1. 1. The decreased sense of smell resulting from atrophy of olfactory organs is a safety hazard, and clients may not be able to smell gas leaks or fire, so the nurse should recommend a carbon monoxide detector and a smoke alarm. This safety equipment is critical for the elderly.

2. Night lights do not address the client’s sense of smell.

3. High humidity may help with breathing, but it does not help the sense of smell.

4. The client’s sense of smell is decreased; therefore, smelling food before eating is not an appropriate intervention.


2. 1. The nurse needs to discuss possible causes with the client and not talk to the wife.

2. The acuity of the taste buds decreases with age, which could cause regular foods to seem bland and tasteless.

3. Some medications may cause a metallic taste in the mouth, but medication does not cause foods to taste bland.

4. Telling the client to cook if he doesn’t like his wife’s food is an argumentative and judgmental response.


3. 1. Because of altered temperature regulation, the client usually needs a warmer room temperature, not a cooler room temperature.

2. The nurse should use a low-pitched, normal-volume, clear voice. Talking louder or shouting only makes it harder for the client to understand the nurse.

3. The elderly client requires adequate time to receive and respond to stimuli, to learn, and to react; therefore, the nurse should take time and not rush the admission.

4. Sensory isolation resulting from visual and hearing loss can cause confusion, anxiety, disorientation, and misinterpretation of the new environment; therefore, the nurse should provide extra orientation.


4. 1. This assesses proprioception, or position sense; direction of the toe must be evaluated.

2. Vibration is assessed by using a low-frequency tuning fork on a bony prominence and asking the client whether he or she feels the sensation and, if so, when the sensation ceases.

3. Tapping the cheek assesses for tetany, not cranial nerve involvement.

4. A two-point discrimination test evaluates integration of sensation, but it does not assess for vibration.


2. 1. Adequate lighting without a glare should be provided when having the client read written material; therefore, the curtains should be closed, not open.

2. The nurse should provide short, concise, and concrete material, not a variety of material.

3. Because fewer tactile cues are received from the bottom of the feet, the client may get confused as to body position and location. Safety is priority, and assisting the client getting out of bed and sitting in a chair is appropriate.

4. This is making a judgment. Not all elderly clients are hard of hearing, and telephones for the hearing impaired require special training for the user.


6. 1. Loss of peripheral vision as a result of glaucoma causes the client problems with seeing things on each side, resulting in a “blind spot.” This problem can lead to the client having car accidents when switching lanes.

2. This is indicative of cataracts because clients with cataracts have blurred vision and cannot read clearly.
3. This is indicative of cataracts because there is a color shift to yellow–brown and there is reduced light transmission.
4. This is indicative of macular degeneration, in which the central vision is affected.


7. 1. If gas tamponade is used to flatten the retina, the client may have to be specially positioned to make the gas bubble float into the best position; clients must lie face down or on the side for days.
2. The HOB should not be elevated after this surgery.
3. There is no need for the client to wear sunglasses; this surgery does not cause photophobia.
4. The client does not need to avoid reading.

**Content – Surgical: Category of Health Alteration – Neurosensory: Integrated Nursing Process – Planning: Client Needs – Physiological Integrity, Physiological Adaptation: Cognitive Level – Synthesis.**

8. 1. The tuning fork should be struck to produce vibrations and then placed midline between the ears on top of the head.
2. The right temple area is not an appropriate place to assess for conductive hearing loss.
3. The right occipital area is not the appropriate place to assess for conductive hearing loss; this is the area behind the ear where the Rinne test is performed.
4. The chin area is not the appropriate area to put the tuning fork.

**Content – Medical: Category of Health Alteration – Neurosensory: Integrated Nursing Process – Assessment: Client Needs – Safe Effective Care Environment, Management of Care: Cognitive Level – Knowledge.**

9. 1. Conductive hearing loss results from an external ear disorder, such as impacted cerumen, or a middle ear disorder, such as otitis media or otosclerosis.
2. Functional (psychogenic) hearing loss is nonorganic and unrelated to detectable structural changes in the hearing mechanisms. It is usually a manifestation of an emotional disturbance.
3. Mixed hearing loss involves both conductive loss and sensorineural loss. It results from dysfunction of air and bone conduction.
4. Sensorineural hearing loss is described in the stem of the question. It involves damage to the cochlea or vestibulocochlear nerve.

