Skills in Clinical Nursing 8th edition Berman Test Bank

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Berman/Snyder, Test Bank for *Skills in Clinical Nursing* 8th Edition
Chapter 2

Question 1
Type: MCSA

The client has an elevated temperature. Which statement is the most clinically appropriate for the nurse to use when documenting this finding in the medical record?

1. The client is fever.

2. The client is febrile.

3. The client is hyperpyrexia.

4. The client is hyperthermia.

Correct Answer: 2

Rationale 1: The client is febrile. The client has a fever, hyperpyrexia, and hyperthermia.

Rationale 2: The client is febrile. The client has a fever, hyperpyrexia, and hyperthermia.

Rationale 3: The client is febrile. The client has a fever, hyperpyrexia, and hyperthermia.

Rationale 4: The client is febrile. The client has a fever, hyperpyrexia, and hyperthermia.

Global Rationale: The client is febrile. The client has a fever, hyperpyrexia, and hyperthermia.

Cognitive Level: Analyzing
Client Need: Physiological Integrity
Client Need Sub: Physiological Adaptation
QSEN Competencies: II.B.3. Base individualized care plan on client values, clinical expertise, and evidence
AACN Essential Competencies: III.1. Explain the interrelationships among theory, practice, and research
NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe client care
Nursing/Integrated Concepts: Nursing Process: Implementation
Learning Outcome: Define the key terms used in the skills of measuring vital signs.
Page Number: p. 26

Question 2
Type: MCSA

The nurse assesses the client in respiratory distress and notes that the client has see-saw respirations with the chest and abdomen alternately rising, blue discoloration of the fingertips, and noisy difficult respirations. How would the nurse describe the client's condition when calling the health care provider?

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1. Client is tachypneic with costal breathing and cyanosis.

2. Client is bradycardic with diaphragmatic breathing and cyanosis.

3. Client is demonstrating diaphragmatic breathing, and is dyspneic and cyanotic.

4. Client is demonstrating diaphragmatic breathing with audible Korotkoff's sounds.

Correct Answer: 3

Rationale 1: The use of the abdominal muscles for respiration indicates diaphragmatic breathing. The difficult respirations would be described as dyspnea, and the blue discoloration of the fingertips is cyanosis. The client's respiratory rate is unknown, so she cannot be described as tachypneic. Bradycardia is a slow heart rate, and the client's pulse is unknown.

Rationale 2: The use of the abdominal muscles for respiration indicates diaphragmatic breathing. The difficult respirations would be described as dyspnea, and the blue discoloration of the fingertips is cyanosis. The client's respiratory rate is unknown, so she cannot be described as tachypneic. Bradycardia is a slow heart rate, and the client's pulse is unknown.

Rationale 3: The use of the abdominal muscles for respiration indicates diaphragmatic breathing. The difficult respirations would be described as dyspnea, and the blue discoloration of the fingertips is cyanosis. The client's respiratory rate is unknown, so she cannot be described as tachypneic. Bradycardia is a slow heart rate, and the client's pulse is unknown.

Rationale 4: The use of the abdominal muscles for respiration indicates diaphragmatic breathing. The difficult respirations would be described as dyspnea, and the blue discoloration of the fingertips is cyanosis. The client's respiratory rate is unknown, so she cannot be described as tachypneic. Bradycardia is a slow heart rate, and the client's pulse is unknown.

Global Rationale: The use of the abdominal muscles for respiration indicates diaphragmatic breathing. The difficult respirations would be described as dyspnea, and the blue discoloration of the fingertips is cyanosis. The client's respiratory rate is unknown, so she cannot be described as tachypneic. Bradycardia is a slow heart rate, and the client's pulse is unknown.

Cognitive Level: Applying
Client Need: Physiological Integrity
Client Need Sub: Physiological Adaptation
QSEN Competencies: II.B.3. Base individualized care plan on client values, clinical expertise, and evidence
AACN Essential Competencies: III.1. Explain the interrelationships among theory, practice, and research
NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe client care
Nursing/Integrated Concepts: Nursing Process: Assessment
Learning Outcome: Define the key terms used in the skills of measuring vital signs.
Page Number: pp. 37-40

Question 3

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Type: MCSA

The nurse is informed during shift report that the assigned client has a wide pulse pressure, is hypertensive, and has a pulse deficit. When the nurse enters the client's room, which assessments would the nurse perform in order to confirm this report?

1. Blood pressure and apical pulse assessments

2. Blood pressure and radial pulse assessment

3. Blood pressure and respiratory rate assessment

4. Blood pressure and radial-apical pulse assessment

Correct Answer: 4

Rationale 1: In order to assess a pulse deficit, defined as a discrepancy between the apical and radial pulse rate, the nurse must perform an apical–radial pulse assessment. Wide pulse pressure and hypertension would be assessed by measuring blood pressure.

Rationale 2: In order to assess a pulse deficit, defined as a discrepancy between the apical and radial pulse rate, the nurse must perform an apical–radial pulse assessment. Wide pulse pressure and hypertension would be assessed by measuring blood pressure.

Rationale 3: In order to assess a pulse deficit, defined as a discrepancy between the apical and radial pulse rate, the nurse must perform an apical–radial pulse assessment. Wide pulse pressure and hypertension would be assessed by measuring blood pressure.

Rationale 4: In order to assess a pulse deficit, defined as a discrepancy between the apical and radial pulse rate, the nurse must perform an apical–radial pulse assessment. Wide pulse pressure and hypertension would be assessed by measuring blood pressure.

Global Rationale: In order to assess a pulse deficit, defined as a discrepancy between the apical and radial pulse rate, the nurse must perform an apical–radial pulse assessment. Wide pulse pressure and hypertension would be assessed by measuring blood pressure.

Cognitive Level: Analyzing
Client Need: Physiological Integrity
Client Need Sub: Physiological Adaptation
QSEN Competencies: II.B.3. Base individualized care plan on client values, clinical expertise, and evidence
AACN Essential Competencies: III.1. Explain the interrelationships among theory, practice, and research
NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe client care
Nursing/Integrated Concepts: Nursing Process: Assessment
Learning Outcome: Define the key terms used in the skills of measuring vital signs.
Page Number: pp. 36, 40-41

Question 4

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Skills in Clinical Nursing 8th edition Berman Test Bank

Type: MCSA

When might it be inappropriate for the nurse to assess a client's vital signs?

1. When a client has a change in health status

2. Upon admitting the client to the facility

3. Before and after the client ambulates

4. When a terminal client with a do-not-resuscitate order has a change in condition

Correct Answer: 4

Rationale 1: When caring for a terminal client who has a do-not-resuscitate order, the nurse might not need to assess vital signs when his condition changes if it will not impact the plan of care and death is imminent. In all of the other situations, vital signs should be measured.

Rationale 2: When caring for a terminal client who has a do-not-resuscitate order, the nurse might not need to assess vital signs when his condition changes if it will not impact the plan of care and death is imminent. In all of the other situations, vital signs should be measured.

Rationale 3: When caring for a terminal client who has a do-not-resuscitate order, the nurse might not need to assess vital signs when his condition changes if it will not impact the plan of care and death is imminent. In all of the other situations, vital signs should be measured.

Rationale 4: When caring for a terminal client who has a do-not-resuscitate order, the nurse might not need to assess vital signs when his condition changes if it will not impact the plan of care and death is imminent. In all of the other situations, vital signs should be measured.

Global Rationale: When caring for a terminal client who has a do-not-resuscitate order, the nurse might not need to assess vital signs when his condition changes if it will not impact the plan of care and death is imminent. In all of the other situations, vital signs should be measured.

Cognitive Level: Remembering
Client Need: Physiological Integrity
Client Need Sub: Reduction of Risk Potential
QSEN Competencies: II.B.3. Base individualized care plan on client values, clinical expertise, and evidence
AACN Essential Competencies: IX.1. Conduct comprehensive and focused physical, behavioral, psychological, spiritual, socioeconomic, and environmental assessments of health and illness parameters in clients, using developmentally and culturally appropriate approaches
NLN Competencies: Context and Environment: Health promotion/disease prevention
Nursing/Integrated Concepts: Nursing Process: Planning
Learning Outcome: Identify the indications for measuring and assessing:
a. Temperature.
b. Pulse.
c. Respirations.
d. Blood pressure.
e. Oxygen saturation.
Page Number: pp. 21-22

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Question 5
Type: SEQ

The nurse is caring for several clients. Rank the order in which the nurse would assess vital signs for these clients.

Standard Text: Click on the down arrow for each response in the right column and select the correct choice from the list.

Response 1. Client who is returning from the operating room after abdominal surgery

Response 2. Client who will walk the hallway for the first time

Response 3. Client who was febrile and required an antipyretic medication 1 hour ago

Response 4. Client who is to be discharged this morning

Correct Answer: 1,3,2,4

Rationale 1: The client returning from the operating room after abdominal surgery would be the client the nurse would assess first.

Rationale 2: The client who is walking down the hallway for the first time would be assessed third.

Rationale 3: The client who is febrile and required antipyretic medication an hour ago would be assessed second.

Rationale 4: The client who is being discharged is the most stable, and the nurse would assess this client last.

Global Rationale: The client returning from the operating room after abdominal surgery would be the client the nurse would assess first. The client who is febrile and required antipyretic medication an hour ago would be assessed second. The client who is walking down the hallway for the first time would be assessed third. The client who is being discharged is the most stable, so the nurse would assess this client last.

Cognitive Level: Applying
Client Need: Safe and Effective Care Environment
Client Need Sub: Management of Care
QSEN Competencies: II.B.3. Base individualized care plan on client values, clinical expertise, and evidence
AACN Essential Competencies: IX.1. Conduct comprehensive and focused physical, behavioral, psychological, spiritual, socioeconomic, and environmental assessments of health and illness parameters in clients, using developmentally and culturally appropriate approaches
NLN Competencies: Context and Environment: Health promotion/disease prevention
Nursing/Integrated Concepts: Nursing Process: Planning
Learning Outcome: Identify the indications for measuring and assessing:
a. Temperature.
b. Pulse.
c. Respirations.
d. Blood pressure.
e. Oxygen saturation.
Page Number: pp. 21-22

Question 6

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Type: MCSA

The nurse working night shift recognizes the value of allowing clients to sleep uninterrupted whenever possible. Which client would the nurse wake to assess vital signs?

1. Postoperative client who had surgery 5 days ago and will be discharged in the morning

2. Client who has been afebrile for 3 days on antibiotics

3. Client who required medication earlier in the day for chest pain

4. A client who required the insertion of an indwelling catheter this evening secondary to urine retention related to an enlarged prostate

Correct Answer: 3

Rationale 1: The client who complained of chest pain earlier in the day requires careful monitoring of vital signs, and would need to be awakened. The postoperative client is stable enough to be discharged, and would not need to be awakened. The client who has been afebrile for 3 days would not need to be awakened, and insertion of an indwelling urinary catheter would require careful monitoring of urine output but would not necessitate awakening. If any of these clients were to exhibit any symptoms of concern, the nurse would assess vital signs.

Rationale 2: The client who complained of chest pain earlier in the day requires careful monitoring of vital signs, and would need to be awakened. The postoperative client is stable enough to be discharged, and would not need to be awakened. The client who has been afebrile for 3 days would not need to be awakened, and insertion of an indwelling urinary catheter would require careful monitoring of urine output but would not necessitate awakening. If any of these clients were to exhibit any symptoms of concern, the nurse would assess vital signs.

Rationale 3: The client who complained of chest pain earlier in the day requires careful monitoring of vital signs, and would need to be awakened. The postoperative client is stable enough to be discharged, and would not need to be awakened. The client who has been afebrile for 3 days would not need to be awakened, and insertion of an indwelling urinary catheter would require careful monitoring of urine output but would not necessitate awakening. If any of these clients were to exhibit any symptoms of concern, the nurse would assess vital signs.

Rationale 4: The client who complained of chest pain earlier in the day requires careful monitoring of vital signs, and would need to be awakened. The postoperative client is stable enough to be discharged, and would not need to be awakened. The client who has been afebrile for 3 days would not need to be awakened, and insertion of an indwelling urinary catheter would require careful monitoring of urine output but would not necessitate awakening. If any of these clients were to exhibit any symptoms of concern, the nurse would assess vital signs.

Global Rationale: The client who complained of chest pain earlier in the day requires careful monitoring of vital signs, and would need to be awakened. The postoperative client is stable enough to be discharged, and would not need to be awakened. The client who has been afebrile for 3 days would not need to be awakened, and insertion of an indwelling urinary catheter would require careful monitoring of urine output but would not necessitate awakening. If any of these clients were to exhibit any symptoms of concern, the nurse would assess vital signs.

Cognitive Level: Analyzing
Client Need: Physiological Integrity
Client Need Sub: Reduction of Risk Potential

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QSEN Competencies: II.B.3. Base individualized care plan on client values, clinical expertise, and evidence
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NLN Competencies: Context and Environment: Health promotion/disease prevention
Nursing/Integrated Concepts: Nursing Process: Planning
Learning Outcome: Identify the indications for measuring and assessing:
a. Temperature.
b. Pulse.
c. Respirations.
d. Blood pressure.
e. Oxygen saturation.
Page Number: p. 22

Question 7
Type: MCMA

When the nurse delegates measurement of vital signs to an unlicensed assistive personnel (UAP), which are the nurse's responsibilities?

Standard Text: Select all that apply.

1. Assessment of vital sign readings obtained by the unlicensed assistive personnel

2. Assessment of the UAP's skills in measuring vital signs

3. Determination that the vital signs were obtained correctly

4. Follow up on vital sign measurements that are abnormal or unexpected

5. Observe the UAP as she measures vital signs

Correct Answer: 1,2,3,4

Rationale 1: Although the nurse can delegate the performance of tasks, the responsibility for those tasks is not delegated, and rests with the nurse. The nurse should review and assess all vital signs. The nurse should determine that the UAP is competent to perform any task delegated to her, and should assess the UAP's competence while performing the task. If the UAP reports an unusual reading, the nurse should recheck the vital sign to determine that it is accurate before treating or responding to the reading. The nurse does not need to follow the UAP around once she is judged to be competent, but the nurse should instruct the UAP regarding exactly what the nurse wants reported immediately and what would be outside the acceptable level.

Rationale 2: Although the nurse can delegate the performance of tasks, the responsibility for those tasks is not delegated, and rests with the nurse. The nurse should review and assess all vital signs. The nurse should determine that the UAP is competent to perform any task delegated to her, and should assess the UAP's competence while performing the task. If the UAP reports an unusual reading, the nurse should recheck the vital sign to determine that it is accurate before treating or responding to the reading. The nurse does not need to follow the UAP around once she is judged to be competent, but the nurse should instruct the UAP regarding exactly what the nurse wants reported immediately and what would be outside the acceptable level.

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Rationale 3: Although the nurse can delegate the performance of tasks, the responsibility for those tasks is not delegated, and rests with the nurse. The nurse should review and assess all vital signs. The nurse should determine that the UAP is competent to perform any task delegated to her, and should assess the UAP's competence while performing the task. If the UAP reports an unusual reading, the nurse should recheck the vital sign to determine that it is accurate before treating or responding to the reading. The nurse does not need to follow the UAP around once she is judged to be competent, but the nurse should instruct the UAP regarding exactly what the nurse wants reported immediately and what would be outside the acceptable level.

Rationale 4: Although the nurse can delegate the performance of tasks, the responsibility for those tasks is not delegated, and rests with the nurse. The nurse should review and assess all vital signs. The nurse should determine that the UAP is competent to perform any task delegated to her, and should assess the UAP's competence while performing the task. If the UAP reports an unusual reading, the nurse should recheck the vital sign to determine that it is accurate before treating or responding to the reading. The nurse does not need to follow the UAP around once she is judged to be competent, but the nurse should instruct the UAP regarding exactly what the nurse wants reported immediately and what would be outside the acceptable level.

Rationale 5: Although the nurse can delegate the performance of tasks, the responsibility for those tasks is not delegated, and rests with the nurse. The nurse should review and assess all vital signs. The nurse should determine that the UAP is competent to perform any task delegated to her, and should assess the UAP's competence while performing the task. If the UAP reports an unusual reading, the nurse should recheck the vital sign to determine that it is accurate before treating or responding to the reading. The nurse does not need to follow the UAP around once she is judged to be competent, but the nurse should instruct the UAP regarding exactly what the nurse wants reported immediately and what would be outside the acceptable level.

Global Rationale: Although the nurse can delegate the performance of tasks, the responsibility for those tasks is not delegated, and rests with the nurse. The nurse should review and assess all vital signs. The nurse should determine that the UAP is competent to perform any task delegated to her, and should assess the UAP's competence while performing the task. If the UAP reports an unusual reading, the nurse should recheck the vital sign to determine that it is accurate before treating or responding to the reading. The nurse does not need to follow the UAP around once she is judged to be competent, but the nurse should instruct the UAP regarding exactly what the nurse wants reported immediately and what would be outside the acceptable level.

