

M_PTQ_ACHPN (300+ Questions) - Quiz Questions with Answers

1.

A patient complains of inability to sleep because of persistent severe restless legs syndrome. Which of the following medications is most indicated?

Pramipexole.

Levo-dopa.

Cabergoline.

Gabapentin.

Explanation:

While various drugs have been used to treat restless legs syndrome, drugs that are FDA-approved for RLS and that are usually well-tolerated are pramipexole (Mirapex®) and Ropinirole (Requip®). The initial dose of pramipexole is usually 0,25 mg PO 2 to 3 hours before bedtime with dosage increased in 4 to 7 days if needed. Levo-dopa sometimes causes worsening of symptoms over time. Cabergoline is associated with severe adverse effects, and gabapentin may provide some relief of mild to moderate RLS but is associated with numerous adverse effects as well.

2.

A 46-year-old male with HIV/AIDS has anorexia and marked weight loss. Which of the following drugs may be indicated to relieve nausea and improve appetite?

Dronabinol.

Haloperidol.

Compazine.

Metoclopramide.

Explanation:

If a 46-year-old male with HIV/AIDS has anorexia and marked weight loss, the drug that is indicated to relieve nausea and improve appetite is dronabinol. The usual initial dosage for adults is 2.5 mg PO before lunch and dinner or 2.5 mg PO in a single dose in the evening. The dosage may be gradually increased to 20 mg daily in divided doses if necessary. Dronabinol is a cannabinoid and is also used to relieve chemotherapy-associated nausea and vomiting.

3.

Which of the following support surfaces used to prevent pressure ulcers has low moisture retention and reduced heat accumulation as well as reduction in shear and pressure?

Powered low air loss surfaces.

Powered alternating pressure air surface.

Non-powered foam surface.

Non-powered air surface.

Explanation:

The support surface used to prevent pressure ulcers that has low moisture retention and reduced heat accumulation as well as reduction in shear and pressure includes the powered low air loss surface and the powered air fluidized surface. However, both of these surfaces are expensive. The low air loss surface is suitable for pressure reduction in the hospital and at home and fits on top of the existing mattress, but the powered air fluidized surface requires a special bed frame that is filled with silicone-coated glass beads through which air is pumped.

4.

Scheduled toileting to control incontinence in palliative care patients should include

asking the patient to delay voiding to scheduled time.

suggesting the patient ignore the urge to urinate as long as possible.

restricting fluids throughout the day to 1000 mL.

asking the patient to attempt to urinate at scheduled intervals.

Explanation:

Scheduled toileting to control incontinence in palliative care patients should include asking the patient to attempt to urinate at scheduled intervals, such as every 2 to 3 hours or after each meal and at bedtime. If possible, it's best to try to approximate the schedule to the patient's usual urination times. The patient should not be expected to restrict fluids throughout the day but may be asked to restrict fluids near bedtime if nocturia is a problem. The patient should not be asked to delay voiding or ignore the urge to urinate.

5.

When describing a pressure ulcer and undermining, the location of the undermining is described according to

quadrant.

clock-face reference.

degrees of a circle.

position—top, bottom, right side, left side.

Explanation:

When describing a pressure ulcer and undermining, the location of the undermining is described according to clock-face reference. For example, a description may be stated as “Undermining of 2 cm width extending from 1 to 3 o’clock.” If the undermining is open to the wound, it may be measured by inserting a sterile swab. If it is not open to the wound, the tissue may feel boggy when palpated. The wound itself should be measured in centimeters at its widest length and width: “6 X 8 cm.”

6.

Which of the following dressing types is most appropriate for a necrotic full-thickness wound with a small amount of exudate?

Dry sterile gauze.

Hydrocolloid.

Alginate.

Hydrogel.

Explanation:

Hydrogel dressings, such as AquaForm®, are most appropriate for a necrotic full-thickness wound with a small amount of exudate. These dressings, which may come in various forms (pates, sheets, strips) are applied directly to the wound and are then covered with a secondary dressing. Hydrogel dressings are effective to provide warmth and moisture to the wound and autolysis to aid in the removal of the necrotic tissue. Hydrogel dressings are not appropriate for wounds with large amounts of exudate.

7.

A caregiver reports that a patient with Alzheimer's tends to get up during the night and has gone out into the street on two occasions and wandered about the neighborhood before being found. The advanced care registered nurse should advise the caregiver to place

the patient in a memory care facility.

restraints on the patient.

latches at the top or bottom of doors.

alarms on the doors.

Explanation:

If a caregiver reports that a patient with Alzheimer's tends to get up during the night and has gone out into the street on two occasions and wandered about the neighborhood before being found, the advanced care registered nurse should advise the caregiver to place latches at the top or bottom of doors as patients with Alzheimer's rarely look for the latches in those areas. Door alarms, especially those that are loud, are often very frightening for patients, and restraints should be avoided.

8.

The advanced practice registered nurse speaks to a state medical commission reviewing nursing practice and outlines the preparation that advanced practice nurses have and their ability to function effectively without physician supervision, urging that advanced practice nurses in the state be allowed more autonomy. In regards to the profession of advanced practice nursing, the APRN is serving primarily in the role of

consultant.

advocate.

advisor.

educator.

Explanation:

If the advanced practice registered nurse speaks to a state medical commission reviewing nursing practice and outlines the preparation that advanced practice nurses have and their ability to function effectively without physician supervision, urging that advanced practice nurses in the state be allowed more autonomy, the APRN is serving primarily in the role of advocate for advanced practice nursing. Advancing opportunities for advanced practice nurses is especially important in areas with a shortage of physicians as the APRN can fill a vital role in providing medical care.

9.

A 56-year-old patient has demonstrated marked changes in personality and behavior and has increasing difficulty using and understanding language. The type of non-Alzheimer dementia that this likely represents is

fronto-temporal dementia.

normal pressure hydrocephalus.

Creutzfeld-Jakob disease.

dementia with Lewy bodies.

Explanation:

If a 56-year-old patient has demonstrated marked changes in personality and behavior and has increasing difficulty using and understanding language, the type of non-Alzheimer dementia that this likely represents is fronto-temporal dementia. Onset of FTD is most common in people who are in their 50s. Patients may develop disinhibited and/or rigid ritualistic behaviors, and some may develop increased interest (sometimes inappropriate) in sex and may crave sweet and/or fatty foods.

10.

A 40-year-old male who has been diagnosed with Huntington's disease exhibits hyperkinetic chorea and frequently grinds his teeth. While the patient had been demonstrating eccentric behavior, the patient now exhibits signs of obsessive-compulsive disorder and depression and has become increasingly sexually aggressive although this behavior remains manageable. On examination, the patient exhibits chorea and tics. While still able to ambulate, the patient's balance is staggering and gait is uneven. Which medication regimen may be most indicated to control symptoms?

tetrabenazine, antidepressant, and mood stabilizer.

memantine, anti-androgen, and benzodiazepine.

levodopa, benzodiazepine, and botulinum toxin.

tetrabenazine, levodopa, and mood stabilizer.

Explanation:

For a patient with Huntington's disease whose symptoms include hyperkinetic chorea, obsessive-compulsive disorder, and depression, the medication regimen that is most indicated include tetrabenazine (FDA approved to treat chorea), antidepressant, and mood stabilizer. Memantine usually shows little results, and levodopa is used to treat hypokinetic rigidity (not chorea). Some patients act sexually inappropriate while others lose interest in sex, but anti-androgens are usually reserved for those who become so sexually aggressive that they place others at risk.

11.

A patient with advanced Parkinson's disease is no longer ambulatory and has increased tremors, muscular rigidity, and dysphagia as well as increased dementia with impaired cognitive ability, executive function, and memory. When instructing the caregiver about patient needs and risks, the risk of most concern is

falls.

aspiration.

pressure ulcer.

constipation.

Explanation:

While falls, pressure ulcers, and constipation are all concerns for patients with advanced Parkinson's disease, the greatest concern is aspiration because the most common cause of death in Parkinson's disease is aspiration pneumonia associated with increasing dysphagia. Unfortunately, there is no satisfactory medical treatment. The patient may benefit from exercises to strengthen the muscles of swallowing and should eat soft foods in small amount and while sitting upright. Thickening liquids may help prevent aspiration.

12.

A patient with a history of alcoholism weighs 70 kg (154 lb.) and, despite chronic heart disease, continues to drink. If the patient is admitted in a stupor with blood alcohol of 140 mg/dL, how long does the advanced practice registered nurse expect it will take to metabolize the alcohol?

3 hours.

5 hours.

7 hours.

9 hours.

Explanation:

If a patient with a history of alcoholism weighs 70 kg (154 lb.) and, despite chronic heart disease, continues to drink, and the patient is admitted in a stupor with blood alcohol of 140 mg/dL, it should take approximately 7 hours (20 mg/dL per hour) to metabolize the alcohol. For a patient weighing 70 kg, one drink (1 ounce liquor, 4 to 6 ounces of wine, or 12 ounces of beer) usually raises the blood alcohol level by about 25 mg/dL (35 mg/dL if the person weighs 50 kg).

13.

Following a stroke, a patient had progressed well but has become increasingly unwilling to carry out exercises or participate in activities of daily living. The patient has not joined in any activities in the unit and increasingly stays in her room with the blinds drawn. These observations are probably an indication of

small strokes.

dementia.

depression.

boredom.

Explanation:

If, following a stroke, a patient had progressed well but has become increasingly unwilling to carry out exercises or participate in activities of daily living, and the patient has not joined in any activities in the unit and increasingly stays in her room with the blinds drawn, these observations may likely be an indication of depression. Depression is common in those with chronic disease, especially if the disease involves disabilities that limit mobility.

14.

A patient with liver disease and long-term alcohol use has been referred to a therapist for motivational enhancement therapy. The patient completes the stages of change (cycle) and remains abstinent for 3 months and then suffers a relapse. According to the MET approach, the response should be to

tell the patient to try a different method.

chastise the patient for relapsing.

advise the patient on what to do to stop drinking.

encourage the patient to begin the cycle again.

Explanation:

If a patient with liver disease and long-term alcohol use has been referred to a therapist for motivational enhancement therapy, completes the stages of change (cycle), remains abstinent for 3 months, and then suffers a relapse, according to the MET approach, the response should

be to encourage (not criticize, label or advise) the patient to start the cycle again. Stages of change:

Pre-contemplation No desire to change behavior.

Contemplation Considers positive and negative aspects of drug/alcohol use.

Determination Decides to change.

Action Modifies behavior over time (2 to 6 months).

Maintenance Remains abstinent.

Relapse Begins cycle again. (Several relapses are common).

15.

A patient who has undergone long-term treatment for schizophrenia with antipsychotic medications has begun exhibiting persistent lip smacking, tongue protrusion, and eye blinking and repeatedly grabs at her hair. The most likely reason for these signs and symptoms is

neuroleptic malignant syndrome.

tardive dyskinesia.

psychotic break.

hallucinations and delusions.

Explanation:

If a patient who has undergone long-term treatment for schizophrenia with antipsychotic medications has begun exhibiting persistent lip smacking, tongue protrusion, and eye blinking

and repeatedly grabs at her hair, the most likely reason for these signs and symptoms is tardive dyskinesia. This chronic syndrome associated with use of antipsychotic drugs most affects older adults. Patients with schizophrenia are also especially at risk because of treatments and substance abuse. In about 50% of patients, even stopping the medication will not relieve the symptoms.

16.

If a patient is diagnosed with class III heart failure, the advanced care registered nurse expects that the patient

experiences discomfort on any exertion and has limitations in most ADLs.

has symptoms even at rest and has limitations in all ADLs.

has symptoms with exertion but none at rest with some limitation on ADLs.

is essentially asymptomatic.

Explanation:

If a patient is diagnosed with class III heart failure, the advanced care registered nurse expects that the patient experiences discomfort of any exertion and has limitations in most ADLs.

Class I Essentially asymptomatic during normal activities with no pulmonary congestion or peripheral hypotension. No restriction on activities, good prognosis.

Class II Symptoms with some physical exertion, usually absent at rest, some limitations of ADLs. Slight pulmonary edema may be evident by basilar rales. Good prognosis.

Class III Obvious limitations of ADLs and discomfort on any exertion, prognosis is fair.

