

M_CRRNPQ (300+ Questions) - Quiz Questions with Answers

1.

A 78-year-old male Navajo patient was recently admitted to the rehabilitation unit after undergoing an emergent T12– L2 lumbar fusion secondary to a burst fracture at L1 sustained during a motor vehicle accident. What would be the most culturally appropriate means of providing nursing care for this elderly Navajo patient who is to begin walking as part of his rehabilitation plan of care?

Advise the patient about the possible complications that can arise if he does not comply with the rehabilitation plan of care.

Help the patient get out of bed by directing him and helping him through the proper mechanism of logrolling.

Making eye contact with the patient, allow the patient to take charge, and allow him to set attainable goals pertaining to the plan of care.

Allow the medicine man to explain the plan of care, goals, and expectations to the patient.

Explanation:

The Navajos, especially the elders, believe exclusively in the use of a medicine man for all ailments. They do not believe in modern medicine and are very wary of Western health care methods and facilities, including hospital settings. If a Navajo patient is admitted to the hospital, a medicine man may be sought to be with the patient throughout his stay. The presence of a medicine man can be beneficial as he or she knows the Navajo beliefs and is able to explain to the patient without causing confusion or conflict.

2.

A 55-year-old woman has been in the rehabilitation unit for 5 weeks for multiple pelvic fractures. During the assessment, the patient informs the nurse that she wants to continue rehabilitation at home. She is alert and oriented. She has made all of her medical decisions on her own regardless of her family's input. Which of the following nursing actions would constitute advocating for the patient?

Ask the patient why she would like to do rehabilitation at home.

Seek more information from the patient in regards to her wish.

Tell the rehabilitation physician about the patient's statement.

Request that the social worker meet with the patient.

Explanation:

By seeking more information from the patient, the nurse will be able to get a clearer picture of the patient's willingness to continue rehabilitation from home. The nurse would also want to get more information before consulting with the physician and the social worker; there may be underlying reasons why she wants to be discharged from the hospital.

3.

All of the following are appropriate choices for a patient who had a total hip replacement surgery 2 weeks ago and is receiving daily physical therapy in a rehabilitation setting EXCEPT

ambulating with a walker, cane, or crutches with supervision.

gluteal sets, quadriceps sets, and ankle pumps performed lying flat.

climbing stairs with assistance.

exercises that involve adduction, internal rotation, or hip flexion of the operative hip.

Explanation:

Certain exercises should be done after a total hip arthroplasty while others should be avoided. Exercises that involve adduction, internal rotation, or hip flexion, soon after total hip arthroplasty (total hip replacement surgery) can result in hip joint dislocation. Therefore, exercises, such as ankle pumps, ankle rotations, bed-supported knee bends, and buttock contractions should be encouraged.

4.

When the incision line on a patient who had a total hip replacement has completely healed, the physician may order hydrotherapy. What equipment would be needed for hydrotherapy?

Bathtub or shower with safety bars

Swimming pool or whirlpool tub

Hand-held shower wand with massage settings

Aqua K-pad

Explanation:

Hydrotherapy, or water therapy, may be ordered as hot or cold for patients who have had total hip replacements because low-impact exercising in water has many benefits, such as increased circulation, muscle strengthening, decreased discomfort, and relaxation. A swimming pool may be a preferred choice for some patients.

5.

A 59-year-old man with the diagnosis of a left hemisphere cerebral vascular accident is admitted to the rehabilitation hospital. What accommodations would be necessary for this patient to comply with his religious faith, Sikhism?

The patient's head should be kept shaved at all times.

All caregivers should be women.

The steel bracelet on the patient's right wrist should not be removed.

The patient should have a strict vegan diet.

Explanation:

Sikhism preaches a message of devotion and remembrance of God at all times, truthful living, and equality of mankind; it denounces superstitions and blind rituals. The steel bracelet worn on the patient's right wrist is a religious symbol for those who have the religious faith of Sikhism and should not be removed

6.

What religion listed below uses amulets, talisman, crystals, medallions, rings, and other small religious objects, sometimes inscribed with symbols or writing, and keeps them in direct contact with the skin at all times?

Jehovah's Witnesses

Wiccanism

Hinduism

Scientology

Explanation:

Wiccanism is a religion based upon the belief of a God and Goddess that are supreme deities. Those who practice the Wiccan religion often use amulets, talisman, or crystals, which are sometimes inscribed with symbols and writings and are always in direct contact with the skin.

7.

What respiratory symptoms might indicate compression of the brain stem and medulla in a patient with a brain-stem tumor?

Sudden onset of wheezing episodes

Changes in the ratio of inspiration to expiration

Frequent harsh, non-productive cough

Expectoration of frothy, pink secretions

Explanation:

The brain stem, located at the lower part of the brain and directly connected to the spinal cord, houses the breathing and other autonomic functions. If the patient displays non-rhythmic breathing patterns, this could indicate compression of the brain stem.

8.

The term "plateau" is frequently used in a rehabilitation setting to describe which of the following clinical scenarios?

A patient's progress has significantly slowed down.

A patient is no longer willing or motivated to participate in rehabilitative treatment.

A patient is neither improving and progressing nor deteriorating and declining.

A patient has returned to his or her previous level of physical and cognitive function.

Explanation:

A time when a patient is not improving or progressing but also is not deteriorating is referred to as a "plateau." This can be seen in rehabilitation care if the patient's muscles are not challenged on a daily basis. To overcome a rehabilitation plateau, different therapies are introduced, which use different techniques to promote recovery.

9.

A 34-year-old man has been admitted to the rehabilitation unit for physical therapy of his right lower leg due to neuropathy. Which of the following nursing assessments would the nurse perform to assess the patient's motor dysfunction?

Movement and strength of all four extremities, including left side to right side comparison

Presence or absence of cognitive deficits

Perception of touch, pressure, and pain

Bowel and bladder continence

Explanation:

Nursing assessment of a patient with both motor and sensory dysfunction should include evaluation of the upper and lower extremities. This allows the nurse to assess and intervene for any changes that the patient may be displaying. The nurse should examine the patient's strength and sensory function with the pin test, touch test, and reflex tests.

10.

What appropriate and beneficial actions should the nurse suggest to a patient's family member or friend, to facilitate the patient's well-being during rehabilitative care?

Attend and participate in all of the patient's rehabilitation care-plan meetings, even if the patient disagrees.

Accompany the patient to therapy sessions several times a week, if the patient and therapists agree.

Ask church members, neighbors, and others to visit the patient frequently during rehabilitation.

Tell the patient frequently that they will be good as new and back at home soon, to encourage them.

Explanation:

Accompanying the patient can be beneficial, especially if it is a patient's family member or friend. The patient's family or friend could facilitate the patient's comfort, well-being, and recovery during rehabilitative care. Providing the patient with a support system is imperative not just in the acute phase of recovery but soon after discharge as well.

11.

The nurse reviews the care plan for a 54-year-old man who has been admitted to the rehabilitation unit after sustaining a femoral hair fracture. The nurse is planning nursing care for the day with the

patient, according to the care plan. Which nursing process is the nurse focusing on?

Assessment

Implementation

Diagnosing

Evaluation

Explanation:

When implementing the plan of care for the patient, it is imperative that the nurse includes patients in their own plan of care. By doing this, the nurse empowers patients to take ownership of their own care progression. The nurse plans the day, according to the patient's needs; thus, the nurse implements the plan of care, according to that patient.

12.

The nurse is listening to the lungs of a 34-year-old woman. During the assessment, the nurse notes that the patient is now using accessory muscles on inspiration and expiration; this is a new change. What aspect of the nursing process is the nurse using?

Assessment

Diagnosis

Planning

Implementation

Explanation:

As the nurse performs the head-to-toe assessment, it is important to listen to the patient both subjectively and objectively. This helps the nurse to gather pertinent information about the patient's diagnosis and the patient's response to these diagnoses.

13.

The nurse is caring for a 14-year-old boy who has been admitted for a neuroblastoma. The patient and his adoptive parents have just been notified that the best treatment is chemotherapy and rehabilitation. During the nurse's shift, the patient's biological parents called to ask about the status of the patient. The nurse's best response to the biological parents would be to

deny that there is a patient by that name in the unit.

tell them they are not the child's parents.

ask them to talk to the patient's adoptive parents.

seek help from the charge nurse.

Explanation:

The nurse's best response to the biological parents would be for them to seek any information pertaining to the patient from the adoptive parents. Because the biological parents already know that the patient is in the hospital, it is pointless to deny it. In the event that the biological parents become unruly, then the nurse should seek help from the charge nurse. Even though the biological parents are the "real" parents, they have given up parental rights to the child through adoption.

14.

Based on these guidelines, what is an appropriate activity to recommend to the patient?

Walking 2.2 mph.

Swimming 40 yd/min.

Golfing.

Walking briskly upstairs.

Explanation:

The patient who is restricted to a heart rate of 20 bpm over resting heart rate, 1 to 3 METS, and 10-12 points on the 20-point BORG exertion scale should engage in light activity with fairly light exertion, so an appropriate activity would be to walk at the rate of 2.2 mph. Other acceptable activities are those involved in activities of daily living, such as bathing, dressing, driving (when permitted), and doing light housework.

15.

Following discharge, the patient develops an upper respiratory infection with cough and fever and calls to ask about whether to continue with the exercise program. The patient should be advised to do which of the following?

Continue with exercise but decrease the intensity.

Stop the exercise until 2 days after symptoms subside.

Exercise if he feels like doing so.

Stop exercise for 2 days after onset of symptoms.

Explanation:

A patient who has had a myocardial infarction with CABG and is engaged in cardiac rehabilitation should not exercise when fever is present or the patient is otherwise ill because of the added demands of illness on the body. The patient should be advised to rest to allow recovery and to wait to resume the exercise regimen until two days after the symptoms subside.

16.

A 52-year-old woman with newly diagnosed chronic lymphocytic leukemia has been admitted to the rehabilitation unit after receiving inpatient chemotherapy treatment. The nurse is likely to include all of the following significant problems in this patient's care plan EXCEPT the potential for

infection and septicemia.

bleeding and anemia.

nutrition and weight loss.

cognitive deficits and confusion.

Explanation:

There is no concrete research stating that cognitive deficits and confusion are common after receiving chemotherapy for cancer. Some of the more common side effects of chemotherapy include bleeding, anemia, nausea, infection, and weight loss.

17.

What appropriate nursing interventions could help prevent possible infections in an at-risk rehabilitation patient?

Arrange for the patient to have a semiprivate room, if possible.

Use good hand washing and strict aseptic technique at all times.

Instruct all caregivers and visitors to wear masks and gloves.

Both B and C are correct.

Explanation:

Instructing visitors to wear masks and gloves, using good hand washing and aseptic techniques at all times, and discouraging visits by any of the patient's family members and friends who are sick will all help to prevent possible infections. It is good practice to let patients know that they can request that anyone who enters their room must wash their hands without retaliation from a staff member.

18.

A 17-year-old adolescent with a fractured right femur and fractured right wrist has been admitted for rehabilitation. He has had type-1 diabetes since age 6. Based on this information, what potential problems would the nurse anticipate when developing his rehabilitation care plan?

There would be potential difficulty for the patient to perform his blood glucose testing four times daily and insulin injections twice a day, independently.

There is the potential for possible urinary tract infections.

There is the potential for possible dehydration and fluid and electrolyte imbalances.

There is the potential for a possible increased level of fear and anxiety.