Cognitive Level: Remembering
Client Need: Safe and Effective Care Environment
Client Need Sub: Management of Care
QSEN Competencies: II.A.2. Describe scopes of practice and roles of health care team members
AACN Essential Competencies: IX.14. Demonstrate clinical judgment and accountability for client outcomes when delegating to and supervising other members of the health care team
NLN Competencies: Teamwork: Manage delegation effectively.
Nursing/Integrated Concepts: Nursing Process: Planning
Learning Outcome: Recognize when it is appropriate to delegate measurement of vital signs to unlicensed assistive personnel.
Page Number: pp. 21-22

Question 8
Type: MCSA

Which task could not be delegated by the nurse to the unlicensed assistive personnel (UAP)?

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1. Monitor client's vital signs and oxygen saturation every 4 hours.

2. Measure client's blood pressure and report to the nurse after administration of routine daily antihypertensive medication.

3. Monitor vital signs of client who complained of chest pain, requiring three doses of nitroglycerin to resolve, earlier in the shift.

4. Measure vital signs on client who had a stroke 3 years ago and is admitted for urinary tract infection.

Correct Answer: 3

Rationale 1: The client who is unstable secondary to chest pain should be assessed by the nurse, and this should not be delegated to the UAP. The other clients' vital signs could be measured by the UAP, but the nurse should instruct the UAP regarding exactly what values should be reported immediately.

Rationale 2: The client who is unstable secondary to chest pain should be assessed by the nurse, and this should not be delegated to the UAP. The other clients' vital signs could be measured by the UAP, but the nurse should instruct the UAP regarding exactly what values should be reported immediately.

Rationale 3: The client who is unstable secondary to chest pain should be assessed by the nurse, and this should not be delegated to the UAP. The other clients' vital signs could be measured by the UAP, but the nurse should instruct the UAP regarding exactly what values should be reported immediately.

Rationale 4: The client who is unstable secondary to chest pain should be assessed by the nurse, and this should not be delegated to the UAP. The other clients' vital signs could be measured by the UAP, but the nurse should instruct the UAP regarding exactly what values should be reported immediately.

Global Rationale: The client who is unstable secondary to chest pain should be assessed by the nurse, and this should not be delegated to the UAP. The other clients' vital signs could be measured by the UAP, but the nurse should instruct the UAP regarding exactly what values should be reported immediately.

Cognitive Level: Analyzing
Client Need: Safe and Effective Care Environment
Client Need Sub: Management of Care
QSEN Competencies: II.A.2. Describe scopes of practice and roles of health care team members
AACN Essential Competencies: IX.14. Demonstrate clinical judgment and accountability for client outcomes when delegating to and supervising other members of the health care team
NLN Competencies: Teamwork: Manage delegation effectively.
Nursing/Integrated Concepts: Nursing Process: Planning
Learning Outcome: Recognize when it is appropriate to delegate measurement of vital signs to unlicensed assistive personnel.
Page Number: pp. 26, 31. 33, 36, 39, 42, 47

Question 9
Type: MCSA

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The nurse delegates the measurement of vital signs on three clients to the unlicensed assistive personnel (UAP). The nurse evaluates the UAP's performance and notes that blood pressure is measured on a client by having the client hold the arm hanging over the side of the bed. Which is the priority action by the nurse?

1. Commend the UAP for following the proper procedure.

2. Inform the charge nurse that the UAP does not know how to measure blood pressures.

3. Yell at the UAP and tell her she is incompetent.

4. Instruct the UAP that blood pressure should be measured with the artery at or above the level of the heart, and demonstrate correct technique.

Correct Answer: 4

Rationale 1: The nurse is responsible for teaching the UAP how to measure vital signs properly in a professional manner. Demonstrating proper technique is far more effective than just discussing it. The nurse would not commend the UAP for proper technique, because blood pressure measurement performed with the artery lower than the heart will give a false reading. Telling the charge nurse transfers the responsibility held by the nurse delegating the procedure to another team member, and would not be the best choice. Yelling at a team member is never correct, and would be highly unprofessional.

Rationale 2: The nurse is responsible for teaching the UAP how to measure vital signs properly in a professional manner. Demonstrating proper technique is far more effective than just discussing it. The nurse would not commend the UAP for proper technique, because blood pressure measurement performed with the artery lower than the heart will give a false reading. Telling the charge nurse transfers the responsibility held by the nurse delegating the procedure to another team member, and would not be the best choice. Yelling at a team member is never correct, and would be highly unprofessional.

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Rationale 4: The nurse is responsible for teaching the UAP how to measure vital signs properly in a professional manner. Demonstrating proper technique is far more effective than just discussing it. The nurse would not commend the UAP for proper technique, because blood pressure measurement performed with the artery lower than the heart will give a false reading. Telling the charge nurse transfers the responsibility held by the nurse delegating the procedure to another team member, and would not be the best choice. Yelling at a team member is never correct, and would be highly unprofessional.

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Cognitive Level: Analyzing
Client Need: Safe and Effective Care Environment
Client Need Sub: Management of Care
QSEN Competencies: II.A.2. Describe scopes of practice and roles of health care team members
AACN Essential Competencies: IX.14. Demonstrate clinical judgment and accountability for client outcomes when delegating to and supervising other members of the health care team
NLN Competencies: Teamwork: Manage delegation effectively.
Nursing/Integrated Concepts: Nursing Process: Implementation
Learning Outcome: Recognize when it is appropriate to delegate measurement of vital signs to unlicensed assistive personnel.
Page Number: pp. 40-45

Question 10
Type: MCSA

Prior to assessing the adult client's temperature rectally, which action by the nurse is the most appropriate?

1. Lubricate the tip of the thermometer.

2. Obtain a health care provider's order.

3. Position the client in the Trendelenburg position.

4. Position the client in the Fowler's position.

Correct Answer: 1

Rationale 1: Prior to inserting the thermometer, the nurse should apply a water-soluble lubricant to the tip of the thermometer to prevent tissue damage. A health care provider's order is not required. Both the Trendelenburg and Fowler's positions would make obtaining a rectal temperature difficult; a side-lying position would be preferable.

Rationale 2: Prior to inserting the thermometer, the nurse should apply a water-soluble lubricant to the tip of the thermometer to prevent tissue damage. A health care provider's order is not required. Both the Trendelenburg and Fowler's positions would make obtaining a rectal temperature difficult; a side-lying position would be preferable.

Rationale 3: Prior to inserting the thermometer, the nurse should apply a water-soluble lubricant to the tip of the thermometer to prevent tissue damage. A health care provider's order is not required. Both the Trendelenburg and Fowler's positions would make obtaining a rectal temperature difficult; a side-lying position would be preferable.

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Global Rationale: Prior to inserting the thermometer, the nurse should apply a water-soluble lubricant to the tip of the thermometer to prevent tissue damage. A health care provider's order is not required. Both the Trendelenburg and Fowler's positions would make obtaining a rectal temperature difficult; a side-lying position would be preferable.

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Cognitive Level: Applying
Client Need: Safe and Effective Care Environment
Client Need Sub: Safety and Infection Control
QSEN Competencies: III.A.5. Explain the role of evidence in determining best clinical practice
AACN Essential Competencies: IX.8. Implement evidence-based nursing interventions as appropriate for managing the acute and chronic care of clients and promoting health across the life span
NLN Competencies: Quality and Safety: Current best practices
Nursing/Integrated Concepts: Nursing Process: Implementation
Learning Outcome: Verbalize the steps used to measure:

a. Temperature.
b. Pulse.
c. Respirations.
d. Blood pressure.
e. Oxygen saturation.

Page Number: p. 26

Question 11
Type: MCSA

The nurse is measuring the client's radial pulse. How does the nurse properly perform this procedure?

1. Place two fingers on the medial side of the inner wrist gently on the surface of the skin.

2. Place the thumb on the lateral side of the wrist and apply gentle pressure.

3. Place two fingers on the lateral side of the inner wrist and apply gentle pressure.

4. Place the thumb on the medial side of the wrist gently.

Correct Answer: 3

Rationale 1: The radial pulse is on the lateral, or thumb, side of the wrist. Gentle pressure is required to palpate the pulse, but care should be taken not to put too much pressure on the artery, which would occlude the pulse. The thumb should never be used to palpate the client's pulse, as the artery in the thumb of the nurse will interfere with accurate measurement.

Rationale 2: The radial pulse is on the lateral, or thumb, side of the wrist. Gentle pressure is required to palpate the pulse, but care should be taken not to put too much pressure on the artery, which would occlude the pulse. The thumb should never be used to palpate the client's pulse, as the artery in the thumb of the nurse will interfere with accurate measurement.

Rationale 3: The radial pulse is on the lateral, or thumb, side of the wrist. Gentle pressure is required to palpate the pulse, but care should be taken not to put too much pressure on the artery, which would occlude the pulse. The thumb should never be used to palpate the client's pulse, as the artery in the thumb of the nurse will interfere with accurate measurement.

Rationale 4: The radial pulse is on the lateral, or thumb, side of the wrist. Gentle pressure is required to palpate the pulse, but care should be taken not to put too much pressure on the artery, which would occlude the pulse. The

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thumb should never be used to palpate the client's pulse, as the artery in the thumb of the nurse will interfere with accurate measurement.

Global Rationale: The radial pulse is on the lateral, or thumb, side of the wrist. Gentle pressure is required to palpate the pulse, but care should be taken not to put too much pressure on the artery, which would occlude the pulse. The thumb should never be used to palpate the client's pulse, as the artery in the thumb of the nurse will interfere with accurate measurement.

Cognitive Level: Remembering
Client Need: Safe and Effective Care Environment
Client Need Sub: Management of Care
QSEN Competencies: III.A.5. Explain the role of evidence in determining best clinical practice
AACN Essential Competencies: IX.8. Implement evidence-based nursing interventions as appropriate for managing the acute and chronic care of clients and promoting health across the life span
NLN Competencies: Quality and Safety: Current best practices
Nursing/Integrated Concepts: Nursing Process: Implementation
Learning Outcome: Verbalize the steps used to measure:

a. Temperature.
b. Pulse.
c. Respirations.
d. Blood pressure.
e. Oxygen saturation.

Page Number: pp. 36-37

Question 12
Type: MCSA

In order to get an accurate reading, which technique would the nurse use to measure the client's respirations?

1. Stare intently at the client's chest.

2. Place a hand on the client's chest to feel the thoracic cavity move.

3. Maintain the fingers on the radial pulse.

4. Watch the nose flare with each respiration.

Correct Answer: 3

Rationale 1: If the client is aware that respirations are being measured, it will often cause her to alter her breathing pattern. It is best for the nurse to count respirations while maintaining the fingers on the radial pulse, in order to avoid alerting the client to what the nurse is assessing. Staring intently at the client's chest or placing a hand on the chest would indicate what the nurse is assessing. The nose does not flare with normal respirations in most clients, so this would not be effective.

Rationale 2: If the client is aware that respirations are being measured, it will often cause her to alter her breathing pattern. It is best for the nurse to count respirations while maintaining the fingers on the radial pulse, in order to avoid alerting the client to what the nurse is assessing. Staring intently at the client's chest or placing a

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hand on the chest would indicate what the nurse is assessing. The nose does not flare with normal respirations in most clients, so this would not be effective.

Rationale 3: If the client is aware that respirations are being measured, it will often cause her to alter her breathing pattern. It is best for the nurse to count respirations while maintaining the fingers on the radial pulse, in order to avoid alerting the client to what the nurse is assessing. Staring intently at the client's chest or placing a hand on the chest would indicate what the nurse is assessing. The nose does not flare with normal respirations in most clients, so this would not be effective.

Rationale 4: If the client is aware that respirations are being measured, it will often cause her to alter her breathing pattern. It is best for the nurse to count respirations while maintaining the fingers on the radial pulse, in order to avoid alerting the client to what the nurse is assessing. Staring intently at the client's chest or placing a hand on the chest would indicate what the nurse is assessing. The nose does not flare with normal respirations in most clients, so this would not be effective.

Global Rationale: If the client is aware that respirations are being measured, it will often cause her to alter her breathing pattern. It is best for the nurse to count respirations while maintaining the fingers on the radial pulse, in order to avoid alerting the client to what the nurse is assessing. Staring intently at the client's chest or placing a hand on the chest would indicate what the nurse is assessing. The nose does not flare with normal respirations in most clients, so this would not be effective.

Cognitive Level: Remembering
Client Need: Physiological Integrity
Client Need Sub: Physiological Adaptation
QSEN Competencies: III.A.5. Explain the role of evidence in determining best clinical practice
AACN Essential Competencies: IX.8. Implement evidence-based nursing interventions as appropriate for managing the acute and chronic care of clients and promoting health across the life span
NLN Competencies: Quality and Safety: Current best practices
Nursing/Integrated Concepts: Nursing Process: Implementation
Learning Outcome: Verbalize the steps used to measure:

a. Temperature.
b. Pulse.
c. Respirations.
d. Blood pressure.
e. Oxygen saturation.

Page Number: pp. 38-39

Question 13
Type: MCSA

Which term is used to describe the first sound heard by the nurse when measuring the client's blood pressure?

1. Diastolic

2. Systolic

3. Korotkoff's sound phase 4

4. Korotkoff's sound phase 5

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Correct Answer: 2

Rationale 1: The first sound heard is the systolic pressure reading, or phase 1 of Korotkoff's sounds. Diastolic is the last sound heard of Korotkoff's sound phase 5.

Rationale 2: The first sound heard is the systolic pressure reading, or phase 1 of Korotkoff's sounds. Diastolic is the last sound heard of Korotkoff's sound phase 5.

Rationale 3: The first sound heard is the systolic pressure reading, or phase 1 of Korotkoff's sounds. Diastolic is the last sound heard of Korotkoff's sound phase 5.

Rationale 4: The first sound heard is the systolic pressure reading, or phase 1 of Korotkoff's sounds. Diastolic is the last sound heard of Korotkoff's sound phase 5.

Global Rationale: The first sound heard is the systolic pressure reading, or phase 1 of Korotkoff's sounds. Diastolic is the last sound heard of Korotkoff's sound phase 5.

Cognitive Level: Remembering
Client Need: Physiological Integrity
Client Need Sub: Physiological Adaptation
QSEN Competencies: II.B.3. Base individualized care plan on client values, clinical expertise, and evidence
AACN Essential Competencies: III.1. Explain the interrelationships among theory, practice, and research
NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe client care
Nursing/Integrated Concepts: Nursing Process: Implementation
Learning Outcome: Define the key terms used in the skills of measuring vital signs.
Page Number: pp. 40-41

Question 14
Type: MCSA

In order to obtain an accurate oxygen saturation reading, on which location will the nurse place the probe?

1. On a spot that the client cannot move

2. On the client's nondominant hand

3. On the client's dominant hand

4. On a site that is well perfused and warm on the client

Correct Answer: 4

Rationale 1: The nurse should place the probe on a site that is well perfused and warm because the probe works by measuring blood flowing through the site. The most common site for measuring oxygen saturation is the finger, and the probe can be placed on the dominant or nondominant hand. The client should be asked not to move the finger until the reading is obtained. If the oximeter probe is to remain in place, the position should be changed periodically to avoid injury.

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Rationale 2: The nurse should place the probe on a site that is well perfused and warm because the probe works by measuring blood flowing through the site. The most common site for measuring oxygen saturation is the finger, and the probe can be placed on the dominant or nondominant hand. The client should be asked not to move the finger until the reading is obtained. If the oximeter probe is to remain in place, the position should be changed periodically to avoid injury.

Rationale 3: The nurse should place the probe on a site that is well perfused and warm because the probe works by measuring blood flowing through the site. The most common site for measuring oxygen saturation is the finger, and the probe can be placed on the dominant or nondominant hand. The client should be asked not to move the finger until the reading is obtained. If the oximeter probe is to remain in place, the position should be changed periodically to avoid injury.

Rationale 4: The nurse should place the probe on a site that is well perfused and warm because the probe works by measuring blood flowing through the site. The most common site for measuring oxygen saturation is the finger, and the probe can be placed on the dominant or nondominant hand. The client should be asked not to move the finger until the reading is obtained. If the oximeter probe is to remain in place, the position should be changed periodically to avoid injury.

Global Rationale: The nurse should place the probe on a site that is well perfused and warm because the probe works by measuring blood flowing through the site. The most common site for measuring oxygen saturation is the finger, and the probe can be placed on the dominant or nondominant hand. The client should be asked not to move the finger until the reading is obtained. If the oximeter probe is to remain in place, the position should be changed periodically to avoid injury.

Cognitive Level: Remembering
Client Need: Physiological Integrity
Client Need Sub: Physiological Adaptation
QSEN Competencies: III.A.5. Explain the role of evidence in determining best clinical practice
AACN Essential Competencies: IX.8. Implement evidence-based nursing interventions as appropriate for managing the acute and chronic care of clients and promoting health across the life span
NLN Competencies: Quality and Safety: Current best practices
Nursing/Integrated Concepts: Nursing Process: Implementation
Learning Outcome: Verbalize the steps used to measure:

a. Temperature.
b. Pulse.
c. Respirations.
d. Blood pressure.
e. Oxygen saturation.

Page Number: pp. 46-48

Question 15
Type: MCSA

Where would the nurse measure temperature if the client was confused and disoriented following rectal surgery?

