NCSBN ON-LINE REVIEW

1. A client has been hospitalized after an automobile accident. A full leg cast was applied in the emergency room. The **most** important reason for the nurse to elevate the casted leg is to

   A) Promote the client's comfort
   B) Reduce the drying time
   C) Decrease irritation to the skin
   D) Improve venous return

   D: Improve venous return. Elevating the leg both improves venous return and reduces swelling. Client comfort will be improved as well.

2. The nurse is reviewing with a client how to collect a clean catch urine specimen. What is the appropriate sequence to teach the client?

   A) Clean the meatus, begin voiding, then catch urine stream
   B) Void a little, clean the meatus, then collect specimen
   C) Clean the meatus, then urinate into container
   D) Void continuously and catch some of the urine

   A: Clean the meatus, begin voiding, then catch urine stream. A clean catch urine is difficult to obtain and requires clear directions. Instructing the client to carefully clean the meatus, then void naturally with a steady stream prevents surface bacteria from contaminating the urine specimen. As starting and stopping flow can be difficult, once the client begins voiding it's best to just slip the container into the stream. Other responses do not reflect correct technique

3. Following change-of-shift report on an orthopedic unit, which client should the nurse see **first**?

   A) 16 year-old who had an open reduction of a fractured wrist 10 hours ago
   B) 20 year-old in skeletal traction for 2 weeks since a motor cycle accident
   C) 72 year-old recovering from surgery after a hip replacement 2 hours ago
   D) 75 year-old who is in skin traction prior to planned hip pinning surgery.

   C: Look for the client who has the most imminent risks and acute vulnerability. The client who returned from surgery 2 hours ago is at risk for life threatening hemorrhage and should be seen first. The 16 year-old should be seen next because it is still the first post-op day. The 75 year-old is potentially vulnerable to age-related physical and cognitive consequences in skin traction should be seen next. The client who can safely be seen last is the 20 year-old who is 2 weeks post-injury.

4. A client with Guillain Barre is in a nonresponsive state, yet vital signs are stable and breathing is independent. What should the nurse document to most accurately describe the client's condition?

   A) Comatose, breathing unlabored
   B) Glascow Coma Scale 8, respirations regular
   C) Appears to be sleeping, vital signs stable
   D) Glascow Coma Scale 13, no ventilator required

   B: Glascow Coma Scale 8, respirations regular. The Glascow Coma Scale provides a standard reference for assessing or monitoring level of consciousness. Any score less than 13 indicates a neurological impairment. Using the term comatose provides too much room for interpretation and is not very precise.

5. When caring for a client receiving warfarin sodium (Coumadin), which lab test would the nurse monitor to determine therapeutic response to the drug?

   A) Bleeding time
   B) Coagulation time
   C) Prothrombin time
   D) Partial thromboplastin time

   C: Prothrombin time. Coumadin is ordered daily, based on the client"s prothrombin time (PT). This test evaluates the adequacy of the extrinsic system and common pathway in the clotting cascade; Coumadin affects the Vitamin K dependent clotting factors.

6. A client with moderate persistent asthma is admitted for a minor surgical procedure. On admission the peak flow meter is measured at 480 liters/minute. Post-operatively the client is complaining of chest tightness. The peak flow has dropped to 200 liters/minute. What should the nurse do first?

   A) Notify both the surgeon and provider
   B) Administer the prn dose of albuterol
   C) Apply oxygen at 2 liters per nasal cannula
   D) Repeat the peak flow reading in 30 minutes

   B: Administer the prn dose of albuterol. Peak flow monitoring during exacerbations of asthma is recommended for clients with moderate-to-severe persistent asthma to determine the severity of the exacerbation and to guide the treatment. A peak flow reading of less than 50% of the client"s baseline reading is a medical alert condition and a short-acting beta-agonist must be taken immediately.

7. A client had 20 mg of Lasix (furosemide) PO at 10 AM. Which would be essential for the nurse to include at the change of shift report?

   A) The client lost 2 pounds in 24 hours

B) The client's potassium level is 4 mEq/liter.

C) The client's urine output was 1500 cc in 5 hours
D) The client is to receive another dose of Lasix at 10 PM

C: The client's urine output was 1500 cc in 5 hours. Although all of these may be correct information to include in report, the essential piece would be the urine output.

8. A client has been tentatively diagnosed with Graves' disease (hyperthyroidism). Which of these findings noted on the **initial** nursing assessment requires quick intervention by the nurse?

A) a report of 10 pounds weight loss in the last month
B) a comment by the client "I just can't sit still."
C) the appearance of eyeballs that appear to "pop" out of the client's eye sockets
D) a report of the sudden onset of irritability in the past 2 weeks

C: the appearance of eyeballs that appear to "pop" out of the client"s eye sockets. Exophthalmos or protruding eyeballs is a distinctive characteristic of Graves" Disease. It can result in corneal abrasions with severe eye pain or damage when the eyelid is unable to blink down over the protruding eyeball. Eye drops or ointment may be needed.

9. The nurse has performed the initial assessments of 4 clients admitted with an acute episode of asthma. Which assessment finding would cause the nurse to call the provider immediately?

A) prolonged inspiration with each breath
B) expiratory wheezes that are suddenly absent in 1 lobe
C) expectoration of large amounts of purulent mucous
D) appearance of the use of abdominal muscles for breathing

B: expiratory wheezes that are suddenly absent in 1 lobe. Acute asthma is characterized by expiratory wheezes caused by obstruction of the airways. Wheezes are a high pitched musical sounds produced by air moving through narrowed airways. Clients often associate wheezes with the feeling of tightness in the chest. However, sudden cessation of wheezing is an ominous or bad sign that indicates an emergency -- the small airways are now collapsed.

10. During the initial home visit, a nurse is discussing the care of a client newly diagnosed with Alzheimer's disease with family members. Which of these interventions would be **most** helpful at this time?

A) leave a book about relaxation techniques
B) write out a daily exercise routine for them to assist the client to do
C) list actions to improve the client's daily nutritional intake
D) suggest communication strategies

D: suggest communication strategies. Alzheimer"s disease, a progressive chronic illness, greatly challenges caregivers. The nurse can be of greatest assistance in helping the family to use communication strategies to enhance their ability to relate to the client. By use of select verbal and nonverbal communication strategies the family can best support the client's strengths and cope with any aberrant behavior.

11. An 80 year-old client admitted with a diagnosis of possible cerebral vascular accident has had a blood pressure from 160/100 to 180/110 over the past 2 hours. The nurse has also noted increased lethargy. Which assessment finding should the nurse report **immediately** to the provider?

A) Slurred speech
B) Incontinence
C) Muscle weakness
D) Rapid pulse

A: Slurred speech. Changes in speech patterns and level of conscious can be indicators of continued intracranial bleeding or extension of the stroke. Further diagnostic testing may be indicated.

12. A school-aged child has had a long leg (hip to ankle) synthetic cast applied 4 hours ago. Which statement from the parent indicates that teaching has been inadequate?

A) "I will keep the cast uncovered for the next day to prevent burning of the skin."
B) "I can apply an ice pack over the area to relieve itching inside the cast."
C) "The cast should be propped on at least 2 pillows when my child is lying down."
D) "I think I remember that my child should not stand until after 72 hours."

D: "I think I remember that my child should not stand until after 72 hours.". Synthetic casts will typically set up in 30 minutes and dry in a few hours. Thus, the client may stand within the initial 24 hours. With plaster casts, the set up and drying time, especially in a long leg cast which is thicker than an arm cast, can take up to 72 hours. Both types of casts give off a lot of heat when drying and it is preferable to keep the cast uncovered for the first 24 hours. Clients may complain of a chill from the wet cast and therefore can simply be covered lightly with a sheet or blanket. Applying ice is a safe method of relieving the itching.

13. Which blood serum finding in a client with diabetic ketoacidosis alerts the nurse that immediate action is required?

A) pH below 7.3
B) Potassium of 5.0
C) HCT of 60
D) Pa O_2 of 79%

C: HCT of 60. This high hematocrit is indicative of severe dehydration which requires priority attention in diabetic ketoacidosis. Without sufficient hydration, all systems of the body are at risk for hypoxia from a lack of or sluggish circulation. In the absence of insulin, which facilitates the transport of glucose into the cell, the body breaks down fats and proteins to supply energy

ketones, a by-product of fat metabolism. These accumulate causing metabolic acidosis (pH < 7.3), which would be the second concern for this client. The potassium and PaO_2 levels are near normal.

14. The nurse is preparing a client with a deep vein thrombosis (DVT) for a Venous Doppler evaluation. Which of the following would be necessary for preparing the client for this test?

    A) Client should be NPO after midnight
    B) Client should receive a sedative medication prior to the test
    C) Discontinue anti-coagulant therapy prior to the test
    D) No special preparation is necessary

    D: No special preparation is necessary. This is a non-invasive procedure and does not require preparation other than client education.

15. A client is admitted with infective endocarditis (IE). Which finding would alert the nurse to a complication of this condition?

    A) dyspnea
    B) heart murmur
    C) macular rash
    D) Hemorrhage

    B: heart murmur. Large, soft, rapidly developing vegetations attach to the heart valves. They have a tendency to break off, causing emboli and leaving ulcerations on the valve leaflets. These emboli produce findings of cardiac murmur, fever, anorexia, malaise and neurologic sequelae of emboli. Furthermore, the vegetations may travel to various organs such as spleen, kidney, coronary artery, brain and lungs, and obstruct blood flow.

16. The nurse explains an autograft to a client scheduled for excision of a skin tumor. The nurse knows the client understands the procedure when the client says, "I will receive tissue from

    A) a tissue bank."
    B) a pig."
    C) my thigh."
    D) synthetic skin."

    C: my thigh.". Autografts are done with tissue transplanted from the client"s own skin.

17. A client is admitted to the emergency room following an acute asthma attack. Which of the following assessments would be expected by the nurse?

    A) Diffuse expiratory wheezing
    B) Loose, productive cough
    C) No relief from inhalant
    D) Fever and chills

    A: Diffuse expiratory wheezing. In asthma, the airways are narrowed, creating difficulty getting air in. A wheezing sound results.

18. A client has been admitted with a fractured femur and has been placed in skeletal traction. Which of the following nursing interventions should receive **priority**?

    A) Maintaining proper body alignment
    B) Frequent neurovascular assessments of the affected leg
    C) Inspection of pin sites for evidence of drainage or inflammation
    D) Applying an over-bed trapeze to assist the client with movement in bed

    B: Frequent neurovascular assessments of the affected leg. The most important activity for the nurse is to assess neurovascular status. Compartment syndrome is a serious complication of fractures. Prompt recognition of this neurovascular problem and early intervention may prevent permanent limb damage.

19. The nurse is assigned to care for a client who had a myocardial infarction (MI) 2 days ago. The client has many questions about this condition. What area is a priority for the nurse to discuss at this time?

    A) Daily needs and concerns
    B) The overview cardiac rehabilitation
    C) Medication and diet guideline
    D) Activity and rest guidelines

    A: Daily needs and concerns. At 2 days post-MI, the client’s education should be focused on the immediate needs and concerns for the day.

20. A 3 year-old child is brought to the clinic by his grandmother to be seen for "scratching his bottom and wetting the bed at night." Based on these complaints, the nurse would initially assess for which problem?

    A) allergies
    B) scabies
    C) regression
    D) pinworms

D: pinworms. Signs of pinworm infection include intense perianal itching, poor sleep patterns, general irritability, restlessness, bed-wetting, distractibility and short attention span. Scabies is an itchy skin condition caused by a tiny, eight-legged burrowing mite called *Sarcoptes scabiei* . The presence of the mite leads to intense itching in the area of its burrows.

21. The nurse is caring for a newborn with tracheoesophageal fistula. Which nursing diagnosis is a **priority**?

    A) Risk for dehydration
    B) Ineffective airway clearance
    C) Altered nutrition
    D) Risk for injury

    B: Ineffective airway clearance. The most common form of TEF is one in which the proximal esophageal segment terminates in a blind pouch and the distal segment is connected to the trachea or primary bronchus by a short fistula at or near the bifurcation. Thus, a priority is maintaining an open airway, preventing aspiration. Other nursing diagnoses are then addressed.

22. The nurse is developing a meal plan that would provide the maximum possible amount of iron for a child with anemia. Which dinner menu would be best?

    A) Fish sticks, french fries, banana, cookies, milk
    B) Ground beef patty, lima beans, wheat roll, raisins, milk
    C) Chicken nuggets, macaroni, peas, cantaloupe, milk
    D) Peanut butter and jelly sandwich, apple slices, milk

    B: Ground beef patty, lima beans, wheat roll, raisins, milk. Iron rich foods include red meat, fish, egg yolks, green leafy vegetables, legumes, whole grains, and dried fruits such as raisins. This dinner is the best choice: It is high in iron and is appropriate for a toddler.

23. The nurse admitting a 5 month-old who vomited 9 times in the past 6 hours should observe for signs of which overall imbalance?

    A) Metabolic acidosis
    B) Metabolic alkalosis
    C) Some increase in the serum hemoglobin
    D) A little decrease in the serum potassium

    B: Metabolic alkalosis. Vomiting causes loss of acid from the stomach. Prolonged vomiting can result in excess loss of acid and lead to metabolic alkalosis. Findings include irritability, increased activity, hyperactive reflexes, muscle twitching and elevated pulse. Options C and D are correct answers but not the best answers since they are too general.

24. A two year-old child is brought to the provider's office with a chief complaint of mild diarrhea for two days. Nutritional counseling by the nurse should include which statement?

    A) Place the child on clear liquids and gelatin for 24 hours
    B) Continue with the regular diet and include oral rehydration fluids
    C) Give bananas, apples, rice and toast as tolerated
    D) Place NPO for 24 hours, then rehydrate with milk and water

    B: Continue with the regular diet and include oral rehydration fluids. Current recommendations for mild to moderate diarrhea are to maintain a normal diet with fluids to rehydrate.

25. The nurse is teaching parents about the appropriate diet for a 4 month-old infant with gastroenteritis and mild dehydration. In addition to oral rehydration fluids, the diet should include

    A) formula or breast milk
    B) broth and tea
    C) rice cereal and apple juice
    D) gelatin and ginger ale

    A: formula or breast milk. The usual diet for a young infant should be followed.

26. A child is injured on the school playground and appears to have a fractured leg. The **first** action the school nurse should take is

    A) call for emergency transport to the hospital
    B) immobilize the limb and joints above and below the injury
    C) assess the child and the extent of the injury
    D) apply cold compresses to the injured area

    C: assess the child and the extent of the injury. When applying the nursing process, assessment is the first step in providing care. The "5 Ps" of vascular impairment can be used as a guide (pain, pulse, pallor, paresthesia, paralysis).

27. The mother of a 3 month-old infant tells the nurse that she wants to change from formula to whole milk and add cereal and meats to the diet. What should be emphasized as the nurse teaches about infant nutrition?

    A) Solid foods should be introduced at 3-4 months
    B) Whole milk is difficult for a young infant to digest
    C) Fluoridated tap water should be used to dilute milk
    D) Supplemental apple juice can be used between feedings

    B: Whole milk is difficult for a young infant to digest. Cow"s milk is not given to infants younger than 1 year because the tough, hard curd is difficult to digest. In addition, it contains little iron and creates a high renal solute load.

28. The nurse is preparing a handout on infant feeding to be distributed to families visiting the clinic. Which notation should be included in the teaching materials?

A) Solid foods are introduced one at a time beginning with cereal
B) Finely ground meat should be started early to provide iron
C) Egg white is added early to increase protein intake
D) Solid foods should be mixed with formula in a bottle

A: Solid foods are introduced one at a time beginning with cereal. Solid foods should be added one at a time between 4-6 months. If the infant is able to tolerate the food, another may be added in a week. Iron fortified cereal is the recommended first food.

29. The nurse planning care for a 12 year-old child with sickle cell disease in a vaso-occlusive crisis of the elbow should include which one of the following as a **priority**?

A) Limit fluids
B) Client controlled analgesia
C) Cold compresses to elbow
D) Passive range of motion exercise

B: Client controlled analgesia. Management of a sickle cell crisis is directed towards supportive and symptomatic treatment. The priority of care is pain relief. In a 12 year-old child, client controlled analgesia promotes maximum comfort.

30. The nurse is performing a physical assessment on a toddler. Which of the following actions should be the **first**?

A) Perform traumatic procedures
B) Use minimal physical contact
C) Proceed from head to toe
D) Explain the exam in detail

B: Use minimal physical contact. The nurse should approach the toddler slowly and use minimal physical contact initially so as to gain the toddler"s cooperation. Be flexible in the sequence of the exam, and give only brief simple explanations just prior to the action.

31. What finding signifies that children have attained the stage of concrete operations (Piaget)?

A) Explores the environment with the use of sight and movement
B) Thinks in mental images or word pictures
C) Makes the moral judgment that "stealing is wrong"
D) Reasons that homework is time-consuming yet necessary

C: Makes the moral judgment that "stealing is wrong". The stage of concrete operations is depicted by logical thinking and moral judgments.

32. The mother of a child with a neural tube defect asks the nurse what she can do to decrease the chances of having another baby with a neural tube defect. What is the best response by the nurse?

A) "Folic acid should be taken before and after conception."
B) "Multivitamin supplements are recommended during pregnancy."
C) "A well balanced diet promotes normal fetal development."
D) "Increased dietary iron improves the health of mother and fetus."

A: "Folic acid should be taken before and after conception.". The American Academy of Pediatrics recommends that all childbearing women increase folic acid from dietary sources and/or supplements. There is evidence that increased amounts of folic acid prevents neural tube defects.

33. The provider orders Lanoxin (digoxin) 0.125 mg PO and furosemide 40 mg every day. Which of these foods would the nurse reinforce for the client to eat at least daily?

A) Spaghetti
B) Watermelon
C) Chicken
D) Tomatoes

B: Watermelon. Watermelon is high in potassium and will replace potassium lost by the diuretic. The other foods are not high in potassium.

34. While teaching the family of a child who will take phenytoin (Dilantin) regularly for seizure control, it is most important for the nurse to teach them about which of the following actions?

A) Maintain good oral hygiene and dental care
B) Omit medication if the child is seizure free
C) Administer acetaminophen to promote sleep
D) Serve a diet that is high in iron

A: Maintain good oral hygiene and dental care. Swollen and tender gums occur often with use of phenytoin. Good oral hygiene and regular visits to the dentist should be emphasized.

35. The nurse is offering safety instructions to a parent with a four month-old infant and a four year-old child. Which statement by the parent indicates understanding of appropriate precautions to take with the children?

A) "I strap the infant car seat on the front seat to face backwards."
B) "I place my infant in the middle of the living room floor on a blanket to play with my four year-old while I make supper in the kitchen."
C) "My sleeping baby lies so cute in the crib with the little buttocks stuck up in the air while the four year-old naps on the sofa."
D) "I have the four year-old hold and help feed the four month-old a bottle in the kitchen while I make supper."

D: The infant seat is to be placed on the rear seat. Small children and infants are not to be left unsupervised.

36. The nurse admits a 7 year-old to the emergency room after a leg injury. The x-rays show a femur fracture near the epiphysis. The parents ask what will be the outcome of this injury. The **appropriate** response by the nurse should be which of these statements?

A) "The injury is expected to heal quickly because of thin periosteum."
B) "In some instances the result is a retarded bone growth."
C) "Bone growth is stimulated in the affected leg."
D) "This type of injury shows more rapid union than that of younger children."

B: "In some instances the result is a retarded bone growth.". An epiphyseal (growth) plate fracture in a 7 year-old often results in retarded bone growth. The leg often will be different in length than the uninjured leg.

37. The parents of a 4 year-old hospitalized child tell the nurse, "We are leaving now and will be back at 6 PM." A few hours later the child asks the nurse when the parents will come again. What is the best response by the nurse?

A) "They will be back right after supper."
B) "In about 2 hours, you will see them."
C) "After you play awhile, they will be here."
D) "When the clock hands are on 6 and 12."

A: "They will be back right after supper." Time is not completely understood by a 4 year-old. Preschoolers interpret time with their own frame of reference. Thus, it is best to explain time in relationship to a known, common event.

38. The nurse is giving instructions to the parents of a child with cystic fibrosis. The nurse would emphasize that pancreatic enzymes should be taken

A) once each day
B) 3 times daily after meals
C) with each meal or snack
D) each time carbohydrates are eaten

C: Pancreatic enzymes should be taken with each meal and every snack to allow for digestion of all foods that are eaten.

39. A nurse is providing a parenting class to individuals living in a community of older homes. In discussing formula preparation, which of the following is **most** important to prevent lead poisoning?

A) Use ready-to-feed commercial infant formula
B) Boil the tap water for 10 minutes prior to preparing the formula
C) Let tap water run for 2 minutes before adding to concentrate
D) Buy bottled water labeled "lead free" to mix the formula

C: Let tap water run for 2 minutes before adding to concentrate. Use of lead-contaminated water to prepare formula is a major source of poisoning in infants. Drinking water may be contaminated by lead from old lead pipes or lead solder used in sealing water pipes. Letting tap water run for several minutes will diminish the lead contamination.

40. Which of the following manifestations observed by the school nurse confirms the presence of pediculosis capitis in students?

A) Scratching the head more than usual
B) Flakes evident on a student's shoulders
C) Oval pattern occipital hair loss
D) Whitish oval specks sticking to the hair

D: Whitish oval specks sticking to the hair. Diagnosis of pediculosis capitis is made by observation of the white eggs (nits) firmly attached to the hair shafts. Treatment can include application of a medicated shampoo with lindane for children over 2 years of age, and meticulous combing and removal of all nits.

41. When interviewing the parents of a child with asthma, it is most important to assess the child's environment for what factor?

A) Household pets
B) New furniture
C) Lead based paint
D) Plants such as cactus

A: Household pets. Animal dander is a very common allergen affecting persons with asthma. Other triggers may include pollens, carpeting and household dust.

42. The mother of a 2 month-old baby calls the nurse 2 days after the first DTaP, IPV, Hepatitis B and HIB immunizations. She reports that the baby feels very warm, cries inconsolably for as long as 3 hours, and has had several shaking spells. In addition to referring her to the emergency room, the nurse should document the reaction on the baby's record and expect which immunization to be **most** associated with the findings the infant is displaying?

A) DTaP
B) Hepatitis B
C) Polio
D) H. Influenza

A: DTaP. The majority of reactions occur with the administration of the DTaP vaccination. Contradictions to giving repeat DTaP immunizations include the occurrence of severe side effects after a previous dose as well as signs of encephalopathy within 7 days of the immunization.

43. The mother of a 2 year-old hospitalized child asks the nurse's advice about the child's screaming every time the mother gets ready to leave the hospital room. What is the best response by the nurse?

A) "I think you or your partner needs to stay with the child while in the hospital."
B) "Oh, that behavior will stop in a few days."
C) "Keep in mind that for the age this is a normal response to being in the hospital."
D) "You might want to "sneak out" of the room once the child falls asleep."

C: The protest phase of separation anxiety is a normal response for a child this age. In toddlers, ages 1 to 3, separation anxiety is at its peak

44. A couple experienced the loss of a 7 month-old fetus. In planning for discharge, what should the nurse emphasize?

A) To discuss feelings with each other and use support persons
B) To focus on the other healthy children and move through the loss
C) To seek causes for the fetal death and come to some safe conclusion
D) To plan for another pregnancy within 2 years and maintain physical health

A: To discuss feelings with each other and use support persons. To communicate in a therapeutic manner, the nurse"s goal is to help the couple begin the grief process by suggesting they talk to each other, seek family, friends and support groups to listen to their feelings.

45. The nurse is performing a pre-kindergarten physical on a 5 year-old. The last series of vaccines will be administered. What is the preferred site for injection by the nurse?

A) vastus intermedius
B) gluteus maximus
C) vastus lateralis
D) dorsogluteaI

C: vastus lateralis. Vastus lateralis, a large and well developed muscle, is the preferred site, since it is removed from major nerves and blood vessels.

46. A 7 month pregnant woman is admitted with complaints of painless vaginal bleeding over several hours. The nurse should prepare the client for an immediate

A) Non stress test
B) Abdominal ultrasound
C) Pelvic exam
D) X-ray of abdomen

B: Abdominal ultrasound. The standard for diagnosis of placenta previa, which is suggested in the client"s history of painless bleeding, is abdominal ultrasound.

47. A nurse entering the room of a postpartum mother observes the baby lying at the edge of the bed while the woman sits in a chair. The mother states "This is not my baby, and I do not want it." After repositioning the child safely, the nurse's **best** response is

A) "This is a common occurrence after birth, but you will come to accept the baby."
B) "Many women have postpartum blues and need some time to love the baby."
C) "What a beautiful baby! Her eyes are just like yours."
D) "You seem upset; tell me what the pregnancy and birth were like for you."

D: "You seem upset; tell me what the pregnancy and birth were like for you." A non-judgmental, open ended response facilitates dialogue between the client and nurse.

48. The nurse notes that a 2 year-old child recovering from a tonsillectomy has an temperature of 98.2 degrees Fahrenheit at 8:00 AM. At 10:00 AM the child's parent reports that the child "feels very warm" to touch. The **first** action by the nurse should be to

A) reassure the parent that this is normal
B) offer the child cold oral fluids
C) reassess the child's temperature
D) administer the prescribed acetaminophen

C: reassess the child"s temperature. A child"s temperature may have rapid fluctuations. The nurse should listen to and show respect for what parents say. Parental caretakers are often quite sensitive to variations in their children"s condition that may not be immediately evident to others.

49. The nurse is caring for a client who was successfully resuscitated from a pulseless dysrhythmia. Which of the following assessments is **critical** for the nurse to include in the plan of care?

A) hourly urine output
B) white blood count
C) blood glucose every 4 hours
D) temperature every 2 hours

A: hourly urine output. Clients who have had an episode of decreased glomerular perfusion are at risk for pre-renal failure. This is caused by any abnormal decline in kidney perfusion that reduces glomerular perfusion. Pre-renal failure occurs when the effective arterial blood volume falls. Examples of this phenomena include a drop in circulating blood volume as in a cardiac arrest state or in low cardiac perfusion states such as congestive heart failure associated with a cardiomyopathy. Close observation of hourly urinary output is necessary for early detection of this condition.

50. A client is admitted to the rehabilitation unit following a cerebral vascular accident (CVA) and mild dysphagia. The **most** appropriate intervention for this client is to

A) position client in upright position while eating
B) place client on a clear liquid diet
C) tilt head back to facilitate swallowing reflex
D) offer finger foods such as crackers or pretzels

A: position client in upright position while eating. An upright position facilitates proper chewing and swallowing.

51. A 72 year-old client with osteomyelitis requires a 6 week course of intravenous antibiotics. In planning for home care, what is the most important action by the nurse?

A) Investigating the client's insurance coverage for home IV antibiotic therapy
B) Determining if there are adequate hand washing facilities in the home
C) Assessing the client's ability to participate in self care and/or the reliability of a caregiver
D) Selecting the appropriate venous access device

C: Assessing the client"s ability to participate in self care and/or the reliability of a caregiver. The cognitive ability of the client as well as the availability and reliability of a caregiver must be assessed to determine if home care is a feasible option.

52. A nurse administers the influenza vaccine to a client in a clinic. Within 15 minutes after the immunization was given, the client complains of itchy and watery eyes, increased anxiety, and difficulty breathing. The nurse expects that the **first** action in the sequence of care for this client will be to

A) Maintain the airway
B) Administer epinephrine 1:1000 as ordered
C) Monitor for hypotension with shock
D) Administer diphenhydramine as ordered

B: Administer epinephrine 1:1000 as ordered. All the answers are correct given the circumstances, but the priority is to administer the epinephrine, then maintain the airway. In the early stages of anaphylaxis, when the patient has not lost consciousness and is normotensive, administering the epinephrine is first, and applying the oxygen, and watching for hypotension and shock, are later responses. The prevention of a severe crisis is maintained by using diphenhydramine.

53. The nurse instructs the client taking dexamethasone (Decadron) to take it with food or milk. The physiological basis for this instruction is that the medication

A) retards pepsin production
B) stimulates hydrochloric acid production
C) slows stomach emptying time
D) decreases production of hydrochloric acid

B: stimulates hydrochloric acid production. Decadron increases the production of hydrochloric acid, which may cause gastrointestinal ulcers.

54. A client receiving chlorpromazine HCL (Thorazine) is in psychiatric home care. During a home visit the nurse observes the client smacking her lips alternately with grinding her teeth. The nurse recognizes this assessment finding as what?

A) Dystonia
B) Akathisia
C) Brady dyskinesia
D) Tardive dyskinesia

D: Tardive dyskinesia. Signs of tardive dyskinesia include smacking lips, grinding of teeth and "fly catching" tongue movements. These findings are often described as Parkinsonian.

55. Which of the following findings contraindicate the use of haloperidol (Haldol) and warrant withholding the dose?

A) Drowsiness, lethargy, and inactivity
B) Dry mouth, nasal congestion, and blurred vision
C) Rash, blood dyscrasias, severe depression
D) Hyperglycemia, weight gain, and edema

C: Rash, blood dyscrasias, severe depression. Rash and blood dyscrasias are side effects of anti-psychotic drugs. A history of severe depression is a contraindication to the use of neuroleptics.

56. The nurse is reinforcing teaching to a 24 year-old woman receiving acyclovir (Zovirax) for a Herpes Simplex Virus type 2 infection. Which of these instructions should the nurse give the client?

    A) Complete the entire course of the medication for an effective cure
    B) Begin treatment with acyclovir at the onset of symptoms of recurrence
    C) Stop treatment if she thinks she may be pregnant to prevent birth defects
    D) Continue to take prophylactic doses for at least 5 years after the diagnosis

    B: Begin treatment with acyclovir at the onset of symptoms of recurrence. When the client is aware of early symptoms, such as pain, itching or tingling, treatment is very effective. Medications for herpes simplex do not cure the disease; they simply decrease the level of symptoms.

57. A 14 month-old child ingested half a bottle of aspirin tablets. Which of the following would the nurse expect to see in the child?

    A) Hypothermia
    B) Edema
    C) Dyspnea
    D) Epistaxis

    D: Epistaxis. A large dose of aspirin inhibits prothrombin formation and lowers platelet levels. With an overdose, clotting time is prolonged.

58. An 80 year-old client on digitalis (Lanoxin) reports nausea, vomiting, abdominal cramps and halo vision. Which of the following laboratory results should the nurse analyze first?

    A) Potassium levels
    B) Blood pH
    C) Magnesium levels
    D) Blood urea nitrogen

    A: Potassium levels. The most common cause of digitalis toxicity is a low potassium level. Clients must be taught that it is important to have adequate potassium intake especially if taking diuretics that enhance the loss of potassium while they are taking digitalis.

59. A 42 year-old male client refuses to take propranolol hydrochloride (Inderal) as prescribed. Which client statement from the assessment data is likely to explain his noncompliance?

    A) "I have problems with diarrhea."
    B) "I have difficulty falling asleep."
    C) "I have diminished sexual function."
    D) "I often feel jittery."

    C: "I have diminished sexual function." Inderal, a beta-blocking agent used in hypertension, prohibits the release of epinephrine into the cells; this may result in hypotension which results in decreased libido and impotence.

60. The nurse caring for a 9 year-old child with a fractured femur is told that a medication error occurred. The child received twice the ordered dose of morphine an hour ago. Which nursing diagnosis is a priority at this time?

    A) Risk for fluid volume deficit related to morphine overdose
    B) Decreased gastrointestinal mobility related to mucosal irritation
    C) Ineffective breathing patterns related to central nervous system depression
    D) Altered nutrition related to inability to control nausea and vomiting

    C: Ineffective breathing patterns related to central nervous system depression. Respiratory depression is a life-threatening risk in this overdose.

61. Lactulose (Chronulac) has been prescribed for a client with advanced liver disease. Which of the following assessments would the nurse use to evaluate the effectiveness of this treatment?

    A) An increase in appetite
    B) A decrease in fluid retention
    C) A decrease in lethargy
    D) A reduction in jaundice

    C: A decrease in lethargy. Lactulose produces an acid environment in the bowel and traps ammonia in the gut; the laxative effect then aids in removing the ammonia from the body. This decreases the effects of hepatic encephalopathy, including lethargy and confusion.

62. The nurse is teaching a class on HIV prevention. Which of the following should be emphasized as increasing risk?

    A) Donating blood
    B) Using public bathrooms
    C) Unprotected sex
    D) Touching a person with AIDS

    C: Unprotected sex. Because HIV is spread through exposure to bodily fluids, unprotected intercourse and shared drug paraphernalia remain the highest risks for infection.

63. While interviewing a new admission, the nurse notices that the client is shifting positions, wringing her hands, and avoiding eye contact. It is important for the nurse to

A) ask the client what she is feeling
B) assess the client for auditory hallucination
C) recognize the behavior as a side effect of medication
D) re-focus the discussion on a less anxiety provoking topic

A: ask the client what she is feeling. The initial step in anxiety intervention is observing, identifying, and assessing anxiety. The nurse should seek client validation of the accuracy of nursing assessments and avoid drawing conclusions based on limited data. In the situation above, the client may simply need to use the restroom but be reluctant to communicate her need!

64. A young adult seeks treatment in an outpatient mental health center. The client tells the nurse he is a government official being followed by spies. On further questioning, he reveals that his warnings must be heeded to prevent nuclear war. What is the **most** therapeutic approach by the nurse?

A) Listen quietly without comment
B) Ask for further information on the spies
C) Confront the client's delusion
D) Contact the government agency

A: Listen quietly without comment. The client"s comments demonstrate grandiose ideas. The most therapeutic response is to listen but avoid being incorporated into the client's delusional system.

65. The nurse is assessing a 17 year-old female client with bulimia. Which of the following laboratory reports would the nurse anticipate?

A) Increased serum glucose
B) Decreased albumin
C) Decreased potassium
D) Increased sodium retention

C: Decreased potassium. In bulimia, loss of electrolytes can occur in addition to other findings of starvation and dehydration.

66. A client, recovering from alcoholism, asks the nurse, "What can I do when I start recognizing relapse triggers within myself?" How might the nurse **best** respond?

A) "When you have the impulse to stop in a bar, contact a sober friend and talk with him."
B) "Go to an AA meeting when you feel the urge to drink."
C) "It is important to exercise daily and get involved in activities that will cause you not to think about drug use."
D) "Let's talk about possible options you have when you recognize relapse triggers in yourself."

D: This option encourages the process of self evaluation and problem solving, while avoiding telling the client what to do. Encouraging the client to brainstorm about response options validates the nurse's belief in the client's personal competency and reinforces a coping strategy that will be needed when the nurse may not be available to offer solutions.

67. Therapeutic nurse-client interaction occurs when the nurse

A) assists the client to clarify the meaning of what the client has said
B) interprets the client's covert communication
C) praises the client for appropriate feelings and behavior
D) advises the client on ways to resolve problems

A: assists the client to clarify the meaning of what the client has said. Clarification is a facilitating/therapeutic communication strategy. Interpretation, changing the focus/subject, giving approval, and advising are non-therapeutic/barriers to communication.

68. Which nursing intervention will be **most** effective in helping a withdrawn client to develop relationship skills?

A) Offer the client frequent opportunities to interact with 1 person
B) Provide the client with frequent opportunities to interact with other clients
C) Assist the client to analyze the meaning of the withdrawn behavior
D) Discuss with the client the focus that other clients have similar problems

A: Offer the client frequent opportunities to interact with 1 person. The withdrawn client is uncomfortable in social interaction. The nurse-client relationship is a corrective relationship in which the client learns both tolerance and skills for relationships.

69. An important goal in the development of a therapeutic inpatient milieu is to

A) provide a businesslike atmosphere where clients can work on individual goals
B) provide a group forum in which clients decide on unit rules, regulations, and policies
C) provide a testing ground for new patterns of behavior while the client takes responsibility for his or her own actions
D) discourage expressions of anger because they can be disruptive to other clients

C: provide a testing ground for new patterns of behavior while the client takes responsibility for his or her own actions. A therapeutic milieu is purposeful and planned to provide safety and a testing ground for new patterns of behavior.

70. A client with paranoid delusions stares at the nurse over a period of several days. The client suddenly walks up to the nurse and shouts "You think you're so perfect and pure and good." An appropriate response for the nurse is

A) "Is that why you've been staring at me?"
B) "You seem to be in a really bad mood."
C) "Perfect? I don't quite understand."
D) "You seem angry right now."

D: "You seem angry right now.". The nurse recognizes the underlying emotion with a matter of fact attitude, but avoids telling the clients how they feel.

71. A client who is a former actress enters the day room wearing a sheer nightgown, high heels, numerous bracelets, bright red lipstick and heavily rouged cheeks. Which nursing action is the **best** in response to the client's attire?

A) Gently remind her that she is no longer on stage
B) Directly assist client to her room for appropriate apparel
C) Quietly point out to her the dress of other clients on the unit
D) Tactfully explain appropriate clothing for the hospital

B: Directly assist client to her room for appropriate apparel. It assists the client to maintain self-esteem while modifying behavior.

72. When teaching suicide prevention to the parents of a 15 year-old who recently attempted suicide, the nurse describes the following behavioral cue as indicating a need for intervention.

A) Angry outbursts at significant others
B) Fear of being left alone
C) Giving away valued personal items
D) Experiencing the loss of a boyfriend

C: Giving away valued personal items. Eighty percent of all potential suicide victims give some type of indication that self-destructiveness should be addressed. These clues might lead one to suspect that a client is having suicidal thoughts or is developing a plan.

73. Which statement made by a client indicates to the nurse that the client may have a thought disorder?

A) "I'm so angry about this. Wait until my partner hears about this."
B) "I'm a little confused. What time is it?"
C) "I can't find my 'mesmer' shoes. Have you seen them?"
D) "I'm fine. It's my daughter who has the problem."

C: "I can"t find my "mesmer" shoes. Have you seen them?". A neologism is a new word self invented by a person and not readily understood by another. Using neologisms is often associated with a thought disorder.

74. In a psychiatric setting, the nurse limits touch or contact used with clients to handshaking because

A) some clients misconstrue hugs as an invitation to sexual advances
B) handshaking keeps the gesture on a professional level
C) refusal to touch a client denotes lack of concern
D) inappropriate touch often results in charges of assault and battery

A: some clients misconstrue hugs as an invitation to sexual advances. Touch denotes positive feelings for another person. The client may interpret hugging and holding hands as sexual advances.

75. A client with anorexia is hospitalized on a medical unit due to electrolyte imbalance and cardiac dysrhythmias. Additional assessment findings that the nurse would expect to observe are

A) brittle hair, lanugo, amenorrhea
B) diarrhea, nausea, vomiting, dental erosion
C) hyperthermia, tachycardia, increased metabolic rate
D) excessive anxiety about symptoms

A: brittle hair, lanugo, amenorrhea. Physical findings associated with anorexia also include reduced metabolic rate and lower vital signs.

76. Which intervention **best** demonstrates the nurse's sensitivity to a 16 year-old's appropriate need for autonomy?

A) Alertness for feelings regarding body image
B) Allows young siblings to visit
C) Provides opportunity to discuss concerns without presence of parents
D) Explores his feelings of resentment to identify causes

C: Provides opportunity to discuss concerns without presence of parents. This intervention provides the teen with the opportunity to have control and encourages decision making.

77. The nurse's **primary** intervention for a client who is experiencing a panic attack is to

A) develop a trusting relationship
B) assist the client to describe his experience in detail
C) maintain safety for the client

D) teach the client to control his or her own behavior

C: maintain safety for the client. Clients who display signs of severe anxiety need to be supervised closely until the anxiety is decreased because they may harm themselves or others.

78. A client was admitted to the eating disorder unit with bulimia nervosa. The nurse assessing for a history of complications of this disorder expects

A) Respiratory distress, dyspnea
B) Bacterial gastrointestinal infections, overhydration
C) Metabolic acidosis, constricted colon
D) Dental erosion, parotid gland enlargement

D: Dental erosion, parotid gland enlargement. Dental erosion and parotid gland enlargement due to purging are common complications of binge eating followed by self-induced vomiting.

79. Which of the following times is a depressed client at **highest** risk for attempting suicide?

A) Immediately after admission, during one-to-one observation
B) 7 to 14 days after initiation of antidepressant medication and psychotherapy
C) Following an angry outburst with family
D) When the client is removed from the security room

B: 7 to 14 days after initiation of antidepressant medication and psychotherapy. As the depression lessens, the depressed client acquires energy to follow the plan.

80. A client is admitted to a psychiatric unit with delusions. What findings could the nurse observe that would be consistent with delusional thought patterns?

A) Flight of ideas and hyperactivity
B) Suspiciousness and resistance to therapy
C) Anorexia and hopelessness
D) Panic and multiple physical complaints

B: Suspiciousness and resistance to therapy. Clinical features of paranoid delusional disorder include extreme suspiciousness, jealousy, distrust, and a belief that others intend to invoke harm.

81. As the nurse takes a history of a 3 year-old with neuroblastoma, what comments by the parents require follow-up and are consistent with the diagnosis?

A) "The child has been listless and has lost weight."
B) "The urine is dark yellow and small in amounts."
C) "Clothes are becoming tighter across her abdomen."
D) "We notice muscle weakness and some unsteadiness."

C: "Clothes are becoming tighter across her abdomen.". One of the most common signs of neuroblastoma is increased abdominal girth. The parents" report that clothing is tight is significant, and should be responded to with additional assessments.

82. Parents call the emergency room to report that a toddler has swallowed drain cleaner. The triage nurse instructs them to call for emergency transport to the hospital. The nurse would also suggest that the parents give the toddler sips of _____ while waiting for an ambulance.

A) Tea
B) Water
C) Milk
D) Soda

B: Water. Small amounts of water will dilute the corrosive substance prior to gastric lavage.

83. A 16 year-old enters the emergency department. The triage nurse identifies that this teenager is legally married and signs the consent form for treatment. What would be the **appropriate** action by the nurse?

A) Ask the teenager to wait until a parent or legal guardian can be contacted
B) Withhold treatment until telephone consent can be obtained from the partner
C) Refer the teenager to a community pediatric hospital emergency department
D) Proceed with the triage process in the same manner as any adult client

D: Proceed with the triage process in the same manner as any adult client. Minors may become known as an "emancipated minor" through marriage, pregnancy, high school graduation, independent living or service in the military. Therefore, this married client has the legal capacity of an adult.

84. The pediatric clinic nurse examines a toddler with a tentative diagnosis of neuroblastoma. Findings observed by the nurse that is associated with this problem include which of these?

A) Lymphedema and nerve palsy
B) Hearing loss and ataxia
C) Headaches and vomiting
D) Abdominal mass and weakness

D: Abdominal mass and weakness. Clinical manifestations of neuroblastoma include an irregular abdominal mass that crosses the midline, weakness, pallor, anorexia, weight loss and irritability.

85. The nurse is preparing the teaching plan for a group of parents about risks to toddlers and is including the proper communication in the event of accidental poisoning. The nurse should tell the parents to first state what substance was ingested and then what information should be the priority for the parents to communicate?

    A) The parents' name and telephone number
    B) The currency of the immunization and allergy history of the child
    C) The estimated time of the accidental poisoning and a confirmation that the parents will bring the containers of the ingested substance

    D) The affected child's age and weight

D: The affected child"s age and weight. All of the above information is important. However, after the substance is identified the age and weight are the priorities. This gives the appropriate health care providers an opportunity to calculate the needed dosage for an antidote while the child is being transported to the emergency department. After this information, the time of the

86. The nurse has admitted a 4 year-old with the diagnosis of possible rheumatic fever. Which statement by the parent would the nurse suspect is relevant to this disease?

    A) Our child had chickenpox 6 months ago.
    B) Strep throat went through all the children at the day care last month.
    C) Both ears were infected at 3 months of age.
    D) Last week both feet had a fungal skin infection.

B: Strep throat went through all the children at the day care last month.. Evidence supports a strong relationship between infection with Group A streptococci and subsequent rheumatic fever (usually within 2 to 6 weeks). Therefore, the history of playmates recovering from strep throat would indicate that the child most likely also had strep throat. Sometimes such an infection has no clinical symptoms.

87. The nurse provides discharge teaching to the parents of a 15 month-old child with Kawasaki disease. The child has received immunoglobulin therapy. Which instruction would be appropriate?

    A) High doses of aspirin will be continued for some time
    B) Complete recovery is expected within several days
    C) Active range of motion exercises should be done frequently
    D) The measles, mumps and rubella vaccine should be delayed

D: The measles, mumps and rubella vaccine should be delayed. Discharge instructions for a child with Kawasaki disease should include the information that immunoglobulin therapy may interfere with the body"s ability to form appropriate amounts of antibodies. Therefore, live immunizations should be delayed.

88. A 10 year-old client is recovering from a splenectomy following a traumatic injury. The clients laboratory results show a hemoglobin of 9 g/dL and a hematocrit of 28 percent. The **best** approach for the nurse to use is to

    A) limit milk and milk products
    B) encourage bed activities and games
    C) plan nursing care around lengthy rest periods
    D) promote a diet rich in iron

C: plan nursing care around lengthy rest periods. The initial priority for this client is rest due to the inability of red blood cells to carry oxygen.

89. The nurse is planning care for a 14 year-old client returning from scoliosis corrective surgery. Which of the following actions should receive **priority** in the plan?

    A) Antibiotic therapy for 10 days
    B) Teach client isometric exercises for legs
    C) Assess movement and sensation of extremities
    D) Assist to stand up at bedside within the first 24 hours

C: Assess movement and sensation of extremities. Following corrective surgery for scoliosis, neurological status requires special attention and assessment, especially that of the extremities.

90. The nurse is teaching parents about accidental poisoning in children. Which point should be emphasized?

    A) Call the Poison Control Center once the situation is identified
    B) Empty the child's mouth in any case of possible poisoning
    C) Keep the child as quiet as possible if a toxic substance was inhaled
    D) Do not induce vomiting if the poison is a hydrocarbon

B: Empty the child"s mouth in any case of possible poisoning. Emptying the mouth of poison prevents further ingestion and should be done first to limit damage from the substance. Note that all of the actions are correct, but option B is the priority.

91. The nurse is assessing an 8 month-old infant with a malfunctioning ventriculoperitoneal shunt. Which one of the following manifestations would the infant be **most** likely to exhibit?

    A) Lethargy
    B) Irritability

C) Negative Moro
D) Depressed fontanel

B: Irritability. Signs of increased intracranial pressure (IICP) in infants include bulging fontanel, instability, high-pitched cry, and cries when held. Vital sign changes include pulse that is variable, e.g., rapid, slow and bounding, or feeble. Respirations are more often slow, deep, and irregular.

92. The nurse is caring for a 4 year-old two hours after tonsillectomy and adenoidectomy. Which of the following assessments must be reported **immediately**?

A) Vomiting of dark emesis
B) Complaints of throat pain
C) Apical heart rate of 110
D) Increased restlessness

D: Increased restlessness. Restlessness and increased respiratory and heart rates are often early signs of hemorrhage.

93. The nurse is caring for a client with sickle cell disease who is scheduled to receive a unit of packed red blood cells. Which of the following is an appropriate action for the nurse when administering the infusion?

A) Storing the packed red cells in the medicine refrigerator while starting IV
B) Slow the rate of infusion if the client develops fever or chills
C) Limit the infusion time of each of the unit to a maximum of 4 hours
D) Assess vital signs every 15 minutes throughout the entire infusion

C: Limit the infusion time of each of the unit to a maximum of 4 hours. Infuse the specified amount of blood within 4 hours. If the infusion will exceed this time, the blood should be divided into appropriately sized quantities.

94. The nurse is caring for a 17 month-old with acetaminophen poisoning. Which of the following lab reports should the nurse review **first**?

A) Prothrombin Time (PT) and partial thromboplastin time (PTT)
B) Red blood cell and white blood cell counts
C) Blood urea nitrogen and creatinine clearance
D) Liver enzymes (AST and ALT)

D: Liver enzymes (AST and ALT). Because acetaminophen is toxic to the liver and causes hepatic cellular necrosis, liver enzymes are released into the blood stream and serum levels of those enzymes rise. Other lab values are reviewed as well.

95. A nurse admits a premature infant who has respiratory distress syndrome (RDS). In planning care, nursing actions are based on the fact that the most likely cause of this problem stems from the infant's inability to

A) stabilize thermoregulation
B) maintain alveolar surface tension
C) begin normal pulmonary blood flow
D) regulate intracardiac pressure

B: maintain alveolar surface tension. RDS is primarily a disease related to a developmental delay in lung maturation. Although many factors may lead to the development of the problem, the central factor is the lack of a normally functioning surfactant system in the alveolar sac from immaturity in lung development since the infant is premature.

96. The nurse is planning care for a 3 month-old infant immediately postoperative following placement of a ventriculoperitoneal shunt for hydrocephalus. The nurse needs to

A) assess for abdominal distention
B) maintain infant in an upright position
C) begin formula feedings when infant is alert
D) pump the shunt to assess for proper function

A: assess for abdominal distention. The child is observed for abdominal distention because cerebrospinal fluid may cause peritonitis or a postoperative ileus as a complication of distal catheter placement.

97. A 6 year-old child is seen for the first time in the clinic. Upon assessment, the nurse finds that the child has deformities of the joints, limbs, and fingers, thinned upper lip, and small teeth with faulty enamel. The mother states: ”My child seems to have problems in learning to count and recognizing basic colors.” Based on this data, the nurse suspects that the child is **most** likely showing the effects of which problem?

A) congenital abnormalities
B) chronic toxoplasmosis
C) fetal alcohol syndrome (FAS)
D) lead poisoning

C: fetal alcohol syndrome (FAS). Major features of FAS consist of facial and associated physical features, such as small head circumference and brain size (microcephaly), small eyelid openings, a sunken nasal bridge, an exceptionally thin upper lip, a short, upturned nose and a smooth skin surface between the nose and upper lip. Vision difficulties include nearsightedness (myopia). Other findings are mental retardation, delayed development, abnormal behavior such as short attention span, hyperactivity, poor impulse control, extreme nervousness and anxiety. Many behavioral problems, cognitive impairment and psychosocial deficits are also associated with this syndrome.

98. A 15 year-old client has been placed in a Milwaukee brace. Which statement from the adolescent indicates the need for additional teaching?

A) "I will only have to wear this for 6 months."
B) "I should inspect my skin daily."
C) "The brace will be worn day and night."
D) "I can take it off when I shower."

A: "I will only have to wear this for 6 months.". The brace must be worn long-term, during periods of growth, usually for 1 to 2 years. It is used to correct curvature of the spine.

99. The nurse is caring for a 4 year-old admitted after receiving burns to more than 50% of his body. Which laboratory data should be reviewed by the nurse as a **priority** in the first 24 hours?

A) Blood urea nitrogen
B) Hematocrit
C) Blood glucose
D) White blood count

A: Blood urea nitrogen. Glomerular filtration is decreased in the initial response to severe burns, with fluid shift occurring. Kidney function must be monitored closely, or renal failure may follow in a few days.

100. The nurse is caring for a client with a colostomy pouch. During a teaching session, the nurse appropriately recommends that the pouch be emptied

A) when it is 1/3 to 1/2 full
B) prior to meals
C) after each fecal elimination
D) at the same time each day

A: when it is 1/3 to 1/2 full. If the pouch becomes more than half full it may separate from the flange.

101. An 18 year-old client is admitted to intensive care from the emergency room following a diving accident. The injury is suspected to be at the level of the 2nd cervical vertebrae. The nurse's priority assessment should be the client's

A) response to stimuli
B) bladder control
C) respiratory function
D) muscle weakness

C: respiratory function. Spinal injury at the C-2 level results in quadriplegia. While the client will experience all of the problems identified, respiratory assessment is a priority.

102. A client has been admitted to the coronary care unit with a myocardial infarction. Which nursing diagnosis should have priority?

A) pain related to ischemia
B) risk for altered elimination: constipation
C) risk for complication: dysrhythmias
D) anxiety related to pain

A: pain related to ischemia. Pain is related to ischemia of the heart muscle, and relief of pain will decrease myocardial oxygen demands, reduce blood pressure and heart rate and relieve anxiety. Pain also stimulates the sympathetic nervous system and increased preload, further increasing myocardial demands.

103. The nurse is caring for a client with a distal tibia fracture. The client has had a closed reduction and application of a toe to groin cast. 36 hours after surgery, the client suddenly becomes confused, short of breath and spikes a temperature of 103 degrees Fahrenheit. The **first** assessment the nurse should perform is

A) orientation to time, place and person
B) pulse oximetry
C) circulation to casted extremity
D) blood pressure

B: pulse oximetry. Restlessness, confusion, irritability and disorientation may be the first signs of fat embolism syndrome followed by a very high temperature. The nurse needs to confirm hypoxia first.

104. The nurse is assessing a client with a Stage 2 skin ulcer. Which of the following treatments is **most** effective to promote healing?

A) Covering the wound with a dry dressing
B) Using hydrogen peroxide soak
C) Leaving the area open to dry
D) Applying a hydrocolloid or foam dressing

D: Applying a hydrocolloid or foam dressing. While the previously accepted treatment was a transparent cover, evidence now indicates that the foam (DuoDerm) dressings work best.

105. A client is recovering from a thyroidectomy. While monitoring the client's **initial** post-operative condition, which of the following should the nurse report immediately?

A) Tetany and paresthesia
B) Mild stridor and hoarseness
C) Irritability and insomnia
D) Headache and nausea

A: Tetany and paresthesia. Because the parathyroid gland may be damaged in this surgery, secondary hypocalcemia may occur. Findings of hypoparathyroidism include tetany, paresthesia, muscle cramps and seizures.

106. A client is scheduled for an intravenous pyelogram (IVP). Which of the following data from the client's history indicate a potential hazard for this test?

A) Reflex incontinence
B) Allergy to shellfish
C) Claustrophobia
D) Hypertension

B: Allergy to shellfish. It is important to know if the client has an allergy to iodine or shellfish. If the client does, they may have an allergic reaction to the IVP contrast dye injected during the procedure.

107. A client enters the emergency department unconscious via ambulance. What document should be given priority to guide the direction of care for this client?

A) The statement of client rights and the client self determination act
B) Orders written by the provider
C) A notarized original of advance directives brought in by the partner
D) The clinical pathway protocol of the agency and the emergency department

C: A notarized original of advance directives brought in by the partner. This document specifies the client"s wishes.

108. A client diagnosed with hepatitis C discusses his health history with the admitting nurse. The nurse should recognize which statement by the client as the most important?

A) I got back from Central America a few weeks ago.
B) I had the best raw oysters last week.
C) I have many different sex partners.
D) I had a blood transfusion 15 years ago.

D: I had a blood transfusion 15 years ago.. The client who was transfused prior to blood screening for hepatitis C may show findings many years later. Options B and C are associated with risk of hepatitis B.

109. Which of these children at the site of a disaster at a child day care center would the triage nurse put in the "treat last" category?

A) An infant with intermittent bulging anterior fontanel between crying episodes
B) A toddler with severe deep abrasions over 98% of the body
C) A preschooler with a lower leg fracture on one side and an upper leg fracture on the other
D) A school-age child with singed eyebrows and hair on the arms

B: A toddler with severe deep abrasions over 98% of the body. This child has the least chance of survival. Severe deep abrasions should be thought of as second and third degree burns. The child has great risk of both shock and infection combined.

110. A client has returned to the unit following a renal biopsy. Which of the following nursing interventions is appropriate?

A) Ambulate the client 4 hours after procedure
B) Maintain client on NPO status for 24 hours
C) Monitor vital signs
D) Change dressing every 8 hours

C: Monitor vital signs. The potential complication of this procedure is internal hemorrhage. Monitoring vital signs is critical to detect early indications of bleeding.

111. The nurse is providing instructions for a client with asthma. Which of the following should the client monitor on a daily basis?

A) Respiratory rate
B) Peak air flow volumes
C) Pulse oximetry
D) Skin color

B: Peak air flow volumes. The peak airflow volume decreases about 24 hours before clinical manifestations of exacerbation of asthma.

112. A client with a documented pulmonary embolism has the following arterial blood gases: PO_2 - 70 mm hg, PCO_2 - 32 mm hg, pH - 7.45, SaO_2 - 87%, HCO_3 - 22. Based on these data, what is the **first** nursing action?

A) Review other lab data
B) Notify the health care provider
C) Administer oxygen
D) Calm the client

C: Administer oxygen. The client has a low PCO_2 due to increased respiratory rate from the hypoxemia and signs of respiratory alkalosis. Immediate intervention is indicated.

113. The nurse is teaching a newly diagnosed asthma client on how to use a peak flow meter. The nurse explains that this should be used to

A) determine oxygen saturation
B) measure forced expiratory volume
C) monitor atmosphere for presence of allergens
D) provide metered doses for inhaled bronchodilator

B: measure forced expiratory volume. The peak flow meter is used to measure peak expiratory flow volume. It provides useful information about the presence and/or severity of airway obstruction.

114. The nurse is assessing a 55 year-old female client who is scheduled for abdominal surgery. Which of the following information would indicate that the client is at risk for thrombus formation in the post-operative period?

A) Estrogen replacement therapy
B) 10% less than ideal body weight
C) Hypersensitivity to heparin
D) History of hepatitis

A: Estrogen replacement therapy. Estrogen increases the hypercoagulability of the blood and increased the risk for development of thrombophlebitis.

115. During the check up of a 2 month-old infant at a well baby clinic, the mother expresses concern to the nurse because a flat pink birthmark on the baby's forehead and eyelid has not gone away. What is an appropriate response by the nurse?

A) "Mongolian spots are a normal finding in dark-skinned children."
B) "Port wine stains are often associated with other malformations."
C) "Telangiectatic nevi are normal and will disappear as the baby grows."
D) "The child is too young for consideration of surgical removal of these at this time."

C: Telangiectatic nevi, salmon patch or stork bite birthmarks, are a normal variation and the facial nevi will generally disappear by ages 1 to 2 years.

116. A 3 year-old child diagnosed as having celiac disease attends a day care center. Which of the following would be an appropriate snack?

A) Cheese crackers
B) Peanut butter sandwich
C) Potato chips
D) Vanilla cookies

C: Children with celiac disease should eat a gluten free diet. Gluten is found mainly in grains of wheat and rye and in smaller quantities in barley and oats. Corn, rice, soybeans and potatoes are digestible by persons with celiac disease.: F.A. Davis Company.

117. A nurse assigned to a manipulative client for 5 days becomes aware of feelings of reluctance to interact with the client. The next action by the nurse should be to

A) Discuss the feeling of reluctance with an objective peer or supervisor
B) Limit contacts with the client to avoid reinforcement of the manipulative behavior
C) Confront the client about the negative effects of behaviors on other clients and staff
D) Develop a behavior modification plan that will promote more functional behavior

A: Discuss the feeling of reluctance with an objective peer or supervisor. The nurse who experiences stress in the therapeutic relationship can gain objectivity through supervision. The nurse must attempt to discover attitudes and feelings in the self that influence the nurse-client relationship.

118. A client is being treated for paranoid schizophrenia. When the client became loud and boisterous, the nurse immediately placed him in seclusion as a precautionary measure. The client willingly complied. The nurse’s action

A) may result in charges of unlawful seclusion and restraint
B) leaves the nurse vulnerable for charges of assault and battery
C) was appropriate in view of a client history of violence
D) was necessary to maintain the therapeutic milieu of the unit

A: may result in charges of unlawful seclusion and restraint. Seclusion should only be used when there is an immediate threat of violence or threatening behavior toward the staff, the other clients, or the client himself.

119. The provisions of the law for the Americans with Disabilities Act require nurse managers to

A) Maintain an environment free from associated hazards
B) Provide reasonable accommodations for disabled individuals

C) Make all necessary accommodations for disabled individuals
D) Consider both mental and physical disabilities

B: Provide reasonable accommodations for disabled individuals. The law is designed to permit persons with disabilities access to job opportunities. Employers must evaluate an applicant's ability to perform the job and not discriminate on the basis of a disability. Employers also must make "reasonable accommodations."

120. Upon completing the admission documents, the nurse learns that the 87 year-old client does not have an advance directive. What action should the nurse take?

A) Record the information on the chart
B) Give information about advance directives
C) Assume that this client wishes a full code
D) Refer this issue to the unit secretary

B: Give information about advance directives. For each admission, nurses should request a copy of the current advance directive. If there is none, the nurse must offer information about what an advance directive implies. It is then the client's choice to sign it. In option 1 just recording the information is not sufficient. In option 3 the nurse should not assume that the client has been informed of choices for emergency care. In option 4 this represents an inappropriate delegation approach.

121. A client with a diagnosis of Methicillin resistant *Staphylococcus aureus* (MRSA) has died. Which type of precautions is appropriate to use when performing postmortem care?

A) Airborne precautions
B) Droplet precautions
C) Contact precautions
D) Compromised host precautions

C: Contact precautions. The resistant bacteria remain alive for up to 3 days after the client dies. Therefore, contact precautions must still be implemented. The body should also be labeled as MRSA-contaminated so that the funeral home staff can protect themselves as well. Gown and gloves are required.

122. An 8 year-old client is admitted to the hospital for surgery. The child's parent reports the allergies listed below. Which of these allergies should all health care personnel be aware of?

A) Shellfish
B) Molds
C) Balloons
D) Perfumed soap

C: Balloons. Allergy to balloons indicates a latex allergy. All personnel in contact with the child will need to be aware of this condition and use non-latex gloves.

123. A nurse is stuck in the hand by an exposed used hypodermic needle. What **immediate** action should the nurse take?

A) Look up the policy on needle sticks
B) Contact employee health services
C) Immediately wash the hands with vigor
D) Notify the supervisor and risk management

C: Immediately wash the hands with vigor. The immediate action of vigorously washing will help remove possible contamination. Then the sequence would be options D, A, B.

124. The nurse is having difficulty reading the health care provider's written order that was left just before the shift change. What action should be taken?

A) Leave the order for the oncoming staff to follow-up on
B) Contact the charge nurse for an interpretation
C) Ask the pharmacy for assistance in the interpretation
D) Call the provider for clarification

D: Call the provider for clarification. Relying on anyone else"s interpretation is very risky. When in doubt, check it out with the person who wrote the difficult-to-read order. Order entry systems help to minimize this problem.

125. When admitting a client to an acute care facility, an identification bracelet is sent up with the admission form. In the event these do not match, the nurse's best action is to

A) change whichever item is incorrect to the correct information
B) use the bracelet and admission form until a replacement is supplied
C) notify the admissions office and wait to apply the bracelet
D) make a corrected identification bracelet for the client

C: notify the admissions office and wait to apply the bracelet. The Admissions Office has the responsibility to verify the client's identity and keep all the records in the system consistent. Making the changes puts the client at risk for misidentification. Using an incorrect identification bracelet is unsafe.

126. The nurse is planning discharge for a 90 year-old client with musculo-skeletal weakness. Which intervention should be included in the plan that would be **most** effective for the prevention of falls?

A) Place nightlights in the bedroom
B) Wear eyeglasses at all times
C) Install grab bars in the bathroom
D) Teach muscle strengthening exercises

A: Place nightlights in the bedroom. Because more falls occur in the bedroom than any other location, begin there. However, work in partnership with the client and family so they are willing to move furniture, lamp cords, and storage areas, add lighting, remove throw rugs, and eliminate other environmental hazards.

127. An 8 year-old child is hospitalized during the edema phase of minimal change nephrotic syndrome. The nurse is assisting in choosing the lunch menu. Which menu is the **best** choice?

A) Bologna sandwich, pudding, milk
B) Frankfurter, baked potato, milk
C) Chicken strips, corn on the cob, milk

D) Grilled cheese sandwich, apple, milk

C: Chicken strips, corn on the cob, milk. This menu is lowest in sodium. Ideally, low fat milk would be available.

128. The nurse is teaching a client with non-insulin dependent diabetes mellitus about the prescribed diet. The nurse should teach the client to

A) maintain previous calorie intake
B) keep a candy bar available at all times
C) reduce carbohydrates intake to 25% of total calories
D) keep a regular schedule of meals and snacks

D: keep a regular schedule of meals and snacks. Currently, calorie-controlled diets with strict meal plans are rarely suggested for clients who have diabetes. Try to incorporate schedule or food changes into clients" existing dietary patterns. Help clients learn to read labels and identify specific canned foods, frozen entrees, or other foods which are acceptable and those which should be avoided.

129. A depressed client in an assisted living facility tells the nurse that "life isn't worth living anymore." What is the best response to this statement?

A) "Come on, it is not that bad."
B) "Have you thought about hurting yourself?"
C) "Did you tell that to your family?"
D) "Think of the many positive things in life."

B: "Have you thought about hurting yourself?". It is appropriate and necessary to determine if someone who has voiced thoughts about death is considering a suicidal act. This response is most therapeutic in the circumstances. Options A and D deny the validity of the client's statement, and the purpose of option C is unclear and it lacks client focus.

130. The nurse is observing a client with an obsessive-compulsive disorder in an inpatient setting. Which behavior is consistent with this diagnosis?

A) Repeatedly checking that the door is locked
B) Verbalized suspicions about thefts
C) Preference for consistent caregivers
D) Repetitive, involuntary movements

A: Repeatedly checking that the door is locked. Behaviors that are repeated are symptomatic of obsessive-compulsive disorders. These behaviors, performed to reduced feelings of anxiety, often interfere with normal function and employment.

131. A female client is admitted for a breast biopsy. She says, tearfully to the nurse, "If this turns out to be cancer and I have to have my breast removed, my partner will never come near me." The nurse's **best** response would be which of these statements?

A) "I hear you saying that you have a fear for the loss of love."
B) "You sound concerned that your partner will reject you."
C) "Are you wondering about the effects on your sexuality?"
D) "Are you worried that the surgery will lead to changes?"

D: "Are you worried that the surgery will lead to changes?". This is a general lead in type of response that encourages further discussion without focusing on an area that the nurse, but possibly not the client, feels is a problem.

132. A client is admitted for treatment of a right upper lobe infiltrate and to rule out tuberculosis. Which of these would be the most appropriate self-protective action by the nurse ?

A) Provide negative room ventilation
B) Wear a face mask with shield
C) Wear a particulate respirator mask
D) Institute airborne precautions

C: Wear a particulate respirator mask. Tight fitting, high-efficiency masks are required when caring for clients who have a suspected communicable disease of the airborne variety.

133. The charge nurse has a health care team that consists of 1 practical nurse (PN), 1 unlicensed assistive personnel (UAP) and 1 PN nursing student. Which assignment should be questioned by the nurse manager?

A) An admission at the change of shifts with atrial fibrillation and heart failure - PN
B) Client who had a major stroke 6 days ago - PN nursing student
C) A child with burns who has packed cells and albumin IV running - charge nurse
D) An elderly client who had a myocardial infarction a week ago – UAP

A: An admission at the change of shifts with atrial fibrillation and heart failure - PN. The care for a new admissions should be performed by an RN. Since the client was admitted at the change of shifts, the stability of the client would not have been established. The charge nurse should take this client. The PN could monitor the IV fluids in option C. Tasks that do not require independent judgment should be delegated. The nurse may delegate the care for a stable client to a UAP.

134. The nurse is teaching an elderly client how to use MDI's (multi-dose inhalers). The nurse is concerned that the client is unable to coordinate the release of the medication with the inhalation phase. What is the nurse's best recommendation to improve delivery of the medication?

A) Nebulized treatments for home care
B) Adding a spacer device to the MDI canister
C) Asking a family member to assist the client with the MDI
D) Request a visiting nurse to follow the client at home

B: Adding a spacer device to the MDI canister. If the client is not using the MDI properly, the medication can get trapped in the upper airway, resulting in dry mouth and throat irritation. Using a spacer will allow more drug to be deposited in the lungs and less in the mouth. It is especially useful in the elderly because it allows more time to inhale and requires less eye-hand coordination.

135. The nurse is teaching a client newly diagnosed with asthma how to use the metered-dose inhaler (MDI). The client asks when they will know the canister is empty. The **best** response is

A) Drop the canister in water to observe floating
B) Estimate how many doses are usually in the canister
C) Count the number of doses as the inhaler is used
D) Shake the canister to detect any fluid movement

A: Drop the canister in water to observe floating. Dropping the canister into a bowl of water assesses the amount of medications remaining in a metered-dose inhaler. The client should obtain a refill when the inhaler rises to the surface and begins to tip over. Some of the newer canisters have counters.

136. A client has an order for 1000 ml of D5W over an 8 hour period. The nurse discovers that 800 ml has been infused after 4 hours. What is the **priority** nursing action?

A) Ask the client if there are any breathing problems
B) Have the client void as much as possible
C) Check the vital signs
D) Auscultate the lungs

D: Auscultate the lungs. All of the options would be part of the evaluation for the effects of the large amount of fluid in a short period of time. However the worst result is heart failure with lung congestion so the auscultation of the lungs is the priority action. The sequence of actions would be D, A, C, B.

