M_NurseACEIFNPQ (300+ Questions) - Quiz Questions with Answers

1.

If a patient with a history of asthma is experiencing an acute exacerbation with wheezing and dyspnea, the medication likely to provide the most immediate relief is

prednisone (corticosteroid)

montelukast (leukotriene receptor antagonist).

ipratropium (anticholinergic).

albuterol (beta-adrenergic agonist).

Explanation:

If a patient with a history of asthma is experiencing an acute exacerbation with wheezing and dyspnea, the medication likely to provide the most immediate relief is albuterol, which is a beta-adrenergic agonist, commonly used during the acute stage of asthma, because this class of drugs provides fast-acting bronchodilation. Because these drugs have some vasoconstrictive properties, they should be avoided in patients with uncontrolled cardiac dysrhythmias and high stroke risk.

2.

The correct position to place a patient in when he is going into shock is

semi-Fowler's.

reverse Trendelenburg.

flat, supine.

Trendelenburg.

Explanation:

The correct position to place a patient in when he is going into shock is Trendelenburg (feet elevated above the heart). If the patient is not on a bed that can be placed in this position, then he should lie flat with pillows placed under his legs to elevate them. Although treatment varies somewhat depending on the cause and type of shock, in most cases, fluid resuscitation with intravenous (IV) fluids is necessary as well as administration of medication such as dopamine to constrict blood vessels and increase blood pressure.

3.

An older adult hospitalized after a fall has been prescribed 50 mg diphenhydramine (Benadryl) for sleep, but the nurse is concerned that this prescription is inappropriate for an older adult. The nurse should

administer the medication as prescribed.

verify the prescription with the physician.

refuse to give the medication.

consult a supervisor about the prescription.

Explanation:

If an older adult hospitalized after a fall has been prescribed 50 mg diphenhydramine (Benadryl) for sleep, but the nurse is concerned that this prescription is inappropriate for an older adult, the nurse should verify the prescription with the physician. Diphenhydramine is on the list of medications that should be avoided with older adults because of the risk of confusion and falls, so the nurse should express concerns about this to the physician.

4.

The chance that a patient taking eight different medications will have a drug interaction is approximately

25%.

50%.

75%.

100%.

Explanation:

The chance that a patient taking eight different medications will have a drug interaction is approximately 100%. Because of this, it's very important to accurately carry out drug reconciliation, carefully compiling a list that includes not only prescription drugs but also over-the-counter (OTC) drugs and supplements, such as vitamins and minerals. Sometimes, one drug may be given specifically to counteract the side effects of another drug (such as potassium for diuretics).

5.

Which type of angina is associated with smoking, alcohol, and illicit stimulants?

Variant (Prinzmetal's).

Stable.

Unstable.

Atypical.

Explanation:

The type of angina that is associated with smoking, alcohol, and illicit stimulants is variant (Prinzmetal's) angina. For example, variant angina is a complication of cocaine use. Unlike other forms of angina, which typically occur with exertion, variant angina virtually always occurs when the patient is at rest between midnight and early morning. This type of angina tends to occur at a younger age than other types. Some medications may precipitate variant angina.

6.

If an order calls for eye ointment to be applied "OD," the nurse should administer the ointment to

the eyelids only.

both eyes.

the left eye.

the right eye.

Explanation:

If an order calls for eye ointment to be applied OD, the nurse should administer the ointment to the right eye. OD is the abbreviation for the Latin term oculus dextrus, with oculus meaning eye, and dextrus meaning right. The left eye is indicated by OS, which stands for oculus sinister. Both eyes are indicated by OU, which stands for oculus uterque. These abbreviations, although commonly used in ophthalmology and optometry, should be avoided in prescriptions or documentation of administration because they can easily be misinterpreted.

7.

A patient has been experiencing orthostatic hypotension. Which of the patient's medications is most likely the cause?

Metoprolol (Inderal)

Metformin (Glucophage).

An NSAID (Ibuprofen).

Docusate (Colace).

Explanation:

If a patient has been experiencing orthostatic hypotension, the medication that is most likely the cause is metoprolol (Inderal), which is a beta-blocker. These drugs block beta-adrenergic receptors. Thus, although the heart normally speeds up and vasoconstriction occurs when a patient changes position, the beta-blocker prevents this action so that the heart contracts with less force, and this, coupled with vasodilation, results in a drop in blood pressure when the patient changes position, such as from sitting to standing.

8.

A patient is considered hypoxic when his pulse oximetry falls below

95%.

90%.

85%.

80%.

Explanation:

A patient is considered hypoxic when his pulse oximetry falls below 90%; however, because pulse oximeters can easily become dislodged, the oximeter should be repositioned and the level rechecked for low readings. If the patient's oxygenation is inadequate, he should appear in respiratory distress. The patient's vital signs and respiratory status should be assessed, and his oxygen saturation level should be reported to the physician unless this is a normal finding for the patient, such as those with advanced chronic obstructive pulmonary disease (COPD).

9.

If a patient has episodes of fever that persist for 48 to 72 hours alternating with episodes of normal temperatures that persist for up to two weeks, the pattern of her fever is described as

sustained.

intermittent.

remittent.

relapsing.

Explanation:

If a patient has episodes of fever that persist for 48 to 72 hours alternating with episodes of normal temperatures that persist for up to two weeks, the pattern of her fever is described as relapsing. This fever pattern is associated with both louse-borne relapsing fever and tick-borne relapsing fever and may be caused by one of 15 different types of spirochetes. The fever elevations occur with the release of spirochetes into the bloodstream.

10.

The ability of the nurse to listen to a patient, perceive the patient's feelings, and understand the patient's perspectives is an example of

sympathy.

empathy.

patience.

compassion.

Explanation:

Empathy is the ability of the nurse to listen to a patient, perceive the patient's feelings, and understand the patient's perspectives. Sympathy, on the other hand, involves feelings of pity or concern for the patient. Sympathy, a subjective response, can sometimes interfere with objective evaluation. Patience is the ability to deal with problems without getting upset or angry. Compassion is a feeling of understanding that can move a person to action in response.

11.

Which of the temperature measurement sites provides the most accurate and rapid core temperature measurement?

Temporal artery.

Axillary.

Rectal.

Oral.

Explanation:

The temperature measurement site that provides the most accurate and rapid core temperature measure is the temporal artery site. The site is easy to access, but it must be clear of hair and moisture because these can affect the results. Oral and rectal temperatures also provide fairly accurate temperatures, although both have numerous limitations. Tympanic, skin, and axillary temperatures are less reliable.

12.

If a patient has experienced a stroke on the right side of the brain, which of the following signs or symptoms should the nurse expect?

Right-sided weakness.

Depression and anxiety.

Impaired speech

Impulsivity and impaired judgment.

Explanation:

If a patient has experienced a stroke on the right side of the brain, the nurse should expect the patient to exhibit impulsivity and impaired judgment. The patient may have weakness or paralysis on the left side of the body and may experience left-sided neglect. The patient's attention span may be quite short, and he may have little concept of time. The patient's language centers remain intact, so he is able to communicate verbally.

13.

If a patient is receiving warfarin therapy, her international normalized ratio (INR) should generally be maintained at a range of

1.0 to 2.0.

2.0 to 3.0.

3.5 to 3.5.

3.5 to 4.5.

Explanation:

If a patient is receiving warfarin therapy, her international normalized ratio (INR), the laboratory test done to evaluate coagulation, should generally be maintained at a range of 2.0 to 3.0. The target range may be slightly higher, 2.5 to 3.5, for those with mechanical heart valves or recurring thrombi or emboli. The INR reflects the warfarin dosage given 36 to 72 hours prior to the test. The INR is calculated based on the prothrombin time, so both test results may be reported.

14.

If a patient's chest tube becomes dislodged, the nurse's first action should be to

evaluate the patient's respiratory status.

notify the physician.

apply pressure to the tube insertion site.

call for assistance.

Explanation:

If a patient's chest tube becomes dislodged, the nurse's first action should be to apply pressure to the tube insertion site. The nurse should call for assistance in order to apply a sterile dressing while the physician is notified because this is an emergent situation. If air is escaping, the dressing should not be occlusive because this can result in a tension pneumothorax. The patient should be continually monitored and assessed for hypotension, changes in breath sounds, cyanosis, and signs of tension pneumothorax.

15.

If a patient chooses words at random, such as "The dog sun burst moving and afterwards," what form of thought is the patient exhibiting?

Word salad.

Clang association.

Neologism.

Associative looseness.

Explanation:

If a patient chooses words at random, such as "The dog sun burst moving and afterwards," she is exhibiting word salad (aka schizophasia). Patients with schizophrenia or the manic phase of bipolar disorder who have disorganized thinking and speech may engage in word salad when trying to communicate. This type of disorganized thinking pattern is one of the positive symptoms of the disease. Patients may also make up words, rhyme words, or repeat the same word or phrase over and over.

16.

If a patient expresses concern about managing ileostomy care after discharge, the most effective reassurance is

"I'm sure you'll do fine."

"Let's work on this together."

"Don't worry. You're smart and capable."

"It can be pretty complicated."

Explanation:

If a patient expresses concern about managing ileostomy care after discharge, the most effective reassurance is "Let's work on this together." The patient's primary concern is the inability to perform as needed, so the focus of the response should be on working toward a solution, which is itself reassuring to the patient, rather than simply providing words of reassurance, such as "Don't worry. You're smart and capable," which does little to solve the problem.

17.

Which one of the following laboratory test values should the nurse report to the physician because it's outside of the normal range?

Hemoglobin 9.1 g/dL.

Platelets 165,000/mm3.

Hgb A1c 5.5

Glucose 98 g/dL.

Explanation:

The laboratory test value that the nurse should report to the physician because it is outside of the normal range is hemoglobin 9.1 g/dL. Hemoglobin carries oxygen and is decreased in anemia and increased in polycythemia. Normal values vary somewhat by gender and include

- *Males >18 years: 14.0–17.46 g/dL and*
- *Females >18 years: 12.0–16.0 g/dL.*

Hemoglobin is generally reported with hematocrit, which shows the proportion of red blood cells in a liter of blood and usually is about three times the hemoglobin number:

- *Males >18 years: 45–52% and*
- *Females >18 years: 36–48%.*

18.

Which of the following types of insulin should not be mixed with other types of insulin in the same syringe?

NPH insulin.

Regular insulin.

Insulin glargine.

Insulin glulisine.

Explanation:

Insulin glargine (Lantus) should not be mixed with other types of insulin in the same syringe or diluted because this may alter the pH (which is neutral) and interfere with the absorption of the insulin. Insulin glargine is a human recombinant long-acting insulin analog. It is usually administered one time daily in the morning, but it may be administered every 12 hours if necessary for glycemic control. Insulin glargine should be stored in the refrigerator but should not be frozen; however, it is stable at room temperature for 28 days.

19.

In an adult female, the center of gravity is usually approximately

at the waist.

midway between the umbilicus and symphysis pubis.

at the base of the sternum.

at the widest part of the hips.

