

Chapter 03: Examination Techniques and Equipment Test Bank—Nursing

MULTIPLE CHOICE

1. Guidelines for Standard Precautions indicate that mask and eye protection or a face mask should be used while performing:
 - a. tube feedings.
 - b. patient bathing.
 - c. wet to dry dressing changes.
 - d. trachea care and suctioning.

ANS: D

Use of masks and eye protection or a face mask is indicated during procedures that are likely to generate splashes or sprays of body fluids, which include endotracheal secretions. During tube feedings, patient bathing, and wet to dry dressing changes, there is no splashing of body fluids.

DIF: Cognitive Level: Applying (Application)

REF: p. 30

OBJ: Nursing process—assessment

MSC: Physiologic Integrity: Physiologic Adaptation

2. Standard Precautions apply:
 - a. only to patients with bloodborne infections.
 - b. only to patients with infected, draining wounds.
 - c. only to patients believed to have an infectious disease.
 - d. to all patients receiving care in hospitals.

ANS: D

Standard Precautions were developed with the intent of application to the care of all hospitalized patients; however, the standard has merit to be applied to all cases of patient care, regardless of the environment in which care is delivered. Standard Precautions apply to all patients, not just those with bloodborne infections, infected, draining wounds, or those believed to have an infectious disease.

DIF: Cognitive Level: Remembering (Knowledge)

REF: p. 31

OBJ: Nursing process—assessment

MSC: Physiologic Integrity: Physiologic Adaptation

3. According to the guidelines for Standard Precautions, the caregiver's hands should be washed:
 - a. only after touching body fluids with ungloved hands and between patient contacts.
 - b. only after touching blood products with ungloved hands and after caring for infectious patients.
 - c. only after working with patients who are thought to be infectious.
 - d. after touching any body fluids or contaminated items, regardless of whether gloves are worn.

ANS: D

Hand washing is to be done after removal of gloves, between patient contacts, and after touching body fluids, regardless of whether gloves are used. The nurse should never touch body fluids or blood products with ungloved hands. The nurse should use hand hygiene regardless of a patient's possible infection.

DIF: Cognitive Level: Remembering (Knowledge) REF: p. 31
OBJ: Nursing process—assessment MSC: Physiologic Integrity: Physiologic Adaptation

4. Which patient is at the highest risk for developing latex allergy?
- The new patient who has no chronic illness and has never been hospitalized
 - The patient who has had multiple procedures or surgeries
 - The patient who is a vegetarian
 - The patient who is allergic to contrast dye

ANS: B

The patient who has had multiple procedures or surgeries has a higher rate of exposure to rubber gloves and to equipment and supplies that contain latex and therefore is at a higher risk for developing an allergic response.

DIF: Cognitive Level: Understanding (Comprehension) REF: p. 30
OBJ: Nursing process—assessment MSC: Physiologic Integrity: Physiologic Adaptation

5. One recommendation to prevent latex allergy is to:
- wear latex gloves frequently to reduce sensitivity.
 - use oil-based creams or lotions before donning gloves.
 - wash hands with mild soap after removing gloves and then dry thoroughly.
 - use well-powdered gloves with increased protein content.

ANS: C

The recommendations are to use nonlatex gloves for situations not likely to involve infectious materials, not to use oil-based creams or lotions, wash hands with mild soap and dry thoroughly after removing gloves, or use powder-free latex gloves with reduced protein content.

DIF: Cognitive Level: Applying (Application) REF: p. 30
OBJ: Nursing process—assessment MSC: Physiologic Integrity: Physiologic Adaptation

6. Mr. Walder is a 56-year-old man who has been complaining of chest palpitations. Which position is useful for auscultating heart sounds?
- Prone
 - Dorsal recumbent
 - Left lateral recumbent
 - Right Sims

ANS: C

The left lateral recumbent position places the left ventricle closer to the chest wall and is recommended for auscultating low-pitched sounds, such as the third and fourth heart sounds. If the patient is in the prone, dorsal recumbent, or right Sims position, you will not be able to auscultate heart sounds. The dorsal recumbent position is for examination of the rectum and genitalia. The Sims position is the position for examination of the rectum.

