does not help the child with cognitive development.
Rationale 2: Playing with water toys in the bathtub helps a child to develop motor, not cognitive, skills.
Rationale 3: Providing a child with numbered blocks targets motor skill development, not cognitive development.
Rationale 4: Playing peek-a-boo helps the infant begin to understand that someone is there even when that person is not visible. Piaget's theory explores how thinking, reasoning, and language develop (cognitive skills). In the sensorimotor stage (birth to 2 years) the infant progresses from responding primarily through reflexes, to purposeful movement and organized activity. It is during this stage that the infant begins to recognize objects and develop object permanence, the knowledge that objects continue to exist even though they are not seen.
Global Rationale: Playing the game peek-a-boo helps the child to understand that someone is there even when they are not visible. Piaget's theory explores how thinking, reasoning, and language develop (cognitive skills). In the sensorimotor stage (birth to 2 years) the child progresses from responding primarily through reflexes, to purposeful movement and organized activity. It is during this stage that the child begins to recognize objects and develop object permanence, the knowledge that objects continue to exist even though they are not seen. Buying more colorful toys fosters visual stimulation as the child experiences physiologic growth and development (nervous system), but does not help the child with cognitive development. Playing with water toys in the bathtub and providing a child with numbered blocks targets motor skill development, not cognitive development.
Cognitive Level: Analyzing
Client Need: Health Promotion and Maintenance
Client Need Sub:
QSEN Competencies: III.A.5. Explain the role of evidence in determining best clinical practice.
AACN Essentials Competencies: I.1. Integrate theories and concepts from liberal education into nursing practice.
NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care.
Nursing/Integrated Concepts: Nursing Process: Evaluation
Learning Outcome: 2.2: Examine theories of development.
MNL Learning Outcome:
Page Number: pp. 24–25

Question 4
Type: MCSA
The nurse is developing a plan of care for a school-age pediatric client. Which goal would be most appropriate for the nurse to include which would demonstrate the child is accomplishing the tasks of Erikson's Stage 4 of development?
1. Watch peers play team sports.
2. Identify one or two pets that would be fun to care for.

3. Complete school homework and have a passing grade within 1 month.
4. Volunteer to help with one or more community projects each week.
Correct Answer: 3
Rationale 1: A child who is observing others playing team sports (not participating) may be afraid to join in for fear of not being an adequate player or team member. This does not demonstrate accomplishment of the task at this developmental level.
Rationale 2: Identifying one or two pets to care for would not foster a sense of competency, creativity, and perseverance since mastering this task would require actually caring for the pet or pets.
Rationale 3: Erickson identified 8 stages of personality development in which a person must resolve a conflict based on physiologic and societal expectations. During Stage 4 (ages 6–11 years), the crisis of industry versus inferiority presents. Industry results in the development of competency, creativity, and perseverance. Inferiority creates feelings of hopelessness, and a sense of being mediocre or incompetent. At this age, school is a major focus in a child's life; thus reaching a goal of completing school homework and having passing grades within 1 month would help develop a sense of competency and creativity, and would also require perseverance in order to be successful.
Rationale 4: Volunteering to help with one or more community projects each week is an unrealistic goal for a child of this age.
Global Rationale: Erickson identified eight stages of personality development in which a person must resolve a conflict based on physiologic and societal expectations. During Stage 4 (ages 6–11 years), the child is presented with the crisis of industry versus inferiority. Industry results in the development of competency, creativity, and perseverance. Inferiority creates feelings of hopelessness, and a sense of being mediocre or incompetent. At this age, school is a major focus in a child's life; thus reaching a goal of completing school homework and having passing grades within 1 month would help develop a sense of competency and creativity, and would also require perseverance in order to be successful. A child who is observing others playing team sports (not participating) may be afraid to join in for fear of not being an adequate player or team member. This does not demonstrate accomplishment of the task at this developmental level. The crisis of autonomy versus shame and self-doubt presents much earlier at Stage 2 (ages 1–2 years). Identifying one or two pets to care for would not foster a sense of competency, creativity, and perseverance since mastering this task would require actually caring for the pet or pets. Volunteering to help with one or more community projects each week is an unrealistic goal for a child of this age.
Cognitive Level: Applying
Client Need: Health Promotion and Maintenance
Client Need Sub:
QSEN Competencies: III.A.5. Explain the role of evidence in determining best clinical practice.
AACN Essentials Competencies: I.1. Integrate theories and concepts from liberal education into nursing practice.
NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care.
Nursing/Integrated Concepts: Nursing Process: Planning
Learning Outcome: 2.2: Examine theories of development.
MNL Learning Outcome:
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Question 5
Type: MCSA
The nurse working at an assisted living facility has just counseled a client experiencing a crisis in Erickson's developmental stage of integrity versus despair. Which suggestion by the nurse would be most appropriate to assist this client?
1. "You should consider buying a bigger house so that your divorced son can come and live with you."
2. "You should consider getting a job to fill your time."
3. "You should organize your family photos into an album"
4. "You should consider playing a sport."
Correct Answer: 3
Rationale 1: Buying a bigger house in order to help an adult child may place a financial burden on an older adult, causing resentment and dissatisfaction with life.
Rationale 2: Older adults may have physical limitations related to the normal aging process or health problems that may interfere with their abilities to work. This may actually exacerbate a sense of loss, sadness, and despair.
Rationale 3: During the stage of integrity versus despair, an individual reviews life experiences and will either feel contentment and satisfaction with life or feel sadness and a sense of loss. Reviewing life through photos and organizing them into an album may bring a sense of satisfaction to the individual.
Rationale 4: While older adults are encouraged to remain active, playing sports may be limited in the older adult due to the normal physiologic changes that occur with aging.
Global Rationale: During the stage of integrity versus despair an individual reviews life experiences and will either feel contentment and satisfaction with life or feel sadness and a sense of loss. Reviewing life through photos and organizing them into an album may bring a sense of satisfaction to the individual. Buying a bigger house in order to help an adult child may place a financial burden on an older adult, causing resentment and dissatisfaction with life. Older adults may have physical limitations related to the normal aging process or health problems that may interfere with their abilities to work. This may actually exacerbate a sense of loss, sadness, and despair. While older adults are encouraged to remain active, playing sports may be limited in the older adult due to the normal physiologic changes that occur with aging.
Cognitive Level: Applying
Client Need: Health Promotion and Maintenance
Client Need Sub:
QSEN Competencies: III.A.5. Explain the role of evidence in determining best clinical practice.
AACN Essentials Competencies: I.1. Integrate theories and concepts from liberal education into nursing practice.
NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care.
Nursing/Integrated Concepts: Nursing Process: Implementation
Learning Outcome: 2.2: Examine theories of development.
MNL Learning Outcome:
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Question 6