Explanation:

Because the patient has an injured hand, it will be difficult for him to check his blood sugars. By identifying this need, resources will be sought to help him keep his blood glucose levels within range. Community programs or a good friend or neighbor are good resources to help the patient out while recovering from his injuries.

19.

A rehabilitation patient has a secondary diagnosis of expressive aphasia after a left hemisphere cerebral vascular accident. Based on this information, what potential problem would the nurse need to address, when developing this patient's rehab care plan?

Cognitive deficit

Balance problems

Speech impairment

Swallowing problems

Explanation:

Aphasia is an impairment of speech where the patient is aware of what he or she wants to say but is not able to say the words correctly. Sometimes words are transposed for similar ones. Aphasia can be seen in a variety of diagnoses.

20.

A 75-year-old man fractured his left hip when he slipped and fell, playing golf with his friends. He had open reduction, internal fixation hip surgery a week ago. He has been admitted to the rehabilitation hospital to continue his recovery and begin his rehabilitation. Since his surgery, the patient has been somewhat confused and disoriented. He is divorced and lives alone. What would be an appropriate discharge plan for this patient?

Discharge the patient to his home, as soon as possible, with intermittent home health nursing care.

Transfer the patient to a skilled nursing facility as soon as possible to continue rehabilitation there.

Discharge the patient to his home as soon as possible with outpatient physical and occupational therapies.

The appropriate plan is unknown at this time, since the patient's status may change significantly during the course of his recovery and rehabilitation.

Explanation:

The discharge plan is unknown at this time, since the patient's status may change significantly, during the course of his recovery and rehabilitation. The rehab team will develop an appropriate discharge plan for this patient at a later more appropriate time. Ideally, the nurse would want to include the patient or the family in the discharge planning phase of care as well.

21.

Nutritional deficiencies can be a significant problem for patients in rehabilitation oncology. What potential problems concerning gastrointestinal side effects can affect the patient's nutritional status and level of hydration?

Gastroenteritis related to chemotherapy treatment

Difficulty drinking, eating, and chewing because of possible stomatitis and mucosal ulceration

Anorexia and dehydration related to dysarthria

Frequent loose stools

Explanation:

There are various complications that can be associated with gastrointestinal problems, such as stomatitis, mucosal ulceration, jaw pain, and dysarthria. Some of these complications are associated with difficulty drinking, eating, and chewing.

22.

A 64-year-old man is admitted to the rehabilitation unit after a recent fall from a ladder at his home. He has a right hip fracture and chronic traumatic encephalopathy. Based on his neurological diagnosis, what possible cognitive changes or neurological symptoms should be addressed in the care plan for this patient?

Altered decision-making ability, lack of impulse control, and irritability

Disorientation, tremors, and slurred speech

Generalized weakness and bowel and bladder incontinence

Seizures, altered short-term memory, and confusion

Explanation:

Patients with chronic traumatic encephalopathy, which is caused by repeated head trauma, can exhibit multiple cognitive changes, including altered decision-making ability, lack of impulse

control, and irritability.

23.

An 18-year-old man who is recovering and receiving rehabilitative care after an all-terrain vehicle accident is refusing to participate in physical therapy. What would the most appropriate nursing intervention be in this situation?

Speak to the patient in a calm and caring manner and attempt to identify the reason he does not want to participate in physical therapy.

Notify the patient's physical therapist and physician, so they can address this issue.

Cancel the patient's physical therapy session, as per his request and document this information in the nurses' notes.

Insist that the patient attend his scheduled physical therapy sessions.

Explanation:

It is important to speak to the patient in a calm and caring manner in an attempt to identify the true reason that he does not want to participate in physical therapy. He may be fearful or experiencing increased pain or discomfort. It is important to identify the problem so that a reasonable solution can be found.

24.

An 87-year-old man has been admitted to the rehabilitation unit for a swallowing evaluation after being diagnosed with terminal esophageal cancer. During the assessment, the nurse notes that he is only alert to self and place which indicates a mental status change from the previous day. His chart notes that he has no family with whom he stays in touch and has no medical power of attorney or living will. What should the nurse do when planning for this patient's plan of care?

Find his immediate family, and have the patient reconnect with them.

Notify the physician about the mental status change of the patient.

Consult the hospital social worker for evaluation.

Do nothing at the present time as he is probably temporarily disoriented.

Explanation:

By informing the physician of the mental status change of the patient, the nurse is being proactive in making changes to the plan of care, according to the patient's needs. In the event that the patient would need an invasive procedure or treatment as a means to determine the patient's change in mental status, then next of kin should be sought; if the situation is deemed emergent, two physicians could sign the consent.

25.

When developing the rehabilitation care plan for a patient at risk for increased intracranial pressure, what significant signs and symptoms would the nurse closely monitor?

Altered levels of consciousness, vomiting, and headaches

Diaphoresis, elevated temperature, and back pain

Insomnia, decreased appetite, and joint pain

Peripheral edema, constipation, and increased thirst

Explanation:

Altered levels of consciousness, vomiting, and headaches are all significant neurological signs and symptoms that could indicate increased intracranial pressure in an at-risk patient. These are also signs and symptoms of other diagnoses.

26.

All of the following nursing actions or interventions would be appropriate for a patient who has symptoms of increased intracranial pressure EXCEPT to

contact the patient's physician to report the signs and symptoms of increased intracranial pressure that were observed during the assessment.

maintain strict fluid restriction as ordered by the physician, and keep an accurate record of input and output.

keep the head of the patient's bed elevated at 30 degrees, and position the patient to keep their head midline.

position the patient in the Trendelenberg position.

Explanation:

The nurse should not position a patient with symptoms of increased intracranial pressure in the Trendelenberg position. The head of the patient's bed should be kept elevated at 30 degrees to promote intracranial drainage, and the patient's head should be positioned at midline to avoid compression of the jugular veins.

27.

A 28-year-old woman has been receiving rehabilitative care after sustaining a traumatic brain injury. Increased intracranial pressure has been a persistent problem for this patient. What medication currently ordered for this patient will help to prevent increased intracranial pressure?

Ciprofloxacin

Furosemide

Acetaminophen

Rhinocort Aqua

Explanation:

Furosemide, also known as Lasix, is a loop diuretic to prevent increased intracranial pressure in an at-risk patient. This medication may also be used in conjunction with mannitol when decreasing intracranial pressure is necessary. The nurse may want to observe urine output and keep a strict log of input and output.

28.

A 28-year-old man sustained a herniated disk while on the job. He has opted for a conservative plan of care instead of surgery. Part of his plan of care is for him to receive physical therapy two times a week and to receive a cortisone injection. He is the sole provider for his disabled parents and younger sibling. Which of the following nursing diagnoses is the most important?

Acute pain related to the herniated disk

Disabled family coping

Risk for disturbed personal identity

Impaired walking related to back pain

Explanation:

It is important for the patient to do physical therapy to keep his pain under control. Because this patient sought a conservative treatment plan, it is imperative that pain and therapy be followed. It is important that the patient's pain and physical therapy are underway before he addresses his inability to work, which will affect his ability support his family.

29.

Upon the arrival of a new admission, the nurse notes that this 54-year-old Hispanic man is very sad and will not communicate. Which aspect of the nursing process will allow the nurse to collect and analyze data to provide appropriate nursing care for this patient?

Assessment

Diagnosis

Planning

Implementation

Explanation:

The assessment is to be done by the primary nurse. The nurse needs to assess the patient and his needs to deliver adequate nursing care and provide nursing interventions adequate to the nursing diagnoses.

30.

A 16-year-old adolescent boy sustained a traumatic brain injury when he fell from the bed of a moving pick-up truck 2 months ago. He has been increasingly irritable, angry, and uncooperative for the past 2 days, according to his mother. He has no other changes in status. What nursing intervention would be most appropriate for this scenario?

Call the patient's parents regarding their uncooperative son and his bad behavior and anger issues.

Document the patient's irritability, anger, and uncooperative attitude in the nurses' notes.

Ask the discharge coordinator how soon the patient can be discharged, since he is ready to go home.

Have a dialogue with the patient when he is calm, and try to establish rapport to identify the underlying cause for his behavior.

Explanation:

Every nursing care plan should be individualized to meet the needs of patients and what they perceive to be the most important goals for them to achieve during their stay. A dialogue with the patient to gather information regarding his feelings and fears is the most appropriate nursing intervention.

31.

A rehabilitation nurse has been floated to the medical–surgical floor and assigned a patient with a new order for a continuous positive motion (CPM) machine. The nurse's role will be to educate the patient regarding this apparatus. Which of the following statements by the patient would lead the nurse to believe that the patient has a full understanding of the CPM machine?

"I can use the CPM machine off and on when I am in bed or whenever I feel like it."

"Once I start using the CPM machine, I will not have any more pain."

"The CPM machine will help me to heal and regain range of motion."

"I will not need to go to physical therapy if I use the CPM machine."

Explanation:

The continuous passive motion (CPM) machine is used for a variety of patients, most commonly postsurgical patients. The CPM machine will not resolve the patient's pain but will certainly decrease the pain by increasing blood flow to and decreasing edema in the affected area.

32.

A 34-year-old woman with cervical spondylosis has had a C4–C5 anterior cervical discectomy and fusion and has been instructed by her physician to wear a cervical collar postoperatively. Which of the following potential postsurgical complications does the rehabilitation nurse know are important to report?

Dysphagia

Hoarse voice

Numbness and tingling of the fingers

Infection

Explanation:

Numbness and tingling of the upper extremities indicate that there is a nerve that is being impinged, which could indicate that the patient may have to go back to surgery to alleviate the impingement. By not notifying the surgeon of such a change could lead to permanent nerve injury.

33.

A 44-year-old rehabilitation patient reports that she was shocked to discover that she has come down with leukemia, since she takes great care of herself. She reports that she takes supplements to boost her immunity, works out, and eats a healthy diet. An important goal for this patient would be for her to

have a good understanding regarding her diagnosis, disease process, medications, and treatment.

return to her previous level of function and activity as soon as possible.

reach her maximum level of cognitive ability.

do none of the above.

Explanation:

The patient does not appear to have a good understanding of her diagnosis. The most important goal for this patient would be education regarding her diagnosis, treatment, and medications. A learning assessment should be done to determine the best way to provide learning material for her.

34.

The rehabilitation nurse is caring for a patient who had an extreme lateral interbody fusion 2 days ago. Which of the following statements would indicate that the patient has a clear understanding of the nursing outcome?

"I will walk up and down the halls with assistance as much as I can."

"I think that it is best that I stay in my room; it is nice and quiet here."

"I am to walk three times today for a minimum of 100 feet with assistance."

"I will get up, take a shower, sit in a chair, and then walk up and down the hall with my friend."

Explanation:

The nurse needs to know the obtainable outcomes that need to be achieved for the patient. In the event that the patient is not able to achieve such outcomes, then the plan of care needs to be changed to fit his or her current needs.

35.

The nurse is caring for a 32-year-old non-English-speaking woman. She sustained a right femur fracture and needs an emergent open reduction and internal fixation. Who would be the most appropriate person to assist the patient with the surgical consent form and the blood consent form?

The surgeon and family translator

The anesthesiologist and certified translator

A telephone medical translator and preoperative holding nurse

None of the above people

Explanation:

None of the people listed in the question are adequate to help the individual understand and sign the surgical consent and blood consent forms. The family translator is not a properly certified professional; the anesthesiologist can only consent for his or her portion of the blood consent. The most appropriate means of translation is through translation services or a certified translator.

