1. **Assessment**

During the initial interview, the registered nurse inspects the external anatomy of the eye. The eye is a sensory organ of vision, and it is well protected by a bony orbital cavity and surrounded with a cushion of fat. The nurse notes that the cornea looks cloudy and an arcus senilis is seen around the cornea. Which action should the nurse take first?

A. Prepare to assist the HCP in obtaining ocular pressures. (*Elevated eye pressure is related to glaucoma.*)

B. Assess the client's retinal structures. (*This action is done during an internal, not external, examination of the eye.*)

C. **Assess whether the cornea looks thickened and raised and document the finding.** *(As the lipid accumulates, the cornea may look thickened and raised. The assessment finding should be documented in the electronic medical record.)*

D. Document any report of tearing or burning sensation. (*The lacrimal apparatus may decrease tear production, causing the eyes to look dry and lusterless. A person may report a burning sensation. This is not related to the arcus senilis.)*

2. During the assessment of Fred's hearing, the nurse performs a series of tests, including Fred's ability to hear whispered and conversational tones. How will the nurse assess for the presence of tinnitus?

A. *Ask the client if he ever hears ringing in his ears.* (*Tinnitus is the presence of ringing in the ears, which is often associated with hearing loss.)*

B. *Hold the auricle up and back and observe the ear canal.* (*This is the correct technique to examine the ear canal in the adult, but it will not provide data about tinnitus.)*

3. Fred seems nervous and asks for a glass of water. After taking a drink, he attempts to set the glass down, but places the glass on the edge of the counter, causing it to crash to the floor. To follow up this situation, which assessment will provide the most useful data?

A. **Visual field and depth perception.** *(Under or over reaching for objects is an indication of a visual deficit. Assessment of visual field and depth perception will provide the most useful data related to this situation.)*

4. Fred's visual acuity is measured using a Snellen chart. The reading obtained is 20/200 in the right eye and 20/80 in the left eye. How should the nurse explain these findings to Fred?

A. *"You are very near-sighted, especially in your right eye."

The larger the denominator (bottom number), the poorer the visual acuity. This is commonly referred to as being near-sighted. Standing at 20 feet, the client can read what the person with normal vision can read at further distances, such as 80 feet (left eye) or 200 feet (right eye).*

1. **Nursing Process: Assessment/Communication**

As the interview continues, the nurse notes that Fred is very pleasant and nods his head in agreement with all of the nurse's statements, but that he often does not respond to simple requests during the assessment.

Which nursing diagnosis is best supported by the data available?