# D'Amico/Barbarito *Health & Physical Assessment in Nursing*, 2/e
# Chapter 3

**Question 1**
**Type:** MCMA

The nurse is conducting a prenatal class to expectant parents. When one of the couples asks how children grow, the nurse explains that growth and development proceeds in a number of ways. Which of the following descriptions will the nurse use to accurately reflect normal growth and development?

**Standard Text:** Select all that apply.

**1.** Cephalocaudal direction

**2.** Simple to complex

**3.** Distal to proximal direction

**4.** Generalized response to specific response

**5.** Anterior to posterior

**Correct Answer:** 1,2,4

**Rationale 1**: **Cephalocaudal direction.** Growth and development occurs in a cephalocaudal direction; from head to toe.

**Rationale 2**: **Simple to complex.** Growth and development proceeds from simple to complex; an infant will reach out for an object before actually being able to grasp the object.

**Rationale 3**: **Distal to proximal direction.** Growth and development does not proceed from distal to proximal but rather from proximal to distal; i.e., from the center of the body outward.

**Rationale 4**: **Generalized response to specific response.** Growth and development progresses from general to specific responses; an infant responds to stimuli with the entire body, and older child will respond more specifically, for example, with a smile.

**Rationale 5**: **Anterior to posterior.** Anterior to posterior does not describe a pattern of normal growth and development.

**Global Rationale:** Growth and development (G and D) occurs in a cephalocaudal direction; from head to toe. G and D proceeds from simple to complex; an infant will reach out for an object before actually being able to grasp the object. G and D progresses from general to specific responses; an infant responds to stimuli with the entire body, and older child will respond more specifically, for example with a smile. G and D does not proceed from distal to proximal but rather from proximal to distal; i.e., from the center of the body outward. Anterior to posterior does not describe a pattern of normal growth and development.

**Cognitive Level:** Understanding
**Client Need:** Health Promotion and Maintenance
**Client Need Sub:**
**Nursing/Integrated Concepts:** Nursing Process: Implementation
**Learning Outcome:** 3.1: Identify the principles of growth and development.

**Question 2**
**Type:** MCMA

The nurse identifies which of the following as environmental factors that can influence the growth and development of an individual?

**Standard Text:** Select all that apply.

**1.** Nutrition

**2.** Climate

**3.** Heredity

**4.** Culture

**5.** Religion

**Correct Answer:** 1,2,4

**Rationale 1**: **Nutrition.** Nutrition is an environmental factor that can affect the growth and development of an individual.

**Rationale 2**: **Climate.** Climate is an environmental factor that can affect the growth and development of an individual.

**Rationale 3**: **Heredity.** Heredity drives the physical attributes of growth and development such as stature, gender, and race.

**Rationale 4**: **Culture.** Culture is an environmental factor that can affect the growth and development of an individual.

**Rationale 5**: **Religion.** Religion is an environmental factor that can affect the growth and development of an individual.

**Global Rationale:** Nutrition, climate, culture, and religion are all external, environmental factors that can affect how an individual grows and develops over time. Heredity drives the physical attributes of growth and development such as stature, gender, and race.

**Cognitive Level:** Understanding
**Client Need:** Health Promotion and Maintenance
**Client Need Sub:**

**Nursing/Integrated Concepts:** Nursing Process: Assessment
**Learning Outcome:** 3.1: Identify the principles of growth and development.

**Question 3**
**Type:** MCSA

The nurse is teaching the parents of a child who is in Piaget's sensorimotor stage of development. Which statement, made by the parents, indicates to the nurse that they understand the teaching and are working appropriately to help the child accomplish developmental tasks of this stage?

**1.** "We have started buying more colorful toys."

**2.** "We play with water toys in the bathtub."

**3.** "We bought some blocks with numbers."

**4.** "We have been playing peek-a-boo."

**Correct Answer:** 4

**Rationale 1**: Buying more colorful toys fosters visual stimulation as the child experiences physiologic growth and development (nervous system), but does not help the child with cognitive development.

**Rationale 2**: Playing with water toys in the bathtub helps a child to develop motor. not cognitive. skills.

**Rationale 3**: Providing a child with numbered blocks targets motor skill development, not cognitive development.

**Rationale 4**: Playing peek-a-boo helps the infant begin to understand that someone is there even when that person is not visible. Piaget's theory explores how thinking, reasoning, and language develop (cognitive skills). In the sensorimotor stage (birth to 2 years) the infant progresses from responding primarily through reflexes, to purposeful movement and organized activity. It is during this stage that the infant begins to recognize objects and develop object permanence, the knowledge that objects continue to exist even though they are not seen.

**Global Rationale:** Playing the game "peek-a-boo" helps the child to understand that someone is there even when they are not visible. Piaget's theory explores how thinking, reasoning, and language develop (cognitive skills). In the sensorimotor stage (birth to 2 years) the child progresses from responding primarily through reflexes, to purposeful movement and organized activity. It is during this stage that the child begins to recognize objects and develop object permanence, the knowledge that objects continue to exist even though they are not seen. Buying more colorful toys fosters visual stimulation as the child experiences physiologic growth and development (nervous system), but does not help the child with cognitive development. Playing with water toys in the bathtub helps a child to develop motor not cognitive skills. Providing a child with numbered blocks targets motor skill development, not cognitive development.

**Cognitive Level:** Analyzing
**Client Need:** Health Promotion and Maintenance
**Client Need Sub:**
**Nursing/Integrated Concepts:** Nursing Process: Evaluation
**Learning Outcome:** 3.2: Discuss theories of development.

**Question 4**
**Type:** MCSA

The nurse is developing a care plan for a pediatric client who is at the age to work on Erickson's developmental stage 4. Which of the following goals would be most appropriate for the nurse to include which would demonstrate the child is accomplishing the tasks in this stage of development? The child will:

**1.** Watch peers play team sports.

**2.** Identify one or two pets that would be fun to care for.

**3.** Complete school homework and have a passing grade within 1 month.

**4.** Volunteer to help with one or more community projects each week.

**Correct Answer:** 3

**Rationale 1**: A child who is observing others playing team sports (not participating) may be afraid to join in for fear of not being an adequate player or team member. This does not demonstrate accomplishment of the task at this developmental level.

**Rationale 2**: Identifying one or two pets to care for would not foster a sense of competency, creativity, and perseverance since mastering this task would require actually caring for the pet or pets.

**Rationale 3**: Erickson identified 8 stages of personality development in which a person must resolve a conflict based on physiologic and societal expectations. During Stage 4 (ages 6–11 years), the crisis of industry versus inferiority presents. Industry results in the development of competency, creativity and perseverance. Inferiority creates feelings of hopelessness, and a sense of being mediocre or incompetent. At this age, school is a major focus in a child's life; thus reaching a goal of completing school homework and having passing grades within 1 month would help develop a sense of competency and creativity and would also require perseverance in order to be successful.

**Rationale 4**: Volunteering to help with one or more community projects each week is an unrealistic goal for a child of this age.