1. Rectally

2. Orally

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3. Axillary

4. Either orally or tympanically

Correct Answer: 3

Rationale 1: The best means of checking this client's temperature would be axillary. A rectal temperature would be contraindicated by rectal surgery. The client who is confused should not have an oral temperature taken for fear the client will bite down on the thermometer and injure himself. The tympanic route would be acceptable, but oral would be contraindicated.

Rationale 2: The best means of checking this client's temperature would be axillary. A rectal temperature would be contraindicated by rectal surgery. The client who is confused should not have an oral temperature taken for fear the client will bite down on the thermometer and injure himself. The tympanic route would be acceptable, but oral would be contraindicated.

Rationale 3: The best means of checking this client's temperature would be axillary. A rectal temperature would be contraindicated by rectal surgery. The client who is confused should not have an oral temperature taken for fear the client will bite down on the thermometer and injure himself. The tympanic route would be acceptable, but oral would be contraindicated.

Rationale 4: The best means of checking this client's temperature would be axillary. A rectal temperature would be contraindicated by rectal surgery. The client who is confused should not have an oral temperature taken for fear the client will bite down on the thermometer and injure himself. The tympanic route would be acceptable, but oral would be contraindicated.

Global Rationale: The best means of checking this client's temperature would be axillary. A rectal temperature would be contraindicated by rectal surgery. The client who is confused should not have an oral temperature taken for fear the client will bite down on the thermometer and injure himself. The tympanic route would be acceptable, but oral would be contraindicated.

Cognitive Level: Applying
Client Need: Safe and Effective Care Environment
Client Need Sub: Management of Care
QSEN Competencies: III.A.5. Explain the role of evidence in determining best clinical practice
AACN Essential Competencies: IX.1. Conduct comprehensive and focused physical, behavioral, psychological, spiritual, socioeconomic, and environmental assessments of health and illness parameters in clients, using developmentally and culturally appropriate approaches
NLN Competencies: Context and Environment: Conduct population-based transcultural health assessments and interventions
Nursing/Integrated Concepts: Nursing Process: Implementation
Learning Outcome: Describe factors that affect the measurement of:

a. Temperature.
b. Pulse.
c. Respirations.
d. Blood pressure.
e. Oxygen saturation.

Page Number: p. 23

Question 16
Type: MCSA

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The nurse is caring for a client with a history of arrhythmia resulting in an irregular pulse. How long would the nurse count the pulse to get the most accurate reading?

1. 15 seconds and multiply by 4

2. 30 seconds and multiply by 2

3. 1 minute

4. 2 minutes

Correct Answer: 3

Rationale 1: The pulse should be counted for 1 full minute when the client has an irregular heart rate in order to get an accurate reading.

Rationale 2: The pulse should be counted for 1 full minute when the client has an irregular heart rate in order to get an accurate reading.

Rationale 3: The pulse should be counted for 1 full minute when the client has an irregular heart rate in order to get an accurate reading.

Rationale 4: The pulse should be counted for 1 full minute when the client has an irregular heart rate in order to get an accurate reading.

Global Rationale: The pulse should be counted for 1 full minute when the client has an irregular heart rate in order to get an accurate reading.

Cognitive Level: Applying
Client Need: Safe and Effective Care Environment
Client Need Sub: Management of Care
QSEN Competencies: III.A.5. Explain the role of evidence in determining best clinical practice
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NLN Competencies: Context and Environment: Conduct population-based transcultural health assessments and interventions
Nursing/Integrated Concepts: Nursing Process: Implementation
Learning Outcome: Describe factors that affect the measurement of:

a. Temperature.
b. Pulse.
c. Respirations.
d. Blood pressure.
e. Oxygen saturation.

Page Number: p. 31

Question 17
Type: MCSA

The nurse is caring for a newborn with rapid respirations. How would the nurse get an accurate respiratory rate?

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1. Remove the client's clothing so the chest movement can be seen.

2. Count respirations for 30 seconds and multiply by two.

3. Place the hand on the client's back to feel the respirations.

4. Use a stethoscope to hear respirations.

Correct Answer: 4

Rationale 1: The nurse would be able to get the most accurate respiratory rate in an infant who is breathing quickly by using a stethoscope. Removing clothes will allow the nurse to see chest movement, but when the infant is undressed, he might begin crying, which would alter the respiratory rate. Placing a hand on the infant's back would allow the nurse to feel most respirations, but would not yield as accurate an assessment as would the use of the stethoscope.

Rationale 2: The nurse would be able to get the most accurate respiratory rate in an infant who is breathing quickly by using a stethoscope. Removing clothes will allow the nurse to see chest movement, but when the infant is undressed, he might begin crying, which would alter the respiratory rate. Placing a hand on the infant's back would allow the nurse to feel most respirations, but would not yield as accurate an assessment as would the use of the stethoscope.

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Global Rationale: The nurse would be able to get the most accurate respiratory rate in an infant who is breathing quickly by using a stethoscope. Removing clothes will allow the nurse to see chest movement, but when the infant is undressed, he might begin crying, which would alter the respiratory rate. Placing a hand on the infant's back would allow the nurse to feel most respirations, but would not yield as accurate an assessment as would the use of the stethoscope.

Cognitive Level: Applying
Client Need: Safe and Effective Care Environment
Client Need Sub: Management of Care
QSEN Competencies: III.A.5. Explain the role of evidence in determining best clinical practice
AACN Essential Competencies: IX.1. Conduct comprehensive and focused physical, behavioral, psychological, spiritual, socioeconomic, and environmental assessments of health and illness parameters in clients, using developmentally and culturally appropriate approaches
NLN Competencies: Context and Environment: Conduct population-based transcultural health assessments and interventions
Nursing/Integrated Concepts: Nursing Process: Implementation
Learning Outcome: Describe factors that affect the measurement of:

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a. Temperature.
b. Pulse.
c. Respirations.
d. Blood pressure.
e. Oxygen saturation.

Page Number: p. 39

Question 18
Type: MCSA

The nurse is caring for a client who had bilateral mastectomies. Where would the nurse measure the client's blood pressure to obtain the most accurate reading?

1. Either upper arm using the brachial artery

2. Either forearm using the radial artery

3. In the lower leg using the posterior tibial artery

4. In the thigh using the popliteal artery

Correct Answer: 4

Rationale 1: The thigh would be best. Although the lower leg could be used, it is not as accurate as the thigh. The client with bilateral mastectomies should not have blood pressure measured in the arms due to the reduced lymphatic flow as the result of removal of the axillary lymph nodes.

Rationale 2: The thigh would be best. Although the lower leg could be used, it is not as accurate as the thigh. The client with bilateral mastectomies should not have blood pressure measured in the arms due to the reduced lymphatic flow as the result of removal of the axillary lymph nodes.

Rationale 3: The thigh would be best. Although the lower leg could be used, it is not as accurate as the thigh. The client with bilateral mastectomies should not have blood pressure measured in the arms due to the reduced lymphatic flow as the result of removal of the axillary lymph nodes.

Rationale 4: The thigh would be best. Although the lower leg could be used, it is not as accurate as the thigh. The client with bilateral mastectomies should not have blood pressure measured in the arms due to the reduced lymphatic flow as the result of removal of the axillary lymph nodes.

Global Rationale: The thigh would be best. Although the lower leg could be used, it is not as accurate as the thigh. The client with bilateral mastectomies should not have blood pressure measured in the arms due to the reduced lymphatic flow as the result of removal of the axillary lymph nodes.

Cognitive Level: Applying
Client Need: Physiological Integrity
Client Need Sub: Reduction of Risk Potential
QSEN Competencies: III.A.5. Explain the role of evidence in determining best clinical practice
AACN Essential Competencies: IX.1. Conduct comprehensive and focused physical, behavioral, psychological, spiritual, socioeconomic, and environmental assessments of health and illness parameters in clients, using developmentally and culturally appropriate approaches

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NLN Competencies: Context and Environment: Conduct population-based transcultural health assessments and interventions
Nursing/Integrated Concepts: Nursing Process: Implementation
Learning Outcome: Describe factors that affect the measurement of:
a. Temperature.
b. Pulse.
c. Respirations.
d. Blood pressure.
e. Oxygen saturation.
Page Number: p. 40

Question 19
Type: MCSA

The nurse is caring for a client requiring continuous pulse oximetry readings. How often would the nurse alter the probe site?

1. Every 2 hours

2. Every 4 hours if the probe is an adhesive wraparound sensor

3. Every 4 hours if the probe is a spring-loaded sensor

4. Every 2 hours if the probe is an adhesive wraparound sensor

Correct Answer: 2

Rationale 1: Adhesive wraparound sensors should be repositioned every 4 hours. Spring-loaded tension probes should be repositioned every 2 hours.

Rationale 2: Adhesive wraparound sensors should be repositioned every 4 hours. Spring-loaded tension probes should be repositioned every 2 hours.

Rationale 3: Adhesive wraparound sensors should be repositioned every 4 hours. Spring-loaded tension probes should be repositioned every 2 hours.

Rationale 4: Adhesive wraparound sensors should be repositioned every 4 hours. Spring-loaded tension probes should be repositioned every 2 hours.

Global Rationale: Adhesive wraparound sensors should be repositioned every 4 hours. Spring-loaded tension probes should be repositioned every 2 hours.

Cognitive Level: Applying
Client Need: Safe and Effective Care Environment
Client Need Sub: Management of Care
QSEN Competencies: III.A.5. Explain the role of evidence in determining best clinical practice
AACN Essential Competencies: IX.8. Implement evidence-based nursing interventions as appropriate for managing the acute and chronic care of clients and promoting health across the life span
NLN Competencies: Quality and Safety: Current best practices

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Nursing/Integrated Concepts: Nursing Process: Implementation
Learning Outcome: Verbalize the steps used to measure:
a. Temperature.
b. Pulse.
c. Respirations.
d. Blood pressure.
e. Oxygen saturation.
Page Number: p. 48

Question 20
Type: MCSA

The nurse working in the emergency department admits a 2-month-old infant whose mother reports had a temperature of 104.2°F axillary. Which route would the nurse use to measure the infant's temperature?

1. Tympanically

2. Orally

3. Axillary

4. Rectally

Correct Answer: 4

Rationale 1: Although rectal temperature measurement may be discouraged for routine use in infants, when the temperature is very high and it is important to get the most accurate reading, the rectal route is best. Oral and tympanic temperatures are generally not considered accurate in infants, and axillary readings are not as accurate as rectal readings.

Rationale 2: Although rectal temperature measurement may be discouraged for routine use in infants, when the temperature is very high and it is important to get the most accurate reading, the rectal route is best. Oral and tympanic temperatures are generally not considered accurate in infants, and axillary readings are not as accurate as rectal readings.

Rationale 3: Although rectal temperature measurement may be discouraged for routine use in infants, when the temperature is very high and it is important to get the most accurate reading, the rectal route is best. Oral and tympanic temperatures are generally not considered accurate in infants, and axillary readings are not as accurate as rectal readings.

Rationale 4: Although rectal temperature measurement may be discouraged for routine use in infants, when the temperature is very high and it is important to get the most accurate reading, the rectal route is best. Oral and tympanic temperatures are generally not considered accurate in infants, and axillary readings are not as accurate as rectal readings.

Global Rationale: Although rectal temperature measurement may be discouraged for routine use in infants, when the temperature is very high and it is important to get the most accurate reading, the rectal route is best. Oral and

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tympanic temperatures are generally not considered accurate in infants, and axillary readings are not as accurate as rectal readings.

Cognitive Level: Analyzing
Client Need: Physiological Integrity
Client Need Sub: Reduction of Risk Potential
QSEN Competencies: III.A.5. Explain the role of evidence in determining best clinical practice
AACN Essential Competencies: IX.1. Conduct comprehensive and focused physical, behavioral, psychological, spiritual, socioeconomic, and environmental assessments of health and illness parameters in clients, using developmentally and culturally appropriate approaches
NLN Competencies: Context and Environment: Conduct population-based transcultural health assessments and interventions
Nursing/Integrated Concepts: Nursing Process: Implementation
Learning Outcome: Describe factors that affect the measurement of:

a. Temperature.
b. Pulse.
c. Respirations.
d. Blood pressure.
e. Oxygen saturation.

Page Number: p. 28

Question 21
Type: MCSA

The nurse is caring for a client who is experiencing acute hemorrhagic shock. The client's blood pressure is 60/28. How will the nurse assess this client's pulse?

1. Measure the radial pulse for 1 minute.

2. Measure the brachial pulse for 1 minute.

3. Measure the radial pulse for 30 seconds and multiply by 2.

4. Measure the client's apical pulse for 1 minute.

Correct Answer: 4

Rationale 1: In all likelihood, a client whose blood pressure is this low who is in shock will not have a radial or brachial pulse because perfusion will be significantly diminished. The most accurate pulse assessment will be obtained centrally, and the nurse can either auscultate apical pulsation or palpate carotid pulsation. Care should be taken not to ever palpate both carotid arteries at the same time.

Rationale 2: In all likelihood, a client whose blood pressure is this low who is in shock will not have a radial or brachial pulse because perfusion will be significantly diminished. The most accurate pulse assessment will be obtained centrally, and the nurse can either auscultate apical pulsation or palpate carotid pulsation. Care should be taken not to ever palpate both carotid arteries at the same time.

Rationale 3: In all likelihood, a client whose blood pressure is this low who is in shock will not have a radial or brachial pulse because perfusion will be significantly diminished. The most accurate pulse assessment will be

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obtained centrally, and the nurse can either auscultate apical pulsation or palpate carotid pulsation. Care should be taken not to ever palpate both carotid arteries at the same time.

Rationale 4: In all likelihood, a client whose blood pressure is this low who is in shock will not have a radial or brachial pulse because perfusion will be significantly diminished. The most accurate pulse assessment will be obtained centrally, and the nurse can either auscultate apical pulsation or palpate carotid pulsation. Care should be taken not to ever palpate both carotid arteries at the same time.

Global Rationale: In all likelihood, a client whose blood pressure is this low who is in shock will not have a radial or brachial pulse because perfusion will be significantly diminished. The most accurate pulse assessment will be obtained centrally, and the nurse can either auscultate apical pulsation or palpate carotid pulsation. Care should be taken not to ever palpate both carotid arteries at the same time.

Cognitive Level: Analyzing
Client Need: Physiological Integrity
Client Need Sub: Physiological Adaptation
QSEN Competencies: III.A.5. Explain the role of evidence in determining best clinical practice
AACN Essential Competencies: IX.1. Conduct comprehensive and focused physical, behavioral, psychological, spiritual, socioeconomic, and environmental assessments of health and illness parameters in clients, using developmentally and culturally appropriate approaches
NLN Competencies: Context and Environment: Conduct population-based transcultural health assessments and interventions
Nursing/Integrated Concepts: Nursing Process: Implementation
Learning Outcome: Describe factors that affect the measurement of:

a. Temperature.
b. Pulse.
c. Respirations.
d. Blood pressure.
e. Oxygen saturation.

Page Number: p. 29

Question 22
Type: MCSA

The nurse is caring for a client diagnosed with cardiogenic shock who requires continuous oxygen saturation monitoring. Where would the nurse place the probe?

1. The fingers

2. The toes

3. The ear

4. The thumb

Correct Answer: 3

Rationale 1: A client in shock will have reduced perfusion to the extremities, so either the nose or the ear should be used, and the reading can be assessed for accuracy based on the pulse reading obtained from the oxygen saturation monitor.

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Rationale 2: A client in shock will have reduced perfusion to the extremities, so either the nose or the ear should be used, and the reading can be assessed for accuracy based on the pulse reading obtained from the oxygen saturation monitor.

Rationale 3: A client in shock will have reduced perfusion to the extremities, so either the nose or the ear should be used, and the reading can be assessed for accuracy based on the pulse reading obtained from the oxygen saturation monitor.

Rationale 4: A client in shock will have reduced perfusion to the extremities, so either the nose or the ear should be used, and the reading can be assessed for accuracy based on the pulse reading obtained from the oxygen saturation monitor.

Global Rationale: A client in shock will have reduced perfusion to the extremities, so either the nose or the ear should be used, and the reading can be assessed for accuracy based on the pulse reading obtained from the oxygen saturation monitor.

Cognitive Level: Analyzing
Client Need: Physiological Integrity
Client Need Sub: Physiological Adaptation
QSEN Competencies: III.A.5. Explain the role of evidence in determining best clinical practice
AACN Essential Competencies: IX.1. Conduct comprehensive and focused physical, behavioral, psychological, spiritual, socioeconomic, and environmental assessments of health and illness parameters in clients, using developmentally and culturally appropriate approaches
NLN Competencies: Context and Environment: Conduct population-based transcultural health assessments and interventions
Nursing/Integrated Concepts: Nursing Process: Implementation
Learning Outcome: Describe factors that affect the measurement of:

a. Temperature.
b. Pulse.
c. Respirations.
d. Blood pressure.
e. Oxygen saturation.

Page Number: pp. 47-48

Question 23
Type: MCMA

Which factors could influence oral temperature measurement?