Type: MCSA
The nurse is interviewing the mother of a toddler who verbalizes concerns that her child uses the toilet to void, but refuses to use the toilet for bowel movements, and often hides to defecate. Which stage of Freud's psychologic development is this toddler experiencing?
1. Genital.
2. Phallic.
3. Anal.
4. Latency.
Correct Answer: 3
Rationale 1: The genital phase occurs during puberty through adulthood; the individual experiences sexual urges stimulated by hormonal influences and sexual development.
Rationale 2: The phallic phase occurs during years 4 to 6; pleasure is focused on the genital area.
Rationale 3: Freud's anal phase follows the oral phase and continues through age 3. The anus becomes the focus for gratification and the child experiences conflict when expectations about toileting are presented.
Rationale 4: The latency phase occurs during years 5 to 6 when energy is focused on intellectual and physical activities and a time to work on unresolved conflicts.
Global Rationale: Freud's anal phase follows the oral phase and continues through age 3. The anus becomes the focus for gratification and the child experiences conflict when expectations about toileting are presented. The genital phase occurs during puberty through adulthood; the individual experiences sexual urges stimulated by hormonal influences and sexual development. The phallic phase occurs during years 4 to 6; pleasure is focused on the genital area. The latency phase occurs during years 5 to 6 when energy is focused on intellectual and physical activities and a time to work on unresolved conflicts.
Cognitive Level: Applying
Client Need: Health Promotion and Maintenance
Client Need Sub:
QSEN Competencies: III.A.5. Explain the role of evidence in determining best clinical practice.
AACN Essentials Competencies: I.1. Integrate theories and concepts from liberal education into nursing practice.
NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care.
Nursing/Integrated Concepts: Nursing Process: Assessment
Learning Outcome: 2.2: Examine theories of development.
MNL Learning Outcome:
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Question 7
Type: MCMA
According to Piaget's theory of cognitive development, which behaviors does the nurse expect when assessing a preschool-age client?
Standard Text: Select all that apply.
1. Being egocentric and failing to see another's point of view.
2. Focusing on many aspects of a given situation at once.
3. Assuming everyone else in their world sees things as they do.

4. Believing in magical powers of thought to control the universe.
5. Understanding cause-and-effect relationships.
Correct Answer: 1, 2, 3, 4
Rationale 1: The preschooler continues to be egocentric and unable to see another's point of view.
Rationale 2: Preschoolers demonstrate centration. That is, they focus on one aspect of a situation and ignore others, leading to illogical reasoning.
Rationale 3: Preschoolers feel no need to defend their point of view, because they assume that everyone else sees things as they do.
Rationale 4: Preschoolers believe their wishes, thoughts, and gestures command the universe. The child believes that these "magical" powers of thought are the cause of all events.
Rationale 5: Understanding cause-and-effect relationships is developed during the school-age years.
Global Rationale: The preschooler continues to be egocentric and unable to see another's point of view. They feel no need to defend their point of view, because they assume that everyone else sees things as they do. Preschoolers demonstrate centration. That is, they focus on one aspect of a situation and ignore others, leading to illogical reasoning. They believe their wishes, thoughts, and gestures command the universe. The child believes that these "magical" powers of thought are the cause of all events. Understanding cause-and-effect relationships is developed during the school-age years.
Cognitive Level: Applying
Client Need: Health Promotion and Maintenance
Client Need Sub:
QSEN Competencies: III.A.5. Explain the role of evidence in determining best clinical practice.
AACN Essentials Competencies: I.1. Integrate theories and concepts from liberal education into nursing practice.
NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care.
Nursing/Integrated Concepts: Nursing Process: Assessment
Learning Outcome: 2.2: Examine theories of development.
MNL Learning Outcome:
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Question 8
Type: MCSA
While assessing a preschool-age child at play, which behavior indicates that the child is successfully moving through Piaget's cognitive stages of development?
1. The child is able to consider the differing opinions of playmates.
2. The child is able to recall the good time experienced the previous weekend at the playground and is anticipating going there again the following week.
3. The child reports being able to rationalize why it is better to eat fruit than candy.
4. The child understands that his mother loves him as much as she loves the child's older siblings.
Correct Answer: 2
Rationale 1: The ability to consider the points of view of others does not occur until the Concrete Operations stage.

Rationale 2: The child is able to recall the good time experienced the previous weekend at the playground and is anticipating going there again the following week. This indicates that add the child is progressing without difficulty in Piaget's Cognitive Theory. Stage 2: Preoperational Skills encompasses ages 2 to 7 years. During this time, the child is able to recall past events and anticipate future events.

Rationale 3: The ability to consider the points of view of others does not occur until the Concrete Operations stage.
Rationale 4: Rational thinking begins around the age of 11 and continues into adulthood. This is the stage known as Formal Operations.
Global Rationale: The child is able to recall the good time experienced the previous weekend at the playground and is anticipating going there again the following week. This indicates that the child is progressing without difficulty in Piaget's Cognitive Theory. Stage 2: Preoperational Skills encompasses ages 2 to 7 years. During this time, the child is able to recall past events and anticipate future events. The ability to consider the points of view of others does not occur until the Concrete Operations stage. Rational thinking begins around the age of 11 and continues into adulthood. This is the stage known as Formal Operations. The issue of maternal love does not impact this question.
Cognitive Level: Applying
Client Need: Psychosocial Integrity
Client Need Sub:
QSEN Competencies: III.A.5. Explain the role of evidence in determining best clinical practice.
AACN Essentials Competencies: I.1. Integrate theories and concepts from liberal education into nursing practice.
NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care.
Nursing/Integrated Concepts: Nursing Process: Evaluation
Learning Outcome: 2.2: Examine theories of development.
MNL Learning Outcome:
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Question 9
Type: MCSA
An older adult client voices concerns to the nurse regarding the seemingly continued loss of family and friends to illness and death. The client states, "God is cruel. I have no one anymore. I am too old to make new friends; it's useless, everyone leaves me." Using Erickson's psychosocial theory, which interpretation by the nurse is the most appropriate based on the client's statements?
1. A successful mastering of the stage of integrity versus despair.
2. Difficulty passing through the stage of generativity versus stagnation.
3. A struggle to succeed in the stage of integrity versus despair.
4. Unsuccessful completion of the intimacy versus isolation stage of development.
Correct Answer: 3
Rationale 1: During the stage of integrity versus despair (ages 65 to death) the client reflects on life and the inevitability of death. Clients are often faced with the loss of friends and family members. Acceptance of these losses results in successful movement through this stage.

Rationale 2: During the stage of generativity versus stagnation (ages 40–65), the client either demonstrates productivity and creativity or begins to become self-absorbed and nonproductive.
Rationale 3: The client is experiencing struggles to succeed in the stage of integrity versus despair. During this phase, the client reflects on life and the inevitability of death. Clients are often faced with the loss of friends and family members. Failure to accept this stage of life will result in bitterness.
Rationale 4: In the phase of intimacy versus isolation (ages 19–40) adults find mates or face a life of loneliness.
Global Rationale: The client is experiencing struggles to succeed in the stage of integrity versus despair. During this phase (ages 65 to death), the client reflects on life and the inevitability of death. Clients are often faced with the loss of friends and family members. Acceptance of these losses results in successful movement through this stage. Failure to accept this stage of life will result in bitterness. During the stage of generativity versus stagnation (ages 40–65), the client either demonstrates productivity and creativity or begins to become self-absorbed and nonproductive. In the phase of intimacy versus isolation (ages 19–40) adults find mates or face a life of loneliness.
Cognitive Level: Applying
Client Need: Health Promotion and Maintenance
Client Need Sub:
QSEN Competencies: III.A.5. Explain the role of evidence in determining best clinical practice.
AACN Essentials Competencies: I.1. Integrate theories and concepts from liberal education into nursing practice.
NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care.
Nursing/Integrated Concepts: Nursing Process: Evaluation
Learning Outcome: 2.2: Examine theories of development.
MNL Learning Outcome:
Page Number: pp. 24–25

Question 10
Type: MCSA
During a well-baby health maintenance visit, the nurse notices the infant does not demonstrate expected developmental milestones for age. Which nursing intervention is the priority in this situation?
1. The nurse should initiate a consult with social services for a home assessment.
2. The nurse should consult with the health care provider.
3. The nurse should ask the parents questions about their play activities with the infant.
4. The nurse should prepare the family for a potentially upsetting diagnosis.
Correct Answer: 3
Rationale 1: It is outside the nurse's scope of practice to initiate consults. The healthcare provider will recommend and manage consultations.
Rationale 2: The nurse should complete the assessment before consulting with the health care provider.
Rationale 3: The nurse should first assess the parental knowledge and expectations concerning normal infant development. The parents may not be aware of the appropriate activities that will stimulate the child.

