M_MedSurgNursePQ (300+ Questions) - Quiz Questions with Answers

1.

A patient has contracted chlamydia through unprotected sex. Which of the following is the most appropriate response?

“It is a bacterial infection and can be treated with antibiotics.”

“You should abstain from sex until marriage.”

“There is no treatment for this disease, but symptoms can be managed.”

“You do not need to inform past sexual partners about this disease if it is treated.”

Explanation:

Chlamydia and gonorrhea are some of the few sexually transmitted diseases (STDs) that can be treated with antibiotics. Left untreated they can lead to pelvic inflammatory disease and infertility. Though some medical practitioners may believe that sex should be reserved until marriage, they should not push their personal beliefs on their patients. Patients should be educated about the spread of STDs and understand that one way to prevent the spread of diseases is by abstinence or practicing safe sex. Partners should always be informed once the diagnosis of an STD is made so they can be treated and prevent spreading the disease to others.

2.

A nurse is caring for a patient who ruptured his spleen in a motor vehicle accident and required a splenectomy. What vaccine should the nurse expect to administer before surgery?

Recombivax HB

Attenuvax

Pneumovax 23

Tetanus toxoid

Explanation:

Pneumovax 23 is a polyvalent pneumococcal vaccine, given prophylactically before surgery to prevent pneumococcal sepsis after splenectomy. Recombivax HB is a vaccine that protects against hepatitis. Attenuvax is a live, attenuated virus vaccine for immunization against measles (rubeola). Tetanus toxoid prevents tetanus (lockjaw) from Clostridium tetani infection after a puncture wound.

3.

Which of the following may help prevent cervical cancer?

Routine testing for venereal disease

Refraining from using diaphragms

Avoiding alcohol

Limiting the number of sexual partners

Explanation:

Many cases of cervical cancer are caused by the human papilloma virus (HPV). Limiting one's sexual partners can decrease one's exposure to HPV and can decrease the risk of developing cervical cancer. Regular Pap smears and gynecological examinations can help detect any anomalies early. Venereal/sexually transmitted disease screening plays little role since HPV is not treatable. The use of diaphragms plays no role in the development or prevention of cervical cancer. Alcohol intake does not increase one's risk significantly.

4.

Which of the following is NOT a complication of beriberi?

Muscle weakness

Diabetes

Encephalopathy

Seizures

Explanation:

Beriberi is caused by a thiamine deficiency primarily seen in developing or underdeveloped countries. Symptoms may include muscle weakness or paralysis due to damaged nerves, heart failure, pleural effusion, encephalopathy, seizures, decreased reflexes, as well as a multitude of other complications. Some of these complications may be permanent if the thiamine deficiency is not corrected quickly.

5.

Which of the following is the best way to prevent diabetes mellitus?

Decrease processed foods

Increase thiamine intake

Decrease alcohol intake

Increase iron intake

Explanation:

Diabetes mellitus is the insufficient production of insulin resulting in hyperglycemia. Maintaining an ideal body weight and limiting the amount of sugar and processed foods can help prevent the development of the disease. Increasing one's thiamine intake would help prevent beriberi. Decreasing alcohol intake would help those who are chronic alcoholics or those with gout. Increasing iron intake will help those with anemia.

6.

A 48-year-old awake and alert patient on the unit normally manages his diabetes with Novolin R sliding scale insulin. His wife is helping him get his lunch tray set up when the nurse assistant reports to the nurse that his blood sugar is 68. He did not receive any insulin. Which of the following would be the least appropriate intervention for this patient?

Administer D5W

Encourage intake of lunch, especially long and short acting carbohydrates

Recheck blood sugar in 30 minutes

Advise the patient to avoid rising quickly or walking until after his blood sugar has stabilized, and his wife to report and change in mental status

Explanation:

In the awake, alert patient with a caretaker at the bedside, who is asymptomatic, other interventions should be considered first before giving D5W. Eating lunch, especially consuming a short acting carb to raise the blood sugar now, and a long acting carb to help sustain blood sugar levels and prevent rebound hypoglycemia is advisable. However, if the patient in the situation had depressed mental status, juice should not be given since the patient would be at risk for aspiration. The blood sugar should be rechecked to make sure that it is rising appropriately. Advising the patient to avoid rising and walking will help the patient stay safe from falls. Change in mental status could indicate that the patient's blood sugar is getting lower and further intervention is needed.

7.

A patient who has suffered a stroke is being discharged home today. The patient's wife is concerned about caring for her husband at home. Which of the following is NOT an appropriate response to the patient's wife?

"He should gradually increase his activity as tolerated."

"I can help coordinate referrals for various medical specialists."

"He should be on bed rest except for bathing or toileting."

"If there is any change in his neurological status please call 911."

Explanation:

The patient does not need to be on bed rest. Reasonable physical activity as tolerated is encouraged in both inpatient and outpatient settings for stroke patients to help them improve their range of motion, ambulation, and strength. Recommending bed rest will only exacerbate their residual deficits caused by the stroke and increase the risk for deep vein thromboses, decubitus ulcers, and atelectasis.

8.

A patient develops a fever, mild chest pain, and a generalized body rash while being transfused with blood. Which of the following should be the nurse's first step in this patient's management?

Administer Benadryl

Stop the transfusion

Administer Tylenol

Perform an EKG

Explanation:

This patient is having a transfusion reaction. The transfusion should be stopped immediately before performing any interventions. The nurse may administer Benadryl for pruritus and for the rash, and Tylenol may be given for fever and pain. Steroids may also be given to help decrease inflammation. Since the patient is having chest pain, an EKG would also be an appropriate intervention.

9.

A patient is admitted to the hospital for a pulmonary embolus likely caused by her sickle cell disease. She is placed on a heparin infusion and started on Coumadin. While on anticoagulation the patient develops massive epistaxis requiring a blood transfusion. The patient develops a hemolytic transfusion reaction because she was transfused with the wrong blood type. Which of the following is the sentinel event?

Sickle cell disease

Pulmonary embolus

Epistaxis

Transfusion

Explanation:

The transfusion reaction was caused by the patient receiving the incorrect blood type. Any time a patient is receiving medication, blood products, or is undergoing a procedure, the patient's identity and blood type should be verified by at least two nurses. The blood product should also be examined to make sure it has the correct name and blood type. The Joint Commission defines a sentinel event as an unexpected injury or complication, which may or may not cause the death of the patient, not due to the patient's primary diagnosis. The pulmonary embolus is an expected potential complication of having sickle cell disease. Although the patient developed epistaxis from the Coumadin and heparin, it is an expected potential complication of anticoagulation medications. The patient developed a transfusion reaction due to human error and not from her primary diagnosis.

10.

A patient with a subarachnoid hemorrhage has developed vasospasm. Which of the following would help prevent further complication?

Maintaining elevated blood pressure

Applying warm compresses

Administering antihypertensive medication

Maintaining euvolemia

Explanation:

Hypervolemia, hypertension, and hemodilution, otherwise known as "triple H" therapy of subarachnoid hemorrhages, is the gold standard of treatment. Keeping a patient's blood pressure elevated, maintaining hypervolemia through blood transfusions and hemodilution through aggressive fluid hydration helps prevent further complication from vasospasm such as stroke.

11.

Which of the following is the most appropriate intervention for an ileus?

Trickle feeds

Surgery

Narcotic pain medications

Transfusions

Explanation:

An ileus is the impaired peristalsis of the gastrointestinal tract following a surgery or accompanying certain diseases. It may present with nausea, vomiting, constipation, and distended abdomen. Trickle feeds, bowel regimen medications such as Colace and senna, and anti-emetic medications are the mainstays of therapy for an ileus.

12.

Which of the following is NOT a phase in the nurse-client therapeutic relationship?

Uncooperative stage

Orientation stage

Exploration stage

Termination stage

Explanation:

There are three stages in the nurse-client therapeutic relationship: orientation, exploration, and termination. In the first stage the nurse and client establish limitations, boundaries, trust, and rapport. In the second stage the nurse and client should be able to identify problems or issues and potential solutions to those issues. The nurse may offer assistance or teach the client coping mechanisms in order to face some of the issues. The nurse may assume different roles in order to help the client deal with the stressful situation he or she is facing. In the last phase, the relationship is terminated upon discharge or transfer. The goal of the third stage is the resolution of the client's issues and/or achieving acceptance of the problems and ways to cope with them.

13.

A patient is scheduled for an evacuation of a small subdural hematoma the following morning. He is scheduled to receive a Lantus dose at 11 pm and was ordered to be NPO past midnight. What is the next step in management?

Give the Lantus

Give half the dose of Lantus

Hold the Lantus

Call the attending to clarify the order

Explanation:

The nurse should call the attending to clarify the order. Lantus is a type of long-acting insulin and if the patient is being kept NPO he has no glucose intake to counteract the insulin therapy. This may result in dangerously low blood sugar levels. Since the patient has a subdural hematoma, he cannot have D5 in his IV fluids since this may result in cerebral edema. Generally, Lantus is held prior to a procedure where the patient will be kept NPO, and the patient will be placed on regular insulin on a sliding scale.

14.

A patient is being treated with Pradaxa. Which of the following is one of the most common dangerous side effects?

Liver failure

Bleeding

Ototoxicity

Cough

Explanation:

Bleeding is a common side effect of blood thinners such as Coumadin or Pradaxa or anti-platelet medications like aspirin or Plavix. Ototoxicity is one of the most common side effects of the aminoglycosides, such as gentamicin. Cough is one of the most common side effects of ACE inhibitors. Liver failure can be caused by a number of medications.

15.

A nurse has just started a job in a long-term-care facility and is becoming familiar with the laws and regulations relevant to that field. Which of the following acts is the most important for the nurse to be familiar with?

OAA

ADA

OBRA

EMTALA

Explanation:

The Omnibus Budget Reconciliation Act (OBRA) (1993) contains the 1990 Nursing Home Reform Amendments, which establish guidelines for nursing facilities such as long-term-care facilities. Provisions include outlawing Medicaid discrimination; requiring physical and mental assessments of patients on admission, annually, and with change of condition; mandating nurse aide training and in-service training; and requiring 24-hour nursing with registered nurses on duty for at least one shift. The Older Americans Act (OAA) was created in 1995 to provide social services to elderly individuals as a means to promote health and wellness. The Americans with Disabilities Act (ADA) was established to protect individuals with disabilities from discrimination. The Emergency Medical Treatment and Active Labor Act (EMTALA) is specific to emergency departments, mandating that individuals arriving to an emergency department must be provided care through stabilization prior to their transfer.

16.

Which of the following two medications should NOT be taken together?

Lopressor and Norvasc

Metformin and Lantus

Aspirin and Lasix

Nexium and Plavix

Explanation:

Nexium and Plavix should never be taken together since Nexium blunts the effects of Plavix. Nexium blocks an enzyme in the body that turns Plavix into its active form. This can increase the risk of a patient developing an adverse event such as stroke or heart attack. If a patient who needs Plavix is taking Nexium, this should be switched to a histamine-2 blocker such as Pepcid.

17.

A patient with Sjögren's syndrome asks her nurse which medications she can take to help decrease the severity of her symptoms. Which of the following should the nurse suggest?

NSAIDs and birth control pills

Albuterol and Atrovent

Saline nasal spray and eye drops

Benadryl and Decadron

Explanation:

Sjögren's syndrome is an autoimmune disease that causes insufficient production of saliva and mucus in the body. The most common complaints of patients include eye, nasal, and vaginal dryness. In order to help alleviate these symptoms, medical professionals should recommend the use of lubricants, nasal sprays, and eye drops.

18.

A nurse is taking care of a patient with bilateral lower extremity superficial vein thromboses (SVTs). Which of the following should NOT be ordered for this patient?

Repeat lower extremity ultrasound Dopplers

Subcutaneous heparin or Lovenox

Bed rest

Placement of an inferior vena cava filter (IVCF)

Explanation:

Superficial vein thrombosis (SVT) or deep vein thrombosis (DVT) is usually caused by lack of physical activity; bed rest will only cause more clots to develop. Subcutaneous heparin or Lovenox are used as treatment and prevention of SVTs and DVTs. If the patient is at high risk and there are no contraindications, Coumadin may be started. In cases where Coumadin is contraindicated, placement of an inferior vena cava filter (IVCF) may be indicated. If a patient is diagnosed with a clot, repeat ultrasound Dopplers should be ordered to monitor the progression of the clot.

