4,000+ NCLEX Simple Nursing Question Bank

1. Hematological / Oncological Question #2

Which client statement indicates an accurate understanding of the medication teaching provided by the nurse related to the use of a new prescription for apixaban as medical management for deep vein thrombosis (DVT)? **Select all that apply**.

☑	**"It is okay to eat green leafy vegetables each night for dinner."**
	This client statement indicates a correct understanding of the information presented. A benefit of this medication to treat DVT is that there is no drug to food interactions related to vitamin K.
☐	"It is not ok for me to eat foods that are rich in vitamin K."
	This client statement indicates a need for additional teaching as this medication does not interact with foods rich in vitamin K.
☐	"I will take frequent resting periods every 2 hours."
	This client statement indicates a need for additional teaching as the client is taught to move around every 2 hours to enhance circulation.
☐	"I can take aspirin, ibuprofen, and naproxen for aches and pains while taking this medication."
	This client statement indicates a need for additional teaching as the client is taught to avoid any medication that increases the risk for bleeding (e.g., aspirin, ibuprofen, naproxen) while prescribed an anticoagulant agent.
☑	**"I can take acetaminophen for headaches while on this medication."**
	This client statement indicates a correct understanding of the information as acetaminophen does not increase the client's risk for bleeding; therefore, it can be taken safely for a headache will prescribed apixaban.

Apixaban is a newer anticoagulant agent that is used to treat and/or prevent DVT. It works by blocking Factor Xa; therefore, there are no drug to food interactions associated with this type of anticoagulant when compared with other types (e.g., warfarin). Warfarin requires the client to consume consistent amounts of foods that are rich in vitamin K (e.g., green leafy vegetables). The client, however, should still not take other medications that are known to cause bleeding, including aspirin, ibuprofen, and naproxen; however, it is safe to take acetaminophen if needed. The client statements that indicate a correct understanding of the information presented by the nurse are as follows: “It is okay to eat green leafy vegetables each night for dinner.” and “I will not take aspirin, ibuprofen, or naproxen while taking this medication.”

👉 *Video Rationale: https://d1pumg6d5kr18o.cloudfront.net/rationales-v2/pharmacology_hematological_oncological_2167/part.m3u8*

2. Hematological / Oncological Question #5

What instruction should the nurse provide to a client who will receive enoxaparin injections at home? **Select all that apply**.

☑	**"You should avoid taking aspirin and nonsteroidal anti-inflammatory drugs (NSAIDs) while on this medication."**
	Aspirin and NSAIDs both have a risk for bleeding; therefore, these medications are avoided when enoxaparin therapy is prescribed.
☑	**"It is important to consult with your doctor before taking any herbal supplements."**
	Certain herbal supplements can increase the risk for bleeding; therefore, it is important to consult with a healthcare provider prior to taking supplements when prescribed enoxaparin therapy.
☑	**"You should avoid antihistamines while on this medication."**
	Antihistamines can decrease the anticoagulant effect of heparin and low molecular weight heparins (e.g., enoxaparin); therefore, these medications are avoided when prescribed enoxaparin therapy.
☐	"You will need to have your blood count checked every three days for this medication."
	A benefit of low molecular weight heparin therapy (e.g., enoxaparin) is that there is no need to draw blood to monitor effectiveness.
☐	"You should avoid foods that are rich in vitamin K."
	Another benefit of low molecular weight heparin therapy (e.g., enoxaparin) is that there is no drug to food interaction with vitamin K.

The nurse is responsible for providing medication teaching when a client will require the use of prescription medications in the home environment. The nurse should include information regarding safe administration in addition to side effects, adverse reactions, interactions, and the need for blood draws to monitor for effectiveness. Information that the nurse includes for the client who is prescribed enoxaparin injections includes the following information: avoid taking aspirin or NSAIDs while on this medication; consult with the HCP before taking any herbal supplements; and avoiding antihistamines while on this medication. Two benefits of this medication prescription is that there is no need for blood draws to monitor effectiveness and there is no need to avoid foods that are rich in vitamin K which can negatively impact the effectiveness of other anticoagulant therapy, such as warfarin.

👉 *Video Rationale: https://d1pumg6d5kr18o.cloudfront.net/rationales-v2/pharmacology_hematological_oncological_2170/part.m3u8*

3. Hematological / Oncological Question #6

The nurse provides care for a postmenopausal client who is diagnosed with ductal carcinoma in situ (DCIS), a non-invasive breast cancer. The client is presently taking anastrozole. Which client statement does the nurse report to the healthcare provider (HCP) based on the current data? **Select all that apply**.

☐	"I have not had a menstrual flow for 6 months"
	This statement does not cause the nurse concern as a result of the prescribed medication.
☐	"I sometimes have trouble sleeping at night."
	While insomnia is a side effect of this medication, this finding does not warrant notification to the HCP. The nurse should provide the client with information on methods to enhance sleep hygiene.
☐	"I have gained two pounds since I started taking this medication three months ago."
	While weight gain is a noted side effect of this medication, this finding does not warrant notification to the HCP. The nurse should provide the client with information that will increase the likelihood of healthy eating habits.
☑	**"I have noticed an increase in vaginal discharge and some spotting."**
	Any vaginal bleeding for a postmenopausal woman is often indicative of problem. The client who is taking this medication is at an increased risk for endometrial cancer which is suspected with any vaginal bleeding post menopause; therefore, this statement warrants notification to the HCP.
☑	**"I am having severe nausea with food and oral liquids."**
	Severe nausea and vomiting can be an indication of liver damage, which can be caused by this medication; therefore, this statement warrants notification to the HCP.

The nurse must conduct a thorough health history and physical examination to determine the presence of serious side effects to the prescribed medication. While some side effects are expected (e.g., insomnia, weight gain), there are others that warrant further evaluation as they are considered serious. Examples of serious side effects that warrant HCP notification includes any unusual vaginal bleeding/burning/discharge/itching/odor and signs of liver toxicity (e.g., abdominal pain, dark urine, nausea/vomiting that does not stop, yellowing eyes/skin). Therefore, the client statements that require the nurse to notify the HCP include the following: “I have noticed an increase in vaginal discharge and some spotting.” and “I am having severe nausea with food and oral liquids.”

👉 *Video Rationale: https://d1pumg6d5kr18o.cloudfront.net/rationales-v2/pharmacology_hematological_oncological_2171/part.m3u8*

4. Hematological / Oncological Question #8

The preoperative nurse advises clients who will have procedures in the ambulatory surgery center. Which client prescription would require a phone call to the healthcare practitioner (HCP) for clarification? **Select all that apply**.

☑	**Give heparin 1500 units by subcutaneous injection upon admission for surgery at 1300 today.**
	Typically, a low molecular weight heparin is administered the day of surgery versus heparin; therefore, this prescription requires HCP clarification.
☐	Continue glyburide due to hemoglobin A1C of 10%.
	This is an appropriate medication prescription; therefore, the nurse does not seek clarification from the HCP.
☐	Give sodium polystyrene sulfonate 15 grams once daily for a serum potassium of 7 mEq/L.
	This medication is often prescribed to lower serum potassium levels and can be administered per rectum; therefore, the nurse does not seek clarification from the HCP.
☑	**Use recent lab work as prescribed chemotherapy given over two weeks ago resulted in a platelet count of 40,000 mm3.**
	Chemotherapy can significantly alter laboratory data; therefore, this prescription requires HCP clarification.
☑	**Give ibuprofen 800 mg before surgery.**
	Ibuprofen, along with other nonsteroidal anti-inflammatory drugs (NSAIDs), are often held for 7 days prior to surgical procedures to decrease the client's risk for bleeding; therefore, this prescription requires HCP clarification.

The nurse is responsible for reviewing prescriptions for the client who is scheduled for a surgical procedure the next day. Some medications should be held to decrease the client's risk of bleeding. Other prescriptions may require clarification as well. The prescriptions that the nurse clarifies with the HCP include the following: administering heparin the day of surgery; using recent lab work for a client with a platelet count that is 40,000 mm3; and giving ibuprofen three times per day. The other prescriptions do not require clarification as they are appropriate based on the current data.

👉 *Video Rationale: https://d1pumg6d5kr18o.cloudfront.net/rationales-v2/pharmacology_hematological_oncological_2173/part.m3u8*

5. Hematological / Oncological Question #9

When preparing to administer letrozole for treatment of breast cancer for a postmenopausal client, which health history information requires the nurse to consult with the healthcare provider (HCP)?

1. Documented allergy to latex.

> A documented allergy to latex is not a contraindication for this prescribed medication; therefore, this finding does not warrant consultation with the HCP.

2. History of low iron two years ago.

> A history of anemia not a contraindication for this prescribed medication; therefore, this finding does not warrant consultation with the HCP.

3. Hot flashes during menopause.

> Documented hot flashes during menopause is not a contraindication for this prescribed medication; therefore, this finding does not warrant consultation with the HCP.

✓ 4. Previous deep vein thrombosis (DVT).

> A history of blood clots, including DVT, is a contraindication for this prescribed medication; therefore, this finding warrants consultation with the HCP.

> The nurse is responsible for reviewing the client's health history to determine whether prescribed medications are safe. Some conditions are considered contraindications for the use of certain medications. Letrozole is a medication that is prescribed and administered to women with a history of breast cancer who are postmenopausal. A history of DVT is a contraindication for the prescribed medication; therefore, this finding warrants a consult with the HCP before proceeding with medication administration.

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6. Labor & Delivery Question #3

The nurse provides care for a laboring client who is receiving intravenous (IV) oxytocin at 20 mU/min. Which nursing intervention is appropriate for this client when late decelerations are noted on the continuous fetal monitor? **Select all that apply**.

☐	Call the lab for the prescribed STAT nitrazine test.
	There is no need for this test as this time as it is prescribed early in the labor process to determine if the amniotic bag of fluid has ruptured. A blue result with this test indicates the pH is 6.0 + and indicates the membranes have ruptured.
☐	Administer methylergonovine 0.2 mg by mouth, as prescribed.
	Methylergonovine is often prescribed to decrease the likelihood of postpartum hemorrhage. Based on the current data, this is not an appropriate nursing intervention for this client.
☑	**Inform the healthcare provider (HCP) of the current client data.**
	The laboring client who experiences late deceleration requires further assessment by the HCP; therefore, this is an appropriate nursing intervention for this client.
☐	Move the client onto her back.
	Late decelerations often indicate poor oxygenation. To enhance oxygenation to the fetus, the laboring mother is placed on her left side, not on her back; therefore, this is not an appropriate nursing intervention for this client.
☑	**Suspend the infusion of the prescribed IV oxytocin.**
	The nurse should suspend the IV infusion of oxytocin as this will stop any continued decelerations of the fetal heart rate until the situation can be analyzed and stabilized by the healthcare provider.

> Remember VEAL CHOP to determine how to interpret fetal heart rate during labor: V-Variable; E-Early; A-Accelerations; L-Late; C-Cord Compression; H-Head Compression; O-Okay; and P-Placental Insufficiency. A late deceleration is indicative of a complication. Therefore, the appropriate actions for the nurse to implement include: inform the healthcare provider of the findings and suspending the IV oxytocin infusion.

👉 *Video Rationale: https://d1pumg6d5kr18o.cloudfront.net/rationales-v2/maternal_newborn_health_labor_delivery_1746/part.m3u8*

7. Labor & Delivery Question #5

Which is the most appropriate nursing action when providing care for a pregnant client who is receiving an intravenous (IV) infusion of oxytocin at 15 mU/min with moderate variability noted on the monitor?

1. Contact the healthcare provider (HCP) immediately.

> There is no need to contact the HCP at this time as the fetal heart rate pattern is reassuring and not indicative of a complication.

✓ 2. Continue with current plan of care.

This strip indicates a reassuring fetal heart rate pattern. The nurse should continue with the current plan of care which includes monitoring and continuing the oxytocin IV infusion.

3. Give a tocolytic medication immediately.

Tocolytic medications are administered to delay premature uterine activity. This client is in active labor; therefore, this medication is not indicated.

4. Stop the oxytocin drip immediately.

There is not a need to stop the oxytocin IV infusion at this time. The fetal heart rate patterns are within normal limits and reassuring.

Reassuring fetal heart rate patterns are normal and expected when providing care to the laboring mother. Nonreassuring and ominous heart rate patterns are not expected and are often indicative of a problem that requires additional evaluation and prompt intervention. The fetal heart rate pattern noted for this client is reassuring. Therefore, the most appropriate action by the nurse is to continue with the current plan of care.

👉 *Video Rationale: https://d1pumg6d5kr18o.cloudfront.net/rationales-v2/maternal_newborn_health_labor_delivery_1748/part.m3u8*

8. Labor & Delivery Question #7

Which assessment finding noted by the nurse for a laboring mother whose cervix is dilated to 7 cm warrants immediate intervention?

1. A resting uterine tone of 6 mm Hg.

Normal uterine resting tone is between 10 to 15 mm Hg but can dip tone to 6 mm Hg; therefore, this finding does not require immediate intervention by the nurse.

✓ 2. Contractions that last 102 seconds

This finding is indicative of tetanic contractions, a complication of labor; therefore, this finding requires immediate intervention by the nurse.

3. Uterine contractions occurring every 7 minutes.

This finding may indicate that labor is no longer progressing and requires further assessment; however, this finding is not indicative of an emergent complication. Therefore, this finding does not require immediate intervention by the nurse.

4. Intensity does not change with each contraction.

The intensity of contractions stays the same as the cervix is dilated but the contractions come closer together. Therefore, this finding does not require immediate intervention by the nurse as this is expected during the active phase of labor.

Labor is the process of when the fetus leaves the uterus. Effective uterine contractions are required for this process. Contractions can last anywhere from 30 to 90 seconds. Regular contractions change the size of the cervix allowing a vaginal birth. Contractions that last longer than 90 seconds (e.g., contractions that are 102 seconds each) are termed tetanic and are indicative of a complication; therefore, require immediate intervention by the nurse.

👉 *Video Rationale: https://d1pumg6d5kr18o.cloudfront.net/rationales-v2/maternal_newborn_health_labor_delivery_1750/part.m3u8*

9. Labor & Delivery Question #8

A laboring mother weighing 220 lbs is 6 cm dilated and having contractions every 2 minutes. The healthcare provider (HCP) prescribes a single dose of nalbuphine hydrochloride 7 mg/70 kg intravenous (IV) push. Nalbuphine hydrochloride is available in 10 mg/2 ml. How many milliliters will the nurse need to administer? Record the answer using one decimal place. Answer: _____ mL

Correct Answer: **2**

This medication has been deemed safe for using during labor to treat pain. The medication, however, should not be administered with other opioid analgesics as it increases the risk for respiratory depression for the fetus after birth. The nurse should monitor both the mother and the neonate for respiratory depression when this medication is administered during labor.

👉 *Video Rationale: https://d1pumg6d5kr18o.cloudfront.net/rationales-v2/maternal_newborn_health_labor_delivery_1751/part.m3u8*

10. Labor & Delivery Question #10

Which action should the nurse take when the tocotransducer of a pregnant client receiving oxytocin indicates 6 contractions in 10 minutes and the obstetric healthcare provider (HCP) requests a decrease the oxytocin

infusion rate?