Class
IV *Symptoms at rest, poor prognosis.*

17.

Which of the following is characteristic of peripheral arterial disease?

Brownish discoloration about ankles and anterior tibial area.

Irregular ulcers on medial or lateral malleolus.

Constant severe pain in legs.

Moderate to severe peripheral edema.

Explanation:

Peripheral arterial disease is characterized by pain that may range from intermittent to severe constant pain. Pedal pulses are generally very weak or absent. The foot may be rubor on dependency and pale on elevation, and the skin may be pale, shiny, and cool with hair loss on foot and toes. Nails may be thick and ridged. If ulcers are present, they are often deep, painful, necrotic, and circular and typically occur in toe tips, toe webs, heels, and pressure areas. Edema is usually absent or minimal.

18.

When assessing a patient for perfusion of lower extremities, which of the following venous refill times is consistent with venous occlusion?

>2 to 3 seconds.

>20 seconds.

>30 seconds.

>40 seconds.

Explanation:

When assessing a patient for perfusion of lower extremities, the venous refill time that is consistent with venous occlusion is greater than 20 seconds. To assess venous refill time, the advanced practice registered nurse should direct the patient to lie in supine position for a few minutes and then quickly place the patient in sitting position with the feet dependent. The APRN observes the vessels in the dorsal surface of the foot and counts the seconds until the veins have normal filling.

19.

Which of the following pharmacological interventions is typically indicated to maximize perfusion and prevent clot formation?

antiplatelet agent (aspirin, clopidogrel).

vasodilator (cilostazol).

antilipemic (simvastatin).

hemorheologic (pentoxifylline).

Explanation:

The pharmacological intervention that is typically indicated to maximize perfusion and prevent clot formation is an antiplatelet agent, such as aspirin or clopidogrel (Plavix®). Current recommendations for aspirin preventive therapy include low dose (81 mg) aspirin daily for males ages 45 to 79 and female ages 55 to 79 if potential reduction in myocardial infarcts in females and ischemic strokes in males outweigh risks of gastrointestinal bleeding. Aspirin preventive therapy is not recommended for younger patients or those 80 and older.

20.

The advanced practice registered nurse is assessing cholesterol levels. Which of the following values is of most concern?

LDL cholesterol 98.

HDL 62.

Triglycerides 320.

Total cholesterol 198.

Explanation:

If an advanced practice registered nurse is assessing cholesterol levels, the value that is of most concern is triglycerides, which is elevated and reflects carbohydrate intake.

<100: Optimal

100-129: Near optimal

LDL cholesterol 130-159: Borderline high

160-189: High

≥190: Very high

Total cholesterol <200 Optimal

200-239 Borderline high

	≥ 240	High
HDL cholesterol	< 40	Low
	≥ 60	High (optimal)
Triglycerides	< 150	Normal
	150-199	Borderline-high
	200-499	High
	≥ 500	Very high

21.

The advanced practice registered nurse's prescriptive authority is regulated by the states nurse practice act, which permits the APRN to prescribe controlled substances. In order to do so, the APRN must first apply to

Centers for Medicare and Medicaid Services (CMS).

State Board of Nursing.

Food and Drug Administration (FDA).

Drug Enforcement Agency (DEA).

Explanation:

The advanced practice registered nurse's prescriptive authority is regulated by the state's nurse practice act, so prescriptive authority may vary from one state to another. However, if the prescriptive authority includes prescription of controlled substances, the APRN must apply for Drug Enforcement Agency (DEA) registration. Some states allow the APRN to diagnose and

treat without supervision, but other states require that the APRN work with complete or partial physician supervision.

22.

The advanced practice registered nurse is using the ankle-brachial index to assess peripheral arterial disease in a patient. The patient's ankle systolic pressure is 90 and brachial systolic pressure is 120 for an ABI score of 0.75. This score indicates

normal reading, asymptomatic.

pain, even at rest, limb threatening.

critical limb threatening.

severe disease, ischemia.

Explanation:

Severe disease, ischemia.

ABI scoring

>1.3 *Abnormally high, may indicate calcification of vessel wall.*

1 to 1.1 *Normal reading, asymptomatic.*

<0.95 *Indicates narrowing of one or more leg blood vessels.*

<0.8 *Moderate, often associated with intermittent claudication during exercise.*

≤0.6 to 0.8 *Borderline perfusion.*

0.5 to 0.75 Severe disease, ischemia.

<0.5 Pain, even at rest, limb threatened.

0.25 Critical limb-threatening condition.

23.

If a patient is to following the Senokot S® protocol for cancer-associated constipation, on the first day the patient should take

2 tablets at bedtime.

2 tablets BID.

3 to 4 tablets BID.

2 tabs at bedtime with 8 ounces magnesium citrate.

Explanation:

If a patient is following the Senokot S® protocol for cancer-associated constipation, on the first day the patient should take 2 tablets at bedtime with increasing doses for 3 days if no results:

- 2 tablets BID*
- 3-4 tablets BID or TID.*
- If no BM by the next day, rule out impaction and take bisacodyl 2-3 tablets TID and/or at bedtime. If impacted, resolve. If not impacted, give additional laxatives, such as lactulose (45-60 mL), magnesium citrate (8 oz.), bisacodyl suppository, or Fleet enema.*

If patient has less than one bowel movement per day, the protocol should be stepped up, but if more than 2 per day, the protocol should be stepped back.

24.

If a patient with metastatic breast cancer has informed healthcare providers that she wants a DNR order and no heroic measures to prolong life but the patient's son and daughter insist that all life-prolonging measures be carried out, the best response is to

tell the son and daughter that the patient has a right to make this decision.

arrange a family meeting so that the patient and children can discuss this issue.

tell the son and daughter that they have no legal standing since the patient is alert.

urge the patient to tell her children not to interfere.

Explanation:

If a patient with metastatic breast cancer has informed healthcare providers that she wants a DNR order and no heroic measures to prolong life but the patient's son and daughter insist that all life-prolonging measures be carried out, the best response is to arrange a family meeting so that the patient and children can discuss this issue. Both the patient and her children need to express their reasoning and their feelings about the patient's condition and treatment.

25.

When using the Plan-Do-Check-Act method to solve a problem, a number of possible interventions are considered and one implemented on a trial basis. If during the "check" step of gathering and analyzing data to determine if the trial intervention is effective, the analysis shows that the intervention is not successful, the next step is to

Return to "Do" and pick a different solution to try.

Continue with the intervention and reassess.

Continue to "Act" and determine changes needed for complete implementation.

Return to "Plan" and make a list of new possible solutions.

Explanation:

If one intervention out of many possibilities is implemented to solve a problem and data analysis shows the intervention is not effective, then the best solution is to return to the list of possible solutions and to choose a different one to implement on a trial basis. It should not be necessary to completely begin the process again, and failure should be recognized and dealt with effectively rather than prolonged. Full implementation should not be carried out if results of the trial implementation were negative.

26.

A patient hospitalized with renal disease develops pneumonia. In order to be categorized as "hospital-acquired pneumonia" (HAP), the pneumonia must not be present on admission and must occur

12 hours or more after admission.

24 hours or more after admission.

48 hours or more after admission.

72 hours or more after admission.

Explanation:

If a patient hospitalized with renal disease develops pneumonia, in order to be categorized as 'hospital-acquired pneumonia" (HAP), the pneumonia must not be present on admission and must occur 48 hours or more after admission. If the pneumonia occurs prior to that time, the infection was likely contracted prior to admission. Healthcare-associated pneumonia occurs

within 90 days of hospitalization or 30 days of other contact with healthcare providers, such as for wound care or chemotherapy.

27.

A patient with chronic hypertension is to begin the DASH (dietary approaches to stop hypertension diet). How many ounces of lean meat, poultry, or fish should the person eat daily?

≤6.

≤8

≤10.

≤12.

Explanation:

If a patient with chronic hypertension is beginning the DASH (dietary approaches to stop hypertension diet), the person should eat 6 or fewer ounces of lean meat, poultry, or fish daily. Total fat 27%, Saturated fat 6%, protein 18%, and carbohydrates 55%.

<i>Food group</i>	<i>Daily servings</i>
<i>Grains (whole grains preferred)</i>	<i>6-8</i>
<i>Vegetables and fruits</i>	<i>4-5 each</i>
<i>Fat-free or low-fat milk/milk products</i>	<i>2-3</i>
<i>Lean meat, poultry, fish</i>	<i>≤6 (serving = 1 ounce)</i>
<i>Nuts, seeds, legumes</i>	<i>4-5 per week</i>

Fats and oils

2-3

Sweets and added sugars

≤5 per week

28.

When considering quality control issues, the 3 basic types of failures in an organization are

medicine-based, safety-based, and time-based.

medicine-based, treatment-based, and safety-based.

skill-based, rule-based, and knowledge-based.

skill-based, treatment-based and knowledge-based.

Explanation:

The 3 basic types of failures in an organization are:

- ***Skill-based:*** *Slips occur when the individual has the correct intent but does not carry out an action (such as intended mistakenly using the wrong piece of equipment). Mistakes occur when the individual has an incorrect intention that leads to incorrect action.*
- ***Rules-based:*** *The individual incorrectly applies a rule, applies a bad or wrong rule, or fails to apply the correct rule (injury because of failing to assess safety before assisting a patient).*
- ***Knowledge-based:*** *Knowledge is inadequate for situation.*

29.

A patient hospitalized for renal failure is frightened she may die and upset, and tells the advanced practice registered nurse that her biggest regret is having to give a child up for adoption when she

was young. The APRN should

document this information.

share this information with the physician.

share this information with team members.

keep this information confidential.

Explanation:

If a patient hospitalized for renal failure is frightened she may die and upset and tells the advanced practice registered nurse that her biggest regret is having to give a child up for adoption when she was young, the APRN should keep this information confidential. Patients often divulge information, especially when under stress, that is unrelated to their medical condition and will not affect treatment. In those cases, the information should not be shared although it may be appropriate to share that the patient is upset about personal issues.

30.

When interviewing a patient, the advanced practice registered nurse notes that the patient is tapping his foot, moving his legs, and fidgeting with his clothes. The APRN recognizes that these actions may indicate

anger.

despair.

nervousness.

embarrassment.

Explanation:

If, when interviewing a patient, the advanced practice registered nurse notes that the patient is tapping his foot, moving his legs, and fidgeting with his clothes, the APRN recognizes that these actions may indicate nervousness. Patients may also twist their hair or frequently change position. Some patients may rub their hands together as a comforting measure. The APRN should carefully observe the patient's gestures, posture, eye contact, and distance as these can help to assess how the patient is feeling.

31.

The advanced practice registered nurse must visit a number of different patients, administering medications and treatments. How frequently should the APRN document?

every 1 to 2 hours.

every 2 to 4 hours.

every 4 to 6 hours.

after each administration/treatment.

Explanation:

If the advanced practice registered nurse must visit a number of different patients administering medications and treatments, the APRN should try to document as soon as possible after each administration or treatment to ensure that nothing is forgotten and to avoid the risk of duplicated treatments. Routine care, such as assisting patients to bathe or walk, can be charted every 1 to 2 hours. Documenting should not be done only at the end of the shift.

32.

Which patient characteristic puts a patient at increased risk and may interfere with recovery and/or compliance?

Resiliency.

Vulnerability.

Stability.

Complexity.

Explanation:

The patient that puts a patient at increased risk and may interfere with recovery and/or compliance is vulnerability. Factors that may make the patient more vulnerable include fear, lack of support, chronic illness, anxiety, and lack of adequate information about disease, treatment options, and/or resources. Patients who are homeless, elderly, or mentally ill are also vulnerable. Poverty and lack of adequate insurance are important factors in vulnerability.

33.

If a patient has Broca's aphasia and can understand but cannot produce language, what can the advanced practice registered nurse do to help the patient communicate?

Provide picture charts.

Provide letter boards.

Ask the patient to shake his head for "yes" or "no."

Ask the patient to draw pictures.

Explanation:

If a patient has Broca's aphasia and can understand but cannot produce language, the advanced practice registered nurse can provide the patient with picture charts so that patient can point to what is needed. Pictures may include glasses of water, food, fruit, toilet, shower, linen, clothes. The FACES pain scale may be helpful in allowing the patient to indicate the level of pain. Patients may also understand gestures and may be able to learn some hand signs to indicate needs.