36.

A 72-year-old woman, who has had surgery for a femoral head fracture, has a significant history of hypertension and as a one pack-per-day smoker for 40 years. Which of the following nursing diagnoses would be a priority with this patient?

Impaired tissue integrity

Impaired gas exchange

Risk for fall

Acute pain

Explanation:

Impaired gas exchange, which may result in impaired tissue perfusion, is related to the patient's extensive smoking history; thus, the lack of gas exchange in her lungs impairs tissue integrity and the healing process, which, in turn, puts the patient at risk for infection.

37.

A 92-year-old man has been receiving rehabilitation care after a right hemisphere cerebral vascular accident. The patient has reached a plateau and is ready for discharge the following day, but his caregiver informs the nurse that she will not be able to care for the patient at home as planned. What would be the most appropriate action under these circumstances?

Find an alternate caregiver and train them quickly, since Medicare stops paying for inpatient care for this patient tomorrow.

Request that the original caregiver find someone to care for the patient at home and train them herself.

Check the patient's rehabilitation care plan for an alternate discharge plan for this patient; then notify the patient, patient's family members, and other members of the rehabilitation team.

Notify the discharge planner that this patient will need to be transferred to a skilled nursing facility as soon as possible

Explanation:

The nurse must check the patient's rehab care plan for the alternate discharge plan for this patient. It is imperative that when nurses make any significant changes to the patient's plan of care that they notify the members of the rehab team as well as the patient. This prevents miscommunication and timely discharge.

38.

A 16-year-old patient has been admitted to the rehabilitation unit after sustaining a traumatic brain injury from an all-terrain vehicle (ATV) accident. He has undergone all of the required physical therapy and is getting ready to go home. Which of the following statements by the patient would indicate that he has a clear understanding of how to improve safety and prevent future injuries?

"I can resume all of my favorite activities that I did before, including riding my ATV off road. I just need to be less of a daredevil."

"I have to try to remember to wear a helmet when I play football with my friends."

"When I drive my parent's car, I have to make sure that I always wear my seat belt at all times, even if I am taking a quick trip."

"I do not have to wear a helmet if I am riding my bike, just my ATV."

Explanation:

Teens are at a high risk for sustaining head injuries due to high-risk behaviors; therefore, it is important to teach them how to use safety measures to prevent future head injuries. Because this patient had a head injury, he would not be allowed to play football just yet.

39.

The best definition of the nursing diagnosis as part of the nursing process in care plans for rehabilitation patients would be

an effective rehabilitation assessment tool.

a clinical judgment regarding actual and potential problems during the recovery and rehabilitation of the patient.

a checklist for planning patient care.

none of the above.

Explanation:

A rehabilitation patient needs a detailed care plan that includes the patient's home rehabilitation team as well as the patient. The plan needs to be consistent with the patient's needs. This also delineates the patient's maximum potential by including the patient and his or her willingness to succeed. By incorporating all important members of the team, the nurse is setting the patient up for success.

40.

A 64-year-old man has sustained a cerebral vascular accident. Upon assessment of the patient, the nurse recognizes that the patient is having difficulty comprehending speech and naming objects. Which part of the brain has been affected?

Broca's area

Wernicke's area

Parietal lobe

Occipital lobe

Explanation:

Wernicke's area is located in the posterior left temporal lobe of the brain; it is associated with language comprehension. When affected, Wernicke's area can cause difficulty speaking understandably; speech comprehension; confusion; and difficulty reading, writing, and naming objects.

41.

A 45-year-old Hispanic man has been admitted after sustaining a mild concussion. Upon admission, the patient tells you he has a feeling of impending doom. What would be the best nursing intervention?

Advise the patient that he is going to be okay.

Ask the patient why he feels this way.

Let the patient express what he is feeling.

Talk to the family about what the patient is experiencing.

Explanation:

By allowing the patient to communicate what he is feeling and what the most important aspect of his care is allows the nurse to formulate a plan of care that is adequate for the patient. In addition, it will let the nurse better understand what the patient feels and desires. By having the patient openly communicate allows the nurse to plan for his individual care and needs.

42.

The nursing process, an effective method of planning and providing quality patient care, consists of five important steps, which include

nursing assessment, nursing diagnosis, planning, implementation, and evaluation.

nursing assessment, nursing diagnosis, nursing implementation, patient outcomes, and discharge planning.

nursing assessment, nursing diagnosis, nursing care plan, evaluation, and discharge planning.

nursing assessment, nursing evaluation, nursing diagnosis, patient goals, and implementation.

Explanation:

Nursing care is to be given to each and every patient following the nursing process of the American Nurses Association, which includes the following: nursing assessment, nursing diagnosis, planning, implementation, and evaluation.

43.

A patient who has been diagnosed with dysphagia has been given exercises recommended by the physical therapist, one of which is to lie flat on the back, raising the head while gazing at the toes without out raising the shoulders. This exercise is called the

Shaker exercise.

hyoid lift maneuver.

Mendelsohn maneuver.

supraglottic maneuver.

Explanation:

The purpose of the Shaker exercises is to increase the opening of the top of the esophagus. The patient lies flat on the back on a supportive surface and lifts the head high enough to see the feet and then lowers the head and repeats. This exercise is used to improve swallowing ability and should be performed three to six times a day for 6 weeks.

44.

A 54-year-old woman has dysphagia after an anterior cervical discectomy. One of the exercises that were ordered for the patient is the supraglottic swallow. The nurse knows that this specific exercise consists of

taking a deep breath, holding the breath and swallowing, and finally coughing to clear saliva or food.

taking a deep breath, letting it out slowly, and then coughing to clear fluids.

sucking a thick smoothie through a small straw.

swishing, gargling, and swallowing non-carbonated clear liquids.

Explanation:

The super supraglottic swallow maneuver is used in patients with reduced closure of the airway entrance. Patients are given instructions to inhale, hold the breath very tightly, bear down, and then swallow; the patient then coughs when finished. The pressure that is created helps with swallowing and increases the strength of the muscles used with swallowing.

45.

A 22-year-old college student with the diagnosis of *Coccidioides* fungal meningitis and significant physical and neurological deficits has been transferred from acute care to the rehabilitation unit. Which of the following would be required for this patient?

Seizure precautions

Isolation precautions

Fall precautions

Frequent hand washing by staff caring for the patient

Explanation:

Coccidioidal meningitis is not contagious. Coccidioidomycosis is only found in the western hemisphere, especially in the southwestern United States and northwestern Mexico. Isolation precautions are not required, but hand washing is encouraged with every visitor and among health care staff caring for the patient.

46.

The nurse is assigned to a 32-year-old diabetic man who has a history of uncontrolled blood glucose levels. During the assessment, the nurse notices that the patient is diaphoretic and not speaking in clear sentences. What would be the most important nursing action to document in the chart?

Finger stick or a blood draw if the blood glucose is high

Physician notified and orders given

Symptoms and nursing actions

All of the above

Explanation:

The most important aspect to document in the nurses' notes is the patient's objective and subjective presentation. Although, glucose levels and nursing interventions are also adequate to document, they typically would be documented elsewhere, such as on a medication or glucose form. Within the nurses' notes, the nurse should document the nurse's interventions as well as any physician contact.

47.

One of the patients in the rehabilitation unit just had a total knee replacement 3 days ago. The nurse anticipates that this patient will need which of the following today?

Cane

Walker

Anti-embolism stocking

Continuous passive motion machine

Explanation:

Although all of the devices may be used by the patient who just had a total knee replacement, the one that the patient would be using 3 days postoperatively would be a walker as the patient would be engaging in physical therapy, which consists primarily of walking.

48.

When developing the rehabilitation care plan for a 72-year-old man with Parkinson's disease, the potential problems anticipated by the nurse would be

urinary incontinence or difficulty voiding.

altered elimination and constipation.

cognitive deficits and depression.

all of the above problems.

Explanation:

Parkinson's disease is a neurodegenerative brain disorder that progresses slowly in most people. Typically, onset of this disorder is seen in middle age to the elderly populations. Because of the vast array of potential problems that can arise from this diagnosis, the patient can experience all of these plus more or fewer symptoms.

49.

A 16-year-old African-American woman has sustained a C1–C2 fracture requiring surgical intervention. The nurse knows that part of the rehabilitation process for the patient is to wear which of the following spinal orthotics?

Cervical soft collar

Miami J collar

Halo device

Boston brace

Explanation:

The orthopedic halo device is used for the treatment of unstable cervical and upper thoracic fractures and dislocations from C1 to T3. The halo can provide greater motion restriction than any other cervical orthotic device, such as an aspen or soft collar.

50.

A three-year-old pediatric patient has been admitted to the rehabilitation hospital's pediatric unit after 3 weeks in acute care for treatment of severe bacterial meningitis. He has physical and neurological deficits and hearing loss. Potential problems to be included in his rehabilitation care plan are

increased fear and anxiety.

falls and injuries.

developmental delays, regression, and learning disabilities.

all of the above problems.

Explanation:

Pediatric patients undergoing rehabilitation can display a vast array of potential complications and or problems associated not only with rehabilitation but also with their primary diagnosis. Therefore, choices A, B, and C are all potential problems for a pediatric patient recovering and receiving rehabilitation services after severe bacterial meningitis.

51.

A 32-year-old Hispanic man sustained a C1–C2 fracture requiring, surgical intervention. The patient has been placed in a halo. The nurse knows that the patient has a clear understanding of why he must be in a halo when he states which of the following?

“The halo is the best orthotic for use in controlling rotation and side bending.”

“The halo is the best orthotic for use in controlling movements.”

“The halo is the best orthotic for use in surgical site healing.”

“The halo is the best orthotic for use for controlling anterior and posterior neck movements.”

Explanation:

Although there are many cervical stabilization methods that could be used with this patient, such as the aspen collar, in this case, the halo is the best orthotic device as it controls rotation and lateral bending at C1–C3. When a halo is placed on a patient, it is important to note as part of nursing care to pad all prominences exposed to the metal chest plate as it could cause skin breakdown.

52.

A 36-year-old woman has been transferred to the rehabilitation unit because of a near fatal ruptured cerebral aneurysm; she has had emergency neurosurgery twice. She has been receiving oxygen

therapy and has significant cognitive and physical deficits. What nursing interventions would be most important for this patient during rehabilitative treatment?

Encourage the patient's friends and family members to visit frequently.

Carefully monitor the patient for signs and symptoms of increased intracranial pressure, infection, skin breakdown, fluid and electrolyte imbalance, and altered elimination.

Arrange for a private room and only female caregivers.

Transport the patient to and from therapy sessions via wheelchair for optimal safety.

Explanation:

Important nursing interventions for this patient, considering the history of this patient, may change on a daily basis, according to her needs. However, carefully monitoring the patient for signs and symptoms of intracranial pressure, infection, and skin breakdown are paramount. It would also be important to monitor electrolytes and input and output.

53.

An 82-year-old Asian man has been admitted to the rehabilitation unit after having a right total hip replacement. The nurse understands that the patient has a clear understanding of the planning aspect of the nursing process when he states which of the following:

"I should be discharged by this afternoon because I have things to do at home."

"I need to sit up in a chair at least three times today."

"I am going to stay in bed and let my wife feed me."

"I am going to wait for the physical therapist before getting out of bed."

Explanation:

The patient has a clear understanding that he is to get out of bed and sit in a chair at least three times during the day. This indicates that the patient has a clear understanding of what the short-term goal is for him to progress in his plan of care.