**Content – Medical: Category of Health Alteration – Neurosensory: Integrated Nursing Process – Diagnosis: Client Needs – Safe Effective Care Environment, Management of Care: Cognitive Level – Knowledge.**

10. 1. Balance disturbance, or true vertigo, rarely occurs with other middle-ear surgical procedures, but it does occur for a short time after a stapedectomy. Safety is an important issue, and ambulating without assistance requires intervention by the nurse.
2. Pressure changes in the middle ear will be minimal if the client sneezes or blows the nose with the mouth open instead of closed.
3. Slightly bloody or serosanguineous drainage is normal after ear surgery.
4. Popping and crackling in the operative ear is normal for about three (3) to five (5) weeks after surgery.

**Content – Surgical: Category of Health Alteration – Neurosensory: Integrated Nursing Process – Assessment: Client Needs – Safe Effective Care Environment, Management of Care: Cognitive Level – Analysis.**

11. 1. This is not a condition requiring an appointment with the health-care provider.
2. Anticholinergic medications, such as scopolamine patches, can be recommended by the nurse; this is not prescribing. Motion sickness is a disturbance of equilibrium caused by constant motion.
3. Motion sickness can be controlled with medication and it may not even occur. Therefore, discussing canceling the trip is not providing the client with appropriate information.
4. This is providing the client with false information. Lying down may or may not help motion sickness. To be able to enjoy the cruise, the client needs medication.

**Content – Medical: Category of Health Alteration – Neurosensory: Integrated Nursing Process – Planning: Client Needs – Physiological Integrity, Physiological Adaptation: Cognitive Level – Synthesis.**

12. 1. This is appropriate for a diagnosis of “knowledge deficit.”
2. This is appropriate for a diagnosis of “deficient diversional activity” related to environmental lack of activity.
3. Balance depends on visual, vestibular, and proprioceptive systems; therefore, the nurse should assess these systems for signs/symptoms.
4. This is appropriate for a diagnosis of “ineffective coping.”


13. 1. Being able to identify cold and hot on the face indicates an intact trigeminal nerve, cranial nerve V.
2. Not having any tongue tremor indicates an intact hypoglossal nerve, cranial nerve XI.
3. No ptosis of the eyelids indicates an intact oculomotor nerve (cranial nerve III), trochlear nerve (IV), and abducens nerve (VI). Tests also assess for ocular motion, conjugate movements, nystagmus, and papillary reflexes.
4. Cranial nerve I is the olfactory nerve, which involves the sense of smell. With the eyes closed, the client must identify familiar smells to indicate an intact cranial nerve I.


14. 1. This is an inaccurate statement.
2. The elderly client usually requires less pain medication because of the effects of the normal aging process on the liver (metabolism) and renal system (excretion).
3. Decreased reaction to painful stimuli is a normal developmental change; therefore, complaints of pain may be more serious than the client’s perception might indicate and thus such complaints require careful evaluation.
4. The Wong scale is used to assess pain for the pediatric client, not the adult client.


15. 1. The client should be in the sitting position during a sensory assessment.
2. The eyes are closed so tactile, superficial pain, vibration, and position sense (proprioception) can be assessed without the client seeing what the nurse is doing.
3. The sensory assessment can be conducted at the bedside; there is no reason to take the client to the treatment room.
4. There is no reason the lights should be off during the sensory assessment; the client should close his or her eyes.


16. 1. Vertigo and otorrhea are not the signs/symptoms of an acoustic neuroma.
2. Neither nystagmus, an involuntary rhythmic movement of the eyes, nor dizziness is a sign of an acoustic neuroma.
3. Nausea and vomiting are not signs/symptoms of an acoustic neuroma.
4. An acoustic neuroma is a slow-growing, benign tumor of cranial nerve VII. It usually arises from the Schwann cells of the vestibular portion of the nerve and results in unilateral hearing loss and tinnitus, with or without vertigo.


17. 1. This assesses cranial nerve I, the olfactory nerve.
2. This assesses cranial nerve IX, the glossopharyngeal nerve.
3. This assesses cranial nerve II, the optic nerve, along with visual field testing and ophthalmoscopic examination.
4. This assesses cranial nerve X, the vagus nerve.


18. 1. The purpose of aural rehabilitation is to maximize the communication skills of the client who is hearing impaired. It includes auditory training, speech reading, speech training, and the use of hearing aids and hearing guide dogs.
2. A speech therapist may be part of the aural rehabilitation team, but the most important referral is aural rehabilitation.
3. The client may or may not need financial assistance, but the most important referral is aural rehabilitation.
4. The client may or may not need assistance with employment because of hearing loss,
but the most important referral is the aural rehabilitation.