34.

A patient who has had frequent hospitalizations for heart disease develops severe diarrhea associated with *Clostridium difficile* infection. What type(s) of precautions are indicated?

Standard only.

Standard and contact.

Standard and airborne.

Standard, contact, and airborne.

Explanation:

*If a patient who has had frequent hospitalizations for heart disease develops severe diarrhea associated with *Clostridium difficile* infection, both standard and contact precautions should be used for the duration of the disorder because the spores are highly infective and resistant to most disinfectant processes. Careful handwashing with soap and water is essential as well because outbreaks can occur from spores carried on healthcare workers clothes and/or hands.*

35.

If using the ask-tell-ask framework to educate a patient about self-care, the advanced practice registered nurse would begin by

waiting for the patient to ask a question.

providing information and asking the patient to repeat it back.

asking the patient to write down a number of questions.

asking the patient what he/she knows and wants to know.

Explanation:

If using the ask-tell-ask framework to educate a patient about self-care, the advanced practice registered nurse would begin by asking the patient what the patient already knows about the condition and needs and what the patient wants to know. When the patient responds, the APRN tells the patient the information needed or wanted and then asks if the patient still has more questions or needs more information, continuing the cycle of ask-tell-ask.

36.

When conducting a history under Medicare documentation guidelines, which elements must be covered for a problem-focused history?

Chief complaint and history of present illness (1-3 elements).

Chief complaint only.

Chief complaint, history of present illness, and review of symptoms.

Chief complaint, history of present illness, review of symptoms, and pertinent past, family/ and/or social history.

Explanation:

When conducting a history under Medicare documentation guidelines, the elements that must be covered include:

- *Problem-focused:* Chief complaint (CC) and brief history of present illness (HPI) with 1-3 elements.
- *Expanded problem-focused:* CC, brief HPI, and problem pertinent review of systems (ROS).
- *Detailed:* CC, extended HPI (≥ 4 elements), extended ROS, and pertinent past, family and/or social history (PFSH).
- *Comprehensive:* CC, extended HIP, complete ROS, and complete PFSH.

Each type of history has a separate billing code.

37.

The advanced care registered nurse is carrying out a needs assessment to determine what needs in palliative and hospice care are unmet. The first step is to

select data collection methods.

develop tools, such as questionnaires.

identify the population to be assessed.

train data collectors.

Explanation:

If the advanced care registered nurse is carrying out a needs assessment to determine what needs in palliative and hospice care are unmet, the first step is to identify the population to be

assessed. Subsequent steps include:

- Determine the information needed.
- Select data collection methods.
- Develop tools, such as questionnaires or interview questions, and data collection procedures.
- Train data collectors.
- Select a representative sample of the whole aggregate if necessary.
- Conduct the needs assessment.
- Analyze the data and identify needs.

38.

When conducting the history and physical examination of a patient, the advanced practice registered nurse leans forward when the patient is talking and nods the head, occasionally making comments and asking questions for clarification. This is an example of

assertive communication.

passive communication

active listening.

passive listening.

Explanation:

If when conducting the history and physical examination of a patient, the advanced practice registered nurse leans forward when the patient is talking and nods the head, occasionally making comments and asking questions for clarification, this is an example of active listening. As part of active listening, the APRN needs to direct attention to the patient and observe nonverbal behaviors, such as the patient's posture, eye contact, facial expression, and tone of voice.

39.

A stroke patient's family has elected to place the patient, who is no longer able to make decisions, on hospice care. Which 2 criteria must be met?

Palliative Performance Scale (PPS) \leq 40% and evidence of active pulmonary aspiration

PPS \leq 50% and serum albumin $<$ 3.5gm/dL.

PPS \leq 50% and \geq 10% loss of weight in prior 6 months.

PPS \leq 40% and \geq 7.5% loss of weight in prior 6 months.

Explanation:

If a stroke patient's family has elected to place the patient, who is no longer able to make decisions, on hospice care, the 2 criteria that must be met include (1) Palliative Performance Scale (PPS) equal to or less than 40% and (2) poor nutritional status/inability to maintain adequate food and fluid intake as demonstrated by one or more of the following:

- *Loss of 10% or greater amount of weight in the previous 6 months*
- *Loss of 7.5% or greater amount of weight in the previous 3 months.*
- *Serum albumin less than 2.5 gm/dL.*
- *Current evidence of pulmonary aspiration that is not responsive to speech therapy interventions.*

40.

If a hospice patient who is no longer responsive has developed coolness in the extremities, progressing from distal to proximal, this usually means that death will occur within

1 to 2 hours.

2 to 3 hours.

3 to 4 hours.

4 to 5 hours.

Explanation:

If a hospice patient who is no longer responsive has developed coolness in the extremities, progressing from distal to proximal, this usually means that death will occur within 2 to 3 hours. This is an indication that circulation is beginning to shut down and blood is being shunted to the internal organs, and blood pressure and pulse are beginning to decrease. The family should be advised that death is imminent and family members called if they are not present and wish to be.

41.

The most common cause of hiccups in palliative and hospice care patients is

nausea.

respiratory distress.

gastric distention.

constipation.

Explanation:

The most common cause of hiccups in palliative and hospice care patient is gastric distention; therefore, initial treatment often includes simethicone or metoclopramide. Various non-

pharmacological methods, such as breath holding, may provide some relief. Muscle relaxants, such as baclofen, may benefit some patients. If the patient receives no relief from more conservative treatment and the hiccups are causing pain or marked distress, then more aggressive treatments, such as anticonvulsants or antipsychotic drugs, may be tried, but the patient may develop adverse effects, such as drowsiness.

42.

A patient with systemic lupus erythematosus has had some serious complications in the past few years, but recently the patient's disease has been stable; however, the patient has begun to complain of a wide variety of complaints, including poor appetite, headache, backache, insomnia, nausea, sore knee, diarrhea, and constipation. The patient does not appear sad but is more hyperactive than usual for the patient. The advanced practice registered nurse should assess the patient for

infection.

substance abuse.

hypochondria.

depression.

Explanation:

If a patient with systemic lupus erythematosus has had some serious complications in the past few years, but recently the patient's disease has been stable but the patient appears more hyperactive than usual and has begun to complain of a wide variety of complaints, the advanced practice registered nurse should assess the patient for depression. When complaints involve multiple systems and no discernible pattern and the patients exhibits changes in behavior, even though the patient does not appear sad or depressed, the patient may be exhibiting atypical signs of depression.

43.

Which of the following herbal preparations should the advanced practice registered nurse advise a patient to avoid when taking immunosuppressant drugs?

Melatonin.

St. John's wort.

Ginseng.

Curcumin.

Explanation:

The advanced practice registered nurse should advise a patient to avoid taking St. John's wort when taking immunosuppressant drugs. St. John's wort is commonly used to treat depression and anxiety; however, it may interact with many different drugs, so if patients indicate an interest in taking the herbal preparation, the APRN should carefully review the patient's list of drugs. St. John's wort should also not be taken with antibiotics, birth control pills, antidepressants, warfarin, anticonvulsants, MAO inhibitors, antiviral medications, and migraine drugs.

44.

When using music therapy along with relaxation exercises to reduce a patient's anxiety, the best type of music is

orchestral.

new-age.

patient's preference.

opera.

Explanation:

When using music therapy along with relaxation exercises to reduce a patient's anxiety, the best type of music is the patient's preference. An older adult, for example, might find orchestral or classical music soothing while a younger patient may make a very different choice. People may want to listen to music that reflects their ethnic or cultural background. There is no wrong choice although fast and loud music tends to be more stimulating than slower and quieter music.

45.

A COPD patient may need continuous oxygen to relieve dyspnea when the PaO₂ and oxygen saturation reach

PaO₂ ≤50 mm Hg or oxygen saturation ≤85% at rest.

PaO₂ ≤55 mm Hg or oxygen saturation ≤88% at rest.

PaO₂ ≤60 mm Hg or oxygen saturation ≤90% at rest.

PaO₂ ≤65 mm Hg or oxygen saturation ≤92% at rest.

Explanation:

A COPD patient may need continuous oxygen to relieve dyspnea when the PaO₂ and oxygen saturation reach PaO₂ ≤50 mm Hg or oxygen saturation ≤85% at rest. If the patient has other signs and symptoms, such as cor pulmonale, peripheral edema, pulmonary hypertension, or hematocrit greater than 56%, then the patient may need continuous oxygen with PaO₂ up to 59 mm Hg and oxygen saturation to 89%. The critical value for PaO₂ is 40 mm Hg.

46.

The advanced practice registered nurse has completed a history and exam of a palliative care patient and produced a problem list of nursing diagnoses that includes:

- Latex allergy response.
- Deficient fluid volume.
- Spiritual distress.
- Defensive coping.
- Anxiety.

When applying Maslow's Hierarchy of Needs, which order of priority (first to last) should be assigned to each problem?

(1) Deficient fluid volume, (2) latex allergy response, (3) anxiety, (4) defensive coping, (5) spiritual distress.

(1) Anxiety, (2) deficient fluid volume, (3) latex allergy response, (4) spiritual distress, (5) defensive coping.

(1) Latex allergy response, (2) deficient fluid volume, (3) spiritual distress, (4) defensive coping, (5) anxiety.

(1) Deficient fluid volume, (2), anxiety (3), latex allergy response, (4) defensive coping, (5) spiritual distress.

Explanation:

If the advanced practice nurse has completed a history and exam of a palliative care patient and produced a problem list, when applying Maslow's Hierarchy of Needs, the order of priority is:

1 Physiological (Basic life-sustaining needs)

Deficient fluid volume

2 Safety and security (Physiological/Psychological threats) Latex allergy response

3 Love/Belonging (Support, caring, intimacy)

Anxiety

4 Self-esteem (Sense of worth, respect, independence)

Defensive coping

5 Self-actualization

Spiritual distress

47.

A patient who did not seek medical care for years after developing a breast lesion has a large fungating lesion that has enveloped the left breast with copious amounts of foul-smelling drainage. Which of the following may help to relieve the odor?

Hydrogen peroxide.

Dakin's solution.

Metronidazole gel or solution.

Buttermilk.

Explanation:

If a patient who did not seek medical care for years after developing a breast lesion has a large fungating lesion that has enveloped the left breast with copious amounts of foul-smelling drainage, metronidazole in gel or solution form may help to control infection and decrease odor. The lesion may be irrigated with the solution to cleanse it and then metronidazole gel applied and absorbent dressings. Hydrogen peroxide may be irritating to the tissue, and Dakin's solution has a strong odor. People have tried various other things, such as yogurt and buttermilk, but with little effectiveness.

48.

Which of the following diagnoses puts a patient most at risk for the development of anorexia/cachexia syndrome?

COPD.

CHF.

HIV/AIDS.

Cancer.

Explanation:

The diagnosis that puts patients most at risk for the development of anorexia/cachexia syndrome is cancer. While patients with some types of cancer, such as cancers that make swallowing difficult, may derive some benefit from enteral or parenteral feedings, especially if needed for a limited period of time, cancer patients in general show little benefit long-term from these nutritional approaches. Up to 86% of patients with end-stage cancer develop anorexia/cachexia syndrome.

49.

If a hospice patient complains of frequent nausea and vomiting, the advanced practice registered nurse should begin treatment by

assessing the pattern of nausea and vomiting.

reviewing the patient's medication list.

ordering lab work such as CBC and differential and basic metabolic panel.

ordering abdominal imaging, such as CT or MRI.

Explanation:

If a hospice patient complains of frequent nausea and vomiting, the advanced practice registered nurse should begin treatment by assessing the pattern of nausea and vomiting. For example, the APRN should determine if the nausea and vomiting occur at the same times, before or after meals, and before or after medications or activities. The APRN should try to identify triggers, such as brushing the teeth or smelling certain odors. If a cause and effect relationship can be identified, then controlling the nausea and vomiting is easier.

50.

If a patient is to following the Senokot S® protocol for cancer-associated constipation and has not had a bowel movement after the first day, on the second day the patient should take

2 tablets at bedtime.

2 tablets BID.

3 to 4 tablets BID or TID.

2 tabs at bedtime with 8 ounces magnesium citrate.