Explanation:

In an adult female, the center of gravity is usually about midway between the umbilicus and symphysis pubis, whereas the center of gravity for males tends to be higher — at about the base of the sternum. In order to maintain balance, the patient's center of gravity must be over the

base of support (the feet). This may mean that males and females will use their bodies somewhat differently when trying to maintain balance.

20.

A patient with diabetes mellitus, type 1, took insulin before lunch but ate little because of nausea. Shortly thereafter, the patient became shaky, anxious, pale, diaphoretic, combative, and confused. The immediate response should be to

administer quick-acting carbohydrate.

do point-of-care blood glucose.

take vital signs.

administer insulin.

Explanation:

If a patient with diabetes mellitus, type 1, took insulin before lunch but ate little because of nausea and shortly thereafter became shaky, anxious, pale, diaphoretic, combative, and confused, the immediate response should be to administer quick-acting carbohydrate because these symptoms indicate an insulin reaction (hypoglycemia). Quick-acting carbohydrates include 4 to 6 ounces of a sugary drink or orange juice, 8 to 10 Life Savers, 1 tablespoon honey/syrup, 4 teaspoons jelly, or commercial dextrose.

21.

A crisis is most likely to occur when a patient

experiences a new or unfamiliar situation.

is physically weak and tired.

has inadequate coping strategies for a stressful event.

lacks an adequate support system.

Explanation:

A crisis is most likely to occur when a patient has inadequate coping strategies for a stressful event. The patient's inability to determine a course of action or a method of coping increases the stress to the point that the patient is overwhelmed. A crisis may be dispositional, may be related to life transitions, may result from trauma, may be maturational/developmental, or may reflect psychopathology. Patients may exhibit anger, aggression, withdrawal, and disorganized thinking and behavior.

22.

If a patient has dysphagia and is at risk for aspiration, how long should she remain sitting upright after finishing a meal?

5 to 10 minutes.

10 to 20 minutes.

20 to 30 minutes.

30 to 60 minutes.

Explanation:

If a patient has dysphagia and is at risk for aspiration, she should remain sitting upright for at least 30 to 60 minutes after finishing a meal. Patients should sit as upright as possible while eating and should tilt their heads slightly forward because this position makes swallowing easier. If one side of the patient's mouth is weak or paralyzed, the patient should place food and liquids on the opposite side. Thin liquids should usually be thickened.

23.

Which of the following respiration patterns is characterized by two or three abnormally shallow respirations alternating with irregular periods of apnea resulting injury to the pons area of the brain?

Kussmaul.

Biot.

Cheyne-Stokes.

Bradypnea.

Explanation:

Biot's respirations are characterized by two or three abnormally quick shallow respirations alternating with irregular periods of apnea. Biot's respirations result from injury to the pons area of the brain. This can occur with a stroke or herniation. Biot's respirations may be misclassified as Cheyne-Stokes respirations, which are similar. If Biot's respirations are evident, the patient's condition is grave.

24.

With Raynaud's disease, the patient should be advised to avoid

smoking.

hot weather.

alcohol.

milk products.

Explanation:

With Raynaud's disease (intermittent digital arteriolar vasoconstriction), the patient should be advised to avoid smoking because this results in vasoconstriction, which can trigger an acute episode. Raynaud's phenomenon (red, white, and blue) occurs with vasoconstriction causing pallor (white), pallor leading to cyanosis (blue), and recovery leading to hyperemia (red). Patients must avoid cold because this triggers episodes. Primary Raynaud's disease is usually bilateral and progressive, starting with one or two digits and then spreading. The hands, feet, nose, and ears can all be affected.

25.

Which of the following antihistamines has the highest level of sedation?

Fexofenadine (Allegra).

Loratadine (Claritin).

Diphenhydramine (Benadryl).

Chlorpheniramine (Chlor-Trimeton).

Explanation:

The antihistamine with the highest level of sedation is diphenhydramine (Benadryl), which is an early antihistamine in the ethanolamine class and is sometimes used as a sleep aid. Later antihistamines, such as fexofenadine and loratadine, have low sedation. Antihistamines are most effective for the treatment of nasal allergies and seasonal or chronic rhinitis. Antihistamines should be avoided as sole treatment for asthmatic attacks. Drowsiness is usually the primarily adverse effect, although some users may complain of dry mouth, dysuria, and constipation.

26.

If the nurse administers a medication to the wrong patient, her priority response should be to

file an incident report.

notify the physician.

assess the patient for an adverse reaction.

notify the supervisor.

Explanation:

If the nurse administers a medication to the wrong patient, her response should be to assess the patient for an adverse reaction. The nurse should also check the patient's known allergies. Then, the nurse should notify the physician and the supervisor. The medication should be documented in the patient's health record, but the incident report detailing the error is filed separately.

27.

After going to bed at night, a patient should be able to transition from awake to asleep within

5 to 10 minutes.

10 to 20 minutes.

20 to 30 minutes.

30 to 40 minutes.

Explanation:

After going to bed at night, a patient should be able to transition from awake to asleep within 10 to 20 minutes. If the patient is not asleep within 20 minutes, it's usually better to get up out of bed to do something rather than to toss and turn. People who have trouble falling asleep should be advised to avoid eating, drinking alcohol, and smoking near bedtime and to avoid caffeine. Patients should wait until they are sleepy to go to bed and should try to establish a routine bedtime.

28.

When assisting a patient with a bed bath with soap and water, the maximum temperature of the bath water should be

90° to 100° F (32° to 37.7° C).

100° to 105° F (37.7° to 40.5° C).

110° to 115° F (43° to 46° C).

120° to 125° F (49° to 51.6° C).

Explanation:

When assisting a patient with a bed bath with soap and water, the maximum temperature of the water should be 110° to 115° F (43° to 46° C). The nurse should verify the temperature with a thermometer if possible, but at this temperature, the nurse should be able to place a finger in the water without discomfort. Because the normal body temperature is about 98.6°, water that is close to that temperature range may feel cool to the patient. Water that is too hot increases the risk of burns. The water should be changed when it begins to cool.

29.

When applying a condom sheath to a male patient, how much space should be maintained between the tip of the glans penis and the end of the condom sheath?

2.5 to 5 cm.

2 to 3 cm.

1 to 2 cm.

None, the sheath should fit snugly.

Explanation:

When applying a condom sheath to a male patient, there should be 2.5 to 5 cm distance between the tip of the glans penis and the end of the condom sheath in order to avoid irritation to the glans penis. The sheath must be applied with care with elastic adhesive applied in a spiral, nonoverlapping wrap to help secure it in place. The penis should be carefully monitored after application to ensure that circulation is not impaired.

30.

If a patient's right leg is to be positioned in abduction, this means that the best method is to

advise the patient to keep his legs apart.

place a pillow or bolster between his legs.

place a pillow under his right leg.

cross the right ankle over his left leg.

Explanation:

If a patient's right leg is to be positioned in abduction (which means away from the center of the body), the best method is to place a pillow or bolster between his legs because he may forget to maintain the correct position or may move his legs during sleep. Abduction is often required following hip replacement surgery in order to reduce the risk of dislocation of the prosthesis, although this is a rare occurrence.

31.

If a patient's blood pressure reading is typically about 135/85, her blood pressure would be categorized as

normal.

prehypertension.

stage 1 hypertension.

stage 2 hypertension.

Explanation:

If a patient's blood pressure reading is typically about 135/85, her blood pressure would be categorized as prehypertension:

Category	*Systolic*	*Diastolic*
Normal	*<120*	*<80*
Prehypertension	*120 to 139*	*80 to 89*
Stage 1 hypertension	*140 to 159*	*90 to 99*
Stage 2 hypertension	*≥160*	*≤100*

32.

Xanthine derivatives, such as theophylline, are primarily used to treat

bronchoconstriction.

nasal congestion.

cough.

allergic reactions.

Explanation:

Xanthine derivatives, such as theophylline, are primarily used to treat bronchoconstriction. Xanthine derivatives have been supplanted as first-line treatment of acute asthma by beta-agonists because xanthine derivatives have slower onset and more drug interactions. However, they are often used for asthma prevention and as adjunct bronchodilators for treatment of chronic bronchitis and emphysema. Adverse effects include nausea; vomiting; anorexia; reflux;

as well as various cardiac abnormalities including tachycardia, extrasystole, palpitations, and ventricular dysrhythmias.

33.

Patients who are unconscious should receive oral care routinely every

hour.

two hours.

four hours.

eight hours.

Explanation:

Patients who are unconscious should receive oral care routinely every two hours because the mucous membranes tend to dry out because of oxygen therapy, mouth breathing, and the inability to take oral fluids. Although lemon and glycerine swabs are sometimes available for mouth care, they may increase drying if used over a prolonged period and can damage the tooth enamel. The best solution to use is normal saline. When brushing and rinsing the patient's teeth, patients should be placed on their sides with their heads lowered so that they don't aspirate.

34.

If a patient has experienced an overdose of oxycodone (OxyContin), the antidote is

glucagon.

N-acetylcysteine.

flumazenil (Romazicon).

naloxone (Narcan).

Explanation:

If a patient has experienced an overdose of oxycodone (OxyContin), the antidote is naloxone (Narcan), which can also be used for other opioid overdoses, such as morphine, heroin, methadone, butorphanol, and fentanyl. Adults are usually treated with 0.4 to 2.0 mg parenterally with doses repeated every two to three minutes as needed. If there is no response after 10 mg total has been administered, then the patient's symptoms may be caused by something other than opioids.

35.

According to Freud, at which stage of development is masturbation and sexual relationships with peers a normal part of development?

Anal stage.

Phallic stage.

Latency stage.

Genital stage.

Explanation:

Although children may begin experimenting with masturbation during the phallic stage (ages 3 to 6 years), the genital stage (ages 12 and older) is the one in which masturbation and sexual relationships with peers are part of normal development according to Freud. The psychosocial stages of development include

- *oral stage: ages birth to 1 year.*
- *anal stage: ages 1 to 3.*
- *phallic stage: ages 3 to 6.*
- *latency stage: ages 6 to 12.*
- *genital stage: ages 12 and older.*

36.

Which phase of healing occurs within minutes of injury and results in vasoconstriction?

Maturation/Remodeling.

Hemostasis.

Proliferation.

Resolution.

Explanation:

The phase of healing that occurs within minutes of injury and results in vasoconstriction is hemostasis. This is followed within minutes by the inflammation phase, which occurs over days 1 to 4. Phagocytosis begins and erythema, pain, and swelling may be evident. Over days 5 to 20, proliferation occurs, collagen is produced, and granulation tissue appears. The wound begins to contract. The last phase is maturation, which begins at about day 21 and continues for up to two years. During this time, scarring reduces and the tissue strengthens.

37.

A patient has had severe watery diarrhea and vomiting for 48 hours. Which electrolyte imbalance is likely to occur with persistent vomiting and diarrhea?