19.

Which of the following interventions would NOT help treat a patient in status epilepticus?

Finger sweep the mouth for obstruction

Reverse Trendelenburg

Supplemental oxygen

Antiepileptic medications

Explanation:

Status epilepticus is a condition in which a patient continually seizes without break. Finger sweeps are contraindicated because the patient can bite down on the examiner's finger causing injury or amputation. The patient should be placed in reverse Trendelenburg position to maintain a patent airway; if the patient develops hypoxia, supplemental oxygen is recommended. Anti-seizure medications such as Vimpat, Dilantin, or Keppra are warranted.

20.

A nurse is caring for a patient with a known history of anxiety. She is scheduled for an MRI later that day and the patient tearfully tells the nurse that she is very claustrophobic. Which of the following medications should the nurse ask to be ordered for the patient prior to undergoing the test?

Lorazepam

Lantus

Levoxyl

Lopressor

Explanation:

Lorazepam is a benzodiazepine. Benzodiazepines cause sedation, so they are commonly used as treatment for anxiety disorders, phobia disorders, and seizures. Lantus is an anti-hyperglycemic medication commonly used in diabetic patients. Levoxyl is a synthetic thyroid hormone medication used in patients who have hypothyroidism. Lopressor is a beta-blocker, which is used to decrease heart rate and blood pressure. It is used for treatment of hypertension, atrial fibrillation, heart failure, and acute myocardial infarction.

21.

Which of the following medications would be used for a person diagnosed with bipolar disorder?

Decadron

Lantus

Permethrin

Lexapro

Explanation:

Lexapro is used to treat generalized anxiety disorder, depression, post-traumatic stress disorder, and other psychiatric conditions. Decadron is a type of steroid used to treat inflammatory reactions such as localized skin reactions and asthma. Lantus is used to treat those with hyperglycemia. Permethrin is used to treat infections caused by scabies.

22.

A patient with advanced cirrhosis is admitted with bleeding esophageal varices and associated hepatic encephalopathy. The nurse expects to give neomycin to:

control secondary infection in the hepatic bile ducts.

prevent the development of bacterial bronchitis and pneumonia.

eliminate microorganisms from the kidney, ureters, and bladder.

destroy intestinal organisms that break down proteins to ammonia.

Explanation:

Hepatic encephalopathy is characterized by elevations of ammonia levels in the brain and cerebrospinal fluid. Ammonia is produced in the GI tract when bacteria break down protein. Neomycin reduces ammonia-forming bacteria in the intestinal tract. Neomycin is not absorbed into the circulation, so it exerts a powerful effect on intestinal bacteria. The other options do not correctly explain neomycin's use.

23.

Which of the following scenarios would NOT require RhoGAM administration?

A mother with AB- blood whose fetus is AB+

A fetus with O+ blood whose mother is A-

A mother with B- blood whose fetus is O+

A fetus with A- blood whose mother is B-

Explanation:

RhoGAM is administered to prevent hemolytic disease of the newborn, or Rhesus disease. This can result in jaundice, heart failure, hepatosplenomegaly, and fetal death. It is caused by maternal antibodies of a Rhesus negative mother that attack a Rhesus positive fetus. The positive Rhesus factor is regarded by the mother's body as a foreign antigen, so the mother's antibodies attack the fetus. RhoGAM is an immune globulin that depresses the mother's immune system temporarily so that it does not recognize the positive Rhesus fetus.

24.

According to Maslow's hierarchy of needs, which of the following would have priority in the care of a patient?

The patient states that medical staff is discriminating against her because she is transgender.

The patient is incontinent of urine and feces.

The patient's pulse is 38 and irregular with skipped beats.

The patient states that she is thirsty and wants something to drink.

Explanation:

According to Maslow's hierarchy of needs, physiologic needs have priority over other needs, so priority in the care of the patient is to address the patient's apparent heart block, pulse 38, irregular pulse with skipped beats. Physiologic needs are those that are essential to maintain life, including adequate airway, breathing, and circulation. Other physiologic needs may include adequate fluid and nutrition. Maslow's hierarchy of needs form a pyramid that builds from physiologic needs, to safety and security, to belonginess and affection, to esteem and self-respect, and finally to self-actualization.

25.

A surgical nurse accidentally sticks herself with a needle during surgery. The patient has a known history of hepatitis C. Which of the following actions is NOT advisable?

Continue assisting with the surgery

Notify the patient of the incident once he/she is conscious

Notify Employee Health and a supervisor

Immediately scrub out of the procedure

Explanation:

If a needle-stick injury occurs, the most important first step is to scrub out and immediately irrigate or wash the wound with soap and water. This is done not only for the nurse's safety, but also for the safety of the patient. The patient should be notified of the incident once he/she has awakened from anesthesia. Employee health and the nursing supervisor should be immediately notified. The nurse with the needle-stick injury should report to the emergency department so blood can be drawn for virology.

26.

A nurse is assessing a patient with a history of hepatitis. How should this patient be evaluated for asterixis?

Instruct the patient to squat

Measure the patient's abdominal girth

Ask the patient to hyperextend her feet

Ask the patient to extend her arm and hyperextend her hand

Explanation:

Asterixis is a flapping hand tremor that is a classic sign of hepatic failure. To check for asterixis, ask the patient to extend her arm and hyperextend her fingers toward the ceiling. Observe if the patient can maintain this position or if her fingers begin to tremble. Asterixis is a hand tremor

only, testing the feet, having the patient squat, and measuring the abdominal girth are inappropriate measures.

27.

A patient begins to choke while she is eating her food. Her face starts turning bright red, but she is able to cough. Which of the following should be the next course of action?

Start performing abdominal thrusts

Begin back slaps

Allow the patient to drink small sips of water

Perform finger sweeps of the mouth to remove the food

Explanation:

The patient should be allowed to drink small sips of water to try and clear her throat. The patient is able to cough which means that her airway is not completely obstructed. Finger sweeps should never be performed because it increases the risk of pushing the object further into the airway. Since the patient is still coughing, she is able to move air in and out of her lungs. Performing back slaps or abdominal thrusts is indicated only if there is a complete obstruction.

28.

A patient is in the process of being directly admitted to a unit from the doctor's office. The only orders on his chart so far are admit the patient to medical surgical unit, stat lab work, bedrest, and NPO status. The patient's daughters are at his side and he is talking to the registrar when he starts seizing. Which of the following is NOT an appropriate action by the nurse?

Administer a Dilantin bolus

Place the patient on his side

Call the attending/admitting physician

Ask the family members to please step outside

Explanation:

Though Dilantin may be an appropriate medication to be given during an acute seizure, a nurse should never give a medication without an order from an attending physician, resident, or licensed independent practitioner (LIP). In order to prevent aspiration, the patient should be placed on his side, and if the patient had been eating, food should be cleared from the mouth. The attending should be called immediately so orders can be given to treat the patient. The family should be kindly asked to leave the room so the patient can be treated more effectively. Once the patient is stabilized the family members can be brought back into the room and be given updates on how the patient was treated and his response to the treatment.

29.

A patient with a history of alcohol abuse is hospitalized with acute pancreatitis. The nurse would expect to find which of the following upon assessment?

Chvostek's sign

Shortness of breath

Hyperactive bowel sounds

Decreased serum glucose level

Explanation:

Chvostek's sign is seen with hypocalcemia, which occurs in acute pancreatitis as calcium binds to areas of fat necrosis in the pancreas. Check for Chvostek's sign by tapping over the facial nerve and observing facial twitching. Trousseau's sign also indicates hypocalcemia. Acute pancreatitis usually causes hypoactive bowel sounds, and the serum glucose level is increased. Shortness of breath usually is not seen in alcoholic pancreatitis.

30.

Which of the following foods/drinks should a patient with frequent episodes of acid reflux avoid?

Tea

Oatmeal

Fennel

Wine

Explanation:

Gastroesophageal reflux disease (GERD) is caused by the lower esophageal sphincter closing improperly, which allows stomach acid to escape into the esophagus. Any acidic foods/drinks such as grapefruit, oranges, lemons, limes, grapes, and wine should be avoided. Fatty or fried foods can also cause an acid reflux exacerbation and should generally be limited or avoided altogether. Oatmeal helps absorb acidity and helps prevent acid reflux. Other foods that help those with acid reflux include tea, fennel, green leafy vegetables, watermelon, potatoes, and cereal.

31.

A patient with gallbladder disease develops acute pancreatitis. What drug-free pain relief measure is appropriate for this patient?

Encourage ambulation

Give frequent, small sips of milk

Place a heating pad over the epigastrium

Have the patient lie in a lateral decubitus knee-bent position

Explanation:

Lying on the side with knees bent (lateral decubitus knee-bent position) reduces the amount of tension on abdominal muscles and may provide some pain relief. Lying supine or standing would increase abdominal tension and pain. Food, heat, and activity also increase pain.

32.

A patient with a history of Hepatitis C now has a total bilirubin level of 2.3 mg/dl, elevated liver enzyme levels, ascites, and jaundice. Nursing interventions for this patient should include:

frequent meals.

daily mouth care.

increased activity.

frequent repositioning.

Explanation:

The liver synthesizes coagulation factors and converts ammonia to urea. Hepatic failure is indicated by this patient's laboratory values. Liver failure increases serum ammonia levels and bleeding times, which can cause tissue breakdown. Frequent repositioning helps to avoid liver destruction. Liver patients should receive mouth care several times a day and be placed in a quiet environment. In addition, most liver patients have a nasogastric tube in place, due to abdominal distention and vomiting.

33.

The medical-surgical nurse is reviewing results of an intraocular pressure reading for a patient with suspected glaucoma. Which of the following results supports this suspected diagnosis?

8 mmHg

14 mmHg

20 mmHg

24 mmHg

Explanation:

24 mmHg indicates increased intraocular pressure, one of the diagnostic features of glaucoma (in addition to optic nerve damage). Glaucoma is the second leading cause of adult blindness in the United States. The normal range for intraocular pressure is 10-21 mmHg. The pressure increases when the flow of aqueous fluid is inhibited so that fluid builds up in the aqueous humor. This increased pressure can cause damage to the optic nerve, causing vision impairment.

34.

What condition may occur in a patient who is receiving total parenteral nutrition?

Hypoglycemia

Metabolic acidosis

Metabolic alkalosis

Hyperphosphatemia

Explanation:

Total parenteral nutrition may lead to hyperchloremia, causing bicarbonate levels to decrease, which in turn leads to metabolic acidosis. Hypokalemia, hyperglycemia, hyponatremia, and hypophosphatemia are also common with total parenteral nutrition.

35.

A patient is 2 hours postoperative bowel resection and colostomy formation, spikes a fever of 39.2 °C (102.6 °F), and exhibits hypotension, tachycardia, and muscle rigidity. Which of the following does the nurse suspect is the cause of these signs and symptoms?

Sepsis

Surgical site infection

Hospital-associated infection, such as a central line infection

Malignant hyperthermia

Explanation:

Following a surgical procedure that requires inhalational therapy, a patient may develop malignant hyperthermia, characterized by a sudden spiking of high fever (within 30 minutes to a few hours) and hypotension. The patient exhibits muscle rigidity (from release of calcium from muscle cells) and rhabdomyolysis as well as an electrolyte imbalance, such as hyperkalemia. Immediate recognition and treatment are essential because this condition is life-threatening. Treatment includes aggressive cooling and dantrolene.

36.

A patient with a history of I.V. drug abuse and acute Hepatitis B now has with shallow, labored respirations, and severe ascites. The intervention that best relieves respiratory distress caused by ascites is:

nasopharyngeal suction.

placing the patient in a supine position.

administering diuretics, as prescribed, and maintaining sodium restriction.

maintaining a low protein and fat-restricted diet.

Explanation:

Ascites is fluid accumulation in the abdominal cavity from inflammation of the liver. Administering diuretics and maintaining sodium restriction best relieves ascites. Supplemental oxygen does not change the underlying problem of ascites. The patient would breathe best in semi-Fowler's position, not supine position. A low protein and fat-restricted diet is appropriate for hepatic failure, but does not affect ascites.

37.

A patient is made Comfort Measures Only (CMO) by family members. Which of the following medications should be given to help control the patient's tachycardia?