Standard Text: Select all that apply.

1. Smoking

2. Eating or drinking

3. Exercise

4. Perfusion

5. Time of day

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Correct Answer: 1,2,3,5

Rationale 1: If the client has smoked a cigarette, the nurse should wait 15–30 minutes before measuring temperature because of the heat created in the oral cavity by the inhaled smoke. Eating or drinking will alter temperature readings, and the nurse should postpone temperature assessment 15–30 minutes after intake. The client who is exercising will have a slight elevation in temperature due to the heat produced by the muscles. Temperature readings have been shown to be lower in the morning than in the evening. Perfusion does not impact oral temperature readings, because the sublingual area is a very vascular area that is not greatly impacted by reduced peripheral perfusion.

Rationale 2: If the client has smoked a cigarette, the nurse should wait 15–30 minutes before measuring temperature because of the heat created in the oral cavity by the inhaled smoke. Eating or drinking will alter temperature readings, and the nurse should postpone temperature assessment 15–30 minutes after intake. The client who is exercising will have a slight elevation in temperature due to the heat produced by the muscles. Temperature readings have been shown to be lower in the morning than in the evening. Perfusion does not impact oral temperature readings, because the sublingual area is a very vascular area that is not greatly impacted by reduced peripheral perfusion.

Rationale 3: If the client has smoked a cigarette, the nurse should wait 15–30 minutes before measuring temperature because of the heat created in the oral cavity by the inhaled smoke. Eating or drinking will alter temperature readings, and the nurse should postpone temperature assessment 15–30 minutes after intake. The client who is exercising will have a slight elevation in temperature due to the heat produced by the muscles. Temperature readings have been shown to be lower in the morning than in the evening. Perfusion does not impact oral temperature readings, because the sublingual area is a very vascular area that is not greatly impacted by reduced peripheral perfusion.

Rationale 4: If the client has smoked a cigarette, the nurse should wait 15–30 minutes before measuring temperature because of the heat created in the oral cavity by the inhaled smoke. Eating or drinking will alter temperature readings, and the nurse should postpone temperature assessment 15–30 minutes after intake. The client who is exercising will have a slight elevation in temperature due to the heat produced by the muscles. Temperature readings have been shown to be lower in the morning than in the evening. Perfusion does not impact oral temperature readings, because the sublingual area is a very vascular area that is not greatly impacted by reduced peripheral perfusion.

Rationale 5: If the client has smoked a cigarette, the nurse should wait 15–30 minutes before measuring temperature because of the heat created in the oral cavity by the inhaled smoke. Eating or drinking will alter temperature readings, and the nurse should postpone temperature assessment 15–30 minutes after intake. The client who is exercising will have a slight elevation in temperature due to the heat produced by the muscles. Temperature readings have been shown to be lower in the morning than in the evening. Perfusion does not impact oral temperature readings, because the sublingual area is a very vascular area that is not greatly impacted by reduced peripheral perfusion.

Global Rationale: If the client has smoked a cigarette, the nurse should wait 15–30 minutes before measuring temperature because of the heat created in the oral cavity by the inhaled smoke. Eating or drinking will alter temperature readings, and the nurse should postpone temperature assessment 15–30 minutes after intake. The client who is exercising will have a slight elevation in temperature due to the heat produced by the muscles. Temperature readings have been shown to be lower in the morning than in the evening. Perfusion does not impact oral temperature readings, because the sublingual area is a very vascular area that is not greatly impacted by reduced peripheral perfusion.

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Cognitive Level: Remembering
Client Need: Physiological Integrity
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QSEN Competencies: III.A.5. Explain the role of evidence in determining best clinical practice
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Learning Outcome: Describe factors that affect the measurement of:

a. Temperature.
b. Pulse.
c. Respirations.
d. Blood pressure.
e. Oxygen saturation.

Page Number: p. 23

Question 24
Type: MCMA

Which factors could influence pulse measurement?

Standard Text: Select all that apply.

1. Activity

2. Temperature

3. Stress

4. Antibiotic medications

5. Hydration

Correct Answer: 1,2,3,5

Rationale 1: As the client moves or exercises, heart rate will increase. A client with a fever will have an increased heart rate. Stress increases heart rate. A client experiencing dehydration will have an increased heart rate. Antibiotics do not impact heart rate, although if the client has a fever associated with the need for antibiotics, that could increase the heart rate.

Rationale 2: As the client moves or exercises, heart rate will increase. A client with a fever will have an increased heart rate. Stress increases heart rate. A client experiencing dehydration will have an increased heart rate. Antibiotics do not impact heart rate, although if the client has a fever associated with the need for antibiotics, that could increase the heart rate.

Rationale 3: As the client moves or exercises, heart rate will increase. A client with a fever will have an increased heart rate. Stress increases heart rate. A client experiencing dehydration will have an increased heart rate.

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Antibiotics do not impact heart rate, although if the client has a fever associated with the need for antibiotics, that could increase the heart rate.

Rationale 4: As the client moves or exercises, heart rate will increase. A client with a fever will have an increased heart rate. Stress increases heart rate. A client experiencing dehydration will have an increased heart rate. Antibiotics do not impact heart rate, although if the client has a fever associated with the need for antibiotics, that could increase the heart rate.

Rationale 5: As the client moves or exercises, heart rate will increase. A client with a fever will have an increased heart rate. Stress increases heart rate. A client experiencing dehydration will have an increased heart rate. Antibiotics do not impact heart rate, although if the client has a fever associated with the need for antibiotics, that could increase the heart rate.

Global Rationale: As the client moves or exercises, heart rate will increase. A client with a fever will have an increased heart rate. Stress increases heart rate. A client experiencing dehydration will have an increased heart rate. Antibiotics do not impact heart rate, although if the client has a fever associated with the need for antibiotics, that could increase the heart rate.

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Client Need: Physiological Integrity
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d. Blood pressure.
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Page Number: p. 29

Question 25
Type: MCMA

Which factors could influence respiratory rate measurement?

Standard Text: Select all that apply.

1. Age

2. Exercise

3. Fever

4. Medications

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5. Rapid heart rate

Correct Answer: 1,2,3,4

Rationale 1: As age increases, respiratory rate gradually decreases. Respirations increase in rate and depth with exercise to supply oxygen to the working muscles. Fever will increase a client's respiratory rate as the body attempts to lower the temperature by releasing heat. Many medications impact respiratory rate. Narcotics and central nervous system depressants reduce respiratory rate, whereas stimulants can increase respiratory rate. A rapid heart rate usually will not impact respiratory rate, but a slowing heart rate could cause apnea.

Rationale 2: As age increases, respiratory rate gradually decreases. Respirations increase in rate and depth with exercise to supply oxygen to the working muscles. Fever will increase a client's respiratory rate as the body attempts to lower the temperature by releasing heat. Many medications impact respiratory rate. Narcotics and central nervous system depressants reduce respiratory rate, whereas stimulants can increase respiratory rate. A rapid heart rate usually will not impact respiratory rate, but a slowing heart rate could cause apnea.

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a. Temperature.
b. Pulse.
c. Respirations.
d. Blood pressure.
e. Oxygen saturation.

Page Number: p. 37

Question 26
Type: MCMA

Which factors could influence blood pressure measurement?

Standard Text: Select all that apply.

1. Age

2. Height

3. Sex

4. Race

5. Obesity

Correct Answer: 1,3,4,5

Rationale 1: Systolic and diastolic pressures rise gradually with age until adulthood, and then again in the elderly. Height does not have an impact on blood pressure. Women usually have lower blood pressure than men of the same age. African Americans over 35 tend to have higher blood pressure than European American males of the same age. Obesity predisposes persons to hypertension.

Rationale 2: Systolic and diastolic pressures rise gradually with age until adulthood, and then again in the elderly. Height does not have an impact on blood pressure. Women usually have lower blood pressure than men of the same age. African Americans over 35 tend to have higher blood pressure than European American males of the same age. Obesity predisposes persons to hypertension.

Rationale 3: Systolic and diastolic pressures rise gradually with age until adulthood, and then again in the elderly. Height does not have an impact on blood pressure. Women usually have lower blood pressure than men of the same age. African Americans over 35 tend to have higher blood pressure than European American males of the same age. Obesity predisposes persons to hypertension.

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b. Pulse.
c. Respirations.
d. Blood pressure.
e. Oxygen saturation.
Page Number: p. 40

Question 27
Type: MCMA

Which factors could influence oxygen saturation measurement?

Standard Text: Select all that apply.

1. Hemoglobin

2. Hematocrit

3. Carbon dioxide poisoning

4. Activity

5. Circulation

Correct Answer: 1,4,5

Rationale 1: Hemoglobin is required to carry oxygen. A client who is severely anemic might have hemoglobin that is fully saturated with oxygen but inadequate oxygen to supply the tissues, yet the pulse oximeter will return a normal value. Hematocrit values have no impact on oximeter readings. Carbon monoxide, not dioxide, poisoning will yield false measurements because the oximeter cannot discriminate between hemoglobin saturated with carbon monoxide versus oxygen. Shivering or excessive movement of the oximeter sensor site will interfere with

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accurate readings. The oximeter will not return an accurate reading if the sensor is placed in an area with reduced circulation.

Rationale 2: Hemoglobin is required to carry oxygen. A client who is severely anemic might have hemoglobin that is fully saturated with oxygen but inadequate oxygen to supply the tissues, yet the pulse oximeter will return a normal value. Hematocrit values have no impact on oximeter readings. Carbon monoxide, not dioxide, poisoning will yield false measurements because the oximeter cannot discriminate between hemoglobin saturated with carbon monoxide versus oxygen. Shivering or excessive movement of the oximeter sensor site will interfere with accurate readings. The oximeter will not return an accurate reading if the sensor is placed in an area with reduced circulation.

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b. Pulse.
c. Respirations.
d. Blood pressure.
e. Oxygen saturation.
Page Number: p. 46

Question 28
Type: MCMA

The nurse is caring for a client with a fever of 101.8°F oral. Which other vital signs would the nurse anticipate would be affected?

Standard Text: Select all that apply.

1. Pulse rate

2. Respiratory rate

3. Diastolic blood pressure

4. Systolic blood pressure

5. Oxygen saturation

Correct Answer: 1,2

Rationale 1: Pulse and respiratory rate will increase with fever. The client's oxygen saturation might remain normal with a fever unless his respiratory status is compromised, and then the increased demand for oxygen could cause a drop in oxygen saturation. Blood pressure is usually not significantly impacted by fever.

Rationale 2: Pulse and respiratory rate will increase with fever. The client's oxygen saturation might remain normal with a fever unless his respiratory status is compromised, and then the increased demand for oxygen could cause a drop in oxygen saturation. Blood pressure is usually not significantly impacted by fever.

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b. Pulse.
c. Respirations.
d. Blood pressure.
e. Oxygen saturation.
Page Number: pp. 29, 37

Question 29
Type: MCSA

Which client would the nurse anticipate to most likely have a higher-than-normal pulse rate?

1. An obese young adult client admitted for a fractured femur requiring traction

2. A middle-aged adult client with hypertension admitted for removal of a tumor that might be cancerous

3. A febrile elderly client with diabetes admitted for treatment of cellulitis

4. An adolescent client admitted with an anxiety disorder

Correct Answer: 3

Rationale 1: The elderly client is more likely to have a faster heart rate than are younger clients, and with the addition of a fever and a diagnosis of diabetes that increases the risk of peripheral vascular disease, the risk for an elevated pulse rate is almost a certainty. The client who is obese could have a higher heart rate, but because she is on bed rest, she is not at greatest risk. The hypertensive client is experiencing a stressful event—both states can elevate heart rate—but has fewer risk factors than does the elderly client. The adolescent client would be expected to have a lower heart rate than an elderly client, and has only one factor influencing heart rate elevation.

Rationale 2: The elderly client is more likely to have a faster heart rate than are younger clients, and with the addition of a fever and a diagnosis of diabetes that increases the risk of peripheral vascular disease, the risk for an elevated pulse rate is almost a certainty. The client who is obese could have a higher heart rate, but because she is on bed rest, she is not at greatest risk. The hypertensive client is experiencing a stressful event—both states can elevate heart rate—but has fewer risk factors than does the elderly client. The adolescent client would be expected to have a lower heart rate than an elderly client, and has only one factor influencing heart rate elevation.

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Rationale 3: The elderly client is more likely to have a faster heart rate than are younger clients, and with the addition of a fever and a diagnosis of diabetes that increases the risk of peripheral vascular disease, the risk for an elevated pulse rate is almost a certainty. The client who is obese could have a higher heart rate, but because she is on bed rest, she is not at greatest risk. The hypertensive client is experiencing a stressful event—both states can elevate heart rate—but has fewer risk factors than does the elderly client. The adolescent client would be expected to have a lower heart rate than an elderly client, and has only one factor influencing heart rate elevation.

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b. Pulse.
c. Respirations.
d. Blood pressure.
e. Oxygen saturation.

Page Number: p. 29

Question 30
Type: MCSA

The nurse working in an outpatient clinic provides care for a client who arrives a few minutes late for an appointment. The client is diaphoretic with a respiratory rate of 24 breaths per minute. Which is the priority action by the nurse?

1. Call the health care provider STAT to examine the client.

2. Apply oxygen and sit the client up.

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3. Assess the client.

4. Document the client's status, and place the chart so that the primary care provider is aware the client is ready to be seen.

Correct Answer: 3

Rationale 1: Although the client's symptoms indicate a potential problem, the nurse first must assess the client. Perhaps the client ran up several flights of stairs because he was running late for an appointment. It would be irresponsible practice to treat the client before assessing him first. After assessing the client, the nurse can determine the best course of action.

Rationale 2: Although the client's symptoms indicate a potential problem, the nurse first must assess the client. Perhaps the client ran up several flights of stairs because he was running late for an appointment. It would be irresponsible practice to treat the client before assessing him first. After assessing the client, the nurse can determine the best course of action.

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Global Rationale: Although the client's symptoms indicate a potential problem, the nurse first must assess the client. Perhaps the client ran up several flights of stairs because he was running late for an appointment. It would be irresponsible practice to treat the client before assessing him first. After assessing the client, the nurse can determine the best course of action.

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c. Respirations.
d. Blood pressure.
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Page Number: pp. 37-38

Question 31

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Type: MCMA

The clinic nurse measures the client's blood pressure and obtains a reading of 144/82. The client's baseline blood pressure has been normal. For what factors would the nurse assess the client based on the current blood pressure reading?

Standard Text: Select all that apply.

1. Diet

2. Medication history

3. Activity

4. History of recent symptoms of hypertension

5. Recent stress factors the client has experienced

Correct Answer: 1,2,3,5

Rationale 1: The client's diet should be assessed because foods high in sodium could elevate the systolic pressure mildly. The nurse should also assess the client's medication history and activity, as these can impact blood pressure. There is not likely to be a history of symptoms of hypertension, because borderline hypertension usually does not cause symptoms. The client's exposure to stress such as financial pressures and family issues can cause an elevation in systolic pressure.

Rationale 2: The client's diet should be assessed because foods high in sodium could elevate the systolic pressure mildly. The nurse should also assess the client's medication history and activity, as these can impact blood pressure. There is not likely to be a history of symptoms of hypertension, because borderline hypertension usually does not cause symptoms. The client's exposure to stress such as financial pressures and family issues can cause an elevation in systolic pressure.

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a. Temperature.
b. Pulse.
c. Respirations.
d. Blood pressure.
e. Oxygen saturation.

Page Number: p. 40

Question 32
Type: MCSA

The nurse is caring for a homeless client brought to the emergency department with possible hypothermia. The nurse places the pulse oximeter probe on the client's finger and gets a reading of 38%. The client's respiratory rate is 22 breaths per minute, breath sounds are clear and equal, color is pale pink, and the client denies any history of respiratory distress. Which is the priority action by the nurse?

1. Apply oxygen

2. Call the health care provider

3. Call the rapid response team

4. Move the pulse oximetry sensor to the ear or nose

Correct Answer: 4

Rationale 1: The nurse should move the sensor to a central area, such as the ear or nose, because the client who was exposed to the cold most likely has diminished peripheral perfusion, which could give a falsely low oximetry reading. The client's assessment does not indicate respiratory distress, so application of oxygen or calling the health care provider would not be warranted at this time. The rapid response team usually is not required in the emergency department because there are health care providers available.

Rationale 2: The nurse should move the sensor to a central area, such as the ear or nose, because the client who was exposed to the cold most likely has diminished peripheral perfusion, which could give a falsely low oximetry

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a. Temperature.
b. Pulse.
c. Respirations.
d. Blood pressure.
e. Oxygen saturation.

Page Number: pp. 47-48

Question 33
Type: MCSA

Which set of vital signs obtained by the nurse would indicate the need to notify the health care provider?

1. Postoperative client who had abdominal surgery has vital signs of 99.8°F oral; 120; 10; 108/56.

2. Pulse oximeter probe on the finger of a client diagnosed with hypotension reads 72%.

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3. Client who successfully walked the entire hallway after 2 weeks of bed rest has vital signs of 98.8°F oral; 108; 22; 140/88.