**Global Rationale:** Erickson identified 8 stages of personality development in which a person must resolve a conflict based on physiologic and societal expectations. During Stage 4 (ages 6–11 years), the child is presented with the crisis of industry versus inferiority. Industry results in the development of competency, creativity and perseverance. Inferiority creates feelings of hopelessness, and a sense of being mediocre or incompetent. At this age, school is a major focus in a child's life; thus reaching a goal of completing school homework and having passing grades within 1 month would help develop a sense of competency and creativity and would also require perseverance in order to be successful. A child who is observing others playing team sports (not participating) may be afraid to join in for fear of not being an adequate player or team member. This does not demonstrate accomplishment of the task at this developmental level. The crisis of autonomy versus shame and self-doubt presents much earlier at Stage 2 (ages 1–2 years). Identifying one or two pets to care for would not foster a sense of competency, creativity, and perseverance since mastering this task would require actually caring for the pet or

pets. Volunteering to help with one or more community projects each week is an unrealistic goal for a child of this age.

**Cognitive Level:** Applying
**Client Need:** Health Promotion and Maintenance
**Client Need Sub:**
**Nursing/Integrated Concepts:** Nursing Process: Planning
**Learning Outcome:** 3.2: Discuss theories of development.

**Question 5**
**Type:** MCSA

The nurse working at an assisted living facility has just counseled a client experiencing a crisis in Erickson's developmental stage of integrity versus despair. Which of the following suggestions by the nurse would be most appropriate to assist this client?

**1.** "You should consider buying a bigger house so that your divorced son can come and live with you."

**2.** "You should consider getting a job to fill your time."

**3.** "You should organize your family photos into an album"

**4.** "You should consider playing a sport."

**Correct Answer:** 3

**Rationale 1**: During the stage of integrity versus despair an individual reviews life experiences and will either feel contentment and satisfaction with life or feel sadness and a sense of loss. Reviewing life through photos and organizing them into an album may bring a sense of satisfaction to the individual.

**Rationale 2**: Buying a bigger house in order to help an adult child may place a financial burden on an older adult, causing resentment and dissatisfaction with life.

**Rationale 3**: Older adults may have physical limitations related to the normal aging process or health problems that may interfere with their abilities to work. This may actually exacerbate a sense of loss, sadness, and despair.

**Rationale 4**: While older adults are encouraged to remain active, playing sports may be limited in the older adult due to the normal physiologic changes that occur with aging.

**Global Rationale:** During the stage of integrity versus despair an individual reviews life experiences and will either feel contentment and satisfaction with life or feel sadness and a sense of loss. Reviewing life through photos and organizing them into an album may bring a sense of satisfaction to the individual. Buying a bigger house in order to help an adult child may place a financial burden on an older adult, causing resentment and dissatisfaction with life. Older adults may have physical limitations related to the normal aging process or health problems that may interfere with their abilities to work. This may actually exacerbate a sense of loss, sadness, and despair. While older adults are encouraged to remain active, playing sports may be limited in the older adult due to the normal physiologic changes that occur with aging.

**Cognitive Level:** Applying
**Client Need:** Health Promotion and Maintenance
**Client Need Sub:**
**Nursing/Integrated Concepts:** Nursing Process: Implementation
**Learning Outcome:** 3.2: Discuss theories of development.

**Question 6**
**Type:** MCSA

The nurse is interviewing the mother of a toddler who verbalizes concerns that her child uses the toilet to void, but refuses to use the toilet for bowel movements, and often hides to defecate. The nurse identifies that this child is in which of the following Freudian phases of psychologic development?

**1.** Genital

**2.** Phallic

**3.** Anal

**4.** Latency

**Correct Answer:** 3

**Rationale 1**: The genital phase occurs during puberty through adulthood; the individual experiences sexual urges stimulated by hormonal influences and sexual development.

**Rationale 2**: The phallic phase occurs during years 4 to 6; pleasure is focused on the genital area.

**Rationale 3**: Freud's anal phase follows the oral phase and continues through age 3. The anus becomes the focus for gratification and the child experiences conflict when expectations about toileting are presented.

**Rationale 4**: The latency phase occurs during years 5 to 6 when energy is focused on intellectual and physical activities and a time to work on unresolved conflicts.

**Global Rationale:** Freud's anal phase follows the oral phase and continues through age 3. The anus becomes the focus for gratification and the child experiences conflict when expectations about toileting are presented. The genital phase occurs during puberty through adulthood; the individual experiences sexual urges stimulated by hormonal influences and sexual development. The phallic phase occurs during years 4 to 6; pleasure is focused on the genital area. The latency phase occurs during years 5 to 6 when energy is focused on intellectual and physical activities and a time to work on unresolved conflicts.

**Cognitive Level:** Applying
**Client Need:** Health Promotion and Maintenance
**Client Need Sub:**
**Nursing/Integrated Concepts:** Nursing Process: Assessment
**Learning Outcome:** 3.2: Discuss theories of development.

**Question 7**

**Type:** MCMA

Using Piaget's theory of cognitive development, the nurse expects preschoolers will:

**Standard Text:** Select all that apply.

**1.** Be egocentric and fail to see another's point of view.

**2.** Focus on many aspects of a given situation at once.

**3.** Assume everyone else in their world sees things as they do.

**4.** Believe they have magical powers of thought to control the universe.

**5.** Understand cause-and-effect relationships

**Correct Answer:** 1,3,4

**Rationale 1**: **Be egocentric and fail to see another's point of view.** The preschooler continues to be egocentric and unable to see another's point of view.

**Rationale 2**: **Focus on many aspects of a given situation at once.** Preschoolers demonstrate centration. That is, they focus on one aspect of a situation and ignore others, leading to illogical reasoning.

**Rationale 3**: **Assume everyone else in their world sees things as they do.** Preschoolers feel no need to defend their point of view, because they assume that everyone else sees things as they do.

**Rationale 4**: **Believe they have magical powers of thought to control the universe.** Preschoolers believe their wishes, thoughts, and gestures command the universe. The child believes that these "magical" powers of thought are the cause of all events.

**Rationale 5**: **Understand cause-and-effect relationships.** Understanding cause-and-effect relationships is developed during the school-age years.

**Global Rationale:** The preschooler continues to be egocentric and unable to see another's point of view. They feel no need to defend their point of view, because they assume that everyone else sees things as they do. Preschoolers demonstrate centration. That is, they focus on one aspect of a situation and ignore others, leading to illogical reasoning. They believe their wishes, thoughts, and gestures command the universe. The child believes that these "magical" powers of thought are the cause of all events. Understanding cause-and-effect relationships is developed during the school-age years.

**Cognitive Level:** Applying
**Client Need:** Health Promotion and Maintenance
**Client Need Sub:**
**Nursing/Integrated Concepts:** Nursing Process: Assessment
**Learning Outcome:** 3.2: Discuss theories of development.

**Question 8**
**Type:** MCSA
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A preschool-age child is at play. Which of the following behaviors indicates to the nurse that the child is successfully moving through Piaget's cognitive stages of development appropriate for this age?

**1.** The child is able to consider the differing opinions of playmates.

**2.** The child is able to recall the good time experienced the previous weekend at the playground and is anticipating going there again the following week.

**3.** The child reports being able to rationalize why it is better to eat fruit than candy.

**4.** The child understands that his mother loves him as much as she loves the child's older siblings.

**Correct Answer:** 2

**Rationale 1**: The ability to consider the points of view of others does not occur until the Concrete Operations stage.

