

NSG 121
STUDY GUIDE FOR ASSESSING BREATH SOUNDS

Name _____

SITUATION: You are to assess Mrs. Bayton's breath sounds.

- 1. Which of the following statements is not important as a reason to assess breath sounds? Breath sounds can:**
 - a. reveal if the lungs are not working effectively.
 - b. provide a basis for evaluating further information about respiratory function.
 - c. help you make nursing care decisions.
 - d. indicate the presence of undiagnosed tuberculosis.

- 2. The best position for Mrs. Bayton to effectively assess posterior breath sounds is:**
 - a. sitting on bedside with legs dangling over the side.
 - b. sitting on bedside leaning over the bedside table.
 - c. prone.
 - d. supine propped with pillows.

- 3. An effective routine or pattern to follow in auscultating breath sounds is:**
 - a. apex to base, comparing right side to left side.
 - b. base to apex, comparing right side to left side.
 - c. apex to base, right side of the chest first.
 - d. all of the anterior chest after the posterior chest.

- 4. During auscultation, you would ask Mrs. Bayton to:**
 - a. breathe normally, mouth open.
 - b. breathe normally, mouth closed.
 - c. breathe deeply, mouth open.
 - d. breathe deeply, mouth closed.

- 5. The breath sounds with the longest inspiratory phase are:**
 - a. bronchial.
 - b. bronchovesicular.
 - c. vesicular.

- 6. Bronchial breath sounds are usually:**
 - a. breezy and soft-pitched.
 - b. loud, high pitched and hollow.
 - c. soft, swishy and breezy.
 - d. low pitched and crackly.

- 7. While auscultating Mrs. Bayton's chest, you note soft, low-pitched breath sounds over most of her lungs. These sounds are:**
 - a. bronchial.
 - b. bronchovesicular.
 - c. vesicular.