137. A nurse observes a family member administer a rectal suppository by having the client lie on the left side for the administration. The family member pushed the suppository until the finger went up to the second knuckle. After 10 minutes the client was told by the family member to turn to the right side and the client did this. What is the appropriate comment for the nurse to make?

A) Why don't we now have the client turn back to the left side.
B) That was done correctly. Did you have any problems with the insertion?
C) Let's check to see if the suppository is in far enough.
D) Did you feel any stool in the intestinal tract?

B: That was done correctly. Did you have any problems with the insertion?. Left side-lying position is the optimal position for the client receiving rectal medications. Due to the position of the descending colon, left side-lying allows the medication to be inserted and move along the natural curve of the intestine and facilitates retention of the medication. After a short time it will not hurt the client to turn in any manner. The suppository should be somewhat melted after 10 to 15 minutes. The other responses are incorrect since no data are in the stem to support such comments.

138. As the nurse observes the student nurse during the administration of a narcotic analgesic IM injection, the nurse notes that the student begins to give the medication without first aspirating. What should the nurse do?

A) Ask the student: "What did you forget to do?"
B) Stop. Tell me why aspiration is needed.
C) Loudly state: "You forgot to aspirate."

D) Walk up and whisper in the student's ear "Stop. Aspirate. Then inject."

D: Walk up and whisper in the student's ear "Stop. Aspirate. Then inject.". This action is a direct threat to the client if the medication enters into the blood stream instead of the muscle. The purpose of aspiration with IM injections is to prevent the injection of the drug directly into the blood stream. Option 4 protects the client and is the most professional.

139. An adult client is found to be unresponsive on morning rounds. After checking for responsiveness and calling for help, the next action that should be taken by the nurse is to:

A) check the carotid pulse
B) deliver 5 abdominal thrusts
C) give 2 rescue breaths
D) ensure an open airway

D: ensure an open airway. According to the ABCs of CPR the first step in rescuing an unresponsive victim after checking responsiveness and calling for help is to open the victims airway. The airway must be opened appropriately before the need for rescue breaths can be determined. The pulse is assessed, after breathing is evaluated. The need for abdominal thrusts is determined by inability to achieve chest rise when ventilation is attempted.

140. A practical nurse (PN) is assigned to care for a newborn with a neural tube defect. Which dressing, if applied by the PN, would need no further intervention by the charge nurse?

A) Telfa dressing with antibiotic ointment
B) Moist sterile nonadherent dressing
C) Dry sterile dressing that is occlusive
D) Sterile occlusive pressure dressing

B: Moist sterile nonadherent dressing. Before surgical closure, the sac is prevented from drying by the application of a sterile, moist, nonadherent dressing over the defect. Dressings are changed frequently to keep them moist.

141. A parent brings her 3 month-old into the clinic, reporting that the child seems to be spitting up all the time and has a lot of gas. The nurse expects to find which of the following on the initial history and physical assessment?

A) increased temperature and lethargy
B) restlessness and increased mucus production
C) increased sleeping and listlessness
D) diarrhea and poor skin turgor

B: restlessness and increased mucus production. This infant could be experiencing gastroesophageal reflux, or could be allergic to the formula. Restlessness, irritability and increased mucus production can develop if an allergy is present. Soy based formula is often recommended.

142. The nurse manager hears a provider loudly criticize one of the staff nurses within the hearing range of others. The nurse manager's **next** action should be to

A) Walk up to the provider and quietly state: "Stop this unacceptable behavior."
B) Allow the staff nurse to handle this situation without interference
C) Notify the of the other administrative persons of a breech of professional conduct
D) Request an immediate private meeting with the provider and staff nurse

D: Request an immediate private meeting with the provider and staff nurse. Assertive communication respects the needs of all parties to express themselves, but not at the expense of others. The nurse manager needs first to protect clients and other staff from this display and come to the assistance of the nurse employee.

143. The charge nurse is planning assignments on a medical unit. The client with _____should be assigned to the unlicensed assistive personnel (UAP).

A) d ifficulty swallowing after a mild stroke
B) an order of enemas until clear prior to colonoscopy
C) an order for a post-op abdominal dressing change
D) transfer orders to a long term facility

B: an order of enemas until clear prior to colonoscopy. The UAP can be assigned routine tasks which have predictable outcomes.

144. The nurse manager has been using a block scheduling plan to staff the nursing unit. However, staff have asked for many changes and exceptions to the schedule over the past few months. The manager considers self-scheduling knowing that this method will

A) Improve the quality of care
B) Decrease staff turnover
C) Minimize the amount of overtime payouts
D) Improve team morale

D: Improve team morale. Nurses are more satisfied when opportunities exist for autonomy and control. The nurse manager becomes the facilitator of scheduling rather than the decision-maker of the schedule when self-scheduling exists.

145. A client is admitted to a voluntary hospital mental health unit due to suicidal ideation. The client has been on the unit for 2 days and now states "I demand to be released now!" The appropriate from the nurse is

A) You cannot be released because you are still suicidal.
B) You can be released only if you sign a no suicide contract.
C) Let's discuss your decision to leave and then we can prepare you for discharge.
D) You have a right to sign out as soon as we get the provider's discharge order.

C: Let's discuss your decision to leave and then we can prepare you for discharge.. Clients voluntarily admitted to the hospital have a right to demand and obtain release. Discussing the decision initially allows an opportunity for other interventions.

146. The nurse is caring for a client who is post-op following a thoracotomy. The client has 2 chest tubes in place, connected to 1 chest drain. The nursing assessment reveals bubbling in the water seal chamber when the client coughs. What is the **most** appropriate nursing action?

A) Clamp the chest tube
B) Call the surgeon immediately
C) Continue to monitor the client to see if the bubbling increases
D) Instruct the client to try to avoid coughing

C: Continue to monitor the client to see if the bubbling increases. Bubbling associated with coughing after lung surgery is to be expected as small amounts of air escape the pleural space when pressures inside the chest increase with coughing. Monitoring is the only nursing action required at this time.

147. A newly admitted elderly client is severely dehydrated. When planning care for this client, which task is appropriate to assign to an unlicensed assistive personnel (UAP)?

A) Converse with the client to determine if the mucous membranes are impaired
B) Report hourly outputs of less than 30 ml/hr
C) Monitor client's ability for movement in the bed
D) Check skin turgor every 4 hours

B: Report hourly outputs of less than 30 ml/hr. When directing a UAP, the nurse must communicate clearly about each delegated task with specific instructions on what must be reported. Because the RN is responsible for all care-related decisions, only implementation tasks should be assigned because they do not require independent judgment.

148. Which statement best describes time management strategies applied to the role of a nurse manager?

A) Schedule staff efficiently to cover the anticipated needs on the managed unit
B) Assume a fair share of direct client care as a role model
C) Set daily goals with a prioritization of the work
D) Delegate tasks to reduce work load associated with direct care and meetings

C: Set daily goals with a prioritization of the work. Time management strategies include setting goals and prioritization . This is similar to time management of direct care for clients

149. The charge nurse on the night shift at an urgent care center has to deal with admitting clients of a higher acuity than usual because of a large fire in the area. Which style of leadership and decision-making would be best in this circumstance?

A) Assume a decision-making role
B) Seek input from staff
C) Use a non-directive approach
D) Shared decision-making with others

A: Assume a decision-making role. Authoritarian leadership assumes that decision-making is the role of the leader with little input by subordinates. This style is best used in emergency situations or as a triage nurse.

150. Which activity can the RN ask an unlicensed assistive personnel (UAP) to perform?

A) Take a history on a newly admitted client
B) Adjust the rate of a gastric tube feeding
C) Check the blood pressure of a 2 hours post operative client
D) Check on a client receiving chemotherapy

C: Check the blood pressure of a 2 hours post operative client. UAPs must be assigned tasks that require no nursing judgment or decision making situations. Vital signs on stable clients are commonly assigned to unlicensed staff.

Management of Care

1. The nurse receives a report on an older adult client with middle stage dementia. What information suggests the nurse should do immediate follow up rather than delegate care to the nursing assistant? The client

    A) has had a change in respiratory rate by an increase of 2 breaths
    B) has had a change in heart rate by an increase of 10 beats
    C) was minimally responsive to voice and touch
    D) has had a blood pressure change by a drop in 8 mmHg systolic

C: was minimally responsive to voice and touch. A change in level of consciousness indicates delirium related to acute illness. This would require the assessment of a nurse. The other changes could occur within the range of normal fluctuations.

2. A client tells the nurse, "I have something very important to tell you if you promise not to tell." The best response by the nurse is

    A) "I must document and report any information."
    B) "I can't make such a promise."
    C) "That depends on what you tell me."
    D) "I must report everything to the treatment team."

B: "I can't make such a promise." Secrets are inappropriate in therapeutic relationships and are counter productive to the therapeutic efforts of the interdisciplinary team. Secrets may be related to risk for harm to self or others. The nurse honors and helps clients to understand rights, limitations, and boundaries regarding confidentiality.

3. The nurse is caring for a 69 year-old client with a diagnosis of hyperglycemia. Which tasks could the nurse delegate to the unlicensed assistive personnel (UAP)?

    A) Test blood sugar every 2 hours by Accu-Check
    B) Review with family and client signs of hyperglycemia
    C) Monitor for mental status changes
    D) Check skin condition of lower extremities

A: Test blood sugar every 2 hours by Accu-Check. The UAP can do standard, unchanging procedures.

4. A nurse from the maternity unit is floated to the critical care unit because of staff shortage on the evening shift. Which client would be appropriate to assign to this nurse? A client with

    A) a Dopamine drip IV with vital signs monitored every 5 minutes
    B) a myocardial infarction that is free from pain and dysrhythmias
    C) a tracheotomy of 24 hours in some respiratory distress
    D) a pacemaker inserted this morning with intermittent capture

B: A myocardial infarction that is free from pain and dysrhythmias. This client is the most stable with minimal risk of complications or instability. The nurse can utilize basic nursing skills to care for this client.

5. Which task could be safely delegated by the nurse to an unlicensed assistive personnel (UAP)?

    A) Be with a client who self-administers insulin
    B) Cleanse and dress a small decubitus ulcer
    C) Monitor a client's response to passive range of motion exercises
    D) Apply and care for a client's rectal pouch

D: Apply and care for a client"s rectal pouch. The RN may delegate the application and care of rectal pouches to a UAP. This is an uncomplicated, routine task.

6. The unlicensed assistive personnel (UAP) reports a sudden increase in temperature to 101 degrees Fahrenheit for a post surgical client. The nurse checks on the client's condition and observes a cup of steaming coffee at the bedside. What instructions are appropriate to give to the UAP?

A) Encourage oral fluids to prevent dehydration
B) Recheck temperature 15 minutes after removing hot liquids from the bedside
C) Ask the client to drink only cold water and juices
D) Chart this temperature elevation on the flow sheet

B: Recheck temperature 15 minutes after removing hot liquids from the bedside. Recheck temperature to eliminate possible artificial elevation of temperature. Hot liquids, smoking, eating, chewing gum, and talking can all elevate temperature. Waiting to take the temperature for 15 minutes will help the temperature return to its normal, in order to get an accurate reading. Avoid premature assumptions about explanations for findings. The other options are incorrect.

7. A client has a nasogastric tube after colon surgery. Which one of these tasks can be safely delegated to an unlicensed assistive personnel (UAP)?

A) To observe the type and amount of nasogastric tube drainage
B) Monitor the client for nausea or other complications
C) Irrigate the nasogastric tube with the ordered irrigant
D) Perform nostril and mouth care

D: Perform nostril and mouth care. Skin care around a nasogastric tube is a routine task that is appropriate for UAPs. The other tasks would be appropriate for a PN or RN to do since they are advanced skills or require evaluation.

8. A client asks the nurse to call the police and states: "I need to report that I am being abused by a nurse." The nurse should first

A) focus on reality orientation to place and person
B) assist with the report of the client's complaint to the police
C) obtain more details of the client's claim of abuse
D) document the statement on the client's chart with a report to the manager

C: Obtain more details of the client's claim of abuse. The advocacy role of the professional nurse as well as the legal duty of the reasonable prudent nurse requires the investigation of claims of abuse or violation of rights. The nurse is legally accountable for actions delegated to others. The application of the nursing process requires that the nurse gather more information, further assessment, before documentation or the reporting of the complaint.

9. When assessing a client, it is important for the nurse to be informed about cultural issues related to the client's background because

A) normal patterns of behavior may be labeled as deviant, immoral, or insane
B) the meaning of the client's behavior can be derived from conventional wisdom
C) personal values will guide the interaction between persons from 2 cultures
D) the nurse should rely on her knowledge of different developmental mental stages

A: Normal patterns of behavior may be labeled as deviant, immoral, or insane. Culture is an important variable in the assessment of individuals. To work effectively with clients, the nurse must be aware of a cultural distinctive qualities.

10. The nursing student is discussing with a preceptor the delegation of tasks to an unlicensed assistive personnel (UAP). Assigning which of these tasks to a UAP indicates the student needs further teaching about the delegation process?

A) Assist a client post cerebral vascular accident to ambulate
B) Feed a 2 year-old in balanced skeletal traction
C) Care for a client with discharge orders
D) Collect a sputum specimen for acid fast bacillus

C: Care for a client with discharge orders. A registered nurse (RN) is the best person to do teaching or evaluation that is needed at time of discharge.

11. The nurse is responsible for several elderly clients, including a client on bed rest with a skin tear and hematoma from a fall 2 days ago. What is the best care assignment for this client?

A) Assign an RN to provide total care of the client
B) Assign a nursing assistant to help the client with self-care activities
C) Delegate complete care to an unlicensed assistive personnel
D) Supervise a nursing assistant for skin care

D: Supervise a nursing assistant for skin care. The nursing assistant can inspect the skin while giving hygiene care, but the nurse should supervise skin care since assessment and analysis are needed.

12. A client continuously calls out to the nursing staff when anyone passes the client's door and asks them to do something in the room. The best response by the charge nurse would be to

A) keep the client's room door cracked to minimize the distractions
B) assign 1 of the nursing staff to visit the client regularly
C) reassure the client that 1 staff person will check frequently if the client needs anything
D) arrange for each staff member to go into the client's room to check on needs every hour on the hour

B: Assign 1 of the nursing staff to visit the client regularly. Regular, frequent, planned contact by 1 staff member provides continuity of care and communicates to the client that care will be available when needed.

13. A client is admitted with a diagnosis of schizophrenia. The client refuses to take medication and states "I don't think I need those medications. They make me too sleepy and drowsy. I insist that you explain their use and side effects." The nurse should understand that

    A) a referral is needed to the psychiatrist who is to provide the client with answers
    B) the client has a right to know about the prescribed medications
    C) such education is an independent decision of the individual nurse whether or not to teach clients about their medications
    D) clients with schizophrenia are at a higher risk of psychosocial complications when they know about their medication side effects

B: The client has a right to know about the prescribed medications. Clients have a right to informed consent which includes information about medications, treatments, and diagnostic studies.

14. The charge nurse is planning assignments on a medical unit. Which client should be assigned to the practical nurse (PN)?

    A) Test a stool specimen for occult blood
    B) Assist with the ambulation of a client with a chest tube system
    C) Irrigate and redress a leg wound
    D) Admit a client from the emergency room

C: Irrigate and redress a leg wound. The PN is a licensed provider and can perform this complex task. Options A and B could be delegated to an unlicensed assistive personnel (UAP), and option D requires an RN.

15. An unlicensed assistive personnel (UAP), who usually works on a surgical unit is assigned to float to a pediatric unit. Which question by the charge nurse would be most appropriate when making delegation decisions?

    A) "How long have you been a UAP and what units you have worked on?"
    B) "What type of care do you give on the surgical unit and what ages of clients?"
    C) "What is your comfort level in caring for children and at what ages?"
    D) "Have you reviewed the list of expected skills you might need on this unit?"

D: "Have you reviewed the list of expected skills you might need on this unit?". The UAP must be competent to accept the delegated task. Review of skills needed versus level of performance is the most efficient and effective way to determine this.

16. A client with a diagnosis of bipolar disorder has been referred to a local boarding home for consideration for placement. The social worker telephoned the hospital unit for information about the client's mental status and adjustment. The appropriate response of the nurse should be which of these statements?

    A) "I am sorry. Referral information can only be provided by the client's providers"
    B) "I can never give any information out by telephone. How do I know who you are?"
    C) "Since this is a referral, I can give you this information"
    D) "I need to get the client's written consent before I release any information to you"

D: In order to release information about a client there must be a signed consent form with designation of to whom information can be given, and what information can be shared.

17. A client frequently admitted to the locked psychiatric unit repeatedly compliments and invites one of the nurses to go out on a date. The nurse's response should be to

    A) ask to not be assigned to this client or to work on another unit
    B) tell the client that such behavior is inappropriate
    C) inform the client that hospital policy prohibits staff to date clients
    D) discuss the boundaries of the therapeutic relationship with the client

D: Discuss the boundaries of the therapeutic relationship with the client. The nurse-client relationship is one with professional not social boundaries. Consistent adherence to the limits of the professional relationship builds trust.

18. Which statement by the nurse is appropriate when directing an unlicensed assistive personnel (UAP) to assist a 69 year-old surgical client to ambulate for the first time?

    A) "Have the client sit on the side of the bed for at least 2 minutes before helping him stand."
    B) "If the client is dizzy on standing, ask him to take some deep breaths."
    C) "Assist the client to the bathroom at least twice on this shift."
    D) "After you assist him to the chair, let me know how he feels."

A: Give clear information to the UAP about what is expected for client safety.

19. After working with a client, an unlicensed assistive personnel (UAP) tells the nurse, "I have had it with that demanding client. I just can't do anything that pleases him. I'm not going in there again." The nurse should respond by saying

    A) "He has a lot of problems. You need to have patience with him."
    B) "I will talk with him and try to figure out what to do."
    C) "He may be scared and taking it out on you. Let's talk to figure out what to do."
    D) "Ignore him and get the rest of your work done. Someone else can take care of him for the rest of the day."

C: "He may be scared and taking it out on you. Let"s talk to figure out what to do." This response explains the client"s behavior without belittling the UAP's feelings. The UAP is encouraged to contribute to the plan of care to help solve the problem.

20. A nurse is working with one licensed practical nurse (PN), a student nurse and an unlicensed assistive personnel (UAP). Which newly admitted clients would be **most** appropriate to assign to the UAP?

A) A 76-year-old client with severe depression
B) A middle-aged client with an obsessive compulsive disorder
C) An adolescent with dehydration and anorexia
D) A young adult who is a heroin addict in withdrawal with hallucinations

B: A middle-aged client with an obsessive compulsive disorder. The UAP can be assigned to care for a client with a chronic condition after an initial assessment by the nurse. This client has minimal risk of instability of condition.

Delegation

1. Which statement by the nurse is appropriate when giving an assignment to an unlicensed assistive personnel (UAP) to help a client ambulate for the first time after a colon resection?

A) "Have the client sit on the side of the bed before helping the client to walk."
B) "If the client is dizzy ask the client to take some slow, deep breaths."
C) "Help the client to walk in the room as often as the client wishes."
D) "When you help the client to walk, ask if any pain occurs."

A: This statement gives clear directions to the UAP about the task and is most closely associated with the information provided in the stem that this is the client"s first time out of bed after surgery.

2. The home care nurse has been managing a client for 6 weeks. What is the **best** method to determine the quality of care provided by a home health care aide assigned to assist with the care of this client?

A) Ask the client and family if they are satisfied with the care given
B) Determine if the home health aide's care is consistent with the plan of care
C) Investigate if the home health aide is prompt and stays an appropriate length of time for care
D) Check the documentation of the aide for appropriateness and comprehensiveness

B: Although the nurse must complete all of the above responsibilities, evaluation of an adherence to the plan of care is the first priority. The plan of care is based on the reason for referral, provider"s orders, the initial nursing assessment, the client's responses to the planned interventions, and the client"s and family"s feedback or inquires. The other possible answers represent aspects of accomplishing "B".

3. Which task for a client with anemia and confusion could the nurse delegate to the unlicensed assistive personnel (UAP)?

A) Assess and document skin turgor and color changes
B) Test stool for occult blood and urine for glucose and report results
C) Suggest foods high in iron and those easily consumed
D) Report mental status changes and the degree of mental clarity

B: Test stool for occult blood and urine for glucose and report results. The UAP can do standard, unchanging procedures that require no decision making.

4. The care of which of the following clients can the nurse safely delegate to an unlicensed assistive personnel (UAP)?

A) A client with peripheral vascular disease and an ulceration of the lower leg.
B) A pre-operative client awaiting adrenalectomy with a history of asthma
C) An elderly client with hypertension and self-reported non-compliance
D) A new admission with a history of transient ischemic attacks and dizziness

A: A client with peripheral vascular disease and an ulceration of the lower leg.

This client is stable with no risk of instability as compared to the other clients. And this client has a chronic condition, needs supportive care.

5. A practical nurse (PN) from the pediatric unit is assigned to work in a critical care unit. Which client assignment would be appropriate?

A) A client admitted with multiple trauma with a history of a newly implanted pacemaker
B) A new admission with left-sided weakness from a stroke and mild confusion
C) A 53 year-old client diagnosed with cardiac arrest from a suspected myocardial infarction
D) A 35 year-old client in balanced traction admitted 6 days ago after a motor vehicle accident

D: A 35 year-old client in balanced traction admitted 6 days ago after a motor vehicle accident. This client is the most stable with a predictable outcome.

6. The RN delegates the task of taking vital signs of all the clients on the medical-surgical unit to an unlicensed assistive personnel (UAP). Specific written and verbal instructions are given to not take a post-mastectomy client's blood pressure on the left arm. Later as the RN is making rounds, the nurse finds the blood pressure cuff on that client's left arm. Which of these statements is most immediately accurate?

    A) The RN has no accountability for this situation
    B) The RN did not delegate appropriately
    C) The UAP is covered by the RN's license
    D) The UAP is responsible for following instructions

D: The UAP is responsible for carrying out the activity correctly once directions have been clearly communicated especially if given verbally and in writing.

7. As the RN responsible for a client in isolation, which can be delegated to the practical nurse (PN)?

    A) Reinforcement of isolation precautions
    B) Assessment of the client's attitude about infection control
    C) Evaluation of staffs' compliance with control measures
    D) Observation of the client's total environment for risks

A: PNs and UAPs can reinforce information that was originally given by the RN.

8. A 25 year-old client, unresponsive after a motor vehicle accident, is being transferred from the hospital to a long term care facility. To which staff member should the charge nurse assign the client?

    A) Unlicensed assistive personnel (UAP)
    B) Senior nursing student
    C) PN
    D) RN

D: RN. The RN is responsible for teaching and assessment associated with discharge and these activities cannot be delegated to the others listed.

9. The charge nurse on a cardiac step-down unit makes assignments for the team consisting of a registered nurse (RN), a practical nurse (PN), and an unlicensed assistive personnel (UAP). Which client should be assigned to the PN?

    A) A 49 year-old with new onset atrial fibrillation with a rapid ventricular response
    B) A 58 year-old hypertensive with possible angina
    C) A 35 year-old scheduled for cardiac catheterization
    D) A 65 year-old for discharge after angioplasty and stent placement

B: A 58 year-old hypertensive with possible angina. This is the most stable client. The clients in options C and D require initial teaching. The client in option A is considered unstable since the dysrhythmia is a new onset.

10. The measurement and documentation of vital signs is expected for clients in a long term facility. Which staff type would it be a priority to delegate these tasks to?

    A) Practical nurse (PN)
    B) Registered Nurse (RN)
    C) Unlicensed assistive personnel (UAP)
    D) Volunteer

C: Unlicensed assistive personnel (UAP). The measurement and recording of vital signs may be delegated to UAP. This falls under the umbrella of routine task with stable clients. Other considerations for delegation of care to UAP would be: Who is capable and is the least expensive worker to do each task?

11. Which of these clients would be appropriate to assign to a practical nurse (PN)?

    A) A trauma victim with multiple lacerations and requires complex dressings
    B) An elderly client with cystitis and an indwelling urethral catheter
    C) A confused client whose family complains about the nursing care 2 days after surgery
    D) A client admitted for possible transient ischemic attack with unstable neurological signs

B: This is a stable client, with predictable outcome and care and minimal risk for complications.

12. Two people call in sick on the medical-surgical unit and no additional help is available. The team consists of an RN, an LPN and an unlicensed assistive personnel (UAP). Which of these activities should the nurse assign to the UAP?

    A) Assist with plans for any clients discharged
    B) Provide basic hygiene care to all clients on the unit
    C) Assess a client after an acute myocardial infarction
    D) Gather the vital signs of all clients on the unit

B: Basic client care, which is routine, should be delegated to a UAP since the unit is short on help. The vital signs can be done by the RN and PN as they make rounds since this data is more critical to making decisions about the care of the clients.

13. A staff nurse complains to the nurse manager that an unlicensed assistive personnel (UAP) consistently leaves the work area untidy and does not restock supplies. The best initial response by the nurse manager is which of these statements?

A) "I will arrange for a conference with you and the UAP within the next week"
B) "I can assure you that I will look into the matter"
C) "I would like for you to approach the UAP about the problem the next time it occurs"
D) I will add this concern to the agenda for the next unit meeting

C: Helping staff manage conflict is part of the manager"s role. It is appropriate to urge the nurse to confront the other staff member to work out problems without a manager"s intervention when possible.

14. A client has had a tracheostomy for 2 weeks after a motor vehicle accident. Which task could the RN safely delegate to unlicensed assistive personnel (UAP)?

A) Teach the client how to cough up secretions
B) Changes the tracheostomy trach ties
C) Monitor if client has shortness of breath
D) Perform routine tracheostomy dressing care

D: Unlicensed assistive personnel should be able to perform routine tracheostomy care.

15. An RN from the women's health clinic is temporarily reassigned to a medical-surgical unit. Which of these client assignments would be most appropriate for this nurse?

A) A newly diagnosed client with type 2 diabetes mellitus who is learning foot care
B) A client from a motor vehicle accident with an external fixation device on the leg

C) A client admitted for a barium swallow after a transient ischemic attack
D) A newly admitted client with a diagnosis of pancreatic cancer

B: This client is the most stable, requires basic safety measures and has a predictable outcome.

16. The nurse in a same-day surgery unit assigns the unlicensed assistive personnel (UAP) to provide a hernia patient with a lunch tray. Which statement by the nurse is **most** appropriate?

A) "Tell the family they can bring in a pizza if the patient would prefer that."
B) "Make sure the patient gets at least 2 cartons of milk."
C) "Stop the IV if the patient is able to eat solid food."
D) "Encourage the patient to eat slowly to prevent gas."

D: The professional nurse can delegate tasks with an expected outcome. The UAP is given adequate information about the task and how to promote the best outcome.

17. Which one of these tasks can be safely delegated to a practical nurse (PN)?

A) Assess the function of a newly created ileostomy
B) Care for a client with a recent complicated double barrel colostomy
C) Provide stoma care for a client with a well functioning ostomy
D) Teach ostomy care to a client and their family members

C: Provide stoma care for a client with a well functioning ostomy. The care of a mature stoma and the application of an ostomy appliance may be delegated to a PN. This client has minimal risk of instability of the situation.

18. An unlicensed assistive personnel (UAP), who usually works in pediatrics is assigned to work on a medical-surgical unit. Which one of the questions by the charge nurse would be **most** appropriate prior to making delegation decisions?

A) "How long have you been a UAP?"
B) "What type of care did you give in pediatrics?"
C) "Do you have your competency checklist that we can review?"
D) "How comfortable are you to care for adult clients?"

C: "Do you have your competency checklist that we can review?". The UAP must be competent to accept the delegated task. Further assessment of the qualifications of the UAP is important in order to assign the right task.

19. During the interview of a prospective employee who just completed the agency orientation, which approach would be the best for the nurse manager to use to assess competence?

A) "What degree of supervision for basic care do you think you need?"
B) "Let's review your skills check-list for type and level of skill"
C) "Are you comfortable working independently?"
D) "What client care tasks or assignments do you prefer?"

B: The nurse needs to know that the employee has competence in certain tasks. One way to do this is to do mutual review of documented skills.

20. A charge nurse working in a long term care facility is making out assignments. Which assignment made by a registered nurse to an unlicensed assistive personnel (UAP) requires intervention by the supervisor?

A) Provide decubitus ulcer care and apply a dry dressing
B) Bathe and feed a client on bed rest
C) Oral suctioning of an unresponsive elderly client
D) Teaching a family intermittent (bolus) feedings via G-tube before discharge

D: Teaching a family intermittent (bolus) feedings via G-tube before discharge. Initial teaching can not be delegated to a UAP or a PN and must be done by RNs.

21. Which of these clients would be most appropriate to assign to a practical nurse (PN)?

    A) A trauma victim with quadriplegia and a client 1 day post-op radical neck dissection
    B) A client with newly diagnosed type 2 diabetes mellitus and a client with a history of AIDS admitted for pneumonia
    C) A client with hemiplegia is fed by a nasogastric tube and client with a left leg amputation in rehabilitation
    D) A client with a history of schizophrenia in alcohol withdrawal and a client with chronic renal failure

C: A client with hemiplegia is fed by a nasogastric tube and client with a left leg amputation in rehabilitation This client requires supportive care and interventions within the scope of practice of a PN. This client is stable with little risk of complications or instability.

22. The nurse assigns an unlicensed assistive personnel (UAP) to care for a client with a musculoskeletal disorder. The client ambulates with a leg splint. Which task requires supervision of the UAP?

    A) Report signs of redness overlying a joint
    B) Monitor the client's response to ambulatory activity
    C) Encouragement for the independence in self-care
    D) Assist the client to transfer from a bed to a chair

B: Monitor the client"s response to ambulatory activity. Monitoring the client's response to interventions requires assessment, a task to be performed by an RN.

23. When walking past a client's room, the nurse hears 1 unlicensed assistive personnel (UAP) talking to another UAP. Which statement requires follow-up intervention?

    A) "If we work together we can get all of the client care completed."
    B) "Since I am late for lunch, would you do this one client's glucose test?"
    C) "This client seems confused, we need to watch monitor closely."
    D) "I'll come back and make the bed after I go to the lab."

B: Only the RN and PN can delegate to UAPs. One UAP can not delegate a task to another UAP. The RN or PN is legally accountable for the nursing care.

24. A client is receiving an intravenous (IV) infusion for pain control. When caring for this client, which one of these actions can the RN safely assign to an unlicensed assistive personnel (UAP)?

    A) Ask the client the degree of relief and document the client's response
    B) Decrease the set rate on the pump by 2 ml/minute
    C) Check the IV site for drainage and loose tape
    D) Assist the client with ambulation and a gown change with supervision

D: When directing the UAP, communicate clearly and specifically what the task is and what should be reported to the nurse. Implementation of routine tasks should be delegated since they do not require independent judgment.

25. Which client data should the nurse act upon when a home health aide calls the nurse from the client's home to report these items?

    A) "The client has complaints of not sleeping well for the past week"
    B) "The family wants to discontinue the home meal service, meals on wheels"
    C) "The urine in the urinary catheter bag is of a deeper amber, almost brown color"
    D) "The partner says the client has slower days every other day"

C: Home health aides need to report diverse information to nurses through phone calls and documentation. The nurse who develops the plan of care for a specific client, and supervises the aide, must identify potential danger signs which require immediate action and follow-up. The color of the urine requires follow-up evaluation.

Priority

1. The nurse must know that the **most** accurate oxygen delivery system available is

    A) the Venturi mask
    B) nasal cannula
    C) partial non-rebreather mask
    D) simple face mask

A: the Venturi mask. The most accurate way to deliver oxygen to the client is through a Venturi system such as the Venti Mask. The Venti Mask is a high flow device that entrains room air into a reservoir device on the mask and mixes the room air with 100% oxygen. The size of the opening to the reservoir determines the concentration of oxygen. The client's respiratory rate and respiratory pattern do not affect the concentration of oxygen delivered. The maximum amount of oxygen that can be delivered by this system is 55%.

2. A client arrives in the emergency department after a radiologic accident at a local factory. The **first** action of the nurse would be to

    A) begin decontamination procedures for the client
    B) ensure physiologic stability of the client
    C) wrap the client in blankets to minimize staff contamination
    D) double bag the client's contaminated clothing

B: ensure physiologic stability of the client. The nurse must initially assist in stabilizing the patient prior to performing the other tasks related to radiologic contamination.

3. The nurse is caring for a client on complete bed rest. Which action by the nurse is **most** important in preventing the formation of deep vein thrombosis?

    A) Elevate the foot of the bed
    B) Apply knee high support stockings
    C) Encourage passive exercises
    D) Prevent pressure at back of knees

D: Prevent pressure at back of knees. Preventing popliteal pressure will prevent venous stasis and possibly deep vein thrombosis.

4. If a very active two year-old client pulls his tunneled central venous catheter out, what initial nursing action is appropriate?

    A) Obtain emergency equipment
    B) Assess heart rate, rhythm and all pulses
    C) Apply pressure to the vessel insertion site
    D) Use cold packs at the exit incision site

C: If a central venous catheter is accidentally removed, pressure should be applied to the vein entry site.

5. The nurse assesses several post partum women in the clinic. Which of the following women is at **highest** risk for puerperal infection?

    A) 12 hours post partum, temperature of 100.4 degrees Fahrenheit since delivery
    B) 2 days post partum, temperature of 101.2 degrees Fahrenheit this morning
    C) 3 days post partum, temperature of 100.8 degrees Fahrenheit the past 2 days
    D) 4 days post partum, temperature of 100 degrees Fahrenheit since delivery

C: A temperature of 100.4 degrees Fahrenheit or higher on 2 successive days, not counting the first 24 hours after birth, indicates a post partum infection.

6. The nurse is caring for a client with a chest tube. On the second postoperative day, the chest tube accidentally disconnects from the drainage tube. The **first** action the nurse should take is

A) reconnect the tube
B) raise the collection chamber above the client's chest
C) call the health care provider
D) clamp the chest tube

D: clamp the chest tube. Immediate steps should be taken to prevent air from entering the chest cavity. Lung collapse may occur if air enters the chest cavity. Clamping the tube close to the client's chest is the first action to take, followed by health care provider notification.

7. A client is placed on sulfamethoxazole-trimethoprim (Bactrim) for a recurrent urinary tract infection. Which of the following is appropriate reinforcement of information by the nurse?

A) "Drink at least 8 glasses of water a day."
B) "Be sure to take the medication with food."
C) "It is safe to take with oral contraceptives."
D) "Stop the medication after 5 days."

A: "Drink at least 8 glasses of water a day." Bactrim is a highly insoluble drug and requires a large volume of fluid intake. It is not necessary to take it with food. Options C and D are incorrect instructions for those taking Bactrim.

8. A client calls the evening health clinic to state "I know I have a severely low sugar since the Lantus insulin was given 3 hours ago and it peaks in 2 hours." What should be the nurse's **initial** response to the client?

A) What else do you know about this type of insulin?
B) What are you feeling at this moment?
C) Have you eaten anything today?
D) Are you taking any other insulin or medication?

B: What are you feeling at this moment? When a client has changed from stable to unstable, the nurse's initial response should be to do further assessment of the client.

9. The nurse is caring for a client who is receiving total parenteral nutrition (TPN) (hyperalimentation and lipids). What is the priority nursing action on every 8 hour shift?

A) Monitor blood pressure, temperature and weight
B) Change the tubing under sterile conditions
C) Check urine glucose, acetone and specific gravity
D) Adjust the infusion rate to provide for total volume

C: Check urine glucose, acetone and specific gravity. Because of the high dextrose and protein content in parenteral nutrition, the nurse should assess the urine at least every 8 hours.

10. The nurse reviews an order to administer Rh (D) immune globulin to an Rh negative woman following the birth of an Rh positive baby. Which assessment is a **priority** before the nurse gives the injection?

A) Newborn's blood type
B) Coombs' test results
C) Previous RhoGAM history
D) Gravida and parity

B: Coombs" test results. Rh (D) immune globulin (RhoGAM) is given only if antibody formation has not occurred. A negative Coombs" test confirms this.

11. A client has been on antibiotics for 72 hours for cystitis. Which report from the client requires priority attention by the nurse?

A) foul smelling urine
B) burning on urination
C) elevated temperature
D) nausea and anorexia

C: elevated temperature. Elevated temperature after 72 hours on an antibiotic indicates the antibiotic has not been effective in eradicating the offending organism. The provider should be informed immediately so that an appropriate medication can be prescribed, and complications such as pyelonephritis are prevented. Options A and B are expected with cystitis. Option D may be related to the antibiotics as a side effect and should also be reported to the provider.

12. The nurse is caring for a school-aged child with a diagnosis of secondary hyperparathyroidism following treatment for chronic renal disease. Which of the following lab data should receive **priority** attention?

A) Calcium and phosphorus levels
B) Blood sugar
C) Urine specific gravity

D) Blood urea nitrogen

A: Calcium and phosphorus levels. Calcium and phosphorous levels will be elevated until the client is stabilized.

13. When caring for a client with urinary incontinence, which content should be reinforced by the nurse?

A) hold the urine to increase bladder capacity
B) avoid eating foods high in sodium
C) restrict fluid to prevent elimination accidents
D) avoid taking antihistamines

D: avoid taking antihistamines. Antihistamines can aggravate urinary incontinence and should be avoided by these clients. Holding the urine, avoiding sodium, and restricting fluids have not been shown to reduce urinary incontinence.

14. A client returns from the operating room after a right orchiectomy. For the immediate post-operative period the nursing **priority** would be to

A) maintain fluid and electrolyte balance
B) manage post-operative pain
C) ambulate the client within 1 hour of surgery
D) control bladder spasms

B: manage post-operative pain. Due to the location of the incision, pain management is the priority. Bladder spasms are more related to prostate surgery.

15. A client with a fracture of the radius had a plaster cast applied 2 days ago. The client complains of constant pain and swelling of the fingers. The **first** action of the nurse should be

A) elevate the arm no higher than heart level
B) remove the cast
C) assess capillary refill of the exposed hand and fingers
D) apply a warm soak to the hand

C: assess capillary refill of the exposed hand and fingers. A deterioration in neurovascular status indicates the development of compartment syndrome (elevated tissue pressure within a confined area) which requires immediate pressure-reducing interventions.

16. A client is 2 days post operative. The vital signs are: BP - 120/70, HR -- 110 BPM, RR - 26, and Temperature - 100.4 degrees Fahrenheit (38 degrees Celsius). The client suddenly becomes profoundly short of breath, skin color is gray. Which assessment would have alerted the nurse **first** to the client's change in condition?

A) Heart rate
B) Respiratory rate
C) Blood pressure
D) Temperature

B: Respiratory rate. Tachypnea is one of the first clues that the client is not oxygenating appropriately. The compensatory mechanism for decreased oxygenation is increased respiratory rate.

17. A client is waiting to have an intravenous pyelogram (IVP). The most important information to be obtained by the nurse prior to the procedure is

A) time of the client's last meal
B) client's allergy history
C) assessment of the peripheral pulses
D) results of the blood coagulation studies

B: client"s allergy history. Intravenous Pyelogram is a dye study that uses an iodine-based contract. Therefore, the study is contraindicated in clients with allergy to iodine.

18. What must the nurse emphasize when teaching a client with depression about a new prescription for nortriptyline (Pamelor)?

A) Symptom relief occurs in a few days
B) Alcohol use is to be avoided
C) Medication must be stored in the refrigerator
D) Episodes of diarrhea can be expected

B: Alcohol use is to be avoided. Alcohol potentiates the action of tricyclic antidepressants.

19. Before administering a feeding through a gastrostomy tube, what is the **priority** nursing assessment?

A) Measure the vital signs
B) Palpate the abdomen
C) Assess for breath sounds
D) Verify tube patency

D: Verify tube patency. Tube patency should be checked prior to all feedings. The feeding should not be attempted if the tube is not patent.

20. The nurse is caring for a client with a vascular access for hemodialysis. Which of these findings necessitates **immediate** action by the nurse?

    A) pruritic rash
    B) dry, hacking cough
    C) chronic fatigue
    D) elevated temperature

D: elevated temperature. It is a priority to report this finding since clients on hemodialysis are prone to infection, and the first sign is an elevated temperature. The other findings should be reported to the provider as well.

21. The nurse is caring for a client several days following a cerebral vascular accident. Coumadin (warfarin) has been prescribed. Today's prothrombin level is 40 seconds (normal range 10-14 seconds). Which of the following findings requires priority follow-up?

    A) Gum bleeding
    B) Lung sounds
    C) Homan's sign
    D) Generalized weakness

A: Gum bleeding. The prothrombin time is elevated, indicating a high risk for bleeding. Neurological assessments remain important for post-CVA clients.

22. The registered nurse (RN) is making decisions regarding client room assignments on a pediatric unit. Which possible roommate would be **most** appropriate for a 3 year-old child with minimal change nephrotic syndrome?

    A) 2 year-old with respiratory infection
    B) 3 year-old fracture whose sibling has chickenpox
    C) 4 year-old with bilateral inguinal hernia repair
    D) 6 year-old with a sickle cell anemia crisis

C: 4 year-old with bilateral inguinal hernia repair. The nurse must know that children with nephrotic syndrome are at high risk for development of infections as a result of the standard use of immunosuppressant therapy, as well as from the accumulation of fluid (edema). Therefore, these children must be protected from sources of possible infection. D is incorrect because the sickle cell crisis is potentially due to an infectious process.

23. The nurse is caring for a pregnant woman with pregnancy induced hypertension (PIH) receiving magnesium sulfate intravenously. In assessing the client, it is noted that respirations are 12, pulse and blood pressure have dropped significantly, and 8 hour output is 200 ml. What should the nurse do first?

    A) Administer calcium gluconate
    B) Call the provider immediately
    C) Discontinue the magnesium sulfate
    D) Perform additional assessments

C: Discontinue the magnesium sulfate. The assessments strongly suggest magnesium sulfate toxicity. The nurse must discontinue the IV immediately and take measures to ensure the safety of the client.

24. A client has a serum glucose of 385 mg/dl. Which of these orders would the nurse question **first**?

    A) Repeat glycohemoglobin in 24 hours
    B) Document Accu-checks, intake and output every 4 hours
    C) Humulin N 20 units IV push
    D) IV fluids of 0.9% normal saline at 125 ml per hour

C: Humulin N 20 units IV push. Regular insulin is the only insulin that can be given by the intravenous route. This is the initial order to question. Option A should also be questioned, although it is not a priority since the client would not be harmed by this action. This lab test gives the average glucose on the hemoglobin molecule for the past 2 to 3 months. There would be no need to repeat it at this time. A fasting glucose in the morning would be a more appropriate assessment. The other orders are within expected actions in this situation.

25. The nurse performs an assessment during a fluid exchange for the client who is 48 hours post-insertion of an abdominal Tenckhoff catheter for peritoneal dialysis. The nurse knows that the appearance of which of the following needs to be reported to the provider immediately?

    A) slight pink-tinged drainage
    B) abdominal discomfort
    C) muscle weakness
    D) cloudy drainage

D: cloudy drainage. Cloudy drainage is a sign of infection that can lead to peritonitis (inflammation of the peritoneum). The other options are expected side effects of peritoneal dialysis.

Safety and Infection Control

1. After an explosion at a factory one of the employees approaches the nurse and says “I am an unlicensed assistive personnel (UAP) at the local hospital.” Which of these tasks should the nurse assign first to this worker who wants to help care for the wounded workers?

    A) Get temperatures
    B) Take blood pressure
    C) Palpate pulses
    D) Check alertness

C: Palpate pulses. The heart rates would indicate if the client is in shock or has potential for shock. If the pulses could not be palpated, those clients would need to be seen first.

2. A client is diagnosed with methicillin resistant *staphylococcus aureus* pneumonia (MRSA). What type of isolation is most appropriate for this client?

    A) Reverse
    B) Airborne
    C) Standard precautions
    D) Contact

D: Contact. Contact precautions or Body Substance Isolation (BSI) involves the use of barrier protection (e.g. gloves, mask, gown, or protective eyewear as appropriate) whenever direct contact with any body fluid is expected. When determining the type of isolation to use, one must consider the mode of transmission. The hands of personnel continue to be the principal mode of transmission for methicillin resistant *staphylococcus aureus* (MRSA). Because the organism is limited to the sputum in this example, precautions are taken if contact with the patient"s sputum is expected. A private room and contact precautions , along with good hand washing techniques, are the best defenses against the spread of MRSA pneumonia.

3. A newly admitted adult client has a diagnosis of hepatitis A. The charge nurse should reinforce to the staff members that the **most** significant routine infection control strategy, in addition to handwashing, is which of these?

    A) Place appropriate signs outside and inside the room
    B) Use a mask with a shield if there is a risk of fluid splash
    C) Wear a gown to change soiled linens from incontinence
    D) Have gloves on while handling bedpans with feces

D: Have gloves on while handling bedpans with feces. The specific measure to prevent the spread of hepatitis A is careful handling and protection while working with fecal material. All of the other actions are correct but not the most significant specific approach used with hepatitis A.

4. The nurse is assigned to a client newly diagnosed with active tuberculosis. Which of these interventions would be a **priority** for the nurse to implement?

    A) Have the client cough into a tissue and dispose in a separate bag
    B) Instruct the client to cover the mouth with a tissue when coughing
    C) Reinforce that everyone should wash their hands before and after entering the room
    D) Place client in a negative pressure private room and have all who enter the room use masks with shields

D: Place client in a negative pressure private room and have all who enter the room use masks with shields. A client with active tuberculosis should be hospitalized in a negative pressure room to prevent respiratory droplets from leaving the room when the door is opened. Tuberculosis (TB) is caused by spore-forming mycobacteria, more often *Mycobacterium tuberculosis*. In developed countries the infection is airborne and is spread by inhalation of infected droplets. In underdeveloped countries, transmission also occurs by ingestion or by skin invasion, particularly when bovine TB is poorly controlled.

5. A nurse who is assigned to the emergency department needs to understand that gastric lavage is a **priority** in which situation?

A) An infant who has been identified as suffering from botulism
B) A toddler who has eaten a number of ibuprofen tablets
C) A preschooler who has swallowed powdered plant food
D) A school aged child who has taken a handful of vitamins

A: An infant who has been identified as suffering from botulism *C. botulinum* forms a toxin in improperly processed foods in anaerobic conditions. It is a neurotoxin that impairs autonomic and voluntary neurotransmission and causes muscular paralysis. Findings appear within 36 hours of ingestion. The nurse should be aware that all of these clients may be candidates for gastric lavage or for activated charcoal administration.

6. The parents of a toddler who is being treated for pesticide poisoning ask: “Why is activated charcoal used? What does it do?” What is the nurse's **best** response?

A) "Activated charcoal decreases the body’s absorption of the poison from the stomach."
B) "The charcoal absorbs the poison and forms a compound that doesn't hurt your child."
C) "This substance helps to get the poison out of the body through the gastrointestinal system."
D) "The action may bind or inactivate the toxins or irritants that are ingested by children and adults."

B: "The charcoal absorbs the poison and forms a compound that doesn"t hurt your child." All of the options are correct responses. However, option B is most accurate information to answer the parents’ questions about the use and action of activated charcoal. The language is appropriate for a parent"s understanding.

7. Which of these nursing diagnoses, appropriate for elderly clients, would indicate the client is at **greatest** risk for falls?

A) Sensory perceptual alterations related to decreased vision
B) Alteration in mobility related to fatigue
C) Impaired gas exchange related to retained secretions
D) Altered patterns of urinary elimination related to nocturia

D: Altered patterns of urinary elimination related to nocturia. Nocturia is especially problematic because many elders fall when they rush to reach the bathroom at night. They may be confused or not fully alert. Inadequate lighting can increase their chances of stumbling, and then they may fall over furniture or carpets.

8. A child is admitted to the pediatric unit with a diagnosis of suspected meningococcal meningitis. Which admission orders should the nurse implement **first**?

A) Institute seizure precautions
B) Monitor neurologic status every hour
C) Place in respiratory/secretion precautions
D) Cefotaxime IV 50 mg/kg/day divided q6h

C: Place in respiratory/secretion precautions Meningococcal meningitis is a bacterial infection that can be communicated to others. The initial therapeutic management of acute bacterial meningitis includes respiratory/secretions precautions, initiation of antimicrobial therapy, monitoring neurological status along with vital signs, instituting seizure precautions and lastly maintaining optimum hydration. The first action for nurses to take is initiate any necessary precautions to protect themselves and others from possible infection. Viral meningitis usually does not require protective measures of isolation.

9. Several clients are admitted to an adult medical unit. For which client condition(s) would the nurse institute airborne precautions?

A) Autoimmune deficiency syndrome (AIDS) with cytomegalovirus (CMV)
B) A positive purified protein derivative (PPD) test with an abnormal chest x-ray
C) A tentative diagnosis of viral pneumonia with productive brown sputum
D) Advanced carcinoma of the lung with hemoptysis

B: A positive purified protein derivative (PPD) test with an abnormal chest x-ray. The client who must be placed in airborne precautions is the client with these findings that suggest a suspicious tuberculin lesion. A sputum smear for acid fast bacillus would be done next. CMV usually causes no signs or symptoms in children and adults with healthy immune systems. Good handwashing is recommended for CMV. When signs and symptoms do occur, they are often similar to those of mononucleosis, including sore throat, fever, muscle aches and fatigue.

10. A client is scheduled to receive an oral solution of radioactive iodine (^{131}I). In order to reduce hazards, the priority information for the nurse to include in client teaching is which of these statements?

A) "In the initial 48 hours, avoid contact with children and pregnant women, and flush the commode twice after urination or defecation."
B) "Use disposable utensils for 2 days and if vomiting occurs within 10 hours of the dose, do so in the toilet and flush it twice."
C) "Your family can use the same bathroom that you use without any special precautions."

D) "Drink plenty of water and empty your bladder often during the initial 3 days of therapy."

A: "In the initial 48 hours, avoid contact with children and pregnant women, and flush the commode twice after urination or defecation." The client's urine and saliva are radioactive for 24 hours after ingestion, and vomitus is radioactive for 6 to 8 hours. The client should drink 3 to 4 liters of fluid a day for the initial 48 hours to help remove the (^{131}I) from the body. Staff should limit contact with hospitalized clients to 30 minutes per day per person.

11. The nurse is to administer a new medication to a client. Which of these actions best demonstrate awareness of safe, proficient nursing practice?

    A) Verify the order for the medication. Prior to giving the medication the nurse should say, "Please state your name."
    B) Upon entering the room the nurse should ask: "What is your name? What allergies do you have?" and then check the client's name band and allergy band.
    C) As the room is entered say "What is your name?" then check the client's name band.
    D) Verify the client's allergies on the admission sheet and order. Verify the client's name on the nameplate outside the room then as the nurse enters the room ask the client "What is your first, middle and last name?"

B: Upon entering the room the nurse should ask: "What is your name? What allergies do you have?" and then check the client"s name band and allergy band. A dual check is always done for a client"s name. This would involve verbal and visual checks. Since this is a new medication an allergy check is appropriate.

12. The school nurse is teaching the faculty the most effective methods to prevent the spread of lice (Pediculus Humanus Capitis) in the school. The information that would be most important to include is reflected in which of these statements?

    A) "The treatment medication requires reapplication in 8 to 10 days."
    B) "Bedding and clothing can be boiled or steamed to kill lice."
    C) "Children should not share hats, scarves and combs."
    D) "Nit combs are necessary to comb lice eggs (nits) out of children's hair."

C: "Children should not share hats, scarves and combs." Head lice live only on human beings and can be spread easily by sharing hats, combs, scarves, coats and other items of clothing that touch the hair. All of the options are correct statements, however they do not best answer the question of how to prevent the spread of lice in a school setting.

13. Which approach is the **best** way to prevent infections when providing care to clients in the home setting?

    A) Handwashing before and after examination of clients
    B) Wearing nonpowdered latex-free gloves to examine the client
    C) Using a barrier between the client's furniture and the nurse's bag
    D) Wearing a mask with a shield during any eye/mouth/nose examination

A: Handwashing before and after examination of clients. Handwashing remains the most effective way to avoid spreading infection. However, too often nurses do not practice good handwashing techniques and do not teach families to do so. Nurses need to wash their hands before and after touching the client and before entering the nursing bag. All of the options are correct, and the sequence of priorities would be options A, C, B, and D.

14. A nurse is reinforcing teaching with a client about compromised host precautions. The client is receiving filgrastim (Neupogen) for neutropenia. Which lunch selection suggests the client has learned about necessary dietary changes?

    A) grilled chicken sandwich and skim milk
    B) roast beef, mashed potatoes, and green beans
    C) peanut butter sandwich, banana, and iced tea
    D) barbeque beef, baked beans, and cole slaw

B: roast beef, mashed potatoes, and green beans. The client has correctly selected an appropriate lunch and appears to know the dietary restrictions. Low granulocyte counts and susceptibility to infection are expected. Compromised host precautions require that foods are either cooked or canned. Options A, C and D do not demonstrate learning, as raw fruits, vegetables, and milk are to be avoided.

15. A school nurse has a 10 year-old child with a history of epilepsy with tonic-clonic seizures attending classes regularly. The school nurse should inform the teacher that if the child experiences a seizure in the classroom, the most important action to take during the seizure would be to

    A) move any chairs or desks at least 3 feet away from the child
    B) note the sequence of movements with the time lapse of the event
    C) provide privacy as much as possible to minimize frightening the other children
    D) place the hands or a folded blanket under the head of the child

D: place the hands or a folded blanket under the head of the child. The priority during seizure activity is to protect the person from physical injury. Place a pillow, folded blanket or your hands under the child"s head to prevent concussion or other head trauma. The other body parts are at less risk for injury, consequently the prioritized sequence of the actions above would be options D, A, B, and C.

16. A parent calls the hospital hot line and is connected to the triage nurse. The caller proclaims: “I found my child with odd stuff coming from the mouth and an unmarked bottle nearby.” Which of these comments would be the **best** tool for the nurse to determine if the child has swallowed a corrosive substance?

    A) "Ask the child if the mouth is burning or throat pain is present."
    B) "Take the child’s pulse at the wrist and see if the child is has trouble breathing lying flat."
    C) "What color is the child’s lips and nails and has the child voided today?"

D) "Has the child had vomiting, diarrhea or stomach cramps?"

A: "Ask the child if the mouth is burning or throat pain is present." Local irritation of tissues indicates a corrosive poisoning. The other comments may be helpful in determining the child's overall condition, however the question concerns evaluation for ingesting a caustic substance.

17. Which of these clients would the nurse recommend keeping in the hospital during an internal disaster at that facility?

A) An adolescent diagnosed with sepsis 7 days ago and whose vital signs are maintained within low normal limits.
B) A middle-aged woman known to have had an uncomplicated myocardial infarction 4 days ago
C) An elderly man admitted 2 days ago with an acute exacerbation of ulcerative colitis
D) A young adult in the second day of treatment for an overdose of acetometaphen

D: A young adult in the second day of treatment for an overdose of acetometaphen. An overdose of Tylenol requires close observation for 3 to 4 days as well as Mucomyst PO during that time . A strong risk of liver failure exists immediately following Tylenol overdose.

18. When an infant car seat is properly installed, the infant should face

A) forward, so child may look out window
B) backward, so child faces the seat
C) the side window, to increase sensory stimulation
D) upward, as child lies on back with seat installed sideways

B: backward, so child faces the seat. Nurses are now responsible for promoting the continued safety of infants and children outside of the hospital. Emergency Department and Women's Services staff are trained in child seat placement. Growth and development data indicate that infants still require support of the head. Therefore, they should be positioned reclining and facing the rear until their leg muscles are strong enough to kick away from the backseat (about 10-12 months-old) for the greatest protection.

19. Which of these clients is the priority for the nurse to report to the public health department within the next 24 hours?

A) An infant with a positive culture of stool for *Shigella*
B) An elderly factory worker with a lab report that is positive for acid-fast bacillus smear
C) A young adult commercial pilot with a positive histopathological examination from an induced sputum for *Pneumocystis carinii*
D) A middle-aged nurse with a history of *varicella zoster* virus and with crops of vesicles on an erythematous base that appear on the skin

B: An elderly factory worker with a lab report that is positive for acid-fast bacillus smear. Tuberculosis is a reportable disease because persons who had contact with the client must be traced and often must be treated with chemoprophylaxis for a designated time. Options A and D may need contact isolation precautions. Option C -- findings may indicate the initial stage of autoimmune deficiency syndrome (AIDS).

20. Which of these actions is the primary nursing intervention designed to limit transmission of a client's Salmonella infection?

A) Wash hands thoroughly before and after client contact
B) Wear gloves when in contact with body secretions
C) Double glove when in contact with feces or vomitus
D) Wear gloves when disposing of contaminated linens

A: Wash hands thoroughly before and after client contact. Gram-negative bacilli cause Salmonella infection, and lack of sanitation is the primary means of contamination. Two million new cases appear each year. Thorough handwashing can prevent the spread of salmonella. Note that all of the options are appropriate activities, but handwashing is primary.

Health Promotion and Maintenance

1. The nurse has been teaching adult clients about cardiac risks when they visit the hypertension clinic. Which evaluation data would best measure learning?

    A) Performance on written tests
    B) Responses to verbal questions
    C) Completion of a mailed survey
    D) Reported behavioral changes

D: Reported behavioral changes. If the client alters behaviors such as smoking, drinking alcohol, and stress management, these suggest that learning has occurred. Additionally, physical assessments and lab data may confirm risk reduction.

2. The nurse is assessing a client who states her last menstrual period was March 16, and she has missed one period. She reports episodes of nausea and vomiting. Pregnancy is confirmed by a urine test. What will the nurse calculate as the estimated date of delivery (EDD)?

    A) April 8
    B) January 15
    C) February 11
    D) December 23

D: December 23. Naegele"s rule states: Add 7 days and subtract 3 months from the first day of the last regular menstrual period to calculate the estimated date of delivery.

3. The parents of a child who has suddenly been hospitalized for an acute illness state that they should have taken the child to the pediatrician earlier. Which approach by the nurse is best when dealing with the parents' comments?

    A) Focus on the child's needs and recovery
    B) Explain the cause of the child's illness
    C) Acknowledge that early care would have been better
    D) Accept their feelings without judgment

D: Accept their feelings without judgment. Parents often blame themselves for their child"s illness. Feeling helpless and angry is normal and these feelings must be accepted.

4. When observing 4 year-old children playing in the hospital playroom, what activity would the nurse expect to see the children participating in?

    A) Competitive board games with older children
    B) Playing with their own toys along side with other children
    C) Playing alone with hand held computer games
    D) Playing cooperatively with other preschoolers

D: Playing cooperatively with other preschoolers. Cooperative play is typical of the late preschool period.

5. A 64 year-old client scheduled for surgery with a general anesthetic refuses to remove a set of dentures prior to leaving the unit for the operating room. What would be the most appropriate intervention by the nurse?

A) Explain to the client that the dentures must come out as they may get lost or broken in operating room
B) Ask the client if there are second thoughts about having the procedure
C) Notify the anesthesia department and the surgeon of the client's refusal
D) Ask the client if the preference would be to remove the dentures in the operating room receiving area

D: Ask the client if the preference would be to remove the dentures in the operating room receiving area Clients anticipating surgery may experience a variety of fears. This choice allows the client control over the situation and fosters the client"s sense of self-esteem and self-concept.

6. When teaching a 10 year-old child about their impending heart surgery, which form of explanation meets the developmental needs of this age child?

A) Provide a verbal explanation just prior to the surgery
B) Provide the child with a booklet to read about the surgery
C) Introduce the child to another child who had heart surgery 3 days ago
D) Explain the surgery using a model of the heart

D: Explain the surgery using a model of the heart. According to Piaget, the school age child is in the concrete operations stage of cognitive development. Using something concrete, like a model will help the child understand the explanation of the heart surgery.

7. When screening children for scoliosis, at what time of development would the nurse expect early signs to appear?

A) Prenatally on ultrasound
B) In early infancy
C) When the child begins to bear weight
D) During the preadolescent growth spurt

D: During the preadolescent growth spurt. Idiopathic scoliosis is seldom apparent before 10 years of age and is most noticeable at the beginning of the preadolescent growth spurt. It is more common in females than in males.

8. A client is admitted to the hospital with a history of confusion. The client has difficulty remembering recent events and becomes disoriented when away from home. Which statement would provide the best reality orientation for this client?

A) "Good morning. Do you remember where you are?"
B) "Hello. My name is Elaine Jones and I am your nurse for today."
C) "How are you today? Remember, you're in the hospital."
D) "Good morning. You're in the hospital. I am your nurse Elaine Jones."

D: "Good morning. You're in the hospital. I am your nurse Elaine Jones." As cognitive ability declines, the nurse provides a calm, predictable environment for the client. This response establishes time, location and the caregiver's name.

9. The nurse is assessing a 4 month-old infant. Which motor skill would the nurse anticipate finding?

A) Hold a rattle
B) Bang two blocks
C) Drink from a cup
D) Wave "bye-bye"

A: Hold a rattle. The age at which a baby will develop the skill of grasping a toy with help is 4 to 6 months.

10. An appropriate treatment goal for a client with anxiety would be to

A) ventilate anxious feelings to the nurse
B) establish contact with reality
C) learn self-help techniques
D) become desensitized to past trauma

C: learn self-help techniques. Exploring alternative coping mechanisms will decrease present anxiety to a manageable level. Assisting the client to learn self-help techniques will assist in learning to cope with anxiety.

11. The family of a 6 year-old with a fractured femur asks the nurse if the child's height will be affected by the injury. Which statement is true concerning long bone fractures in children?

A) Growth problems will occur if the fracture involves the periosteum
B) Epiphyseal fractures often interrupt a child's normal growth pattern
C) Children usually heal very quickly, so growth problems are rare
D) Adequate blood supply to the bone prevents growth delay after fractures

B: Epiphyseal fractures often interrupt a child"s normal growth pattern. The epiphyseal plate in children is where active bone growth occurs. Damage to this area may cause growth arrest in either longitudinal growth of the limb or in progressive deformity if the plate is involved. An epiphyseal fracture is serious because it can interrupt and alter growth.

12. While caring for a client, the nurse notes a pulsating mass in the client's periumbilical area. Which of the following assessments is appropriate for the nurse to perform?

A) Measure the length of the mass

B) Auscultate the mass
C) Percuss the mass
D) Palpate the mass

B: Auscultate the mass. Auscultation of the abdomen and finding a bruit will confirm the presence of an abdominal aneurysm and will form the basis of information given to the provider. The mass should not be palpated because of the risk of rupture.

13. While the nurse is administering medications to a client, the client states "I do not want to take that medicine today." Which of the following responses by the nurse would be best?

A) "That's OK, its all right to skip your medication now and then."
B) "I will have to call your doctor and report this."
C) "Is there a reason why you don't want to take your medicine?"
D) "Do you understand the consequences of refusing your prescribed treatment?"

C: When a new problem is identified, it is important for the nurse to collect accurate assessment data. This is crucial to ensure that client needs are adequately identified in order to select the best nursing care approaches. The nurse should try to discover the reason for the refusal which may be that the client has developed untoward side effects.

14. The nurse is teaching the parents of a 3 month-old infant about nutrition. What is the main source of fluids for an infant until about 12 months of age?

A) Formula or breast milk
B) Dilute nonfat dry milk
C) Warmed fruit juice
D) Fluoridated tap water

A: Formula or breast milk. Formula or breast milk are the perfect food and source of nutrients and liquids up to 1 year of age.

15. A client states, "People think I'm no good, you know what I mean?" Which of these responses would be **most** therapeutic?

A) "Well people often take their own feelings of inadequacy out on others."
B) "I think you're good. So you see, there's one person who likes you."
C) "I'm not sure what you mean. Tell me a bit more about that."

D) "Let's discuss this to see the reasons you create this impression on people."

C: "I'm not sure what you mean. Tell me a bit more about that." This therapeutic communication technique elicits more information, especially when delivered in an open, non-judgmental fashion.

16. When teaching effective stress management techniques to a client 1 hour before surgery, which of the following should the nurse recommend?

A) Biofeedback
B) Deep breathing
C) Distraction
D) Imagery

B: Deep breathing. Deep breathing is a reliable and valid method for reducing stress, and can be taught and reinforced in a short period pre-operatively.

17. The nurse is planning care for an 18 month-old child. Which action should be included in the child's care?

A) Hold and cuddle the child frequently
B) Encourage the child to feed himself finger food
C) Allow the child to walk independently on the nursing unit
D) Engage the child in games with other children

B: Encourage the child to feed himself finger food. According to Erikson, the toddler is in the stage of autonomy versus shame and doubt. The nurse should encourage increasingly independent activities of daily living that allow the toddler to assert his budding sense of control.

18. A client being treated for hypertension returns to the community clinic for follow up. The client says, "I know these pills are important, but I just can't take these water pills anymore. I drive a truck for a living, and I can't be stopping every 20 minutes to go to the bathroom." Which of these is the **best** nursing diagnosis?

A) Noncompliance related to medication side effects
B) Knowledge deficit related to misunderstanding of disease state
C) Defensive coping related to chronic illness
D) Altered health maintenance related to occupation

A: Noncompliance related to medication side effects. The client kept his appointment, and stated he knew the pills were important. He is unable to comply with the regimen due to side effects, not because of a lack of knowledge about the disease process.

19. A client with congestive heart failure is newly admitted to home health care. The nurse discovers that the client has not been following the prescribed diet. What would be the most appropriate nursing action?

A) Discharge the client from home health care because of noncompliance
B) Notify the provider of the client's failure to follow prescribed diet

C) Discuss diet with the client to learn the reasons for not following the diet
D) Make a referral to Meals-on-Wheels

C: Discuss diet with the client to learn the reasons for not following the diet. When new problems are identified, it is important for the nurse to collect accurate assessment data. Before reporting findings to the provider, it is best to have a complete understanding of the client"s behavior and feelings as a basis for future teaching and intervention.

20. A partner is concerned because the client frequently daydreams about moving to Arizona to get away from the pollution and crowding in southern California. The nurse explains that

A) such fantasies can gratify unconscious wishes or prepare for anticipated future events
B) detaching or dissociating in this way postpones painful feelings
C) converting or transferring a mental conflict to a physical symptom can lead to conflict within the partnership
D) isolating the feelings in this way reduces conflict within the client and with others

A: such fantasies can gratify unconscious wishes or prepare for anticipated future events. Fantasy is imagined events (daydreaming) to express unconscious conflicts or gratify unconscious wishes.

Basic Care and Comfort

1. The nurse is planning care for a client with a cerebral vascular accident (CVA). Which of the following measures planned by the nurse would be **most** effective in preventing skin breakdown?

A) Place client in the wheelchair for four hours each day
B) Pad the bony prominence
C) Reposition every two hours
D) Massage reddened bony prominence

C: Reposition every two hours. Clients who are at risk for skin breakdown develop fewer pressure ulcers when turned every two hours. By relieving the pressure over bony prominences at frequent scheduled intervals, blood flow to areas of potential injury is maintained.

2. After a client has an enteral feeding tube inserted, the **most** accurate method for verification of placement is
A) abdominal x-ray
B) auscultation
C) flushing tube with saline
D) aspiration for gastric contents

A: abdominal x-ray. Placement should be verified by radiograph to determine that the tube is in the stomach or intestine rather than in the airways.

3. The nurse has been teaching a client with congestive heart failure about proper nutrition. Which of these lunch selections indicates the client has learned about sodium restriction?

A) Cheese sandwich with a glass of 2% milk
B) Sliced turkey sandwich and canned pineapple
C) Cheeseburger and baked potato
D) Mushroom pizza and ice cream

B: Sliced turkey sandwich and canned pineapple. Sliced turkey sandwich is appropriate since it is not a highly processed food and canned fruits are low in sodium. All of the other choices contain one or more high-sodium foods.

4. The nurse is caring for a 7 year-old with acute glomerulonephritis (AGN). Findings include moderate edema and oliguria. Serum blood urea nitrogen and creatinine are elevated. What dietary modifications are **most** appropriate?

A) Decreased carbohydrates and fat
B) Decreased sodium and potassium
C) Increased potassium and protein
D) Increased sodium and fluids

B: Decreased sodium and potassium. Children with AGN who have edema, hypertension oliguria, and azotemia have dietary restrictions limiting sodium, potassium, fluids, and protein.

5. After a myocardial infarction, a client is placed on a sodium restricted diet. When the nurse is teaching the client about the diet, which meal plan would be the **most** appropriate to suggest?

A) 3 oz. broiled fish, 1 baked potato, ½ cup canned beets, 1 orange, and milk
B) 3 oz. canned salmon, fresh broccoli, 1 biscuit, tea, and 1 apple
C) A bologna sandwich, fresh eggplant, 2 oz fresh fruit, tea, and apple juice
D) 3 oz. turkey, 1 fresh sweet potato, 1/2 cup fresh green beans, milk, and 1 orange

D: 3 oz. turkey, 1 fresh sweet potato, 1/2 cup fresh green beans, milk, and 1 orange. Canned fish and vegetables and cured meats are high in sodium. This meal does not contain any canned fish and/or vegetables or cured meats.