Amiodarone

Morphine

Lopressor

Digoxin

Explanation:

A patient with a terminal disease or injury with severely depressed mental status may be made CMO by the family/power of attorney, which allows the healthcare team to assist in the process of dying while ensuring that the patient is made comfortable. This entails withholding life-saving measures/medications, supplemental oxygen, CPR, IV fluids, and tube feeds/food. Since the patient cannot be asked how much pain/discomfort he is in, the healthcare team assesses the patient's discomfort by his vital signs. A patient is usually placed on narcotic pain medications and/or sedatives (depending on the hospital protocol and the state in which the hospital is located), which will be given if the patient develops tachycardia, tachypnea, or becomes hypertensive.

38.

A nurse coming on for the night shift is assigned to a patient who had an open cholecystectomy approximately 10 hours ago. The patient is awake, alert, and oriented. Which of the following complaints from the patient should be most concerning to the night nurse?

"My appetite is not the same as it is normally."

"I have a moderate amount of abdominal pain."

"I haven't been able to urinate since I got out of surgery."

“It hurts to cough or sneeze.”

Explanation:

A patient should be able to urinate normally after surgery; this patient may be suffering from urinary retention, and a bladder scan should be ordered after notifying the attending physician. It is normal to have abdominal pain upon coughing or sneezing after undergoing abdominal surgery since these actions can increase intra-abdominal pressure. A nurse may suggest that the patient hold a pillow to her abdomen to help alleviate the discomfort. A patient’s appetite may take a few days to return to normal after abdominal surgery; a nurse may suggest that she eat/drink as tolerated and limit fatty or greasy foods since these can further exacerbate abdominal discomfort. Abdominal pain is normal after abdominal surgery as long as it is not severe, intractable pain.

39.

The intervention that is most important to perform before a patient undergoes surgery to correct a complete small bowel obstruction is to:

ensure proper fluid and electrolyte replacement.

teach the patient about ileostomy care.

obtain informed consent for the procedure.

begin total parenteral nutrition (TPN).

Explanation:

Small bowel obstruction causes profuse vomiting, which leads to fluid and electrolyte loss. It is essential to correct electrolyte loss before surgery. There is no indication that an ileostomy is required. The physician obtains informed consent, not the nurse. TPN will most likely be used later, but is not as important as preventing shock from fluid loss or electrolyte depletion.

40.

A patient receiving intravenous vancomycin develops erythema on her face, neck, hands, and feet. She also reports mild nausea. She denies pruritus, shortness of breath, or chest pain. Her vital signs are stable. She has no history of drug allergies. Which of the following is the most appropriate first step?

Administer supplemental oxygen

Continue the infusion of vancomycin

Administer Benadryl

Discontinue the vancomycin

Explanation:

The patient is developing "Red Man Syndrome" which is a hypersensitivity reaction to Vancomycin. It is not considered a true allergy since it is generally due to the drug being infused too quickly rather than being due to the drug itself. The first step is to discontinue the infusion. Next, the patient may be treated with NSAIDs, Benadryl, or steroids, and/or antiemetics for additional relief. If the drug is to be given again in the future, the patient should be given NSAIDs, Benadryl, and/or steroids prior to the antibiotic being infused. Also, the drug should be infused at a very slow rate. Administering supplemental oxygen in this case is unnecessary since the patient's vital signs are stable.

41.

A patient confides in his nurse that he may have AIDS, but he has never been checked. Which of the following tests would confirm the diagnosis?

India ink

Western blot

Mantoux

Rapid Plasma Reagin (RPR)

Explanation:

The western blot test would confirm the diagnosis of HIV/AIDS. The Mantoux tuberculin skin test diagnoses tuberculosis. The RPR will help diagnose those who have syphilis. The India ink test would be positive in those who are suffering from a cryptococcal infection. Cryptococcal infections are common in patients with depressed immune function, such as AIDS patients, but the presence of the infection is not diagnostic for AIDS.

42.

A patient with which of the following lab values would benefit from being prescribed a statin?

LDL 165, HDL 65, Triglycerides 200

HDL 55, Triglycerides 155, LDL 135

HDL 60, LDL 120, Triglycerides 150

Triglycerides 130, LDL 100, HDL 50

Explanation:

Although the patient's HDL (a.k.a. "good" cholesterol) is very good, both the LDL and triglyceride levels are high, so the patient would benefit from a statin. In women an HDL level less than fifty and in men a level less than forty increases the risk for having a stroke or heart attack. A

triglyceride level less than 150 is considered normal. A triglyceride level above 200 is considered high and warrants medical management. An LDL level of less than 100 is considered normal. A level above 160 is considered high and warrants medical management.

43.

When caring for a patient with acute pancreatitis, the nurse should be alert for:

hypercalcemia.

acute respiratory distress syndrome (ARDS).

pericarditis.

diabetes insipidus.

Explanation:

Acute respiratory distress syndrome (ARDS) can occur in acute pancreatitis as a result of hypoperfusion and shock. Hypocalcemia and diabetes mellitus, not hypercalcemia and diabetes insipidus, may occur in pancreatitis. Pericarditis is not associated with pancreatitis.

44.

A nurse is caring for a patient who is diagnosed with type 2 diabetes mellitus. Which of the following test results would give the most cause for concern?

Blood glucose of 125 mg/dL

HbA1c of 8.2%

HbA1C of 5.0%

Glucose tolerance test of 150 mg/dL

Explanation:

If a patient is diagnosed with type 2 diabetes mellitus, the test result that gives the most cause for concern is the HbA1c level of 8.2% because normal is less than 5.7%. Prediabetic levels are 5.7-6.4%, and diabetes is diagnosed with HbA1c results of 6.5% or greater. Patients with diabetes should try to maintain their HbA1c at 7% or lower. A blood glucose reading of 125 mg/dL indicates prediabetes, as does a glucose tolerance test result of 150 mg/dL.

45.

The nurse is caring for a patient with hepatic failure due to liver cancer. The patient's prothrombin time is 56 seconds. The nurse should expect to administer:

heparin.

protamine sulfate.

packed red blood cells.

phytonadione (Vitamin K).

Explanation:

Phytonadione (Vitamin K) is necessary to produce prothrombin, which aids in clotting and therefore would help improve this patient's prothrombin time. Heparin increases the risk of bleeding. Packed red blood cells increase the oxygen carrying capacity of the blood but do not prevent bleeding. Protamine sulfate antagonizes heparin and has no effect on prothrombin.

46.

After a patient's death, the family is grieving. The patient's mother states that she is overwhelmed and doesn't know how to proceed since she has never had a death in the family before. Which of the following would NOT be a suggestion the nurse would make to the patient's family member?

Call the family's religious leader for support

Recommend grief counseling groups

Recommend starting anti-depressant medications

Call the hospital social worker

Explanation:

It is not advised that anyone recommend anti-depressant medications to a patient or patient's family member. If concerned about a psychological issue, a healthcare provider may make a referral to a psychiatrist and/or clinical psychologist who will then make his/her recommendations. Grief is very common after the loss of a loved one or a traumatic event, and medications, although usually beneficial, may not always be needed.

47.

A patient who has Hashimoto's disease asks his nurse what the most common cause is for this condition. Which of the following is the most appropriate response?

Autoimmune disorder

Hormone imbalances

Lack of physical exercise

Cancer

Explanation:

Hashimoto's disease is an autoimmune disease that causes hypothyroidism. If hypothyroidism is left untreated it can cause bradycardia, unintentional weight gain, hair loss, and permanent neurological deficit. There is no way to cure Hashimoto's disease, but exogenous thyroid hormone may be taken daily to prevent complication.

48.

A nurse is examining a patient with suspected osteomyelitis. Which of the following is the best test to help aid in the diagnosis?

MRI

Ultrasound

X-ray

EKG

Explanation:

An MRI is the best test to diagnose osteomyelitis. Osteomyelitis is an infection and inflammation of the bone. X-rays may be diagnostic, but in some cases, they may be normal or show nonspecific findings. The use of ultrasound and EKG are not helpful in making the diagnosis. Once the diagnosis is made, administration of IV antibiotics is initiated.

49.

A mother pregnant with her first child is Rh negative. The child is Rh negative. What is the next step in medical management?

Antibiotics

Transvaginal ultrasound

No intervention

RhoGAM

Explanation:

No intervention is needed if both the mother and baby are Rh negative. The Rh factor is an antigen that may or may not be attached to one's blood cells. Those who have a positive blood type (A+, B+, O+, AB+) have the antigen. Those who have a negative blood type do not have the antigen and are Rh negative. If a mother is Rh negative and her unborn child is Rh positive, RhoGAM needs to be administered. RhoGAM is an injection that suppresses the mother's immune response to the Rh-positive baby, which can help prevent hemolytic disease of the newborn. Antibiotics are unnecessary because it is a blood incompatibility issue, not an infection. An ultrasound would be ineffective for concerns regarding Rh factor.

50.

A patient is diagnosed with trichomoniasis. Which of the following is the most appropriate preventative therapy?

Use birth control pills

Practice safe sex

Refrain from eating uncooked pork

Limit alcohol use

Explanation:

The patient has trichomoniasis. It is caused by a protozoan infection of the genitourinary tract. It is a sexually transmitted disease, which can cause green frothy discharge from the penis or vagina, dysuria, pain with sexual intercourse, and strong, foul vaginal odor. The treatment of choice is metronidazole. The patient should be advised to maintain abstinence or practice safe sex.

51.

A student is helping a nurse care for a patient with an intracerebral hemorrhage with moderate surrounding edema. He asks his preceptor if there are any IV fluids that would be contraindicated in this patient. Which of the following would be the most appropriate answer?

D5W

Lactated Ringer's

Normal saline

3% NaCl

Explanation:

D5W contains 5% dextrose in water, which is a hypotonic solution. It draws water out of the circulation and into the cells. This is a problem in patients with intracerebral hemorrhages, vasogenic edema, and/or patients with high intracranial pressure because this can exacerbate their condition. D5W should never be ordered in these patients. The other options are either

isotonic solutions (normal saline and lactated Ringer's) or hypertonic solutions (3% NaCl), which are acceptable to use in brain injury patients.

52.

A 24-year-old patient newly diagnosed with uterine fibroids asks her nurse what therapies should alleviate her symptoms. Which of the following is NOT an appropriate response?

NSAIDs

Hysterectomy

Birth control pills

Iron supplements

Explanation:

Fibroids are benign growths that may cause dysmenorrhea, menorrhagia, pain with sexual intercourse, abdominal cramping, and urinary frequency. NSAIDs, birth control pills, and iron supplements are the initial treatments. For symptoms refractory to conservative therapy or for severe bleeding, surgery may be recommended. Since the patient is newly diagnosed and because she is so young, hysterectomy would not be considered the initial treatment.

53.

A patient is accidentally given the wrong medications by a nursing student. The nursing student apologized to the patient, but the patient does not speak English and has dementia. As the supervising nurse, which of the following is NOT an appropriate action?

Call the nursing manager and the attending physician

Educate the nursing student about checking the medications and patient's identity prior to administration

Obtain a translator and discuss the error with the patient's family

Refrain from disclosing the incident unless negative sequelae develop

Explanation:

Full disclosure is of the utmost importance not only because it is the ethical thing to do, but also for legal purposes. Even though the patient does not speak English and has dementia, the family member(s) or power of attorney should be notified of the error whether or not negative sequelae develop. The nursing student should be educated about checking and rechecking the patient's identity (by room number and by hospital bracelet) and the medications that are due to be given. The attending physician and the nurse manager should also be made aware so they can also monitor for negative reactions to the medication.

54.

A nurse comes on for the night shift and receives a patient who complained that he did not get his pain medications all day. The day nurse's notes reflect that no pain medications were given. Which of the following actions is the most appropriate?

Tell the patient that the prior nurse forgot to give him medications

Give the patient extra pain medication to make up for it

Send the nurse an e-mail explaining that he/she did a poor job

Speak to the nurse manager about the issue

Explanation:

Speaking to the nurse manager privately about the issue so she or he can investigate it further is the most appropriate action. Perhaps the patient did not complain to his nurse that he was in pain and that is why she or he did not give the medications. Even if the patient did complain to the nurse about his pain and the nurse did not provide adequate pain management, it is unprofessional to discuss the nurse's behavior with the patient. It is illegal and unethical to give patients extra medication that is not ordered for them. It is unprofessional to send emails to colleagues regarding their performance.