Rationale 4: There is no need to prepare the parents for a negative outcome at this point.
Global Rationale: The nurse should first assess the parental knowledge and expectations concerning normal infant development. The parents may not be aware of the appropriate activities that will stimulate the child. It is outside the nurse's scope of practice to initiate consults. The healthcare provider will recommend and manage consultations. The nurse should complete the assessment before consulting with the health care provider. There is no need to prepare the parents for a negative outcome at this point.
Cognitive Level: Analyzing
Client Need: Health Promotion and Maintenance
Client Need Sub:
QSEN Competencies: III.A.5. Explain the role of evidence in determining best clinical practice.
AACN Essentials Competencies: I.1. Integrate theories and concepts from liberal education into nursing practice.
NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care.
Nursing/Integrated Concepts: Nursing Process: Assessment
Learning Outcome: 2.3: Appraise stages of development.
MNL Learning Outcome:
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Question 11
Type: MCSA
In preparation for a sport's physical examination, the nurse is assessing the height of an adolescent client, who measures 5′5″. The client voices concerns about his lack of stature and asks if he has reached his full height. Which response by the nurse is most appropriate?
1. "By age 16, you are finished growing."
2. "Is your father very tall?"
3. "Why do you hope to grow taller?"
4. "You may continue to grow into your early 20s."
Correct Answer: 4
Rationale 1: On average, the fastest rate of growth in adolescent males occurs at about age 14 and continues for 24–30 months. After that time, growth continues but at a slower rate.
Rationale 2: Although a child's height may relate to that of the parents, this statement does not respond to the client's question.
Rationale 3: Asking the teen about his motivation to grow taller does not respond to his question.
Rationale 4: Skeletal growth may continue until age 25, when the epiphyses of the long bones are finally fused.
Global Rationale: Skeletal growth may continue until age 25, when the epiphyses of the long bones are finally fused. On average, the fastest rate of growth in adolescent males occurs at about age 14 and continues for 24–30 months. After that time, growth continues but at a slower rate. Although a child's height may relate to that of the parents, this statement does not respond to the client's question. Asking the teen about his motivation to grow taller does not respond to his question.
Cognitive Level: Applying
Client Need: Health Promotion and Maintenance

Client Need Sub:
QSEN Competencies: III.A.5. Explain the role of evidence in determining best clinical practice.
AACN Essentials Competencies: I.1. Integrate theories and concepts from liberal education into nursing practice.
NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care.
Nursing/Integrated Concepts: Nursing Process: Implementation
Learning Outcome: 2.3: Appraise stages of development.
MNL Learning Outcome:
Page Number: pp. 25–41

Question 12
Type: MCSA
During a routine physical examination, a middle-aged female client reports concern about weight gain over the past 2 years despite not having made any significant changes in diet or exercise patterns. Which factor may be responsible for the reported changes in the client's weight?
1. Increased hormone levels.
2. Increased body mass index.
3. Reduced muscle nerve conduction.
4. Increased adipose tissue.
Correct Answer: 4
Rationale 1: During this client's stage of development, there is a reduction, not an increase, in hormone levels as menopause (the female climacteric) approaches.
Rationale 2: Body mass index is determined by height and weight, but is not responsible for weight changes.
Rationale 3: The changes in muscle and nerve development are not directly implicated in the body changes being reported.
Rationale 4: The amount of adipose tissue increases because of a decrease in hormone production, which can lead to weight gain.
Global Rationale: During this client's stage of development, there is a reduction, not an increase, in hormone levels as menopause (the female climacteric) approaches. Decreased hormone production results in an increase in body weight; the amount of adipose tissue also increases. Body mass index is determined by height and weight, but is not responsible for weight changes. The changes in muscle and nerve development are not directly implicated in the body changes being reported.
Cognitive Level: Applying
Client Need: Health Promotion and Maintenance
Client Need Sub:
QSEN Competencies: III.A.5. Explain the role of evidence in determining best clinical practice.
AACN Essentials Competencies: I.1. Integrate theories and concepts from liberal education into nursing practice.
NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care.
Nursing/Integrated Concepts: Nursing Process: Assessment
Learning Outcome: 2.3: Appraise stages of development.
MNL Learning Outcome:

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Question 13
Type: MCMA
The nurse educator is conducting a seminar at an assisted living village regarding the importance of staying active after the age of 65. Which statements are appropriate for the nurse to include in the seminar?
Standard Text: Select all that apply.
1. "Participating in activities enhances your ability to remain productive."
2. "Older adults who lack intellectual challenges may demonstrate cognitive declines."
3. "Slowing down as you age will increase your quality of life."
4. "Retirement will promote rest and relaxation."
5. "It is important for older adults to have opportunities to develop and maintain friendships."
Correct Answer: 1, 2, 5
Rationale 1: It is important for older adults to engage in activities that promote a sense of self–worth and usefulness.
Rationale 2: Studies have shown that seniors who continue to demonstrate intellectual interaction may have higher cognitive function levels.
Rationale 3: A lack of activity is consistent with a decline in function.
Rationale 4: Retirement may become more a source of stress than "rest and relaxation," as income is reduced. Lack of financial resources can limit activities and lifestyle.
Rationale 5: Developing friendships with people of like interests promote the self-worth and usefulness of older adults.
Global Rationale: It is important for older adults to engage in activities that promote a sense of self-worth and usefulness. Studies have shown that seniors who continue to demonstrate intellectual interaction may have higher cognitive function levels. A lack of activity is consistent with a decline in function. Retirement may become more a source of stress than "rest and relaxation," as income is reduced. Lack of financial resources can limit activities and lifestyle. Developing friendships with people of like interests promote the self-worth and usefulness of older adults.
Cognitive Level: Applying
Client Need: Health Promotion and Maintenance
Client Need Sub:
QSEN Competencies: III.A.5. Explain the role of evidence in determining best clinical practice.
AACN Essentials Competencies: I.1. Integrate theories and concepts from liberal education into nursing practice.
NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care.
Nursing/Integrated Concepts: Nursing Process: Implementation
Learning Outcome: 2.3: Appraise stages of development.
MNL Learning Outcome:
Page Number: pp. 25–41

Question 14
Type: MCSA

Just after an appointment with the health care provider, an older adult client asks the nurse, "Why can't I seem to exercise like I did when I was younger? I just don't have the endurance that I did when I was 45, even though I feel good. The health care provider says I'm in good health and can exercise, but do you think there could be something wrong with me?" Which response by the nurse is the most appropriate?

1. "I think you should discuss this further with the health care provider; maybe you need more tests."

2. "As individuals get older, there are normal changes that occur in the body, specifically the heart and lungs, that may contribute to decreased endurance."

3. "The health care provider cleared you for exercise. I'm sure you are fine."

4. "The body undergoes physiologic changes that can affect your endurance, such as decreased cardiac output and increased residual air volume in the lungs."