4. Client with no significant medical history who has recently been selected to be a member of the U.S. Olympic swimming team has vital signs of 98.6°F oral; 52; 12; 98/52.

Correct Answer: 1

Rationale 1: The postoperative client is demonstrating tachycardia and mildly depressed respirations, which could indicate blood loss or dehydration, which is further supported by the mildly elevated temperature. The client with hypotension and a low oxygen saturation reading might be seeing the result of poor perfusion to the sensor site. The sensor should be moved and the client further assessed prior to notifying the primary care provider. It would be expected that the client on bed rest who walked the hall for the first time could be mildly tachycardic and tachypneic. Athletic individuals who are well conditioned often have reduced heart rate and blood pressures, so this client's vital signs might be normal for this individual.

Rationale 2: The postoperative client is demonstrating tachycardia and mildly depressed respirations, which could indicate blood loss or dehydration, which is further supported by the mildly elevated temperature. The client with hypotension and a low oxygen saturation reading might be seeing the result of poor perfusion to the sensor site. The sensor should be moved and the client further assessed prior to notifying the primary care provider. It would be expected that the client on bed rest who walked the hall for the first time could be mildly tachycardic and tachypneic. Athletic individuals who are well conditioned often have reduced heart rate and blood pressures, so this client's vital signs might be normal for this individual.

Rationale 3: The postoperative client is demonstrating tachycardia and mildly depressed respirations, which could indicate blood loss or dehydration, which is further supported by the mildly elevated temperature. The client with hypotension and a low oxygen saturation reading might be seeing the result of poor perfusion to the sensor site. The sensor should be moved and the client further assessed prior to notifying the primary care provider. It would be expected that the client on bed rest who walked the hall for the first time could be mildly tachycardic and tachypneic. Athletic individuals who are well conditioned often have reduced heart rate and blood pressures, so this client's vital signs might be normal for this individual.

Rationale 4: The postoperative client is demonstrating tachycardia and mildly depressed respirations, which could indicate blood loss or dehydration, which is further supported by the mildly elevated temperature. The client with hypotension and a low oxygen saturation reading might be seeing the result of poor perfusion to the sensor site. The sensor should be moved and the client further assessed prior to notifying the primary care provider. It would be expected that the client on bed rest who walked the hall for the first time could be mildly tachycardic and tachypneic. Athletic individuals who are well conditioned often have reduced heart rate and blood pressures, so this client's vital signs might be normal for this individual.

Global Rationale: The postoperative client is demonstrating tachycardia and mildly depressed respirations, which could indicate blood loss or dehydration, which is further supported by the mildly elevated temperature. The client with hypotension and a low oxygen saturation reading might be seeing the result of poor perfusion to the sensor site. The sensor should be moved and the client further assessed prior to notifying the primary care provider. It would be expected that the client on bed rest who walked the hall for the first time could be mildly tachycardic and tachypneic. Athletic individuals who are well conditioned often have reduced heart rate and blood pressures, so this client's vital signs might be normal for this individual.

Cognitive Level: Analyzing
Client Need: Physiological Integrity

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Client Need Sub: Reduction of Risk Potential
QSEN Competencies: III.A.5. Explain the role of evidence in determining best clinical practice
AACN Essential Competencies: IX.1. Conduct comprehensive and focused physical, behavioral, psychological, spiritual, socioeconomic, and environmental assessments of health and illness parameters in clients, using developmentally and culturally appropriate approaches
NLN Competencies: Context and Environment: Conduct population-based transcultural health assessments and interventions
Nursing/Integrated Concepts: Nursing Process: Assessment
Learning Outcome: Describe factors that affect the measurement of:
a. Temperature.
b. Pulse.
c. Respirations.
d. Blood pressure.
e. Oxygen saturation.
Page Number: pp. 29-40

Question 34
Type: MCSA

The nurse is reviewing a client's vital signs from birth to age 10. Which changes would the nurse expect to find?

1. Reduction in temperature, increase in heart rate, decrease in respiratory rate, and increase in blood pressure

2. Reduction in oxygen saturation, decreased heart and respiratory rate, and decreased blood pressure

3. Reduced heart and respiratory rate and increased blood pressure

4. Decreased temperature, reduced heart and respiratory rate, and increased blood pressure

Correct Answer: 3

Rationale 1: The nurse would expect to see a reduced heart and respiratory rate, and an increase in blood pressure from birth through childhood. Oxygen saturation and temperature will not normally change throughout childhood.

Rationale 2: The nurse would expect to see a reduced heart and respiratory rate, and an increase in blood pressure from birth through childhood. Oxygen saturation and temperature will not normally change throughout childhood.

Rationale 3: The nurse would expect to see a reduced heart and respiratory rate, and an increase in blood pressure from birth through childhood. Oxygen saturation and temperature will not normally change throughout childhood.

Rationale 4: The nurse would expect to see a reduced heart and respiratory rate, and an increase in blood pressure from birth through childhood. Oxygen saturation and temperature will not normally change throughout childhood.

Global Rationale: The nurse would expect to see a reduced heart and respiratory rate, and an increase in blood pressure from birth through childhood. Oxygen saturation and temperature will not normally change throughout childhood.

Cognitive Level: Remembering
Client Need: Physiological Integrity
Client Need Sub: Physiological Adapatation

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QSEN Competencies: I.B.3. Provide client-centered care with sensitivity and respect for the diversity of human experience
AACN Essential Competencies: IX.1. Conduct comprehensive and focused physical, behavioral, psychological, spiritual, socioeconomic, and environmental assessments of health and illness parameters in clients, using developmentally and culturally appropriate approaches
NLN Competencies: Context and Environment: Conduct population-based transcultural health assessments and interventions
Nursing/Integrated Concepts: Nursing Process: Assessment
Learning Outcome: Predict the variations in vital signs that occur from infancy to old age.
Page Number:

Question 35
Type: MCSA

The nurse is working at a local fair on a warm day in August. Which reading would concern the nurse the most?

1. 22-year-old man with temperature of 100.2°F oral

2. 74-year-old woman with temperature of 100.8°F oral

3. Newborn temperature of 99.6°F axillary

4. Middle-aged adult with temperature of 99.2°F oral

Correct Answer: 2

Rationale 1: Older adult clients do not have efficient temperature regulatory systems, placing them at increased risk for hypothermia and hyperthermia. On a warm day, an older adult client with a temperature of 100.8°F would be a concern to the nurse, who would attempt to cool the client and encourage fluid intake. It is not unusual for the other adult clients to have a mildly elevated temperature on a warm day. Newborns' temperatures are highly dependent on environmental temperature and how they are dressed, so the infant should be undressed and allowed to cool, and then temperature should be reassessed.

Rationale 2: Older adult clients do not have efficient temperature regulatory systems, placing them at increased risk for hypothermia and hyperthermia. On a warm day, an older adult client with a temperature of 100.8°F would be a concern to the nurse, who would attempt to cool the client and encourage fluid intake. It is not unusual for the other adult clients to have a mildly elevated temperature on a warm day. Newborns' temperatures are highly dependent on environmental temperature and how they are dressed, so the infant should be undressed and allowed to cool, and then temperature should be reassessed.

Rationale 3: Older adult clients do not have efficient temperature regulatory systems, placing them at increased risk for hypothermia and hyperthermia. On a warm day, an older adult client with a temperature of 100.8°F would be a concern to the nurse, who would attempt to cool the client and encourage fluid intake. It is not unusual for the other adult clients to have a mildly elevated temperature on a warm day. Newborns' temperatures are highly dependent on environmental temperature and how they are dressed, so the infant should be undressed and allowed to cool, and then temperature should be reassessed.

Rationale 4: Older adult clients do not have efficient temperature regulatory systems, placing them at increased risk for hypothermia and hyperthermia. On a warm day, an older adult client with a temperature of 100.8°F would be a concern to the nurse, who would attempt to cool the client and encourage fluid intake. It is not unusual for the other adult clients to have a mildly elevated temperature on a warm day. Newborns' temperatures are highly

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dependent on environmental temperature and how they are dressed, so the infant should be undressed and allowed to cool, and then temperature should be reassessed.

Global Rationale: Older adult clients do not have efficient temperature regulatory systems, placing them at increased risk for hypothermia and hyperthermia. On a warm day, an older adult client with a temperature of 100.8°F would be a concern to the nurse, who would attempt to cool the client and encourage fluid intake. It is not unusual for the other adult clients to have a mildly elevated temperature on a warm day. Newborns' temperatures are highly dependent on environmental temperature and how they are dressed, so the infant should be undressed and allowed to cool, and then temperature should be reassessed.

Cognitive Level: Applying
Client Need: Physiological Integrity
Client Need Sub: Physiological Adaptation
QSEN Competencies: I.B.3. Provide client-centered care with sensitivity and respect for the diversity of human experience
AACN Essential Competencies: IX.1. Conduct comprehensive and focused physical, behavioral, psychological, spiritual, socioeconomic, and environmental assessments of health and illness parameters in clients, using developmentally and culturally appropriate approaches
NLN Competencies: Context and Environment: Conduct population-based transcultural health assessments and interventions
Nursing/Integrated Concepts: Nursing Process: Assessment
Learning Outcome: Predict the variations in vital signs that occur from infancy to old age.
Page Number: pp. 37, 39, 45

Question 36
Type: MCSA

The nurse working in the delivery room assesses a newborn infant delivered vaginally. The infant has a strong cry, is moving all extremities vigorously, and its color is pink. Which action by the nurse is the priority?

1. Stimulate the infant.

2. Encourage infant-maternal bonding.

3. Dry the infant.

4. Administer oxygen.

Correct Answer: 3

Rationale 1: The nurse's priority action is to dry the infant, because heat can be lost through condensation if the infant's skin is wet. The infant is vigorous, and so does not require stimulation; color is pink, and so oxygen is not needed; and bonding should be fostered as soon as the infant is dried.

Rationale 2: The nurse's priority action is to dry the infant, because heat can be lost through condensation if the infant's skin is wet. The infant is vigorous, and so does not require stimulation; color is pink, and so oxygen is not needed; and bonding should be fostered as soon as the infant is dried.

Rationale 3: The nurse's priority action is to dry the infant, because heat can be lost through condensation if the infant's skin is wet. The infant is vigorous, and so does not require stimulation; color is pink, and so oxygen is not needed; and bonding should be fostered as soon as the infant is dried.

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Rationale 4: The nurse's priority action is to dry the infant, because heat can be lost through condensation if the infant's skin is wet. The infant is vigorous, and so does not require stimulation; color is pink, and so oxygen is not needed; and bonding should be fostered as soon as the infant is dried.

Global Rationale: The nurse's priority action is to dry the infant, because heat can be lost through condensation if the infant's skin is wet. The infant is vigorous, and so does not require stimulation; color is pink, and so oxygen is not needed; and bonding should be fostered as soon as the infant is dried.

Cognitive Level: Analyzing
Client Need: Physiological Integrity
Client Need Sub: Reduction of Risk Potential
QSEN Competencies: I.B.3. Provide client-centered care with sensitivity and respect for the diversity of human experience
AACN Essential Competencies: IX.1. Conduct comprehensive and focused physical, behavioral, psychological, spiritual, socioeconomic, and environmental assessments of health and illness parameters in clients, using developmentally and culturally appropriate approaches
NLN Competencies: Context and Environment: Conduct population-based transcultural health assessments and interventions
Nursing/Integrated Concepts: Nursing Process: Implementation
Learning Outcome: Predict the variations in vital signs that occur from infancy to old age.
Page Number: p. 28

Question 37
Type: FIB

What is a normal oral temperature range for an adult client?
____ to ____°F

Standard Text: Record your answer as appropriate.

Correct Answer: 98°F to 98.6°F

Rationale: The normal oral temperature range for an adult client is 98°F to 98.6°F.

Global Rationale: The normal oral temperature range for an adult client is 98°F to 98.6°F.

Cognitive Level: Understanding
Client Need: Physiological Integrity
Client Need Sub: Physiological Adaptation
QSEN Competencies: I.B.3. Provide client-centered care with sensitivity and respect for the diversity of human experience
AACN Essential Competencies: IX.1. Conduct comprehensive and focused physical, behavioral, psychological, spiritual, socioeconomic, and environmental assessments of health and illness parameters in clients, using developmentally and culturally appropriate approaches
NLN Competencies: Context and Environment: Conduct population-based transcultural health assessments and interventions
Nursing/Integrated Concepts: Nursing Process: Assessment
Learning Outcome: Identify the normal range for:
a. Temperature.
b. Pulse.
c. Respirations.
d. Blood pressure.
e. Oxygen saturation.

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Page Number: p. 22

Question 38
Type: FIB

What is a normal pulse range for an adult?
____ to ____ beats per minute

Standard Text: Record your answer rounding to the nearest whole number.

Correct Answer: 60–100

Rationale: Normal pulse range for an adult is 60–100 beats per minute, with 80 being an average pulse rate.

Global Rationale: Normal pulse range for an adult is 60–100 beats per minute, with 80 being an average pulse rate.

Cognitive Level: Understanding
Client Need: Physiological Integrity
Client Need Sub: Physiological Adaptation
QSEN Competencies: I.B.3. Provide client-centered care with sensitivity and respect for the diversity of human experience
AACN Essential Competencies: IX.1. Conduct comprehensive and focused physical, behavioral, psychological, spiritual, socioeconomic, and environmental assessments of health and illness parameters in clients, using developmentally and culturally appropriate approaches
NLN Competencies: Context and Environment: Conduct population-based transcultural health assessments and interventions
Nursing/Integrated Concepts: Nursing Process: Assessment
Learning Outcome: Identify the normal range for:
a. Temperature.
b. Pulse.
c. Respirations.
d. Blood pressure.
e. Oxygen saturation.
Page Number: p. 29

Question 39
Type: FIB

What is a normal respiratory range for an adult?
____ to ____ breaths per minute

Standard Text: Record your answer rounding to the nearest whole number.

Correct Answer: 12–20

Rationale: 12–20 breaths per minute is an average range of respirations for an adult.

Global Rationale: 12–20 breaths per minute is an average range of respirations for an adult.

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Cognitive Level: Understanding
Client Need: Physiological Integrity
Client Need Sub: Physiological Adaptation
QSEN Competencies: I.B.3. Provide client-centered care with sensitivity and respect for the diversity of human experience
AACN Essential Competencies: IX.1. Conduct comprehensive and focused physical, behavioral, psychological, spiritual, socioeconomic, and environmental assessments of health and illness parameters in clients, using developmentally and culturally appropriate approaches
NLN Competencies: Context and Environment: Conduct population-based transcultural health assessments and interventions
Nursing/Integrated Concepts: Nursing Process: Assessment
Learning Outcome: Identify the normal range for:
a. Temperature.
b. Pulse.
c. Respirations.
d. Blood pressure.
e. Oxygen saturation.
Page Number: p. 29

Question 40
Type: FIB

What is a normal range for an adult's blood pressure reading?
____ to ____ mmHg diastolic
____ to ____ mmHg systolic

Standard Text: Record your answer rounding to the nearest whole number.

Correct Answer: 60–90; 90–140

Rationale: The normal blood pressure range for an adult is 60–90 mmHg diastolic and 90–140 mmHg systolic.

Global Rationale: The normal blood pressure range for an adult is 60–90 mmHg diastolic and 90–140 mmHg systolic.

Cognitive Level: Understanding
Client Need: Physiological Integrity
Client Need Sub: Physiological Adaptation
QSEN Competencies: I.B.3. Provide client-centered care with sensitivity and respect for the diversity of human experience
AACN Essential Competencies: IX.1. Conduct comprehensive and focused physical, behavioral, psychological, spiritual, socioeconomic, and environmental assessments of health and illness parameters in clients, using developmentally and culturally appropriate approaches
NLN Competencies: Context and Environment: Conduct population-based transcultural health assessments and interventions
Nursing/Integrated Concepts: Nursing Process: Assessment
Learning Outcome: Identify the normal range for:
a. Temperature.
b. Pulse.
c. Respirations.
d. Blood pressure.
e. Oxygen saturation.
Page Number: p. 40

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Question 41
Type: FIB

What is a normal oxygen saturation reading?
____ to ____%

Standard Text: Record your answer rounding to the nearest whole number.

Correct Answer: 95% to 100%

Rationale: Normal oxygen saturation readings range between 95% and 100%. An oxygen saturation reading less than 70% could be life-threatening.

Global Rationale: Normal oxygen saturation readings range between 95% and 100%. An oxygen saturation reading less than 70% could be life-threatening.

Cognitive Level: Understanding
Client Need: Physiological Integrity
Client Need Sub: Physiological Adaptation
QSEN Competencies: I.B.3. Provide client-centered care with sensitivity and respect for the diversity of human experience
AACN Essential Competencies: IX.1. Conduct comprehensive and focused physical, behavioral, psychological, spiritual, socioeconomic, and environmental assessments of health and illness parameters in clients, using developmentally and culturally appropriate approaches
NLN Competencies: Context and Environment: Conduct population-based transcultural health assessments and interventions
Nursing/Integrated Concepts: Nursing Process: Assessment
Learning Outcome: Identify the normal range for:
a. Temperature.
b. Pulse.
c. Respirations.
d. Blood pressure.
e. Oxygen saturation.
Page Number: p. 46

Question 42
Type: MCSA

The nurse assesses vital signs on four clients. Which client would be the first priority for the nurse to assess based on the vital signs?