Hypernatremia.

Hyponatremia.

Hypercalcemia.

Hypocalcemia.

Explanation:

The electrolyte imbalance that is likely to occur with persistent vomiting and diarrhea is hyponatremia. Gastric and intestinal fluids contain high levels of sodium, so sodium can become depleted with nausea and diarrhea. Hyponatremia is a sodium level of less than 135 mEq/L. This type of hyponatremia resulting from hypovolemia is characterized by dry mucous membranes, orthostatic hypotension, tachycardia, and poor skin turgor. The patient may appear weak, stuporous, confused, and/or lethargic.

38.

If a patient is angry with his or her physician and lashes out at the nurse, the defense mechanism that the patient is exhibiting is

compensation.

reaction formation.

displacement.

projection.

Explanation:

If a patient is angry with his or her physician and lashes out at the nurse, the defense mechanism that the patient is exhibiting is displacement. With displacement, the patient transfers feelings toward one target (the physician) to another (the nurse) because the second target seems less threatening to the patient. Because patients often feel intimidated by physicians, it is common for them to relieve tension by expressing anger (the most common emotion expressed in displacement) toward nursing personnel or even family members.

39.

The three parameters that are evaluated with the Glasgow Coma Scale (GCS) are

respirations, behavior, and appearance.

response, memory, and movement.

movement, reflex, and cognition.

eye opening, verbal, and motor.

Explanation:

Glasgow Coma Scale

Eye opening

4: Spontaneous.

3: To verbal stimuli.

2: To pain (not of face).

1: No response.

Verbal	*5: Oriented.* *4: Conversation confused, but can answer questions.* *3: Uses inappropriate words.* *2: Speech incomprehensible.* *1: No response.*
Motor	*6: Moves on command.* *5: Moves purposefully in response to pain.* *4: Withdraws in response to pain.* *3: Decorticate posturing (flexion) in response to pain.* *2: Decerebrate posturing (extension) in response to pain.* *1: No response.*

Injuries/Conditions are classified according to the total score: 3–8, Coma; ≤8, Severe head injury; 9–12, moderate head injury; 13–15, mild head injury.

40.

A patient who has been diagnosed with human immunodeficiency virus/acquired immunodeficiency syndrome (HIV/AIDS) has become very withdrawn and depressed, telling the nurse that she knows she is going to die. The most appropriate response for the nurse is to

encourage the patient to express her feelings.

remind the patient that many treatments are available.

tell the patient that her feelings of depression will pass.

ask the physician to refer the patient to a psychiatrist.

Explanation:

Depression is a normal response to the grief associated with bad news, such as a patient who has been diagnosed with HIV/AIDS. The patient should be encouraged to express her feelings, and the nurse should remain supportive. This stage usually passes, but if it is prolonged or if the patient becomes suicidal, then referral to a psychiatrist may be indicated. Patients may benefit from participating in a support group of other patients who are undergoing similar health problems.

41.

Which type of maladaptive grief response is a patient exhibiting if the patient remains fixed in the anger stage of grieving, refusing to cooperate and insulting family and healthcare providers?

Prolonged.

Distorted.

Delayed.

Inhibited.

Explanation:

The type of maladaptive grief response a patient is exhibiting if he remains fixed in the anger stage of grieving, refusing to cooperate and insulting family and healthcare providers, is distorted grieving. In this stage, the normal behaviors or feelings (such as helplessness and sadness) are exaggerated out of proportion so that the patient reacts in a volatile manner to even the smallest inconvenience. The patient often turns the anger internally and may blame himself for the problems, becoming overwhelmed with despair.

42.

If a patient engages in moderate aerobic exercise, such as brisk walking, how much time per week should she plan to exercise to meet recommended exercise guidelines for healthy adults?

75 minutes.

100 minutes.

150 minutes.

175 minutes.

Explanation:

If a patient engages in moderate aerobic exercise, such as brisk walking, she should plan to exercise 150 minutes per week to meet recommended exercise guidelines for healthy adults. Patients should generally be encouraged to exercise about 30 minutes a day at least 5 days a week and to engage in strength training at least twice a week. If patients are unable to exercise for this length of time, exercising for 10 minutes three times daily provides the same benefit.

43.

Keyboards and monitors are in each patient's room so that documentation can be done at the point of care, and the monitor is mounted on the wall. When viewing the monitor, the nurse should adjust the monitor so that the top of the monitor is

at or slightly below the level of the eyes.

at or slightly above the level of the eyes.

placed so the eyes are centered midmonitor.

in line with the bottom of the viewer's chin.

Explanation:

If keyboards and monitors are in each patient's room so that documentation can be done at the point of care and the monitor is mounted on the wall, when viewing the monitor, the nurse should adjust the top of the monitor so that the monitor is at or slightly below the level of the eyes. The nurse should be able to maintain the head in neutral position while viewing the monitor. Those who wear bifocals may need to have the monitor slightly lower, however, to avoid having to tip the head up.

44.

What percentage of the body weight is accounted for by water?

20% to 30%.

30% to 40%.

40% to 50%.

50% to 60%.

Explanation:

Approximately 50% to 60% of the body weight is accounted for by water. Males tend to have a greater percentage of water than females because men usually have a greater lean body mass and fat cells contain less water than muscle tissue. For the same reason, older adults who tend to lose lean body mass have a lower percentage of water. Water is critical to the cells because it dissolves and transports nutrients, electrolytes, and waste products.

45.

A patient's nosebleed has stopped, but the nurse notes that the patient is swallowing frequently. The nurse should suspect that

the patient is nervous and anxious.

blood is running down the patient's throat.

the patient is dehydrated and thirsty.

the patient's throat is irritated.

Explanation:

If a patient's nosebleed has stopped but the nurse notes that the patient is swallowing frequently, the nurse should suspect that blood is running down the patient's throat. If the nosebleed occurs at the back of the nasal passages, then bleeding is not always evident externally. The nurse should examine the patient's mouth and check the back of the throat. Blood is often evident in the mouth with posterior bleeding.

46.

The movement of water between two compartments separated by a semipermeable membrane is referred to as

active transport.

diffusion.

osmosis.

facilitated diffusion.

Explanation:

The movement of water between two compartments separated by a semipermeable membrane is referred to as osmosis. Solutes do not move through the membrane. The water moves from one side of the membrane to the other, from low concentration to high (the opposite of diffusion), to equalize the concentration of solutes. Osmotic pressure is the amount necessary to stop the process of osmosis and relates to the concentration of solutes in a solution.

47.

If a patient is declared brain dead after a motorcycle accident, who should discuss organ donation with the family?

The patient's physician.

Any nurse on duty.

Registered nurses only.

Specially trained personnel.

Explanation:

If a patient is declared brain dead after a motorcycle accident, a person who is specially trained, often a transplant coordinator or other designated healthcare professional, should discuss organ donation with the family. However, the nurse should remain supportive of the family, answer any questions, and ensure that the transplant coordinator or designated professional is notified in advance. This is often a very emotional time for family members, so it's important that only people who are trained approach the family about organ donation.

48.

At what degree of angle should a subcutaneous injection be administered?

45 to 90.

90.

30 to 45.

30.

Explanation:

A subcutaneous injection should be administered at a 45- to 90-degree angle, depending on the amount of subcutaneous tissue. If the nurse is able to grasp only about 2.5 cm of tissue, then a 45-degree angle should be used with a 5/8-inch needle. If the nurse can grasp 5 cm of tissue (indicating obesity), then a 90-degree angle should be used with a 1/2-inch needle, although a longer needle may be used if the patient is morbidly obese.

49.

The normal value for potassium (K+) is

2.0 to 2.5 mEq/L.

3.0 to 3.5 mEq/L.

3.5 to 5.5 mEq/L.

5.5 to 7.5 mEq/L.

Explanation:

The normal value for potassium ($K+$) is 3.5 to 5.5 mEq/L. Potassium, the primary electrolyte in intracellular fluid, influences activity of the skeletal and cardiac muscles. Hypokalemia occurs at levels less than 3.5 mEq/L with the critical value at less than 2.5 mEq/L. Hyperkalemia occurs with levels greater than 5.5 mEq/L with the critical value at greater than 6.5 mEq/L. Potassium levels depend on renal function because 80% is excreted through the kidneys and only 20% through the bowels and perspiration.

50.

Which of the following is an indication that a nurse has breached a professional boundary?

The nurse gives a birthday card to a long-term patient.

The nurse likes one patient more than another.

The nurse sits with the patient when the patient receives bad news.

The nurse tells the patient a personal secret.

Explanation:

Telling a patient a personal secret is an indication that a nurse has breached a professional boundary. Liking one patient more than another is only a breach of boundary if the nurse acts on it, showing favoritism to one patient. Simple acts of kindness, such as sitting with a patient when the patient receives bad news or giving a birthday card to a long-term patient are only boundary violations if they are part of a consistent pattern of favors done for that patient and not for others.

51.

If a hospitalized patient requests that a tribal healer participate in his treatment, the nurse should

tell the patient that is not acceptable.

help to arrange for this to happen.

advise the patient to wait until after discharge.

ask the patient why he wants a tribal healer.

Explanation:

If a hospitalized patient requests that a tribal healer participate in his treatment, the nurse should help to arrange for this to happen. Some healers use herbs or other preparations that may interfere with medical treatments, so the nurse should inquire about the type of healing procedures that will be carried out, when, and how. Every effort should be made to accommodate the patient's request and to respect the patient's traditions.

52.

For which of the following sexually transmitted diseases is no cure yet available?

Genital herpes simplex virus, type 1 or 2 (HSV-1 or HSV-2).

Gonorrhea.

Chlamydia.

Syphilis.

Explanation:

No cure is yet available for genital herpes simplex virus, type 1 or 2. Most infections are caused by type 2, but type 1 (the cause of most cold sores) can also be transmitted if people have active lesions. Palliative treatment is available with acyclovir, valacyclovir, or famciclovir. Even after the lesions (which are usually painful and blistery) clear, recurrence is possible. Genital herpes is spread through vaginal, anal, and oral sex, as well as skin-to-skin contact with infected lesions. Infants may become infected by vaginal delivery.

53.

If a patient with obesity has begun a weight reduction program, a reasonable weekly weight loss is

5 to 6 pounds.

3 to 4 pounds.

1 to 2 pounds.

1/2 to 1 pound.

Explanation:

If a patient with obesity has begun a weight reduction program, a reasonable weekly weight loss is 1 to 2 pounds. Patients who are very obese may lose more initially, sometimes up to 5 pounds in a week, but much of this weight loss may be attributed to fluid loss, and the patient may develop unrealistic goals because of this. Patients are more likely to sustain weight loss if it occurs more slowly than if they starve themselves or exercise excessively to lose weight.

54.

According to Maslow's hierarchy of needs, which need must be met first?

Need for self-actualization.

Physiological needs.

Need for safety and security.

Belonging/Love needs.