Correct Answer: 2

Rationale 1: The nurse should first answer the client's question/concern. It may be appropriate to suggest further discussion with the health care provider if the client isn't satisfied with the nurse's explanation, but suggesting further testing may lead the client to believe the nurse suspects there is something wrong.

Rationale 2: The nurse should explain to the client in simple terms that it is normal in the older years to experience a decrease in endurance due to the physiologic changes that occur with aging. Specifically, the heart becomes stiffer, which affects the pumping action, the valves of the heart become less pliable, leading to decreased filling and emptying, and cardiac output and reserve is decreased. This makes it difficult for the heart to adjust quickly to increased demands. The respiratory system is less efficient. Lungs are stiffer, residual air (space where gas exchange does not occur) is increased, and vital capacity (area where gas exchange does take place) is decreased. The respiratory effort is increased to keep up with oxygen demands. Staying active will help a person build endurance.

Rationale 3: Telling the client, "The health care provider cleared you for exercise. I'm sure you are fine," does not answer the client's questions or address the concern.

Rationale 4: Responding to the client with "The body undergoes physiologic changes that can affect your endurance, such as decreased cardiac output and increased residual air volume in the lungs," is a medical explanation that the client may not understand.

Global Rationale: The nurse should explain to the client in simple terms that it is normal in the older years to experience a decrease in endurance due to the physiologic changes that occur with aging. Specifically, the heart becomes stiffer, which affects the pumping action, the valves of the heart become less pliable, leading to decreased filling and emptying, and cardiac output and reserve is decreased. This makes it difficult for the heart to adjust quickly to increased demands. The respiratory system is less efficient. Lungs are stiffer, residual air (space where gas exchange does not occur) is increased, and vital capacity (area where gas exchange does take place) is decreased. The respiratory effort is increased to keep up with oxygen demands. Staying active will help a person build endurance. The nurse should first answer the client's question/concern. It may be appropriate to suggest further discussion with the health care provider if the client isn't satisfied with the nurse's explanation, but suggesting further testing may lead the client to believe the nurse suspects there is something wrong. Telling the client, "The health care provider cleared you for exercise. I'm sure you are fine," does not answer the client's questions or address the concern. Responding to the client with "The body undergoes physiologic changes that can

affect your endurance, such as decreased cardiac output and increased residual air volume in the lungs," is a medical explanation that the client may not understand.
Cognitive Level: Applying
Client Need: Health Promotion and Maintenance
Client Need Sub:
QSEN Competencies: III.A.5. Explain the role of evidence in determining best clinical practice.
AACN Essentials Competencies: I.1. Integrate theories and concepts from liberal education into nursing practice.
NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care.
Nursing/Integrated Concepts: Nursing Process: Implementation
Learning Outcome: 2.3: Appraise stages of development.
MNL Learning Outcome:
Page Number: pp. 25–41

Question 15
Type: MCSA
The nurse is talking with an older adult client who has recently retired after 45 years of working as an executive at the same company. Which activity demonstrates that the client is adjusting to this new phase of life?
1. The client spends most of the day at home and declines invitations to outside gatherings with friends because there is "so much to do" at home.
2. The client has enrolled in courses at the local university to complete the college degree that was started "years ago," but interrupted by family responsibilities.
3. The client has lunch at the company cafeteria several times each week.
4. The client has purchased hearing aids, but rarely uses them.
Correct Answer: 2
Rationale 1: Spending the day at home and declining outside invitations may be a sign that the client is not adjusting well to retirement.
Rationale 2: Enrolling in college courses is an activity that can be very fulfilling in the older adult years, especially after retirement when there is more time to pursue interests. This can provide a stimulating environment intellectually and socially, as well as give a person a sense of self-worth and accomplishment.
Rationale 3: Eating lunch at the company cafeteria several times a week does not demonstrate a healthy adjustment to retirement.
Rationale 4: Refusing to wear hearing aids may indicate that the client is not adjusting to the physical changes of the older adult years.
Global Rationale: Enrolling in college courses is an activity that can be very fulfilling in the older adult years, especially after retirement when there is more time to pursue interests. This can provide a stimulating environment intellectually and socially, as well as give a person a sense of self-worth and accomplishment. Spending the day at home and declining outside invitations may be a sign that the client is not adjusting well to retirement. Eating lunch at the company cafeteria several times a week does not demonstrate a healthy adjustment to retirement. Refusing to wear hearing aids may indicate that the client is not adjusting to the physical changes of the older adult years.
Cognitive Level: Applying

Client Need: Health Promotion and Maintenance
Client Need Sub:
QSEN Competencies: III.A.5. Explain the role of evidence in determining best clinical practice.
AACN Essentials Competencies: I.1. Integrate theories and concepts from liberal education into nursing practice.
NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care.
Nursing/Integrated Concepts: Nursing Process: Evaluation
Learning Outcome: 2.3: Appraise stages of development.
MNL Learning Outcome:
Page Number: pp. 25–41

Question 16
Type: MCSA
An older adult presents to the clinic for a routine physical examination. The client reports having trouble with memory and often has to "search" for words when having a conversation with friends or family. Which assessment tools will help the nurse to gather more data about this client's concerns?
1. The Denver II.
2. Mini-Mental Status Examination.
3. Life Experiences Survey.
4. Hassles and Uplifts Scale.
Correct Answer: 2
Rationale 1: The Denver II is a screening tool used to assess personal-social, fine motor adaptive, language, and gross motor skills in children between birth and 6 years of age.
Rationale 2: The nurse should use the Mini-Mental Status Examination to gather more information about the cognitive status of this client. This tool is also useful to estimate cognitive impairment as well as to track cognitive changes over time.
Rationale 3: The Life Experiences Survey is used to evaluate the level of stress an individual is experiencing; this is not appropriate for this client's concerns.
Rationale 4: The Hassles and Uplifts Scale measures attitudes about daily situations; it does not screen for cognitive changes.
Global Rationale: The nurse should use the Mini-Mental Status Examination to gather more information about the cognitive status of this client. This tool is also useful to estimate cognitive impairment as well as to track cognitive changes over time. The Denver II is a screening tool used to assess personal-social, fine motor adaptive, language, and gross motor skills in children between birth and 6 years of age. The Life Experiences Survey is used to evaluate the level of stress an individual is experiencing; this is not appropriate for this client's concerns. The Hassles and Uplifts Scale measures attitudes about daily situations; it does not screen for cognitive changes.
Cognitive Level: Understanding
Client Need: Health Promotion and Maintenance
Client Need Sub:
QSEN Competencies: III.A.5. Explain the role of evidence in determining best clinical practice.
AACN Essentials Competencies: IX.3. Implement holistic, patient-centered care that reflects an understanding of human growth and development, pathophysiology, pharmacology, medical

management, and nursing management across the health-illness continuum, across lifespan, and in all healthcare settings.
NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care.
Nursing/Integrated Concepts: Nursing Process: Assessment
Learning Outcome: 2.4: Differentiate between various tools used for measurement of growth and development across the age span.
MNL Learning Outcome: 1.1.1. Identify factors that affect safety across the life span.
Page Number: pp. 41–43