1. Ask the charge nurse to discuss the request with the client's HCP.

> This action could potentially harm the client as the frequency of uterine contractions indicates a complication.

✓ 2. Decrease the rate of oxytocin IV infusion as prescribed by the HCP.

> During the active phase of labor, contractions get stronger and are about 3 minutes apart. 6 contractions in 10 minutes may indicate unwanted progression of labor as oxytocin increases the rate of contractions; therefore, the nurse implements the prescription from the HCP.

3. Explain to the HCP that the oxytocin infusion rate should not be decreased.

> This is not an appropriate action by the nurse based on the current data for the laboring client.

4. Request to leave the infusion rate the same since the client's contractions are adequate.

> This client's labor is progressing too quickly; therefore, this is not an appropriate action by the nurse.

> Labor is the process when the fetus leaves the uterus. Uterine contractions facilitate the progression of labor. Regular contractions change the size of the cervix which allows for dilation. Oxytocin is often administered to increase the strength, frequency, and duration of contractions. The frequency of this laboring client's contractions indicate a need for intervention. Therefore, the nurse decreases the rate of the oxytocin infusion as prescribed by the HCP.

👉 *Video Rationale: https://d1pumg6d5kr18o.cloudfront.net/rationales-v2/maternal_newborn_health_labor_delivery_1753/part.m3u8*

11. Labor & Delivery Question #11

Which nursing action is most appropriate following the precipitous birth of a 39-week neonate while waiting for the arrival of the healthcare provider (HCP) to deliver the placenta?

1. Document the details of the client's childbirth.

> While documentation is appropriate, it is not the most appropriate action. Documentation can occur after other client care tasks are implemented.

✓ 2. Ensure the neonate is warm.

It is important to keep the newborn dry and warm. The newborn does not have adequate fat or body systems to control body temperature; therefore, this is the most appropriate action by the nurse.

3. Vigorously rub the client's fundus.

The fundus should be massaged gently with firm pressure but not rubbed vigorously; therefore, this is not the most appropriate action by the nurse at this time.

4. Weigh the neonate.

While obtaining a neonatal weight is important, it is not the most appropriate action in this scenario.

Newborn care is implemented immediately after birth in a separate space near the birthing area. Equipment such as radiant warmer and heated blankets should be used to decrease the neonate's likelihood of heat loss that can cause cold stress. While all the actions may be appropriate, the most appropriate action is to ensure that the neonate is warm.

👉 *Video Rationale: https://d1pumg6d5kr18o.cloudfront.net/rationales-v2/maternal_newborn_health_labor_delivery_1754/part.m3u8*

12. Labor & Delivery Question #12

Which clinical manifestation noted by the nurse is most closely associated as an indication that a client is in true labor? **Select all that apply**.

☐	An increase in blood-tinged, mucoid vaginal discharge noted with vaginal examination.
	This finding is often indicative that true labor is approaching; however, it is not a clinical manifestation associated with true labor.
☑	**Effacement of the cervix progresses with each vaginal examination.**
	As true labor progresses, the cervix is progressing toward 100 percent effacement; therefore, this finding is associated with true labor.
☑	**Dilation of the cervix progresses with each vaginal examination.**
	As true labor progresses, cervical dilation progresses to 10 cm; therefore, this finding is associated with true labor.
☐	A decrease in the frequency of contractions noted by the external monitor.

	This finding is indicative of false, not true, labor.
☐	The client reports lower back pain that radiates to the shoulder.
	A client in labor may have pain in the lower back in addition to pain in the abdomen that is caused by uterine contractions. Pain that radiates to the shoulder is not expected; therefore, this finding is not an indicator of true labor.
☐	A reduction in the strength of contractions when the client is resting.
	Contractions would remain the same weather standing, sitting or laying down when true labor is presented.

Contractions progress in strength and increase in frequency as the client progresses through the stages of labor. Manifestations indicative of true labor include the following: strong and regular contractions and the amniotic bag of fluid breaks. True labor will cause dilation and effacement of the cervix. Therefore, the clinical findings indicative of true labor include progression of both the effacement and dilation of the cervix.

👉 *Video Rationale: https://d1pumg6d5kr18o.cloudfront.net/rationales-v2/maternal_newborn_health_labor_delivery_1755/part.m3u8*

13. Labor & Delivery Question #25

Which is the **priority** nursing action when providing care for a neonate born with anencephaly?

1. Encourage the mother to take prenatal vitamins before the next pregnancy.

While this is an appropriate nursing action to decrease the risk for anencephaly in subsequent pregnancies, this is not the priority in this situation.

2. Immediately consult a perinatal grief support group for the parents.

While this is an appropriate nursing action, this is not the priority immediately following the birth of a neonate with anencephaly.

✓ 3. Place the newborn in the parent's arms to ensure skin to skin contact.

Skin to skin contact promotes the bonding process and initiates the grieving process in this situation; therefore, this is the priority nursing action.

4. Volunteer to hold the baby for the parents to take pictures.

Involving the parents as much as possible aids in the grief process and allows the parents to grieve; however, this is not the priority nursing action based on the current data.

Anencephaly is a neural tube defect (NTD) that often results in stillbirth or death within the first few hours of life. The priority action by the nurse is to place the newborn in the parent's arms and ensure skin to skin contact. This action facilitates the grieving process thus is appropriate when providing care to this family. While the other actions are appropriate, they are not the priority immediately following the birth of the neonate diagnosed with anencephaly.

👉 *Video Rationale: https://d1pumg6d5kr18o.cloudfront.net/rationales-v2/maternal_newborn_health_labor_delivery_1768/part.m3u8*

14. Labor & Delivery Question #29

Which intervention is appropriate when the nurse assists the healthcare provider (HCP) with an amniotomy on a client with full term pregnancy admitted for induction of labor?

✓ 1. Documenting the color, consistency, and odor of amniotic fluid.

Documenting the color, consistency, and odor of the amniotic fluid following an amniotomy provides other HCPs involved in the client's care with appropriate information; therefore, this is an appropriate intervention by the nurse.

2. Informing the client she will feel sharp pains during the amniotomy.

Pain is not associated with the amniotomy procedure; therefore, this is not an appropriate action by the nurse. This procedure, however, is likely to cause strengthening of uterine contractions and this information should be shared with the client.

3. Maintaining the client in the supine position after the amniotomy.

The client is not required to stay in a supine position following an amniotomy. Additionally, a supine position can cause vena cava syndrome thus decreasing oxygenation to the placenta and fetus; therefore, this action is not appropriate by the nurse.

4. Obtaining the client's temperature at least every shift.

The client's temperature should be monitored more frequently after an amniotomy as a means of evaluating for infection; therefore, this nursing action is not appropriate by the nurse.

The nurse assists the HCP with an amniotomy. This procedure is often implemented for labor induction or to enhance labor progress. The nurse must document this procedure in the client's medical record. Aspects that the nurse includes in this documentation is the color, consistency, and odor of amniotic fluid.

👉 *Video Rationale: https://d1pumg6d5kr18o.cloudfront.net/rationales-v2/maternal_newborn_health_labor_delivery_1772/part.m3u8*

15. Labor & Delivery Question #31

Which is the **priority** nursing action when providing care for a client who has a boggy, midline uterus after the birth of the placenta?

1. Administer methylergonovine intramuscular (IM), as prescribed.

Methylergonovine IM is an appropriate intervention if other less invasive actions for a boggy uterus are not successful; therefore, this is not the priority action by the nurse.

2. Assure a blood type and crossmatch (T&C) have been completed, as prescribed.

Getting a T&C is an appropriate intervention; however, this is not the priority action base on the current data. The priority action by the nurse is fundal massage.

✓ 3. Immediately massage the client's fundus.

Uterine massage will stimulate uterine contractions and frequently stops uterine hemorrhage; therefore, this is the priority nursing action for this client.

4. Increase the oxytocin infusion rate gradually by 1-5 mU/minute, as prescribed.

The addition of oxytocin may be necessary; however, other less invasive interventions should be implemented by the nurse first.

A boggy uterus that is noted immediately after the birth of the placenta is a risk factor for postpartum hemorrhage. The priority action in this situation is to immediately massage the client's fundus. Fundal massage stimulates uterine contractions and decrease the risk for hemorrhage in the immediate postpartum period. While the other interventions may be required, they are not the priority based on the current clinical data.

👉 *Video Rationale: https://d1pumg6d5kr18o.cloudfront.net/rationales-v2/maternal_newborn_health_labor_delivery_1774/part.m3u8*

16. Labor & Delivery Question #36

The nurse provides care for a laboring client who will receive epidural anesthesia to address pain. Which laboratory value is most important for the nurse to report to the anesthesiologist prior to the implementation of the epidural?

1. The client's hematocrit is 35%.

> This hematocrit is within the normal range for a pregnant client; therefore, this finding does not require the nurse to report the data to the anesthesiologist prior to the implementation of the epidural.

2. The client's blood type is O and negative for the Rh factor.

> These findings do not impact the initiation of epidural anesthesia; therefore, do not require the nurse to report them to the anesthesiologist.

✓ 3. The client's platelet count is 89,000/mm3.

> A platelet count is needed to determine the client's risk of bleeding; therefore, this finding is reported to the anesthesia prior to the initiation of epidural anesthesia.

4. The client's prothrombin time of 12 seconds.

> This prothrombin time (PT) is normal; therefore, there is no reason for the nurse to report this data to the anesthesiologist prior to the initiation of epidural anesthesia.

> Epidural anesthesia involves the introduction of local analgesics into the epidural space. Appropriate interventions prior to the initiation of this therapy include obtaining informed consent, taking and documenting initial vital signs, and monitoring a serum platelet count. A low platelet count (e.g., platelet count of 89,000/mm3) is important to report prior to the initiation of epidural anesthesia as this finding increases the client's risk for bleeding. The other laboratory data does not require the nurse to report the findings to the anesthesiologist.

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17. Postpartum Question #1 - V2

The nurse is planning care for a client who is at risk for postpartum hemorrhage following a vaginal delivery. Which risk factor should the nurse identify for this client and complication?

1. Maternal blood loss of approximately 400 mL.

Blood loss greater than 500 mL is indicative of hemorrhage for a woman who delivers vaginally; therefore, this is not a risk factor but an actual problem.

2. Prolonged labor lasting 24 hours.

Labor lasting over 24 hours can put the mother at increased risk for postpartum hemorrhage, but this is not the best choice. Prolonged labor is often associated with postpartum infection or poor outcomes for the neonate.

3. Newborn weight of 5 lb, 4 oz.

Macrosomia, or a neonate significantly larger than average weight, is a risk factor for postpartum hemorrhage, not microsomia. The average weight of infants born in the United States is approximately 7 lbs, 6 oz; therefore, this data is not a risk factor.

✓ 4. Newborn weight of 11 lb, 8 oz.

A neonatal weight of greater 8 lbs, 13 oz is considered macrosomia. Macrosomia puts the mother at risk for hemorrhage as this finding prolongs labor and the uterus may not involute properly thus increasing the risk for postpartum hemorrhage.

A woman experiencing postpartum hemorrhage will exhibit clinical manifestations similar to any client who is hemorrhaging. Clinical manifestations indicative of this include changes in the complete blood count (CBC), a decreased blood pressure, an increased heart rate and respirations, lethargy, and changes in levels of consciousness (LOC). Causes include uterine atony, birth trauma, retained placenta (or placental abnormalities), and coagulopathy. Risk factors include neonatal macrosomia, prolonged labor, multiparity, multiple gestation, placenta previa, placental abruption, and blood dyscrasias. The nurse must monitor the amount of postpartum bleeding, including a peri-pad count. Saturating more than one pad every hour is often an indicator of postpartum hemorrhage.

18. Postpartum Question #2 - V2

The nurse is caring for a client who is 8 hours post vaginal delivery. Which clinical manifestation noted by the nurse requires **immediate** notification to the obstetrician?

1. Fundal discomfort during palpation.

Fundal discomfort during palpation is normal as the fundus contracts to involute, or go back to its position

within the pelvis; therefore, this finding does not require immediate notification.

✓ 2. Lochia that is malodorous.

Lochia is the vaginal discharge after childbirth. The lochia smells like menstrual blood, but should not be malodorous; therefore, this finding requires immediate notification.

3. Oral temperature of 100.2° F (37.9° C).

An oral temperature greater than 38° C (100.4° F) represents fever. It is normal to have a slightly elevated temperature after delivery as the body starts to heal; therefore, this finding does not require immediate notification.

4. Hemoglobin level of 15.5 g/dL.

A hemoglobin level of 12 to 15.5 g/dL is normal for female clients; therefore, this finding does not require immediate notification.

The nurse monitors the client for both expected and unexpected manifestation during the provision of care. For approximately a week after a vaginal birth, lochia should be bright red in color, with no more than six inches on the peripad every hour. The lochia then becomes lighter in color and thinner, lasting about two weeks. The last stage is lochia alba, which is whitish/tan in color, but without an odor. Malodorous lochia anytime during the postpartum period of care indicates an infection thus requires immediate notification to the HCP for evaluation and treatment.

19. Postpartum Question #3

The nurse provides care to a postpartum client who is 4 weeks post vaginal birth. The new mother begins to cry and states, “I am a horrible mother and can’t do anything right!” Which response by the nurse is **best** when postpartum depression (PPD) is suspected?

1. "Are there any specific questions that I could help answer for you regarding your baby?"

This question does not elicit information that supports a diagnosis of PPD; additionally, the postpartum client is clearly upset and may not be able to verbalize questions regarding newborn care. Based on this data, this is not the best response by the nurse.

2. "Do you experience insomnia or difficulty resting when your newborn sleeps?"

While women who experience PPD are likely to experience insomnia, this issue with sleep will occur at all times and not just when the newborn is resting; therefore, this is not the best response by the nurse to

assess for symptoms indicative of PPD.

3. "Do you have a ladies group who you could reach out to help or share your feelings?"

While this response includes a coping mechanism that can be further discussed, it does not provide the nurse with necessary information to determine the client is experiencing PPD; therefore, this is not the best response by the nurse to this client.

✓ 4. "Do you have feelings of despair, or thoughts of harming yourself or the baby?"

This response provides the nurse information to determine if the woman is at risk for harming herself or the baby, which is appropriate when collecting data regarding PPD; therefore, this is the best response by the nurse.

A women may experience “baby blues” after childbirth, but if symptoms continue for more than four weeks, the mother may be experiencing postpartum depression (PPD). Nurses can offer support by providing anticipatory guidance at each encounter. Nurses are also obligated to assess for signs of depression and to arrange for follow up referrals if needed. The symptoms of PPD commonly include mood swings, crying spells, anxiety, and difficulty sleeping. Additionally, PPD can lead to postpartum psychosis which is diagnosed when the client has thoughts of harming self or others, including the newborn.

👉 *Video Rationale: https://d1pumg6d5kr18o.cloudfront.net/rationales-v2/maternal_newborn_health_postpartum_1826/part.m3u8*

20. Postpartum Question #3 - V2

The nurse is caring for a client who is 4 weeks post vaginal delivery. The client begins to cry and states, “I am a horrible mother and can’t do anything right!” Which question by the nurse is **best**?

1. "Are there any specific questions that I could help answer for you regarding your baby?"