**Rationale 2**: The child is able to recall the good time experienced the previous weekend at the playground and is anticipating going there again the following week. This indicates that

**Rationale 3**: The child is progressing without difficulty in Piaget's Cognitive Theory. Stage 2: Preoperational Skills encompasses ages 2 to 7 years.

**Rationale 4**: Rational thinking begins around the age of 11 and continues into adulthood. This is the stage known as Formal Operations.

**Global Rationale:** The child is able to recall the good time experienced the previous weekend at the playground and is anticipating going there again the following week. This indicates that the child is progressing without difficulty in Piaget's Cognitive Theory. Stage 2: Preoperational Skills encompasses ages 2 to 7 years. During this time, the child is able to recall past events and anticipate future events. The ability to consider the points of view of others does not occur until the Concrete Operations stage. Rational thinking begins around the age of 11 and continues into adulthood. This is the stage known as Formal Operations. The issue of maternal love does not impact this question.

**Cognitive Level:** Applying
**Client Need:** Psychosocial Integrity
**Client Need Sub:**
**Nursing/Integrated Concepts:** Nursing Process: Evaluation
**Learning Outcome:** 3.2: Discuss theories of development.

**Question 9**
**Type:** MCSA

An older adult client voices concerns to the nurse regarding the seemingly continued loss of family and friends to illness and death. The client states, "God is cruel. I have no one anymore. I am too old to make new friends; it's useless, everyone leaves me." Using Erickson's psychosocial theory, the nurse interprets the client's remarks. This client is:

**1.** Successfully mastering the stage of integrity versus despair.

**2.** Is having difficulty passing through the stage of generativity versus stagnation.

**3.** Is experiencing struggles to succeed in the stage of integrity versus despair.

**4.** Is demonstrating unsuccessful completion of the intimacy versus isolation stage of development.

**Correct Answer:** 3

**Rationale 1**: During the stage of integrity versus despair (ages 65 to death) the client reflects on life and the inevitability of death. Clients are often faced with the loss of friends and family members. Acceptance of these losses results in successful movement through this stage.

**Rationale 2**: During the stage of generativity versus stagnation (ages 40–65), the client either demonstrates productivity and creativity or begins to become self absorbed and nonproductive.

**Rationale 3**: The client is experiencing struggles to succeed in the stage of integrity versus despair. During this phase, the client reflects on life and the inevitability of death. Clients are often faced with the loss of friends and family members. Failure to accept this stage of life will result in bitterness.

**Rationale 4**: In the phase of intimacy versus isolation (ages 19–40) adults find mates or face a life of loneliness.

**Global Rationale:** The client is experiencing struggles to succeed in the stage of integrity versus despair. During this phase (ages 65 to death), the client reflects on life and the inevitability of death. Clients are often faced with the loss of friends and family members. Acceptance of these losses results in successful movement through this stage. Failure to accept this stage of life will result in bitterness. During the stage of generativity versus stagnation (ages 40–65), the client either demonstrates productivity and creativity or begins to become self-absorbed and nonproductive. In the phase of intimacy versus isolation (ages 19–40) adults find mates or face a life of loneliness.

**Cognitive Level:** Applying
**Client Need:** Health Promotion and Maintenance
**Client Need Sub:**
**Nursing/Integrated Concepts:** Nursing Process: Evaluation
**Learning Outcome:** 3.2: Discuss theories of development.

**Question 10**
**Type:** MCSA

During a well-baby check the nurse notices the infant does not demonstrate the expected developmental milestones for this age. Which of the following nursing interventions should be completed first?

**1.** The nurse should initiate a consult with social services for a home assessment.

**2.** The nurse should consult with the health care provider.

**3.** The nurse should ask the parents questions about their play activities with the infant.

**4.** The nurse should prepare the family for a potentially upsetting diagnosis.

**Correct Answer:** 3

**Rationale 1**: It is outside the nurse's scope of practice to initiate consults. The healthcare provider will recommend and manage consultations.

**Rationale 2**: The nurse should complete the assessment before consulting with the health care provider.

**Rationale 3**: The nurse should first assess the parental knowledge and expectations concerning normal infant development. The parents may not be aware of the appropriate activities that will stimulate the child.

**Rationale 4**: There is no need to prepare the parents for a negative outcome at this point.

**Global Rationale:** The nurse should first assess the parental knowledge and expectations concerning normal infant development. The parents may not be aware of the appropriate activities that will stimulate the child. It is outside the nurse's scope of practice to initiate consults. The healthcare provider will recommend and manage consultations. The nurse should complete the assessment before consulting with the health care provider. There is no need to prepare the parents for a negative outcome at this point.

**Cognitive Level:** Analyzing
**Client Need:** Health Promotion and Maintenance
**Client Need Sub:**
**Nursing/Integrated Concepts:** Nursing Process: Assessment
**Learning Outcome:** 3.3: Describe stages of development.

**Question 11**
**Type:** MCSA

In preparation for a sport's physical examination, the nurse is assessing the height of a 16-year-old male client. The client measures 5′5″. The client voices concerns about his lack of stature. He asks if he has reached his full height. Which of the responses by the nurse is most appropriate?

**1.** "By age 16, you are finished growing."

**2.** "Is your father very tall?"

**3.** "Why do you hope to grow taller?"

**4.** "You may continue to grow into your early 20s."

**Correct Answer:** 4

**Rationale 1**: On average, the fastest rate of growth in adolescent males occurs at about age 14 and continues for 24–30 months. After that time, growth continues but at a slower rate.

**Rationale 2**: Although a child's height may relate to that of the parents, this statement does not respond to the client's question.

**Rationale 3**: Asking the teen about his motivation to grow taller does not respond to his question.

**Rationale 4**: Skeletal growth may continue until age 25, when the epiphyses of the long bones are finally fused.

**Global Rationale:** Skeletal growth may continue until age 25, when the epiphyses of the long bones are finally fused. On average, the fastest rate of growth in adolescent males occurs at about age 14 and continues for 24–30 months. After that time, growth continues but at a slower rate. Although a child's height may relate to that of the parents, this statement does not respond to the client's question. Asking the teen about his motivation to grow taller does not respond to his question.

**Cognitive Level:** Applying
**Client Need:** Health Promotion and Maintenance
**Client Need Sub:**
**Nursing/Integrated Concepts:** Nursing Process: Implementation
**Learning Outcome:** 3.3: Describe stages of development.

**Question 12**
**Type:** MCSA

During a routine physical examination, a middle-aged female client reports concern about the weight gained over the past 2 years despite not having made any significant changes in diet or exercise patterns. The nurse understands that which of the following factors may be responsible for the client's reported changes in weight?

**1.** The client's increasing hormone levels

**2.** The client's increase in body mass index

**3.** The reduction in muscle nerve conduction

**4.** The hormonal changes of the female climacteric

**Correct Answer:** 4

**Rationale 1**: During this client's stage of development, there is a reduction, not an increase, in hormone levels as menopause (the female climacteric) approaches.

**Rationale 2**: Body mass index is determined by height and weight, but is not responsible for weight changes.

**Rationale 3**: The changes in muscle and nerve development are not directly implicated in the body changes being reported.