Explanation:

If a patient is following the Senokot S® protocol for cancer-associated constipation and has not had a bowel movement after the first day, on the second day the patient should take 3-4 tablets BID or TID. If no BM by the next day, rule out impaction and take bisacodyl 2-3 tablets TID and/or at bedtime. If impacted, resolve. If not impacted, give additional laxatives, such as lactulose (45-60 mL), magnesium citrate (8 oz.), bisacodyl suppository, or Fleet enema. If patient has less than one bowel movement per day, the protocol should be stepped up, but if more than 2 per day, the protocol should be stepped back.

51.

A 72-year-old patient with chronic heart disease has blood pressure readings that have stabilized at about 150/94. This is categorized as

normal.

prehypertension.

stage 1 hypertension.

stage 2 hypertension.

Explanation:

A 72-year-old patient with chronic heart disease and blood readings that have stabilized at about 150/94 would be categorized as having stage 1 hypertension.

- *Normal BP: <120/80.*
- *Prehypertension: 120-130/80-89 mm Hg.*
- *Stage 1 hypertension: 140-159/90-99 mm Hg.*
- *Stage 2 hypertension: \geq 160/100.*

Systolic BP over 140 mm Hg poses a greater threat to health than elevated diastolic pressure.

52.

If a male patient has urinary incontinence that is characterized by small leakages of urine, difficulty initiating flow (requiring the patient to strain to urinate), and post-urination dribbling of urine as well as frequency, these signs and symptoms are consistent with

stress incontinence.

overflow incontinence.

urge incontinence.

functional incontinence.

Explanation:

If a male patient has urinary incontinence that is characterized by small leakages of urine, difficulty initiating flow (requiring the patient to strain to urinate), and post-urination dribbling of urine as well as frequency, these signs and symptoms are consistent with overflow incontinence. The incontinence usually results from an over-distended bladder and inability to completely empty the bladder during urination. Overflow incontinence is most common in male patients and often results from prostatic hypertrophy.

53.

A palliative care patient recently suffered a stroke. The patient has regained strength although some residual weakness remains as well as expressive aphasia. Additionally, the patient has some short-term memory loss and exhibits slow cautious behavior. The patient needs repeated instructions to carry out tasks and has difficulty with math. Which part of the brain is likely affected by the stroke?

Left hemisphere.

Right hemisphere.

Brain stem.

Cerebellum.

Explanation:

If a palliative care patient recently suffered a stroke and has regained strength but has residual weakness, expressive aphasia, difficulty with math, and short-term memory loss, and exhibits slow cautious behavior and needs repeated instructions to carry out tasks, the part of the brain

affected by the stroke is the left hemisphere. The weakness is on the right side and the patient may have a right visual field deficit, making it difficult for the patient to judge distance.

54.

An overweight male patient with hypertension and heart disease has been diagnosed as having obstructive sleep apnea by nocturnal polysomnography. Treatment includes use of the CPAP machine. The patient reports to the advanced practice registered nurse that she uses the CPAP machine about 5 nights a week while sleeping but doesn't use it when he takes a one-hour afternoon nap because he sleeps in his recliner with his head slightly elevated. The APRN should tell the patient that

the patient is using the CPAP machine correctly.

the patient should use the CPAP machine if the nap is longer than an hour.

the patient must increase CPAP use to every night.

the patient must use the CPAP machine every night and for all naps.

Explanation:

A patient with hypertension, heart disease, and obstructive sleep apnea should use the CPAP machine whenever sleeping—every night and for all naps. With obstructive sleep apnea, passive collapse of the pharynx occurs during sleep, resulting in apneic periods that may last up to 60 seconds and may occur up to 30 times a night. These apneic periods correspond to bradycardia during apnea and tachycardia when breathing resumes, stressing the heart. Patients often exhibit daytime symptoms that include somnolence, headache, depression, personality changes, and impotence.

55.

A patient with Alzheimer's disease becomes increasingly agitated in the evening and gets in and out of bed at night, wanders about the house, and empties the drawers in her room repeatedly. The

patient is experiencing

hypersomnia.

insomnia.

sundowner's syndrome.

hyperactivity.

Explanation:

If a patient with Alzheimer's disease becomes increasingly agitated in the evening and gets in and out of bed at night and wanders about the house and empties the drawers in her room repeated, the patient is experiencing sundowner's syndrome. This is a common sign of increasing dementia. If the patient takes frequent or long naps during the daytime, then the caregiver should try to reduce daytime sleeping to encourage longer sleep periods at night.

56.

A palliative care patient under treatment for throat cancer is receiving total parenteral nutrition (TPN) because of severe dysphagia. The patient exhibits signs of azotemia with evidence of dehydration (dry mucous membranes, decreased skin turgor) as well as increased BUN and urine specific gravity. Management should include

decreasing amino acids.

increasing dextrose concentration.

increasing lipid intake.

decreasing lipid intake.

Explanation:

Total parenteral nutrition (TPN) is an intravenous hypertonic solution containing glucose, fat emulsion, protein, minerals, and vitamins. If a patient receiving TPN because of severe dysphagia exhibits signs of azotemia with evidence of dehydration (dry mucous membranes, decreased skin turgor) as well as increased BUN and urine specific gravity, management includes decreasing amino acids in the TPN formula or changing to NephrAmine® solution.

57.

A hospice patient has increasing episodes of dyspnea, especially after exertion. The position of comfort that is most likely to reduce the dyspnea is

lying in bed with head of bed elevated to 45°.

sitting upright in chair with arms hanging loosely to the sides.

leaning slightly forward in a chair with arms supported.

leaning back in a recliner chair.

Explanation:

If a hospice patient has increasing episodes of dyspnea, especially after exertion, the position of comfort that is most likely to reduce the dyspnea is sitting in a chair and leaning slightly forward with the arms supported. The patient should be encouraged to take slow even breaths. Relaxation exercises may help the patient to breathe more slowly. A fan directed at the patient's face may help the patient to feel less anxious. Some patients may need oxygen for exertion if dyspnea is severe.

58.

When instructing a patient with chronic constipation in bowel retraining, the advanced practice registered nurse advises the patient that the best time to schedule defecation is usually

upon arising, 20 to 30 minutes before breakfast.

20 to 30 minutes after a meal.

any time that is convenient.

at bedtime.

Explanation:

When instructing a patient with chronic constipation in bowel retraining, the advanced practice registered nurse advised the patient that the best time to schedule defecation is usually 20 to 30 minutes after a meal because eating stimulates the gastrocolic reflex and this propels fecal material through the colon. A stimulus (suppository, enema, digital stimulation, hot drink) may be needed initially to promote defecation but the goal is to decrease such use over time.

59.

Protein-calorie malnutrition (marasmus) is common in patients with chronic illness and is characterized by

sudden weight loss with loss of visceral protein but retention of skeletal muscle mass.

gradual weight loss with loss of visceral protein but retention of skeletal muscle mass.

sudden weight loss with loss of visceral protein and skeletal muscle mass.

gradual weight loss with intact visceral protein but loss of skeletal muscle mass.

Explanation:

Protein-calorie malnutrition (marasmus) results from inadequate intake of both protein and calories and is common in patients with chronic illness and is characterized by gradual weight loss with intact visceral protein but loss of skeletal muscle mass; therefore, patients are often very thin or emaciated in appearance. Symptoms include decreased basal metabolism, lack of subcutaneous fat, tissue turgor, bradycardia, and hypothermia. Protein malnutrition (kwashiorkor) is characterized by rapid loss of visceral protein while skeletal muscle mass is retained, making it more difficult to detect.

60.

If the average person requires about 0.8 g of protein per kilogram daily, how much protein should a person with a wound have each day in order to promote healing?

0.8 g/kg.

1.0 g/kg.

1.25 to 2.0 g/kg.

2.0 to 3.0 g/kg.

Explanation:

If the average person requires about 0.8 g of protein per kilogram daily, a person with a wound should have 1.25 to 2.0 g/kg daily in order to promote healing. Other daily needs needed for healing include:

- *Vitamin A: 1600-2000 retinal equivalents.*
- *Vitamin C: 100-1000 mg.*
- *Zinc: 15-30 mg.*
- *B vitamins: 200% of RDA.*

- Iron: 20-30 mg.

61.

A patient is admitted to the unit with a 7 X 10 cm coccygeal pressure ulcer. On examination, the advanced care registered nurse notes that the exudate is green and a strong foul sweet-smelling odor is present. The most likely infective agent is

Proteus.

Pseudomonas.

Staphylococcus aureus.

Escherichia coli.

Explanation:

If a patient is admitted to the unit with a 7 X 10 cm coccygeal pressure ulcer and, on examination, the advanced care registered nurse notes that the exudate is green and a strong foul sweet-smelling odor is present, the most likely infective agent is pseudomonas. Pseudomonas infections are aggressive and are common in hospitalized patients whose immune systems are depressed. Pseudomonas favors a moist environment. Treatment includes antibiotics although organisms are becoming increasingly resistant to treatment.

62.

An older patient who suffered a fall from a hospital bed, resulting in a head injury and scalp laceration, has a Glasgow Coma Score of 10. This indicates

coma.

severe head injury.

moderate head injury.

mild head injury.

Explanation:

If an older patient who suffered a fall from a hospital bed, resulting in a in a head injury and scalp laceration, has a Glasgow Coma Score of 10, this indicates a moderate head injury. The GCS measures three parameters—best eye response, best verbal response, and best motor response—with a total possible score that ranges from 3 to 15 Scores:

- *3 to 8: Coma.*
- *≤8: Severe head injury.*
- *9 to 12: Moderate head injury.*
- *13 to 15: Mild head injury.*

63.

A patient with cirrhosis of the liver has portal hypertension with ascites. The patient is especially at risk for:

hemorrhage.

heart attack.

stroke.

kidney failure.

Explanation:

If a patient with cirrhosis of the liver has portal hypertension with ascites, the patient is especially at risk for hemorrhage from esophageal varices. Portal hypertension results from obstructed blood flow increasing blood pressure throughout the portal venous system, preventing the liver from filtering blood and causing the development of collateral blood vessels that return unfiltered blood to the systemic circulation. This causes increased serum aldosterone level, which in turn causes sodium and fluid retention in the kidneys, resulting in hypervolemia, ascites, and esophageal varices.

64.

A patient has the following arterial blood gas values:

- pH: 7.26.
- PaCO₂: 57 mm Hg.
- PaO₂: 53 mm Hg
- HCO₃: 22 mEq/L.
- Oxygen saturation: 84%.

What do these ABG results indicate?

Respiratory acidosis.

Respiratory alkalosis.

Metabolic acidosis.

Metabolic alkalosis.

Explanation:

The following blood gas values indicate respiratory acidosis:

- H: 7.26. (Normal value 7.35-7.45).
- PaCO₂: 57 mm Hg. (Normal value 35-45 mm Hg).
- PaO₂: 53 mm Hg (Normal value ≥ 80 mg Hg)
- HCO₃: 22 mEq/L. (Normal value 22-26 mEq/L)

- *Oxygen saturation: 84%. (Normal value $\geq 95\%$.)*

The respiratory acidosis is uncompensated because the HCO_3 value increases with compensation. Respiratory acidosis occurs when ventilation of the alveoli is inadequate and gaseous exchange is impaired, resulting in PaCO_2 levels increasing and PaO_2 levels decreasing.

65.

A 72-year-old female underwent a CABG because of severe chronic coronary artery disease and has been recovering well, but on the second post-operative day the patient has an acute sudden change in consciousness characterized by language disturbance, disorientation, confusion, and visual hallucinations. The signs and symptoms are fluctuating. The most likely cause is

stroke.

dehydration.

electrolyte imbalance.

delirium.

Explanation:

If a 72-year-old female underwent a CABG because of severe chronic coronary artery disease and has been recovering well, but on the second post-operative day the patient has an acute sudden change in consciousness characterized by language disturbance, disorientation, confusion, and visual hallucinations, and the signs and symptoms are fluctuating, the most likely cause is delirium. Up to 40% of older hospitalized patients and 80% of patient with terminal illness develop delirium. Treatment includes trazadone, lorazepam, or haloperidol.

66.