55.

A nursing colleague is assigned to take care of a local celebrity admitted to the hospital for an incomplete abortion. A news crew stops her outside of the hospital and asks for information about the patient. Which of the following is NOT an appropriate response?

"No comment."

"I was not responsible for the care of this patient."

"She had an incomplete abortion and is in stable condition."

"Only the patient or her power of attorney may give you that information."

Explanation:

In accordance with The Health Insurance Portability and Accountability Act (HIPAA) healthcare providers may not give out patient information to anyone unless the patient gives permission to do so. In the event that the patient is unconscious or lacking the capacity to give permission, the healthcare provider may give information to the power of attorney or closest known family member (i.e., spouse, parent, child) as long as documentation of the relationship status is provided. Healthcare providers are not allowed to give information over the phone or in person to anyone other than the power of attorney unless the power of attorney grants permission.

56.

A nursing student was walking through the hallway of the hospital and fell on a wet floor. The wet floor was caused by a leak in the ceiling. The maintenance worker was notified about the ceiling leak earlier, but never placed a caution sign. The goal of a root cause analysis would be to:

examine all of the contributing factors that led to the event.

identify the person/event to blame for the accident.

examine the efficacy of hospital hiring practices for its janitorial staff.

identify what caused the leak in the roof.

Explanation:

The goal of root cause analysis is to examine all of the factors leading to the event that allowed an accident or error to occur. The goal is not to blame one particular person or event. It attempts to look at ways in which practices, policies, and/or behaviors can be modified or changed in order to help ensure that the accident/error does not happen in the future.

57.

A patient with diabetes mellitus type 1 is hospitalized with moderate to severe ketoacidosis, characterized by stupor, hyperglycemia, hyperkalemia, and dehydration. How much fluid replacement does the nurse expect should be administered in the first 8 hours?

1-2 L

3-4 L

5-6 L

7-8 L

Explanation:

If a patient with diabetes mellitus type 1 is hospitalized with moderate to severe ketoacidosis, characterized by stupor, hyperglycemia, hyperkalemia, and dehydration, the nurse should expect that the patient will receive 3-4 L of fluid in the initial 8 hours. The first 2 L, usually normal saline, are administered rapidly at the rate of 1 L/hour, and the remaining fluids are administered at 300-400 mL/hour. The patient should be monitored carefully for signs of cerebral edema or respiratory distress from excessive fluid replacement.

58.

A nursing student asks his preceptor about Lantus's mechanism of action. Which of the following is the most appropriate response?

"Its peak time is 8 to 12 hours."

"Its peak time is 1 to 2 hours."

"It is a short-acting insulin."

"It is a continuous long-acting insulin."

Explanation:

Lantus is a type of long-acting continuous insulin. It is useful in patients who do not experience intermittent hypoglycemia. It should not be used in patients who are going to be undergoing surgery and need to be NPO, since Lantus can cause their blood sugar to drop dangerously low.

The Lantus dose may need to be lower in those with hepatic or renal impairment since the drug will be metabolized slower and end up in the patient's system longer than intended.

59.

All of the following are true about sickle cell anemia EXCEPT:

it is a genetic disease.

it increases risk for stroke and heart attack.

it can be diagnosed with a complete blood count (CBC).

treatment includes blood transfusion and oxygen.

Explanation:

Sickle cell disease is an autosomal recessive disease that causes red blood cells to be abnormally shaped. This can cause chronic anemia, renal failure, cardiac arrest, splenomegaly, stroke, heart attack, and pulmonary embolus. There is no cure. Treatments include blood transfusions, pain medications, supplemental oxygen, and antibiotics or blood thinners/anti-platelet medications for secondary complications. It is diagnosed with a peripheral blood smear. A CBC may show nonspecific abnormalities, but is generally not diagnostic.

60.

If a patient is to take clopidogrel (Plavix) following a recent stroke, which of the following should the nurse remind the patient to avoid?

Grapefruit, nonsteroidal anti-inflammatory drugs (NSAIDs), and aspirin

Bananas, antacids, and NSAIDs

Alcohol and antidepressants

Antacids and antibiotics

Explanation:

If a patient is to take clopidogrel (Plavix) following a recent stroke, the nurse should remind the patient to avoid the intake of grapefruit (fruit and juice), nonsteroidal anti-inflammatory drugs (NSAIDs), and aspirin. Grapefruit may inhibit the drug's antiplatelet activity, whereas NSAIDs and aspirin may increase the risk of excessive bleeding. Other drugs such as bupropion and macrolides may also inhibit clopidogrel's antiplatelet activity, whereas rifamycin may increase antiplatelet activity. Salicylates must be avoided in patients who have experienced transient ischemic attacks or ischemic stroke because they may cause serious bleeding.

61.

A patient is admitted with a history of peptic ulcer disease and vomiting for several days. His arterial blood gas (ABG) results are: pH 7.52; $PaCO_2$ 49 mm/Hg; PaO_2 62 mm/ Hg; and HCO_3^- 40 mEq/L. He has a nasogastric tube inserted. What condition is the patient experiencing?

Metabolic acidosis

Metabolic alkalosis

Respiratory acidosis

Respiratory alkalosis

Explanation:

Metabolic alkalosis. A blood pH higher than 7.45 and a bicarbonate level greater than 29 mEq/L confirm the diagnosis of metabolic alkalosis. A $PaCO_2$ greater than 45 mm/Hg indicates the patient's attempts at respiratory compensation.

62.

In response to being told that she has terminal lung cancer, a patient states "Well I really don't feel that sick; you must be mistaken regarding my diagnosis." Which stage of Kübler-Ross's five stages of grief would best describe this patient?

Anger

Denial

Bargaining

Acceptance

Explanation:

The patient is in denial according to her response to her diagnosis. The five stages include denial, anger, bargaining, depression, and acceptance. Not all people go through all of the stages of grief, nor are they necessarily experienced in a particular order. In some cases, patients return to one or more stages several times until they are able to work through it.

63.

A patient with an external ventricular drain (EVD) has an intracranial pressure (ICP) of 30. The output of the drain is very sluggish when it is opened. What is the next step?

Flush the drain proximally

Continue to monitor the ICP

Flush the drain distally

Call the attending/resident/PA

Explanation:

Calling the attending/resident/physician assistant on call is appropriate since the patient's ICP is high and the drain is not working. There may be a clot in the drain, which may or may not need to be flushed. Flushing should not be done by the nurse. There are other reasons why a drain may not be working and it is up to the attending as to what the next step should be. A normal ICP should be between 0 and 20. A sustained ICP of 30 may cause permanent brain injury; monitoring it without calling an attending is inappropriate.

64.

What is the most important recommendation that can be given to a patient prior to receiving the bowel prep for a colonoscopy?

Stop taking your medications prior to the procedure

Eat a pureed diet only during the prep

Eat red foods/fluids

Remain hydrated

Explanation:

Remaining hydrated is one of the most important recommendations that can be given to patients. If patients are in a hospital prior to the procedure, they should be on IV fluids. If they are doing the prep at home, they should be told to drink water, Gatorade, and/or Jell-O to help prevent against dehydration, since they will be losing much of their body fluid due to the prep. They should never be advised to discontinue all of their medication. Sometimes medication does need to be discontinued prior to the procedure, but at other times it may be continued or the dosage may be adjusted depending on what the medication is and the condition it is treating. The patient should be ingesting fluids only; eating a pureed diet will interrupt the bowel prep and delay the procedure. Red foods or fluids should be avoided since they can mimic blood in the bowel, which will impair the results of the colonoscopy.

65.

All of the following statements are recommendations to prevent an asthma attack EXCEPT:

"Keep away from pet dander."

"Treat upper respiratory infections quickly."

"If you smoke, smoke outside the house."

"Avoid strong fragrances."

Explanation:

Smoking should be avoided altogether since cigarette smoke can remain on someone's breath, skin, and clothing and therefore be inhaled when the affected person is nearby. Cigarette smoke is one of the most common triggers for an asthma attack. It is recommended that caregivers avoid smoking completely. Pet dander, strong perfumes/fragrances, and upper respiratory infections are also stimuli that can trigger an asthma exacerbation.

66.

What is NOT a common side effect seen with the long-term use of prednisone?

Skin atrophy

Impaired immune response

Diabetes

Orange urine

Explanation:

Steroids such as Decadron or prednisone can be used to treat a variety of disorders such as arthritis, dermatological conditions such as rosacea, and severe asthma, but can cause a multitude of complications if used long term such as diabetes, glaucoma, osteoporosis, hypertension, obesity, lowered immune system, and skin atrophy. Orange urine is a common side effect of Pyridium, which is used in conjunction with an antibiotic to treat urinary tract infections.

67.

What electrolyte imbalance is most likely to affect a patient with Crohn's disease?

Hyperkalemia

Hypermagnesemia

Hypokalemia

Hypomagnesemia

Explanation:

Hypomagnesemia is the most common electrolyte imbalance to affect a patient with Crohn's disease. Crohn's disease is a type of autoimmune inflammatory bowel disease (IBD) that affects mostly the ileum and colon. However, the Crohn's patient may also have edema, redness, and dysfunction in the mouth, esophagus, and stomach. The Crohn's patient cannot absorb magnesium through the lower GI tract. Closely monitor this patient for hypomagnesemia. By contrast, potassium is affected by upper GI tract problems, such as vomiting.

68.

A patient is a chronic alcoholic with hypomagnesemia. What other electrolyte imbalance may result from a magnesium deficiency?

Hypercalcemia

Hypernatremia

Hypokalemia

Hypophosphatemia

Explanation:

Magnesium deficiency leads to impaired conservation of phosphate and, consequently, hypophosphatemia. Magnesium deficiency may also lead to hypocalcemia, hyponatremia, and hyperkalemia. Hypophosphatemia also occurs with inadequate nutrition.

69.

A nurse is treating a patient with *C. difficile* colitis. Which of the following are the most important measures to prevent the spread of the disease to herself/himself and other patients?

Goggles and gown

Gloves and gown

Hand washing and gloves

Face mask and gloves

Explanation:

Hand washing is the most important measure in preventing communicable diseases. Wearing gloves is important, but they may rip. If the gloves touch a contaminated surface and then touch someone's mouth or face, the gloves will not prevent against getting ill. However, wearing gloves in conjunction with hand washing is the most important way to prevent from getting ill and spreading disease to others. Wearing a face mask may help, but it does not fully prevent against spreading diseases. If someone's hands are contaminated and they touch their mouth or eyes, wearing a face mask will not prevent them from getting ill. Wearing goggles will prevent against splash of body fluids in one's eyes, but if one's hands are contaminated and the eyes are then touched, they will become contaminated as well.

70.

Which of the following foods should be avoided to help to prevent listeriosis?

Chocolate

Pasteurized milk

Soda

Hot dogs

Explanation:

Listeriosis is spread through contaminated food. Therefore, avoiding unpasteurized milk is recommended. It is also recommended to thoroughly wash produce, cook meat and fish prior to eating it, and to limit processed foods such as hot dogs and deli meats during pregnancy. Hot dogs and deli meats may be contaminated after they are cooked and prior to being packaged. Pregnant women infected with Listeria may only exhibit mild symptoms, but the illness may result in death of the fetus.

71.

The nurse administers nalbuphine hydrochloride (Nubain), an opiate antagonist, to his patient for pain control. What sign(s) would prompt the nurse to further assess his patient for opiate dependence?

Respiratory depression

Nausea and vomiting

Gooseflesh and diarrhea

Seizures

Explanation:

A drug with opiate antagonist properties may precipitate drug withdrawal in an opiate-dependent patient. Signs of opiate withdrawal include chills, sweats, gooseflesh, abdominal pain, muscle cramps, diarrhea, tearfulness, and irritability. Respiratory depression, nausea, and

vomiting are adverse reactions to opiates, rather than signs of dependence. Seizures are a sign of sedative, hypnotic, or anxiolytic withdrawal.

72.

Which of the following is the best method to treat scabies?

Application of permethrin

Application of Lamisil

Condoms

Hand washing

Explanation:

Scabies infections are caused by mites burrowing underneath the skin in the web spaces of the fingers and toes. Topical medications such as permethrin cream can be used to treat infections. Pills are available for persistent infections refractory to topical treatment. Avoiding infected people and washing linens in hot water and bleach are other ways to treat the infection.