Explanation:

According to Maslow's hierarchy of needs, physiological needs (the need for food, water, air, body functions, sleep) must be met first because survival is dependent on these needs. Once these needs are met, then the next need is for safety and security (which includes comfort, the ability to avoid harm, and freedom from fear), followed by the need for belonging and love (giving and receiving affection, identifying with a group, interpersonal relationships). The next level of the hierarchy is the need for self-esteem/esteem of others. Maslow believed these needs must be met before a person can achieve self-actualization.

55.

With conscious sedation, the patient is

awake but has no later memory of the procedure.

awake and has only vague and fleeting memories of the procedure.

awake and alert throughout the procedure.

completely unconscious throughout the procedure.

Explanation:

With conscious sedation, the patient is awake but later has no memory of the procedure. Conscious sedation is often used for minor procedures, such as colonoscopies. Midazolam (Versed) is commonly used because it provides excellent amnesia. Midazolam is also sometimes administered as part of preoperative preparation when the patient must have a number of preoperative invasive procedures done, such as placement of a central venous catheter or Foley catheter, in order to reduce the patient's stress and discomfort.

56.

After giving a patient an injection, the nurse should

wrap the syringe and needle in paper before discarding.

bend or break the needle before discarding.

discard the syringe and needle intact.

recap the needle before discarding.

Explanation:

After giving a patient an injection, the nurse should discard the syringe and needle intact. Attempting to recap the needle or to break or bend the needle may result in a needlestick injury and is no longer recommended. Needles should be disposed of in a special sharps hazardous waste container. These containers are often red and are made of hard plastic that needles and other sharps (blades, broken glass) cannot penetrate. The containers should be self-locking and sealable so that people cannot access them.

57.

When carrying out cardiopulmonary resuscitation (CPR), the cardiac compression rate per minute should be

40.

60.

80.

100.

Explanation:

When carrying out CPR, the cardiac compression rate per minute should be 100. This rate is roughly equivalent to beat in the song "Staying Alive," so keeping this in mind when beginning compressions can help to establish the correct rate. Compression for adults should be at least two inches. Nonmedical rescuers now use a compression-only protocol, but medical personnel use a 30:2 compression to ventilation rate with 30 initial compressions given before ventilation is initiated.

58.

Which of the following foods is an example of a "starchy" (high-carbohydrate) vegetable?

Corn.

Carrots.

Asparagus.

Spinach.

Explanation:

Corn is an example of a "starchy" (high-carbohydrate) vegetable. Most starchy vegetables average about 15 g of carbohydrate per 1/2 cup serving, whereas watery vegetables average about 5 g per 1/2-cup serving. Other starchy vegetables include pinto beans, lentils, peas, potatoes (white and sweet), yams, and winter squash. "Watery" vegetables include asparagus, bean sprouts, broccoli, carrots, green beans, okra, spinach and other greens, and tomatoes (technically a fruit).

59.

A patient tells the nurse that he has a question about the DASH diet that the nutritionist reviewed with him. Which of the following is the best response?

"I'll tell the nutritionist that you still have some questions."

"Ask your doctor about that question."

"The answer is probably in your diet handout."

"Ask me. If I don't know the answer, I'll get the information for you."

Explanation:

If a patient tells the nurse that he has a question about the DASH diet that the nutritionist reviewed with him, the best response is "Ask me. If I don't know the answer, I'll get the information for you." The nurse should always try to answer a patient's questions promptly or offer to find the information so that the burden isn't on the patient. While it may be true that the answer is in the diet handout, there may be various reasons why the patient is unable to find the information (poor vision, low literacy, confusing text), so the nurse can help to locate and explain the information.

60.

Which of the following is an example of secondary prevention?

Routine Pap smear.

Exercise program.

Smoking cessation.

12-step program.

Explanation:

The routine Pap smear (recommended every three years for patients ages 21 to 65) is an example of secondary prevention. Whereas primary prevention focuses on preventing disease and tertiary prevention focuses on treating disease and preventing deterioration, the aim of secondary prevention is to identify patients with a disease in order to initiate treatment. Secondary prevention includes numerous types of screening, such as those for elevated blood pressure, tuberculosis (purified protein derivative [PPD] and chest X-rays), scoliosis, HIV infection, and diabetes.

61.

When a patient's respiratory status must be continually monitored, the most effective method is to rely on

visual observation.

pulse oximetry.

auscultation.

patient's complaint of dyspnea.

Explanation:

When a patient's respiratory status must be continually monitored, the most effective method is to rely on pulse oximetry. Visual observation alone is never reliable because chest excursion may appear normal when the patient is actually in distress. Auscultation is also effective but requires moving the patient and takes more time than pulse oximetry, which can provide continuous readings. The pulse oximeter must be properly positioned to provide accurate readings.

62.

The study of actions that are considered right or wrong when related to medicine, treatment, life, or death is

morality.

ethics.

bioethics.

values.

Explanation:

Bioethics is the study of actions that are considered right or wrong when related to medicine, treatment, life, or death. Bioethics relates to controversial issues to which people take differing moral stands. For example, assisted suicide is a bioethical issue because some people believe it is ethical and right to assist people to die with dignity at a time of their choosing whereas

others believe just as strongly that purposefully taking a life for any reason is wrong and is an act of murder.

63.

A disinfectant that is bacteriostatic

spreads some types of bacteria.

destroys bacterial spores.

destroys bacteria.

prevents growth and reproduction of some bacteria.

Explanation:

A disinfectant that is bacteriostatic prevents the growth and reproduction of some bacteria but does not destroy bacteria as a bactericidal disinfectant does. Most of the commonly used disinfectants are bactericidal, although they may be bacteriostatic at low concentrations, so it is essential that the directions be followed exactly when disinfecting materials because if the solution is too weak or the contact time is inadequate, the desired bactericidal action may not occur.

64.

The moral principle that decrees that the nurse provide equal care and attention to all patients is

beneficence.

nonmaleficence.

justice.

fidelity.

Explanation:

The moral principle that decrees that the nurse provide equal care and attention to all patients is justice. This principle is usually applied to the idea that patients should have equal access to care, although the reality is that the patient's ability to pay or insurance coverage is often a prime determiner. For example, patients without insurance may not be able to have necessary surgeries, and patients who are illegal immigrants may be denied healthcare in some places.

65.

According to Erikson, the primary task of young adults is

autonomy versus shame.

identify versus role confusion.

intimacy versus isolation.

integrity versus despair.

Explanation:

According to Erikson, the primary task of young adults is intimacy versus isolation. The young adult should have developed a sense of identity and should be prepared to love others and establish intimate relationships. If the young adult experiences disappointment or rejection in

efforts to establish intimacy, then isolation may result as the person withdraws from others. Young adults who are ill or undergoing periods of stress may have an increased need of intimacy and the support of others.

66.

If a nurse takes a photograph of a patient to use in a journal article without the patient's consent, this is an example of

negligence.

invasion of privacy.

malpractice.

unprofessional conduct.

Explanation:

If a nurse takes a photograph of a patient to use in a journal article without the patient's consent, this is an example of invasion of privacy. Anytime personal information or images of a patient are to be used publicly in any way, the patient must give informed consent. Invasion of privacy occurs when a nurse breaches a patient's privacy by divulging personal information to those who have no right or need to know, even if the people obtaining the information are other healthcare providers.

67.

Items that belong to a patient should not be placed on the floor primarily because

the floor is considered grossly contaminated.

the item may contaminate the floor.

bending over to pick up the item may cause back injury.

the items may be overlooked and lost or misplaced.

Explanation:

Items that belong to a patient should not be placed on the floor primarily because the floor is considered grossly contaminated, so anything that falls on the floor is also considered contaminated. For this reason, soiled linens or other materials should never be placed on the floor. Floors may become contaminated with an airborne organism that settles to the floor. Floors may also become contaminated by shoes or equipment. Clostridium difficile spores can remain viable for up to five months on floors.

68.

If a nurse provides emergent care at the scene of an accident but the person dies from severe injuries, the nurse

may be legally liable for the person's death.

is protected by federal Good Samaritan law.

is protected by state Good Samaritan law.

should have provided no care without informed consent.

Explanation:

If a nurse provides emergent care at the scene of an accident but the person dies from severe injuries, the nurse is protected by the state (not federal) Good Samaritan law as long as the care the nurse provided was reasonable for the situation. For example, it would be reasonable to apply pressure to stop bleeding, to carry out CPR, and to remove a patient from a burning vehicle, but it is probably unreasonable to amputate a patient's arm in order to move the patient.

69.

If a patient has been placed in physical restraints to protect the safety of himself and others, what is the maximum number of consecutive hours that the patient may generally be maintained in restraints with renewal of orders?

4 hours.

8 hours.

12 hours.

24 hours.

Explanation:

If a patient has been placed in physical restraints to protect the safety of himself and others, the orders must be renewed every 4 hours for adults and 2 hours for children and adolescents, and the physical restraints may generally be maintained for a maximum of 24 consecutive hours (unless state law is more restrictive). Patients must be continually monitored while restraints are in place to ensure they are removed as soon as this can safely be done.

70.

When removing a mask secured with two ties, the nurse should first

untie the lower tie.

untie the upper tie.

untie either tie.

leave the ties intact and pull the mask up over the head.

Explanation:

When removing a mask secured with two ties, the nurse should first untie the lower tie because the mask will still remain in place. Then, the nurse unties the upper tie while holding onto the ties to remove the mask. If the nurse were to remove the upper ties first, the mask could fall forward and slip down the neck because the upper ties secure the mask above the nurse's ears. Masks should be changed if they become contaminated with fluids or secretions and if the nurse sneezes.

71.

If the nurse is aspirating stomach contents per an NG tube to ensure proper placement before administering a tube feeding, the pH reading that likely indicates gastric fluid is

4.0

7.6

7.38

7.10

Explanation:

If the nurse is aspirating stomach contents per an NG tube to ensure proper placement before administering a tube feeding, the pH that likely indicates gastric fluid is 4.0. Gastric fluid tends to be highly acidic, usually 4.0 or even lower. A pH reading of 7.6 is alkaline, whereas a pH of 7.38 is within the normal limits for blood (7.35 to 7.45). A pH of 7.10 is slightly acidic.

72.

If a patient complains of rectal discomfort, abdominal distention, and flatus as well as a continuous urge to defecate and states he has passed only small amounts of liquid stool for the past three to four days, the nurse should suspect

bowel obstruction.

diarrhea.

constipation.

fecal impaction.

Explanation:

If a patient complains of rectal discomfort, abdominal distention, and flatus as well as a continuous urge to defecate and states he has passed only small amounts of liquid stool for the past three to four days, the nurse should suspect fecal impaction. The body attempts to compensate for the impaction by decreasing absorption above the impaction, and this liquid stool tends to leak around the mass of impacted stool.

73.

If a female patient objects to a male nurse administering a vaginal suppository, the nurse should

instruct the patient in self-administration.

discard the suppository and document patient's refusal.

arrange for a female nurse to administer the suppository.

remind the patient that many doctors are male.

Explanation:

If a female patient objects to a male nurse administering a vaginal suppository, the male nurse should arrange for a female nurse to administer the suppository if at all possible. Studies indicate that most female patients are accepting of male nurses, but there may be a number of reasons why female patients prefer a female nurse, including cultural standards, modesty, and a history of sexual abuse. Therefore, it's important to respect the patient's preference.

74.

If the nurse has asked an unlicensed assistive personnel (UAP) to assist a patient with mouth care and walks by the open door to the room 30 minutes later and notes that the UAP is assisting the patient to brush his teeth, the nurse's greatest concern should be that

the door is open.

the patient is compliant.

the mouth care was delayed.

the care be documented.

Explanation:

If the nurse has asked an unlicensed assistive personnel (UAP) to assist a patient with mouth care and walks by the open door to the room 30 minutes later and notes that the UAP is assisting the patient to brush his teeth, the nurse's greatest concern should be that the door is open. A patient's privacy should always be considered when providing personal care, so the curtains should be pulled around the patient's bed even if the door is closed.

75.

Watery wound drainage that is yellow tinged and has occasional red streaks would be categorized as

purulent.

sanguineous.

serous.

serosanguineous.

Explanation:

Watery wound drainage that is yellow tinged and has occasional red streaks would be categorized as serosanguineous. Serous drainage, which is essentially serum, is watery and clear and often slightly yellow tinged. Sanguineous drainage is thicker and frankly bloody. Purulent discharge is thick and opaque and may have a foul odor, depending on the type of infection that is present. When describing discharge, the nurse should note the color, consistency, odor, and estimated volume.

76.

During manual removal of a fecal impaction, the patient becomes very faint with a sudden drop in blood pressure and heart rate. The most likely cause is

heart attack.

vasovagal response.

rectal perforation.

stroke.

Explanation:

During manual removal of a fecal impaction, if the patient becomes very faint with a sudden drop in blood pressure and heart rate, the most likely cause is vasovagal response. The nurse should be careful to avoid unnecessary manipulation or pressure against the rectal walls. The vasovagal response may also be caused by the pressure of the impaction alone. Manual removal of a fecal impaction should be the last resort and should be preceded by an oil retention enema to try to soften the stool and allow defecation.

77.

Which of the following types of laxatives/cathartics is most recommended for chronic constipation?

Stimulant.

Lubricant.

Emollient/wetting.

Bulk-forming.

Explanation:

Bulk-forming products, such as psyllium (Metamucil), methylcellulose (Citrucel), and polycarbophil (Fibercon) are generally the drugs of choice for chronic constipation because they increase absorption of fluid in the stool, helping to increase mass, soften stool, and stimulate peristalsis. Bulk-forming products have few adverse effects and are less irritating to the intestines than other preparations. However, if fluid intake is inadequate, bulk formers can cause obstruction, so they should be avoided with patients who are dehydrated or on fluid restriction.

78.

If a patient's hand is swelling and a ring is beginning to impair circulation, the first method to use in attempting to remove the ring is

twisting ring downward to attempt removal without further intervention.

elevating and soaking hand in cool water and applying lubricant before attempting removal.

using the string-wrap method with a tape anchor.

using a circular-blade ring cutter to cut the ring off the finger.

Explanation:

If a patient's hand is swelling and a ring is beginning to impair circulation, the first method to use in attempting to remove the ring is elevating and soaking the hand in cool water for about five minutes to try to reduce edema and then applying lubricant such as dishwashing soap or lubricant jelly liberally about and under the ring. It's important to avoid damaging the tissue. If this method is ineffective, then the string wrap method may be tried before cutting the ring with a circular saw, which should be the last resort unless the risk of gangrene is severe.

79.

Following a vasectomy, which comment by the patient indicates a need for education?

"I know that sterility is almost immediate after vasectomy."

"I need to have semen analysis in about 12 weeks."

"Vasectomy does not increase the risk of testicular cancer."

"I should avoid ejaculating for one week."

Explanation:

Following a vasectomy, the comment by the patient that indicates a need for education is "I know that sterility is almost immediate after vasectomy." In fact, sterility can take more than 8 weeks to attain. Patients should have a postvasectomy semen analysis after 8 to 16 weeks (physicians vary in the timeframe). Patients should avoid ejaculation for one week and then should use alternate means of contraception until occlusion of the vas is confirmed through testing.

80.

Which of the following observations may indicate that a patient with cognitive impairment and the inability to verbalize pain is experiencing pain?

Patient is sleeping frequently.

Patient's respiration rate has slowed.

Patient is tense and combative and appears frightened.

Patient's blood pressure and heart rate have decreased.

Explanation:

Patients with cognitive impairment and the inability to verbalize pain may appear tense and frightened and exhibit increased combativeness when they have pain. Respirations may become more rapid and labored. Patients may remain silent and withdrawn or begin to moan or cry out, especially as pain increases. Patients in pain often are very difficult to console or distract. The Pain Assessment IN Advanced Dementia (PAINAD) tool is helpful when assessing pain in patients with cognitive impairment and evaluates breathing, negative vocalization, facial expression, body language, and consolability.

81.

A patient who has been awaiting chemotherapy treatment becomes suddenly very anxious and exhibits rapid pulse, trembling, and diaphoresis. Which response is the most helpful?

"Take deep breaths and relax."

"What were you thinking about right before you started feeling bad?"

"Don't worry. Everything will be fine."

"Try to think of something positive instead of worrying."

Explanation:

The response that is most helpful if a patient who has been awaiting chemotherapy treatment suddenly becomes anxious and exhibits rapid pulse, trembling, and diaphoresis is "What were you thinking about right before you started feeling bad?" This encourages the patient to focus less on the physical reactions and more on feelings and to discuss the source of anxiety. Admonitions to stop worrying are usually not helpful, although some patients may benefit from

deep breathing and relaxation especially if they have practiced the technique as a way to reduce stress.

82.

Patients with gynoid (pear-shaped) obesity have increased risk of

breast cancer.

varicose veins.

heart disease.

diabetes mellitus.

Explanation:

Patients with gynoid (pear-shaped) obesity have increased risk of varicose veins, cellulitis, osteoporosis, and increased triglycerides. However, gynoid obesity poses less of a risk to overall health than android (apple-shaped) obesity, which is implicated in diabetes and heart disease as well as breast and endometrial cancer. With gynoid obesity, most of the excess weight is carried in the upper arms, buttocks, and thighs.

83.

If a patient is very upset because she is nearing her 65th birthday, the type of crisis the patient is likely experiencing is

life transitional.

traumatic.

maturational.

situational.

Explanation:

If a patient is very upset because she is nearing her 65th birthday, the type of crisis the patient is likely experiencing is life transitional. Life transitions are those changes in life that are predictable (graduation from high school, marriage, aging, divorce, moving) but over which the patient may feel a lack of control and may be unsure as to how to deal with the changes brought about by the transition, even if it is ultimately positive.

84.

A patient who has had a stroke with right-sided paralysis has persistent drooling and impaired swallowing. Which type of suctioning is indicated?

Tracheal.

Endotracheal.

Oropharyngeal.

Nasopharyngeal.

Explanation:

Oropharyngeal suctioning is indicated for a patient who has had a stroke with right-sided paralysis and has persistent drooling and impaired swallowing. This type is the least invasive

and uncomfortable for the patient and uses a Yankauer nozzle to suction mucous secretions from the mouth in order to prevent the patient from aspirating them. Patients should be placed in the semi-Fowler's or upright position for suctioning.

85.

If a patient is allowed no weight bearing on the left leg, the most appropriate crutch gait is

two-point.

three-point.

four-point.

swing-through.

Explanation:

If a patient is allowed no weight bearing on the left leg, the most appropriate crutch gait is three-point. With this gait, all of the weight is borne on the crutches at the onset. The uninvolved leg moves forward and then bears all the weight while the person advances both crutches. The left leg is usually maintained in a slightly flexed position, or, if that isn't possible, it is extended slightly in front.

86.

If a patient develops signs of bacterial food poisoning within 30 minutes of eating, the most likely causative agent is

Clostridium perfringens.

Salmonella typhimurium.

Clostridium botulinum.

Staphylococcus aureus.

Explanation:

If a patient develops signs of bacterial food poisoning within 30 minutes of eating, the most likely causative agent is Staphylococcus aureus. Staphylococcus infections occur much more rapidly than other types of food poisoning, although the symptoms may be delayed for up to 7 hours in some patients. Symptoms are usually nausea, vomiting, and diarrhea. Treatment includes supportive care, electrolyte replacement if needed, and antiemetics.

87.

Adults should receive the tetanus, diphtheria, and pertussis (Tdap) vaccination

every 10 years.

one time.

annually.

every 5 years.

Explanation:

Adults should receive the tetanus, diphtheria, and pertussis (Tdap) vaccination one time. Then, every 10 years the patient should have the Td booster, which serves as a booster for tetanus and diphtheria, but not pertussis. Tdap is usually given at age 11 or 12, but adults who did not

receive this vaccination should do so as soon as possible. Women who are pregnant should also receive the Tdap vaccination in order to provide protection from pertussis for the neonate.

88.

Which cultural/ethnic group is likely to experience a condition referred to as "ghost sickness," which may involve having bad dreams or exhibiting abnormal behavior?

Navajo.

Chinese.

Hispanic.

Hmong.

Explanation:

The cultural/ethnic group that is likely to experience a condition referred to as "ghost sickness," which may involve having bad dreams or exhibiting abnormal behavior, is the Navajo as well as a few other tribes. The Navajo believe that ghost sickness is caused by evil spirits and treatment requires overcoming this spirit through a healing ritual. Patients may be terrified and complain of weakness and loss of appetite. Patients often believe that one particular deceased person is causing the problem because the person was not properly buried or cared for after death.

89.

In order to prevent food poisoning, ground beef should be cooked to

125° F.

140° F.

160° F.

180° F.

Explanation:

In order to prevent food poisoning, ground beef should be cooked to 160° F. Ground beef should not be served rare because it is more likely to be contaminated because the grinding process mixes the bacteria throughout the meat whereas solid pieces of meat have surface contamination that is more easily destroyed in cooking. Poultry should also always be cooked well done and to a minimum of 165° F, although many authorities recommend cooking to 180° F.

90.

Peak flow meters are used to measure the

airflow after normal exhalation.

airflow after normal inhalation.

highest airflow during forced inhalation.

highest airflow during forced exhalation.

Explanation:

Peak flow meters measure the highest airflow during forced exhalation. Peak flow is usually monitored for patients with moderate to severe asthma because it can help to determine when

airflow is impaired. Typically, the meters are set for each individual, with a green range that indicates the patient is doing well, a yellow range that indicates airflow has decreased and the patient may need intervention, and a red range that indicates the patient is in an emergent situation and needs immediate medical attention.

91.

Which of the following increases the risk of pulmonary embolus in the postoperative period?

Hypocoagulability.

Age younger than 60.

Prolonged immobilization.

Thyroid disease.

Explanation:

Prolonged immobilization is one of the primary risk factors for the development of pulmonary embolus in the postoperative period because immobilization can lead to deep vein thrombosis (DVT). DVT, in turn, can lead to pulmonary embolus if part of the thrombus formation breaks away and enters the bloodstream. It is for this reason that patients are encouraged to move about in bed and ambulate as soon as possible. Other risk factors include hypercoagulability of the blood, which makes it prone to clot, and older age.

92.

A patient has slipped down in the bed and is in an uncomfortable position. Which of the following nursing actions should be avoided?

Use a slip sheet and an assistant to move the patient.

Sit the patient on the side of the bed and have the patient move up.

Grasp the patient under the arms from the head of the bed and pull.

Instruct the patient on the use of the trapeze to change position.

Explanation:

If a patient has slipped down in the bed and is in an uncomfortable position, the nursing action that should be avoided is to grasp the patient under the arms from the head of the bed and pull. This is not only uncomfortable for the patient and increases the risk of friction damage to the skin but also increases the risk of back injury to the nurse. Various methods can be used to move the patient, including the use of a slip sheet or trapeze.

93.

Which of the following complications is most common with Crohn's disease?

Rectal bleeding.

Fistulas.

Tenesmus.

Toxic megacolon.

Explanation:

Fistulas are a common complication of Crohn's disease. Fistulas may develop between layers of intestines or between intestines and the bladder or the vagina. Crohn's disease is one type of inflammatory bowel disease. Crohn's disease can affect any part of the gastrointestinal system,

although it is most common in the terminal ileum and the colon. Deep ulcerations develop, and scarring can form strictures that result in bowel obstruction. Other common complications include diarrhea, fever, rectal bleeding, and perforation.

94.

Which of the following complementary therapies uses meters and monitors to help patients learn to control bodily functions?

Homeopathy.

Ayurveda.

Acupuncture.

Biofeedback.

Explanation:

The complementary therapy that uses meters and monitors to help patients learn to control bodily functions is biofeedback. Biofeedback involves a number of different techniques, but all methods provide feedback of some type to help the patient gauge the effectiveness of their actions. For example, a patient may concentrate on relaxing and reducing the heart rate while watching a heart rate monitor. Over time, the patient should be able to slow the heart without the feedback. Biofeedback is often used to help control hypertension, pain, and headaches.

95.

If a patient complains that something in the abdominal surgical site "gave way" when coughing, and the dressings are immediately saturated with serosanguineous drainage, then the nurse should suspect

dehiscence.

evisceration.

hemorrhage.

normal response to cough.

Explanation:

If a patient complains that something in the abdominal surgical site "gave way" when coughing and the dressings are immediately saturated with serosanguineous drainage, the nurse should suspect dehiscence. The patient should be positioned in a supine position with the knees slightly flexed to reduce tension on the incision. The wound should be examined to verify the dehiscence and determine its extent, and the physician should be notified. The patient should be reassured and administered pain medication if it is due.

96.

If the nurse is assigned by the supervisor to do a task for which he does not feel prepared, then he should

ask other staff members to help.

attempt to research the task.

tell the supervisor immediately.

refuse to do the task.

Explanation:

If the nurse is assigned by the supervisor to do a task for which he does not feel prepared, then he should tell his supervisor immediately so that the task can be delegated to someone else or he can receive instruction or assistance in carrying out the task. The nurse should never attempt to carry out a task without adequate knowledge and/or experience because this can result in medical errors or injury to the patient.

97.

If a confused patient insists that someone is being tortured when she hears the ambulance siren, the best response is

"No one is being tortured here."

"That noise is an ambulance siren."

"Don't worry; I'll take care of it."

"No one is going to hurt you. You are safe."

Explanation:

If a confused patient insists that someone is being tortured when she hears the ambulance siren, the best response is "That noise is an ambulance siren." The nurse should orient the patient to reality by saying what is true without arguing with the patient ("No one is being tortured here") or playing along with the patient's delusion ("Don't worry; I'll take care of it"). Stating, "No one is going to hurt you. You are safe," does not really address the issue that is confusing the patient—the sound of the siren.

98.

If a patient has an ascending colostomy, the consistency of the stool is usually

solid, firm.

semiliquid to soft.

soft formed.

liquid.

Explanation:

If a patient has an ascending colostomy, the consistency of the stool is usually liquid because most absorption of fluids takes place within the colon. A patient with an ascending colostomy will not need to do colostomy irrigations but will need to continually wear a colostomy appliance, so this may be very stressful for patients, especially in the beginning when they are learning self-management. A number of different types of appliances are available.

99.

For nasopharyngeal suctioning of adults, the catheter should be inserted approximately how far?

6 cm.

10 cm.

16 cm.

20 cm.

Explanation:

For nasopharyngeal suctioning of adults, the catheter should be inserted approximately 16 cm (about 6.5 inches). The nurse should be careful to apply no suction while the catheter is inserted because this may result in damage to the mucous membranes. The catheter should only be inserted on inhalation, and the patient should be cautioned to avoid swallowing, which increases the risk that the tube will enter the esophagus.

100.

If a patient has severe ascites, a paracentesis is usually

done only to relieve severe dyspnea or pain.

done routinely every week or so.

avoided under all circumstances.

done as an elective procedure at the patient's request.

Explanation:

If a patient has severe ascites (most often associated with cirrhosis or liver cancer), a paracentesis is usually done only to relieve severe dyspnea or pain because the fluid rapidly accumulates again, and the procedure may increase the loss of electrolytes. If a patient is to undergo paracentesis, she must empty her bladder first. Ideally, the patient should have the procedure while sitting upright because this facilitates drainage of the fluid.

101.

A patient who has undergone a colectomy for a bowel obstruction is refusing to turn, get out of bed, or cooperate. Which assessment has priority?

Pain.

Wound.

Vital signs.

Emotional status.

Explanation:

A patient who has undergone a colectomy for a bowel obstruction and is refusing to turn, get out of bed, or cooperate should likely be assessed for pain first because the most common reason for failing to move after surgery is pain. Next, the wound should be examined, vital signs taken, and emotional status evaluated. The patient may be fearful that movement will increase pain or cause the wound to tear or open.

102.

If a patient is able to respond but does not recall his son's name or the date and doesn't know where he is, the patient could be described as

confused.

disoriented.

psychotic.

delirious.

Explanation:

If a patient is able to respond but does not recall his son's name or the date and doesn't know where he is, he could be described as disoriented. If the onset of disorientation is sudden, it

may indicate a medical emergency, such as with a head injury, and the patient's vital signs should be recorded and the physician notified. In some cases, disorientation may result from medications. Patients with Alzheimer's disease are often disoriented, especially as the disease progresses.

103.

If the nurse is caring for a patient who is receiving a transfusion of platelets because of severe thrombocytopenia, which of the following observations should be reported immediately?

Bruising at the IV puncture site.

Sleepiness and lethargy.

Slight bloody discharge when blowing nose.

Chills and itching.

Explanation:

If the nurse is caring for a patient who is receiving a transfusion of platelets because of severe thrombocytopenia, the observation that should be reported immediately is chills and itching because these symptoms may indicate a transfusion reaction. Bruising at the IV puncture site is common for those with a low platelet counts as is a slight bloody discharge when blowing the nose. Sleepiness and lethargy are unrelated to the transfusion

104.

Which of the following types of pressure-reducing beds/mattresses may result in increased perspiration and dehydration?

Egg-crate mattress.

Air-suspension bed.

Air-fluidized bed.

Memory foam mattress.

Explanation:

The type of pressure-reducing bed/mattress that can result in increased perspiration and dehydration is the air-fluidized bed. Patients experience evaporative fluid loss because warm air constantly blows across the patient. The operating temperature can be set between 82 and 102° F (usually maintained between 85 and 95° F for most patients). A patient's electrolyte levels should be checked regularly and fluid intake should be monitored when the patient is using the bed. About two-thirds of the patient's body is immersed.

105.

If a patient that the nurse is caring for has had continuous IV therapy for four days and the nurse notes that the IV insertion site in his arm is swollen and the tissue is red and tender with a red streak extending proximally, the most likely reason is

infiltration.

phlebitis.

allergic reaction.

thrombosis.

Explanation:

If a patient that the nurse is caring for has had continuous IV therapy for four days and the nurse notes that the IV insertion site in his arm is swollen and the tissue is red and tender with a red streak extending proximally, the most likely reason is phlebitis. The IV infusion should be discontinued and restarted at a different site. Mild phlebitis will usually clear without specific treatment, although antibiotics may be indicated if purulent discharge is evident.

106.

If a patient has developed a postoperative infection and has a large open wound that must be packed with alginate, the alginate should be

packed to above skin level.

packed in a single layer only.

packed tightly.

packed loosely.

Explanation:

If a patient has developed a postoperative infection and has a large open wound that must be packed with alginate, the alginate should be packed loosely because it absorbs exudate and swells into a gelled form. Alginate is made from brown seaweed and comes in various forms: wafers, rope, or fibers. Alginate can be used with wounds that have undermining and tunneling. Alginates must be covered by a secondary dressing.

107.

A patient who is being discharged states she is happy about going home but appears anxious, is wringing her hands, and is avoiding eye contact. Which response is most therapeutic?

"I'm sure you'll do fine at home."

"I get the feeling that you aren't telling me the truth."

"You say you're happy, but you seem anxious."

"Are you sure you're ok?"

Explanation:

If a patient who is being discharged states she is happy about going home but appears anxious, is wringing her hands (a self-comforting measure), and is avoiding eye contact (which could mean the patient is fearful or being untruthful), the most therapeutic response is "You say you're happy, but you seem anxious." This is an observational statement about what the nurse sees and how the nurse interprets it but does not directly contradict the patient.

108.

When assisting a patient with overactive bladder to extend time between urinations, if the patient usually urinates every hour, the first goal should be to extend this time by

5 minutes.

15 minutes.

30 minutes.

60 minutes.

Explanation:

When assisting a patient with overactive bladder to extend time between urinations, if the patient usually urinates every hour, the first goal should be to extend this time by 15 minutes. The nurse should advise the patient to try to hold urination until the scheduled time but to urinate if in danger of incontinence. The patient should be urged to stop and take deep breaths rather than immediately rushing to the bathroom, which usually increases urgency.

109.

Bariatric beds are intended for

patients who are more than 100 lb. (45 kg) overweight.

patients who are malnourished and cachectic.

patients in need of pressure reduction.

patients taller than 6 feet 5 inches (1.8 m).

Explanation:

Bariatric beds are intended for patients who are more than 100 lb. (45 kg) overweight. The bariatric bed is adjustable so that the patient can be in an upright or sitting position and the bed can be wheeled for transportation. Even though the bed is wider than the normal bed, the standard bariatric bed fits through doorways. However, full or double-wide bariatric beds are available for patients up to 1,000 lb. (450 kg), and these beds must be set up and dismantled inside a room because they cannot fit through doorways.

110.

If a woman tells the nurse that her child has swallowed a poison, the first question should be

“How much poison did the child swallow?”

“When did the child swallow the poison?”

“Did the child vomit after swallowing the poison?”

“What poison did the child swallow?”

Explanation:

If a woman tells the nurse that her child has swallowed a poison, the first question should be “What poison did the child swallow?” This information is the most critical because protocols for treatment vary according to the type of poison. Once this is established, the nurse needs to ask when the incident occurred, how much poison was swallowed, and whether the child vomited because some poisons can cause additional damage if vomited before they are neutralized.

111.

A patient has diabetic ketoacidosis, and her arterial blood gases are

- **pH 7.22.**
- **$PaCO_2$ 41 mm Hg.**
- **HCO_3 15 mEq/L.**

Which one of the following acid-base imbalances do these findings indicate?

Respiratory acidosis.

Respiratory alkalosis.

Metabolic acidosis.

Metabolic alkalosis.

Explanation:

If a patient has diabetic ketoacidosis and her arterial blood gases are pH, 7.22; $PaCO_2$, 41 mm Hg; and HCO_3, 15 mEq/L, the acid-base imbalance indicated is metabolic acidosis. The patient is acidotic because her pH is less than 7.35. The $PaCO_2$ remains within normal limits, so the problem is not respiratory, but the HCO_3 is low at 15 mEq/L (normal 22–26 mEq/L), indicating a metabolic abnormality. The condition is uncompensated because the $PaCO_2$ has not changed to compensate.

112.

If a patient is developing pneumonia, which stage of the disease is likely to occur first?

Resolution.

Dilation of capillaries (red hepatization).

Congestion.

Consolidation (gray hepatization).

Explanation:

If a patient is developing pneumonia, the stage of the disease that is likely to occur first is congestion. During this early stage, the microorganisms have reached the alveoli, which causes fluid to fill the alveoli, providing a medium for the microorganisms to multiply and impairs gas exchange. The next stage is dilation of the capillaries (red hepatization), which causes the lungs to take on a red appearance as organisms, neutrophils, red blood cells, and fibrin fill the alveoli. Consolidation (gray hepatization) occurs as the leukocytes and fibrin fill the alveoli. Resolution is the healing stage when the lung tissue recovers.

113.

In the orientation phase of a therapeutic relationship, the primary role of the nurse is to

guide the patient.

build trust.

establish rules of interaction.

take action.

Explanation:

In the orientation phase of a therapeutic relationship, the primary role of the nurse is to build trust and to begin to help the patient to set goals. This phase begins when the nurse meets the patient for the first time. The patient may be reluctant to admit to the need for help until she feels more comfortable with the nurse, so the nurse may spend some time engaging in nonthreatening conversation to put the patient at ease before beginning to clarify the problems and to outline patient and nurse obligations.

114.

Which of the following wound care products is designed to hydrate a wound?

Hydrogel.

Hydrocolloid.

Alginate.

Transparent film.

Explanation:

The wound care product that is designed to hydrate a wound is hydrogel, which is a glycerin- or water-based product. Hydrogel is applied directly to partial- or full-thickness wounds that are dry or have only a small amount of exudate in order to provide moisture and autolysis. Hydrogel should not be used on third-degree burns or wounds with heavy exudate because it has limited absorbent quality. Hydrogel can cause skin maceration and candidiasis of the periwound area. Some products have adhesive covers, so they can be left in place for two or three days.

115.

Which of the following is the primary problem with narrative documentation?

It is difficult to do.

It is completed too quickly.

It is impersonal.

It is difficult to retrieve data from.

Explanation:

The primary problem with narrative documentation is that it's difficult to retrieve data because important details may be embedded in a long narrative description. The reader may need to read through many days of narratives to determine if patterns are emerging in the patient's condition. Narrative documentation can be quite time consuming and may vary widely in quality. It is often repetitive, with the same information about routine care (such as "mouth care") repeated many times.

116.

When using the PLISSIT assessment of sexuality, the nurse should always begin the assessment by

asking the patient directly about sexual matters.

waiting for the patient to bring up the topic of sexuality.

asking permission to discuss sexual matters.

telling the patient that some people are uncomfortable discussing sexuality.

Explanation:

When using the PLISSIT assessment of sexuality, the nurse should always begin the assessment by asking permission to discuss sexual matters:

- *(P) Permission*
- *(L) (I) Limited information: Related to sexual health problems that the patient is experiencing.*
- *(S) (S) Specific suggestions: May be provided if the nurse is clear about the problem.*
- *(T) Intensive therapy: Referral to the appropriate healthcare professional as indicated.*

117.

Patients with cirrhosis of the liver should be advised that they must maintain abstinence of

caffeinated products.

alcohol.

tobacco products.

fatty foods.

Explanation:

Patients with cirrhosis of the liver should be advised that they must maintain abstinence of alcohol. Patients should also be advised to avoid the use of aspirin or nonsteroidal anti-inflammatory drugs (NSAIDs) because of the increased risk of bleeding. There is no treatment that can reverse cirrhosis, so treatment usually focuses on maintenance and prevention of ascites and includes rest, vitamin B-complex vitamins, a low-sodium diet, and diuretics. Paracentesis may be done to relieve severe dyspnea or pain associated with ascites.

118.

An aide reports to the nurse that a patient with pancreatic cancer is complaining of severe abdominal pain and lying rigidly in bed, but the nurse notes that the patient only has an NSAID ordered for pain. The nurse's first action should be to

administer the NSAID.

request an opioid order from the physician.

assess the patient's pain.

tell the aide to have the patient practice relaxation exercises.

Explanation:

If an aide reports to the nurse that a patient with pancreatic cancer is complaining of severe abdominal pain and lying rigidly in bed and he has only an NSAID ordered for pain, the nurse's first action should be to assess the patient's pain because she should not administer pain

medication based on someone else's assessment. If the patient's pain is severe, then the NSAID may be inadequate, so the nurse may need to contact the physician for a stronger analgesic.

119.

When using charting by exception, which of the following information would need to be documented?

The patient vomited after lunch.

The patient's lungs are clear.

The patient is eating meals well.

The patient's bowels are moving daily.

Explanation:

When using charting by exception, the information that would need to be documented is the following: The patient vomited after lunch. With charting by exception, a baseline is established for the patient, and as long as the patient stays within that baseline (such as having clear lungs, eating well, and having daily bowel movements), then no further notation needs to be done about those matters. However, vomiting is an abnormal finding and would, therefore, need to be documented.

120.

The most malignant form of lung cancer is

adenocarcinoma.

large cell carcinoma.

squamous cell carcinoma.

small cell carcinoma (aka oat cell).

Explanation:

The most malignant form of lung cancer is small cell carcinoma (aka oat cell carcinoma), which causes about 10% to 15% of lung cancers. Small cell carcinoma tends to spread early and quickly and responds poorly to treatment. Almost all cases of small cell carcinoma are associated with cigarette smoking or exposure to environmental carcinogens. Current treatments are usually not curative, and patients may be encouraged to participate in clinical trials in an effort to prolong life.

121.

If an Orthodox Jewish patient who is refusing to use electrical appliances on the Sabbath will not use the call bell or respond to the intercom, the nurse should

tell him that exceptions are made for ill patients.

provide him with a hand bell or alternate means of calling the nurse.

check on him every 15 to 30 minutes.

advise him that he is putting himself at risk.

Explanation:

If an Orthodox Jewish patient who is refusing to use electrical appliances on the Sabbath will not use the call bell or respond to the intercom, the nurse should provide him with a hand bell or alternate means of calling the nurse. The nurse should not try to pressure the patient into changing religious practice and should make an effort to look in on him whenever possible, although every 15 to 30 minutes may not be possible.

122.

The Ambularm monitor should be placed on the patient's leg

just below the knee.

just above the knee.

mid-calf.

just above the ankle.

Explanation:

The Ambularm should be placed on the patient's leg just above the knee. The nurse should measure the mid-calf area to determine the correct cuff size. A small battery is snapped into place on the side of the cuff to activate the alarm. The alarm sounds when the sensor detects a near-vertical position, so patients need to keep their leg in a fairly horizontal position. Patients who are kicking their legs about or extremely restless may not be good candidates for this alarm.

123.

Which of the following should be avoided as a method of control for an older patient who has urge incontinence?

Limiting fluid intake.

Asking if the patient needs to urinate every two hours.

Providing clothing with elasticized waistbands.

Leaving the light on in the bathroom at night.

Explanation:

If an older patient has urge incontinence, limiting fluid intake is a poor strategy because dehydration is common in older adults, and concentrated urine may increase bladder irritability, making incontinence worse. Most adults require about eight glasses of water daily. However, if the patient's fluid intake is adequate, the patient may be discouraged from drinking large amounts of liquids in the evening before retiring because this will likely result in nocturia, increasing the risk of incontinence.

124.

With the tumor, node, and metastasis (TNM) staging system for cancer, a tumor that is staged as T1, N1, and M0 means that the tumor

is localized but cannot be measured.

is nonmalignant.

has spread to distant organs.

has spread to adjacent lymph nodes.

Explanation:

With the TNM staging system for cancer, a tumor that is staged as T1, N1, and M0 means that the tumor is stage 1, so it is localized. N1 means that it has spread to one or more adjacent lymph nodes. M0 means that there is no metastasis. The TNM staging system is useful for a number of different types of cancers. T refers to the primary tumor, N to nodes, and M to metastasis. Numbers indicate the degree of severity from 1 to 4. A zero indicates absence. X indicates that the component cannot be measured or evaluated.

125.

Patients with celiac disease should avoid

milk products.

berries.

gluten.

soy products.

Explanation:

Patients with celiac disease should avoid gluten, which is found in grains such as wheat, rye, oats, and barley. Gluten is also commonly found in many prepared foods, including prepared meats and salad dressings. Even a very small amount of gluten can result in severe diarrhea and steatorrhea. The only adequate treatment for celiac disease is complete elimination of gluten from the diet. Many gluten-free products, including breads and pastries, are now available.

126.

Which of the following ethnic groups is most sensitive to alcohol based on genetic factors?

Caucasians.

Native Americans.

Hispanics.

African-Americans.

Explanation:

Native Americans are especially sensitive to alcohol based on genetic factors. They have faster metabolism of alcohol than other ethnic groups and less tolerance. Rates of fetal alcohol syndrome are highest among Native Americans. About 12% of deaths among Native Americans are attributed to alcohol. Native Americans are about two and a half times more likely to have chronic liver disease than Caucasians because of alcohol intake.

127.

If a patient states, "I tossed and turned all night," an example of paraphrasing to convey understanding is

"What was upsetting you?"

"You seem upset about that."

"I guess you are still sleepy."

"You slept poorly."

