

# M\_NCLEXRNPQ (700+ Questions) - Quiz Questions with Answers

1.

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 PaCO<sub>2</sub> are now within the normal range, which indicates that the client's respiratory acidosis has resolved.*

2.

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 PaCO<sub>2</sub> are now within the normal range, which indicates that the client's respiratory acidosis has resolved.*

3.

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 PaCO<sub>2</sub> are now within the normal range, which indicates that the client's respiratory acidosis has resolved.*

4.

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

PaCO<sub>2</sub>, 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 PaCO<sub>2</sub> are now within the normal range, which indicates that the client's respiratory acidosis has resolved.*

5.

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 (CO<sub>2</sub>) because it is not being released. An increase in CO<sub>2</sub> secondary to insufficient ventilation results in respiratory acidosis, which is a complication of COPD exacerbations.*

6.

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  $\text{PaCO}_2$  and decreased pH readings. The kidneys are attempting to compensate for the acidosis by retaining  $\text{HCO}_3^-$  (demonstrated by a slightly elevated  $\text{HCO}_3^-$  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.*

7.

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<sub>2</sub> and decreased pH readings. The kidneys are attempting to compensate for the acidosis by retaining HCO<sup>3</sup> (demonstrated by a slightly elevated HCO<sup>3</sup> 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.*

8.

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 PaCO<sub>2</sub> are now within the normal range, which indicates that the client's respiratory acidosis has resolved.*

9.

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 PaCO<sub>2</sub> are now within the normal range, which indicates that the client's respiratory acidosis has resolved.*

10.

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 PaCO<sub>2</sub> are now within the normal range, which indicates that the client's respiratory acidosis has resolved.*

11.

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.

12.

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.

13.

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.*

14.

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.*

15.

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.*

16.

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.*

17.

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.*

18.

**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.*

19.

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.*

20.

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.*

21.

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.*

22.

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.

23.

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.*

24.

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.*

25.

**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.*

26.

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.*

27.

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.*

28.

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

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

notify the physician

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.*

29.

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

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

notify the physician

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.*

30.

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

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

notify the physician

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.*

31.

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

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

notify the physician

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.*

32.

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.*

33.

A client with uterine cancer is receiving intracavity irradiation with an intrauterine "stem" device. On examination, the nurse discovers that the radiation source has become dislodged and is partially outside of the vagina. Which action should the nurse carry out?

wear rubber gloves to lift the stem and place it in a shielded container

**immediately notify the radiation department**

cover the stem with a folded towel to protect the client's skin

use rubber gloves to gently reinsert the stem into the vagina

***Explanation:***

*The nurse should immediately notify the radiation department and make no attempt to touch or move the radiation source. Nurses caring for the client should minimize their time in the room and maximize the distance from the source of radiation (such as standing at the door instead of next to the bed to speak with the client). Although the client should have all necessary care, the nurse must avoid excessive exposure to radiation and may be required to wear appropriate shielding. Nurses who are pregnant should not be involved in care of clients undergoing radiation therapy.*

34.

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.*

35.

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.*

36.

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.*

37.

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.*

38.

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

thumb

fingertips

palm

**dorsum**

***Explanation:***

*The hand is used for palpation, but different parts of the hand are sensitive to different things. The dorsum (back surface) of the hand is most sensitive to variations in skin temperature, such as may occur during an infection or fever. The palm of the hand is used to detect vibrations, such as on the chest wall. The fingertips are very sensitive to shape and texture and are also used to assess pulsations, such as the radial and carotid pulses.*

39.

When conducting a physical exam and assessing the apical pulse in an adult client, where should the nurse place the stethoscope?

second left intercostal space at the midclavicular line

fourth left intercostal space at the sternal margin

fourth left intercostal space at the midclavicular line

**fifth left intercostal space at the midclavicular line**

***Explanation:***

*The apical pulse is assessed at the fifth left intercostal space at the midclavicular line, which is the point of maximal impulse. The nurse first locates the sternal notch, and from there the second intercostal space and then moves her fingers lightly down the side of the sternum to the fifth intercostal space and over to the midclavicular line. The nurse should be able to auscultate the S1 and S2 normal heart sounds at this point.*

40.

A 52-year-old client tells the nurse that her yearly pap smears have always been negative, and she asks if she needs continue to have a pap smear yearly. Which of the following is the best recommendation?

"You should continue with yearly pap smears."

**"You should have pap smears every two to three years."**

"You should have pap smears every five years."

"You no longer need to have pap smears."

**Explanation:**

*Current guidelines advise women ages 40–64 to have pap smears every two to three years. If Pap smears have been negative for three consecutive years, then many physicians recommend three-year intervals; however, pelvic exams may be done more frequently to assess for other abnormalities or disorders, such as chlamydia or other sexually transmitted diseases. Women who have undergone a total hysterectomy may be advised that they no longer need Pap smears because of removal of the cervix.*

41.

**A client arrives at the emergency department with a sliver of metal penetrating his right eye, resulting from a work injury. Which of the following initial actions does the nurse anticipate?**

cover the affected eye with patch

irrigate the affected eye

remove the penetrating object with forceps

**request consultation with an ophthalmologist**

**Explanation:**

*Any time an object has penetrated the eye, it should be left as undisturbed as possible until the client can be examined by an ophthalmologist because removing the object may cause more damage to the eye. Applying a patch or irrigating the eye may disturb the object as well and should be avoided. The client should be positioned on his back with his head elevated, and he may need medication for pain or relaxation while awaiting the consult. A gauze pad may be placed below the eye if tearing is excessive.*

42.

**The Tensilon (edrophonium chloride) test is used to diagnose which of the following?**

myasthenia gravis

multiple sclerosis

Parkinson's disease

Bell's palsy

**Explanation:**

*The Tensilon (edrophonium chloride) test is used to diagnose myasthenia gravis. Tensilon is an anticholinesterase medication used to increase levels of acetylcholine at the myoneural junctions to relieve symptoms. For the test, the patient is given an injection of Tensilon. If the symptoms are relieved, then the test is positive for myasthenia gravis. If the symptoms remain the same or worsen, then the test is negative. Tensilon is also used to determine if the client is under- or overmedicated with anticholinesterase.*

43.

Which of the following is an indication of primary graft dysfunction in a lung transplant recipient?

frequent oxygen desaturation

chest pressure

fever

cough

**Explanation:**

*Primary graft dysfunction (reperfusion injury) is a major cause of illness and death in lung recipients with symptoms and treatment similar to acute respiratory distress syndrome (ARDS). Indications of primary graft dysfunction include frequent oxygen desaturation, general malaise, increased dyspnea and work associated with the act of breathing, and intolerance to activity. Causes may include increased capillary permeability, interrupted lymphatic drainage, edema, and mismatch in compliance and vascular resistance between the donor and the recipient.*

44.

In many cultures, pregnancy is viewed as a natural rather than a medical condition. How does this affect prenatal care?

pregnant women often seek prenatal care later and less frequently

these views have little effect on prenatal care

pregnant women believe prenatal care is harmful to the fetus

these views often result in increased rates of fetal mortality

**Explanation:**

*If pregnancy is viewed as a natural rather than a medical condition, then pregnant women often seek prenatal care later and less frequently than typical American women. However, the women from other cultures usually follow cultural traditions related to pregnancy, such as restrictions on types of food or activities. They may also seek the advice of older family members or shamans, so lack of prenatal care does not mean that the pregnancy has not been considered or is necessarily at risk.*

45.

A client who has been taking oral prednisone to control his chronic obstructive pulmonary disease (COPD) wants to transition to inhaled corticosteroids. The nurse anticipates which of the following scenarios?

the client must be tapered from the oral drug while beginning treatment with the inhaled drug

the client must be tapered from the oral drug before beginning treatment with the inhaled drug

the oral medication can be discontinued immediately, and the client can be started on the inhaled drug

the oral medication cannot be discontinued, so the client cannot transition to the inhaled drug

***Explanation:***

*Oral steroids should never be abruptly discontinued and replaced by inhaled steroids because the inhaled steroids alone produce lower plasma levels than do oral preparations. Tapering allows the adrenal glands to recover and function properly. The prednisone dosage should be tapered while the inhaled steroid is introduced to avoid exacerbation of the client's COPD. Clients who have been on oral steroids for extended periods of time may have difficulty with the transition to inhaled steroids and must be monitored carefully.*

46.

A client has had a ventricular pacemaker implanted, but he has lethargy, headache, pain in the jaw, breathlessness, and anxiety. On examination, the nurse notes pulsations evident in the neck and the abdomen. Which of the following is the most likely reason for the client's symptoms?

client is having a panic attack

client is experiencing pacemaker syndrome

client is having a myocardial infarction

client is experiencing pacemaker-mediated tachycardia

**Explanation:**

*If a client has had a ventricular pacemaker implanted, has lethargy, headache, pain in the jaw, breathlessness, and anxiety, and the nurse notes pulsations evident in the neck and the abdomen, the most likely reason is that the client is experiencing mild pacemaker syndrome. This occurs when the timing of atrial and ventricular contractions is not adequately synchronized. With moderate pacemaker syndrome, the client may experience increased dyspnea, orthopnea, dizziness, and confusion. With severe pacemaker syndrome, the client may develop pulmonary edema and heart failure.*

47.

A 76-year-old client became a widow 10 years previously, but she speaks about her husband almost constantly, visits his grave daily, cries daily, and appears unable to make decisions or care for herself because of grief. How would the nurse best describe the client's grieving?

prolonged

normal

delayed

**distorted**

**Explanation:**

*Although each person grieves differently, this client's grieving behavior is distorted because she is in a state of prolonged despair that prevents her from working through her grief and finding some resolution. Distorted responses to grief often derive from profound unresolved anger,*

*directed toward oneself and preventing the person from functioning. Clients who had ambivalent feelings toward the deceased may experience prolonged grieving because of guilt and may begin to blame themselves for the person's death.*

48.

A client with ovarian cancer works for a small company with six employees and asks the nurse if she is allowed accommodations at work because of her cancer under provisions of the Americans with Disabilities Act (ADA). Which is the best response?

"The company must accommodate your needs under provisions of the ADA."

**"The company is exempt from the provisions of the ADA because of its size."**

"The company must allow you time for treatment but can require you to continue to work full time."

"Cancer is not considered a disability, so the provisions of the ADA do not apply."

***Explanation:***

*"The company is exempt from the provisions of the ADA because of its size" is the correct response because small businesses employing 15 or fewer employees are not required to comply with the provisions of the ADA even though cancer is considered to be a disability. However, the client should be encouraged to discuss her needs with her employer because some may be willing to make reasonable accommodations. The ADA (1990) is intended to protect persons with disabilities against discrimination. The ADA was amended in 2008.*

49.

Under which delivery care model would the nurse expect to be responsible for the least number of clients?

functional

**total patient care**

team nursing

modified primary care

***Explanation:***

*Total patient care: A nurse is assigned to do all the care of one or two clients. Modified primary care: A nurse is responsible for the same group of clients every day, usually with assistive personnel. Team nursing: A team leader of a group that comprises unlicensed assistive personnel and licensed vocational/practical nurses as well as other registered nurses (RNs) may be responsible for a fairly large group of clients, often ranging from 10–20. Functional nursing: Tasks are divided; for example, one nurse may give medications to all clients, and another nurse might do all the dressing changes.*

50.

**A client with Alzheimer's disease is hospitalized after a mild stroke. The client calls out frequently and often tries to climb out of bed. What is the best room assignment for the client?**

**a private room within the line of sight of the nursing station**

a private room at the end of the hallway away from other, more critically ill, clients

a shared room with another cognitively impaired client

any room as long as the client is physically restrained

**Explanation:**

*Confused clients with Alzheimer's disease should be placed in a private room to minimize disturbances to other clients. The client should be near the nursing station and within the nurses' line of sight so a close watch can be kept over the client. Restraints should be avoided if at all possible because they often cause clients to become more agitated. Clients who are confused and trying to climb out of bed may require a sitter during hospitalization.*

51.

Following a stroke, a client has impaired swallowing and is unable to feed himself. What is the best position to place the client in when preparing to assist him with meals?

semi-Fowler's, head in midline position, and chin tilted upward

supine position, head in midline, and chin tilted downward

**upright position, head in midline, and chin tilted downward**

upright position, head in midline, and chin tilted upward

**Explanation:**

*The best position for a client with impaired swallowing is upright with the head midline and the chin down (flexed about 75% of the way toward the chest) because this position provides better protection of the airway and decreases the risk of choking and aspirating. The patient may be positioned with the arms on the overbed table with positioning aids used, if necessary, to maintain body alignment. The client should continue to remain in the upright position for at least 30 minutes after the feeding is completed.*

52.

If monitoring a client's control of diabetes, which of the following sources of information is the most reliable?

serum glucose level

**HbA1c**

client's food and exercise log

client's diet/exercise log

***Explanation:***

*If monitoring a client's control of diabetes, the most reliable source of information is the client's HbA1c, which indicates the average level of glucose over a 3-month period. The serum glucose level can change from day to day depending on carbohydrate intake and various other factors, so it is less reliable. While the client's diet and exercise log and report can provide valuable information, clients are not always accurate or honest with reports.*

53.

A pregnant woman admitted for preeclampsia experiences a seizure. In what position should the nurse place the client during the seizure?

supine semi-Fowler's position

right lateral

supine flat position

**left lateral**

***Explanation:***

*If a client with preeclampsia experiences a seizure (indicating eclampsia), the client should be placed in the most protective position for herself and the fetus, the left lateral position. This position decreases the risk that she will aspirate, and it relieves the pressure of the uterus against the vena cava, increasing blood flow to the fetus. The side rails should be raised if the client is in bed, but they should be padded with a blanket or pillows to prevent her from injuring herself.*

54.

According to federal law, if a client dies in a hospital setting, which of the following must be done by the staff?

the coroner must be notified

**the family decision maker must be asked about organ donation**

the family must be provided information about funeral regulations

the Social Security Administration must be notified

***Explanation:***

*According to federal law, if a client dies in a hospital setting, the staff must ask the family decision maker about organ donation. In some cases, the client will have indicated a preference on an advance directive, but in practice, if family members object, the harvesting of organs is usually not carried out, so it's important that the staff member approaching the family be trained and sensitive to the family members' feelings and concerns. Information about organ donation is often provided to the client and family on admission.*

55.

A client with moderately advanced dementia is frequently incontinent of urine. Which scheduled urination regimen is most appropriate for this client?

bladder training

**timed voiding**

patterned urge response toileting

prompted voiding

***Explanation:***

*Timed voiding: Toileting is carried out on a regularly scheduled basis, usually every two hours during waking hours and one or two times during the night. This is especially useful for those with cognitive impairment. Bladder training: Toileting is scheduled with progressive voiding intervals, but clients must be cognitively aware. Patterned urge response toileting: A form of habit training using an electronic monitoring device. Prompted voiding: Suitable for mild dementia clients, toileting is prompted on a regular schedule for those able to use the toilet independently.*

56.

A client is treated in the emergency department for rape, and a rape kit is completed. The client remains calm, staring at the wall, and she does not appear upset or traumatized, stating repeatedly that she is "fine." Based on these observations, the nurse believes which of the following?

**the client is in a state of denial**

the client is lying about the rape

the client is in shock

the client suffered a head injury during the rape

**Explanation:**

*A common response to severe trauma, such as rape, is denial. Clients may at one extreme deny an event has even happened, but more often they exhibit denial by closing down their emotions and remaining calm, insisting that they are "fine" and need no intervention or help. They may try to appear and function as though the event has not happened at all and start "getting on with life," but this is rarely a good solution because they may not adequately deal emotionally with the trauma, resulting in ongoing psychological problems, such as depression, suicidal ideation, flashbacks, and fear.*

57.

A client receiving oral tetracycline for the treatment of acne should be advised to avoid which of the following?

sunbathing

swimming

running

weight lifting

**Explanation:**

*The client should be advised to avoid sunbathing because tetracycline causes photosensitivity, which can occur immediately upon exposure or sometime after exposure to sunlight. Tetracycline should be taken with a full glass of water one hour before or two hours after meals. Clients should be cautioned that milk, other dairy products, and iron products reduce the*

absorption of tetracycline, so they should not be taken within two hours of the drug dosing. Tetracycline should not be given to children younger than eight years of age.

58.

Which of the following drugs is the appropriate antidote for an overdose of acetaminophen?

protamine sulfate

folic acid

naloxone

**N-acetylcysteine**

**Explanation:**

*N-acetylcysteine is the antidote for acetaminophen overdose. Acetaminophen toxicity occurs with a single dose of greater than 140 mg/kg of body weight or with greater than 7.5 g in 24 hours. The antidote is given for serum levels greater than 150. It is most effective if given within 8 hours of ingestion. N-acetylcysteine is given at the rate of 140 mg/kg initially and repeated with 70 mg/kg every 4 hours for 17 additional doses, either by mouth or intravenously.*

59.

The client is to use a metered-dose inhaler (MDI) without a spacer for albuterol. How should the nurse advise the client to position the inhaler for self-administration?

in her mouth with her lips sealed around the opening

touching her lips but outside of the mouth

**one to two inches in front of her mouth**

three to four inches in front of her mouth

***Explanation:***

*The nurse should instruct the client to open her mouth and hold the inhaler one to two inches in front of her mouth (about two finger widths). The client should exhale and then inhale deeply for 5 seconds while pressing down on the inhaler to release a dose of medication. After inhaling the medication, the client should hold her breath for about 10 seconds and then exhale slowly through pursed lips. Children and those who have difficulty managing the procedure should use spacers.*

60.

**The most common route of entry of microbial agents into the lungs is through:**

**Aspiration**

Translocation from the GI tract

Inhalation

Vascular spread from a distant site

***Explanation:***

*The most common route of entry of microbial agents into the lungs is aspiration. Most aspiration does not result in pneumonia, depending on the microbial load and the patient's*

*condition, because the healthy lung is able to handle small amounts of aspirant. Inhalation is also a common route, either from people who are infected or from contaminated equipment. Vascular spread (bacteremia) is fairly rare but can occur, resulting in pneumonia. In some cases, bacteria and toxins may translocate from the GI system to the lungs per the mesenteric lymph nodes.*

61.

A client with extensive burns of the lower extremities is treated with topical agents, and the burns are wrapped with several layers of dressings. On examination, the nurse finds that the peripheral pulses are diminished. Which is the best initial action for the nurse?

elevate the extremities to reduce edema

remove the dressings

**loosen the dressings**

reevaluate the peripheral pulses after 15 minutes

***Explanation:***

*Edema is a common problem related to burns, so the nurse must check peripheral pulses frequently (at least every two hours) and keep the extremities elevated on two pillows. If the pulses become diminished, the first step is to loosen the dressings and recheck the pulses to determine if the dressings are restricting blood flow. Burns are often treated with topical agents and several layers of dressings, which should be applied on the lower extremities distally to proximally.*

62.

A 48-year-old female client complains of episodes of severe right upper quadrant abdominal pain lasting two to six hours, indigestion, nausea and vomiting, and clay-colored stools. The nurse suspects the client may have which of the following diagnoses?

colitis

pancreatitis

**cholecystitis**

diverticulitis

***Explanation:***

*Cholecystitis may result in severe episodes of pain in the right upper quadrant of the abdomen, often lasting two to six hours, and sometimes radiating to the back. Clients may also experience indigestion, nausea and vomiting, and clay-colored stools if the bile duct is blocked. In severe cases, jaundice may be evident. Cholecystitis may result from calculi or pancreatitis and is most common in overweight females ages 20–40, but it also may occur in women who are pregnant.*

63.

If a client is to undergo gastric lavage after ingesting poison, what position should the nurse place the client in for the procedure?

semi-Fowler's position with head elevated to 30–40 degrees

upright position with head elevated to 80–90 degrees

Trendelenburg position with the client supine

**left lateral position with head lowered 15 degrees**

**Explanation:**

*While a nasogastric tube for decompression is usually placed with the client's head elevated, when gastric lavage is done to remove drugs or poisons, the client is placed in left lateral position with the head lowered 15 degrees because this position causes substances in the stomach to pool and reduces movement of the substances into the duodenum. A large bore tube (36–40 Fr) is usually used for gastric lavage and may be placed nasally or orally.*

64.

A client tells the nurse, "I was awake half the night suffering!" Which of the following responses demonstrates therapeutic communication?

"Your pain is not well controlled."

"You should have asked for more pain medication."

"Why didn't you call the nurse?"

"You poor thing. I'm so sorry."

**Explanation:**

*The response that demonstrates therapeutic communication is "Your pain is not well controlled" because it is restating the implied message that the client is communicating. The nurse should avoid making "should" statements or questioning the client's actions, but she should attempt to explore the issue to determine what intervention is needed. "You poor thing" is not helpful in solving the problem and suggests that the client is a victim rather than an active collaborator in his own care.*

65.

The nurse is caring for a client who is undergoing peritoneal dialysis. How long does the nurse expect that a typical exchange cycle (infusion, dwell time, and drainage) will take to complete?

12 hours

3–4 hours

60–90 minutes

30–45 minutes

***Explanation:***

*With peritoneal dialysis, a typical exchange cycle takes 30–45 minutes and includes three phases: infusion (5–10 minutes) of 2–3 liters of dialysate, dwell time (about 10 minutes), and drainage (10–30 minutes). The number of cycles each day is determined on an individual basis. The drainage fluid should be straw-colored or clear. Cloudy drainage may indicate an infection. Blood-tinged drainage may occur shortly after insertion of the abdominal catheter and during menses.*

66.

Which of the following positions may result in blood pooling in the extremities, decreased blood pressure (BP) and cardiac output, increased respiratory effort, decreased lung compliance, and decreased cerebral circulation?

Trendelenburg

right side-lying

supine

prone

**Explanation:**

*Prone position: Blood may pool in the extremities, and pressure on the abdomen may result in a decrease in blood pressure (BP), preload, and cardiac output. Respiratory effort increases, and lung compliance decreases. The head positioned sharply to one side may interfere with cerebral circulation. If the head is turned laterally, the dependent eye must be observed carefully for external compression. Bilateral bolsters or other supports should be used to support the thorax (clavicle to iliac crest) to relieve abdominal compression, which may impede respirations and venous return.*

67.

A client with severe diarrhea, nausea, and vomiting has become increasingly lethargic and weak with tingling in the hands and feet, muscle cramps and tetany, hypotension, and dysrhythmias with ECG abnormalities that include PVCs and flattened T waves. Based on these signs and symptoms, which of the following electrolyte imbalances should the nurse suspect?

hypokalemia

hyperkalemia

hyponatremia

hypernatremia

**Explanation:**

*If a client with severe diarrhea, nausea, and vomiting has become increasingly lethargic and weak with tingling in the hands and feet, muscle cramps and tetany, hypotension, and dysrhythmias with ECG abnormalities that include PVCs and flattened T waves, the nurse should suspect hypokalemia. Potassium influences the activity of both skeletal and cardiac*

muscles. Normal values range from 3.5–5.5 mEq/L. Hypokalemia occurs with levels of less than 3.4 mEq/L and critical values of less than 2.5 mEq/L.

68.

When the nurse enters the break room, she finds that a colleague is sharing personal information about his client with other staff members. What is the best action for the nurse?

leave the break room

report the situation to a supervisor

tell the colleague that he should not be talking about a client

**tell the colleague and staff members that you are not comfortable violating a client's privacy**

***Explanation:***

*The best solution to hearing a colleague divulge personal information about a client is to use an "I" statement, which conveys the message that the conversation is inappropriate without being accusing: "I don't feel comfortable violating a client's privacy." If an organization is to maintain an ethical environment, then every member of the staff must be willing to address the issue when it arises so others may understand that gossiping about clients is not acceptable behavior.*

69.

A client with chronic obstructive pulmonary disease (COPD) feels breathless despite oxygen administration and bronchodilators. Which of the following positions should the nurse place the client in to best relieve breathlessness?

semi-Fowler's, at 30°

high Fowler's, upright at 90°

semi-Fowler's, at 45°

leaning forward at 30° to 40°

**Explanation:**

*COPD clients are unable to adequately use accessory muscles of respiration, so leaning forward at 30° to 40° improves the upward movement of the diaphragm, allowing more air to be expelled with each exhalation, and helping to reduce breathlessness. The patient may be positioned with the arms resting on an overbed table if in bed or on the thighs or a small table if sitting in a chair. Many COPD clients sleep sitting up because of increased shortness of breath when they try to recline.*

70.

A child weighing 30 kg is being treated with Zosyn (piperacillin/tazobactam) IV every eight hours with a dose of 100 mg piperacillin/12.5 mg tazobactam per kg of body weight. What is the child's correct dosage in grams (g)?

3000 g piperacillin/375 g tazobactam

30 g piperacillin/37.5 g tazobactam

3 g piperacillin/3.75 g tazobactam

3 g piperacillin/0.375 g tazobactam

**Explanation:**

*The correct dosage in grams is 3 g piperacillin/0.375 g tazobactam. Calculation:*

*30 (weight in kg) × 100 (mg piperacillin) = 3000 mg.*

*30 (weight in kg) × 12.5 (mg tazobactam) = 375 mg.*

*To convert mg to grams:*

*3000/1000 = 3 g piperacillin.*

*375/1,000 = 0.375 g tazobactam.*

71.

The nurse believes that the dosage of a medication is too high for a client, based on the recommended mg per kg of weight. Which of the following initial actions should the nurse carry out?

contact the pharmacy to determine if the dosage is within acceptable limits

notify the supervisor of her concerns

**telephone the physician to question the dosage**

assume the dosage was verified when ordered, and administer the drug

***Explanation:***

*The nurse should telephone the physician to question the dosage and should be prepared to tell the physician the client's weight in kg and the recommended dosage. In some cases, the physician may have a valid reason for exceeding the usual dosage, but the staff should be aware of the reasons. It is the nurse's responsibility to ensure that the five rights of medication administration are adhered to: right client, right drug, right dose, right route, and right time.*

72.

The team leader has asked the nurse to change the tracheostomy tube on a client, but the nurse has never done this procedure before. Which of the following is the correct action for the nurse to take?

ask another nurse on the team to assist with the procedure

look up the procedure in the procedure manual before attempting it

**ask the team leader for assistance with the procedure**

use a smartphone to access a YouTube video showing how to do the procedure

***Explanation:***

*Because the team leader is ultimately responsible for care that has been delegated to other staff members, the nurse should tell the team leader that she has never changed a tracheostomy tube before and ask for assistance. The team leader should make the decision as to whether to assist her or assign the task of assisting to another nurse on the team. The nurse should never attempt a procedure for which she is not prepared or knowledgeable.*

73.

The nurse has used a needle and syringe to add medication to an intravenous (IV) solution. Which of the following actions should the nurse carry out after injecting the medication into the solution?

invert the IV bag briefly

begin the infusion with no further action

roll the IV bag back and forth between the hands a few times

gently shake the IV bag

**Explanation:**

*After medication is injected into the port of an intravenous bag, it will tend to pool in the lower part of the bag, so the nurse should gently shake the bag to distribute the medication more evenly throughout the solution. The infusion bag must be labeled according to facility policy, usually with the patient's name, room number, name of the medication, date and time the medication is mixed, date and time the infusion is started, and the initials of the nurse administering the infusion.*

74.

A client has had a Port-a-Cath inserted in the upper chest and is receiving chemotherapy, but the client is very tense and complains of much discomfort when the port is accessed. Which of the following is the best solution to the client's discomfort?

administer pain medication prior to the treatment

apply EMLA cream prior to the treatment

inject a local anesthetic prior to the treatment

instruct the client in deep-breathing and relaxation techniques

**Explanation:**

*Although the client may benefit from pain medication prior to treatment because of increased pain associated with administration of chemotherapy and may be less tense if instructed in deep-breathing and relaxation exercises, these are not good solutions for the local discomfort associated with port access. The best solution is to apply EMLA (lidocaine/prilocaine) cream to the port area about 20–45 minutes prior to treatment. If receiving chemotherapy as an*

outpatient, the client can apply the cream and cover the area with plastic wrap before leaving home.

75.

The nurse agrees to represent the hospital at a job fair, distributing alcohol-based hand cleansers to participants and telling them about methods of preventing the flu. Which of the following does this participation primarily represent?

professional development

community health education

community service

hospital promotion

***Explanation:***

*The nurse is participating in community health education by providing alcohol-based cleansers and also by educating the public about methods to prevent the flu. Community health education may be formal, with classes scheduled on a number of different health topics, or informal, such as answering questions about health matters and setting an example for others in the community. The nurse often serves as a resource person for others with questions about health matters.*

76.

A train accident has resulted in many severe casualties, and the emergency department is inundated with clients, but few hospital beds are available. What is the best solution to this emergency situation?

transfer incoming clients to other facilities as soon as they are stabilized

place newly admitted clients in the hallways

close the emergency room to further clients

carry out early discharge for low-risk, noncritical clients to free up some beds

**Explanation:**

*The best solution to an influx of clients during an emergency situation is to carry out early discharge for low-risk, noncritical clients. Often, elective procedures, such as ambulatory surgeries and testing, are canceled and rescheduled. Clients may be sent home with home health care or, in some cases, transferred to other facilities, such as convalescent hospitals. Each facility should have a disaster plan in place that outlines the steps to take in an emergency.*

77.

In the normal electrocardiogram (ECG) complex, the QRS complex represents which of the following?

 graphic for question

ventricular repolarization

AV node depolarization


atrial depolarization

## ventricular depolarization

### **Explanation:**

*In the normal electrocardiogram (ECG) complex, the QRS complex represents ventricular depolarization:*

- *P wave: Start of electrical impulse in the sinus node and spreading through the atria, muscle depolarization*
- *QRS complex: Ventricular muscle depolarization and atrial repolarization. The width of the complex represents intraventricular conduction time.*
- *T wave: Ventricular muscle repolarization (resting state) as cells regain negative charge*
- *U wave: Repolarization of the Purkinje fibers*

 *graphic for question*

78.

The nurse notes that a client has slid down onto the floor, and he is unable to get up. Which of the following is the best method of lifting him?

belt lift

**mechanical lift**

two-person chicken lift (lifting under the client's arms)

blanket lift

### **Explanation:**

*The nurse should assist the client into a position of comfort on the floor and use a mechanical lift to raise the client. There is no other lift that will raise the client and not pose a risk of injury to the nurse or those assisting. If the client is fairly mobile and strong, he may be assisted into a*

*four-point position on his knees, and a chair is placed next to him so he can raise himself with minimal assistance.*

79.

The nurse is monitoring a woman in labor. During which stage of labor does the nurse expect that the woman will become fully dilated (10 cm)?

first stage

second stage

third stage

fourth stage

***Explanation:***

*There are four stages of labor:*

*Stage 1: The period between the onset of labor and full dilation (10 cm). Comprises two phases: latent (cervical effacement and beginning dilation) and active (continued dilation from 4 to 10 cm).*

*Stage 2: The period from full dilation through the delivery of the infant.*

*Stage 3: The period after delivery of the infant through delivery of the placenta.*

*Stage 4: The postpartum period lasting two hours after delivery.*

80.

An eight-year-old client lives with his married parents, siblings, grandparents, two aunts, and a cousin. Which of the following family types does this situation comprise?

nuclear family

coparenting

**extended family**

extended kin network

***Explanation:***

*Extended family: Multigenerational families or shared households with parents, friends, or other family members, such as aunts and uncles. Nuclear family: The traditional family with mother, father, and children. Generally, the husband is the breadwinner in this model and the mother remains at home to care for the children. Coparenting: Custody is shared between two families, such as with a divorce custody agreement. Extended kin network: Two nuclear families live together or near each other and share goods and services, such as childcare.*

81.

A client with breast cancer who has the BRCA1 gene, which is transmitted in an autosomal-dominant manner, asks the nurse if her children are likely to inherit the gene. Which of the following information should the nurse provide?

each child has a 25% chance of inheriting the gene

**each child has a 50% chance of inheriting the gene**

all children will inherit the gene

no children will inherit the gene

**Explanation:**

*When a mother has an autosomal-dominant gene, each child has a 50% chance of inheriting the gene. However, because inheritance is a random process, this does not mean that 50% will actually inherit the gene. In fact, all children or no children may inherit. Humans should have 23 pairs of chromosomes: Pairs 1–22 are autosomal, and pair 23 is sex with XX for female and XY for male.*

*N = normal gene, and D = dominant mutated gene.*

*N D*

*N N N*  
*ND*  
*(mutation)*

*N N N*  
*ND*  
*(mutation)*

82.

**A client is to have continuous measuring of oxygen saturation with a pulse oximeter, but he has a constant tremor of both of his hands and he tends to pick at the covers. Which of the following is the best solution?**

apply the oximeter to the little finger because the tremors will not interfere

apply the oximeter to the little finger, and tape it in place

advise the physician that pulse oximetry is not possible

**apply an earlobe oximeter**

***Explanation:***

*The nurse should apply an earlobe oximeter. A digit pulse oximeter should be avoided if the client has tremors or if he is likely to move his hand frequently. The skin should be clean and dry when the oximeter is applied. If using a digit oximeter, a client should not have artificial nails or wear colored nail polish because these may interfere with readings. If a client is severely obese, the clip on the oximeter may not stay in place, so a disposable (single-use) sensor pad may be necessary.*

83.

The nurse is completing the health history with a client, and he appears obviously uncomfortable when the nurse asks questions about sexuality. Which of the following is the best method of dealing with the client's discomfort?

**acknowledge the client's discomfort in a supportive manner**

make a casual joke, stating that everyone feels discomfort talking about personal issues

stop asking about sexuality and continue with the next part of the history

ignore the client's discomfort

***Explanation:***

*The best solution to dealing with a client's discomfort is to acknowledge the discomfort in a supportive manner: "I can see that these questions are making you uncomfortable because it's difficult for most people to talk about personal issues." Joking about the client's discomfort or ignoring it altogether shows a lack of respect for the client's feelings, and stopping the questions is not a good solution because the information may be important for providing a full understanding of the client and his health issues.*

84.

When doing nasotracheal suctioning, during which of the following should the catheter be inserted?

inhalation

exhalation

swallowing

coughing

**Explanation:**

*When doing nasotracheal suctioning, the catheter should be inserted only during inhalation because during this phase of respiration the epiglottis is open. However, suction should not be applied during insertion. During suctioning, a normal reaction is for the client to cough, but if the client begins to gag or becomes nauseated, the catheter may be in the esophagus. Tracheal suctioning should be completed before pharyngeal because the pharynx contains more bacteria than the trachea.*

85.

Which pain assessment tool is the most appropriate to use with an adolescent?

face, legs, activity, cry, consolability (FLACC) scale

Wong–Baker FACES pain rating scale

Children’s Hospital of Eastern Ontario Pain Scale (CHEOPS)

## one-to-ten scale

### **Explanation:**

*Unless the adolescent has a cognitive or other physical impairment that interferes with his ability to comprehend, the most appropriate pain assessment tool is the 1-to-10 scale, which is commonly used with adults. The face, legs, activity, cry, consolability (FLACC) scale is appropriate for children from two months to seven years of age. The Wong–Baker FACES tool can be used from ages three on up through adulthood, but it is most appropriate for children before adolescence because of its cartoonish nature.*

86.

**What should be the first intervention completed?**

Loosen any constrictive clothing.

Check the bladder and catheterize the client.

Check for fecal impaction.

**Check the blood pressure (BP) and pulse.**

Check the BP and administer a rapid-acting antihypertensive agent if the systolic BP is  $\geq 150$  mmHg.

### **Explanation:**

*The first intervention is to check the blood pressure (BP) and pulse.*

*Treatment should always begin by checking vital signs (VS) and loosening clothes and then progressing to assessment of the bladder. If there is no indwelling catheter, the client should be catheterized. If a catheter is in place, it must be checked for patency and irrigated if necessary.*

*The BP should be checked again and an antihypertensive agent administered if the BP remains elevated before checking for fecal impaction.*

87.

What should be the second intervention completed?

Loosen any constrictive clothing.

Check the bladder and catheterize the client.

Check for fecal impaction.

Check the blood pressure (BP) and pulse.

Check the BP and administer a rapid-acting antihypertensive agent if the systolic BP is  $\geq 150$  mmHg.

**Explanation:**

*The second intervention is to loosen any constrictive clothing.*

*Treatment should always begin by checking vital signs (VS) and loosening clothes and then progressing to assessment of the bladder. If there is no indwelling catheter, the client should be catheterized. If a catheter is in place, it must be checked for patency and irrigated if necessary. The BP should be checked again and an antihypertensive agent administered if the BP remains elevated before checking for fecal impaction.*

88.

What should be the third intervention completed?

Loosen any constrictive clothing.

**Check the bladder and catheterize the client.**

Check for fecal impaction.

Check the blood pressure (BP) and pulse.

Check the BP and administer a rapid-acting antihypertensive agent if the systolic BP is  $\geq 150$  mmHg.

***Explanation:***

*The third intervention is to check the bladder and catheterize the client.*

*Treatment should always begin by checking vital signs (VS) and loosening clothes and then progressing to assessment of the bladder. If there is no indwelling catheter, the client should be catheterized. If a catheter is in place, it must be checked for patency and irrigated if necessary. The BP should be checked again and an antihypertensive agent administered if the BP remains elevated before checking for fecal impaction.*

89.

**What should be the fourth intervention completed?**

Loosen any constrictive clothing.

Check the bladder and catheterize the client.

Check for fecal impaction.

Check the blood pressure (BP) and pulse.

**Check the BP and administer a rapid-acting antihypertensive agent if the systolic BP is  $\geq 150$  mmHg.**

***Explanation:***

*The fourth intervention is to check the BP and administer a rapid-acting antihypertensive agent if the systolic BP is  $\geq 150$  mmHg.*

*Treatment should always begin by checking vital signs (VS) and loosening clothes and then progressing to assessment of the bladder. If there is no indwelling catheter, the client should be catheterized. If a catheter is in place, it must be checked for patency and irrigated if necessary. The BP should be checked again and an antihypertensive agent administered if the BP remains elevated before checking for fecal impaction.*

90.

**What should be the fifth intervention completed?**

Loosen any constrictive clothing.

Check the bladder and catheterize the client.

**Check for fecal impaction.**

Check the blood pressure (BP) and pulse.

Check the BP and administer a rapid-acting antihypertensive agent if the systolic BP is  $\geq 150$  mmHg.

**Explanation:**

*The fifth intervention is to check for fecal impaction.*

*Treatment should always begin by checking vital signs (VS) and loosening clothes and then progressing to assessment of the bladder. If there is no indwelling catheter, the client should be catheterized. If a catheter is in place, it must be checked for patency and irrigated if necessary. The BP should be checked again and an antihypertensive agent administered if the BP remains elevated before checking for fecal impaction.*

91.

A client with pancreatic cancer is prescribed fentanyl patches to control pain. Which statement by the client indicates the need for more education?

**"The patch will give better pain control if I apply heat over it."**

"I should rotate the sites of administration."

"I can dispose of the patch by rolling it up and flushing it down the toilet."

"I should cover the patch with plastic when showering."

**Explanation:**

*Clients must avoid placing direct sources of heat, such as a heating pad, over a fentanyl patch because this action increases the rate of absorption and may cause the client to have an overdose. Clients are allowed to bathe or shower wearing the patch, but this may cause the patch to loosen, so clients may cover the patch with plastic wrap taped in place over the patch*

*while bathing if this tends to occur. A patch should be disposed of by rolling it and flushing it down the toilet because some medication will remain in the patch.*

92.

The unit supervisor assigns a nurse to three clients for primary care, but the nurse discovers that one of the clients is a close neighbor and casual friend. Which of the following is the most appropriate action?

care for the patient as assigned

ask the client if the assignment is acceptable

informally ask another nurse to trade clients

**ask the supervisor to reassign the client**

***Explanation:***

*If the unit supervisor assigns a nurse to three clients for primary care and the nurse discovers that one client is a close neighbor and casual friend, the nurse should immediately inform the supervisor and ask that the client be reassigned. Since the nurse and client have a preexisting social relationship, the client may be uncomfortable with the nurse knowing personal information or providing care but may not be comfortable stating so outright.*

93.

A client involved in a motorcycle accident has a complete spinal cord injury at level C8. Which of the following functional abilities would the nurse expect to observe?

requires an electric wheelchair with breath or head controls and assistance with all activities of daily living (ADLs)

able to use a manual wheelchair on level surfaces but not all surfaces and may shave, brush hair, and is able to feed herself with adaptive equipment

able to use a manual wheelchair on most surfaces, and she is independent in transferring and personal care

requires an electric wheelchair with hand controls, and she is able to feed herself with adaptive equipment

***Explanation:***

*A client with a complete spinal cord injury at level C8 is a quadriplegic and should be able to use a manual wheelchair independently on most surfaces but may require adaptive devices for activities of daily living (ADLs). The client should have full extension and flexion of her elbows and wrists and some movement in the fingers and thumbs. She should be able to transfer independently and drive a car with hand controls. The client may need some assistance with ADLs, such as lower body dressing.*

94.

A client with end-stage liver disease is to be discharged from the acute care hospital to his home; however, the client has stated he does not want hospice and that his family will care for him. Which of the following is the most appropriate response?

tell the client she is placing too large a burden on family

advise the client that she is making a mistake

insist the client reconsider and accept hospice care

provide information about the benefits of hospice

**Explanation:**

*Clients may turn down offers of hospice care because they have no clear idea of the benefits and may mistakenly believe that hospice is just there to provide support during death. The nurse should explain the benefits, such as the provision of equipment, supplies, pain medication, and pain control, as well as services by other supportive members of the hospice team, such as home health aides and social workers. The client should be advised that he can contact hospice at any time if he changes his mind.*

95.

**A client with fourth-stage cancer of the colon tells the nurse that he has opted to receive no treatment, even though his life may be prolonged with surgery and chemotherapy, because he feels that the emotional and financial costs to himself and to his family are too high. Which of the following responses is most appropriate for the nurse to make?**

"I hope you will reconsider."

"I'm sure your family would rather bear the emotional and financial costs than to lose you."

**"The palliative care and hospice program can help you with comfort measures, such as pain control."**

"I think you've made the right decision."

**Explanation:**

*The most appropriate response to a client who has chosen to receive no treatment is the one that supports the client's choice and provides useful information: "The palliative care and hospice program can help you with comfort measures, such as pain control." The nurse should avoid trying to pressure the client into accepting treatment, and holding out the possibility of a cure for someone with fourth-stage cancer is essentially meaningless. For some clients, having no treatment is the best choice.*

96.

A client with a new hearing aid complains of acoustic feedback—whistling—that prevents him from hearing. What should the nurse advise as the initial step to relieve the feedback?

turn down the volume

remove the hearing aid and reinsert it to ensure it is fit correctly

decrease the high-frequency amplification

change the battery

**Explanation:**

*A frequent cause of acoustic feedback with a hearing aid is incorrect fit, so removing the hearing aid and reinserting it, making sure that it is seated properly in the ear canal may alleviate the problem. If the acoustic feedback persists, then the client may have earwax or the hearing aid may need to be refitted because the fit may be too loose. In some cases, adjusting the high-frequency amplification may reduce acoustic feedback, but it may also decrease the ability to hear speech, so this is usually not a good solution.*

97.

Following the death of a client, the nurse anticipates that rigor mortis will begin in what period of time?

4–6 hours

2–4 hours

1–2 hours

30–60 minutes

**Explanation:**

*Following the death of a client, rigor mortis usually begins within two to four hours because adenosine triphosphate (ATP), which is necessary to relax muscles, is no longer synthesized, so muscles contract. It's important to position the client before rigor mortis begins. This includes closing the eyes, placing dentures in the mouth, closing the jaw (using a rolled towel to keep the mouth closed), positioning the hands, and positioning the body in correct alignment.*

98.

**A client hospitalized for cocaine overdose has removed his intravenous line and is putting on his clothes, stating that he intends to leave the hospital immediately even though he has no discharge order. Which of the following actions is the best response?**

tell the client that he is not allowed to leave

call security to detain the client

restrain the client

**ask the client to sign the release for leaving against medical advice (AMA)**

**Explanation:**

*Unless treatment is court ordered, clients cannot be prevented from leaving the hospital, so telling the client that he cannot leave, calling security, or restraining the client would be to violate his rights to self-determination and could be construed as unlawful imprisonment. The nurse should ask the client to sign the release for leaving against medical advice (AMA) and*

*should follow hospital protocol for such situations. The nurse should ask the client to speak with the physician before leaving.*

99.

If a client has expressed a desire to quit smoking and asks the nurse for advice, what is the first step that the nurse should suggest the client take?

throw away cigarettes

ask family members to provide support

**make a quit plan**

sign a contract agreeing to quit

***Explanation:***

*If a client has expressed a desire to quit smoking and asks the nurse for advice, the first step that the nurse should suggest is that the client take is to make a quit plan. The client should determine a quit date, preferably within 2 weeks. During that time, the client should inform family and friends, make a list of possible adverse effects (cravings, withdrawal) and plan how a response. The client should review smoking habits (when, where, and how) and make a plan to avoid those situations. On the quit date, the client should throw away all tobacco products.*

100.

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.*

101.

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.*

102.

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.*

103.

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.*

104.

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.*

105.

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.*

106.

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.*

107.

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.*

108.

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.*

109.

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.*

110.

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.*

111.

**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.*

112.

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 ( $\leq 5$  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.*

113.

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.*

114.

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.

115.

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.*

116.

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.*

117.

**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.*

118.

**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.*

119.

**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.*

120.

**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.*

121.

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.*

122.

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.*

123.

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.*

124.

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.*

125.

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.*

126.

When administering total parenteral nutrition (TPN) to a client, how often should the nurse change the filters, intravenous (IV) tubing, and solution?

every 8 hours

every 12 hours

**every 24 hours**

every 48 hours

***Explanation:***

*When administering total parenteral nutrition (TPN), the filters, tubing, and solution should be changed every 24 hours. Aseptic technique must be maintained to avoid infection, vital signs (VS) should be monitored every 4 hours, and weight should be checked daily. Laboratory testing is usually done at least every three days until the client stabilizes and then at least one time weekly. Cloudiness in the formula indicates contamination, so any cloudy solution should be immediately discarded. Micropore filters are used for solutions without fat emulsion, and 0.1-micron filters are used for solutions with fat emulsion.*

127.

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.*

128.

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.*

129.

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.*

130.

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.*

131.

**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.*

132.

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.*

133.

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.*

134.

**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.*

135.

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.*

136.

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.*

137.

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.*

138.

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.*

139.

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.*

140.

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