73.

If a patient is suffering from a dysrhythmia, which of the following rhythms would not require defibrillation or cardioversion?

Pulseless ventricular tachycardia

Ventricular fibrillation

Symptomatic supraventricular tachycardia (SVT)

Asystole

Explanation:

If a patient is suffering from a dysrhythmia, the rhythms that are classified as nonshockable include asystole and pulseless electrical activity and they do not indicate the need for defibrillation or cardioversion. Shockable rhythms include those that require defibrillation (pulseless ventricular tachycardia and ventricular fibrillation) and those that require cardioversion (symptomatic supraventricular tachycardia [SVT] or symptomatic atrial fibrillation). Treatment for nonshockable rhythms includes ensuring effective cardiac compressions and ventilation and administering epinephrine, but only a small number of patients with nonshockable rhythms achieve return of spontaneous circulation.

74.

While turning an 81-year-old nursing home patient, the nurse notices that the patient has a stage II decubitus ulcer on the right buttock. Which of the following is NOT a measure that the nurse should take in the treatment of the decubitus ulcer?

Use of air mattresses

Use of restraints to keep the patient from moving or worsening the ulcer

Frequent turning of the patient

Use of wet-to-dry dressings on the ulcer

Explanation:

The use of restraints may worsen a decubitus ulcer because they keep the patient lying in one position. Frequent turning is important, allowing the patient's body weight to be distributed to

other areas so that the pressure sore can heal. Air mattresses help alleviate the pressure that is placed on the body areas and wet-to-dry dressings help prevent against infection and promote healing.

75.

During which phase of the nursing process does a nurse prioritize addressing a patient's medical issues according to their severity?

Diagnosing

Planning

Implementing

Evaluating

Explanation:

During the planning phase a nurse will develop his/her nursing care plan: how he or she will address the patient's medical problems according to the immediacy of each issue. The nurse will then develop a plan of desired outcomes to achieve based on the treatment plan. During the implementing phase the nurse will carry out his/her treatment plan and delegate tasks to others on the team. During the evaluating phase the nurse will monitor the patient's progress in response to treatment and further tailor or change the treatment plan accordingly if the results are unsatisfactory. During the diagnosing phase the nurse will create one or more diagnoses based on the patient's history and physical assessment.

76.

What is the primary treatment of cystic fibrosis?

Chemotherapy and radiation

Maintain ideal body mass index

Symptomatic relief

Surgical intervention

Explanation:

Cystic fibrosis (CF) is an autosomal recessive genetic disorder that results in excessive accumulation of mucus in the GI and pulmonary tracts resulting in abdominal discomfort, chronic constipation, salty-tasting skin, poor appetite, fatigue, fever, and pancreatitis. Patients will experience a myriad of complications throughout their lifetime, but the most life threatening are persistent pulmonary infections such as pneumonia and progressive respiratory failure. The only treatment is symptomatic relief (i.e., skin emollients, nebulizers, stool softeners for constipation). The average lifespan is 30 to 40 years. Some patients have undergone lung transplants, but eventually the new lung will become diseased as well. Surgical intervention is used to prolong lifespan and will not cure the disease.

77.

In response to being told that she has terminal lung cancer, the patient states "If I stop smoking, I think you will be able to cure me." Which stage of Kübler-Ross's five stages of grief would best describe this patient?

Depression

Acceptance

Anger

Bargaining

Explanation:

The patient is in the bargaining stage according to her response to her diagnosis. Patients hope that if they give up something, they can change their outcome. The five stages include denial, anger, bargaining, depression, and acceptance. Not all people go through all of the stages of grief nor are they necessarily experienced in a particular order. In some cases, patients return to one or more stages several times until they are able to work through it.

78.

Among the following signs and symptoms, which would be the least likely to be present in a patient with acute asthma exacerbation?

Low-grade fever

Chest pain

Shortness of breath

Tinnitus

Explanation:

Tinnitus or ringing in the ears is not a typical symptom of asthma exacerbation. Asthma is a pulmonary disease that causes inflammation and bronchoconstriction of the airways. It may present with low-grade fever, wheezing, shortness of breath, nonproductive cough, and chest pain. It should be treated with supplemental oxygen and nebulizers, and in some cases, steroids may be warranted.

79.

A patient suddenly develops diffuse extremity tremors, drooling, eye-rolling, and does not respond to verbal or tactile stimuli for several minutes. The episode resolves spontaneously and afterward the patient is confused and lethargic. What type of seizure did this patient most likely experience?

Petit mal seizure

Tonic-clonic seizure

Absence seizure

Simple partial seizure

Explanation:

Tonic-clonic or grand mal seizures present with generalized body tremors, tongue biting, diaphoresis, and/or urinary or bowel incontinence followed by a postictal period. The patient usually has no memory of the seizure itself. Petit mal is an outdated term for a cerebral seizure not exhibiting tonic-clonic movements. Absence seizures are more common in children than adults. They can sometimes be misdiagnosed due to the unusual presentation of intermittently occurring blank staring episodes. A simple partial seizure presents with unilateral or generalized tremors, but the patient remains awake and alert throughout the entire seizure.

80.

A patient with multiple lower-extremity fractures following a motorcycle crash has a cast placed on the affected extremity. Which of the following is the most serious complication that could result from this patient's injury?

Compartment syndrome

Deep vein thrombosis

Muscle weakness

Arthritis

Explanation:

Compartment syndrome is a life-threatening condition that compromises the blood flow to the affected extremity. This could result in amputation if not treated emergently. Deep vein thrombosis (DVT) is dangerous because it puts a patient at higher risk for a pulmonary embolus (PE), but the development of a PE does not always occur. The presence of a DVT does not necessarily require emergent treatment. Muscle weakness and arthritis are potential complications of this patient's injury, but are not life threatening.

81.

A nurse is caring for a patient with a potential acute cerebral vascular accident. The symptoms started two hours ago. The CT scan of the head shows a hemorrhagic infarct. Which of the following should the nurse expect to be the next step in the physician's management?

Order aspirin and Plavix

Repeat a CT scan in the morning

Administer tissue plasminogen activator (tPA)

Discharge the patient home

Explanation:

A repeat CT scan should be ordered in several hours to monitor the bleed. If the bleed increases in size then surgical intervention may be warranted. Since the patient has a bleed, anti-platelet medications such as aspirin and Plavix are contraindicated. Tissue plasminogen activator (tPA) is a very strong clot-busting medication given to patients with ischemic stroke or acute myocardial infarctions. Aspirin and Plavix can be given in cases of an ischemic stroke that is no longer in the tPA window or may be given to a patient who has a completed stroke. The tPA window is approximately three to four hours from time of witnessed onset of symptoms. The patient needs to be monitored in the hospital and should not be discharged home.

82.

What is primary cause of a celiac sprue exacerbation?

Alcohol

Green leafy vegetables

Dehydration

Gluten-based products

Explanation:

Celiac disease or celiac sprue is an immune reaction that damages the lining of the small intestine and prevents it from absorbing important nutrients. It presents as nausea, vomiting, diarrhea, and abdominal pain, which occur after ingesting gluten-based products. The mainstay of treatment is to maintain a gluten-free diet to help prevent future exacerbations.

83.

Which of the following plays an important role in confirming the diagnosis of septic arthritis?

X-ray

2D echo

Blood cultures

NSAIDs

Explanation:

A patient with septic arthritis has an infection in the blood that is attacking a joint or joints. Obtaining blood cultures, lab work, getting a joint aspiration, and administering pain medications and IV antibiotics are several ways to help diagnose and treat this infection. NSAIDS may provide symptomatic relief, but would not help confirm the diagnosis. A 2D echo is an ultrasound of the heart; since the infection occurs in the joints, this would not help confirm the diagnosis. X-rays may be normal or may show nonspecific findings, but would not help confirm the diagnosis.

84.

Which of the following nursing theorists developed the interpersonal relations model of nursing and stressed the importance of the nurse collaborating with the patient and helping patients to use illness as an opportunity for learning?

Peplau

Rogers

Orem

Neuman

Explanation:

Hildegard Peplau developed the interpersonal relations model of nursing and stressed the importance of the nurse collaborating with the patient and helping patients to use illness as an opportunity for learning and maturing. Peplau believed that the environment can affect a patient negatively and positively. Additionally, Peplau believed that there are a number of overlapping phases to the nurse–patient relationship, including orientation, identification of the problem, explanation of potential solutions, and resolution of the problem.

85.

A patient with nephrolithiasis is found to have absorptive hypercalciuria type I because of increased absorption of calcium in the small bowel, especially the jejunum, and exhibits increased urinary calcium independent of dietary intake. Which of the following is the least effective treatment of this condition?

Decreasing dietary calcium by 50%

Thiazide diuretics

Cellulose phosphate

Orthophosphates

Explanation:

If a patient with nephrolithiasis is found to have absorptive hypercalciuria type I because of increased absorption of calcium in the small bowel, especially the jejunum, and exhibits increased urinary calcium independent of dietary intake, the treatments of choice include thiazide diuretics (which increase calcium reabsorption in the distal tubule, therefore decreasing its excretion), cellulose phosphate (which binds to calcium and limits absorption), and orthophosphates (which also reduce the excretion of calcium). Cellulose phosphate should be administered with meals so it is available to bind to calcium that was ingested. Patients

should be monitored to make sure they do not develop hypocalcemia, which can result in increased reabsorption of calcium in the bones. Decreasing calcium intake is not a recommended treatment unless calcium excretion is excessive (>1,500 mg/day).

86.

Which of the following foods would NOT be recommended in a patient with a history of fecal impaction?

Raspberries

Fish

Lentils

Oatmeal

Explanation:

Fish are very low in fiber and would not be recommended to patients who have a history of fecal impaction. High fiber foods such as bran, oatmeal, barley, raspberries, lentils, beans, broccoli, and peas would be recommended to help promote bowel movements and prevent fecal impaction in the future. Limiting narcotic medications and using stool softeners may also provide additional relief.

87.

The patient's diagnosis is hypernatremia. The primary treatment for this patient is:

sodium polystyrene sulfonate (Kayexalate).

fluid replacement.

diuretics.

activated charcoal.

Explanation:

The primary treatment for a patient with hypernatremia is fluid replacement. The fluid of choice is determined by the cause of the imbalance. If the patient is hypovolemic, fluid replacement begins with normal saline solution and proceeds to 0.45 saline solution. If the cause of the hypernatremia is pure water loss, the fluid of choice is dextrose 5% in water. Giving sodium polystyrene sulfonate, which contains up to 10 g of sodium, would only increase the serum sodium level. Hypernatremia is associated with the use of diuretics, so avoid them. Activated charcoal does not absorb sodium and other small electrolytes.

88.

Following an open appendectomy a patient is unable to pass a bowel movement and has persistent nausea and vomiting. Which of the following should the nurse suspect as the most likely diagnosis?

Ileus

Intussusception

Toxic megacolon

C. difficile colitis

Explanation:

An ileus is the most likely diagnosis for this patient's symptoms. It is the loss of peristalsis of the GI tract caused by disease, spinal cord injury, or following recent surgery. Symptoms include constipation, abdominal distention, nausea, and vomiting. Decompression with a nasogastric tube is usually the treatment. C. difficile colitis is a type of bacterial infection that causes severe profuse watery diarrhea, abdominal pain, and fever. It is common in patients who have been in the hospital for long periods of time and/or those who have been on long-term chemotherapy or antibiotics. Intussusception is a condition in which one part of the bowel folds in on itself and causes an obstruction. This is common in children. Symptoms include nausea, vomiting, lethargy, and red currant jelly stools. Toxic megacolon is a complication of C. difficile colitis. It is the pathologic distention of the colon caused by C. difficile, Crohn's disease, and ulcerative colitis. Signs and symptoms may include tachycardia, abdominal pain, abdominal distention, leukocytosis, and fever.

89.

A patient recently diagnosed with gout asks his nurse about what he can do to reduce the prevalence of gout attacks. Which of the following dietary recommendations should the nurse NOT recommend?