1. 98.6°F; 88; 16; 134/88

2. 98.2°F; 60; 12; 92/64

3. 100.8°F; 102; 18; 136/84

4. 98.7°F; 96; 14; 156/102

Correct Answer: 4

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Rationale 1: Although the client in option 3 reflects a low-grade temperature with resulting mild tachycardia, the client in option 4 has a dangerously high blood pressure, which would be the nurse's highest priority. Options 1 and 2 reflect vital signs within normal range.

Rationale 2: Although the client in option 3 reflects a low-grade temperature with resulting mild tachycardia, the client in option 4 has a dangerously high blood pressure, which would be the nurse's highest priority. Options 1 and 2 reflect vital signs within normal range.

Rationale 3: Although the client in option 3 reflects a low-grade temperature with resulting mild tachycardia, the client in option 4 has a dangerously high blood pressure, which would be the nurse's highest priority. Options 1 and 2 reflect vital signs within normal range.

Rationale 4: Although the client in option 3 reflects a low-grade temperature with resulting mild tachycardia, the client in option 4 has a dangerously high blood pressure, which would be the nurse's highest priority. Options 1 and 2 reflect vital signs within normal range.

Global Rationale: Although the client in option 3 reflects a low-grade temperature with resulting mild tachycardia, the client in option 4 has a dangerously high blood pressure, which would be the nurse's highest priority. Options 1 and 2 reflect vital signs within normal range.

Cognitive Level: Analyzing
Client Need: Physiological Integrity
Client Need Sub: Reduction of Risk Potential
QSEN Competencies: I.B.3. Provide client-centered care with sensitivity and respect for the diversity of human experience
AACN Essential Competencies: IX.1. Conduct comprehensive and focused physical, behavioral, psychological, spiritual, socioeconomic, and environmental assessments of health and illness parameters in clients, using developmentally and culturally appropriate approaches
NLN Competencies: Context and Environment: Conduct population-based transcultural health assessments and interventions
Nursing/Integrated Concepts: Nursing Process: Assessment
Learning Outcome: Identify the normal range for:
a. Temperature.
b. Pulse.
c. Respirations.
d. Blood pressure.
e. Oxygen saturation.
Page Number: p. 40

Question 43
Type: MCSA

The nurse is admitting a client who plays professional football. The nurse assesses vital signs and records the following measurements: 98.6°F; 48; 10; 88/54. The client says he "feels fine" and denies any symptoms. Which action by the nurse is the priority?

1. Notify the health care provider.

2. Encourage fluids.

3. Document the client's vital signs and continue the admission history.

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4. Place client in the Trendelenburg position.

Correct Answer: 3

Rationale 1: Clients in excellent physical condition will often run a lower heart rate and respiratory rate because the cardiac muscle is strong and requires fewer contractions to maintain an adequate cardiac output. There would be no need to intervene for this client.

Rationale 2: Clients in excellent physical condition will often run a lower heart rate and respiratory rate because the cardiac muscle is strong and requires fewer contractions to maintain an adequate cardiac output. There would be no need to intervene for this client.

Rationale 3: Clients in excellent physical condition will often run a lower heart rate and respiratory rate because the cardiac muscle is strong and requires fewer contractions to maintain an adequate cardiac output. There would be no need to intervene for this client.

Rationale 4: Clients in excellent physical condition will often run a lower heart rate and respiratory rate because the cardiac muscle is strong and requires fewer contractions to maintain an adequate cardiac output. There would be no need to intervene for this client.

Global Rationale: Clients in excellent physical condition will often run a lower heart rate and respiratory rate because the cardiac muscle is strong and requires fewer contractions to maintain an adequate cardiac output. There would be no need to intervene for this client.

Cognitive Level: Analyzing
Client Need: Physiological Integrity
Client Need Sub: Physiological Adaptation
QSEN Competencies: I.B.3. Provide client-centered care with sensitivity and respect for the diversity of human experience
AACN Essential Competencies: IX.1. Conduct comprehensive and focused physical, behavioral, psychological, spiritual, socioeconomic, and environmental assessments of health and illness parameters in clients, using developmentally and culturally appropriate approaches
NLN Competencies: Context and Environment: Conduct population-based transcultural health assessments and interventions
Nursing/Integrated Concepts: Nursing Process: Implementation
Learning Outcome: Identify the normal range for:
a. Temperature.
b. Pulse.
c. Respirations.
d. Blood pressure.
e. Oxygen saturation.
Page Number: pp. 29, 37

Question 44
Type: MCSA

The nurse is preparing to assess vital signs for clients currently assigned. For which client would measuring temperature via the rectal route be contraindicated?

1. A comatose client with an oral endotracheal tube in place

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2. An adolescent client who has had recent maxillofacial surgery

3. A toddler with previous temperature reading of 104.2°F axillary

4. A client with a fever who is in a chronic vegetative state

Correct Answer: 2

Rationale 1: The adolescent client is in a developmental stage where exposing the buttocks would be very embarrassing, so it would be best to take this client's temperature via the axillary or tympanic route. The comatose client or the client in a chronic vegetative state would not be embarrassed by a rectal temperature measurement, and it could be safely and accurately performed. The toddler with the extremely high temperature needs the most accurate temperature measurement, and would be an ideal candidate for measuring temperature via the rectal route.

Rationale 2: The adolescent client is in a developmental stage where exposing the buttocks would be very embarrassing, so it would be best to take this client's temperature via the axillary or tympanic route. The comatose client or the client in a chronic vegetative state would not be embarrassed by a rectal temperature measurement, and it could be safely and accurately performed. The toddler with the extremely high temperature needs the most accurate temperature measurement, and would be an ideal candidate for measuring temperature via the rectal route.

Rationale 3: The adolescent client is in a developmental stage where exposing the buttocks would be very embarrassing, so it would be best to take this client's temperature via the axillary or tympanic route. The comatose client or the client in a chronic vegetative state would not be embarrassed by a rectal temperature measurement, and it could be safely and accurately performed. The toddler with the extremely high temperature needs the most accurate temperature measurement, and would be an ideal candidate for measuring temperature via the rectal route.

Rationale 4: The adolescent client is in a developmental stage where exposing the buttocks would be very embarrassing, so it would be best to take this client's temperature via the axillary or tympanic route. The comatose client or the client in a chronic vegetative state would not be embarrassed by a rectal temperature measurement, and it could be safely and accurately performed. The toddler with the extremely high temperature needs the most accurate temperature measurement, and would be an ideal candidate for measuring temperature via the rectal route.

Global Rationale: The adolescent client is in a developmental stage where exposing the buttocks would be very embarrassing, so it would be best to take this client's temperature via the axillary or tympanic route. The comatose client or the client in a chronic vegetative state would not be embarrassed by a rectal temperature measurement, and it could be safely and accurately performed. The toddler with the extremely high temperature needs the most accurate temperature measurement, and would be an ideal candidate for measuring temperature via the rectal route.

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 Essential Competencies:
NLN Competencies: Quality and Safety: Current best practices
Nursing/Integrated Concepts: Nursing Process: Implementation

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Learning Outcome: Describe the advantages and disadvantages of the various routes of measuring body temperature (e.g., oral, rectal, axillary, tympanic, temporal artery).
Page Number: p. 28

Question 45
Type: MCSA

The nurse observes the unlicensed assistive personnel (UAP) obtaining vital signs. Which would indicate a safe temperature measurement procedure?

1. Taking an oral temperature on a 2-year-old child

2. Taking a rectal temperature on a client who had a hemorrhoidectomy earlier this morning

3. Taking an axillary temperature on a confused client who was combative earlier in the day

4. Taking a tympanic temperature on a client with a large amount of cerumen in the ear

Correct Answer: 3

Rationale 1: Taking the confused client's temperature axillary would be a safe and effective means of temperature measurement. Oral temperatures are generally contraindicated in a 2-year-old client due to the child's inability to cooperate. Rectal temperature should not be measured on a client who has had rectal surgery. The presence of a large amount of cerumen in the ear will result in an inaccurate tympanic measurement.

Rationale 2: Taking the confused client's temperature axillary would be a safe and effective means of temperature measurement. Oral temperatures are generally contraindicated in a 2-year-old client due to the child's inability to cooperate. Rectal temperature should not be measured on a client who has had rectal surgery. The presence of a large amount of cerumen in the ear will result in an inaccurate tympanic measurement.

Rationale 3: Taking the confused client's temperature axillary would be a safe and effective means of temperature measurement. Oral temperatures are generally contraindicated in a 2-year-old client due to the child's inability to cooperate. Rectal temperature should not be measured on a client who has had rectal surgery. The presence of a large amount of cerumen in the ear will result in an inaccurate tympanic measurement.

Rationale 4: Taking the confused client's temperature axillary would be a safe and effective means of temperature measurement. Oral temperatures are generally contraindicated in a 2-year-old client due to the child's inability to cooperate. Rectal temperature should not be measured on a client who has had rectal surgery. The presence of a large amount of cerumen in the ear will result in an inaccurate tympanic measurement.

Global Rationale: Taking the confused client's temperature axillary would be a safe and effective means of temperature measurement. Oral temperatures are generally contraindicated in a 2-year-old client due to the child's inability to cooperate. Rectal temperature should not be measured on a client who has had rectal surgery. The presence of a large amount of cerumen in the ear will result in an inaccurate tympanic measurement.

Cognitive Level: Applying
Client Need: Physiological Integrity
Client Need Sub: Physiological Adaptation
QSEN Competencies: III.A.5. Explain the role of evidence in determining best clinical practice

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AACN Essential Competencies:
NLN Competencies: Quality and Safety: Current best practices
Nursing/Integrated Concepts: Nursing Process: Implementation
Learning Outcome: Describe the advantages and disadvantages of the various routes of measuring body temperature (e.g., oral, rectal, axillary, tympanic, temporal artery).
Page Number: pp. 25-28

Question 46
Type: MCSA

Which client could safely have a temperature taken via the oral route?

1. A client who is confused and disoriented secondary to a diagnosis of Alzheimer disease

2. A client who had maxillofacial surgery

3. An adult client with an elevated temperature of 102.4°F

4. A client with a diagnosis of Bell palsy

Correct Answer: 3

Rationale 1: A client with an elevated temperature can safely have his temperature measured using the oral route because oral temperatures are accurate if the client can follow directions. The confused client's temperature should not be taken orally due to the risk that he will bite the thermometer. A client who had maxillofacial surgery will have his jaw wired closed, so oral temperatures are not safely performed. A client with Bell palsy might experience extreme discomfort if the nerve in the mouth is stimulated, so the temperature should be taken via an alternative route.

Rationale 2: A client with an elevated temperature can safely have his temperature measured using the oral route because oral temperatures are accurate if the client can follow directions. The confused client's temperature should not be taken orally due to the risk that he will bite the thermometer. A client who had maxillofacial surgery will have his jaw wired closed, so oral temperatures are not safely performed. A client with Bell palsy might experience extreme discomfort if the nerve in the mouth is stimulated, so the temperature should be taken via an alternative route.

Rationale 3: A client with an elevated temperature can safely have his temperature measured using the oral route because oral temperatures are accurate if the client can follow directions. The confused client's temperature should not be taken orally due to the risk that he will bite the thermometer. A client who had maxillofacial surgery will have his jaw wired closed, so oral temperatures are not safely performed. A client with Bell palsy might experience extreme discomfort if the nerve in the mouth is stimulated, so the temperature should be taken via an alternative route.

Rationale 4: A client with an elevated temperature can safely have his temperature measured using the oral route because oral temperatures are accurate if the client can follow directions. The confused client's temperature should not be taken orally due to the risk that he will bite the thermometer. A client who had maxillofacial surgery will have his jaw wired closed, so oral temperatures are not safely performed. A client with Bell palsy might experience extreme discomfort if the nerve in the mouth is stimulated, so the temperature should be taken via an alternative route.

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Global Rationale: A client with an elevated temperature can safely have his temperature measured using the oral route because oral temperatures are accurate if the client can follow directions. The confused client's temperature should not be taken orally due to the risk that he will bite the thermometer. A client who had maxillofacial surgery will have his jaw wired closed, so oral temperatures are not safely performed. A client with Bell palsy might experience extreme discomfort if the nerve in the mouth is stimulated, so the temperature should be taken via an alternative route.

Cognitive Level: Analyzing
Client Need: Physiological Integrity
Client Need Sub: Reduction of Risk Potential
QSEN Competencies: III.A.5. Explain the role of evidence in determining best clinical practice
AACN Essential Competencies:
NLN Competencies: Quality and Safety: Current best practices
Nursing/Integrated Concepts: Nursing Process: Implementation
Learning Outcome: Describe the advantages and disadvantages of the various routes of measuring body temperature (e.g., oral, rectal, axillary, tympanic, temporal artery).
Page Number: p. 23

Question 47
Type: MCSA

The most accurate pulse rate is obtained at which pulse site?

1. Radial

2. Apical

3. Brachial

4. Carotid

Correct Answer: 2

Rationale 1: The apical pulse is the site that yields the most accurate pulse rate; however, it requires the use of a stethoscope.

Rationale 2: The apical pulse is the site that yields the most accurate pulse rate; however, it requires the use of a stethoscope.

Rationale 3: The apical pulse is the site that yields the most accurate pulse rate; however, it requires the use of a stethoscope.

Rationale 4: The apical pulse is the site that yields the most accurate pulse rate; however, it requires the use of a stethoscope.

Global Rationale: The apical pulse is the site that yields the most accurate pulse rate; however, it requires the use of a stethoscope.

Cognitive Level: Remembering

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Client Need: Physiological Integrity
Client Need Sub: Physiological Adaptation
QSEN Competencies: III.A.5. Explain the role of evidence in determining best clinical practice
AACN Essential Competencies: IX.8. Implement evidence-based nursing interventions as appropriate for managing the acute and chronic care of clients and promoting health across the life span
NLN Competencies: Quality and Safety: Current best practices
Nursing/Integrated Concepts: Nursing Process: Assessment
Learning Outcome: List nine anatomic sites commonly used to assess the pulse and state the reasons for their use.
Page Number: pp. 33-35

Question 48
Type: MCSA

The nurse working at a community health center is caring for a client who required bilateral amputation of both arms. How would the nurse measure pulse rate?

1. By palpating the temporal pulse

2. By palpating the carotid pulse

3. By palpating the brachial pulse

4. By palpating the femoral pulse

Correct Answer: 1

Rationale 1: The temporal pulse site is easily accessible, and would be the best site to use when the radial pulse is not available. Care should be taken when assessing the carotid pulse not to palpate both sides at once, as this can cause a drop in blood pressure and heart rate. If the client had both arms amputated, she would not have a brachial pulse located in the center of the arm. Palpating the femoral pulse would require the client to undress.

Rationale 2: The temporal pulse site is easily accessible, and would be the best site to use when the radial pulse is not available. Care should be taken when assessing the carotid pulse not to palpate both sides at once, as this can cause a drop in blood pressure and heart rate. If the client had both arms amputated, she would not have a brachial pulse located in the center of the arm. Palpating the femoral pulse would require the client to undress.

Rationale 3: The temporal pulse site is easily accessible, and would be the best site to use when the radial pulse is not available. Care should be taken when assessing the carotid pulse not to palpate both sides at once, as this can cause a drop in blood pressure and heart rate. If the client had both arms amputated, she would not have a brachial pulse located in the center of the arm. Palpating the femoral pulse would require the client to undress.

Rationale 4: The temporal pulse site is easily accessible, and would be the best site to use when the radial pulse is not available. Care should be taken when assessing the carotid pulse not to palpate both sides at once, as this can cause a drop in blood pressure and heart rate. If the client had both arms amputated, she would not have a brachial pulse located in the center of the arm. Palpating the femoral pulse would require the client to undress.

Global Rationale: The temporal pulse site is easily accessible, and would be the best site to use when the radial pulse is not available. Care should be taken when assessing the carotid pulse not to palpate both sides at once, as

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this can cause a drop in blood pressure and heart rate. If the client had both arms amputated, she would not have a brachial pulse located in the center of the arm. Palpating the femoral pulse would require the client to undress.

Cognitive Level: Analyzing
Client Need: Physiological Integrity
Client Need Sub: Physiological Adaptation
QSEN Competencies: III.A.5. Explain the role of evidence in determining best clinical practice
AACN Essential Competencies: IX.8. Implement evidence-based nursing interventions as appropriate for managing the acute and chronic care of clients and promoting health across the life span
NLN Competencies: Quality and Safety: Current best practices
Nursing/Integrated Concepts: Nursing Process: Implementation
Learning Outcome: List nine anatomic sites commonly used to assess the pulse and state the reasons for their use.
Page Number: p. 30

Question 49
Type: MCSA

The nurse is assisting with resuscitative efforts on an infant who is experiencing cardiac arrest. Where would the nurse measure pulse rate?