**Rationale 4**: Decreased hormone production results in an increase in body weight. The amount of adipose tissue also increases.

**Global Rationale:** During this client's stage of development, there is a reduction, not an increase, in hormone levels as menopause (the female climacteric) approaches. Decreased hormone production results in an increase in body weight. The amount of adipose tissue also increases. Body mass index is determined by height and weight,

but is not responsible for weight changes. The changes in muscle and nerve development are not directly implicated in the body changes being reported.

**Cognitive Level:** Applying
**Client Need:** Health Promotion and Maintenance
**Client Need Sub:**
**Nursing/Integrated Concepts:** Nursing Process: Assessment
**Learning Outcome:** 3.3: Describe stages of development.

**Question 13**
**Type:** MCMA

The adult children of an older adult client report they are becoming frustrated. They relate they are trying to get their parent to "take it easy"; stop working and reduce social activities. When questioned by the nurse, they report feeling this lessened stress will protect their loved one. Which of the following statements should be included in the nurses responses?

**Standard Text:** Select all that apply.

**1.** "Keeping busy will assist your parent to remain productive."

**2.** "Older adults who lack intellectual challenges may demonstrate cognitive declines."

**3.** "Your plans will increase your parent's quality of life."

**4.** "Retirement will promote rest and relaxation for your parent."

**5.** "It is important for older adults to have opportunities to develop and maintain friendships."

**Correct Answer:** 1,2,5

**Rationale 1**: **"Keeping busy will assist your parent to remain productive."** It is important for older adults to engage in activities that promote a sense of self–worth and usefulness.

**Rationale 2**: **"Older adults who lack intellectual challenges may demonstrate cognitive declines."** Studies have shown that seniors who continue to demonstrate intellectual interaction may have higher cognitive function levels.

**Rationale 3**: **"Your plans will increase your parent's quality of life."** While the children of the client believe that "taking it easy" will be protective, a lack of activity is consistent with a decline in function.

**Rationale 4**: **"Retirement will promote rest and relaxation for your parent."** Retirement may become more a source of stress than "rest and relaxation" as income is reduced. Lack of financial resources can limit activities and lifestyle.

**Rationale 5**: **"It is important for older adults to have opportunities to develop and maintain friendships."** Developing friendships with people of like interests promote the self-worth and usefulness of older adults.

**Global Rationale:** It is important for older adults to engage in activities that promote a sense of self–worth and usefulness. Studies have shown that seniors who continue to demonstrate intellectual interaction may have higher cognitive function levels. While the children of the client believe that "taking it easy" will be protective, a lack of activity is consistent with a decline in function. Retirement may become more a source of stress than "rest and relaxation" as income is reduced. Lack of financial resources can limit activities and lifestyle. Developing friendships with people of like interests promote the self-worth and usefulness of older adults.

**Cognitive Level:** Applying
**Client Need:** Health Promotion and Maintenance
**Client Need Sub:**
**Nursing/Integrated Concepts:** Nursing Process: Implementation
**Learning Outcome:** 3.3: Describe stages of development.

**Question 14**
**Type:** MCSA

Just after an appointment with the health care provider, an older adult client asks the nurse, "Why can't I seem to exercise like I did when I was younger? I just don't have the endurance that I did when I was 45, even though I feel good. The health care provider says I'm in good health and can exercise, but do you think there could be something wrong with me?" The nurse's best response to this client's statement is:

**1.** "I think you should discuss this further with the health care provider; maybe you need more tests."

**2.** "As individuals get older, there are normal changes that occur in the body, specifically the heart and lungs, that may contribute to decreased endurance. "

**3.** "The health care provider cleared you for exercise. I'm sure you are fine."

**4.** "The body undergoes physiologic changes that can affect your endurance, such as decreased cardiac output and increased residual air volume in the lungs."

**Correct Answer:** 2

**Rationale 1**: The nurse should first answer the client's question/concern. It may be appropriate to suggest further discussion with the health care provider if the client isn't satisfied with the nurse's explanation, but suggesting further testing may lead the client to believe the nurse suspects there is something wrong.

**Rationale 2**: The nurse should explain to the client in simple terms that it is normal in the older years to experience a decrease in endurance due to the physiologic changes that occur with aging. Specifically, the heart becomes stiffer, which affects the pumping action, the valves of the heart become less pliable, leading to decreased filling and emptying, and cardiac output and reserve is decreased. This makes it difficult for the heart to adjust quickly to increased demands. The respiratory system is less efficient. Lungs are stiffer, residual air (space where gas exchange does not occur) is increased, and vital capacity (area where gas exchange does take place) is decreased. The respiratory effort is increased to keep up with oxygen demands. Staying active will help a person build endurance.

**Rationale 3**: Telling the client, "The health care provider cleared you for exercise. I'm sure you are fine," does not answer the client's questions or address the concern.

**Rationale 4**: Responding to the client with "The body undergoes physiologic changes that can affect your endurance, such as decreased cardiac output and increased residual air volume in the lungs," is a medical explanation that the client may not understand.

**Global Rationale:** The nurse should explain to the client in simple terms that it is normal in the older years to experience a decrease in endurance due to the physiologic changes that occur with aging. Specifically, the heart becomes stiffer, which affects the pumping action, the valves of the heart become less pliable, leading to decreased filling and emptying, and cardiac output and reserve is decreased. This makes it difficult for the heart to adjust quickly to increased demands. The respiratory system is less efficient. Lungs are stiffer, residual air (space where gas exchange does not occur) is increased, and vital capacity (area where gas exchange does take place) is decreased. The respiratory effort is increased to keep up with oxygen demands. Staying active will help a person build endurance. The nurse should first answer the client's question/concern. It may be appropriate to suggest further discussion with the health care provider if the client isn't satisfied with the nurse's explanation, but suggesting further testing may lead the client to believe the nurse suspects there is something wrong. Telling the client, "The health care provider cleared you for exercise. I'm sure you are fine," does not answer the client's questions or address the concern. Responding to the client with "The body undergoes physiologic changes that can affect your endurance, such as decreased cardiac output and increased residual air volume in the lungs," is a medical explanation that the client may not understand.

**Cognitive Level:** Applying
**Client Need:** Health Promotion and Maintenance
**Client Need Sub:**
**Nursing/Integrated Concepts:** Nursing Process: Implementation
**Learning Outcome:** 3.3: Describe stages of development.

**Question 15**
**Type:** MCSA

The nurse is talking with an older adult client who has recently retired after 45 years of working as an executive at the same company. Which of the following demonstrates to the nurse that the client is adjusting to this new phase of life?

**1.** The client spends most of the day at home and declines invitations to outside gatherings with friends because there is "so much to do" at home.

**2.** The client has enrolled in courses at the local university to complete the college degree that was started "years ago," but interrupted by family responsibilities.

**3.** The client has lunch at the company cafeteria several times each week.

**4.** The client has purchased hearing aids, but rarely uses them.

**Correct Answer:** 2

**Rationale 1**: Enrolling in college courses is an activity that can be very fulfilling in the older adult years, especially after retirement when there is more time to pursue interests. This can provide a stimulating environment intellectually and socially, as well as give a person a sense of self-worth and accomplishment.