54.

A 33-year-old woman fell through the ice while figure skating and survived the near drowning, but she has physical and neurological deficits as a result of the accident. After 2 weeks in the intensive care unit and acute care unit, her rehabilitative care should include which of the following?

Physical therapy, occupational therapy, speech therapy, and rehabilitation nursing care

Physical therapy, occupational therapy, and rehabilitation nursing care

Physical therapy and rehabilitation nursing care

Occupational therapy and rehabilitation nursing care

Explanation:

Physical, occupational, and speech therapies will help the patient achieve her overall goal of recovering as closely as possible to baseline prior to the accident. The nurse caring for this patient will work with the family and the patient to formulate a plan that will be adequate to meet her needs.

55.

A patient needs to be evaluated for swallowing difficulty after sustaining a cerebral stroke 3 days ago. Her family is very concerned about the patient's inability to swallow effectively without choking. She has no significant medical–surgical history, other than her recent stroke. Which of the following nursing diagnoses would be the most important for this patient?

Nutritional deficiency intake below metabolic needs

Fluid volume deficit

Risk for ineffective airway clearance

Total inability to eat

Explanation:

Several clinical manifestations indicate that an airway and, therefore, circulation is being compromised. For example, cyanosis of the lips and a bluish color of the fingers are two hallmark signs of impaired oxygenation. When assessing the patient, airway, breathing, and circulation are important factors to assess.

56.

A 16-year-old high school football player lost consciousness after being tackled during a football game. Upon admission to the hospital, the patient was diagnosed with a basal skull fracture. In addition, he has been admitted for rehabilitation care. What rehabilitation goals are appropriate for this patient?

The patient will achieve a maximum level of independence with activities of daily living within 2 weeks.

The patient will return to a pre-injury level of cognitive and physical ability as soon as possible.

The patient will recover fully and return to normal activities as soon as possible.

The patient will be discharged to home with care provided by his parents in 1 week.

Explanation:

A concrete achievable and attainable goal for this patient is for him to achieve maximum level of independence with the activities of daily living within 2 weeks. It is important to state within the care plan when these goals are attainable and change them as needed so they are achieved by the patient.

57.

The nurse is caring for a 64-year-old Hispanic man. He has had many members of his extended family come to visit him. When the physician visits the patient, the nurse notes that the entire family is having a conversation with the physician about the patient's health status just outside of his room. The nurse notes that this behavior violates which of the following health care acts?

Patient Healthcare Discretion Act

Healthcare Confidentiality and Performance Act

Health Insurance Portability and Accountability Act

Act of Privacy and Healthcare Security Act

Explanation:

The U.S. Department of Health and Human Services defines the Health Insurance Portability and Accountability Act as being the federal protection of a patient's health care information. The patient's nurse should realize that the conversation that is taking place in the hallway between the patient's family and the physician is not contained and anyone can hear the conversation.

The nurse should intervene and redirect the conversation to another location to protect patient information.

58.

A 31-year-old Hispanic woman sustained a spinal cord injury when she attempted to dive into a swimming pool while intoxicated. She was diagnosed with paraplegia upon admission to the emergency department. She has a medical history consisting of alcoholism and depression. What psychosocial problem would the nurse anticipate this patient to exhibit first during her rehabilitation?

Risk of loneliness

Risk for immobility

Ineffective coping

Disturbed body image

Explanation:

The patient has sustained life-altering injuries. Because of her young age, fear and anxiety play a significant role in her ability to recover fully. She is at risk for displaying the five phases of grief and loss as depicted by Kübler Ross, which are denial, anger, bargaining, depression, and acceptance.

59.

A charge nurse must adhere to specific managerial standards within the unit as delineated within the job description as well as attend to the staffing of the unit and the education that all staff nurses must attain. This leadership style expresses which of the following ethical theories:

Deontology

Utilitarianism

Casuist

Virtue

Explanation:

Deontology refers to the duty or obligation of nurses to provide care to patients (or society) because this is what is considered ethically correct. The nurse manager in the situation described in the question must uphold his or her duties as well as the duties of the unit's staff members.

60.

A nurse's unit and hospital are experiencing financial difficulties. The nurse is asked by the clinical nurse leader to brainstorm on ways to decrease the number of disposables that are wasted by staff. The most effective means of getting the rest of the staff on board to reduce the products being wasted is to

help lock all the patients who currently have an intravenous line and only run fluids when needed.

have the patient's family brings toiletries for the patient.

place a price tag on each disposable on the unit.

educate the staff on the cost of items.

Explanation:

Placing price tags on all disposables within the unit will allow staff members to learn the price differences among all disposable items; thus, staff members will be able to choose a less-expensive disposable over another that serves the same purpose. Thus, the unit can save money that can be allocated to other areas.

61.

The clinical nurse leader for the rehabilitation unit is in charge of evaluating all the staff members on the day shift. The nurse leader will glean the most information about the staff's professional performance with

peer reviews.

professional portfolios.

self-evaluation forms.

personal conversations.

Explanation:

The professional portfolio is the documentation of ongoing professional development, career planning, and continuing professional nursing development. It is used as a tool to help provide a structure for identifying the strengths and learning needs of nursing staff. It can also be used during the hiring process to identify the most appropriate nurse for the position.

62.

A 34-year-old police officer on duty fell while chasing a suspect. He sustained a torn right anterior cruciate ligament, a torn medial meniscus, a compound medial tibia/fibula fracture, and a right open ankle fracture. What percentage of his care and rehabilitation will worker's compensation insurance cover since he was on duty when he received them?

Varies by case

80% if compensable and authorized

100%

0%

Explanation:

Although the police officer was injured while on duty, there is no way to know the specifics of the patient's medical-surgical history, including previous fractures or ligament injuries. More information is needed to determine what percentage of his medical bill would be paid by worker's compensation.

63.

A 35-year-old man was diagnosed with a right cerebral stroke 3 days ago. He is a one pack-per-day smoker and drinks heavily on the weekends. He is alert and oriented but has upper left extremity residual weakness. What is the best evidence-based practice that would prevent the patient from having another stroke?

Eat healthy food as nothing else will prevent a genetic condition.

Stop smoking and using alcohol, and increase physical activity.

Follow up with the primary care physician, and take medication for hypertension, hyperlipidemia, and atrial fibrillation, if needed.

Both B and C are correct.

Explanation:

Approximately 185,000 of the 795,000 individuals or 1 in 4 people who sustain a stroke will have a recurrent stroke. Modifying risk-taking behaviors, such as smoking cessation and control of alcohol use; eating a healthy diet; increasing physical activity; and following the suggested medical management of hypertension, hyperlipidemia, and atrial fibrillation can significantly reduce the chances of another stroke.

64.

An 88-year-old demented woman has been admitted to the rehabilitation unit after having a total right hip replacement performed 3 days ago. She has no significant medical or surgical history besides her right hip fracture. What would be the nurse's primary safety concern for this patient?

Sepsis

Falls

Infection

Urinary incontinence

Explanation:

Because of the patient's age and having had a new hip replacement, the patient is more at risk for falling than all of the other risks. The nurse should take precautionary measures to prevent

*the patient from falling, such as placing the call light within reach and checking on her often.
The risks for sepsis and infection are not a safety concern.*

65.

A patient had a left-sided stroke with resultant paralysis of the right arm and face as well as right lingual paralysis. When assisting the patient to eat, it's important to place the bolus of food in what position on the tongue?

Midline at the back of the tongue.

Midline at the front of the tongue.

On the right side of the tongues.

On the left side of the tongue.

Explanation:

If a patient has a left-sided stroke with resultant paralysis of the right arm and face including right lingual paralysis, when feeding the patient, it's important to place the bolus of food on the left side of the tongue so that the patient can feel it. If the patient has difficulty moving the food to the back of the throat to swallow, then the bolus should be placed near the back of the left side of the tongue.

66.

A 59-year-old female patient with multiple sclerosis has lower urinary tract symptoms (LUTS). The patient experiences overactive bladder with urinary frequency, urgency, nocturia, and some incontinence. The patient has had little response to bladder training and anticholinergics. Which of the following is the LEAST invasive next approach?

Percutaneous tibial nerve stimulation (PTNS).

Intermittent self-catheterization (ISC).

Implantation of an InterStim®.

Suprapubic cystostomy.

Explanation:

If a 59-year-old female patient with multiple sclerosis has lower urinary tract symptoms (LUTS) with an overactive bladder with urinary frequency, urgency, nocturia, and some incontinence and has had little response to bladder training and anticholinergics, the least invasive next approach is percutaneous tibial nerve stimulation (PTNS). A tiny needle electrode is inserted by the ankle and transmits signals to the nerves that control the bladder, the sacral plexus. Treatments usually take 30 minutes and are continued for 12 weeks.

67.

During phase I of rehabilitation, the primary goal should focus on which of the following?

weight loss.

exercise.

smoking cessation.

nutrition.

Explanation:

During phase I of rehabilitation for a 65-year-old male who experienced an MI and had a stent placed with his history and BMI, the primary goal should be smoking cessation. The patient cannot smoke during hospitalization and is likely experiencing withdrawal but also concerned about health, so this is an ideal time to begin to teach the patient about dealing with nicotine craving and steps to smoking cessation.

68.

The patient's initial goal for weight loss is 15% (37.5 pounds, BMI 30). The discussions about diet should begin with which of the following?

Low fat foods.

Triggers.

Diabetic diet.

Low calorie snacks.

Explanation:

If the patient initial goal for weight loss is 15% of current weight of 250, a weight loss of 37.5 pounds to a BMI of 30 from 34.9, the initial discussions about diet should focus on triggers for eating. A trigger can be many things, such as a place (sitting in a recliner), a habit (smoking), a time (in the evening), or an emotional response (stress, anger, sadness, grief). The patient needs to make a list of triggers and then develop strategies to avoid the trigger or deal with it more effectively.

69.

A 35-year-old, newly diagnosed diabetic, male patient sustained a traumatic lower left leg amputation in a motor vehicle accident. What nursing diagnosis should the nurse prioritize for this

patient?

Impaired physical mobility

Disturbed body image

Knowledge deficit

Risk for infection

Explanation:

Although all the answers are correct, it is important to prioritize the patient's knowledge deficit, as the nurse needs to assess what the patient knows about his diabetes and the new amputation. By doing this, the nurse will be able to put together a plan of care that is appropriate to the patient's needs.

70.

A 43-year-old male patient had a right cerebral vascular accident and is now displaying residual paralysis. The nurse knows that he will need extensive rehabilitation services and will probably not return to his baseline before the insult. During the assessment, the patient asks, "What are the odds that I will recover completely?" What would be the most appropriate answer to this question?

10%

25%

33%

50%

Explanation:

Approximately 10% of all stroke survivors recover almost completely after sustaining a stroke. The odds do go up when treatment is given within the "golden hour," which starts when the onset of symptoms occurs. It is important for the nurse to note when the onset of symptoms occurred so an appropriate course of treatment can be administered.

71.

A 67-year-old man has been admitted to the rehabilitation unit after sustaining a cerebral vascular accident. Although he has recovered from the initial insult, he is displaying major deficits and has been put on precautions for a subsequent stroke. The patient asks the nurse, "What are the odds that I will die from this stroke?" The nurse's best response should be which of the following:

"You should not worry about that, as you are getting the best of care."

"Approximately 15% of patient's do not survive strokes, but that is only if they do not receive care."