Question 17
Type: MCSA
During a health maintenance visit, the nurse measures the height and weight of an infant and plots the measurements on the growth chart. The nurse notes a slowed growth pattern. Which action by the nurse is the most appropriate at this time?
1. Obtaining an endocrinologist referral.
2. Performing a nutritional assessment.
3. Waiting until the next visit to intervene.
4. Assessing for circulatory problems.
Correct Answer: 2
Rationale 1: Referring the baby to an endocrinologist would be done by the health care provider, not the nurse, as this is outside the nurse's scope of practice.
Rationale 2: The nurse should perform a nutritional assessment because slowed growth is an early indicator of inadequate nutrition. It is expected that the rate of growth will remain consistent throughout infancy.
Rationale 3: The nurse should not wait until the next visit to intervene as early intervention, which commonly involves parent education and support, can often resolve problems.
Rationale 4: Before looking for other causes of slowed growth, the nurse should first assess the baby's nutritional status. Assessing for circulatory problems might follow if adequate nutrition has already been established.
Global Rationale: The nurse should perform a nutritional assessment because slowed growth is an early indicator of inadequate nutrition. It is expected that the rate of growth will remain consistent throughout infancy. Referring the baby to an endocrinologist would be done by the health care provider, not the nurse, as this is outside the nurse's scope of practice. The nurse should not wait until the next visit to intervene as early intervention, which commonly involves parent education and support, can often resolve problems. Before looking for other causes of slowed growth, the nurse should first assess the baby's nutritional status. Assessing for circulatory problems might follow if adequate nutrition has already been established.
Cognitive Level: Analyzing
Client Need: Physiological Integrity
Client Need Sub:
QSEN Competencies: III.A.5. Explain the role of evidence in determining best clinical practice.
AACN Essentials Competencies: IX.3. Implement holistic, patient-centered care that reflects an understanding of human growth and development, pathophysiology, pharmacology, medical management, and nursing management across the health-illness continuum, across lifespan, and in all healthcare settings.

NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care.
Nursing/Integrated Concepts: Nursing Process: Assessment
Learning Outcome: 2.4: Differentiate between various tools used for measurement of growth and development across the age span.
MNL Learning Outcome: 1.1.1. Identify factors that affect safety across the life span.
Page Number: pp. 41–44

Question 18
Type: MCSA
The parent of a preschool-age client voices concerns about potential developmental delays stating that the older sibling reached milestones significantly ahead of the younger child. An assessment reveals the child is able to assist with dressing and can play catch. Based on this assessment finding, which response by the nurse is the most appropriate?
1. "Your child appears to be on target with the expected milestones for age."
2. "Your older child may simply be smarter than your 3 year old."
3. "I would recommend extensive testing to determine the source of the delays."
4. "Have you spoken with the health care provider about these delays?"
Correct Answer: 1
Rationale 1: The developmental tasks of the child are on track for age.
Rationale 2: Advising the parent one child is "smarter" than another is potentially damaging, as well as inappropriate.
Rationale 3: Testing is not warranted at this time, the child is within the norms of development.
Rationale 4: There are not evident delays to review with the healthcare provider.
Global Rationale: The developmental tasks of the child are on track for age. Advising the parent one child is "smarter" than another is potentially damaging, as well as inappropriate. Testing is not warranted at this time, the child is within the norms of development. There are not evident delays to review with the healthcare provider.
Cognitive Level: Understanding
Client Need: Health Promotion and Maintenance
Client Need Sub:
QSEN Competencies: III.A.5. Explain the role of evidence in determining best clinical practice.
AACN Essentials Competencies: IX.3. Implement holistic, patient-centered care that reflects an understanding of human growth and development, pathophysiology, pharmacology, medical management, and nursing management across the health-illness continuum, across lifespan, and in all healthcare settings.
NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care.
Nursing/Integrated Concepts: Nursing Process: Implementation
Learning Outcome: 2.4: Differentiate between various tools used for measurement of growth and development across the age span.
MNL Learning Outcome: 1.1.1. Identify factors that affect safety across the life span.
Page Number: pp. 41–44

Question 19
Type: MCMA

When reviewing the developmental behaviors of an 8-month-old infant, which behaviors are considered age-appropriate?
Standard Text: Select all that apply.
1. Unable to sit for brief periods of time without support.
2. Moro reflex present.
3. Crawling on abdomen.
4. Pulls self to standing position.
5. Positive Babinski reflex.
Correct Answer: 3, 4, 5
Rationale 1: By the age of 8 months the child should be able to sit for brief periods without support. Some children can sit alone well at this age. The child who is unable to sit for short periods alone needs further testing and evaluation.
Rationale 2: The Moro (startle) reflex should disappear between the ages of 4–6 months. The presence of this reflex beyond that age warrants follow-up.
Rationale 3: Around 6 months of age infants begin to crawl on their abdomens, so it is expected that an 8-month-old will do this.
Rationale 4: Some 8-month-old babies may also be able to pull themselves up to a standing position. This is more typical of a 9-month-old.
Rationale 5: The Babinski reflex doesn't begin to fade until 12 months, and is absent by the age of 2 years.
Global Rationale: By the age of 8 months the child should be able to sit for brief periods without support. Some children can sit alone well at this age. The child who is unable to sit for short periods alone needs further testing and evaluation. The Moro (startle) reflex should disappear between the ages of 4–6 months. The presence of this reflex beyond that age warrants follow-up. Around 6 months of age infants begin to crawl on their abdomens, so it is expected that an 8-month-old will do this. Some 8-month-old babies may also be able to pull themselves up to a standing position. This is more typical of a 9-month-old. The Babinski reflex doesn't begin to fade until 12 months, and is absent by the age of 2 years.
Cognitive Level: Applying
Client Need: Health Promotion and Maintenance
Client Need Sub:
QSEN Competencies: III.A.5. Explain the role of evidence in determining best clinical practice.
AACN Essentials Competencies: IX.3. Implement holistic, patient-centered care that reflects an understanding of human growth and development, pathophysiology, pharmacology, medical management, and nursing management across the health-illness continuum, across lifespan, and in all healthcare settings.
NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care.
Nursing/Integrated Concepts: Nursing Process: Assessment
Learning Outcome: 2.4: Differentiate between various tools used for measurement of growth and development across the age span.
MNL Learning Outcome: 1.1.1. Identify factors that affect safety across the life span.
Page Number: pp. 25–29

Question 20
Type: MCSA

The mother of a toddler-age client expresses concern about the child's lower back curving in and the child's belly sticking out. Which action by the nurse is appropriate?
1. Suggest that the mother to buy the child bigger clothes.
2. Give the mother the first available appointment to see the health care provider.
3. Contact the health care provider to see if an orthopedic referral is necessary.
4. Reassure the mother that this is normal for a toddler.
Correct Answer: 4
Rationale 1: Suggesting that the mother buy her child larger clothes does not address her concern that there is something abnormal with her child.
Rationale 2: The mother is describing a normal finding in a toddler; therefore a visit with the health care provider is not needed.
Rationale 3: There is no need for the nurse to consult with the health care provider or consider orthopedic referral since this is a normal finding in a toddler.
Rationale 4: The mother is describing toddler lordosis (a curving in of the lower back, which produces a potbelly). This is a normal finding in this age group and resolves as the abdominal muscles develop and pull the abdomen in.
Global Rationale: Young toddlers have pronounced lordosis, which makes their abdomens protrude. This is a normal finding, and the mother should be reassured of this. Suggesting that the mother buy her child larger clothes does not address her concern that there is something abnormal with her child. The mother is describing a normal finding in a toddler; therefore a visit with the health care provider is not needed. There is no need for the nurse to consult with the health care provider or consider orthopedic referral since this is a normal finding in a toddler.
Cognitive Level: Applying
Client Need: Health Promotion and Maintenance
Client Need Sub:
QSEN Competencies: III.A.5. Explain the role of evidence in determining best clinical practice.
AACN Essentials Competencies: IX.3. Implement holistic, patient-centered care that reflects an understanding of human growth and development, pathophysiology, pharmacology, medical management, and nursing management across the health-illness continuum, across lifespan, and in all healthcare settings.
NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care.
Nursing/Integrated Concepts: Nursing Process: Implementation
Learning Outcome: 2.5: Examine growth and development in relation to health assessment.
MNL Learning Outcome: 1.1.1. Identify factors that affect safety across the life span.
Page Number: pp. 29–31

