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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