6. What finding of the nursing assessment of a paralyzed client would indicate the probable presence of a fecal impaction?

A) Presence of blood in stools
B) Oozing liquid stool
C) Continuous rumbling flatulence
D) Absence of bowel movements

B: Oozing liquid stool. When the bowel is impacted with hardened feces, there is often a seepage of liquid feces around the obstruction. This is often mistaken for uncontrolled diarrhea.

7. The nurse is teaching the client to select foods rich in potassium to help prevent digitalis toxicity. Which choice indicates the client understands dietary needs?

A) three apricots
B) medium banana
C) naval orange
D) baked potato

D: baked potato. A baked potato contains 610 milligrams of potassium.

8. When administering enteral feeding to a client via a jejunostomy tube, the nurse should administer the formula

A) every four to six hours
B) continuously

C) in a bolus
D) every hour

B: continuously. Usually gastrostomy and jejunostomy feedings are given continuously to ensure proper absorption. However, initial feedings may be given by bolus to assess the client"s tolerance to formula.

9. An 86 year-old nursing home resident who has impaired mental status is hospitalized with pneumonic infiltrates in the right lower lobe. When the nurse assists the client with a clear liquid diet, the client begins to cough. What should the nurse do next?

A) Add a thickening agent to the fluids
B) Check the client's gag reflex
C) Feed the client only solid foods
D) Increase the rate of intravenous fluids

B: Check the client's gag reflex. When a new problem emerges, the nurse should perform appropriate assessment so that suitable nursing interventions can be planned. Aspiration pneumonia follows aspiration of material from the mouth into the trachea and finally the lung. A loss or an impairment of the protective cough reflex can result in aspiration.

10. An 85 year-old client complains of generalized muscle aches and pains. The **first** action by the nurse should be

A) assess the severity and location of the pain
B) obtain an order for an analgesic
C) reassure him that this is not unusual for his age
D) encourage him to increase his activity

A: assess the severity and location of the pain. Most older adults have 1 or more chronic painful illnesses, and in fact, they often must be asked about discomfort (rather than "pain") to reveal the presence of pain. There is no evidence that pain of older adults is less intense than younger adults. It is important for the nurse to assess the pain thoroughly before implementing pain relief measures.

11. A client was just taken off the ventilator after surgery and has a nasogastric tube draining bile-colored liquids. Which nursing measure will provide the most comfort to the client?

A) Allow the client to melt ice chips in the mouth
B) Provide mints to freshen the breath
C) Perform frequent oral care with a tooth sponge
D) Swab the mouth with glycerin swabs

C: Perform frequent oral care with a tooth sponge. Frequent cleansing and stimulation of the mucous membrane is important for a client with a nasogastric tube to prevent development of lesions and to promote comfort. Ice chips or mints could be contraindicated, and do not stimulate the tissue. Glycerin swabs do not cleanse since they only moisturize.

12. The nurse is instructing a 65 year-old female client diagnosed with osteoporosis. The **most** important instruction regarding exercise would be to

A) exercise doing weight bearing activities
B) exercise to reduce weight
C) avoid exercise activities that increase the risk of fracture
D) exercise to strengthen muscles and thereby protect bones

A: exercise doing weight bearing activities. Weight bearing exercises are beneficial in the treatment of osteoporosis. Although loss of bone cannot be substantially reversed, further loss can be greatly reduced if the client includes weight bearing exercises along with estrogen replacement and calcium supplements in their treatment protocol.

13. A nurse is assessing several clients in a long term health care facility. Which client is at **highest** risk for development of decubitus ulcers?

A) A 79 year-old malnourished client on bed rest
B) An obese client who uses a wheelchair
C) An incontinent client who has had 3 diarrhea stools
D) An 80 year-old ambulatory diabetic client

A: A 79 year-old malnourished client on bed rest. Weighing significantly less than ideal body weight increases the number and surface area of bony prominences which are susceptible to pressure ulcers. Thus, malnutrition is a major risk factor for decubiti, due in part to poor hydration and inadequate protein intake.

14. Constipation is one of the most frequent complaints of elders. When assessing this problem, which action should be the nurse's priority?

A) obtain a complete blood count
B) obtain a health and dietary history
C) refer to a provider for a physical examination
D) measure height and weight

B: obtain a health and dietary history. Initially, the nurse should obtain information about the chronicity of and details about constipation, recent changes in bowel habits, physical and emotional health, medications, activity pattern, and food and fluid history. This information may suggest causes as well as an appropriate, safe treatment plan.

15. A nurse is working with a client in an extended care facility. Which bed position is preferred for a client, who is at risk for falls, as part of a prevention protocol?

A) All 4 side rails up, wheels locked, bed closest to door
B) Lower side rails up, bed facing doorway
C) Knees bent, head slightly elevated, bed in lowest position
D) Bed in lowest position, wheels locked, place bed against wall

D: It is no longer advisable to use only the lower side rails. Using all 4 side rails (upper and lower siderails at the top and bottom of the bed) is an inappropriate use of restraint without an order. If all 4 are pulled up, an order for protective restraints is needed that usually has to be renewed in 48 to 72 hours along with more frequent documentation. Having all 4 side rails raised limits the client's autonomy and freedom of movement. Using 3 of the 4 side rails pulled up is acceptable, because clients can safely exit the bed on their own initiative. Placing the bed against the wall permits getting out of bed on only 1 side. Locking the wheels keeps the bed from sliding. Keeping the bed in the lowest position (without bending limbs to restrict movement) provides a shorter distance to the ground if the client chooses to get out of bed.

16. The nurse is teaching an 87 year-old client methods for maintaining regular bowel movements. The nurse would caution the client to **avoid**

A) glycerine suppositories
B) fiber supplements
C) laxatives
D) stool softeners

C: laxatives. Some elders are constipated because they have used over-the-counter laxatives for a long time. In addition, many people do not eat enough fiber, drink enough water, or exercise adequately. Certain medications, including opioid analgesics, are constipating. Elders are rarely constipated because of organic or pathological reasons.

17. Which statement **best** describes the effects of immobility in children?

A) Immobility prevents the progression of language and fine motor development
B) Immobility in children has similar physical effects to those found in adults
C) Children are more susceptible to the effects of immobility than are adults
D) Children are likely to have prolonged immobility with subsequent complications

B: Immobility in children has similar physical effects to those found in adults

Care of the immobile child includes efforts to prevent complications of muscle atrophy, contractures, skin breakdown, decreased metabolism and bone demineralization. Secondary alterations also occur in the cardiovascular, respiratory and renal systems. Similar effects and alterations occur in adults.

18. A client with diarrhea should avoid which of the following?

A) orange juice
B) tuna
C) eggs
D) macaroni

A: Orange juice is contraindicated for a client with diarrhea because it increases the motility of the gastrointestinal tract.

19. A client is being maintained on heparin therapy for deep vein thrombosis (DVT). The nurse must closely monitor which of the following laboratory values?

A) bleeding time
B) platelet count
C) activated PTT
D) clotting time

C: activated PTT. Heparin is used to prevent further clots from being formed and to prevent the present clot from enlarging. The Activated Prothromboplastin Time (APTT) test is a highly sensitive test to monitor the client on heparin.

20. A client in a long term care facility complains of pain. The nurse collects data about the client's pain. The **first** step in pain assessment is for the nurse to

A) have the client identify coping methods
B) get the description of the location and intensity of the pain
C) accept the client's report of pain
D) determine the client's status of pain

C: accept the client's report of pain. Although all of the options above are correct, the first and most important piece of information in this client's pain assessment is what the client is telling you about the pain --"the client's report."

Pharmacological and Parenteral Therapies

1. A client is receiving intravenous heparin therapy. What medication should the nurse have available in the event of an overdose of heparin?

A) Protamine
B) Amicar
C) Imferon
D) Diltiazem

A: Protamine. Protamine binds heparin, making it ineffective.

2. Although nonsteroidal anti-inflammatory drugs (NSAIDs) such as ibuprofen (Motrin) are beneficial in managing arthritis pain, the nurse should caution clients about which of the following common side effects?

A) Urinary incontinence
B) Constipation
C) Nystagmus
D) Occult bleeding

D: Occult bleeding. Nonsteroidal anti-inflammatory drugs (NSAIDs) taken for long periods of time may cause serious side effects, including bleeding in the gastrointestinal track.

3. A client is being discharged with a prescription for chlorpromazine (Thorazine). Before leaving for home, which of these findings should the nurse teach the client to report?

A) Change in libido, breast enlargement
B) Sore throat, fever
C) Abdominal pain, nausea, diarrhea
D) Dyspnea, nasal congestion

B: A sore throat and fever may be findings of agranulocytosis, a serious side effect of chlorpromazine (Thorazine).

4. The nurse receives an order to give a client iron by deep injection. The nurse know that the reason for this route is to

A) enhance absorption of the medication
B) ensure that the entire dose of medication is given
C) provide more even distribution of the drug
D) prevent the drug from causing tissue irritation

D: prevent the drug from causing tissue irritation. Deep injection or Z-track is a special method of giving medications via the intramuscular route. Use of this technique prevents irritating or staining medications from being tracked through tissue. Use of Z-track does not affect dose, absorption, or distribution of the drug.

5. A client diagnosed with cirrhosis of the liver and ascites is receiving spironolactone (Aldactone). The nurse understands that this medication spares elimination of which element?

   A) Sodium
   B) Potassium
   C) Phosphate
   D) Albumin

B: Potassium. If ascites is present in the client with cirrhosis of the liver, potassium-sparing diuretics such as Aldactone should be administered because it inhibits the action of aldosterone on the kidneys.

6. Discharge instructions for a client taking alprazolam (Xanax) should include which of the following?

   A) Sedative hypnotics are effective analgesics
   B) Sudden cessation of alprazolam (Xanax) can cause rebound insomnia and nightmares
   C) Caffeine beverages can increase the effect of sedative hypnotics
   D) Avoidance of excessive exercise and high temperature is recommended

B: Sudden cessation of any medication, unless medically necessary, is ill-advised.

7. A client has received 2 units of whole blood today following an episode of GI bleeding. Which of the following laboratory reports would the nurse monitor most closely?

   A) Bleeding time
   B) Hemoglobin and hematocrit
   C) White blood cells
   D) Platelets

B: Hemoglobin and hematocrit. The post-transfusion hematocrit provides immediate information about red cell replacement and about continued blood loss.

8. The nurse is caring for a client receiving a blood transfusion who develops urticaria one-half hour after the transfusion has begun. What is the first action the nurse should take?

   A) Stop the infusion
   B) Slow the rate of infusion
   C) Take vital signs and observe for further deterioration
   D) Administer Benadryl and continue the infusion

A: Stop the infusion. This is an indication of an allergy to the plasma protein. The priority action of the nurse is to stop the transfusion.

9. A nurse is providing care to a 63 year-old client with pneumonia. Which intervention promotes the client's comfort?

   A) Increase oral fluid intake
   B) Encourage visits from family and friends
   C) Keep conversations short
   D) Monitor vital signs frequently

C: Keep conversations short. Keeping conversations short will promote the client's comfort by decreasing demands on the client's breathing and energy. Increased intake is not related to comfort. While the presence of family is supportive, demands on the client to interact with the visitors may interfere with the client's rest. Monitoring vital signs is an important assessment but not related to promoting the client's comfort.

10. An antibiotic IM injection for a 2 year-old child is ordered. The total volume of the injection equals 2.0 ml. The correct action is to

    A) administer the medication in 2 separate injections
    B) give the medication in the dorsal gluteal site
    C) call to get a smaller volume ordered
    D) check with pharmacy for a liquid form of the medication

A: administer the medication in 2 separate injections. Intramuscular injections should not exceed a volume of 1 ml for small children. Medication doses exceeding this volume should be split into 2 separate injections of 1.0 ml each. In adults the maximum intramuscular injection volume is 5 ml per site

11. A client is recovering from a hip replacement and is taking Tylenol #3 every 3 hours for pain. In checking the client, which finding suggests a side effect of the analgesic?

    A) Bruising at the operative site
    B) Elevated heart rate
    C) Decreased platelet count
    D) No bowel movement for 3 days

D: No bowel movement for 3 days. With opioid analgesics, observe for respiratory depression, sedation, and constipation. Bruising is not related to the analgesic, but could be the result of corticosteroids or previously used anticoagulants. Elevated heart rate could be the result of bronchodilators. Some antibiotics can lower platelet count.

12. Why is it important for the nurse to monitor blood pressure in clients receiving antipsychotic drugs?

A) Orthostatic hypotension is a common side effect
B) Most antipsychotic drugs cause elevated blood pressure
C) This provides information on the amount of sodium allowed in the diet
D) It will indicate the need to institute antiparkinsonian drugs

A: Orthostatic hypotension is a common side effect. Clients should be made aware of the possibility of dizziness and syncope from postural hypotension for about an hour after receiving medication. They should be advised to get up slowly, especially from a supine position.

13. A parent asks the school nurse how to eliminate lice from their child. What is the most appropriate response by the nurse?

A) Cut the child's hair short to remove the nits
B) Apply warm soaks to the head twice daily
C) Wash the child's linen and clothing in a bleach solution
D) Application of pediculicides

D: Application of pediculicides. Treatment of head lice consists of application of pediculicides. Pediculicides vary, and the directions must be followed carefully.

14. The nurse has given discharge instructions to parents of a child on phenytoin (Dilantin). Which of the following statements suggests that the teaching was effective?

A) "We will call the health care provider if the child develops acne."
B) "Our child should brush and floss carefully after every meal."
C) "We will skip the next dose if vomiting or fever occur."
D) "When our child is seizure-free for 6 months, we can stop the medication."

B: "Our child should brush and floss carefully after every meal." Phenytoin causes lymphoid hyperplasia that is most noticeable in the gums. Frequent gum massage and careful attention to good oral hygiene may reduce the gingival hyperplasia.

15. A client with heart failure has Lanoxin (digoxin) ordered. What would the nurse expect to find when evaluating for the therapeutic effectiveness of this drug?

A) Diaphoresis with decreased urinary output
B) Increased heart rate with increased respirations
C) Improved respiratory status and increased urinary output

D) Decreased chest pain and decreased blood pressure

C: Improved respiratory status and increased urinary output. Digoxin, a cardiac glycoside, is used in clients with heart failure to slow and strengthen the heartbeat. As cardiac output is improved, renal perfusion is improved and urinary output increases. Clients can become toxic on this drug, indicated by findings of bradycardia, dysrhythmia, and visual and GI disturbances. Clients being treated with digoxin should have their apical pulse evaluated for 1 full minute prior to the administration of the drug.

16. The nurse is teaching a client about precautions with Coumadin therapy. The client should be instructed to avoid which over-the-counter medication?

A) Non-steroidal anti-inflammatory drugs (NSAIDs)
B) Cough medicines with guaifenesin
C) Histamine blockers
D) Laxatives containing magnesium salts

A: Non-steroidal anti-inflammatory drugs (NSAIDs). Medications with NSAIDs may increase the response to Coumadin (warfarin) and increase the risk of bleeding.

17. The nurse is caring for a client with clinical depression who is receiving a monoamine oxidase inhibitor (MAOI). When providing instructions about precautions with this medication, which action should the nurse stress to the client as important?

A) Avoid chocolate and cheese
B) Take frequent naps
C) Take the medication with milk
D) Avoid walking without assistance

A: Avoid chocolate and cheese. Foods high in tryptophan, tyramine and caffeine, such as chocolate, wine and cheese may precipitate hypertensive crisis.

18. The nurse has been teaching a client with Insulin Dependent Diabetes Mellitus. Which statement by the client indicates a need for further teaching?

A) "I use a sliding scale to adjust regular insulin to my sugar level."
B) "Since my eyesight is so bad, I ask the nurse to fill several syringes."
C) "I keep my regular insulin bottle in the refrigerator."
D) "I always make sure to shake the NPH bottle hard to mix it well."

D: "I always make sure to shake the NPH bottle hard to mix it well." The bottle should by rolled gently, not shaken.

19. A client with amyotrophic lateral sclerosis has a percutaneous endoscopic gastrostomy (PEG) tube for the administration of feedings and medications. Which nursing action is appropriate?

A) Pulverize all medications to a powdery condition
B) Squeeze the tube before using it to break up stagnant liquids
C) Cleanse the skin around the tube daily with hydrogen peroxide
D) Flush adequately with water before and after using the tube

D: Flush adequately with water before and after using the tube. Flushing the tube before and after use not only provides for good flow and keeps the tube patent, it also provides water to maintain hydration. While medications should be crushed to pass through the tube, it is flushing that moves them through. Not all medications should be crushed, for example sustained release preparations should not be cut or pulverized. Stagnant liquids are reduced by flushing after tube use. Cleansing is important, but soap and water are sufficient without the added irritation of hydrogen peroxide

20. While providing home care to a client with congestive heart failure, the nurse is asked how long diuretics must be taken. What is the nurse's best response?

A) "As you urinate more, you will need less medication to control fluid."
B) "You will have to take this medication for about a year."
C) "The medication must be continued so the fluid problem is controlled."
D) "Please talk to your health care provider about medications and treatments."

C: "The medication must be continued so the fluid problem is controlled." This is the most therapeutic response and gives the client accurate information.

Q&A Pharmacology

1. A post-operative client has a prescription for acetaminophen with codeine. What should the nurse recognizes as a primary effect of this combination?

A) Enhanced pain relief
B) Minimized side effects
C) Prevention of drug tolerance
D) Increased onset of action

A: Enhanced pain relief. Combination of analgesics with different mechanisms of action can afford greater pain relief.

2. A nurse is caring for a client who is receiving methyldopa hydrochloride (Aldomet) intravenously. Which of the following assessment findings would indicate to the nurse that the client may be having an adverse reaction to the medication?

A) Headache
B) Mood changes
C) Hyperkalemia
D) Palpitations

B: Mood changes. The nurse should assess the client for alterations in mental status such as mood changes. These symptoms should be reported promptly.

3. When providing discharge teaching to a client with asthma, the nurse will warn against the use of which of the following over-the-counter medications?

A) Cortisone ointments for skin rashes
B) Aspirin products for pain relief
C) Cough medications containing guaifenesin
D) Histamine blockers for gastric distress

B: Aspirin products for pain relief. Aspirin is known to induce asthma attacks. Aspirin can also cause nasal polyps and rhinitis. Warn individuals with asthma about signs and symptoms resulting from complications due to aspirin ingestion.

4. The nurse practicing in a long term care facility recognizes that elderly clients are at greater risk for drug toxicity than younger adults because of which of the following physiological changes of advancing age?

A) Drugs are absorbed more readily from the GI tract
B) Elders have less body water and more fat
C) The elderly have more rapid hepatic metabolism
D) Older people are often malnourished and anemic

B: Elders have less body water and more fat. Because elderly persons have decreased lean body tissue/water in which to distribute medications, more drug remains in the circulatory system with potential for drug toxicity. Increased body fat results in greater amounts of fat-soluble drugs being absorbed, leaving less in circulation, thus increasing the duration of action of the drug.

5. In providing care for a client with pain from a sickle cell crisis, which one of the following medication orders for pain control should be questioned by the nurse?

A) Demerol
B) Morphine
C) Methadone
D) Codeine

A: Demerol. Meperidine is not recommended in clients with sickle cell disease. Normeperidine, a metabolite of meperidine, is a central nervous system stimulant that produces anxiety, tremors, myoclonus, and generalized seizures when it accumulates with repetitive dosing. Clients with sickle cell disease are particularly at risk for normeperidine-induced seizures.

6. The nurse is administering diltiazem (Cardizem) to a client. Prior to administration, it is important for the nurse to assess which parameter?

    A) Temperature
    B) Blood pressure
    C) Vision
    D) Bowel sounds

B: Blood pressure. Diltiazem (Cardizem) is a calcium channel blocker that causes systemic vasodilation resulting in decreased blood pressure.

7. A client with an aplastic sickle cell crisis is receiving a blood transfusion and begins to complain of "feeling hot." Almost immediately, the client begins to wheeze. What is the nurse's first action?

    A) Stop the blood infusion
    B) Notify the health care provider
    C) Take/record vital signs
    D) Send blood samples to lab

A: Stop the blood infusion. If a reaction of any type is suspected during administration of blood products, stop the infusion immediately, keep the line open with saline, notify the health care provider, monitor vital signs and other changes, and then send a blood sample to the lab.

8. A client with atrial fibrillation is receiving digoxin (Lanoxin). Which of these assessments is most important for the nurse to perform?

    A) Monitor blood pressure every 4 hours
    B) Measure apical pulse prior to administration
    C) Maintain accurate intake and output records
    D) Record an EKG strip after administration

B: Measure apical pulse prior to administration. Digitoxin decreases conduction velocity through the AV node and prolongs the refractory period. If the apical heart rate is less than 60 beats/minute, withhold the drug. The apical pulse should be taken with a stethoscope so that there will be no mistake about what the heart rate actually is.

9. The nurse is caring for a 10 year-old client who will be placed on heparin therapy. Which assessment is critical for the nurse to make before initiating therapy

    A) Vital signs
    B) Weight
    C) Lung sounds
    D) Skin turgor

B: Weight. Check the client"s weight because dosage is calculated on the basis of weight.

10. The use of atropine for treatment of symptomatic bradycardia is contraindicated for a client with which of the following conditions?

    A) Urinary incontinence
    B) Glaucoma
    C) Increased intracranial pressure
    D) Right sided heart failure

B: Glaucoma. Atropine is contraindicated in clients with angle-closure glaucoma because it can cause pupillary dilation with an increase in aqueous humor, leading to a resultant increase in optic pressure.

11. The health care provider orders an IV aminophylline infusion at 30 mg/hr. The pharmacy sends a 1,000 ml bag of D5W containing 500 mg of aminophylline. In order to administer 30 mg per hour, the RN will set the infusion rate at:

    A) 20 ml per hour
    B) 30 ml per hour
    C) 50 ml per hour
    D) 60 ml per hour

D: 60 ml per hour. Using the ratio method to calculate infusion rate: mg to be given (30) : ml to be infused (X) :: mg available (500) : ml of solution (1,000). Solve for X by cross-multiplying: 30 x 1,000 = 500 x X (or cancel), 30,000 = 500 X, X = 30,000/500, X = 60 ml per hour.

12. The nurse is applying silver sulfadiazine (Silvadene) to a child with severe burns to arms and legs. Which side effect should the nurse be monitoring for?

    A) Skin discoloration
    B) Hardened eschar
    C) Increased neutrophils
    D) Urine sulfa crystals

D: Urine sulfa crystals. Silver sulfadiazine is a broad spectrum anti-microbial, especially effective against *pseudomonas*. When applied to extensive areas, however, it may cause a transient neutropenia, as well as renal function changes with sulfa crystals production and kernicterus.

13. The nurse is caring for a client who is receiving procainamide (Pronestyl) intravenously. It is important for the nurse to monitor which of the following parameters?

    A) Hourly urinary output
    B) Serum potassium levels
    C) Continuous EKG readings
    D) Neurological signs

C: Continuous EKG readings. Procainamide (Pronestyl) is used to suppress cardiac arrhythmias. When administered intravenously, it must be accompanied by continuous cardiac monitoring by ECG.

14. The nurse is teaching a parent how to administer oral iron supplements to a 2 year-old child. Which of the following interventions should be included in the teaching?

    A) Stop the medication if the stools become tarry green
    B) Give the medicine with orange juice and through a straw
    C) Add the medicine to a bottle of formula
    D) Administer the iron with your child's meals

B: Give the medicine with orange juice and through a straw. Absorption of iron is facilitated in an environment rich in Vitamin C. Since liquid iron preparation will stain teeth, a straw is preferred.

15. A client with bi-polar disorder is taking lithium (Lithane). What should the nurse emphasize when teaching about this medication?

    A) Take the medication before meals
    B) Maintain adequate daily salt intake
    C) Reduce fluid intake to minimize diuresis
    D) Use antacids to prevent heartburn

B: Maintain adequate daily salt intake. Salt intake affects fluid volume, which can affect lithium (Lithane) levels; therefore, maintaining adequate salt intake is advised.

16. The nurse is assessing a 7 year-old after several days of treatment for a documented strep throat. Which of the following statements suggests that further teaching is needed?

    A) "Sometimes I take my medicine with fruit juice."
    B) "My mother makes me take my medicine right after school."
    C) "Sometimes I take the pills in the morning and other times at night."
    D) "I am feeling much better than I did last week."

C: "Sometimes I take the pills in the morning and other times at night." Inconsistency in taking the prescribed medication indicates more teaching is needed.

17. An elderly client is on an anticholinergic metered dose inhaler (MDI) for chronic obstructive pulmonary disease. The nurse would suggest a spacer to

    A) enhance the administration of the medication
    B) increase client compliance
    C) improve aerosol delivery in clients who are not able to coordinate the MDI
    D) prevent exacerbation of COPD

C: Spacers improve the medication delivery in clients who are unable to coordinate the movements of administering a dose with an MDI.

18. The nurse is providing education for a client with newly diagnosed tuberculosis. Which statement should be included in the information that is given to the client?

    A) "Isolate yourself from others until you are finished taking your medication."
    B) "Follow up with your primary care provider in 3 months."
    C) "Continue to take your medications even when you are feeling fine."
    D) "Continue to get yearly tuberculin skin tests."

C: The most important piece of information the tuberculosis client needs is to understand the importance of medication compliance, even if no longer experiencing symptoms. Clients are most infectious early in the course of therapy. The numbers of acid-fast bacilli are greatly reduced as early as 2 weeks after therapy begins.

19. The nurse is administering an intravenous vesicant chemotherapeutic agent to a client. Which assessment would require the nurse's immediate action?

    A) Stomatitis lesion in the mouth
    B) Severe nausea and vomiting
    C) Complaints of pain at site of infusion
    D) A rash on the client's extremities

C: Complaints of pain at site of infusion. A vesicant is a chemotherapeutic agent capable of causing blistering of tissues and possible tissue necrosis if there is extravasation. These agents are irritants which cause pain along the vein wall, with or without inflammation.

20. The nurse is instructing a client with moderate persistent asthma on the proper method for using MDIs (multi-dose inhalers). Which medication should be administered first?

    A) Steroid
    B) Anticholinergic
    C) Mast cell stabilizer
    D) Beta agonist

D: Beta agonist. The beta-agonist drugs help to relieve bronchospasm by relaxing the smooth muscle of the airway. These drugs should be taken first so that other medications can reach the lungs.

21. The nurse is teaching a group of women in a community clinic about prevention of osteoporosis. Which of the following over-the-counter medications should the nurse recognize as having the most elemental calcium per tablet?

    A) Calcium chloride
    B) Calcium citrate
    C) Calcium gluconate
    D) Calcium carbonate

D: Calcium carbonate. Calcium carbonate contains 400mg of elemental calcium in 1 gram of calcium carbonate.

22. The provider has ordered daily high doses of aspirin for a client with rheumatoid arthritis. The nurse instructs the client to discontinue the medication and contact the provider if which of the following symptoms occur?

    A) Infection of the gums
    B) Diarrhea for more than one day
    C) Numbness in the lower extremities
    D) Ringing in the ears

D: Ringing in the ears. Aspirin stimulates the central nervous system which may result in ringing in the ears.

23. A 5 year-old has been rushed to the emergency room several hours after acetaminophen poisoning. Which laboratory result should receive attention by the nurse?

    A) Sedimentation rate
    B) Profile 2
    C) Bilirubin
    D) Neutrophils

C: Bilirubin. Bilirubin, along with liver enzymes ALT and AST, may rise in the second stage (1-3 days) after a significant overdose, indicating cellular necrosis and liver dysfunction.

24. The nurse is caring for a client with schizophrenia who has been treated with quetiapine (Seroquel) for 1 month. Today the client is increasingly agitated and complains of muscle stiffness. Which of these findings should be reported to the health care provider?

    A) Elevated temperature and sweating.
    B) Decreased pulse and blood pressure.
    C) Mental confusion and general weakness.
    D) Muscle spasms and seizures.

A: Elevated temperature and sweating. Neuroleptic malignant syndrome (NMS) is a rare disorder that can occur as a side effect of antipsychotic medications. It is characterized by muscular rigidity, tachycardia, hyperthermia, sweating, altered consciousness, autonomic dysfunction, and increase in CPK. This is a life-threatening complication.

25. A client is receiving dexamethasone (Decadron) therapy. What should the nurse plan to monitor in this client?

    A) Urine output every 4 hours
    B) Blood glucose levels every 12 hours
    C) Neurological signs every 2 hours
    D) Oxygen saturation every 8 hours

B: The drug Decadron increases glycogenesis. This may lead to hyperglycemia. Therefore the blood sugar level and acetone production must be monitored.

26. The nurse is teaching a child and the family about the medication phenytoin (Dilantin) prescribed for seizure control. Which of the following side effects is **most** likely to occur?

    A) Vertigo
    B) Drowsiness
    C) Gingival hyperplasia
    D) Vomiting

C: Swollen and tender gums occur often with use of phenytoin. Good oral hygiene and regular visits to the dentist should be emphasized.

27. A newly admitted client has a diagnosis of depression. She complains of “twitching muscles” and a “racing heart”, and states she stopped taking Zoloft a few days ago because it was not helping her depression. Instead, she began to take her partner's Parnate. The nurse should immediately assess for which of these adverse reactions?

    A) Pulmonary edema
    B) Atrial fibrillation
    C) Mental status changes
    D) Muscle weakness

C: Mental status changes. Use of serotonergic agents may result in Serotonin Syndrome with confusion, nausea, palpitations, increased muscle tone with twitching muscles, and agitation. Serotonin syndrome is most often reported in patients taking 2 or more medications that increase CNS serotonin levels by different mechanisms. The most common drug combinations associated with serotonin syndrome involve the MAOIs, SSRIs, and the tricyclic antidepressants.). Philadelphia: Saunders.

28. A client has been receiving dexamethasone (Decadron) for control of cerebral edema. Which of the following assessments would indicate that the treatment is effective?

    A) A positive Babinski's reflex
    B) Increased response to motor stimuli
    C) A widening pulse pressure
    D) Temperature of 37 degrees Celsius

B: Decadron is a corticosteroid that acts on the cell membrane to decrease inflammatory responses as well as stabilize the blood-brain barrier. Once Decadron reaches a therapeutic level, there should be a decrease in symptomology with improvement in motor skills.

29. The nurse is assessing a client who is on long term glucocorticoid therapy. Which of the following findings would the nurse expect?

    A) Buffalo hump
    B) Increased muscle mass
    C) Peripheral edema
    D) Jaundice

A: Buffalo hump. With high doses of glucocorticoid, iatrogenic Cushing"s syndrome develops. The exaggerated physiological action causes abnormal fat distribution which results in a moon-shaped face, a intrascapular pad on the neck (buffalo hump) and truncal obesity with slender limbs.

30. A client is ordered atropine to be administered preoperatively. Which physiological effect should the nurse monitor for?

    A) Elevate blood pressure
    B) Drying up of secretions
    C) Reduce heart rate
    D) Enhance sedation

B: Drying up of secretions. Atropine dries secretions which may get in the way during the operative procedure.

31. A client confides in the RN that a friend has told her the medication she takes for depression, Wellbutrin, was taken off the market because it caused seizures. What is an appropriate response by the nurse?

    A) "Ask your friend about the source of this information."
    B) "Omit the next doses until you talk with the doctor."
    C) "There were problems, but the recommended dose is changed."
    D) "Your health care provider knows the best drug for your condition."

C: Wellbutrin was introduced in the U.S. in 1985 and then withdrawn because of the occurrence of seizures in some patients taking the drug. The drug was reintroduced in 1989 with specific recommendations regarding dose ranges to limit the occurrence of seizures. The risk of seizure appears to be strongly associated with dose.

32. A child presents to the Emergency Department with documented acetaminophen poisoning. In order to provide counseling and education for the parents, which principle must the nurse understand?

    A) The problem occurs in stages with recovery within 12-24 hours
    B) Hepatic problems may occur and may be life-threatening
    C) Full and rapid recovery can be expected in most children
    D) This poisoning is usually fatal, as no antidote is available

B: Hepatic problems may occur and may be life-threatening. Clinical manifestations associated with acetaminophen poisoning occurs in 4 stages. The third stage is hepatic involvement which may last up to 7 days and be permanent. Clients who do not die in the hepatic stage gradually recover.

33. A client is receiving digitalis. The nurse should instruct the client to report which of the following side effects?

    A) Nausea, vomiting, fatigue
    B) Rash, dyspnea, edema
    C) Polyuria, thirst, dry skin

D) Hunger, dizziness, diaphoresis

A: Nausea, vomiting, fatigue. Side effects of digitalis toxicity include fatigue, nausea, vomiting, anorexia, and bradycardia. Digitalis inhibits the sodium potassium ATPase, which makes more calcium available for contractile proteins, resulting in increased cardiac output.

34. The provider has ordered transdermal nitroglycerin patches for a client. Which of these instructions should be included when teaching a client about how to use the patches?

    A) Remove the patch when swimming or bathing
    B) Apply the patch to any non-hairy area of the body
    C) Apply a second patch with chest pain
    D) Remove the patch if ankle edema occurs

B: Apply the patch to any non-hairy area of the body. The patch application sites should be rotated.

35. A pregnant woman is hospitalized for treatment of pregnancy induced hypertension (PIH) in the third trimester. She is receiving magnesium sulfate intravenously. The nurse understands that this medication is used mainly for what purpose?

    A) Maintain normal blood pressure
    B) Prevent convulsive seizures
    C) Decrease the respiratory rate
    D) Increase uterine blood flow

B: Prevent convulsive seizures. Magnesium sulfate is a central nervous system depressant. While it has many systemic effects, it is used in the client with pregnancy induced hypertension (PIH) to prevent seizures.

36. A client with anemia has a new prescription for ferrous sulfate. In teaching the client about diet and iron supplements, the nurse should emphasize that absorption of iron is enhanced if taken with which substance?

    A) Acetaminophen
    B) Orange juice
    C) Low fat milk
    D) An antacid

B: Orange juice. Ascorbic acid enhances the absorption of iron.

37. The health care provider has written "Morphine sulfate 2 mgs IV every 3-4 hours prn for pain" on the chart of a child weighing 22 lb. (10 kg). What is the nurse's initial action?

    A) Check with the pharmacist
    B) Hold the medication and contact the provider
    C) Administer the prescribed dose as ordered
    D) Give the dose every 6-8 hours

B: Hold the medication and contact the provider. The usual pediatric dose of morphine is 0.1 mg/kg every 3 to 4 hours. At 10 kg, this child typically should receive 1.0 mg every 3 to 4 hours.

38. The nurse is monitoring a client receiving a thrombolytic agent, alteplase (Activase tissue plasminogen activator), for treatment of a myocardial infarction. What outcome indicates the client is receiving adequate therapy within the first hours of treatment?

    A) Absence of a dysrhythmia (or arrhythmia)
    B) Blood pressure reduction
    C) Cardiac enzymes are within normal limits
    D) Return of ST segment to baseline on ECG

D: Return of ST segment to baseline on ECG. Improved perfusion should result from this medication, along with the reduction of ST segment elevation.

39. A nurse is assigned to perform well-child assessments at a day care center. A staff member interrupts the examinations to ask for assistance. They find a crying 3 year-old child on the floor with mouth wide open and gums bleeding. Two unlabeled open bottles lie nearby. The nurse's **first** action should be

    A) call the poison control center, then 911
    B) administer syrup of Ipecac to induce vomiting
    C) give the child milk to coat her stomach
    D) ask the staff about the contents of the bottles

D: ask the staff about the contents of the bottles. The nurse needs to assess what the child ingested before determining the next action. Once the substance is identified, the poison control center and emergency response team should be called.

40. A client is receiving erythromycin 500mg IV every 6 hours to treat a pneumonia. Which of the following is the most common side effect of the medication?

    A) Blurred vision
    B) Nausea and vomiting
    C) Severe headache

D) Insomnia

B: Nausea and vomiting. Nausea is a common side-effect of erythromycin in both oral and intravenous forms.

41. A 4 year-old child is admitted with burns on his legs and lower abdomen. When assessing the child's hydration status, which of the following indicates a less than adequate fluid replacement?

    A) Decreasing hematocrit and increasing urine volume
    B) Rising hematocrit and decreasing urine volume
    C) Falling hematocrit and decreasing urine volume
    D) Stable hematocrit and increasing urine volume

B: Rising hematocrit and decreasing urine volume. A rising hematocrit indicates a decreased total blood volume, a finding consistent with dehydration.

42. Prior to administering Alteplase (TPA) to a client admitted for a cerebral vascular accident (CVA), it is critical that the nurse assess:

    A) Neuro signs
    B) Mental status
    C) Blood pressure
    D) PT/PTT

D: PT/PTT. TPA is a potent thrombolytic enzyme. Because bleeding is the most common side effect, it is most essential to evaluate clotting studies including PT, PTT, APTT, platelets, and hematocrit before beginning therapy.

43. A nurse who has been named in a lawsuit can use which of these factors for the best protection in a court of law?

    A) Clinical specialty certification in the associated area of practice
    B) Documentation on the specific client record with a focus on the nursing process
    C) Yearly evaluations and proficiency reports prepared by nurse's manager
    D) Verification of provider's orders for the plan of care with identification of outcomes

B: Documentation is the key to protect nurses when a lawsuit is filed. The thorough documentation should include all steps of the nursing process – assessment, analysis, plan, intervention, evaluation. In addition, it should include pertinent data such as times, dosages and sites of actions, assessment data, the nurse's response to a change in the client's condition, specific actions taken, if and when the notification occurred to the provider or other health care team members, and what was prescribed along with the client's outcomes.

44. The nurse is caring for clients over the age of 70. The nurse knows that due to age-related changes, the elderly clients tolerate diets that are

    A) high protein
    B) high carbohydrates
    C) low fat
    D) high calories

C: low fat. Due to age related changes, the diet of the elderly should include a lower quantity and higher quality of food. Fewer carbohydrates and fats are required in their diets.

45. A client is to receive 3 doses of potassium chloride 10 mEq in 100cc normal saline to infuse over 30 minutes each. Which of the following is a priority assessment to perform before giving this medication?

    A) Oral fluid intake
    B) Bowel sounds
    C) Grip strength
    D) Urine output

D: Urine output. Potassium chloride should only be administered after adequate urine output (>20cc/hour for 2 consecutive hours) has been established. Impaired ability to excrete potassium via the kidneys can result in hyperkalemia.

46. A hypertensive client is started on atenolol (Tenormin). The nurse instructs the client to immediately report which of these findings?

    A) Rapid breathing
    B) Slow, bounding pulse
    C) Jaundiced sclera
    D) Weight gain

B: Slow, bounding pulse. Atenolol (Tenormin) is a beta-blocker that can cause side effects including bradycardia and hypotension.

47. During nursing rounds which of these assessments would require immediate corrective action and further instruction to the practical nurse (PN) about proper care?

    A) The weights of the skin traction of a client are hanging about 2 inches from the floor
    B) A client with a hip prosthesis 1 day post operatively is lying in bed with internal rotation and adduction of the affected leg
    C) The nurse observes that the PN moves the extremity of a client with an external fixation device by picking up the frame

D) A client with skeletal traction states "The other nurse said that the clear, yellow and crusty drainage around the pin site is a good sign"

B: A client with a hip prosthesis 1 day post operatively is lying in bed with internal rotation and adduction of the affected leg. This position should be prevented in order to prevent dislodgment of the hip prosthesis, especially in the first 48 to 72 hours post-op. The other assessments are not of concern.

48. A client is scheduled for an intravenous pyelogram (IVP). After the contrast material is injected, which of the following client reactions should be reported immediately?

A) Feeling warm
B) Face flushing
C) Salty taste
D) Hives

D: Hives. This is a sign of anaphylaxis and should be reported immediately. The other reactions are considered normal and the client should be informed that they may occur.

49. You are caring for a hypertensive client with a new order for captopril (Capoten). Which information should the nurse include in client teaching?

A) Avoid green leafy vegetables
B) Restrict fluids to 1000cc/day
C) Avoid the use of salt substitutes
D) Take the medication with meals

C: Avoid the use of salt substitutes. Captopril can cause an accumulation of potassium or hyperkalemia. Clients should avoid the use of salt substitutes, which are generally potassium-based.

50. A client has bilateral knee pain from osteoarthritis. In addition to taking the prescribed non-steroidal anti-inflammatory drug (NSAID), the nurse should instruct the client to

A) start a regular exercise program
B) rest the knees as much as possible to decrease inflammation
C) avoid foods high in citric acid
D) keep the legs elevated when sitting

A: start a regular exercise program. A regular exercise program is beneficial in treating osteoarthritis. It can restore self-esteem and improve physical functioning.

51. A client in respiratory distress is admitted with arterial blood gas results of: PH 7.30; PO_2 58, PCO_2 34; and HCO_3 19. The nurse determines that the client is in

A) metabolic acidosis
B) metabolic alkalosis
C) respiratory acidosis
D) respiratory alkalosis

A: metabolic acidosis. These lab values indicate metabolic acidosis: the PH is low, PCO_2 is normal, and bicarbonate level is low.

52. A woman with a 28 week pregnancy is on the way to the emergency department by ambulance with a tentative diagnosis of abruptio placenta. Which should the nurse do **first** when the woman arrives?

A) administer oxygen by mask at 100%
B) start a second IV with an 18 gauge cannula
C) check fetal heart rate every 15 minutes
D) insert urethral catheter with hourly urine outputs

A: administer oxygen by mask at 100%. Administering oxygen in this situation would increase the circulating oxygen in the mother's circulation to the fetus's circulation. This action will minimize complications.

53. You are caring for a client with deep vein thrombosis who is on Heparin IV. The latest APTT is 50 seconds. If the laboratory normal range is 16-24 seconds, you would anticipate

A) maintaining the current heparin dose
B) increasing the heparin as it does not appear therapeutic.
C) giving protamine sulfate as an antidote.
D) repeating the blood test 1 hour after giving heparin.

A: maintaining the current heparin dose. The range for a therapeutic APTT is 1.5-2 times the control. Therefore the client is receiving a therapeutic dose of Heparin.

54. A client newly diagnosed with Type I Diabetes Mellitus asks the purpose of the test measuring glycosylated hemoglobin. The nurse should explain that the purpose of this test is to determine:

A) The presence of anemia often associated with Diabetes
B) The oxygen carrying capacity of the client's red cells
C) The average blood glucose for the past 2-3 months
D) The client's risk for cardiac complications

C: The average blood glucose for the past 2-3 months. By testing the portion of the hemoglobin that absorbs glucose, it is possible to determine the average blood glucose over the life span of the red cell, 120 days.

55. An 80 year-old client is admitted with a diagnosis of malnutrition. In addition to physical assessments, which of the following lab tests should be closely monitored?

    A) Urine protein
    B) Urine creatinine
    C) Serum calcium
    D) Serum albumin

D: Serum albumin. Serum albumin is a valuable indicator of protein deficiency and, later, nutritional status in adults. A normal reading for an elder's serum albumin is between 3.0-5.0 g/dl.

56. A 66 year-old client is admitted for mitral valve replacement surgery. The client has a history of mitral valve regurgitation and mitral stenosis since her teenage years. During the admission assessment, the nurse should ask the client if as a child she had

    A) measles
    B) rheumatic fever
    C) hay fever
    D) encephalitis

B: rheumatic fever. Clients that present with mitral stenosis often have a history of rheumatic fever or bacterial endocarditis.

57. Which of these clients should the charge nurse assign to the registered nurse (RN)?

    A) A 56 year-old with atrial fibrillation receiving digoxin
    B) A 60 year-old client with COPD on oxygen at 2 L/min
    C) A 24 year-old post-op client with type 1 diabetes in the process of discharge
    D) An 80 year-old client recovering 24 hours post right hip replacement

C: Discharge teaching must be done by an RN. Practical nurses (PNs) or unlicensed assistive personnel (UAPs) can reinforce education after the RN does the initial teaching.

58. The nurse discusses nutrition with a pregnant woman who is iron deficient and follows a vegetarian diet. The selection of which foods indicates the woman has learned sources of iron?

    A) Cereal and dried fruits
    B) Whole grains and yellow vegetables
    C) Leafy green vegetables and oranges
    D) Fish and dairy products

A: Cereal and dried fruits. Both of these foods would be a good source of iron.

59. A client diagnosed with gouty arthritis is admitted with severe pain and edema in the right foot. When the nurse develops a plan of care, which intervention should be included?

    A) high protein diet
    B) salicylates
    C) hot compresses to affected joints
    D) intake of at least 3000cc/day

D: intake of at least 3000cc/day. Fluid intake should be increased to prevent precipitation of urate in the kidneys.

60. One hour before the first treatment is scheduled, the client becomes anxious and states he does not wish to go through with electroconvulsive therapy. Which response by the nurse is **most** appropriate?

    A) "I'll go with you and will be there with you during the treatment."
    B) "You'll be asleep and won't remember anything."
    C) "You have the right to change your mind. You seem anxious. Can we talk about it?"
    D) "I'll call the health care provider to notify them of your decision."

C: This response indicates acknowledgment of the client's rights and the opportunity for the client to clarify and ventilate concerns. After this, if the client continues to refuse, the provider should be notified.

61. A male client is admitted with a spinal cord injury at level C4. The client asks the nurse how the injury is going to affect his sexual function. The nurse would respond

    A) "Normal sexual function is not possible."
    B) "Sexual functioning will not be impaired at all."
    C) "Erections will be possible."
    D) "Ejaculation will be normal."

C: "Erections will be possible." Because they are a reflex reaction, erections can be stimulated by stroking the genitalia.

62. An 82 year-old client complains of chronic constipation. To improve bowel function, the nurse should **first** suggest

    A) Increasing fiber intake to 20-30 grams daily
    B) Daily use of laxatives

C) Avoidance of binding foods such as cheese and chocolate
D) Monitoring a balance between activity and rest

A: The incorporation of high fiber into the diet is an effective way to promote bowel elimination in the elderly.

63. The unlicensed assistive personnel (UAP) reports to the nurse that a client with cirrhosis who had a paracentesis yesterday has become more lethargic and has musty smelling breath. A critical assessment for increasing encephalopathy is

A) monitor the client's clotting status
B) assess upper abdomen for bruits
C) assess for flap-like tremors of the hands
D) measure abdominal girth changes

C: assess for flap-like tremors of the hands. A client with cirrhosis of the liver who develops subtle changes in mental status and has a musty odor to the breath is at risk for developing more advanced signs of encephalopathy.

64. A client is admitted with a diagnosis of nodal bigeminy. The nurse knows that the atrioventricular (AV) node has an intrinsic rate of

A) 60-100 beats/minute
B) 10-30 beats/minute
C) 40-70 beats/minute
D) 20-50 beats/minute

C: 40-70 beats/minute. The intrinsic rate of the AV node is within the range of 40-70 beats per minute.

65. A client is admitted for a possible pacemaker insertion. What is the intrinsic rate of the heart's own pacemaker?

A) 30-50 beats/minute
B) 60-100 beats/minute
C) 20-60 beats/minute
D) 90-100 beats/minute

B: 60-100 beats/minute. This is the intrinsic rate of the SA node.

66. A client is diagnosed with gastroesophageal reflux disease (GERD). The nurse's instruction to the client regarding diet should be to

A) avoid all raw fruits and vegetables
B) increase intake of milk products
C) decrease intake of fatty foods

D) focus on 3 average size meals a day

C: GERD may be aggravated by a fatty diet. A diet low in fat would decrease the symptoms of GERD. Other agents which should also be decreased or avoided are: cigarette smoking, caffeine, alcohol, chocolate, and meperidine (Demerol).

67. The nurse is teaching a client with chronic renal failure (CRF) about medications. The client questions the purpose of aluminum hydroxide (Amphojel) in her medication regimen. What is the best explanation for the nurse to give the client about the therapeutic effects of this medication?

A) It decreases serum phosphate
B) It will reduce serum calcium
C) Amphojel increases urine output
D) The drug is taken to control gastric acid secretion

A: It decreases serum phosphate. Aluminum binds phosphates that tend to accumulate in the patient with chronic renal failure due to decreased filtration capacity of the kidney. Antacids such as Amphojel are commonly used to accomplish this.

68. The client with goiter is treated with potassium iodide preoperatively. What should the nurse recognize as the purpose of this medication?

A) Reduce vascularity of the thyroid
B) Correct chronic hyperthyroidism
C) Destroy the thyroid gland function
D) Balance enzymes and electrolytes

A: Potassium iodide solution, or Lugol"s solution may be used preoperatively to reduce the size and vascularity of the thyroid gland.

69. A client with testicular cancer has had an orchiectomy. Prior to discharge the client expresses his fears related to his prognosis. Which principle should the nurse base the response on?

A) Testicular cancer has a cure rate of 90% with early diagnosis
B) Testicular cancer has a cure rate of 50% with early diagnosis
C) Intensive chemotherapy is the treatment of choice
D) Testicular cancer is usually fatal

A: With aggressive treatment and early detection/diagnosis the cure rate is 90%.

70. The nurse is caring for clients over the age of 70. The nurse is aware that when giving medications to older clients, it is **best** to

A) start low, go slow
B) avoid stopping a medication entirely
C) avoid drugs with side effects that impact cognition
D) review the drug regimen yearly

A: Due to physiological changes in the elderly, as well as conditions such as dehydration, hyperthermia, immobility and liver disease, the effective metabolism of drugs may decrease. As a result, drugs can accumulate to toxic levels and cause serious adverse reactions.

71. The nurse enters the room of a client diagnosed with COPD. The client's skin is pink, and respirations are 8 per minute. The client's oxygen is running at 6 liters per minute. What should be the nurse's **first** action?

A) Call the health care provider
B) Put the client in Fowler's position
C) Lower the oxygen rate
D) Take the vital signs

C: In client's diagnosed with COPD, the drive to breathe is hypoxia. If oxygen is delivered at too high of a concentration, this drive will be eliminated and the client's depth and rate of respirations will decrease. Therefore the first action should be to lower the oxygen rate.

72. A client has an order for antibiotic therapy after hospital treatment of a staph infection. Which of the following should the nurse emphasize?

A) Scheduling follow-up blood cultures
B) Completing the full course of medications
C) Visiting the provider in a few weeks
D) Monitoring for signs of recurrent infection

B: In order for antibiotic therapy to be effective in eradicating an infection, the client must compete the entire course of prescribed therapy. When findings subside, stopping the medication early may lead to recurrence or subsequent drug resistance.

73. A 55 year-old woman is taking Prednisone and aspirin (ASA) as part of her treatment for rheumatoid arthritis. Which of the following would be an appropriate intervention for the nurse?

A) Assess the pulse rate q 4 hours
B) Monitor her level of consciousness q shift
C) Test her stools for occult blood
D) Discuss fiber in the diet to prevent constipation

C: Both Prednisone and ASA can lead to GI bleeding, therefore monitoring for occult blood would be appropriate.

74. A client is prescribed an inhaler. How should the nurse instruct the client to breathe in the medication?

A) As quickly as possible
B) As slowly as possible
C) Deeply for 3-4 seconds
D) Until hearing whistling by the spacer

C: The client should be instructed to breath in the medication for 3-4 seconds in order to receive the correct dosage of medication.

75. After surgery, a client with a nasogastric tube complains of nausea. What action would the nurse take?

A) Call the health care provider
B) Administer an antiemetic
C) Put the bed in Fowler's position
D) Check the patency of the tube

D: Check the patency of the tube. An indication that the nasogastric tube is obstructed is a client's complaint of nausea. Nasogastric tubes may become obstructed with mucus or sediment.

76. A 72 year-old client is admitted for possible dehydration. The nurse knows that older adults are particularly at risk for dehydration because they have

A) an increased need for extravascular fluid
B) a decreased sensation of thirst
C) an increase in diaphoresis
D) higher metabolic demands

B: a decreased sensation of thirst. The elderly have a reduction in thirst sensation causing them to consume less fluid. Other risk factors may include fear of incontinence, inability to drink fluids independently and lack of motivation.

77. Upon admission to an intensive care unit, a client diagnosed with an acute myocardial infarction is ordered oxygen. The nurse knows that the **major** reason that oxygen is administered in this situation is to

A) saturate the red blood cells
B) relieve dyspnea

C) decrease cyanosis
D) increase oxygen level in the myocardium

D: Anoxia of the myocardium occurs in myocardial infarction. Oxygen administration will help relieve dyspnea and cyanosis associated with the condition but the major purpose is to increase the oxygen concentration in the damaged myocardial tissue.

78. An arterial blood gases test (ABG) is ordered for a confused client. The respiratory therapist draws the blood and then asks the nurse to apply pressure to the area so the therapist can take the specimen to the lab. How long should the nurse apply pressure to the area?

A) 3 minutes
B) 5 minutes
C) 8 minutes
D) 10 minutes

B: 5 minutes. It is necessary to apply pressure to the area for 5 minutes to prevent bleeding and the formation of hematomas.

79. A client receiving chemotherapy has developed sores in his mouth. He asks the nurse why this happened. What is the nurse's best response?

A) "It is a sign that the medication is working."
B) "You need to have better oral hygiene."
C) "The cells in the mouth are sensitive to the chemotherapy."

D) "This always happens with chemotherapy."

C: The epithelial cells in the mouth are very sensitive to chemotherapy due to their high rate of cell turnover.

80. A client with testicular cancer is scheduled for a right orchiectomy. The nurse knows that an orchiectomy is the

A) surgical removal of the entire scrotum
B) surgical removal of a testicle
C) dissection of related lymph nodes
D) partial surgical removal of the penis

B: surgical removal of a testicle. The affected testicle is surgically removed along with its tunica and spermatic cord.

Reduction of Risk Potential

1. The nurse is caring for a child immediately after surgical correction of a ventricular septal defect. Which of the following nursing assessments should be a **priority**?

A) Blanch nail beds for color and refill
B) Assess for post-operative arrhythmias
C) Auscultate for pulmonary congestion
D) Monitor equality of peripheral pulses

B: Assess for post-operative arrhythmias. The atrioventricular bundle (bundle of His), a part of the electrical conduction system of the heart, extends from the atrioventricular node along each side of the interventricular septum and then divides into right and left bundle branches. Surgical repair of a ventricular septal defect consists of a purse-string approach or a patch sewn over the opening.

2. A client is receiving external beam radiation to the mediastinum for treatment of bronchial cancer. Addressing which of the following should take **priority** in planning care?

A) Esophagitis
B) Leukopenia
C) Fatigue
D) Skin irritation

B: Leukopenia. Clients develop leukopenia due to the depressant effect of radiation therapy on bone marrow function. Infection is the most frequent cause of morbidity and death in clients with cancer.

3. A nurse is to collect a sputum specimen for acid-fast bacillus (AFB) from a client. Which action should the nurse take **first**?

A) Ask client to cough sputum into container
B) Have the client take several deep breaths
C) Provide a appropriate specimen container
D) Assist with oral hygiene

D: Assist with oral hygiene. Obtain a specimen early in the morning after mouth care. The other responses follow this first action: the client should take several deep breaths then cough into the appropriate sterile container to obtain the AFB specimen of the sputum.

4. A client has a history of chronic obstructive pulmonary disease (COPD). As the nurse enters the client's room, his oxygen is running at 6 liters per minute, his color is flushed and his respirations are 8 per minute. What should the nurse do first?

A) Obtain a 12-lead EKG
B) Place client in high Fowler's position
C) Lower the oxygen rate
D) Take baseline vital signs

C: Lower the oxygen rate. A low oxygen level acts as a stimulus for respiration. A high concentration of supplemental oxygen removes the hypoxic drive to breathe, leading to increased hypoventilation, respiratory decompensation, and the development of or worsening of respiratory acidosis. Unless corrected, it can lead to the client"s death.

5. A 4 year-old has been hospitalized for 24 hours with skeletal traction for treatment of a fracture of the right femur. The nurse finds that the child is now crying and the right foot is pale with the absence of a pulse. What should the nurse do **first**?

A) Notify the health care provider
B) Readjust the traction
C) Administer the ordered prn medication
D) Reassess the foot in fifteen minutes

A: Notify the health care provider. The findings are indicative of circulatory impairment. The health care provider (or practitioner) must be notified immediately.

6. A nurse checks a client who is on a volume-cycled ventilator. Which finding indicates that the client may need suctioning?

A) Drowsiness
B) Complaint of nausea
C) Pulse rate of 82
D) Restlessness

D: Restlessness. Restlessness, increased heart and respiratory rates, and noisy expiration suggest hypoxia and are indications for suctioning.

7. A client has returned from a cardiac catheterization. Which one of the following findings would indicate the client is experiencing a complication from the procedure?

A) Increased blood pressure
B) Increased heart rate
C) Loss of pulse in the extremity
D) Decreased urine output

C: Loss of pulse in the extremity. Loss of the pulse in the extremity would indicate impaired circulation.

8. The nurse is assessing a client 2 hours postoperatively after a femoral popliteal bypass. The upper leg dressing becomes saturated with blood. The nurse's **first** action should be to

A) wrap the leg with elastic bandages
B) apply pressure at the bleeding site
C) reinforce the dressing and elevate the leg
D) remove the dressings and re-dress the incision

C: The interventions that must be taken are: reinforce the dressing, elevate the extremity to decrease blood flow into the extremity and thus decrease bleeding, and call the provider immediately. This is an emergency post surgical situation.

9. The **most** effective nursing intervention to prevent atelectasis from developing in a post-operative client is to

A) maintain adequate hydration
B) assist client to turn, deep breathe, and cough
C) ambulate client within 12 hours
D) splint incision

B: assist client to turn, deep breathe, and cough. Deep air excursion by turning, deep breathing, and coughing will expand the lungs and stimulate surfactant production. The nurse should instruct the client on how to splint the chest when coughing. Humidification, hydration and nutrition all play a part in preventing atelectasis following surgery.

10. The nurse is reviewing laboratory results on a client with acute renal failure. Which one of the following should be reported **immediately**?

A) Blood urea nitrogen 50 mg/dl
B) Hemoglobin of 10.3 mg/dl
C) Venous blood pH 7.30
D) Serum potassium 6 mEq/L

D: Serum potassium 6 mEq/L. Although all of these findings are abnormal, the elevated potassium level is a life threatening finding and must be reported immediately.

11. The nurse is caring for a client undergoing the placement of a central venous catheter line. Which of the following would require the nurse's **immediate** attention?

A) Pallor
B) Increased temperature
C) Dyspnea
D) Involuntary muscle spasms

C: Dyspnea. Client's having the insertion of a central venous catheter are at risk for tension pneumothorax. Dyspnea, shortness of breath and chest pain are indications of this complication.

12. The nurse is caring for a client who requires a mechanical ventilator for breathing. The high pressure alarm goes off on the ventilator. What is the **first** action the nurse should perform?

A) Disconnect the client from the ventilator and use a manual resuscitation bag
B) Perform a quick assessment of the client's condition
C) Call the respiratory therapist for help
D) Press the alarm re-set button on the ventilator

B: A number of situations can cause the high pressure alarm to sound. It can be as simple as the client coughing. A quick assessment of the client will alert the nurse to whether it is a more serious or complex situation that might then require using a manual resuscitation bag and calling the respiratory therapist.

13. A 60 year-old male client had a hernia repair in an outpatient surgery clinic. He is awake and alert, but has not been able to void since he returned from surgery 6 hours ago. He received 1000 mL of IV fluid. Which action would be most likely to help him void?

A) Have him drink several glasses of water
B) Perform Credé's method on the bladder from the bottom to the top
C) Assist him to stand by the side of the bed to void
D) Wait 2 hours and have him try to void again

C: When a male is not able to use a urinal unassisted, the client should stand by the side of the bed to void. This is the most desirable position for normal voiding for male clients. Also, given his age, he most likely has some degree of prostate enlargement which may interfere with voiding.

14. The provider order reads "Aspirate nasogastric (NG) feeding tube every 4 hours and check pH of aspirate." The pH of the aspirate is 10. Which action should the nurse take?

A) Hold the tube feeding and notify the provider
B) Administer the tube feeding as scheduled
C) Irrigate the tube with diet cola soda
D) Apply intermittent suction to the feeding tube

A: Hold the tube feeding and notify the provider. A pH of less than 4 indicates that the tube is appropriately placed in the stomach, a highly acidic environment. A pH higher than 4 (alkaline pH) indicates intestinal placement.

15. When caring for a client with a post-right thoracotomy who has undergone an upper lobectomy, the nurse focuses on pain management to promote

A) relaxation and sleep
B) deep breathing and coughing
C) incisional healing
D) range of motion exercises

B: The priority is preventing postoperative respiratory complications. This client will quickly develop profound atelectasis and eventually pneumonia without adequate gas exchange. Client compliance with recommended deep breathing and coughing exercises will only be achieved with the appropriate pain management.

16. A client is diagnosed with a spontaneous pneumothorax necessitating the insertion of a chest tube. What is the **best** explanation for the nurse to provide this client?

A) "The tube will drain fluid from your chest."
B) "The tube will remove excess air from your chest."
C) "The tube controls the amount of air that enters your chest."
D) "The tube will seal the hole in your lung."

B: The purpose of the chest tube is to create negative pressure and remove the air that has accumulated in the pleural space.

17. To prevent unnecessary hypoxia during suctioning of a tracheostomy, the nurse must

A) apply suction for no more than 10 seconds
B) maintain sterile technique
C) lubricate 3 to 4 inches of the catheter tip
D) withdraw catheter in a circular motion

A: Applying suction for more than 10 seconds may result in hypoxia. Although options B, C, and D are important in during suctioning a tracheostomy, hypoxia results from actions that decrease the oxygen supply.

18. A client has a chest tube inserted following a left lower lobectomy required by a stab wound to the chest. While repositioning the client, the nurse notices 200 cc of dark, red fluid flows into the collection chamber of the chest drain. What is the **most** appropriate nursing action?

A) Clamp the chest tube
B) Call the surgeon immediately
C) Prepare for blood transfusion
D) Continue to monitor the rate of drainage

D: It is not unusual for blood to collect in the chest and be released into the chest drain when the client changes position. The dark color of the blood indicates it is not fresh bleeding inside the chest.

19. The nurse is preparing a client who will undergo a myelogram. Which of the following statements by the client indicates a contraindication for this test?

A) "I can't lie in one position for more than thirty minutes."
B) "I am allergic to shrimp."
C) "I suffer from claustrophobia."
D) "I developed a severe headache after a spinal tap."

B: "I am allergic to shrimp." A client undergoing myelography should be questioned carefully about allergies to iodine and iodine-containing substances such as seafood. An allergy to iodine or seafood may indicate sensitivity to the radiopaque contrast agent used in the test. An allergic reaction could even include seizures.

20. The nurse is performing a physical assessment on a client who just had an endotracheal tube (ET) inserted. Which finding would call for **immediate** action by the nurse?

A) Breath sounds can be heard bilaterally
B) Mist is visible in the T-Piece
C) Pulse oximetry of 88 BPM
D) Client is unable to speak

C: Pulse oximetry of 88 BPM. Pulse oximetry should not be lower than 90. Placement of the ET will need to be checked, along with the ventilator settings.

Physiological Adaptation

1. A man diagnosed with epididymitis 2 days ago calls the nurse at a health clinic to discuss the problem. What information is most important for the nurse to ask about at this time?

A) "What are you taking for pain and does it provide total relief?"
B) "Did your provider recommend that you be tested for Chlamydia?"
C) "Do you have any questions about your care?"
D) "Did you know a consequence of epididymitis is infertility?"

B: "Did your provider recommend that you be tested for Chlamydia?" Epididymitis can result from Chlamydia infection, in which case the client's sexual partners should be tested as well. All of the questions should be asked, however, determining the reason for the client's referral is the most important to start with.

2. A client with heart failure has a prescription for Digoxin. The nurse is aware that sufficient potassium should be included in the diet because hypokalemia in combination with this medication

A) can predispose to dysrhythmias
B) may lead to oliguria
C) may cause irritability and anxiety
D) sometimes alters consciousness

A: can predispose to dysrhythmias. The nurse should be aware of a decrease in the client's potassium levels because low potassium can enhance the effects of digoxin and predispose the client to dysrhythmias. The other options are seen in hyperkalemia. Muscle weakness occurs in both hyperkalemia and hypokalemia.

3. A client has altered renal function and is being treated at home. The nurse recognizes that the most accurate indicator of fluid balance during the weekly visits is

A) difference in the intake and output
B) changes in the mucous membranes

C) skin turgor
D) weekly weight

D: weekly weight. The most accurate indicator of fluid balance in an acutely ill individual is the daily weight. A one-kilogram or 2.2 pounds of weight gain is equal to approximately 1,000 ml of retained fluid. Other options are considered as part of data collection, but they are not the most accurate indicators of fluid balance.

4. A nurse is performing CPR on an adult who went into cardiopulmonary arrest. Another nurse enters the room in response to the call. After checking the client's pulse and respirations, what should be the function of the second nurse?

A) Relieve the nurse performing CPR
B) Go get the code cart
C) Participate with the compressions or breathing
D) Validate the client's advanced directive

C: Participate with the compressions or breathing. Once CPR is started, it is to be continued using the approved technique until such time as a provider pronounces the client dead or the client becomes stable. American Heart Association studies have shown that the 2 person technique is most effective in sustaining the client. It is not appropriate to relieve the first nurse to leave the room for equipment. The client's advanced directives should have been filed on admission and his choices known prior to the initiation of CPR.

5. Which these findings would the nurse more closely associate with anemia in a 10 month-old infant?

A) hemoglobin level of 12 g/dL
B) pale mucosa of the eyelids and lips
C) hypoactivity
D) a heart rate between 80 and 130

B: pale mucosa of the eyelids and lips. In iron-deficiency anemia, the physical exam reveals a pale, tired-appearing infant with mild to severe tachycardia.

6. An elderly client admitted after a fall begins to seize and loses consciousness. What action by the nurse is appropriate to do next?

A) Stay with client and observe for airway obstruction
B) Collect pillows and pad the side rails of the bed
C) Place an oral airway in the mouth and suction
D) Announce a cardiac arrest, and assist with intubation

A: Stay with client and observe for airway obstruction. For the client's safety, remain at the bedside and observe respirations and level of consciousness. Prepare to clear the airway if obstructed. Do not place anything in the client's mouth. For safety, do not leave the client unattended. A cardiac arrest should only be announced if pulse or respirations are absent after the seizure

7. Which of these statements from clients who call the community health clinic would suggest the need for a same-day appointment to be seen by the health care provider?

A) "I started my period and now my urine has turned bright red"

B) "I am an diabetic and today I have been going to the bathroom every hour"
C) "I was started on medicine yesterday for a urine infection. Now my lower belly hurts when I go to the bathroom"
D) "I went to the bathroom and my urine looked very red and it didn't hurt when I went"

D: With this description of symptoms this client needs to be seen that day since painless gross hematuria is closely associated with bladder cancer. The other complaints can be handled over the phone.

8. A 14 year-old with a history of sickle cell disease is admitted to the hospital with a diagnosis of vaso-occlusive crisis. Which statements by the client would be most indicative of the etiology of this crisis?

A) "I knew this would happen. I've been eating too much red meat lately."
B) "I really enjoyed my fishing trip yesterday. I caught two fish."
C) "I have really been working hard practicing with the debate team at school."
D) "I went to get a cold checked out last week, and I have gotten worse."

D: "I went to get a cold checked out last week, and I have gotten worse." Any condition that increases the body"s need for oxygen or alters the transport of oxygen, such as infection, trauma or dehydration may result in a sickle cell crisis.

9. The nurse assesses a 72 year-old client who was admitted for right-sided congestive heart failure. Which of the following would the nurse anticipate finding?

A) Decreased urinary output
B) Jugular vein distention
C) Pleural effusion
D) Bibasilar crackles

B: Signs of right-sided heart failure include jugular vein distention, ascites, nausea, and vomiting.

10. The nurse is caring for a client in atrial fibrillation. The atrial heart rate is 250 and the ventricular rate is controlled at 75. Which of the following findings is cause for the **most** concern?

A) Diminished bowel sounds

B) Loss of appetite
C) A cold, pale lower leg
D) Tachypnea

C: A cold, pale lower leg. This assessment suggests the presence of an embolus probably from the atrial fibrillation. Peripheral pulses should be checked immediately.

11. A client is admitted with a tentative diagnosis of congestive heart failure. Which of the following assessments would the nurse expect to be consistent with this problem?

A) Chest pain
B) Pallor
C) Inspiratory crackles
D) Heart murmur

C: Inspiratory crackles. In congestive heart failure, fluid backs up into the lungs (creating crackles) as a result of inefficient cardiac pumping.

12. A client is admitted for first and second degree burns on the face, neck, anterior chest and hands. The nurse's **priority** should be to

A) cover the areas with dry sterile dressings
B) assess for dyspnea or stridor
C) initiate intravenous therapy
D) administer pain medication

B: assess for dyspnea or stridor. Due to the location of the burns, the client is at risk for developing upper airway edema and subsequent respiratory distress.

13. A client with pneumococcal pneumonia was started on antibiotics 16 hours ago. During the nurse's initial evening rounds the nurse notices a foul smell in the room. The client makes all of these statements during their conversation. Which one would alert the nurse to a complication?