1. Apical site

2. Radial site

3. Brachial site

4. Posterior tibial site

Correct Answer: 3

Rationale 1: The brachial site is easily accessible, and would be the best site for the nurse to use in this scenario. The radial site is not used on infants, and the apical site would be difficult to access when chest compressions are performed. The posterior tibial site would not yield an accurate reading due to the difficulty in finding it.

Rationale 2: The brachial site is easily accessible, and would be the best site for the nurse to use in this scenario. The radial site is not used on infants, and the apical site would be difficult to access when chest compressions are performed. The posterior tibial site would not yield an accurate reading due to the difficulty in finding it.

Rationale 3: The brachial site is easily accessible, and would be the best site for the nurse to use in this scenario. The radial site is not used on infants, and the apical site would be difficult to access when chest compressions are performed. The posterior tibial site would not yield an accurate reading due to the difficulty in finding it.

Rationale 4: The brachial site is easily accessible, and would be the best site for the nurse to use in this scenario. The radial site is not used on infants, and the apical site would be difficult to access when chest compressions are performed. The posterior tibial site would not yield an accurate reading due to the difficulty in finding it.

Global Rationale: The brachial site is easily accessible, and would be the best site for the nurse to use in this scenario. The radial site is not used on infants, and the apical site would be difficult to access when chest

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compressions are performed. The posterior tibial site would not yield an accurate reading due to the difficulty in finding it.

Cognitive Level: Analyzing
Client Need: Physiological Integrity
Client Need Sub: Physiological Adaptation
QSEN Competencies: III.A.5. Explain the role of evidence in determining best clinical practice
AACN Essential Competencies: IX.8. Implement evidence-based nursing interventions as appropriate for managing the acute and chronic care of clients and promoting health across the life span
NLN Competencies: Quality and Safety: Current best practices
Nursing/Integrated Concepts: Nursing Process: Assessment
Learning Outcome: List nine anatomic sites commonly used to assess the pulse and state the reasons for their use.
Page Number: p. 30

Question 50
Type: MCMA

The nurse is assessing the client's peripheral pulses. What would the nurse assess for?

Standard Text: Select all that apply.

1. Bilaterality

2. Regularity

3. Strength

4. Rate

5. Arrhythmia

Correct Answer: 1,2,3,4

Rationale 1: When assessing peripheral pulses, the nurse assesses for bilaterality, regularity, strength, and rate. The nurse could not determine if there were an arrhythmia without the use of an ECG.

Rationale 2: When assessing peripheral pulses, the nurse assesses for bilaterality, regularity, strength, and rate. The nurse could not determine if there were an arrhythmia without the use of an ECG.

Rationale 3: When assessing peripheral pulses, the nurse assesses for bilaterality, regularity, strength, and rate. The nurse could not determine if there were an arrhythmia without the use of an ECG.

Rationale 4: When assessing peripheral pulses, the nurse assesses for bilaterality, regularity, strength, and rate. The nurse could not determine if there were an arrhythmia without the use of an ECG.

Rationale 5: When assessing peripheral pulses, the nurse assesses for bilaterality, regularity, strength, and rate. The nurse could not determine if there were an arrhythmia without the use of an ECG.

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Global Rationale: When assessing peripheral pulses, the nurse assesses for bilaterality, regularity, strength, and rate. The nurse could not determine if there were an arrhythmia without the use of an ECG.

Cognitive Level: Remembering
Client Need: Physiological Integrity
Client Need Sub: Physiological Adaptation
QSEN Competencies: III.A.5. Explain the role of evidence in determining best clinical practice
AACN Essential Competencies: IX.1. Conduct comprehensive and focused physical, behavioral, psychological, spiritual, socioeconomic, and environmental assessments of health and illness parameters in clients, using developmentally and culturally appropriate approaches
NLN Competencies: Quality and Safety: Current best practices
Nursing/Integrated Concepts: Nursing Process: Assessment
Learning Outcome: Explain the characteristics that should be included when assessing pulses.
Page Number: pp. 30-33

Question 51
Type: MCSA

The nurse is assessing the client's peripheral pulse, and is not able to palpate a pedal pulse. The client's foot is pink and warm. Which action by the nurse is the most appropriate?

1. Apply a warm soak to the foot.

2. Notify the health care provider that the client has lost circulation to the foot.

3. Elevate the foot.

4. Auscultate the pulse using an ultrasound Doppler.

Correct Answer: 4

Rationale 1: If the pulse is not palpable, the nurse would attempt to auscultate using a Doppler. The nurse would not apply a warm soak, because there is the potential for reduced sensation if pulses are not palpable, which could result in a burn. There is no need to notify the health care provider, and elevating the foot would reduce blood flow, making the pulse more difficult to palpate.

Rationale 2: If the pulse is not palpable, the nurse would attempt to auscultate using a Doppler. The nurse would not apply a warm soak, because there is the potential for reduced sensation if pulses are not palpable, which could result in a burn. There is no need to notify the health care provider, and elevating the foot would reduce blood flow, making the pulse more difficult to palpate.

Rationale 3: If the pulse is not palpable, the nurse would attempt to auscultate using a Doppler. The nurse would not apply a warm soak, because there is the potential for reduced sensation if pulses are not palpable, which could result in a burn. There is no need to notify the health care provider, and elevating the foot would reduce blood flow, making the pulse more difficult to palpate.

Rationale 4: If the pulse is not palpable, the nurse would attempt to auscultate using a Doppler. The nurse would not apply a warm soak, because there is the potential for reduced sensation if pulses are not palpable, which could result in a burn. There is no need to notify the health care provider, and elevating the foot would reduce blood flow, making the pulse more difficult to palpate.

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Global Rationale: If the pulse is not palpable, the nurse would attempt to auscultate using a Doppler. The nurse would not apply a warm soak, because there is the potential for reduced sensation if pulses are not palpable, which could result in a burn. There is no need to notify the health care provider, and elevating the foot would reduce blood flow, making the pulse more difficult to palpate.

Cognitive Level: Applying
Client Need: Physiological Integrity
Client Need Sub: Physiological Adaptation
QSEN Competencies: III.A.5. Explain the role of evidence in determining best clinical practice
AACN Essential Competencies: IX.1. Conduct comprehensive and focused physical, behavioral, psychological, spiritual, socioeconomic, and environmental assessments of health and illness parameters in clients, using developmentally and culturally appropriate approaches
NLN Competencies: Quality and Safety: Current best practices
Nursing/Integrated Concepts: Nursing Process: Implementation
Learning Outcome: Explain the characteristics that should be included when assessing pulses.
Page Number: pp. 32-33

Question 52
Type: MCSA

The nurse admits a client with a medical diagnosis of peripheral artery disease complaining of severe pain in the right leg. Which is the nurse's priority assessment?

1. Assessing the client's femoral pulses bilaterally

2. Obtaining a thorough nursing history

3. Assessing the client's radial and brachial pulses bilaterally

4. Assessing the femoral, popliteal, posterior tibial, and pedal pulses bilaterally

Correct Answer: 4

Rationale 1: This client is at risk for arterial occlusion, and the severe pain in the right leg could be the result of reduced or absent blood flow to the leg. The nurse should assess pulses in both legs immediately, because if the leg is pale, cyanotic, or lacking in pulses, it is a surgical emergency to avoid amputation of the leg. A nursing history would be obtained after assessing the leg and notifying the primary care provider. Assessing only the femoral pulses would not be thorough, because if blood flow is occluded below the femoral pulse, it would be missed. Assessment of pulsation in the arm would be a later priority.

Rationale 2: This client is at risk for arterial occlusion, and the severe pain in the right leg could be the result of reduced or absent blood flow to the leg. The nurse should assess pulses in both legs immediately, because if the leg is pale, cyanotic, or lacking in pulses, it is a surgical emergency to avoid amputation of the leg. A nursing history would be obtained after assessing the leg and notifying the primary care provider. Assessing only the femoral pulses would not be thorough, because if blood flow is occluded below the femoral pulse, it would be missed. Assessment of pulsation in the arm would be a later priority.

Rationale 3: This client is at risk for arterial occlusion, and the severe pain in the right leg could be the result of reduced or absent blood flow to the leg. The nurse should assess pulses in both legs immediately, because if the leg is pale, cyanotic, or lacking in pulses, it is a surgical emergency to avoid amputation of the leg. A nursing

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history would be obtained after assessing the leg and notifying the primary care provider. Assessing only the femoral pulses would not be thorough, because if blood flow is occluded below the femoral pulse, it would be missed. Assessment of pulsation in the arm would be a later priority.

Rationale 4: This client is at risk for arterial occlusion, and the severe pain in the right leg could be the result of reduced or absent blood flow to the leg. The nurse should assess pulses in both legs immediately, because if the leg is pale, cyanotic, or lacking in pulses, it is a surgical emergency to avoid amputation of the leg. A nursing history would be obtained after assessing the leg and notifying the primary care provider. Assessing only the femoral pulses would not be thorough, because if blood flow is occluded below the femoral pulse, it would be missed. Assessment of pulsation in the arm would be a later priority.

Global Rationale: This client is at risk for arterial occlusion, and the severe pain in the right leg could be the result of reduced or absent blood flow to the leg. The nurse should assess pulses in both legs immediately, because if the leg is pale, cyanotic, or lacking in pulses, it is a surgical emergency to avoid amputation of the leg. A nursing history would be obtained after assessing the leg and notifying the primary care provider. Assessing only the femoral pulses would not be thorough, because if blood flow is occluded below the femoral pulse, it would be missed. Assessment of pulsation in the arm would be a later priority.

Cognitive Level: Analyzing
Client Need: Physiological Integrity
Client Need Sub: Reduction of Risk Potential
QSEN Competencies: III.A.5. Explain the role of evidence in determining best clinical practice
AACN Essential Competencies: IX.1. Conduct comprehensive and focused physical, behavioral, psychological, spiritual, socioeconomic, and environmental assessments of health and illness parameters in clients, using developmentally and culturally appropriate approaches
NLN Competencies: Quality and Safety: Current best practices
Nursing/Integrated Concepts: Nursing Process: Assessment
Learning Outcome: Explain the characteristics that should be included when assessing pulses.
Page Number: pp. 30-33

Question 53
Type: MCSA

Which respiratory finding would indicate the need for further assessment by the nurse?

1. Regular

2. Quiet

3. Deep

4. Rate of 12–20 per minute

Correct Answer: 3

Rationale 1: Normal respirations are regular and quiet at a rate of 12–20. Depth of respirations is described as normal, deep, or shallow, and would usually be normal in depth with occasional signs of deeper breaths. Continuous deep breathing would indicate the need for further assessment.

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Rationale 2: Normal respirations are regular and quiet at a rate of 12–20. Depth of respirations is described as normal, deep, or shallow, and would usually be normal in depth with occasional signs of deeper breaths. Continuous deep breathing would indicate the need for further assessment.

Rationale 3: Normal respirations are regular and quiet at a rate of 12–20. Depth of respirations is described as normal, deep, or shallow, and would usually be normal in depth with occasional signs of deeper breaths. Continuous deep breathing would indicate the need for further assessment.

Rationale 4: Normal respirations are regular and quiet at a rate of 12–20. Depth of respirations is described as normal, deep, or shallow, and would usually be normal in depth with occasional signs of deeper breaths. Continuous deep breathing would indicate the need for further assessment.

Global Rationale: Normal respirations are regular and quiet at a rate of 12–20. Depth of respirations is described as normal, deep, or shallow, and would usually be normal in depth with occasional signs of deeper breaths. Continuous deep breathing would indicate the need for further assessment.

Cognitive Level: Remembering
Client Need: Physiological Integrity
Client Need Sub: Physiological Adaptation
QSEN Competencies: III.A.5. Explain the role of evidence in determining best clinical practice
AACN Essential Competencies: IX.1. Conduct comprehensive and focused physical, behavioral, psychological, spiritual, socioeconomic, and environmental assessments of health and illness parameters in clients, using developmentally and culturally appropriate approaches
NLN Competencies: Quality and Safety: Current best practices
Nursing/Integrated Concepts: Nursing Process: Assessment
Learning Outcome: Describe assessment of the rate, depth, rhythm, and characteristics of respirations.
Page Number: p. 38

Question 54
Type: MCMA

The nurse is caring for a client experiencing dyspnea. Which symptoms would the nurse anticipate this client to have?

Standard Text: Select all that apply.

1. Rapid respirations

2. Reduced oxygen saturation

3. Noisy breath sounds

4. Deep breathing

5. Shallow breathing

Correct Answer: 1,2,3

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Rationale 1: The client with dyspnea normally will breathe faster and have lower oxygen saturation, and often has noisy breath sounds that might reveal rales, rhonchi, or wheezing. The client might breathe deeply if experiencing air hunger, or more shallowly if an obstruction exists, so it is not possible to predict depth.

Rationale 2: The client with dyspnea normally will breathe faster and have lower oxygen saturation, and often has noisy breath sounds that might reveal rales, rhonchi, or wheezing. The client might breathe deeply if experiencing air hunger, or more shallowly if an obstruction exists, so it is not possible to predict depth.

Rationale 3: The client with dyspnea normally will breathe faster and have lower oxygen saturation, and often has noisy breath sounds that might reveal rales, rhonchi, or wheezing. The client might breathe deeply if experiencing air hunger, or more shallowly if an obstruction exists, so it is not possible to predict depth.

Rationale 4: The client with dyspnea normally will breathe faster and have lower oxygen saturation, and often has noisy breath sounds that might reveal rales, rhonchi, or wheezing. The client might breathe deeply if experiencing air hunger, or more shallowly if an obstruction exists, so it is not possible to predict depth.

Rationale 5: The client with dyspnea normally will breathe faster and have lower oxygen saturation, and often has noisy breath sounds that might reveal rales, rhonchi, or wheezing. The client might breathe deeply if experiencing air hunger, or more shallowly if an obstruction exists, so it is not possible to predict depth.

Global Rationale: The client with dyspnea normally will breathe faster and have lower oxygen saturation, and often has noisy breath sounds that might reveal rales, rhonchi, or wheezing. The client might breathe deeply if experiencing air hunger, or more shallowly if an obstruction exists, so it is not possible to predict depth.

Cognitive Level: Applying
Client Need: Physiological Integrity
Client Need Sub: Physiological Adaptation
QSEN Competencies: III.A.5. Explain the role of evidence in determining best clinical practice
AACN Essential Competencies: IX.1. Conduct comprehensive and focused physical, behavioral, psychological, spiritual, socioeconomic, and environmental assessments of health and illness parameters in clients, using developmentally and culturally appropriate approaches
NLN Competencies: Quality and Safety: Current best practices
Nursing/Integrated Concepts: Nursing Process: Assessment
Learning Outcome: Describe assessment of the rate, depth, rhythm, and characteristics of respirations.
Page Number: p. 38

Question 55
Type: MCSA

The nurse is caring for a postoperative client who returned from surgery a few hours ago. The client is currently demonstrating shallow, slow breathing, with audible adventitious sounds. Which is the most likely cause for the client's clinical manifestations?

1. Low blood sugar

2. Pneumonia

3. Asthma

4. Deep narcotic sedation

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Correct Answer: 4

Rationale 1: Clients who receive narcotic analgesics can have reduced respiratory effort and ineffective airway clearance, which would be demonstrated by shallow, slow breathing and adventitious breath sounds caused by air passing over the secretions. Pneumonia, low blood sugar, or asthma would be more likely to result in rapid respirations.

Rationale 2: Clients who receive narcotic analgesics can have reduced respiratory effort and ineffective airway clearance, which would be demonstrated by shallow, slow breathing and adventitious breath sounds caused by air passing over the secretions. Pneumonia, low blood sugar, or asthma would be more likely to result in rapid respirations.

Rationale 3: Clients who receive narcotic analgesics can have reduced respiratory effort and ineffective airway clearance, which would be demonstrated by shallow, slow breathing and adventitious breath sounds caused by air passing over the secretions. Pneumonia, low blood sugar, or asthma would be more likely to result in rapid respirations.

Rationale 4: Clients who receive narcotic analgesics can have reduced respiratory effort and ineffective airway clearance, which would be demonstrated by shallow, slow breathing and adventitious breath sounds caused by air passing over the secretions. Pneumonia, low blood sugar, or asthma would be more likely to result in rapid respirations.

Global Rationale: Clients who receive narcotic analgesics can have reduced respiratory effort and ineffective airway clearance, which would be demonstrated by shallow, slow breathing and adventitious breath sounds caused by air passing over the secretions. Pneumonia, low blood sugar, or asthma would be more likely to result in rapid respirations.

Cognitive Level: Analyzing
Client Need: Physiological Integrity
Client Need Sub: Physiological Adaptation
QSEN Competencies: III.A.5. Explain the role of evidence in determining best clinical practice
AACN Essential Competencies: IX.1. Conduct comprehensive and focused physical, behavioral, psychological, spiritual, socioeconomic, and environmental assessments of health and illness parameters in clients, using developmentally and culturally appropriate approaches
NLN Competencies: Quality and Safety: Current best practices
Nursing/Integrated Concepts: Nursing Process: Assessment
Learning Outcome: Describe assessment of the rate, depth, rhythm, and characteristics of respirations.
Page Number: p. 37

Question 56
Type: MCSA

Which adult vital signs would the nurse need to report immediately?