**Rationale 2**: Spending the day at home and declining outside invitations may be a sign that the client is not adjusting well to retirement.

**Rationale 3**: Eating lunch at the company cafeteria several times a week does not demonstrate a healthy adjustment to retirement.

**Rationale 4**: Refusing to wear hearing aids may indicate that the client is not adjusting to the physical changes of the older adult years.

**Global Rationale:** Enrolling in college courses is an activity that can be very fulfilling in the older adult years, especially after retirement when there is more time to pursue interests. This can provide a stimulating environment intellectually and socially, as well as give a person a sense of self-worth and accomplishment. Spending the day at home and declining outside invitations may be a sign that the client is not adjusting well to retirement. Eating lunch at the company cafeteria several times a week does not demonstrate a healthy adjustment to retirement. Refusing to wear hearing aids may indicate that the client is not adjusting to the physical changes of the older adult years.

**Cognitive Level:** Applying
**Client Need:** Health Promotion and Maintenance
**Client Need Sub:**
**Nursing/Integrated Concepts:** Nursing Process: Evaluation
**Learning Outcome:** 3.3: Describe stages of development.

**Question 16**
**Type:** MCSA

An older adult presents to the clinic for a routine physical examination. The client reports having trouble with memory and often has to "search" for words when having a conversation with friends or family. Which of the following assessment tools will help the nurse to gather more data about this client's concerns?

**1.** The Denver II

**2.** Mini-Mental Status Examination

**3.** Life Experiences Survey

**4.** Hassles and Uplifts Scale

**Correct Answer:** 2

**Rationale 1**: The Denver II is a screening tool used to assess personal-social, fine motor adaptive, language, and gross motor skills in children between birth and 6 years of age.

**Rationale 2**: The nurse should use the Mini-Mental Status Examination to gather more information about the cognitive status of this client. This tool is also useful to estimate cognitive impairment as well as to track cognitive changes over time.

**Rationale 3**: The Life Experiences Survey is used to evaluate the level of stress an individual is experiencing; this is not appropriate for this client's concerns.

**Rationale 4**: The Hassles and Uplifts Scale measures attitudes about daily situations; it does not screen for cognitive changes.

**Global Rationale:** The nurse should use the Mini-Mental Status Examination to gather more information about the cognitive status of this client. This tool is also useful to estimate cognitive impairment as well as to track cognitive changes over time. The Denver II is a screening tool used to assess personal-social, fine motor adaptive, language, and gross motor skills in children between birth and 6 years of age. The Life Experiences Survey is used to evaluate the level of stress an individual is experiencing; this is not appropriate for this client's concerns. The Hassles and Uplifts Scale measures attitudes about daily situations; it does not screen for cognitive changes.

**Cognitive Level:** Understanding
**Client Need:** Health Promotion and Maintenance
**Client Need Sub:**
**Nursing/Integrated Concepts:** Nursing Process: Assessment
**Learning Outcome:** 3.4: Identify a variety of measurements of growth and development across the age span.

**Question 17**
**Type:** MCSA

During a well-baby visit, the nurse measures the height and weight of an infant and plots the measurements on the baby's growth chart. The nurse notes a slowed growth pattern. Which of the following would be an appropriate action for the nurse to take?

**1.** Obtain an endocrinologist referral.

**2.** Perform a nutritional assessment.

**3.** Wait until the next visit to intervene.

**4.** Assess for circulatory problems.

**Correct Answer:** 2

**Rationale 1**: Referring the baby to an endocrinologist would be done by the health care provider, not the nurse, as this is outside the nurse's scope of practice.

**Rationale 2**: The nurse should perform a nutritional assessment because slowed growth is an early indicator of inadequate nutrition. It is expected that the rate of growth will remain consistent throughout infancy.

**Rationale 3**: The nurse should not wait until the next visit to intervene as early intervention, which commonly involves parent education and support, can often resolve problems.

**Rationale 4**: Before looking for other causes of slowed growth, the nurse should first assess the baby's nutritional status. Assessing for circulatory problems might follow if adequate nutrition has already been established.

**Global Rationale:** The nurse should perform a nutritional assessment because slowed growth is an early indicator of inadequate nutrition. It is expected that the rate of growth will remain consistent throughout infancy. Referring the baby to an endocrinologist would be done by the health care provider, not the nurse, as this is outside the nurse's scope of practice. The nurse should not wait until the next visit to intervene as early intervention, which commonly involves parent education and support, can often resolve problems. Before looking for other causes of slowed growth, the nurse should first assess the baby's nutritional status. Assessing for circulatory problems might follow if adequate nutrition has already been established.

**Cognitive Level:** Analyzing
**Client Need:** Physiological Integrity
**Client Need Sub:**
**Nursing/Integrated Concepts:** Nursing Process: Assessment
**Learning Outcome:** 3.4: Identify a variety of measurements of growth and development across the age span.

**Question 18**
**Type:** MCSA

The parent of a 3-year-old child voices concerns about the child's potential developmental delays. The parent reports an older child reached milestones significantly ahead of the younger child. An assessment reveals the child is able to assist with dressing and can play catch. Which of the following responses by the nurse is appropriate?

**1.** "Your child appears to be on target with the expected milestones for age."

**2.** "Your older child may simply be smarter than your 3 year old."

**3.** "I would recommend extensive testing to determine the source of the delays."

**4.** "Have you spoken with the health care provider about these delays?"

**Correct Answer:** 1

**Rationale 1**: The developmental tasks of the child are on track for age.

**Rationale 2**: Advising the parent one child is "smarter" than another is potentially damaging as well as inappropriate.

**Rationale 3**: Testing is not warranted at this time, the child is within the norms of development.

**Rationale 4**: There are not evident delays to review with the healthcare provider.

**Global Rationale:** The developmental tasks of the child are on track for age. Advising the parent one child is "smarter" than another is potentially damaging as well as inappropriate. Testing is not warranted at this time, the child is within the norms of development. There are not evident delays to review with the healthcare provider.

**Cognitive Level:** Understanding
**Client Need:** Health Promotion and Maintenance
**Client Need Sub:**
**Nursing/Integrated Concepts:** Nursing Process: Implementation

**Learning Outcome:** 3.4: Identify a variety of measurements of growth and development across the age span.

**Question 19**
**Type:** MCMA

When reviewing the developmental behaviors of an 8-month-old infant, which of the following behaviors indicates to the nurse the need for follow-up assessments?

**Standard Text:** Select all that apply.

**1.** Unable to sit for brief periods of time without support

**2.** Moro reflex present

**3.** Crawling on abdomen

**4.** Pulls self to standing position

**5.** Positive Babinski reflex

**Correct Answer:** 1,2

**Rationale 1**: **Unable to sit for brief periods of time without support.** By the age of 8 months the child should be able to sit for brief periods without support. Some children can sit alone well at this age. The child who is unable to sit for short periods alone needs further testing and evaluation.

**Rationale 2**: **Moro reflex present.** The Moro (startle) reflex should disappear between the ages of 4–6 months. The presence of this reflex beyond that age warrants follow-up.

**Rationale 3**: **Crawling on abdomen.** Around 6 months of age, infants begin to crawl on their abdomens, so it is expected that an 8-month-old will do this.