Reduce coffee intake

Increase seafood intake

Reduce calcium intake

Increase fructose intake

Explanation:

Calcium-rich foods such as yogurt, ice cream, milk, and cheese help prevent against gout exacerbations. Coffee and foods rich in Vitamin C such as oranges, strawberries, peppers, kiwi, and kale also help reduce a patient's risk. Patients should be counseled to refrain from or severely limit their intake of red meat, seafood, alcohol, and fructose. Medications used to prevent gout include allopurinol, NSAIDs, and steroids.

90.

A patient in the hospital for a subdural hematoma was previously able to follow commands and is now only localizing to pain. The patient's next dose of Percocet is due now. Which of the following should be the first step in intervention?

Order a CT scan of the brain

Reassess exam in 30 minutes

Give the patient the Percocet

Call the attending

Explanation:

The patient with a known head trauma is experiencing a change in his neurological exam. The attending in charge of this patient's care should be made aware so he/she can decide the next step in intervention. Reassessing the exam in 30 minutes can delay the patient's treatment. A CT scan will most likely be ordered, but the attending should be made aware of the neurological change prior to ordering a CT scan. Percocet should be withheld from the patient for two reasons. First, Percocet is a narcotic that can further depress the neurological status and may hinder the ability to monitor whether or not this is a true change or it is due to the medication. Second, if the patient is lethargic, he may aspirate on the medication, causing further complication to his condition.

91.

A patient is being discharged on warfarin (Coumadin) and is to have follow-up international normalized ratio (INR) laboratory testing. The target INR for most patients is:

1.0-2.0.

2.0-3.0.

2.5-3.5.

3.0-4.0.

Explanation:

If a patient is being discharged on warfarin (Coumadin) and is to have follow-up international normalized ratio (INR) laboratory testing, the target INR for most patients is 2.0-3.0. The normal INR is 1.0. Some patients, such as those with mechanical mitral valves, may have a target INR slightly higher, of 2.5-3.5. Patients starting on warfarin usually have INR testing done in the healthcare setting for a few months until being stabilized, and then may switch to self-testing at home.

92.

Which of the following interventions would NOT help prevent acute sickle cell crisis?

Limit alcohol use

Avoid cigarette smoke

Exercise regularly

Maintaining a cold environment

Explanation:

Exposure to extreme temperatures can cause an acute sickle cell crisis. Other common triggers can include hypoxia, dehydration, exposure to cigarette smoke, exposure to alcohol, and stress.

Medical providers should encourage regular exercise with rest when becoming fatigued, adequate hydration, limiting tobacco, stress, and alcohol. Administration of fluids, pain medications, supplemental oxygen, and in some cases blood transfusions, are treatment modalities used during an acute sickle cell crisis.

93.

A patient recovering from an acute myocardial infarction asks his nurse why he was given aspirin. What is the most appropriate response?

"It decreases workload on the heart."

"It causes vasodilation."

"It prevents clot formation."

"It thins out the blood."

Explanation:

Medications such as aspirin and Plavix act as anti-platelet medications. They prevent the platelets from sticking together too readily, which helps treat and prevent the formation of clots. Medications such as warfarin and Pradaxa act as blood thinners; warfarin and Pradaxa are not typically given for an acute myocardial infarction (MI). Medications like beta-blockers and narcotics are given to decrease workload on the heart and lower blood pressure by causing vasodilation. Morphine helps alleviate pain, which will also help lower blood pressure.

94.

A 30-year-old patient is being seen in the ER today for a wrist fracture. His blood pressure is 138/88. He smokes half a pack of cigarettes per day. His other vital signs are normal. Which of the following is the most appropriate intervention?

Monitor for now; recommend limiting tobacco

Recommend an electrocardiogram

Recommend use of antihypertensive medications

Recommend use of an inhaler

Explanation:

This patient may have pre-hypertension. Pre-hypertension is defined as a systolic blood pressure of 120 to 139 and diastolic blood pressure 81 to 89 on three consecutive visits four to six weeks apart. Medications can sometimes be avoided if patients take conservative measures to lower their blood pressure. However, since this patient is here for a wrist fracture, the elevated blood pressure may be due to pain. It should be recommended that the patient monitor his blood pressure for now and limit tobacco use.

95.

A patient presents to the hospital with suspected pneumothorax. Which of the following tests would confirm the diagnosis?

Electrocardiogram

Echocardiogram

Chest x-ray

Blood cultures

Explanation:

A chest x-ray is one of the best diagnostic tests to confirm the presence of a pneumothorax or "dropped lung." It will show absence of lung markings and, if large enough, deviation of the trachea. An electrocardiogram may show some nonspecific abnormalities, but will not confirm the diagnosis. An echocardiogram is an ultrasound of the heart; it will not help confirm the diagnosis. Blood cultures play no role in diagnosing a pneumothorax.

96.

A patient has just returned from the operating room. On the pre-operative orders, the patient was ordered to receive Lopressor 25 mg po bid. On the post-operative orders, the attending physician wrote for Lopressor 25 mg IV bid. The patient is due for the Lopressor dose. What is the next step in the nurse's management?

Do not give Lopressor

Give the po dose

Give the IV dose

Call the attending to clarify the order

Explanation:

The nurse should call the physician to clarify the order. Lopressor is a beta blocker that can lower blood pressure and heart rate. If given an overdose of this medication, a patient may become dangerously hypotensive and may even die. It needs to be given in much smaller amounts in IV form since it is being injected directly into the bloodstream.

97.

A patient who was admitted for an acute exacerbation of congestive heart failure asks why she is being discharged on Lasix. What is the most appropriate response?

“It prevents excessive edema.”

“It increases vasodilation.”

“It prevents clots.”

“It reduces inflammation.”

Explanation:

Lasix is a diuretic which helps prevent and treat the presence of edema or excessive congestion. In cases of congestive heart failure, pulmonary edema, cirrhosis, and renal disease, fluid may collect in the body causing respiratory distress and/or extremity edema. Lasix inhibits sodium (and therefore water) from being absorbed in the kidneys, so it is excreted in the urine.

98.

A patient receiving furosemide (Lasix) to control edema has developed muscle weakness and muscle cramps. Which laboratory test is indicated?

Electrolyte panel

Complete blood count

Uric acid

Blood glucose

Explanation:

If a patient is receiving furosemide (Lasix) to control edema and has developed muscle weakness and muscle cramps, these symptoms are indicative of hypokalemia, so the laboratory test that is indicated is an electrolyte panel. Patients taking furosemide often receive potassium supplements to prevent hypokalemia. In addition to hypokalemia, patients may also develop hypocalcemia, hypomagnesemia, and hyponatremia.

99.

A patient notes that he has a family history of diabetes. His fasting blood sugar is 138 and his HbA1c is 6.2. What should the nurse expect the attending to recommend for this patient?

Recheck his HbA1c in a week

Recommend low sugar diet and exercise

Start Lantus and metformin

Start levothyroxine

Explanation:

The patient is at risk for developing diabetes. His fasting blood sugar and his HbA1c are borderline and he has a family history of diabetes. Anti-hyperglycemic medications such as Lantus and metformin at this point are unnecessary, but may be needed if his blood sugar cannot be controlled with diet and exercise. Rechecking an HbA1c in one week would be useless because it is a calculation of an average blood sugar level over a three-month period. This patient's HbA1c doesn't need to be checked for another three months. Levothyroxine is a medication used to treat hypothyroidism, not hyperglycemia.

100.

A 45-year-old female with no remarkable past medical history has never had a colonoscopy. When should the nurse advise this patient to get her first colonoscopy?

This year

At age 70

At age 60

At age 50

Explanation:

This woman should be checked when she's 50 years old. The current recommendation in the United States is to get screened 10 years prior to the age of a first-degree relative who was diagnosed with colon cancer. If no risk factors are present then it is recommended to obtain a colonoscopy by 50 years of age.

101.

A patient is suspected to have a pulmonary embolism. Which of the following tests should the nurse NOT expect to be ordered?

Echocardiogram

Chest x-ray

Arterial blood gas

Ventilation perfusion scan

Explanation:

A spiral CT scan or a CT angiogram (CTA) is the most diagnostic test for detecting the presence of a pulmonary embolus (PE). A ventilation perfusion scan may also be performed but it is generally less diagnostic. It can only suggest the probability of a pulmonary embolism. The other drawback is that it cannot be done in patients on a ventilator. An echocardiogram is an ultrasound of the heart and plays no role in the workup of a PE. A chest x-ray may be completely normal or may show nonspecific abnormalities. However, it is generally quicker to obtain than a CTA or ventilation perfusion scan, and may be ordered during the initial workup. An arterial blood gas may also be ordered in the initial workup to determine the severity of hypoxia.

102.

A patient sustained a fracture of the left femur in a motorcycle accident and developed a fat embolism. The expected laboratory findings include:

decreased serum lipase levels.

decreased erythrocyte sedimentation rate.

decreased red blood cell and platelet counts.

increased serum albumin and calcium levels.

Explanation:

The nurse should expect to find a decreased red blood cell count and platelet count in a patient with a fat embolism. Increased circulating catecholamines mobilize fatty acids, which leads to platelet aggregation. The reason red blood cells decrease is not clearly understood.

103.

A few minutes after the nurse changes a patient's total parenteral nutrition (TPN) tubing, he complains of chest pain and shortness of breath. His pulse is weak and thready. What is the top priority intervention?

Turn the patient on his left side, with his head lower than his body

Call a Code Blue and initiate cardiopulmonary resuscitation (CPR)

Stop the TPN and keep the line open with saline solution

Notify the physician because the patient is having an allergic reaction

Explanation:

Turn the patient on his left side, with his head lower than his body. Chest pain and shortness of breath are associated with air embolism. Embolism is a serious complication that can occur with TPN administered through a central venous catheter. Turning the patient on his left side with his head lower than his body prevents the air from entering his pulmonary circulation. Calling a Code Blue and performing CPR are only appropriate if the patient experiences cardiac arrest. Do not stop TPN, unless air is visible in the tubing. The patient's signs and symptoms do not correlate with allergic reaction.

104.

A diabetic patient is hypertensive. Treatment is carvedilol (Coreg). What instruction should be emphasized to the patient during discharge teaching?

Check pulses daily because carvedilol causes tachycardia

Resume vigorous foot care because carvedilol decreases perfusion

Monitor blood sugar levels because carvedilol masks signs of hypoglycemia

Monitor blood sugar levels because carvedilol may cause hyperglycemia

Explanation:

Monitor blood sugar levels is important because carvedilol masks signs of hypoglycemia. Beta-adrenergic blockers such as carvedilol can mask a drop in blood sugar level, so the patient needs to monitor his blood sugar carefully. Carvedilol does not directly decrease perfusion, but may cause bradycardia, which could lead to decreased perfusion. All patients with diabetes should perform meticulous foot care because of neuropathy.

105.

Three days after surgery, a patient develops a low-grade fever and a tender, swollen calf. The most appropriate intervention is to:

tell the physician.

massage the calf.

ambulate the patient.

perform range of motion (ROM) exercises on the legs.

Explanation:

A low-grade fever and calf swelling after recent surgery indicate probable deep vein thrombosis, so the nurse should call the physician. Avoid manipulation (massaging the affected limb) or ambulation, as they could move the clot. Enforce bed rest until the presence of a clot is assessed through a venous Doppler series.

106.

Which of the following is a common risk factor for developing condyloma acuminata?

Family history

IV drug abuse

Smoking

Multiple pregnancies

Explanation:

Condyloma acuminata or genital warts is a sexually transmitted disease. Factors such as birth-control usage, smoking, early age of first coitus, and multiple sexual partners increases the risk of contracting genital warts. There is no cure. The human papilloma virus (HPV) vaccine is available to help prevent genital warts.

107.

Which of the following is NOT a risk factor for developing a decubitus ulcer?

Bowel or bladder retention

Diabetes mellitus

Aging skin

Peripheral vascular disease

Explanation:

Bowel or bladder retention is not a risk factor for developing a decubitus ulcer. Bladder or bowel incontinence, however, is a risk factor since the skin is frequently in contact with feces and urine. Bacteria in the feces and/or urine may enter through a small break in the skin, causing an infection. Also, if the skin is constantly covered in moisture the skin may become macerated and break down much more easily. Diabetics are much more prone to infections and are at risk for developing decubitus ulcers. Skin atrophy increases with increasing age, making it more susceptible to breakdown. Patients with peripheral vascular disease may have decreased sensation in their extremities and may not notice when they have a small wound on a part of their extremity. Also, skin will heal poorly if the blood flow to the extremities is insufficient.