A patient with a history of severe combat injuries, including amputation of the left arm and chronic back pain from shrapnel, also suffers from chronic alcoholism and amphetamine use and has refused substance abuse rehabilitation services. The patient comes to the office with complaints of eye pain. On examination, the advanced practice registered nurse notes that the patient seems confused and is ataxic when ambulating. These signs and symptoms suggest

hallucinosi.

Wernicke's encephalopathy.

Wernicke-Korsakoff syndrome.

ethanol overdose.

Explanation:

If a patient who suffers from chronic alcoholism and amphetamine use has complaints of eye pain and, on examination, the advanced practice registered nurse notes that the patient seems confused and is ataxic when ambulating, these signs and symptoms suggest the triad of symptoms common to Wernicke's encephalopathy. This condition results from brain damage to the thalamus and hypothalamus because of inadequate thiamine (B1). Treatment includes IV fluids and thiamine injections to prevent progression to Wernicke-Korsakoff syndrome.

67.

The advanced practice registered nurse notes that patients never seem to have adequate pain relief when opioids are administered by another nurse, and this same nurse frequently offers to work double shifts and take on extra patients. The APRN should suspect that the nurse is

especially dedicated to seriously ill patients.

making errors when administering drugs.

diverting drugs for personal use.

purposefully withholding drugs from patients.

Explanation:

If the advanced practice registered nurse notes that patients never seem to have adequate pain relief when opioids are administered by another nurse, and this same nurse frequently offers to work double shifts and take on other patients, the APRN should suspect that the nurse is diverting drugs for personal use. The APRN should immediately report the concerns to administration but should not confront the nurse directly or alert the nurse to the concerns.

68.

A patient with peripheral edema and venous ulcers may benefit from an Unna's boot. Which of the following is a contraindication for application of the Unna's boot?

Diabetes mellitus.

Peripheral arterial disease.

Ambulatory status.

Bedbound status.

Explanation:

A contraindication to application of the Unna's boot, which is a compression therapy, is bedbound status because the purpose of the boot is to apply support to the muscles of the calf when the patient ambulates. Unna's boot may be used if the patient has peripheral arterial

disease and/or diabetes. Impregnated gauze (commonly zinc oxide or glycerin) is wrapped around the foot and lower leg and allowed to dry and covered with a self-adherent wrapping.

69.

If the advanced practice registered nurse is working with and supervising the clinical practice of a graduate student preparing to enter the field for a semester of study and providing feedback that helps to determine the student's grade, the APRN is serving in the role of

preceptor.

coach.

mentor.

instructor.

Explanation:

If the advanced practice registered nurse is working with and supervising the clinical practice of a graduate student preparing to enter the field for a semester of study and providing feedback that helps to determine the student's grade, the APRN is serving in the role of preceptor. The APRN should include the student in all APRN activities and help the student to understand his/her role. Preceptoring is usually a time-limited (one semester) arrangement.

70.

Which of the following indicates the need for a patient/family conference?

The patient feels his family are only interested in their inheritance.

The family members have unrealistic expectations of the patient.

The patient has opted to begin hospice care.

The family visits the patient daily and is actively involved in her care.

Explanation:

The following situations indicate the need for a patient/family conference:

- *Family members have unrealistic expectations of patient.*
- *Patient and family have conflicts regarding patient needs or care.*
- *Patient and family are unable to communicate effectively.*
- *Patient and/or family seem confused about patient's condition.*

In some cases, a spiritual adviser may be present during the conference or other team members (such as a nutritionist or occupational therapist), depending on the situation.

71.

A patient has advanced pancreatic cancer that has metastasized to the bowel and liver. When the patient asks if having chemotherapy will prolong her life indefinitely, the healthcare providers agree that this is possible even though the healthcare provider knows that chemotherapy usually only prolongs life a few months. The ethical principle that the healthcare provider has violated is

confidentiality.

nonmaleficence.

veracity.

beneficence.

Explanation:

If patient has advanced pancreatic cancer that has metastasized to the bowel and liver and asks if having chemotherapy will prolong her life indefinitely, the healthcare providers agree that this is possible even though the healthcare provider knows that chemotherapy usually only prolongs life a few months, the ethical principle that the healthcare provider has violated is veracity. The healthcare provider is obligated to not only tell the truth but to avoid making misleading statements or evading the truth.

72.

If a patient is dying, in addition to analgesics, which of the following medications are usually administered as long as possible?

Antihypertensives.

Diuretics.

Hormones.

Antiemetics.

Explanation:

If a patient is dying, in addition to analgesics, medications that are usually administered as long as possible include antipyretics and antiemetics because they help to maintain patient comfort. Medications that are usually discontinued a few days before death include antihypertensives, diuretics, hormones, antibiotics, hypoglycemic agents, antidysrhythmics, and laxatives. Corticosteroids should be tapered rather than abruptly discontinued.

73.

If a patient's family member administers an intentional overdose of a prescription opioid without the physician's knowledge (although the physician ordered the drug) in order to bring about a patient's

death because the patient asks the family member to do so, this would be classified as

euthanasia.

homicide.

suicide.

physician-assisted suicide.

Explanation:

If a patient's family member administers an intentional overdose of a prescription opioid without the physician's knowledge (although the physician ordered the drug) in order to bring about a patient's death because the patient asks the family member to do so, this would be classified as homicide. Despite the best intentions, it is not legal to purposely put a patient to death. In states in which physician-assisted is legal, the patient must follow a legal procedure.

74.

At what stage of clinical competence (Benner) should the advanced practice registered nurse first consider forming a professional development plan?

Novice.

Advanced beginner.

Competent.

Proficient.

Explanation:

The advanced practice registered nurse should first consider forming a professional development plan during the novice stage of clinical competence, which is at the beginning of the APRN's career when the APRN has little experience. The APRN should always have a goal in mind and take steps to maintain currency in knowledge through study, practice, and research. Benner's stages of clinical competence include novice, advanced beginner, competent, proficient, and expert.

75.

The advanced care registered nurse is serving as a consultant to a home health agency regarding palliative care. When asked to carry out a consultation for a patient, the APRN's first step should be to

determine if the visit will be billable.

ask for the referring healthcare provider's assessment of the patient.

arrange for an appointment to visit the patient.

assess the appropriateness of the request.

Explanation:

If the advanced care registered nurse is serving as a consultant to a home health agency regarding palliative care and when asked to carry out a consultation for a patient, the APRN's first step should be to assess the appropriateness of the request, obtaining data to review. Based on data and observation/evaluation, the APRN should make recommendations for interventions and document findings and recommendations. The APRN should obtain feedback regarding the effectiveness of interventions.

76.

A patient with persistent urinary frequency associated with overactive bladder has been treated with oral oxybutynin and tolterodine but both oral medications in regular and extended release forms resulted in severe dry mouth. The advanced practice registered nurse should recommend

increasing fluids.

discontinuing medications.

decreasing dosage.

switching to transdermal patches.

Explanation:

If a patient with persistent urinary frequency associated with overactive bladder has been treated with oral oxybutynin and tolterodine but both oral medications in regular and extended release forms resulted in severe dry mouth, the advanced practice registered nurse should recommend switching to transdermal patches (such as oxybutynin TDS). The transdermal patches usually do not result in dry mouth and provide better bioavailability of the drug although they may cause some local skin irritation.

77.

As a team leader, the advanced practice registered nurse presents a problem to the team and asks members to arrive at a solution although the APRN usually makes the final decision. This type of leadership is classified as

consultative.

democratic.

bureaucratic.

autocratic.

Explanation:

If, as a team leader, the advanced practice registered nurse presents a problem to the team and asks members to arrive at a solution although the APRN usually makes the final decision, this type of leadership is classified as democratic. This democratic approach may, in some cases, delay decision-making because of the need to include others and leave time for discussion, but team members are often more committed to decisions because their opinions have been considered.

78.

A 28-year-old patient with cancer is not able to work and her husband makes minimum wage. The patient has no insurance and requires expensive treatment. Which of the following resources is most appropriate for the patient?

Medicaid.

Free clinic.

Medicare.

Go-Fund-Me campaign.

Explanation:

If a 28-year-old patient is not able to work, her husband makes minimum wage, and the patient has no insurance and requires expensive treatment, the resource that is most appropriate for the patient is Medicaid, a combined federal and state welfare program authorized by Title XIX of

the Social Security Act to assist people with low income with payment for medical care. Each state administers its own Medicaid program, so eligibility criteria and funding may vary.

79.

The 5 key elements of the pain assessment include (1) words, (2) intensity, (3) location, (4) duration, and (5)

method/administration.

aggravating/alleviating factors.

frequency.

quality.

Explanation:

The 5 key elements of pain assessment include:

- *Words: Used to describe pain, such as burning, stabbing, deep, shooting, and sharp. Some may complain of pressure, squeezing, and discomfort rather than pain.*
- *Intensity: Use of 0-10 scale or other appropriate scale to quantify the degree of pain.*
- *Location: Where patient indicates pain is located.*
- *Duration: Constant or comes and goes, breakthrough pain.*
- *Aggravating/alleviating factors: Those things that increase the intensity of pain and those that relieve the pain.*

80.

An 80-year-old patient has developed constant dribbling of urine. The patient is no longer ambulatory and spends most of his time in bed or in a chair. Which of the following options is likely most appropriate?

Indwelling Foley catheter (urethral).

Indwelling Foley catheter (suprapubic).

Adult containment briefs ("adult diapers").

External condom catheter.

Explanation:

If an 80-year-old patient has developed constant dribbling of urine and the patient is no longer ambulatory and spends most of his time in bed or in a chair, the most appropriate option is likely an external condom catheter. Indwelling catheters pose the risk of infection, and may become accidentally pulled out, causing trauma. Adult containment briefs must be changed frequently to avoid skin irritation and may feel uncomfortable to the patient.

81.

A patient has a stage III pressure ulcer. Which of the following is a contraindication for negative pressure wound therapy (NPWT)?

Draining wound.

Post debridement.

Exposed vessels.

Slow-healing wound.

Explanation:

If a patient has a stage III pressure ulcer, a contraindication for treatment with negative pressure wound therapy (NPWT) is exposed vessels because the suction may cause further trauma and bleeding. Other contraindications include malignant wounds and osteomyelitis. NPWT devices provide suction at 75 to 125 pounds of pressure. The dressing is usually removed, wound examined, and dressing reapplied 2 to 3 times weekly. NPWT is used after debridement and is especially effective for wounds with large amounts of exudate and those that are slow healing.

82.

A patient is at risk for venous ulcers because of peripheral venous insufficiency. Which class of compression stocking is most appropriate?

Class I.

Class II.

Class III.

Class IV.

Explanation:

If a patient is at risk for venous ulcers because of peripheral venous insufficiency, the class of compression stocking that is most appropriate is class II. Stocking:

- *Class I: 20 to 30 mm Hg, used to provide support for varicose veins.*
- *Class II: 30 to 40 mm Hg, used to prevent venous ulcers.*
- *Class III: 40 to 50 mm Hg, used for treatment of refractory venous ulcers and to control lymphedema.*
- *Class IV: 50 to 60 mm Hg, used for treatment of severe lymphedema.*

83.

After application of eutectic mixture of local anesthetic (EMLA) cream to the skin prior to placement of an intravenous catheter, the area should be

covered with plastic wrap.

left open to air dry.

covered with an absorbent dressing.

irrigated after 5 minutes to remove residue.

Explanation:

After application of eutectic mixture of local anesthetic (EMLA) cream (lidocaine 2.5% and prilocaine 2.5%) to a wound prior to debridement, the wound should be covered with plastic wrap for at least 60 minutes before the catheter placement to allow time for the tissue to numb. Some patients may develop transient local reactions, such as blanching, erythema, pruritis, and rash. Systemic reactions are rare. A one-gram dosage is 3.8 cm in length and 5 mm in width.

84.

If a patient's treatment has not been covered by Medicare and the patient wants to file an appeal, the first level of appeals is a

hearing.

redetermination.

review.

judicial review.

Explanation:

If a patient's treatment has not been covered by Medicare and the patient wants to file an appeal, the first level of appeals is a redetermination. The five levels of appeals include:

- 1. Redetermination: Claims reviewed by a different Medicare Administrative Contractor (MAC).*
- 2. Reconsideration: Case reconsidered by a Qualified Independent Contractor (QIC).*
- 3. Hearing: Case reviewed at a hearing before an Administrative Law Judge (ALJ)*
- 4. Review: Medicare Appeals Council reviews the case.*
- 5. Judicial review: Case goes to the US District Court.*

85.

An adolescent patient hospitalized for leukemia has been unfailingly cheerful and avoids talking about the disease. The patient is making plans for an upcoming dance at school even though the patient is severely immunocompromised. The defense mechanism that the patient is likely using to help cope is

repression.

sublimation.

denial.

suppression.

Explanation:

If an adolescent patient hospitalized for leukemia has been unfailingly cheerful, avoids talking about the disease, and is making plans for an upcoming dance at school even though the patient is severely immunocompromised, the defense mechanism that the patient is likely using to help cope is suppression.

Suppression Trying to forget

Consciously choosing not to deal with issues.

Repression Forgetting.

Unconsciously failing to recall traumatic incidents/feelings.

Sublimation Redirecting feelings/impulses

Finding a socially-acceptable way to express feelings/impulses.

Denial Refusing to believe

Seeking other opinions, changing doctors.

86.

A 69-year-old patient with severe cognitive impairment has fallen and fractured her elbow. Which if the following pain assessment methods is most appropriate?

PAINAD.

FACES.

1-10 scale.

LANSS.

Explanation:

If a 69-year-old patient with severe cognitive impairment has fallen and fractured her elbow, the pain assessment method that is most appropriate is PAINAD (Pain Assessment in Advanced Dementia). This scale assesses 5 elements: respirations (hyperventilation, tachypnea, Cheyne-Stokes), vocalization (silence, moan, groan, cry), facial expression (sad, frightened, grimacing), body language (tense, fidgeting, fist clinched, fetal position, combative), and consolability (inability to distract or console).

87.

The advanced practice registered nurse is conducting the timed-up-and-go test as part of gait assessment of a patient. The patient is able to stand from a chair with armrests, walk 3 meters, and turn and sit down. Which of the following times required to carry out these activities first indicates an increased risk for falls?

7 seconds.

10 seconds.

14 seconds.

16 seconds.

Explanation:

If the advanced practice registered nurse is conducting the timed-up-and-go test as part of gait assessment of a patient and the patient is able to stand from a chair with armrests, walk 3 meters, and turn and sit down, the time that indicates a risk for falls is equal to or greater than 14 seconds. The normal time needed to carry out the activities ranges from 7 to 10 seconds. Gait speed is also a consideration with gait speed of less than 0.6 m/second when walking 5 meters predicting limitations in mobility.

88.

According to staging of tissue damage resulting from radiation, if the area is painful because of exposed nerves and the skin is moist and blistering with epidermal tissue having sloughed off and serous drainage is present, the damage would be classified as

stage I.

stage II.

stage III.

stage IV.

Explanation:

Stage III. Skin damage from radiation is common but usually begins to heal after radiation is completed and usually completes healing within 3 months.

Stage I Slight edema, inflammation, erythema, itching, burning, or pain.

Stage II Dry, itching, and scaly skin, and epidermis beginning to slough.

Stage III Moist, blistering skin, epidermis sloughed off, serous drainage, and increased pain (exposed nerves).

Stage IV Permanent hair loss, atrophy, pigment changes, and ulcerations.

89.

A male patient is being admitted for advanced cirrhosis of the liver and is hostile and angry, lashing out verbally at caregivers and refusing to cooperate. The best approach when conducting the history and physical exam is to

ask the patient to lower the voice and cooperate.

tell the patient that he cannot receive care unless he cooperates.

ask security personnel to stand by during the examination.

remain calm and patient, responding to the patient as appropriate.

Explanation:

If a male patient is being admitted for advanced cirrhosis of the liver and is hostile and angry, lashing out verbally at caregivers and refusing to cooperate, the best approach when conducting the history and physical exam is to remain calm and patient, responding to the patient as appropriate. Cirrhosis is often associated with some degree of confusion, and the patient may be frightened and anxious, so speaking calmly and remaining empathetic and supportive is important.

90.

The advanced practice registered nurse has begun to overly identify with the pain and suffering of patients and frequently finds that concerns about patients are interfering with personal life. The APRN often skips lunch and breaks in order to spend more time with patients and is beginning to have nightmares and trouble concentrating. The APRN is likely experiencing

depression.

compassion fatigue.

anxiety.

empathy.

Explanation:

If the advanced practice registered nurse has begun to overly identify with the pain and suffering of patients and frequently finds that concerns about patients are interfering with personal life, and the APRN often skips lunch and breaks in order to spend more time with

patients and is beginning to have nightmares and trouble concentrating, the APRN is likely experiencing compassion fatigue. The APRN may need to take a break from work and participate in a stress management program.

91.

If a patient with chronic bowel disease has developed persistent diarrhea, the treatment most indicated to control the diarrhea is

loperamide.

codeine.

diphenoxylate.

methylcellulose.

Explanation:

If a patient with chronic bowel disease has developed persistent diarrhea, the treatment most indicated to control the diarrhea is loperamide, which is indicated for nonspecific diarrhea but should be avoided if the patient has grossly bloody stool or temperature above 38° C (101° F) or if infection with *C. difficile* or *Shigella* is suspected. Loperamide is usually given at 4 mg initially followed by 2 mg after each loose stool to a total of 16 mg per day.

92.

When utilizing the SPIRIT (Maugen) mnemonic (Spirit, Personal, Integration, Ritual, Implication, and Terminal events) as a spiritual assessment tool for a patient in hospice care, the first question to ask for the “S” or “spirit” part of the assessment is

“Does spirituality play a part in your personal life?”

“Are there any restriction in your religious convictions that affect your healthcare decisions?”

“How does your faith affect how you feel about death?”

“Do you have a formal religious affiliation?”

Explanation:

The SPIRIT mnemonic (Maugen):

S Spiritual *Formal religious affiliation?*

P Personal *Practices and beliefs? Spirituality in daily life?*

I Integration *Participation in a spiritual community and receive support?*

R Ritual *Specific practices and restrictions that affect healthcare choices?*

I Implication *Aspects of your spirituatlity you would like caregivers to keep in mind during care?*

T Terminal events *Faith affects decisions or feelings about death?*

93.

An obese patient with diabetes mellitus who underwent surgery for bowel obstruction 6 days previously and has had persistent abdominal distention and episodes of nausea and vomiting indicates a desire for palliative care. The patient complains of feeling a “popping” sensation at the incision site, and the advanced practice registered nurse notes a large amount of serosanguinous drainage on the dressing and separation at the center of the incision line with beginning intestinal evisceration. The initial response should be to

administer an opioid and keep patient comfortable with no further intervention.

place patient in semi-Fowler's position with knees elevated and notify surgeon.

explain to the patient what is happening and ask for guidance.

place the patient in supine position and cover the wound with dry sterile gauze.

Explanation:

If a patient who has indicated a desire for palliative care complains of feeling a "popping" sensation at an abdominal incision site, and the advanced practice registered nurse notes a large amount of serosanguinous drainage on the dressing and separation at the center of the incision line with beginning intestinal evisceration, the initial response should be to place the patient in semi-Fowler's position, notify the surgeon, cover the wound with sterile saline soaked gauze, start an IV line, and administer oxygen. Palliative care does not preclude responding to emergent changes in condition.

94.

A 76-year-old female patient who has generally been in good health has suffered a pathological fracture of the proximal femur. The patient states it occurred while walking, resulting in a fall. The most likely cause is

abuse.

multiple myeloma.

osteoporosis.

bone cyst.

Explanation:

If a 76-year-old female patient who has generally been in good health has suffered a pathological fracture of the proximal femur while walking, resulting in a fall, the most likely cause is osteoporosis. All women age 65 and older should be routinely screened for osteoporosis. Bone loss often exceeds 35% before the patient experiences symptoms. The DEXA scan is the imaging method of choice with results expressed as T scores. A T score of minus 2 (-2) is diagnostic of osteoporosis and indicates bone mass is 20% less than normal.

95.

When collaborating with a patient and family in developing the plan of care, it's important for the patient and family to understand

their rights and responsibilities.

their limitations.

the organization's philosophy.

the difference between goals and objectives.

Explanation:

When collaborating with a patient and family in developing the plan of care, it's important for the patient and family to understand their rights and responsibilities. The advanced practice registered nurse should ask them what their goals and expectation are and what is most important to them. The APRN may ask the patient and family members to separately list those things that are important to them and then compare and discuss the lists because they may not always be in agreement.

96.

A Native American patient has stage IV multiple myeloma and is under hospice care in an extended care facility. A staff nurse tells the advanced care registered nurse that, despite the diagnosis, the patient seems to have little pain. The patient does not complain or request pain medication although the patient has been lying in fetal position and refusing most food and drink. The advanced care registered nurse should advise the staff nurse that

the patient is probably comfortable without pain medication.

the patient may avoid outward expressions of pain.

the staff nurse should be more aware of patient needs.

the patient probably prefers to suffer rather than take pain medication.

Explanation:

If a Native American patient has stage IV multiple myeloma and is under hospice care in an extended care facility and a staff nurse tells the advanced care registered nurse that, despite the diagnosis, the patient seems to have little pain; and the patient does not complain or request pain medication although the patient has been lying in fetal position and refusing most food and drink, the advanced care registered nurse should advise the staff nurse that Native Americans often avoid an outward expression of pain. However, the patient's body language indicates discomfort.

97.

A Middle Eastern hospice patient is being cared for in the home by the patient's sisters and daughters. During a home visit, the advanced care registered nurse notes that the patient has rows of circular slightly reddened areas up and down the back. The most appropriate response is to

notify adult protective services of physical abuse.

tell the family that hospice patients cannot receive cupping.

acknowledge the use of cupping on the patient.

provide supportive care for pressure sores.

Explanation:

If a Middle Eastern hospice patient is being care for in the home by the patient's sisters and daughters and during a home visit the advanced care registered nurse notes that the patient has rows of circular slightly reddened areas up and down the back, the most appropriate response is to acknowledge the use of cupping on the patient. Cupping is an ancient form of healing believed to rid the body of toxins and poses little danger to the patient if done correctly.

98.

A patient with progressive onset multiple sclerosis has chronic bladder dysfunction with bladder spasms, urgency, frequency, and stress incontinence. The patient takes extended release oxybutynin, which helps to reduce symptoms but not completely eliminate them. Which dietary/substance restrictions should the advanced practice registered nurse advise?

Simple carbohydrates (sugar, white bread).

Citrus fruits.

Apples and apple juice.

Caffeine and alcohol.

Explanation:

If a patient with multiple sclerosis has chronic bladder dysfunction with bladder spasms, urgency, frequency, and stress incontinence and takes extended release oxybutynin, which helps to reduce symptoms but not completely eliminate them, the patient should be advised to avoid caffeine and alcohol because they are bladder irritants and also promote diuresis. The patient should drink adequate water during the day but limit intake in the evening in order to decrease nocturia.

99.

A COPD patient on corticosteroids has friable skin and has developed a skin tear with complete loss of tissue. This would be categorized according to the International Skin Tear Advisory Panel (ISTAP) Skin Tear Classification as

type 1.

type 2.

type 3.

type 4.

Explanation:

If a COPD patient on corticosteroids has friable skin and has developed a skin tear with complete loss of tissue, this would be categorized according to the International Skin Tear Advisory Panel (ISTAP) Skin Tear Classification as type 3:

- *Type 1: Linear tear with skin flap that can be positioned to cover the open area.*
- *Type 2: Tear with partial loss of flap leaving some tissue exposed.*
- *Type 3: Tear with complete loss of flap leaving the entire wound surface exposed.*

Preventive methods include wearing long sleeves to protect the arms and applying emollients to skin.

100.

A family reports that the patient who raised Catholic has not attended Mass for 50 years. The patient is nearing death but remains responsive and has not requested a priest. The advanced care registered nurse should

assume the patient will not want to see a priest.

ask the priest on call to visit the patient.

ask the patient if he or she wants to see a priest.

ask the family if a priest should be called.

Explanation:

If a patient was raised Catholic but has not attended Mass for 50 years and is nearing death but remains responsive, the advanced care registered nurse should ask the patient directly if the patient wants to see a priest. Even lapsed Catholics who have not been active in the church may obtain spiritual comfort from the sacraments commonly referred to as last rites. The advanced care registered nurse should never make assumptions about a patient's spirituality.

101.

When educating a patient or family about disease and treatment, the first step is to begin by assessing the patient's

emotional status.

knowledge base.

experience.

physical condition.

Explanation:

When educating a patient or family about disease and treatment, the first step is to begin by assessing the patient's knowledge base and health literacy. Informed patients may already have a good understanding and may understand basic medical terminology while others may have little or no knowledge of health matters and may require much more intensive education geared toward their levels of literacy. The initial question may be, "Can you tell me what you know about your illness?"

102.

Indications that the spouse of a patient who died is suffering from traumatic grief include prolonged period (≥ 60 days) of

expressing anger, bitterness, and blame regarding the death.

decrying negative habits of deceased (smoking, drinking).

focusing on occupational role.

talking frequently about the deceased.

Explanation:

Indications that the spouse of a patient who died is suffering from traumatic grief include prolonged period (at least 60 days) of expressing anger, bitterness and blame regarding the death. Other indications include avoiding talking about the deceased, avoiding social and occupational roles, showing signs of depressing, assuming some of the negative behaviors of

the deceased (such as smoking and drinking), feeling and acting numb and dazed, and showing signs of impaired functioning (cluttered home, careless dress, poor hygiene).

103.

A family member is concerned about the “death rattle” exhibited by a patient. When discussing administration of antimuscarinic agents, such as glycopyrrolate, what possible adverse effects should the advanced practice registered nurse consider?

Increased sedation, delirium, xerostomia.

Prolonged suffering, inability to communicate.

Insomnia, depression, anxiety.

Excessive sedation, respiratory depression, and itching.

Explanation:

If a family member is concerned about the “death rattle” exhibited by a patient, when discussing administration of antimuscarinic agents, such as glycopyrrolate (which can help to reduce the death rattle by drying up secretions), the possible adverse effects the advanced practice registered nurse should consider include xerostomia, increased sedation, and increased delirium. The nurse must balance these concerns against the stress the rattle may cause family members.

104.

When conducting a review of the literature as part of evidence-based research, the level of evidence that is based on a quasi-experimental study, such as a matched case-control study, would be categorized as

Level I.

Level II.

Level III.

Level IV.

Explanation:

When conducting a review of the literature as part of evidence-based research, the level of evidence based on a quasi-experimental study, such as a matched case-control study, would be categorized as level III:

- *Level I: Meta-analysis, randomized controlled studies.*
- *Level II: One or more well-designed study, may or not be randomized.*
- *Level III: As above.*
- *Level IV: Comparative non-experimental studies.*
- *Level V: Case reports and clinical examples but without empirical evidence.*

105.

A patient has osteomyelitis and an open draining wound in the proximal anterior thigh with copious amounts of purulent drainage. The wound has been requiring dressing changes 4 to 5 times a day. The most effective method of managing the wound care is

apply alginate packing.

apply a pouch (such as Hollister® Wound Manager).

utilize negative pressure wound therapy.

applying absorptive dressings with cellulose fibers.

Explanation:

If a patient has osteomyelitis and an opening draining wound in the proximal anterior thigh with copious amounts of purulent drainage requiring dressing changes 4 to 5 times daily, the most effective method of managing the wound care is to apply a pouch, such as the Hollister® Wound Manager. A skin barrier is applied around the wound and the bag is attached and has a drain that can be opened. The pouch is usually changed about every 4 to 7 days.

106.

A female patient who has undergone surgery, radiotherapy, and chemotherapy for breast cancer has lost her hair but states she cannot afford to buy a wig. Which organization can the advanced care registered nurse refer the patient to for financial assistance for a hair replacement wig?

Songs of Love Foundation.

Association of Cancer Online Resources.

CancerCare.

American Cancer Society.

Explanation:

If a female patient who has undergone surgery, radiotherapy, and chemotherapy for breast cancer has lost her hair but states she cannot afford to buy a wig, the organization that the advanced care registered nurse can refer the patient to for financial assistance for a hair replacement is the American Cancer Society. ACS also provides financial assistance for durable medical equipment and transportation costs. The “Look Good, Feel Better” program provides assistance with techniques to minimize physical changes caused by treatment.

107.

According to the American Geriatrics Society Guideline for the Prevention of Falls in Older Persons, if a patient has had one fall in the previous year

the patient should be assessed for gait and balance.

no further assessment is needed.

a full assessment, including vision, joint function, mental status, and neurological status, should be carried out.

the patient should be referred to a geriatric specialist.

Explanation:

According to the American Geriatrics Society Guideline for the Prevention of Falls in Older Persons, if a patient has had one fall in the previous year, the patient should be assessed for gait and balance, including the get-up-and-go test. If the patient is steady, no further assessment is needed. If the patient demonstrates unsteadiness, further assessment to determine the cause is necessary. With multiple falls, a full assessment including history, vision, joint function, mental status, muscle strength, reflexes, neurological status, and cardiovascular status, should be carried out.

108.

If a patient receiving abdominal radiation has 7 to 9 loose stools daily with severe cramping and some incontinence, according to the National Cancer Institute Scale of Severity of Diarrhea, the patient's score would be

1.

2.

3.

4.

Explanation:

If a patient receiving abdominal radiation has 7 to 9 loose stools daily with severe cramping and some incontinence, according to the National Cancer Institute Scale of Severity of Diarrhea, the patient's score would be 3. Scale:

Score #of stools above normal Description

<i>0</i>	<i>Normal stools</i>	<i>--</i>
<i>1</i>	<i>2 to 3</i>	<i>No other symptoms</i>
<i>2</i>	<i>4 to 6</i>	<i>Nocturnal stools and/or abdominal cramping</i>
<i>3</i>	<i>7 to 9</i>	<i>Severe cramping and some incontinence</i>
<i>4</i>	<i>10 or more</i>	<i>Grossly bloody stools and/or need for parenteral support</i>

109.

A palliative care patient with multiple sclerosis is increasingly immobile and spends most of the time in bed. Which of the following scores (range 6 to 23) on the Braden Scale is the breakpoint for risk of pressure ulcer?

≤8.

≤12.

≤16.

≤18.

Explanation:

If a palliative care patient with multiple sclerosis is increasingly immobile and spends most of the time in bed. The score on the Braden Scale that is the breakpoint for risk of pressure ulcer is equal to or less than 16. The Braden Scale scores 5 areas with 1 to 4 points: sensory perception, moisture, activity, mobility, and usual nutrition pattern. The 6th area, friction and shear, is scored with 1 to 3 points. A score of 23 indicates minimal risk and 6 indicates a strong likelihood of developing pressure ulcers.

110.

According to the American Pain Society's guideline for the use of chronic opioid therapy for chronic non-cancer pain, the factor that most indicates a risk of drug abuse or misuse after beginning chronic opioid therapy is

severe pain.

older age

preexisting cognitive impairment.

personal/family history of substance abuse.

Explanation:

According to the American Pain Society's guideline for the use of chronic opioid therapy for chronic non-cancer pain, the factor that most indicates a risk of drug abuse or misuse after beginning chronic opioid therapy is personal/family history of substance abuse. Patients with this history should be educated thoroughly about risks and monitored carefully. Other risk factors for abuse or misuse include a younger age and psychiatric comorbidity.

111.

A 68-year-old patient has appeared depressed, so the advance practice registered nurse assesses the patient with the Geriatric Depression Scale, which comprises 15 questions. How many "yes" answers are needed to indicate depression?

4.

6.

8.

12.

Explanation:

If a 68-year-old patient has appeared depressed, so the advance practice registered nurse assesses the patient with the Geriatric Depression Scale, which comprises 15 questions, 6 "yes" answers indicate depression. The Geriatric Depression Scale is a self-assessment tool to identify older adults with depression. The test can be used with those with normal cognition and those with mild to moderate impairment. Patients answer "yes" or "no" to the questions.

112.

When conducting the history and physical exam of a military veteran who served in the Vietnam conflict, which of the following is a concern that applies primarily to only this population of veterans?

PTSD.

Shrapnel injuries.

Substance abuse.

Agent orange-associated illnesses.

Explanation:

Agent orange-associated illnesses primarily affect veterans who served in the Vietnam conflict between 1961 and 1971, when the defoliant was used against combatants, exposing both the Vietnamese and American soldiers to potent pesticides (including dioxin) that may cause ongoing health problems. Agent-orange has been found to have teratogenic effects and to cause a number of different types of cancer, including leukemia and Hodgkin's lymphoma. Other associated diseases include diabetes mellitus, type 2, ischemic heart disease, Parkinson's disease, and peripheral neuropathy.

113.

If a dying patient tells the nurse that she has been seeing her mother, who has been deceased for many years, the most appropriate response is

"Does seeing your mother comfort or frighten you?"

"You are just dreaming."

"I'm sure your mother is watching over you."

"It's probably because of the medicine."

Explanation:

If a dying patient tells the nurse that she has been seeing her mother, who has been deceased for many years, the most appropriate response is: "Does seeing your mother comfort or frighten you?" Patients who are dying often report visits from loved ones who are deceased or from spiritual figures, such as angels or devils. The advanced practice registered nurse should neither challenge or support these perceptions but should encourage the patient to discuss feelings about them if the patient is still able to verbalize.

114.

Which of the following unique needs may need to be addressed in the plan of care for homeless patients?

Fall and dysphagia precautions.

PTSD interventions.

Lice and malnutrition.

Drug-seeking behaviors.

Explanation:

While homeless patients may face many of the same needs as other patients, the homeless are most likely to suffer from lice and malnutrition because of lack of access to adequate nutritional food and to bathing facilities. Homeless often share sleeping areas with others, so lice spread easily from person to person. Many homeless suffer from mental illness (such as schizophrenia) and are substance abusers, so general health may be very poor.

115.

A patient who completed a course of mantle radiation therapy for Hodgkin's disease 20 years previously has developed increasing weakness and shortness of breath on exertion. Because of the patient's previous radiation therapy, the patient is especially at risk of

pancreatic cancer.

breast and lung cancer.

liver cancer.

colon and rectal cancer.

Explanation:

If a patient who completed a course of mantle radiation therapy for Hodgkin's disease 20 years previously has developed increasing weakness and shortness of breath on exertion, because of the patient's previous radiation therapy, the patient is especially at risk of breast and lung cancer. Patients treated for Hodgkin's disease have a 17% risk of developing another malignancy, including an increased risk of leukemia, with onset often within 4 years.

116.

The advance practice registered nurse has taken an active role in developing a support group for patients with Parkinson's disease to help them cope with their disease and delay progression. The group meets weekly at a local community center, and the APRN serves as the group facilitator. This type of preventive program is classified as

primary.

secondary.

tertiary.

quaternary.

Explanation:

Support groups, such as one for patients with Parkinson's disease, are classified as tertiary prevention programs:

- *Primary: Aims to prevent disease occurrence and may include educational campaigns (no smoking, seatbelts), vaccinations.*
- *Secondary: Aims to identify and reduce impact (screening mammograms, BP checks).*
- *Tertiary: Aims to prevent/delay disease progression (support programs). This is of primary importance in maintenance with palliative care/hospice patients.*

117.

A 17-year-old patient with AIDS and pneumonia is medically unstable and his parents have broached the subject of end-of-life decisions with him; however, the patient has steadfastly refused to discuss the issue, becoming quite agitated and stating that he is not going to "commit suicide." The parents are unsure how to respond. The APRN advises the parents to

remain supportive and wait for the patient's readiness to discuss end-of-life.

explain the difference between end-of-life decisions and suicide.

urge the patient to participate in some decision-making.

tell the patient that they will make the decisions for him.

Explanation:

Adolescents may be confused and indecisive about matters relating to end-of-life care; and some may, in fact, view end-of-life decisions as planning for suicide. The adolescent patient has been given an opening to discuss end-of-life care but has refused to do so and should not be forced to make decisions before the patient is emotionally ready. Decision-making can be especially difficult if a patient's condition is unstable because the patient may be experiencing a real fear that death is imminent. The parents should remain supportive and wait for the patient's readiness to discuss end-of-life.

118.

A 15-year-old patient with leukemia tells the APRN that she wants to fill out a living will so that her parents will not have to make decisions about her end-of-life care by themselves. A document that is appropriate for adolescent patients is

Five Wishes®.

Voicing My Choices®.

My Wishes®.

Willmaker Plus®.

Explanation:

If a 15-year-old patient with leukemia want to fill out a living will, a document that is appropriate for adolescent patients is Voicing My Choices®. The booklet allows the patient to indicate how the patient would like to be comforted and supported and who is to make medical decisions as well as the type of life support the patient wants. Additionally, there are sections where the patient can write personal notes, such as how the patient wants to be remembered and who is to have the patient's personal belongings. Voicing My Choices® is available from <agingwithdignity.org>.

119.

A 48-year-old patient with myasthenia gravis had been fairly stable but after a recent bout of gastroenteritis, the patient has experienced a marked weakening of muscles. The APRN notes tachypnea, a single-breath-count test result of 14, and oxygen saturation of 95%. This likely indicates

normal respiratory status for MG.

atelectasis.

pneumonia.

impeding respiratory failure.

Explanation:

If a 48-year-old patient with myasthenia gravis had been fairly stable but, after a recent bout of gastroenteritis, the patient has experienced a marked weakening of muscles, and the advanced practice registered nurse notes tachypnea, a single breath count test result of 14 (normal 50), and oxygen saturation of 95%. This likely indicates impending respiratory failure. An illness, such as gastroenteritis, can trigger a myasthenia crisis, which can severely impair respiratory function. With MG, the oxygen saturation level may remain adequate until the situation is life threatening.

120.

A hospice patient who has been taking oral morphine to control the pain of pancreatic cancer reports little relief of constant pain, so the patient is to receive ketamine to relieve pain along with lorazepam once or twice daily in addition to the opioid. When ketamine is administered parenterally, the dosage of the opioid should

be reduced by 25 to 50%.

remain unchanged.

be increased by 25%.

be increased by 50%.

Explanation:

If a patient is to receive parenteral ketamine to relieve pain along with lorazepam 1 mg once or twice daily in addition to the opioid, the dosage of the opioid should be reduced by 25 to 50% when ketamine is initiated. Ketamine can be administered orally, sublingually, or parenterally. An initial test dose, such as 25 mg, is often given and then the dosage is titrated upward until relief of pain is achieved. If PO or SL, doses may be taken 3 or 4 times daily. Continuous infusions are often used for SC or IV dosing. A number of different protocols are in use.

121.

For which of the following diagnoses may a patient be eligible for hospice care on diagnosis if the patient chooses to forego treatment?

Leukemia.

Small cell lung cancer.

Amyotrophic lateral sclerosis.

Amyotrophic lateral sclerosis.

Amyotrophic lateral sclerosis.

Amyotrophic lateral sclerosis.

Explanation:

A patient may be eligible for hospice care on diagnosis of small cell lung cancer if the patient chooses to forego treatment because the prognosis is so poor and the average life expectancy is about 2 to 3 months. Other diagnoses that also may make a patient foregoing treatment eligible include pancreatic cancer, which results in a life expectancy of 4 to 8 months, and brain tumor (such as glioblastoma multiforme) with a life expectancy of about 6 to 8 months.

122.

A hospice patient asks if the advance practice registered nurse or doctor can give her an overdose to cause her death because she is tired of suffering pain. The most appropriate initial response is:

"It's illegal for nurses and doctors to give overdoses to cause death."

"You don't really mean that!"

"Let's work together to better control your pain."

"You should talk to the doctor about that."

Explanation:

If a hospice patient asks if the advance practice registered nurse or doctor can give her an overdose to cause her death because she is tired of suffering pain, the most appropriate initial response is: "Let's work together to better control your pain." Patients who express the desire to die to escape pain often just want to be free of pain rather than really wanting to die, so the patient's pain control should be reviewed and stepped up until pain relief is adequate.

123.

A 26-year-old male with no advance directive suffered a traumatic brain injury that left him in a vegetative state on life support. The patient's mother, sister, best friend, and fiancée are present. Which family member or other person can legally make the decision to withdraw life support?

Friend.

Sister.

Mother.

Fiancée.

Explanation:

If a 26-year-old male with no advance directive suffered a traumatic brain injury that left him in a vegetative state on life support, the family member who can legally make the decision to withdraw life support is the patient's mother. If the patient were married, the wife would be first in line, followed by adult children, parents, and then siblings. Unless the fiancée has power of attorney, the person is unrelated and, like the friend, has no legal authority to make decisions for the patient.

124.

The principle of the double effect refers to the idea that

drugs may not be used to control pain if they hasten death.

drugs may be used to control pain even if they hasten death.

drugs should not be administered in order to hasten death.

drugs can be administered in order to hasten death.

Explanation:

The principle of the double effect is the idea that drugs may be used to control pain even if they hasten death because the intent is not to cause death but rather to relieve suffering. The Supreme Court (1997) affirmed the principle of the double effect. Most all religions also support the double effect. Patients are usually nearing death when they require such high doses that they may shorten life. In practice, sometimes alleviating pain reduces anxiety and may actually prolong life.

125.

A patient with amyotrophic lateral sclerosis is no longer able to breathe independently but has elected to be extubated, understanding that this will lead to death. In addition to an opioid to relieve dyspnea, which other medication is usually administered?

Benzodiazepine.

Antipsychotic.

SSRI.

Atypical antipsychotic.

Explanation:

If a patient with amyotrophic lateral sclerosis is no longer able to breathe independently but has elected to be extubated, understanding that this will lead to death, in addition to an opioid to relieve dyspnea, a benzodiazepine is usually administered to help to relieve anxiety. The patient may also be administered oxygen. The patient should be supine with the head of the bed elevated to about 30° and family in attendance if possible.

126.

A patient with end-stage liver disease has made the decision to voluntarily stop eating and drinking (VSED) to hasten death, and the patient's family is supportive of this decision. What action should the advance practice registered nurse take?

Notify adult protective services.

Provide supportive care.

Advise the patient that VSED is an act of suicide.

Discontinue services to the patient.

Explanation:

If a patient with severe heart disease has made the decision to voluntarily stop eating and drinking (VSED), the patient has every right to do so under the law, and in states where physician-assisted death is not legal, this may be the only legal option available to the patient. The advanced practice registered nurse should remain supportive of the patient's decision, and should advise the family on comfort measures. Providing morphine and/or mild sedative may help to relieve feelings of hunger and thirst.

127.

A 50-year-old patient receiving chemotherapy complains that her biggest problem is managing her home and family while dealing with fatigue. Which of the following referrals may most benefit the patient?

Nutritionist.

Physical therapist.

Psychologist.

Occupational therapist.

Explanation:

If a 50-year-old patient receiving chemotherapy complains that her biggest problem is managing her home and family and dealing with fatigue, the referral that may most benefit the patient is an occupational therapist. The occupational therapist can assess the patient's needs and recommend strategies to conserve energy as well as help the patient to recognize the need to make some changes and to set realistic goals during treatment and recovery. The patient may need help in establishing priorities.

128.

The advanced practice registered nurse notes that a team member usually prefers to work alone and makes excuses for not delegating more of his workload. The team member frequently takes overtime shifts when the unit is shorthanded, but is increasingly short-tempered and complains of fatigue and headaches. The team member is likely to experience

burnout.

advancement.

ostracism.

injury.

Explanation:

If a team member usually prefers to work alone, makes excuses for not delegating more of his workload, frequently takes overtime shifts when the unit is shorthanded, is increasingly short-tempered, and complains of fatigue and headaches, the team member is likely to experience

burnout as these are all common factors. Burnout occurs when nurses become overworked and overwhelmed by the stress of the job and is a reason that many nurses leave the profession.

129.

When educating an 80-year-old patient about self-care and pain control, the teaching strategy that is most useful is to

review study skills.

allow ample time for learning and practicing.

utilize role-playing.

utilize problem-centered learning.

Explanation:

The approach to educating patients and family members should be adjusted according to their age and experiences. Teaching strategies for older adults includes:

- *Allowing ample time for learning and practicing.*
- *Spending time chatting to get to know the individual.*
- *Eliminating non-essential information.*
- *Allowing the individual to set the pace.*
- *Remaining patient and supportive.*
- *Determining the individual's preferred learning style.*
- *Preparing materials that are age-appropriate.*
- *Providing written materials in large fonts and at appropriate reading level.*

130.

An advanced practice registered nurse has accepted a position in a different hospital and is in the "being" stage of role transition after 6 months in the position. This stage is characterized by

emotional lability and recognition of limitations.

acceptance of the new role.

increase in knowledge and self-doubt.

limited problem-solving skills.

Explanation:

The “being stage” of role transition is characterized by increase in knowledge and self-doubt:

Stages of role transition (12 months)

Doing (3-4 months) Transition shock with emotional lability and self-doubt. Problem-solving skills limited.

Being (4-5 months) Transition crisis, knowledge increases along with self-doubt. continued stress but increased awareness of role, feel unprepared for clinical situations.

Knowing (3-4 months) Acceptance of the new role and recovering from some of the problems and stresses of earlier stages, explore and critique their new roles, gaining confidence.

131.

A patient with COPD is recovering from pneumonia and has spent much of the day in bed with the curtains drawn and appears to have been crying. The most appropriate response is:

“You seem upset.”

"Why are you crying?"

"Please, tell me what is bothering you."

"I'm sure everything will be OK."

Explanation:

If a patient with COPD is recovering from pneumonia and has spent much of the day in bed with the curtains drawn and appears to have been crying, the most appropriate response is: "You seem upset." This empathetic response acknowledges what is evident and recognizes the patient's feelings without prying into the reason. This response gives the patient the option to discuss the situation or not. Patients have a right to the privacy of their thoughts and emotions and should not be pushed to discuss issues.

132.

An 80-year-old non-diabetic patient with renal failure who has refused hemodialysis and is not a candidate for kidney transplantation has requested hospice services. Which of the following laboratory findings supports admission to hospice?

Creatinine clearance <10 mL/min and serum creatinine >8.0 mg/dL.

Creatinine clearance <15 mL/min and serum creatinine >7.0 mg/dL.

Creatinine clearance <15 mL/min and serum creatinine >6.0 mg/dL.

Creatinine clearance <10 mL/min and serum creatinine >4 mg/dL.

Explanation:

If an 80-year-old non-diabetic patient with renal failure who has refused hemodialysis and is not a candidate for kidney transplantation has requested hospice services, the laboratory findings that support admission to hospice are creatinine clearance < 10 mL/min and serum creatinine >8.0 mg/dL. Requirements for diabetic patients with renal failure are slightly different: creatinine clearance <15 mL/min and serum creatinine >6.0 mg/dL. The patient must also have documentation that outlines signs and symptoms consistent with chronic or acute renal failure.

133.

When the advanced practice registered nurse (sender) is talking (transmission) and giving information (message) to a patient (recipient), communication is most dependent on the

situation.

sender.

message.

recipient.

Explanation:

When the advanced practice registered nurse (sender) is talking (transmission) and giving information (message) to a patient (recipient), communication is most dependent on the recipient. The recipient must be motivated to receive the message and must have no barrier, such as hearing impairment or emotional upset, that interferes with the transmission. The ability of the recipient to comprehend a message depends on many complex factors, such as cognitive ability, knowledge base, emotional status, sensory impairment, and health status.

134.

Which of the following is most likely to be a barrier to effective communication?

The advanced practice registered nurse is nervous and speaks in a high pitch.

The advanced practice registered nurse speaks in a cheerful voice.

The advanced practice registered nurse rubs the hands together when speaking.

The advanced practice registered nurse leans toward the patient when speaking.

Explanation:

The tone of voice can be a barrier to effective communication. For example, if the advanced practice registered nurse is nervous, this can raise the pitch of the voice, conveying nervousness and making the patient uncomfortable. People are more likely to listen to a cheerful voice (depending on the situation). While rubbing the hands together is a self-comforting measure, unless it is very obvious, it should not interfere with communication. The APRN should also make eye contact and stand or sit at a comfortable distance for the patient.

135.

The advanced practice registered nurse frequently listens attentively to others and gives honest opinions, often beginning with "I" statements, such as "I would like to consider a different approach," and asking for opinions of others: "How do you feel about that?" The type of communication that the APRN is exhibiting is

passive.

aggressive.

neutral.