**Rationale 4**: **Pulls self to standing position.** Some 8-month-old babies may also be able to pull themselves up to a standing position. This is more typical of a 9-month-old.

**Rationale 5**: **Positive Babinski reflex.** The Babinski reflex doesn't begin to fade until 12 months, and is absent by the age of 2 years.

**Global Rationale:** By the age of 8 months the child should be able to sit for brief periods without support. Some children can sit alone well at this age. The child who is unable to sit for short periods alone needs further testing and evaluation. The Moro (startle) reflex should disappear between the ages of 4–6 months. The presence of this reflex beyond that age warrants follow-up. Around 6 months of age, infants begin to crawl on their abdomens, so it is expected that an 8-month-old will do this. Some 8-month-old babies may also be able to pull themselves up to a standing position. This is more typical of a 9-month-old. The Babinski reflex doesn't begin to fade until 12 months, and is absent by the age of 2 years.

**Cognitive Level:** Applying
**Client Need:** Health Promotion and Maintenance

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**Client Need Sub:**
**Nursing/Integrated Concepts:** Nursing Process: Assessment
**Learning Outcome:** 3.4: Identify a variety of measurements of growth and development across the age span.

**Question 20**
**Type:** MCSA

The mother of a toddler tells the nurse that she is concerned about her child's lower back curving in and the child's belly sticking out. Which of the following actions would be appropriate for the nurse?

**1.** Suggest that the mother to buy the child bigger clothes.

**2.** Give the mother the first available appointment to see the health care provider.

**3.** Contact the health care provider to see if an orthopedic referral is necessary.

**4.** Reassure the mother that this is normal for a toddler.

**Correct Answer:** 4

**Rationale 1**: Suggesting that the mother buy her child larger clothes does not address her concern that there is something abnormal with her child.

**Rationale 2**: The mother is describing a normal finding in a toddler; therefore a visit with the health care provider is not needed.

**Rationale 3**: There is no need for the nurse to consult with the health care provider or consider orthopedic referral since this is a normal finding in a toddler.

**Rationale 4**: The mother is describing toddler lordosis (a curving in of the lower back, which produces a potbelly). This is a normal finding in this age group and resolves as the abdominal muscles develop and pull the abdomen in.

**Global Rationale:** Young toddlers have pronounced lordosis, which makes their abdomens protrude. This is a normal finding, and the mother should be reassured of this. Suggesting that the mother buy her child larger clothes does not address her concern that there is something abnormal with her child. The mother is describing a normal finding in a toddler; therefore a visit with the health care provider is not needed. There is no need for the nurse to consult with the health care provider or consider orthopedic referral since this is a normal finding in a toddler.

**Cognitive Level:** Applying
**Client Need:** Health Promotion and Maintenance
**Client Need Sub:**
**Nursing/Integrated Concepts:** Nursing Process: Implementation
**Learning Outcome:** 3.5: Discuss growth and development in relation to health assessment.

**Question 21**
**Type:** MCSA

The mother of a 5-month-old infant calls the pediatrician's office to report to the nurse that she has noticed that her infant still has tremors of the extremities and chin at times. Which of the following actions would be appropriate for the nurse?

**1.** Reassure the mother that these tremors are a normal part of the infant's development.

**2.** Give the mother the first available appointment to see the health care provider.

**3.** Contact the health care provider to see if an electroencephalogram (EEG) should be ordered.

**4.** Ask the mother to keep a diary of the tremors and schedule an appointment for next week.

**Correct Answer:** 1

**Rationale 1**: Tremors of the extremities or chin of an infant are normal and reflect immature myelinization. This will disappear by 1 year of age as the nervous system continues to develop and myelinization of the efferent pathways matures.

**Rationale 2**: It is not necessary for the infant to be seen on an urgent basis; this is a normal phase of development.

**Rationale 3**: It is not necessary to consult the health care provider to discuss possible EEG as this is not indicative of seizure activity, but rather the result of an immature but normal nervous system.

**Rationale 4**: It is not necessary for the mother to record these tremors or see the health care provider since this is normal for a child of this age.

**Global Rationale:** Tremors of the extremities or chin of an infant are normal and reflect immature myelinization. This will disappear by 1 year of age as the nervous system continues to develop and myelinization of the efferent pathways matures. It is not necessary for the infant to be seen on an urgent basis; this is a normal phase of development. It is not necessary to consult the health care provider to discuss possible EEG as this is not indicative of seizure activity, but rather the result of an immature but normal nervous system. It is not necessary for the mother to record these tremors or see the health care provider since this is normal for a child of this age.

**Cognitive Level:** Applying
**Client Need:** Health Promotion and Maintenance
**Client Need Sub:**
**Nursing/Integrated Concepts:** Nursing Process: Implementation
**Learning Outcome:** 3.5: Discuss growth and development in relation to health assessment.

**Question 22**
**Type:** MCSA

The father of a preschool-aged child tells the nurse he is concerned that his son cannot ride a tricycle. Which of the following actions would be appropriate for the nurse?

**1.** Reassure the father that this is normal.

**2.** Refer the child to the health care provider.

**3.** Perform further growth and development assessments.

**4.** Ask the father about any siblings and at what age they rode a tricycle.

**Correct Answer:** 3

**Rationale 1**: While the child may not be developmentally delayed, simply reassuring the father that this is normal without further assessment is not an appropriate action by the nurse.

**Rationale 2**: By first performing further growth and developmental assessments the nurse is better informed as to the need and urgency of a referral to the health care provider.

**Rationale 3**: The nurse should perform further growth and development assessments as gross and fine motor development undergo rapid development during the toddler years (ages 1–3). A preschool aged child (ages 3–5) should be able to pedal a tricycle, a major accomplishment typically mastered at the end of the toddler years.

**Rationale 4**: Before gathering information about other children in the family and their developmental milestones, this child should be thoroughly assessed.

**Global Rationale:** The nurse should perform further growth and development assessments as gross and fine motor development undergo rapid development during the toddler years (ages 1–3). A preschool aged child (ages 3–5) should be able to pedal a tricycle, a major accomplishment typically mastered at the end of the toddler years. While the child may not be developmentally delayed, simply reassuring the father that this is normal without further assessment is not an appropriate action by the nurse. By first performing further growth and developmental assessments the nurse is better informed as to the need and urgency of a referral to the health care provider. Before gathering information about other children in the family and their developmental milestones, this child should be thoroughly assessed.

**Cognitive Level:** Applying
**Client Need:** Health Promotion and Maintenance
**Client Need Sub:**
**Nursing/Integrated Concepts:** Nursing Process: Assessment
**Learning Outcome:** 3.5: Discuss growth and development in relation to health assessment.

**Question 23**
**Type:** MCSA

The nurse is counseling the parents of a young teenager who is experiencing behavioral problems. The nurse would correctly choose which of the following assessment tools in this situation?

**1.** Family Psychosocial Screening

**2.** Eyeburg Child Behavior Inventory

**3.** Ages and Stages Questionnaire

**4.** Child Development Inventory

**Correct Answer:** 2

**Rationale 1**: The Family Psychosocial Screening is a tool that helps to identify psychosocial risk factors associated with developmental problems, such as parental history of physical abuse as a child, parental substance abuse, and maternal depression.