DIF: Cognitive Level: Applying (Application) REF: p. 32
OBJ: Nursing process—assessment MSC: Physiologic Integrity: Physiologic Adaptation

7. Which technique is used during both the history taking and the physical examination process?
- Auscultation

- b. Inspection
- c. Palpation
- d. Percussion

ANS: B

Inspection is the technique that is used while gathering and validating data during both the history taking and the actual hands-on physical examination. Auscultation, palpation, and percussion are not used during the history taking and physical examination processes. It is not possible to listen to the patient talking and use the stethoscope at the same time. The focus is on the patient's response to your touch and what you are feeling; it is not possible to perform palpation and listen to the patient talking at the same time.

DIF: Cognitive Level: Understanding (Comprehension) REF: p. 32
OBJ: Nursing process—assessment MSC: Physiologic Integrity: Physiologic Adaptation

8. Ms. Jones is a 31-year-old female patient who presents for a routine physical examination. Which examination technique will be used first?
- a. Light palpation
 - b. Deep palpation
 - c. Percussion
 - d. Inspection

ANS: D

Inspection, the process of systematic observation, is the first technique used in an examination. Light palpation is used after inspection. The order for examination is usually inspection, palpation, percussion, and then auscultation. Deep palpation is used after inspection. Percussion is used after inspection and palpation.

DIF: Cognitive Level: Remembering (Knowledge) REF: p. 32
OBJ: Nursing process—assessment MSC: Physiologic Integrity: Physiologic Adaptation

9. The use of secondary, tangential lighting is most helpful in the detection of:
- a. variations in skin color.
 - b. enlarged tonsils.
 - c. foreign objects in the nose or ear.
 - d. variations in contour of the body surface.

ANS: D

Tangential lighting is used to cast shadows to observe contours and variations in body surfaces best.

DIF: Cognitive Level: Understanding (Comprehension) REF: p. 33
OBJ: Nursing process—assessment MSC: Physiologic Integrity: Physiologic Adaptation

10. You are caring for a nonambulatory 80-year-old male patient and he tells you, a female nurse, that he feels like he is having drainage from his rectum. Which initial nursing action is appropriate?
- a. Drape the patient and observe the rectal area.
 - b. Tell the patient that his doctor will be notified of his problem.
 - c. Tell the patient that you will ask the male nurse on the next shift to check on the problem.
 - d. Give the patient an ice pack to apply to the area.

ANS: A

Necessary exposure for direct observation, while adjusting for modesty, is warranted. The complaint warrants validation before referral or delegation. Before you call the physician, you need to assess the patient. The assessment should not wait for another shift. Before treatment, it is important to assess the complaint.

DIF: Cognitive Level: Applying (Application)

REF: p. 32

OBJ: Nursing process—assessment

MSC: Physiologic Integrity: Physiologic Adaptation

11. Mrs. Smalls is a 42-year-old woman who has presented to the office for a head to toe examination as part of her preventive health care assessment. The room has adequate lighting, and you have access to both sides of the examining table. What position should you assume while conducting this examination?
- Behind the patient
 - Either side of the patient
 - Seated in a chair in front of the patient
 - To the right side of the patient

ANS: B

Although examiners are conventionally taught to approach an examination from the patient's right side, it is not always practical; therefore the most appropriate response is that the examiner should develop skills necessary to approach either side of the patient. If you approach the patient from behind, you will not have access to the anterior areas for assessment. If you are seated, you will not be able to assess all areas of the patient.

DIF: Cognitive Level: Remembering (Knowledge)

REF: p. 33

OBJ: Nursing process—assessment

MSC: Physiologic Integrity: Physiologic Adaptation

12. You are planning to palpate the abdomen of your patient. Which part of the examiner's hand is best for palpating vibration?
- Dorsal surface
 - Finger pads
 - Fingertips
 - Ulnar surface

ANS: D

The ulnar surface of the hand and bases of the fingers can best feel vibratory sensations such as thrills and fremitus. The dorsal surface of the hand is best for assessing temperature. The finger pads and fingertips are best for palpating pulses.