1. 99.2°F; 100; 20; 138/88

2. 100.2°F; 88; 18; 128/72

3. 97.4°F; 96; 28; 142/82

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4. 98°F; 64; 14; 88/60

Correct Answer: 3

Rationale 1: The client with these vital signs—97.4°F; 96; 28; 142/82—has a rapid respiratory rate and a high normal heart rate, which could be secondary to respiratory distress and anxiety related to hypoxemia, so it should be reported to the health care provider immediately. The client with these vital signs—98°F; 64; 14; 88/60—needs further assessment of symptoms to determine if a problem exists, but vital signs are close to normal values, so the nurse would not be the most concerned with these measurements. The clients with these vital signs—99.2°F; 100; 20; 138/88 and 100.2°F; 88; 18; 128/72—both have mild fevers. The nurse would need to report the temperature of 100.2°F to the health care provider, but there is no urgency.

Rationale 2: The client with these vital signs—97.4°F; 96; 28; 142/82—has a rapid respiratory rate and a high normal heart rate, which could be secondary to respiratory distress and anxiety related to hypoxemia, so it should be reported to the health care provider immediately. The client with these vital signs—98°F; 64; 14; 88/60—needs further assessment of symptoms to determine if a problem exists, but vital signs are close to normal values, so the nurse would not be the most concerned with these measurements. The clients with these vital signs—99.2°F; 100; 20; 138/88 and 100.2°F; 88; 18; 128/72—both have mild fevers. The nurse would need to report the temperature of 100.2°F to the health care provider, but there is no urgency.

Rationale 3: The client with these vital signs—97.4°F; 96; 28; 142/82—has a rapid respiratory rate and a high normal heart rate, which could be secondary to respiratory distress and anxiety related to hypoxemia, so it should be reported to the health care provider immediately. The client with these vital signs—98°F; 64; 14; 88/60—needs further assessment of symptoms to determine if a problem exists, but vital signs are close to normal values, so the nurse would not be the most concerned with these measurements. The clients with these vital signs—99.2°F; 100; 20; 138/88 and 100.2°F; 88; 18; 128/72—both have mild fevers. The nurse would need to report the temperature of 100.2°F to the health care provider, but there is no urgency.

Rationale 4: The client with these vital signs—97.4°F; 96; 28; 142/82—has a rapid respiratory rate and a high normal heart rate, which could be secondary to respiratory distress and anxiety related to hypoxemia, so it should be reported to the health care provider immediately. The client with these vital signs—98°F; 64; 14; 88/60—needs further assessment of symptoms to determine if a problem exists, but vital signs are close to normal values, so the nurse would not be the most concerned with these measurements. The clients with these vital signs—99.2°F; 100; 20; 138/88 and 100.2°F; 88; 18; 128/72—both have mild fevers. The nurse would need to report the temperature of 100.2°F to the health care provider, but there is no urgency.

Global Rationale: The client with these vital signs—97.4°F; 96; 28; 142/82—has a rapid respiratory rate and a high normal heart rate, which could be secondary to respiratory distress and anxiety related to hypoxemia, so it should be reported to the health care provider immediately. The client with these vital signs—98°F; 64; 14; 88/60—needs further assessment of symptoms to determine if a problem exists, but vital signs are close to normal values, so the nurse would not be the most concerned with these measurements. The clients with these vital signs—99.2°F; 100; 20; 138/88 and 100.2°F; 88; 18; 128/72—both have mild fevers. The nurse would need to report the temperature of 100.2°F to the health care provider, but there is no urgency.

Cognitive Level: Remembering
Client Need: Physiological Integrity
Client Need Sub: Reduction of Risk Potential
QSEN Competencies: VI.B.4. Document and plan client care in an electronic health record
AACN Essential Competencies: IV.5. Use standardized terminology in a care environment that reflects nursing's unique contribution to client outcomes

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NLN Competencies: Quality and Safety: Carefully maintain and use electronic and/or written health records
Nursing/Integrated Concepts: Nursing Process: Implementation
Learning Outcome: Demonstrate appropriate documentation and reporting of vital signs.
Page Number: p. 29, 38

Question 57
Type: MCSA

The nurse is caring for a client admitted with pneumonia requiring oxygen administration. Which are the priority assessments to document for this client?

1. Pulses in all extremities

2. Respirations and oxygen saturation

3. Blood pressure and temperature

4. Pulse rate and blood pressure

Correct Answer: 2

Rationale 1: The priority assessments to document for this client will be respiratory status and oxygen saturation, as the plan of care will focus on the need for respiratory treatment and support. Complete vital signs should be measured often, but the priority is respiratory status.

Rationale 2: The priority assessments to document for this client will be respiratory status and oxygen saturation, as the plan of care will focus on the need for respiratory treatment and support. Complete vital signs should be measured often, but the priority is respiratory status.

Rationale 3: The priority assessments to document for this client will be respiratory status and oxygen saturation, as the plan of care will focus on the need for respiratory treatment and support. Complete vital signs should be measured often, but the priority is respiratory status.

Rationale 4: The priority assessments to document for this client will be respiratory status and oxygen saturation, as the plan of care will focus on the need for respiratory treatment and support. Complete vital signs should be measured often, but the priority is respiratory status.

Global Rationale: The priority assessments to document for this client will be respiratory status and oxygen saturation, as the plan of care will focus on the need for respiratory treatment and support. Complete vital signs should be measured often, but the priority is respiratory status.

Cognitive Level: Applying
Client Need: Physiological Integrity
Client Need Sub: Reduction of Risk Potential
QSEN Competencies: VI.B.4. Document and plan client care in an electronic health record
AACN Essential Competencies: IV.5. Use standardized terminology in a care environment that reflects nursing's unique contribution to client outcomes
NLN Competencies: Quality and Safety: Carefully maintain and use electronic and/or written health records

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Nursing/Integrated Concepts: Nursing Process: Implementation
Learning Outcome: Demonstrate appropriate documentation and reporting of vital signs.
Page Number: pp. 29, 37-38

Question 58
Type: SEQ

The nurse is caring for a client with vital signs 97.2°F; 112; 48; 104/86; and oxygen saturation is 76%. Place the nursing actions in order of their priority for this client.

Standard Text: Click on the down arrow for each response in the right column and select the correct choice from the list.

Response 1. Assess the client.

Response 2. Reduce client anxiety.

Response 3. Notify the health care provider.

Response 4. Obtain assistance from another nurse or member of the team.

Response 5. Administer oxygen.

Correct Answer: 5,1,4,3,2

Rationale 1: Because of the client's rapid respirations and reduced oxygen saturation, the nurse's first priority would be to administer oxygen to improve oxygenation. After oxygen is applied, the client should be assessed quickly, and the nurse should obtain assistance from another nurse or member of the team who can stay with the client or notify the health care provider. When the health care provider has been notified, or while the health care provider is being notified, the nurse should attempt to allay the client's anxiety, as that otherwise will lead to greater dyspnea.

Rationale 2: Because of the client's rapid respirations and reduced oxygen saturation, the nurse's first priority would be to administer oxygen to improve oxygenation. After oxygen is applied, the client should be assessed quickly, and the nurse should obtain assistance from another nurse or member of the team who can stay with the client or notify the health care provider. When the health care provider has been notified, or while the health care provider is being notified, the nurse should attempt to allay the client's anxiety, as that otherwise will lead to greater dyspnea.

Rationale 3: Because of the client's rapid respirations and reduced oxygen saturation, the nurse's first priority would be to administer oxygen to improve oxygenation. After oxygen is applied, the client should be assessed quickly, and the nurse should obtain assistance from another nurse or member of the team who can stay with the client or notify the health care provider. When the health care provider has been notified, or while the health care provider is being notified, the nurse should attempt to allay the client's anxiety, as that otherwise will lead to greater dyspnea.

Rationale 4: Because of the client's rapid respirations and reduced oxygen saturation, the nurse's first priority would be to administer oxygen to improve oxygenation. After oxygen is applied, the client should be assessed quickly, and the nurse should obtain assistance from another nurse or member of the team who can stay with the

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client or notify the health care provider. When the health care provider has been notified, or while the health care provider is being notified, the nurse should attempt to allay the client's anxiety, as that otherwise will lead to greater dyspnea.

Rationale 5: Because of the client's rapid respirations and reduced oxygen saturation, the nurse's first priority would be to administer oxygen to improve oxygenation. After oxygen is applied, the client should be assessed quickly, and the nurse should obtain assistance from another nurse or member of the team who can stay with the client or notify the health care provider. When the health care provider has been notified, or while the health care provider is being notified, the nurse should attempt to allay the client's anxiety, as that otherwise will lead to greater dyspnea.

Global Rationale: Because of the client's rapid respirations and reduced oxygen saturation, the nurse's first priority would be to administer oxygen to improve oxygenation. After oxygen is applied, the client should be assessed quickly, and the nurse should obtain assistance from another nurse or member of the team who can stay with the client or notify the health care provider. When the health care provider has been notified, or while the health care provider is being notified, the nurse should attempt to allay the client's anxiety, as that otherwise will lead to greater dyspnea.

Cognitive Level: Analyzing
Client Need: Physiological Integrity
Client Need Sub: Reduction of Risk Potential
QSEN Competencies: VI.B.4. Document and plan client care in an electronic health record
AACN Essential Competencies: IV.5. Use standardized terminology in a care environment that reflects nursing's unique contribution to client outcomes
NLN Competencies: Quality and Safety: Carefully maintain and use electronic and/or written health records
Nursing/Integrated Concepts: Nursing Process: Implementation
Learning Outcome: Demonstrate appropriate documentation and reporting of vital signs.
Page Number: pp. 39, 48

Question 59
Type: MCMA

Which statement should the nurse question when discussing what is included when taking vital signs?

Standard Text: Select all that apply.

1. "You are taking my temperature."

2. "You will be listening to my heart."

3. "You will be measuring what I have eaten."

4. "You will be taking my blood pressure."

5. "You will be listening to my stomach."

Correct Answer: 3,5

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Rationale 1: Temperature is measured when assessing vital signs.

Rationale 2: Heart rate is measured when assessing vital signs.

Rationale 3: Food intake is not included when assessing vital signs.

Rationale 4: Blood pressure is measured when assessing vital signs.

Rationale 5: Bowel sounds are auscultated when assessing vital signs.

Global Rationale: Temperature, pulse, and blood pressure are all measured when assessing a client's vital signs. Food intake and assessing bowel sounds are not included in a vital signs assessment.

Cognitive Level: Remembering
Client Need: Safe and Effective Care Environment
Client Need Sub: Management of Care
QSEN Competencies: II.B.3. Base individualized care plan on client values, clinical expertise, and evidence
AACN Essential Competencies: IX.1. Conduct comprehensive and focused physical, behavioral, psychological, spiritual, socioeconomic, and environmental assessments of health and illness parameters in clients, using developmentally and culturally appropriate approaches
NLN Competencies: Context and Environment: Health promotion/disease prevention
Nursing/Integrated Concepts: Nursing Process: Assessment
Learning Outcome: Identify the indications for measuring and assessing:
a. Temperature.
b. Pulse.
c. Respirations.
d. Blood pressure.
e. Oxygen saturation.
Page Number: pp. 21-22

Question 60
Type: MCSA

When is it inappropriate to measure vital signs?

1. Before and after a procedure

2. On admission to the hospital

3. When client is in pain

4. When the client is resting

Correct Answer: 4

Rationale 1: It is appropriate to measure vital signs before and after a procedure.

Rationale 2: It is appropriate to measure vital signs on admission to the hospital.

Rationale 3: It is appropriate to measure vital signs when a client is in pain.

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Rationale 4: If a client is resting and stable, there is no need to measure vital signs until the client is awake.

Global Rationale: If a client is resting and stable, there is no need to measure vital signs until the client is awake. It is appropriate to measure vital signs before and after a procedure, on admission to the hospital, and when the client is in pain.

Cognitive Level: Remembering
Client Need: Physiological Integrity
Client Need Sub: Basic Care and Comfort
QSEN Competencies: II.B.3. Base individualized care plan on client values, clinical expertise, and evidence
AACN Essential Competencies: IX.1. Conduct comprehensive and focused physical, behavioral, psychological, spiritual, socioeconomic, and environmental assessments of health and illness parameters in clients, using developmentally and culturally appropriate approaches
NLN Competencies: Context and Environment: Health promotion/disease prevention
Nursing/Integrated Concepts: Nursing Process: Assessment
Learning Outcome: Identify the indications for measuring and assessing:
a. Temperature.
b. Pulse.
c. Respirations.
d. Blood pressure.
e. Oxygen saturation.
Page Number: p. 22

Question 61
Type: MCSA

Which is the appropriate site to use when taking an infant's temperature?

1. Axillae

2. Temporal artery

3. Tympanic membrane

4. Oral cavity

Correct Answer: 1

Rationale 1: It is appropriate to monitor an infant's temperature using the axillae.

Rationale 2: The temporal artery is not an appropriate site to assess an infant's temperature.

Rationale 3: The tympanic membrane is not an appropriate site to assess an infant's temperature.

Rationale 4: The oral cavity is not an appropriate site to assess an infant's temperature.

Global Rationale: It is appropriate to monitor an infant's temperature using the axillae. It is not appropriate to use the temporal artery, the tympanic membrane, or the oral cavity to assess an infant's temperature.

Cognitive Level: Understanding

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Client Need: Physiological Integrity
Client Need Sub: Basic Care and Comfort
QSEN Competencies: III.A.5. Explain the role of evidence in determining best clinical practice
AACN Essential Competencies: IX.8. Implement evidence-based nursing interventions as appropriate for managing the acute and chronic care of clients and promoting health across the life span
NLN Competencies: Quality and Safety: Current best practices
Nursing/Integrated Concepts: Nursing Process: Planning
Learning Outcome: Verbalize the steps used to measure:
a. Temperature.
b. Pulse.
c. Respirations.
d. Blood pressure.
e. Oxygen saturation.
Page Number: p. 28

Question 62
Type: MCSA

The nurse is able to demonstrate proper placement of the stethoscope when assessing the apical pulse by placing the bell at which location?

1. The brachial site

2. The apex of the heart

3. The carotid site

4. The radial site

Correct Answer: 2

Rationale 1: An apical pulse cannot be assessed at the brachial site.

Rationale 2: An apical pulse is assessed at the apex of the heart.

Rationale 3: An apical pulse cannot be assessed at the carotid site.

Rationale 4: An apical pulse cannot be assessed at the radial site.

Global Rationale: An apical pulse is assessed at the apex of the heart. An apical pulse cannot be assessed at the brachial, carotid, and radial sites.

Cognitive Level: Remembering
Client Need: Physiological Integrity
Client Need Sub: Basic Care and Comfort
QSEN Competencies: III.A.5. Explain the role of evidence in determining best clinical practice
AACN Essential Competencies: IX.8. Implement evidence-based nursing interventions as appropriate for managing the acute and chronic care of clients and promoting health across the life span

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NLN Competencies: Quality and Safety: Current best practices
Nursing/Integrated Concepts: Nursing Process: Assessment
Learning Outcome: Verbalize the steps used to measure:
a. Temperature.
b. Pulse.
c. Respirations.
d. Blood pressure.
e. Oxygen saturation.
Page Number: pp. 33-35

Question 63
Type: MCSA

When observing the unlicensed assistive personnel (UAP) checking pedal pulses, the nurse identifies which technique as appropriate?

1. Palpating the inner aspect of the biceps muscle of the arm

2. Palpating the femoral artery as it passes alongside the inguinal ligament

3. Palpating the pulse from the middle of the ankle to the space between the big and second toe

4. Palpating the client's chest

Correct Answer: 3

Rationale 1: Palpating the inner aspect of the biceps muscle of the arm is not an appropriate technique when checking pedal pulses.

Rationale 2: Palpating the femoral artery as it passes alongside the inguinal ligament is not an appropriate technique when checking pedal pulses.

Rationale 3: This artery can be palpated by feeling the dorsum of the foot on an imaginary line from the middle of the ankle to the space between the big and second toe.

Rationale 4: Palpating the client's chest is not an appropriate technique when checking pedal pulses.

Global Rationale: This artery can be palpated by feeling the dorsum of the foot on an imaginary line from the middle of the ankle to the space between the big and second toe; therefore, this technique is appropriate. The other techniques described are not appropriate when checking pedal pulses.

Cognitive Level: Remembering
Client Need: Physiological Integrity
Client Need Sub: Physiological Adaptation
QSEN Competencies: III.A.5. Explain the role of evidence in determining best clinical practice
AACN Essential Competencies: IX.8. Implement evidence-based nursing interventions as appropriate for managing the acute and chronic care of clients and promoting health across the life span
NLN Competencies: Quality and Safety: Current best practices
Nursing/Integrated Concepts: Nursing Process: Assessment

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Learning Outcome: Verbalize the steps used to measure:
a. Temperature.
b. Pulse.
c. Respirations.
d. Blood pressure.
e. Oxygen saturation.
Page Number: p. 30

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