**Rationale 2**: The Eyeburg Child Behavior Inventory is a parent report scale of conduct problems in children ages 2 to 16 and would be the best choice for the nurse in this situation.

**Rationale 3**: The Ages and Stages Questionnaire is a tool that covers developmental areas of communication, gross and fine motor, and problem solving, not behavior.

**Rationale 4**: The Child Development Inventory is used to measure development in children between the ages of 15 months to 6 years and is not appropriate for a young teenager.

**Global Rationale:** The Eyeburg Child Behavior Inventory is a parent report scale of conduct problems in children ages 2 to 16 and would be the best choice for the nurse in this situation. The Family Psychosocial Screening is a tool that helps to identify psychosocial risk factors associated with developmental problems, such as parental history of physical abuse as a child, parental substance abuse, and maternal depression. The Ages and Stages Questionnaire is a tool that covers developmental areas of communication, gross and fine motor, and problem solving, not behavior. The Child Development Inventory is used to measure development in children between the ages of 15 months to 6 years and is not appropriate for a young teenager.

**Cognitive Level:** Applying
**Client Need:** Health Promotion and Maintenance
**Client Need Sub:**
**Nursing/Integrated Concepts:** Nursing Process: Assessment
**Learning Outcome:** 3.5: Discuss growth and development in relation to health assessment.

**Question 24**
**Type:** MCMA

The nurse is caring for a young adult client in the clinic who presents for a routine health examination. The nurse anticipates which of the following interventions for this client?

**Standard Text:** Select all that apply.

**1.** Counseling on injury prevention

**2.** Tetanus/diphtheria vaccination booster

**3.** Counseling on fluoride supplements

**4.** Information on diet and exercise

**5.** Fecal occult blood test

**Correct Answer:** 1,2,3,4

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**Rationale 1**: **Counseling on injury prevention.** Counseling on injury prevention is part of the periodic health exam of the young adult.

**Rationale 2**: **Tetanus/diphtheria vaccination booster.** Young adults should receive a Td booster if it has been > 10 years since the last booster.

**Rationale 3**: **Counseling on fluoride supplements.** Counseling on the use of fluoride toothpaste to deter tooth decay is included in the periodic health exam of the young adult.

**Rationale 4**: **Information on diet and exercise.** Information on diet and exercise is part of the periodic health exam of the young adult.

**Rationale 5**: **Fecal occult blood test.** Fecal occult blood testing is not routinely done until adults reach middle age (> 50 years of age).

**Global Rationale:** Interventions for periodic health examinations for young adults include counseling on injury prevention, counseling on dental health and the regular use of a toothpaste containing fluoride, counseling on recommended immunizations, which include tetanus/diphtheria booster (Td) if none in the past 10 years, and information on diet and exercise. Fecal occult blood testing is not routinely done until adults reach middle age (> 50 years of age).

**Cognitive Level:** Applying
**Client Need:** Health Promotion and Maintenance
**Client Need Sub:**
**Nursing/Integrated Concepts:** Nursing Process: Implementation
**Learning Outcome:** 3.5: Discuss growth and development in relation to health assessment.

**Question 25**
**Type:** MCMA

Which of the following assessment findings in an older adult client does the nurse associate with the normal aging process?

**Standard Text:** Select all that apply.

**1.** Increased systolic blood pressure

**2.** Increased muscle tone

**3.** Decreased cardiac output

**4.** Increased vital capacity

**5.** Decreased renal function

**Correct Answer:** 1,3,5

**Rationale 1**: **Increased systolic blood pressure.** Systolic blood pressure increases due to a decrease in the elasticity of the arteries and increased peripheral vascular resistance.

**Rationale 2**: **Increased muscle tone.** Muscle tone is decreased.

**Rationale 3**: **Decreased cardiac output.** Cardiac output is diminished due to alteration in pumping action as the heart muscle thickens.

**Rationale 4**: **Increased vital capacity.** Respiratory vital capacity is decreased as the lungs become stiffer and less efficient.

**Rationale 5**: **Decreased renal function.** Renal function decreases as blood flow to the kidneys is affected by arteriosclerotic changes and a decrease in the number of nephrons.

**Global Rationale:** The older adult experiences a normal decline in body function. Systolic blood pressure increases due to a decrease in the elasticity of the arteries and increased peripheral vascular resistance. Cardiac output is diminished due to alteration in pumping action, as the heart muscle thickens. Renal function decreases as blood flow to the kidneys is affected by arteriosclerotic changes and a decrease in the number of nephrons. Respiratory vital capacity is decreased as the lungs become stiffer and less efficient. Muscle tone is decreased.

**Cognitive Level:** Remembering
**Client Need:** Health Promotion and Maintenance
**Client Need Sub:**
**Nursing/Integrated Concepts:** Nursing Process: Assessment
**Learning Outcome:** 3.5: Discuss growth and development in relation to health assessment.

**Question 26**
**Type:** MCSA

The nurse is counseling a middle-aged couple when the man asks if his wife is going through menopause. His wife has told him that both men and women experience decreasing hormonal production during middle adulthood, and he asks the nurse if this is true. What is the most appropriate response by the nurse?

**1.** "Your wife has obtained some incorrect data."

**2.** "Why do you ask?"

**3.** "Your hormonal levels increase, not decrease with age."

**4.** "Your wife is correct. Both men and women experience a decrease in hormone production with aging."

**Correct Answer:** 4

**Rationale 1**: The statement by the nurse, "Your wife is correct, both men and women experience a decrease in hormone production with aging" accurately describes changes that take place in the middle-age years.

**Rationale 2**: Responding by asking another question such as "Why do you ask?" does not answer the initial question asked by the husband of the couple. It is most appropriate for the nurse to answer the husband's question first and later explore his concerns.

**Rationale 3**: Hormone levels in men and women do not increase with aging.

**Rationale 4**: The statement by the nurse, "Your wife is correct, both men and women experience a decrease in hormone production with aging" accurately describes changes that take place in the middle-age years. During menopause, which usually occurs between ages 40 and 55, the ovaries decrease in size, and the uterus becomes smaller and firmer. Progesterone is not produced and estrogen levels fall. Men also have a decrease in hormonal production and experience a gradual decrease in testosterone.

**Global Rationale:** The statement by the nurse, "Your wife is correct, both men and women experience a decrease in hormone production with aging" accurately describes changes that take place in the middle-age years. During menopause, which usually occurs between ages 40 and 55, the ovaries decrease in size, and the uterus becomes smaller and firmer. Progesterone is not produced and estrogen levels fall. Men also have a decrease in hormonal production and experience a gradual decrease in testosterone. Hormone levels in men and women do not increase with aging. Responding by asking another question such as "Why do you ask?" does not answer the initial question asked by the husband of the couple. It is most appropriate for the nurse to answer the husband's question first and later explore his concerns.

**Cognitive Level:** Applying
**Client Need:** Health Promotion and Maintenance
**Client Need Sub:**
**Nursing/Integrated Concepts:** Nursing Process: Implementation
**Learning Outcome:** 3.6: Discuss factors that influence growth and development.