"It does not matter now."

"Approximately 40% of patients die from strokes so there is a good probability that you will not make it."

Explanation:

Approximately 15% of all patients who have a cerebral vascular accident do not survive. This is due to the lack of immediate treatment either because a stroke is not recognized as a stroke or the hospital admittance process takes too long.

72.

A 43-year-old Hispanic man sustained a cerebral vascular accident (CVA) while working at a construction site. During the rehabilitation phase of his recovery, he expressed to the nurse that he is the sole provider for his family and that it is imperative for him to return to work as soon as possible. Referring to the National Stroke Association, General Recovery Guidelines, the nurse should respond to the patient's question by saying, "Approximately

15% of patients who sustain a CVA have moderate deficits."

20% of patients who sustain a CVA have severe deficits."

25% of patients who sustain a CVA have mild deficits."

40% of patients who sustain a CVA never recover fully from their deficits."

Explanation:

Approximately 25% of patients who have a cerebral vascular accident recover with only minor deficits after sustaining a stroke. Therefore, it is important that the nurse let the patient know of accurate statistics pertaining to the patient's prognosis. By allowing the patient to understand the recovery statistics, the nurse is empowering the patient with knowledge and not giving him false hopes.

73.

A 49-year-old patient has had a myocardial infarction and has the following:

- Ejection fraction 40%.
- Reperfusion of myocardium with PTCA.
- Asymptomatic orthostatic hypotension.
- No activity-induced cardiac ischemia.
- No other health problems that interfere with activities.
- History of active lifestyle but no exercise program.

Based on these criteria, in which cardiovascular risk category would the patient belong?

No risk.

Low risk.

Intermediate risk.

High risk.

Explanation:

The cardiovascular risk category to which the patient belongs is intermediate risk. There is not a "no risk" category. The patient has some left ventricular dysfunction because of the ejection fraction of 40%. Low risk requires EF of greater than 50% and high risk less than 30%. The patient also has asymptomatic orthostatic hypotension, which should not be present with low risk and is symptomatic with high risk. Being active is an advantage although a regular exercise program is ideal.

74.

The nurse has been assigned to a 23-year-old female patient who was admitted for right leg rehabilitation after a motor vehicle accident. The patient is very positive and wants to perform many of her own activities of daily living and rehabilitation exercises with minimal assistance. Which author's nursing theory is this patient exhibiting?

Martha E. Rodgers

Imogene King

Dorothea Orem

Katharine Kolcaba

Explanation:

Dorothea Orem, a nursing theorist, contributed the Self-care Deficit Nursing Theory. The theory states that patients who perform their own self-care as much as possible recover more quickly and more holistically. The Self-care Deficit Nursing Theory is one that is commonly used in rehabilitation nursing.

75.

A 14-year-old boy sustained a mild traumatic brain injury 2 weeks ago. His mother related that he is showing signs of cognitive impairment. Because the child lives in a rural town, what would be the most appropriate means of providing him cognitive rehabilitation?

Have a rehabilitation nurse assigned to his care, and follow up with him three times a week.

Have the patient follow up with his primary care physician.

Teach the mom cognitive exercises that she can perform with her son.

Enroll the patient in telerehabilitation.

Explanation:

By enrolling the patient in telerehabilitation, which could be by telephone, computer, or handheld device, a multidisciplinary team will be able to follow up with the patient and his mother more frequently. They will be able to address new problems that the patient may be experiencing rather than have him wait until he next sees his health care provider.

76.

A 45-year-old patient just had a T10–L4 transforaminal lumbar interbody fusion 4 days ago. During the assessment, the patient states that he is having difficulty urinating, and a bladder scan shows 600 cc of urine. The nurse is immediately concerned because the area around which of the following vertebrae provides functionality to the bladder?

T12

L1

L3

L4

Explanation:

The peripheral motor system carries information to and from muscles, organs, and glands to the central nervous system and essentially to the brain for translation. Each peripheral nerve is responsible for a dedicated area. Peripheral nerve T12 provides functionality to the sex organs, uterus, bladder, knee, prostate, and large intestine.

77.

A 65-year-old man has sustained a burst fracture after being involved in a rollover on the freeway. He has undergone surgical intervention and has been downgraded to the rehabilitation unit. He is displaying bowel incontinence and requires retraining. Which region of the spine does the nurse suspect was affected?

Cervical

Thoracic

Lumbar

Sacral

Explanation:

The sacral region of the spinal column provides rectal function. The nurse must therefore take special consideration when repositioning the patient or getting him out of bed. The patient should additionally be encouraged and taught the rationale for why he needs bowel re-training.

78.

A 56-year-old Hispanic man has been admitted to the rehabilitation unit with a diagnosis of autonomic dysreflexia. The nurse knows that autonomic dysreflexia occurs at which level in the spine?

T5–T6

T7–T8

T6–T8

T9–T12

Explanation:

Autonomic dysreflexia is a syndrome of massive imbalanced reflex sympathetic discharge occurring in patients with spinal cord injury (SCI) above the splanchnic sympathetic outflow (T5–T6). This condition represents a medical emergency, so recognizing and treating the earliest signs and symptoms efficiently can avoid dangerous sequelae of elevated blood pressure.

79.

A 17-year-old adolescent has sustained a burst fracture at T5 after being ejected from a car. He develops autonomic dysreflexia and becomes unstable. If not treated promptly, the nurse knows that which of the following can occur:

Emboli

Seizures

Myocardial infarction

Aneurysm

Explanation:

If left untreated or incorrectly treated, constant autonomic dysreflexia can lead to life-changing complications, such as severe peripheral hypertension, retinal/cerebral hemorrhage, pulmonary edema, and seizures. Morbidity related to autonomic dysreflexia is associated with hypertension, initiating headaches, blurred vision, and sweating. Mortality is rare.

80.

A 16-year-old Hispanic man has been admitted for bladder spasms and requires bladder rehabilitation. During rounds, the physician tells the patient that the nephrons are not working properly. The patient then asks the nurse, "What do the nephrons do?" The most appropriate answer by the nurse is that the primary function of the nephron within the kidney is to

filtrate the blood.

excrete wastes.

transport glucose.

make urine.

Explanation:

There are multiple components to the kidney. The functional unit of the kidney is the nephron, which is responsible for filtration of the blood. It is also responsible for the resorption of water and salts and the absorption of glucose, thus enabling the kidneys to get rid of excess water, wastes, and other substances from the blood.

81.

The mucosa is the layer of the mucous membrane that forms the inner lining of the gastrointestinal (GI) tract. It has three layers. All of the following are mucosal layers of the GI tract EXCEPT

muscularis mucosae layer.

lamina propria.

epithelium.

papillae.

Explanation:

The epithelium, the innermost area, protects the esophagus from the abrasive flow of undigested food en route to the stomach. The lamina propria, a layer of connective tissue, contains blood and lymph vessels. The muscularis mucosae layer contains smooth muscle fibers.

82.

A 43-year-old Asian man has been admitted to the rehabilitation unit for a spastic bladder for which he was prescribed an antispasmodic medication. The nurse knows that one of the most common side effects of this medication, of which the patient should be informed, is

headache.

diarrhea.

dry mouth.

double vision.

Explanation:

P Selective M3 receptor blockers can cause constipation, dry mouth, and blurred vision. The patient should be encouraged to ingest more fluids to alleviate dry mouth and report any blurred vision. Fluids should not include caffeinated beverages, which could make a dry mouth worse.

83.

A 40-year-old Caucasian woman is being discharged. When putting together the discharge package, the nurse notices that she has been prescribed a medication for her overactive bladder. All of the following medications are appropriate for her overactive bladder EXCEPT

tamsulosin.

solifenacin.

oxybutynin.

fluoxetine.

Explanation:

Fluoxetine, also known as Prozac, is a selective serotonin reuptake inhibitor and is commonly used in individuals who have irritable bowel syndrome, anxiety, or depression. Side effects when taking this medication include nervousness, nausea, dry mouth, sore throat, drowsiness, weakness, uncontrollable shaking of a part of the body, loss of appetite, weight loss, changes in sex drive or ability, and excessive sweating.

84.

A 32-year-old construction worker has been admitted to the rehabilitation unit after being diagnosed with herniation of a lumbar disk. Which of the following symptoms does the nurse anticipate that the patient is experiencing?

Tingling

Phantom pain

Instability

None of the above

Explanation:

Because the herniated disk is pushing on the nerves located alongside the vertebral body, it is therefore affecting the information relay between an extremity and the brain. By relieving the impingement, pressure that is placed on the nerves is relieved. Other symptoms that the patient could be experiencing include burning, stabbing pain, or deferred pain.

85.

A 16-year-old adolescent boy has sustained a mild traumatic brain injury a week ago while skateboarding. He has since been discharged to an outpatient rehabilitation clinic because he is having some psychosocial and motor deficits, according to his mother. The patient is very distraught, denies having any deficits, and wants to go back to school to “hang out” with his friends. As the assigned nurse, what would be the best way to assess the patient’s deficits?

Use normal conversation as a means of assessing the patient’s psychosocial status, and allow time for the patient to express his concerns in private before the assessment.

Have the mother step out while assessing the patient. This will allow the patient to build a trusting relationship with the nurse and to open up about his feelings.

Remove all guests from the patient’s room during the assessment; assess the patient’s strength in all extremities as well as fine and gross motor skills.

Allow the patient to open up about his feelings regarding his hospital stay, family system, anxiety, and depression, or panic attacks.

Explanation:

By allowing the patient to sit in a chair, the nurse can assess the patient’s motor skills, including walking, gait, balance, and strength in his lower extremities. By allowing the patient to express his concerns in private, the nurse eliminates the input of his mother’s opinion. In conversation, it is important to ask questions pertaining to the patient’s psychosocial state of mind.

86.

A 23-year-old patient was transferred from out of state for treatment of a burst fracture related to a motor vehicle accident. During the nurse’s assessment, the patient asks, “What is a burst fracture?” The nurse’s most appropriate response is,

“The front of vertebral body is fractured.”

“The spinous process is crushed.”

“The vertebral body is crushed.”

“The pedicle and joint facets are compounded.”

Explanation:

A burst fracture describes when a vertebral body is completely crushed. When this type of injury occurs, immediate surgery is necessary to maintain nerve integrity. Some of the signs and symptoms associated with a burst fracture include back pain, which can be moderate to severe and worsens with movement; numbness; tingling; and weakness. Patients may also present with an inability to empty the bowel or bladder.

87.

In the PLISSIT (Permission, Limited Information, Specific Suggestions, and Intensive Therapy) model of addressing sexual functioning, which of the following is the MOST effective method of giving a patient permission to discuss the issue?

Ask the physician to discuss the issue with the patient.

Be supportive if the patient broaches the subject.

Ask if the patient has concerns about sexuality.

Provide the patient literature about sexuality.

Explanation:

In the PLISSIT (Permission, Limited Information, Specific Suggestions, and Intensive Therapy) model of addressing sexual functioning, the most effective method of giving a patient permission to discuss the issue is to ask the patient directly about concerns regarding sexuality. Patients often feel very uncomfortable discussing issues of sexuality and may have little knowledge of options that are available to them, so it's important to discuss the issue matter-of-factly in a supportive manner.

88.

The day charge nurse on the rehabilitation unit is informed by the night charge nurse that a "sitter" called in sick at 7 am, and a substitute sitter will be an hour late. Which of the following patients would the nurse suggest be without a sitter while waiting for the substitute?