DIF: Cognitive Level: Understanding (Comprehension)

REF: p. 33

OBJ: Nursing process—assessment

MSC: Physiologic Integrity: Physiologic Adaptation

13. The dorsal surface of the hand is most often used for the assessment of:
- crepitus.
 - temperature.
 - texture.
 - vibration.

ANS: B

The dorsal surface, or back of the hand, is best for assessing warmth, or temperature. The palmar surface, rather than the dorsal surface, is best for assessing crepitus. The palmar surface, rather than the dorsal surface, is best for assessing texture. The ulnar surfaces of the hand and fingers, rather than the dorsal surface, are best for assessing vibration.

DIF: Cognitive Level: Understanding (Comprehension) REF: p. 33
OBJ: Nursing process—assessment MSC: Physiologic Integrity: Physiologic Adaptation

14. Mrs. Berger is a 39-year-old woman who presents with a complaint of epigastric abdominal pain. You have completed the inspection of the abdomen. What is your next step in the assessment process?
- Light palpation
 - Deep palpation
 - Percussion
 - Auscultation

ANS: D

Auscultation precedes palpation or percussion of the abdomen because these techniques can stimulate peristalsis, which may alter correct assessment of the abdominal sounds. Light palpation, deep palpation, and percussion should not be completed until auscultation is completed.

DIF: Cognitive Level: Understanding (Comprehension) REF: p. 35
OBJ: Nursing process—assessment MSC: Physiologic Integrity: Physiologic Adaptation

15. The degree of percussion tone is determined by the density of the medium through which the sound waves travel. Which statement is *true* regarding the relationship between density of the medium and percussion tone?
- The more dense the medium, the louder is the percussion tone.
 - The less dense the medium, the louder is the percussion tone.
 - The more hollow the area percussed, the quieter is the percussion tone.
 - Percussion over muscle areas produces the loudest percussion tones.

ANS: B

Percussion sounds vary according to the tissue being percussed. Less dense tissue (such as that over normal lungs) produces a loud tone, whereas more dense tissue (such as a muscle) produces a softer tone. The more dense the medium, the softer is the percussion tone. The more hollow the area, the louder is the percussion tone. Percussion tones over muscle are soft and flat.

DIF: Cognitive Level: Understanding (Comprehension) REF: p. 34
OBJ: Nursing process—assessment MSC: Physiologic Integrity: Physiologic Adaptation

16. Expected normal percussion tones include:
- dullness over the lungs.
 - hyperresonance over the lungs.
 - tympany over an empty stomach.
 - flatness over an empty stomach.

ANS: C

A normal lung produces resonance percussion tones, whereas an empty stomach is expected to produce tympany. Dullness indicates atelectasis of the lung. Hyperresonance over the lungs indicates emphysema. Flatness occurs over muscle.

DIF: Cognitive Level: Understanding (Comprehension) REF: p. 34
OBJ: Nursing process—assessment MSC: Physiologic Integrity: Physiologic Adaptation

17. During percussion, a dull tone is expected to be heard over:
- healthy lung tissue.
 - emphysemic lungs.
 - the liver.
 - most of the abdomen.

ANS: C

Dull tones are expected over denser areas such as the liver. Healthy lung tissue is resonant. Emphysemic lungs are hyperresonant. Tympany is heard over most of the abdomen.

DIF: Cognitive Level: Understanding (Comprehension) REF: p. 34
OBJ: Nursing process—assessment MSC: Physiologic Integrity: Physiologic Adaptation

18. When using mediate or indirect percussion, which technique is appropriate?
- Place the palmar surface of the nondominant hand on the body surface, with the fingers held together.
 - Place the palmar surface of the nondominant hand on the body surface, with the fingers slightly spread apart.
 - Place the ulnar surface of the nondominant hand on the body surface, with the fingers together.
 - Place the ulnar surface of the nondominant hand on the body surface, with the fingers slightly spread apart.

