

# 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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**Trivium Health Care Exam Prep Team**

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