An 81-year-old demented women who had right hip hemiarthroplasty

A 52-year-old diabetic man who had a stroke and whose diabetes is uncontrolled

A 67-year-man with a right above-the-knee amputation with phantom pain

None of the above

Explanation:

A physician's order is needed for a patient to have a sitter; therefore, by not having a sitter as ordered, the nurse would be going against physician's orders. In this instance, the nurse would need someone, either the charge nurse or another staff member, to sit with the patient until the substitute sitter arrives.

89.

What nursing actions would be most effective and appropriate to prevent decubitus ulcers for a semicomatose patient?

Turn and reposition the patient every 2 hours.

Inspect and frequently assess the patients' skin, head to toe, for changes.

Request a physician's order for a therapeutic mattress and chair cushion.

Request a wound consultation.

Explanation:

Although all the answers listed in the question are technically correct, repositioning the patient every 2 hours is the best nursing intervention that does not require a physician's order or medical intervention. The nurse could initiate further intervention if the ulcer got worse. By turning the patient every 2 hours, the nurse is practicing preventative measures.

90.

A patient who is totally blind has developed non-24-hour sleep wake disorder, making it difficult for the patient to participate in the rehabilitation program because of sleepiness. Which medication has been FDA-approved for the treatment of this disorder in people who are blind?

methylphenidate (Ritalin®).

tasimelteon (Hetlioz®).

melatonin.

escitalopram (Lexapro®).

Explanation:

The medication that is FDA-approved for the treatment of non-24-hour sleep wake disorder for people who are blind is tasimelteon (Hetlioz®), a melatonin receptor agonist. This drug helps patients sleep for longer periods during the night and to be less sleepy during the day.

Tasimelteon is taken at bedtime and causes drowsiness leading to sleep. Tasimelteon has not been tested with children or women who are pregnant. Melatonin is a supplement that is also sometimes used for non-24-hour sleep wake disorder to advance or delay the internal circadian clock.

91.

A 34-year-old Hispanic woman has been admitted with an acoustic neuroma. Symptoms that are consistent with this diagnosis include

blurred vision and cognitive deficits.

hearing loss and vertigo.

bowel and bladder incontinence.

ataxia and weakness.

Explanation:

Patients with acoustic neuromas, a slow-growing tumor of the nerve that connects the ear to the brain, can exhibit a variety of symptoms. Two of the premier symptoms of acoustic neuromas are hearing loss and vertigo. These occur predominately because of the lesion's proximity to the eighth cranial nerve.

92.

A 34-year-old woman has been diagnosed with an acoustic neuroma and is experiencing hearing loss and vertigo. The patient asks the nurse why she is experiencing these symptoms. The nurse

says that it is because of the lesion's proximity to the

first cranial nerve.

third cranial nerve.

seventh cranial nerve.

eighth cranial nerve.

Explanation:

The eighth cranial nerve is also known as the vestibulocochlear nerve. It originates from the middle of the brain, and it splits to become the cochlear nerve. The vestibular nerve is responsible for balance and sense of orientation. Problems with the vestibulocochlear nerve may result in deafness, tinnitus (ringing or noise in the ears), dizziness, vertigo, and vomiting.

93.

A patient with COPD is often anxious because of shortness of breath, and this exacerbates the patient's ineffective breathing pattern. The patient has tried relaxation exercises but didn't persist because the patient didn't see immediate results. Which of the following complementary therapies may be MOST effective in helping the patient to relax and control anxiety?

Acupuncture.

Yoga.

Herbal preparations, such as St. John's Wort.

Biofeedback.

Explanation:

Patients with COPD may become impatient and want to see immediate improvement with relaxation exercises. If a patient is unsuccessful when trying relaxation exercises, a good alternative is biofeedback because it provides the patient tangible evidence that the mind can control some body functions, and the patient is better able to see what is effective in bringing about changes. Yoga may also be helpful to some patients although, with advanced COPD, the patient may not be able to participate.

94.

A 54-year-old Asian man was diagnosed with carcinomatous meningitis. His family wants to know when they will be able to take him home. The nurse knows that his prognosis is

excellent.

good.

fair.

poor.

Explanation:

Carcinomatous meningitis, a form of metastatic cancer that has spread to the lining of the brain and spinal cord and the parts of the body that make up the central nervous system, is caused by dissemination of cancerous cells throughout the subarachnoid space. The prognosis is poor. Patients usually survive for less than 1 year with treatment.

95.

An outpatient patient with a left AK amputation complains of discomfort from excessive sweating in the stump when wearing the prosthesis. What can the patient do to relieve this discomfort?

Apply an unscented antiperspirant to stump.

Apply alcohol to the stump.

Apply a double stump sock.

Remove the prosthesis periodically during the day.

Explanation:

A patient with a left AK amputation complaining of discomfort from excessive sweating in the stump when wearing a prosthesis should be advised to apply an unscented antiperspirant to the stump. Dampness can cause skin irritation with redness and blisters that may progress to skin ulcers. If perspiration is mild, applying powder may also help. Some stump socks have moisture management that wicks moisture from the skin and help to prevent irritation.

96.

The rehabilitation nurse arrives at the unit and must immediately admit a 45-year-old man who has had a transforaminal lumbar interbody fusion. While assessing the patient, the nurse realizes that the patient has a neurogenic bladder and is unable to void. What would be the most appropriate nursing action?

Give the patient water, and insert an intravenous line as he is probably dehydrated.

Scan his bladder to see how much urine is there.

Catheterize the patient to see how much urine is there.

Inform the attending physician of the findings.

Explanation:

Before calling the physician, the nurse must gather as much information as possible so the physician can make an informed decision based on the nurse's findings. The nurse should gather information that is non-invasive to the patient, such as a bladder scan, vitals, and a record of input and output. The nurse should not insert a catheter, as it is out of the scope of practice to make such decision.

97.

A 56-year-old homeless Hispanic man with no significant medical–surgical history has been admitted with benign and malignant temporal lobe tumors after sustaining a fall. What specific symptoms would the nurse expect to find in this patient?

Dysnomia and comprehension problems

Vertigo and nausea

Bowel and bladder incontinence

Headache

Explanation:

The temporal region of the brain (cerebral cortex) controls language comprehension and the processing of sensory input; thus, patients with lesions in this region exhibit the symptoms of dysnomia and comprehension difficulty.

98.

During a presentation to the unit, the nurse indicates that patients with large malignant neurological tumors located in the brain or spinal cord could become gradually less independent because of

injury to neural structures.

chemotherapy.

radiation therapy.

all of the above.

Explanation:

Large malignant tumors cause direct damage to neural structures. Chemotherapy and radiation therapy cause side effects. All of these factors can decrease the independence of patients.

99.

An 89-year-old man has been diagnosed with stage 4 prostate cancer. What is the best plan of care for a patient in an inpatient rehabilitation unit who has reached the terminal stage of their illness?

The patient should be transferred to inpatient hospice care.

The patient should receive hospice care at home.

The patient should remain in the rehabilitation unit with modified goals.

An individualized plan should be developed for the patient.

Explanation:

An individualized plan should be developed for each patient, with consideration for his or her specific needs and circumstances, as well as their socio-economic situation, insurance benefits, and other financial considerations. The patient and family members should make an informed choice that is best for them, based on all of the factors.

100.

A 45-year-old Caucasian man was diagnosed with a spastic bladder. Which of the following medications would the nurse most likely see on the medication administration record for a patient with this condition?

Darifenacin

Leflunomide

Trimethoprim

Cephalexin

Explanation:

Darifenacin is commonly used for the reduction of muscle spasms and symptoms, such as overactive bladder, frequent or urgent urination, and incontinence. This medication may cause blurred vision and or may impair thinking or reaction times.

101.

Alan is a 4-year-old child with cerebral palsy and limited mobility because of muscle spasticity. Alan's speech is slow but appropriate for his age. Alan likes established routines, but resists therapy and often becomes physically or verbally aggressive during therapy. Considering that Alan is in the initiative versus guilt stage (Erikson) of development, which strategy is likely to be MOST effective in gaining Alan's cooperation with therapy?

Establish a system of rewards.

Engage parents in disciplining the child's behavior.

Explain to the child the importance of therapy.

Integrate play and fantasy into therapy.

Explanation:

If a 4-year-old child with cerebral palsy is resistive of therapy and becomes verbally or physically aggressive during therapy, the most effect strategy in gaining cooperation with therapy is likely to integrate play and fantasy into therapy. In the initiative vs guilt stage (Erikson) of development, children enjoy initiating play activities, but they are also becoming more independent and showing initiative, which can include resisting activities they don't enjoy, especially if these activities elicit discomfort.

102.

A 17-year-old African-American adolescent has had had no visitors in the past couple of weeks. What factors could affect the ability of the patient's family to visit?

Financial problems

Time constrictions

Transportation constrictions

All of the above

Explanation:

Many factors can influence the family's ability to come see their loved one. It is imperative that the nurse assesses of the family's ability to visit and provide support for the patient before incorporating outside assistive services.

103.

A 45-year-old man has been admitted to the rehabilitation unit after undergoing a right total knee arthroscopy. The nurse overhears the family argue with the patient after which time no family member visits the patient. What would the best nursing assessment be for the decreased family support for the patient?

The grieving process

Family dysfunction

Stressors related to the patient's illness

Fear

Explanation:

Multiple contributing factors can significantly affect the ability of the patient's family to cope, especially when there is an unexpected significant illness or severe injury. The family member's ability to cope can vary and can result in disagreements. It is important to identify factors contributing to the dysfunction of the family and address them as needed.

104.

A patient is to be assessed for cognitive impairment. Which of the following would preclude the use of the MMSE?

Patient speaks English as a second language.

Patient wears hearing aids.

Patient has a fourth grade education.

Patient becomes confused when responding to items on the MMSE.

Explanation:

If a patient is to be assessed for cognitive impairment, the MMSE is a commonly used instrument, but it should only be administered to patients with at least an eighth-grade education to ensure reliability. If the test is administered in English, the patient should also be fluent in English (although speaking English as a second language does not necessarily disqualify a patient). If a patient wears a hearing aid, it's important to check to make sure the patient hears the directions and questions. Confusion is expected if dementia is present.

105.

A 25-year-old man was severely injured in a motorcycle accident while not wearing a helmet. He has an unremarkable medical–surgical history besides the fact that he has diabetes. Which of the following short-term goals takes priority?

Restoring or maximizing nutritional status

Restoring or maximizing independence with the activities of daily living

Restoring or maximizing cognitive ability

Restoring or maximizing mobility

Explanation:

Short-term goals, such as achieving nutritional status is needed to achieve other goals noted for this patient. Without the short-term goal of achieving nutritional status, the patient may not have a large enough caloric intake for the necessary caloric expenditure needed for the activities of daily living and proper healing.

106.

A 26-year-old patient who was in a motorcycle accident that resulted in an L1-L2 spinal cord injury has remained consistently cheerful but is making little progress in therapy because the patient insists that he can “manage just fine without help.” What stage of grief (Kübler-Ross) does this suggest that the patient is experiencing?

Anger.

Denial.

Depression.

Acceptance.

Explanation:

If a 26-year-old patient who was in a motorcycle accident that resulted in an L1-L2 spinal cord injury has remained consistently cheerful but is making little progress in therapy because the patient insists that he can “manage just fine,” the stage of grief that this suggests is denial. The patient is acting as though a profound change in his life has not occurred. The stages of grief

(Kübler-Ross) may vary among individuals but may also include anger, depression, bargaining, and acceptance.