108.

A patient has a deficiency of human growth hormone. Which of the following will be the most likely diagnosis?

Gigantism

Dwarfism

Diabetes

Acromegaly

Explanation:

Dwarfism occurs when there is a deficiency in growth hormone. Acromegaly will result in the presence of excessive growth hormone in an adult patient. Since adult patients have already stopped growing, growth hormone will cause bones to thicken and widen causing pain, weakness, and deformity. If excessive growth hormone occurs in children, gigantism will result since bones are still in the process of growing longitudinally. Diabetes occurs where there is either insufficient production of insulin (Type 2) or no insulin production due to an autoimmune reaction (Type 1).

109.

A patient is admitted to the hospital for multiple extremity and rib fractures after a fall that occurred today. A CT scan of the head is negative. He has a known history of alcohol abuse. He is oriented to person and place but not the year. His speech is slurred. His alcohol level is 396. He denies drug abuse. Based on his history and physical exam, what is the most likely diagnosis?

Delusional disorder

Alcohol intoxication

Alcohol withdrawal

Depression

Explanation:

The patient is suffering from acute alcohol intoxication. A normal alcohol level is less than 10; this patient's is 396. Treatment for acute alcohol intoxication is symptomatic relief. Anti-nausea medications, fluid hydration, and rest are the mainstays of therapy. Supplemental vitamins sometimes are given since chronic alcoholics are malnourished.

110.

A patient being discharged on Pyridium should be advised of which of the following side effects?

Bright orange urine

Bleeding

Tinnitus

Angioedema

Explanation:

Pyridium is often given in conjunction with an antibiotic to help alleviate dysuria. The most common side effect of Pyridium is bright orange urine. Other common side effects may include headache and rash. While the decision to discontinue the medication must be based on the severity of the side effects, change in urine color should not be a reason to discontinue the medication. The urine will go back to its normal color once the medication course has been completed.

111.

A newborn is diagnosed with phenylketonuria (PKU). Which of the following should be avoided?

Protein

Fruit

Juices

Vegetables

Explanation:

Dietary restrictions are an important part of controlling the neurological complications phenylketonuria (PKU) may cause. Patients with PKU are unable to break down phenylalanine, a common amino acid found in foods, most notably proteins. Patients with PKU must strictly adhere to diets low in phenylalanine. If the diagnosis is not made early or if patients are not compliant with their dietary restrictions, complications such as hyperactivity, seizures, and intellectual disability may occur.

112.

Which of the following patients should NOT get the flu vaccine?

A 46-year-old man who smokes half a pack per day

A 2-month-old child

A 33-year-old pregnant patient

An 89-year-old patient with no significant past medical history

Explanation:

Children less than six months of age are not recommended to get the influenza vaccine. Though almost everyone should get the flu vaccine every year, it is especially important for healthcare workers, immunocompromised individuals, people who are living in close quarters such as assisted-living facilities, hospitalized patients, and pregnant women.

113.

A patient is hospitalized for a stroke and experiences homonymous hemianopsia on her left side. The most important intervention is to:

approach the patient on her left side.

speak clearly into the patient's right ear.

teach the patient to scan her visual field.

have the patient chew slowly and thoroughly before swallowing.

Explanation:

Teach the patient to scan her visual field. Homonymous hemianopsia is the loss of one-half of the visual field in both eyes, either the right half or left half of the vertical midline. Teach the patient to scan her visual field. Approaching the patient on her left side is ineffective because the loss is in both eyes. Homonymous hemianopsia does not affect hearing or swallowing.

114.

A pediatric patient has just been diagnosed with thalassemia major. Which of the following is a common complication?

Obesity

Diabetes

Heart failure

Cataracts

Explanation:

Cardiac arrhythmias leading to heart failure are a common complication of thalassemia major. Thalassemia major is a rare genetic blood disorder in which the hemoglobin is defective. It causes mild to severe hemolytic anemia, which can commonly cause cardiac arrhythmias. The mainstays of treatment for thalassemia major are folate supplements and regular blood transfusions. In cases of severe disease, chelation therapy (removal of excess iron from the blood) and bone marrow transplants are necessary.

115.

A patient is diagnosed with moderate iron deficiency anemia. Aside from iron supplements, of which of the following should the patient increase her intake?

Yogurt

Pasta

Oranges

Broccoli

Explanation:

Pasta, baked goods, and processed foods lack iron and therefore should be avoided or severely limited in patients who have iron deficiency anemia. Foods high in calcium such as yogurt or broccoli have low iron content and impair iron absorption. Meat, eggs, and beans are obviously rich in protein and iron, but green leafy vegetables such as kale and spinach are also good sources of iron. Foods that have high vitamin C content such as oranges increase the body's ability to absorb iron.

116.

A patient with hypovolemic shock should be placed in which of the following positions to help increase blood pressure?

Prone

Lithotomy

Supine

Trendelenburg

Explanation:

A patient with hypovolemic shock should be placed in the Trendelenburg position. This involves the patient lying supine with the head of the bed tilted downward toward the floor, and the patient's legs may be either flexed or extended. This provides increased blood flow to the heart and other vital organs. The other positions involve the patient lying supine with the bed parallel to the ground.

117.

A patient is suspected of having compartment syndrome. Which of the following tests should the nurse expect to be initially ordered?

CT scan

Arterial Doppler

MRI

X-ray

Explanation:

Compartment syndrome is the swelling of muscle and surrounding tissue in response to an injury, which can swell to the point of cutting off the blood flow to the affected area. If not diagnosed quickly, it can result in loss of the limb. An arterial ultrasound Doppler, along with obtaining a history and physical examination, is the gold standard for diagnosing compartment syndrome. It is easily obtainable, the test is resulted quickly, and there is minimal radiation involved. A CT scan may also be ordered, but it usually takes longer to obtain. MRIs are almost

never ordered since not all hospitals have MRI machines and there is little information that an MRI can give that a CT scan cannot. X-rays are never ordered since they only show bones; vasculature is unable to be visualized on these films.

118.

A nurse has just placed a nasogastric tube in a patient. Which of the following would be expected to be ordered after nasogastric tube placement?

Abdominal ultrasound

Chest x-ray

Abdominal x-ray

EKG

Explanation:

A chest x-ray should always be ordered after the placement of a nasogastric tube (NGT) to confirm that it is in the stomach and not in the lung. An abdominal x-ray would not be helpful. If the abdominal x-ray does not show the NGT, it tells the provider that it is not in the correct spot, but will not show where the NGT actually is. An abdominal ultrasound is used to examine visceral organs and vessels, which would not help identify an NGT placement. An EKG would not be helpful because it only monitors the heart.

119.

A patient who arrived at the hospital as a trauma alert and initially was an 11 on the Glasgow Coma Scale (GCS) undergoes a neurological change and now has a GCS of 3. The telemetry monitor shows that the patient is in pulseless ventricular tachycardia. What should be the first step in taking care of this patient?

Intubate the patient

Get a CT scan of the brain

Administer atropine

Administer epinephrine

Explanation:

Intubating the patient and maintaining the airway is the crucial first step in managing this patient. When taking care of an unresponsive patient, think of the mnemonic ABC (Airway, Breathing, Circulation) as a way to prioritize things that need to be addressed. All three of these issues need to be addressed quickly in order to maximize the patient's chance for survival.

120.

A nurse suspects that her patient's chest tube unit has an air leak. Which of the following interventions would be appropriate?

Pull out the tube

Administer Dermabond around the incision site

Use rubber-tipped clamps to momentarily clamp the tubing

Strip or "milk" the tubing

Explanation:

A nurse may try to find the air leak by gently clamping the chest tube momentarily along various sites using rubber-tipped clamps. A chest tube can be destroyed or partially by repeatedly stripping or "milking" it. A chest tube should never be pulled out unless the attending physician is present and authorizes the nurse to do so. Chest tubes are secured to the patient with sutures; in the event the chest tube is taken out, the sutures are cut and the chest tube is easily removed. By administering glue to the insertion site, it will be incredibly difficult for the healthcare provider and very painful for the patient when the chest tube needs to be removed.

121.

A nurse is taking care of a patient with a traumatic brain injury. The patient has developed a steadily increasing intracranial pressure. Which of the following medications should the nurse expect to be given to this patient?

Lantus

Levothyroxine

Lanoxin

Lasix

Explanation:

Lasix is a diuretic that decreases cerebral edema (thereby lowering the ICP) by causing fluid to shift out of the cranial vault into the circulation. It also interferes with the sodium transport, which slows the production of cerebrospinal fluid. Lantus is used to treat hyperglycemia. Levothyroxine is used to treat hypothyroidism. Lanoxin is used to treat cardiac arrhythmias such as atrial fibrillation.

122.

A patient is hospitalized with a possible diagnosis of Guillain-Barré syndrome. What question should be asked when collecting history data from this patient?

"Do you bruise easily?"

"Have you had an upper respiratory tract infection recently?"

"Have you been out of the country during the past 4 months?"

"Has anyone in your family ever had Guillain-Barré syndrome?"

Explanation:

About 60% to 70% of clients with Guillain-Barré experience upper respiratory or GI viral infection 1 to 4 weeks before the symptoms of Guillain-Barré begin. The exact cause of Guillain-Barré syndrome is unknown, but it may be a cell-mediated immune response that attacks the peripheral nerves in response to a virus. The major pathological effect is segmental demyelination of the peripheral nerves, which destroys the myelin sheath of the nerve. Guillain-Barré is not a hereditary disorder. It is unrelated to viral exposure during foreign travel. It does not affect the clotting cascade.

123.

A male patient is brought to the hospital with sudden-onset unilateral testicular pain following a trauma that occurred four hours ago. What diagnosis should the nurse suspect?

Testicular carcinoma

Testicular torsion

Varicocele

Hydrocele

Explanation:

Testicular torsion is a medical emergency. It occurs when the spermatic cord becomes twisted and blood flow to the testicle is severely diminished or absent, which may be precipitated by trauma. It presents with acute onset of pain and swelling of the affected testicle. A varicocele is an enlargement of the veins in the scrotum causing testicular aching and/or swelling to occur. The venous enlargement is usually due to faulty valves in the veins or compression of a neighboring vein disrupting blood flow in nearby veins. Palpation of the affected testicle is often described as feeling like "a bag of worms." A hydrocele is the collection of fluid around the testicle due to infection, malignancy, or unknown cause. It appears as a soft, usually painless mass on the testicle. This is not harmful and has no serious long-term complications. Testicular carcinomas present as hard, painless, fixed, solid testicular lesions.

124.

A patient suddenly loses consciousness and is found to be in pulseless ventricular tachycardia. All of the following medications may be administered EXCEPT:

magnesium sulfate.

lidocaine.

dopamine.

amiodarone.

Explanation:

Amiodarone, lidocaine, magnesium sulfate, vasopressin and/or epinephrine could be given during a code involving a patient with pulseless ventricular tachycardia. Dopamine is used in patients with symptomatic bradycardia since dopamine increases one's heart rate. Since

patients with ventricular tachycardia have an abnormally fast heart rate, dopamine should be avoided.

125.

A patient admitted for a stroke is due for his dose of a full aspirin. The patient has failed his swallow evaluation. What should the nurse do?

Cancel the aspirin order

Crush the aspirin and give it to him with applesauce

Skip the dose

Get an order to give it to the patient per rectum

Explanation:

The patient can be given a full aspirin either by mouth or per rectum. The other option is to place a nasogastric tube (NGT) and give him his medications through the NGT. In either case the nurse should always clarify the order with the attending. A nurse should never skip a dose or cancel a medication without speaking to the attending first. If the patient has failed a swallow evaluation the nurse should not be feeding the patient at all. By giving the patient applesauce the nurse runs the risk of causing the patient to aspirate.

126.

A patient admitted for stroke has failed his swallow evaluation for two consecutive days. Which of the following should the nurse suggest to the medical team in regards to the patient's nutrition?