ANS: B

The palmar surface of the nondominant (stationary) hand should rest against the body surface, with the fingers spread slightly. A helpful tip to improve elicitation of correct tones is to hyperextend the middle finger of the stationary hand and place the distal interphalangeal joint firmly against the body surface. This lifting of the fingertip avoids dampening of the vibratory sounds.

DIF: Cognitive Level: Understanding (Comprehension) REF: p. 34
OBJ: Nursing process—assessment MSC: Physiologic Integrity: Physiologic Adaptation

19. During percussion, the downward snap of the striking fingers should originate from the:
- shoulder.
 - forearm.
 - wrist.
 - interphalangeal joint.

ANS: C

The downward snap of the striking fingers should originate from the wrist.

DIF: Cognitive Level: Understanding (Comprehension) REF: p. 34
OBJ: Nursing process—assessment MSC: Physiologic Integrity: Physiologic Adaptation

20. Which technique is commonly used to elicit tenderness arising from the liver, gallbladder, or kidneys?
- Finger percussion
 - Palmar percussion
 - Fist percussion
 - Forearm percussion

ANS: C

Fist percussion is a direct percussion technique used to elicit tenderness over organs such as the liver, gallbladder, or kidneys.

DIF: Cognitive Level: Remembering (Knowledge)

REF: p. 34

OBJ: Nursing process—assessment

MSC: Physiologic Integrity: Physiologic Adaptation

21. During auscultation, you can limit your perceptual field best by:
- asking patients to describe their symptoms.
 - closing your eyes.
 - performing auscultation before percussion.
 - using an aneroid manometer.

ANS: B

By closing your eyes, your sense of hearing becomes more acute, and it increases your ability to isolate sounds. Asking patients to describe their symptoms does not assist in the technique of auscultation. The only time that auscultation occurs before percussion is in examination of the abdomen. Using an aneroid manometer does not assist in the technique of auscultation. During auscultation, the only equipment needed is the stethoscope.

DIF: Cognitive Level: Applying (Application)

REF: p. 35

OBJ: Nursing process—assessment

MSC: Physiologic Integrity: Physiologic Adaptation

22. You are auscultating a patient's chest. The sounds are not clear, and you are having difficulty distinguishing between respirations and heartbeats. Which technique can you use to facilitate your assessment?
- Anticipate the next sounds.
 - Isolate each cycle segment.
 - Listen to all sounds together.
 - Move the stethoscope clockwise.

ANS: B

If you are hearing everything at once, it is more difficult to distinguish different sounds. Try isolating each segment and listen to that segment intently; then move on to another segment. For example, listen only to breath sounds, then only to inspiratory breath sounds, and then only to expiratory breath sounds. Anticipating the next sounds will not facilitate the assessment. Listening to all sounds together will not facilitate the assessment. One of the most difficult achievements in auscultation is learning to isolate sounds. Moving the stethoscope clockwise will not facilitate the assessment.

DIF: Cognitive Level: Applying (Application)

REF: p. 35

OBJ: Nursing process—assessment

MSC: Physiologic Integrity: Physiologic Adaptation

23. Auscultation should be carried out last, except when examining the:
- neck area.

- b. heart.
- c. lungs.
- d. abdomen.

ANS: D

Auscultation is the last examination technique used for all areas except the abdomen. In this case, it is performed after inspection.

DIF: Cognitive Level: Understanding (Comprehension) REF: p. 35
OBJ: Nursing process—assessment MSC: Physiologic Integrity: Physiologic Adaptation

24. Tympanic thermometers measure body temperature when a probe is placed:
- a. anterior to the ear.
 - b. posterior to the ear.
 - c. under the ear.
 - d. in the auditory canal.

ANS: D

Tympanic thermometer probes are placed at the external opening of the auditory canal.

DIF: Cognitive Level: Understanding (Comprehension) REF: p. 38
OBJ: Nursing process—assessment MSC: Physiologic Integrity: Physiologic Adaptation

25. A scale used to assess patients' weight should be calibrated:
- a. only by the manufacturer.
 - b. by a qualified technician at regularly scheduled intervals.
 - c. each time it is used.
 - d. when necessary, with the patient standing on the scale.