107.

A 34-year-old Hispanic man is currently undergoing rehabilitation after having right ankle surgery. Upon assessment, the nurse notes that he is hardly moving and has a grimace on his face. The nurse also notices on his medication administration record that he has refused pain medication. After a cultural assessment, what would be the best nursing strategy to encourage the patient to take pain medication?

Tell the patient that he needs to take pain medication if he wants to get better, as it will allow him to do the exercises indicated by the physical therapist.

Ask his wife to encourage him to take the pain medication whether he wants to or not.

Educate him on the advantages of pain medication.

Do not make the patient do something that he does not want to do.

Explanation:

Opening the lines of communication between the patient and the nurse allows for a better understanding as to why the patient refuses to take pain medication. By educating the patient on the pros of taking pain medication, especially prophylactically, will allow for successful rehabilitation.

108.

A 45-year-old construction worker had surgery to repair a right tibial fracture that he sustained while on the job. He has been taking pain medications to help with the postsurgical pain. What is an important side effect that the nurse should discuss with the patient before administering narcotic pain medication?

Drowsiness

Constipation

Shortness of breath

Nausea and vomiting

Explanation:

The first aspect of health maintenance is establishing a patent airway, which needs to stay open without obstruction. Therefore, if a patient is displaying shortness of breath, measures must be taken to improve the patient's oxygenation exchange.

109.

A 36-year-old woman had a surgical excision of a malignant brain tumor and received radiation therapy postoperatively. She has nausea, bruising, and mild scalp erythema, and her surgical wound is oozing sanguineous fluid. Which of the following manifestations does the nurse anticipate being attributed to the cranial radiation?

Mild scalp erythema

Surgical-site oozing sanguineous fluid

Nausea

Bruising

Explanation:

Radiation therapy can disrupt normal incisional healing, and it can cause local skin reactions, including erythema and epilation. Since the patient is a post-surgical patient, it is important for the nurse to note that narcotics do not cause the erythema.

110.

A frail, 80-year-old woman, who fell at home 2 months previously, suffered a traumatic brain injury and subsequent cerebral hemorrhage. The results of her latest computed tomography scan show no significant improvement, and clinically she has no recent positive changes in her status. Her prognosis has been changed from fair to poor. Which of the following goals would be most realistic for this patient?

The patient will return to her previous level of cognitive function, as soon as possible.

The patient will receive ongoing palliative care to maintain her safety and comfort and to prevent injuries or complications.

The patient will be discharged home with home health nursing care as soon as possible.

The patient will return to her previous level of physical activity as soon as possible.

Explanation:

The patient described in the question has shown no significant improvement in her status, and her prognosis has been changed from fair to poor. Aggressive therapy would not be therapeutic for this patient, so ongoing palliative care to maintain her safety and comfort is indicated at this time.

111.

Why is a patient's rehabilitation potential an important consideration when developing an effective, individualized nursing care plan?

Patients may heal and progress at different rates because of a variety of unknown factors.

Patients may not all improve even with extensive rehabilitative treatment and therapy.

Patients may suffer unexpected complications and circumstances that impede their rehabilitative progress.

Patients may have significant challenges that will affect their ability to participate in and benefit from rehabilitative care.

Explanation:

Patients may have significant challenges that will affect their ability to participate in and benefit from rehabilitative care. These challenges are quickly identified and addressed when planning patients' care. Examples would be their level of consciousness and permanent deficits.

112.

A patient with myasthenia gravis exhibits hypernasality of speech with slurred feeble speech sounds. What type of dysarthria does this represent?

Flaccid.

Hypokinetic.

Ataxic.

Spastic.

Explanation:

If a patient with myasthenia gravis exhibits hypernasality of speech with slurred feeble speech sounds, the type of dysarthria this represents is flaccid. This is the most common type of aphasia and results from weakness or paralysis of muscles utilized for articulation. Flaccid aphasia may result from damage to the neurological system in the lower brainstem or in cranial nerves VII IX, X, and/or XII. Weakness or paralysis of the tongue makes language indistinct, and patients often have trouble with consonant sounds.

113.

A 37-year-old woman fell 40 feet, while hiking in a canyon with friends. She survived the fall, but sustained multiple injuries, including a fractured pelvis, a fractured right elbow, and a depressed frontal skull fracture. She is awake and alert, but disoriented. What is the most appropriate long-term goal for this patient?

The patient should be discharged to home as soon as possible.

The patient will achieve the maximum level of independence with her activities of daily living.

Multiple fractures usually heal 100% without complications.

The hazards of immobility will be prevented by early mobilization.

Explanation:

The most appropriate long-term goal for the patient described in the question is to achieve the maximum level of independence with the activities of daily living. The patient may not be able to return to her home to live independently because of cognitive or functional deficits related to her injuries. The healing of fractures and preventing the hazards of immobility are short-term goals for this patient, not long-term goals.

114.

An 81-year-old woman has been admitted to the rehabilitation unit after falling. During hourly rounds, the nurse finds the patient teary eyed while praying quietly in bed. This scenario best describes which of the following nursing processes:

Assessment

Diagnosis

Planning

Implementation

Explanation:

According to the American Nurses Association (2013), the registered nurse uses various means to collect and analyze data about the client. Assessment includes not only physiological data but also sociocultural, spiritual, economic, and lifestyle factors as well.

115.

A 54-year-old patient with chronic obstructive pulmonary disease is in the process of being discharged home with oxygen therapy. All of the following nursing diagnoses would be appropriate for this patient EXCEPT

shortness of breath.

large airway resistance.

nutrition less than requirements of the body.

knowledge deficit.

Explanation:

Nutrition for the patient with chronic obstructive pulmonary disease who is being discharged with oxygen is an important factor but not a critical aspect of the nursing process at this point. All aspects of breathing and circulation should be addressed before addressing the nutritional needs of this patient.

116.

A 20-year-old university student from China is receiving rehabilitative care after a near fatal bout of bacterial meningitis. He unfortunately has both cognitive and physical deficits related to his illness, but is improving daily. Based on traditional Chinese cultural and religious preferences, what nursing considerations should be included in his care plan?

A Mandarin or Cantonese translator may be needed to speak to the patient and his family.

The patient and his family may request that traditional eastern medical treatments, such as herbs and acupuncture be used.

The number of venipunctures for blood draws should be limited, since this is an issue in the traditional Chinese culture.

Both A and C are correct.

Explanation:

The question asks for nursing interventions. Thus, securing a translator and limiting venipunctures are nursing interventions that can be included in the care plan. Religious and cultural issues must be considered by health care professionals when providing holistic therapeutic care for a patient from China.

117.

An 87-year-old Chinese elder is admitted to the hospital very ill. The admitting physician has ordered a regular diet. Based on knowledge of Chinese culture, the nurse is most likely to suggest to nutrition services not to place which of the following food on the patient's tray?

Beef and eggs

Tomatoes and citrus fruits

Pork and shellfish

Milk and milk products

Explanation:

The traditional Chinese belief is that beef and eggs should not be served to those who are ill. It is important that the nurse assesses the patient's own beliefs and not predetermine what the patient is to ingest or not. It is important to ask before making assumptions.

118.

Transcultural nursing has become an important aspect of nursing because of the multitude of cultures for which they care. Which of the following theorists first proposed the idea of transcultural nursing as we know it today?

Madaleine Leininger

Joyce Travelbee

Rosemarie Rizzo Parse

Virginia Henderson

Explanation:

Transcultural nursing is the practice of culture-specific and universal nursing care. Using the values, beliefs, and practices of patients can promote health and well-being and can help people face illness or death in culturally meaningful ways.

119.

Based on traditional Chinese cultural beliefs, which hospital room number, designated for a new admission to the rehabilitation unit, would most likely be unacceptable for an elderly Chinese patient and his or her family?

666

4444

33

1001

Explanation:

According to traditional Chinese cultural preferences and beliefs, the number four is very bad luck (four is associated with negative Chi or bad energy); for example, people who have traditional Chinese beliefs avoid doing any business transactions at 4:00 p.m. and prefer not to live on the fourth floor of a building.

120.

A 62-year-old man is admitted to the rehabilitation unit after a bilateral total knee replacement surgery. His stated religious preference is Orthodox Judaism. What special considerations and accommodations should be included in his nursing care plan?

All caregivers for this patient should be male.

Alcohol and opiate drugs are not permitted

A strict kosher diet is required.

All of the above are true.

Explanation:

A strict kosher diet is required for an Orthodox Jewish person. There are no religious or cultural preferences in Orthodox Judaism that indicate that all caregivers for a male patient be men or that alcohol and opiate drugs are not permitted.

121.

A 43-year-old Orthodox Jewish patient was placed on a strict, low-sodium, kosher diet. Which of the following food items would concern the nurse if they were on the patient's tray?

Pork and pork products

Clams and oysters

Scallops and shrimp

All of the above

Explanation:

A strict kosher diet has many rules and restrictions. Pork, pork products, such as ham and bacon, and all shellfish are not allowed within the kosher diet. Only fish with fins and scales may be eaten.

122.

A 26-year-old woman is admitted to the rehabilitation unit with a traumatic brain injury sustained when she fell from a second-story balcony. Her neurological status has improved significantly over the past week. During the nurse's initial assessment, she stated that she is a member of the Hindu faith and that she is sure that she knew the nurse in a previous life. What would be the most appropriate nursing action based on this conversation with the patient?

Check the patient's chart, and speak to the patient's family to verify that her religious preference is in fact Hinduism.

Document exactly what the patient said during the initial assessment.

Update the patient's care plan to include accommodations for her Hindu faith, based on the information provided.

Ask the patient how she knew the nurse in a previous life.

Explanation:

Since the patient has sustained a traumatic brain injury, the information she provided regarding her Hindu faith may not be accurate. The most appropriate nursing action would be to check the patient's medical record and verify her religious preference with her family.

123.

What would an important nursing intervention be for a 66-year-old woman with the diagnosis of dysarthria?

Encourage the patient to communicate with whatever alternate method of communication she is most comfortable.

Request a physician's order for a speech therapy evaluation for this patient as soon as possible.

Ensure that the nurses' call bell and an alternate communication system are readily available to the patient at all times.

Both A and C are correct.

Explanation:

Focusing on nursing interventions, the patient should be encouraged to use a communication method with which she is most comfortable. It is very important for the patient to have easy access to the nurses' call bell and an alternate communication system at all times since she is unable to communicate effectively by spoken language.

124.

A 26-year-old man sustained a minor closed head injury when he fell in his hospital room today. He was attempting to ambulate to the bathroom for the first time without assistance. Which of the following signs and symptoms would concern the nurse most?

Changes in behavior and drowsiness

Severe headache and vomiting

Stiff neck and weakness

Vertigo

Explanation:

The nurse would be most concerned about a severe headache and vomiting; these could indicate something more severe that would need further evaluation and diagnostic testing.

125.

A 25-year-old woman with a fractured pelvis was transferred to the rehabilitation unit from acute care. While reviewing the patient's record, the nurse notices that she has checked Buddhist as her religious preference. What special considerations related to her religious beliefs would be important when planning her care?

The patient may refuse pain medications to remain 100% alert.

The patient may refuse to eat meals prepared by the hospital kitchen staff.

The patient may refuse to allow nursing staff to perform bed baths and other personal care.

None of the above is true.

