

During the initial interview, the nurse notes that Frank often turns his head so that he is looking away from the nurse.

Which action should the nurse take first?      Ask the client to explain the reason for turning his head.

First, determine why the client is turning his head, then complete any additional follow-up assessment and documentation.

During the assessment of Frank's hearing, the nurse performs a series of tests, including Frank's ability to hear whispered and conversational tones.

How will the nurse assess for the presence of tinnitus?      Ask the client if he ever hears ringing in his ears.

Tinnitus is the presence of ringing in the ears, which is often associated with hearing loss. Frank seems nervous and asks for a glass of water. After taking a drink, he attempts to set the glass down, but places the glass on the edge of the counter, causing it to crash to the floor.

To follow up this situation, which assessment will provide the most useful data?      Visual field and depth perception.

Under- or over-reaching for objects is an indication of a visual deficit. Assessment of visual field and depth perception will provide the most useful data related to this situation. Frank's visual acuity is measured using a Snellen chart. The reading obtained is 20/80 in the right eye and 20/200 in the left eye.

How should the nurse explain these findings to Frank?      "You are very near-sighted, especially in your left eye."

The larger the denominator (bottom number), the poorer the visual acuity. This is commonly referred to as being near-sighted. Standing at 20 feet, the client can read what the person with normal vision can read at further distances, such as 80 feet (right eye) or 200 feet (left eye). As the interview continues, the nurse notes that Frank is very pleasant and nods his head in agreement with all of the nurse's statements, but that he often does not respond to simple requests during the assessment.

Which nursing diagnosis is best supported by the data available?      Disturbed sensory alteration (auditory).

Clients with impaired hearing often smile and nod in agreement with the person conversing even though they are unable to clearly hear the conversation. Appearing to be inattentive, speaking loudly, and difficulty following directions are other indications of a disturbance in auditory sensory function.

In identifying this problem, the nurse clustered the assessment data and compared it with which information?      Defining characteristics of the problem.

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**M Mark**



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