Question 21
Type: MCSA
The mother of a 5-month-old infant calls the pediatric clinic to report tremors in the infant's extremities and chin. Which action by the nurse is the most appropriate?
1. Reassure the mother that these tremors are a normal part of the infant's development.
2. Give the mother the first available appointment to see the health care provider.
3. Contact the health care provider to see if an electroencephalogram (EEG) should be ordered.
4. Ask the mother to keep a diary of the tremors and schedule an appointment for next week.
Correct Answer: 1

Rationale 1: Tremors of the extremities or chin of an infant are normal and reflect immature myelinization. This will disappear by 1 year of age as the nervous system continues to develop and myelinization of the efferent pathways matures.
Rationale 2: It is not necessary for the infant to be seen on an urgent basis; this is a normal phase of development.
Rationale 3: It is not necessary to consult the health care provider to discuss possible EEG as this is not indicative of seizure activity, but rather the result of an immature but normal nervous system.
Rationale 4: It is not necessary for the mother to record these tremors or see the health care provider since this is normal for a child of this age.
Global Rationale: Tremors of the extremities or chin of an infant are normal and reflect immature myelinization. This will disappear by 1 year of age as the nervous system continues to develop and myelinization of the efferent pathways matures. It is not necessary for the infant to be seen on an urgent basis; this is a normal phase of development. It is not necessary to consult the health care provider to discuss possible EEG as this is not indicative of seizure activity, but rather the result of an immature but normal nervous system. It is not necessary for the mother to record these tremors or see the health care provider since this is normal for a child of this age.
Cognitive Level: Applying
Client Need: Health Promotion and Maintenance
Client Need Sub:
QSEN Competencies: III.A.5. Explain the role of evidence in determining best clinical practice.
AACN Essentials Competencies: IX.3. Implement holistic, patient-centered care that reflects an understanding of human growth and development, pathophysiology, pharmacology, medical management, and nursing management across the health-illness continuum, across lifespan, and in all healthcare settings.
NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care.
Nursing/Integrated Concepts: Nursing Process: Implementation
Learning Outcome: 2.5: Examine growth and development in relation to health assessment.
MNL Learning Outcome: 1.1.1. Identify factors that affect safety across the life span.
Page Number: pp. 25–29

Question 22
Type: MCSA
The parent of a preschool-aged client expresses concern that the client cannot ride a tricycle. Which action by the nurse is the most appropriate?
1. Reassure the father that this is normal.
2. Refer the child to the health care provider.
3. Perform further growth and development assessments.
4. Ask the father about any siblings and at what age they rode a tricycle.
Correct Answer: 3
Rationale 1: While the child may not be developmentally delayed, simply reassuring the father that this is normal without further assessment is not an appropriate action by the nurse.
Rationale 2: By first performing further growth and developmental assessments the nurse is better informed as to the need and urgency of a referral to the health care provider.

Rationale 3: The nurse should perform further growth and development assessments, as gross and fine motor development undergo rapid development during the toddler years (ages 1–3). A preschool-aged child (ages 3–5) should be able to pedal a tricycle, a major accomplishment typically mastered at the end of the toddler years.
Rationale 4: Before gathering information about other children in the family and their developmental milestones, this child should be thoroughly assessed.
Global Rationale: The nurse should perform further growth and development assessments, as gross and fine motor development undergo rapid development during the toddler years (ages 1–3). A preschool-aged child (ages 3–5) should be able to pedal a tricycle, a major accomplishment typically mastered at the end of the toddler years. While the child may not be developmentally delayed, simply reassuring the father that this is normal without further assessment is not an appropriate action by the nurse. By first performing further growth and developmental assessments the nurse is better informed as to the need and urgency of a referral to the health care provider. Before gathering information about other children in the family and their developmental milestones, this child should be thoroughly assessed.
Cognitive Level: Applying
Client Need: Health Promotion and Maintenance
Client Need Sub:
QSEN Competencies: III.A.5. Explain the role of evidence in determining best clinical practice.
AACN Essentials Competencies: IX.3. Implement holistic, patient-centered care that reflects an understanding of human growth and development, pathophysiology, pharmacology, medical management, and nursing management across the health-illness continuum, across lifespan, and in all healthcare settings.
NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care.
Nursing/Integrated Concepts: Nursing Process: Assessment
Learning Outcome: 2.5: Examine growth and development in relation to health assessment.
MNL Learning Outcome: 1.1.1. Identify factors that affect safety across the life span.
Page Number: pp. 31–32

Question 23
Type: MCSA
The nurse is counseling the parents an adolescent client who is experiencing behavioral problems. Which assessment tool would be appropriate for the nurse to use to further assess this adolescent?
1. Family Psychosocial Screening.
2. Eyeburg Child Behavior Inventory.
3. Ages and Stages Questionnaire.
4. Child Development Inventory.
Correct Answer: 2
Rationale 1: The Family Psychosocial Screening is a tool that helps to identify psychosocial risk factors associated with developmental problems, such as parental history of physical abuse as a child, parental substance abuse, and maternal depression.
Rationale 2: The Eyeburg Child Behavior Inventory is a parent report scale of conduct problems in children ages 2 to 16 and would be the best choice for the nurse in this situation.

Rationale 3: The Ages and Stages Questionnaire is a tool that covers developmental areas of communication, gross and fine motor, and problem solving, not behavior.
Rationale 4: The Child Development Inventory is used to measure development in children between the ages of 15 months to 6 years and is not appropriate for a young teenager.
Global Rationale: The Eyeburg Child Behavior Inventory is a parent report scale of conduct problems in children ages 2 to 16 and would be the best choice for the nurse in this situation. The Family Psychosocial Screening is a tool that helps to identify psychosocial risk factors associated with developmental problems, such as parental history of physical abuse as a child, parental substance abuse, and maternal depression. The Ages and Stages Questionnaire is a tool that covers developmental areas of communication, gross and fine motor, and problem solving, not behavior. The Child Development Inventory is used to measure development in children between the ages of 15 months to 6 years and is not appropriate for a young teenager.
Cognitive Level: Applying
Client Need: Health Promotion and Maintenance
Client Need Sub:
QSEN Competencies: III.A.5. Explain the role of evidence in determining best clinical practice.
AACN Essentials Competencies: IX.3. Implement holistic, patient-centered care that reflects an understanding of human growth and development, pathophysiology, pharmacology, medical management, and nursing management across the health-illness continuum, across lifespan, and in all healthcare settings.
NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care.
Nursing/Integrated Concepts: Nursing Process: Assessment
Learning Outcome: 2.5: Examine growth and development in relation to health assessment.
MNL Learning Outcome: 1.1.1. Identify factors that affect safety across the life span.
Page Number: pp. 35–37; 41–42

Question 24
Type: MCMA
The nurse is assessing a young adult client in the clinic who presents for a routine health examination. Which interventions does the nurse anticipate for this client?
Standard Text: Select all that apply.
1. Counseling on injury prevention.
2. Measles, muscles, rubella (MMR) vaccination.
3. Counseling on fluoride supplements.
4. Information on diet and exercise.
5. Fecal occult blood test.
Correct Answer: 1, 2, 3, 4
Rationale 1: Counseling on injury prevention is part of the periodic health exam of the young adult.
Rationale 2: Counseling on recommended immunizations. Young adults should receive a Td booster if it has been more than 10 years since the last booster. An MMR is appropriate for the pediatric client.
Rationale 3: Counseling on the use of fluoride toothpaste to deter tooth decay is included in the periodic health exam of the young adult.

