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

Chapter 2 Physical Examination Strategies

MULTIPLE CHOICE

1. When performing a physical assessment, the first technique the nurse will always use is:

a. Palpation.

b. Inspection.

c. Percussion.

d. Auscultation.

ANS: B

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

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

a. Usually yields little information.

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

c. May be somewhat uncomfortable for the expert practitioner.

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

ANS: B

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

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

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

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

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

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

ANS: B

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

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

a. Palpation

b. Inspection

c. Percussion

d. Auscultation

ANS: A

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

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

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

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

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

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

ANS: D

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

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

a. Palpating the thorax of an infant

b. Palpating the kidneys and uterus

c. Assessing pulsations and vibrations

d. Assessing the presence of tenderness and pain

ANS: B

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

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

a. Turgor

b. Texture

c. Density

d. Consistency

ANS: C

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

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

a. Percussing once over each area

b. Quickly lifting the striking finger after each stroke

c. Striking with the fingertip, not the finger pad

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

ANS: A

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

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

a. Consider this a normal finding.

b. Palpate this area for an underlying mass.

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

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

ANS: A

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

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

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

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

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

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

ANS: C

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

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

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

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

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

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

ANS: D

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

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

a. Count the patients respirations.

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

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

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

ANS: B

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

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

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

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

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

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

ANS: B

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

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

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

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

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

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

ANS: A

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

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

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

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

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

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

ANS: D

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

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

a. Palpation

b. Inspection

c. Percussion

d. Auscultation

ANS: A

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

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

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

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

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

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

ANS: D

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

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

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

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

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

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

ANS: D

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

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

a. Auscultate over the area with a fetoscope.

b. Use a goniometer to measure the pulsations.

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

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

ANS: C

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

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

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

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

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

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

ANS: D

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

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

a. Appear unhurried and confident when examining him.

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

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

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

ANS: A

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

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

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

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

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

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

ANS: B

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

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

a. Washing hands, and contacting the physician

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

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

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

ANS: C

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

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

a. Your atrial dysrhythmias are under control.

b. You have pitting edema and mild varicosities.

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

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

ANS: C

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

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

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

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

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

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

ANS: B

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

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

a. When the infant is sleeping

b. At the end of the examination

c. Before auscultation of the thorax

d. Halfway through the examination

ANS: B

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

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

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

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

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

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

ANS: A

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

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

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

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

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

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

ANS: A

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

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

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

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

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

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

ANS: C

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

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

a. Asking questions enhances the childs autonomy

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

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

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

ANS: D

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

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

a. Infant

b. Preschool child

c. School-age child

d. Adolescent

ANS: B

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

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

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

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

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

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

ANS: B

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

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

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

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

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

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

ANS: D

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

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

a. Avoid touching the patient too much.

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

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

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

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

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

a. Wear protective eye wear at all times.

b. Wear gloves during any and all contact with patients.

c. Wash hands before and after contact with each patient.

d. Clean the stethoscope with an alcohol swab between patients.

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

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

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

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

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

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

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

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

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

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

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

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

ANS: D

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

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

a. Ear

b. Nose

c. Throat

d. Abdomen

ANS: D

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

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

a. Electrocardiogram

b. Bell of the stethoscope

c. Diaphragm of the stethoscope

d. Palpation with the nurses palm of the hand

ANS: B

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

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

a. Constipation.

b. Air-filled areas.

c. Presence of a tumor.

d. Presence of dense organs.

ANS: B

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

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

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

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

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

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

ANS: C

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

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

a. Document the findings in the patients record.

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

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

d. Ask another nurse to double check the finding.

ANS: D

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

MULTIPLE RESPONSE

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

a. Warm the hands first before touching the patient.

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

c. Start with light palpation to detect surface characteristics.

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

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

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

ANS: A, C, D, E

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