This question does not elicit information that supports a diagnosis of PPD; additionally, the postpartum client is clearly upset and may not be able to verbalize questions regarding newborn care. Based on this data, this is not the best question by the nurse.

2. "Do you experience insomnia or difficulty resting when your newborn sleeps?"

While women who experience PPD are likely to experience insomnia, this issue with sleep will occur at all times and not just when the newborn is resting; therefore, this is not the best question by the nurse to assess for symptoms indicative of PPD.

3. "Do you have a ladies group who you could reach out to for help or share your feelings?"

While this response includes a coping mechanism that can be further discussed, it does not provide the nurse with necessary information to determine the client is experiencing PPD; therefore, this is not the best question by the nurse to this client.

✓ 4. "Do you have feelings of despair, or thoughts of harming yourself or the baby?"

This response provides the nurse information to determine if the client is at risk for harming themself or the baby, which is appropriate when collecting data regarding PPD; therefore, this is the best question by the nurse.

The client may experience “baby blues” after delivery, but if symptoms continue for more than 4 weeks, the client may be experiencing postpartum depression (PPD). Nurses can offer support by providing anticipatory guidance at each encounter. Nurses are also obligated to assess for signs of depression and to arrange for follow up referrals if needed. The symptoms of PPD commonly include mood swings, crying spells, anxiety, and difficulty sleeping. Additionally, PPD can lead to postpartum psychosis which is diagnosed when the client has thoughts of harming themself or others, including the newborn.

21. Postpartum Question #4 - V2

The nurse is caring for a client and their significant other who has experienced fetal death. Which nursing intervention is appropriate for this client? Select all that apply.

☐	Caution the parents against naming their newborn.
	In order to facilitate the grieving process, the nurse should encourage the parents to name their baby; therefore, this is not an appropriate intervention by the nurse based on the current data.
☑	**Offer to cut a lock of the newborn's hair for the parents.**
	Parents who experience a loss of a child are encouraged to keep a momento as this assists in the grieving process; therefore, this intervention by the nurse is appropriate.
☑	**Offer to help the parents dress their newborn.**
	Placing an outfit on the newborn may act as a coping mechanism for the parents. Additionally, this action offers the grieving parents a sense of control by choosing an outfit; therefore, this is an appropriate intervention by the nurse in the provision of care.
☑	**Promote holding and admiring of the newborn.**

	The parents experiencing a loss should not be discouraged from holding their newborn in the postpartum period, even when fetal loss occurs; therefore, this is an appropriate intervention by the nurse in the provision of care.
☐	Remind the parents about possible organ donation.
	While organ donation may be possible with fetal demise, this is not an appropriate action by the nurse as it is not included in the standard of care for this situation. This task would belong to the organ donation center, not the nurse.

It is important for the nurse to ask the parents what they would like included in their bereavement package in order to begin the grieving process and closure. The stages of grieving include denial, anger, bargaining, depression, and acceptance. The stages are not linear and individuals can move back and forth between them during the grieving process. In order to address denial, the nurse encourages that the parents spend time with the newborn.

22. Postpartum Question #5 - V2

The nurse is talking with a client who is postpartum following an uncomplicated vaginal birth with episiotomy. The client asks about sexual relations. Which response by the nurse is appropriate? Select all that apply.

☐	"Feeding your baby before sexual activity will reduce distraction and concerns."
	This has no bearing on sexual activity and the postpartum client should be encouraged to feed the newborn on demand; therefore, this is not an appropriate response by the nurse.
☐	"If you continue breastfeeding regularly, you shouldn't have to use birth control."
	There is a common misconception that breastfeeding mimics birth control. A client who is breastfeeding should be advised they can safely use hormonal and/or barrier methods of birth control; therefore, this is not an appropriate response by the nurse.
☑	**"You should avoid sexual intercourse until after vaginal bleeding stops."**
	The uterus, cervix, vagina, labia, and perineum need time to heal after vaginal delivery; therefore, sexual activity during the postpartum period when the client is still experiencing bleeding may lead to infection and delayed healing. Based on this data, this is an appropriate response by the nurse.
☐	"You will need to use a condom at all times until your menstrual period resumes."
	The use of a condom, or other form of contraception, should be used when pregnancy is not an outcome that is preferred by the couple during the postpartum period regardless of the status of a menstrual period. Based on this data, this is not an appropriate response by the nurse.

☑	**"When you resume sexual intercourse, you might need a water-soluble lubricant."**
	After a vaginal delivery, natural lubrication might not be enough for up to six months to facilitate sexual activity without pain; therefore, the client should be advised to use a water-soluble lubricant to decrease the risk for injury.

Sexual relations after delivery can be scary for many clients during the postpartum period of care. The nurse should reinforce sexual health education, even if the couple has other children. The nurse informs the client that the couple can begin to have sexual relations when postpartum bleeding has ceased. Additionally, any perineal lacerations or episiotomy, if performed, should be healed. While there's no required waiting period before a postpartum client can engage in sexual activity after delivery, many obstetricians recommend waiting to have sex until four to six weeks after birth, regardless of the method of delivery.

23. Postpartum Question #6 - V2

The nurse working on the postpartum unit has received a hand-off report on assigned clients. Which client should the nurse see **first**?

1. The client who is gravida 2, para 2, post cesarean delivery, with a temperature of 100° F (37.8° C), and has swollen breasts.

There is no need to prioritize this client based on the current data. This temperature is not indicative of infection unless greater than 100.4° F in the first 24 hours after delivery or over 101.6° F after that time frame; additionally, breasts are normally sore after delivery due to the impending arrival of milk.

2. The client who is gravida 3 para 2, post cesarean delivery, who is diagnosed with deep vein thrombosis (DVT), and receiving subcutaneous enoxaparin 20 mg.

There is no need to prioritize a client with a diagnosis of DVT who is prescribed and receiving enoxaparin 20 mg subcutaneous injections.

✓ 3. The client who is gravida 4, para 4, less than 24 hours post vaginal delivery, denies pain, and is changing a saturated perineal pad every 45 minutes.

Changing the saturated perineal pad every 45 minutes is abnormal and may be indicative of postpartum hemorrhage, especially given the client's history of multiparity; therefore, this client should be seen first by the nurse.

4. The client who is gravida 5, para 4, post vaginal delivery, and reports moderate cramping.

Moderate cramping is expected as the uterus returns to its previous size and position in the pelvic cavity during the postpartum period of care; therefore, this client does not need to be seen first by the nurse.

Postpartum hemorrhage (PPH) usually occurs soon after childbirth; however, it can occur anytime during the postpartum period of care. Postpartum hemorrhage is defined as a blood loss of over 500 mL after a vaginal birth or greater than 100 mL after cesarean birth. Perineal pads that are saturated in less than one hour is not an expected finding and can be indicative of PPH; therefore, this is the client the nurse sees first based on the current data.

24. Postpartum Question #7 - V2

The nurse has assessed a client who is postpartum. Which finding indicates a need for **immediate** intervention by the nurse?

1. Dark, red nipples with pain reported at 6 of 10 using a numeric scale.

Based on the current data, this client does not require immediate action by the nurse. Darkened nipples are normal during pregnancy and the postpartum period of care due to hormonal changes that increase pigmentation; additionally, sore nipples often occur with breastfeeding and can be addressed with a proper latch.

2. Non malodorous vaginal discharge noted with reports of cramping.

Dark red vaginal discharge (i.e., lochia rubra) and cramping are normal findings during the postpartum period of care; therefore, this data does not warrant immediate action by the nurse.

3. Perineal pads saturated with lochia every 3 hours.

Perineal pads saturated with lochia every 3 hours is a normal finding after delivery; therefore, this client does not require immediate action by the nurse.

✓ 4. Reports of pain and redness to the lower calf.

Symptoms indicative of deep vein thrombosis (DVT) include pain, redness, warmth, and edema; therefore, this client requires immediate action by the nurse to prevent a pulmonary embolism (PE), which is life-threatening.

The client is at an increased risk for clotting in the immediate postpartum period due to the increased production of blood-clotting factors, which help prevent excessive bleeding during delivery. However, this

also puts the client at an increased risk for deep vein thrombosis (DVT). Symptoms that may be indicative of DVT include a heavy or painful feeling in the leg that persists; tenderness, warmth, and redness of the calf or thigh; and slight to severe edema. Based on this information, the data that warrants immediate action by the nurse is pain and redness of the lower calf.

25. Postpartum Question #8 - V2

The nurse is caring for a client who is 28-hours post cesarean delivery, has a history of endometritis, and has the below vital signs.

T	101.7° F (38.7° C)
P	118 beats per minute
RR	16 breaths per minute
BP	128/78 mm Hg
SpO2	98% on room air

Which prescription is **most** important for the nurse to administer?

1. 0.9% sodium chloride, 500 mL bolus by intravenous (IV) x 1 dose.

0.9% sodium chloride 500 mL bolus x 1 is not appropriate based on the current data as 1000 mL is supported by evidence-based practice (EBP) guidelines.

2. Acetaminophen 325 mg per rectum.

Giving acetaminophen by the oral route should be tried before rectal administration, but either action will not help resolve the problem, which is infection; therefore, this is not the prescription that is most important for the nurse to administer to this client based on the current data.

✓ 3. Ampicillin 2 g by intravenous piggyback (IVPB) every 6 hours.

The administration of ampicillin 2 g IVPB every 6 hours is the most important prescription for the nurse to implement based on the current data as this medication will treat the infection thereby addressing the abnormalities notes in the client's vital signs.

4. Betamethasone 12 mg intramuscular (IM) x 2 doses.

Betamethasone is a steroid that is often prescribed for a woman who is at risk for imminent preterm birth to assist with the maturation of fetal lungs; therefore, this data does not support this intervention.

Endometritis causes inflammation of the uterus thus increasing the risk for infection during the postpartum period of care. A long labor or cesarean delivery are both risk factors for this condition. The treatment for endometritis includes the administration of antibiotics and therapy that addresses the client's symptoms, including antipyretic medications to address fever and the administration of intravenous (IV) fluids. The prescription that is most important for the nurse to implement is the prescribed antibiotics as this intervention addresses the infection which is the priority.

26. Postpartum Question #9 - V2

The nurse is checking in a client who presents for their first postpartum visit. Which client statement requires additional follow u by the nurse?

1. "My baby needs frequent feeding at night so I have asked the babysitter to help overnight."

Frequent feedings at night are normal for a newborn. Getting help with the newborn shows that the client is finding outside support to help during this life transition; therefore, this statement does not require additional questioning by the nurse.

2. "I no longer take sleeping medication because I want to hear if my baby cries."

Clients are cautioned not to take sedatives, sleeping pills, alcohol, or other substances that will impair their ability to care for the newborn; therefore, this statement does not require additional questioning by the nurse.

3. "My husband is worried about me because I have gotten so moody since having the baby."

Mood swings are normal after delivery as estrogen and progesterone levels are returning to pre-pregnancy level; therefore, this statement does not require additional questioning by the nurse.

✓ 4. "My mother has stayed with us every day because I can't stand my baby's cry."

The nurse should ask more questions about the feelings toward the baby as this statement may indicate problems with bonding.

The client may experience postpartum "baby blues" after delivery, but if these blues last longer than four weeks, the client may be experiencing postpartum depression (PPD). The symptoms of PPD include: mood swings, crying spells, anxiety, and difficulty sleeping. Nurses can offer support by providing anticipatory guidance before the birth. Additionally, nurses are obligated to assess for signs of depression and to arrange for follow up referrals if needed. The statement, "My mother has stayed with us every day because

I can't stand my baby's cry." could be indicative of a bonding issue which can occur with PPD; therefore, this is the statement that requires additional questioning by the nurse.

27. Postpartum Question #10 - V2

The nurse is caring for a client who is bottle feeding their newborn. The client is now experiencing breast swelling. Which instruction is most appropriate for the nurse to give to the client?

1. "Avoid wearing a bra to help the breasts heal more quickly."

Swelling in the breast is normal after birth; however, a bra should be worn for support. Therefore, this is not an appropriate statement by the nurse based on the current data.

✓ 2. "Apply ice packs on the breasts daily for at least a week."

A cold compress or ice pack applied to the breasts will help to relieve pain and swelling; therefore, this is an appropriate instruction from the nurse.

3. "Take warm, relaxing baths a couple of times a day."

Hot baths should not be taken until lochia has stopped and the perineum is healed in order to prevent infection. Additionally, hot showers should be avoided because the warmth will stimulate milk production which is not wanted for a bottle feeding mother.

4. "Use a heating pad on your breasts every 6 hours."

Using a heating pad is not recommended; heat to the breast should be avoided in the bottle-feeding client. Additionally, home heating pads increase the risk for burns, and should not be encouraged.

The client who does not breastfeed should not stimulate milk production by using warmth on the breast as heat causes breast milk to leak, which will increase milk production. Cold compresses provide pain relief. Other treatments for engorged breasts include wearing a supportive bra; placing raw cabbage leaves on the breasts; and avoiding nipple stimulation. Breast engorgement is usually alleviated by the fifth day after delivery for a bottle-feeding mother.

28. Postpartum Question #11 - V2

The nurse is caring for a client who received epidural anesthesia during labor and is now postpartum with a fundus located above the umbilicus and displaced to the right. The client has experienced no urge to urinate since giving birth. Which nursing action is **priority** at this time?

1. Continue to monitor the client's fundus hourly.

The client's fundus should be at the umbilicus and midline during the immediate postpartum period. Continuing to monitor versus acting increases the client's risk for hemorrhage; therefore, this action is not appropriate.

2. Encourage the client to drink 2000 mL of water a day.

While encouraging an increase in fluid intake is appropriate for the postpartum client, this is not the priority at this time. The fundus is already displaced thus this finding requires immediate intervention by the nurse to decrease the risk for postpartum hemorrhage.

3. Assist the client to the bathroom.

Because the client received epidural anesthesia during labor, the client is likely still numb from the waist down; therefore, this is not the priority action by the nurse. Before ambulating a client to the bathroom, the nurse should ensure that the client's numbness has worn off and the client is able to move her lower extremities without problems.

✓ 4. Prepare for a straight urethral catheterization.

A straight catheterization is the priority action based on the current data. Facilitating the bladder to empty will likely cause the uterus to become midline and return to the umbilicus thus decreasing the risk for postpartum hemorrhage.

The fundus should be at the umbilicus, midline, and firm. A full bladder will cause the fundus to displace to the side. The client is at increased risk for postpartum hemorrhage with delayed uterine involution. The client may not have the urge to urinate because of the tissue trauma during childbirth, or because she had an epidural. While assisting the client to the bathroom is the least invasive method to assist with emptying of the bladder, this may not be safe based on receiving epidural anesthesia; therefore, the priority nursing action is to perform a straight urinary catheterization.

29. Postpartum Question #12

Which statement or question by a postpartum client who gave birth about one week ago should cause the nurse concern?

✓ 1. "I am having to change my peripad hourly."

Changing the perineal pad every hour could indicate a possible postpartum hemorrhage, especially one week after birth; therefore, this finding should concern the nurse.

2. "I am so emotional and depressed since the baby was born."

Though the nurse should assess for postpartum depression, this is not the most concerning statement or question from postpartum client.