Rationale 4: Information on diet and exercise is part of the periodic health exam of the young adult.
Rationale 5: Fecal occult blood testing is not routinely done until adults reach middle age (> 50 years of age).
Global Rationale: Interventions for periodic health examinations for young adults include counseling on injury prevention, counseling on dental health and the regular use of a toothpaste containing fluoride, counseling on recommended immunizations, which include tetanus/diphtheria booster (Td) if none in the past 10 years, and information on diet and exercise. Fecal occult blood testing is not routinely done until adults reach middle age (> 50 years of age).
Cognitive Level: Applying
Client Need: Health Promotion and Maintenance
Client Need Sub:
QSEN Competencies: III.A.5. Explain the role of evidence in determining best clinical practice.
AACN Essentials Competencies: IX.3. Implement holistic, patient-centered care that reflects an understanding of human growth and development, pathophysiology, pharmacology, medical management, and nursing management across the health-illness continuum, across lifespan, and in all healthcare settings.
NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care.
Nursing/Integrated Concepts: Nursing Process: Implementation
Learning Outcome: 2.5: Examine growth and development in relation to health assessment.
MNL Learning Outcome: 1.1.1. Identify factors that affect safety across the life span.
Page Number: p. 37

Question 25
Type: MCMA
Which assessment findings in an older adult client does the nurse associate with the normal aging process?
Standard Text: Select all that apply.
1. Increased systolic blood pressure.
2. Increased muscle tone.
3. Decreased cardiac output.
4. Increased vital capacity.
5. Decreased renal function.
Correct Answer: 1, 3, 5
Rationale 1: Systolic blood pressure increases due to a decrease in the elasticity of the arteries and increased peripheral vascular resistance.
Rationale 2: Muscle tone is decreased.
Rationale 3: Cardiac output is diminished due to alteration in pumping action as the heart muscle thickens.
Rationale 4: Respiratory vital capacity is decreased as the lungs become stiffer and less efficient.
Rationale 5: Renal function decreases as blood flow to the kidneys is affected by arteriosclerotic changes and a decrease in the number of nephrons.
Global Rationale: The older adult experiences a normal decline in body function. Systolic blood pressure increases due to a decrease in the elasticity of the arteries and increased peripheral

vascular resistance. Cardiac output is diminished due to alteration in pumping action, as the heart muscle thickens. Renal function decreases as blood flow to the kidneys is affected by arteriosclerotic changes and a decrease in the number of nephrons. Respiratory vital capacity is decreased as the lungs become stiffer and less efficient. Muscle tone is decreased.
Cognitive Level: Remembering
Client Need: Health Promotion and Maintenance
Client Need Sub:
QSEN Competencies: III.A.5. Explain the role of evidence in determining best clinical practice.
AACN Essentials Competencies: IX.3. Implement holistic, patient-centered care that reflects an understanding of human growth and development, pathophysiology, pharmacology, medical management, and nursing management across the health-illness continuum, across lifespan, and in all healthcare settings.
NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care.
Nursing/Integrated Concepts: Nursing Process: Assessment
Learning Outcome: 2.5: Examine growth and development in relation to health assessment.
MNL Learning Outcome: 1.1.1. Identify factors that affect safety across the life span.
Page Number: pp. 39–41

Question 26
Type: MCSA
The nurse is counseling a middle-aged couple regarding hormonal shifts that occur during middle age. His wife has told him that both men and women experience decreasing hormonal production during middle adulthood, and he asks the nurse if this is true. Which response by the nurse is the most appropriate?
1. "Your wife has obtained some incorrect data."
2. "Why do you ask?"
3. "Your hormonal levels increase, not decrease with age."
4. "Your wife is correct. Both men and women experience a decrease in hormone production with aging."
Correct Answer: 4
Rationale 1: The statement by the nurse, "Your wife is correct, both men and women experience a decrease in hormone production with aging" accurately describes changes that take place in the middle-age years.
Rationale 2: Responding by asking another question such as "Why do you ask?" does not answer the initial question asked by the husband of the couple. It is most appropriate for the nurse to answer the husband's question first and later explore his concerns.
Rationale 3: Hormone levels in men and women do not increase with aging.
Rationale 4: The statement by the nurse, "Your wife is correct, both men and women experience a decrease in hormone production with aging" accurately describes changes that take place in the middle-age years. During menopause, which usually occurs between ages 40 and 55, the ovaries decrease in size, and the uterus becomes smaller and firmer. Progesterone is not produced and estrogen levels fall. Men also have a decrease in hormonal production and experience a gradual decrease in testosterone.
Global Rationale: The statement by the nurse, "Your wife is correct, both men and women experience a decrease in hormone production with aging" accurately describes changes that take

place in the middle-age years. During menopause, which usually occurs between ages 40 and 55, the ovaries decrease in size, and the uterus becomes smaller and firmer. Progesterone is not produced and estrogen levels fall. Men also have a decrease in hormonal production and experience a gradual decrease in testosterone. Hormone levels in men and women do not increase with aging. Responding by asking another question such as "Why do you ask?" does not answer the initial question asked by the husband of the couple. It is most appropriate for the nurse to answer the husband's question first and later explore his concerns.
Cognitive Level: Applying
Client Need: Health Promotion and Maintenance
Client Need Sub:
QSEN Competencies: I.B.3. Provide patient-centered care with sensitivity and respect for the diversity of human experience.
AACN Essentials Competencies: IX.3. Implement holistic, patient-centered care that reflects an understanding of human growth and development, pathophysiology, pharmacology, medical management, and nursing management across the health-illness continuum, across lifespan, and in all healthcare settings.
NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care.
Nursing/Integrated Concepts: Nursing Process: Implementation
Learning Outcome: 2.6: Appraise factors that influence growth and development.
MNL Learning Outcome:
Page Number: pp. 37–39