Pureed diet

Liquid diet

Tube feeds

Total parenteral nutrition

Explanation:

Tube feeds through a nasogastric tube (NGT) would be the preferred way to feed this patient. Since the patient has failed two swallow evaluations, choices A and B are contraindications since they can cause the patient to aspirate. Total parenteral nutrition (TPN) should be reserved for patients who suffer from severe chronic malnourishment, those who are on pressors, and those who have severe abdominal injuries or complications (e.g., pancreatitis or bowel fistula). TPN can cause liver failure, bowel atrophy, and infections. The general rule is that if the gut works, use it.

127.

A 25-year-old female is admitted to the hospital for attempted suicide. She admits to rapid mood swings alternating between feelings of euphoria and severe depression. What is the most likely diagnosis?

Anorexia nervosa

Bulimia nervosa

Generalized anxiety disorder

Bipolar disorder

Explanation:

Bipolar disorder is a psychiatric disorder featuring episodes of extreme happiness and energy followed by periods of depression. Anorexia nervosa is an eating disorder, much more common in girls than boys and most common in adolescents, which involves purposely starving oneself in order to lose weight. Bulimia nervosa is an eating disorder, much more common in girls than boys and most common in adolescents, which involves periods of binging followed by periods of fasting in order to lose weight. Generalized anxiety disorder is a psychiatric disorder causing a person to feel anxious or nervous most or all of the time with no known cause.

128.

A patient who has just undergone a lumbar puncture is now complaining of headache and dizziness. Which of the positions would help alleviate the symptoms?

Supine

Fowler's

Reverse Trendelenburg

Sitting

Explanation:

The supine position is best for a patient who is suffering from a headache post lumbar puncture. This is because the cerebrospinal fluid bathes the brain in fluid, which may alleviate or at least improve the headache. All of the other positions involve the patient sitting up or having the head raised, which will exacerbate the headache and increase the risk for developing a subdural hematoma and/or seizure.

129.

Which of the following treatments is the most important when treating a patient who is hypotensive and lethargic?

Obtaining a CT scan of the brain

Obtaining a pan culture

Maintaining the airway

Administering a fluid bolus

Explanation:

Maintaining a patient's airway is of utmost importance. Fluid boluses help increase blood pressure, which increases the perfusion to vital organs and can be done in conjunction with or after maintaining the patient's airway. Obtaining a CT scan of the brain is important because it may help explain why the patient is hypotensive and lethargic (e.g., cerebral herniation may cause altered mental status and blood pressure changes). Emergent surgery may be needed to correct any intracranial pathology found. Antibiotics, if warranted, may be given once the patient is stabilized.

130.

A patient with a history of paroxysmal SVT has a sudden episode of SVT with a pulse rate of 160 beats per minute. Which initial treatment is most indicated?

Adenosine

Oxygen administration

Carotid massage

Vagal maneuver

Explanation:

Paroxysmal SVT is episodic with normal cardiac rates between episodes, so the initial treatment should be to try to stop the SVT through a vagal maneuver, which can cause the autonomic nervous system to act and slow the electrical conduction. Vagal maneuvers may include coughing forcefully, blowing through a straw forcefully, and holding the breath and bearing down as though having a bowel movement. Carotid massage should only be carried out by a physician with knowledge of the patient's medical history because of the risk of dislodging a clot. If these techniques are not effective, adenosine or cardioversion may be indicated. Oxygen administration is indicated if the patient's oxygen saturation drops below 94% but will not convert this rhythm.

131.

Which of the following classification systems compiles a list of nursing diagnoses?

NANDA-I

NOC

NIC

UMLS

Explanation:

NANDA-I (International) is a classification system that compiles a list of nursing diagnoses that can be used for study and research. The Nursing-Sensitive Outcomes Classification (NOC) lists nursing outcomes, and the Nursing Interventions Classification (NIC) provides interventions for specific nursing needs. The Unified Medial Language System (UMLS) is a unified medical dictionary that integrates a number of different medical vocabularies.

132.

A patient is admitted to the unit after a traumatic brain injury. The nurse notices that the patient has developed foot drop. Which of the following is the most appropriate intervention?

Daily massage of the affected extremity

Placement of an orthopedic boot

Elevation of the foot on a pillow

Placement of an elastic stocking

Explanation:

Placement of an orthopedic boot is the most appropriate treatment for foot drop. For severe cases, surgery may be indicated. Foot drop causes the foot to be extended with limited or no ability to dorsiflex; it is most often caused by trauma or disease affecting the muscles or the nerves. Keeping the foot propped up on the pillow or massaging the foot would be ineffective treatments since the foot itself is not being treated. Placement of an elastic stocking would help with circulation, but foot drop is not caused by a circulatory disorder.

133.

A patient with osteopenia asks her nurse how to prevent progression of the disease. Which of the following is the best advice the nurse can give to this patient?

Increasing fluid intake

Wearing thick layers of clothing

Limiting intake of red meat and alcohol

Increasing calcium intake

Explanation:

Increasing one's calcium intake is advice usually given to someone with osteopenia or osteoporosis. Osteopenia is lower than average bone mineral density, but is not as severe as osteoporosis. Raynaud's disease is caused by the body's abnormal response to cold weather and to stress. A way to prevent or limit the severity of an exacerbation is to avoid cold exposure as much as possible by dressing in warm layers. Limiting one's intake of red meat and alcohol is advice usually given to someone with gout. Increasing one's fluid intake is advice usually given to someone with nephrolithiasis.

134.

A nurse notices that a patient has pain while the doctor palpates the patient's left costovertebral angle. Which of the following is the most likely diagnosis?

Small bowel obstruction

Appendicitis

Pyelonephritis

Cholecystitis

Explanation:

The costovertebral angle (CVA) is defined as the area where the twelfth rib joins the spine. If palpation causes costovertebral angle tenderness (CVAT) then a kidney infection is likely present since the kidneys are located just below the twelfth ribs. Cholecystitis or appendicitis may be suspected if the patient had right-sided or epigastric abdominal pain. A small bowel

obstruction may be present if a patient has constipation, diffusely distended and tender abdomen, and has persistent nausea and/or vomiting.

135.

What does Reynold's pentad include?

Wheezing, nonproductive cough, fever, chest pain, hypoxia

RUQ pain, fever, jaundice, hypotension, and confusion

Back pain, fever, chills, anorexia, and vomiting

Dysuria, hematuria, penile discharge, fever, skin lesions

Explanation:

Reynold's pentad is Charcot's triad (RUQ pain, fever, jaundice) that occurs with shock (hypotension) and altered mental status. This is seen in patients with ascending cholangitis. In cases of patients with Charcot's triad, biliary drainage should be performed once the patient is stabilized. When a patient presents with Reynold's pentad, a biliary drainage should be performed emergently.

136.

A patient with cystic fibrosis asks her nurse what medications she can take for symptomatic relief. Which of the following medications should the nurse NOT advise this patient to use?

Motrin

Permethrin

Colace

Emollients

Explanation:

Permethrin is used to treat scabies and plays no role in the treatment of cystic fibrosis. Cystic fibrosis (CF) is an autosomal recessive genetic disorder that results in excessive accumulation of mucus in the GI and pulmonary tracts resulting in abdominal discomfort from chronic constipation, dry salty-tasting skin, poor appetite, fatigue, fever, and pancreatitis. The only treatment is symptomatic relief (i.e., nebulizer treatments, emollients, stool softeners for constipation). Antibiotics are used for infections.

137.

A patient confides in his nurse that he wants to commit suicide. He tells the nurse how and when he plans to do it. Which of the following is NOT an appropriate action as a medical professional?

Advise the patient to call a suicide hotline.

Obtain a stat psychiatric referral.

Do not report the patient's actions due to confidentiality laws.

Advise the patient's spouse or parents of his intent.

Explanation:

Although all medical professionals are bound by HIPAA (Health Insurance Portability and Accountability Act), which ensures patient privacy, there are instances where the medical professional may share a patient's information. If a patient threatens to injure themselves or others, a medical professional may reach out to local authorities or family members to warn them of the patient's potential plans in order to ensure the safety of the patient and others.

138.

A 22-year-old patient is being discharged from the hospital with a long leg cast due to a broken femur. Which of the following should NOT occur three months after hospital discharge?

Performing self-care activities independently

Ambulating independently

Participating in physical therapy

Riding a motorcycle

Explanation:

After a recent femur fracture a patient should not be riding a motorcycle since high speed collisions are the number one cause of femur fractures. These collisions commonly involve motorcycles, though they can also occur during a car accident. Most patients are encouraged to participate in physical therapy and to ambulate early in the post-operative period to help prevent muscle wasting, pressure ulcers, and blood clots. Three months after the event the patient should be able to perform self-care activities since the cast and/or external fixator(s) should be removed by then.

139.

A patient is admitted to the hospital for cardiac arrhythmias and muscle weakness. An EKG shows peaked T waves. The patient has a known history of chronic renal insufficiency and has been taking

an angiotensin converting enzyme (ACE) inhibitor for his high blood pressure. Which of the following best describes what the patient's electrolytes may look like?

K 5.6, creatinine 1.4, BUN 28

BUN 35, K 4.9, creatinine 2.3

K 6.5, creatinine 1.0, BUN 16

Creatinine 0.9, K 3.1, BUN 7

Explanation:

Patients who are taking ACE inhibitors have approximately a 10 percent chance of developing hyperkalemia. A patient with chronic renal insufficiency may have hyperkalemia at baseline since the kidneys are responsible for filtering excess potassium from the body. Further evidence that the patient has hyperkalemia is the appearance of peaked T waves on the EKG. Since the patient has chronic renal insufficiency, the BUN and creatinine should be mildly elevated. Variations exist between labs, but a normal BUN is 12–22, normal creatinine is 0.9–1.1, and normal potassium level is 3.5–5.1. Choice A is the only one that has abnormally high values for all three labs.

140.

A woman calls the unit and identifies herself as a patient's cousin and asks how the patient fared overnight. The patient is unable to communicate. The patient's power of attorney and only known family member is her husband. What should be the response?

Give her a brief synopsis of how the patient is doing

Apologize, but explain to the cousin that you cannot give out the information

Give the cousin your patient's husband's phone number and instruct her to speak to him

Give her directions to the hospital and request that she speak to you in person since you cannot give that information over the phone

Explanation:

In accordance with The Health Insurance Portability and Accountability Act (HIPAA) healthcare providers may not give out patient information to anyone unless the patient gives permission to do so. In the event that patients are unconscious or lacking the capacity to give permission, healthcare providers may give information to the power of attorney or closest known family member (e.g., spouse, parent, child) as long as they provide documentation of their relationship status. Healthcare providers are not allowed to give information over the phone or in person to anyone other than the power of attorney unless the power of attorney grants permission. Healthcare providers may also not give the power of attorney's contact information to anyone.

141.

A patient has been diagnosed with an upper extremity superficial vein thrombus. Which of the following would be a part of the medical management?

Lovenox

Compression stockings

Coumadin

Warm compresses

Explanation:

Lovenox or heparin are generally used to treat superficial vein thromboses (SVTs). Coumadin is generally not indicated unless multiple clots are present and/or if a patient has an underlying

hypercoagulable disorder. Compression stockings are contraindicated in those with a DVT/SVT since they can propagate the clot. They would also not be used since compression stockings are used for lower extremities only. Warm compresses are not indicated unless there is a secondary infection.

142.

Which of the following is NOT a treatment of thalassemia major?

Folate supplements

Chelation therapy

Blood transfusions

Lumbar puncture

Explanation:

A lumbar puncture plays no role in the treatment of thalassemia major. Thalassemia major is a genetic blood disorder that results in moderate to severe hemolytic anemia. Folate supplements are commonly used, but may not be sufficient enough. Since patients have an abundance of iron in their blood, chelation therapy is often used in conjunction with blood transfusions.

143.

Which of the following is not a sign or symptom of Cushing's disease?

Acromegaly

Obesity

Skin striae

Facial edema

Explanation:

Acromegaly is not a sign of Cushing's disease. Acromegaly results from the presence of excessive growth hormone in an adult patient. Since adult patients have already stopped growing, growth hormone will cause bones to thicken and widen causing pain, weakness, and deformity. Cushing's disease is due to the presence of excessive cortisol causing unintentional weight gain, striae, a fat pad or buffalo hump on the posterior neck, facial swelling, and osteoporosis.

144.

Which of the following treatments is NOT an intervention for a patient with acute alcohol intoxication?

Zofran

Folate

Thiamine

Ativan

Explanation: