Taylor's Clinical Nursing Skills 6th edition Lynn Test Bank

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Test Generator Questions, Chapter 2, Vital Signs

Format: Multiple Choice
Chapter Number: 2
Client Needs: Safe and Effective Care Environment: Management of Care
Integrated Process: Nursing Process
Cognitive Level: Apply
Objective: 1,4, 9
Page and Header: 44, Fundamentals Review 2-2
1. A nurse is attempting to obtain vital signs from a 4-year-old child, clinging to a parent's legs and asking to go home. How can the nurse facilitate a complete and accurate assessment?
A) Perform the blood pressure assessment first because it is the most frightening procedure for a child.
B) Perform as many of the assessments as possible with the child seated on the parent's lap.
C) Avoid showing the child equipment until it is about to be used.
D) Remove any distractions from the room in order to improve the child's focus.

Ans: B

Feedback: The nurse should perform as many tasks as possible while the child is sitting on the parent's lap or in a chair next to the parent. Let the child see and touch the equipment before using it. Due to the fear factor of blood pressure measurement, the nurse should save the blood pressure assessment for last. Children and infants often begin to cry during blood pressure assessment, and this may affect the respiration and pulse rate assessment. Distractions can be potentially beneficial and do not always complicate the assessment.

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Format: Multiple Choice
Chapter Number: 2
Client Needs: Physiological Integrity: Basic Care and Comfort
Integrated Process: Nursing Process
Cognitive Level: Apply
Objective: 1
Page and Header: 46, Skill 2-1
2. A nurse will assess the temperature of a postoperative client. Prior to performing this assessment, which will the nurse identify?
A) Client's preferred site for temperature assessment
B) Client's nutritional status
C) Client's most recent temperature
D) Client's wellness goals

Ans: C

Feedback: Prior to assessment, the nurse will note the client's baseline or previous temperature measurements. Assessment results must always be considered in light of client-specific baselines. The client's wellness goals are important, but these are not directly relevant to temperature assessment. Similarly, nutritional status has a minimal bearing on temperature assessment. The client's preferred site for assessment is important, but the nurse ultimately determines the most appropriate site based on clinical judgement.

Format: Multiple Choice
Chapter Number: 2
Client Needs: Safe and Effective Care Environment: Safety and Infection Control
Integrated Process: Teaching/Learning
Cognitive Level: Apply
Objective: 1
Page and Header: 55, Skill 2-1

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3. The nurse instructs the parent of young children how to properly use a nonmercury glass thermometer. Which statement made by the parent indicates a need for further instruction?
A) "I will clean the thermometer in the dishwasher."
B) "I will store the thermometer in the case that it came with."
C) "I will wait 30 minutes before taking an oral temperature if my child ate or drank."
D) "I will place the thermometer under the tongue ask my child to close the mouth and lips."

Ans: A

Feedback: The nurse needs to provide further instruction if the parent plans to clean the thermometer in the dishwasher, because this cleaning will lead to breakage. The thermometer should be washed in warm, sudsy water, dried and placed into its protective case. The client is correct to wait to take a temperature 30 minutes after food or drink is ingested. The client is correct in that children must be able to follow directions, place the thermometer under the tongue, and close the mouth around it.

Format: Multiple Choice
Chapter Number: 2
Client Needs: Safe and Effective Care Environment: Management of Care
Integrated Process: Nursing Process
Cognitive Level: Apply
Objective: 1
Page and Header: 46, Skill 2-1
4. The nurse assesses a client admitted with bilateral clear drainage from the ears after sustaining a head injury and on 40% oxygen via Venturi mask. A family member states that the client recently underwent a hemorrhoidectomy. Which method will the nurse use to evaluate the client's temperature?

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A) Temporal artery
B) Oral
C) Rectal
D) Tympanic

Ans: A

Feedback: The best way to evaluate the client's temperature is the temporal artery, because the area is unobstructed. The oral route is not accurate when the client is wearing an oxygen mask. The tympanic route should not be used because of the head injury and the clear drainage from the ears. The client has a recent history of a hemorrhoidectomy, so the rectal temperature is contraindicated in this situation.

Format: Multiple Choice
Chapter Number: 2
Client Needs: Safe and Effective Care Environment: Management of Care
Integrated Process: Nursing Process
Cognitive Level: Apply
Objective: 1
Page and Header: 50, Skill 2-1
5. The nurse prepares to take a temperature of a client admitted with a myocardial infarction. The client is eating breakfast. Which action will the nurse choose?
A) Take the temperature using the axillary route.
B) Wait 3 to 5 minutes after breakfast to take the oral temperature.
C) Assess the temperature using the rectal route.
D) Cleanse the temporal artery thermometer to prevent a false high reading.

Ans: A

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Feedback: The client had a myocardial infarction, making the rectal route is contraindicated. The stimulation of the vagus nerve could lead to an excessive decrease in the heart rate. The axillary route is the best action to use, because the client has recently had food and fluids. If the client smoked, chewed gum, or consumed hot or cold food or fluids recently, the nurse should wait 15 to 30 minutes before taking an oral temperature to allow the oral tissues to return to baseline temperature. A dirty probe lens and cone on the temporal artery thermometer can cause a falsely low reading.

Format: Multiple Choice
Chapter Number: 2
Client Needs: Safe and Effective Care Environment: Safety and Infection Control
Integrated Process: Nursing Process
Cognitive Level: Apply
Objective: 3
Page and Header: 61, Skill 2-3
6. The nurse provides a hypothermia blanket as prescribed for an unconscious client with a temperature of 104.2°F (40.2°C). The client develops facial muscle and extremity twitching. Which action will the nurse take at this time?
A) Turn the client and reapply lanolin cream as needed.
B) Observe skin, lips, and nails for change in color or edema.
C) Increase the temperature of the hypothermia blanket.
D) Discontinue the hypothermia blanket and notify the health care provider.

Ans: C

Feedback: The client is exhibiting symptoms of shivering, so the nurse will increase the temperature of the hypothermia blanket to decrease the symptoms. The nurse will reassess the client in 15 minutes to determine if the assessment

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stabilizes. If the client's symptoms persist, then the nurse would discontinue the hypothermia blanket and notify the primary care provider for further orders. Turning the client and applying lanolin cream as needed is the best action to take during ongoing therapy with the hypothermia blanket when the client is not exhibiting shivering. Shivering will lead to increasing the body's temperature. Observing the skin, lips, and nails for color and edema is ongoing assessment and does not address the shivering.

Format: Multiple Choice
Chapter Number: 2
Client Needs: Safe and Effective Care Environment: Management of Care
Integrated Process: Nursing Process
Cognitive Level: Apply
Objective: 2
Page and Header: 57, Skill 2-2

7. Which client does the nurse identify is an appropriate candidate for the use of a radiant warmer?

A) Older adult suffering from hypothermia
B) Premature infant
C) Infant with jaundice
D) Child recovering from a near-drowning incident

Ans: B

Feedback: Neonates, infants who are exposed to stressors or chilling (e.g., from undergoing numerous procedures), and infants who have an underlying condition that interferes with thermoregulation (e.g., prematurity) are highly susceptible to heat loss, and radiant warmers are used for these infants who have trouble maintaining body temperature. This is a more likely use of a warmer than in the care of a near-drowning victim, a jaundiced child, or a hypothermic adult.

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Format: Multiple Choice
Chapter Number: 2
Client Needs: Physiological Integrity: Basic Care and Comfort
Integrated Process: Nursing Process
Cognitive Level: Apply
Objective: 2
Page and Header: 58, Skill 2-2
8. A nurse implements an order to place an infant in an overhead radiant warmer. Which guideline will the nurse follow?
A) Attach the probe to the infant's skin over a bony prominence.
B) Allow the blankets to warm before placing the infant under the warmer.
C) Make sure nothing is covering the probe to allow it to register an accurate temperature.
D) Keep the setting of the warmer on manual and adjust it at 15-minute intervals according to the temperature registered.

Ans: B

Feedback: Allowing the blankets to warm first prevents heat loss through conduction. The probe should not be attached on a bony area, and the probe should be covered with a foil patch to prevent direct warming of the probe. The setting of the warmer should be on automatic to ensure safety.

Format: Multiple Choice
Chapter Number: 2
Client Needs: Physiological Integrity: Basic Care and Comfort
Integrated Process: Nursing Process
Cognitive Level: Apply
Objective: 3
Page and Header: 61, Skill 2-3

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9. A nurse is using a hypothermia blanket for an adult client with a fever that is not affected by the use of antipyretics. Which action by the nurse will ensure the safe and effective use of the hypothermia blanket?
A) Position the blanket under the client so that the top edge of the pad is aligned with the client's neck.
B) If the client becomes comatose, use a rectal probe to monitor core body temperature.
C) Cover the hypothermia blanket with a thick blanket or mattress pad to promote thermoregulation.
D) Avoid applying lotions or ointments to the client's skin where it will be in contact with the blanket.

Ans: A

Feedback: The nurse will position the blanket under the client so that the top edge of the pad is aligned with the client's neck; if the client becomes comatose or is anesthetized, use an esophageal probe; cover the hypothermia blanket with a thin sheet or bath blanket; and apply lanolin or a mixture of lanolin and cold cream to the client's skin where it will be in contact with the blanket.

Format: Multiple Choice
Chapter Number: 2
Client Needs: Physiological Integrity: Basic Care and Comfort
Integrated Process: Nursing Process
Cognitive Level: Analyze
Objective: 4
Page and Header: 44, Fundamentals Review 2-1
10. A nurse records a pulse rate of 170 beats per minute on a client's electronic health record. For which client is this be considered a normal assessment finding?
A) Healthy newborn
B) School-aged child who is visibly anxious

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C) Client in the third trimester of pregnancy
D) Older adult client with chronic lung disease

Ans: A

Feedback: For a newborn, a pulse rate of 70 to 190 beats per minute is considered normal. A pulse of 170 would constitute tachycardia in each of the other listed clients and may be indicative of an increase in metabolic demand.

Format: Multiple Choice
Chapter Number: 2
Client Needs: Physiological Integrity: Basic Care and Comfort
Integrated Process: Communication and Documentation
Cognitive Level: Apply
Objective: 4
Page and Header: 65, Box 2-2
11. A nurse reviews a client's health record and reads that the client had a +3 pulse at the left dorsalis pedis. How does the nurse interpret this finding?
A) The client's pulse rate was higher than baseline.
B) The client had a bounding pulse at this site.
C) The nurse assessed a pulse deficit at the client's dorsalis pedis.
D) The nurse needed three attempts to palpate the client's pulse.

Ans: B

Feedback: Pulse quality/amplitude describes the quality of the pulse in terms of its fullness, ranging from absent (0) to bounding (+3). Pulse rates are not gauged on this scale. The pulse deficit is the difference between the apical and radial pulse rates. The rating does not designate the amount of attempts to palpate the pulse.

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Format: Multiple Choice
Chapter Number: 2
Client Needs: Physiological Integrity: Basic Care and Comfort
Integrated Process: Communication and Documentation
Cognitive Level: Apply
Objective: 4
Page and Header: 65, Box 2-2
12. On assessment, a nurse notes that a client's posterior tibial pulse is difficult to palpate and that applying light pressure causes it to disappear. How will the nurse document this finding in the client's health record?
A) 0
B) +1
C) +2
D) +3

Ans: B

Feedback: Pulse amplitude is assessed according to the following scale: 0: Absent, unable to palpate; +1: Diminished, weaker than expected; +2: Brisk, expected (normal); +3: Bounding.

Format: Multiple Choice
Chapter Number: 2
Client Needs: Physiological Integrity: Basic Care and Comfort
Integrated Process: Nursing Process
Cognitive Level: Apply
Objective: 5
Page and Header: 69, Skill 2-5
13. The nurse is preparing to administer a medication that the client takes to treat a cardiac arrhythmia. Which site will the nurse use to assess pulse in this client?
A) Brachial

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B) Radial
C) Carotid
D) Apical

Ans: D

Feedback: An apical pulse is assessed when giving medications that alter heart rate and rhythm as well as if the client has a cardiac problem or congenital heart disease. The brachial and radial pulse will determine the rate the heart is beating but may be altered by peripheral vascular disease. Palpating the carotid pulse should be done by a trained individual; if the pulse is palpated on both sides of the neck, it could cause reduced blood flow and cause unconsciousness.