3. "Is it okay that I feel so exhausted and overwhelmed?"

Exhaustion and feelings of being overwhelmed are often normal findings during the postpartum period. While the nurse should collect additional data regarding this question, this does not cause the nurse the most concern.

4. "Is it okay that I have to strain with bowel movements?"

Constipation can be normal after birth and the nurse should encourage oral fluids and fiber intake; however, this statement does not concern the nurse.

A postpartum hemorrhage is diagnosed when the client experiences the following in the immediate postpartum period of care: greater than 500 mL of blood loss for a vaginal birth and greater than 1000 mL of blood is noted after a postpartum birth. A postpartum client who continues to experience heavy blood flow that requires changing a peripad every hour is likely indicative of a postpartum hemorrhage; therefore, this finding causes the nurse to be concerned. Often the mother is doing too much which leads to excessive vaginal bleeding. The nurse should further investigate how much the mother is bleeding as some women change the peripad with just a small amount of blood.

👉 *Video Rationale: https://d1pumg6d5kr18o.cloudfront.net/rationales-v2/maternal_newborn_health_postpartum_1835/part.m3u8*

30. Postpartum Question #12 - V2

The nurse is talking with a client who is 1 week postpartum. Which client response causes the nurse the **most** concern?

✓ 1. "I am having to change my peripad hourly."

Changing the perineal pad every hour could indicate a possible postpartum hemorrhage, especially one week after birth; therefore, this finding should concern the nurse.

2. "I have been so emotional and depressed since the baby was born."

Though the nurse should assess for postpartum depression, this is not the most concerning statement or question from a postpartum client.

3. "Is it normal to feel so exhausted and overwhelmed?"

Exhaustion and feelings of being overwhelmed are often normal findings during the postpartum period. While the nurse should collect additional data regarding this question, this does not cause the nurse the most concern.

4. "Is it okay that I have to strain with bowel movements?"

Constipation can be normal after birth and the nurse should encourage oral fluids and fiber intake; however, this statement does not concern the nurse.

A postpartum hemorrhage is diagnosed when the client experiences the following in the immediate postpartum period of care: greater than 500 mL of blood loss for a vaginal birth and greater than 1000 mL of blood is noted after a postpartum birth. A postpartum client who continues to experience heavy blood flow that requires changing a peripad every hour is likely indicative of a postpartum hemorrhage; therefore, this finding causes the nurse to be concerned. Often the mother is doing too much which leads to excessive vaginal bleeding. The nurse should further investigate how much the mother is bleeding as some women change the peripad with just a small amount of blood.

31. Postpartum Question #13 - V2

The nurse is caring for a client who is 11 hours postpartum and reports pain, restlessness, and anxiety. The nurse assesses that the client is also experiencing tachycardia. Which is the **priority** nursing action for this client?

1. Administer a PRN dose of morphine 2 mg intravenous push (IVP) for pain.

Though pain assessment and management is important, this is not the priority action based on the current data.

2. Determine the client's ability to relax and take slow, deep breaths.

Having the client take slow deep breaths to relax will not provide the nurse with further information; therefore, this is not the priority action by the nurse.

3. Check both lower extremities for warmth, edema, and pain.

Warmth, edema, and pain of the extremity are signs of a possible deep vein thrombosis (DVT). While these findings should be noted as part of the nurse's assessment, this is not the priority action based on the current data.

✓ 4. Assess respiratory rate and oxygen saturation levels.

Assessment of the client's respiratory status is the priority. Pain, anxiety, restlessness, and tachycardia are signs and symptoms of pulmonary embolism.

Postpartum care involves a head to toe assessment. The nurse can use acronym BUBBLEHER to guide this assessment: breasts, uterus, bowel, bladder, lochia, episiotomy (i.e., perineal), hemorrhoids, engagement (i.e., bonding); and respiratory status. The client's current data is indicative of pulmonary emboli; therefore, the nurse assesses the client's respiratory status as the priority action.

32. Postpartum Question #14 - V2

The nurse is caring for a client who is breastfeeding and has been diagnosed with left breast mastitis. Which recommendation should the nurse make to the client? Select all that apply.

☑	**"Be sure to increase fluid intake to 1 or 2 liters per day."**
	Appropriate fluid intake will prevent dehydration due to an elevated temperature and promote milk production; therefore, this is an appropriate recommendation.
☐	"Decrease the frequency of feedings and use only the right breast."
	Both breasts should be alternated for breastfeeding, even when mastitis occurs. The client can pump the affected breast as well, but it is not mandatory; therefore, this is not an appropriate recommendation by the nurse.
☐	"Discontinue breastfeeding with the affected breast for 5 days."
	It is recommended that women continue to breastfeed during an episode of mastitis, unless the breast becomes abscessed; therefore, this is not an appropriate recommendation by the nurse.
☑	**"Apply warm compresses to the affected breast."**
	Application of warm compresses will promote circulation, healing, and comfort; therefore, this recommendation by the nurse is appropriate.
☑	**"It is important for you to complete your antibiotic therapy."**

	It is important that the nurse reinforces completion of antibiotics to treat the infection; therefore, this is an appropriate recommendation by the nurse.

When mastitis occurs for a client who is breastfeeding, it is usually caused by staphylococcus aureus. Prevention of mastitis includes washing hands before touching the breast; correct latch during breastfeeding; frequent breastfeeding to avoid engorgement; and changing nursing pads when moist. Recommendations appropriate for this client from the nurse includes increasing oral fluid intake; applying warm compresses to the affected breast; and completing the entire course of the prescribed antibiotics.

33. Postpartum Question #15 - V2

The nurse is caring for a client who gave birth 3 hours ago. The client is saturating perineal pads every 30 minutes and the fundus is above the umbilicus with deviation to the right. Which action should the nurse take? Select all that apply.

☐	Contact the obstetrician immediately.
	The nurse should implement fundal massage prior to contacting the healthcare provider (HCP); therefore, this is not an appropriate nursing action.
☐	Encourage increased oral intake of at least 2000 mL/day.
	Encouraging fluids of 1000-2000 mL is important, but does not address the client's problem; therefore, this is not an appropriate nursing action.
☐	Obtain a prescription for an oxytocin infusion.
	Until the nurse implements fundal massage and other interventions, such as assisting the client to the bathroom, this is not an appropriate nursing action.
☑	**Offer a bedside commode, bedpan, or assist the client to the bathroom.**
	Assisting the client to urinate is an appropriate nursing action. Emptying the bladder will enable the uterus to increase tone and prevent abnormal vaginal bleeding.
☑	**Obtain an order for a straight urethral catheterization if the client is unable to urinate.**
	A straight catheterization may be needed if the client is unable to urinate because of the effects of an epidural or narcotics; therefore, this is an appropriate action by the nurse.

During the process of uterine descent, or involution, the fundal height decreases gradually over a week's time. Immediately after birth the fundal height should be approximately at the umbilicus. A full bladder will prevent the uterus from descending; therefore, cause deviation and increase the risk for postpartum hemorrhage. The nursing actions appropriate for this client include assisting the client to urinate. If the client is unable to urinate independently, the nurse notifies the healthcare provider for an order for a straight catheterization.

34. Postpartum Question #16 - V2

The nurse has taught a client about breastfeeding. Which client statement indicates a correct understanding of the teaching?

1. "Breastfeeding 20 minutes per breast will assure colostrum is received."

The average latch time can vary between 10 minutes to 40 minutes; therefore, this client statement indicates a need for additional teaching from the nurse.

2. "If my baby does not latch, it often means they are not hungry."

The ability to effectively latch takes some time; therefore, this is not an indication that the neonate is not hungry; therefore, this statement does not indicate a correct understanding of breastfeeding.

✓ 3. "My baby should have their nose and chin against my breast to help with latching."

The baby's face should be against the mother's breast and tilted slightly back. This allows for a good latch on and feeding position; therefore, this statement indicates a correct understanding of breastfeeding.

4. "To prevent suffocation, my baby's nose should not touch the breast."

Babies who are placed in the correct position for breastfeeding have little risk of suffocation. If a woman has large breasts, she can slightly push on the top of the breast; therefore, this statement does not indicate understanding of breastfeeding.

The client should aim the nipple toward the baby's upper lip and/or nose. The baby's mouth should be wide open to facilitate an effective latch. Additionally, rubbing the nipple across the baby's top lip to elicit the rooting reflex is important for latching. Finally, the baby's body should be turned toward the breast while nursing. The nurse must provide this education to the lactating client and then evaluate understanding. Statements indicative of an inaccurate understanding should be clarified by the nurse.

35. Maternal & Newborn Health - Labor & Delivery - Reduction of Risk Potential – Q3

The nurse provides education to a laboring client who is prescribed an amnioinfusion. Which statement should the nurse include in the teaching session for the client and support person?

1. “The procedure typically takes several hours to complete.”

Once the procedure is initiated, it is typically complete in 20 to 30 minutes; therefore, this statement should not be included in the teaching session for the laboring client and support person regarding the amnioinfusion procedure.

✓ 2. “A vaginal examination will be required before the procedure.”

A vaginal examination is performed prior to the initiation of an amnioinfusion to confirm presentation, establish dilation, and evaluate for cord prolapse; therefore, this is an appropriate statement for the nurse to include when providing education regarding this procedure.

3. “Once the procedure begins, you can walk to assist with labor progression.”

The laboring client will be prescribed bed rest during the procedure; therefore, this statement should not be included in the teaching session for the laboring client and support person regarding the amnioinfusion procedure.

4. “You will be prepared for a cesarean birth immediately following this procedure.”

While it is important to prepare the laboring mother and support person that a cesarean birth may be required after the amnioinfusion if the fetal heart rate (FHR) does not improve, a surgical birth is not always required; therefore, this statement should not be included in the teaching session regarding this procedure.

There is **no standard protocol for amnioinfusion**; therefore, nurses should follow their own institution protocols. After obtaining informed consent, a vaginal examination is performed to confirm presentation, establish dilation, and evaluate for cord prolapse. Next, 250 to 500 mL of warmed fluid is administered using an infusion pump over 20 to 30 minutes. The nurse closely monitors the laboring client for symptoms associated with complications during and after the procedure. The statement the nurse includes when educating the laboring client and support person prior to the procedure is: **“A vaginal examination will be required before the procedure.”**

👉 *Video Rationale: https://d1pumg6d5kr18o.cloudfront.net/rationales-v2/maternal_newborn_health_labor_delivery_reduction_of_risk_potential_03/part.m3u8*

36. Maternal & Newborn Health - Postpartum - Reduction of Risk Potential - Q4

The nurse provides education to a postpartum client who requires fundal massage. Which client statement indicates a need for additional instruction?

1. “I will likely pass some clots during and after this procedure.”

Once the uterus begins to contract and becomes firm, bleeding and the passage of clots often occurs; therefore, this client statement does not indicate a need for additional instruction regarding fundal massage.

✓ 2. “I should drink extra water before the procedure to help flush out clots.”

An empty bladder prevents displacement of the uterus and ensures accurate assessment of uterine tone; therefore, this client statement indicates a need for additional instruction regarding fundal massage.

3. “This procedure may be uncomfortable but should not be overly painful.”

A fundal massage may cause mild discomfort but is not usually intensely painful; therefore, this client statement does not indicate a need for additional instruction regarding this procedure.

4. “This procedure should cause my uterus to contract and decrease my bleeding.”

The purpose of a fundal massage is to cause uterine contractions and firming and decreased bleeding; therefore, this client statement does not indicate a need for additional instruction regarding fundal massage.

Fundal checks are performed at frequent intervals to monitor uterine involution. The fundus

should be firm and midline. When a fundus is deviated from midline but firm, this usually indicates a full bladder. When a fundus is deviated and boggy, this usually indicates uterine atony. Fundal massage is only implemented to firm up a **boggy uterus (i.e., uterine atony)**. It can be performed as frequently as necessary; however, pharmacotherapy should be considered if the condition persists to decrease the risk for PPH. The nurse must educate the client prior to the procedure and then utilize the “teach-back” method to evaluate understanding. The client statement that indicates a need for additional instruction is: **“I should drink extra water before the procedure to help flush out clots.”**

👉 *Video Rationale: https://d1pumg6d5kr18o.cloudfront.net/rationales-v2/maternal_newborn_health_postpartum_reduction_of_risk_potential_4/part.m3u8*

37. Maternal & Newborn Health - Postpartum - Pharmacological and Parenteral Therapies - Q1

The nurse provides care for a client who requires the administration of methylergonovine to achieve uterine contraction to assist with involution and heavy bleeding. Which finding prior to administering this medication requires practitioner notification?

✓ 1. A blood pressure of 150/95 mm Hg.

Due to the impact of the uterotonic medication on all smooth muscles, including those in the client's blood vessels, hypertension is a complication associated with the prescribed medication. It is essential for the nurse to monitor the client's BP prior to administering the prescribed medication as a preexisting elevation over 140/90 mm Hg is a contraindication for administration; therefore, a blood pressure of 150/95 mm Hg warrants immediate practitioner notification prior to the administration of the methylergonovine.

2. An oral temperature of 99.8 degrees F.

A low-grade fever of 99 to 100 degrees F is expected during the early postpartum period of care due to the inflammatory process associated with childbirth and uterine involution. This finding does not warrant practitioner notification prior to the administration of the prescribed uterotonic medication.

3. A pain rate of 4/10 using a numeric scale.

Pain and discomfort is common during the postpartum period of care and the goal of care is keep pain at a level of 2 or less using a numeric scale. While the client's pain should be addressed, this finding does not warrant practitioner notification prior to the administration of the prescribed uterotonic medication.

4. An increase in urine output since childbirth.

This finding does not warrant practitioner notification prior to the administration of the prescribed uterotonic medication. Diuresis occurs almost immediately following childbirth thus allowing the bladder to fill with urine; therefore, an increase in urine output is expected.

Uterotonics such as methylergonovine cause contraction of all smooth muscles, including blood vessels. As a result, this medication can significantly **increase blood pressure** to the point of a hypertensive emergency which increases the client's risk for stroke. It is essential that the nurse **monitor the client's blood pressure prior to administering** the prescribed medication to decrease the risk for adverse reactions, including hypertension. If the client's blood pressure is greater than 140/90 mm Hg, the nurse should withhold the medication and notify the client's practitioner; therefore, the finding that requires practitioner notification is **a blood pressure of 150/95 mm Hg**.

👉 *Video Rationale: https://d1pumg6d5kr18o.cloudfront.net/rationales-v2/maternal_newborn_health_postpartum_pharmacological_and_parenteral_therapies_1/part.m3u8*

38. Maternal & Newborn Health - Labor & Delivery -Psychosocial Integrity – Q2

The nurse provides care for a client who has a history of intrauterine fetal demise (IUFD). When initiating intravenous (IV) access for the induction of labor, the client cries and screams, “Why did my baby die!” Which action by the nurse is appropriate?

1. Placing the client in physical restraints

> The use of physical restraint should only be implemented to enhance client and staff safety when other less invasive methods have been unsuccessful in the provision of care; therefore, this is not an appropriate action by the nurse.

✓ 2. Providing a calm and reassuring client environment

> This action by the nurse is appropriate. Clients with PTSD due to IUFD are often fearful; therefore, providing a calm, relaxing environment can help relieve anxiety and promote a feeling of safety.

3. Encouraging the identification of ineffective coping methods

> This is not an appropriate action by the nurse when a client is experiencing an acute PTSD flashback. This action is more appropriate when providing ongoing client care to address a nursing diagnosis of post trauma syndrome.

4. Facilitating access to community resources with a social work referral

> This is not an appropriate action by the nurse when a client is experiencing an acute PTSD flashback. This action is more appropriate when providing ongoing client care to address a nursing diagnosis of post trauma syndrome.

> In a **PTSD flashback**, clients may feel as if they are reliving a past traumatic incident as if it is currently happening. These flashbacks can be triggered by anything that reminds the client of a past trauma. Often an IUFD requires the induction of labor, thus admission for this same procedure for the current pregnancy may cause flashbacks, as evidenced by the client’s behavior. The appropriate action by the nurse is **providing a calm and reassuring client environment**.

👉 *Video Rationale: https://d1pumg6d5kr18o.cloudfront.net/rationales-v2/mn_health_labor_delivery_psychosocial_integrity_2/part.m3u8*

39. Maternal & Newborn Health - Postpartum - Management of Care - Q1

The nurse develops a plan of care for a primipara postpartum client who is breastfeeding. Which discharge referral should be included in the nursing plan of care?

1. Social work

There is no indication that this postpartum client and neonate require a social work referral after hospital discharge. Social workers specialize in the protection of vulnerable children and support families in need of assistance.

✓ 2. Lactation services

A primipara postpartum client has little to no breastfeeding experience; therefore, a referral to lactation services is warranted to enhance success.

3. Psychiatric services

While the postpartum client is at risk for depression, there is no indication that a psychiatric services referral is warranted upon hospital discharge. The client should be taught about postpartum depression and symptoms that require intervention during discharge instruction.

4. Occupational therapy

There is no indication that this postpartum client and neonate require an occupational therapy referral after hospital discharge. Occupational therapists treat disabled, ill, and injured clients through the therapeutic use of everyday activities.

According to the American Association of Pediatrics (AAP), there is sufficient evidence that **breastfeeding** provides the best nutrition for newborns and should be continued for the first 6 months; additionally, breastfeeding should continue for at least the first year of life with the introduction of solid foods. Evidence suggests the need for extended breastfeeding support beyond the hospital setting discharge for clients to continue to breastfeed longer. Nurses can be instrumental in making referrals to promote the safe transition from the hospital to the home as new mothers need to have access to community-based resources after discharge, including **lactation services** to reinforce the postpartum education.

👉 *Video Rationale: https://d1pumg6d5kr18o.cloudfront.net/rationales-v2/maternal_newborn_health_postpartum_management_of_care_1/part.m3u8*

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40. Maternal & Newborn Health - Labor & Delivery - Reduction of Risk Potential – Q2

The nurse monitors a client who receives a prescribed amnioinfusion during labor. Which finding requires immediate action by the nurse? **Select all that apply.**

☐	Accelerations noted on the fetal heart monitor
	This finding does not warrant immediate action by the nurse. Fetal distress is indicated by deceleration, not acceleration noted when monitoring the fetal heart rate pattern.
☑	**Changes in level of consciousness (LOC)**
	Changes in LOC, including confusion is a finding that warrants immediate action by the nurse during or after the administration of an amnioinfusion. This finding is indicative of amniotic fluid embolism, a potentially life-threatening complication associated with amnioinfusion.
☐	Pink skin that is warm to the touch
	This finding does not warrant immediate action by the nurse as skin that is pink and warm to the touch does not indicate a complication associated with amnioinfusion. Skin discoloration (e.g., cyanosis, paleness) is an indicator of amniotic fluid embolism (AFE).
☑	**Chills and nausea**
	Chills and nausea are both early indicators of amniotic fluid embolism (AFE), a potentially life-threatening complication associated with an amnioinfusion; therefore, this finding warrants immediate action by the nurse.
☐	Diarrhea
	This finding does not warrant immediate action by the nurse. Vomiting, not diarrhea, is an early clinical manifestation of amniotic fluid embolism, a complication associated with amnioinfusion.

An amnioinfusion is typically prescribed to address severe variable decelerations, an indicator of cord compression which negatively impacts fetal circulation. Complications of amnioinfusion include **amniotic fluid embolism (AFE)**, fetal bradycardia, umbilical cord prolapse and uterine overdistention. A client experiencing AFE, a potentially life-threatening condition, often reports or exhibits early symptoms that when identified and treated decreases the risk for maternal morbidity and mortality. Early clinical manifestations of AFE may include agitation, anxiety, **changes in LOC** (e.g., confusion), **chills**, fetal distress, impending sense of doom, **nausea**, skin discoloration, and vomiting; therefore, these findings warrant immediate action by the nurse.

👉 *Video Rationale: https://d1pumg6d5kr18o.cloudfront.net/rationales-v2/maternal_newborn_health_labor_delivery_reduction_of_risk_potential_02/part.m3u8*

41. Maternal & Newborn Health - Postpartum - Basic Care and Comfort - Q4

Which nonpharmacologic strategy should the nurse implement in the provision of care for a postpartum client who reports muscular pain in the shoulders?

✓ 1. Providing the client with a massage

Massage therapy relaxes muscle tissue, which reduces painful contractions and spasms; therefore, this is an appropriate non pharmacological strategy for the nurse to implement to address muscle pain in the postpartum period of care.

2. Applying ice to the area of discomfort

The application of ice causes vasoconstriction which can worsen muscle aches and pains; therefore, this is not an appropriate non pharmacological action by the nurse. The application of heat, however, may be soothing so some clients.

3. Reminding the client to void frequently

Voiding frequently is an intervention to decrease the risk for bladder distention; however, this action by the nurse does not address muscular pain in the postpartum period of care.

4. Instructing on the steps for Kegel exercises

Kegel exercises are recommended to relieve perineal edema that occurs with vaginal births. This action, however, does not address muscular pain in the postpartum period of care.

Pain during the postpartum period of care is common and is often caused by perineal discomfort after vaginal births; uterine involution which causes cramping, or “afterpains;” and muscle aches. Clients often describe the muscular discomfort as feelings of achiness or soreness; some may describe it as feeling like they, “have run for miles.” A backrub is usually effective for relieving muscular discomfort in the back or shoulders; therefore, **providing the client with a massage** is an appropriate non pharmacological nursing action. If the pain persists, however, over-the-counter analgesics may be required.

👉 *Video Rationale: https://d1pumg6d5kr18o.cloudfront.net/rationales-v2/maternal_newborn_health_postpartum_basic_care_and_comfort_4/part.m3u8*

42. Maternal & Newborn Health - Postpartum - Psychosocial Integrity - Q1

The home care nurse assesses a client who is 10 day’s postpartum. Which client statement warrants the use of a depression scale to detect postpartum depression (PPD)?

1. “One minute I am happy and the next I am sad.”

Emotional lability is the most prominent symptom of postpartum blues.

2. “I sometimes don’t eat because I am so exhausted.”

Exhaustion is common in the postpartum period of care and not wanting to eat because of it is not indicative of PPD. The client should be counseled on the importance of adequate nutrition for both physiologic and psychosocial well-being.

3. “I get teary-eyed over the smallest things since I came home.”

Tearfulness to small annoyances is a common finding with postpartum blues.

✓ 4. “I feel so alone and I spend most of my days crying that I am a bad mother.”

Isolation that causes the postpartum client to cry on most days and feel like a bad mother are signs of PPD; therefore, data warrants a PPD screening.

The nurse must **differentiate symptoms of postpartum (i.e., baby) blues from PPD** in the provision of client care. The baby blues typically manifest as sadness and tears 1 to 10 days after birth; emotional lability is common with postpartum blues. Clinical manifestations of PPD, however, can occur anytime within 12 months of childbirth and include anxiety in addition to feelings of loss and sadness. It is not uncommon for the client to express feelings of isolation, worthlessness, and a lot of crying. The client statement that indicates a need for a focused PPD screening is: **“I feel so alone and I spend most of my days crying that I am a bad mother.”**

👉 *Video Rationale: https://d1pumg6d5kr18o.cloudfront.net/rationales-v2/maternal_newborn_health_postpartum_psychosocial_integrity_1/part.m3u8*

43. Critical Care Question #1

The nurse prepares to insert a nasogastric (NG) tube into a client who sustained severe facial injury due to a motor vehicle accident. Which finding requires the nurse to notify the health care provider (HCP) prior to performing the prescribed procedure?

✓ 1. A positive halo test for nasal drainage added to a 2 x 2 gauze sponge.

A positive halo test indicates that there is the presence of cerebrospinal fluid (CSF). This finding contraindicates the use of an NG tube due to a potential skull fracture; therefore, the HCP should be notified prior to the nurse implementing this procedure.

2. Laceration located just above the lip that is oozing a small amount of bright red blood.

Small lacerations are to be expected when providing care for a client who sustained facial trauma. It would be concerning if the wound were to begin to show signs of infection (e.g., warm to the touch, purulent drainage, fever).

3. Client reports a throbbing headache rated as a 7/10 on a 1-10 numeric pain scale.

A headache is an expected finding after direct trauma to the head. It would be concerning if the headache is not relieved by analgesics or is accompanied by signs of increased intracranial pressure (ICP) such as nausea, vomiting, or double vision.

4. Significant amount of bruising on the client's forehead.

Bruising is an expected finding for clients who experience direct trauma to the face. Bruising around the eyes (i.e., raccoon eyes) or postauricular bruising (i.e, Battle sign) would indicate a need for further evaluation for skull fracture.

The HCP may prescribe the insertion of an NG tube for client's to receive enteral nutrition. There are certain instances, however, where the insertion of an NG tube is contraindicated. One such instance is a client who is suspected of having a basilar skull fracture. A basilar skull fracture is suspected for any client who has the drainage of CSF via the nose, confirmed with a positive halo test. This client will likely be prescribed an orogastric (OG) tube to provide enteral nutrition.

👉 *Video Rationale: https://d1pumg6d5kr18o.cloudfront.net/rationales-v2/critical_care_1547/part.m3u8*

44. Critical Care Question #1 - V2

The nurse is preparing to insert a nasogastric (NG) tube into a client who sustained severe facial injury due to a motor vehicle crash (MVC). Which finding requires the nurse to notify the health care provider (HCP) prior to performing the prescribed procedure?

✓ 1. Nasal drainage that has a positive halo sign when applied to a gauze sponge.

A positive halo test indicates that there is the presence of cerebrospinal fluid (CSF). This finding contraindicates the use of an NG tube due to a potential skull fracture; therefore, the HCP should be

notified prior to the nurse implementing this procedure.

2. A laceration located above the lip that is oozing a small amount of bright red blood.

Small lacerations are to be expected when providing care for a client who sustained facial trauma. It would be concerning if the wound were to begin to show signs of infection (e.g., warm to the touch, purulent drainage, fever).

3. The client reports a throbbing headache rated as a 7/10 on a 0-10 pain scale.

A headache is an expected finding after direct trauma to the head. It would be concerning if the headache is not relieved by analgesics or is accompanied by signs of increased intracranial pressure (ICP) such as nausea, vomiting, or double vision.

4. A significant amount of bruising noted on the client's forehead.

Bruising is an expected finding for clients who experience direct trauma to the face. Bruising around the eyes (i.e., raccoon eyes) or postauricular bruising (i.e, Battle sign) would indicate a need for further evaluation for skull fracture.

The HCP may prescribe the insertion of an NG tube for client's to receive enteral nutrition. There are certain instances, however, where the insertion of an NG tube is contraindicated. One such instance is a client who is suspected of having a basilar skull fracture. A basilar skull fracture is suspected for any client who has the drainage of CSF via the nose, confirmed with a positive halo test. This client will likely be prescribed an orogastric (OG) tube to provide enteral nutrition.

45. Critical Care Question #2 - V2

The newly hired nurse is assessing a client who is diagnosed with septic shock and is receiving an intravenous (IV) dopamine infusion. The nurse notes that the client's second IV site has infiltrated and the below vital sign findings.

	Assessment Findings
T	98.6° F (37° C)
HR	88
RR	20
BP	102/54 mm Hg

SaO2	98% on 40% aerosol face mask

Which action by the newly hired nurse requires follow up by the nurse preceptor?

✓ 1. Failing to notify the pharmacy in a timely manner when a new IV dopamine bag is needed.

Dopamine is considered a first line treatment vasopressor for clients who are diagnosed with septic shock. This medication is needed to preserve adequate organ perfusion through increasing systemic blood pressure; therefore, this action by the novice nurse warrants priority intervention by the nurse preceptor.

2. Changing the client's face mask to a nasal cannula per standing protocol to maintain oxygen saturation at 95%.

It is appropriate to wean this client from a mask to a nasal cannula when oxygen saturations are maintained above parameters; therefore, this action by the novice nurse does not warrant priority intervention by the nurse preceptor.

3. Clarifying a new prescription to change the client's maintenance IV fluids from 0.9% sodium chloride (NS) to 0.45% sodium chloride (NS).

It is appropriate to seek clarification of this IV prescription because an isotonic fluid such as full strength normal saline is required to increase circulatory function while 1/2 strength normal saline is more appropriate for clients who experience hypertonic dehydration.

4. Rescheduling the client's IV antibiotic for a later time due to a currently infiltrated IV site.

It is appropriate to reschedule the prescribed antibiotic infusion to ensure that the client has a patent IV site for proper administration.

Blood pressure is of critical importance when caring for a client that is currently experiencing septic shock. Low blood pressure is a sign that the blood volume is decreasing. This can cause organ dysfunction and adversely affect the contractility of the heart. Abruptly discontinuing vasoactive medications, such as dopamine, can cause hemodynamic instability and these medications should be slowly tapered. Based on this information, the action by the newly hired nurse that requires priority intervention by the nurse preceptor is allowing the bag of dopamine to run low without having a replacement sent from the pharmacy.

46. Critical Care Question #3

The nurse provides care for a newly extubated client. Which is the first nursing intervention when providing care for this client?

✓ 1. Auscultate breath sounds in all fields.

Airway status should be assessed first to ensure that the client is not experiencing respiratory distress and lung fields are being oxygenated; therefore, this is the priority action by the nurse when providing care for a client who is newly extubated.

2. Provide oral care every two hours.

Mouth care should be provided to decrease oral bacteria and provide for client comfort; however, this is not the priority nursing action for the client who is newly extubated as this task can be performed once the client's airway status is assesses post extubation.

3. Administer oxygen, 2 liters per minute by nasal cannula (NC).

While supplemental oxygen may be necessary after extubation to ensure adequate oxygenation of the client's body tissues, this intervention is not implemented until the nurse assesses the client's airway. Supplemental oxygen that is administered should be warmed and humidified to prevent drying of the mucosa.

4. Teach the client to use the incentive spirometer.

While the newly extubated client should be encouraged to breathe deeply through the use of an incentive spirometer as this device expands the alveoli and prevents the development of atelectasis, this is not the priority nursing action. This intervention can be implemented once the nurse assesses the client's respiratory status.

Evidence-based practice guidelines dictate the interventions that must be implemented when providing care for a client who is newly extubated. The priority nursing action is to closely assess the client's respiratory status to ensure a patent airway. Additionally, the client may require supplemental oxygen to decrease the risk for hypoxia. These clients should also remain NPO until the client's swallowing status can be evaluated by a speech therapist. The nurse should also ensure the implementation of routine oral care to decrease the risk of infection.

👉 *Video Rationale: https://d1pumg6d5kr18o.cloudfront.net/rationales-v2/critical_care_1549/part.m3u8*

47. Critical Care Question #3 - V2

The nurse is caring for a client who has just been extubated. The nurse should perform which nursing intervention **first**?

✓ 1. Auscultate breath sounds in all fields.

Airway status should be assessed first to ensure that the client is not experiencing respiratory distress and lung fields are being oxygenated; therefore, this is the priority action by the nurse when providing care for a client who is newly extubated.

2. Provide thorough oral care.

Mouth care should be provided to decrease oral bacteria and provide for client comfort; however, this is not the first nursing action for the client who is newly extubated as this task can be performed once the client's airway status is assessed.

3. Administer oxygen at 2 L/min via nasal cannula (NC).

While supplemental oxygen may be necessary after extubation to ensure adequate oxygenation of the client's body tissues, this intervention is not implemented until the nurse assesses the client's airway. Supplemental oxygen that is administered should be warmed and humidified to prevent drying of the mucosa.

4. Teach the client to use the incentive spirometer (IS).

While the newly extubated client should be encouraged to breathe deeply through the use of an incentive spirometer as this device expands the alveoli and prevents the development of atelectasis, this is not the first nursing action. This intervention can be implemented once the nurse assesses the client's respiratory status.

Evidence-based practice guidelines dictate the interventions that must be implemented when providing care for a client who is newly extubated. The first nursing action is to closely assess the client's respiratory status to ensure a patent airway. Additionally, the client may require supplemental oxygen to decrease the risk for hypoxia. These clients should also remain NPO until the client's swallowing status can be evaluated by a speech therapist. The nurse should also ensure the implementation of routine oral care to decrease the risk of infection.

48. Critical Care Question #4 - V2

The nurse is planning care for a client who is newly diagnosed with Guillain-Barre syndrome (GBS). The nurse should include which intervention in the plan of care? **Select all that apply.**

☑	**Close monitoring of the rate and depth of respirations.**
	The depth and rate of the client's respirations should be monitored closely as respiratory failure is the most life-threatening complication of GBS.

☐	Document non-reactive pupils and continue to monitor.
	Pupil assessment evaluates the function of multiple cranial nerves; however, GBS rarely ascends to affect cranial nerve function; therefore, this intervention is not included by the nurse in the plan of care.
☑	**Encourage slow position changes during transfers.**
	Due to autonomic dysfunction common in GBS, interventions to prevent orthostatic hypotension should be implemented for client safety; therefore, this intervention is included by the nurse in this client's plan of care.
☐	Immediately report absent knee reflexes to the health care provider (HCP).
	Absence of knee reflexes is expected in the early course of GBS. As this is an expected finding, immediate reporting to the HCP is not necessary; therefore, this intervention should not be included in the client's plan of care.
☑	**Keep an incentive spirometer at your bedside at all times.**
	The utilization of an incentive spirometer is standard of care for assessing early ventilation failure for a client who is diagnosed with GBS; therefore, this intervention is included in the client's plan of care by the nurse.

Neuromuscular respiratory failure is the most life-threatening complication of GBS as paralysis ascends into the thoracic region. The nurse should ensure a thorough respiratory assessment is completed. This assessment needs to include both the rate and depth of respirations. The nurse should record the client's vital capacity through an incentive spirometer as additional evidence of respiratory function.

49. Critical Care Question #5 - V2

The nurse is assisting with a rapid sequence intubation on a client who is in respiratory failure. Soon after succinylcholine is administered for sedation, the client develops muscle rigidity and diaphoresis. Which intravenous (IV) medication should the nurse prepare to administer?

1. Atropine.

IV atropine is used to treat bradycardia. There is no indication that this client is experiencing a decreased heart rate; therefore, this is not the medication the nurse prepares to administer.

✓ 2. Dantrolene.

IV dantrolene is the antidote to succinylcholine because it slows the metabolism by inhibiting calcium release to prevent muscle contractions; therefore, this is the medication the nurse should prepare to administer for this client.

3. Dopamine.

IV dopamine is utilized to increase the pumping strength of the heart and, in certain dosages, improves blood flow to the kidneys. In this client dopamine could potentially cause acute renal failure as diuretics are used to ensure renal function after administering dantrolene; therefore, the nurse should not prepare to administer this medication to this client.

4. Metoprolol.

Metoprolol is a beta blocker that can be used to treat persistent tachyarrhythmia if the antidote, dantrolene, is not effective; therefore, this is not the medication that the nurse should prepare to administer to the client based on the current data.

Malignant hyperthermia causes tachypnea, tachycardia, increased temperature, and rigid jaw or generalized rigidity in the client. Further progression leads to high fevers, breakdown of muscle tissue, hyperkalemia, and cardiac dysrhythmia. Primary treatment for malignant hyperthermia is the administration of IV dantrolene, the antidote. Additional interventions for this client may include cooling the client and treating abnormal laboratory values.

50. Critical Care Question #6 - V2

The nurse is caring for a client who has a mediastinal chest tube. The nurse notes bubbling in the suction control chamber. Which action should the nurse take?

✓ 1. Continue to monitor the client and document chest tube drainage.

Air bubbles within the suction control chamber is an expected finding and the nurse should continue to monitor with subsequent documentation.

2. Disconnect the chest tube from suction for one hour and restart suction.

Discontinuing the suction would negate the benefit of the drainage system as a whole; therefore, this is not an appropriate nursing action based on the current data.

3. Notify the healthcare provider (HCP) of the presence of an air leak.

An air leak would appear as bubbling within the air leak gauge or water seal chamber of the drainage unit. Since the bubbling is within the correct area of the drainage system, this data does not need to be reported to the HCP by the nurse.

4. Palpate around the chest tube dressing to assess for crepitus.

Crepitus, if present, is the leak of air into the tissue surrounding the chest tube insertion site. This finding does not affect the bubbling within the drainage system; therefore, this is not an appropriate action by the nurse based on the current data.

Gentle, continuous bubbling in the suction chamber is an expected finding when providing care for a client with a mediastinal chest tube. The bubbling indicates the presence of suction within the suction control chamber. The nurse should be familiar with the brand of chest tube drainage systems that are used within their specific care area. This baseline knowledge ensures the nurse can identify a true abnormal finding within a chest tube drainage system in use for an assigned client.

51. Critical Care Question #7 - V2

The nurse is caring for a client who returns to the unit following abdominal surgery. The most recent vital signs are as follows:

T	100° F (37.8° C)
HR	110 bpm
RR	24 breath/min
BP	88/60 mm Hg
Oxygen Saturation	97% on room air
Central Venous Pressure (CVP)	2 mm Hg

Which healthcare provider (HCP) prescription should the nurse implement **first**?

1. Acetaminophen 650 mg PRN fever.

The client's hemodynamic status must be addressed first prior to the administration of an antipyretic agent for a fever; therefore, this is not the first prescription the nurse implements based on the current client data.

✓ 2. 1000 mL bolus of 0.9% sodium chloride (NS).

An isotonic solution is required to restore this client's fluid volume as current data indicates hypovolemia; therefore, this is the first HCP prescription that the nurse implements based on the current information for this client.

3. Vancomycin 1250 mg intravenous piggyback (IVPB).

Antibiotics are prescribed in the prevention, and or treatment, of infection following abdominal surgery; however, this is not the first HCP prescription that the nurse implements as the client's fluid volume deficit must be addressed first.

4. Dopamine 5 mcg/kg/min for systolic BP less than 90 mm Hg.

Vasopressors or inotropic medications should only be used if the client remains hypotensive after the prescribed fluid bolus; therefore, this is not the first HCP prescription that the nurse implements based on the current client data.

A client who experiences a fluid volume deficit can progress to hypovolemic shock without the implementation of appropriate interventions that are supported by evidence-based practice guidelines. Manifestations of hypovolemic shock include hypotension, tachycardia, and a CVP. Initial interventions should include medication that is meant to increase the client's BP. Increasing the BP will ultimately ensure end-organ perfusion. The HCP prescription that the nurse implements first based on the current data is the administration of isotonic fluids. Once this prescription is implemented by the nurse, other interventions can be implemented as prescribed.

52. Critical Care Question #8 - V2

The nurse manager is observing the implementation of cardiopulmonary resuscitation (CPR) for a client. Which action, noted by the nurse manager, indicates effective CPR? **Select all that apply.**

☐	Assessment of carotid pulse for 20 seconds every two minutes.
	The assessment for pulse between compression cycles should not be greater than 10 seconds; therefore, this is not an action that indicates effective CPR.
☑	**Chest compressions performed at a rate of 100-120 per minute.**
	The standard rate of delivery of chest compressions is 100-120 per minute; therefore, this finding is indicative of effective CPR.
☐	Compressions given at a depth of one inch then allowing full chest recoil.
	The recommended depth of chest compressions is 2.0-2.4 inches, not one inch; therefore, this finding does not indicate effective CPR.
☑	**Continuance of chest compressions while the defibrillator pads are placed.**
	The placement of defibrillator pads should not interrupt the compression cycles; therefore, this finding is indicative of effective CPR. When defibrillation is set to be implemented, the individual responsible for delivery of

	this intervention states, “STAND CLEAR” and then shock is delivered.
☑	**Manual breaths delivered at a rate of 2 breaths per 30 compressions.**
	Manual breaths are administered at a rate of 2 per 30 chest compressions to clients that do not have an advanced airway placed; therefore, this finding is indicative of effective CPR.

Chest compressions should be performed at a rate of 100 to 120 per minute and the chest should be allowed to completely recoil between these compressions with the implementation of CPR. In the presence of a defibrillator, the pads should be placed on the client while compressions are being delivered. These pads are placed opposite each other on an adult, one on the right upper chest and the other on the left lateral chest. Manual breaths are delivered at a rate of 2 per 30 compressions in conjunction with chest compressions. These findings are indicative of effective CPR.

53. Critical Care Question #9 - V2

The nurse is caring for a client who is sedated, intubated, and receiving continuous enteral feedings via a nasogastric (NG) tube. Which intervention should the nurse implement to prevent aspiration? **Select all that apply.**

☐	Assess the location of the NG tube at least once per shift.
	When a client is prescribed continuous enteral feedings via an NG tube, evidence-based practice guidelines dictate that tube placement is checked every 4 hours, not once a shift.
☑	**Maintains the head of bed at 45 degrees or higher at all times.**
	Unless medically contraindicated, the head of the bed should be elevated at a minimum of 30 degrees up to 45 degrees to reduce the risk of aspiration; therefore, this is an appropriate intervention by the nurse when providing care for a client who is prescribed continuous enteral feeding by NG tube.
☑	**Measure gastric residual volume at least every four hours.**
	Assessing gastric residual volumes is the standard of care for clients receiving continuous feedings and is monitored every 4 hours when assessing NG tube placement. Clients who experience increasing residual volume may be experiencing poor absorption which increases the risk of regurgitation and aspiration.
☑	**Perform regular sedation vacations to assess mental status.**
	A sedation scale such as the Ramsay Scale can be used to assess the level of sedation. Keeping the client minimally sedated helps decrease the risk of aspiration; therefore, this intervention by the nurse is appropriate.
☐	Request that the health care provider (HCP) change the client to bolus feedings.

	Bolus feedings are contraindicated in critically ill clients as the large fluid amount in shorter intervals places the clients at a greater risk of aspiration; therefore, this is not an appropriate nursing action based on the current data.

Continuous feedings delivered via NG tube are recommended by evidence-based practice (EBP) guidelines for critically ill clients. Bolus feedings increase the risk of aspiration in clients who are sedated; therefore, this type of feeding is contraindicated. The nurse can implement interventions that are supported by EBP guidelines to decrease the client's risk for aspiration. These nursing actions include assessing gastric residual volumes and NG tube placement every 4 hours and maintaining the head of the client's bed at 30 to 45 degrees or higher to decrease the risk for aspiration.

54. Critical Care Question #10 - V2

The nurse is caring for a client who is intubated and experiencing a decline in oxygen saturation. Which nursing action should the nurse take **first**?

✓ 1. Listen to breath sounds throughout all lung fields.

Auscultating lung sounds is the first and quickest nursing action to assess endotracheal tube (ETT) placement for a client who is exhibiting declining oxygen saturation levels. Additionally, this nursing action also monitors for the development of a pneumothorax which could be the reason for the client's declining oxygen saturation levels.

2. Manually oxygenate the client with a bag valve mask (BVM).

If the client's endotracheal tube (ETT) is not in the correct place, this action would not enhance ventilations thus address the client's declining oxygen saturation levels; therefore, this is not the priority nursing action for this client.

3. Notify the healthcare provider (HCP) immediately.

An assessment should occur prior to reporting client data to the HCP to ensure that all information needed is reported in a timely manner; therefore, this is not the priority nursing action for this client.

4. Perform sterile suctioning of the endotracheal tube (ETT).

Secretions in the artificial airway can create mucus plugs which activate high-pressure ventilator alarms. Because of this, auscultation of lung sounds prior to suctioning must occur otherwise further damage could be done to the airway when suctioning a displaced tube; therefore, this is not the priority nursing action for this client.

An assessment of the artificial airway tube is the quickest and first nursing action when determining the reason for a client's declining oxygen saturation level. It is not uncommon for the tube to become displaced. Additionally, declining oxygen saturation levels can also occur as a result of a pneumothorax, a potential complication related to the use of mechanical ventilation. Pneumothorax can also cause the client to experience hypotension, or a low blood pressure.

55. Critical Care Question #11 - V2

The nurse is assessing a client who sustained a T1 spinal fracture after a fall. The client has a blood pressure (BP) of 76/42 mm Hg, a heart rate (HR) of 48 beats per minute, and skin that is dry. Which action should the nurse perform **first**?

1. Perform a complete neurological assessment.

While a complete neurological assessment is appropriate for this client, it is not the nurse's first action based on the current data as the client's circulatory status must be stabilized first.

2. Check for a fecal impaction or a full bladder.

Lack of bowel and/or bladder function is associated with a high-level fracture; however, these symptoms occur weeks to years after the initial injury; therefore, this is not the first action by the nurse based on the current data.

3. Collect a urine sample to check for red blood cells (RBCs).

The presence of RBCs within the client's urine can indicate kidney damage from the accident; however, the stabilization of the client's circulatory system is the priority.

✓ 4. Quickly administer 500 mL 0.9% sodium chloride (NS) bolus.

Systolic blood pressure needs to remain above 80 mm Hg for adequate kidney and organ perfusion; therefore, the administration of prescribed fluids is the priority nursing action when providing care for this client.

The classic signs of neurogenic shock are hypotension, bradycardia and pink/dry skin from vasodilation. Vascular dilation with decreased venous return to the heart is due to loss of innervation from the spine. The hypotension must be treated with isotonic fluids to maintain end organ perfusion. Systolic blood pressure should remain at 80 mm Hg or above for adequate perfusion to the kidneys.