Question 27
Type: MCSA
A Cuban-American infant is admitted to the pediatric unit for observation. When assessing the family's interactions the nurse notes the mother does all the care of the child while the father seems detached from the infant. Which nursing diagnosis is the most appropriate for this situation?
1. Family Processes; Dysfunctional.
2. Role Performance; Ineffective.
3. Violence; Other-Directed, Risk for.
4. Family Processes; Readiness for Enhanced.
Correct Answer: 4
Rationale 1: The family is operating and coping within the norm of its Cuban American culture; therefore, 'family processes; dysfunctional' is not an appropriate nursing diagnosis for this infant and family.
Rationale 2: The role functions of the parents are not altered and are culturally appropriate with the mother being the infant's primary caretaker.
Rationale 3: The nurse must be cognizant of a client's cultural norms in order to accurately make assessments and determine real or potential problems. There is nothing to suggest a risk for family violence.
Rationale 4: The readiness for enhanced family processes is by definition a pattern of family functioning that is sufficient to support the well-being of family members and can be strengthened. Paternal and maternal attachment differs among cultures. In the Cuban American culture, the mother is the primary caregiver and bonds with the child earlier and continually,

while the father remains detached from infant care and begins attachment behaviors only when the child is able to walk and communicate.
Global Rationale: The readiness for enhanced family processes is by definition a pattern of family functioning that is sufficient to support the well-being of family members and can be strengthened. Paternal and maternal attachment differs among cultures. In the Cuban American culture, the mother is the primary caregiver and bonds with the child earlier and continually, while the father remains detached from infant care and begins attachment behaviors only when the child is able to walk and communicate. The family is operating and coping within the norm of its Cuban American culture; therefore, compromised family coping is not an appropriate nursing diagnosis for this infant and family. The role functions of the parents are not altered and are culturally appropriate with the mother being the infant's primary caretaker. And finally, the nurse must be cognizant of a client's cultural norms in order to accurately make assessments and determine real or potential problems. There is nothing to suggest a risk for family violence.
Cognitive Level: Applying
Client Need: Psychosocial Integrity
Client Need Sub:
QSEN Competencies: I.B.3. Provide patient-centered care with sensitivity and respect for the diversity of human experience.
AACN Essentials Competencies: IX.3. Implement holistic, patient-centered care that reflects an understanding of human growth and development, pathophysiology, pharmacology, medical management, and nursing management across the health-illness continuum, across lifespan, and in all healthcare settings.
NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care.
Nursing/Integrated Concepts: Nursing Process: Diagnosis
Learning Outcome: 2.6: Appraise factors that influence growth and development.
MNL Learning Outcome:
Page Number: p. 44

Question 28
Type: MCSA
The nurse is completing discharge teaching to the family of a hospitalized older adult client. Which is the priority to include in the teaching plan for this family?
1. Reducing the amount of odor in the client's immediate environment.
2. Protecting the client from injury due to increased pain threshold.
3. Speaking in an increasingly loud voice as client's hearing decreases.
4. Avoiding range of motion exercises due to loss of bone density and increased risk for fracture.
Correct Answer: 2
Rationale 1: The sense of smell decreases with age; reducing the amount of odor in the client's immediate environment is not a priority.
Rationale 2: Protecting the client from injury is the most important teaching point. In the older adult there is an increased threshold for the sensation of pain and touch, as well as a decrease in reaction time.
Rationale 3: Older adults experience a gradual loss of hearing; speaking at a level that the client can hear is important, but not above protection from injury.

Rationale 4: Range of motion should be encouraged to facilitate mobility and is not a risk factor for fractures.
Global Rationale: Protecting the client from injury is the most important teaching point. In the older adult there is an increased threshold for the sensation of pain and touch, as well as a decrease in reaction time. The sense of smell decreases with age; reducing the amount of odor in the client's immediate environment is not a priority. Older adults experience a gradual loss of hearing; speaking at a level that the client can hear is important, but not above protection from injury. Range of motion should be encouraged to facilitate mobility and is not a risk factor for fractures.
Cognitive Level: Applying
Client Need: Health Promotion and Maintenance
Client Need Sub:
QSEN Competencies: I.B.3. Provide patient-centered care with sensitivity and respect for the diversity of human experience.
AACN Essentials Competencies: IX.3. Implement holistic, patient-centered care that reflects an understanding of human growth and development, pathophysiology, pharmacology, medical management, and nursing management across the health-illness continuum, across lifespan, and in all healthcare settings.
NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care.
Nursing/Integrated Concepts: Nursing Process: Implementation
Learning Outcome: 2.6: Appraise factors that influence growth and development.
MNL Learning Outcome:
Page Number: p. 43

Question 29
Type: MCSA
The nurse is caring for a hospitalized infant. When the infant begins to cry, the parents report they do not believe in responding too rapidly, as they do not wish to spoil their child. Which response by the nurse is most appropriate?
1. "I agree with your philosophy of child rearing."
2. "There are many studies that support this belief."
3. "Responding quickly to your baby's cries will assist the baby in feeling secure and does not result in a spoiled child."
4. "Children who experience separation anxiety have been spoiled by their parents."
Correct Answer: 3
Rationale 1: The nurse should not be offering personal beliefs or philosophies to clients or their families.
Rationale 2: Concern over "spoiling" infants by promptly responding to their cries is no longer an accepted concept. Research has shown that infants whose mothers respond promptly to their cries during the early months of life cry less at 1 year of age.
Rationale 3: A timely response to infant crying does not result in a spoiled child. It promotes the infant's sense of security and promotes independence during later stages of development.
Rationale 4: Children who have received inconsistent nurturing may experience clingy, angry, or distrustful behaviors.

Global Rationale: A timely response to infant crying does not result in a spoiled child. It promotes the infant's sense of security and promotes independence during later stages of development. The nurse should not be offering personal beliefs or philosophies to clients or their families. Concern over "spoiling" infants by promptly responding to their cries is no longer an accepted concept. Research has shown that infants whose mothers respond promptly to their cries during the early months of life cry less at 1 year of age. Children who have received inconsistent nurturing may experience clingy, angry, or distrustful behaviors.
Cognitive Level: Applying
Client Need: Health Promotion and Maintenance
Client Need Sub:
QSEN Competencies: I.B.3. Provide patient-centered care with sensitivity and respect for the diversity of human experience.
AACN Essentials Competencies: IX.3. Implement holistic, patient-centered care that reflects an understanding of human growth and development, pathophysiology, pharmacology, medical management, and nursing management across the health-illness continuum, across lifespan, and in all healthcare settings.
NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care.
Nursing/Integrated Concepts: Nursing Process: Implementation
Learning Outcome: 2.6: Appraise factors that influence growth and development.
MNL Learning Outcome:
Page Number: pp. 25–29

Question 30
Type: MCSA
The nurse is explaining the influence of culture on growth and development to a group of expectant first-time parents. Which expectant parent statement indicates the need for further teaching?
1. "Mothers and fathers should always share in the responsibilities of caring for a new baby."
2. "Culture may influence the rate at which developmental milestones occur."
3. "The ways in which children are disciplined may vary among cultures."
4. "The value of education varies among cultures."
Correct Answer: 1
Rationale 1: Family roles differ among cultures. While it is customary among Caucasian parents to bond with the infant early in the neonatal period, it is the mother who bonds with the infant in the Cuban American culture.
Rationale 2: Developmental milestones can be affected by culture; for example, African American toddlers have been found to develop some motor skills earlier than Caucasian toddlers.
Rationale 3: The discipline of children varies among cultures.
Rationale 4: The value of education varies among cultures.
Global Rationale: Family roles differ among cultures. While it is customary among Caucasian parents to bond with the infant early in the neonatal period, it is the mother who bonds with the infant in the Cuban American culture. Developmental milestones can be affected by culture; for example, African American toddlers have been found to develop some motor skills earlier than Caucasian toddlers. The discipline of children varies among cultures. The value of education varies among cultures.

Cognitive Level: Applying
Client Need: Health Promotion and Maintenance
Client Need Sub:
QSEN Competencies: I.B.3. Provide patient-centered care with sensitivity and respect for the diversity of human experience.
AACN Essentials Competencies: IX.3. Implement holistic, patient-centered care that reflects an understanding of human growth and development, pathophysiology, pharmacology, medical management, and nursing management across the health-illness continuum, across lifespan, and in all healthcare settings.
NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care.
Nursing/Integrated Concepts: Nursing Process: Implementation
Learning Outcome: 2.6: Appraise factors that influence growth and development.
MNL Learning Outcome:
Page Number: p. 44