19. 1. The client should be aware eye pain (a sandy sensation and sensitivity to light) will occur with conjunctivitis.

2. **Viral conjunctivitis is a highly contagious eye infection.** It is easily spread from one person to another; therefore, the client should not share personal items.

3. Cold compresses should be placed over the eyes for about 10 minutes four (4) to five (5) times a day to soothe the pain.

4. The client must not apply any makeup until the disease is over and should discard all old makeup to help prevent reinfection.


20. 1. Aural fullness or pressure after surgery is caused by residual blood or fluid in the middle ear. This is an expected occurrence after surgery, and the nurse should administer the prescribed analgesic.

2. Hearing in the operated ear may be reduced for several weeks because of edema, accumulation of blood and tissue fluid in the middle ear, and dressings or packing, so this does not need to be reported to the health-care provider.

3. Vertigo (dizziness) is uncommon after this surgery, but if it occurs the nurse should administer an antiemetic or antivertigo medication and does not need to report it to the health-care provider.

4. The **facial nerve, which runs through the middle ear and mastoid,** is at risk for injury during mastoid surgery; therefore, a facial paresis should be reported to the health-care provider.


21. 1. Voices in the head may indicate schizophrenia, but it is not a symptom of hearing loss.

2. **Fatigue may be the result of straining to hear, and a client may tire easily when listening to a conversation.** Under these circumstances, the client may become irritable very easily.

3. **Loss of self-confidence makes it increasingly difficult for a person who is hearing impaired to make a decision.**

4. **Often it is not the person with the hearing loss but a significant other who notices hearing loss; hearing loss is usually gradual.**

5. Many clients who are hearing impaired tend to dominate the conversation because, as long as it is centered on the client, they can control it and are not as likely to be embarrassed by some mistake.


22. 1. The client should not lift, push, or pull objects heavier than 15 pounds; 50 pounds is excessive.

2. The client should avoid lying on the side of the affected eye at night.

3. **The eyes must be protected by wearing glasses or metal eye shields at all times following surgery.** Very few answer options with “all” will be correct, but if the option involves ensuring safety, it may be the correct option.

4. The client should avoid bending or stooping for an extended period—but not forever.


23. 1. This is an abnormal finding for testing proprioception, or position sense.

2. This is an abnormal finding for assessing superficial pain perception.

3. This is a normal Babinski’s reflex in an adult client.

4. **Sterognosis is a test evaluating higher cortical sensory ability.** The client is instructed to close both eyes and identify a variety of objects (e.g., keys, coins) placed in one hand by the examiner.


24. 1. With normal aging comes decreased peripheral vision, constricted visual field, and tactile alterations. A night-light
addresses safety issues and warrants praise, not intervention.
2. Carbon monoxide detectors help ensure safety in the mother's home, so this comment doesn't warrant intervention.

3. Decreased peripheral vision, constricted visual fields, and tactile alterations are associated with normal aging. The client needs a familiar arrangement of furniture for safety. Moving the furniture may cause the client to trip or fall. The nurse should intervene in this situation.

4. As a result of normal aging, vision may become impaired, and the provision of large-print books warrants praise.

25. 1. The acuity of taste buds decreases with age, which may cause a decreased appetite and subsequent weight loss. Extra seasoning may help the food taste better to the client.

2. This may be an appropriate intervention if excessive weight is lost or if seasoning the food does not increase appetite, but it is not necessary at this time.

3. The client does not need a dietary consult for food not tasting good. The nurse can address the client's concern.

4. This recommendation does not address the client's comment about food not tasting good.

26. In order of priority: 5, 3, 2, 1, 4.

5. The nurse should question the client further to obtain information such as which eye is affected, how long the client has been seeing the spots, and whether this ever occurred before.

3. The Amsler grid is helpful in determining losses occurring in the visual fields.

2. The hemoglobin A1c laboratory tests results indicate glucose control over the past two (2) to three (3) months. Diabetic retinopathy is directly related to poor blood glucose control.

1. The health-care provider should be notified to plan for laser surgery on the eye.

4. The client should be instructed about controlling blood glucose levels, but this can wait until the immediate situation is resolved or at least until measures to address the potential loss of eyesight have been taken.