

M_NCLEXPNPQ (700+ Questions) - Quiz Questions with Answers

1.

Based on the nurse's assessment findings, the client is most likely experiencing _____.

compartment syndrome

osteomyelitis

an open fracture

a dislocation

Explanation:

Given the mechanism of injury, laceration to the wrist, the decreased range of motion, and deformity to the wrist, this client is most likely experiencing an open fracture. Dislocation could be possible as well (and it should be ruled out), but because the client fell and landed on his wrist, there is more likely a fracture from the impact than a dislocation (which is typically caused by a pulling mechanism to the joint). Compartment syndrome is a concern, as swelling to the wrist causes an increased risk for this complication, but this is not a likely diagnosis because the client's pain is relieved with analgesics, pulses are present distal to the injury, and the client denies any tingling of his fingers. Osteomyelitis is the least likely complication because the injury just occurred and it takes time for a bone infection to set in. However, it would be important to consider this complication in the context of older open injuries.

2.

For the following assessment finding, specify whether it indicates that the client's condition has improved, is unchanged, or has worsened.

Fingertip numbness

Improved

Unchanged

Worsened

Explanation:

The client's heart rate is lower than at admission, which may be a result of better pain control with the patient-controlled analgesia pump. His temperature is higher than at admission, which could be an early sign of infection, which the client is at high risk for due to having an open wound following the fasciotomy. The client has possible worsening compartment syndrome because the fingertip tingling present on admission has now progressed to numbness. The pale skin color, although still being indicative of compartment syndrome, is unchanged from admission. The client's inability to move the affected wrist is of concern for paralysis—a late symptom of compartment syndrome and often indicative of irreversible muscle damage.

3.

For the following assessment finding, specify whether it indicates that the client's condition has improved, is unchanged, or has worsened.

Pale skin color

Improved

Unchanged

Worsened

Explanation:

The client's heart rate is lower than at admission, which may be a result of better pain control with the patient-controlled analgesia pump. His temperature is higher than at admission, which could be an early sign of infection, which the client is at high risk for due to having an open wound following the fasciotomy. The client has possible worsening compartment syndrome because the fingertip tingling present on admission has now progressed to numbness. The pale skin color, although still being indicative of compartment syndrome, is unchanged from admission. The client's inability to move the affected wrist is of concern for paralysis—a late symptom of compartment syndrome and often indicative of irreversible muscle damage.

4.

For the following assessment finding, specify whether it indicates that the client's condition has improved, is unchanged, or has worsened.

Wrist range of motion

Improved

Unchanged

Worsened

Explanation:

The client's heart rate is lower than at admission, which may be a result of better pain control with the patient-controlled analgesia pump. His temperature is higher than at admission, which could be an early sign of infection, which the client is at high risk for due to having an open wound following the fasciotomy. The client has possible worsening compartment syndrome because the fingertip tingling present on admission has now progressed to numbness. The pale skin color, although still being indicative of compartment syndrome, is unchanged from admission. The client's inability to move the affected wrist is of concern for paralysis—a late symptom of compartment syndrome and often indicative of irreversible muscle damage.

5.

The nurse anticipates multiple new orders from the primary care physician. The nurse should get ready to administer _____.

furosemide 40 mg via IV

Dilaudid 0.5 mg via IV

ampicillin 1.5 g via IV

Explanation:

The client is in severe pain, and the nurse should anticipate orders to address his pain with a strong analgesic. Furosemide may be used if the client does not produce adequate urine, but it would not be needed at this time because the client is voiding adequately. There is no sign of infection at this time, so ampicillin would not be indicated.

6.

The nurse anticipates multiple new orders from the primary care physician. It would be a priority for the nurse to infuse _____.

0.9% sodium chloride (normal saline) via IV at 200 mL/hr

5% dextrose in normal saline (D5NS) with 20 mEq potassium chloride (KCl), 500 mL via IV once

one unit of packed red blood cells

Explanation:

With rhabdomyolysis, isotonic IV fluids such as normal saline help prevent kidney damage by diluting myoglobin in the blood. D5NS with 20 mEq KCl would not be appropriate for the client at

this time because he already has an elevated potassium level. There is no indication for a blood transfusion at this time.

7.

The nurse anticipates multiple new orders from the primary care physician. The nurse should prepare the client for surgery within _____.

2 hours

12 hours

24 hours

Explanation:

Compartment syndrome is a medical emergency, and the client would need emergency surgery in order to prevent permanent damage to his arm. The nurse should prepare the client for surgery as soon as possible.

8.

For the following assessment finding, specify whether it indicates that the client's condition has improved, is unchanged, or has worsened.

Heart rate, 89

Improved

Unchanged

Worsened

Explanation:

The client's heart rate is lower than at admission, which may be a result of better pain control with the patient-controlled analgesia pump. His temperature is higher than at admission, which could be an early sign of infection, which the client is at high risk for due to having an open wound following the fasciotomy. The client has possible worsening compartment syndrome because the fingertip tingling present on admission has now progressed to numbness. The pale skin color, although still being indicative of compartment syndrome, is unchanged from admission. The client's inability to move the affected wrist is of concern for paralysis—a late symptom of compartment syndrome and often indicative of irreversible muscle damage.

9.

For the following assessment finding, specify whether it indicates that the client's condition has improved, is unchanged, or has worsened.

Temperature, 100.4 °F oral

Improved

Unchanged

Worsened

Explanation:

The client's heart rate is lower than at admission, which may be a result of better pain control with the patient-controlled analgesia pump. His temperature is higher than at admission, which could be an early sign of infection, which the client is at high risk for due to having an open wound following the fasciotomy. The client has possible worsening compartment syndrome because the fingertip tingling present on admission has now progressed to numbness. The pale skin color, although still being indicative of compartment syndrome, is unchanged from

admission. The client's inability to move the affected wrist is of concern for paralysis—a late symptom of compartment syndrome and often indicative of irreversible muscle damage.

10.

What is the most appropriate solution by the healthcare team in treating this client?

Follow the client's wishes to stop treatment but wait to consult hospice.

Follow the daughter's wishes because she is the healthcare POA, and arrange for the next cycle of treatment.

Follow the client's wishes to stop treatment and arrange for hospice.

Follow the client's and her daughter's wishes by holding treatment for a week and consulting palliative services so the client can continue to receive treatment.

Explanation:

Despite some forgetfulness, the client remains of sound mind, and she has clearly expressed her wishes regarding her care plan. The medical team must identify what the client's wishes are and ensure that the care plan meets these expectations, specifically those outlined in a DNR and living will. In this case, curative treatment should cease and hospice is arranged. The client's healthcare POA would not be indicated to make decisions for the client at this time because she is mentally capable to do so herself. All of the other options violate these legal documents and leave the team open to litigation.

11.

The daughter notices that her mother is unresponsive and calls out to the nurse for help. The nurse rushes to the client's bedside and determines that the client does not have a pulse. Given the client's signed DNR order, the nurse quietly explains to the daughter that there is nothing left to do. The daughter demands that the medical team initiate cardiopulmonary resuscitation (CPR). When evaluating the client's clinical picture and wishes, what is the nurse's best response?

Offer the daughter emotional support and remind her that her mother signed a DNR order, requesting that CPR not be done in this type of circumstance. The team is honoring her mother's wishes.

Offer the daughter emotional support and initiate CPR as the daughter has requested because she knows what is best for her mother.

Call another nurse to see what he or she thinks should be done.

Call the physician for an order to start CPR.

Explanation:

A signed DNR is a legally binding document; therefore, the nurse's best course of action is to abide by the wishes outlined in the document and withhold any life-sustaining measures, including CPR. She should also provide the daughter with the emotional support needed during this difficult time. Calling another nurse or the physician is not indicated because the nurse must follow the DNR order as written regardless of her own personal opinion, and this would divert attention from supporting the daughter, which is the priority at this time.

12.

A patient with interstitial cystitis has been prescribed home bladder instillations with an anesthetic (lidocaine) mixture but has not been doing the instillations consistently because the instillation causes severe burning when she urinates to empty the instillation from the bladder after the prescribed period. Which of the following is likely the best solution?

discontinue instillations

clamp the catheter for the prescribed period and then open to drain fluid before removal

remove the catheter after instillation and then insert a second catheter to drain the bladder

take an analgesic prior to the instillation

Explanation:

The best solution for the interstitial cystitis patient who experiences severe burning when emptying the bladder after an instillation is to leave the catheter in place, clamp it for the prescribed period, and then open the catheter to drain the solution. If the patient finds the catheter itself irritating, it can be removed and a second catheter inserted to drain the bladder, but a better solution is to try to change the type or size of the catheter to find one that is less irritating.

13.

The nurse has obtained a unit of packed red blood cells that is to be administered to a client with leukemia. Within how many minutes must the transfusion be initiated after removal from the blood bank refrigerator?

15 minutes

30 minutes

45 minutes

60 minutes

Explanation:

A unit of packed red blood cells must be administered to a client within 30 minutes after removal from the blood bank refrigerator. The unit should be examined and returned to the blood bank if gas bubbles or cloudiness are evident as these may be indications of bacterial growth or hemolysis. The cells should be administered slowly (≤ 5 mL/min) for the first 15

minutes, but the flow rate can be increased after that time if the patient has no untoward reaction or is not at risk of circulatory overload.

14.

A client is receiving warfarin for venous thrombosis, and the client's INR is 4.0 with no evidence of bleeding. What action does the nurse anticipate?

administer warfarin as prescribed

administer increased dosage of warfarin until INR increases

hold or administer reduced dosage until INR decreases

hold warfarin and administer vitamin K orally

Explanation:

If a client is receiving warfarin for venous thrombosis and the client's INR is 4.0 without evidence of bleeding, the nurse should anticipate that the dosage of warfarin will be held or reduced until the INR decreases. The INR level should be maintained at 2.0–3.0 for venous thrombosis, pulmonary embolism, and valvular heart disease, and at 2.5–3.5 for clients with mechanical heart valves or recurrent systemic emboli. Vitamin K is generally not indicated as a reversal agent with an INR below 5.0, especially with no evidence of bleeding.

15.

Which metabolic effect is most common if a client is taking a loop diuretic?

hypouricemia

hyperglycemia

hyperkalemia

hypokalemia

Explanation:

The metabolic effect that is most common if a client is taking a loop diuretic is hypokalemia. Therefore, clients are often prescribed supplementary potassium to take with the loop diuretic and have regular monitoring of electrolytes. Other metabolic effects that may occur are hyperglycemia and hyperuricemia. Some people may develop gastrointestinal problems, such as nausea, vomiting, and diarrhea. Other adverse effects include thrombocytopenia, neutropenia, agranulocytosis, headache, tinnitus, dizziness, and blurred vision.

16.

The first indication of amniotic fluid embolism (also called pregnancy-related anaphylactoid syndrome) is usually sudden onset of which of the following?

severe chest pain

acute dyspnea

hemorrhage

hypotension

Explanation:

The first indication of amniotic fluid embolism (also called pregnancy-related anaphylactoid syndrome) is usually sudden onset of acute dyspnea because the amniotic fluid containing fetal debris (meconium, hair, skin cells, vernix) enters the maternal circulation and obstructs the pulmonary vessels, leading to acute respiratory distress followed by circulatory collapse. Because the amniotic fluid is high in thromboplastin, which interferes with clotting, the patient may develop disseminated intravascular coagulation. Maternal mortality rates are about 80% and those who survive often have neurological impairment.

17.

What is the first step to emptying the Hemovac?

open the plug on the port

hold the Hemovac over the container and tilt the port toward the container so that fluid drains into the container

place the plug into the port

cleanse the plug and the port with an alcohol wipe in the dominant hand while compressing and holding the top and bottom of the Hemovac together with the other hand

wash hands and apply gloves

Explanation:

The first step to emptying the Hemovac is to wash hands and apply gloves.

18.

What is the second step to emptying the Hemovac?

open the plug on the port

hold the Hemovac over the container and tilt the port toward the container so that fluid drains into the container

place the plug into the port

cleanse the plug and the port with an alcohol wipe in the dominant hand while compressing and holding the top and bottom of the Hemovac together with the other hand

wash hands and apply gloves

Explanation:

The second step to emptying the Hemovac is to open the plug on the port.

19.

What is the third step to emptying the Hemovac?

open the plug on the port

hold the Hemovac over the container and tilt the port toward the container so that fluid drains into the container

place the plug into the port

cleanse the plug and the port with an alcohol wipe in the dominant hand while compressing and holding the top and bottom of the Hemovac together with the other hand

wash hands and apply gloves

Explanation:

The third step to emptying the Hemovac is to open the Hemovac over the container, and tilt the port toward the container so the fluid drains into the container.

20.

What is the fourth step to emptying the Hemovac?

open the plug on the port

hold the Hemovac over the container and tilt the port toward the container so that fluid drains into the container

place the plug into the port

cleanse the plug and the port with an alcohol wipe in the dominant hand while compressing and holding the top and bottom of the Hemovac together with the other hand

wash hands and apply gloves

Explanation:

The fourth step to emptying the Hemovac is to cleanse the plug and the port with an alcohol wipe in the dominant hand while compressing and holding the top and bottom of the Hemovac together with the other hand.

21.

What is the fifth step to emptying the Hemovac?

open the plug on the port

hold the Hemovac over the container and tilt the port toward the container so that fluid drains into the container

place the plug into the port

cleanse the plug and the port with an alcohol wipe in the dominant hand while compressing and holding the top and bottom of the Hemovac together with the other hand

wash hands and apply gloves

Explanation:

The fifth step to emptying the Hemovac is to place the plug into the port.

22.

A client has terminal cancer. For months, the client's spouse has been teary and obviously grieving about the impending death, but now that death is imminent, the spouse seems detached and relatively unemotional. Which of the following is the most likely reason for the spouse's reaction?

lack of feelings for the spouse

state of emotional shock

dulling of responses because of substance abuse

premature completion of anticipatory grief

Explanation:

If a dying client's spouse has been teary and obviously grieving for months but seems detached and relatively unemotional when death is imminent, the most likely reason for the spouse's reaction is premature completion of anticipatory grief. The spouse began the grieving process early, anticipating the loss and the emotions, and may be quite spent and emotionally withdrawn when this process completes. A different type of grieving will occur when the client actually dies.

23.

A client is in cervical traction for a herniated cervical disc. The client complains of increasing pain in the jaw and both ears. Which of the following interventions is most indicated?

provide increased analgesia

adjust weights

correct head position

correct body position

Explanation:

If a client in cervical traction complains of increasing pain in the jaw and ears, the chinstrap may be exerting excess pull on the chin, resulting in increased pressure on the temporomandibular joint. The nurse should gently correct the client's head position by tilting the head slightly forward to relieve the pull on the chin. If the pain occurs on only one side, then the traction may be uneven, and the client's body may need to be positioned correctly.

24.

A hospital must be evacuated because of flooding in the area. The nurse is working in the neonatal nursery and has been advised to utilize the Baby Mover Safe Babies apron to transfer infants. How many infants does the nurse anticipate can be moved in one trip in the apron pockets?

two

three

four

five

Explanation:

The Safe Babies apron is a one-piece apron that fits over the head and attaches on the side with Velcro closures. The apron contains three large pockets, one in the front and two on the sides, so the nurse can carry 3 infants at one time (up to 60 lb). Infants should be wrapped in blankets for warmth prior to being placed in the pockets. The apron is designed so the person's arms are free. This allows the nurse to carry supplies or even additional infants if necessary.

25.

A client is recovering from placement of an implantable cardioverter-defibrillator (ICD) and suddenly exhibits hypotension with narrowing pulse pressure, pulsus paradoxus, distant heart sounds,

restlessness, bulging neck veins, and increasing cyanosis. Which of the following is the most likely cause of these signs and symptoms?

perforation of the ventricle with cardiac tamponade

incorrect positioning of the leads

myocardial infarction

heart failure

Explanation:

Hypotension with narrowing pulse pressure, pulsus paradoxus, distant heart sounds, restlessness, bulging neck veins, and increasing cyanosis are indications of cardiac tamponade resulting from perforation of the ventricle and bleeding into the pericardial sac. This is a medical emergency, and the nurse must immediately notify the physician and prepare the client for surgery. Although nonhemorrhagic tamponade will usually respond well to pericardiocentesis, hemorrhagic tamponade requires thoracotomy because the bleeding will continue until its cause is corrected.

26.

A client tells the nurse that she was recently bitten on the hand by a bat that was inside her house, but the wound has healed. Based on this information, what should the nurse advise the client?

no further treatment is necessary

the client must see a physician immediately because the client is at risk for rabies

the client should see a physician because a latent bacterial infection may occur

the client should see the physician if she develops any symptoms

Explanation:

The client must see a physician immediately because she is at risk for rabies; most cases of rabies in the United States are traced to infections from bats. Most bats that humans are able to approach are ill, increasing the danger. Rabies prophylaxis must be given before the onset of neurological symptoms, so the nurse should stress that the client should not wait to see if symptoms occur because, once she develops rabies, death is almost certain.

27.

How much fluid should a patient with an ileostomy be advised to drink each day?

800 mL

1000 mL

1500 mL

2000 mL

Explanation:

A patient with an ileostomy should be advised to drink about 2000 mL (8 to 10 glasses) of fluid daily because the high output of semi-liquid stool from the colostomy increases the risk of dehydration. Electrolyte levels should be monitored closely and electrolytes replaced as needed. Patients may need to further increase intake when stool output increases. In some cases, patients may be advised to take loperamide to decrease stool output if it remains excessive.

28.

Two months following allogenic hematopoietic cell transplantation, a client has increasing diarrhea, a red rash over parts of the body, and severe generalized itching; the client's sclerae appear slightly yellow tinged. Which of the following disorders does the nurse suspect?

allergic response to anti-rejection drugs

acute graft vs host disease

liver failure

chronic graft vs host disease

Explanation:

If 2 months following allogenic hematopoietic cell transplantation a client has increasing diarrhea, a red rash over parts of the body, and severe generalized itching, and the client's sclerae appear slightly yellow tinged, the nurse should suspect that the client is developing acute graft vs host disease. The typical symptoms (rash, itch, and enteritis) most commonly occur within the first 100 days after transplantation and may progress to chronic graft vs host disease over time.

29.

A client receiving chemotherapy for breast cancer (stage 2) tells the nurse that she is considering complementary therapy to relieve her almost constant nausea and asks the nurse for advice. Which of the following complementary therapies is most likely to be safe and effective?

acupuncture

therapeutic touch

magnetic therapy

herbal therapies

Explanation:

Acupuncture has been demonstrated to relieve chemotherapy-induced nausea and vomiting in a number of studies. Some studies also seem to indicate that ginger (usually in tea form) can reduce the intensity of nausea but not vomiting. The nurse may recommend both of these therapies. However, there is no evidence to suggest that therapeutic touch or magnetic therapy are effective in relieving nausea, and herbal therapies must be evaluated individually as some may interact negatively with the client's medications.

30.

A 26-year-old female who has been hospitalized because of injuries sustained during a robbery is preparing for discharge and tells the nurse that she works as a prostitute and was beaten by a customer. Which of the following is the best response?

"Prostitution is illegal! Don't you want to do something else with your life?"

"You should stop before you get killed."

"I'm sorry. That must be very difficult."

"Would you like information about community programs available to help you be safer?"

Explanation:

The best response is "Would you like information about community programs available to help you be safer?" because it is neither judgmental nor pitying and doesn't try to impose a course of action that the client may be unwilling to accept, but it does allow the client to have a choice.

Nurses often hear information from clients that is surprising or even shocking, and it's important to deal with this information in a very professional, matter-of-fact manner.

31.

When changing a colostomy appliance, with which of the following should the skin about the stoma be cleansed after the pouch is removed?

soap and water

alcohol swabs

tap water

baby wipes

Explanation:

When changing a colostomy appliance, the skin about the stoma should be cleansed with warm tap water. Alcohol may be irritating to the tissue, and soap or baby wipes may leave residue on the tissue that interferes with adhesion. If any soap is used, it should be mild and without oils or perfume and should be rinsed off thoroughly with warm water. If skin paste is present, it should be removed before wetting the skin.

32.

A client is no longer responding to curative treatments. What is the best approach to initiating a discussion about the referral to palliative and hospice care?

"Further treatment is not going to help you."

“Would you like to transfer to palliative and hospice care?”

“Have you thought about stopping all treatments?”

“What do you understand about your options for care?”

Explanation:

The best approach is “What do you understand about your options for care?” The nurse should never suggest that treatment won’t help because even those in hospice and palliative care receive treatment. However, the focus of treatment is different, so the nurse should stress that the goal of hospice and palliative care is to keep the client as comfortable as possible. Clients may feel they are being abandoned if the nurse suggests stopping all treatments.

33.

A hospitalized client calls the nurse into the room and reports that another nurse has been rude to her. Which of the following initial responses by the nurse is most appropriate?

“I’m sure the nurse didn’t mean to be rude.”

“The nurse was probably just very busy.”

“I’m sorry! There’s no excuse for a nurse being rude.”

“I’m so sorry you felt that way. Can you tell me what happened?”

Explanation:

The most appropriate response to a client’s complaint is to express empathy and gather information without placing blame or making excuses: “I’m so sorry you felt that way. Can you

tell me what happened?" Allowing a client to ventilate feelings is often sufficient, but if the issue is serious, the nurse should describe the client's response to the nurse involved and then follow the same procedures in listening to the nurse in order to try to reach a resolution.

34.

The hospital receives news that a train has crashed one-half mile away and that a cloud of nonlethal hazardous material has blanketed the area. Which of the following emergency responses does the nurse anticipate?

evacuation

shelter in place

relocation of staff and clients to interior of building

partial evacuation—children and critically ill only

Explanation:

Because attempting to evacuate clients from the facility is likely to increase exposure to the hazardous material, the most likely emergency response is to shelter in place. This applies to both staff and clients. Guidelines may vary according to the type of waste but can include locking doors, sealing doors and windows, and shutting off air-conditioning and forced-air systems. Many facilities have windows that do not open, but if not, windows should be closed immediately. Staff should monitor news reports because emergency personnel may not be readily available to provide information.

35.

A client has developed signs of tardive dyskinesia with repetitive behavior, including lip smacking and tongue protrusion with choreiform movements of the trunk and extremities. Which of the following medications is most likely the cause of these symptoms?

donepezil HCl (Aricept)

fluoxetine HCl (Prozac)

celecoxib (Celebrex)

haloperidol (Haldol)

Explanation:

Tardive dyskinesia (TD) is a chronic adverse effect associated with haloperidol and other neuroleptic drugs as well as anticholinergics and substances of abuse. Elderly clients and those with schizophrenia and other neuropsychiatric diseases have an increased risk of developing TD, so these drugs should be used with care or avoided. Once symptoms develop, up to 50% of clients remain afflicted, even if the medication is discontinued. No established treatment is available, although different approaches can be tried, including herbal medicines.

36.

A client brought to the emergency department has been exposed to cold temperatures, and his core body temperature is 34°C. Which of the following rewarming techniques is most indicated?

cardiopulmonary bypass

warm IV fluid administration

warm peritoneal lavage

forced air warm blankets

Explanation:

If a client is experiencing hypothermia, treatment depends on the core body temperature. For temperatures ranging from less than 28°C to 32.2°C, active internal rewarming procedures are carried out. These include cardiopulmonary bypass, warm IV fluid administration, and warm peritoneal lavage. However, for temperatures ranging from 32.2°C to 35°C, passive or active external rewarming procedures are used. These include over-the-bed heaters and forced air warm blankets. Patients with hypothermia have reduced sensation, so they must be carefully monitored to prevent burns.

37.

A client in the psychiatric unit engages in yelling and name-calling with anger escalating, exhibiting the prodromal syndrome. The nurse is concerned that the client is at risk of self- or other-directed violence. Which of the following is the most appropriate initial intervention?

restrain the client

offer medication to relax client

attempt to talk the client down

call for additional help

Explanation:

If a client engages in yelling and name calling with anger escalating, exhibiting the prodromal syndrome, and the nurse is concerned that the client is at risk of self- or other-directed violence, the initial intervention should be to call for additional help in case the situation turns violent. Then, the nurse can use techniques to try to deal with the aggression, including talking down, giving medication, removing self and others from the immediate area, and using restraints.

38.

A client has been diagnosed with end-stage kidney disease and is to begin hemodialysis at an outpatient dialysis center. Which of the following types of access is the best option for most clients?

venous catheter

AV graft

AV fistula

implanted port

Explanation:

If a client is to begin hemodialysis, the best option for access is an AV fistula, which is formed by connecting an artery to a vein, usually in the lower arm above the wrist or in the upper arm. The AV fistula requires 2–3 months to mature and strengthen before it can be used for hemodialysis, so a client may have a temporary venous catheter placed during this time. An AV graft, which involves connecting an artery and vein with a synthetic vessel matures within 2–3 weeks but is more likely to develop clotting or infection than an AV fistula.

39.

The nurse believes he observes another nurse taking an opioid medication intended for a client. Which of the following initial actions is the most appropriate?

confront the nurse taking the client's medication

notify a supervisor about the observation

notify the client's physician

carry out a personal investigation

Explanation:

Unless the client is in danger, the nurse should not confront the nurse he suspects of taking an opioid medication intended for a client, because a confrontation may end badly. The other nurse may deny the accusation and place blame on the first nurse or may even react violently. Instead, the observing nurse should immediately notify a supervisor of his concerns so that the administration can carry out an investigation according to facility protocol, which also determines whether an incident report needs to be completed.

40.

A client with end-stage heart failure is bedridden, and the skin in the coccygeal area is red and tender despite frequent turning because the client is occasionally incontinent of urine. The client weighs 180 pounds. Which type of pressure-relieving surface should the nurse most recommend at this time?

foam overlay

sheepskin

alternating pressure overlay

low air loss bed

Explanation:

Both foam overlays and sheepskin are inappropriate for incontinent clients. The alternating pressure overlay is the best choice because it is liquid-resistant and has cells or cylinders that alternately inflate and deflate at intervals, controlled by a pump. They should only be used with clients <250 pounds, so the client fits this criterion. While the low air loss bed provides a

superior support surface, it is much more expensive and must be monitored carefully and maintained properly, and it can result in hypothermia because of the constant flow of air.

41.

A client with moderately advanced Alzheimer's disease believes that her deceased husband is living with her and frequently "talks" to him about the happy things they do together. Which is the best nursing response?

tell the client that her husband has died

try to distract the client when she discusses her husband

ask the physician for medication to help control the client's hallucinations and delusions

allow the client to believe that her husband is alive

Explanation:

As Alzheimer's disease progresses, hallucinations, delusions, and "living in the past" are very common, and trying to convince clients that what they believe is not true can often result in frustration and aggressive behavior. If the hallucinations and delusions are benign and happy memories, the nurse should allow clients to believe them and not interfere. However, if they are frightening or upsetting to the clients, then the nurse should attempt to distract the clients and refocus their attention.

42.

A parent tells the nurse that her children, 5 and 10 years old, have been complaining of anal itching and have been sleeping poorly and complaining of occasional abdominal pain and nausea. What diagnostic test does the nurse anticipate?

complete blood count

tape test

abdominal x-ray

carbon urea breath test

Explanation:

*While some children with pinworms (*Enterobius vermicularis*) may be essentially asymptomatic, common findings include intense anal itching and vulvovaginitis in girls. Those infected often are restless at night and sleep poorly and may complain of intermittent abdominal pain and nausea. The tape test (tape across the anus at bedtime) is the most common diagnostic procedure because the mature worms crawl through the anus to lay eggs in the perineal folds and become attached to the tape.*

43.

Indicate the location of the right lumbar region.

 graphic for question

A

B

C

D

E

F

G

H

I

Explanation:

 *graphic for question*

A. Right hypochondriac

B. Epigastric

C. Left hypochondriac

D. Right lumbar

E. Umbilical

F. Left lumbar

G. Right Inguinal

H. Hypogastric/Suprapubic

I. Left Inguinal

The nurse asks a Hispanic immigrant to evaluate his pain on a scale of one to ten, and the client states his pain is at level one. However, the client looks distressed and is bent over and rubbing his stomach. Which of the following approaches by the nurse is most indicated?

use a different type of questioning to ascertain pain level

accept the client's word about pain

tell the client he appears to be minimizing his discomfort

ask the client if he is afraid to admit to pain

Explanation:

While pain is usually considered to be that which the client states it is, the one-to-ten scale that is commonly used in the United States is not always used in other countries. People from Hispanic countries often describe pain in terms of small amount, normal, or strong. The nurse should use a different type of questioning to ascertain pain and might state, "I see that you are rubbing your stomach and seem to be in pain" to encourage dialogue.

45.

A client newly diagnosed with schizophrenia has been exhibiting both negative and positive symptoms. Which of the following symptoms would be categorized as negative?

inappropriate affect

visual hallucination

delusion of grandeur

disheveled appearance

Explanation:

Inappropriate affect is a negative symptom. Schizophrenia is characterized by both negative and positive symptoms:

Positive

Hallucinations (auditory, visual, olfactory, gustatory, tactile)

Delusions (persecution, grandeur, reference, control, somatic)

Disorganized thinking and speech (echolalia, word salad, incoherence, loose association)

Disorganized behavior (disheveled appearance, restlessness, agitation, inappropriate sexual behavior)

Negative

Affective flattening (poor eye contact, diminished expression, inappropriate affect)

Alogia [poverty of speech] (decreased fluency and content)

Avolition/Apathy (inability to initiate goal-directed activities, lack of interest in work, grooming, hygiene)

Anhedonia (lack of pleasure in social activities and diminished interest in intimacy)

Social isolation

46.

The nurse is educating a 23-year-old client about oral contraceptives. Which of the following should the nurse counsel the client to avoid?

drinking alcohol

smoking

eating a high-fat diet

doing aerobic exercises

Explanation:

Clients taking oral contraceptives should be advised to avoid smoking because smoking increases the risk of clot formation, which can result in heart attacks or strokes. The risk is especially high after age 35, but all women who smoke should consider an alternate method of birth control. Alcohol and diet do not increase health risks with contraceptives, although alcohol may have other negative effects. There is some evidence that women taking oral contraceptives have more muscle tenderness after exercise, but there is no increased health risk.

47.

When a client is terminally ill and in the end stages of life, decisions about treatment options, such as whether to provide rehydration, should be based on which of the following considerations?

alleviating symptoms that may cause family distress

prolonging the client's life as long as possible

following standard protocols for end-of-life care

providing comfort and honoring client's wishes

Explanation:

When a client is terminally ill and in the end stages of life, decisions about treatment options, such as providing rehydration, should be based on whether the treatment in question provides comfort and honors the client's wishes. The consequences of treatment or no treatment must be considered. In some cases, if a client does not have an advance directive and cannot express an opinion, the decision about treatment may lie with a healthcare proxy, such as a family member.

48.

A client has had a long-leg plaster of Paris cast applied. What precautions should the nurse take to promote drying of the cast?

the cast should be covered with a blanket to increase heat

the cast should be left exposed and the client turned every 2–3 hours

the cast should be elevated on bolsters at the ankle to allow air to circulate

the cast should be dried manually with a hair dryer set on high heat

Explanation:

If a client has had a long-leg plaster of Paris cast applied, the cast should be left exposed to the air and not covered because covering it could slow the drying process. The client should be turned with the cast carefully repositioned with the palms of the hands (to avoid making indentations with the fingers) every 2–3 hours. A heat cradle with a low-wattage bulb (25 watts) may be placed over the cast or a commercial dryer may be used, but speeding the drying process may result in the cast drying on the outside and staying wet on the inside.

49.

A 2-year-old child is at the 25th percentile in height but the fourth percentile in weight. The child is slightly anemic, but other laboratory tests, including those for parasites and lead poisoning, are negative. Which of the following is the most likely next step?

identify food allergies/ restrictions

refer the child to Child Protective Services

observe the child's meal behaviors/practices

obtain a dietary intake history for the previous 24 hours and next 3–5 days

Explanation:

Weight at the 5th percentile or lower is an indication of failure to thrive. The next step after physical exam and laboratory work is generally a dietary intake history that lists all fluid and food intake, including amounts and times, for the previous 24 hours and for the next 3–5 days, so the child's caloric and nutritional intake can be estimated. While failure to thrive may be an indication of neglect or abuse, many issues must be considered, including health condition, income, health beliefs, lack of parental education, psychosocial issues, and the child's resistance to feeding.

50.

Which of the following is the primary purpose in the nurse administering the Apgar (appearance, pulse, grimace, activity, respiration) test to a neonate?

determine the infant's biophysical profile

determine if the infant needs emergency medical care

determine if the infant has congenital defects

determine if the infant is preterm, full term, or post-term

Explanation:

The Apgar test is given at one minute and five minutes after birth to determine if emergency care is needed. A total score of ≥ 7 is a sign of good health.

<i>Sign</i>	<i>0</i>	<i>1</i>	<i>2</i>
<i>Appearance (skin color)</i>	<i>Cyanosis or pallor over entire body</i>	<i>Normal, except for extremities</i>	<i>Entire body is normal</i>
<i>Pulse (heart rate)</i>	<i>Absent</i>	<i><100 bpm</i>	<i>>100 bpm</i>
<i>Grimace (reflex irritability)</i>	<i>Unresponsive</i>	<i>Grimace</i>	<i>Infant sneezes, coughs, and recoils</i>
<i>Activity (muscle tone)</i>	<i>Absent</i>	<i>Flexed extremities</i>	<i>Infant moves freely</i>
<i>Respiration (breathing rate and effort)</i>	<i>Absent</i>	<i>Bradypnea, dyspnea</i>	<i>Good breathing and crying</i>

51.

A wheelchair-bound client is to be discharged from a rehabilitation facility to the home environment. He still needs minimal assistance for transfers because he is unable to stand and is concerned about transferring from the wheelchair to the toilet and back. Which of the following assistive devices is most indicated to facilitate safe transfer?

gait/transfer belt

full-body sling lift

caregiver assistance only

sliding board

Explanation:

While a gait/transfer belt may be used by a caregiver until the client is independent, a sliding board is most indicated because the client cannot stand and requires sitting transfer. Use is quite simple and sliding boards are relatively inexpensive. They are usually made of rigid plastic material with low friction so that the client can easily slide from the chair onto the toilet or another surface. Any caregiver who will be assisting should be instructed in methods to use to assist the client without causing injury to the caregiver or the client.

52.

The nurse receives a delivery of a container with this marking (see diagram).

 graphic for question

What is the meaning of this international symbol?

poison

medical equipment

biohazard

radioactive

Explanation:

 graphic for question

This is the international symbol for biohazards. Biohazards are biological materials (plants, animals, organisms), such as bacteria, viruses, and parasites, which are dangerous to people's health or pose the risk of infection. In medical facilities, items that must be labeled as biohazards include used hypodermic needles and contaminated dressings because they may contain infectious biological material. Each facility should establish protocols for handling and disposing of biohazardous materials. Biohazardous waste products are generally disposed of in red plastic bags with the biohazard symbol on the bag.

53.

A patient with chronic glomerulonephritis has the following nursing diagnoses: activity intolerance, self-care deficit, excess fluid volume, ineffective self-health management, and anxiety. Considering Maslow's hierarchy of needs, which two of these needs should have priority?

excess fluid volume and anxiety

excess fluid volume and self-care deficit

excess fluid volume and activity intolerance

excess fluid volume and ineffective self-health management

Explanation:

If a patient with chronic glomerulonephritis has nursing diagnoses of activity intolerance, self-care deficit, excess fluid volume, ineffective self-health management, and anxiety, the first need that should have priority is excess fluid volume because resolving this is a physiological need. Physiological needs always must be dealt with first. The second need to consider is anxiety because being free from anxiety is associated with safety needs, which include the need to have security and to be free of fear and anxiety.

54.

A client has weakness of both lower extremities, more pronounced on the right, and uses crutches to ambulate. Which of the following gaits requires the most upper body strength and balance?

4-point

3-point

2-point

swing-through

Explanation:

The 3-point gait requires the client to have the most upper body strength and balance because the client must support the entire weight of the body with the arms. The sequence for ambulation is to start with both feet together and the crutch tips slightly to the front and side of the feet. Then, the client advances the weaker leg and both crutches at the same time with the toe even with the crutches, followed by the stronger leg with the toe advancing slightly past the crutches. Note: the crutches are advanced only with the weaker leg.

55.

A gang member who killed two children in a shooting is hospitalized under police guard and recovering from a gunshot wound. Which of the following violates the ANA Code of Ethics for Nurses?

a nurse provides basic care but refuses to talk to the client

a nurse asks to be assigned to a different client

a nurse asks to take vacation time to avoid caring for the client

a nurse tells the team leader that he feels conflicted about caring for the client

Explanation:

Providing basic care but refusing to talk to the client is a violation of provision 1 of the ANA Code of Ethics for Nurses. This provision requires that the nurse practice with compassion and show respect for each individual, regardless of social/economic status, personal attributes, or type of health problems. It's the nurse's responsibility to provide care to the highest standard to

all patients. Attempting to avoid caring for a particular client does not violate the Code of Ethics but it may be construed as unprofessional.

56.

Which of the following findings are consistent with early graft rejection in intestine recipients?

change in stool output

decreased hemoglobin and hematocrit

hypotension

decreased serum amylase

Explanation:

Indications of graft rejection in intestine recipients are often nonspecific, but beginning signs may be a change in stool output. There are no specific laboratory findings that indicate rejection. Patients may develop fever, abdominal cramping and pain, and vomiting, and the stoma may change in appearance. As rejection progresses, peristalsis may be diminished or absent, and erythema or duskiness of graft may occur. With severe rejection, peristalsis is absent and the mucosa begins to ulcerate and slough.

57.

What stage in the continuum of states of consciousness belongs in space (1) in the table below:

Consciousness

Wakefulness

(1)

Drowsiness

(2)

Inattentiveness

(3)

(4)

(5)

Coma

confusion

delirium

arousal

vegetative state

stupor

Explanation:

The stage of arousal is in space (1) of the continuum of states of consciousness.

Correct order:

Consciousness

Wakefulness

(1) Arousal

Drowsiness

(2) Confusion

Inattentiveness

(3) Delirium

(4) Stupor

(5) Vegetative state

Coma

58.

What stage in the continuum of states of consciousness belongs in space (2) in the table below:

Consciousness

Wakefulness

(1)

Drowsiness

(2)

Inattentiveness

(3)

(4)

(5)

Coma

confusion

delirium

arousal

vegetative state

stupor

Explanation:

The stage of confusion is in space (2) of the continuum of states of consciousness.

Correct order:

Consciousness

Wakefulness

(1) Arousal

Drowsiness

(2) Confusion

Inattentiveness

(3) *Delirium*

(4) *Stupor*

(5) *Vegetative state*

Coma

59.

What stage in the continuum of states of consciousness belongs in space (3) in the table below:

Consciousness

Wakefulness

(1)

Drowsiness

(2)

Inattentiveness

(3)

(4)

(5)

Coma

confusion

delirium

arousal

vegetative state

stupor

Explanation:

The stage of delirium is in space (3) of the continuum of states of consciousness.

Correct order:

Consciousness

Wakefulness

(1) Arousal

Drowsiness

(2) Confusion

Inattentiveness

(3) Delirium

(4) Stupor

(5) Vegetative state

Coma

60.

What stage in the continuum of states of consciousness belongs in space (4) in the table below:

Consciousness

Wakefulness

(1)

Drowsiness

(2)

Inattentiveness

(3)

(4)

(5)

Coma

confusion

delirium

arousal

vegetative state

stupor

Explanation:

The stage of stupor is in space (4) of the continuum of states of consciousness.

Correct order:

Consciousness

Wakefulness

(1) Arousal

Drowsiness

(2) Confusion

Inattentiveness

(3) Delirium

(4) Stupor

(5) Vegetative state

Coma

61.

What stage in the continuum of states of consciousness belongs in space (5) in the table below:

Consciousness

Wakefulness

(1)

Drowsiness

(2)

Inattentiveness

(3)

(4)

(5)

Coma

confusion

delirium

arousal

vegetative state

stupor

Explanation:

The stage of vegetative state is in space (5) of the continuum of states of consciousness.

Correct order:

Consciousness

Wakefulness

(1) Arousal

Drowsiness

(2) Confusion

Inattentiveness

(3) Delirium

(4) Stupor

(5) Vegetative state

Coma

62.

A nurse must retrieve supplies on the top shelf of a supply room but cannot reach the shelf, which is about a foot above the nurse's reach. Which of the following is an acceptable work practice?

stand on a footstool

use a ladder

climb onto a chair

step onto the second shelf of the cabinet

Explanation:

According to OSHA guidelines, if items are out of reach, the acceptable work practice is to get a properly maintained ladder and use that to climb up to reach the objects. The nurse should never use stools, chairs, or boxes in place of a ladder or try to "climb" up a cabinet by standing on a lower shelf. It's important to climb high enough on the ladder that the nurse is not lifting items over the head because this can result in injuries and falls.

63.

To facilitate the client's right of autonomy, which of the following assessments by the nurse is the most important?

the client's cognitive ability

legal obligations

the physician's wishes

the client's physical ability

Explanation:

The ethical principle of autonomy recognizes that clients have the right to make their own informed decisions about their care. The most important assessment is of the client's cognitive ability because the client needs to be able to understand and consider information that is given by healthcare providers. Children may be able to make informed decisions, but the law does not allow them to do so unless they are emancipated, so the right of autonomy passes to the parents or guardians. Likewise, clients who have cognitive impairment may not be able to make informed decisions.

64.

Nurse A notes that nurse B on the unit smells of alcohol and is slightly slurring her words. What is the best course of action for nurse A?

tell nurse B that she needs to go home because she appears to be inebriated

immediately notify a supervisor

observe nurse B to ensure that she is providing safe care

assist nurse B in caring for her clients until she is less impaired

Explanation:

An impaired nurse should not under any circumstances be allowed to care for clients. Nor should nurse A attempt to cover for the impaired nurse by observing her or assisting her with client care. Nurse A should immediately notify a supervisor of the concerns about nurse B. Confronting another nurse about substance abuse could result in denials or even a violent confrontation, so nurse A should not attempt to handle the situation independently.

65.

A client with 2+ peripheral edema and increasing complaints of lethargy has the following laboratory results:

Test	Result
BUN	172 mg/dL
Serum creatinine	16.4 mg/dL
Glucose	98 mg/dL

Which further testing does the nurse expect based on these findings?

testing for diabetes

testing for liver disease

testing results are inconclusive

testing for kidney disease

Explanation:

The glucose is high normal, but both kidney function tests, the BUN and serum creatinine, are markedly elevated, indicating probable kidney failure, so further testing for kidney disease is indicated.

<i>Test</i>	<i>Result</i>	<i>Normal value</i>
<i>BUN</i>	<i>172 mg/dL</i>	<i>7-17 mg/dL</i>
<i>Serum creatinine</i>	<i>16.4 mg/dL</i>	<i>8.4-10.2 mg/dL</i>
<i>Glucose</i>	<i>98 mg/dL</i>	<i>70-99 mg/dL</i>

66.

The nurse has inserted a Foley catheter into a male client who is bedridden. Which of the following is the best position in which to secure the catheter?

the penis is positioned down with the Foley catheter taped to the front of the inner thigh, and then the tubing is looped to allow for turning and it is taped to the edge of the bed

the penis is positioned up with the Foley catheter taped to the right or left lower abdomen, and then the tubing is looped to allow for turning and it is taped to the edge of the bed

the penis is left unpositioned with the catheter curved over one leg, and the tubing is looped and secured only to the edge of the bed

the penis is positioned downward with the catheter secured to the posterior thigh, and the tubing is looped and secured to the edge of the bed

Explanation:

After insertion of a Foley catheter into a male client, his penis should be positioned upward so that the catheter doesn't catch on his legs, and it should be secured by tape to the right or left lower abdomen, with the tubing looped so the client has slack to turn from side to side, and then the tube is taped to the edge of the bed. The tubing should hang vertically down from the mattress to the collection bag so the urine drains properly.

67.

When assessing a client's health history regarding intake of alcohol, which of the following would qualify the person as an "at-risk" drinker?

a male client goes out with friends 1 or 2 times a week and has 4–6 drinks

a female client rarely drinks but "got drunk" at a college party 4 years earlier

a male client typically has 2 glasses of wine each day

a female client typically has 5–6 beers per week

Explanation:

When assessing a client's health history regarding intake of alcohol, the male client who goes out with friends 1 or 2 times a week and has 4–6 drinks each time would qualify as a person who is an "at-risk" drinker because he routinely drinks 4 or more drinks per occasion even though he is within the acceptable drinking range of up to 14 drinks (2 daily) per week. Females,

because of differences in size and metabolism, should restrict drinking to no more than 1 drink per day.

68.

When assessing the fetal heart rate with the nonstress test (NST) at 34 weeks, what type of accelerations should normally occur during a 20-minute period of observation?

at least 2 accelerations of at least 20 bpm over 20 seconds

at least 2 accelerations of at least 15 bpm over 15 seconds

at least 1 acceleration of at least 10 bpm over 10 seconds

at least 1 acceleration of at least 5 bpm over 5 seconds

Explanation:

When assessing the fetal heart rate with the nonstress test (NST), a normal finding is at least 2 accelerations of at least 15 bpm over 15 seconds for a fetus of ≥ 32 weeks (the normal rate is 10 bpm over 10 seconds at < 32 weeks.) A healthy fetus should exhibit an increased fetal heart rate with movement, and lack of accelerations may indicate hypoxemia or acidosis. However, if a 20-minute period does not show accelerations, the fetus may be in a sleeping cycle, so the testing should be extended to a 40-minute period.

69.

A mother's amniotic fluid is meconium stained. Which of the following complications does the nurse anticipate the neonate may develop?

anemia

respiratory distress

growth retardation

cognitive impairment

Explanation:

If the neonate swallowed amniotic fluid, the child may be born in acute respiratory distress, but symptoms may be delayed for a few hours, so the child must be monitored carefully. If the neonate cries at delivery and shows no signs of distress, then the mouth and throat are suctioned, but if respiratory distress is evident, the child should be intubated and tracheobronchial suctioning done to remove meconium plugs. The gastric contents may be suctioned as well to prevent the infant from regurgitating and aspirating meconium.

70.

If the nurse is to give a client two oral medications (capsules) per the enteral feeding tube, which of the following is the correct procedure?

open the capsules directly into the feeding formula and instill

open the capsules together and dilute with water before instilling

open the capsules separately and dilute each with water before instilling

oral medications cannot be given per the enteral feeding tube

Explanation:

If a client is to receive two oral medications (capsules) per the enteral feeding tube, the nurse should open the capsules separately and dilute each with water. They should be drawn up in separate syringes for instilling. If the client has continuous feeding, the feeding should be stopped and the tube flushed with about 15 mL of water before instilling the first drug and then flushed again with the same volume after instillation to empty the tube of the medication before the second drug instillation. Then, the tube is flushed again before restarting the feeding.

71.

The nurse is administering an intermittent tube feeding to a client per an NG tube. The nurse has checked placement of the tube, checked for gastric residual, and aspirated 150 mL of gastric contents. Which of the following next actions is most appropriate?

hold feeding and notify MD of gastric residual

proceed with tube feeding

return the aspirated gastric contents to the stomach and flush the tubing with 30 mL water

return 100 mL of aspirated gastric contents to the stomach followed by the tube feeding

Explanation:

While protocols regarding tube feedings may vary somewhat, generally if gastric residual is less than 100 mL, it is returned to the stomach and the tubing flushed with 30 mL of water, but if it is more than 100 mL (in this case 150 mL) it may indicate that an obstruction has occurred, and the nurse should hold the feeding and notify the MD before proceeding. The amount of residual gastric contents should be aspirated and measured at least every 8 hours.

72.

Two years after the death of her spouse, a client remains preoccupied with memories of her deceased husband, neglecting family and friends. Which of the following types of grief response is the client experiencing?

inhibited

distorted

prolonged

normal

Explanation:

If 2 years after the death of her spouse, a client remains preoccupied with memories of her deceased husband, neglecting family and friends, the type of grief response the client is experiencing is prolonged. Prolonged grief may persist for many years after a death and may seriously impact a person's ability to function. Some who experience prolonged grief become suicidal. Exposure therapy, reliving and talking about the death, can help to relieve prolonged grief.

73.

A patient presents in a deep coma with decorticate posturing, which suggests damage to which part of the brain?

midbrain

right and left hemispheres

medulla

diencephalon

Explanation:

Decorticate (flexion) posturing indicates damage to the diencephalon, decerebrate posturing damage to the midbrain and pons, and flaccid posturing damage to the medulla. Comas may be structural or metabolic-induced. Other assessments that may assist in determining cause include assessment of pupillary size and reaction (usually within normal limits with metabolic causes), oculomotor eye movements, and breathing patterns. CT or MRI is also used to identify structural lesions while laboratory testing may identify metabolic abnormalities, such as drug overdose.

74.

The nurse is caring for a client who is awaiting open reduction and internal fixation (ORIF) of a hip fracture and is temporarily immobilized with Buck's traction. The nurse notes that the knot of the rope is lodged against the pulley. What is the primary concern with this finding?

there is no concern because this is the correct placement of the knot

this may change body alignment

this may interfere with the line of pull

this may change the direction of pull

Explanation:

Knots should always be free of the pulleys with any type of traction because if the knot lodges in the pulley, it may interfere with the line of pull, which should be along the bone axis, with the weights hanging freely. The tension rope should be in the groove of the pulley and should slide easily. The nurse should ensure that the client is lying centered on the bed because if the client's body is not aligned properly with the traction, then the line of pull may be altered.

75.

A client at a family planning clinic has received a prescription for oral contraceptives. When reviewing the client's medication list, the nurse notes that the client takes the following:

- St. John's wort 300 mg three times daily
- vitamin D3 500 mg daily
- calcium carbonate 1000 mg daily
- acetaminophen 650 mg every 6 hours as needed for headache
- multivitamin capsule daily

Which of the following information should the nurse include when educating the client about taking oral contraceptives?

these medications and supplements should not interfere with oral contraceptives

vitamin D3 and calcium carbonate should not be taken with oral contraceptives

St. John's wort may decrease the effectiveness of oral contraceptives

St. John's wort should not be taken with calcium carbonate or multivitamins

Explanation:

If a client who has been prescribed oral contraceptives also takes St. John's wort, vitamin D3, calcium carbonate, acetaminophen, and multivitamins, then the nurse should tell the client that St. John's wort should not be taken with oral contraceptives because the herbal preparation increases the rate of absorption of some medications, such as oral contraceptives, decreasing their effectiveness. Acetaminophen, vitamin D, calcium carbonate, and multivitamins pose no problem.

76.

Which of the following ensures minimal proper identification prior to administering medication?

nurse recognizes client

nurse asks client's name and checks hospital ID bracelet

nurse reads client's name on intake and output record at the foot of the client's bed

nurse asks client's name

Explanation:

Two forms of identifiers should always be used prior to administering medication to any client, even if the nurse recognizes the client and is relatively sure of the client's identity. Asking the client's name and checking the hospital ID bracelet meet minimal requirements. In some cases, clients may be identified by asking their names and birthdates. The nurse should always double check the name on the medication as well. An ID bracelet that is not on the client but elsewhere, such as on a bedside stand, should not be used for identification.

77.

A 76-year-old female tells the nurse that she and her husband want to continue to engage in sexual activity, but both have osteoarthritis and limited mobility. Which position should the nurse recommend that will be putting the least strain on both partners?

"missionary" position (male on top)

female on top

"spooning" position with male behind female, side lying

rear vaginal entry with female prone and male on top

Explanation:

The “spooning” position, in which the female and her partner are lying on their sides with the male behind the female, allows penetration without undue strain on either the male or the female. The nurse should also encourage them to engage in sexual activities during the times of day when they have less pain. Taking a warm bath prior to sexual activity may also help to reduce muscle stiffness and discomfort. Intimacy is important at all ages, and the nurse should discuss the matter openly with older clients.

78.

The nurse is working as a team leader and discussing assignments with team members. Which of the following statements to the group by a team member is a HIPAA violation of privacy?

“Mrs. Brown says she has no support system when she goes home.”

“Mrs. Brown says she has been having an affair with her husband’s brother!”

“Mrs. Brown says she dislikes her therapist, so she refuses to cooperate.”

“Mrs. Brown seems angry all of the time and yells at her family when they visit.”

Explanation:

Because nurses work closely with clients, a client often divulges confidential information, such as the fact that she has been having an affair with her husband’s brother. However, the nurse must evaluate communications to determine if they are health related and can and should be reported or if they are private communications. In this case, no purpose is served by reporting the client’s statement except to spread gossip, so this is a HIPAA violation of privacy.

79.

Prioritize the clients according to the order in which the nurse should attend to them. Which is the first client?

six-hour postoperative client is asking for pain medication for pain of 8 on a scale of 1–10

two-day postoperative client needs a routine dressing change

five-day postoperative client needs intermittent tube feeding

three-day postoperative client needs assessment for sudden elevated temperature

Explanation:

The first client the nurse should prioritize for care is the six-hour postoperative client who is asking for pain medication for pain of 8 on a scale of 1–10.

Acute needs are handled first (pain medication and evaluation). Because a routine dressing change is not time sensitive and tube feedings are given on a regular schedule (usually every four to six hours), the tube feeding should be done before the dressing change.

80.

Prioritize the clients according to the order in which the nurse should attend to them. Which is the second client?

six-hour postoperative client is asking for pain medication for pain of 8 on a scale of 1–10

two-day postoperative client needs a routine dressing change

five-day postoperative client needs intermittent tube feeding

three-day postoperative client needs assessment for sudden elevated temperature

Explanation:

The second client the nurse should prioritize for care is the three-day postoperative client who needs assessment for sudden elevated temperature.

Acute needs are handled first (pain medication and evaluation). Because a routine dressing change is not time sensitive and tube feedings are given on a regular schedule (usually every four to six hours), the tube feeding should be done before the dressing change.

81.

Prioritize the clients according to the order in which the nurse should attend to them. Which is the third client?

six-hour postoperative client is asking for pain medication for pain of 8 on a scale of 1–10

two-day postoperative client needs a routine dressing change

five-day postoperative client needs intermittent tube feeding

three-day postoperative client needs assessment for sudden elevated temperature

Explanation:

The third client the nurse should prioritize for care is the five-day postoperative client who needs intermittent tube feeding.

Acute needs are handled first (pain medication and evaluation). Because a routine dressing change is not time sensitive and tube feedings are given on a regular schedule (usually every four to six hours), the tube feeding should be done before the dressing change.

82.

Prioritize the clients according to the order in which the nurse should attend to them. Which is the fourth client?

six-hour postoperative client is asking for pain medication for pain of 8 on a scale of 1–10

two-day postoperative client needs a routine dressing change

five-day postoperative client needs intermittent tube feeding

three-day postoperative client needs assessment for sudden elevated temperature

Explanation:

The fourth client the nurse should prioritize for care is the two-day postoperative client who needs routine dressing change.

Acute needs are handled first (pain medication and evaluation). Because a routine dressing change is not time sensitive and tube feedings are given on a regular schedule (usually every four to six hours), the tube feeding should be done before the dressing change.

83.

A pregnant client is at term and in the first stages of labor, and the nurse is monitoring the fetal heart rate. Which of the following is the normal fetal heart rate at term?

60–90 bpm

90–100 bpm

120–160 bpm

160–200 bpm

Explanation:

The normal fetal heart rate (FHR) at term is 120–160, with rates lower than 120 being considered bradycardia and greater than 160 being considered tachycardia. The FHR at 5 weeks is usually in the 80s, increasing each day by about 3 beats over the next month. By week 9 of gestation, the FHR has increased to about 175 and ranges from 120–180 by midpregnancy. However, the FHR tends to slow somewhat during the last 10 weeks.

84.

When giving an intramuscular injection, which site should the nurse avoid in obese adults?

ventrogluteal

deltoid

dorsogluteal

vastus lateralis

Explanation:

The nurse should avoid using the dorsogluteal site in obese adults because adipose tissue may make it difficult to inject into the muscle. Generally, this site should be avoided if at all possible in all clients because of the danger of hitting the sciatic nerve. The deltoid muscle should be used only for small volumes of medication. The preferred site for intramuscular (IM) injections is the ventrogluteal site. When giving an IM injection in the vastus lateralis site, the tissue must be pinched and the muscle should be pulled away rather than the skin being held taut. This site is preferred for children younger than 18 months of age.

85.

The nurse is caring for an elderly Hmong client who had a severe myocardial infarction and whose death appears imminent. Even though healthcare providers are still trying to save the client's life,

family members are insisting that she be dressed in traditional clothing that they have brought from home. Which of the following is the most appropriate response?

tell them that they cannot interrupt treatment

suggest they wait until efforts to save the client end

assist them to dress the client if possible

advise them that clothing is not important

Explanation:

If the nurse is caring for a Hmong client whose death appears imminent and the family members want to dress the client in traditional clothing, the nurse should realize that this is part of a death ritual and assist them in dressing the client as much as possible while treatment is still ongoing. Hmong belief is that people's souls go to the afterlife in the same clothing they wore at death, so the clothing the client is wearing at death may be very important to them.

86.

The nurse must give an intramuscular injection to an adult. What length of needle is most appropriate?

0.5 in

0.625 in

1 in

1.5 in

Explanation:

Intramuscular (IM) injections are almost always given to adults with a needle that is 1.5 inches in length. A shorter length (1 inch) should be reserved for children or for very thin adults. The needle gauge usually varies from 21–25, although very thick preparations may require a gauge of 18 or 19. IM injections are usually given with a 3-mL syringe, although the maximum amount of medication in each injection should not exceed 2 mL. If larger volumes are ordered, then the dose should be divided and administered in two injections.

87.

A pregnant client tells the nurse that she is Rh– and her husband is Rh+, but she believes she does not need to receive RhoGAM with a first pregnancy. Which of the following is the best response?

“You are right, but you will need the treatment during a second pregnancy.”

“You need treatment during your first pregnancy to prevent Rh incompatibility reactions during a second pregnancy.”

“You are wrong. You need the treatment with your first pregnancy.”

“You should ask the doctor about that.”

Explanation:

The best response to the client who believes she does not need RhoGAM with a first pregnancy is the one that provides a reason why the treatment is needed: “You need treatment during your first pregnancy to prevent Rh incompatibility reactions during a second pregnancy.” The serum RhoGAM contains Rh+ antibodies that agglutinate any stray fetal red blood cells that enter the mother’s bloodstream to prevent antibodies forming against them because these antibodies

can attack a future fetus. The mother receives RhoGAM at 26–28 weeks and again within 72 hours of delivery.

88.

Which of the following is a common psychosocial response of a pregnant client to pregnancy during the first trimester?

increasing dependency

alteration in body image

ambivalence

changes in sexuality

Explanation:

A common psychosocial response of a pregnant client to pregnancy during the first trimester is ambivalence. Because many pregnancies are unplanned, the client may not feel prepared for motherhood or may feel apprehensive about the physical changes. Multiparas may be concerned about coping with additional children and the expenses involved in raising children. During this first trimester, pregnant women tend to be more concerned about the self than the fetus, especially if they experience morning sickness and/or mood swings associated with hormonal changes.

89.

A client tells the nurse that he wants to designate his son to make only his healthcare decisions in the event that he is not able to do so, but he is unsure what document he needs to complete. Which of the following should the nurse advise?

Living Will

Advance Directive

Power of Attorney

Durable Power of Attorney for Healthcare

Explanation:

A Durable Power of Attorney for Healthcare remains in effect (durable) if the client is unable to make decisions, so this is the best option. While state laws vary somewhat, a Durable Power of Attorney for Healthcare is generally limited to healthcare decisions only. In some states, a healthcare proxy can be established as part of an Advance Directive, but in other states two different documents are required, so the nurse should always be familiar with state regulations.

90.

Following an automobile accident that resulted in what appeared to be a mild head injury and fractured right clavicle, the client is being carefully monitored. The client's telemetry had shown a normal ECG complex with normal pulse rate until the following changes occurred:

 graphic for question

What does this tracing most likely represent?

sinus bradycardia resulting from increasing intracranial pressure

sinus bradycardia resulting from hypovolemia

premature ventricular contraction resulting from hypovolemia

premature ventricular contraction resulting from increasing intracranial pressure

Explanation:

If a patient was in an automobile accident that resulted in what appeared to be a mild head injury and a fractured femur, and telemetry had been normal until the ECG changes occurred, the changes most likely represent sinus bradycardia resulting from increasing intracranial pressure. As the pulse rate falls, blood pressure increases and breathing may become irregular. Sinus bradycardia can also result from hypovolemia, although blood loss should be minimal with a fractured clavicle.

 graphic for question

91.

A client has been diagnosed with amyotrophic lateral sclerosis (ALS) and uses a wheelchair, but still breathes independently. At what point may the client receive palliative care?

when the client becomes ventilator dependent or near death

when the client's life expectancy is 6 months or less

at any time since the client has a life-threatening disease

when the client is in need of pain control

Explanation:

A client who has been diagnosed with amyotrophic lateral sclerosis (ALS) and uses a wheelchair but still breathes independently may receive palliative care at any time since the client has a life-threatening disease. While hospice care is indicated for client's whose life expectancy is 6 months or less and who are receiving no active treatment, these limitations do

not apply to palliative care, which aims to provide comfort measures, such as pain control, and to allow the client to deal with the ongoing stress and needs of severe illness.

92.

The nurse calls a physician to report a client's sudden increase in temperature and receives a telephone order for an antibiotic. Which of the following is the correct procedure for the nurse?

write the telephone order, order from the pharmacy, and administer the medication

write the telephone order, read it back, and ask for verbal verification before ordering the drug from the pharmacy and administering the medication

write the order, repeating it back, and then order the drug from the pharmacy and administer the medication

write the order and check with a supervisor before ordering the drug from the pharmacy and administering the medication

Explanation:

When taking a verbal order of any kind, including a telephone order, the nurse should write the order and then read it back, asking for verbal verification that the order is correct, before notifying the pharmacy of the order or administering the medication. In an emergency situation only, such as may occur with a cardiac arrest, the nurse may repeat back an order for verification. Verbal orders should not be accepted if the physician is present on the unit.

93.

The nurse is working in the emergency department. Which of the following injuries must be reported to the police or appropriate authorities?

a woman has multiple facial injuries and defensive wounds on the hands and arms but insists she fell

a 6-year-old child has severe head and face injuries and multiple broken ribs. X-rays indicate numerous old orthopedic injuries, and the mother states the child fell off a swing

a client has a large open cut on his torso and claims he was injured when a large light fixture fell on him

an 18-year-old girl who was severely intoxicated from drinking fell and broke her arm

Explanation:

While state laws vary regarding how to report and what to report, all states require mandatory reporting of suspected child abuse. Because the type and extent of injuries to the child are not consistent with a fall off of a swing and the child has evidence of multiple previous injuries, the incident must be reported to the proper authorities. In most states, the report is made to Child Protective Services, who in turn may notify the police.

94.

For the following assessment finding, specify whether it indicates that the client's condition has improved, is unchanged, or has worsened.

Pulse oximetry reading, 92%

Improved

Unchanged

Worsened

Explanation:

During the 1130 assessment, the client was only able to speak one word at a time; however, he is now able to speak in short sentences, which demonstrates improvement of his dyspnea. The client's respiratory rate has decreased from 23 to 19, showing improvement because he is no longer tachypneic. The client remains afebrile; therefore, this component is unchanged. The client's pulse oximetry reading increased from 83% to 92%, which represents an improvement to an acceptable oximetry reading for an individual with COPD. The client's heart rate has increased from 102 to 121, which represents worsening tachycardia. The client's pH and PaCO₂ are now within the normal range, which indicates that the client's respiratory acidosis has resolved.

95.

For the following assessment finding, specify whether it indicates that the client's condition has improved, is unchanged, or has worsened.

Heart rate, 121 and irregular

Improved

Unchanged

Worsened

Explanation:

During the 1130 assessment, the client was only able to speak one word at a time; however, he is now able to speak in short sentences, which demonstrates improvement of his dyspnea. The client's respiratory rate has decreased from 23 to 19, showing improvement because he is no longer tachypneic. The client remains afebrile; therefore, this component is unchanged. The client's pulse oximetry reading increased from 83% to 92%, which represents an improvement to an acceptable oximetry reading for an individual with COPD. The client's heart rate has increased from 102 to 121, which represents worsening tachycardia. The client's pH and PaCO₂ are now within the normal range, which indicates that the client's respiratory acidosis has resolved.

96.

For the following assessment finding, specify whether it indicates that the client's condition has improved, is unchanged, or has worsened.

pH, 7.37

Improved

Unchanged

Worsened

Explanation:

During the 1130 assessment, the client was only able to speak one word at a time; however, he is now able to speak in short sentences, which demonstrates improvement of his dyspnea. The client's respiratory rate has decreased from 23 to 19, showing improvement because he is no longer tachypneic. The client remains afebrile; therefore, this component is unchanged. The client's pulse oximetry reading increased from 83% to 92%, which represents an improvement to an acceptable oximetry reading for an individual with COPD. The client's heart rate has increased from 102 to 121, which represents worsening tachycardia. The client's pH and PaCO₂ are now within the normal range, which indicates that the client's respiratory acidosis has resolved.

97.

For the following assessment finding, specify whether it indicates that the client's condition has improved, is unchanged, or has worsened.

PaCO₂, 43

Improved

Unchanged

Worsened

Explanation:

During the 1130 assessment, the client was only able to speak one word at a time; however, he is now able to speak in short sentences, which demonstrates improvement of his dyspnea. The client's respiratory rate has decreased from 23 to 19, showing improvement because he is no longer tachypneic. The client remains afebrile; therefore, this component is unchanged. The client's pulse oximetry reading increased from 83% to 92%, which represents an improvement to an acceptable oximetry reading for an individual with COPD. The client's heart rate has increased from 102 to 121, which represents worsening tachycardia. The client's pH and PaCO₂ are now within the normal range, which indicates that the client's respiratory acidosis has resolved.

98.

Based on the client's current clinical picture, he is at the highest risk for developing _____.

respiratory alkalosis

respiratory acidosis

diabetic ketoacidosis

metabolic acidosis

Explanation:

The client is demonstrating the signs and symptoms of respiratory distress, which could lead to respiratory failure if left untreated. These include dyspnea at rest, decreased oxygen saturation, tachypnea, and wheezing. COPD disrupts the body's ability to properly ventilate due to the air trapping that occurs in the lungs. This can result in a buildup of carbon dioxide (CO₂) because it

is not being released. An increase in CO_2 secondary to insufficient ventilation results in respiratory acidosis, which is a complication of COPD exacerbations.

99.

Based on the results of the arterial blood gases collected bedside, the nurse anticipates interventions to address the client's _____ using _____. (Select the best response for the FIRST blank)

compensated respiratory alkalosis

uncompensated respiratory alkalosis

compensated respiratory acidosis

uncompensated respiratory acidosis

Explanation:

The client's COPD exacerbation has resulted in respiratory acidosis demonstrated by his elevated $PaCO_2$ and decreased pH readings. The kidneys are attempting to compensate for the acidosis by retaining HCO_3^- (demonstrated by a slightly elevated HCO_3^- level), but they are unable to do so because the pH level remains below normal. This leaves the client with uncompensated respiratory acidosis. The most effective treatment of respiratory acidosis is bilevel positive airway pressure (BiPAP), which assists in opening the alveoli and releasing the trapped air. This would be done prior to invasive mechanical ventilation. Increasing oxygen via nasal cannula would be insufficient, and extracorporeal membrane oxygenation is not indicated unless the patient continues to decline with a pH of less than 7.2.

100.

Based on the results of the arterial blood gases collected bedside, the nurse anticipates interventions to address the client's _____ using _____. (Select the best response for

the SECOND blank)

mechanical ventilation

BiPAP

increased oxygen via nasal cannula

extracorporeal membrane oxygenation

Explanation:

The client's COPD exacerbation has resulted in respiratory acidosis demonstrated by his elevated PaCO_2 and decreased pH readings. The kidneys are attempting to compensate for the acidosis by retaining HCO_3^- (demonstrated by a slightly elevated HCO_3^- level), but they are unable to do so because the pH level remains below normal. This leaves the client with uncompensated respiratory acidosis. The most effective treatment of respiratory acidosis is bilevel positive airway pressure (BiPAP), which assists in opening the alveoli and releasing the trapped air. This would be done prior to invasive mechanical ventilation. Increasing oxygen via nasal cannula would be insufficient, and extracorporeal membrane oxygenation is not indicated unless the patient continues to decline with a pH of less than 7.2.

101.

For the following assessment finding, specify whether it indicates that the client's condition has improved, is unchanged, or has worsened.

Dyspnea while talking

Improved

Unchanged

Worsened

Explanation:

During the 1130 assessment, the client was only able to speak one word at a time; however, he is now able to speak in short sentences, which demonstrates improvement of his dyspnea. The client's respiratory rate has decreased from 23 to 19, showing improvement because he is no longer tachypneic. The client remains afebrile; therefore, this component is unchanged. The client's pulse oximetry reading increased from 83% to 92%, which represents an improvement to an acceptable oximetry reading for an individual with COPD. The client's heart rate has increased from 102 to 121, which represents worsening tachycardia. The client's pH and PaCO₂ are now within the normal range, which indicates that the client's respiratory acidosis has resolved.

102.

For the following assessment finding, specify whether it indicates that the client's condition has improved, is unchanged, or has worsened.

Respirations, 19

Improved

Unchanged

Worsened

Explanation:

During the 1130 assessment, the client was only able to speak one word at a time; however, he is now able to speak in short sentences, which demonstrates improvement of his dyspnea. The client's respiratory rate has decreased from 23 to 19, showing improvement because he is no longer tachypneic. The client remains afebrile; therefore, this component is unchanged. The client's pulse oximetry reading increased from 83% to 92%, which represents an improvement to an acceptable oximetry reading for an individual with COPD. The client's heart rate has increased from 102 to 121, which represents worsening tachycardia. The client's pH and PaCO₂

are now within the normal range, which indicates that the client's respiratory acidosis has resolved.

103.

For the following assessment finding, specify whether it indicates that the client's condition has improved, is unchanged, or has worsened.

Temperature, 98.5 °F axillary

Improved

Unchanged

Worsened

Explanation:

During the 1130 assessment, the client was only able to speak one word at a time; however, he is now able to speak in short sentences, which demonstrates improvement of his dyspnea. The client's respiratory rate has decreased from 23 to 19, showing improvement because he is no longer tachypneic. The client remains afebrile; therefore, this component is unchanged. The client's pulse oximetry reading increased from 83% to 92%, which represents an improvement to an acceptable oximetry reading for an individual with COPD. The client's heart rate has increased from 102 to 121, which represents worsening tachycardia. The client's pH and PaCO₂ are now within the normal range, which indicates that the client's respiratory acidosis has resolved.

104.

Based on the nurse's assessment findings, the nurse should recognize that the client is most likely experiencing a(n) _____.

myocardial infarction

anxiety attack

asthma exacerbation

spontaneous pneumothorax

tension pneumothorax

Explanation:

The client is most likely experiencing a spontaneous pneumothorax. This occurs most commonly without a traumatic cause in young male clients who are tall and thin. The client's sudden-onset chest pain, difficulty breathing, and absent unilateral breath sounds are also indicators of pneumothorax. Although if left untreated, the client could develop tension pneumothorax, his assessment findings do not indicate that at this time. Typical additional signs and symptoms of a tension pneumothorax are tracheal deviation, jugular vein distension, and decreased blood pressure. If tension pneumothorax is suspected, immediate decompression is indicated to prevent shock and cardiac arrest. Although myocardial infarction should be considered given the client's chest pain and shortness of breath (dyspnea), this is less likely given the expected EKG findings and the client's age and medical history. An asthma exacerbation could also be considered to be a cause of the client's dyspnea. However, this would more likely cause wheezing in the lungs (not unilateral absence of breath sounds) and would possibly respond to nebulizer treatment. An anxiety attack could also cause tachycardia, chest pain, and dyspnea in a client. However, this should only be considered if all other likely medical causes are ruled out.

105.

For the following assessment finding, specify whether it indicates that the client's condition has improved, is unchanged, or has worsened.

Pain, 3/10

Improved

Unchanged

Worsened

Explanation:

The client's pain level has decreased, his respiratory rate is closer to normal, and his integumentary assessment is indicating improved oxygenation. The client's blood pressure is now lower than normal parameters. This could be caused by opiate administration, or it could be a sign of shock. The provider should be notified, and further assessments should be conducted. The client's pulse oximetry has increased slightly, but it remains within normal limits.

106.

For the following assessment finding, specify whether it indicates that the client's condition has improved, is unchanged, or has worsened.

Respirations, 22

Improved

Unchanged

Worsened

Explanation:

The client's pain level has decreased, his respiratory rate is closer to normal, and his integumentary assessment is indicating improved oxygenation. The client's blood pressure is now lower than normal parameters. This could be caused by opiate administration, or it could be a sign of shock. The provider should be notified, and further assessments should be

conducted. The client's pulse oximetry has increased slightly, but it remains within normal limits.

107.

For the following assessment finding, specify whether it indicates that the client's condition has improved, is unchanged, or has worsened.

Blood pressure, 90/76

Improved

Unchanged

Worsened

Explanation:

The client's pain level has decreased, his respiratory rate is closer to normal, and his integumentary assessment is indicating improved oxygenation. The client's blood pressure is now lower than normal parameters. This could be caused by opiate administration, or it could be a sign of shock. The provider should be notified, and further assessments should be conducted. The client's pulse oximetry has increased slightly, but it remains within normal limits.

108.

For the following assessment finding, specify whether it indicates that the client's condition has improved, is unchanged, or has worsened.

Pulse oximetry, 95%

Improved

Unchanged

Worsened

Explanation:

The client's pain level has decreased, his respiratory rate is closer to normal, and his integumentary assessment is indicating improved oxygenation. The client's blood pressure is now lower than normal parameters. This could be caused by opiate administration, or it could be a sign of shock. The provider should be notified, and further assessments should be conducted. The client's pulse oximetry has increased slightly, but it remains within normal limits.

109.

For the following assessment finding, specify whether it indicates that the client's condition has improved, is unchanged, or has worsened.

Integumentary assessment

Improved

Unchanged

Worsened

Explanation:

The client's pain level has decreased, his respiratory rate is closer to normal, and his integumentary assessment is indicating improved oxygenation. The client's blood pressure is now lower than normal parameters. This could be caused by opiate administration, or it could be a sign of shock. The provider should be notified, and further assessments should be

conducted. The client's pulse oximetry has increased slightly, but it remains within normal limits.

110.

If left untreated, the client is most at risk of developing _____.

myocardial infarction

diabetic ketoacidosis

congestive heart failure

cardiac arrhythmia

Explanation:

Because of the client's missed dialysis appointment and critically high potassium level, the client is currently at highest risk of developing a cardiac arrhythmia such as ventricular tachycardia, ventricular fibrillation, or even asystole. It is critical that this risk is addressed first to prevent cardiac arrest. Although the client is having chest pain and has an abnormal EKG, her troponin is normal, revealing that the peaked T-waves are more likely caused by elevated potassium than a blockage in the heart. Therefore, myocardial infarction is unlikely. Diabetic ketoacidosis is also unlikely given that the client's blood sugar is not critically high for an adult with diabetes and her other assessment findings (normal mentation and breathing) do not suggest this. Additional labs, such as blood gases, would be indicated to further rule out diabetic ketoacidosis. Finally, congestive heart failure may eventually occur in the client that is fluid overloaded, but this is a lower risk because it is generally a chronic condition and treatment is not as emergent for this potential complication.

111.

For the following assessment finding, specify whether it indicates that the client's condition has improved, is unchanged, or has worsened.

Glucose, 75

Improved

Unchanged

Worsened

Explanation:

Although the client's serum glucose is now considered within normal limits for the average adult, it has dropped significantly since the IV insulin was administered. To prevent further dropping and hypoglycemia, the nurse should encourage glucose intake. If possible, the client should be given food and a sugary beverage. If the physician states that this is contraindicated or it is not safe for the client to take things by mouth, the nurse should advocate for further IV dextrose administration. The client's troponin is slightly higher than the initial reading, but it is still considered normal and is thus considered unchanged. The client's potassium is still elevated and requires intervention, but it is much closer to the normal range and has improved. The client is now no longer too weak to get up; thus, her neurological assessment has improved. Finally, the client is requesting food, which is a likely indication that her nausea and abdominal pain (gastrointestinal assessment) have improved.

112.

For the following assessment finding, specify whether it indicates that the client's condition has improved, is unchanged, or has worsened.

Troponin, 0.01

Improved

Unchanged

Worsened

Explanation:

Although the client's serum glucose is now considered within normal limits for the average adult, it has dropped significantly since the IV insulin was administered. To prevent further dropping and hypoglycemia, the nurse should encourage glucose intake. If possible, the client should be given food and a sugary beverage. If the physician states that this is contraindicated or it is not safe for the client to take things by mouth, the nurse should advocate for further IV dextrose administration. The client's troponin is slightly higher than the initial reading, but it is still considered normal and is thus considered unchanged. The client's potassium is still elevated and requires intervention, but it is much closer to the normal range and has improved. The client is now no longer too weak to get up; thus, her neurological assessment has improved. Finally, the client is requesting food, which is a likely indication that her nausea and abdominal pain (gastrointestinal assessment) have improved.

113.

For the following assessment finding, specify whether it indicates that the client's condition has improved, is unchanged, or has worsened.

Potassium, 5.2

Improved

Unchanged

Worsened

Explanation:

Although the client's serum glucose is now considered within normal limits for the average adult, it has dropped significantly since the IV insulin was administered. To prevent further dropping and hypoglycemia, the nurse should encourage glucose intake. If possible, the client should be given food and a sugary beverage. If the physician states that this is contraindicated or it is not safe for the client to take things by mouth, the nurse should advocate for further IV dextrose administration. The client's troponin is slightly higher than the initial reading, but it is

still considered normal and is thus considered unchanged. The client's potassium is still elevated and requires intervention, but it is much closer to the normal range and has improved. The client is now no longer too weak to get up; thus, her neurological assessment has improved. Finally, the client is requesting food, which is a likely indication that her nausea and abdominal pain (gastrointestinal assessment) have improved.

114.

For the following assessment finding, specify whether it indicates that the client's condition has improved, is unchanged, or has worsened.

Client's neurological assessment

Improved

Unchanged

Worsened

Explanation:

Although the client's serum glucose is now considered within normal limits for the average adult, it has dropped significantly since the IV insulin was administered. To prevent further dropping and hypoglycemia, the nurse should encourage glucose intake. If possible, the client should be given food and a sugary beverage. If the physician states that this is contraindicated or it is not safe for the client to take things by mouth, the nurse should advocate for further IV dextrose administration. The client's troponin is slightly higher than the initial reading, but it is still considered normal and is thus considered unchanged. The client's potassium is still elevated and requires intervention, but it is much closer to the normal range and has improved. The client is now no longer too weak to get up; thus, her neurological assessment has improved. Finally, the client is requesting food, which is a likely indication that her nausea and abdominal pain (gastrointestinal assessment) have improved.

115.

For the following assessment finding, specify whether it indicates that the client's condition has improved, is unchanged, or has worsened.

Client's gastrointestinal assessment

Improved

Unchanged

Worsened

Explanation:

Although the client's serum glucose is now considered within normal limits for the average adult, it has dropped significantly since the IV insulin was administered. To prevent further dropping and hypoglycemia, the nurse should encourage glucose intake. If possible, the client should be given food and a sugary beverage. If the physician states that this is contraindicated or it is not safe for the client to take things by mouth, the nurse should advocate for further IV dextrose administration. The client's troponin is slightly higher than the initial reading, but it is still considered normal and is thus considered unchanged. The client's potassium is still elevated and requires intervention, but it is much closer to the normal range and has improved. The client is now no longer too weak to get up; thus, her neurological assessment has improved. Finally, the client is requesting food, which is a likely indication that her nausea and abdominal pain (gastrointestinal assessment) have improved.

116.

A patient is admitted with presumed appendicitis. In which abdominal quadrant does the practical nurse anticipate the patient to be experiencing the most pain?

 graphic for question

RUQ

LUQ

RLQ

LLQ

Explanation:

The appendix is located in the right lower quadrant of the abdomen. In a patient with presumed appendicitis, pain should be expected in this region. The pain often initiates closer to the umbilicus and then moves outward in the right lower quadrant. The pain is often described as sharp and stabbing, worsened by movements such as coughing and sneezing. The patient may also be experiencing nausea and vomiting, fever, abdominal distention, and the inability to pass gas.

117.

The nurse is to do chest physiotherapy on an eight-year-old child with cystic fibrosis. Which lobes of the lung are being treated if the child is lying prone with a pillow under the abdomen and lower legs and percussion is administered at the base of the scapulae and immediately inferior to the scapulae?

posterior segments of the right and left upper lobes

anterior segments of the right and left lower lobes

superior segments of the right and left lower lobes

apical segments of the right and left upper lobes

Explanation:

If the child is lying prone with a pillow under the abdomen and lower legs and percussion is administered at the base of the scapulae and immediately inferior to the scapulae, the superior segments of the right and left lower lobes are being treated. Chest physiotherapy (CPT) should

not be administered on bare skin. Percussion may be done with a CPT cup for very small children and with cupped hands for older children and adults. Vibration is done after the client takes a deep breath and while he exhales.

118.

What is the nurse's primary responsibility related to continuous quality performance improvement?

the nurse should cooperate with measures designed to improve performance

the nurse should be informed about methods of continuous quality performance improvement

the nurse should actively seek methods to improve performance

the nurse should help evaluate outcomes of quality performance improvement measures

Explanation:

Although cooperating, being informed, and evaluating outcomes are all important in continuous quality performance improvement, the nurse's primary responsibility is to actively seek methods to improve performance. The nurse must remain current in the profession; evaluate evidence and seek out best practices; observe methods and outcomes; and look for opportunities to make changes, big and small, that may improve the quality of client care and/or improve the cost-effectiveness of care and return on investment.

119.

The nurse is irrigating a Foley urinary catheter using open intermittent irrigation and has instilled 30 mL of fluid, but the fluid does not drain back after the syringe is removed. What is the next step the nurse should carry out?

turn the client onto the side facing the nurse

notify the physician

aspirate the fluid with the syringe

instill 30 mL more fluid and then check for drainage

Explanation:

Because Foley catheters are usually maintained on continuous drainage, the bladder may be essentially empty when it is irrigated, so the small amount of irrigant may pool away from the end of the catheter. Therefore, the best solution if no fluid returns is to turn the client onto the side facing the nurse, being careful to maintain the sterile field. If the irrigant still does not return, then the nurse should gently aspirate using the syringe.

120.

The physician has written an order for the nurse to remove a client's running sutures since the incision is well healed. The running suture line has 8 stitches (including the knotted stitches at the ends). When the suture removal is completed, how many individual pieces of suture should the nurse have removed?

 graphic for question

one

two

three

eight

Explanation:

If a nurse has removed running sutures with 8 stitches (including the knotted stitch at the top and bottom), when the suture removal is complete, the nurse should have removed eight individual pieces of suture. Although the running suture comprises one long piece of suture material, each stitch in the line must be removed individually because suture material that is on the outside of the skin cannot be pulled through the tissue as it may be contaminated with bacteria.

121.

Which of the following actions must the practical nurse do/anticipate first?

- **notify the physician and registered nurse**
- **stop the transfusion**
- **notify the blood bank**
- **administer medications as ordered**

notify the physician and registered nurse

stop the transfusion

notify the blood bank

administer medications as ordered

Explanation:

This type of reaction is classified as a mild to moderate allergic response and may occur during the transfusion and up to an hour after completion of the transfusion and is generally caused by an allergy to a residual plasma protein in the donor's blood.

The first action when any type of adverse reaction occurs with a transfusion is to immediately stop the transfusion.

122.

Which of the following actions must the practical nurse do/anticipate second?

- notify the physician and registered nurse
- stop the transfusion
- notify the blood bank
- administer medications as ordered

notify the physician and registered nurse

stop the transfusion

notify the blood bank

administer medications as ordered

Explanation:

This type of reaction is classified as a mild to moderate allergic response and may occur during the transfusion and up to an hour after completion of the transfusion and is generally caused by an allergy to a residual plasma protein in the donor's blood.

The second action when any type of adverse reaction occurs with a transfusion is to notify the physician and registered nurse.

123.

Which of the following actions must the practical nurse do/anticipate third?

- notify the physician and registered nurse
- stop the transfusion
- notify the blood bank
- administer medications as ordered

notify the physician and registered nurse

stop the transfusion

notify the blood bank

administer medications as ordered

Explanation:

This type of reaction is classified as a mild to moderate allergic response and may occur during the transfusion and up to an hour after completion of the transfusion and is generally caused by an allergy to a residual plasma protein in the donor's blood.

The third action when any type of adverse reaction occurs with a transfusion is to notify the blood bank.

124.

Which of the following actions must the practical nurse do/anticipate fourth?

- notify the physician and registered nurse
- stop the transfusion
- notify the blood bank
- administer medications as ordered

notify the physician and registered nurse

stop the transfusion

notify the blood bank

administer medications as ordered

Explanation:

This type of reaction is classified as a mild to moderate allergic response and may occur during the transfusion and up to an hour after completion of the transfusion and is generally caused by an allergy to a residual plasma protein in the donor's blood.

The fourth action when any type of adverse reaction occurs with a transfusion is to administer medications (usually antihistamine) as ordered.

125.

A 90-year-old client with moderate Alzheimer's disease lives with her son and daughter-in-law. Which statement by the daughter-in-law suggests a need for more education about the disease?

"She purposely hides her belongings from me."

"I have to keep the doors latched at all times."

"She thinks I'm her mother at times."

"She can't remember where the bathroom is located."

Explanation:

The statement "She purposely hides her belongings from me" suggests that the daughter-in-law believes that the client's behavior is intentional rather than related to confusion. This is a common misconception. Caregivers may blame cognitively impaired clients for their behavior and become angry when the behavior persists. Putting things in the wrong place and forgetting their placement are typical behaviors for clients with Alzheimer's disease. The nurse needs to review behaviors associated with Alzheimer's diseases and discuss coping strategies.

126.

The MOST appropriate way for the practical nurse to differentiate between an ischemic stroke and a hemorrhagic stroke is:

non-contrast CT scan of the brain.

CT scan of the brain without and with contrast.

MRI scan of the brain.

lumbar puncture.

Explanation:

Blood in the brain parenchyma is obvious on non-contrast CT scan. CT is more efficient than MRI in this setting. Lumbar puncture is the most sensitive way to detect blood in the cerebrospinal fluid, and lumbar puncture is the definitive procedure to diagnose subarachnoid hemorrhage. Blood in the subarachnoid space is usually not obvious on imaging studies unless the hemorrhage has been massive.

127.

A client receiving total parenteral nutrition (TPN) is exhibiting lethargy and changes in mental status as well as asterixis (flapping tremors of the hands). Which of the following interventions does the nurse anticipate?

increase the dextrose concentration of the formula

decrease the dextrose concentration of the formula

decrease the protein concentration of the formula

increase lipid intake

Explanation:

Lethargy, change in mental status, and asterixis in a client when receiving TPN are indications of hyperammonemia, so the protein concentration of the formula should be decreased, and the client should be evaluated for hepatic insufficiency. Other complications include insertion trauma, thrombus formation, phlebitis, fluid imbalance, hyperglycemia, hypoglycemia, electrolyte imbalance, azotemia, essential fatty acid deficiency, and hyperlipidemia. Formulas that are commercially prepared contain dextrose and protein, but other trace elements, electrolytes, and vitamins are added as well as fat emulsions on an individual basis.

128.

Although the sister of a client with end-stage kidney disease has stated she will donate a kidney to her brother, she actually does not want to do so even though testing shows she is a good match. However, she does not want her brother or family to know that she has refused to donate a kidney. If the client asks if his sister is honest about not being a match, which of the following is the most appropriate response?

"I don't believe she was a match."

"You should ask your sister."

"I don't know the answer to that question."

"You should discuss that with your doctor."

Explanation:

If the sister of a client with end-stage kidney disease has stated she will donate a kidney to her brother but actually does not want to do so even though testing shows she is a good match and does not want her brother or family to know she has refused to donate, the best response to the client, who questions this, is: "I don't believe she was a match." While the sister is physically matched, she is not emotionally matched. Because people often feel coerced into donating, the United Network for Organ Sharing (UNOS) has provided guidelines that state that potential donors who do not want to donate should receive a nonspecific statement of unsuitability.

129.

Which of the following is the most effective method for reducing the spread of nosocomial infections, such as *Clostridium difficile*?

placing clients in private rooms

providing antibiotic prophylaxis

cleaning the rooms with a disinfectant

practicing a thorough, consistent handwashing routine

Explanation:

*The most effective method of reducing the spread of nosocomial infections, such as *Clostridium difficile*, is by practicing a thorough, consistent handwashing routine. The hands may be routinely decontaminated with alcohol-based hand rubs or antimicrobial soap and water. If the hands are visibly dirty or contaminated with body fluids (feces, urine, blood, or sputum), then they should be washed under running water with nonantimicrobial soap and water or antimicrobial soap and water. The hands should be decontaminated before and after direct contact with clients and before and after donning gloves.*

130.

A patient underwent a fiberoptic bronchoscopy for right lung biopsy under conscious sedation, but within a few minutes of being sent to the recovery room, the client shows increasing signs of dyspnea and, although groggy, has ipsilateral chest pain. The pulse rate increases from 82 to 100, and the client is slightly hypotensive and coughing. Which of the following should the nurse suspect?

heart attack

pulmonary edema

pneumothorax or bleeding

pulmonary embolism

Explanation:

If a patient who underwent a fiberoptic bronchoscopy for a right lung biopsy develops dyspnea, ipsilateral pain, increased pulse rate, hypotension, and coughing during the recovery period, the most likely reason is pneumothorax or bleeding. The nurse should immediately assess the client's lungs to determine if the breath sounds are diminished and notify the physician of the changes in condition. The physician will likely order a chest x-ray and a hemoglobin and hematocrit.

131.

When the nurse is doing a physical exam, which part of his hand is most sensitive to temperature variations?

thumb

fingertips