A) "I have a sharp pain in my chest when I take a breath."
B) "I have been coughing up foul-tasting, brown, thick sputum."
C) "I have been sweating all day."
D) "I feel hot off and on."

B:Foul smelling and tasting sputum signals a risk of a lung abscess. This puts the client is grave danger since abscesses are often caused by anaerobic organisms. This client most likely would need a change of antibiotics. Sharp chest pain on inspiration called pleuritic pain is an expected finding with this type of pneumonia. The other options are expected in the initial 24 to 48 hours of therapy for infections.

14. Which information is a **priority** for the nurse to reinforce to an older client after intravenous pyelography?

A) Eat a light diet for the rest of the day
B) Rest for the next 24 hours since the preparation and the test is tiring

C) During waking hours drink at least 1 8-ounce glass of fluid every hour for the next 2 days
D) Measure the urine output for the next day and immediately notify the health care provider if it should decrease

D: This information would alert to the complication of acute renal failure which may occur as a complication from the dye and the procedure. Renal failure occurs most often in elderly patients who are chronically dehydrated before the dye injection.

15. A nurse is providing care to a 17 year-old client in the post-operative care unit (PACU) after an emergency appendectomy. Which finding is an early indication that the client is experiencing poor oxygenation?

A) Abnormal breath sounds
B) Cyanosis of the lips
C) Increasing pulse rate
D) Pulse oximeter reading of 92%

C: The earliest sign of poor oxygenation is an increasing pulse rate as a part of the body's compensatory mechanism. Abnormal breath sounds and cyanosis are late signs of poor oxygenation. A pulse oximetry reading of 92% is normal.

16. A nurse is observing a client during an excretory urogram. Which of these observations indicate a complication is occurring?

A) "The client complains of a salty taste in the mouth when the dye is injected."
B) "The client's entire body turns a bright red color.
C) "The client states "I have a feeling of getting warm."
D) "The client gags and complains "I am getting sick."

B: "The client's entire body turns a bright red color. This observation suggest anaphylaxis which results in massive vasodilation. Other findings would be immediate wheezing and/or respiratory arrest.

17. The nurse is assessing an 8 month-old child with atonic cerebral palsy. Which statement from the parent supports the presence of this problem?

A) "When I put my finger in the left hand the baby doesn't respond with a grasp."

B) "My baby doesn't seem to follow when I shake toys in front of its face."
C) "When it thundered loudly last night the baby didn't even jump."
D) "When I put the baby in a back lying position that's how I find it hours later."

D: "When I put the baby in a back lying position that's how I find it hours later." Cerebral palsy is known as a condition whereby motor dysfunction occurs secondary to damage in the motor centers of the brain. Inability to roll over by 8 months of age would illustrate one delay in the infant"s attainment of developmental milestones.

18. A client who is to have antineoplastic chemotherapy tells the nurses of a fear of being sick all the time and indicates a wish to try acupuncture. Which of these beliefs stated by the client would be incorrect about acupuncture?

A) "Some needles go as deep as 3 inches, depending on where they're placed in the body and what the treatment is for. The needles usually are left in for 15 to 30 minutes."
B) "In traditional Chinese medicine, imbalances in the basic energetic flow of life — known as qi or chi — are thought to cause illness."
C) "The flow of life is believed to flow through major pathways called nerve clusters in your body."
D) "By inserting extremely fine needles into some of the over 400 acupuncture points in various combinations it is believed that energy flow will rebalance to allow the body's natural healing mechanisms to take over."

C: The major pathways are called meridians, not nerve clusters.

19. A primigravida in the third trimester is hospitalized for preeclampsia. The nurse determines that the client's blood pressure is increasing. Which action should the nurse take **first**?

A) Check the protein level in urine
B) Have the client turn to the left side
C) Take the temperature
D) Monitor the urine output

B: A priority action is to turn the client to the left side to decrease pressure on the vena cava and promote adequate circulation to the placenta and kidneys. Urine protein level and output should be checked with each voiding. Temperature should be monitored every 4 hours or more often if indicated, but no data in the stem supports a check of temperature.

20. A client has viral pneumonia affecting 2/3 of the right lung. What would be the **best** position to teach the client to lie in every other hour during first 12 hours after admission?

A) Side-lying on the left with the head elevated 10 degrees
B) Side-lying on the left with the head elevated 35 degrees
C) Side-lying on the right with the head elevated 10 degrees
D) Side-lying on the right with the head elevated 35 degrees

A: Side-lying on the left with the head elevated 10 degrees. Gravity will draw the most blood flow to the dependent portion of the lung. For unilateral chest disease, it is best to place the healthiest part of the lung in the dependent position to enhance blood flow to the area where gas exchange will be best. Ventilation would be minimally affected in the right dependent lung. This position also enhances the drainage of the infected part of the lung. A head elevation of 35 degrees is counterproductive to therapeutic blood flow and the drainage of secretions.

21. The nurse is caring for a client in hypertensive crisis in an intensive care unit. The priority assessment in the first hour of care is

A) heart rate
B) pedal pulses
C) lung sounds
D) pupil responses

D: pupil responses. The organ most susceptible to damage in hypertensive crisis is the brain due to rupture of the cerebral blood vessels. Neurologic status must be closely monitored.

22. The nurse is performing an assessment on a client in congestive heart failure. Auscultation of the heart is **most** likely to reveal

A) S3 ventricular gallop
B) apical click
C) systolic murmur
D) split S2

A: S3 ventricular gallop. An S3 ventricular gallop is caused by blood flowing rapidly into a distended non-compliant ventricle. This is most common with congestive heart failure.

23. A 2 year-old child is brought to the emergency department at 2:00 in the afternoon. The mother states: "My child has not had a wet diaper all day." The nurse finds the child is pale with a heart rate of 132. What assessment data should the nurse obtain next?

A) Status of the eyes and the tongue
B) Description of play activity
C) History of fluid intake
D) Dietary patterns

A: Status of the eyes and the tongue. Clinical findings of dehydration include sunken eyes, dry tongue, lethargy, irritability, dry skin, decreased play activity, and increased pulse. The normal pulse rate in this age child is 70-110.

24. Which of these clients who are all in the terminal stage of cancer is least appropriate to suggest the use of patient controlled analgesia (PCA) with a pump?

    A) A young adult with a history of Down syndrome
    B) A teenager who reads at a 4th grade level
    C) An elderly client with numerous arthritic nodules on the hands
    D) A preschooler with intermittent episodes of alertness

D: A preschooler with intermittent episodes of alertness. A preschooler is most likely of these clients to have difficulty with the use or understanding of a PCA pump. This very young child lacking a normal level of consciousness would not benefit from the use of a PCA pump.

25. The client with infective endocarditis must be assessed frequently by the home health nurse. Which finding suggests that antibiotic therapy is not effective, and must be reported by the nurse **immediately** to the provider?

    A) nausea and vomiting
    B) fever of 103 degrees Fahrenheit (39.5 degrees Celsius)
    C) diffuse macular rash
    D) muscle tenderness

B: fever of 103 degrees Fahrenheit (39.5 degrees Celsius). Persistent, prolonged fever may be an indication that the antibiotics are not effective and may need to be changed.

26. The nurse is caring for a client with uncontrolled hypertension. Which findings require immediate nursing action?

    A) lower extremity pitting edema
    B) rales
    C) jugular vein distension
    D) weakness in left arm

D: weakness in left arm. In a client with hypertension, weakness in the extremities is a sign of cerebral involvement with the potential for cerebral infarction or stroke. Cerebral infarctions account for about 80% of the strokes in clients with hypertension. The remaining 3 choices indicate mild fluid overload and are not medical emergencies.

27. A client has had heart failure. Which intervention is most important for the nurse to implement prior to the initial administration of digoxin to this client?

    A) Assess the apical pulse, counting for a full 60 seconds
    B) Take a radial pulse, counting for a full 60 seconds
    C) Use the pulse reading from the electronic blood pressure device
    D) Check for a pulse deficit

A: Assess the apical pulse, counting for a full 60 seconds. It is the nurse's responsibility to take the client's pulse before administering digoxin. The correct technique for taking an apical pulse is to use the stethoscope and listen for a full 60 seconds. Digoxin is held for a pulse below 60 beats per minute. A radial pulse, potentially less accurate, or blood pressure are not part of the initial assessment before administering an initial dose of digoxin.

28. A client has been diagnosed with Zollinger-Ellison syndrome. Which information is **most important** for the nurse to reinforce?

    A) It is a condition in which one or more tumors called gastrinomas form in the pancreas or in the upper part of the small intestine (duodenum)
    B) It is critical to report promptly to your health care provider any findings of peptic ulcers
    C) Treatment consists of medications to reduce acid and heal any peptic ulcers and, if possible, surgery to remove any tumors
    D) With the average age at diagnosis at 50 years the peptic ulcers may occur at unusual areas of the stomach or intestine

B: It is critical to report promptly to your health care provider any findings of peptic ulcers. Such findings include night-time awakening with burning, cramp-like abdominal pain, vomiting and even hematemesis, and change in appetite. Abdominal pain, rigidity and tenderness can signal perforation of the ulcer and should be reported to the provider immediately. Zollinger-Ellison syndrome can occur in both children and adults.

29. As the nurse is speaking with a group of teens, which of these side effects of chemotherapy for cancer would the nurse expect this group to be more interested in during the discussion?

    A) Mouth sores
    B) Fatigue
    C) Diarrhea
    D) Hair loss

D: Hair loss. The major concern for adolescence is body image, so hair loss would be the most disturbing.

30. The nurse is discussing Kawasaki disease with a group of students. What statement made by a student about Kawasaki disease is **incorrect**?

A) "It also called mucocutaneous lymph node syndrome because it affects the mucous membranes (inside the mouth, throat and nose), skin and lymph nodes."
B) "In the second phase of the disease, findings include peeling of the skin on the hands and feet with joint and abdominal pain."
C) "Kawasaki disease occurs most often in boys, children younger than age 5 and children of Hispanic descent."
D) "Initially findings are a sudden high fever, usually above 104 degrees Fahrenheit, which lasts 1 to 2 weeks."

C: Kawasaki disease occurs most often in boys, children younger than age 5 and children of Asian descent, particularly Japanese. Other findings in the initial phase are extremely red eyes (conjunctivitis), a rash on the main part of the body (trunk) and in the genital area, red, dry, cracked lips; a red, swollen tongue resembling a strawberry; swollen, red skin on the palms of the hands and the soles of the feet; swollen lymph nodes in the neck. Fever reduction signals the second phase, when the findings slowly go away. In the third phase findings, except for abnormal lab values, are gone unless complications associated with the heart develop. The disease lasts from 2 to 12 weeks without treatment. With treatment, the child usually improves within 24 hours. The cause of Kawasaki disease is not known.

31. The nurse is about to assess a 6 month-old child with non-organic failure-to-thrive (NOFTT). Upon entering the room, the nurse would expect the baby to be

A) irritable and "colicky," making no attempts to pull to standing
B) alert, laughing, playing with a rattle, and sitting with support
C) dusky in color with poor skin turgor over abdomen
D) pale, have thin arms and legs, and uninterested in surroundings

D: pale, have thin arms and legs, and uninterested in surroundings. Diagnosis of NOFTT is made on anthropomorphic findings documenting growth retardation which would lead the nurse to expect muscle-wasting and paleness. In cases of NOFTT, the cause may be a variety of psychosocial factors and these children may be below normal in intellectual development, language and social interactions.

32. A client who was medicated with meperidine hydrochloride (Demerol) 100 mg and hydroxyzine hydrochloride (Vistaril Intramuscular) 50 mg IM for pain related to a fractured lower right leg 1 hour ago reports that the pain is getting worse. The nurse should recognize that the client may be developing which complication?

A) acute compartment syndrome
B) thromboembolitic complications
C) fatty embolism
D) osteomyelitis

A: acute compartment syndrome. Increasing pain that is not relieved by narcotic analgesics is an indication of compartment syndrome after a bone fracture and requires immediate action by the nurse. Thromboembolic complications include deep vein thrombosis and pulmonary embolism which are not characterized by increasing pain at the site of injury. Both pulmonary embolism and fat embolism present with respiratory findings. Osteomyelitis is a bone infection which could occur some time after the initial injury, usually at least 48 to 72 hours.

33. Which statements by the client would indicate to the nurse an understanding of the issues with end stage renal disease?

A) "I have to go at intervals for epoetin (Procrit) injections at the health department."
B) "I know I have a high risk of clot formation since my blood is thick from too many red cells."
C) "I expect to have periods of little water with voiding and then sometimes to have a lot of water."
D) "My bones will be stronger with this disease since I will have higher calcium than normal."

A: Anemia caused by reduced endogenous erythropoietin production, primarily end-stage renal disease is treated with subcutaneous injections of Procrit or Epogen to stimulate the bone marrow to produce red blood cells.

34. While caring for a client who was admitted with myocardial infarction (MI) 2 days ago, the nurse notes today's temperature is 101.1 degrees Fahrenheit (38.5 degrees Celsius). The appropriate nursing intervention is to

A) call the health care provider immediately
B) administer acetaminophen as ordered as this is normal at this time
C) send blood, urine and sputum for culture
D) increase the client's fluid intake

B: Leukocytosis and fever are common starting on day 2 because of the inflammatory process associated with an acute MI. Nursing interventions should focus on promoting comfort.

35. A nurse is providing care to a primigravida whose membranes spontaneously ruptured (ROM) 4 hours ago. Labor is to be induced. At the time of the ROM, the vital signs were T-99.8 degrees Fahrenheit, P-84, R-20, BP-130/78, and fetal heart tones (FHT) 148 beats/min. Which assessment findings may be an early indication that the client is developing a complication of labor?

A) FHT 168 beats/min
B) Temperature 100 degrees Fahrenheit
C) Cervical dilation of 4 cm
D) BP 138/88

A: An increase in FHT may indicate maternal infection. The other assessment findings are normal.

36. A client who had a vasectomy is in the post recovery unit at an outpatient clinic. Which of these points is most important to be reinforced by the nurse?

A) "Until the health care provider has determined that your ejaculate doesn't contain sperm, continue to use another form of contraception."
B) "This procedure doesn't impede the production of male hormones or the production of sperm in the testicles. The sperm can no longer enter your semen and no sperm are in your ejaculate."
C) "After your vasectomy, strenuous activity needs to be avoided for at least 48 hours. If your work doesn't involve hard physical labor, you can return to your job as soon as you feel to it. The stitches generally dissolve in 7-10 days."
D) "The health care provider at this clinic recommends rest, ice, an athletic supporter or over-the-counter pain medication to relieve any discomfort."

A: All of these options are correct information. The most important point to reinforce is the continuing need to take additional action for birth control.

37. A female client talks to the nurse in the provider's office about uterine fibroids, also called leiomyomas or myomas. What statement by the woman indicates more education is needed?

A) "I am the one out of every 4 women that get fibroids, and of women my age – between the 30s or 40s, fibroids occur more frequently."
B) "My fibroids are noncancerous tumors that grow slowly."
C) "My associated problems I have had are pelvic pressure and pain, urinary incontinence,and constipation."
D) "Fibroids that cause no problems still need to be taken out."

D: Fibroids that cause no findings may require only "watchful waiting" with no treatment. Only when the client's findings become disturbing to them would surgical interventions be considered.

38. A client has an indwelling catheter with continuous bladder irrigation after undergoing a transurethral resection of the prostate (TURP) 12 hours ago. Which finding at this time should be reported to the health care provider?

A) light, pink urine
B) occasional suprapubic cramping
C) minimal drainage into the urinary collection bag
D) reports of the feeling of pulling on the urinary catheter

C: Options A, B, and D are expected complaints after this procedure. Option C needs to be reported immediately since minimal urinary drainage puts the client at risk for bladder rupture. The flow rate of the continuous irrigation would need to be slowed until the provider is notified. If an order to irrigate the system is written, sterile technique would be used.

39. Which order can be associated with the prevention of atelectasis and pneumonia in a client with amyotrophic lateral sclerosis (ALS)?

A) Active and passive range of motion exercises twice a day
B) Use incentive spirometer every 4 hours
C) Chest physiotherapy twice a day
D) Repositioning every 2 hours around the clock

C: Chest physiotherapy twice a day. These clients have potential inability to have voluntary and involuntary muscle movement or activity. Thus, options A and B may not be feasible for the immobilized client. Option D is not specific for prevention of complications associated with the lung.

40. A nurse assesses a young adult in the emergency room following a motor vehicle accident. Which of the following neurological signs is of most concern?

A) Flaccid paralysis
B) Pupils fixed and dilated
C) Diminished spinal reflexes
D) Reduced sensory responses

B: Pupils fixed and dilated. Pupils that are fixed and dilated indicate overwhelming injury and intrinsic damage to the upper brain stem. It is a poor prognostic sign.

Q&A Random Selection #1

1. An older adult client is to receive and antibiotic, gentamicin. What diagnostic finding indicates the client may have difficult excreting the medication?

    A) High gastric pH
    B) High serum creatinine
    C) Low serum albumin
    D) Low serum blood urea nitrogen

B: High serum creatinine. An elevated serum creatinine indicates reduced renal function. Reduced renal function will delay the excretion of many medications.

2. A client is admitted to the hospital with findings of liver failure with ascites. The health care provider orders spironolactone (Aldactone). What is the pharmacological effect of this medication?

    A) Promotes sodium and chloride excretion
    B) Increases aldosterone levels
    C) Depletes potassium reserves
    D) Combines safely with antihypertensives

A: Promotes sodium and chloride excretion. Spironolactone promotes sodium and chloride excretion while sparing potassium and decreasing aldosterone levels. It had no effect on ammonia levels.

3. A client with tuberculosis is started on Rifampin. Which one of the following statements by the nurse would be appropriate to include in teaching? "You may notice:

    A) an orange-red color to your urine."
    B) your appetite may increase for the first week."

C) it is common to experience occasional sleep disturbances."
D) if you take the medication with food, you may have nausea."

A: an orange-red color to your urine." Discoloration of the urine and other body fluids may occur. It is a harmless response to the drug, but the patient needs to be aware it may happen.

4. The nurse has just received report on a group of clients and plans to delegate care of several of the clients to a practical nurse (PN). The **first** thing the RN should do before the delegation of care is

A) Provide a time-frame for the completion of the client care
B) Assure the PN that the RN will be available for assistance
C) Ask about prior experience with similar clients
D) Review the specific procedures unique to the assignment

C: Ask about prior experience with similar clients. The first step in delegation is to determine the qualifications of the person to whom one is delegating. By asking about the PN"s prior experience with similar clients/tasks, the RN can determine whether the PN has the requisite experience to care for the assigned clients.

5. Which of the following assessments by the nurse would indicate that the client is having a possible adverse response to the isoniazid (INH)?

A) Severe headache
B) Appearance of jaundice
C) Tachycardia
D) Decreased hearing

B: Appearance of jaundice. Clients receiving INH therapy are at risk for developing drug induced hepatitis. The appearance of jaundice may indicate that the client has liver damage.

6. The nurse is caring for a client who is 4 days post-op for a transverse colostomy. The client is ready for discharge and asks the nurse to empty his colostomy pouch. What is the best response by the nurse?

A) "You should be emptying the pouch yourself."
B) "Let me demonstrate to you how to empty the pouch."
C) "What have you learned about emptying your pouch?"
D) "Show me what you have learned about emptying your pouch."

D: Most adult learners obtain skills by participating in the activities. Anxiety about discharge can be causing the client to forget that they have mastered the skill of emptying the pouch. The client should show the nurse how the pouch is emptied.

7. A post-operative client is admitted to the post-anesthesia recovery room (PACU). The anesthetist reports that malignant hyperthermia occurred during surgery. The nurse recognizes that this complication is related to what factor?

A) Allergy to general anesthesia
B) Pre-existing bacterial infection
C) A genetic predisposition
D) Selected surgical procedures

C: A genetic predisposition. Malignant hyperthermia is a rare, potentially fatal adverse reaction to inhaled anesthetics. There is a genetic predisposition to this disorder.

8. Which of the following laboratory results would suggest to the emergency room nurse that a client admitted after a severe motor vehicle crash is in acidosis?

A) Hemoglobin 15 gm/dl
B) Chloride 100 mEq/L
C) Sodium 130 mEq/L
D) Carbon dioxide 20 mEq/L

D: Carbon dioxide 20 mEq/L. Serum carbon dioxide is an indicator of acid-base status. This finding would indicate acidosis.

9. The nurse is teaching a school-aged child and family about the use of inhalers prescribed for asthma. What is the best way to evaluate effectiveness of the treatments?

A) Rely on child's self-report
B) Use a peak-flow meter
C) Note skin color changes
D) Monitor pulse rate

B: Use a peak-flow meter. The peak flowmeter, if used correctly, shows effectiveness of inhalants.

10. The nurse is providing care to a newly a hospitalized adolescent. What is the major threat experienced by the hospitalized adolescent?

A) Pain management
B) Restricted physical activity
C) Altered body image
D) Separation from family

C: Altered body image. The hospitalized adolescent may see each of these as a threat, but the major threat that they feel when hospitalized is the fear of altered body image, because of the emphasis on physical appearance during this developmental stage.

11. A client on telemetry begins having premature ventricular beats (PVBs) at 12 per minute. In reviewing the **most** recent laboratory results, which would require immediate action by the nurse?

    A) Calcium 9 mg/dl
    B) Magnesium 2.5 mg/dl
    C) Potassium 2.5 mEq/L
    D) PTT 70 seconds

C: Potassium 2.5 mEq/L. The patient is at risk for ventricular dysrhythmias when the potassium level is low.

12. A client has just been diagnosed with breast cancer. The nurse enters the room and the client tells the nurse that she is stupid. What is the most therapeutic response by the nurse?

    A) Explore what is going on with the client
    B) Accept the client's statement without comment
    C) Tell the client that the comment is inappropriate
    D) Leave the client's room

A: Explore what is going on with the client. Exploring feelings with the verbally aggressive client helps to put angry feelings into words and then to engage in problem solving.

13. A 12 year-old child is admitted with a broken arm and is told surgery is required. The nurse finds him crying and unwilling to talk. What is the most appropriate response by the nurse?

    A) Give him privacy
    B) Tell him he will get through the surgery with no problem
    C) Try to distract him
    D) Make arrangements for his friends to visit

A: Give him privacy. A 12 year-old child needs the opportunity to express his emotions privately.

14. A nurse is assigned to care for a comatose diabetic on IV insulin therapy. Which task would be **most** appropriate to delegate to an unlicensed assistive personnel (UAP)?

    A) Check the client's level of consciousness
    B) Obtain the regular blood glucose readings
    C) Determine if special skin care is needed
    D) Answer questions from the client's spouse about the plan of care

B: Obtain the regular blood glucose readings. The UAP can safely obtain blood glucose readings, which are routine tasks.

15. The clinic nurse is discussing health promotion with a group of parents. A mother is concerned about Reye's Syndrome, and asks about prevention. Which of these demonstrates appropriate teaching?

    A) "Immunize your child against this disease."
    B) "Seek medical attention for serious injuries."
    C) "Report exposure to this illness."
    D) "Avoid use of aspirin for viral infections."

D: "Avoid use of aspirin for viral infections." The link between aspirin use and Reye"s Syndrome has not been confirmed, but evidence suggests that the risk is sufficiently grave to include the warning on aspirin products.

16. The nurse is caring for a client with a new order for bupropion (Wellbutrin) for treatment of depression. The order reads "Wellbutrin 175 mg. BID x 4 days." What is the appropriate action?

    A) Give the medication as ordered
    B) Question this medication dose
    C) Observe the client for mood swings
    D) Monitor neuro signs frequently

B: Question this medication dose. Bupropion (Wellbutrin) should be started at 100mg BID for three days then increased to 150mg BID. When used for depression, it may take up to four weeks for results. Common side effects are dry mouth, headache, and agitation. Doses should be administered in equally spaced time increments throughout the day to minimize the risk of seizures.

17. A 3 year-old child has tympanostomy tubes in place. The child's parent asks the nurse if he can swim in the family pool. The **best** response from the nurse is

    A) "Your child should not swim at all while the tubes are in place."
    B) "Your child may swim in your own pool but not in a lake or ocean."
    C) "Your child may swim if he wears ear plugs."
    D) "Your child may swim anywhere."

C: "Your child may swim if he wears ear plugs." Water should not enter the ears. Children should use ear plugs when bathing or swimming and should not put their heads under the water.

18. A nurse has administered several blood transfusions over 3 days to a 12 year-old client with Thalassemia. What lab value should the nurse monitor closely during this therapy?

A) Hemoglobin
B) Red Blood Cell Indices
C) Platelet count
D) Neutrophil percent

A: Hemoglobin should be in a therapeutic range of approximately 10 g/dl (100gL). "This level is low enough to foster the patient"s own erythropoiesis without enlarging the spleen." (Lewis, p. 744)

19. The nurse is explaining the effects of cocaine abuse to a pregnant client. Which of the following must the nurse understand as a basis for teaching?

A) Cocaine use can cause fetal growth retardation
B) The drug has been linked to neural tube defects
C) Newborn withdrawal generally occurs immediately after birth
D) Breast feeding promotes positive parenting behaviors

A: Cocaine use can cause fetal growth retardation. Cocaine is vasoconstrictive, and this effect in the placental vessels causes fetal hypoxia and diminished growth. Other risks of continued cocaine use during pregnancy include preterm labor, congenital abnormalities, altered brain development and subsequent behavioral problems in the infant.

20. The feeling of trust can **best** be established by the nurse during the process of the development of a nurse-client relationship by which of these characteristics?

A) Reliability and kindness
B) Demeanor and sincerity
C) Honesty and consistency
D) Sympathy and appreciativeness

C: Honesty and consistency. Characteristics of a trusting relationship include respect, honesty, consistency, faith and caring.

21. A client is receiving and IV antibiotic infusion and is scheduled to have blood drawn at 1:00 pm for a "peak" antibiotic level measurement. The nurse notes that the IV infusion is running behind schedule and will not be competed by 1:00. The nurse should:

A) Notify the client's health care provider
B) Stop the infusion at 1:00 pm
C) Reschedule the laboratory test
D) Increase the infusion rate

C: Reschedule the laboratory test. If the antibiotic infusion will not be completed at the time the peak blood level is due to be drawn, the nurse should ask that the blood sampling time be adjusted

22. A 52 year-old post menopausal woman asks the nurse how frequently she should have a mammogram. What is the nurse's best response?

A) "Your doctor will advise you about your risks."
B) "Unless you had previous problems, every 2 years is best."
C) "Once a woman reaches 50, she should have a mammogram yearly."
D) "Yearly mammograms are advised for all women over 35."

C: "Once a woman reaches 50, she should have a mammogram yearly." The American Cancer Society recommends a screening mammogram by age 40, every 1 - 2 years for women 40-49, and every year from age 50. If there are family or personal health risks, other assessments may be recommended.

23. In discharge teaching, the nurse should emphasize that which of these is a common side effect of clozapine (Clozaril) therapy?

A) Dry mouth
B) Rhinitis
C) Dry skin
D) Extreme salivation

D: Extreme salivation. A significant number of clients receiving Clozapine (Clozaril) therapy experience extreme salivation.

24. A client was admitted to the psychiatric unit for severe depression. After several days, the client continues to withdraw from the other clients. Which of these statements by the nurse would be the **most** appropriate to promote interaction with other clients?

A) "Your team here thinks it's good for you to spend time with others.
B) "It is important for you to participate in group activities."
C) "Come with me so you can paint a picture to help you feel better."
D) "Come play Chinese Checkers with Gloria and me."

D: This gradually engages the client in interactions with others in small groups rather than large groups. In addition, focusing on an activity is less anxiety-provoking than unstructured discussion. The statement is an example of a positive behavioral expectation.

25. The mother of a 4 month-old infant asks the nurse about the dangers of sunburn while they are on vacation at the beach. Which of the following is the best advice about sun protection for this child?

A) "Use a sunscreen with a minimum sun protective factor of 15."
B) "Applications of sunscreen should be repeated every few hours."
C) "An infant should be protected by the maximum strength sunscreen."
D) "Sunscreens are not recommended in children younger than 6 months."

D: Infants under 6 months of age should be kept out of the sun or shielded from it. Even on a cloudy day, the infant can be sunburned while near water. A hat and light protective clothing should be worn.

26. A client has had a positive reaction to purified protein derivative (PPD). The client asks the nurse what this means. The nurse should indicate that the client has

A) active tuberculosis
B) been exposed to *mycobacterium tuberculosis*
C) never had tuberculosis
D) never been infected with mycobacterium tuberculosis

B: been exposed to *mycobacterium tuberculosis*. The PPD skin test is used to determine the presence of tuberculosis antibodies and a positive result indicates that the person has been exposed to *mycobacterium tuberculosis*. Additional tests are needed to determine if active tuberculosis is present.

27. The nurse administers cimetidine (Tagamet) to a 79 year-old male with a gastric ulcer. Which parameter may be affected by this drug, and should be closely monitored by the nurse?

A) Blood pressure
B) Liver function
C) Mental status
D) Hemoglobin

C: Mental status. The elderly are at risk for developing confusion when taking cimetidine, a drug that interacts with many other medications.

28. A 9 year-old is taken to the emergency room with right lower quadrant pain and vomiting. When preparing the child for an emergency appendectomy, what must the nurse expect to be the child's greatest fear?

A) Change in body image
B) An unfamiliar environment
C) Perceived loss of control
D) Guilt over being hospitalized

C: Perceived loss of control. For school age children, major fears are loss of control and separation from friends/peers.

29. The nurse is planning care for a client who is taking cyclosporin (Neoral). What would be an appropriate nursing diagnosis for this client?

A) Alteration in body image
B) High risk for infection
C) Altered growth and development
D) Impaired physical mobility

B: Cyclosporin (Neoral) inhibits normal immune responses. Clients receiving cyclosporin are at risk for infection.

30. A client with paranoid thoughts refuses to eat because of the belief that the food is poisoned. The **appropriate statement at this time for the nurse to say is**

A) "Here, I will pour a little of the juice in a medicine cup to drink it to show you that it is OK."
B) "The food has been prepared in our kitchen and is not poisoned."
C) "Let's see if your partner could bring food from home."
D) "If you don't eat, I will have to suggest for you to be tube fed."

C: Reassurance is ineffective when a client is actively delusional. This option avoids both arguing with the client and agreeing with the delusional premise. Option D offers a logical response to a primarily affective concern. When the client's condition has improved, gentle negation of the delusional premise can be employed.

31. A client has many delusions. As the nurse helps the client prepare for breakfast the client comments "Don't waste good food on me. I'm dying from this disease I have." The appropriate response would be

A) "You need some nutritious food to help you regain your weight."
B) "None of the laboratory reports show that you have any physical disease."
C) "Try to eat a little bit, breakfast is the most important meal of the day."
D) "I know you believe that you have an incurable disease."

D: This response does not challenge the client's delusional system and thus forms an alliance by providing reassurance of desire to help the client.

32. A client tells the RN she has decided to stop taking sertraline (Zoloft) because she doesn't like the nightmares, sex dreams, and obsessions she's experiencing since starting on the medication. What is an appropriate response by the nurse?

A) "It is unsafe to abruptly stop taking any prescribed medication."
B) "Side effects and benefits should be discussed with your health care provider."
C) "This medication should be continued despite unpleasant symptoms."
D) "Many medications have potential side effects."

A: Abrupt withdrawal may occasionally cause serotonin syndrome, consisting of lethargy, nausea, headache, fever, sweating and chills. A slow withdrawal may be prescribed with sertraline to avoid dizziness, nausea, vomiting, and diarrhea.

33. The nurse is beginning nutritional counseling/teaching with a pregnant woman. What is the initial step in this interaction?

A) Teach her how to meet the needs of self and her family
B) Explain the changes in diet necessary for pregnant women
C) Question her understanding and use of the food pyramid
D) Conduct a diet history to determine her normal eating routines

D: Conduct a diet history to determine her normal eating routines. Assessment is always the first step in planning teaching for any client. A thorough and accurate history is essential for gathering the needed information.

34. A client diagnosed with cirrhosis is started on lactulose (Cephulac). The main purpose of the drug for this client is to

A) add dietary fiber
B) reduce ammonia levels
C) stimulate peristalsis
D) control portal hypertension

B: reduce ammonia levels. Lactulose blocks the absorption of ammonia from the GI tract and secondarily stimulates bowel elimination.

35. The nurse is teaching a client about the toxicity of digoxin. Which one of the following statements made by the client to the nurse indicates more teaching is needed?

A) "I may experience a loss of appetite."
B) "I can expect occasional double vision."
C) "Nausea and vomiting may last a few days."
D) "I must report a bounding pulse of 62 immediately."

D: Slow heart rate is related to increased cardiac output and an intended effect of digoxin. The ideal heart rate is above 60 BPM with digoxin. The client needs further teaching.

36. A client is to begin taking Fosamax. The nurse must emphasize which of these instructions to the client when taking this medication? "Take Fosamax

A) on an empty stomach."
B) after meals."
C) with calcium."
D) with milk 2 hours after meals."

A: on an empty stomach." Fosamax should be taken first thing in the morning with 6-8 ounces of plain water at least 30 minutes before other medication or food. Food and fluids (other than water) greatly decrease the absorption of Fosamax. The client must also be instructed to remain in the upright position for 30 minutes following the dose to facilitate passage into the stomach and minimize irritation of the esophagus.

37. The nurse is caring for a 10 year-old child who has just been diagnosed with diabetes insipidus. The parents ask about the treatment prescribed, vasopressin. A What is priority in teaching the child and family about this drug?

A) The child should carry a nasal spray for emergency use
B) The family must observe the child for dehydration
C) Parents should administer the daily intramuscular injections
D) The client needs to take daily injections in the short-term

A: The child should carry a nasal spray for emergency use. Diabetes insipidus results from reduced secretion of the antidiuretic hormone, vasopressin. The child will need to administer daily injections of vasopressin, and should have the nasal spray form of the medication readily available. A medical alert tag should be worn.

38. The nurse is caring for a client with asthma who has developed gastroesophageal reflux disease (GERD). Which of the following medications prescribed for the client may aggravate GERD?

A) Anticholinergics
B) Corticosteroids
C) Histamine blocker
D) Antibiotics

A: Anticholinergics. An anticholinergic medication will decrease gastric emptying and the pressure on the lower esophageal sphincter.

39. A client is receiving a nitroglycerin infusion for unstable angina. What assessment would be a priority when monitoring the effects of this medication?

A) Blood pressure
B) Cardiac enzymes
C) ECG analysis
D) Respiratory rate

A: Blood pressure. Since an effect of this drug is vasodilation, the client must be monitored for hypotension.

40. The nurse assesses the use of coping mechanisms by an adolescent 1 week after the client had a motor vehicle accident resulting in multiple serious injuries. Which of these characteristics are **most** likely to be displayed?

A) Ambivalence, dependence, demanding
B) Denial, projection, regression
C) Intellectualization, rationalization, repression
D) Identification, assimilation, withdrawal

B: Denial, projection, regression. Helplessness and hopelessness may contribute to regressive, dependent behavior which often occurs at any age with hospitalization. Denying or minimizing the seriousness of the illness is used to avoid facing the worst situation. Recall that denial is the initial step in the process of working through any loss.

Q &A Random Selection # 2

1. The nurse is administering lidocaine (Xylocaine) to a client with a myocardial infarction. Which of the following assessment findings requires the nurse's immediate action?

A) Central venous pressure reading of 11
B) Respiratory rate of 22
C) Pulse rate of 48 BPM
D) Blood pressure of 144/92

C: Pulse rate of 48 BPM. One of the side effects of lidocaine is bradycardia, heart block, cardiovascular collapse and cardiac arrest (this drug should never be administered without continuous EKG monitoring).

2. The nurse is teaching a group of college students about breast self-examination. A woman asks for the best time to perform the monthly exam. What is the best reply by the nurse?

A) "The first of every month, because it is easiest to remember"
B) "Right after the period, when your breasts are less tender"
C) "Do the exam at the same time every month"
D) "Ovulation, or mid-cycle is the best time to detect changes"

B: The best time for a breast self exam (BSE) is a week after a menstrual cycle, when the breasts are no longer swollen and tender due to hormone elevation.

3. Which medication is more helpful in treating bulimia than anorexia?

A) Amphetamines
B) Sedatives
C) Anticholinergics
D) Narcotics

C: Anticholinergics. In contrast to anorexics, individuals with bulimia are troubled by their behavioral characteristics and become depressed. The person feels compelled to binge, purge and fast. Feeling helpless to stop the behavior, feelings of self-disgust occur.

4. The nurse is assessing a client with chronic obstructive pulmonary disease receiving oxygen for low PaO_2 levels. Which assessment is a nursing **priority**?

A) Evaluating SaO_2 levels frequently
B) Observing skin color changes
C) Assessing for clubbing fingers
D) Identifying tactile fremitus

A: Evaluating SaO_2 levels frequently. The best method to evaluate a client"s oxygenation is to evaluate the SaO_2. This is just as effective as an arterial blood gas reading to evaluate oxygenation status, and is less traumatic and expensive.

5. The nurse is teaching a client about the difference between tardive dyskinesia (TD) and neuroleptic malignant syndrome (NMS). Which statement is true with regards to tardive dyskinesia?

A) TD develops within hours or years of continued antipsychotic drug use in people under 20 and over 30
B) It can occur in clients taking antipsychotic drugs longer than 2 years
C) Tardive dyskinesia occurs within minutes of the first dose of antipsychotic drugs and is reversible
D) TD can easily be treated with anticholinergic drugs

B: It can occur in clients taking antipsychotic drugs longer than 2 years. Tardive dyskinesia is a extrapyramidal side effect that appears after prolonged treatment with antipsychotic medication. Early symptoms of tardive dyskinesia are fasciculations of the tongue or constant smacking of the lips.

6. A client is treated in the emergency room for diabetic ketoacidosis and a glucose level of 650mg.D/L. In assessing the client, the nurse's review of which of the following tests suggests an understanding of this health problem?

A) Serum calcium
B) Serum magnesium
C) Serum creatinine
D) Serum potassium

D: Serum potassium. Potassium is lost in diabetic ketoacidosis during rehydration and insulin administration. Review of this lab finding suggests the nurse has knowledge of this problem.

7. A client is discharged on warfarin sulfate (Coumadin). Which statement by the client indicated a need for further teaching?

A) "I know I must avoid crowds."
B) "I will keep all laboratory appointments."
C) "I plan to use an electric razor for shaving."
D) "I will report any bruises for bleeding."

A: "I know I must avoid crowds." There are no specific reasons for the client on Coumadin to avoid crowds. General instructions for any cardiac surgical client include limiting exposure to infection.

8. When teaching a client with a new prescription for lithium (Lithane) for treatment of a bi-polar disorder which of these should the nurse emphasize?

A) Maintaining a salt restricted diet
B) Reporting vomiting or diarrhea
C) Taking other medication as usual
D) Substituting generic form if desired

B: Reporting vomiting or diarrhea. If dehydration results from vomiting, diarrhea or excessive perspiration, tolerance to the drug may be altered and symptoms may return.

9. After assessing a 70 year-old male client's laboratory results during a routine clinic visit, which one of the following findings would indicate an area in which teaching is needed:

A) Serum albumin 2.5 g/dl
B) LDL Cholesterol 140 mg/dl
C) Serum glucose 90 mg/dl
D) RBC 5.0 million/mm3

A: Serum albumin 2.5 g/dl. Serum albumin level is low (normal 3.0 – 5.0 g/dl in elders), indicating nutritional counseling to increase dietary protein is needed. Socioeconomic factors may need to be addressed to help the client comply with the recommendation.

10. The nurse is assessing a woman in early labor. While positioning for a vaginal exam, she complains of dizziness and nausea and appears pale. Her blood pressure has dropped slightly. What should be the initial nursing action?

A) Call the health care provider
B) Encourage deep breathing
C) Elevate the foot of the bed
D) Turn her to her left side

D: Turn her to her left side. The weight of the uterus can put pressure on the vena cava and aorta when a pregnant woman is flat on her back causing supine hypotension. Action is needed to relieve the pressure on the vena cava and aorta. Turning the woman to the side reduces this pressure and relieves postural hypotension.

11. Initial postoperative nursing care for an infant who has had a pyloromyotomy would **initially** include

A) bland diet appropriate for age
B) intravenous fluids for 3-4 days
C) NPO then glucose and electrolyte solutions
D) formula or breast milk as tolerated

C: NPO then glucose and electrolyte solutions. Post-operatively, the initial feedings are clear liquids in small quantities to provide calories and electrolytes.

12. A client is receiving lithium carbonate 600 mg T.I.D. to treat bipolar disorder. Which of these indicate early signs of toxicity?

A) Ataxia and course hand tremors
B) Vomiting, diarrhea and lethargy
C) Pruritus, rash and photosensitivity
D) Electrolyte imbalance and cardiac arrhythmias

B: Vomiting, diarrhea and lethargy. These are early signs of lithium toxicity.

13. The nurse is caring for a 2 month-old infant with a congenital heart defect. Which of the following is a priority nursing action?

A) Provide small feedings every 3 hours
B) Maintain intravenous fluids
C) Add strained cereal to the diet
D) Change to reduced calorie formula

A: Provide small feedings every 3 hours. Infants with congenital heart defects are at increased risk for developing congestive heart failure. Infants with congestive heart failure have an increased metabolic rate and require additional calories to grow. At the same time, however, rest and conservation of energy for eating is important. Feedings should be smaller and every 3 hours rather than the usual 4 hour schedule.

14. Clients taking lithium must be particularly sure to maintain adequate intake of which of these elements?

A) Potassium
B) Sodium
C) Chloride
D) Calcium

B: Sodium. Clients taking lithium need to maintain an adequate intake of sodium. Serum lithium concentrations may increase in the presence of conditions that cause sodium loss.

15. A client is admitted with severe injuries from an auto accident. The client's vital signs are BP 120/50, pulse rate 110, and respiratory rate of 28. The **initial** nursing intervention would be to

A) begin intravenous therapy
B) initiate continuous blood pressure monitoring
C) administer oxygen therapy
D) institute cardiac monitoring

C: administer oxygen therapy. Early findings of shock reveal hypoxia with rapid heart rate and rapid respirations, and oxygen is the most critical initial intervention. The other interventions are secondary to oxygen therapy.

16. A woman in labor calls the nurse to assist her in the bathroom. The nurse notices a large amount of clear fluid on the bed linens. The nurse knows that fetal monitoring must now assess for what complication?

A) Early decelerations
B) Late accelerations
C) Variable decelerations
D) Periodic accelerations

C: Variable decelerations. When the membranes rupture, there is increased risk initially of cord prolapse. Fetal heart rate patterns may show variable decelerations, which require immediate nursing action to promote gas exchange.

17. The nurse can **best** ensure the safety of a client suffering from dementia who wanders from the room by which action?

A) Repeatedly remind the client of the time and location
B) Explain the risks of walking with no purpose
C) Use protective devices to keep the client in the bed or chair in the room
D) Attach a wander-guard sensor band to the client's wrist

D: This type of identification band easily tracks the client"s movements and ensures safety while the client wanders on the unit. Restriction of activity is inappropriate for any client unless they are potentially harmful to themselves or others.

18. A client is taking tranylcypromine (Parnate) and has received dietary instruction. Which of the following food selections would be contraindicated for this client?

A) Fresh juice, carrots, vanilla pudding
B) Apple juice, ham salad, fresh pineapple
C) Hamburger, fries, strawberry shake
D) Red wine, fava beans, aged cheese

D: Red wine, fava beans, aged cheese. Red wine and cheese contain tyramine (as do chicken liver and ripe bananas) and so are contraindicated when taking MAOIs. Fava beans contain other vasopressors that can interact with MAOIs also causing malignant hypertension.

19. The nurse is assessing a client's home in preparation for discharge. Which of the following should be given priority consideration?

A) Family understanding of client needs
B) Financial status
C) Location of bathrooms
D) Proximity to emergency services

A: Family understanding of client needs. Functional communication patterns between family members are fundamental to meeting the needs of the client and family.

20. A client, admitted to the unit because of severe depression and suicidal threats, is placed on suicidal precautions. The nurse should be aware that the danger of the client committing suicide is **greatest**

A) during the night shift when staffing is limited
B) when the client’s mood improves with an increase in energy level
C) at the time of the client's greatest despair
D) after a visit from the client's estranged partner

B: when the client’s mood improves with an increase in energy level. Suicide potential is often increased when there is an improvement in mood and energy level. At this time ambivalence is often decreased and a decision is made to commit suicide.

21. A male client calls for a nurse because of chest pain. Which statement by the client would require the **most** immediate action by the nurse?

A) "When I take in a deep breath, it stabs like a knife."
B) "The pain came on after dinner. That soup seemed very spicy."
C) "When I turn in bed to reach the remote for the TV, my chest hurts."
D) "I feel pressure in the middle of my chest, like an elephant is sitting on my chest."

D: "I feel pressure in the middle of my chest, like an elephant is sitting on my chest." This is a classic description of chest pain in men caused by myocardial ischemia. Women experience vague feelings of fatigue and back and jaw pain.

22. A client has been started on a long term corticosteroid therapy. Which of the following comments by the client indicate the need for further teaching?

A) "I will keep a weekly weight record."
B) "I will take medication with food."
C) "I will stop taking the medication for 1 week every month."
D) "I will eat foods high in potassium."

C: "I will stop taking the medication for 1 week every month." Emphatically warn against discontinuing steroid dosage abruptly because that may produce a fatal adrenal crisis.

23. The visiting nurse makes a postpartum visit to a married female client. Upon arrival, the nurse observes that the client has a black eye and numerous bruises on her arms and legs. The **initial** nursing intervention would be to

A) call the police to report indications of domestic violence
B) confront the husband about abusing his wife
C) leave the home because of the unsafe environment
D) interview the client alone to determine the origin of the injuries

D: interview the client alone to determine the origin of the injuries. It would be wrong to assume domestic violence without further assessment. Separate the suspected victim from the partner until battering has been ruled out.

24. A nurse is caring for a client who has just been admitted with an overdose of aspirin. The following lab data is available: PaO_2 95, $PaCO_2$ 30, pH 7.5, K 3.2 mEq/l. Which should be the nurse's **first** action?

A) Monitor respiratory rate
B) Monitor intake and output every hour
C) Assist the client to breathe into a paper bag
D) Prepare to administer oxygen by mask

C: Assist the client to breathe into a paper bag. Side effects of aspirin toxicity include hyperventilation, which can result in respiratory alkalosis in the initial stages. Breathing into a paper bag will prevent further reduction in $PaCO_2$.

25. The spouse of a client with Alzheimer's disease expresses concern about the burden of caregiving. Which of the following actions by the nurse should be a **priority**?

A) Link the caregiver with a support group
B) Ask friends to visit regularly
C) Schedule a home visit each week
D) Request anti-anxiety prescriptions

A: Link the caregiver with a support group. Assisting caregivers to locate and join support groups is most helpful. Families share feelings and learn about services such as respite care. Health education is also available through local and national Alzheimer"s chapters.

26. In response to a call for assistance by a client in labor, the nurse notes that a loop on the umbilical cord protrudes from the vagina. What is the **priority** nursing action?

A) call the health care provider
B) check fetal heart beat
C) put the client in knee-chest position
D) turn the client to the side

C: put the client in knee-chest position. Immediate action is needed to relieve pressure on the cord, which puts the fetus at risk due to hypoxia. The Trendelenburg position accomplishes this. The exposed cord is covered with saline soaked gauze, not reinserted. The fetal heart rate also should be checked, and the provider called. A prolapsed umbilical cord is a medical emergency.

27. When teaching a client about an oral hypoglycemic medication, the nurse should place primary emphasis on

A) recognizing findings of toxicity
B) taking the medication at specified times
C) increasing the dosage based on blood glucose
D) distinguishing hypoglycemia from hyperglycemia

B: taking the medication at specified times. A regular interval between doses should be maintained since oral hypoglycemics stimulate the islets of Langerhans to produce insulin.

28. A male client is preparing for discharge following an acute myocardial infarction. He asks the nurse about his sexual activity once he is home. What would be the nurse's initial response?

A) Give him written material from the American Heart Association about sexual activity with heart disease
B) Answer his questions accurately in a private environment
C) Schedule a private, uninterrupted teaching session with both the client and his wife
D) Assess the client's knowledge about his health problems

D: Assess the client"s knowledge about his health problems. The nursing process is continuous and cyclical in nature. When a client expresses a specific concern, the nurse performs a focused assessment to gather additional data prior to planning and implementing nursing interventions.

29. The nurse is aware that the effect of antihypertensive drug therapy may be affected by a 75 year-old client's

A) poor nutritional status
B) decreased gastrointestinal motility
C) increased splanchnic blood flow
D) altered peripheral resistance

B: decreased gastrointestinal motility. Together with shrinkage of the gastric mucosa, and changes in the levels of hydrochloric acid, this will decrease absorption of medications and interfere with their actions.

30. After 4 electroconvulsive treatments over 2 weeks, a client is very upset and states “I am so confused. I lose my money. I just can’t remember telephone numbers.” The **most** therapeutic response for the nurse to make is

A) "You were seriously ill and needed the treatments."
B) "Don't get upset. The confusion will clear up in a day or two."
C) "It is to be expected since most clients have the same results."
D) "I can hear your concern and that your confusion is upsetting to you."

D: "I can hear your concern and that your confusion is upsetting to you." Communicating caring and empathy with the acknowledgement of feelings is the initial response. Afterwards, teaching about the expected short term effects would be discussed.

31. The client asks the nurse how the health care provider could tell she was pregnant “just by looking inside.” What is the best explanation by the nurse?

A) Bluish coloration of the cervix and vaginal walls
B) Pronounced softening of the cervix
C) Clot of very thick mucous that obstructs the cervical canal
D) Slight rotation of the uterus to the right

A: Bluish coloration of the cervix and vaginal walls. Chadwick"s sign is a bluish-purple coloration of the cervix and vaginal walls, occurring at 4 weeks of pregnancy, that is caused by vasocongestion.

32. What must be the priority consideration for nurses when communicating with children?

A) Present environment
B) Physical condition
C) Nonverbal cues
D) Developmental level

D: Developmental level. While each of the factors affect communication, the nurse recognizes that developmental differences have implications for processing and understanding information. Consequently, a child’s developmental level must be considered when selecting communication approaches.

33. The nurse is caring for a post-operative client who develops a wound evisceration. The **first** nursing intervention should be

A) medicate the client for pain
B) call the provider
C) cover the wound with sterile saline dressing
D) place the bed in a flat position

C: cover the wound with sterile saline dressing. When evisceration occurs, the wound should first be quickly covered by sterile dressings soaked in sterile saline. This prevents tissue damage until a repair can be effected.

34. The nurse is caring for a client receiving intravenous nitroglycerin for acute angina. What is the most important assessment during treatment?

A) Heart rate
B) Neurologic status
C) Urine output
D) Blood pressure

D: Blood pressure. The vasodilatation that occurs as a result of this medication can cause profound hypotension. The client"s blood pressure must be evaluated every 15 minutes until stable and then every 30 minutes to every hour.

35. A client diagnosed with chronic depression is maintained on tranylcypromine (Parnate). An important nursing intervention is to teach the client to avoid which of the following foods?

A) Wine, beer, cheese, liver and chocolate
B) Wine, citrus fruits, yogurt and broccoli
C) Beer, cheese, beef and carrots
D) Wine, apples, sour cream and beef steak

A: Wine, beer, cheese, liver and chocolate. These foods are tyramine rich and ingestion of these foods while taking monoamine oxidase inhibitors (MAOIs) can precipitate a life-threatening hypertensive crisis.

36. Which clinical finding would the nurse expect to assess **first** in a newborn with spastic cerebral palsy?

A) cognitive impairment
B) hypotonic muscular activity
C) seizures
D) criss-crossing leg movement

D: criss-crossing leg movement. Cerebral palsy is a neuromuscular impairment resulting in muscular and reflexive hypertonicity and the criss-crossing, or scissoring leg movements.

37. The nurse is working in a high risk antepartum clinic. A 40 year-old woman in the first trimester gives a thorough health history. Which information should receive **priority** attention by the nurse?

A) Her father and brother are insulin dependent diabetics
B) She has taken 800 mcg of folic acid daily for the past year
C) Her husband was treated for tuberculosis as a child
D) She reports recent use of over-the counter sinus remedies

D: Over-the-counter drugs are a possible danger in early pregnancy. A report by the client that she has taken medications should be followed up immediately.

38. A client telephones the clinic to ask about a home pregnancy test she used this morning. The nurse understands that the presence of which hormone strongly suggests a woman is pregnant?

A) Estrogen
B) HCG
C) Alpha-fetoprotein

D) Progesterone

B: HCG. Human chorionic gonadotropin (HCG) is the biologic marker on which pregnancy tests are based. Reliability is about 98%, but the test does not conclusively confirm pregnancy.

39. As a general guide for emergency management of acute alcohol intoxication, it is important for the nurse initially to obtain data regarding which of the following?

A) What and how much the client drinks, according to family and friends
B) The blood alcohol level of the client
C) The blood pressure level of the client
D) The blood glucose level of the client

B: Blood alcohol levels are generally obtained to determine the level of intoxication. The amount of alcohol consumed determines how much medication the client needs for detoxification and treatment. Reports of alcohol consumption are notoriously inaccurate.

40. A client is admitted to the hospital with a diagnosis of deep vein thrombosis. During the initial assessment, the client complains of sudden shortness of breath. The SaO_2 is 87. The **priority** nursing assessment at this time is

A) bowel sounds
B) heart rate
C) peripheral pulses
D) lung sounds

D: lung sounds. Lung sounds are critical assessments at this point. The nurse should be alert to crackles or a pleural friction rub, highly suggestive of a pulmonary embolism.

Q & A Random Selection #3

1. The nurse is performing an assessment on a client who is cachectic and has developed an enterocutaneous fistula following surgery to relieve a small bowel obstruction. The client's total protein level is reported as 4.5 g/dl. Which of the following would the nurse anticipate?

A) Additional potassium will be given IV
B) Blood for coagulation studies will be drawn
C) Total parenteral nutrition (TPN) will be started
D) Serum lipase levels will be evaluated

C: Total parenteral nutrition (TPN) will be started. The client is not absorbing nutrients adequately as evidenced by the cachexia and low protein levels. (A normal total serum protein level is 6.0-8.0 g/dl.) TPN will promote a positive nitrogen balance in this client who is unable to digest and absorb nutrients adequately.

2. The nurse is assessing a comatose client receiving gastric tube feedings. Which of the following assessments requires an **immediate** response from the nurse?

A) Decreased breath sounds in right lower lobe
B) Aspiration of a residual of 100cc of formula

C) Decrease in bowel sounds
D) Urine output of 250 cc in past 8 hours

A: Decreased breath sounds in right lower lobe. The most common problem associated with enteral feedings is atelectasis. Maintain client at 30 degrees of head elevation during feedings and monitor for signs of aspiration. Check for tube placement prior to each feeding or every 4 to 8 hours if the client is receiving continuous feeding.

3. The nurse is preparing to take a toddler's blood pressure for the first time. Which of the following actions should the nurse perform **first**?

A) Explain that the procedure will help him to get well
B) Show a cartoon character with a blood pressure cuff
C) Explain that the blood pressure checks the heart pump
D) Permit handling the equipment before putting the cuff in place

D: Permit handling the equipment before putting the cuff in place. The best way to gain the toddler"s cooperation is to encourage handling the equipment. Detailed explanations are not helpful.

4. A 35-year-old client of Puerto Rican-American descent is diagnosed with ovarian cancer. The client states, "I refuse both radiation and chemotherapy because they are 'hot.'" The next action for the nurse to take is to

A) document the situation in the notes
B) report the situation to the health care provider
C) talk with the client's family about the situation
D) ask the client to talk about concerns regarding "hot" treatments

D: ask the client to talk about concerns regarding "hot" treatments. The "hot-cold" system is found among Mexican-Americans, Puerto Ricans, and other Hispanic-Latinos. Most foods, beverages, herbs, and medicines are categorized as hot or cold, which are symbolic designations and do not necessarily indicate temperature or spiciness. Care and treatment regimens can be negotiated with clients within this framework.

5. Which of the following drugs should the nurse anticipate administering to a client before they are to receive electroconvulsive therapy?

A) Benzodiazepines
B) Chlorpromazine (Thorazine)
C) Succinylcholine (Anectine)
D) Thiopental sodium (Pentothal Sodium)

C: Succinylcholine (Anectine). Succinylcholine is given intravenously to promote skeletal muscle relaxation.

6. Which statement made by a nurse about the goal of total quality management or continuous quality improvement in a health care setting is correct?

A) It is to observe reactive service and product problem solving
B) Improvement of the processes in a proactive, preventive mode is paramount
C) A chart audits to finds common errors in practice and outcomes associated with goals
D) A flow chart to organize daily tasks is critical to the initial stages

B: Improvement of the processes in a proactive, preventive mode is paramount. Total quality management and continuous quality improvement have a major goal of identifying ways to do the right thing at the right time in the right way by proactive problem-solving.

7. The nurse admits a 2 year-old child who has had a seizure. Which of the following statement by the child's parent would be important in determining the etiology of the seizure?

A) "He has been taking long naps for a week."
B) "He has had an ear infection for the past 2 days."
C) "He has been eating more red meat lately."
D) "He seems to be going to the bathroom more frequently."

B: "He has had an ear infection for the past 2 days." Contributing factors to seizures in children include those such as age (more common in first 2 years), infections (late infancy and early childhood), fatigue, not eating properly and excessive fluid intake or fluid retention.

8. The nurse is caring for a client with Hodgkin's disease who will be receiving radiation therapy. The nurse recognizes that, as a result of the radiation therapy, the client is **most** likely to experience

A) high fever
B) nausea
C) face and neck edema
D) night sweats

B: nausea. Because the client with Hodgkin"s disease is usually healthy when therapy begins, the nausea is especially troubling.

9. A client with a panic disorder has a new prescription for Xanax (alprazolam). In teaching the client about the drug's actions and side effects, which of the following should the nurse emphasize?

A) Short-term relief can be expected
B) The medication acts as a stimulant
C) Dosage will be increased as tolerated

D) Initial side effects often continue

A: Short-term relief can be expected. Xanax is a short-acting benzodiazepine useful in controlling panic symptoms quickly.

10. While assessing the vital signs in children, the nurse should know that the apical heart rate is preferred until the radial pulse can be accurately assessed at about what age?

    A) 1 year of age
    B) 2 years of age
    C) 3 years of age
    D) 4 years of age

B: 2 years of age. A child should be at least 2 years of age to use the radial pulse to assess heart rate.

11. As a part of a 9 pound full-term newborn's assessment, the nurse performs a dextro-stick at 1 hour post birth. The serum glucose reading is 45 mg/dl. What action by the nurse is appropriate at this time?

    A) Give oral glucose water
    B) Notify the pediatrician
    C) Repeat the test in 2 hours
    D) Check the pulse oximetry reading

C: Repeat the test in 2 hours. This blood sugar is within the normal range for a full-term newborn. Normal values are: Premature infant: 20-60 mg/dl or 1.1-3.3 mmol/L, Neonate: 30-60 mg/dl or 1.7-3.3 mmol/L, Infant: 40-90 mg/dl or 2.2-5.0 mmol/L. Critical values are: Infant: <40 mg/dl and in a Newborn: <30 and >300 mg/dl. Because of the increased birth weight which can be associated with diabetes mellitus, repeated blood sugars will be drawn.

12. The nurse is teaching parents of a 7 month-old about adding table foods. Which of the following is an appropriate finger food?

    A) Hot dog pieces
    B) Sliced bananas
    C) Whole grapes
    D) Popcorn

B: Sliced bananas. Finger foods should be bite-size pieces of soft food such as bananas. Hot dogs and grapes can accidentally be swallowed whole and can occlude the airway. Popcorn is too difficult to chew at this age and can irritate the airway if swallowed.

13. During a routine check-up, an insulin-dependent diabetic has his glycosylated hemoglobin checked. The results indicate a level of 11%. Based on this result, what teaching should the nurse emphasize?

    A) Rotation of injection sties
    B) Insulin mixing and preparation
    C) Daily blood sugar monitoring
    D) Regular high protein diet

C: Daily blood sugar monitoring. Normal hemoglobin A1C (glycosylated hemoglobin) level is 7 to 9%. Elevation indicates elevated glucose levels over time.

14. A newborn weighed 7 pounds 2 ounces at birth. The nurse assesses the newborn at home 2 days later and finds the weight to be 6 pounds 7 ounces. What should the nurse tell the parents about this weight loss?

    A) The newborn needs additional assessments
    B) The mother should breast feed more often
    C) A change to formula is indicated
    D) The loss is within normal limits

D: The loss is within normal limits. A newborn is expected to lose 5-10% of the birth weight in the first few days post-partum because of changes in elimination and feeding.

15. A client with chronic obstructive pulmonary disease (COPD) and a history of coronary artery disease is receiving aminophylline, 25mg/hour. Which one of the following findings by the nurse would require immediate intervention?

    A) Decreased blood pressure and respirations
    B) Flushing and headache
    C) Restlessness and palpitations
    D) Increased heart rate and blood pressure

C: Restlessness and palpitations. Side effects of Aminophylline include restlessness and palpitations.

16. A 72 year-old client is scheduled to have a cardioversion. A nurse reviews the client's medication administration record. The nurse should notify the health care provider if the client received which medication during the preceding 24 hours?

    A) Digoxin (Lanoxin)
    B) Diltiazem (Cardizem)
    C) Nitroglycerine ointment
    D) Metoprolol (Toprol XL)

A: Digoxin (Lanoxin). Digoxin increases ventricular irritability and increases the risk of ventricular fibrillation following cardioversion. The other medications do not increase ventricular irritability.

17. A client taking isoniazid (INH) for tuberculosis asks the nurse about side effects of the medication. The client should be instructed to immediately report which of these?

A) Double vision and visual halos
B) Extremity tingling and numbness
C) Confusion and lightheadedness
D) Sensitivity of sunlight

B: Extremity tingling and numbness. Peripheral neuropathy is the most common side effect of INH and should be reported to the provider. It can be reversed.

18. Which of these clients would the nurse monitor for the complication of *C. difficile* diarrhea?

A) An adolescent taking medications for acne
B) An elderly client living in a retirement center taking prednisone
C) A young adult at home taking a prescribed aminoglycoside
D) A hospitalized middle aged client receiving clindamycin

D: A hospitalized middle aged client receiving clindamycin. Hospitalized patients, especially those receiving antibiotic therapy, are primary targets for *C. difficile*. Of clients receiving antibiotics, 5-38% experience antibiotic-associated diarrhea; *C. difficile* causes 15 to 20% of the cases. Several antibiotic agents have been associated with *C. difficile*. Broad-spectrum agents, such as clindamycin, ampicillin, amoxicillin, and cephalosporins, are the most frequent sources of *C. difficile*. Also, *C. difficile* infection has been caused by the administration of agents containing beta-lactamase inhibitors (i.e., clavulanic acid, sulbactam, tazobactam) and intravenous agents that achieve substantial colonic intraluminal concentrations (i.e., ceftriaxone, nafcillin, oxacillin). Fluoroquinolones, aminoglycosides, vancomycin, and trimethoprim are seldom associated with *C. difficile* infection or pseudomembranous colitis.

19. The clinic nurse is counseling a substance-abusing post partum client on the risks of continued cocaine use. In order to provide continuity of care, which nursing diagnosis is a priority?

A) Social isolation
B) Ineffective coping
C) Altered parenting
D) Sexual dysfunction

C: Altered parenting. The cocaine abusing mother puts her newborn and other children at risk for neglect and abuse. Continuing to use drugs has the potential to impact parenting behaviors. Social service referrals are indicated.

20. An 18 month-old child is on peritoneal dialysis in preparation for a renal transplant in the near future. When the nurse obtains the child's health history, the mother indicates that the child has not had the first measles, mumps, rubella (MMR) immunization. The nurse understands that which of the following is true in regards to giving immunizations to this child?

A) Live vaccines are withheld in children with renal chronic illness
B) The MMR vaccine should be given now, prior to the transplant
C) An inactivated form of the vaccine can be given at any time
D) The risk of vaccine side effects precludes giving the vaccine

B: MMR is a live virus vaccine, and should be given at this time. Post-transplant, immunosuppressive drugs will be given and the administration of the live vaccine at that time would be contraindicated because of the compromised immune system.

21. A client is receiving Total Parenteral Nutrition (TPN) via a Hickman catheter. The catheter accidentally becomes dislodged from the site. Which action by the nurse should take priority?

A) Check that the catheter tip is intact
B) Apply a pressure dressing to the site
C) Monitor respiratory status
D) Assess for mental status changes

B: The client is at risk of bleeding or developing an air embolus if the catheter exit site is not covered immediately.

22. The nurse is preparing to administer a tube feeding to a postoperative client. To accurately assess for a gastrostomy tube placement, the **priority** is to

A) auscultate the abdomen while instilling 10 cc of air into the tube
B) place the end of the tube in water to check for air bubbles
C) retract the tube several inches to check for resistance
D) measure the length of tubing from nose to epigastrium

A: auscultate the abdomen while instilling 10 cc of air into the tube. If a swoosh of air is heard over the abdominal cavity while instilling air into the gastric tube, this indicates that it is accurately placed in the stomach. The feeding can begin after further assessing the client for bowel sounds.

23. A nurse admits a client transferred from the emergency room (ER). The client, diagnosed with a myocardial infarction, is complaining of substernal chest pain, diaphoresis and nausea. The **first** action by the nurse should be to

A) order an EKG
B) administer morphine sulfate
C) start an IV

D) measure vital signs

B: administer morphine sulfate. Decreasing the clients pain is the most important priority at this time. As long as pain is present there is danger in extending the infarcted area. Morphine will decrease the oxygen demands of the heart and act as a mild diuretic as well. It is probable that an EKG and IV insertion were performed in the ER.

24. The nurse is planning care for an 8 year-old child. Which of the following should be included in the plan of care?

A) Encourage child to engage in activities in the playroom
B) Promote independence in activities of daily living
C) Talk with the child and allow him to express his opinions
D) Provide frequent reassurance and cuddling

A: Encourage child to engage in activities in the playroom. According to Erikson, the school age child is in the stage of industry versus inferiority. To help them achieve industry, the nurse should encourage them to carry out tasks and activities in their room or in the playroom.

25. A client being discharged from the cardiac step-down unit following a myocardial infarction (MI), is given a prescription for a beta-blocking drug. A nursing student asks the charge nurse why this drug would be used by a client who is not hypertensive. What is an appropriate response by the charge nurse?

A) "Most people develop hypertension following an MI."
B) "A beta-Blocker will prevent orthostatic hypotension."
C) "This drug will decrease the workload on his heart."
D) "Beta-blockers increase the strength of heart contractions."

C: One action of beta-blockers is to decrease systemic vascular resistance by dilating arterioles. This is useful for the client with coronary artery disease, and will reduce the risk of another MI or sudden death.

26. To prevent drug resistance from developing, the nurse is aware that which of the following is a characteristic of the typical treatment plan to eliminate the tuberculosis bacilli?

A) An anti-inflammatory agent
B) High doses of B complex vitamins
C) Aminoglycoside antibiotics
D) Administering two anti-tuberculosis drugs

D: Administering two anti-tuberculosis drugs. Resistance of the tubercle bacilli often occurs to a single antimicrobial agent. Therefore, therapy with multiple drugs over a long period of time helps to ensure eradication of the organism.

27. Which of these questions is priority when assessing a client with hypertension?

A) "What over-the-counter medications do you take?"
B) "Describe your usual exercise and activity patterns."
C) "Tell me about your usual diet."
D) "Describe your family's cardiovascular history."

A: "What over-the-counter medications do you take?" Over-the-counter medications, especially those that contain cold preparations can increase the blood pressure to the point of hypertension.

28. The nurse is performing an assessment of the motor function in a client with a head injury. The **best** technique is

A) touching the trapezius muscle or arm firmly
B) pinching any body part
C) shaking a limb vigorously
D) rubbing the sternum

D: rubbing the sternum. The purpose is to assess the non-responsive client's reaction to a painful stimulus after less noxious methods have been tried.

29. Which approach is a **priority** for the nurse who works with clients from many different cultures?

A) Speak at least 2 other languages of clients in the neighborhood
B) Learn about the cultures of clients who are most often encountered
C) Have a list of persons for referral when interaction with these clients occur
D) Recognize personal attitudes about cultural differences and real or expected biases

D: The nurse must discover personal attitudes, prejudices and biases specific to different cultures. Awareness of these will prevent negative consequences for interactions with clients and families across cultures.

30. A client has gastroesophageal reflux. Which recommendation made by the nurse would be most helpful to the client?

A) Avoid liquids unless a thickening agent is used
B) Sit upright for at least 1 hour after eating
C) Maintain a diet of soft foods and cooked vegetables
D) Avoid eating 2 hours before going to sleep

D: Avoid eating 2 hours before going to sleep. Eating before sleeping enhances the regurgitation of stomach contents, which have increased acidity, into the esophagus. An upright posture should be maintained for about 2 hours after eating to allow for the stomach emptying. Options A and C are interventions for clients with swallowing difficulties.

31. A client is brought to the emergency room following a motor vehicle accident. When assessing the client one-half hour after admission, the nurse notes several physical changes. Which finding would require the nurse's **immediate** attention?

A) increased restlessness
B) tachycardia
C) tracheal deviation
D) tachypnea

C: tracheal deviation. The deviated trachea is a sign that a mediastinal shift has occurred. This is a medical emergency.

32. During a situation of pain management, which statement is a **priority** to consider for the ethical guidelines of the nurse?

A) The client's self-report is the most important consideration
B) Cultural sensitivity is fundamental to pain management
C) Clients have the right to have their pain relieved
D) Nurses should not prejudge a client's pain using their own values

A: The client's self-report is the most important consideration. Pain is a complex phenomenon that is perceived differently by each individual. Pain is whatever the client says it is. The other statements are correct but not the most important considerations.

33. When teaching a client about the side effects of fluoxetine (Prozac), which of the following will the nurse include?

A) Tachycardia blurred vision, hypotension, anorexia
B) Orthostatic hypotension, vertigo, reactions to tyramine-rich foods
C) Diarrhea, dry mouth, weight loss, reduced libido
D) Photosensitivity, seizures, edema, hyperglycemia

C: Diarrhea, dry mouth, weight loss, reduced libido. Commonly reported side effects for fluoxetine (Prozac) are diarrhea, dry mouth, weight loss and reduced libido.

34. The nurse is talking with the family of an 18 months-old newly diagnosed with retinoblastoma. A **priority** in communicating with the parents is

A) Discuss the need for genetic counseling
B) Inform them that combined therapy is seldom effective
C) Prepare for the child's permanent disfigurement
D) Suggest that total blindness may follow surgery

A: Discuss the need for genetic counseling. The hereditary aspects of this disease are well documented. While the parents focus on the needs of this child, they should be aware that the risk is high for future offspring.

35. The nurse manager informs the nursing staff at morning report that the clinical nurse specialist will be conducting a research study on staff attitudes toward client care. All staff are invited to participate in the study if they wish. This affirms the ethical principle of

A) Anonymity
B) Beneficence
C) Justice
D) Autonomy

D: Autonomy. Individuals must be free to make independent decisions about participation in research without coercion from others.

36. Which of these clients, all of whom have the findings of a board-like abdomen, would the nurse suggest that the provider examine first?

A) An elderly client who stated, "My awful pain in my right side suddenly stopped about 3 hours ago."
B) A pregnant woman of 8 weeks newly diagnosed with an ectopic pregnancy
C) A middle-aged client admitted with diverticulitis who has taken only clear liquids for the past week

D) A teenager with a history of falling off a bicycle without hitting the handle bars

A: An elderly client who stated, "My awful pain in my right side suddenly stopped about 3 hours ago." This client has the highest risk for hypovolemic and septic shock since the appendix has most likely ruptured, based on the history of the pain suddenly stopping over three hours ago. Elderly clients have less functional reserve for the body to cope with shock and infection over long periods. The others are at risk for shock also, however given that they fall in younger age groups, they would more likely be able to tolerate an imbalance in circulation. A common complication of falling off a bicycle is hitting the handle bars in the upper abdomen often on the left, resulting in a ruptured spleen.

37. The nurse is assigned to care for 4 clients. Which of the following should be assessed immediately after hearing the report?

A) The client with asthma who is now ready for discharge
B) The client with a peptic ulcer who has been vomiting all night
C) The client with chronic renal failure returning from dialysis
D) The client with pancreatitis who was admitted yesterday

B: The client with a peptic ulcer who has been vomiting all night. A perforated peptic ulcer could cause nausea, vomiting and abdominal distention, and may be a life threatening situation. The client should be assessed immediately and findings reported to the provider.

38. The nurse is teaching about nonsteroidal anti-inflammatory drugs (NSAIDs) to a group of arthritic clients. To minimize the side effects, the nurse should emphasize which of the following actions?

    A) Reporting joint stiffness in the morning
    B) Taking the medication 1 hour before or 2 hours after meals
    C) Using alcohol in moderation unless driving
    D) Continuing to take aspirin for short term relief

B: Taking the medication 1 hour before or 2 hours after meals. Taking the medication 1 hour before or 2 hours after meals will result in a more rapid effect.

39. A client is prescribed warfarin sodium (Coumadin) to be continued at home. Which focus is critical to be included in the nurse's discharge instruction?

    A) Maintain a consistent intake of green leafy foods
    B) Report any nose or gum bleeds
    C) Take Tylenol for minor pains
    D) Use a soft toothbrush

B: Report any nose or gum bleeds. The client should notify the health care provider if blood is noted in stools or urine, or any other signs of bleeding occur.

40. A pregnant client who is at 34 weeks gestation is diagnosed with a pulmonary embolism (PE). Which of these medications would the nurse anticipate the provider ordering?

    A) Oral Coumadin therapy
    B) Heparin 5000 units subcutaneously B.I.D.
    C) Heparin infusion to maintain the PTT at 1.5-2.5 times the control value
    D) Heparin by subcutaneous injection to maintain the PTT at 1.5 times the control value

D: Several studies have been conducted in pregnant women where oral anticoagulation agents are contraindicated. Warfarin is known to cross the placenta and is therefore reported to be teratogenic.

Q&A Random Selection #4

1. In addition to standard precautions, a nurse should implement contact precautions for which client?

    A) 60 year-old with herpes simplex
    B) 6 year-old with mononucleosis
    C) 45 year-old with pneumonia
    D) 3 year-old with scarlet fever

A: 60 year-old with herpes simplex. Clients who have herpes simplex infections must have contact precautions in addition to standard precautions because of the associated, potentially weeping, skin lesions. Contact precautions are used for clients who are infected by microorganisms that are transmitted by direct contact with the client, including hand or skin-to-skin contact.

2. A 70 year-old woman is evaluated in the emergency department for a wrist fracture of unknown causes. During the process of taking client history, which of these items should the nurse identify as related to the client's greatest risk factors for osteoporosis?

A) History of menopause at age 50
B) Taking high doses of steroids for arthritis for many years
C) Maintaining an inactive lifestyle for the past 10 years
D) Drinking 2 glasses of red wine each day for the past 30 years

B: Taking high doses of steroids for arthritis for many years. The use of steroids, especially at high doses over time, increases the risk for osteoporosis. The other options also predispose to osteoporosis, as do low bone mass, poor calcium absorption and moderate to high alcohol ingestion. Long-term steroid treatment is the most significant risk factor, however.

3. Which contraindication should the nurse assess for prior to giving a child immunizations?

A) Mild cold symptoms
B) Chronic asthma
C) Depressed immune system
D) Allergy to eggs

C: Depressed immune system. Children who have a depressed immune system related to HIV or chemotherapy should not be given routine immunizations.

4. The nurse is caring for a 1 year-old child who has 6 teeth. What is the **best** way for the nurse to give mouth care to this child?

A) Using a moist soft brush or cloth to clean teeth and gums
B) Swabbing teeth and gums with flavored mouthwash
C) Offering a bottle of water for the child to drink
D) Brushing with toothpaste and flossing each tooth

A: Using a moist soft brush or cloth to clean teeth and gums. The nurse should use a soft cloth or soft brush to do mouth care so that the child can adjust to the routine of cleaning the mouth and teeth.

5. The nurse is teaching the mother of a 5 month-old about nutrition for her baby. Which statement by the mother indicates the need for further teaching?

A) "I'm going to try feeding my baby some rice cereal."
B) "When he wakes at night for a bottle, I feed him."
C) "I dip his pacifier in honey so he'll take it."
D) "I keep formula in the refrigerator for 24 hours."

C: "I dip his pacifier in honey so he"ll take it." Honey has been associated with infant botulism and should be avoided. Older children and adults have digestive enzymes that kill the botulism spores.

6. A client with a fractured femur has been in Russell's traction for 24 hours. Which nursing action is associated with this therapy?

A) Check the skin on the sacrum for breakdown
B) Inspect the pin site for signs of infection
C) Auscultate the lungs for atelectasis
D) Perform a neurovascular check for circulation

D: Perform a neurovascular check for circulation. While each of these is an important assessment, the neurovascular integrity check is most associated with this type of traction. Russell's traction is Buck's traction with a sling under the knee.

7. The nurse is teaching a parent about side effects of routine immunizations. Which of the following must be reported immediately?

A) Irritability
B) Slight edema at site
C) Local tenderness
D) Seizure activity

D: Seizure activity. Other reactions that should be reported include crying for >3 hours, temperature over 104.8 degrees Fahrenheit following DPT immunization, and tender, swollen, reddened areas.

8. Decentralized scheduling is used on a nursing unit. A chief advantage of this management strategy is that it:

A) considers client and staff needs
B) conserves time spent on planning
C) frees the nurse manager to handle other priorities
D) allows requests for special privileges

A: Decentralized staffing takes into consideration specific client needs and staff interests and abilities.

9. A couple trying to conceive asks the nurse when ovulation occurs. The woman reports a regular 32 day cycle. Which response by the nurse is correct?

A) Days 7-10
B) Days 10-13
C) Days 14-16
D) Days 17-19

D: Days 17-19. Ovulation occurs 14 days prior to menses. Considering that the woman"s cycle is 32 days, subtracting 14 from 32 suggests ovulation is at about the 18th day.

10. The nurse is caring for a client with a myocardial infarction. Which finding requires the nurse's **immediate** action?

A) Periorbital edema
B) Dizzy spells
C) Lethargy
D) Shortness of breath

B: Dizzy spells. Cardiac dysrhythmias may cause a transient drop in cardiac output and decreased blood flow to the brain. Near syncope refers to lightheartedness, dizziness, temporary confusion. Such "spells" may indicate runs of ventricular tachycardia or periods of asystole and should be reported immediately.

11. At a senior citizens meeting a nurse talks with a client who has Type 1 diabetes mellitus. Which statement by the client during the conversation is **most** predictive of a potential for impaired skin integrity?

A) "I give my insulin to myself in my thighs."
B) "Sometimes when I put my shoes on I don't know where my toes are."
C) "Here are my up and down glucose readings that I wrote on my calendar."
D) "If I bathe more than once a week my skin feels too dry."

B: "Sometimes when I put my shoes on I don"t know where my toes are."

Peripheral neuropathy can lead to lack of sensation in the lower extremities. Clients who do not feel pressure and/or pain are at high risk for skin impairment.

12. Which client is at **highest** risk for developing a pressure ulcer?

A) 23 year-old in traction for fractured femur
B) 72 year-old with peripheral vascular disease, who is unable to walk without assistance
C) 75 year-old with left sided paresthesia who is incontinent of urine and stool
D) 30 year-old who is comatose following a ruptured aneurysm

C: 75 year-old with left sided paresthesia who is incontinent of urine and stool
Risk factors for pressure ulcers include: immobility, absence of sensation, decreased LOC, poor nutrition and hydration, skin moisture, incontinence, increased age, decreased immune response. This client has the greatest number of risk factors.

13. A 16 year-old boy is admitted for Ewing's sarcoma of the tibia. In discussing his care with the parents, the nurse understands that the **initial** treatment most often includes

A) amputation just above the tumor
B) surgical excision of the mass
C) bone marrow graft in the affected leg
D) radiation and chemotherapy

D: radiation and chemotherapy. The initial treatment of choice for Ewing"s sarcoma is a combination of radiation and chemotherapy.

14. The parents of a toddler ask the nurse how long their child will have to sit in a car seat while in the automobile. What is the nurse’s best response to the parents?

A) "Your child must use a care seat until he weighs at least 40 pounds."
B) "The child must be 5 years of age to use a regular seat belt."
C) "Your child must reach a height of 50 inches to sit in a seat belt."
D) "The child can use a regular seat belt when he can sit still."

A: "Your child must use a care seat until he weighs at least 40 pounds." Children should use car seats until they weigh 40 pounds.

15. A woman in her third trimester complains of severe heartburn. What is appropriate teaching by the nurse to help the woman alleviate these symptoms?

A) Drink small amounts of liquids frequently
B) Eat the evening meal just before retiring
C) Take sodium bicarbonate after each meal
D) Sleep with head propped on several pillows

D: Sleep with head propped on several pillows. Heartburn is a burning sensation caused by regurgitation of gastric contents. It is best relieved by sleeping position, eating small meals, and not eating before bedtime.

16. A client is admitted with the diagnosis of pulmonary embolism. While taking a history, the client tells the nurse he was admitted for the same thing twice before, the last time just 3 months ago. The nurse would anticipate the provider ordering

A) pulmonary embolectomy
B) vena caval interruption

C) increasing the Coumadin therapy to an INR of 3-4
D) thrombolytic therapy

B: vena caval interruption. Clients with contraindications to Heparin, recurrent PE or those with complications related to the medical therapy may require vena caval interruption by the placement of a filter device in the inferior vena cava. A filter can be placed transvenously to trap clots before they travel to the pulmonary circulation.

17. The nurse is caring for a 2 year-old who is being treated with chelation therapy, calcium disodium edetate, for lead poisoning. The nurse should be alert for which of the following side effects?

A) Neurotoxicity
B) Hepatomegaly
C) Nephrotoxicity
D) Ototoxicity

C: Nephrotoxicity. Nephrotoxicity is a common side effect of calcium disodium edetate, in addition to lead poisoning in general.

18. A newborn is having difficulty maintaining a temperature above 98 degrees Fahrenheit and has been placed in an incubator. Which action is a nursing **priority**?

A) Protect the eyes of the neonate from the heat lamp
B) Monitor the neonate's temperature
C) Warm all medications and liquids before giving
D) Avoid touching the neonate with cold hands

B: Monitor the neonate's temperature. When using a warming device the neonate's temperature should be continuously monitored for undesired elevations. The use of heat lamps is not safe as there is no way to regulate their temperature. Warming medications and fluids is not indicated. While touching with cold hands can startle the infant it does not pose a safety risk.

19. What is the best way that parents of pre-schoolers can begin teaching their child about injury prevention?

A) Set good examples themselves
B) Protect their child from outside influences
C) Make sure their child understands all the safety rules
D) Discuss the consequences of not wearing protective devices

A: Set good examples themselves. The preschool years are the time for parents to begin emphasizing safety principles as well as providing protection. Setting a good example themselves is crucial because of the imitative behaviors of pre-schoolers; they are quick to notice discrepancies between what they see and what they are told.

20. A client complains of some discomfort after a below the knee amputation. Which action by the nurse is most appropriate **initially**?

A) Conduct guided imagery or distraction
B) Ensure that the stump is elevated the first day post-op
C) Wrap the stump snugly in an elastic bandage
D) Administer opioid narcotics as ordered

B: Ensure that the stump is elevated the first day post-op. This priority intervention prevents pressure caused by pooling of blood, thus minimizing the pain. Without this measure, a firm elastic bandage, opioid narcotics, or guided imagery will have little effect. Opioid narcotics are given for severe pain.

21. The nurse is caring for a client with extracellular fluid volume deficit. Which of the following assessments would the nurse anticipate finding?

A) bounding pulse
B) rapid respirations
C) oliguria
D) neck veins are distended

C: oliguria. Kidneys maintain fluid volume through adjustments in urine volume.

22. The nurse is performing a gestational age assessment on a newborn delivered 2 hours ago. When coming to a conclusion using the Ballard scale, which of these factors may affect the score?

A) Birth weight
B) Racial differences
C) Fetal distress in labor
D) Birth trauma

C: Fetal distress in labor. The effects of earlier distress may alter the findings of reflex responses as measured on the Ballard tool. Other physical characteristics that estimate gestational age, such as amount of lanugo, sole creases and ear cartilage are unaffected by the other factors.

23. Which oxygen delivery system would the nurse apply that would provide the **highest** concentrations of oxygen to the client?

A) Venturi mask

B) Partial rebreather mask
C) Non-rebreather mask
D) Simple face mask

C: Non-rebreather mask. The non-rebreather mask has a one-way valve that prevents exhales air from entering the reservoir bag and one or more valves covering the air holes on the face mask itself to prevent inhalation of room air but to allow exhalation of air. When a tight seal is achieved around the mask up to 100% of the oxygen is available.

24. Which of the following situations is most likely to produce sepsis in the neonate?

A) Maternal diabetes
B) Prolonged rupture of membranes
C) Cesarean delivery
D) Precipitous vaginal birth

B: Prolonged rupture of membranes. Premature rupture of the membranes (PROM) is a leading cause of newborn sepsis. After 12-24 hours of leaking fluid, measures are taken to reduce the risk to mother and the fetus/newborn.

25. A 4 year-old hospitalized child begins to have a seizure while playing with hard plastic toys in the hallway. Of the following nursing actions, which one should the nurse do **first**?

A) Place the child in the nearest bed
B) Administer IV medication to slow down the seizure
C) Place a padded tongue blade in the child's mouth
D) Remove the child's toys from the immediate area

D: Remove the child"s toys from the immediate area. Nursing care for a child having a seizure includes, maintaining airway patency, ensuring safety, administering medications, and providing emotional support. Since the seizure has already started, nothing should be forced into the child"s mouth and the child should not be moved. Of the choices given, the first priority would be to provide a safe environment.

26. A 78 year-old client with pneumonia has a productive cough, but is confused. Safety protective devices (restraints) have been ordered for this client. How can the nurse prevent aspiration?

A) Suction the client frequently while restrained
B) Secure all 4 restraints to 1 side of bed
C) Obtain a sitter for the client while restrained
D) Request an order for a cough suppressant

C: The plan to use safety devices (restraints) should be rethought. Restraints are used to protect the client from harm caused by removing tubes or getting out of bed. In the event that this restricted movement could cause more harm, such as aspiration, then a sitter should be requested. These are to be provided by the facility in the event the family cannot do so. This client needs to cough and be watched rather than restricted. Suctioning will not prevent aspiration in this situation. Cough suppressants should be avoided for this client.

27. A client asks the nurse to explain the basic ideas of homeopathic medicine. The response that **best** explains this approach is that such remedies

A) destroy organisms causing disease
B) maintain fluid balance
C) boost the immune system
D) increase bodily energy

C: boost the immune system. The practitioner treats with minute doses of plant, mineral or animal substances which provide a gentle stimulus to the body"s own defenses.

28. A newborn has hyperbilirubinemia and is undergoing phototherapy with a fiberoptic blanket. Which safety measure is most important during this process?

A) Regulate the neonate’s temperature using a radiant heater
B) Withhold feedings while under the phototherapy
C) Provide water feedings at least every 2 hours
D) Protect the eyes of neonate from the phototherapy lights

C: Provide water feedings at least every 2 hours. Protecting the eyes of the neonates is very important to prevent damage when under the ultraviolet lights, but since the blanket is used, extra protection of the eyes is unnecessary. It is recommended that the neonate remain under the lights for extended periods. The neonate’s skin is exposed to the light and the temperature is monitored, but a heater may not be necessary. There is no reason to withhold feedings. Frequent water or feedings are given to help with the excretion of the bilirubin in the stool.

29. The nurse is assigned to care for a client who has a leaking intracranial aneurysm. To minimize the risk of rebleeding, the nurse should plan to

A) restrict visitors to immediate family
B) avoid arousal of the client except for family visits
C) keep client's hips flexed at no less than 90 degrees
D) apply a warming blanket for temperatures of 98 degrees Fahrenheit or less

A: restrict visitors to immediate family. Maintaining a quiet environment will assist in minimizing cerebral rebleeding. When family visit, the client should not be disturbed. If the client is awake, topics of a general nature are better choices for discussion than topics that result in emotional or physiological stimulation.

30. A new nurse manager is responsible for interviewing applicants for a staff nurse position. Which interview strategy would be the **best** approach?

A) Vary the interview style for each candidate to learn different techniques
B) Use simple questions requiring "yes" and "no" answers to gain definitive information
C) Obtain an interview guide from human resources for consistency in interviewing each candidate
D) Ask personal information of each applicant to assure he/she can meet job demands

C: Obtain an interview guide from human resources for consistency in interviewing each candidate
An interview guide used for each candidate enables the nurse manager to be more objective in the decision making. The nurse should use resources available in the agency before attempts to develop one from scratch. Certain personal questions are prohibited, and HR can identify these for novice managers.

31. When suctioning a client's tracheostomy, the nurse should instill saline in order to

A) decrease the client's discomfort
B) reduce viscosity of secretions
C) prevent client aspiration
D) remove a mucus plug

D: remove a mucus plug. While no longer recommended for routine suctioning, saline may thin and loosen viscous secretions that are very difficult to move, perhaps making them easier to suction.

32. A client returns from surgery after an open reduction of a femur fracture. There is a small bloodstain on the cast. Four hours later, the nurse observes that the stain has doubled in size. What is the **best** action for the nurse to take?

A) Call the health care provider
B) Access the site by cutting a window in the cast
C) Simply record the findings in the nurse's notes only
D) Outline the spot with a pencil and note the time and date on the cast

D: Outline the spot with a pencil and note the time and date on the cast. This is a good way to assess the amount of bleeding over a period of time. The bleeding does not appear to be excessive and some bleeding is expected with this type of surgery. The bleeding should also be documented in the nurse's notes.

33. Included in teaching the client with tuberculosis taking isoniazid (INH) about follow-up home care, the nurse should emphasize that a laboratory appointment for which of the following lab tests is critical?

A) Liver function
B) Kidney function
C) Blood sugar
D) Cardiac enzymes

A: Liver function. INH can cause hepatocellular injury and hepatitis. This side effect is age-related and can be detected with regular assessment of liver enzymes, which are released into the blood from damaged liver cells.

34. The nurse is at the community center speaking with retired people about glaucoma. Which comment by one of the retirees would the nurse support to reinforce correct information?

A) "I usually avoid driving at night since lights sometimes seem to make things blur."
B) "I take half of the usual dose for my sinuses to maintain my blood pressure."
C) "I have to sit at the side of the pool with the grandchildren since I can't swim with this eye problem."
D) "I take extra fiber and drink lots of water to avoid getting constipated."

D: Any activity that involves straining should be avoided in clients with glaucoma. Such activities would increase intraocular pressure.

35. The nurse is teaching home care to the parents of a child with acute spasmodic croup. The **most** important aspects of this care is/are

A) sedation as needed to prevent exhaustion
B) antibiotic therapy for 10 to 14 days
C) humidified air and increased oral fluids
D) antihistamines to decrease allergic response

C: humidified air and increased oral fluids. The most important aspects of home care for a child with acute spasmodic croup are humidified air and increased oral fluids. Moisture soothes inflamed membranes. Adequate systemic hydration aids is mucociliary clearance and keeps secretions thin, white, watery, and easily removed with minimal coughing.

36. A nurse is performing the routine daily cleaning of a tracheostomy. During the procedure, the client coughs and displaces the tracheostomy tube. This negative outcome could have avoided by

A) placing an obturator at the client's bedside
B) having another nurse assist with the procedure

C) fastening clean tracheostomy ties before removing old ties
D) placing the client in a flat, supine position

C: fastening clean tracheostomy ties before removing old ties. Fastening clean tracheostomy ties before removing old ones will ensure that the tracheostomy is secured during the entire cleaning procedure. The obturator is useful to keep the airway open only after the tracheostomy outer tube is coughed out. A second nurse is not needed. Changing the position may not prevent a dislodged tracheostomy.

37. A client who is 12 hour post-op becomes confused and says: "Giant sharks are swimming across the ceiling." Which assessment is necessary to adequately identify the source of this client's behavior?

A) Cardiac rhythm strip
B) Pupillary response
C) Pulse oximetry
D) Peripheral glucose stick

C: Pulse oximetry. A sudden change in mental status in any post-op client should trigger a nursing intervention directed toward respiratory evaluation. Pulse oximetry would be the initial assessment. If available, arterial blood gases would be better. Acute respiratory failure is the sudden inability of the respiratory system to maintain adequate gas exchange which may result in hypercapnia and/or hypoxemia. Clinical findings of hypoxemia include these finding which are listed in order of initial to later findings: restlessness, irritability, agitation, dyspnea, disorientation, confusion, delirium, hallucinations, and loss of consciousness. While there may be other factors influencing the client"s behavior, the first nursing action should be directed toward maintaining oxygenation. Once respiratory or oxygenation issues are ruled out then significant changes in glucose would be evaluated.

38. A nurse assessing the newborn of a mother with diabetes understands that hypoglycemia is related to what pathophysiological process?

A) Disruption of fetal glucose supply
B) Pancreatic insufficiency
C) Maternal insulin dependency
D) Reduced glycogen reserves

A: After delivery, the high glucose levels which crossed the placenta to the fetus are suddenly stopped. The newborn continues to secrete insulin in anticipation of glucose. When oral feedings begin, the newborn will adjust insulin production within a day or two.

39. A newborn delivered at home without a birth attendant is admitted to the hospital for observation. The initial temperature is 95 degrees Fahrenheit (35 degrees Celsius) axillary. The nurse recognizes that cold stress may lead to what complication?

A) Lowered BMR
B) Reduced PaO2
C) Lethargy
D) Metabolic alkalosis

B: Reduced PaO2. Cold stress causes increased risk for respiratory distress. The baby delivered in such circumstances needs careful monitoring. In this situation, the newborn must be warmed immediately to increase its temperature to at least 97 degrees Fahrenheit (36 degrees Celsius).

40. A nurse is caring for a client who had a closed reduction of a fractured right wrist followed by the application of a fiberglass cast 12 hours ago. Which finding requires the nurse's **immediate** attention?

A) Capillary refill of fingers on right hand is 3 seconds
B) Skin warm to touch and normally colored
C) Client reports prickling sensation in the right hand
D) Slight swelling of fingers of right hand

C: Client reports prickling sensation in the right hand. A prickling sensation is an indication of compartment syndrome and requires immediate action by the nurse. The other findings are normal for a client in this situation.

Q&A Random Selection #5

1. The nurse is caring for a client who had a total hip replacement 4 days ago. Which assessment requires the nurse's **immediate** attention?

A) "I have bad muscle spasms in my lower leg of the affected extremity."
B) "I just can't 'catch my breath' over the past few minutes and I think I am in grave danger."
C) "I have to use the bedpan to pass my water at least every 1 to 2 hours."
D) "It seems that the pain medication is not working as well today."

B: The nurse would be concerned about all of these comments, however the most life threatening is option B. Clients who have had hip or knee surgery are at greatest risk for development of post operative pulmonary embolism. Sudden dyspnea and tachycardia are classic findings of pulmonary embolism. Muscle spasms do not require immediate attention. Option C may indicate a urinary tract infection. Although option D requires further investigation, it is not life threatening.

2. While assessing a 1 month-old infant, which finding should the nurse report **immediately**?

    A) Abdominal respirations
    B) Irregular breathing rate
    C) Inspiratory grunt
    D) Increased heart rate with crying

C: Inspiratory grunt. Inspiratory grunting is abnormal and may be a sign of respiratory distress in this infant.

3. A client is receiving digoxin (Lanoxin) 0.25 mg. Daily. The health care provider has written a new order to give metoprolol (Lopressor) 25 mg. B.I.D. In assessing the client prior to administering the medications, which of the following should the nurse report immediately to the health care provider?

    A) Blood pressure 94/60
    B) Heart rate 76 BPM
    C) Urine output 50 ml/hour
    D) Respiratory rate 16

A: Both medications decrease the heart rate. Metoprolol affects blood pressure. Therefore, the heart rate and blood pressure must be within normal range (HR 60-100 BPM; systolic B/P over 100) in order to safely administer both medications.

4. In children suspected to have a diagnosis of diabetes, which one of the following complaints would be most likely to prompt parents to take their school age child for evaluation?

    A) Polyphagia
    B) Dehydration
    C) Bed wetting
    D) Weight loss

C: Bed wetting. In children, fatigue and bed wetting are the chief complaints that prompt parents to take their child for evaluation. Bed wetting in a school age child is readily detected by the parents.

5. During an assessment of a client with cardiomyopathy, the nurse finds that the systolic blood pressure has decreased from 145 to 110 mm Hg and the heart rate has risen from 72 to 96 beats per minute and the client complains of periodic dizzy spells. The nurse instructs the client to

    A) increase fluids that are high in protein
    B) restrict fluids
    C) force fluids and reassess blood pressure
    D) limit fluids to non-caffeine beverages

C: Postural hypotension, a decrease in systolic blood pressure of more than 15 mm Hg and an increase in heart rate of more than 15 percent usually accompanied by dizziness indicates volume depletion, inadequate vasoconstrictor mechanisms, and autonomic insufficiency.

6. The nurse is speaking at a community meeting about personal responsibility for health promotion. A participant asks about chiropractic treatment for illnesses. What should be the focus of the nurse's response?

    A) Electrical energy fields
    B) Spinal column manipulation
    C) Mind-body balance
    D) Exercise of joints

B: Spinal column manipulation. The theory underlying chiropractic is that interference with transmission of mental impulses between the brain and body organs produces diseases. Such interference is caused by misalignment of the vertebrae. Manipulation reduces the misalignment (subluxation).

7. A client is admitted to the emergency room with renal calculi and is complaining of moderate to severe flank pain and nausea. The client's temperature is 100.8 degrees Fahrenheit. The **priority** nursing goal for this client is

    A) Maintain fluid and electrolyte balance
    B) Control nausea
    C) Manage pain
    D) Prevent urinary tract infection

C: Manage pain. The immediate goal of therapy is to alleviate the client's pain, which can be quite severe with kidney stones.

8. A nurse prepares to care for a 4 year-old newly admitted for rhabdomyosarcoma. The nurse should alert the staff to pay more attention to the function of which area of the body?

    A) the muscles
    B) the cerebellum
    C) the kidneys
    D) the leg bones

A: the muscles. Rhabdomyosarcoma is the most common children"s soft tissue sarcoma. It originates in striated (skeletal) muscles and can be found anywhere in the body. The clue is in the middle of the word -- “myo” --which typically means muscle.

9. A triage nurse has these 4 clients arrive in the emergency department within a 15 minute period. Which client should the triage nurse send back to be seen first?

    A) A 2 month old infant with a history of rolling off the bed and has bulging fontanels with crying
    B) A teenager who got a singed beard while camping
    C) An elderly client with complaints of frequent liquid brown colored stools
    D) A middle aged client with intermittent pain behind the right scapula

B: A teenager who got a singed beard while camping. This client is in the greatest danger with a potential of respiratory distress, Any client with singed facial hair has been exposed to heat or fire in close range that could have caused damage to the interior of the lung. Note that the interior lining of the lung has no nerve fibers so the client will not be aware of swelling.

10. While planning care for a toddler, the nurse teaches the parents about the expected developmental changes for this age. Which statement by the mother shows that she understands the child's developmental needs?

    A) "I want to protect my child from any falls."
    B) "I will set limits on exploring the house."
    C) "I understand our child’s need to use those new skills."
    D) "I intend to keep control over our child’s behavior."

C: "I understand our child’s need to use those new skills." Erikson describes the stage of the toddler as being the time when there is normally an increase in autonomy. The child needs to use motor skills to explore the environment.

11. A client who is pregnant comes to the clinic for a first visit. The nurse gathers data about her obstetric history, which includes 3 year-old twins at home and a miscarriage 10 years ago at 12 weeks gestation. How would the nurse accurately document this information?

    A) Gravida 4 para 2
    B) Gravida 2 para 1
    C) Gravida 3 para 1
    D) Gravida 3 para 2

C: Gravida 3 para 1. Gravida is the number of pregnancies and Parity is the number of pregnancies that reach viability (not the number of fetuses). Thus, for this woman, she is now pregnant, had 2 prior pregnancies, and 1 viable birth (twins).

12. A client has been newly diagnosed with hypothyroidism and will take levothyroxine (Synthroid) 50 mcg/day by mouth. As part of the teaching plan, the nurse emphasizes that this medication:

    A) Should be taken in the morning
    B) May decrease the client's energy level
    C) Must be stored in a dark container
    D) Will decrease the client's heart rate

A: Should be taken in the morning. Thyroid supplement should be taken in the morning to minimize the side effect of insomnia.

13. The nurse is performing a neurological assessment on a client post right cerebral vascular accident (CVA). Which finding, if observed by the nurse, would warrant immediate attention?

    A) Decrease in level of consciousness
    B) Loss of bladder control
    C) Altered sensation of stimuli
    D) Emotional lability

A: Decrease in level of consciousness. A further decrease in the level of consciousness would be indicative of a further progression of the CVA.

14. What would the nurse expect to see while assessing the growth of children during their school age years?

    A) Decreasing amounts of body fat and muscle mass
    B) Little change in body appearance from year to year
    C) Progressive height increase of 4 inches each year
    D) Yearly weight gain of about 5.5 pounds per year

D: School age children gain about 5.5 pounds each year and increase about 2 inches in height.

15. The nurse is caring for a client with a venous stasis ulcer. Which nursing intervention would be **most** effective in promoting healing?

    A) Apply dressing using sterile technique
    B) Improve the client's nutrition status
    C) Initiate limb compression therapy
    D) Begin proteolytic debridement

B: The goal of clinical management in a client with venous stasis ulcers is to promote healing. This only can be accomplished with proper nutrition. The other interventions are appropriate, but without proper nutrition, they would be of little help.

16. Which of the following should the nurse implement to prepare a client for a kidney, ureter, bladder (KUB) radiograph test?

    A) Client must be NPO before the examination
    B) Enema to be administered prior to the examination
    C) Medicate client with Lasix 20 mg IV 30 minutes prior to the examination
    D) No special orders are necessary for this examination

D: No special orders are necessary for this examination. No special preparation is necessary for this examination.

17. A nurse is to administer meperidine hydrochloride (Demerol) 100 mg, atropine sulfate (Atropisol) 0.4 mg, and promethazine hydrochloride (Phenergan) 50 mg IM to a pre-operative client. Which action should the nurse take **first**?

    A) Raise the side rails on the bed
    B) Place the call bell within reach
    C) Instruct the client to remain in bed
    D) Have the client empty bladder

D: Have the client empty bladder. The first step in the process is to have the client void prior to administering the pre-operative medication. The other actions follow this initial step in this sequence: D, C, B, A. Note: It is much easier to administer IM meds with the side rails down, and then raising them when the nurse is done. Other activities can then be carried out more safely.

18. The home health nurse visits a male client to provide wound care and finds the client lethargic and confused. His partner states he fell down the stairs 2 hours ago. The nurse should

    A) place a call to the client's provider for instructions
    B) send him to the emergency room for evaluation
    C) reassure the client's partner that the symptoms are transient
    D) instruct the client's partner to call the provider if his symptoms become worse

B: This client requires immediate evaluation. A delay in treatment could result in further deterioration of his condition and possibly permanent harm. Home care nurses must prioritize interventions based on assessment findings that are in the client"s best interest.

19. A client comes to the clinic for treatment of recurrent pelvic inflammatory disease (PID). The nurse recognizes that this condition **most** frequently follows which type of infection?

    A) Trichomoniasis
    B) Chlamydia
    C) Staphylococcus
    D) Streptococcus

B: Chlamydia. Chlamydial infections are one of the most frequent causes of salpingitis or pelvic inflammatory disease.

20. A client has been taking furosemide (Lasix) for the past week. The nurse recognizes which finding may indicate the client is experiencing a negative side effect from the medication?

    A) Weight gain of 5 pounds
    B) Edema of the ankles
    C) Gastric irritability
    D) Decreased appetite

D: Decreased appetite. Lasix causes a loss of potassium if a supplement is not taken. Signs and symptoms of hypokalemia include anorexia, fatigue, nausea, decreased GI motility, muscle weakness, and dysrhythmias.

21. The nurse anticipates that for a family who practices Chinese medicine the **priority** therapeutic goal would be to

    A) achieve harmony
    B) maintain a balance of energy
    C) respect life
    D) restore yin and yang

D: For followers of Chinese medicine, health is maintained through balance between the forces of yin and yang.

22. Which individual is at greatest risk for developing hypertension?

    A) 45 year-old African American attorney
    B) 60 year-old Asian American shop owner
    C) 40 year-old Caucasian nurse
    D) 55 year-old Hispanic teacher

A: 45 year-old African American attorney. The incidence of hypertension is greater among African Americans than other groups in the US. The incidence among the Hispanic population is rising.

23. The hospital has sounded the call for a disaster drill on the evening shift. Which of these clients would the nurse put first on the discharge list in order to make room for a new admission?

A) A middle aged client with a 7 year history of being ventilator dependent and who was admitted with bacterial pneumonia five days ago
B) A young adult with Type 2 diabetes mellitus for over 10 years and who was admitted with antibiotic-induced diarrhea 24 hours ago
C) An elderly client with a history of hypertension, hypercholesterolemia and lupus, and who was admitted with Stevens-Johnson syndrome that morning
D) An adolescent with a positive HIV test and who was admitted for acute cellulitis of the lower leg 48 hours ago

A: The best candidate for discharge is one who has a chronic condition and has an established plan of care. The client in option A is most likely stable and could continue medication therapy at home.

24. A client has a Swan-Ganz catheter in place. The nurse understands that this is intended to measure

A) right heart function
B) left heart function
C) renal tubule function
D) carotid artery function

B: left heart function. The Swan-Ganz catheter is placed in the pulmonary artery to obtain information about the left side of the heart. It can provide hemodynamic information such as intracardiac pressure readings and oxygen saturation data, and even transvenous pacing. Information about left ventricular function is important because it directly affects tissue perfusion. Right-sided heart function is assessed through the evaluation of the central venous pressure (CVP).

25. The nurse is caring for a client with a serum potassium level of 3.5 mEq/L. The client is placed on a cardiac monitor and receives 40 mEq KCL in 1000 ml of 5% dextrose in water IV. Which of the following EKG patterns indicates to the nurse that the infusions should be discontinued?

A) Narrowed QRS complex
B) Shortened "PR" interval
C) Tall peaked T waves
D) Prominent "U" waves

C: A tall peaked T wave is a sign of hyperkalemia. The provider should be notified regarding discontinuing the medication.

26. A 3 year-old child comes to the pediatric clinic after the sudden onset of findings that include irritability, thick muffled voice, croaking on inspiration, skin hot to touch, sits leaning forward, tongue protruding, drooling and suprasternal retractions. What should the nurse do **first**?

A) Prepare the child for x-ray of upper airways
B) Examine the child's throat
C) Collect a sputum specimen
D) Notify the healthcare provider of the child's status

D: These findings suggest a medical emergency and may be due to epiglottitis. Any child with an acute onset of an inflammatory response in the mouth and throat should receive immediate attention in a facility equipped to perform intubation or a tracheostomy in the event of further or complete obstruction.

27. A nurse is evaluating the quality of home care for a client with Alzheimer's disease. It would be a **priority** to reinforce which statement by a family member?

A) "At least 2 full meals a day should be eaten."
B) "We go to a group discussion every week at our community center."
C) "We have safety bars installed in the bathroom and have 24 hour alarms on the doors."
D) "Taking the medication 3 times a day is not a problem."

C: Ensuring safety of the client with increasing memory loss is a priority of home care. Note all options are positive statements, however safety is most important to reinforce.

28. A child who has recently been diagnosed with cystic fibrosis (CF) is being assessed by a pediatric clinic nurse. Which finding of this disease would the nurse not expect to see at this time?

A) Positive sweat test
B) Bulky greasy stools
C) Moist, productive cough
D) Meconium ileus

C: Moist, productive cough. Option C is a later sign. Noisy respirations and a dry non-productive cough are commonly the first of the respiratory signs to appear in a newly diagnosed client with CF. The other options are the earliest findings. CF is an inherited (genetic) condition affecting the cells that produce mucus, sweat, saliva and digestive juices. Normally, these secretions are thin and slippery, but in CF a defective gene causes the secretions to become thick and sticky. Instead of acting as a lubricant, the secretions plug up tubes, ducts and passageways, especially in the pancreas and lungs. Respiratory failure is the most dangerous consequence of CF.

29. When teaching a client with coronary artery disease about nutrition, the nurse should emphasize

A) eating 3 balanced meals a day
B) adding complex carbohydrates
C) avoiding very heavy meals

D) limiting sodium to 7 gms per day

C: avoiding very heavy meals. Eating large, heavy meals can pull blood away from the heart for digestion, which is dangerous for the client with coronary artery disease.

30. Which complication of cardiac catheterization should the nurse monitor for in the initial 24 hours after the procedure?

A) Angina at rest
B) Thrombus formation
C) Dizziness
D) Falling blood pressure

B: Thrombus formation in the coronary arteries is a potential problem in the initial 24 hours after a cardiac catheterization. A falling BP occurs along with hemorrhage of the insertion site which is within the first 12 hours after the procedure.

31. Which of these statements best describes the characteristic of an effective reward-feedback system?

A) Specific feedback is given as close to the event as possible
B) Staff are given feedback in equal amounts over time
C) Positive statements precede a negative statement
D) Performance goals should be higher than what is attainable

A: Feedback is most useful when given immediately. Positive behavior is strengthened through immediate feedback, and it is easier to modify problem behaviors if what constitutes appropriate behavior is clearly understood.

32. A child who ingested 15 maximum strength acetaminophen tablets 45 minutes ago is seen in the emergency department. Which of these orders should the registered nurse implement **first**?

A) Gastric lavage PRN
B) Antidote *N*-acetylcysteine (NAC) (Mucomyst) for age per pharmacy
C) Start a Dextrose 5% with 0.33% normal saline IV to keep vein open
D) Activated charcoal per pharmacy

A: Gastric lavage PRN. Removing as much of the drug as possible is the first step in treatment for this drug overdose. This is best done by gastric lavage. The next actions to complete would be to administer activated charcoal, then Mucomyst and lastly the IV fluids.

33. Which of these findings indicate that a pump set to deliver a basal rate of 10 ml per hour plus PRN morphine drip for breakthrough pain is not working?

A) The client complains of discomfort at the IV insertion site
B) The client states "I just can't get relief from my pain"
C) The level of the drug is 100 ml at 8 AM and is 80 ml at noon
D) The level of the drug is 100 ml at 8 AM and is 50 ml at noon

C: The minimal dose is 10 ml per hour, which would mean 40 mls are given in a 4 hour period. Only 60 mls should be left at noon. The pump is not functioning when more than expected medicine is left in the container.

34. A nurse enters a client's room to discover that the client has no pulse or respirations. After calling for help, the **first** action the nurse should take is

A) start a peripheral IV
B) initiate closed-chest massage
C) establish an airway
D) obtain the crash cart

C: Establishing an open airway is always the primary objective in a cardiopulmonary arrest.

35. The nurse is preparing to administer an enteral feeding to a client via a nasogastric feeding tube. The **most** important action of the nurse is to

A) verify correct placement of the tube
B) check that the feeding solution matches the dietary order
C) aspirate abdominal contents to determine the amount of last feeding remaining in stomach
D) ensure that feeding solution is at room temperature

A: verify correct placement of the tube. Proper placement of the tube prevents aspiration.

36. A client with multiple sclerosis plans to begin an exercise program. In addition to discussing the benefits of regular exercise, the nurse should caution the client to avoid activities which

A) increase the heart rate
B) lead to dehydration
C) are considered aerobic
D) may be competitive

B: lead to dehydration. The client must take in adequate fluids before and during exercise periods.

37. The nurse practicing in a maternity setting recognizes that the post mature fetus is at risk due to

A) Excessive fetal weight

B) Low blood sugar levels
C) Depletion of subcutaneous fat
D) Progressive placental insufficiency

D: The placenta functions less efficiently as pregnancy continues beyond 42 weeks. Immediate and long term effects may be related to hypoxia.

38. At a community health fair the blood pressure of a 62 year-old client is 160/96. The client states “My blood pressure is usually much lower.” The nurse should tell the client to

A) go get a blood pressure check within the next 48 to 72 hours
B) check blood pressure again in 2 months
C) see the health care provider immediately
D) visit the health care provider within 1 week for a BP check

A: The blood pressure reading is moderately high with the need to have it rechecked in a few days. Although the client states it is ‘usually much lower,’ a concern exists for complications such as stroke. An immediate check by the provider of care is not warranted. Waiting 2 months or a week for follow-up is too long.

39. The nurse is giving discharge teaching to a client 7 days post myocardial infarction. He asks the nurse why he must wait 6 weeks before having sexual intercourse. What is the best response by the nurse to this question?

A) "You need to regain your strength before attempting such exertion.
B) "When you can climb 2 flights of stairs without problems, it is generally safe."
C) "Have a glass of wine to relax you, then you can try to have sex."
D) "If you can maintain an active walking program, you will have less risk."

B: There is a risk of cardiac rupture at the point of the myocardial infarction for about 6 weeks. Scar tissue should form about that time. Waiting until the client can tolerate climbing stairs is the usual advice given by health care providers.

40. An RN who usually works in a spinal rehabilitation unit is floated to the emergency department. Which of these clients should the charge nurse assign to this RN?

A) A middle-aged client who says "I took too many diet pills" and "my heart feels like it is racing out of my chest."
B) A young adult who says "I hear songs from heaven. I need money for beer. I quit drinking 2 days ago for my family. Why are my arms and legs jerking?"
C) An adolescent who has been on pain medications for terminal cancer with an initial assessment finding of pinpoint pupils and a relaxed respiratory rate of 10
D) An elderly client who reports having taken a "large crack hit" 10 minutes prior to walking into the emergency room

C: Nurses who are floated to other units should be assigned to a client who has minimal anticipated immediate complications of their problem. The client in option C exhibits opioid toxicity with the pinpoint pupils and has the least risk of complications occurring in the near future.

Q &A Random Selection #6

1. Which of these women in the labor and delivery unit would the nurse check first when the water breaks (ROM) for all of them within a 2 minute period?

A) A multigravida with station at +2, contractions at 15 minutes apart with duration of 30 seconds, cervix dilated at 7 cm, and 50% effacement
B) A multigravida with station at -1, contractions at 15 minutes apart with duration of 30 seconds, cervix dilated at 3 cm, and 10% effacement
C) A primipara with station at 0, contractions at 20 minutes apart with duration of 20 seconds, cervix dilated at 2 cm and 10% effacement
D) A primipara with station at 1, contractions at 15 minutes apart with duration of 35 seconds, cervix dilated at 5 cm and 50% effacement

B: A multigravida with station at -1, contractions at 15 minutes apart with duration of 30 seconds, cervix dilated at 3 cm, and 10% effacement. When the station is -1 or -2 and the water breaks, the risk is greater for a prolapsed cord.

2. The nurse is caring for an 87 year-old client with urinary retention. Which finding should be reported immediately?

A) Fecal impaction
B) Infrequent voiding
C) Stress incontinence
D) Burning with urination

A: Fecal impaction. The nurse should report fecal impaction or constipation which can cause obstruction of the bladder outlet. Bladder outlet obstruction is a common cause of urine retention in the elderly.

3. A 36 year-old female client has a hemoglobin level of 14 g/dl and a hematocrit of 42% following a D&C. Which of the following would the nurse expect to find when assessing this client?

A) Capillary refill less than 3 seconds
B) Pale mucous membranes
C) Respirations 36 breaths per minute
D) Complaints of fatigue when ambulating

A: Capillary refill less than 3 seconds. Since the hemoglobin and hematocrit are normal for an adult female, addition assessments should be normal. This capillary refill time is *normal*.

4. Parents are concerned that their 11 year-old child is a very picky eater. The nurse suggests which of the following as the best **initial** approach?

A) Consider a liquid supplement to increase calories
B) Discuss consequences of an unbalanced diet with the child
C) Provide fruit, vegetable and protein snacks
D) Encourage the child to keep a daily log of foods eaten

B: Discuss consequences of an unbalanced diet with the child. It is important to educate the preadolescent as to appropriate diet, and the problems that might arise if diet is not adequate.

5. The nurse is assessing a pregnant client in her third trimester. The parents are informed that the ultrasound suggests that the baby is small for gestational age (SGA). An earlier ultrasound indicated normal growth. The nurse understands that this change is most likely due to what factor?

A) Sexually transmitted infection
B) Exposure to teratogens
C) Maternal hypertension
D) Chromosomal abnormalities

C: Maternal hypertension. Pregnancy induced hypertension is a common cause of late pregnancy fetal growth retardation. Vasoconstriction reduces placental exchange of oxygen and nutrients.

6. An 80 year-old nursing home resident has a temperature of 101.6 degrees Fahrenheit rectally. This is a sudden change in an otherwise healthy client. Which should the nurse assess **first**?

A) lung sounds
B) urine output
C) level of alertness
D) appetite

C: level of alertness. Assessing the level of consciousness (alert vs. lethargic vs. unresponsive) will help the provider determine the severity of the acute episode. If the client is alert, responses to questions about complaints can be followed-up quickly.

7. While giving care to a 2 year-old client, the nurse should remember that the toddler's tendency to say "no" to almost everything is an indication of what psychosocial skill?

A) Stubborn behavior
B) Rejection of parents
C) Frustration with adults
D) Assertion of control

D: Assertion of control. Negativity is a normal behavior in toddlers. The nurse must be aware that this behavior is an important sign of the child"s progress from dependency to autonomy and independence.

8. The nurse is caring for a client suspected to have Tuberculosis (TB). Which of the following diagnostic tests is essential for determining the presence of active TB?

A) Tuberculin skin testing
B) Sputum culture
C) White blood cell count
D) Chest x-ray

B: Sputum culture. The sputum culture is the most accurate method for determining the presence of active TB.

9. For which of the following mother-baby pairs should the nurse review the Coombs' test in preparation for administering Rh_o (D) immune globulin within 72 hours of birth?

A) Rh negative mother with Rh positive baby
B) Rh negative mother with Rh negative baby
C) Rh positive mother with Rh positive baby
D) Rh positive mother with Rh negative baby

A: Rh negative mother with Rh positive baby. An Rh- mother who delivers an Rh+ baby may develop antibodies to the fetal red cells to which she may be exposed during pregnancy or at placental separation. If the Coombs test is negative, no sensitization has occurred. TheFor which of the following mother-baby pairs should the nurse review the Coomb"s" test in preparation for administering Rh_o(D) immune globulin is given to block antibody formation in the mother.

10. An unlicensed assistive staff member asks the nurse manager to explain the beliefs of a Christian Scientist who refuses admission to the hospital after a motor vehicle accident. The **best** response of the nurse would be which of these statements?

A) "Spiritual healing is emphasized and the mind contributes to the cure."
B) "The primary belief is that dietary practices result in health or illness."
C) "Fasting and prayer are initial actions to take in physical injury."
D) "Meditation is intensive in the initial 48 hours and daily thereafter."

A: "Spiritual healing is emphasized and the mind contributes to the cure." For the Christian Scientist, a mind cure uses spiritual healing methods. For the believer, medical treatments may interfere with drawing closer to God.

11. The nurse has been teaching an apprehensive primipara who has had initial difficulty in nursing the newborn. What observation at the time of discharge suggests that initial breast feeding is effective?

A) The mother feels calmer and talks to the baby while nursing
B) The mother awakens the newborn to feed whenever it falls asleep
C) The newborn falls asleep after 3 minutes at the breast
D) The newborn refuses the supplemental bottle of glucose water

A: The mother feels calmer and talks to the baby while nursing. Early evaluation of successful breastfeeding can be measured by the client"s voiced confidence and satisfaction with the infant.

12. The nurse is caring for a client with congestive heart failure. Which finding requires the nurse's **immediate** attention?

A) pulse oximetry of 85%
B) nocturia
C) crackles in lungs
D) diaphoresis

A: pulse oximetry of 85%. An oxygen saturation of 88% or less indicates hypoxemia and requires the nurse"s immediate attention.

13. The nurse is taking a health history from parents of a child admitted with possible Reye's syndrome. Which recent illness would the nurse recognize as increasing the risk to develop Reye's syndrome?

A) rubeola
B) meningitis
C) varicella
D) hepatitis

C: varicella. Varicella (chicken pox) and influenza are viral illnesses that have been identified as increasing the risk for Reye"s syndrome. Use of aspirin is contraindicated for children with these infections.

14. The nurse is caring for a client with end-stage heart failure. The family members are distressed about the client's impending death. What action should the nurse do first?

A) Explain the stages of death and dying to the family
B) Recommend an easy-to-read book on grief
C) Assess the family's patterns for dealing with death
D) Ask about their religious affiliations

C: Assess the family"s patterns for dealing with death. When a new problem is identified, it is important for the nurse to collect accurate assessment data. This is crucial to ensure that the client and their family"s needs are adequately identified in order to select the best nursing care approaches.

15. The nurse is teaching a mother who will breast feed for the first time. Which of the following is a priority?

A) Show her films on the physiology of lactation
B) Give the client several illustrated pamphlets

C) Assist her to position the newborn at the breast
D) Give her privacy for the initial feeding

C: Assist her to position the newborn at the breast. While all of the responses are helpful in teaching, the priority is placing the infant to breast as soon after birth as possible to establish contact and allow the newborn to begin to suck.

16. The recent increase in the reported cases of active tuberculosis (TB) in the United States is attributed to which factor?

A) The increased homeless population in major cities
B) The rise in reported cases of positive HIV infections
C) The migration patterns of people from foreign countries
D) The aging of the population located in group homes

B: The rise in reported cases of positive HIV infections. Between 1985 and 2002 there has been a significant increase in the reported cases of TB. The increase was most evident in cities with a high incidence of positive HIV infection. Positive HIV infection currently is the greatest known risk factor for reactivating latent TB infections.

17. The nasogastric tube of a post-op gastrectomy client has stopped draining greenish liquid. The nurse should

A) irrigate it as ordered with distilled water
B) irrigate it as ordered with normal saline
C) place the end of the tube in water to see if the water bubbles
D) withdraw the tube several inches and reposition it

B: irrigate it as ordered with normal saline. Nasogastric tubes are only irrigated with normal saline to maintain patency.

18. A client arrived in the USA from a developing country 1 week ago. The client is to be admitted to the medical surgical unit with a diagnosis of AIDS. There is a history of these findings: unintended weight loss, drug abuse, night sweats, productive cough and a "feeling of being hot all the time." The nurse should assign the client to share a room with a client with the diagnosis of

A) Acute tuberculosis with a productive cough of discolored sputum for over three months
B) Lupus and vesicles on one side of the middle trunk from the back to the abdomen
C) Pseudomembranous colitis and *C. difficile*
D) Exacerbation of polyarthritis with severe pain

A: Acute tuberculosis with a productive cough of discolored sputum for over three months. The client being admitted has the classic findings of pulmonary tuberculosis. Of the available choices, the client in option A would be the most appropriate roommate. It is acceptable to put clients with similar diagnoses in the same room when no other alternative exists. Clients are considered contagious until the cough is eliminated with medications, which initially is a combination of 4 simultaneous drugs.

19. A 15 month-old child comes to the clinic for a follow-up visit after hospitalization for treatment of Kawasaki Disease. The nurse recognizes that which of the following scheduled immunizations will be delayed?

A) MMR
B) Hib
C) IPV
D) DTaP

A: MMR. Medical management of Kawasaki involves administration of immunoglobulins. Measles, mumps, rubella (MMR) is a live virus vaccine. Following administration of immunoglobulins, live vaccines should be held due to possible interference with the body"s ability to form antibodies.

20. What is the major purpose of community health research?

A) Describe the health conditions of populations
B) Evaluate illness in the community
C) Explain the health conditions of families
D) Identify the health conditions of the environment

A: Describe the health conditions of populations. Community health focuses upon aggregate population care.

21. The nurse is taking a health history from a Native American client. It is critical that the nurse **must** remember that eye contact with such clients is considered

A) Expected
B) Rude
C) Professional
D) Enjoyable

B: Rude. Native Americans consider direct eye contact to be impolite or aggressive among strangers.

22. The nurse discovers that the parents of a 2 year-old child continue to use an apnea monitor each night. The parents state: “We are concerned about the possible occurrence of sudden infant death syndrome (SIDS).” In order to take appropriate action, the nurse must understand that

A) The child is within the age group most susceptible to SIDS
B) The peak age for occurrence of SIDS is 8 to 12 months of age
C) The apnea monitor is not effective on a child in this age group
D) 95% of SIDS cases occur before 6 months of age

D: 95% of SIDS cases occur before 6 months of age. Peak age of SIDS occurrence is 2 to 4 months and 95% of cases occur by 6 months of age. It is the leading cause of death in infants 1 month to 1 year of age.

23. The parents of a child who has recently been diagnosed with asthma ask the nurse to explain the condition to them. The **best** response is "Asthma causes

A) the airway to become narrow and obstructs airflow."
B) air to be trapped in the lungs because the airways are dilated."
C) the nerves that control respiration to become hyperactive."
D) a decrease in the stress hormones which prevents the airways from opening."

A: the airway to become narrow and obstructs airflow." Asthma is defined as airway obstruction or a narrowing that is characterized by bronchial irritability after exposure to various stimuli.

24. When teaching parents about sickle cell disease, the nurse should tell them that their child's anemia is caused by

A) Reduced oxygen capacity of cells due to lack of iron
B) An imbalance between red cell destruction and production
C) Depression of red and white cells and platelets
D) Inability of sickle shaped cells to regenerate

B: An imbalance between red cell destruction and production. Anemia results when the rate of red cell destruction exceeds the rate of production through stimulated erythropoiesis in bone marrow (red cell life span shortened from 120 days to 12-20 days).

25. An adolescent client is admitted in respiratory alkalosis following aspirin overdose. The nurse recognizes that this imbalance was caused by

A) tachypnea
B) acidic byproducts
C) vomiting and dehydration
D) hyperpyrexia

A: tachypnea. Stimulation of respiratory center leads to hyperventilation, thus decreasing CO_2 levels which causes respiratory alkalosis.

26. A nurse is teaching a class for new parents at a local community center. The nurse would stress that _____ is **most** hazardous for an 8 month-old child.

A) riding in a car
B) falling off a bed
C) an electrical outlet
D) eating peanuts

D: eating peanuts. Asphyxiation due to foreign materials in the respiratory tract is the leading cause of death in children younger than 6 years of age.

27. The mother of a burned child asks the nurse to clarify what is meant by a third degree burn. The **best** response by the nurse is

A) "The top layer of the skin is destroyed."
B) "The skin layers are swollen and reddened."
C) "All layers of the skin were destroyed in the burn."
D) "Muscle, tissue and bone have been injured."

C: "All layers of the skin were destroyed in the burn." A third degree burn is a full thickness injury to dermis, epidermis and subcutaneous tissue.

28. The nurse is providing diet instruction to the parents of a child with cystic fibrosis. The nurse would emphasize that the diet should be high

A) calorie, low fat, low sodium
B) protein, low fat, low carbohydrate
C) protein, high calorie, unrestricted fat
D) carbohydrate, low protein, moderate fat

C: The child with Cystic Fibrosis needs a well balanced diet that is high in protein and calories. Fat does not need to be restricted.

29. The nurse is assessing a young child at a clinic visit for a mild respiratory infection. Koplik spots are noted on the oral mucous membranes. The nurse should then assess which area of the body?

A) the skin
B) the lungs
C) the muscles
D) bowel and bladder

A: the skin. A characteristic sign of rubeola is Koplik spots (small red spots with a bluish white center). These are found on the buccal mucosa about 2 days before and after the onset of the measles rash.

30. A client's admission urinalysis shows the specific gravity value of 1.039. Which of the following assessment data would the nurse expect to find when assessing this client?

A) Moist mucous membranes
B) Urinary frequency
C) Poor skin turgor
D) Increased blood pressure

C: The specific gravity value is high, indicating dehydration. Poor skin turgor (tenting of the skin) is consistent with this problem.

31. The nurse is caring for a client with Meniere's disease. When teaching the client about the disease, the nurse should explain that the client should avoid foods high in

A) calcium
B) fiber
C) sodium
D) carbohydrate

C: sodium. The client with Meniere"s disease has an alteration in the balance of the fluid in the inner ear (endolymph). A low sodium diet will aid in reducing the fluid. Sodium restriction is also ordered as adjunct to diuretic therapy.

32. After the shift report in a labor and delivery unit which of these clients would the nurse check **first**?

A) A middle aged woman with asthma and Type 1 diabetes mellitus has a BP of 150/94
B) A middle aged woman with a history of two prior vaginal term births is 2 cm dilated
C) A young woman who is a grand multipara has cervical dilation of 4 cm and is 50% effaced
D) An adolescent who is 18 weeks pregnant has a report of no fetal heart tones and coughing up frothy sputum

D: This client has an actual complication. The others present with findings of potential complications.

33. The nurse is assessing a child with suspected lead poisoning. Which of the following assessments is the nurse **most** likely to find?

A) Complaints of numbness and tingling in feet
B) Wheezing noted when lung sound auscultated
C) Excessive perspiration
D) Difficulty sleeping

A: Complaints of numbness and tingling in feet. A child who has unusual neurologic signs or symptoms, neuropathy, footdrop, or anemia that cannot be attributed to other causes may be suffering from lead poisoning. This most often occurs when a child ingests or inhales paint chips from lead-based paint or dust from remodeling in older buildings.

34. The nurse is attending a workshop about caring for persons infected with hepatitis. Which characteristic is most appropriate when defining the incidence rate of hepatitis?

A) The number of persons in a population who develop hepatitis B during a specific period of time
B) The total number of persons in a population who have hepatitis B at a particular time
C) The percentage of deaths resulting from hepatitis B during a specific time
D) The occurrence of hepatitis B in the population at a particular time

A: This is the correct definition of incidence of the disease.

35. The nurse is providing home care for a client with heart failure and pulmonary edema. Which nursing diagnosis should have **priority** in planning care?

A) Impaired skin integrity related to dependent edema
B) Activity intolerance related to oxygen supply and demand imbalance
C) Constipation related to immobility
D) Risk for infection related to ineffective mobilization of secretions

B: Activity intolerance related to oxygen supply and demand imbalance. This is the primary problem due to decreased cardiac output related to heart failure. There is a reduction of oxygen, leading to findings of dyspnea and fatigue.

36. The nurse is assessing a newborn delivered at home by a client addicted to heroin. Which of the following would the nurse expect to observe?

A) Hypertonic neuro reflex
B) Immediate CNS depression
C) Lethargy and sleepiness
D) Jitteriness at 24-48 hours

D: Jitteriness at 24-48 hours. Withdrawal signs may not be evident for 1-2 days after birth. Irritability and poor feeding also are evident.

37. Which action is **most** likely to ensure the safety of the nurse while making a home visit?

A) Observe no evidence of weapons in the home during the visit
B) Prior to the visit, review the client's record for any previous entries about violence
C) Remain alert at all times and leave if cues suggest the home is not safe

D) Carry a cell phone, pager and/or hand held alarm for emergencies

C: Remain alert at all times and leave if cues suggest the home is not safe. No person or equipment can guarantee nurses" safety, although the risk of violence can be minimized. Before making initial visits, review referral information carefully and have a plan to communicate with agency staff. Schedule appointments with clients. When driving into an area for the first time, note potential hazards and sources of assistance. Become acquainted with neighbors. Be alert and confident while parking the car, walking to the client"s door, making the visit, walking back to the car, and driving away. LISTEN to clients. If they tell you to leave, do so.

38. As a client is being discharged following resolution of a spontaneous pneumothorax, he tells the nurse that he is now going to Hawaii for a vacation. The nurse would warn him to avoid

A) surfing
B) scuba diving
C) parasailing
D) swimming

B: scuba diving. The nurse would strongly emphasize the need for clients with history of spontaneous pneumothorax problems to avoid high altitudes, flying in unpressurized aircraft and scuba diving. The negative pressures could cause the lung to collapse again.

39. In order to be effective in administering cardiopulmonary resuscitation to a 5 year-old, the nurse must

A) assess the brachial pulses
B) breathe once every 5 compressions
C) use both hands to apply chest pressure
D) compress 80-90 times per minute

B: breathe once every 5 compressions. For a 5 year-old, the nurse should give 1 breath for every 5 compressions.

40. A postpartum client admits to alcohol use throughout the pregnancy. Which of the following newborn findings suggests to the nurse that the infant has fetal alcohol syndrome?

A) Growth retardation is evident
B) Multiple anomalies are identified
C) Cranial facial abnormalities are noted
D) Prune belly syndrome is suspected

C: Cranial facial abnormalities are noted. Characteristic facial abnormalities are seen in the newborn with fetal alcohol syndrome.

Q&A Random Selection #7

1. A nursing student asks the nurse manager to explain the forces that drive health care reform. The appropriate response by the nurse manager should include

    A) The escalation of fees with a decreased reimbursement percentage
    B) High costs of diagnostic and end-of-life treatment procedures
    C) Increased numbers of elderly and of the chronically ill of all ages
    D) A steep rise in provider fees and in insurance premiums

A: The escalation of fees with a decreased reimbursement percentage. The percentage of the gross national product representing health care costs rose dramatically with reimbursement based on fee for service. Reimbursement for Medicare and Medicaid recipients based on fee for service also escalates health care costs.

2. The nurse manager identifies that time spent by staff in charting is excessive, requiring overtime for completion. The nurse manager states that "staff will form a task force to investigate and develop potential solutions to the problem, and report on this at the next staff meeting." The nurse manager's leadership style is **best** described as

    A) Laissez-faire
    B) Autocratic
    C) Participative
    D) Group

C: Participative. A participative style of management involves staff in decision-making processes. Staff/manager interactions are open and trusting. Most work efforts are joint endeavors.

3. The nurse is working with parents to plan home care for a 2 year-old with a heart problem. A **priority** nursing intervention would be to

    A) encourage the parents to enroll in cardiopulmonary resuscitation (CPR) class
    B) assist the parents to plan quiet play activities at home
    C) stress to the parents that they will need relief care givers
    D) instruct the parents to avoid contact with persons with infection

A: encourage the parents to enroll in cardiopulmonary resuscitation (CPR) class. While all suggestions are appropriate, the education of the parents/caregivers should include techniques of cardiopulmonary resuscitation in order to provide for emergency care of their child.

4. Which of these clients would the triage nurse request the provider examine immediately?

    A) A 5 month-old infant who has audible wheezing and grunting
    B) An adolescent who has soot over the face and shirt
    C) A middle-aged man with second degree burns over the right hand
    D) A toddler with singed ends of long hair that extends to the waist

A: A 5 month-old infant who has audible wheezing and grunting. The age and the findings suggest this client is at immediate risk for respiratory complications.

5. The nurse is caring for a client with Rheumatoid Arthritis. Which nursing diagnosis should receive **priority** in the plan of care?

    A) Risk for injury
    B) Self care deficit
    C) Alteration in comfort
    D) Alteration in mobility

C: Alteration in comfort. Relieving pain is the number one objective of this client's plan of care.

6. The nurse is caring for a client with active tuberculosis who has a history of noncompliance. Which of the following actions by the nurse would represent appropriate care for this client?

    A) Instruct the client to wear a high efficiency particulate air mask in public places.
    B) Ask a family member to supervise daily compliance
    C) Schedule weekly clinic visits for the client
    D) Ask the health care provider to change the regimen to fewer medications

B: Ask a family member to supervise daily compliance. Direct-observed therapy (DOT) is a recognized method for ensuring client compliance to the drug regimen. A program can be set up to directly observe the client taking the medication in the clinic, home, workplace or other convenient location.

7. A client has been taking alprazolam (Xanax) for 3 days. Nursing assessment should reveal which expected effect of the drug?

    A) Tranquilization, numbing of emotions
    B) Sedation, analgesia
    C) Relief of insomnia and phobias
    D) Diminished tachycardia and tremors associated with anxiety

A: Tranquilization, numbing of emotions. The anti-anxiety drugs produce tranquilizing effects and may numb the emotions.

8. A woman who delivered 5 days ago and had been diagnosed with pregnancy induced hypertension (PIH) calls the hospital triage nurse hotline to ask for advice. She states, "I have had the worst headache for the past 2 days. It pounds and by the middle of the afternoon everything I look at looks wavy. Nothing I have taken helps." What should the nurse do next?

    A) Advise the client that the swings in her hormones may have that effect. However, suggest for her to call her provider within the next day.
    B) Advise the client to have someone bring her to the emergency room as soon as possible.
    C) Ask the client to stay on the line, get the address and send an ambulance to the home.
    D) Ask what the client has taken? How often? Ask about other specific complaints.

C: Ask the client to stay on the line, get the address and send an ambulance to the home. The woman is at risk for seizure activity. The ambulance needs to bring the woman to the hospital. For at risk clients, PIH (preeclampsia and eclampsia) may occur prior to, during or after delivery. After delivery, the window of time can be up to ten days.

9. A client on warfarin therapy following coronary artery stent placement calls the clinic to ask if he can take Alka-Seltzer for an upset stomach. What is the best response by the nurse?

    A) Avoid Alka-Seltzer because it contains aspirin
    B) Take Alka-Seltzer at a different time of day than the warfarin
    C) Select another antacid that does not inactivate warfarin
    D) Use on-half the recommended dose of Alka-Seltzer

A: Avoid Alka-Seltzer because it contains aspirin. Alka-Seltzer is an over-the-counter aspirin-antacid combination. Aspirin, an antiplatelet drug, will potentiate the anticoagulant effect of warfarin, which may result in excess bleeding.

10. The nurse notes an abrupt onset of confusion in an elderly patient. Which of the following recently-ordered medications would most likely contribute to this change?

    A) Anticoagulant
    B) Liquid antacid
    C) Antihistamine
    D) Cardiac glycoside

C: Antihistamine. Elderly people are susceptible to the side effect of anticholinergic drugs, such as antihistamines. Antihistamines often cause confusion in the elderly, especially at high doses.

11. The nurse is teaching a 27 year-old client with asthma about their therapeutic regime. Which statement would indicate the need for **additional** instruction?

    A) "I should monitor my peak flow every day."
    B) "I should contact the clinic if I am using my medication more often."
    C) "I need to limit my exercise, especially activities such as walking and running."
    D) "I should learn stress reduction and relaxation techniques."

C: Limiting physical activity in an otherwise healthy, young client should not be necessary. If exercise intolerance exists, the asthma management plan should include specific medications to treat the problem such as using an inhaled beta-agonist 5 minutes before exercise. The goal is always to return to a normal lifestyle.

12. In assessing a post partum client, the nurse palpates a firm fundus and observes a constant trickle of bright red blood from the vagina. What is the most likely cause of these findings?

    A) Uterine atony
    B) Genital lacerations
    C) Retained placenta
    D) Clotting disorder

B: Genital lacerations. Continuous bleeding in the absence of a boggy fundus indicates undetected genital tract lacerations.

13. The nurse is caring for a 75 year old client in congestive heart failure. Which finding suggests that digitalis levels should be reviewed?

    A) Extreme fatigue
    B) Increased appetite
    C) Intense itching
    D) Constipation

A: Extreme fatigue. Extreme fatigue and weakness are common, early signs of digitalis toxicity, which would be confirmed by a high blood serum level of digitalis.

14. The nurse is teaching a client with atrial fibrillation about the use of Coumadin (warfarin) at home. The need to avoid which of these should be emphasized to the client?

    A) Large indoor gatherings
    B) Exposure to sunlight
    C) Active physical exercise
    D) Foods rich in vitamin K

D: Foods rich in vitamin K. Vitamin K acts as an antidote to the pharmacologic action of Coumadin therapy, decreasing Coumadin"s effectiveness. Foods high in vitamin K include dark greens, tomatoes, bananas, cheese, and fish.

15. A nurse who is a native English speaker admits an elderly Mexican-American migrant worker after an accident that occurred during work. To facilitate communication the nurse should **initially**

A) Request a Spanish interpreter
B) Speak through the family or co-workers
C) Use pictures, letter boards, or monitoring
D) Assess the client's ability to speak English

D: Assess the client"s ability to speak English. Despite the cultural heritage, the nurse cannot make assumptions. Stereotyping is to be avoided. The nurse should assess the client"s comfort and ability in speaking English.

16. To prevent keratitis in an unconscious client, the nurse should apply moisturizing ointment to the

A) finger and toenail quicks
B) eyes
C) perianal area
D) external ear canals

B: eyes. Keratitis is a corneal ulcer or abrasion. Keratitis is caused by exposure and requires application of moisturizing ointment to the exposed cornea and a plastic bubble shield or eye patch.

17. The nurse is caring for a 5 year-old child whose left leg is in skeletal traction. Which of the following activities would be an appropriate diversional activity?

A) Kicking balloons with right leg
B) Playing "Simon Says"
C) Playing hand held games
D) Throw bean bags

C: Playing hand held games. Immobilization with traction must be maintained until bone ends are in satisfactory alignment. Activities that increase mobility interfere with the goals of treatment.

18. The nurse is teaching a group of adults about modifiable cardiac risk factors. Which of the following should the nurse focus on first?

A) Weight reduction
B) Stress management
C) Physical exercise
D) Smoking cessation

D: Smoking cessation. Stopping smoking is the priority for clients at risk for cardiac disease, because of its effects of reducing oxygenation and constricting blood vessels.

19. The nurse is assessing a client with portal hypertension. Which of the following findings would the nurse expect?

A) Expiratory wheezes
B) Blurred vision
C) Ascites
D) Dilated pupils

C: Ascites. Portal hypertension can occur in a client with right-sided heart failure or cirrhosis of the liver. Portal hypertension can lead to ascites due to the increased portal pressure as well as a lowered colloid osmotic pressure because of low albumin. When liver functioning deteriorates, protein metabolism suffers.

20. The nurse is caring for an acutely ill 10 year-old client. Which of the following assessment findings would require the nurses **immediate** attention?

A) Rapid bounding pulse
B) Temperature of 101.3 degrees Fahrenheit (38.5 degrees Celsius)
C) Profuse diaphoresis
D) Slow, irregular respirations

D: Slow, irregular respirations. A slow and irregular respiratory rate is a sign of fatigue in an acutely ill child. Fatigue can rapidly lead to respiratory arrest.

21. A parent tells the nurse that their 6 year-old child who normally enjoys school, has not been doing well since the grandmother died 2 months ago. Which statement most accurately describes thoughts on death and dying at this age?

A) Death is personified as the bogeyman or devil
B) Death is perceived as being irreversible
C) The child feels guilty for the grandmother's death
D) The child is worried that he, too, might die

A: Death is personified as the bogeyman or devil. Personification of death is typical of this developmental level.

22. While caring for a child with Reye's syndrome, the nurse should give which action the highest **priority**?

A) monitor intake and output
B) provide good skin care
C) assess level of consciousness

D) assist with range of motion

C: assess level of consciousness. An altered level of consciousness suggests increasing intracranial pressure related to cerebral edema.

23. A 70 year-old post-operative client has elevated serum BUN, HCT, Cl, and Na+. Creatinine and K+ are within normal limits. The nurse should perform additional assessments to confirm that an actual problem is:

A) Impaired gas exchange
B) Metabolic acidosis
C) Renal insufficiency
D) Fluid volume deficit

D: Fluid volume deficit. In fluid volume deficit, serum BUN, Na+ and hematocrit may be elevated secondary to hemoconcentration.

24. A 67 year-old client with non-insulin dependent diabetes should be instructed to contact the out-patient clinic **immediately** if the following findings are present

A) Temperature of 99.5 degrees Fahrenheit with painful urination
B) An open, reddened wound on the heel
C) Insomnia and daytime fatigue
D) Nausea with 2 episodes of vomiting

B: An open, reddened wound on the heel. When signs of trauma and/or infection occur in their feet, elderly clients who have diabetes and/or vascular disease should seek health care quickly and continue treatment until the problem is resolved. Without treatment, serious infection, gangrene, limb loss, and death may result.

25. A confused client has been placed in physical restraints by order of the provider. Which task could be assigned to an unlicensed assistive personnel (UAP)?

A) Assist the client with activities of daily living
B) Monitor the clients physical safety
C) Evaluate for basic comfort needs
D) Document mental status and muscle strength

A: Assist the client with activities of daily living. The person to whom the activity is delegated must be capable of performing it . The UAP is capable of assisting clients with basic needs.

26. The nurse is providing foot care instructions to a client with arterial insufficiency. The nurse would identify the need for **additional** teaching if the client stated

A) "I can only wear cotton socks."
B) "I cannot go barefoot around my house."
C) "I will trim corns and calluses regularly."
D) "I should ask a family member to inspect my feet daily."

C: "I will trim corns and calluses regularly." Clients who are elderly, have diabetes, and/or have vascular disease often have decreased circulation and sensation in one or both feet. Their vision may also be impaired. Therefore, they need to be taught to examine their feet daily or have someone else do so. They should wear cotton socks which have not been mended, and always wear shoes when out of bed. They should not cut their nails, corns, and calluses, but should have them trimmed by their provider, nurse, or another provider who specializes in foot care.

27. A client is scheduled to have a blood test for cholesterol and triglycerides the next day. The nurse would tell the client

A) "Be sure and eat a fat-free diet until the test."
B) "Do not eat or drink anything but water for 12 hours before the blood test."
C) "Have the blood drawn within 2 hours of eating breakfast."
D) "Stay at the laboratory so 2 blood samples can be drawn an hour apart."

B: Blood lipid levels should be measured on a fasting sample.

28. A client who is terminally ill has been receiving high doses of an opioid analgesic for the past month. As death approaches and the client becomes unresponsive to verbal stimuli, what orders would the nurse expect from the health care provider?

A) Decrease the analgesic dosage by half
B) Discontinue the analgesic
C) Continue the same analgesic dosage
D) Prescribe a less potent drug

C: Continue the same analgesic dosage. Dying patients who have been in chronic pain will probably continue to experience pain even though they cannot communicate their experience. Pain medication should be continued at the same dose, if effective.

29. The nurse is caring for a child with cystic fibrosis. The nurse would anticipate that the child would be deficient in which vitamins?

A) B, D, and K
B) A, D, and K
C) A, C, and D
D) A, B, and C

B: A, D, and K. The uptake of fat soluble vitamins is decreased in children with Cystic Fibrosis. Vitamins A, D, and K are fat soluble and are likely to be deficient in clients with Cystic Fibrosis.

30. A child is diagnosed with poison ivy. The mother tells the nurse that she does not know how her child contracted the rash since he had not been playing in wooded areas. As the nurse asks questions about possible contact, which of the following would the nurse recognize as highest risk for exposure?

    A) Playing with toys in a back yard flower garden
    B) Eating small amounts of grass while playing "farm"
    C) Playing with cars on the pavement near burning leaves
    D) Throwing a ball to a neighborhood child who has poison ivy

C: Playing with cars on the pavement near burning leaves. Smoke from burning leaves or stems of the poison ivy plant can produce a reaction. Direct contact with the toxic oil, urushiol, is the most common cause for this dermatitis.

31. The nurse observes a staff member caring for a client with a left unilateral mastectomy. The nurse would intervene if she notices the staff member is

    A) advising client to restrict sodium intake
    B) taking the blood pressure in the left arm
    C) elevating her left arm above heart level
    D) compressing the drainage device

B: taking the blood pressure in the left arm. Clients who have had a unilateral mastectomy should not have their blood pressure measured on the affected side. This helps avoid the possibility of lymphedema post-operatively and in the future.

32. The nurse has identified what appears to be ventricular tachycardia on the cardiac monitor of a client being evaluated for possible myocardial infarction. The **first** action the nurse would perform is to

    A) begin cardiopulmonary resuscitation
    B) prepare for immediate defibrillation
    C) notify the "Code" team and provider
    D) assess airway breathing and circulation

D: assess airway breathing and circulation. The nurse must first assess the client to determine the appropriate next step. In this case the first step the nurse must take is to evaluate the A, B, C"s.

33. The primary teaching for a client following an extracorporeal shock-wave lithotripsy (ESWL) procedure is

    A) "Drink 3000 to 4000 cc of fluid each day for one month."
    B) "Limit fluid intake to 1000 cc each day for one month."
    C) "Increase intake of citrus fruits to three servings per day."
    D) "Restrict milk and dairy products for one month."

A: "Drink 3000 to 4000 cc of fluid each day for one month." Drinking three to four quarts (3000 to 4000 cc) of fluid each day will aid passage of fragments and help prevent formation of new calculi.

34. An infant has just returned from surgery for placement of a gastrostomy tube as an initial treatment for tracheoesophageal fistula. The mother asks: ”When can the tube can be used for feeding?” The nurse's **best** response would be which of these comments?

    A) "Feedings can begin in 5 to 7 days."
    B) "The feeding tube can be used immediately."
    C) "The stomach contents and air must be drained first."
    D) "Healing of the incision must be complete before feeding."

C: "The stomach contents and air must be drained first." After surgery for gastrostomy tube placement, the catheter is left open and attached to gravity drainage for 24 hours or more.

35. The community health nurse has been caring for an adolescent with a history of morbid obesity, asthma, and hypertension, and is 22 weeks pregnant. Which of these lab reports need to be called to the teen’s provider within the next hour?

    A) hemoglobin 11 g/L and calcium 6 mg/dl
    B) magnesium 0.8 mEq/L and creatinine 3 mg/dl
    C) blood urea nitrogen 28 and glucose 225 mg/dl
    D) hematocrit 33% and platelets 200,000

B: magnesium 0.8 mEq/L and creatinine 3 mg/dl. The magnesium is low and the creatinine is high which indicates renal failure. With the history of hypertension, the findings exhibit the risk of preeclampsia. The client’s lab values are all abnormal except for the platelets. The client needs to be referred for immediate follow up with a provider.

36. A client with hepatitis A (HAV) is newly admitted to the unit. Which action would be the **priority** to include in this client’s plan of care within the initial 24 hours?

    A) Wear masks with shields if there is potential for fluid splash
    B) Use disposable utensils and plates for meals
    C) Wear gown and gloves during client contact
    D) Provide soft easily digested food with frequent snacks

C: Wear gown and gloves during client contact. HAV is usually transmitted via the fecal-oral route, i.e., someone with the virus handles food without washing his or her hands after using the bathroom. The virus can also be contracted by drinking contaminated water, eating raw shellfish from water polluted with sewage or by being in close contact with a person who"s infected — even if that person has no signs and symptoms. In fact, the disease is most contagious before signs and symptoms ever appear. The nurse should recognize the importance of isolation precautions from the initial contact with the client on admission until the noncontagious convalescence period.

37. A nurse manager is using the technique of brainstorming to help solve a problem. One nurse criticizes another nurse's contribution and begins to find objections to the suggestion. The nurse manager's best response is:

    A) "Let's move on to a new action that deals with the problem."
    B) "I think you need to reserve judgment until after all suggestions are offered."
    C) "Very well thought out. Your analytic skills and interest are incredible."
    D) "Let's move to the 'what if…' as related to these objections and explore spin off ideas."

D: "Let's move to the 'what if…' as related to these objections and explore spin off ideas." The goal of brainstorming is to gather as many ideas as possible without judgment that slows the creative process and may discourage innovative ideas. Exploration of the nurses objections would encourage the generation of new ideas.

38. A pre-term baby develops nasal flaring, cyanosis and diminished breath sounds on one side. The provider's diagnosis is spontaneous pneumothorax. Which procedure should the nurse prepare for **first**?

    A) Cardiopulmonary resuscitation
    B) Insertion of a chest tube
    C) Oxygen therapy
    D) Assisted ventilation

B: Insertion of a chest tube. Because a portion of the lung has collapsed, a chest tube will be inserted to restore negative pressure in the chest cavity.

39. A newborn presents with a pronounced cephalhematoma following a birth in the posterior position. Which nursing diagnosis should guide the plan of care?

    A) Pain related to periosteal injury
    B) Impaired mobility related to bleeding
    C) Parental anxiety related to knowledge deficit
    D) Injury related to intracranial hemorrhage

C: Parental anxiety related to knowledge deficit. This hematoma is related to pressure at the time of labor and birth. The condition resolves within a few days. Parental anxiety must be addressed by listening to their fears and explaining the nature of this common alteration.

40. A nurse caring for premature newborns in an intensive care setting carefully monitors oxygen concentration. What is the most common complication of this therapy?

    A) Intraventricular hemorrhage
    B) Retinopathy of prematurity
    C) Bronchial pulmonary dysplasia
    D) Necrotizing enterocolitis

B: Retinopathy of prematurity. While there are other causes for retinal damage in the premature infant, maintaining the oxygen concentration below 40% reduces this important risk factor.

Q&A Random Selection #8

1. While assessing an Rh positive newborn whose mother is Rh negative, the nurse recognizes the risk for hyperbilirubinemia. Which of the following should be reported immediately?

    A) Jaundice evident at 26 hours
    B) Hematocrit of 55%
    C) Serum bilirubin of 12mg
    D) Positive Coombs' test

C: The elevated bilirubin is in the range that requires immediate intervention, such as phototherapy. At a serum bilirubin of 12 mg., the neonate is at risk for the development of kernicterus, or bilirubin encephalopathy. The provider determines the therapy appropriate after reviewing all laboratory findings.

2. A young adult male has been diagnosed with testicular cancer. Which of these statements by this client would need to be explored by the nurse to clarify his understanding?

    A) "This surgical procedure involves removing one or both testicles through a cut in the groin. My lymph nodes in my lower belly also may be removed."
    B) "I have a good chance to regain my fertility later. However if I am concerned, I can have my sperm frozen and preserved (cryopreserved) before chemotherapy."
    C) "If I have cancer at stage 3 it means I have less involvement of the cancer."
    D) "After the surgical removal of a testicle, I can have an artificial testicle (prosthesis) placed inside my scrotum. This artificial implant has the weight and feel of a normal testicle."

C: Stage 3 is the most extensive involvement of cancer with any type.

3. During the beginning shift assessment of a client with asthma who is receiving oxygen per nasal cannula at 2 liters per minute, the nurse would be most concerned about which unreported finding?

    A) Pulse oximetry reading of 89%
    B) Crackles at the base of the lungs on auscultation
    C) Rapid shallow respirations with intermittent wheezes
    D) Excessive thirst with a dry cracked tongue

C: Of the given findings this has the greatest risk for potential complications. Shallow and rapid respirations may indicate that the client is losing muscle strength required to breath. The intermittent wheezes could be an indication of an increase in narrowed small airways and a worsening condition.

4. A Hispanic client confides in the nurse that she is concerned that staff may give her newborn the "evil eye." The nurse should communicate to other personnel that the appropriate approach is to

    A) touch the baby after looking at him
    B) talk very slowly while speaking to him
    C) avoid touching the child
    D) look only at the parents

A: In many cultures, an "evil eye" is cast when looking at a person without touching him. Thus, the spell is broken by touching while looking or assessing.

5. The nurse is caring for a client on mechanical ventilation. When performing endotracheal suctioning, the nurse will avoid hypoxia by

    A) inserting a fenestrated catheter with a whistle tip without suction
    B) completing suction pass in 30 seconds with pressure of 150 mm Hg
    C) hyperoxygenation with 100% O_2 for 1 to 2 minutes before and after each suction pass
    D) minimizing suction pass to 60 seconds while slowly rotating the lubricated catheter

C: Administer supplemental 100% oxygen through the mechanical ventilator or manual resuscitation bag for 1 to 2 minutes before, after and between suctioning passes to prevent hypoxemia.

6. A client is admitted for COPD. Which findings would require the nurse's **immediate** attention?

    A) Nausea and vomiting
    B) Restlessness and confusion
    C) Low-grade fever and cough
    D) Irritating cough and liquefied sputum

B: Restlessness and confusion. Respiratory failure may be signaled by excessive somnolence, restless, aggressiveness, confusion, central cyanosis and shortness of breath. When these findings occur, arterial blood gases (ABGs) should be obtained.

7. A hospitalized child suddenly has a seizure while his family is visiting. The nurse notes whole body rigidity followed by general jerking movements. The child vomits immediately after the seizure. A **priority** nursing diagnosis for the child is

    A) high risk for infection related to vomiting
    B) altered family processes related to chronic illness
    C) fluid volume deficit related to vomiting
    D) risk for aspiration related to loss of consciousness

D: The tonic-clonic seizure appears suddenly and often leads to brief loss of consciousness. The greatest risk for the child is from airway blockage, as might follow aspiration.

8. A 6 month-old infant who is being treated for developmental dysplasia of the hip has been placed in a hip spica cast. The nurse should teach the parents to

    A) gently rub the skin with a cotton swab to relieve itching
    B) place the favorite books and push-pull toys in the crib
    C) check every few hours for the next day or 2 for swelling in the baby's feet
    D) turn the baby with the abduction stabilizer bar every 2 hours

C: check every few hours for the next day or 2 for swelling in the baby's feet. A child in a hip spica cast must be checked for circulatory impairment. The extremities are observed for swelling, discoloration, movement and sensation. For children beyond the neonatal period, traction and/or surgery followed by hip spica casting are usually needed.

9. The nurse is teaching a client with cardiac disease about the anatomy and physiology of the heart. Which is the correct pathway of blood flow through the heart?

    A) Right ventricle, left ventricle, right atrium, left atrium
    B) Left ventricle, right ventricle, left atrium, right atrium
    C) Right atrium, right ventricle, left atrium, left ventricle
    D) Right atrium, left atrium, right ventricle, left ventricle

C: Right atrium, right ventricle, left atrium, left ventricle. This is the pathway of blood flow through the heart.

10. Which of these tests would the nurse expect to monitor for the evaluation of clients aged 18 and older with poor glycemic control?

    A) A glycosylated hemoglobin (A1c) should be performed during an initial assessment and during follow-up assessments, which should occur at no longer than 3-month intervals
    B) A glycosylated hemoglobin is to be obtained at least twice a year
    C) A fasting glucose and a glycosylated hemoglobin is to be obtained at 3 months intervals after the initial assessment
    D) A glucose tolerance test, a fasting glucose and a glycosylated hemoglobin should be obtained at 6-monthintervals after the initial assessment

A: The American Diabetes Association (ADA) recommends obtaining a glycosylated hemoglobin during an initial assessment and then routinely as part of continuing care. In the absence of well-controlled studies that suggest a definite testing protocol, expert opinion recommends glycosylated hemoglobin be obtained at least twice a year in patients who are meeting treatment goals and who have stable glycemic control and more frequently (quarterly assessment) in patients whose therapy was changed or who are not meeting glycemic goals. The goals for persons with diabetes define the target A1c level as less than or equal to 6.5% or less than 7.0%. American Association of Clinical Endocrinologists/American College of Endocrinology (AACE/ACE) recommends that a glycosylated hemoglobin be performed during an initial assessment and during follow-up assessments, which should occur at no longer than three-month intervals. Most would agree, however, that an A1c level greater than 9.0% is poor control for all patient types.

11. The nurse is assigned to a client with Parkinson's disease. Which findings would the nurse anticipate?

    A) Non-intention tremors and urgency with voiding
    B) Echolalia and a shuffling gait
    C) Muscle spasm and a bent over posture
    D) Intention tremor and jerky movement of the elbows

B: Echolalia and a shuffling gait. Clients with Parkinson"s disease have a very distinctive gait with quick short steps (shuffling) which may increase in speed so that they are unable to stop. They also have echolalia which means the repeating of phrases or words that are directed to them during conversation. In the other options, only one of the findings is associated with Parkinson’s disease: non-intention tremors, bent over posture, and the cogwheel or jerky movement of the elbows.

12. During the care of a client with Legionnaire's disease, which finding would require the nurse's immediate attention?

    A) Pleuritic pain on inspiration
    B) Dry mucus membranes in the mouth
    C) A decrease in respiratory rate from 34 to 24
    D) Decrease in chest wall expansion

D: Decrease in chest wall expansion. The respiratory status of a client with this acute bacterial pneumonia known as Legionnaires" disease is critical. Note that all of these findings would be of concern -- the task is to select the priority. Chest wall expansion reflects a possible decrease in the depth and effort of respirations. Further findings of restlessness may indicate hypoxemia. If these occurred the client may then need mechanical ventilation. Option A is expected with such infections of the lung. Option B indicates dehydration which may result in

13. Which finding would be the most characteristic of an acute episode of reactive airway disease?

    A) auditory gurgling
    B) inspiratory laryngeal stridor
    C) auditory expiratory wheezing
    D) frequent dry coughing

C: In an acute episode of reactive airway disease, breathing is likely to be characterized by wheezing on expiration. This sound is made as air is forced through the narrowed passages and often can be heard by the naked ear without a stethoscope.

14. The school nurse is called to the playground for an episode of mouth trauma. The nurse finds that the front tooth of a 9 year-old child has been avulsed ("knocked out"). After recovering the tooth, the **initial** response should be to

A) rinse the tooth in water before placing it in the socket
B) place the tooth in a clean plastic bag for transport to the dentist
C) hold the tooth by the roots until reaching the emergency room
D) ask the child to replace the tooth even if the bleeding continues

A: rinse the tooth in water before placing it in the socket. Following avulsion of a permanent tooth, it is important to rinse the dirty tooth in water, saline solution or milk before re-implantation. If possible, replace the tooth in its socket within 30 minutes, avoiding contact with the root. The child should be taken to the dentist as soon as possible.

15. At a routine health assessment, a client tells the nurse that she is planning a pregnancy in the near future. She asks about pre-conception diet changes. Which of the statements made by the nurse is best?

A) "Include fibers in your daily diet."
B) "Increase green leafy vegetable intake."
C) "Drink a glass of milk with each meal."
D) "Eat at least 1 serving of fish weekly."

B: "Increase green leafy vegetable intake." Folic acid sources should be included in the diet and are critical in the pre-conceptual and early gestational periods to foster neural tube development and prevent birth defects such as spina bifida.

16. A 67 year-old client is admitted with substernal chest pain with that radiates to the jaw. The admitting diagnosis is acute myocardial infraction (MI). The **priority** nursing diagnosis for this client during the first 24 hours is

A) constipation related to immobility
B) high risk for infection
C) impaired gas exchange
D) fluid volume deficit

C: In the immediate post MI period, impaired gas exchange related to oxygen supply and demand is a major problem.

17. The nurse is caring for a client with status epilepticus. The **most** important nursing assessment(s) of this client is/are

A) intravenous drip rate
B) level of consciousness
C) pulse and respiration
D) injuries to the extremities

B: level of consciousness. Cerebral blood flow undergoes a 250% increase during seizure activity depleting oxygen at the neuronal level. Cerebral anoxia may result in progressive brain tissue injury and destruction. The nurse should monitor the client's level of consciousness continuously. Even when seizures are controlled, the client may be unconscious for a while.

18. Which tasks, if delegated by the new charge nurse to a unlicensed assistive personnel (UAP), would require intervention by the nurse manager?

A) To help an elderly client to the bathroom
B) To empty a Foley catheter bag
C) To bathe a woman with internal radon seeds
D) To feed a 2 year-old with a broken arm

C: To bathe a woman with internal radon seeds. A client with internal radiation is complex care and not suitable to be assigned to a UAP. Additionally, the client would not receive a complete bath because of the radiation risks.

19. The nurse is assessing a newborn the day after birth. A high pitched cry, irritability and lack of interest in feeding are noted. The mother signed her own discharge against medical advice. What intervention is appropriate nursing care?

A) Reduce the environmental stimuli
B) Offer formula every 2 hours
C) Talk to the newborn while feeding
D) Rock the baby frequently

A: Reduce the environmental stimuli. This newborn appears to be withdrawing from substances taken by the mother before its birth. Reducing noise and light will reduce the central nervous system responses to stimuli.

20. An 82 year-old client is prescribed eye drops for treatment of glaucoma. What assessment is needed before the nurse begins teaching proper administration of the medication?

A) Determine third party payment plan for this treatment
B) The client's manual dexterity
C) Proximity to health care services
D) Ability to use visual assistive devices

B: The client's manual dexterity. Inability to self administer eye drops is a common problem among the elderly due to decreased finger dexterity.

21. A child and his family were exposed to *Mycobacterium tuberculosis* about 2 months ago, to confirm the presence or absence of an infection, it is **most** important for all family members to have a

A) chest x-ray
B) blood culture
C) sputum culture
D) PPD intradermal test

D: PPD intradermal test. The administration of the PPD intradermal test determines the presence of the infection with the *Mycobacterium tuberculosis* organism. It is effective at 3 to 6 weeks after the initial infection.

22. A client comes into the community health center upset and crying stating "I will die of cancer now that I have this disease." And then the client hands the nurse a paper with one word written on it: "Pheochromocytoma." Which response should the nurse state initially?

A) "Pheochromocytomas usually aren't cancerous (malignant). But they may be associated with cancerous tumors in other endocrine glands such as the thyroid (medullary carcinoma of the thyroid)"
B) This problem is diagnosed by blood and urine tests that reveal elevated levels of adrenaline and noradrenaline
C) "Computerized tomography (CT) or magnetic resonance imaging (MRI) are used to detect an adrenal tumor"
D) "You probably have had episodes of sweating, heart pounding and headaches"

A: All of the options are correct information. The best response of the nurse is to address the issue presented by the client "fear of cancer." Pheochromocytomas may release large amounts of adrenaline into the bloodstream after an injury or during surgery. For this reason, they can be life-threatening if unrecognized or untreated.

23. On admission to the hospital a client with an acute asthma episode has intermittent nonproductive coughing and a pulse oximeter reading of 88%. The client states, "I feel like this is going to be a bad time this admission. I wish I would not have gone into that bar with all those people who smoke last night." Which nursing diagnoses would be **most** important for this client?

A) Anxiety related to hospitalization
B) Ineffective airway clearance related to potential thick secretions
C) Altered health maintenance related to preventative behaviors associated with asthma
D) Impaired gas exchange related to bronchoconstriction and mucosal edema

D: Impaired gas exchange related to bronchoconstriction and mucosal edema. Pulse oximetry reflects oxygenation of arterial blood. While the other diagnoses may be appropriate for this client, they are not the most appropriate priority at the time of admission.

24. A newly appointed nurse manager is having difficulties with time management. Which advice from an experienced manager should the new manager implement initially?

A) Set daily goals and establish priorities for each hour and each day.
B) Ask for additional assistance when you feel overwhelmed.
C) Keep a time log of your day in hourly blocks for at least 1 week.
D) Complete each task before beginning another activity in selected instances.

C: Keep a time log of your day in hourly blocks for at least 1 week. Apply the nursing process to time management, so the assessment of the current activities is the initial step. A baseline is established for activities and time use so that needed changes can be pinpointed.

25. The nurse is caring for a 4 year-old child with a greenstick fracture. In explaining this type of fracture to the parents, the **best** statement by the nurse should be that,

A) "A child's bone is more flexible and can be bent 45 degrees before breaking."
B) "Bones of children are more porous than adults' and often have incomplete breaks."
C) "Compression of porous bones produces a buckle or torus type break."
D) "Bone fragments often remain attached by a periosteal hinge."

B: "Bones of children are more porous than adults' and often have incomplete breaks." This allows the pliable bones of growing children to bend, buckle, and break in a "greenstick" manner. A greenstick fracture occurs when a bone is angulated beyond the limits of bending. The compressed side bends and the tension side fails, causing an incomplete fracture.

26. While caring for a client with infective endocarditis, the nurse must be alert for signs of pulmonary embolism. Which of the following assessment findings suggests this complication?

A) Positive Homan's sign
B) Fever and chills
C) Dyspnea and cough
D) Sensory impairment

C: Dyspnea and cough. Vegetation from the infected heart valves often leads to pulmonary embolism in the client with infective endocarditis. Cough, pleuritic chest pain and dyspnea are early symptoms.

27. The nurse uses the DRG (Diagnosis Related Group) manual to

A) classify nursing diagnoses from the client's health history
B) identify findings related to a medical diagnosis

C) determine reimbursement for a medical diagnosis

D) implement nursing care based on case management protocol

C: determine reimbursement for a medical diagnosis. DRG"s are the basis of prospective payment plans for reimbursement for Medicare clients.

28. The nurse would teach a client with Raynaud's phenomenon that, after smoking cessation, it is **most** important to

A) avoid caffeine
B) keep feet dry
C) reduce stress
D) wear gloves

A: avoid caffeine. The most important teaching for this client is avoid caffeine after stopping smoking. The question is asking what is the most important teaching. The other approaches tend to be needed less frequently and so are less of a priority.

29. A client returned from surgery for a perforated appendix with localized peritonitis. In view of this diagnosis, how would the nurse position the client?

A) Prone
B) Dorsal recumbent
C) Semi-Fowler
D) Supine

C: Semi-Fowler. The semi-Fowler position assists drainage and prevents spread of infection throughout the abdominal cavity.

30. A 4 month-old child taking digoxin (Lanoxin) has a blood pressure of 92/78; resting pulse of 78 BPM; respirations 28 and a potassium level of 4.8 mEq/L. The client is irritable and has vomited twice since the morning dose of digoxin. Which finding is most indicative of digoxin toxicity?

A) Bradycardia
B) Lethargy
C) Irritability
D) Vomiting

A: Bradycardia. The most common sign of digoxin toxicity in children is bradycardia (heart rate below 100 BPM in an infant).

31. The hospital is planning to downsize and eliminate a number of staff positions as a cost-saving measure. To assist staff in this change process, the nurse manager is preparing for the "unfreezing" phase of change. With this approach the nurse manager should:

A) discuss with the staff how to deal with any defensive behavior
B) explain to the unit staff why change is necessary
C) assist the staff during the acceptance of the new changes
D) clarify what the changes mean to the community and hospital

B: explain to the unit staff why change is necessary. The first phase of change, unfreezing, begins with awareness of the need for change. This can be facilitated by the manager who clearly understands the need and stands behind it. The phase is completed when staff comprehend the need for change.

32. Which of these statements by the nurse is incorrect if the nurse has the goal to reinforce information about cancers to a group of young adults?

A) "You can reduce your risk of this serious type of stomach cancer by eating lots of fruits and vegetables, limiting all meat, and avoiding nitrate-containing foods."
B) "Prostate cancer is the most common cancer in American men with results to threaten sexuality and life."
C) "Colorectal cancer is the second-leading cause of cancer-related deaths in the United States."
D) "Lung cancer is the leading cause of cancer deaths in the United States. Yet it's the most preventable of all cancers."

A: It is recommended that only red meat be limited for the prevention of stomach cancer. All of the other statements offer correct information.

33. The nurse and a student nurse are discussing the specific points about infants born to HBsAg-positive mothers. Which of these comments by the student indicates a need for clarification of information?

A) "The infant will get the hepatitis B vaccine and the hepatitis B immune globulin within 12 hours at birth at separate injection sites."
B) "The second dose can be given at 1 to 2 months of age."
C) "The third dose should be given at least 16 weeks from the second dose."
D) "The last dose in the series is not to be given before age 24 weeks."

C: "The third dose should be given at least 16 weeks from the second dose." The third dose is to be given 16 weeks from the first dose and 8 weeks from the second dose. All of the other options are correct information. These infants will also need to have the blood tested for hepatitis titers and antibodies between 9 and 15 months.

34. A female client diagnosed with genital herpes simplex virus 2 (HSV 2) complains of dysuria, dyspareunia, leukorrhea and lesions on the labia and perianal skin. A primary nursing action with the focus of comfort should be to

A) suggest 3 to 4 warm sitz baths per day
B) cleanse the genitalia twice a day with soap and water

C) spray warm water over genitalia after urination
D) apply heat or cold to lesions as desired

A: suggest 3 to 4 warm sitz baths per day. Frequent sitz baths may sooth the area and reduce inflammation. The other actions are correct actions however, they would not address the entire group of findings.

35. The nurse manager has a nurse employee who is suspected of a problem with chemical dependency. Which intervention would be the **best** approach by the nurse manager?

A) Confront the nurse about the suspicions in a private meeting
B) Schedule a staff conference, without the nurse present, to collect information
C) Consult the human resources department about the issue and needed actions
D) Counsel the employee to resign to avoid investigation

C: Consult the human resources department about the issue and needed actions. To avoid legal repercussions, the nurse needs to consult with the human resources department for proper procedure for documentation, counseling and available resources. The employee may be protected under the Americans with Disabilities Act.

36. A client has been admitted for meningitis. In reviewing the laboratory analysis of cerebrospinal fluid (CSF), the nurse would expect to note

A) high protein
B) clear color
C) elevated sed rate
D) increased glucose

A: high protein. A positive CSF for meningitis would include presence of protein, a positive blood culture, decreased glucose, cloudy color with an increased opening pressure, and an elevated white blood cell count.

37. A client with chronic congestive heart failure should be instructed to contact the home health nurse if which finding occurs?

A) Weight gain of 2 pounds or more in a 48 hour period
B) Urinating 4 to 5 times each day
C) A significant decrease in appetite
D) Appearance of non-pitting ankle edema

A: Weight gain of 2 pounds or more in a 48 hour period. It is critical for clients to report and be treated for rapid weight gain, decreased urinary output, worsening nocturnal orthopnea, pitting ankle edema, and other findings of chronic heart failure. Hospitalization may be avoided with early intervention.

38. A 74 year-old male is admitted due to inability to void. He has a history of an enlarged prostate and has not voided in 14 hours. When assessing for bladder distention, the best method for the nurse to use is to assess for

A) rebound tenderness
B) left lower quadrant dullness
C) rounded swelling above the pubis
D) urinary discharge

C: rounded swelling above the pubis. Swelling above the pubis is representative of a distended bladder in the male client.

39. With an alert of an internal disaster and the need for beds, the charge nurse is asked to list clients who are potential discharges within the next hour. Which client should the charge nurse select?

A) An elderly client who has had type 2 diabetes for over 20 years, admitted with diabetic ketoacidosis 24 hours ago
B) An adolescent admitted the prior night with Tylenol intoxication
C) A middle-aged client with an internal automatic defibrillator and complaints of “passing out at unknown times” admitted yesterday
D) A school-aged child diagnosed with suspected bacterial meningitis and was admitted at the change of shifts

A: This client is the most stable and has a chronic condition. Tylenol intoxication requires at least 3 to 4 days of intensive observation for the risk of hepatic failure. The other clients would be considered unstable.

40. Which one of the following statements, if made by the client, indicates teaching about Inderal (propranolol) has been effective?

A) "I may experience seizures if I stop the medication abruptly."
B) "I may experience an increase in my heart rate for a few weeks."
C) ”I can expect to feel nervousness the first few weeks."
D) “I can have a heart attack if I stop this medication suddenly."

D: “I can have a heart attack if I stop this medication suddenly." Discontinuing beta blockers suddenly can cause angina, hypertension, dysrhythmias, or an MI.

Q&A Random Selection #9

1. The nurse is teaching a client about the healthy use of ego defense mechanisms. An appropriate goal for this client would be

    A) Reduce fear and protect self-esteem
    B) Minimize anxiety and delay apprehension
    C) Avoid conflict and leave unpleasant situations
    D) Increase independence and communicate more often

A: Reduce fear and protect self-esteem. Ego defense mechanisms are unconscious proactive barriers that are used to manage instinct and affect in the presence of stressful situations. Healthy reactions are those in which the client admits that they are feeling various emotions.

2. A child with tetralogy of Fallot visits the clinic several weeks before planned surgery. The nurse should give **priority** attention to

    A) assessment of oxygenation
    B) observation for developmental delays
    C) prevention of infection
    D) maintenance of adequate nutrition

A: assessment of oxygenation. All of the above would be important in a child diagnosed with tetralogy of Fallot. However, persistent hypoxemia causes acidosis which further decreases pulmonary blood flow. Additionally, low oxygenation leads to development of polycythemia and resultant neurologic complications.

3. The registered nurse (RN) is planning care at a team meeting for a 2 month-old child in bilateral leg casts for congenital clubfoot. Which of these outcomes suggested by the practical nurse (PN) should be considered the **priority** nursing goal following cast application?

    A) The infant will experience minimal pain
    B) Muscle spasms will be relieved
    C) Mobility will be managed as tolerated
    D) Tissue perfusion will be maintained

D: Tissue perfusion will be maintained. Immediately following cast application, the chief goal is to maintain circulation and tissue perfusion around the cast. Permanent tissue damage can occur within a few hours if perfusion is not maintained.

4. At a nursing staff meeting, there is discussion of perceived inequities in weekend staff assignments. As a follow-up, the nurse manager should **initially**

    A) Allow the staff to change assignments
    B) Clarify reasons for current assignments
    C) Help staff see the complexity of issues
    D) Facilitate creative thinking on staffing

D: Facilitate creative thinking on staffing. The "moving phase" of change involves viewing the problem from a new perspective, and then incorporating new and different approaches to the problem. The manager, as a change agent, can facilitate staff"s solving the problem.

5. A client is admitted with a distended bladder due to the inability to void. The nurse obtains an order to catheterize the client, and is aware that gradual emptying is preferred over complete emptying because it reduces the

    A) potential for renal collapse
    B) potential for shock
    C) intensity of bladder spasms
    D) chance of bladder atrophy

B: potential for shock. Complete, rapid emptying can cause shock and hypotension due to sudden changes in the abdominal cavity.

6. The nurse is assessing a 12 year-old who has hemophilia A. Which finding would the nurse anticipate?

    A) An excess of red blood cells
    B) An excess of white blood cells
    C) A deficiency of clotting factor VIII
    D) A deficiency of clotting factors VIII and IX

C: Hemophilia A is characterized by an absence or deficiency of Factor VIII.

7. The nurse is caring for a client with left ventricular heart failure. Which one of the following assessments is an early indication of inadequate oxygen transport?

    A) crackles in the lungs
    B) confusion and restlessness
    C) distended neck veins
    D) use of accessory muscles

B: confusion and restlessness. Neurological changes, including impaired mental status, are early signs of inadequate oxygenation.

8. A 6 year-old female is diagnosed with recurrent urinary tract infections (UTIs). Which one of the following instructions would be best for the nurse to tell the caregiver?

    A) Increase bladder tone by delaying voiding
    B) When laundering clothing, rinse several times
    C) Use plain water for the bath, shampooing hair last
    D) Have the child use antibacterial soaps while bathing

C: Use plain water for the bath, shampooing hair last. Hair should be shampooed last with a rinsing of plain water over the genital area. The oils in soaps and bubble bath can cause irritation, which may lead to UTI"s in young girls.

9. While performing an initial assessment on a newborn following a breech delivery, the nurse suspects hip dislocation. Which of the following is most suggestive of the abnormality?

    A) Flexion of lower extremities
    B) Negative Ortolani response
    C) Lengthened leg of affected side
    D) Irregular hip symmetry

D: Irregular hip symmetry. Early assessment of irregular hip symmetry alerts the nurse and the provider to a correctable congenital hip dislocation.

10. In reviewing the assessment data of a client suspected of having diabetes insipidus, the nurse expects which of the following after a water deprivation test?

    A) Increased edema and weight gain
    B) Unchanged urine specific gravity
    C) Rapid protein excretion
    D) Decreased blood potassium

B: Unchanged urine specific gravity. When fluids are restricted, the client continues to excrete large amounts of dilute urine. This finding supports the diagnosis. Normally, urine is more concentrated with reduced fluid intake.

11. The nurse is caring for a client with Parkinson's disease. The client spends over 1 hour to dress for scheduled therapies. What is the most appropriate action for the nurse to take in this situation?

    A) Ask family members to dress the client
    B) Encourage the client to dress more quickly
    C) Allow the client the time needed to dress
    D) Demonstrate methods on how to dress more quickly

C: Allow the client the time needed to dress. Clients with Parkinson"s disease often wish to take care of themselves but become very upset when hurried and then are unable to manage at all. Any form of hurrying the client will result in a very upset and immobilized client.

12. When caring for a client with advanced cirrhosis of the liver, which nursing diagnosis should take **priority**?

    A) risk for injury: hemorrhage
    B) risk for injury related to peripheral neuropathy
    C) altered nutrition: less than body requirements
    D) fluid volume excess: ascites

A: risk for injury: hemorrhage. Liver disease interferes with the production of prothrombin and other factors essential for blood clotting. Hemorrhage, especially from esophageal varices can be life threatening. This takes priority over the other nursing diagnosis.

13. A client is admitted with a diagnosis of myocardial infarction (MI). The client is complaining of chest pain. The nurse knows that pain related to an MI is due to

    A) insufficient oxygenation of the cardiac muscle
    B) potential circulatory overload
    C) left ventricular overload
    D) electrolyte imbalance

A: insufficient oxygenation of the cardiac muscle. Due to ischemia of the heart muscle, the client experiences pain. This happens because an MI can block or interfere with the normal cardiac circulation.

14. On initial examination of a 15 month-old child with suspected otitis media, which group of findings would the registered nurse (RN) anticipate?

    A) Periorbital edema, absent light reflex and translucent tympanic membrane
    B) Irritability, rhinorrhea, and bulging tympanic membrane
    C) Diarrhea, retracted tympanic membrane and enlarged parotid gland
    D) Vomiting, pulling at ears and pearly white tympanic membrane

B: Irritability, rhinorrhea, and bulging tympanic membrane. Clinical manifestations of otitis media include irritability, rhinorrhea, bulging tympanic membrane, and pulling at ears.

15. Postoperative orders for a client undergoing a mitral valve replacement include monitoring pulmonary artery pressure together with pulmonary capillary wedge pressure with a pulmonary artery catheter. The purpose of these actions by the nurse is to assess

    A) right ventricular pressure
    B) left ventricular end-diastolic pressure
    C) acid-base balance
    D) coronary artery stability

B: left ventricular end-diastolic pressure. The pulmonary capillary wedge pressure is reflective of left ventricular end-diastolic pressure. Pulmonary artery pressures are an assessment tool used to determine the ability of the heart to receive and pump blood effectively.

16. A client is receiving oxygen therapy via a nasal cannula. When providing nursing care, which of the following interventions would be appropriate?

    A) Determine that adequate mist is supplied
    B) Inspect the nares and ears for skin breakdown
    C) Lubricate the tips of the cannula before insertion
    D) Maintain sterile technique when handling cannula

B: Inspect the nares and ears for skin breakdown. Oxygen therapy can cause drying of the nasal mucosa. Pressure from the tubing can cause skin irritation. Nasal cannula administering oxygen should not be lubricated with petroleum jelly.

17. The nurse is providing instructions for a client with asthma who is sensitive to house dust-mites. Which information about prevention of asthma episodes would be the **most** helpful to include during the teaching?

    A) Change the pillow covers every month
    B) Wash bed linens in warm water with a cold rinse
    C) Wash and rinse the bed linens in hot water
    D) Use air filters in the furnace system

C: Wash and rinse the bed linens in hot water. For asthma clients who are sensitive to house dust-mites it is essential the mattresses and pillows are encased in allergen-impermeable covers. All bed linens such as pillow cases, sheets and blankets should be washed and rinsed weekly in hot water at temperatures above 130 degrees Fahrenheit, the temperature necessary to kill the dust-mites.

18. A client tells the nurse he is fearful of planned surgery because of evil thoughts about a family member. What is the best initial response by the nurse?

    A) Call a chaplain
    B) Deny the feelings
    C) Cite recovery statistics
    D) Listen to the client

D: Listen to the client. Therapeutic communications are based on attentive listening to expressed feelings. If the nurse is not familiar with the cultural beliefs of a client, acceptance of feelings is followed by questions about the beliefs.

19. The nurse is performing a physical assessment on a client with insulin dependent diabetes mellitus. Which client finding calls for **immediate** nursing action?

    A) Diaphoresis and shakiness
    B) Reduced lower leg sensation
    C) Intense thirst and hunger
    D) Painful hematoma on thigh

A: Diaphoresis and shakiness. Diaphoresis is a sign of hypoglycemia which warrants immediate attention.

20. A Hispanic client refuses emergency room treatment until a curandero is called. The nurse understands that this person brings what to situations of illness?

    A) Holistic healing
    B) Spiritual advising
    C) Herbal preparations
    D) Witchcraft potions

A: Holistic healing. This traditional folk practitioner uses holistic methods for illnesses not related to witchcraft. Many times, the curandero works with traditional health care providers to restore health.

21. You are teaching a client about the patient controlled analgesia (PCA) planned for post-operative care. Which statement indicates further teaching may be needed by the client?

    A) "I will be receiving continuous doses of medication."
    B) "I should call the nurse before I take additional doses."
    C) "I will call for assistance if my pain is not relieved."
    D) "The machine will prevent an overdose."

B: Patient controlled analgesia offers the client more control. The client should be instructed to initiate additional doses as needed without asking for assistance unless there is insufficient control of the pain.

22. The nurse is teaching childbirth preparation classes. One woman asks about her rights to develop a birthing plan. Which response made by the nurse would be best?

    A) "What is your reason for wanting such a plan?"
    B) "Have you talked with your provider about this?"
    C) "Let us discuss your rights as a couple"
    D) "Write your ideal plan for the next class"

C: Discussion of the provider"s role and the couple"s rights and limitations in selecting birth options must precede development of a plan.

23. The nurse is caring for a client admitted to the hospital with right lower lobe (RLL) pneumonia. On assessment, the nurse notes crackles over the RLL. The client has significant pleuritic pain and is unable to take in a deep breath in order to cough effectively. Which nursing diagnosis would be **most** appropriate for this client based on this assessment data?

    A) Impaired gas exchange related to acute infection and sputum production
    B) Ineffective airway clearance related to sputum production and ineffective cough
    C) Ineffective breathing pattern related to acute infection
    D) Anxiety related to hospitalization and role conflict

B: Ineffective airway clearance is defined as the inability to cough effectively. While the other diagnoses may be appropriate for this client, this is the only one supported directly by the assessment data given.

24. A woman comes to the antepartum clinic for a routine prenatal examination. She is 12 weeks pregnant with her second child. Which of the following shows proper documentation of the client's obstetric history by the nurse?

    A) Para 2, Gravida 1
    B) Nulligravida 2, Para 1
    C) Primigravida 1, Para 1
    D) Gravida 2, Para 1

D: Gravida 2, Para 1. Gravida describes a woman who is or has been pregnant, regardless of pregnancy outcome. Para describes the number of babies born past a point of viability. Therefore a woman pregnant with her second child would be described as Gravida 2, Para 1. Primipara refers to a woman who has completed one pregnancy to the period of viability. Multipara refers to a woman who has completed 2 or more pregnancies to the stage of viability.

25. When planning the care for a young adult client diagnosed with anorexia nervosa which of these concerns should the nurse determine to be the **priority** for long term mobility?

    A) digestive problems
    B) amenorrhea
    C) Electrolyte imbalance
    D) blood disorders

B: amenorrhea. Changes in reproductive hormones and in thyroid hormones can cause absence of menstruation, called amenorrhea, which contributes to osteoporosis and bone fractures.

26. A client was admitted with a diagnosis of pneumonia. When auscultating the client's breath sounds, the nurse hears inspiratory crackles in the right base. Temperature is 102.3 degrees Fahrenheit orally. What other finding would the nurse expect?

    A) Flushed skin
    B) Bradycardia
    C) Mental confusion
    D) Hypotension

C: Mental confusion. Crackles suggest pneumonia, which is likely to be accompanied by mental confusion related to hypoxia.

27. The nurse is evaluating the growth and development of a toddler with AIDS. The nurse would anticipate finding that the child has

    A) achieved developmental milestones at an erratic rate
    B) delay in musculoskeletal development
    C) displayed difficulty with speech development
    D) delay in achievement of most developmental milestones

D: The majority of children with AIDS have neurological involvement. There is decreased brain growth as evidenced by microcephaly and abnormal neurologic findings. Developmental delays are common, and after achieving normal development, there may be loss of milestones. The other options are accurate but are too limited to be the best response.

28. The nurse would expect which eating disorder to cause the greatest fluctuations in potassium?

    A) binge eating disorder
    B) anorexia nervosa
    C) bulimia

D) purge syndrome

C: bulimia. With bulimia the purging process tends to make the body dehydrated and to lower the level of potassium in the blood. Low potassium levels can cause weakness, abdominal cramping and irregular heart rhythms.

29. The nurse is planning care for a client with increased intracranial pressure. The **best** position for this client is

A) Trendelenburg
B) Prone
C) Semi-Fowlers
D) Side-lying with head flat

C: Semi-Fowlers. Maintaining the head of the bed at 15-30 degrees reduces cerebral venous congestion.

30. The nurse is assessing a client with a deep vein thrombosis. Which of the following signs and/or symptoms would the nurse anticipate finding?

A) Rapid respirations
B) Diaphoresis
C) Swelling of lower extremity
D) Positive Babinski's sign

C: Swelling of lower extremity. The most common signs of deep vein thrombosis are pain in the region of the thrombus and unilateral swelling distal to the site.

31. The nurse is assessing a newborn infant and observes low set ears, short palpebral fissures, flat nasal bridge and indistinct philtrum. A **priority** maternal assessment by the nurse should be to ask about

A) alcohol use during pregnancy
B) usual nutritional intake
C) family genetic disorders
D) maternal and paternal ages

A: alcohol use during pregnancy. This cluster of facial characteristics is often linked to fetal alcohol syndrome (FAS). Lifelong developmental delays of varying severity can result.

32. A 14 month-old had cleft palate surgical repair several days ago. The parents ask the nurse about feedings after discharge. Which lunch is the **best** example of an appropriate meal?

A) Hot dog, carrot sticks, gelatin, milk
B) Soup, blenderized soft foods, ice cream, milk
C) Peanut butter and jelly sandwich, chips, pudding, milk
D) Baked chicken, applesauce, cookie, milk

B: Soup, blenderized soft foods, ice cream, milk. In a child with cleft palate repair, parents should prepare soft foods and avoid those foods with particles that might traumatize the surgical site.

33. In addition to disturbances in mental awareness and orientation, a client with cognitive impairment is also likely to show loss of ability in

A) Hearing, speech, and sight
B) Endurance, strength, and mobility
C) Learning, creativity, and judgment
D) Balance, flexibility, and coordination

C: Learning, creativity, and judgment. Cognitive impairments are due to physiological processes that affect memory and other higher-level cognitive processes.

34. A client was re-admitted to the hospital following a recent skull fracture. Which finding requires the nurse's **immediate** attention?

A) Lethargy
B) Agitation
C) Ataxia
D) Hearing loss

A: Lethargy. The level of consciousness or responsiveness is the most important measure of the client"s rising intracranial pressure. Look for lethargy, delay in response to verbal suggestions and slowing of speech. Assess for rising blood pressure or widening pulse pressure and for respiratory irregularities. There may be vomiting, usually projectile, without the presence of nausea.

35. A young child is admitted for treatment of lead poisoning. The nurse recognizes that the most serious effect of chronic lead poisoning is

A) central nervous system damage
B) moderate anemia
C) renal tubule damage
D) growth impairment

A: central nervous system damage. The most serious consequences of chronic lead poisoning occur in the central nervous system. Neural cells are destroyed by the toxic effects of the lead, resulting in many problems with the intellect ranging from mild deficits to mental retardation and even death.

36. The new graduate nurse interviews for a position in a nursing department of a large health care agency, described by the interviewer as having shared governance. Which of these statements best illustrates the shared governance model?

    A) An appointed board oversees any administrative decisions
    B) Nursing departments share responsibility for client outcomes
    C) Staff groups are appointed to discuss nursing practice and client education issues
    D) Non-nurse managers supervise nursing staff in groups of units

B: Nursing departments share responsibility for client outcomes. Shared governance or self-governance is a method of organizational design that promotes empowerment of nurses to give them responsibility for client care issues.

37. In a long term rehabilitation care unit, a client with spinal cord injury complains of a pounding headache. The client is sitting in a wheelchair watching television. Further assessment by the nurse reveals excessive sweating, a splotchy rash, pilomotor erection, facial flushing, congested nasal passages and a heart rate of 50. The nurse should perform which action next?

    A) Take the client's respirations, blood pressure (BP), temperature and then pupillary responses
    B) Place the client into the bed and administer the ordered PRN analgesic
    C) Check the client for bladder distention and the client's urinary catheter for kinks
    D) Turn the television off and then assist client to use relaxation techniques

C: These are findings of autonomic dysreflexia, also called hyperreflexia. This response occurs in clients with a spinal cord injury above the T-6 level. It is typically initiated by any noxious stimulus below the level of injury such as a full bladder, an enema or bowel movement, fecal impaction, uterine contractions, changing of the catheter, and vaginal or rectal examinations. The stimulus creates an exaggerated response of the sympathetic nervous system and can be a life-threatening event. The BP is typically extremely high. The priority action of the nurse is to identify and relieve the cause of the stimulus.

38. A 2 month-old infant has both a cleft lip and palate which will be repaired in stages. In the immediate postoperative period for a cleft lip repair, which nursing approach should be the **priority**?

    A) Remove protective arm devices one at a time for short periods with supervision
    B) Initiate by mouth feedings when alert, with the return of the gag reflex
    C) Introduce to the parents how to cleanse the suture line with the prescribed protocol
    D) Position the infant on the back after feedings throughout the day

A: The major efforts in the postoperative period are directed toward protecting the operative site. Elbow restraints should be used and only 1 arm released at a time with close supervision by the nurse and/or parents.

39. When teaching new parents prevention of sudden infant death syndrome (SIDS) what is the most important practice the nurse should instruct them to do?

    A) Place the infant in a supine or side lying position for sleep
    B) Do not allow anyone to smoke in the home
    C) Follow recommended immunization schedule
    D) Be sure to check infant every one hour

A: Place the infant in a supine or side lying position for sleep. Current thinking is that infants become hypoxic when they sleep because of positional narrowing of the airway and respiratory inflammation. The most compelling data comes from studies that link sleep habits with an increased risk of SIDS. Sleeping in the prone position may cause oropharyngeal obstruction or affect the thermal balance or arousal state. Sleep apnea is not the cause of SIDS. Because of research findings and the "Back to Sleep" campaign, the incidence of sleep apnea and the number of SIDS deaths have dropped dramatically.

40. A client is admitted with the diagnosis of myocardial infarction (MI). Which of the following lab values would be consistent with this diagnosis

    A) Low serum albumin
    B) High serum cholesterol
    C) Abnormally low white blood cell count
    D) Elevated creatinine phosphokinase (CPK)

D: Elevated creatinine phosphokinase (CPK). An elevated CPK is a common finding in the client with an MI. CPK levels begin to rise approximately 3 to 12 hours after an acute MI, peak in 24 hours, and return to normal within 2 to 3 days. Troponin levels rise as well.

Q&A Random Selection #10

1. A home health nurse is at the home of a client with diabetes and arthritis. The client has difficulty drawing up insulin. It would be **most** appropriate for the nurse to refer the client to

    A) A social worker from the local hospital
    B) A physical therapist to improve fine motor coordination
    C) An activity therapist from the community center
    D) Another client with diabetes mellitus and takes insulin

B: A physical therapist can assist a client to improve the fine motor skills needed to prepare an insulin injection.

2. A couple asks the nurse about risks of several birth control methods. What is the most appropriate response by the nurse?

    A) Norplant is safe and may be removed easily
    B) Oral contraceptives should not be used by smokers
    C) Depo-Provera is convenient with few side effects
    D) The IUD gives protection from pregnancy and infection

B: Oral contraceptives should not be used by smokers. The use of oral contraceptives in a woman who smokes increases her risk of cardiovascular problems, such as thromboembolic disorders.

3. The nurse is caring for a client with a long leg cast. During discharge teaching about appropriate exercises for the affected extremity, the nurse should recommend _____ exercises

    A) isometric
    B) range of motion
    C) aerobic
    D) isotonic

A: isometric. The nurse should instruct the client on isometric exercises for the muscles of the casted extremity, i.e., instruct the client to alternately contract and relax muscles without moving the affected part. The client should also be instructed to do active range of motion exercises for every joint that is not immobilized at regular and frequent intervals.

4. Which behavioral characteristic describes the domestic abuser?

    A) Alcoholic
    B) Over confident
    C) High tolerance for frustrations
    D) Low self-esteem

D: Low self-esteem. Batterers were usually physically or psychologically abused as children or have had experiences of parental violence. Batterers are also manipulative, and have a great need to exercise control or power over their partners.

5. A client asks the nurse about including her 2 and 12 year-old sons in the care of their newborn sister. Which of the following is an appropriate initial statement by the nurse?

    A) "Focus on your sons' needs during the first days at home."
    B) "Tell each child what he can do to help with the baby."
    C) "Suggest that your husband spend more time with the boys."
    D) "Ask the children what they would like to do for the newborn."

A: In an expanded family, it is important for parents to reassure older children that they are loved and as important as the newborn.

6. The nurse is caring for a post-surgical client at risk for developing deep vein thrombosis. Which intervention is an effective preventive measure?

    A) Place pillows under the knees
    B) Use elastic stockings continuously
    C) Encourage range of motion and ambulation
    D) Massage the legs twice daily

C: Encourage range of motion and ambulation. Mobility reduces the risk of deep vein thrombosis in the post-surgical client and the adult at risk due to other factors.

7. A client is scheduled for a percutaneous transluminal coronary angioplasty (PTCA). The nurse knows that a PTCA is the

    A) surgical repair of a diseased coronary artery
    B) placement of an automatic internal cardiac defibrillator
    C) procedure that compresses plaque against the wall of the diseased coronary artery to improve blood flow
    D) non-invasive radiographic examination of the heart

C: PTCA is performed to improve coronary artery blood flow in a diseased artery. It is performed during a cardiac catheterization. Aorta coronary bypass (CABG) is the surgical procedure to repair a diseased coronary artery.

8. A nurse is caring for a 2 year-old child after corrective surgery for Tetralogy of Fallot. The mother reports that the child has suddenly begun seizing. The nurse recognizes this problem is probably due to

    A) a cerebral vascular accident
    B) postoperative meningitis
    C) medication reaction
    D) metabolic alkalosis

A: a cerebral vascular accident. Polycythemia occurs as a physiological reaction to chronic hypoxemia which commonly occurs in clients with Tetralogy of Fallot. Polycythemia and the resultant increased viscosity of the blood increase the risk of thromboembolic events. Cerebrovascular accidents may occur. Signs and symptoms include sudden paralysis, altered speech, extreme irritability or fatigue, and seizures.

9. A client with asthma has low pitched wheezes present on the final half of exhalation. One hour later the client has high pitched wheezes extending throughout exhalation. This change in assessment indicates to the nurse that the client

    A) has increased airway obstruction
    B) has improved airway obstruction
    C) needs to be suctioned
    D) exhibits hyperventilation

A: has increased airway obstruction. The higher pitched a sound is, the more narrow the airway. Therefore, the obstruction has increased or worsened. With no evidence of secretions, no data supports the need for suctioning.

10. Following a diagnosis of acute glomerulonephritis (AGN) in their 6 year-old child, the parents remark: “We just don’t know how he caught the disease!” The nurse's response is based on an understanding that

    A) AGN is a streptococcal infection that involves the kidney tubules
    B) the disease is easily transmissible in schools and camps
    C) the illness is usually associated with chronic respiratory infections
    D) it is not "caught" but is a response to a previous B-hemolytic strep infection

D: it is not "caught" but is a response to a previous B-hemolytic strep infection. AGN is generally accepted as an immune-complex disease in relation to an antecedent streptococcal infection of 4 to 6 weeks prior, and is considered as a noninfectious renal disease.

11. During the admission assessment on a client with chronic bilateral glaucoma, which statement by the client would the nurse anticipate since it is associated with this problem?

    A) "I have constant blurred vision."
    B) "I can't see on my left side."
    C) "I have to turn my head to see my room."
    D) "I have specks floating in my eyes."

C: "I have to turn my head to see my room." Intraocular pressure becomes elevated which slowly produces a progressive loss of the peripheral visual field in the affected eye along with rainbow halos around lights. Intraocular pressure becomes elevated from the microscopic obstruction of the trabeculae meshwork. If left untreated or undetected blindness results in the affected eye.

12. A 19 year-old client is paralyzed in a car accident. Which statement used by the client would indicate to the nurse that the client is using the mechanism of "suppression"?

    A) "I don't remember anything about what happened to me."
    B) "I'd rather not talk about it right now."
    C) "It's all the other guy's fault! He was going too fast."
    D) "My mother is heartbroken about this."

A: "I don"t remember anything about what happened to me." Suppression is willfully putting an unacceptable thought or feeling out of one’s mind. A deliberate exclusion, "voluntary forgetting," is generally used to protect one’s own self esteem.

13. A client was admitted to the psychiatric unit after complaining to her friends and family that neighbors have bugged her home in order to hear all of her business. She remains aloof from other clients, paces the floor and believes that the hospital is a house of torture. Nursing interventions for the client should appropriately focus on efforts to

    A) convince the client that the hospital staff is trying to help
    B) help the client to enter into group recreational activities
    C) provide interactions to help the client learn to trust staff
    D) arrange the environment to limit the client’s contact with other clients

C: provide interactions to help the client learn to trust staff. Establishing trust helps clients feel safer, and facilitates a therapeutic alliance between staff and client.

14. A client with schizophrenia is receiving haloperidol (Haldol) 5 mg T.I.D. The client’s family is alarmed and calls the clinic when "his eyes rolled upward." The nurse recognizes this as what type of side effect?

    A) Oculogyric crisis
    B) Tardive dyskinesia
    C) Nystagmus
    D) Dysphagia

A: Oculogyric crisis. This refers to involuntary muscles spasm of the eye. There are medications to treat these side effects, for example Artane.

15. The parents of a newborn male with hypospadias want their child circumcised. The **best** response by the nurse would be to inform them that

    A) circumcision is delayed so the foreskin can be used for the surgical repair
    B) this procedure is contraindicated because of the permanent defect
    C) there is no medical indication for performing a circumcision on any child
    D) the procedure should be performed as soon as the infant is stable

A: circumcision is delayed so the foreskin can be used for the surgical repair. Even if only mild hypospadias is suspected, circumcision is not done in order to save the foreskin for surgical repair if needed.

16. A mother brings her 26 month-old to the well-child clinic. She expresses frustration and anger due to her child's constantly saying "no" and his refusal to follow her directions. The nurse explains this is normal for his age, as negativism is attempting to meet which developmental need?

    A) Trust
    B) Initiative
    C) Independence
    D) Self-esteem

C: Independence. In Erikson's theory of development, toddlers struggle to assert independence. They often use the word "no" even when they mean yes. This stage is called autonomy versus shame and doubt.

17. Following mitral valve replacement surgery a client develops PVC's. The health care provider orders a bolus of Lidocaine followed by a continuous Lidocaine infusion at a rate of 2 mg/minute. The IV solution contains 2 grams of Lidocaine in 500 cc's of D5W. The infusion pump delivers 60 microdrops/cc. What rate would deliver 4 mg of Lidocaine/minute?

    A) 60 microdrops/minute
    B) 20 microdrops/minute
    C) 30 microdrops/minute
    D) 40 microdrops/minute

A: 60microdrops/minute.

18. To prevent a Valsalva maneuver in a client recovering from an acute myocardial infarction, the nurse would

    A) assist the client to use the bedside commode
    B) administer stool softeners every day as ordered
    C) administer antidysrhythmics prn as ordered
    D) maintain the client on strict bed rest

B: administer stool softeners every day as ordered. Administering stool softeners every day will prevent straining on defecation which causes the Valsalva maneuver. If constipation occurs then laxatives would be necessary to prevent straining. If straining on defecation (the Valsalva maneuver) produced rhythm disturbances, then antidysrhythmics would be appropriate.

19. A 16 year-old client is admitted to a psychiatric unit with a diagnosis of attempted suicide. The nurse is aware that the **most** frequent cause for suicide in adolescents is

    A) Progressive failure to adapt
    B) Feelings of anger or hostility
    C) Reunion wish or fantasy
    D) Feelings of alienation or isolation

D: Feelings of alienation or isolation. The isolation may occur gradually resulting in a loss of all meaningful social contacts. Isolation can be self imposed or can occur as a result of the inability to express feelings. At this stage of development it is important to achieve a sense of identity and peer acceptance.

20. The nurse is caring for a woman 2 hours after a vaginal delivery. Documentation indicates that the membranes were ruptured for 36 hours prior to delivery. What is the priority nursing diagnoses at this time?

    A) Altered tissue perfusion
    B) Risk for fluid volume deficit
    C) High risk for hemorrhage
    D) Risk for infection

D: Risk for infection. Membranes ruptured over 24 hours prior to birth greatly increases the risk of infection to both mother and the newborn.

21. The nurse is caring for a 20 lbs (9 kg) 6 month-old with a 3 day history of diarrhea, occasional vomiting and fever. Peripheral intravenous therapy has been initiated, with 5% dextrose in 0.33% normal saline with 20 mEq of potassium per liter infusing at 35 ml/hr. Which finding should be reported to the health care provider **immediately**?

    A) 3 episodes of vomiting in 1 hour

B) Periodic crying and irritability
C) Vigorous sucking on a pacifier
D) No measurable voiding in 4 hours

D: No measurable voiding in 4 hours. The concern is possible hyperkalemia, which could occur with continued potassium administration and a decrease in urinary output since potassium is excreted via the kidneys.

22. A client is scheduled for an Intravenous Pyelogram (IVP). In order to prepare the client for this test, the nurse would

A) instruct the client to maintain a regular diet the day prior to the examination
B) restrict the client's fluid intake 4 hours prior to the examination
C) administer a laxative to the client the evening before the examination
D) inform the client that only 1 x-ray of his abdomen is necessary

C: administer a laxative to the client the evening before the examination. Bowel prep is important because it will allow greater visualization of the bladder and ureters.

23. The nurse is caring for a client in the late stages of amyotrophic lateral sclerosis (ALS). Which finding would the nurse expect?

A) confusion
B) loss of half of visual field
C) shallow respirations
D) tonic-clonic seizures

C: shallow respirations. ALS is a chronic progressive disease that involves degeneration of the anterior horn of the spinal cord as well as the corticospinal tracts. When the intercostal muscles and diaphragm become involved, the respirations become shallow and coughing is ineffective.

24. The nurse is caring for a 13 year-old following spinal fusion for scoliosis. Which of the following interventions is appropriate in the immediate post-operative period?

A) Raise the head of the bed at least 30 degrees
B) Encourage ambulation within 24 hours
C) Maintain in a flat position, logrolling as needed
D) Encourage leg contraction and relaxation after 48 hours

C: Maintain in a flat position, logrolling as needed. The bed should remain flat for at least the first 24 hours to prevent injury. Logrolling is the best way to turn the client who is on bed rest.

