

Davis's Nursing Skills Videos Test Bank

Measuring Vital Signs

MULTIPLE CHOICE



1. Where should the nurse place the tip of the thermometer?

- A. To the front of the underarm
- B. Anywhere under the arm is fine
- C. Toward the back of the underarm for maximum coverage
- D. In the middle of the axilla

ANS: D

Topic: Measuring Vital Signs

Video Title: Taking an Axillary Temperature

Concept: Assessment

Rationale: It is important to place the thermometer in the middle of the axilla for the most accurate reading. None of the other positions will allow the thermometer to function properly.

2. What should the nurse do if the patient has a fever?

- A. Take the temperature by a different route.
- B. Retake the temperature using the axillary method to be sure it is accurate.
- C. Call the physician to report the temperature.
- D. Provide the patient with a cool cloth to bring down the fever.

ANS: A

Topic: Measuring Vital Signs

Video Title: Taking an Axillary Temperature

Concept: Assessment

Rationale: Taking an axillary temperature is not the most accurate method so the nurse would need to take the temperature using an alternative, more accurate method. The nurse would then follow the physician's orders regarding increased temperature.

3. In what position should the nurse place the patient's arm?

- A. Place the patient's arm straight down at their side.
- B. Place the patient's arm upright with the hand above the heart.
- C. Place the patient's arm at their side with the lower arm across the chest.
- D. Place the patient's arm at their side with the elbow bent and forearm up.

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ANS: C

Topic: Measuring Vital Signs

Video Title: Taking an Axillary Temperature

Concept: Assessment

Rationale: For the most accurate reading, the patient's arm should be placed in a comfortable position that encases the thermometer. None of the other positions listed hold the thermometer in place while providing a comfortable position for the patient.

4. Where under the tongue should the nurse position the thermometer?

- A. Anywhere inside the patient's mouth
- B. On the top of the tongue
- C. Just inside the lips where the patient can hold the thermometer with their teeth
- D. In the posterior sublingual pocket

ANS: D

Topic: Measuring Vital Signs

Video Title: Taking an Oral Temperature

Concept: Assessment

Rationale: The thermometer needs to be placed far enough back under the patient's tongue to receive an accurate reading. The patient should never bite the thermometer and it is not an accurate reading just inside the lips.

5. How long should the nurse leave the digital thermometer in place?

- A. Until the number stops flashing
- B. Until the number starts flashing
- C. Until it beeps
- D. For 30 seconds

ANS: C

Topic: Measuring Vital Signs

Video Title: Taking an Oral Temperature

Concept: Assessment

Rationale: Digital thermometers are designed to beep when they have reached the temperature of the patient. Taking it out too soon will not provide an accurate reading and leaving it in too long will cause discomfort for the patient.

6. What should the nurse do if there is no cover available for the thermometer?

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- A. Forego taking the patient's temperature.
- B. Use an antimicrobial wipe and thoroughly clean the probe.
- C. Throw the thermometer away.
- D. Use the thermometer only for that patient.

ANS: B

Topic: Measuring Vital Signs

Video Title: Taking an Oral Temperature

Concept: Assessment

Rationale: Cleaning the probe with an antimicrobial wipe will ensure that there are no germs present. The temperature needs to be taken as part of the vital sign group and it is not cost effective to throw the thermometer away or only use the machine for one patient.

7. How would the nurse position an adult when taking a rectal temperature?

- A. Side-lying
- B. Sims'
- C. Prone
- D. Semi-Fowler's

ANS: B

Topic: Measuring Vital Signs

Video Title: Taking a Rectal Temperature

Concept: Assessment

Rationale: The Sims' position is the most comfortable for the patient and creates the greatest accessibility. Having the patient lie prone or in the side-lying position would not be comfortable and it would be impossible to put in a rectal thermometer with the patient in the semi-Fowler's position.

8. How far do you insert the rectal thermometer on an infant?

- A. 0.9 inches or 2.5 cm
- B. 1 to 1.5 inches or 2.5 to 3.7 cm
- C. 0.5 inches or 1.5 cm
- D. 2 inches or 5 cm

ANS: C

Topic: Measuring Vital Signs

Video Title: Taking a Rectal Temperature

Concept: Assessment

Rationale: An infant has a small rectum and the nurse does not want to risk perforation. The other numbers listed are for a child or an adult. The answer 2 inches or 5 cm is too far.

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9. What position should a child be in when taking a rectal temperature?

- A. Prone
- B. Side-lying
- C. Sims'
- D. Upright

ANS: A

Topic: Measuring Vital Signs

Video Title: Taking a Rectal Temperature

Concept: Assessment

Rationale: Having the child lie prone or across a parent's lap will make insertion easier. Do not have the child lie on their side or in the Sims' position.