Format: Multiple Choice
Chapter Number: 2
Client Needs: Physiological Integrity: Basic Care and Comfort
Integrated Process: Nursing Process
Cognitive Level: Apply
Objective: 8
Page and Header: 79, Box 2-5
14. The nurse assessed the client's blood pressure (BP) and heart rate (HR) for orthostatic hypotension. In which step will the nurse intervene?
A) Client in supine position for 3 minutes and BP 120/70; HR 70; asymptomatic
B) Client sitting at edge of bed, feet dangling for 3 minutes; asymptomatic
C) After 3 minutes of sitting, BP 100/50; HR 90
D) Client standing at bedside, becomes pale, diaphoretic

Ans: D

Feedback: Orthostatic hypotension is assessed in three positions, with the client resting in each position 3 minutes before measuring the blood pressure (BP) and

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heart rate (HR). The client is positive for orthostatic hypotension when there is a decrease of 20 mm Hg BP or greater and the heart rate increases as the body's means to help compensate for the postural change. In this case, it is part of the assessment to leave the client in the supine position for 3 minutes and the BP and HR are within a normal range and the client is asymptomatic so the nurse would not intervene. The nurse need not intervene while the client is dangling at the bedside and is asymptomatic. After 3 minutes of sitting, there was a positive orthostatic change, but the client is not exhibiting symptoms, so the nurse would finish the assessment by standing the client at the bedside to determine the extent of the postural changes. When standing, the nurse will intervene because the client is exhibiting symptoms of low cardiac output: pallor and diaphoresis. The nurse will immediately place the client in a supine position to increase the BP and report the findings to the health care provider so adjustments in treatment may be made.

Format: Multiple Choice
Chapter Number: 2
Client Needs: Physiological Integrity: Basic Care and Comfort
Integrated Process: Nursing Process
Cognitive Level: Understand
Objective: 8
Page and Header: 78, Box 2-3

15. The nurse has completed an assessment and notes that the client's blood pressure is 132/92 mm Hg. What is this client's pulse pressure?

A) 224 mm Hg
B) 132 mm Hg
C) 112 mm Hg
D) 40 mm Hg

Ans: D

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Feedback: The difference between systolic and diastolic blood pressure is called the pulse pressure. For this client, 132 − 92 = 40.

Format: Multiple Choice
Chapter Number: 2
Client Needs: Physiological Integrity: Basic Care and Comfort
Integrated Process: Nursing Process
Cognitive Level: Apply
Objective: 7
Page and Header: 74, Skill 2-6

16. A nurse attempts to count the respiratory rate of a client via inspection and finds that the client is breathing at such a shallow rate that it cannot be counted. Which alternative method of measuring the respiratory rate will the nurse attempt?
A) Auscultate lung sounds, count respirations for 60 seconds.
B) Palpate the posterior thorax excursion, count respirations for 15 seconds.
C) Use a pulse oximeter to count the respirations for 1 minute.
D) Monitor arterial blood gas results.

Ans: A

Feedback: The most accurate method of evaluation of respirations is to auscultate for 60 seconds. Palpating the posterior thorax excursion detects vibrations in the lungs. Pulse oximeter and arterial blood gas results assess respiratory effectiveness and acid–base balance, not respiratory rate.

Format: Multiple Choice
Chapter Number: 2
Client Needs: Safe and Effective Care Environment: Management of Care
Integrated Process: Nursing Process
Cognitive Level: Apply

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Objective: 8
Page and Header: 81, Skill 2-7
17. The nurse is taking blood pressure on four clients. Which action is acceptable for the nurse to perform when assessing blood pressure?
A) During the initial nursing assessment of the client, take the blood pressure on both arms and use the arm with the lower reading for subsequent pressures.
B) Use an electronic monitoring device because the client has an irregular heartbeat, tremors, and cannot hold the arm still.
C) Raise the client's arm over the head for 30 seconds to help relieve congestion of blood in the limb and make the sounds louder and more distinct.
D) In the newborn client, take the blood pressure in one arm and one leg and document the difference to check for heart defects.

Ans: C

Feedback: Raising the client's arm over the client's head helps relieve congestion of blood in the limb and increase pressure differences to make the sounds louder and more distinct. On initial assessments, the nurse takes blood pressure in both arms and then uses the arm with the higher reading for subsequent pressures. An electronic monitoring device is contraindicated for the client with heart problems or tremors. Blood pressure should be taken on all four extremities for newborn clients.