**Question 27**
**Type:** MCSA

An infant has been admitted to the pediatric unit for observation. The admission assessment indicates the family is Cuban American. When assessing the family's interactions the nurse notes the mother does all the care of the child while the father seems detached from the infant. Which of the following would be the most appropriate nursing diagnosis in this situation?

**1.** Compromised family coping

**2.** Altered role functions

**3.** Risk for family violence

**4.** Readiness for enhanced family processes

**Correct Answer:** 4

**Rationale 1**: The family is operating and coping within the norm of its Cuban American culture; therefore, compromised family coping is not an appropriate nursing diagnosis for this infant and family.

**Rationale 2**: The role functions of the parents are not altered and are culturally appropriate with the mother being the infant's primary caretaker.

**Rationale 3**: The nurse must be cognizant of a client's cultural norms in order to accurately make assessments and determine real or potential problems. There is nothing to suggest a risk for family violence.

**Rationale 4**: The readiness for enhanced family processes is by definition a pattern of family functioning that is sufficient to support the well-being of family members and can be strengthened. Paternal and maternal attachment differs among cultures. In the Cuban American culture, the mother is the primary caregiver and bonds with the child earlier and continually, while the father remains detached from infant care and begins attachment behaviors only when the child is able to walk and communicate.

**Global Rationale:** The readiness for enhanced family processes is by definition a pattern of family functioning that is sufficient to support the well-being of family members and can be strengthened. Paternal and maternal attachment differs among cultures. In the Cuban American culture, the mother is the primary caregiver and bonds with the child earlier and continually, while the father remains detached from infant care and begins attachment behaviors only when the child is able to walk and communicate. The family is operating and coping within the norm of its Cuban American culture; therefore, compromised family coping is not an appropriate nursing diagnosis for this infant and family. The role functions of the parents are not altered and are culturally appropriate with the mother being the infant's primary caretaker. And finally, the nurse must be cognizant of a client's cultural norms in order to accurately make assessments and determine real or potential problems. There is nothing to suggest a risk for family violence.

**Cognitive Level:** Applying
**Client Need:** Psychosocial Integrity
**Client Need Sub:**
**Nursing/Integrated Concepts:** Nursing Process: Diagnosis
**Learning Outcome:** 3.6: Discuss factors that influence growth and development.

**Question 28**
**Type:** MCSA

The nurse is completing discharge teaching to the family of a hospitalized older adult client. Which of the following is most important for the nurse to include in this teaching plan?

**1.** Reducing the amount of odor in the client's immediate environment

**2.** Protecting the client from injury due to increased pain threshold

**3.** Speaking in an increasingly loud voice as client's hearing decreases

**4.** Avoiding range of motion exercises due to loss of bone density and increased risk for fracture

**Correct Answer:** 2

**Rationale 1**: The sense of smell decreases with age; reducing the amount of odor in the client's immediate environment is not a priority.

**Rationale 2**: Protecting the client from injury is the most important teaching point. In the older adult, there is an increased threshold for the sensation of pain and touch as well as a decrease in reaction time.

**Rationale 3**: Older adults experience a gradual loss of hearing; speaking at a level that the client can hear is important, but not above protection from injury.

**Rationale 4**: Range of motion should be encouraged to facilitate mobility and is not a risk factor for fractures.

**Global Rationale:** Protecting the client from injury is the most important teaching point. In the older adult, there is an increased threshold for the sensation of pain and touch as well as a decrease in reaction time. The sense of smell decreases with age; reducing the amount of odor in the client's immediate environment is not a priority. Older adults experience a gradual loss of hearing; speaking at a level that the client can hear is important, but not above protection from injury. Range of motion should be encouraged to facilitate mobility and is not a risk factor for fractures.

**Cognitive Level:** Applying
**Client Need:** Health Promotion and Maintenance
**Client Need Sub:**
**Nursing/Integrated Concepts:** Nursing Process: Implementation
**Learning Outcome:** 3.6: Discuss factors that influence growth and development.

**Question 29**
**Type:** MCSA

The nurse is caring for a hospitalized infant. When the infant begins to cry, the parents report they do not believe in responding too rapidly, as they do not wish to spoil their child. Which of the following responses by the nurse is most appropriate?

**1.** "I agree with your philosophy of child rearing."

**2.** "There are many studies that support this belief."

**3.** "Responding quickly to your baby's cries will assist the baby in feeling secure and does not result in a spoiled child."

**4.** "Children who experience separation anxiety have been spoiled by their parents."

**Correct Answer:** 3

**Rationale 1**: The nurse should not be offering personal beliefs or philosophies to clients or their families.

**Rationale 2**: Concern over "spoiling" infants by promptly responding to their cries is no longer an accepted concept. Research has shown that infants whose mothers respond promptly to their cries during the early months of life cry less at 1 year of age.

**Rationale 3**: A timely response to infant crying does not result in a spoiled child. It promotes the infant's sense of security and promotes independence during later stages of development.

**Rationale 4**: Children who have received inconsistent nurturing may experience clingy, angry, or distrustful behaviors.

**Global Rationale:** A timely response to infant crying does not result in a spoiled child. It promotes the infant's sense of security and promotes independence during later stages of development. The nurse should not be offering personal beliefs or philosophies to clients or their families. Concern over "spoiling" infants by promptly responding to their cries is no longer an accepted concept. Research has shown that infants whose mothers respond promptly to their cries during the early months of life cry less at 1 year of age. Children who have received inconsistent nurturing may experience clingy, angry, or distrustful behaviors.

**Cognitive Level:** Applying
**Client Need:** Health Promotion and Maintenance
**Client Need Sub:**
**Nursing/Integrated Concepts:** Nursing Process: Implementation
**Learning Outcome:** 3.6: Discuss factors that influence growth and development.

**Question 30**
**Type:** MCSA

The nurse is explaining the influence of culture on growth and development to a group of expectant first-time parents. The nurse recognizes the need for further teaching when a parent states:

**1.** "Mothers and fathers should always share in the responsibilities of caring for a new baby."

**2.** "Culture may influence the rate at which developmental milestones occur."

**3.** "The ways in which children are disciplined may vary among cultures."

**4.** "The value of education varies among cultures."

**Correct Answer:** 1

**Rationale 1**: Family roles differ among cultures. While it is customary among Caucasian parents to bond with the infant early in the neonatal period, it is the mother who bonds with the infant in the Cuban American culture.

**Rationale 2**: Developmental milestones can be affected by culture; for example, African American toddlers have been found to develop some motor skills earlier than Caucasian toddlers.

**Rationale 3**: The discipline of children varies among cultures.

**Rationale 4**: The value of education varies among cultures.

**Global Rationale:** Family roles differ among cultures. While it is customary among Caucasian parents to bond with the infant early in the neonatal period, it is the mother who bonds with the infant in the Cuban American culture. Developmental milestones can be affected by culture; for example, African American toddlers have been found to develop some motor skills earlier than Caucasian toddlers. The discipline of children varies among cultures. The value of education varies among cultures.

**Cognitive Level:** Applying
**Client Need:** Health Promotion and Maintenance
**Client Need Sub:**
**Nursing/Integrated Concepts:** Nursing Process: Implementation
**Learning Outcome:** 3.6: Discuss factors that influence growth and development.