ANS: C

Obtaining weight begins with a manual calibration of the scale before the patient stands on the scale. Electronic scales are automatically calibrated before each reading. The manufacturer does not calibrate the scale after it is sold. A qualified technician does not calibrate the scale at regularly scheduled intervals. Scales cannot be calibrated with the patient standing on the scale.

DIF: Cognitive Level: Understanding (Comprehension) REF: p. 37
OBJ: Nursing process—assessment MSC: Physiologic Integrity: Physiologic Adaptation

26. The height-measuring attachment of the standing platform scale should be pulled up:
- a. before the patient steps on the scale.
 - b. before the scale is balanced.
 - c. after the patient steps on the scale.
 - d. only after weight has been assessed.

ANS: A

To ensure patient safety, the arm of the height-measuring attachment should be pulled up before the patient steps on the scale, after the scale is balanced, and before weight is assessed.

DIF: Cognitive Level: Applying (Application) REF: p. 37
OBJ: Nursing process—assessment MSC: Physiologic Integrity: Physiologic Adaptation

27. The infant should be placed in which position to have his or her height or length measured?
- Vertically, with the examiner's hands under the infant's axillae
 - Supine on a measuring board
 - Prone on a measuring board
 - In the lateral position, with the toes against a measuring board

ANS: B

The infant should be placed supine on a measuring board to measure height or length.

DIF: Cognitive Level: Remembering (Knowledge)

REF: p. 37

OBJ: Nursing process—assessment

MSC: Physiologic Integrity: Physiologic Adaptation

28. Which of the following occurs when firm pressure is used to apply the stethoscope's bell endpiece to the skin?
- It transmits low-pitched sounds.
 - It functionally converts to a diaphragm endpiece.
 - Assessment findings are more accurate.
 - Most sounds are occluded.

ANS: B

Applying firm pressure to the bell endpiece causes the skin to act as a diaphragm, obliterating the low-pitched sounds.

DIF: Cognitive Level: Applying (Application)

REF: p. 39

OBJ: Nursing process—assessment

MSC: Physiologic Integrity: Physiologic Adaptation

29. A rubber or plastic ring should be around the bell endpiece of a stethoscope to:
- prevent the transmission of static electricity.
 - prevent cold metal from touching the patient.
 - prevent the sharp edge of the stethoscope from damaging the patient's skin.
 - ensure secure contact with the body surface.

ANS: D

The ring around the bell portion of the stethoscope secures contact with body surfaces when placed lightly on the skin.

DIF: Cognitive Level: Applying (Application)

REF: p. 39

OBJ: Nursing process—assessment

MSC: Physiologic Integrity: Physiologic Adaptation

30. Weak pulses, fetal heart activity, and vessel patency are all best assessed with which type of stethoscope?
- Acoustic
 - Electronic
 - Ultrasonic
 - Magnetic

ANS: C

Only the ultrasonic stethoscope, the Doppler, can detect blood flow rather than amplify sounds, which is needed in assessing weak pulses, fetal heart activity, and vessel patency.

DIF: Cognitive Level: Analyzing (Analysis)

REF: p. 39

OBJ: Nursing process—assessment

MSC: Physiologic Integrity: Physiologic Adaptation

31. You are using an ophthalmoscope to examine a patient's inner eye. You rotate the lens selector clockwise and then counterclockwise to compensate for:
- amblyopia.
 - astigmatism.
 - myopia.
 - strabismus.

ANS: C

Rotating the lens selector compensates for myopia (nearsightedness) or hyperopia (farsightedness) in the examiner and patient.

DIF: Cognitive Level: Applying (Application)

REF: p. 42

OBJ: Nursing process—assessment

MSC: Physiologic Integrity: Physiologic Adaptation

32. A patient in the emergency department has a concussion. You suspect the patient may also have a retinal hemorrhage. You are using the ophthalmoscope to examine the retina of this patient. Which aperture of the ophthalmoscope is most appropriate for this patient?
- Grid
 - Red-free filter
 - Slit lamp
 - Small aperture

ANS: B

The red-free filter permits recognition of hemorrhages. The grid estimates the size of lesions, the slit lamp examines the anterior eye and assesses the elevation of lesions, and the small aperture is used with small pupils.