56. Critical Care Question #12

The nurse preceptor supervises a novice nurse who is providing care for a mechanically ventilated client with increased intracranial pressure (ICP). Which action by the novice nurse requires the nurse preceptor to intervene? **Select all that apply**.

☐	Encourages visitors to speak softly and keep all lights dimly lit.
	Maintaining a calm, low stimulation environment is supported by evidence-based practice (EBP) guidelines for a client who is mechanically ventilated with increased ICP; therefore, this action by the novice nurse does not require the nurse preceptor to intervene.
☐	Gives the client 100% oxygen before suctioning the endotracheal tube (ETT).
	Hyperventilation and preoxygenation of the client prior to suctioning the ETT reduces the CO2 levels and further induces vasoconstriction and reduces ICP; therefore, this action by the novice nurse does not require the nurse preceptor to intervene.
☑	**Hangs a bag of 0.45% normal saline when the client's maintenance fluids run out.**
	Half-strength normal saline is a hypotonic solution and should be avoided in trauma clients as the solution would cause water to shift from the extracellular fluid compartment to the intracellular compartment; therefore, this action by the novice nurse requires the nurse preceptor to intervene.
☐	Performs minimal stimulation interventions in the provision of client care.
	Maintaining a calm, low stimulation environment is supported by evidence-based practice guidelines in the provision of care for a client who is mechanically ventilated and experiencing increased ICP; therefore, this action by the novice nurse does not require the nurse preceptor to intervene.
☑	**Suctions the endotracheal tube (ETT) for 20 seconds per pass every 30 minutes.**
	Suctioning is only recommended as needed and each pass should not exceed 10 seconds as prolonged suctioning can further increase the client's ICP; therefore, this action by the novice nurse requires the nurse preceptor to intervene.

Nursing activities can increase a client's ICP and should be limited and spread out throughout the day. The goal of nursing care for a client who is diagnosed with increased ICP is to manage the client's basic needs while reducing the ICP. Nursing actions that are supported by evidence-based practice (EBP) guidelines for the management of increased ICP include elevating the head of bed, administering stool softeners, managing pain, and maintaining a calm environment.

👉 *Video Rationale: https://d1pumg6d5kr18o.cloudfront.net/rationales-v2/critical_care_1558/part.m3u8*

57. Critical Care Question #12 - V2

The nurse preceptor is observing a newly hired nurse provide care to a client who is being mechanically ventilated and has increased intracranial pressure (ICP). Which action by the newly hired nurse requires the nurse preceptor to intervene? **Select all that apply.**

☐	Encourages visitors to speak softly and keep lights dimly lit.
	Maintaining a calm, low stimulation environment is supported by evidence-based practice (EBP) guidelines for a client who is mechanically ventilated with increased ICP; therefore, this action by the novice nurse does not require the nurse preceptor to intervene.
☐	Provides 100% oxygen before suctioning the endotracheal tube (ETT).
	Hyperventilation and preoxygenation of the client prior to suctioning the ETT reduces the CO2 levels and further induces vasoconstriction and reduces ICP; therefore, this action by the novice nurse does not require the nurse preceptor to intervene.
☑	**Hangs an intravenous (IV) bag of 0.45% sodium chloride (NS).**
	Half-strength normal saline is a hypotonic solution and should be avoided in trauma clients as the solution would cause water to shift from the extracellular fluid compartment to the intracellular compartment; therefore, this action by the novice nurse requires the nurse preceptor to intervene.
☐	Performs minimal stimulation interventions when providing client care.
	Maintaining a calm, low stimulation environment is supported by evidence-based practice guidelines in the provision of care for a client who is mechanically ventilated and experiencing increased ICP; therefore, this action by the novice nurse does not require the nurse preceptor to intervene.
☑	**Suctions the endotracheal tube (ETT) for 20 seconds per pass every 30 minutes.**
	Suctioning is only recommended as needed and each pass should not exceed 10 seconds as prolonged suctioning can further increase the client's ICP; therefore, this action by the novice nurse requires the nurse preceptor to intervene.

Nursing activities can increase a client's ICP and should be limited and spread out throughout the day. The goal of nursing care for a client who is diagnosed with increased ICP is to manage the client's basic needs while reducing the ICP. Nursing actions that are supported by evidence-based practice (EBP) guidelines for the management of increased ICP include elevating the head of the bed, administering stool softeners, managing pain, and maintaining a calm environment.

58. Critical Care Question #13 - V2

The nurse is teaching the spouse of a client who is receiving mechanical ventilation via an endotracheal tube (ETT). Which statement by the spouse indicates that the nurse needs to provide further teaching?

✓ 1. "My spouse will be suctioned every hour to prevent build up of secretions."

Evidence-based practice (EBP) guidelines indicate that clients who are intubated with an ETT and mechanically ventilated are suctioned when needed or no more than every 2 hours, not hourly; therefore, this statement indicates a need for additional teaching.

2. "My spouse's neck will be assessed to check for leaks in the endotracheal tube."

Frequent auscultation of the neck for leaks is standard practice. A leak increases the risk of extubation, impairs ventilation, and could precipitate aspiration; therefore, this statement does not indicate a need for further teaching.

3. "I can expect my spouse to receive mouth care frequently and with suctioning."

Mouth care is essential to decrease and prevent bacterial growth in the mouth. This intervention prevents bacteria from entering the airway thus decreasing the risk for pneumonia; therefore, this statement does not indicate a need for additional teaching.

4. "I can expect my spouse's position to be changed at least every two hours."

Repositioning every two hours is the recommended practice to prevent secretions from pooling in the lungs in addition to decreasing the client's risk for pressure injury; therefore, this statement does not require additional teaching from the nurse.

Suctioning of the client's ETT improves ventilation in clients who are mechanically ventilated by removing mucus and secretions from the tube. This intervention should be performed based on assessment findings such as adventitious breath sounds, elevated peak airway pressure, coughing, or acute respiratory distress. Suctioning should only be performed when needed and no more than every 2 hours per evidence-based practice (EBP) guidelines for the mechanically ventilated client. Limiting suctioning also reduces the risk of lung trauma and hypoxic episodes.

59. Critical Care Question #14 - V2

The nurse is caring for a client who is in the post anesthesia care unit (PACU). Which client assessment finding requires **immediate** action by the nurse?

1. Lethargy.

Lethargy is an expected finding in a client in the PACU; therefore, this assessment data does not require action by the nurse.

✓ 2. Muscle rigidity.

Muscle rigidity is an early sign of malignant hyperthermia; therefore, this assessment finding requires immediate action by the nurse.

3. Pupils 1+.

Small pupil size (i.e., pupils + 1) is an expected finding for a client in the PACU; therefore, this assessment data does not require immediate action by the nurse.

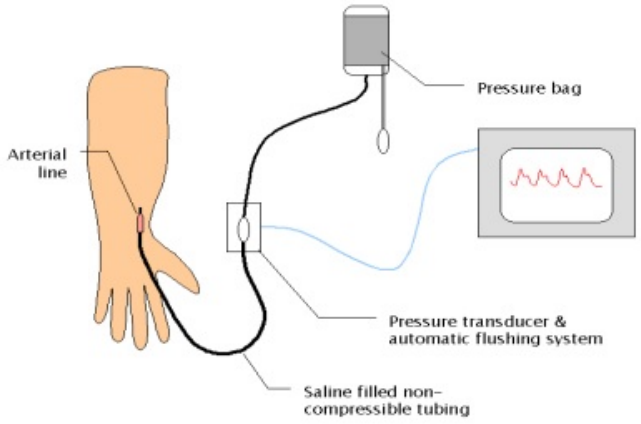
4. Temperature 99° F (37.2° C).

Close monitoring of temperature is appropriate for the client in the PACU as rising temperatures is a late finding in malignant hyperthermia. However, the current data does support a need for immediate action by the nurse.

Malignant hyperthermia (MH) is characterized by hypercapnia, generalized muscle rigidity, and hyperthermia. Hyperthermia is a later sign of a reaction to general anesthetics. This condition can cause the temperature to rise 1 degree every 5 minutes to an excess of 105 degrees F (40.5 degrees C). This reaction is caused by a trigger to body tissues which causes a release of excessive amounts of calcium from the muscles. This is a potentially life-threatening complication associated with general anesthesia thus requires immediate action by the nurse.

60. Critical Care Question #15 - V2

The nurse is assessing a client who is post- operative from cardiac surgery. The low pressure alarm for the brachial arterial line alarms. Which action should the nurse take **first**?



✓ **1. Assess the tubing for loose connections or evidence of bleeding.**

The first action by the nurse is to assess the line for a loose connection or bleeding as hemorrhage can occur if the brachial arterial line becomes disconnected.

2. Ensure the transducer is at the level of the phlebostatic axis.

Evaluating the location of the transducer should only be done after assessing for a physiological cause of the alarm; therefore, this is not the priority action by the nurse.

3. Perform a fast flush of the line and then re-zero the system.

The fast flush is done to verify the arterial line is functioning correctly; however, this action should not be implemented prior to assessing physiological causes for the low pressure alert indicator.

4. Request a prescription for an intravenous (IV) fluid bolus for hypotension.

Assessment of the line should occur prior to requesting health care provider (HCP) directed interventions; therefore, this is not the first action by the nurse.

A low pressure alarm for an arterial line can indicate the development of hypotension or disconnected tubing. Disconnected tubing can rapidly cause a client to hemorrhage. The nurse must immediately assess the client prior to troubleshooting the pressure alarm system. Assessment of the arterial line connection site is vital as the client can rapidly lose large amounts of blood in a short period of time if the tubing is disconnected.

61. Critical Care Question #16

The nurse assesses a client who presents to the emergency department (ED) with a potential diagnosis of frostbite. Assessment data reveals mottled extremities and the client reports numbness and tingling. Which is the **priority** action by the nurse?

1. Cover affected areas with semi-occlusive dressings.

Wounds should be left open until after warming is complete and wounds have dried. Once this occurs, the wound dressings should be loose and nonadherent to prevent constriction; therefore, this is not the priority action by the nurse.

✓ 2. Elevate the affected extremities once they are warm.

Elevating the affected extremity facilitates blood flow and reduces edema and the risk for blistering; therefore, this is the priority intervention action by the nurse.

3. Perform a complete pain assessment on the client.

Pain assessments should be completed after ensuring circulation concerns are addressed; therefore, this is not the priority action by the nurse.

4. Vigorously rub affected areas to stimulate circulation.

Massaging the area is contraindicated as this type of intervention can further damage the tissue; therefore, this is not the priority action by the nurse.

Evidence-based practice (EBP) guidelines for the treatment of frostbite focuses on preventing further injury and reducing pain. This includes the removal of anything that can cause constriction or sloughing of the tissue; including the use of bandages for wound care. The nurse must also ensure that the frostbite area is not massaged, rubbed, or squeezed as this could further damage the already fragile tissue. As thawing occurs, the affected area should be elevated to prevent edema and blistering to the site.

👉 *Video Rationale: https://d1pumg6d5kr18o.cloudfront.net/rationales-v2/critical_care_1562/part.m3u8*

62. Critical Care Question #16 - V2

The nurse is caring for a client who presents to the emergency department (ED) with a potential diagnosis of frostbite. The client reports numbness and tingling and the nurse notes mottled extremities. Which action should the nurse take?

1. Cover affected areas with semi-occlusive dressings.

Wounds should be left open until after warming is complete and wounds have dried. Once this occurs, the wound dressings should be loose and nonadherent to prevent constriction; therefore, this is not the correct action by the nurse.

✓ 2. Elevate the affected extremities once they are warm.

Elevating the affected extremity facilitates blood flow and reduces edema and the risk for blistering; therefore, this is the correct action by the nurse.

3. Perform a complete pain assessment on the client.

Pain assessments should be completed after ensuring circulation concerns are addressed; therefore, this is not the correct action by the nurse.

4. Vigorously rub affected areas to stimulate circulation.

Massaging the area is contraindicated as this type of intervention can further damage the tissue; therefore, this is not the correct action by the nurse.

Evidence-based practice (EBP) guidelines for the treatment of frostbite focuses on preventing further injury and reducing pain. This includes the removal of anything that can cause constriction or sloughing of the tissue; including the use of bandages for wound care. The nurse must also ensure that the frostbite area is not massaged, rubbed, or squeezed as this could further damage the already fragile tissue. As thawing occurs, the affected area should be elevated to prevent edema and blistering to the site.

63. Critical Care Question #17 - V2

The nurse is caring for a client who is suffering from hypothermia. The client is covered with warm blankets and has warm intravenous (IV) fluids infusing. Which action should the nurse take **next**?

1. Check the client's capillary glucose level.

All laboratory testing should be completed after the initiation of cardiac monitoring; therefore, this is not the next action by the nurse.

✓ 2. Place the client on a cardiac monitor.

The myocardium is at great risk for arrhythmias due to irritability from the cold temperature of the muscle fibers; therefore, this is the next action implemented by the nurse.

3. Put a warm towel over the client's head.

Covering the client's head with a warm towel will assist in preventing heat loss; however, this action should occur after the initiation of cardiac monitoring, which is the priority.

4. Start a second 18-gauge IV for rapid IV fluid infusion.

Two large bore IV catheters are preferred for the client who is hypothermic; however, this action should be implemented by the nurse after the initiation of cardiac monitoring.

The nurse must implement interventions that are supported by evidence-based practice (EBP) guidelines when providing care for clients who are diagnosed with hypothermia. The priority action is to initiate continuous cardiac monitoring as the myocardium is extremely irritable and prone to dysrhythmia as a result of hypothermia. The use of continuous cardiac monitoring is implemented as spontaneous ventricular fibrillation is a complication associated with hypothermia; therefore, the nurse should also anticipate the implementation of defibrillation, if needed. Additional interventions to warm the client should only occur after the cardiac monitor is in place.

64. Critical Care Question #18 - V2

The nurse is preparing to teach a class on basic cardiopulmonary resuscitation (CPR). Which instruction should the nurse provide regarding high quality chest compressions? **Select all that apply.**

☑	**Compressions should be administered at a depth of at least 2 inches on adult clients.**
	The correct depth for chest compressions when implementing CPR for an adult client is at least 2 inches (5 centimeters) to adequately pump blood; therefore, this instruction is included by the nurse when teaching a class on basic CPR.
☐	Compressions are provided at a rate of at least 80 to 100 per minute.
	The rate of 80 to 100 compressions per minute is too slow as evidence-based practice guidelines for the implementation of basic CPR indicate the rate should be 100 to 120 per minute.
☑	**Compressions are never paused for more than 10 seconds to check for a pulse.**
	If compressions are stopped for more than 10 seconds to check for a pulse, adequate perfusion to vital organs will not be maintained; therefore, this instruction is included by the nurse when teaching basic CPR.
☑	**Compressions should always allow for complete chest recoil.**

	Complete recoil after each compression allows the heart to completely refill, further promoting effective perfusion; therefore, this instruction is included by the nurse when teaching basic CPR.
☐	Compressions are only administered if the client is breathing adequately.
	The implementation of CPR is not warranted for a client who is breathing adequately and has a strong, palpable pulse.

Chest compressions should occur in the center of the chest at a rate of 100 to 120 per minute. Chest compressions must also be at least 2 inches deep with a full recoil between each compression for an adult client. Chest compressions should not be interrupted for more than 10 seconds as this would increase the likelihood of poor client outcomes. Interruptions in chest compressions should be restricted to reassessment of the carotid pulse and delivery of rescue breaths.