Format: Multiple Select
Chapter Number: 2
Client Needs: Physiological Integrity: Basic Care and Comfort
Integrated Process: Nursing Process
Cognitive Level: Apply
Objective: 8
Page and Header: 83, Skill 2-7

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18. The nurse is caring for a newborn client with bluish nails and lips and rapid respirations. The newborn client is having difficulty feeding. Which consideration(s) will the nurse use when assessing the blood pressure to screen for potential cardiac problems? Select all that apply.
A) Assess blood pressure in upper extremities.
B) Assess blood pressure in lower extremities.
C) Use the fifth Korotkoff sound as the systolic blood pressure.
D) Assess for large differences in upper and lower extremity blood pressures.
E) Report small differences in left and right blood pressures.

Ans: A, B, D

Feedback: Screening a newborn client's blood pressure for possible large differences in readings among all four extremities is performed to screen a newborn client for possible heart defect. The nurse will compare upper right and left blood pressures and lower right and left blood pressures. Lower blood pressure measurements should be higher than upper blood pressure measurements. The fifth Korotkoff sound is the standard for the diastolic blood pressure reading.

Format: Multiple Choice
Chapter Number: 2
Client Needs: Physiological Integrity: Basic Care and Comfort
Integrated Process: Nursing Process
Cognitive Level: Apply
Objective: 9
Page and Header: 88, Skill Variation: Assessing Systolic Blood Pressure Using Doppler Ultrasound
19. The nurse is preparing to assess a client's blood pressure. Which guideline will the nurse follow when using a Doppler ultrasound?
A) Take the measurement with the client in a standing position with the appropriate limb exposed.

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B) Center the bladder of the cuff over the artery, lining up the artery marker on the cuff with the artery.
C) If using a mercury manometer, check to see that the manometer is in the horizontal position and that the mercury is within the zero level.
D) Using the nondominant hand, place the Doppler tip in the gel and adjust the volume as needed; move the Doppler tip around until the pulse is heard.

Ans: B

Feedback: The nurse has the client assume a comfortable lying or sitting position with the appropriate limb exposed and centers the bladder of the cuff over the artery, lining up the artery marker on the cuff with the artery. If using a mercury manometer, the nurse checks to see that the manometer is in the vertical position and that the mercury is within the zero level with the gauge at eye level. The nurse holds the Doppler in the nondominant hand and, using the dominant hand, places the Doppler tip in the gel. The nurse adjusts the volume as needed and moves the Doppler tip around until hearing the pulse.

Format: Multiple Choice
Chapter Number: 2
Client Needs: Physiological Integrity: Basic Care and Comfort
Integrated Process: Nursing Process
Cognitive Level: Apply
Objective: 6
Page and Header: 67, Skill 2-4
20. A nurse has been unable to palpate a client's dorsalis pedis pulse. The nurse attempted to identify the pulse using Doppler ultrasound and is still unable to identify a pulse. Which action will the nurse take?
A) Inform the client's health care provider of this assessment finding.
B) Document this finding and reassess within 2 hours.
C) Reassess after placing the client's leg in a dependent position for 15 minutes.

D) Have the client perform foot flexion and extension exercises to promote circulation.

Ans: A

Feedback: If the nurse cannot find the pulse using a Doppler ultrasound, the nurse will notify the health care provider. Reassessment is necessary, but this is an important assessment finding that should be promptly reported because it indicates an alteration in perfusion. A dependent position may increase the risk of complication such as thromboemboli. Flexion and extension exercises will not be effective if there is clot formation and will not improve perfusion.

Format: Multiple Select
Chapter Number: 2
Client Needs: Safe and Effective Care Environment: Management of Care
Integrated Process: Nursing Process
Cognitive Level: Apply
Objective: 1, 2, 5
Page and Header: 46, 64, Skill 2-1, Skill 2-4
21. The registered nurse is collaborating in the care of several medical clients. Which task(s) may the nurse safely delegate to unlicensed assistive personnel (UAP)? Select all that apply.
A) Palpation of a stable client's apical pulse
B) Assessment of a client's axillary temperature
C) Assessment of body temperature for an infant in a radiant warmer
D) Auscultation of a client's apical heart rate
E) Assessment of a client's radial pulse

Ans: B, E

Feedback: Assessment of axillary temperature and radial pulse can normally be

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delegated to an unlicensed assistive personnel (UAP). Assessment of apical heart rate and assessment of body temperature for an infant in a radiant warmer are beyond the scope of practice for the UAP.