DIF: Cognitive Level: Applying (Application)

REF: p. 42

OBJ: Nursing process—assessment

MSC: Physiologic Integrity: Physiologic Adaptation

33. Which type of speculum should be used to examine a patient's tympanic membrane?
- The smallest speculum that will illuminate the ear
 - The largest speculum that will fit comfortably in the ear
 - The shortest speculum available
 - Any speculum that will fit the otoscope head

ANS: B

To visualize the tympanic membrane adequately, the largest speculum that can comfortably fit in the ear canal should be used.

DIF: Cognitive Level: Understanding (Comprehension)

REF: p. 45

OBJ: Nursing process—assessment

MSC: Physiologic Integrity: Physiologic Adaptation

34. The pneumatic attachment for the otoscope is used to evaluate:
- ear canal patency.
 - eardrum landmarks.
 - hearing acuity.
 - tympanic membrane movement.

ANS: D

The pneumatic attachment on the otoscope produces a puff of air directed to the tympanic membrane, resulting in its movement. The pneumatic attachment for the otoscope is not used to evaluate ear canal patency, eardrum landmarks, or hearing acuity. Ear canal patency is assessed by visually inspecting the ear. Hearing acuity is assessed by the whisper test.

DIF: Cognitive Level: Remembering (Knowledge) REF: p. 45
OBJ: Nursing process—assessment MSC: Physiologic Integrity: Physiologic Adaptation

35. Mr. Walters, a 32-year-old patient, tells you that his ears are “stopped up.” An objective assessment of this complaint is achieved by using the:
- tuning fork.
 - reflex hammer.
 - otoscope with pneumatic attachment.
 - tympanometer.

ANS: D

This patient is describing eustachian tube dysfunction. The tympanometer measures compliance of the middle ear as air pressures are varied. It is an objective means of assessing the function of the ossicular chain, eustachian tube, and tympanic membrane. The tuning fork assesses vibration. The reflex hammer assesses tendon reflexes. The otoscope with pneumatic attachment assesses tympanic membrane movement.

DIF: Cognitive Level: Applying (Application) REF: p. 45
OBJ: Nursing process—assessment MSC: Physiologic Integrity: Physiologic Adaptation

36. Tuning forks with a frequency of 500 to 1000 Hz are most commonly used to measure:
- buzzing or tingling sensations.
 - buzzing from bone conduction.
 - hearing range of normal speech.
 - noise above the threshold level.

ANS: C

Normal speech has a range of 300 to 3000 Hz; therefore the 500- to 1000-Hz fork is used most often because it can estimate hearing loss in the range of normal speech.

DIF: Cognitive Level: Understanding (Comprehension) REF: p. 46
OBJ: Nursing process—assessment MSC: Physiologic Integrity: Physiologic Adaptation

37. To perform a deep tendon reflex measurement, you should:
- briskly tap the tendon with the rubber end of the hammer.
 - place the hammer firmly on the tendon for 3 to 5 seconds.
 - tap the silver end of the hammer on the tendon.
 - use the needle implement to determine sensory perception.

ANS: A

Deep tendon reflexes are measured by quickly and firmly tapping either end of the rubber hammer on the stretched tendon and then observing muscle movement.

DIF: Cognitive Level: Understanding (Comprehension) REF: p. 46
OBJ: Nursing process—assessment MSC: Physiologic Integrity: Physiologic Adaptation

38. A variant of the percussion hammer is the neurologic hammer, which is equipped with which of the following?
- Brush and needle
 - Tuning fork and cotton swab
 - Penlight and goniometer
 - Ruler and bell

ANS: A

The neurologic hammer unscrews at the handle to reveal a soft brush, and the knob on the head unscrews to reveal an attached sharp needle.