10. Which direction should the nurse move the thermometer across the forehead?

- A. In a circular motion
- B. Up and down
- C. Medially to laterally
- D. From left to right only

ANS: C

Topic: Measuring Vital Signs

Video Title: Taking a Temporal Artery Temperature

Concept: Assessment

Rationale: The nurse moves the temporal thermometer from the midline of the body to the side of the body. Up and down, left to right, or in a circular motion will not provide an accurate reading.

11. When should the nurse push the button on the device?

- A. Push only to start the machine.
- B. Push and hold the button down while taking the temperature.
- C. Push the button after the procedure.
- D. There is no need to push the button during the procedure.

ANS: B

Topic: Measuring Vital Signs

Video Title: Taking a Temporal Artery Temperature

Concept: Assessment

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Rationale: It is important to push and hold the button down while taking the temperature. This is the best way to get an accurate reading. The machine will not work properly with the other responses.

12. What should the nurse do if the patient has been lying down on the area where they should place the thermometer?

- A. Do not measure the temperature on the side that was lying on the pillow.
- B. Measure the temperature on the side that was lying on the pillow.
- C. Call the charge nurse.
- D. Notify the physician.

ANS: A

Topic: Measuring Vital Signs

Video Title: Taking a Temporal Artery Temperature

Concept: Assessment

Rationale: To get an accurate temperature the nurse should not use the side that was lying on the pillow. This is not a time to notify either the charge nurse or the physician. Simply use the side that was not on the pillow.

13. Which ear should the nurse use to take the tympanic temperature?

- A. If the nurse is right-handed, they should use the left ear.
- B. If the nurse is left-handed, they should use the left ear.
- C. If the nurse is left-handed, they should use the right ear.
- D. Either hand is fine.

ANS: B

Topic: Measuring Vital Signs

Video Title: Taking a Tympanic Membrane Temperature

Concept: Assessment

Rationale: The nurse should use the dominant hand and the same side ear—for example, a right-handed nurse should use the right ear.

14. How does the nurse straighten the ear canal?

- A. Pull the pinna up and back
- B. Pull the pinna down and back
- C. Pull the pinna out and back
- D. Pull the pinna up and forward

ANS: A

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Topic: Measuring Vital Signs

Video Title: Taking a Tympanic Membrane Temperature

Concept: Assessment

Rationale: The only way the nurse can straighten the canal is to pull the pinna up and back.

15. How would the steps to straighten the ear canal be different if the patient is a child?

- A. Pull the pinna up and back
- B. Pull the pinna down and back
- C. Pull the pinna out and back
- D. Pull the pinna up and forward

ANS: B

Topic: Measuring Vital Signs

Video Title: Taking a Tympanic Membrane Temperature

Concept: Assessment

Rationale: The ear canal in the child is not fully developed and needs to be pulled down and back.

16. After taking the pulse for the first time, how many seconds should the nurse count for?

- A. 15 to 30 seconds
- B. 30 to 45 seconds
- C. 45 to 60 seconds
- D. Always count for 60 seconds

ANS: A

Topic: Measuring Vital Signs

Video Title: Assessing Peripheral Pulses

Concept: Assessment

Rationale: After the nurse takes the initial pulse, it is acceptable to take the pulse for 15 to 30 seconds and then multiply to get the beats per minute. The nurse should take the pulse for a full 60 seconds the first time they take the pulse and if the beat is irregular.

17. Where does the nurse place the fingers when taking a brachial pulse?

- A. Anywhere on the upper arm
- B. At the wrist
- C. At the inner aspect of the brachial artery
- D. Near the shoulder

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ANS: C

Topic: Measuring Vital Signs

Video Title: Assessing Peripheral Pulses

Concept: Assessment

Rationale: The inner aspect of the brachial artery, located near the junction of the upper arm and elbow. This will provide the most accurate reading of the brachial artery. The brachial artery is located deep within the muscle and can be difficult to palpate. The wrist is used to obtain the peripheral pulse.

18. When is the popliteal pulse used?

- A. When there is damage to the wrist
- B. When the brachial pulse is absent
- C. When pedal pulses are absent
- D. When the patient is bedbound

ANS: C

Topic: Measuring Vital Signs

Video Title: Assessing Peripheral Pulses

Concept: Assessment

Rationale: The popliteal pulse is difficult to find and is only used when the pedal pulses are absent. The popliteal pulse would not be used at the other times listed.