Format: Multiple Choice
Chapter Number: 2
Client Needs: Physiological Integrity: Basic Care and Comfort
Integrated Process: Nursing Process
Cognitive Level: Apply
Objective: 8
Page and Header: 77, Skill 2-7
22. A nurse is assessing an adult client's blood pressure. How will the nurse estimate the client's systolic blood pressure?
A) Inflate the blood pressure cuff while palpating the client's brachial artery.
B) Simultaneously compare the amplitude of the client's left and right radial pulses.
C) Palpate the client's brachial pulse while having the client slowly raise the arm.
D) Note the systolic blood pressure that was documented during the client's last vital signs assessment.

Ans: A

Feedback: The point where the brachial or radial pulse disappears provides an estimate of the systolic pressure. Previous baselines are important to know, but these do not provide an estimate of current systolic blood pressure. Simultaneous palpation of radial pulses and having the client raise the arms does not provide an estimate of systolic blood pressure.

Format: Multiple Choice
Chapter Number: 2
Client Needs: Physiological Integrity: Basic Care and Comfort

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Integrated Process: Nursing Process
Cognitive Level: Understand
Objective: 8
Page and Header: 86, Table 2-4
23. A nurse is assessing a client's blood pressure manually. The nurse will identify the client's systolic blood pressure when which event occurs?
A) The first audible sounds begin to decrease in intensity.
B) The first audible sounds cease to be distinct.
C) The initial Korotkoff sounds peak in intensity.
D) The first faint, but clear, sound appears.

Ans: D

Feedback: The first faint, but clear, sound that appears and slowly increases in intensity constitutes the systolic pressure. Each of the other listed sounds would yield an inaccurate systolic blood pressure reading.

Format: Multiple Choice
Chapter Number: 2
Client Needs: Physiological Integrity: Basic Care and Comfort
Integrated Process: Nursing Process
Cognitive Level: Apply
Objective: 5
Page and Header: 72, Skill 2-5
24. The nurse palpates the client's radial artery and identifies a rate of 88 beats per minute with an irregular rate. Which is the nurse's **first** action?
A) Reassess the client's radial pulse in 15 minutes.
B) Document the finding in the electronic health record.
C) Auscultate the client's apical heart rate.
D) Palpate the radial pulse on the opposite wrist.

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Ans: C

Feedback: The first action by the nurse after palpating a radial pulse and finding an irregularity is to confirm with auscultation of the apical heart rate. Waiting to take the pulse rate in 15 minutes from the radial artery will miss an opportunity for further, more accurate assessment from the apical heart rate. Documentation of the assessment is the last step that would be taken with all data that is relevant to the assessment of heart rate and rhythm. Although palpation of the radial pulse on the opposite wrist is not an incorrect action, it is not relevant for the finding of irregularity at this time.

Format: Multiple Choice
Chapter Number: 2
Client Needs: Physiological Integrity: Physiological Adaptation
Integrated Process: Communication and Documentation
Cognitive Level: Apply
Objective: 7
Page and Header: 73, Table 2-1
25. A client is transported to the emergency department after an overdose of opioids. The nurse observes alternating periods of deep, rapid breathing followed by periods of apnea. How will the nurse document this finding?
A) Biot respiration
B) Cheyne--Stokes respiration
C) Hypoventilation
D) Tachypnea

Answer: B

Feedback: Cheyne--Stokes respiration is associated with alternating periods of deep, rapid breathing followed by periods of apnea and can occur with opioid overdose, heart failure, increased intracranial pressure, and renal failure. Biot

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respiration is a varying depth and rate of breathing, followed by periods of apnea. Biot respiration also is irregular. Hypoventilation is a decrease in rate and depth. Tachypnea is a rapid respiration more than 24 breaths/min and shallow.

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