Explanation:

Those who believe and practice the Buddhist faith believe that mindfulness is extremely important and being awake and alert are essential. Thus, they often refuse pain medications to remain 100% alert.

126.

The nurse reviews a patient's chart and realizes that the care plan has not been revised in quite some time. Revising the care plan indicates which of the following nursing processes?

Assessment

Planning

Implementation

Evaluation

Explanation:

During the evaluation phase of the nursing process, the nurse determines whether the goals that were outlined for the patient have been achieved. If not, then the care plan needs to be reevaluated.

127.

A patient has posted a sign above her bed that says, "I am strong and will be able to live independently." The patient repeats this phrase several times during the day. What strategy is the patient utilizing?

Role modeling.

Positive affirmation.

Self-hypnosis.

Visualization.

Explanation:

If a patient has posted a sign above her bed that says, "I am strong and will be able to live independently," and repeats this phrase several times during the day, the strategy the patient is utilizing is positive affirmation. Positive affirmations are positive thoughts to help people overcome negative thought patterns and to help to visualize a goal. Patients often repeat the affirmations during the day to keep reminding themselves to think positively.

128.

A 54-year-old Hispanic woman was admitted for a right lower extremity non-healing wound. The patient's response to potential health problems would reflect what part of the nursing process:

Assessing

Diagnosing

Planning

Evaluating

Explanation:

During the diagnosis step of the nursing process, the nurse identifies actual or potential problems associated with the patient. These problems can be emotional, psychosocial, or physical.

129.

A 50-year-old man has been admitted to the rehab unit after undergoing an evacuation of a subdural hematoma. He is currently undergoing inpatient rehabilitation and will continue rehabilitation as an outpatient. What aspect of the nursing process does this highlight?

Assessment

Diagnosis

Planning

Implementation

Evaluation

Explanation:

According to the American Nurses Association (2013), implementation within the nursing process pertains to the assurance that there will be continuity of care for the patient while in the hospital as well as after discharge.

130.

Upon arrival of a new patient, the nurse introduces herself and begins to assess the patient, knowing that the primary rationale for the assessment is to

diagnose the problem.

meet the patient.

perform a head-to-toe assessment.

identify the patient's needs.

Explanation:

The nurse's primary rationale for performing an assessment is to identify what the patient needs and assess how the plan of care can help to attain these needs. In addition, the nurse must assess the patient's and family's readiness to learn.

131.

An 81-year-old Caucasian woman had a total hip replacement 3 days ago. During a report, the nurse is told that the patient refuses to participate in physical therapy. The nurse realizes that movement is imperative to recovery and, therefore, suggests which of the following nursing interventions for a non-compliant patient:

Active and or passive range of motion, repositioning, and activities of daily living

Deep breathing exercises

Use of a spirometer

All of the above activities

Explanation:

Involving the patient in range of motion exercises, such as stretching and walking, will not feel like exercises to the patient, but these exercises are imperative for recovery. This nursing intervention is the most appropriate for this patient, as it will also diminish the possibility of complications due to inactivity.

132.

A 24-year-old man with an external fixator to his right lower leg is admitted to the rehabilitation unit. During the morning assessment, he tells the nurse that he has been free of pain all night. This achievement would fall under which of the nursing processes:

Assessing

Diagnosing

Planning

Evaluating

Explanation:

The patient has met a short-term goal and, therefore, is ready to achieve a more attainable long-term goal. The nurse will be able to assess the patient's readiness to achieve a long-term goal and plan accordingly.

133.

What type of clothing would be most appropriate and comfortable for a 16-year-old female rehabilitation patient, who receives physical therapy five times a week?

Leggings, tube top, and flip-flops

Hospital gown, pajama pants, and socks

Yoga pants, T-shirt, and tennis shoes

Flannel pajamas, terrycloth robe, and slippers

Explanation:

Loose-fitting clothing, such as yoga pants and a T-shirt, would be the most comfortable and appropriate choice for a 16-year-old rehabilitation patient. Tennis shoes would be the safest choice for participation in physical and occupational therapy and to protect her feet.

134.

According to federal regulations, an inpatient rehabilitation facility (IRF) must meet certain specified "conditions of participation" to be considered an IRF. An example of these conditions would be that an IRF patient must

require and receive at least 3 hours a day of any combination of physical or occupational therapy.

be expected to achieve significant improvement during the first 30 days.

have a length of stay greater than 2 weeks.

demonstrate consistent progress on a daily basis.

Explanation:

For patients to be deemed in need of rehabilitation, they must meet the federal regulations of needing at least 3 hours of therapy a day. Community hospitals and teaching hospitals may have additional requirements, but insurance plays a substantial role in the decision-making efforts.

135.

A care plan meeting is being held to evaluate and discuss a patient's progress in the rehabilitation unit and update his care plan; thus, it is very important that

the care-plan meeting includes all of the members of the rehabilitation health care team who provide care for the patient.

the patient and patient's family members are not invited to participate in the care-plan meeting.

the care-plan meetings are held at least biweekly.

the care-plan meetings are held once every 30 days for insurance purposes.

Explanation:

To achieve optimal rehabilitation, an interdisciplinary rehabilitation team should meet to formulate a care plan appropriate for the patient. By adhering to the care plan created by the team, the end goals will be consistent and obtainable. The care-plan meeting should include all members of the rehabilitation health care team as well as the patient and the patient's family members.

136.

What are the most important factors to consider when deciding what rehabilitation facility or setting would best suit a patient's individual needs?

The type of rehabilitation facility, their admission standards, and the services they provide

The proximity of the rehabilitation facility to the patient's home.

The cost of the patients' rehabilitation care at the facility.

The rehabilitation facility's proximity to an acute care hospital

Explanation:

The facility should provide services consistent with the patient's rehabilitation needs. Other factors, such as cost and location, may be additional factors that may play a role in the decision-making process for the family, but it is key that the rehabilitation services meet the patient's rehabilitation needs.

137.

Rehabilitative units, hospitals, facilities, and settings offer a variety of rehabilitative services by health care professionals and other care providers to assist patients in their recovery and rehabilitation. The rehabilitation team should include

physical therapists, occupational therapists, and speech therapists.

physicians, rehabilitation nurses, and rehabilitation patient-care technicians.

registered dietitians, medical social workers, and discharge planners.

all health care professionals who care for the patient

Explanation:

All multidisciplinary health care providers, such as physical therapists, occupational therapists, and speech therapists, play an intricate role in the recovery phase of the patient. However, all of the health care personnel who care for the patient are integral members of the rehabilitation team and provide care and services to assist the patient in their recovery and rehabilitation.

138.

After a 2-hour rehabilitation care-plan meeting, it is the consensus of all of the rehabilitation team members that a patient's care has been aggressive and appropriate, but the patient has "plateaued" and no longer meets the criteria for inpatient hospitalization at this facility. What would the next appropriate action be?

Discharge the patient to home, as soon as possible.

Discharge the patient to a skilled nursing facility, as soon as a bed is available.

Explain to the patient and patient's family members that the patient's status will most likely never improve.

Develop and execute an appropriate, safe, and individualized discharge plan for the patient.

Explanation:

Discharging the patient to home or a skilled nursing facility may not be the appropriate discharge plan for this patient. An effective and appropriate individualized discharge plan must be developed and executed with consideration for multiple factors, limitations, and circumstances.

139.

A rehabilitation nurse is caring for a 54-year-old, non-English-speaking, Hispanic woman. Upon performing her head-to-toe assessment, the nurse notices that the patient is withdrawn and not particularly interactive. Which of the following nursing processes is the nurse practicing?

Assessment

Diagnosis

Planning

Implementation

Explanation:

By assessing the patient, the nurse gathers information about the client's anxiety and withdrawal. The nurse will then be able to formulate and change the patient's care plan, according to her needs.

140.

The nurse is assigned a patient with an unfamiliar diagnosis. After obtaining help from the clinical nurse leader, the nurse realizes that more information is needed to provide adequate nursing care. Which of the following would be the most valuable resource?

Internet

Physician's Desk Reference

Library

Department of Health and Human Services

Explanation:

The U.S. Department of Health and Human services provides all health care providers with the National Guidelines Clearinghouse, which is a public resource for evidence-based practice guidelines for a multitude of diagnoses. It also provides health care providers with various aspects of the nursing process within the diagnosis.

141.

According to the Health Belief Model, which of the following constructs is most critical to convince a patient to change health behaviors?

Perceived severity.

Perceived barriers.

Perceived benefits.

Perceived susceptibility.

Explanation:

According to the Health Belief Model, the construct that is most critical to convince a person to change health behaviors is perceived susceptibility. If a patient does not believe that a negative consequence (such as lung cancer from smoking) will occur, then the patient has little motivation to change behavior. Perceived severity along with perceived susceptibility comprise what is referred to as perceived threat.

142.

Which of the following factors can negatively affect a patient's rehabilitative progress?

A patient's unrealistic expectations regarding healing and restorative potential

A patient's commitment, motivation, and desire to work hard at rehabilitation

A patient's positive relationships with nursing staff, therapists, and caregivers

A patient who has family members and friends visiting daily

Explanation:

If the patient has unrealistic expectations, the patient's care plan implementation can be adversely affected. The patient can then be at risk for other potential harming factors, which prohibit his overall prognosis.

143.

Which of the religions listed below would require a middle-aged male patient to have only male caregivers to provide medical treatment, bathe, change clothing, or use the restroom and to be covered from his waist to his knees?

Scientology

Seventh-day Adventism

Jehovah's Witnesses

Islam

Explanation:

The Islamic faith requires that male patients have only male caregivers and that they be covered from their waist to their knees, except when they are alone or assisted by a male caregiver, to provide medical treatment, bathe, change clothing or use the restroom.

144.

A 28-year-old woman who had been semicomatose for 2 weeks, after sustaining a traumatic brain injury in a motor vehicle accident, is now awake and alert. She has been transferred to the

rehabilitation unit for rehabilitative care. While performing the initial patient assessment, the new patient informs the nurse that she is a Christian Scientist. This religious preference is not documented in the patient's record. What potential problems could the nurse expect?

The patient may refuse all medications and treatments now that she is awake and alert.

The patient may require a private room for prayer and meditation.

The patient may require all female caregivers.

The patient may refuse to eat meals prepared by the hospital kitchen staff.

Explanation:

Christian Scientists generally do not seek medical care; however, those who do seek medical care can make their own decisions about receiving or refusing care and treatment.

145.

A patient has been admitted with dysarthria. She is concerned because she is aware that this is a secondary diagnosis which can be caused by

HIV/AIDS.

thyroid cancer.

Guillain-Barré syndrome.

Hodgkin's disease.

Explanation:

Guillain-Barré syndrome is an autoimmune disorder that can have symptoms, such as tingling and foot or hand pain. Patients can also develop a secondary diagnosis of dysarthria, a motor speech disorder.

146.

When developing a rehabilitation care plan, a nursing diagnosis is used to

clearly define the appropriate plan of patient care and facilitate clear communication among rehabilitation team members.

document the patient's progress and response to treatment.

document the patient's limitations and deficits.

facilitate approval by insurance companies and Medicare for payment of extended rehabilitation stays.

Explanation:

A nursing diagnosis can give the nurse and patient a clear understanding of what the patient needs to regain full functionality. The nursing diagnoses are clinical judgments regarding actual or potential problems, circumstances, or other factors that significantly affect the patient's well-being, recovery, and rehabilitation.

147.

What subtle changes in a rehabilitation patient's neurological status may be early indications of increasing intracranial pressure?