25. An infant weighed 7 pounds 8 ounces at birth. If growth occurs at a normal rate, what would be the expected weight change at 6 months of age?

A) Double the birth weight
B) Triple the birth weight
C) Gain 6 ounces each week
D) Add 2 pounds each month

A: Double the birth weight. Although growth rates vary, infants normally double their birth weight by 6 months.

26. A client complained of nausea, a metallic taste in her mouth, and fine hand tremors 2 hours after her **first** dose of lithium carbonate (Lithane). What is the nurse's best explanation of these findings?

A) These side effects are common and should subside in a few days
B) The client is probably having an allergic reaction and should discontinue the drug
C) Taking the lithium on an empty stomach should decrease these symptoms
D) Decreasing dietary intake of sodium and fluids should minimize the side effects

A: These side effects are common and should subside in a few days. Nausea, metallic taste and fine hand tremors are common side effects that usually subside quickly. Informing clients of these possible reactions can help them tolerate these initial difficulties and continue taking the drug, obtaining therapeutic effects.

27. Which response by the nurse would **best** assist the chemically impaired client to deal with issues of guilt?

A) "Addiction usually causes people to feel guilty. Don't worry, it is a typical response due to your drinking behavior."
B) "What have you done that you feel most guilty about and what steps can you begin to take to help you lessen this guilt?"
C) "Don't focus on your guilty feelings. These feelings will only lead you to drinking and taking drugs."
D) "You've caused a great deal of pain to your family and close friends, so it will take time to undo all the things you've done."

B: This response encourages the client to get in touch with their feelings and utilize problem solving steps to reduce guilt feelings.

28. Which statement by the client with chronic obstructive lung disease indicates an understanding of the **major** reason for the use of occasional pursed-lip breathing

A) "This position of my lips helps to keep my airway open."

B) "I can expel more when I pucker up my lips to breathe out."
C) "My mouth doesn't get as dry when I breathe with pursed lips."
D) "With prolonging breathing out with pursed lips the little areas in my lungs don't collapse."

D: Clients with chronic obstructive pulmonary disease have difficulty exhaling fully as a result of the weak alveolar walls from the disease process. Alveolar collapse can be avoided with the use of pursed-lip breathing. This is the major reason to use it. The other options are secondary beneficial effects of pursed-lip breathing.

29. A 57 year-old male client has a hemoglobin of 10 mg/dl and a hematocrit of 32%. What would be the **most** appropriate follow-up by the home care nurse?

A) Ask the client if he has noticed any bleeding or dark stools
B) Tell the client to call 911 and go to the emergency department immediately
C) Schedule a repeat Hemoglobin and Hematocrit in 1 month
D) Tell the client to schedule an appointment with a hematologist

A: Normal hemoglobin for males is 13.0 - 18 g/100 ml. Normal hematocrit for males is 42 - 52%. These values are below normal and indicate mild anemia. The first thing the nurse should do is ask the client if he"s noticed any bleeding or change in stools that could indicate bleeding from the GI tract.

30. A client experiences post partum hemorrhage eight hours after the birth of twins. Following administration of IV fluids and 500 ml of whole blood, her hemoglobin and hematocrit are within normal limits. She asks the nurse whether she should continue to breast feed the infants. Which of the following is based on sound rationale?

A) "Nursing will help contract the uterus and reduce your risk of bleeding."
B) "Breastfeeding twins will take too much energy after the hemorrhage."
C) "The blood transfusion may increase the risks to you and the babies."
D) "Lactation should be delayed until the "real milk" is secreted."

A: Stimulation of the breast during nursing releases oxytocin, which contracts the uterus. This contraction is especially important following hemorrhage.

31. On admission to the psychiatric unit, the client is trembling and appears fearful. The nurse's initial response should be to

A) Give the client orientation materials and review the unit rules and regulations
B) Introduce him/herself and accompany the client to the client's room
C) Take the client to the day room and introduce her to the other clients
D) Ask the nursing assistant to get the client's vital signs and complete the admission search

B: Anxiety is triggered by change that threatens the individual's sense of security. In response to anxiety in clients, the nurse should remain calm, minimize stimuli, and move the client to a calmer, more secure/safe setting.

32. While caring for the client during the first hour after delivery, the nurse determines that the uterus is boggy and there is vaginal bleeding. What should be the nurse's first action?

A) Check vital signs
B) Massage the fundus
C) Offer a bedpan
D) Check for perineal lacerations

B: Massage the fundus. The nurse's first action should be to massage the fundus until it is firm, as uterine atony is the primary cause of bleeding in the first hour after delivery.

33. The nurse is teaching parents about the treatment plan for a 2 weeks-old infant with Tetralogy of Fallot. While awaiting future surgery, the nurse instructs the parents to **immediately** report

A) loss of consciousness
B) feeding problems
C) poor weight gain
D) fatigue with crying

A: While parents should report any of these findings, they need to call the provider immediately if the level of alertness changes. This indicates anoxia, which may lead to death. The structural defects associated with Tetralogy of Fallot include pulmonic stenosis, ventricular septal defect, right ventricular hypertrophy and overriding of the aorta. Surgery is often delayed, or may be performed in stages.

34. For a 6 year-old child hospitalized with moderate edema and mild hypertension associated with acute glomerulonephritis (AGN), which one of the following nursing interventions would be appropriate?

A) Institute seizure precautions
B) Weigh the child twice per shift
C) Encourage the child to eat protein-rich foods
D) Relieve boredom through physical activity

A: The severity of the acute phase of AGN is variable and unpredictable; therefore a child with edema, hypertension, and gross hematuria may be subject to complications. Anticipatory preparation such as seizure precautions are needed.

35. A nurse is teaching the parent of a nine month-old infant about diaper dermatitis. Which of the following measures would be appropriate for the nurse to include?

A) Use only cloth diapers that are rinsed in bleach
B) Do not use occlusive ointments on the rash
C) Use commercial baby wipes with each diaper change
D) Discontinue a new food that was added to the infant's diet just prior to the rash

D: The addition of new foods to the infant"s diet can be a cause of diaper dermatitis.

36. An adolescent client comes to the clinic 3 weeks after the birth of her first baby. She tells the nurse she is concerned because she has not returned to her pre-pregnant weight. Which action should the nurse perform first?

A) Review the client's weight pattern over the year
B) Ask the mother to record her diet for the last 24 hours
C) Encourage her to talk about her view of herself
D) Give her several pamphlets on postpartum nutrition

C: Encourage her to talk about her view of herself. To an adolescent, body image is very important. The nurse must acknowledge this before assessment and teaching.

37. The nurse is assessing an infant with developmental dysplasia of the hip. Which finding would the nurse anticipate?

A) unequal leg length
B) limited adduction
C) diminished femoral pulses
D) symmetrical gluteal folds

A: unequal leg length. Shortening of the affected leg is a sign of developmental dysplasia of the hip.

38. A newborn has been diagnosed with hypothyroidism. In discussing the condition and treatment with the family, the nurse should emphasize

A) they can expect the child will be mentally retarded
B) administration of thyroid hormone will prevent problems
C) this rare problem is always hereditary
D) physical growth/development will be delayed

B: administration of thyroid hormone will prevent problems. Early identification and continued treatment with hormone replacement corrects this condition.

39. The nurse understands that a priority goal of involuntary hospitalization of the severely mentally ill client is

A) re-orientation to reality
B) elimination of symptoms
C) protection from harm to self or others
D) return to independent functioning

C: protection from harm to self or others. Involuntary hospitalization may be required for persons considered dangerous to self or others or for individuals who are considered gravely disabled.

40. A 3 year-old had a hip spica cast applied two hours ago. In order to facilitate drying, the nurse should

A) Expose the cast to air and turn the child frequently
B) Use a heat lamp to reduce the drying time
C) Handle the cast with the abductor bar
D) Turn the child as little as possible

A: Expose the cast to air and turn the child frequently. The child should be turned every two hours, with the cast"s surface exposed to the air.

Q&A Random Selection #11

1. While assessing a client in an outpatient facility with a panic disorder, the nurse completes a thorough health history and physical exam. Which finding is **most** significant for this client?

    A) Compulsive behavior
    B) Sense of impending doom
    C) Fear of flying
    D) Predictable episodes

B: Sense of impending doom. The feeling of overwhelming and uncontrollable doom is characteristic of a panic attack.

2. A client has just been admitted with portal hypertension. Which nursing diagnosis would be a **priority** in planning care?

    A) Altered nutrition: less than body requirements
    B) Potential complication hemorrhage
    C) Ineffective individual coping
    D) Fluid volume excess

B: Potential complication hemorrhage. Esophageal varices are dilated and tortuous vessels of the esophagus that are at high risk for rupture if portal circulation pressures rise.

3. A client has just returned to the medical-surgical unit following a segmental lung resection. After assessing the client, the **first** nursing action would be to

    A) administer pain medication
    B) suction excessive tracheobronchial secretions
    C) assist client to turn, deep breathe and cough
    D) monitor oxygen saturation

B: suction excessive tracheobronchial secretions. Suctioning the copious tracheobronchial secretions present in post-thoracic surgery clients maintains an open airway which is always the priority nursing intervention.

4. Which playroom activities should the nurse organize for a small group of 7 year-old hospitalized children?

    A) Sports and games with rules
    B) Finger paints and water play
    C) "Dress-up" clothes and props
    D) Chess and television programs

A: Sports and games with rules. The purpose of play for the 7 year-old is developing cooperation. Rules are very important. Logical reasoning and social skills are developed through play.

5. The nurse is caring for a client with cirrhosis of the liver with ascites. When instructing nursing assistants in the care of the client, the nurse should emphasize that the client

    A) should remain on bed rest in a semi-Fowler's position
    B) should alternate ambulation with bed rest with legs elevated
    C) may ambulate and sit in chair as tolerated
    D) may ambulate as tolerated and remain in semi-Fowlers position in bed

B: should alternate ambulation with bed rest with legs elevated. Encourage alternating periods ambulation and bed rest with legs elevated to mobilize edema and ascites. Encourage and assist the client with gradually increasing periods of ambulation.

6. The nurse is discussing dietary intake with an adolescent who has acne. The **most** appropriate statement for the nurse is

    A) "Eat a balanced diet for your age."
    B) "Increase your intake of protein and Vitamin A."
    C) "Decrease fatty foods from your diet."
    D) "Do not use caffeine in any form, including chocolate."

A: A diet for a teenager with acne should be a well balanced diet for their age. There are no recommended additions and subtractions from the diet.

7. A client is in the third month of her first pregnancy. During the interview, she tells the nurse that she has several sex partners and is unsure of the identity of the baby's father. Which of the following nursing interventions is a **priority**?

    A) Counsel the woman to consent to HIV screening
    B) Perform tests for sexually transmitted diseases
    C) Discuss her high risk for cervical cancer

D) Refer the client to a family planning clinic

A: Counsel the woman to consent to HIV screening. The client"s behavior places her at high risk for HIV. Testing is the first step. If the woman is HIV positive, the earlier treatment begins, the better the outcome.

8. The nurse enters the room as a 3 year-old is having a generalized seizure. Which intervention should the nurse perform **first**?

A) Clear the area of any hazards
B) Place the child on its side

C) Restrain the child
D) Give the prescribed anticonvulsant

B: Place the child on its side. Protecting the airway is the top priority in a seizure. If a child is actively convulsing, a patent airway and oxygenation must be assured.

9. Upon examining the mouth of a 3 year-old child, the nurse discovers that the teeth have chalky white-to-yellowish staining with pitting of the enamel. Which of the following conditions would **most** likely explain these findings?

A) Ingestion of tetracycline
B) Excessive fluoride intake
C) Oral iron therapy
D) Poor dental hygiene

B: Excessive fluoride intake. The described findings are indicative of fluorosis, a condition characterized by an increase in the extent and degree of the enamel"s porosity. This problem can be associated with repeated swallowing of toothpaste with fluoride or drinking water with high levels of fluoride.

10. A client has developed thrombophlebitis of the left leg. Which nursing intervention should be given the **highest** priority?

A) Elevate the leg on 2 pillows
B) Apply support stockings
C) Apply warm compresses
D) Maintain complete bed rest

A: Elevate the leg on 2 pillows. The first goal of nonpharmacologic interventions is to minimize edema of the affected extremity by leg elevation.

11. The nurse is caring for a child who has just returned from surgery following a tonsillectomy and adenoidectomy. Which action by the nurse is appropriate?

A) Offer ice cream every 2 hours
B) Place the child in a supine position
C) Allow the child to drink through a straw
D) Observe swallowing patterns

D: Observe swallowing patterns. The nurse should observe for increased swallowing frequency, which would signal hemorrhage.

12. The nurse is planning care for a client with pneumococcal pneumonia. Which of the following would be **most** effective in removing respiratory secretions?

A) Administration of cough suppressants
B) Increasing oral fluid intake to 3000 cc per day
C) Maintaining bed rest with bathroom privileges
D) Performing chest physiotherapy twice a day

B: Increasing oral fluid intake to 3000 cc per day. Secretion removal is enhanced with adequate hydration which thins and liquefies secretions.

13. Which of these variations in the newborn results from the presence of maternal hormones?

A) Engorgement of the breasts
B) Mongolian spots
C) Edema of the scrotum
D) Lanugo

A: Engorgement of the breasts. Breast engorgement occurs in both sexes as a result of the withdrawal of maternal hormones after birth.

14. A 23 year-old single client is in the 33rd week of her first pregnancy. She tells the nurse that she has everything ready for the baby and has made plans for the first weeks together at home. Which normal emotional reaction does the nurse recognize?

A) Acceptance of the pregnancy
B) Focus on fetal development
C) Anticipation of the birth
D) Ambivalence about pregnancy

C: Anticipation of the birth. Directing activities toward preparation for the newborn"s needs and personal adjustment are indicators of appropriate emotional response in the third trimester.

15. The nurse is reviewing a depressed client's history from an earlier admission. Documentation of anhedonia is noted. The nurse understands that this finding refers to

    A) reports of difficulty falling and staying asleep
    B) expression of persistent suicidal thoughts
    C) lack of enjoyment in usual pleasures
    D) reduced senses of taste and smell

C: lack of enjoyment in usual pleasures. Lack of enjoyment in usual pleasures is the definition of "anhedonia," which is a common finding in depression.

16. A 2 month-old child has had a cleft lip repair. The selection of which restraint would require no further action by the charge nurse?

    A) elbow
    B) mummy
    C) jacket
    D) clove hitch

A: elbow. The elbow restraint will prevent the child from touching the surgical site without hindering movement of other parts of the body.

17. The nurse is caring for a client with trigeminal neuralgia (tic douloureux). To assist the client with nutrition needs, the nurse should

    A) Offer small meals of high calorie soft food
    B) Assist the client to sit in a chair for meals
    C) Provide additional servings of fruits and raw vegetables
    D) Encourage the client to eat fish, liver and chicken

A: Offer small meals of high calorie soft food. If the client is losing weight because of poor appetite due to the pain, assist in selecting foods that are high in calories and nutrients, to provide more nourishment with less chewing. Suggest that frequent, small meals be eaten instead of three large ones. To minimize jaw movements when eating, suggest that foods be pureed.

18. A nurse from the surgical department is reassigned to the pediatric unit. The charge nurse should recognize that the child at highest risk for cardiac arrest and is the least likely to be assigned to this nurse is which child?

    A) congenital cardiac defects
    B) an acute febrile illness
    C) prolonged hypoxemia
    D) severe multiple trauma

C: prolonged hypoxemia. Most often, the cause of cardiac arrest in the pediatric population is prolonged hypoxemia. Children usually have both cardiac and respiratory arrest.

19. Which of the following should the nurse teach the client to avoid when taking chlorpromazine HCL (Thorazine)?

    A) Direct sunlight
    B) Foods containing tyramine
    C) Foods fermented with yeast
    D) Canned citrus fruit drinks

A: Direct sunlight. Phenothiazine increases sensitivity to the sun, making clients especially susceptible to sunburn. The nurse should recommend that clients treated with phenothiazines use sunblock consistently.

20. A nurse who is evaluating a developmentally challenged 2 year-old should stress which goal when talking to the child's mother?

    A) Teaching the child self care skills
    B) Preparing for independent toileting
    C) Promoting the child's optimal development
    D) Helping the family decide on long term care

C: Promoting the child"s optimal development. The primary goal of nursing care for a developmentally challenged child is to promote the child"s optimum development.

21. A 16 month-old child has just been admitted to the hospital. As the nurse assigned to this child enters the hospital room for the **first** time, the toddler runs to the mother, clings to her and begins to cry. What would be the **initial** action by the nurse?

    A) Arrange to change client care assignments
    B) Explain that this behavior is expected
    C) Discuss the appropriate use of "time-out"
    D) Explain that the child needs extra attention

B: Explain that this behavior is expected. During normal development, fear of strangers becomes prominent beginning around age 6-8 months. Such behaviors include clinging to parent, crying, and turning away from the stranger. These fears/behaviors extend into the toddler period and may persist into preschool.

22. The nurse in a well-child clinic examines many children on a daily basis. Which of the following toddlers requires further follow up?

    A) A 13 month-old unable to walk
    B) A 20 month-old only using 2 and 3 word sentences
    C) A 24 month-old who cries during examination
    D) A 30 month-old only drinking from a sippy cup

D: A 30 month-old should be able to drink from a cup without a cover.

23. The nurse is caring for a client with acute pancreatitis. After pain management, which intervention should be included in the plan of care?

    A) Encourage the client to cough and deep breathe every 2 hours
    B) Place the client in contact isolation
    C) Provide a diet high in protein
    D) Institute seizure precautions

A: Encourage the client to cough and deep breathe every 2 hours. Respiratory infections are common because of fluid in the retro-peritoneum pushing up against the diaphragm, causing shallow respirations. Coughing and deep breathing every 2 hours will diminish the occurrence of this complication.

24. When using an interpreter to teach a client about a procedure to do in the home, the nurse should take which approach?

    A) Speak directly to the interpreter while presenting information and use pauses for questions
    B) Talk to the interpreter in advance and leave the client and interpreter alone
    C) Include a family member and direct communications to that person
    D) Face the client while presenting the information as the interpreter talks in the native language

D: Communication is the cornerstone of an effective teaching plan, especially when the nurse and client do not share the same cultural heritage. Even if the nurse uses an interpreter, it is critical that the nurse use conversational style and spacing, personal space, eye contact, touch, and orientation to time strategies that are acceptable to the client. Therefore, face the client and present the information to the client, allow the interpreter to translate the content. Facing the client allows non-verbal communication to take place between the client and nurse.

25. A registered nurse (RN) is assigned to work at the Poison Control Center telephone hotline. In which of these cases of childhood poisoning would the nurse suggest that parents have the child drink orange juice?

    A) An 18 month-old who ate an undetermined amount of crystal drain cleaner
    B) A 14 month-old who chewed 2 leaves of a philodendron plant
    C) A 20 month-old who is found sitting on the bathroom floor beside an empty bottle of diazepam (Valium)
    D) A 30 month-old who has swallowed a mouthful of charcoal lighter fluid

A: An 18 month-old who ate an undetermined amount of crystal drain cleaner. Drain cleaner is very alkaline. Orange juice is acidic and will help to neutralize this substance.

26. While planning care for a 2 year-old hospitalized child, which situation would the nurse expect to most likely affect the behavior?

    A) Strange bed and surroundings
    B) Separation from parents
    C) Presence of other toddlers
    D) Unfamiliar toys and games

B: Separation from parents. Separation anxiety if most evident from 6 months to 30 months of age. It is the greatest stress imposed on a toddler by hospitalization. If separation is avoided, young children have a tremendous capacity to withstand other stress.

27. The nursing care plan for a client with decreased adrenal function should include

    A) encouraging activity
    B) placing client in reverse isolation
    C) limiting visitors
    D) measures to prevent constipation

C: limiting visitors. Any exertion, either physical or emotional, places additional stress on the adrenal glands which could precipitate an Addisonian crisis. The plan of care should protect this client from the physical and emotional exertion of visitors.

28. While explaining an illness to a 10 year-old, what should the nurse keep in mind about the cognitive development at this age?

    A) They are able to make simple association of ideas
    B) They are able to think logically in organizing facts
    C) Interpretation of events originate from their own perspective
    D) Conclusions are based on previous experiences

B: They are able to think logically in organizing facts. The child in the concrete operations stage, according to Piaget, is capable of mature thought when allowed to manipulate and organize objects.

29. The initial response by the nurse to a delusional client who refuses to eat because of a belief that the food is poisoned is

A) "You think that someone wants to poison you?"
B) "Why do you think the food is poisoned?"
C) "These feelings are a symptom of your illness."
D) "You're safe here. I won't let anyone poison you."

A: "You think that someone wants to poison you?" This response acknowledges perception through a reflective question which presents opportunity for discussion, clarification of meaning, and expressing doubt.

30. The registered nurse has just admitted a client with severe depression. What domain should be the priority focus as the nurse identifies the nursing diagnoses?

A) Nutrition
B) Elimination
C) Activity
D) Safety

D: Safety. Safety is a care priority for all inpatients, and a depressed client is at acute risk for self-destructive behavior. Precautions to prevent suicide must be a part of the nursing care plan.

31. The nurse is caring for a client in the coronary care unit. The display on the cardiac monitor indicates ventricular fibrillation. What should the nurse do **first**?

A) perform defibrillation
B) administer epinephrine as ordered
C) assess for presence of pulse
D) institute CPR

C: assess for presence of pulse. Artifact (interference) can mimic ventricular fibrillation on a cardiac monitor. If the client is truly in ventricular fibrillation, no pulse will be present. The standard of care is to verify the monitor display with an assessment of the client's pulse.

32. A client is discharged following hospitalization for congestive heart failure. The nurse teaching the family suggests they encourage the client to rest frequently in which of the following positions?

A) High Fowler's
B) Supine
C) Left lateral
D) Low Fowler's

A: Sitting in a chair or resting in a bed in high Fowler"s position decreases the cardiac workload and facilitates breathing.

33. Which of the following conditions assessed by the nurse would contraindicate the use of benztropine (Cogentin)?

A) Neuro malignant syndrome
B) Acute extrapyramidal syndrome
C) Glaucoma, prostatic hypertrophy
D) Parkinson's disease, atypical tremors

C: Glaucoma, prostatic hypertrophy. Glaucoma and prostatic hypertrophy are contraindications to the use of benztropine (Cogentin) because the drug is an anticholinergic agent. Cogentin is used to treat the side effects of antipsychotic medications.

34. The nurse is assigned to a newly delivered woman with HIV/AIDS. The student asks the nurse about how it is determined that a person has AIDS other than a positive HIV test. The nurse responds:

A) "The complaints of at least 3 common findings."
B) "The absence of any opportunistic infection."
C) "CD4 lymphocyte count is less than 200."
D) "Developmental delays in children."

C: "CD4 lymphocyte count is less than 200." CD4 lymphocyte counts are normally 600 to 1000. In 1993 the Center for Disease Control defined AIDS as having a positive HIV plus one of these – the presence of an opportunistic infection or a CD4 lymphocyte count of less than 200.

35. A client treated for depression tells the nurse at the mental health clinic that he recently purchased a handgun because he is thinking about suicide. The **first** nursing action should be to

A) Notify the primary care provider immediately
B) Suggest in-patient psychiatric care
C) Respect the client's confidential disclosure
D) Phone the family to warn them of the risk

A: Notify the primary care provider immediately. Not only does the client report suicidal intent, he had formulated a plan and taken steps to implement it. The primary care provider and the rest of the health care team will arrange for treatment given the client's serious risk for self-destructive behavior. Hospitalization and most probably work with the family are indicated. The nurse should never agree to help a client "keep secrets" from the health care team.

36. The nurse is performing physical assessments on adolescents. What finding would the nurse anticipate concerning female growth spurts?

    A) They occur about 2 years earlier than for males.
    B) They begin about the same time for males.
    C) They begin just prior to the onset of puberty.
    D) They are characterized by an increase in height of 4 inches each year.

A: They occur about 2 years earlier than for males. Normally, females in their teenage years experience a growth spurt about 2 years earlier than their male peers.

37. Which of the following would be the best strategy for the nurse to use when teaching insulin injection techniques to a newly diagnosed client with diabetes?

    A) Give written pre and post tests
    B) Ask questions during practice
    C) Allow another diabetic to assist
    D) Observe a return demonstration

D: Observe a return demonstration. Since this is a psychomotor skill, this is the best way to know if the client has learned the proper technique.

38. A 15 year-old client with a lengthy confining illness is most at risk for altered psycho-emotional growth and development due to

    A) loss of control
    B) insecurity
    C) dependence
    D) lack of trust

C: dependence. The client role fosters dependency. Adolescents may react to dependency with rejection, uncooperativeness, or withdrawal.

39. The nurse is assessing a 2 year-old client with a possible diagnosis of congenital heart disease. Which of these is most likely to be seen with this diagnosis?

    A) Several otitis media episodes in the last year
    B) Weight and height in the 10th percentile since birth
    C) Takes frequent rest periods while playing
    D) Changing food preferences and dislikes

C: Takes frequent rest periods while playing. Children with heart disease tend to have exercise intolerance. The child self-limits activity, which is consistent with manifestations of congenital heart disease in children.

40. The nurse is caring for a 10 year-old on admission to the burn unit. One assessment parameter that will indicate that the child has adequate fluid replacement is

    A) urinary output of 30 ml per hour
    B) no complaints of thirst
    C) increased hematocrit
    D) good skin turgor around burn

A: urinary output of 30 ml per hour. For a child of this age, this is adequate output, yet does not suggest overload.

Q&A Random Selection #12

1. The nurse is caring for a post-op colostomy client. The client begins to cry, saying "I'll never be attractive again with this ugly red thing." What should be the first action taken by the nurse?

    A) Arrange a consultation with a sex therapist experienced in working with colostomy clients
    B) Suggest sexual positions that hide the colostomy
    C) Invite the partner to participate in colostomy care after viewing an instructional video
    D) Encourage the client to discuss her feelings about the colostomy

D: Encourage the client to discuss her feelings about the colostomy. One of the greatest fears of colostomy clients is the fear that sexual intimacy is no longer possible. However, the client's personal feelings about the stoma and colostomy care, as well as the client"s specific concerns, need to be assessed to accurately identify the problem(s) to be solved. An assessment should occur before specific suggestions for dealing with the sexual concerns are given.

2. A schizophrenic client talks animatedly but the staff are unable to understand what the client is communicating. The client is observed mumbling to herself and speaking to the radio. A desirable outcome for this client's care will be

    A) expresses feelings appropriately through verbal interactions
    B) accurately interprets events and behaviors of others
    C) demonstrates improved social relationships
    D) engages in meaningful and understandable verbal communication

D: engages in meaningful and understandable verbal communication. The outcome must be related to the diagnosis and supporting data. Data support impaired verbal communication deficit as a nursing diagnosis. No direct data are presented related to feelings or to thinking processes, though disorganized verbalizations are typically taken to indicate disorganized thinking.

3. The nurse is caring for a 7 year-old child who is being discharged following a tonsillectomy. Which of the following instructions is appropriate for the nurse to teach the parents?

    A) Report a persistent cough to the health care provider
    B) The child can return to school in 4 days
    C) Administer chewable aspirin for pain
    D) The child may gargle with saline as necessary for discomfort

A: Persistent coughing should be reported to the health care provider as this may indicate bleeding.

4. An anxious parent of a 4 year-old consults the nurse for guidance in how to answer the child's question, "Where do babies come from?" What is the nurse's best response to the parent?

    A) "When a child asks a question, give a simple answer."
    B) "Children ask many questions, but are not looking for answers."
    C) "This question indicates interest in sex beyond this age."
    D) "Full and detailed answers should be given to all questions."

A: During discussions related to sexuality, honesty is very important. However, honesty does not mean imparting every fact of life associated with the question. When children ask 1 question, they are looking for 1 answer. When they are ready, they will ask for more detailed information.

5. The nurse is assessing a 4 year-old for possible developmental dysplasia of the right hip. Which finding would the nurse expect?

    A) Pelvic tip downward
    B) Right leg lengthening
    C) Ortolani sign
    D) Characteristic limp

D: Characteristic limp. Developmental dysplasia produces a characteristic limp in children who are walking.

6. At a routine clinic visit, parents express concern that their 4 year-old is wetting the bed several times a month. What is the nurse's best response?

    A) "This is normal at this time of day."
    B) "How long has this been occurring?"
    C) "Do you offer fluids at night?"
    D) "Have you tried waking her to urinate?"

B: "How long has this been occurring?" Nighttime control should be present by this age, but may not occur until age 5. Involuntary voiding may occur due to infectious, anatomical and/or physiological reasons.

7. The charge nurse on the eating disorder unit instructs a new staff member to weigh each client in his or her hospital gown only. What is the rationale for this nursing intervention?

    A) To reduce the risk of the client feeling cold due to decreased fat and subcutaneous tissue
    B) To cover the bony prominence and areas where there is skin breakdown
    C) The client knows what type of clothing to wear when weighed
    D) To reduce the tendency of the client to hide objects under his or her clothing

D: The client may conceal weights on their body to create the illusion of increased weight gain.

8. The nurse is caring for a client with benign prostatic hypertrophy (BPH). Which of the following assessments would the nurse anticipate finding?

    A) Large volume of urinary output with each voiding
    B) Involuntary voiding with coughing and sneezing
    C) Frequent urination
    D) Urine is dark and concentrated

C: Frequent urination. Clients with BPH have overflow incontinence with frequent urination in small amounts day and night.

9. A client complaining of severe shortness of breath is diagnosed with congestive heart failure. The nurse observes a falling pulse oximetry. The client's color changes to gray and she expectorates large amounts of pink frothy sputum. The **first** action of the nurse would be which of the following?

    A) Call the health care provider
    B) Check vital signs
    C) Position in high Fowler's
    D) Administer oxygen

D: Administer oxygen. When dealing with a medical emergency, the rule is airway first, then breathing, and then circulation. Starting oxygen is the priority.

10. A school nurse is advising a class of unwed pregnant high school students. What is the most important action they can perform to deliver a healthy child?

    A) Maintain good nutrition
    B) Stay in school
    C) Keep in contact with the child's father
    D) Get adequate sleep

A: Maintain good nutrition. Nurses can serve a pivotal role in providing nutritional education and case management interventions. Weight gain during pregnancy is one of the strongest predictors of infant birth weight. Specifically, teens need to increase their intake of protein, vitamins, and minerals including iron. Pregnant teens who gain between 26 and 35 pounds have the lowest incidence of low-birth-weight babies.

11. Which of the following nursing assessment findings require immediate discontinuance of an antipsychotic medication?

    A) Involuntary rhythmic stereotypic movements and tongue protrusion
    B) Cheek puffing, involuntary movements of extremities and trunk
    C) Agitation, constant state of motion
    D) Hyperpyrexia, severe muscle rigidity, malignant hypertension

D: Hyperpyrexia, sever muscle rigidity, and malignant hypertension are assessment signs indicative of NMS (neuroleptic malignant syndrome).

12. A parent has numerous questions regarding normal growth and development of a 10 month-old infant. Which of the following parameters is of **most** concern to the nurse?

    A) 50% increase in birth weight
    B) Head circumference greater than chest
    C) Crying when the parents leave
    D) Able to stand up briefly in play pen

A: 50% increase in birth weight. Birth weight should be doubled at 6 months of age, tripled at 1 year, and quadrupled by 18 months.

13. A 3 year-old child is treated in the emergency department after ingestion of 1 ounce of a liquid narcotic. What action should the nurse perform **first**?

    A) Provide the ordered humidified oxygen via mask
    B) Suction the mouth and the nose
    C) Check the mouth and radial pulse
    D) Start the ordered intravenous fluids

C: Check the mouth and radial pulse. The first step in treatment of a toxic exposure or ingestion is to assess the airway, breathing and circulation, then stabilize the client. The other nursing actions would follow.

14. A client continually repeats phrases that others have just said. The nurse recognizes this behavior as

A) autistic
B) echopraxis
C) echolalic
D) catatonic

C: Echolalia is repeating words or phrases heard before.

15. Which of the following statements describes what the nurse must know in order to provide anticipatory guidance to parents of a toddler about readiness for toilet training?

A) The child learns voluntary sphincter control through repetition
B) Myelination of the spinal cord is completed by this age
C) Neuronal impulses are interrupted at the base of the ganglia
D) The toddler can understand cause and effect

B: Myelination of the spinal cord is completed by this age. Voluntary control of the sphincter muscles can be gradually achieved due to the complete myelination of the spinal cord, sometime between the ages of 18 to 24 months of age.

16. In teaching parents to associate prevention with the lifestyle of their child with sickle cell disease, the nurse should emphasize that a **priority for their child is to**

A) avoid overheating during physical activities
B) maintain normal activity with some restrictions
C) be cautious of others with viruses or temperatures
D) maintain routine immunizations

A: avoid overheating during physical activities. Fluid loss caused by overheating and dehydration can trigger a crisis.

17. The nurse is performing an assessment on a client with pneumococcal pneumonia. Which finding would the nurse anticipate?

A) bronchial breath sounds in outer lung fields
B) decreased tactile fremitus
C) hacking, nonproductive cough
D) hyper-resonance of areas of consolidation

A: bronchial breath sounds in outer lung fields. Pneumonia causes a marked increase in interstitial and alveolar fluid. Consolidated lung tissue transmits bronchial breath sounds to outer lung fields.

18. When teaching a client with chronic obstructive pulmonary disease about oxygen by cannula, the nurse should also instruct the client's family to

A) avoid smoking near the client
B) turn off oxygen during meals
C) adjust the liter flow to 10 as needed
D) remind the client to keep mouth closed

A: avoid smoking near the client. Since oxygen supports combustion, there is a risk of fire if anyone smokes near the oxygen equipment.

19. The nurse is caring for a 14 month-old just diagnosed with cystic fibrosis. The parents state this is the **first** child in either family with this disease, and ask about the risk to future children. What is the best response by the nurse?

A) 1in 4 chance for each child to carry that trait
B) 1in 4 risk for each child to have the disease
C) 1in 2 chance of avoiding the trait and disease
D) 1in 2 chance that each child will have the disease

B: 1in 4 risk for each child to have the disease. Cystic fibrosis has an autosomal recessive transmission pattern. In this situation, both parents must be carriers of the trait for the disease since neither one of them has the disease. Therefore, for each pregnancy, there is a 25% chance of the child having the disease, 50% chance of carrying the trait and a 25% chance of having neither the trait or the disease.

20. In providing care to a 14 year-old adolescent with scoliosis, which of the following will be most difficult for this client?

A) Compliance with treatment regimens
B) Looking different from their peers
C) Lacking independence in activities
D) Reliance on family for their social support

B: Looking different from their peers. Conformity to peer influences peaks at around age 14. Since many persons view any disability as deviant, the client will need help in learning how to deal with reactions of others. Treatment of scoliosis is long-term and involves bracing and/or surgery.

21. The nurse is teaching parents of an infant about introduction of solid food to their baby. What is the **first** food they can add to the diet?

A) Vegetables
B) Cereal
C) Fruit
D) Meats

B: Cereal is usually introduced first because it is well tolerated, easy to digest, and contains iron.

22. During seizure activity which observation is the **priority** to enhance further direction of treatment?

A) Observe the sequence or types of movement
B) Note the time from beginning to end
C) Identify the pattern of breathing
D) Determine if loss of bowel or bladder control occurs

A: Observe the sequence or types of movement. It is a priority to note, and then record, what movements are seen during a seizure because the diagnosis and subsequent treatment often rests solely on the seizure description.

23. The nurse is caring for a client with a sigmoid colostomy who requests assistance in removing the flatus from a 1 piece drainable ostomy pouch. Which is the correct intervention?

A) Piercing the plastic of the ostomy pouch with a pin to vent the flatus
B) Opening the bottom of the pouch, allowing the flatus to be expelled
C) Pulling the adhesive seal around the ostomy pouch to allow the flatus to escape
D) Assisting the client to ambulate to reduce the flatus in the pouch

B: The only correct way to vent the flatus from a 1 piece drainable ostomy pouch is to instruct the client to obtain privacy (the release of the flatus will cause odor), and to open the bottom of the pouch, release the flatus and close the bottom of the pouch.

24. A nurse who travels with an agency is uncertain about what tasks can be performed when working in a different state. It would be **best** for the nurse to check which resource?

A) The state nurse practice act in which the assignment is made
B) With a nurse colleague who has worked in that state 2 years ago
C) The policies and procedures of the assigned agency in that state
D) The Nursing Social Policy Statement within the United States

A: The state nurse practice act is the governing document of the scope of practice in the given state.

25. The parents of a 7 year-old tell the nurse their child has started to "tattle" on siblings. In interpreting this new behavior, how should the nurse explain the child's actions to the parents?

A) The ethical sense and feelings of justice are developing
B) Attempts to control the family use new coping styles
C) Insecurity and attention getting are common motives
D) Complex thought processes help to resolve conflicts

A: The child is developing a sense of justice and a desire to do what is right. At seven, the child is increasingly aware of family roles and responsibilities. They also do what is right because of parental direction or to avoid punishment.

26. Which of these principles should the nurse apply when performing a nutritional assessment on a 2 year-old client?

A) An accurate measurement of intake is not reliable
B) The food pyramid is not used in this age group
C) A serving size at this age is about 2 tablespoons
D) Total intake varies greatly each day

C: A serving size at this age is about 2 tablespoons. In children, a general guide to serving sizes is 1 tablespoon of solid food per year of age. Understanding this, the nurse can assess adequacy of intake.

27. A client with HIV infection has a secondary herpes simplex type 1 (HSV-1) infection. The nurse knows that the most likely reason for the HSV-1 infection in this client is

A) immunosuppression
B) emotional stress
C) unprotected sexual activities
D) contact with saliva

A: immunosuppression. The decreased immunity leads to frequent secondary infections. Herpes simplex virus type 1 is an opportunistic infection. The other options may result in HSV-1. However, they are not the most likely causes in clients with HIV.

28. The nurse is preparing to perform a physical examination on an 8 month-old who is sitting contentedly on his mother's lap. Which of the following should the nurse do **first**?

A) Elicit reflexes
B) Measure height and weight
C) Auscultate heart and lungs
D) Examine the ears

C: Auscultate heart and lungs. The nurse should auscultate the heart and lungs during the first quiet moment with the infant so as to be able to hear sounds clearly. Other assessments may follow in any order.

29. A client is unconscious following a tonic-clonic seizure. What should the nurse do first?

A) check the pulse
B) administer Valium
C) place the client in a side-lying position
D) place a tongue blade in the mouth

C: Place the client in a side-lying position to maintain an open airway, drain secretions, and prevent aspiration if vomiting occurs.

30. The nurse has been assigned to four clients in the emergency room, each experiencing one of these conditions. Which client condition would the nurse check first?

A) Viral pneumonia with atelectasis
B) Spontaneous pneumothorax with a respiratory rate of 38
C) Tension pneumothorax with slight tracheal deviation to the right
D) Acute asthma with episodes of bronchospasm

C: Tension pneumothorax with slight tracheal deviation to the right. Tracheal deviation indicates a significant volume of air being trapped in the chest cavity with a mediastinal shift. In tension pneumothorax the tracheal deviation is away from the affected side. The affected side is the side where the air leak is in the lung. This situation also results in sudden air hunger, agitation, hypotension, pain in the affected side, and cyanosis with a high risk of cardiac tamponade and cardiac arrest.

31. The nurse measures the head and chest circumferences of a 20 month-old infant. After comparing the measurements, the nurse finds that they are approximately the same. What action should the nurse take?

A) Notify the provider
B) Palpate the anterior fontanel
C) Feel the posterior fontanel
D) Record these normal findings

D: Record these normal findings. The rate of increase in head circumference slows by the end of infancy, and the head circumference is usually equal to chest circumference at 1 to 2 years of age.

32. A 2 year-old child has recently been diagnosed with cystic fibrosis. The nurse is teaching the parents about home care for the child. Which of the following information is appropriate for the nurse to include?

A) Allow the child to continue normal activities
B) Schedule frequent rest periods
C) Limit exposure to other children
D) Restrict activities to inside the house

A: Allow the child to continue normal activities. Physical activity is important in a two year-old who is developing autonomy. Physical activity is a valuable adjunct to chest physical therapy. Exercise tends to stimulate mucus secretion and helps develop normal breathing patterns.

33. The nurse understands that during the "tension building" phase of a violent relationship, when the batterer makes unreasonable demands, the battered victim may experience feelings of

A) anger
B) helplessness
C) calm
D) explosiveness

B: helplessness. Battered individuals internalize appropriate anger of the batterer's unfairness. They feel depressed, with a sense of helplessness when their partner explodes, in spite of their best efforts to please the batterer.

34. When counseling parents of a child who has recently been diagnosed with hemophilia, what must the nurse know about the offspring of a normal father and a carrier mother?

A) It is likely that all sons are affected
B) There is a 50% probability that sons will have the disease
C) Every daughter is likely to be a carrier
D) There is a 25% chance a daughter will be a carrier

D: There is a 25% chance a daughter will be a carrier. Hemophilia A is a sex-linked recessive trait seen almost exclusively in males. With a normal father and carrier mother, affected individuals are male. There is a 25% chance of having an affected male, 25% chance of having a carrier female, 25% chance of having a normal female and 25% chance of having a normal male.

35. The nurses on a unit are planning for stoma care for clients who have a stoma for fecal diversion. Which stomal diversion poses the **highest** risk for skin breakdown

A) Ileostomy
B) Transverse colostomy
C) Ileal conduit

D) Sigmoid colostomy

A: Ileostomy output contains gastric and enzymatic agents that when present on skin can denuded skin in several hours. Because of the caustic nature of this stoma output adequate peristomal skin protection must be delivered to prevent skin breakdown.

36. A client is admitted for hemodialysis. Which abnormal lab value would the nurse anticipate not being improved by hemodialysis?

A) Low hemoglobin
B) Hypernatremia
C) High serum creatinine
D) Hyperkalemia

A: Low hemoglobin. Although hemodialysis improves or corrects electrolyte imbalances it has no effect on improving anemia.

37. The nurse is teaching a client who has a hip prosthesis following total hip replacement. Which of the following should be included in the instructions for home care?

A) Avoid climbing stairs for 3 months
B) Ambulate using crutches only
C) Sleep only on your back
D) Do not cross your legs

D: Do not cross your legs. When the client is immediately post-op, hip flexion should not exceed 60 degrees, and after discharge it should not exceed 90 degrees.

38. The nurse is assessing a client with delayed wound healing. Which of the following risk factors is most important in this situation?

A) Glucose level of 120
B) History of myocardial infarction
C) Long term steroid usage
D) Diet high in carbohydrates

C: Long term steroid usage. Steroid dependency tends to delay wound healing. If the client also smokes, the risk is increased.

39. A 7 year-old child is hospitalized following a major burn to the lower extremities. A diet high in protein and carbohydrates is recommended. The nurse informs the child and family that the **most** important reason for this diet is to

A) Promote healing and strengthen the immune system
B) Provide a well balanced nutritional intake
C) Stimulate increased peristalsis absorption
D) Spare protein catabolism to meet metabolic needs

D: Spare protein catabolism to meet metabolic needs. Because of the burn injury, the child has increased metabolism and catabolism. By providing a high carbohydrate diet, the breakdown of protein for energy is avoided. Proteins are then used to restore tissue.

40. A client was admitted to the psychiatric unit after refusing to get out of bed. In the hospital the client talks to unseen people and voids on the floor. The nurse could **best** handle the problem of voiding on the floor by

A) requiring the client to mop the floor
B) restricting the client's fluids throughout the day
C) withholding privileges each time the voiding occurs
D) toileting the client more frequently with supervision

D: toileting the client more frequently with supervision. With a client suffering from altered thought processes, the most appropriate nursing approach to change this behavior is by taking an active role in attending to the physical need.

Q&A Random Selection #13

1. The **primary** nursing diagnosis for a client with congestive heart failure with pulmonary edema is

    A) pain
    B) impaired gas exchange
    C) cardiac output altered: decreased
    D) fluid volume excess

C: cardiac output altered: decreased. All nursing interventions should be focused on improving cardiac output. Increasing cardiac output is the primary goal of therapy. Comfort will improve as the client improves and the respiratory status will improve as cardiac output increases.

2. In assessing the healing of a client's wound during a home visit, which of the following is the **best** indicator of good healing?

    A) White patches
    B) Green drainage
    C) Reddened tissue
    D) Eschar development

C: Reddened tissue. As the wound granulates, redness indicates healing.

3. The nurse is caring for 2 children who have had surgical repair of congenital heart defects. For which defect is it a **priority** to assess for findings of heart conduction disturbance?

    A) Arterial septal defect
    B) Patent ductus arteriosus
    C) Aortic stenosis
    D) Ventricular septal defect

D: Ventricular septal defect. While assessments for conduction disturbance should be included following repair of any defect, it is a priority for this condition. A ventricular septal defect is an abnormal opening between the right and left ventricles. The atrioventricular bundle (bundle of His), is a part of the electrical conduction system of the heart. It extends from the atrioventricular node along each side of the interventricular septum and then divides into right and left bundle branches. Surgical repair of a ventricular septal defect consists of a purse-string approach or a patch sewn over the opening. Either method involves manipulation of the ventricular septum, thereby increasing risk of interrupting the conduction pathway. Consequently, postoperative complications include conduction disturbances.

4. When an autistic client begins to eat with her hands, the nurse can **best** handle the problem by

    A) placing the spoon in the client's hand and stating, "Use the spoon to eat your food."
    B) commenting, "I believe you know better than to eat with your hand."
    C) jokingly stating, "Well I guess fingers sometimes work better than spoons."
    D) removing the food and stating, "You can't have anymore food until you use the spoon."

A: This response identifies instruction and verbal expectation with adaptive behavior.

5. A depressed client who has recently been acting suicidal is now more social and energetic than usual. Smilingly he tells the nurse "I've made some decisions about my life." What should be the nurse's **initial** response?

    A) "You've made some decisions."
    B) "Are you thinking about killing yourself?"
    C) "I'm so glad to hear that you've made some decisions."
    D) "You need to discuss your decisions with your therapist."

B: "Are you thinking about killing yourself?" Sudden mood elevation and energy may signal increased risk of suicide. The nurse must validate suicidal ideation as a beginning step in evaluating seriousness of risk.

6. The nurse is participating in a community health fair. As part of the assessments, the nurse should conduct a mental status examination when

A) an individual displays restlessness
B) there are obvious signs of depression
C) conducting any health assessment
D) the resident reports memory lapses

C: conducting any health assessment. A mental status assessment is a critical part of baseline information, and should be a part of every examination.

7. The nurse asks a client with a history of alcoholism about recent drinking behavior. The client states "I didn't hurt anyone. I just like to have a good time, and drinking helps me to relax." The client is using which defense mechanism?

A) Denial
B) Projection
C) Intellectualization
D) Rationalization

D: Rationalization is justifying illogical or unreasonable ideas, actions, or feelings by developing acceptable explanations for unacceptable actions. Both the teller and the listener find the rationalizations more satisfactory than the reality.

8. When assessing a client who has just undergone a cardioversion, the practical nurse (LPN) finds the respirations are 12/minute. Which action should the nurse take **first**?

A) Try to vigorously stimulate normal breathing
B) Ask the RN to assess the vital signs
C) Measure the pulse oximetry
D) Continue to monitor respirations

D: Continue to monitor respirations. 12 respirations per minute is tolerated post-operatively. A range from 8 to 10 gives cause for concern. At that point pulse oximetry is taken to determine whether that rate is providing sufficient oxygenation. Vigorous stimulation is not indicated beyond deep breathing and coughing. It is not necessary to ask the registered nurse (RN) to check the findings.

9. A client has been receiving lithium (Lithane) for the past two weeks for the treatment of bipolar illness. When planning client teaching, what is most important for the nurse to emphasize?

A) Maintain a low sodium diet
B) Take a diuretic with lithium and avoid excessive fluids
C) Don't be overly concerned if feelings of depression occur
D) Come in for evaluation of serum lithium levels regularly

D: Come in for evaluation of serum lithium levels regularly. This is especially important during hot weather, which may cause excessive perspiration, a loss of sodium and consequently an increase in serum lithium concentration. Diuretics should be avoided, as they could result in an increased serum lithium level. Excessive thirst is a common early finding that subsides over time but may recur. Initiation of treatment for elevated mood at times results in onset of a depressive episode that can be accompanied by risk for self-harm. Clients should be cautioned to report any symptoms of mood instability.

10. Following a cocaine high, the user commonly experiences an extremely unpleasant feeling called

A) craving
B) crashing
C) outward bound
D) nodding out

B: crashing. Following cocaine use, the intense pleasure is replaced by an equally unpleasant feeling referred to as crashing.

11. What is the best way for the nurse to obtain the health history of a 14 year-old client?

A) Have the mother present to verify information
B) Allow an opportunity for the teen to express feelings
C) Use the same type of language as the adolescent
D) Focus the discussion of risk factors in the peer group

B: Allow an opportunity for the teen to express feelings. Adolescents need to express their feelings. Generally, they talk freely when given an opportunity and some privacy to do so.

12. The nurse is caring for a post myocardial infarction client in an intensive care unit. It is noted that urinary output has dropped from 60 -70 ml per hour to 30 ml per hour. This change is most likely due to

A) dehydration
B) diminished blood volume
C) decreased cardiac output
D) renal failure

C: decreased cardiac output. Cardiac output and urinary output are directly correlated. The nurse should suspect a drop in cardiac output if the urinary output drops.

13. When a client is having a general tonic clonic seizure, the nurse should

A) hold the client's arms at their side
B) place the client on their side
C) insert a padded tongue blade in client's mouth
D) elevate the head of the bed

B: place the client on their side. This position keeps the airway patent and prevents aspiration.

14. The nursing intervention that **best** describes treatment to deal with the behaviors of clients with personality disorders include

A) pointing out inconsistencies in speech patterns to correct thought disorders
B) accepting client and the client's behavior unconditionally
C) encouraging dependency in order to develop ego controls
D) consistent limit-setting enforced 24 hours per day

D: consistent limit-setting enforced 24 hours per day. Treatment approaches that include restructuring the personality, assisting the person with advancing developmental level and setting limits for maladaptive behavior such as acting out.

15. After talking with her partner, a client voluntarily admitted herself to the substance abuse unit. After the second day on the unit the client states to the nurse, "My husband told me to get treatment or he would divorce me. I don't believe I really need treatment, but I don't want my husband to leave me." Which response by the nurse would assist the client?

A) "In early recovery, it's quite common to have mixed feelings, but unmotivated people can't get well."
B) "In early recovery, it's quite common to have mixed feelings, but I didn't know you had been pressured to come."
C) "In early recovery it's quite common to have mixed feelings, perhaps it would be best to seek treatment on an outpatient basis."
D) "In early recovery, it's quite common to have mixed feelings. Let's discuss the benefits of sobriety for you."

D: This response gives the client the opportunity to decrease ambivalent feelings by focusing on the benefits of sobriety. Dependency issues are significant for the client, fostering ambivalence.

16. The nurse understands that one reason domestic violence remains extensively undetected is

A) few battered victims seek medical care
B) there is typically a series of minor, vague complaints
C) expenses due to police and court costs are prohibitive
D) very little knowledge is currently known about batterers and battering relationships

B: there is typically a series of minor, vague complaints. Signs of abuse may not be clearly manifested and include a series a minor complaints such as headache, abdominal pain, insomnia, back pain, and dizziness. These may be covert indications of abuse that go undetected. Victim complaints may be vague reflecting their ambivalence about disclosing the abuse.

17. The nurse is caring for a client 2 hours after a right lower lobectomy. During the evaluation of the water-seal chest drainage system, it is noted that the fluid level bubbles constantly in the water seal chamber. On inspection of the chest dressing and tubing, the nurse does not find any air leaks in the system. The next **best** action for the nurse is to

A) check for subcutaneous emphysema in the upper torso
B) reposition the client to improve the level of comfort
C) call the provider as soon as possible
D) check for any increase in the amount of thoracic drainage

A: check for subcutaneous emphysema in the upper torso. Continuous bubbling in the water seal chamber is an abnormal finding 2 hours after a lobectomy. Further assessment of appropriate factors was done by the nurse to rule out an air leak in the system. Thus the conclusion is that the problem is one of an air leak in the lung. This client may need to be returned to surgery to deal with the sustained air leak. Action by the provider is required to prevent further complications.

18. While teaching a client about their medications, the client asks how long it will take before the therapeutic effects of lithium occur. What is the best response of the nurse?

A) Immediately
B) Several days
C) 2 weeks
D) 1 month

C: 2 weeks. Lithium is started immediately to treat bipolar disorder because it is quite effective in controlling mania. Lithium takes approximately 2 weeks to effect change in a client's symptoms.

19. A client develops volume overload from an IV that has infused too rapidly. What assessment would the nurse expect to find?

A) S3 heart sound
B) Thready pulse
C) Flattened neck veins
D) Hypoventilation

A: S3 heart sound. Auscultation of an S3 heart sound. This is an early sign of volume overload (or CHF) because during the first phase of diastole, when blood enters the ventricles, an extra sound is produced due to the presence of fluid left in the ventricles.

20. The nurse is performing a developmental assessment on an 8 month-old. Which finding should be reported to the provider?

A) Lifts head from the prone position
B) Rolls from abdomen to back
C) Responds to parents' voices
D) Falls forward when sitting

D: Falls forward when sitting. Sitting without support is expected at this age.

21. Clients with mitral stenosis would likely manifest findings associated with congestion in the

A) pulmonary circulation
B) descending aorta
C) superior vena cava
D) bundle of His

A: pulmonary circulation. Congestion occurs in the pulmonary circulation due to the inefficient emptying of the left ventricle and the lack of a competent valve to prevent back-flow into the pulmonary vein.

22. The nurse is assessing a client on admission to a community mental health center. The client discloses that she has been thinking about ending her life. The nurse's **best** response would be

A) "Do you want to discuss this with your pastor?"
B) "We will help you deal with those thoughts."
C) "Is your life so terrible that you want to end it?"
D) "Have you thought about how you would do it?"

D: "Have you thought about how you would do it?" This response provides an opening to discuss intent and means of committing suicide. It helps in assessing the severity of the risk, since clients who have formulated a suicide plan are closer to suicidal behavior than those who have had vague, non-specific thoughts.

23. The nurse is caring for a newborn who has just been diagnosed with hypospadias. When discussing the defect with the parents, the nurse should communicate that

A) circumcision can be performed at any time
B) initial repair is delayed until 6-8 years of age
C) post-operative appearance will be normal
D) surgery will be performed in stages

D: surgery will be performed in stages. Hypospadias, a condition in which the urethral opening is located on the ventral surface or below the penis, is corrected in stages as soon as the infant can tolerate surgery.

24. A 2 year-old child is being treated with Amoxicillin suspension, 200 milligrams per dose, for acute otitis media. The child weighs 30 lb. (15 kg) and the daily dose range is 20-40 mg/kg of body weight, in three divided doses every 8 hours. Using principles of safe drug administration, what should the nurse do next?

A) Give the medication as ordered
B) Call the provider to clarify the dose
C) Recognize that antibiotics are over-prescribed
D) Hold the medication as the dosage is too low

A: Give the medication as ordered. Amoxicillin continues to be the drug of choice in the treatment of acute otitis media. The dose range is 20-40 mg/kg/day divided every 8 hours. 15kg x 40mg = 600mg, divided by 3 = 200 mg per dose. The prescribed dose is correct and should be given as ordered.

25. While planning care for a preschool aged child, the nurse takes developmental needs into consideration. Which of the following would be of the most concern to the nurse?

A) Playing imaginatively
B) Expressing shame
C) Identifying with family
D) Exploring the playroom

B: Expressing shame. Erikson describes the stage of the preschool child as being the time when there is normally an increase in initiative. The child should have resolved the sense of shame and doubt in the toddler stage.

26. The nurse is teaching a smoking cessation class and notices there are 2 pregnant women in the group. Which information is a priority for these women?

A) Low tar cigarettes are less harmful during pregnancy
B) There is a relationship between smoking and low birth weight
C) The placenta serves as a barrier to nicotine
D) Moderate smoking is effective in weight control

B: There is a relationship between smoking and low birth weight. Nicotine reduces placental blood flow, and may contribute to fetal hypoxia or placenta previa, decreasing the growth potential of the fetus.

27. In order to enhance a client's response to medication for chest pain from acute angina, the nurse should emphasize

A) learning relaxation techniques
B) limiting alcohol use

C) eating smaller meals
D) avoiding passive smoke

A: learning relaxation techniques. The only factor that can enhance the client"s response to pain medication for angina is reducing anxiety through relaxation methods. Anxiety can be great enough to make the pain medication totally ineffective.

28. When making a home visit to a client with chronic pyelonephritis, which nursing action has the highest priority?

A) follow-up on lab values before the visit
B) observe client findings for the effectiveness of antibiotics
C) ask for a log of urinary output
D) ask for the log of the oral intake

C: ask for a log of urinary output. The nurse must monitor the urine output as a priority because it is the best indictor of renal function. The other options would be appropriate after an evaluation of the urine output.

29. A new nurse on the unit notes that the nurse manager seems to be highly respected by the nursing staff. The new nurse is surprised when one of the nurses states: "The manager makes all decisions and rarely asks for our input." The **best** description of the nurse manager's management style is

A) Participative or democratic
B) Ultraliberal or communicative
C) Autocratic or authoritarian
D) Laissez faire or permissive

C: Autocratic or authoritarian. Autocratic leadership style is suggested in this situation. It is appropriate for groups with little education and experience who need strong direction, while a participative or democratic style is usually more successful on nursing units

30. Clients taking which of the following drugs are at risk for depression?

A) Steroids
B) Diuretics
C) Folic acid
D) Aspirin

A: Steroids. Adverse medication effects can cause a syndrome that may or may not remit when the medication is discontinued. Examples of drugs that can lead to ongoing side effects include: phenothiazines, corticosteroids, and reserpine.

31. The nurse is teaching a client with dysrhythmia about the electrical pathway of an impulse as it travels through the heart. Which of these describes the normal pathway?

A) AV node, SA node, Bundle of His, Purkinje fibers
B) Purkinje fibers, SA node, AV node, Bundle of His
C) Bundle of His, Purkinje fibers, SA node , AV node
D) SA node, AV node, Bundle of His, Purkinje fibers

D: SA node, AV node, Bundle of His, Purkinje fibers. This is the pathway of a normal electrical impulse through the heart.

32. A neonate born 12 hours ago to a methadone maintained woman is exhibiting a hyperactive MORO reflex and slight tremors. The newborn passed one loose, watery stool. Which of these is a nursing priority?

A) Hold the infant at frequent intervals.
B) Assess for neonatal withdrawal syndrome
C) Offer fluids to prevent dehydration
D) Administer paregoric to stop diarrhea

B: Assess for neonatal withdrawal syndrome. Neonatal withdrawal syndrome is a cluster of findings that signal the withdrawal of the infant from the opiates. The findings seen in methadone withdrawal are often more severe than for other substances. Initial signs are central nervous system hyper irritability and gastro-intestinal symptoms. If withdrawal signs are severe, there is an increased mortality risk. Scoring the infant ensures proper treatment during the period of withdrawal.

33. A client has received her first dose of fluphenazine (Prolixin) 2 hours ago. She suddenly experiences torticollis and involuntary spastic muscle movement. In addition to administering the ordered anticholinergic drug, what other measure should the nurse implement?

A) Have respiratory support equipment available
B) Immediately place her in the seclusion room
C) Assess the client for anxiety and agitation
D) Administer prn dose of IM antipsychotic medication

A: Have respiratory support equipment available. Persons receiving neuroleptic medication experiencing torticollis and involuntary muscle movement are demonstrating side effects that could lead to respiratory failure.

34. What principle of HIV disease should the nurse keep in mind when planning care for a newborn who was infected in utero?

A) The disease will incubate longer and progress more slowly in this infant

B) The infant is very susceptible to infections
C) Growth and development patterns will proceed at a normal rate
D) Careful monitoring of renal function is indicated

B: The infant is very susceptible to infections. HIV infected children are susceptible to opportunistic infections due to a compromised immune system.

35. The nurse is caring for a 12 year-old with an acute illness. Which of the following indicates the nurse understands common sibling reactions to hospitalization?

A) Younger siblings adapt very well
B) Visitation is helpful for both
C) The siblings may enjoy privacy
D) Those cared for at home cope better

B: Visitation is helpful for both. Contact with the ill child helps siblings understand the reasons for hospitalization and maintains their relationships.

36. Parents of a 7 year-old child call the clinic nurse because their daughter was sent home from school because of a rash. The child had been seen the day before by the provider and diagnosed with Fifth Disease (erythema infectiosum). What is the most appropriate action by the nurse?

A) Tell the parents to bring the child to the clinic for further evaluation
B) Refer the school officials to printed materials about this viral illness
C) Inform the teacher that the child is receiving antibiotics for the rash
D) Explain that this rash is not contagious and does not require isolation

D: Explain that this rash is not contagious and does not require isolation. Fifth Disease is a viral illness with an uncertain period of communicability (perhaps 1 week prior to and 1 week after onset). Isolation of the child with Fifth Disease is not necessary except in cases of hospitalized children who are immunosuppressed or having aplastic crises. The parents may need written confirmation of this from the provider.

37. Which therapeutic communication skill used by the nurse is most likely to encourage a depressed client to vent feelings?

A) Direct confrontation
B) Reality orientation
C) Projective identification
D) Active listening

D: Use of therapeutic communication skills such as silence and active listening encourages verbalization of feelings.

38. The nurse walks into a client's room and finds the client lying still and silent on the floor. The nurse should **first**

A) assess the client's airway
B) call for help
C) establish that the client is unresponsive
D) see if anyone saw the client fall

C: establish that the client is unresponsive. The first step in CPR is to establish responsiveness. The second is to call for help, and the third is to ensure an open airway.

39. The nurse is caring for a client with end stage renal disease. What action should the nurse take to assess for patency in a fistula used for hemodialysis?

A) observe for edema proximal to the site
B) irrigate with 5 ml of 0.9% Normal Saline
C) palpate for a thrill over the fistula
D) check color and warmth in the extremity

C: palpate for a thrill over the fistula. To assess for patency in a fistula or graft, the nurse auscultates for a bruit and palpates for a thrill. The other options are not related to evaluation of patency.

40. The nurse caring for a 14 year-old boy with severe Hemophilia A, who was admitted after a fall while playing basketball. In understanding his behavior and in planning care for this client, the nurse should understand that adolescents with hemophilia _____.

A) must have structured activities
B) often take part in active sports
C) explain limitations to peer groups
D) avoid risks after bleeding episodes

B: often take part in active sports. An age-appropriate treatment goal is to establish an age-appropriate safe environment. Adolescent hemophiliacs should be aware that contact sports may trigger bleeding. However, developmental characteristics of this age group such as impulsivity, inexperience and peer pressure, place adolescents in unsafe environments.

Q&A Random Selection #14

1. The nurse is caring for a client who is in the late stage of multiple myeloma. Which of the following should be included in the plan of care?

    A) Monitor for hyperkalemia
    B) Place in protective isolation
    C) Precautions with position changes
    D) Administer diuretics as ordered

C: Precautions with position changes. Because multiple myeloma is a condition in which neoplastic plasma cells infiltrate the bone marrow resulting in osteoporosis, clients are at high risk for pathological fractures.

2. A 2 year-old child has just been diagnosed with cystic fibrosis. The child's father asks the nurse "What is our major concern now, and what will we have to deal with in the future?" Which of the following is the **best** response?

    A) "There is a probability of life-long complications."
    B) "Cystic fibrosis results in nutritional concerns that can be dealt with."
    C) "Thin, tenacious secretions from the lungs are a constant struggle in cystic fibrosis."
    D) "You will work with a team of experts and also have access to a support group that the family can attend."

C: All of the options will be concerns with cystic fibrosis, however the respiratory threats are the major concern. Other information of interest is that cystic fibrosis is an autosomal recessive disease. For these parents there is a 25% chance that each pregnancy will result in a child with cystic fibrosis.

3. The nurse is caring for residents in a long term care setting for the elderly. Which of the following activities will be most effective in meeting the growth and development needs for persons in this age group?

    A) Aerobic exercise classes
    B) Transportation for shopping trips
    C) Reminiscence groups
    D) Regularly scheduled social activities

C: According to Erikson"s theory, older adults need to find and accept the meaningfulness of their lives, or they may become depressed, angry, and fear death. Reminiscing contributes to successful adaptation by maintaining self-esteem, reaffirming identity, and working through loss. Erikson identifies this developmental challenge of elders as ego integrity vs despair.

4. A 30 month-old child is admitted to the hospital unit. Which of the following toys would be appropriate for the nurse to select from the toy room for this child?

    A) Cartoon stickers
    B) Large wooden puzzle
    C) Blunt scissors and paper
    D) Beach ball

B: Large wooden puzzle. Appropriate toys for this child"s age include items such as push-pull toys, blocks, pounding board, toy telephone, puppets, wooden puzzles, finger paint, and thick crayons.

5. The nurse is talking to parents about nutrition in school aged children. Which of the following is the most common nutritional disorder in this age group?

    A) Bulimia
    B) Anorexia
    C) Obesity
    D) Malnutrition

C: Obesity. Many factors contribute to the high rate of obesity in school aged children. These include heredity, sedentary lifestyle, social and cultural factors and poor knowledge of balanced nutrition.

6. A pre-term newborn is to be fed breast milk through nasogastric tube. Breast milk is preferred over formula for premature infants because it

A) contains less lactose
B) is higher in calories/ounce
C) provides antibodies
D) has less fatty acid

C: provides antibodies. Breast milk is ideal for the preterm baby who needs additional protection against infection through maternal antibodies. It is also much easier to digest, therefore less residual is left in the infant"s stomach.

7. A mother wants to switch her 9 month-old infant from an iron-fortified formula to whole milk because of the expense. Upon further assessment, the nurse finds that the baby eats table foods well, but drinks less milk than before. What is the best advice by the nurse?

A) Change the baby to whole milk
B) Add chocolate syrup to the bottle
C) Continue with the present formula
D) Offer fruit juice frequently

C: Continue with the present formula. The recommended age for switching from formula to whole milk is 12 months. Switching to cow"s milk before the age of 1 can predispose an infant to allergies and lactose intolerance.

8. Which of the following nursing assessments for an infant is most valuable in identifying serious visual defects?

A) Red reflex test
B) Visual acuity
C) Pupil response to light
D) Cover test

A: Red reflex test. A brilliant, uniform red reflex is an important sign because it virtually rules out almost all serious defects of the cornea, aqueous chamber, lens, and vitreous chamber.

9. A 38 year-old female client is admitted to the hospital with an acute exacerbation of asthma. This is her third admission for asthma in 7 months. She describes how she doesn't really like having to use her medications all the time. Which explanation by the nurse best describes the long-term consequence of uncontrolled airway inflammation?

A) The alveoli will degenerate
B) Chronic bronchoconstriction of the large airways will occur
C) Lung remodeling and permanent changes in lung function will result
D) The client will experience frequent bouts of pneumonia

C: Lung remodeling and permanent changes in lung function will result. While an asthma attack is an acute event from which lung function essentially returns to normal, chronic under-treated asthma can lead to lung remodeling and permanent changes in lung function. Increased bronchial vascular permeability leads to chronic airway edema which leads to mucosal thickening and swelling of the airway. Increased mucous secretion and viscosity may plug airways, leading to airway obstruction. Changes in the extracellular matrix in the airway wall may also lead to airway obstruction. These long-term consequences should help reinforce the need for daily management of the disease whether or not the client "feels better."

10. Which nursing action is a priority as the plan of care is developed for a 7 year-old child hospitalized for acute glomerulonephritis?

A) Assess for generalized edema
B) Monitor for increased urinary output
C) Encourage rest during hyperactive periods
D) Note patterns of increased blood pressure

D: Note patterns of increased blood pressure. Evaluation for hypertension is a key assessment in the course of the disease.

11. A nurse is to present information about Chinese folk medicine to a group of student nurses. Based on this cultural belief system, the nurse would explain that illness is attributed to the

A) Yang, the positive force that represents light, warmth, and fullness
B) Yin, the negative force that represents darkness, cold, and emptiness
C) use of improper hot foods, herbs and plants
D) a failure to keep life in balance with nature and others

B: Yin, the negative force that represents darkness, cold, and emptiness. Chinese folk medicine proposes that health is regulated by the opposing forces of yin and yang. Yin is the negative female force characterized by darkness, cold and emptiness. Excessive yin predisposes one to nervousness.

12. A 65-year-old Hispanic-Latino client with prostate cancer rates his pain as a 6 on a 0-to-10 scale. The client refuses all pain medication other than Motrin, which does not relieve his pain. The next action for the nurse to take is to

A) ask the client about the refusal of certain pain medications
B) talk with the client's family about the situation
C) report the situation to the primary care provider
D) document the situation in the notes

A: ask the client about the refusal of certain pain medications. Beliefs regarding pain are one of the oldest culturally-related research areas in health care. Astute observations and careful assessments must be completed to determine the level of pain a

person can tolerate. Health care practitioners must investigate the meaning of pain to each person within a cultural explanatory framework.

