# Health Assessment Hesi Study guide with complete solutions

1) The nurse hears bilateral louder, longer, and lower tones when percussing over the lungs of a 4-year old child. What should the nurse do next?

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

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

c) Refer the child immediately because of an increased amount of air in the lungs.

d) Consider this a normal finding for a child this age and proceed with the examination. - ANSWER d) Consider this a normal finding for a child this age and proceed with the examination.

2) A patient has suddenly developed shortness of breath and appears to be in significant respiratory distress. After putting a call in to the physician and placing the patient on oxygen, which of these is the best action for the nurse to take when assessing the patient further?

a) Count the patient's respirations.

b) Percuss the thorax bilaterally, noting any differences in percussion tones.

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

d) Inspect the thorax for any new masses and bleeding associated with respirations. - ANSWER b) Percuss the thorax bilaterally, noting any differences in percussion tones.

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

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

b) The stethoscope does not magnify sound but does block out extraneous room noise.

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

d) The ideal tubing length should be 22 inches to dampen distortion of sound. -ANSWER b) The stethoscope does not magnify sound but does block out

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#### **Table of Contents Hesi Study Guides**

- 1. Understanding the eBook Hesi Study Guides
  - The Rise of Digital Reading Hesi Study Guides
  - Advantages of eBooks Over Traditional Books
- 2. Identifying Hesi Study Guides
  - Exploring Different Genres
  - $\circ\,$  Considering Fiction vs. Non-Fiction
  - Determining Your Reading Goals
- 3. Choosing the Right eBook Platform
  - Popular eBook Platforms
  - Features to Look for in an Hesi Study Guides
  - User-Friendly Interface
- 4. Exploring eBook Recommendations from Hesi Study Guides

- Personalized Recommendations
- Hesi Study Guides User Reviews and Ratings
- Hesi Study Guides and Bestseller Lists
- 5. Accessing Hesi Study Guides Free and Paid eBooks
  - Hesi Study Guides Public Domain eBooks
  - Hesi Study Guides eBook Subscription Services
  - Hesi Study Guides Budget-Friendly Options
- 6. Navigating Hesi Study Guides eBook Formats
  - o ePub, PDF, MOBI, and More
  - Hesi Study Guides Compatibility with Devices
  - Hesi Study Guides Enhanced eBook Features
- 7. Enhancing Your Reading Experience
  - Adjustable Fonts and Text Sizes of Hesi Study Guides
  - Highlighting and Note-Taking Hesi Study Guides
  - Interactive Elements Hesi Study Guides
- 8. Staying Engaged with Hesi Study Guides
  - o Joining Online Reading Communities
  - Participating in Virtual Book Clubs
  - Following Authors and Publishers Hesi Study Guides
- 9. Balancing eBooks and Physical Books Hesi Study Guides
  - Benefits of a Digital Library
  - Creating a Diverse Reading Collection Hesi Study Guides
- 10. Overcoming Reading Challenges
  - Dealing with Digital Eye Strain
  - Minimizing Distractions
  - Managing Screen Time
- 11. Cultivating a Reading Routine Hesi Study Guides
  - Setting Reading Goals Hesi Study Guides
  - Carving Out Dedicated Reading Time
- 12. Sourcing Reliable Information of Hesi Study Guides

- Fact-Checking eBook Content of Hesi Study Guides
- Distinguishing Credible Sources
- 13. Promoting Lifelong Learning
  - Utilizing eBooks for Skill Development
  - Exploring Educational eBooks
- 14. Embracing eBook Trends
  - Integration of Multimedia Elements
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