Explanation:

If a patient states, "I tossed and turned all night," an example of paraphrasing to convey understanding is "You slept poorly." Paraphrasing restates in simpler words what the patient has stated rather than making any kind of judgment about meaning. When a nurse paraphrases something the patient has said, this is an effective method of conveying to the patient that the nurse is listening to the patient and understanding the patient's message.

128.

The component of blood that is essential for clotting is

platelets.

red blood cells.

white blood cells.

serum.

Explanation:

The component of blood that is essential for clotting is platelets (thrombocytes). Platelets are the smallest component of the blood because they are fragments of a large cell (megakaryocytes) rather than a complete cell like the other blood cells, so platelets have no nucleus. Platelets are produced in the bone marrow and then leave and circulate in the blood. Platelets are disk shaped in their resting state but develop a globular shape with pseudopodia (false feet) so they can adhere to each other when activated to form a clot.

129.

Most absorption of nutrients occurs in the

stomach

duodenum.

jejunum and ileum.

large intestine.

Explanation:

Most absorption of nutrients occurs in the small intestine, in the jejunum and ileum. The digestive process starts in the mouth as saliva and chewing begin to break down the food that then enters the esophagus and travels to the stomach, where the food is further mixed and broken down by the addition of acid and enzymes. This process continues in the duodenum with most absorption of nutrients occurring in the small intestine. Fluid continues to be absorbed in the large intestine.

130.

Which of the following types of anemia may result from exposure to chemicals or toxins?

Pernicious.

Aplastic.

Hemolytic.

Iron deficiency.

Explanation:

Aplastic anemia may result from exposure to chemicals or toxins, which interferes with the bone marrow's ability to produce cells, so it can affect all elements of the blood, including red blood cells. Symptoms depend on the severity and may include weakness, fatigue, dyspnea, headache, pallor, tachycardia, heart failure, ecchymoses, petechiae, hemorrhage, and infection. Treatment focuses on identifying and eliminating the cause and transfusions of necessary blood components. For severe cases, bone marrow transplantation is the treatment of choice.

131.

In the communication process, *channel* refers to

the means of sending and receiving a message.

the message returned by a receiver.

the factors that influence communication.

the setting in which communication occurs.

Explanation:

In the communication process, channel refers to the means of sending and receiving a message through visual, auditory, or tactile senses, and it includes not only the voice but also facial expression. The communication process includes the referent (motivator), the sender, the receiver, the message, the channel, the feedback (return message), interpersonal variables (influencing factors), and the environment (setting for the interaction).

132.

The most important factor in preventing the spread of *Clostridium difficile* infection is

limiting visitors.

isolating infected patients.

providing adequate signage.

handwashing.

Explanation:

The most important factor in preventing the spread of Clostridium difficile infection is handwashing. The pathogens are spread in the feces, most often when the hands of healthcare providers come in contact with contaminated environmental surfaces. Because infection with C. difficile often results in watery diarrhea and may cause incontinence, contamination can easily occur, so washing the hands thoroughly with soap and water is essential because spores might not be killed with alcohol rubs.

133.

Which of the following is the best method to teach a patient to manage colostomy care after discharge?

Discussion.

Lecture.

Demonstration/Return demonstration.

Video instruction.

Explanation:

The best method to teach a patient to manage colostomy care after discharge is to provide a demonstration and have the patient do a return demonstration. Although supportive materials, such as handouts, guidelines, and videos, may help to prepare the patient or reinforce knowledge, knowing and doing are two different things. Because the patient must carry out a process with numerous steps, the practice and demonstration of skills is critical.

134.

A highly inflamed and swollen pustular area that develops around a hair follicle is a

furuncle.

nodule.

cyst.

carbuncle.

Explanation:

A highly inflamed and swollen pustular area that develops around a hair follicle is a furuncle.

Clustered areas of multiple such lesions connected subcutaneously are referred to as carbuncles. Furuncles and carbuncles are typically caused by Staphylococcus aureus (common skin bacteria) or methicillin-resistant S. aureus (MRSA). Furuncles commonly occur on the back of the neck, the breasts, the buttocks, and the face. Furuncles are very painful and usually require incision and drainage to drain the purulent exudate and antibiotics to promote healing.

135.

If there is no private room available for a patient who is on contact precautions, what distance should separate the infected patient from other patients in the room?

>2 feet.

>3 feet.

>5 feet.

>6 feet.

Explanation:

If there is no private room available for a patient who is on contact precautions, a distance of greater than three feet should separate the patient from others.

Contact	*Use personal protective equipment (PPE), including gown and gloves, for all contacts with the patient or patient's immediate environment. Maintain the patient in a private room or >3 feet away from other patients.*
Droplet	*Use a mask while caring for the patient. Maintain the patient in a private room or >3 feet away from other patients with a curtain separating them. Use a patient mask if transporting the patient from one area to another.*
Airborne	*Place the patient in an airborne infection isolation room.* *Use ≥N95 respirators (or masks) while caring for patient.*

136.

Because sickle cell disease is an autosomal recessive disorder, if both parents are carriers, what percent chance does each of their offspring have of inheriting the disease?

25%.

50%.

75%.

100%.

Explanation:

Because sickle cell disease is an autosomal recessive disorder, if both parents are carriers, each of their offspring has a 25% chance of inheriting the disease. Carriers are unaffected by the disease but can pass on the defective gene to offspring.

Both parents have sickle cell trait: AS (A = normal, S = sickle cell)

	A	*S*
A	*AA (normal)*	*AS (carrier)*
S	*AS (carrier)*	*SS (disease)*

If both parents have the disease, then all of their children will also have the disease.

137.

Which of the following is a risk factor for the development of bladder cancer?

High-protein diet.

Alcohol abuse.

Tobacco use.

Use of illicit drugs.

Explanation:

Smoking is the primary risk factor for the development of bladder cancer with smokers having triple the risk of nonsmokers. Some chemicals found in the workplace as well as arsenic in drinking water and some medications also increase the risk of bladder cancer. Caucasians are more likely to develop bladder cancer than African-Americans or Hispanics, and incidence is higher in males than females. Chronic bladder infections may also make changes in the cells, leading to cancer.

138.

The five risk factors that the Norton scale assesses are (1) physical condition, (2) mental state, (3) activity, (4) mobility, and (5)_____:

pain.

nutritional status.

socioeconomic status.

incontinence.

Explanation:

The five risk factors that the Norton scale assesses are (1) physical condition, (2) mental state, (3) activity, (4) mobility, and (5) incontinence. The Norton scale is used to assess the risk of pressure ulcers. Each item is scored on a scale of 1 to 4 with 1 being the highest risk and 4 being a normal finding. The total score can range from 5 to 20 with scores of less than 14 indicating a high risk for pressure ulcers.

139.

A patient who is near death from cancer repeatedly tells the nurse, "I'm going to get better and go home." The most appropriate response is

"That would be wonderful."

"That's not possible."

"You are dying."

"Miracles sometimes happen."

Explanation:

If a patient who is near death from cancer repeatedly tells the nurse, "I'm going to get better and go home," the most appropriate response is "That would be wonderful." This statement is true and noncommittal and does not hold out false hope but allows the patient to hold onto personal hope. While most patients reach the stage of acceptance, some patients hold onto denial until the last possible moment. Other patients feel they must appear positive for family or friends.

140.

Which of the following is a common finding with right-sided heart failure?

Dyspnea on exertion.

Pitting peripheral edema.

Paroxysmal nocturnal dyspnea.

Cough with frothy sputum.

Explanation:

A common finding with right-sided heart failure is pitting peripheral edema of the feet and ankles. Because the right side of the heart, which receives venous blood from general circulation, is impaired, blood tends to back up into the tissues. If failure is severe, the legs, back, and buttocks areas may be edematous as well. Patients may exhibit distended jugular veins and may develop ascites from portal hypertension and hepatomegaly.

141.

When teaching a patient to do pursed-lip breathing exercises, the target inhalation to exhalation time ratio should be

1:1.

1:2.

1:3.

1:4.

Explanation:

When teaching a patient to do pursed-lip breathing exercises, the target inhalation to exhalation time ratio should be 1:3. That is, if inhalation lasts one second, then exhalation should last three seconds. Pursed-lip breathing is a method that helps to rid the lungs of trapped air to improve air exchange. Pursed-lip breathing involves breathing in through the nose and then breathing out slowly through pursed (circled) lips. Pursed-lip breathing is often taught to patients with chronic obstructive pulmonary disease (COPD) along with diaphragmatic breathing.

142.

Which of the following behavioral characteristics most places a patient at a high risk of suicide?

Daily functioning varies from poor to fairly good.

Patient has few close friends.

Patient expresses hostility toward others.

Coping strategies are primarily destructive.

Explanation:

The behavioral characteristic that most places a patient at risk of suicide is when the patient's coping strategies are primarily destructive because the patient has not learned effective means of dealing with stressful situations. For example, patients who cope with stress by engaging in substance abuse are at increased risk because they are trying to ignore problems rather than dealing with them in any constructive manner.

143.

When auscultating the lungs, the nurse hears low-pitched coarse sounds that indicate secretions in the large airways. These types of breath sounds are called

rhonchi.

rales.

wheezes.

friction rubs.

Explanation:

When auscultating the lungs, if the nurse hears low-pitched coarse sounds that indicate secretions in the large airways, these types of breath sounds are called rhonchi. Rales (aka crackles) are fine crackling sounds (similar to the sound of rustling cellophane). Rales are frequently heard at the base of the lungs when fluid begins to accumulate. Wheezes are high-pitched whistling sounds that occur with constriction of the airways. Friction rubs are grating sounds that occur when inflamed pleural tissue rubs together.

144.

When doing chest percussion and vibration to loosen secretions for a young adult with cystic fibrosis, the percussions should be done

at varying speeds.

with the hands flat.

with the hands cupped.

with as much force as possible.

Explanation:

When doing chest percussion and vibration to loosen secretions for a young adult with cystic fibrosis, the percussions should be done with cupped hands to increase vibration. Holding the hand flat can cause pain. A steady rhythm of alternating hands should be maintained while percussing different rib areas of the back and upper chest. Percussion over the spine, sternum, or lower back should be avoided. Vibration is done with the hands flat and application of pressure and shaking.

145.

During hand-off communication, it's important to

review all routine care procedures.

identify the patient's problems.

describe results as "good," "fair," or "bad."

describe all treatments in detail.

Explanation:

During hand-off communication, it's important to identify the patient's problems. Hand-off communication typically occurs at change of shift, during transitions of care, and during transfers. The nurse should provide only essential information, including nursing diagnoses or healthcare problems. The nurse should describe objective measures and observations and any changes in treatment or condition, establishing a clear list of priorities. The nurse should describe patient teaching or instructions as well.

146.

A confused older adult with no identification or information about her living situation is brought to the emergency department (ED) and left sitting alone in the waiting area. This type of elder mistreatment is categorized as

physical abuse.

emotional abuse.