19. When listening to the apical pulse, where does the nurse place the stethoscope?

- A. Sternal notch
- B. Point of maximal impulse
- C. Angle of Louis
- D. Fifth intercostal space

ANS: B

Topic: Measuring Vital Signs

Video Title: Assessing the Apical Pulse

Concept: Assessment

Rationale: The apical pulse is best heard at the point of maximal impulse (PMI). The other points listed are landmarks used to find the PMI.

20. How long should the nurse count the apical pulse?

- A. 15 seconds
- B. 30 seconds

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- C. 45 seconds
- D. 60 seconds

ANS: D

Topic: Measuring Vital Signs

Video Title: Assessing the Apical Pulse

Concept: Assessment

Rationale: The nurse should listen to the apical pulse for one full minute, or 60 seconds. The other times are too short for the nurse to get an accurate reading.

21. What should the nurse hear when listening to the apical pulse?

- A. Heart sounds S₁, S₂
- B. The breath going in and out
- C. The opening of the mitral and tricuspid valves
- D. Ventricular filling

ANS: A

Topic: Measuring Vital Signs

Video Title: Assessing the Apical Pulse

Concept: Assessment

Rationale: The nurse hears the closing of the valves as “lub-dub.” These are heart sounds S₁ and S₂. The breath going in and out would be heard when listening to the lungs and one cannot hear the valves opening or the ventricles filling.

22. What do both nurses do when assessing for an apical-radial pulse deficit?

- A. Count the pulse simultaneously for one minute
- B. Say start and stop
- C. Hold the stethoscope diaphragm in place
- D. Find the PMI

ANS: A

Topic: Measuring Vital Signs

Video Title: Assessing for an Apical-Radial Pulse Deficit

Concept: Assessment

Rationale: Both nurses count the pulse for one full minute so that they can complete the formula for the apical-radial pulse deficit. The other jobs are done individually by nurse one or nurse two.

23. How does the nurse determine the pulse deficit?

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- A. By subtracting the radial pulse from the apical pulse
- B. By subtracting the apical pulse from the radial pulse
- C. By adding the radial and apical pulse together
- D. By dividing the apical pulse by the radial pulse

ANS: B

Topic: Measuring Vital Signs

Video Title: Assessing for an Apical-Radial Pulse Deficit

Concept: Assessment

Rationale: The pulse deficit is the difference between the number of beats of the heart and the number of beats of the pulse in a minute's time. To find this number, the nurse subtracts the apical pulse from the radial pulse.

24. What is the purpose of the apical-radial pulse deficit reading?

- A. To determine the difference in how many beats of the heart are felt at the apical and radial sites
- B. To see how much faster the radial pulse is than the apical pulse
- C. To make sure that each nurse is getting an accurate reading
- D. To determine which is stronger, the apical pulse or the radial pulse

ANS: A

Topic: Measuring Vital Signs

Video Title: Assessing for an Apical-Radial Pulse Deficit

Concept: Assessment

Rationale: The purpose of the apical radial pulse reading is to see if there is a difference in how many heart beats are felt at each site. This can be a significant indicator in heart disease. The apical pulse will beat faster than the radial pulse as this is the direct reading from the heart.

25. Why should the patient not be aware that the nurse is assessing their respirations?

- A. The patient could be embarrassed by the procedure.
- B. The patient could refuse the procedure.
- C. The family members may feel uncomfortable while you are assessing respirations.
- D. Respirations can be controlled voluntarily.

ANS: D

Topic: Measuring Vital Signs

Video Title: Assessing Respirations

Concept: Assessment

Davis's Nursing Skills Videos Test Bank

Rationale: The patient can control their respirations voluntarily and therefore the nurse will not get an accurate reading. The other reasons would not affect the reading.

26. What should the nurse do to assess the respiratory rate of an infant?

- A. Count for 30 seconds and multiply the number by two.
- B. Use a stethoscope to auscultate the lungs.
- C. Have the parents count the respirations.
- D. Place a hand on the abdomen and count for one full minute.

ANS: D

Topic: Measuring Vital Signs

Video Title: Assessing Respirations

Concept: Assessment

Rationale: The nurse needs to place their hand on the abdomen and count for one full minute. The other methods will not provide an accurate respiratory count.

27. What makes up one respiration?

- A. Just the inhalation
- B. Just the exhalation
- C. One inhalation and one exhalation
- D. The time between the inhalation and the exhalation.

ANS: C

Topic: Measuring Vital Signs

Video Title: Assessing Respirations

Concept: Assessment

Rationale: One inhalation and one exhalation make up one full breath.

28. Where does the center of the cuff bladder go?

- A. Directly over the brachial artery
- B. On the outer side of the arm
- C. Facing the inside of the arm
- D. It doesn't matter

ANS: A

Topic: Measuring Vital Signs

Video Title: Measuring Blood Pressure

Concept: Assessment