13. A client is experiencing hallucinations that are markedly increased at night. The client is very frightened by the hallucinations. The client's partner asked to stay a few hours beyond the visiting time, in the client's private room. What would be the **best** response by the nurse demonstrating emotional support for the client?

    A) "No, it would be best if you brought the client some reading material that she could read at night."
    B) "No, your presence may cause the client to become more anxious."
    C) "Yes, staying with the client and orienting her to her surroundings may decrease her anxiety."
    D) "Yes, would you like to spend the night when the client's behavior indicates that she is frightened?"

C: "Yes, staying with the client and orienting her to her surroundings may decrease her anxiety." Encouraging the family or a close friend to stay with the client in a quiet surrounding can help increase orientation and minimize confusion and anxiety.

14. The nurse is caring for a child receiving chest physiotherapy (CPT). Which of the following actions by the nurse would be appropriate?

    A) Schedule the therapy thirty minutes after meals
    B) Teach the child not to cough during the treatment
    C) Confine the percussion to the rib cage area
    D) Place the child in a prone position for the therapy

C: Percussion (clapping) should be only done in the area of the rib cage.

15. A client is admitted with a pressure ulcer in the sacral area. The partial thickness wound is 4 cm by 7 cm, the wound base is red and moist with no exudate and the surrounding skin is intact. Which of the following coverings is most appropriate for this wound?

    A) transparent dressing
    B) dry sterile dressing with antibiotic ointment
    C) wet to dry dressing
    D) occlusive moist dressing

D: occlusive moist dressing. This wound has granulation tissue present and must be protected. The use of a moisture retentive dressing is the best choice because moisture supports wound healing.

16. A mother asks the nurse if she should be concerned about her child's tendency to stutter. What assessment data will be most useful in counseling the parent?

    A) Age of the child
    B) Sibling position in family
    C) Stressful family events
    D) Parental discipline strategies

A: Age of the child. During the preschool period children are using their rapidly growing vocabulary faster than they can produce their words. This failure to master sensorimotor integrations results in stuttering. This dysfluency in speech pattern is a normal characteristic of language development. Therefore, knowing the child"s age is most important in determining if any true dysfunction might be occurring.

17. The nurse is making a home visit to a client with chronic obstructive pulmonary disease (COPD). The client tells the nurse that he used to be able to walk from the house to the mailbox without difficulty. Now, he has to pause to catch his breath halfway through the trip. Which diagnosis would be **most** appropriate for this client based on this assessment?

    A) Activity intolerance caused by fatigue related to chronic tissue hypoxia
    B) Impaired mobility related to chronic obstructive pulmonary disease
    C) Self care deficit caused by fatigue related to dyspnea
    D) Ineffective airway clearance related to increased bronchial secretions

A: Activity intolerance describes a condition in which the client"s physiological capacity for activities is compromised.

18. At the day treatment center a client diagnosed with schizophrenia - paranoid type sits alone alertly watching the activities of clients and staff. The client is hostile when approached and asserts that the doctor gives her medication to control her mind. The client's behavior **most** likely indicates

    A) Feelings of increasing anxiety related to paranoia
    B) Social isolation related to altered thought processes
    C) Sensory perceptual alteration related to withdrawal from environment
    D) Impaired verbal communication related to impaired judgment

B: Social isolation related to altered thought processes. Hostile alertness and absence of involvement with people are findings supporting a diagnosis of social isolation. Her psychiatric diagnosis and her idea about the purpose of medication suggest altered thinking processes.

19. What is the most important aspect to include when developing a home care plan for a client with severe arthritis?

A) Maintaining and preserving function
B) Anticipating side effects of therapy
C) Supporting coping with limitations
D) Ensuring compliance with medications

A: Maintaining and preserving function. To maintain quality of life, the plan for care must emphasize preserving function. Proper body positioning and posture, and active and passive range of motion exercises are important interventions for maintaining function of affected joints.

20. During an examination of a 2 year-old child with a tentative diagnosis of Wilm's tumor, the nurse would be **most** concerned about which statement by the mother?

A) "My child has lost 3 pounds in the last month."
B) "Urinary output seemed to be less over the past 2 days."
C) "All the pants have become tight around the waist."
D) "The child prefers some salty foods more than others."

C: "All the pants have become tight around the waist." Parents often recognize the increasing abdominal girth first. This is an early sign of Wilm"s tumor, a malignant tumor of the kidney.

21. The nurse is caring for a client who has developed cardiac tamponade. Which finding would the nurse anticipate?

A) Widening pulse pressure
B) Pleural friction rub
C) Distended neck veins
D) Bradycardia

C: Distended neck veins. In cardiac tamponade, intrapericardial pressures rise to a point at which venous blood cannot flow into the heart. As a result, venous pressure rises and the neck veins become distended.

22. At the geriatric day care program a client is crying and repeating "I want to go home. Call my daddy to come for me." The nurse should

A) Inform the client that she must wait until the program ends at 5:00 pm to leave
B) Give the client simple information about what she will be doing
C) Tell the client you will call someone to come for her and suggest joining the exercise group while she waits
D) Firmly direct the client to her assigned group activity

C: Comforting and distraction, key approaches in validation therapy are the kindest and most effective for clients who have advancing dementia. The distressed, disoriented client should be gently oriented to reduce fear and increase the sense of safety and security, but reorientation often is ineffective when the client has moderate dementia and/or is upset. Environmental changes provoke stress and fear, especially in clients suffering from Alzheimer's disease.

23. The nurse assesses a client who has been re-admitted to the psychiatric inpatient unit for schizophrenia. His symptoms have been managed for several months with fluphenazine (Prolixin). Which should be a focus of the first assessment?

A) Stressors in the home
B) Medication compliance
C) Exposure to hot temperatures
D) Alcohol use

B: Medication compliance. Prolixin is an antipsychotic / neuroleptic medication useful in managing the symptoms of schizophrenia. Compliance with daily doses is a critical assessment finding.

24. Which type of accidental poisoning would the nurse expect to occur in children under age 6?

A) Oral ingestion
B) Topical contact
C) Inhalation
D) Eye splashes

A: Oral ingestion. The greatest risk for young children is from oral ingestion. While children under age 6 may come in contact with other poisons or inhale toxic fumes, these are not common.

25. The parents of a 15 month-old child asks the nurse to explain their child's lab results and how they show the child has iron deficiency anemia. The nurse's **best** response is

A) "Although the results are here, your doctor will explain them later."
B) "Your child has fewer red blood cells that carry oxygen."
C) "The blood cells that carry nutrients to the cells are too large."
D) "There are not enough blood cells in your child's circulation."

B: The results of a complete blood count in clients with iron deficiency anemia will show decreased red blood cell levels, low hemoglobin levels and microcytic, hypochromic red blood cells. A simple but clear explanation is appropriate.

26. At a well baby clinic the nurse is assigned to assess an 8 month-old child. Which of these developmental achievements would the nurse anticipate that the child would be able to perform?

A) Say 2 words
B) Pull up to stand
C) Sit without support
D) Drink from a cup

C: Sit without support. The age at which the normal child develops the ability to sit steadily without support is 8 months.

27. The nurse assesses delayed gross motor development in a 3 year-old child. The inability of the child to do which action confirms this finding?

A) Stand on 1 foot
B) Catch a ball
C) Skip on alternate feet
D) Ride a bicycle

A: Stand on 1 foot. At this age, gross motor development allows a child to balance on 1 foot.

28. A client was admitted to the psychiatric unit with major depression after a suicide attempt. In addition to feeling sad and hopeless, the nurse would assess for

A) Anxiety, unconscious anger, and hostility
B) Guilt, indecisiveness, poor self-concept
C) Psychomotor retardation or agitation
D) Meticulous attention to grooming and hygiene

C: Psychomotor retardation or agitation. Somatic or physiologic symptoms of depression include: fatigue, psychomotor retardation or psychomotor agitation, chronic generalized or local pain, sleep disturbances, disturbances in appetite, gastrointestinal complaints and impaired libido.

29. The nurse is caring for a client with an unstable spinal cord injury at the T7 level. Which intervention should take **priority** in planning care?

A) Increase fluid intake to prevent dehydration
B) Place client on a pressure reducing support surface
C) Use skin care products designed for use with incontinence
D) Increase caloric intake to aid healing

B: Place client on a pressure reducing support surface. This client is at greatest risk for skin breakdown because of immobility and decreased sensation. The first action should be to choose and then place the client on the best support surface to relieve pressure, shear and friction forces.

30. A nurse is conducting a community wide seminar on childhood safety issues. Which of these children is at the highest risk for poisoning?

A) 9 month-old who stays with a sitter 5 days a week
B) 20 month-old who has just learned to climb stairs
C) 10 year-old who occasionally stays at home unattended
D) 15 year-old who likes to repair bicycles

B: 20 month-old who has just learned to climb stairs. Toddlers are at most risk for poisoning because they are increasingly mobile, need to explore and engage in autonomous behavior.

31. A polydrug user has been in recovery for 8 months. The client has began skipping breakfast and not eating regular dinners. The client has also started frequenting bars to "see old buddies." The nurse understands that the client's behaviors are warning signs to indicate that the client may be

A) headed for relapse
B) feeling hopeless
C) approaching recovery
D) in need of increased socialization

A: headed for relapse. It takes 9 to 15 months to adjust to a lifestyle free of chemical use, thus it is important for clients to acknowledge that relapse is a possibility and to identify early signs of relapse.

32. Privacy and confidentiality of all client information is legally protected. In which of these situations would the nurse make an exception to this practice?

A) When a family member offers information about their loved one
B) When the client threatens self-harm and harm to others
C) When the provider decides the family has a right to know the client's diagnosis
D) When a visitor insists that the visitor has been given permission by the client

B: When the client threatens self-harm and harm to others. Privacy and confidentiality of all client information is protected with the exception of the client who threatens self harm or endangering the public. (Tarasoff decision,1974)

33. The nurse admits a client newly diagnosed with hypertension. What is the best method for assessing the blood pressure?

A) Standing and sitting
B) In both arms
C) After exercising

D) Supine position

B: In both arms. Blood pressure should be taken in both arms due to the fact that one subclavian artery may be stenosed, causing a false high in that arm.

34. A client is admitted with the diagnosis of meningitis. Which finding would the nurse expect when assessing this client?

A) Hyperextension of the neck with passive shoulder flexion
B) Flexion of the hip and knees with passive flexion of the neck
C) Flexion of the legs with rebound tenderness
D) Hyperflexion of the neck with rebound flexion of the legs

B: Flexion of the hip and knees with passive flexion of the neck. This is known as a positive Brudzinski's sign (flexion of hip and knees with passive flexion of the neck). A positive Kernig's sign, the inability to extend the knee to more than 135 degrees without pain behind the knee while the hip is flexed, usually establishes the diagnosis of meningitis.

35. A victim of domestic violence states to the nurse, "If only I could change and be how my companion wants me to be, I know things would be different." Which would be the **best** response by the nurse?

A) "The violence is temporarily caused by unusual circumstances, don't stop hoping for a change."
B) "Perhaps, if you understood the need to abuse, you could stop the violence."
C) "No one deserves to be beaten. Are you doing anything to provoke your spouse into beating you?"

D) "Batterers lose self-control because of their own internal reasons, not because of what their partner did or did not do."

D: Only the perpetrator has the ability to stop the violence. A change in the victim's behavior will not cause the abuser to become nonviolent.

36. In a child with suspected coarctation of the aorta, the nurse would expect to find

A) strong pedal pulses
B) diminishing carotid pulses
C) normal femoral pulses
D) bounding pulses in the arms

D: bounding pulses in the arms. Coarctation of the aorta, a narrowing or constriction of the descending aorta, causes increased blood flow to the upper extremities resulting in increased pressure and pulses.

37. First-time parents bring their 5 day-old infant to the pediatrician's office because they are extremely concerned about its breathing pattern. The nurse assesses the baby and finds that the breath sounds are clear with equal chest expansion. The respiratory rate is 38-42 breaths per minute with occasional periods of apnea lasting 10 seconds in length. What is the correct analysis of these findings?

A) The pediatrician must examine the baby
B) Emergency equipment should be available
C) This breathing pattern is normal
D) A future referral may be indicated

C: This breathing pattern is normal. Respiratory rate in a newborn is 30-60 breaths/minute and periods of apnea often occur, lasting up to 15 seconds. The nurse should reassure the parents that this is normal to allay their anxiety.

38. A client was admitted to the psychiatric unit with a diagnosis of bipolar disorder. He constantly "bothers" other clients, tries to help the housekeeping staff, demonstrates pressured speech and demands constant attention from the staff. Which activity would be best for the client?

A) Reading
B) Checkers
C) Cards
D) Ping-pong

D: Ping-pong. This provides an outlet for physical energy and requires limited attention. The other options would over-tax the client's level of self-control.

39. When teaching adolescents about sexually transmitted diseases, what should the nurse emphasize that is the most common infection?

A) Gonorrhea
B) Chlamydia
C) Herpes
D) HIV

B: Chlamydia has the highest incidence of any sexually transmitted disease in this country. Prevention is similar to safe sex practices taught to prevent any STD: use of a condom and spermicide for protection during intercourse.

40. Post-procedure nursing interventions for electroconvulsive therapy include

A) applying hard restraints if seizure occurs
B) permitting client to sleep for 4 to 6 hours
C) remaining with client until oriented
D) expecting long-term memory loss

C: remaining with client until oriented. The client awakens post-procedure 20-30 minutes after treatment and appears groggy and confused. The nurse remains with the client until the client is oriented and able to engage in self care. The time frame will vary, but it will not take several hours.

Q&A Random Selection #15

1. The nurse enters a 2 year-old child's hospital room in order to administer an oral medication. When the child is asked if he is ready to take his medicine, he immediately says, "No!". What would be the most appropriate next action?

    A) Leave the room and return five minutes later and give the medicine
    B) Explain to the child that the medicine must be taken now
    C) Give the medication to the father and ask him to give it
    D) Mix the medication with ice cream or applesauce

A: Leave the room and return five minutes later and give the medicine. Since the nurse gave the child a choice about taking the medication, the nurse must comply with the child"s response in order to build or maintain trust. Since toddlers do not have an accurate sense of time, leaving the room and coming back later is another episode to the toddler

2. During the evaluation phase for a client, the nurse should focus on

    A) All finding of physical and psychosocial stressors of the client and in the family
    B) The client's status, progress toward goal achievement, and ongoing re-evaluation
    C) Setting short and long-term goals to insure continuity of care from hospital to home
    D) Select interventions that are measurable and achievable within selected timeframes

B: The client's status, progress toward goal achievement, and ongoing re-evaluation. The evaluation step of the nursing process focuses on the client"s status, progress toward goal achievement and ongoing re-evaluation of the plan of care. The other possible answers focus on other steps of the nursing process.

3. The nurse is providing instructions to a new mother on the proper techniques for breast feeding her infant. Which statement by the mother indicates the need for additional instruction?

    A) "I should position my baby completely facing me with my baby's mouth in front of my nipple."
    B) "The baby should latch onto the nipple and areola areas."
    C) "There may be times that I will need to manually express milk."
    D) " I can switch to a bottle if I need to take a break from breast feeding."

D: Babies adapt more quickly to the breast when they are not confused about what is put into their mouths and its purpose. Artificial nipples do not lengthen and compress the way the human nipples (areola) do. The use of an artificial nipple weakens the baby"s suck as the baby decreases the sucking pressure to slow fluid flow. Babies should not be given a bottle during the learning stage of breast feeding.

4. The nurse is planning to give a 3 year-old child oral digoxin. Which of the following is the best approach by the nurse?

    A) "Do you want to take this pretty red medicine?"
    B) "You will feel better if you take your medicine."
    C) "This is your medicine, and you must take it all right now."
    D) "Would you like to take your medicine from a spoon or a cup?"

D: At 3 years of age, a child often feels a loss of control when hospitalized. Giving a choice about how to take the medicine will allow the child to express an opinion and have some control.

5. A 4 year-old child is recovering from chicken pox (varicella). The parents would like to have the child return to day care as soon as possible. In order to ensure that the illness is no longer communicable, what should the nurse assess for in this child?

    A) All lesions crusted
    B) Elevated temperature
    C) Rhinorrhea and coryza
    D) Presence of vesicles

A: All lesions crusted. The rash begins as a macule, with fever, and progresses to a vesicle that breaks open and then crusts over. When all lesions are crusted, the child is no longer in a communicable stage.

6. The nurse is performing an assessment on a child with severe airway obstruction. Which finding would the nurse anticipate?

A) Retractions in the intercostal tissues of the thorax
B) Chest pain aggravated by respiratory movement
C) Cyanosis and mottling of the skin
D) Rapid, shallow respirations

A: Retractions in the intercostal tissues of the thorax. Slight intercostal retractions are normal, however in disease states, especially in severe airway obstruction, retractions become extreme.

7. A nurse is assigned to a client who is newly admitted for treatment of a frontal lobe brain tumor. Which history offered by the family members would be recognized by the nurse as associated with the diagnosis, and communicated to the provider?

A) "My partner's breathing rate is usually below 12."
B) "I find the mood swings and the change from a calm person to being angry all the time hard to deal with."
C) "It seems our sex life is nonexistent over the past 6 months."
D) "In the morning and evening I hear complaints that reading is next to impossible from blurred print."

B: The frontal lobe of the brain controls affect, judgment and emotions. Dysfunction in this area results in findings such as emotional lability, changes in personality, inattentiveness, flat affect and inappropriate behavior.

8. A client is receiving nitroprusside IV for the treatment of acute heart failure with pulmonary edema. What diagnostic lab value should the nurse monitor when a client is receiving this medication?

A) Potassium level
B) Arterial blood gasses
C) Blood urea nitrogen
D) Thiocyanate

D: Thiocyanate levels rise with the metabolism if nitroprusside is taken, and this can cause cyanide toxicity. Thiocyanate should not be over 1 millimole/liter.

9. A home health nurse is caring for a client with a pressure sore that is red, with serous drainage, is 2 inches in diameter with loss of subcutaneous tissue. The appropriate dressing for this wound is

A) transparent film dressing
B) wet dressing with debridement granules
C) wet to dry with hydrogen peroxide
D) moist saline dressing

D: This wound is a stage III pressure ulcer. The wound is red (granulation tissue) and does not require debridement. The wound must be protected for granulation tissue to proliferate. A moist dressing allows epithelial tissues to migrate more rapidly.

10. The school nurse suspects that a third grade child might have attention deficit hyperactivity disorder (ADHD). Prior to referring the child for further evaluation, the nurse should

A) observe the child's behavior on at least 2 occasions
B) consult with the teacher about how to control impulsivity
C) compile a history of behavior patterns and developmental accomplishments
D) compare the child's behavior with classic signs and symptoms

C: A complete behavioral, and developmental history plays an important role in determining the diagnosis.

11. A client is admitted with a diagnosis of hepatitis B. In reviewing the **initial** laboratory results, the nurse would expect to find elevation in which of the following values?

A) Blood urea nitrogen
B) Acid phosphatase
C) Bilirubin
D) Sedimentation rate

C: Bilirubin. In the laboratory data provided, the only elevated level expected is bilirubin. Additional liver function tests will confirm the diagnosis.

12. The nurse is assessing a child for clinical manifestations of iron deficiency anemia. Which factor would the nurse recognize as the cause of the findings?

A) Decreased cardiac output
B) Tissue hypoxia
C) Cerebral edema
D) Reduced oxygen saturation

B: Tissue hypoxia. When the hemoglobin falls sufficiently to produce clinical manifestations, the findings are directly attributable to tissue hypoxia, resulting from a decrease in the oxygen carrying capacity of the blood.

13. A recovering alcoholic asked the nurse, "Will it be ok for me to just drink at special family gatherings?" Which initial response by the nurse would be best?

A) "A recovering person has to be very careful not to lose control, therefore, confine your drinking only to family gatherings."
B) "At your next AA meeting discuss the possibility of limited drinking with your sponsor."

C) "A recovering person needs to get in touch with their feelings. Do you want a drink?"
D) "A recovering person cannot return to drinking without starting the addiction process over."

D: Recovery requires total abstinence from all drugs.

14. The nurse would expect the cystic fibrosis client to receive supplemental pancreatic enzymes along with a diet

A) high in carbohydrates and proteins
B) low in carbohydrates and proteins
C) high in carbohydrates, low in proteins
D) low in carbohydrates, high in proteins

A: high in carbohydrates and proteins. Provide a high-energy diet by increasing carbohydrates, protein and fat (possibly as high as 40%). A favorable response to the supplemental pancreatic enzymes is based on tolerance of fatty foods, decreased stool frequency, absence of steatorrhea, improved appetite and lack of abdominal pain.

15. A Hispanic client in the postpartum period refuses the hospital food because it is "cold." The **best** initial action by the nurse is to

A) have the unlicensed assistive personnel (UAP) reheat the food if the client wishes
B) ask the client what foods are acceptable or are unacceptable
C) encourage her to eat for healing and strength

D) schedule the dietitian to meet with the client as soon as possible

B: ask the client what foods are acceptable or are unacceptable. Many Hispanic women subscribe to the balance of hot and cold foods in the post partum period. What defines "cold" can best be explained by the client or family.

16. The nurse is assigned to a client who has heart failure . During the morning rounds the nurse sees the client develop sudden anxiety, diaphoresis and dyspnea. The nurse auscultates, crackles bilaterally. Which nursing intervention should be performed **first**?

A) Take the client's vital signs
B) Place the client in a sitting position with legs dangling
C) Contact the health care provider
D) Administer the PRN antianxiety agent

B: .Place the client in a sitting position with legs dangling to pool the blood in the legs. This helps to diminish venous return to the heart and minimize the pulmonary edema. The result will enhance the client's ability to breathe. The next actions would be to contact the heath care provider, then take the vital signs and then the administration of the antianxiety agent.

17. Based on principles of teaching and learning, what is the best initial approach to pre-op teaching for a client scheduled for coronary artery bypass?

A) Touring the coronary intensive unit
B) Mailing a video tape to the home
C) Assessing the client's learning style
D) Administering a written pre-test

C: Assessing the client's learning style. As with any anticipatory teaching, assess the client"s level of knowledge and learning style first.

18. In evaluating the growth of a 12 month-old child, which of these findings would the nurse expect to be present in the infant?

A) Increased 10% in height
B) 2 deciduous teeth
C) Tripled the birth weight
D) Head > chest circumference

C: Tripled the birth weight. The infant usually triples his birth weight by the end of the first year of life. Height usually increases by 50% from birth length. A 12 month- old child should have approximately 6 teeth. (estimate number of teeth by subtracting 6 from age in months, ie 12 – 6 = 6). By 12 months of age, head and chest circumferences are approximately equal.

19. A nurse is doing preconception counseling with a woman who is planning a pregnancy. Which of the following statements suggests that the client understands the connection between alcohol consumption and fetal alcohol syndrome?

A) "I understand that a glass of wine with dinner is healthy."
B) "Beer is not really hard alcohol, so I guess I can drink some."
C) "If I drink, my baby may be harmed before I know I am pregnant."
D) "Drinking with meals reduces the effects of alcohol."

C: Alcohol has the greatest teratogenic effect during organogenesis, in the first weeks of pregnancy. Therefore women considering a pregnancy should not drink.

20. In planning care for a child diagnosed with minimal change nephrotic syndrome, the nurse should understand the relationship between edema formation and

A) increased retention of albumin in the vascular system
B) decreased colloidal osmotic pressure in the capillaries
C) fluid shift from interstitial spaces into the vascular space

D) reduced tubular reabsorption of sodium and water

B: decreased colloidal osmotic pressure in the capillaries. The increased glomerular permeability to protein causes a decrease in serum albumin, which results in decreased colloidal osmotic pressure.

21. Which of these parents' comments about a newborn would most likely reveal an initial finding of a suspected pyloric stenosis?

    A) "I noticed a little lump a little above the belly button."
    B) "The baby seems hungry all the time."
    C) "Mild vomiting turned into vomiting that shot across the room."
    D) "We notice irritation and spitting up immediately after feedings."

C: Mild regurgitation or emesis that progresses to projectile vomiting is a pattern associated with pyloric stenosis as an initial finding. The other findings are present, though not immediately.

22. Which of the actions suggested to the registered nurse (RN) by the practical nurse (PN) during a planning conference for a 10 month-old infant admitted 2 hours ago with bacterial meningitis would be acceptable to add to the plan of care?

    A) measure head circumference
    B) place in airborne isolation
    C) provide passive range of motion
    D) provide an over-the-crib protective top

A: measure head circumference. In meningitis, assessment of neurological signs should be done frequently. Head circumference is measured because subdural effusions and obstructive hydrocephalus can develop as a complication of meningitis. The client will have already been on airborne precautions and crib top applied to the bed on admission to the unit.

23. The nurse is discussing nutritional requirements with the parents of an 18 month-old child. Which of these statements about milk consumption is correct?

    A) May drink as much milk as desired
    B) Can have milk mixed with other foods
    C) Will benefit from fat-free cow's milk
    D) Should be limited to 3-4 cups of milk daily

D: Should be limited to 3-4 cups of milk daily. More than 32 ounces of milk a day considerably limits the intake of solid foods, resulting in a deficiency of dietary iron, as well as other nutrients.

24. A postpartum mother is unwilling to allow the father to participate in the newborn's care, although he is interested in doing so. She states, "I am afraid the baby will be confused about who the mother is. Baby raising is for mothers, not fathers." The nurse's initial intervention should be what focus?

    A) Discuss with the mother sharing parenting responsibilities
    B) Set time aside to get the mother to express her feelings and concerns
    C) Arrange for the parents to attend infant care classes
    D) Talk with the father and help him accept the wife's decision

B: Set time aside to get the mother to express her feelings and concerns. Non-judgmental support for expressed feelings may lead to resolution of competitive feelings in a new family. Cultural influences may also be clarified.

25. The nurse is talking with a client. The client abruptly says to the nurse, "The moon is full. Astronauts walk on the moon. Walking is a good health habit." The client's remarks most likely indicate

    A) neologisms
    B) flight of ideas
    C) loose associations
    D) word salad

C: loose associations. Though the client's statements are not typical of logical communication, remarks 2 and 3 contain elements of the preceding sentence (moon, walk). Option A refers to making up words that have personal meaning to the client, and option B – flight of ideas defines nearly continuous flow of speech, jumping from one unconnected topic to another. Option D – word salad refers to stringing together real words into nonsense "sentences" that have no meaning for the listener.

26. A mother asks about expected motor skills for a 3 year-old child. Which of the following would the nurse emphasize as normal at this age?

    A) Jumping rope
    B) Tying shoelaces
    C) Riding a tricycle
    D) Playing hopscotch

C: Coordination is gained through large muscle use. A child of 3 has the ability to ride a tricycle.

27. The nurse is monitoring the contractions of a woman in labor. A contraction is recorded as beginning at 10:00 A.M. and ending at 10:01 A.M. Another begins at 10:15 A.M. What is the frequency of the contractions?

    A) 14 minutes
    B) 10 minutes
    C) 15 minutes
    D) Nine minutes

C: Frequency is the time from the beginning of one contraction to the beginning of the next contraction.

28. A client who has been drinking for five years states that he drinks when he gets upset about "things" such as being unemployed or feeling like life is not leading anywhere. The nurse understands that the client is using alcohol as a way to deal with

A) recreational and social needs
B) feelings of anger
C) life's stressors
D) issues of guilt and disappointment

C: life's stressors. Alcohol is used by some people to manage anxiety and stress. The overall intent is to decrease negative feelings and increase positive feelings, but substance abuse itself eventually increases negative feelings.

29. The nurse is preparing a 5 year-old for a scheduled tonsillectomy and adenoidectomy. The parents are anxious and concerned about the child's reaction to impending surgery. Which nursing intervention would **best** prepare the child?

A) Introduce the child to all staff the day before surgery
B) Explain the surgery 1 week prior to the procedure
C) Arrange a tour of the operating and recovery rooms
D) Encourage the child to bring a favorite toy to the hospital

B: Explain the surgery 1 week prior to the procedure. A 5 year-old can understand the surgery, and should be prepared well before the procedure. Most of these procedures are "same day" surgeries and do not require an overnight stay.

30. The nurse should recognize that physical dependence is accompanied by what findings when alcohol consumption is first reduced or ended?

A) Seizures
B) Withdrawal
C) Craving
D) Marked tolerance

B: The early signs of alcohol withdrawal develop within a few hours after cessation or reduction of alcohol intake. Seizure activity is one withdrawal symptom but there are many others, like nausea and tremor.

31. The client who is receiving enteral nutrition through a gastrostomy tube has had 4 diarrhea stools in the past 24 hours. The nurse should

A) review the medications the client is receiving
B) increase the formula infusion rate
C) increase the amount of water used to flush the tube
D) attach a rectal bag to protect the skin

A: review the medications the client is receiving. Antibiotics and medications containing sorbitol may induce diarrhea.

32. The nurse, assisting in applying a cast to a client with a broken arm, knows that the

A) cast material should be dipped several times into the warm water
B) cast should be covered until it dries
C) wet cast should be handled with the palms of hands
D) casted extremity should be placed on a cloth-covered surface

C: wet cast should be handled with the palms of hands. Handle cast with palms of the hands and lift at 2 points of the extremity. This will prevent stress at the injury site and pressure areas on the cast.

33. In taking the history of a pregnant woman, which of the following would the nurse recognize as the primary contraindication for breast feeding?

A) Age 40 years
B) Lactose intolerance
C) Family history of breast cancer
D) Use of cocaine on weekends

D: Use of cocaine on weekends. Binge use of cocaine can be just as harmful to the breast fed newborn as regular use.

34. Immediately following an acute battering incident in a violent relationship, the batterer may respond to the partner's injuries by

A) seeking medical help for the victim's injuries
B) minimizing the episode and underestimating the victim's injuries
C) contacting a close friend and asking for help
D) being very remorseful and assisting the victim with medical care

B: Many batterers lack an understanding of the effects of their behavior on the victim and use excessive minimization and denial.

35. A client with emphysema visits the clinic. While teaching about proper nutrition, the nurse should emphasize that the client should

A) eat foods high in sodium to increase sputum liquefaction
B) use oxygen during meals to improve gas exchange
C) perform exercise after respiratory therapy to enhance appetite

D) cleanse the mouth of dried secretions to reduce risk of infection

B: use oxygen during meals to improve gas exchange. Clients with emphysema breathe easier when using oxygen while eating.

36. A victim of domestic violence tells the batterer she needs a little time away. How would the nurse expect that the batterer might respond?

A) With acceptance and views the victim's comment as an indication that their marriage is in trouble
B) With fear of rejection causing increased rage toward the victim
C) With a new commitment to seek counseling to assist with their marital problems
D) With relief, and welcomes the separation as a means to have some personal time

B: The fear of rejection, abandonment, and loss only serve to increase the batterer's rage at the partner.

37. An 18 month-old has been brought to the emergency room with irritability, lethargy over 2 days, dry skin, and increased pulse. Based upon the evaluation of these initial findings, the nurse would assess the child for additional findings of

A) septicemia
B) dehydration
C) hypokalemia
D) hypercalcemia

B: dehydration. Clinical findings of dehydration include lethargy, irritability, dry skin, and increased pulse.

38. The nurse prepares for a Denver Screening of a 3 year-old child in the clinic. The mother asks the nurse to explain the purpose of the test. What is the nurse's best response about the purpose of the Denver?

A) "It measures a child's intelligence."
B) "It assesses a child's development."
C) "It evaluates psychological responses."
D) " It helps to determine problems."

B: The Denver Developmental Test II is a screening test to assess children from birth through 6 years in personal/social, fine motor adaptive, language and gross motor development. A child experiences the fun of play during the test.

39. The nurse is caring for a toddler with atopic dermatitis. The nurse should instruct the parents to

A) Dress the child warmly to avoid chilling
B) Keep the child away from other children for the duration of the rash
C) Clean the affected areas with tepid water and detergent
D) Wrap the child's hand in mittens or socks to prevent scratching

D: Wrap the child"s hand in mittens or socks to prevent scratching. A toddler with atopic dermatitis needs to have fingernails cut short and covered so the child will not be able to scratch the skin lesions, thereby causing new lesions and possibly a secondary infection.

40. The father of an 8 month-old infant asks the nurse if his child's vocalizations are normal for his age. Which of the following would the nurse expect at this age?

A) Cooing
B) Imitation of sounds
C) Throaty sounds
D) Laughter

B: Imitation of sounds such as "da-da" is expected at this time.

Q&A Random Selection #16

1. Which statement by a parent would alert the nurse to assess for iron deficiency anemia in a 14 month-old child?

    A) "I know there is a problem since my baby is always constipated."
    B) "My child doesn't like many fruits and vegetables, but she really loves her milk."
    C) "I can't understand why my child is not eating as much as she did 4 months ago."
    D) "My child doesn't drink a whole glass of juice or water at 1 time."

B: About 2 to 3 cups of milk a day are sufficient for the young child"s needs. Sometimes excess milk intake, a habit carried over from infancy, may exclude many solid foods from the diet. As a result, the child may lack iron and develop a so-called milk anemia. Although the majority of infants with iron deficiency are underweight, many are overweight because of excessive milk ingestion.

2. When counseling a 6 year-old who is experiencing enuresis, what must the nurse understand about the pathophysiological basis of this disorder?

    A) It has no clear etiology
    B) Enuresis may be associated with sleep phobia
    C) It has a definite genetic link
    D) Enuresis is a sign of willful misbehavior

A: Although predictive factors associated with enuresis have been identified, no clear etiology has been determined.

3. Following surgery for placement of a ventriculoperitoneal (VP) shunt as treatment for hydrocephalus, the parents question why the infant has a small abdominal incision. The **best** response by the nurse would be to explain that the incision was made in order to

    A) pass the catheter into the abdominal cavity
    B) place the tubing into the urinary bladder
    C) visualize abdominal organs for catheter placement
    D) insert the catheter into the stomach

A: The preferred procedure in the surgical treatment of hydrocephalus is placement of a ventriculoperitoneal shunt. This shunt procedure provides primary drainage of the cerebrospinal fluid from the ventricles to an extracranial compartment, usually the peritoneum. A small incision is made in the upper quadrant of the abdomen so the shunt can be guided into the peritoneal cavity.

4. A client with bipolar disorder is reluctant to take lithium (Lithane) as prescribed. The **most** therapeutic response by the nurse to his refusal is

    A) "You need to take your medicine, this is how you get well."
    B) "If you refuse your medicine, we'll just have to give you a shot."
    C) "What is it about the medicine that you don't like?"
    D) "I can see that you are uncomfortable right now, I'll wait until tomorrow."

C: Nursing interventions for clients with psychotic disorders are aimed at establishing a trusting relationship, establishing clear communications, presenting reality and reinforcing appropriate behavior.

5. Delirium tremens could best be described as

    A) disorganized thinking, feelings of terror and non-purposeful behavior
    B) a generalized shaking of the body accompanied by repetitive thoughts
    C) an excited state accompanied by disorientation, hallucination and tachycardia
    D) single or multiple jerks caused by rapid contracting muscles

C: During delirium tremens syndrome (DTS), the client experiences confusion, disorientation, hallucinations, tachycardia, hypertension, extreme tremors, agitation, diaphoresis, and fever.

6. When providing nursing measures to relieve a 102-degree Fahrenheit fever in a toddler with an infection, what is the most effective intervention?

A) Use medications to lower the temperature set point
B) Apply extra layers of clothing to prevent shivering
C) Immerse the child in a tub containing cool water
D) Give a tepid sponge bath prior to giving an antipyretic

A: Use medications to lower the temperature set point. Conditions such as infection, malignancy, allergy, central nervous system lesion and radiation cause the temperature set-point to be raised. Because the temperature set point is normal in hyperthermia and elevated in fever, different measures must be taken in order to be effective. The most effective intervention in the management of fever is the administration of antipyretics which lower the set point. Too rapid cooling of a febrile child can lead to seizure activity.

7. In planning care for a 6 month-old infant, what must the nurse provide to assist in the development of trust?

A) Food
B) Warmth
C) Security
D) Comfort

C: Security. While the infant has many physical needs, it must be touched, loved, and stimulated to develop security and trust.

8. Alcohol and drug abuse impairs judgment and increases risk taking behavior. What nursing diagnosis **best** applies?

A) Risk for injury
B) Risk for knowledge deficit
C) Altered thought process
D) Disturbance in self-esteem

A: Risk for injury. Accidents increase as a result of intoxication. Studies indicate alcohol is a factor in 50% of motor vehicle fatalities, 53% of all deaths from accidental falls, 64% of fatal fires, and 80% of suicides.

9. The nurse sees a substance abusing client occasionally in the outpatient clinic. In evaluating the client's progress, the nurse recognizes that the **most** revealing resistant behavior is

A) recurring crises
B) continuing drug use
C) rationalizing comments
D) missing appointments

B: Continuing to use the drug demonstrates lack of commitment to the treatment program. This fact must be understood by the nurse as part of the disease of addiction.

10. A client has been admitted with complaints of lower abdominal pain, difficulty swallowing, nausea, dizziness, headache and fatigue. The client is agitated, fearful, tachycardic and complains of being "too sick to return to work." The client is diagnosed as having somatoform disorder. In formulating a plan of care, the nurse must consider that the client's behavior

A) is controlled by their subconscious mind
B) is manipulative to avoid work responsibilities
C) would respond to psychoeducational strategies
D) could be modified through reality therapy

A: is controlled by their subconscious mind. Persons with somatoform disorder do not intend to feign illness; their complaints are not under their conscious control. Showing intention to use feigned physical complaints to accomplish some goal is called "malingering" or a factitious disorder.

11. The nurse is providing instructions for a client with pneumonia. What is the most important information to convey to the client?

A) "Take at least 2 weeks off from work."
B) "You will need another chest x-ray in 6 weeks."
C) "Take your temperature every day."
D) "Complete all of the antibiotic even if your findings decrease."

D: To avoid a recurrence of the pneumonia the client must complete all of the prescribed medication at the prescribed dosing intervals.

12. The nurse is caring for a pre-adolescent client in skeletal Dunlop traction. Which nursing intervention is appropriate for this child?

A) Make certain the child is maintained in correct body alignment.
B) Be sure the traction weights touch the end of the bed.
C) Adjust the head and foot of the bed for the child's comfort
D) Release the traction for 15-20 minutes every 6 hours PRN.

A: Observe for correct body positioning with emphasis on alignment of shoulders, hips, and legs.

13. A victim of domestic violence states, "If I were better, I would not have been beat." Which feeling **best** describes what the victim may be experiencing?

A) Fear
B) Helplessness
C) Self-blame
D) Rejection

C: Self-blame. Domestic violence victims may be immobilized by a variety of affective responses, one being self-blame. The victim believes that a change in their behavior will cause the abuser to become nonviolent, and may even have been told this by their abuser. This is an untrue but not uncommon myth.

14. A nurse and client are talking about the client's progress toward understanding his behavior under stress. This is typical of which phase in the therapeutic relationship?

A) Pre-interaction
B) Orientation
C) Working
D) Termination

C: During the working phase alternative behaviors and techniques are explored. The nurse and the client discuss the meaning behind the behavior.

15. A client is admitted with low T3 and T4 levels and an elevated thyroid stimulating hormone (TSH) level. On initial assessment, the nurse would anticipate which of the following findings?

A) Lethargy
B) Heat intolerance
C) Diarrhea
D) Skin eruptions

A: Lethargy. In hypothyroidism the metabolic activity of all cells of the body decreases, reducing oxygen consumption, decreasing oxidation of nutrients for energy, and producing less body heat. Therefore, the nurse can expect the client to complain of constipation, lethargy and an inability to get warm.

16. A child is sent to the school nurse by a teacher who has a written note that fifth disease is suspected. Which characteristic would the nurse expect to find?

A) Macule that rapidly progresses to papule and then vesicles
B) Erythema on the face, primarily on cheeks giving a "slapped face" appearance
C) Discrete rose pink macules will appear first on the trunk and fade when pressure is applied
D) Koplik spots appear first followed by a rash that appears first on the face and spreads downward

B: Fifth disease is also referred to it as parvovirus infection or *erythema infectiosum*. Some people may call it slapped-cheek disease because of the face rash that develops resembling slap marks. It is also commonly called fifth disease because it was fifth of a group of once-common childhood diseases that all have similar rashes. The other 4 diseases are measles, rubella, scarlet fever, and Dukes" disease. People will not know that a child has parvovirus infection until the rash appears, and by that time the child is no longer contagious.

17. While working with an obese adolescent, it is important for the nurse to recognize that obesity in adolescence is most often associated with what other finding?

A) Sexual promiscuity
B) Poor body image
C) Dropping out of school
D) Drug experimentation

B: As the adolescent gains weight, there is a lessening sense of self esteem and poor body image.

18. The emergency room nurse admits a child who experienced a seizure at school. The parent comments that this is the first occurrence and denies any family history of epilepsy. What is the **best** response by the nurse?

A) "Do not worry. Epilepsy can be treated with medications."
B) "The seizure may or may not mean your child has epilepsy."
C) "Since this was the first convulsion, it may not happen again."
D) "Long term treatment will prevent future seizures."

B: There are many possible causes for a childhood seizure. These include fever, central nervous system conditions, trauma, metabolic alterations and idiopathic (unknown) etiologies.

19. A nurse is eating in the hospital cafeteria when a toddler at a nearby table chokes on a piece of food and appears slightly blue. The appropriate **initial** action should be to

A) begin mouth to mouth resuscitation
B) give the child water to help in swallowing
C) perform 5 abdominal thrusts

D) call for the emergency response team

C: At this age, the most effective way to clear the airway of food is to perform abdominal thrusts.

20. The parents of a 2 year-old child report that he has been holding his breath whenever he has temper tantrums. What is the best action by the nurse?

A) Teach the parents how to perform cardiopulmonary resuscitation
B) Recommend that the parents give in when he holds his breath to prevent anoxia
C) Advise the parents to ignore breath holding because breathing will begin as a reflex
D) Instruct the parents on how to reason with the child about possible harmful effects

C: If temper tantrums are accompanied by breath holding, the parents need to know that this behavior will not result in harm to the child. Ignoring the breath holding is the best response to this benign behavior.

21. The nurse is teaching a client with metastatic bone disease about measures to prevent hypercalcemia. It would be important for the nurse to emphasize

A) the need for at least 5 servings of dairy products daily
B) restriction of fluid intake to less than 1 liter per day
C) the importance of walking as much as possible
D) early recognition of findings associated with tetany

C: Mobility must be emphasized to prevent demineralization and breakdown of bones.

22. The nurse is talking by telephone with a parent of a 4 year-old child who has chickenpox. Which of the following demonstrates appropriate teaching by the nurse?

A) Chewable aspirin is the preferred analgesic
B) Topical cortisone ointment relieves itching
C) Papules, vesicles, and crusts will be present at one time
D) The illness is only contagious prior to lesion eruption

C: All 3 stages of the chicken pox lesions will be present on the child's body at the same time.

23. An ambulatory client reports edema during the day in his feet and ankles that disappears while sleeping at night. What is the most appropriate follow-up question for the nurse to ask?

A) "Have you had a recent heart attack?"
B) "Do you become short of breath during your normal daily activities?"
C) "How many pillows do you use at night to sleep comfortably?"
D) "Do you smoke?"

B: These are the findings of right-sided heart failure, which causes increased pressure in the systemic venous system. To equalize this pressure, the fluid shifts into the interstitial spaces causing edema. Because of gravity, the lower extremities are first affected in an ambulatory patient. This question would elicit information to confirm the nursing diagnosis of activity intolerance and fluid volume excess, both associated with right-sided heart failure.

24. A 35 year-old client with sickle cell crisis is talking on the telephone but stops as the nurse enters the room to request something for pain. The nurse should

A) administer a placebo
B) encourage increased fluid intake
C) administer the prescribed analgesia
D) recommend relaxation exercises for pain control

C: administer the prescribed analgesia. Relief of pain is the expected outcome for treatment of sickle cell crisis. Pain, especially chronic pain, may be present even without overt signs.

25. The nurse should initiate discharge planning for a client

A) when the client or family demonstrate readiness to learn self care modalities
B) when informed that a date for discharge has been determined
C) upon admission to a hospital unit or the emergency room
D) when the client's condition is stabilized on the assigned unit

C: With decreased lengths of stay, discharge plans must be incorporated into the initial plan of care upon admission to an emergency room or hospital unit.

26. A new nurse manager is seeking a mentor in the administrative realm. Which of these characteristics is a priority for the outcome of a positive experience with a mentor?

A) Information is clarified as needed
B) A teacher-coach role is taken by the mentor
C) The mentee accepts feedback objectively
D) The mentor is randomly assigned by administration

B: Both the mentor and mentee, the nurse manager, initially need to be open to a positive learning experience. The teacher-coach is the priority for the outcome of an ideal relationship.

27. The nurse is assessing a client in the emergency room. Which statement suggests that the problem is acute angina?

A) "My pain is deep in my chest behind my breast bone."
B) "When I sit up the pain gets worse."
C) "As I take a deep breath the pain gets worse."
D) "The pain is right here in my stomach area."

A: The pain of angina is usually localized chest pain.

28. While caring for a toddler with croup, which initial sign of croup requires the nurse's immediate attention?

A) Respiratory rate of 42
B) Lethargy for the past hour
C) Apical pulse of 54
D) Coughing up copious secretions

A: Respiratory rate of 42. Signs of impending airway obstruction include increased respiratory rate and pulse; substernal, suprasternal and intercostal retractions; flaring nares; and increased restlessness or agitation.

29. Parents of a 6 month-old breast fed baby ask the nurse about increasing the baby's diet. Which of the following should be added first?

A) Cereal
B) Eggs

C) Meat
D) Juice

A: Cereal. The guidelines of the American Academy of Pediatrics recommend that one new food be introduced at a time, beginning with strained cereal.

30. The nurse is planning care for a client during the acute phase of a sickle cell vaso-occlusive crisis. Which of the following actions would be **most** appropriate?

A) Fluid restriction 1000cc per day
B) Ambulate in hallway 4 times a day
C) Administer analgesic therapy as ordered
D) Encourage increased caloric intake

C: Administer analgesic therapy as ordered. The main general interventions in the treatment of a sickle cell crisis are bed rest, hydration, electrolyte replacement, analgesics for pain, blood replacement, and antibiotics to treat any existing infection.

31. The nurse is caring for a client with a pressure ulcer on the heel that is covered with black hard tissue. Which would be an appropriate goal in planning care for this client?

A) Protection for the granulation tissue
B) Heal infection
C) Debride eschar
D) Keep the tissue intact

D: Keep the tissue intact. If the black tissue, (eschar) is dry and intact no treatment is necessary. If the area changes (cellulitis, pain) this is a sign of infection, requiring debridement.

32. The nurse is assessing the mental status of a client admitted with possible organic brain disorder. Which of these questions will **best** assess the functioning of the client's recent memory?

A) "Name the year." "What season is this?" (pause for answer after each question)
B) "Subtract 7 from 100 and then subtract 7 from that." (pause for answer) "Now continue to subtract 7 from the new number."
C) "I am going to say the names of three things and I want you to repeat them after me: blue, ball, pen."
D) "What is this on my wrist?" (point to your watch) Then ask, "What is the purpose of it?"

C: Recent memory is the ability to recall events in the immediate past and up to 2 weeks previously.

33. The nursing care plan for a toddler diagnosed with Kawasaki disease (mucocutaneous lymph node syndrome) should be based on the high risk for development of which problem?

A) Chronic vessel plaque formation
B) Pulmonary embolism
C) Occlusions at the vessel bifurcations
D) Coronary artery aneurysms

D: Coronary artery aneurysms. Kawasaki disease involves all the small and medium-sized blood vessels. There is progressive inflammation of the small vessels which progresses to the medium-sized muscular arteries, potentially damaging the walls and leading to coronary artery aneurysms.

34. The nurse auscultates bibasilar inspiratory crackles in a newly admitted 68 year-old client with a diagnosis of congestive heart disease. Which other finding is **most** likely to occur?

A) Chest pain
B) Peripheral edema
C) Nail clubbing
D) Lethargy

B: Peripheral edema. When crackles are heard bibasilarly, congestive heart failure is suspected. This is often accompanied by peripheral edema secondary to fluid overload caused by ineffective cardiac pumping.

35. The nurse is discussing negativity with the parents of a 30 month-old child. How should the nurse tell the parents to best respond to this behavior?

A) Reprimand the child and give a 15 minute "time out"
B) Maintain a permissive attitude for this behavior
C) Use patience and a sense of humor to deal with this behavior
D) Assert authority over the child through limit setting

C: The nurse should help the parents see that negativity as a normal part of growth of autonomy in the toddler. They can best handle the negative toddler by using patience and humor.

36. What is the most important consideration when teaching parents how to reduce risks in the home?

A) Age and knowledge level of the parents
B) Proximity to emergency services
C) Number of children in the home
D) Age of children in the home

D: Age and developmental level of the child are most important considerations in providing a framework for anticipatory guidance.

37. A nurse has just received a medication order which is not legible. Which statement best reflects assertive communication?

A) "I cannot give this medication as it is written. I have no idea of what you mean."
B) "Would you please clarify what you have written so I am sure I am reading it correctly?"
C) "I am having difficulty reading your handwriting. It would save me time if you would be more careful."
D) "Please print in the future so I do not have to spend extra time attempting to read your writing."

B: Assertive communication respects the rights and responsibilities of both parties. This statement is an honest expression of concern for safe practice and a request for clarification without self-depreciation. It reflects the right of the professional to give and receive information.

38. Hospital staff requests that the parents with a Greek heritage of a hospitalized infant remove the amulet from around the child's neck. The parents refuse. The nurse understands that the parents may be concerned about

A) mental development delays
B) evil eye or envy of others
C) fright from spiritual beings
D) balance in body systems

B: Matiasma, "Bad eye" or "evil eye, " results from the envy or admiration of others. The belief is that the eye is able to harm a wide variety of things, including inanimate objects, but children are particularly susceptible to attack. Persons of Greek heritage employ a variety of preventive mechanisms to thwart the effects of envy, including protective charms in the form of amulets consisting of blessed wood or incense.

39. A nurse admits a 3 week-old infant to the special care nursery with a diagnosis of bronchopulmonary dysplasia. As the nurse reviews the birth history, which data would be **most** consistent with this diagnosis?

A) Gestational age assessment suggested growth retardation
B) Meconium was cleared from the airway at delivery
C) Phototherapy was used to treat Rh incompatibility
D) The infant received mechanical ventilation for 2 weeks

D: Bronchopulmonary dysplasia is an iatrogenic disease caused by therapies such as use of positive-pressure ventilation used to treat lung disease.

40. The nurse is assessing a healthy child at the 2 year check up. Which of the following should the nurse report immediately to the health care provider?

A) Height and weight percentiles vary widely
B) Growth pattern appears to have slowed
C) Recumbent and standing height are different
D) Short term weight changes are uneven

A: On the growth curve, height and weight should be close in percentiles at this age. A wide difference may indicate a problem.

Q&A Random Selection #17

1. A client refuses to take the medication prescribed because the client prefers to take self-prescribed herbal preparations. What is the **initial** action the nurse should take?

    A) Report the behavior to the charge nurse
    B) Talk with the client to find out about the preferred herbal preparation
    C) Contact the client's primary care provider
    D) Explain the importance of the medication to the client

B: Respect for differences is demonstrated by incorporating traditional cultural practices for staying healthy into professional prescriptions and interventions. The challenge for the health care provider is to understand the client"s perspective. "Culture care preservation or maintenance refers to those assistive, supporting, facilitative or enabling professional actions and decisions that help people of a particular culture to retain and/or preserve relevant care values to that they can maintain their well-being, recover from illness or face handicaps and/or death."

2. During the two-month well-baby visit, the mother complains that formula seems to stick to her baby's mouth and tongue. Which of the following would provide the most valuable data for nursing assessment?

    A) Inspect the baby's mouth and throat
    B) Obtain cultures of the mucous membranes
    C) Flush both sides of the mouth with normal saline
    D) Use a soft cloth to attempt to remove the patches

D: Candidiasis can be distinguished from coagulated milk when attempts to remove the patches with a soft cloth are unsuccessful.

3. Dual diagnosis indicates that there is a substance abuse problem as well as a

    A) cross addiction
    B) mental disorder
    C) disorder of any type
    D) medical problem

B: mental disorder. Dual diagnosis is the concurrent presence of a major psychiatric disorder and chemical dependence.

4. A client admits to benzodiazepine dependence for several years. She is now in an outpatient detoxification program. The nurse must understand that a **priority** during withdrawal is

    A) avoiding alcohol use during this time
    B) observing the client for hypotension
    C) abrupt discontinuation of the drug
    D) assessing for mild physical symptoms

A: Central nervous system depressants interact with alcohol. The client will gradually reduce the dosage, under the health care provider"s direction. During this time, alcohol must be avoided.

5. To obtain data for the nursing assessment, the nurse should:

    A) observe carefully the client’s nonverbal behaviors
    B) adhere to pre-planned interview goals and structure

C) allow clients to talk about whatever they want
D) elicit clients' description of their experiences, thoughts and behaviors

D: The nurse's understanding of the client rests on the comprehensiveness of assessment data obtained by listening to the client's self revelation.

6. A client with a history of heart disease takes prophylactic aspirin daily. The nurse should monitor which of the following to prevent aspirin toxicity?

A) Serum potassium
B) Protein intake
C) Lactose tolerance
D) Serum albumin

D: Serum albumin. When highly protein-bound drugs are administered to patients with low serum albumin (protein) levels, excess free (unbound) drug can cause exaggerated and dangerous effects.

7. The nurse is teaching diet restrictions for a client with Addison's disease. The client would indicate an understanding of the diet by stating

A) "I will increase sodium and fluids and restrict potassium."
B) "I will increase potassium and sodium and restrict fluids."
C) "I will increase sodium, potassium and fluids."
D) "I will increase fluids and restrict sodium and potassium."

A: The manifestations of Addison"s disease due to mineralocorticoid deficiency, resulting from renal sodium wasting and potassium retention, include dehydration, hypotension, hyponatremia, hyperkalemia and acidosis.

8. A client calls the nurse with a complaint of sudden deep throbbing leg pain. What is the appropriate **first** action by the nurse?

A) Suggest isometric exercises
B) Maintain the client on bed rest
C) Ambulate for several minutes
D) Apply ice to the extremity

B: Maintain the client on bed rest. The finding suggests deep vein thrombosis. The client must be maintained on bed rest and the provider notified immediately.

9. The nurse will administer liquid medicine to a 9 month-old child. Which of the following methods is appropriate?

A) Allow the infant to drink the liquid from a medicine cup
B) Administer the medication with a syringe next to the tongue
C) Mix the medication with the infant's formula in the bottle
D) Hold the child upright and administer the medicine by spoon

B: Using a needle-less syringe to give liquid medicine to an infant is often the safest method. If the nurse directs the medicine toward the side or the back of the mouth, gagging will be reduced.

10. A mother telephones the clinic and says "I am worried because my breast-fed 1 month-old infant has soft, yellow stools after each feeding." The nurse's **best** response would be which of these?

A) "This type of stool is normal for breast fed infants. Keep doing as you have."
B) "The stool should have turned to light brown by now. We need to test the stool."
C) "Formula supplements might need to be added to increase the bulk of the stools."
D) "Water should be offered several times each day in addition to the breast feeding."

A: In breast-fed infants, stools are frequent and yellow to golden, and vary from soft to thick liquid in consistency. No change in feedings is indicated.

11. A nurse manager considers changing staff assignments from 8 hour shifts to 12 hour shifts. A staff-selected planning committee has approved the change, yet the staff are not receptive to the plan. As a change agent, the nurse manager should first

A) support the planning committee and post the new schedule
B) explore how the planning committee evaluated barriers to the plan
C) design a different approach to deliver care with fewer staff
D) retain the previous staffing pattern for another 6 months

B: The manager is ultimately responsible for delivery of care and yet has given a committee chosen by staff the right to approve or disapprove the change. Planned change involves exploring barriers and restraining forces before implementing change. To smooth acceptance of the change, restraining factors need to be evaluated. The manager wants to build the staff"s skills at implementing change. Helping the committee evaluate its decision-making is a useful step before rejecting or implementing the change. When possible all affected by the change should be involved in the planning. The question is whether staff input has been thoroughly taken into consideration.

12. What is the major developmental task that the mother must accomplish during the first trimester of pregnancy?

A) Acceptance of the pregnancy
B) Acceptance of the termination of the pregnancy
C) Acceptance of the fetus as a separate and unique being
D) Satisfactory resolution of fears related to giving birth

A: Acceptance of the pregnancy. During the first trimester the maternal focus is directed toward acceptance of the pregnancy and adjustment to the minor discomforts.

13. The nurse is assigned to care for a client newly diagnosed with angina. As part of discharge teaching, it is important to remind the client to remove the nitroglycerine patch after 12 hours in order to prevent what condition?

A) Skin irritation
B) Drug tolerance
C) Severe headaches
D) Postural hypotension

B: Drug tolerance. Removing a nitroglycerine patch for a period of 10-12 hours daily prevents tolerance to the drug, which can occur with continuous patch use.

14. The most common reason for an Apgar score of 8 and 9 in a newborn is an abnormality of what parameter?

A) Heart rate
B) Muscle tone
C) Cry
D) Color

D: Color. Acrocyanosis (blue hands and feet) is the most common Apgar score deduction, and is a normal adaptation in the newborn.

15. The nurse is caring for a depressed client with a new prescription for a selective serotonin reuptake inhibitor (SSRI) antidepressant. In reviewing the admission history and physical, which of the following should prompt questions about the safety of this medication?

A) History of obesity
B) Prescribed use of a monoamine oxidase (MAO) inhibitor
C) Diagnosis of vascular disease
D) Takes antacids frequently

B: SSRIs should not be taken concurrently with MAO inhibitors because serious, life-threatening reactions may occur with this combination of drugs.

16. The nurse is caring for several 70 to 80 year-old clients on bed rest. What is the **most** important measure to prevent skin breakdown?

A) Massage legs frequently
B) Frequent turning
C) Moisten skin with lotions
D) Apply moist heat to reddened areas

B: Frequent turning. Frequent turning will prevent skin breakdown by relieving prolonged pressure on any one area.

17. A nurse aide is taking care of a 2 year-old child with Wilm's tumor. The nurse aide asks the nurse why there is a sign above the bed that says DO NOT PALPATE THE ABDOMEN? The **best response by the nurse would be which of these statements?**

A) "Touching the abdomen could cause cancer cells to spread."
B) "Examining the area would cause difficulty to the child."
C) "Pushing on the stomach might lead to the spread of infection."
D) "Placing any pressure on the abdomen may cause an abnormal experience."

A: Manipulation of the abdomen can lead to dissemination of cancer cells to nearby and distant areas. Bathing and turning the child should be done carefully. The other options are similar but not the most specific.

18. In preparing medications for a client with a gastrostomy tube, the nurse should contact the health care provider before administering which of the following drugs through the tube?

A) Cardizem SR tablet (diltiazem)
B) Lanoxin liquid
C) Os-cal tablet (calcium carbonate)
D) Tylenol liquid (acetaminophen)

A: Cardizem SR is a "sustained-release" drug form. Sustained release (controlled-release; long-acting) drug formulations are designed to release the drug over an extended period of time. If crushed, as would be required for gastrostomy tube administration, sustained-release properties and blood levels of the drug will be altered. The provider must substitute another medication.

19. A nurse arranges for a interpreter to facilitate communication between the health care team and a non-English speaking client. To promote therapeutic communication, the appropriate action for the nurse to remember when working with an interpreter is to

    A) promote verbal and nonverbal communication with both the client and the interpreter
    B) speak only a few sentences at a time and then pause for a few moments
    C) plan that the encounter will take more time than if the client spoke English
    D) ask the client to speak slowly and to look at the person spoken to

A: The nurse should communicate with the client and the family, not with the interpreter. Culturally appropriate eye contact, gestures, and body language toward the client and family are important factors to enhance rapport and understanding. Maintain eye contact with both the client and interpreter to elicit feedback and read nonverbal cues.

20. A nurse has asked a second staff nurse to sign for a wasted narcotic, which was not witnessed by another person. This seems to be a recent pattern of behavior. What is the appropriate initial action?

    A) Report this immediately to the nurse manager
    B) Confront the nurse about the suspected drug use
    C) Sign the narcotic sheet and document the event in an incident report
    D) Counsel the colleague about the risky behaviors

A: The incident must be reported to the appropriate supervisor, for both ethical and legal reasons. This is not an incident that a co-worker can resolve without referral to a manager.

21. A mother calls the clinic, concerned that her 5 week-old infant is "sleeping more than her brother did." What is the best initial response?

    A) "Do you remember his sleep patterns?"
    B) "How old is your other child?"
    C) "Why do you think this a concern?"
    D) "Does the baby sleep after feeding?"

C: Open ended questions encourage further discussion and conversation, thereby eliciting further information.

22. A diabetic client asks the nurse why the provider ordered a glycosylated hemoglobin (HbA) measurement, since a blood glucose reading was just performed. You will explain to the client that the HbA test:

    A) Provides a more precise blood glucose value than self-monitoring
    B) Is performed to detect complications of diabetes
    C) Measures circulating levels of insulin
    D) Reflects an average blood sugar for several months

D: Glycosylated hemoglobin values reflect the average blood glucose (hemoglobin-bound) for the previous 2-3 months and can be used to monitor client adherence to the therapeutic regimen.

23. The nurse is caring for a client with a deep vein thrombosis. Which finding would require the nurse's **immediate** attention?

    A) Temperature of 102 degrees Fahrenheit
    B) Pulse rate of 98 beats per minute
    C) Respiratory rate of 32
    D) Blood pressure of 90/50

C: Respiratory rate of 32. Clients with deep vein thrombosis are at risk for the development of pulmonary embolism (PE). The most common symptoms of PE are tachypnea, dyspnea, and chest pain.

24. The nurse is planning care for a 2 year-old hospitalized child. Which of the following will produces the most stress at this age?

    A) Separation anxiety
    B) Fear of pain
    C) Loss of control
    D) Bodily injury

A: Separation anxiety. While a toddler will experience all of the stresses, separation from parents is the major stressor.

25. During the initial physical assessment on a client who is a Vietnamese immigrant, the nurse notices small, circular, ecchymotic areas on the client's knees. The **best** action for the nurse to take is to

    A) Ask the client for more information about the nature of the bruises
    B) Ask the client and then the family about the findings
    C) Report the bruising to social services to follow-up
    D) Document the findings on the admission sheet

A: "Cupping" is practiced by Vietnamese. The principle is to create a vacuum inside a special cup by igniting alcohol-soaked cotton inside the cup. When the flame extinguishes, the cup is immediately applied to the skin of the painful site. The belief: the suction exudes the noxious element. The greater the bruise, the greater the seriousness of the illness. There is typically no need to ask an adult's family members.

26. Which type of traction can the nurse expect to be used on a 7 year-old with a fractured femur and extensive skin damage?

A) Ninety-ninety
B) Buck's
C) Bryant
D) Russell

A: Ninety degree-ninety degree traction is used for fractures of the femur or tibia. A skeletal pin or wire is surgically placed through the distal part of the femur, while the lower part of the extremity is in a boot cast. Traction ropes and pulleys are applied.

27. A client with considerable pain asks, “What is your opinion regarding acupuncture as a drug-free method for alleviating pain?” The nurse responds, "I'd forget about it as those weird non-Western treatments can be scary." The nurse's response is an example of

A) prejudice
B) discrimination
C) ethnocentrism
D) cultural insensitivity

C: Ethnocentrism, the universal tendency of human beings to think that their ways of thinking, acting, and believing are the only right, proper, and natural ways, can be a major barrier to providing culturally conscious care. Ethnocentrism perpetuates an attitude that beliefs that differ greatly from one"s own are strange, bizarre, or unenlightened, and therefore wrong. Ethnocentrism refers to the unconscious tendency to look at others through the lens of one"s own cultural norms and customs and to take for granted that one"s own values are the only objective reality. At a more complex level, the ethnocentrist regards others as inferior or immoral and believes his or her own ideas are intrinsically good, right, necessary, and desirable, while remaining unaware of his or her own value judgments.

28. The nurse is speaking to a group of parents and elementary school teachers about care for children with rheumatic fever. It is a **priority** to emphasize that

A) home schooling is preferred to classroom instruction
B) children may remain strep carriers for years
C) most play activities will be restricted indefinitely
D) clumsiness and behavior changes should be reported

D: A major manifestation of rheumatic fever that reflects central nervous system involvement is chorea. Early symptoms of chorea include behavior changes and clumsiness. Chorea is characterized by sudden, aimless, irregular movements of the extremities, involuntary facial grimaces, speech disturbances, emotional lability, and muscle weakness. Chorea is transitory and all manifestations eventually disappear.

29. A 6 year-old child diagnosed with acute glomerulonephritis (AGN) is experiencing anorexia, moderate edema and elevated blood urea nitrogen (BUN) levels. The child requests a peanut butter sandwich for lunch. What would the nurse's best response to this request?

A) "That's a good choice, and I know it is your favorite. You can have it today."
B) "I'm sorry, that is not a good choice, but you could have pasta."
C) "I know that is your favorite, but let me help you pick another lunch."
D) "You cannot have the peanut butter until you are feeling better."

C: Children with AGN who have edema, hypertension oliguria and azotemia may have dietary restrictions limiting sodium, fluids, protein and potassium. Giving the child a short explanation and offering to talk about an alternative is appropriate for this age.

30. A 24 year-old male is admitted with a diagnosis of testicular cancer. The nurse would expect the client to have

A) scrotal discoloration
B) sustained painful erection
C) inability to achieve erection
D) heaviness in the affected testicle

D: The feeling of heaviness in the scrotum is related to testicular cancer and not epididymitis. Sexual performance and related issues are not affected at this time.

31. Which statement describes factors that help build personal power in an organization?

A) Longevity in an organization, social ties to people in power, and a history as someone who does not back down in conflict ends with success
B) Goals are met with the use of networking, mentoring, and coalition building
C) High visibility and formal power are maintained with a confrontational style
D) Credibility to one's position is enhanced when professional dress and demeanor are employed

B: Networking, mentoring, and coalition building are positive uses of personal power to meet goals.

32. Which statement describes the advantage of using a decision grid for decision making?

A) It is both a visual and a quantitative method of decision making
B) It is the fastest way for group decision making
C) It allows the data to be graphed for easy interpretation
D) It is the only truly objective way to make a decision in a group

A: A decision grid allows the group to visually examine alternatives and evaluate them quantitatively with weighting.

33. A nurse is caring for a client with peripheral arterial insufficiency of the lower extremities. Which intervention should be included in the plan of care to reduce leg pain?

A) elevate the legs above the heart
B) increase ingestion of caffeine products
C) apply cold compresses
D) lower the legs to a dependent position

D: Ischemic pain is relieved by placing feet in a dependent position. This position improves peripheral perfusion.

34. The nurse is caring for a client with COPD who becomes dyspneic. The nurse should

A) instruct the client to breathe into a paper bag
B) place the client in a high Fowler's position
C) assist the client with pursed lip breathing
D) administer oxygen at 6L/minute via nasal cannula

C: Use pursed-lip breathing during periods of dyspnea to control rate and depth of respiration and improve respiratory muscle coordination.

35. After successful alcohol detoxification, a client remarked to a friend, "I've tried to stop drinking but I just can't. I can't even work without having a drink." The client's belief that he needs alcohol indicates his dependence is primarily

A) psychological
B) physical
C) biological
D) social-cultural

A: With psychological dependence, it is the client's thoughts and attitude toward alcohol that produce craving and compulsive use.

36. The nurse is caring for several hospitalized children with the following diagnoses. Which disorder is likely to result in metabolic acidosis?

A) Severe diarrhea for 24 hours
B) Nausea with anorexia
C) Alternating constipation and diarrhea
D) Vomiting for over 48 hours

A: Severe diarrhea is the only problem listed that can lead to metabolic acidosis if untreated.

37. The nurse detects blood-tinged fluid leaking from the nose and ears of a head trauma client. What is the appropriate nursing action?

A) Pack the nose and ears with sterile gauze
B) Apply pressure to the injury site
C) Apply bulky, loose dressing to nose and ears
D) Apply an ice pack to the back of the neck

C: Applying a bulky, loose dressing to the nose and ears permits the fluid to drain and provides a visual reference for the amount of drainage.

38. Which of the following should the nurse obtain from a client prior to having electroconvulsive therapy (ECT)?

A) Permission to videotape
B) Salivary pH
C) Mini-mental status exam
D) Pre-anesthesia work-up

D: Pre-anesthesia work-up. ECT is delivered under general anesthesia and the client should be prepared as for any procedure involving anesthesia.