DIF: Cognitive Level: Understanding (Comprehension)

REF: p. 46

OBJ: Nursing process—assessment

MSC: Physiologic Integrity: Physiologic Adaptation

39. When monitoring serial measures, such as head circumference or abdominal girth, which procedure is best to ensure that the tape measure is placed in the same position each time?
- Record the anatomic location for tape placement in the patient's chart.
 - Mark the borders of the tape at several intervals on the skin with a pen.
 - Demonstrate proper tape placement to all members of the health care team.
 - Ask the same person to perform the measurement each time.

ANS: B

The most effective procedure to ensure correct serial measurements is to mark the borders at several intervals so that with the next measurements, the tape is in the same location. Recording the anatomic location for tape placement in the patient's chart or demonstrating proper tape placement does not ensure accuracy. The same person may not always be available.

DIF: Cognitive Level: Applying (Application)

REF: p. 47

OBJ: Nursing process—assessment

MSC: Physiologic Integrity: Physiologic Adaptation

40. Transillumination functions on the principle that:
- air, fluid, and tissue transmit light differentially.
 - black light causes certain substances to fluoresce.
 - converging and diverging light brings structures into focus.
 - tangential light casts shadows that illuminate contours.

ANS: A

Transillumination functions to differentiate between various media in a cavity. It can distinguish among air, fluid, and tissue.

DIF: Cognitive Level: Understanding (Comprehension)

REF: p. 47

OBJ: Nursing process—assessment

MSC: Physiologic Integrity: Physiologic Adaptation

41. When transillumination of a body cavity is performed, the use of which of the following could be harmful to the patient?
- Penlight
 - Flashlight
 - Halogen bulb
 - Otoscope light

ANS: C

A halogen bulb can burn the skin.

DIF: Cognitive Level: Understanding (Comprehension)

REF: p. 47

OBJ: Nursing process—assessment

MSC: Physiologic Integrity: Physiologic Adaptation

42. The Pederson speculum has blades that:
- are smaller than a plastic one.
 - have an auto lock feature
 - are narrower and flatter.
 - only the bottom blade moves.

ANS: C

The Pederson speculum has blades that are as long as those of the Graves speculum but are narrower and flatter. It is used for women with small vaginal openings.

DIF: Cognitive Level: Analyzing (Analysis)

REF: p. 47

OBJ: Nursing process—assessment

MSC: Physiologic Integrity: Physiologic Adaptation

MULTIPLE RESPONSE

1. Which of the following are causes of hyperreflexia? (*Select all that apply.*)
- Cold stirrups
 - Standard scale
 - Insertion of a speculum
 - Fever
 - Pressure during bimanual exam

ANS: A, C, E

Hyperreflexia is often caused by a cold, hard, examination table, cold stirrups, insertion or manipulation of a speculum, or pressure during bimanual or rectal examinations.

DIF: Cognitive Level: Applying (Application)

REF: p. 37

OBJ: Nursing process—assessment

MSC: Physiologic Integrity: Physiologic Adaptation

COMPLETION

1. The Snellen E vision acuity chart would most likely be used for _____.

ANS:

preschool children

The E chart is used for children 3 to 5 years of age or others who do not know the alphabet. The examinee is asked which way the E points.

DIF: Cognitive Level: Understanding (Comprehension)

REF: p. 44

OBJ: Nursing process—assessment

MSC: Physiologic Integrity: Physiologic Adaptation

2. The stethoscope's diaphragm is most useful for the assessment of _____ sounds.

ANS:

high-pitched

The diaphragm is best for hearing high-pitched sounds, such as breath sounds, bowel sounds, and normal heart tones.

DIF: Cognitive Level: Understanding (Comprehension) REF: p. 40
OBJ: Nursing process—assessment MSC: Physiologic Integrity: Physiologic Adaptation

3. For a woman with a small vaginal opening, the examiner should use a _____ speculum.

ANS:
Pederson

The Pederson speculum has blades that are as long as those of the Graves speculum but are narrower and flatter and therefore more comfortable for women with small vaginal openings. Pediatric or nasal speculums would be too small for adult use.

DIF: Cognitive Level: Applying (Application) REF: p. 47
OBJ: Nursing process—assessment MSC: Physiologic Integrity: Physiologic Adaptation