65. Critical Care Question #19 - V2

The nurse is assessing a client who is on a mechanical ventilator when the high pressure alarm goes off. Which factor should the nurse recognize as the potential cause of the alarm? **Select all that apply.**

☐	An air leak in the endotracheal (ET) tube.
	A leak in the ET tube will decrease the airway resistance and trigger the low-pressure, not high-pressure limit alarm.
☑	**Obstruction in endotracheal (ET) tube.**
	The accumulation of secretions within the ET tube can obstruct the airway and increase airway resistance; therefore, a high-pressure alarm is expected with this finding.
☑	**Client biting down on the endotracheal (ET) tube.**
	Biting down on the ET tube can cause an obstruction or kink the tubing, increasing airway resistance thereby causing a high pressure alarm.
☑	**Client coughing vigorously.**
	Excessive coughing or bronchospasms decrease lung compliance which will increase the resistance and set off the high pressure alarm.
☑	**Ventilator tubing is kinked.**
	A kink within the ventilator tube can increase the airway resistance obstructing the airflow thus causing the high pressure alarm.

Because any condition that increases the peak airway pressure can trigger the high pressure alarm, the nurse should assess for conditions that increase airway resistance and/or decrease lung compliance. Incidences that could contribute to a high pressure alarm include bronchospasm, excessive secretions, and biting of the endotracheal (ET) tube. A pneumothorax is an example of a cause that decreases lung compliance. Nursing interventions implemented should be based on the assessment of the alarm cause and evidence-based practice (EBP) guidelines.

66. Critical Care Question #20 - V2

The nurse is caring for a client who is diagnosed with cardiogenic shock. Which interventions should the nurse include in the plan of care? **Select all that apply**.

☐	Maintain the head of bed in a high-Fowler position.
	The high-Fowler position causes the client's blood pressure to decrease due to the height of the head of the bed at 90 degrees; therefore, this is not an appropriate intervention to include in this client's plan of care to address the diagnosed shock.
☑	**Pulse oximeter monitor to the client's forehead.**
	The forehead provides the more accurate oximetry reading for a client who experiences shock while exhibiting poor peripheral tissue perfusion; therefore, this is an intervention the nurse anticipates in this client's plan of care.
☑	**Administer a loop diuretic for a central venous pressure (CVP) of 20 mm Hg.**
	Furosemide is a prescribed diuretic that decreases left ventricular preload for a client experiencing cardiogenic shock; therefore, this intervention is expected by the nurse in this client's plan of care.
☑	**Titrate intravenous (IV) dopamine to maintain a systolic blood pressure (SBP) of 90 mm Hg.**
	For clients who are hypotensive, dopamine is the preferred agent to improve cardiac contractility and support cardiac output as evidenced by a rising systolic blood pressure; therefore, the nurse anticipates the inclusion of this intervention in the client's plan of care.
☑	**Administer intravenous (IV) atropine to treat bradycardia.**
	Atropine 0.5 mg is the preferred treatment for bradycardia of < 60 beats/minute and hypotension with a systolic blood pressure less than 90 mm Hg for the client who is diagnosed with shock; therefore, the nurse anticipates the inclusion of this intervention in the client's plan of care.

Goals of care for a client who experiences shock include the following: maximizing oxygen delivery and increasing stroke volume and cardiac output. Increasing vascular volume with vasopressors is optimal treatment. Vasopressors may be prescribed for a client who is diagnosed with cardiogenic shock to address

the client's low blood pressure. Examples of vasopressors include dopamine, epinephrine, and norepinephrine. Dopamine is used to increase stroke volume and cardiac output. Atropine is often prescribed to address bradycardia that occurs with cardiogenic shock. Additionally, furosemide is an appropriate pharmacotherapeutic to decrease left ventricular preload for the client experiencing cardiogenic shock. In addition to pharmacotherapy, a nursing intervention appropriate for the client who is experiencing cardiogenic shock is the use of pulse oximetry monitoring on the forehead versus the fingers due to poor circulation that occurs with shock.

67. Critical Care Question #21 - V2

The nurse is caring for a client who is diagnosed with pneumonia. The most recent arterial blood gas (ABG) results are: pH 7.29, PaCO2 55, HCO3 26, and PaO2 78. Which acid-base imbalance does the nurse suspect the client is experiencing?

1. Respiratory alkalosis.

Respiratory alkalosis would present as an increased pH (>7.45) and PaCO2 would be decreased (<35 mm Hg); therefore, this is not the acid-base imbalance that is included in the client's plan of care by the nurse.

✓ 2. Respiratory acidosis.

Respiratory acidosis, low pH (<7.35) and high PaCO2 (>45 mm Hg), is caused by a decreased respiratory rate or tidal volume. Based on the current data, this acid-base imbalance is appropriate for the nurse to include in the client's plan of care.

3. Metabolic alkalosis.

Metabolic alkalosis occurs when the pH is increased (>7.45) and HCO3- is increased (>26 mEq/L); therefore, this is not an appropriate acid-base imbalance to include in the client's plan of care.

4. Metabolic acidosis.

Metabolic acidosis occurs when the pH is decreased (<7.35) and HCO3- is decreased (<22 mEq/L); therefore, this is not an appropriate acid-base imbalance for the nurse to include in the client's plan of care.

Pneumonia often causes hyperventilation of the lung tissue which results in a buildup of carbon dioxide in the blood. This leads to a drop in the pH and the subsequent development of respiratory acidosis. Hypoventilation can be caused by a number of disease processes other than pneumonia, including chronic obstructive pulmonary disease (COPD) and sleep apnea. Additionally, a client who experiences chest trauma may also develop hypoventilation.

68. Critical Care Question #22 - V2

The nurse is caring for a client who is admitted to the emergency department (ED) with a traumatic brain injury (TBI). Which nursing intervention is best to assist with visualization of the client's airway for intubation?

1. Head-tilt, chin lift while lying flat

> The chin-lift should be avoided as this involves manipulation of the neck without proper stabilization which is contraindicated for clients who present with TBI. The neck must be cleared by radiography prior to using this method to visualize the client's airway.

2. Head tilt, chin lift with head elevated.

> The chin-lift should be avoided as this involves manipulation of the neck without proper stabilization. The neck must be clear by radiography prior to using this method to visualize the client's airway.

✓ 3. Jaw-thrust while lying flat.

> The jaw thrust while in a supine position provides the most spinal stabilization to reduce further injury for a client who presents with TBI; therefore, this is the best intervention by the nurse when assisting with visualization of the client's airway for intubation.

4. Jaw thrust with head elevated.

> The jaw thrust is the appropriate intervention but should be performed while the client is in a supine position on a hard flat surface; therefore, this action is contraindicated when visualizing the airway for a client who requires intubation post TBI.

> The nurse should take precautions to avoid movement of an unstable spine for a client who presents to the ED with TBI. One health care provider (HCP) should stabilize the cervical vertebra allowing the second HCP to articulate the jaw independently of the spinal column. This intervention allows the visualization of the airway of a client with a TBI. An artificial airway should only be implemented in this manner when providing care for a client whose spine has not been cleared by radiography to decrease the risk for further injury.

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69. Critical Care Question #23 - V2

The nurse is explaining to a client the need to perform an Allen test before having arterial blood gasses (ABGs) drawn. Which explanation should the nurse provide?

1. “It will test for adequate peripheral perfusion via the radial artery.”

The radial artery is assessed by palpation with the fingertips, not with the implementation of the Allen test.

✓ 2. “It will ensure adequate peripheral perfusion via the ulnar artery.”

The ulnar artery needs to be patent (i.e., positive Allen Test) to ensure that there will be blood flow to the hand while performing an arterial stick from the radial artery for a prescribed ABG.

3. “It will determine if capillary refill time is too quick.”

A capillary refill assessment in performed by blanching the client’s fingernail bed and ensuring the refill time is less than 3 seconds; therefore, this is not the rationale for performing an Allen test.

4. “It will ensure the client does not have peripheral arterial disease.”

It is outside the scope of nursing practice to diagnose a client with peripheral arterial disease based on the results of a single test.

If the Allen test is positive then arterial blood gasses (ABGs) can be drawn from the radial artery as the ulnar artery can provide the needed blood flow to the hand. If negative, then an alternative site needs to be assessed for use when drawing a prescribed blood gas. The radial artery is the preferred site of collection for ABGs. This is because the artery is near the surface, easy to palpate, and can be easily stabilized for collection of blood.

70. Critical Care Question #24 - V2

The nurse is witness to a motor vehicle crash (MVC) and renders aid to a client who sustained a head injury and is now unconscious. Which intervention should the nurse implement? **Select all that apply.**

☑	**Assess the quality of the carotid pulse.**
	Assessing the carotid pulse would determine if further intervention is needed to maintain adequate circulation; therefore, this intervention by the nurse is appropriate for this clinical scenario.
☑	**Maintain cervical spine immobilization.**
	Cervical spine immobilization must be maintained throughout the assessment to minimize further injury; therefore, this intervention by the nurse is appropriate based on the current data.

☑	**Check airway patency using the jaw-thrust technique.**
	Airway patency needs to be assessed with the jaw-thrust method to reduce the risk of spinal compression; therefore, this intervention by the nurse is appropriate.
☑	**Perform a focused neurological assessment.**
	Baseline neurological assessment findings are needed to determine the level of neurological impairment. This task can be completed using the Glasgow Coma Scale.
☑	**Place the client on a backboard before moving.**
	The placement of the client on a backboard ensures cervical spine stabilization, and reduces the risk of further spinal injury; therefore, this is an appropriate intervention for the nurse to implement with this client.

After a blunt-force head injury, which is what the client in the MVC experienced, the nurse first checks if the client is breathing and has a pulse. A spinal injury should be presumed based on the nature of the MVC thus requiring the nurse to stabilize the client's cervical spine. Upon the stabilization of the cervical spine then an artificial airway can be placed if needed. Further nursing assessment of the neurological state via the Glasgow Coma Scale should occur after stabilization of the spine.

71. Critical Care Question #25

The nurse provides care for a toddler-age client. Which clinical finding noted by the nurse warrants notification of the rapid response team (RRT)?

1. HR 118 BPM

The normal range for heart rate for a toddler-age client is 100-130 BPM; therefore, this finding does not warrant the activation of the RRT by the nurse.

2. Temperature 100.5 F (38)

A single clinical finding of a temperature of 100.5 would warrant further assessment; however, this finding alone does not warrant the activation of the RRT for this toddler-age client.

✓ 3. Acute onset of lethargy

The acute nature of the toddler's lethargy indicates a rapid change in the level of consciousness (LOC). A rapid change in LOC is emergent in any age group thus this finding warrants the activation of the RRT by the nurse.

4. Loud crying

Loud crying is a normal finding in a toddler-age client; therefore, this data does not warrant the activation of the RRT by the nurse.

The development of RRTs is in response to the need to provide critical care assistance at the bedside of clients who do not reside in a critical care unit. This team responds to acute conditions with rapid deterioration that require immediate attention. Examples of these situations are significant changes in level of consciousness (LOC), sudden change in systolic blood pressure (BP) and/or oxygen saturation.

Video Rationale: https://d1pumg6d5kr18o.cloudfront.net/rationales-v2/critical_care_1571/part.m3u8

72. Critical Care Question #25 - V2

The nurse is assessing a toddler-age client. Which finding requires notification of the rapid response team (RRT)?

1. Heart rate (HR) of 118.

The normal range for heart rate for a toddler-age client is 100-130 BPM; therefore, this finding is normal and does not warrant the activation of the RRT by the nurse.

2. Temperature of 100.5° F (38° C).

A single clinical finding of a temperature of 100.5 would warrant further assessment; however, this finding alone does not warrant the activation of the RRT for this toddler-age client.

✓ 3. Acute onset of lethargy.

The acute nature of the toddler's lethargy indicates a rapid change in the level of consciousness (LOC). A rapid change in LOC is emergent in any age group thus this finding warrants the activation of the RRT by the nurse.

4. Loud crying.

Loud crying is a normal finding in a toddler-age client; therefore, this data does not warrant the activation of the RRT by the nurse.

The development of RRTs is in response to the need to provide critical care assistance at the bedside of clients who do not reside in a critical care unit. This team responds to acute conditions with rapid

deterioration that require immediate attention. Examples of these situations are significant changes in level of consciousness (LOC), sudden change in systolic blood pressure (BP) and/or oxygen saturation.

73. Critical Care Question #26 - V2

The nurse is caring for a client who is newly admitted to the critical care unit after being successfully resuscitated at home. The client is placed in a hypothermic state as part of the initial medical treatment. Which intervention is appropriate to include in the nursing plan of care for this client? **Select all that apply.**

☐	Discuss "do not resuscitate" status with the family.
	A “do not resuscitate” conversation would be appropriate if the client does not respond to prescribed medical interventions or if there is evidence of significant neurologic impairment (e.g., brain death); however, this intervention is not appropriate for the nurse to include in this client’s immediate plan of care.
☐	Insert a nasogastric (NG) tube for enteral feedings.
	Tube feedings should be avoided until the client is more stable due to the risk for aspiration; therefore, this is not an appropriate intervention for the nurse to include in the immediate plan of care for this client.
☑	**Keep the head of the bed elevated to at least 30 degrees.**
	Keeping the head of the bed elevated to 30 degrees is a neuroprotective strategy when conducting therapeutic hypothermia; therefore, this is an appropriate intervention for the nurse to include in this client’s immediate plan of care.
☑	**Place the client on continuous cardiac monitoring.**
	Continuous cardiac monitoring is appropriate due to the common effect of bradycardia when performing therapeutic hypothermia; therefore, this is an appropriate intervention to include in this client’s immediate nursing plan of care.
☑	**Prepare the client's family for the medical intervention.**
	It can be helpful for family members to learn about therapeutic hypothermia prior to seeing their loved one as the decreased body temperature alters the way the client looks; therefore, this is an appropriate intervention for the nurse to include in this client’s immediate plan of care.

Therapeutic hypothermia should be implemented within 24 hours of successful out-of-hospital CPR. If the client is comatose or unable to follow commands, this is due to a neurological injury. Induced therapeutic hypothermia within 6 hours of arrest and maintained for at least 24 hours has shown to decrease mortality rates. This intervention has also been proven to improve neurological outcomes. Therefore, the interventions that are appropriate to include in the client’s immediate plan of care include the following: keeping the client’s head of bed elevated to at least 30 degrees; placing the client on continuous

cardiorespiratory monitoring; and providing education to the client's family regarding what to expect while their loved one is in a hypothermic state.

74. Critical Care Question #27 - V2

The nurse is assessing a client who was stabbed and is postoperative from abdominal surgery to the area. Which finding should the nurse report **immediately** to the health care provider (HCP)?

1. Heart rate of 112 with regular rhythm.

Sinus tachycardia is part of the compensatory response to maintain cardiac output; while this finding is not normal it does not require the nurse to immediately report it to the HCP.

✓ 2. Skin that is mottled and cold to touch.

Cold, clammy skin indicates cardiac output is unable to maintain homeostasis and the client is in the progressive stage of hypovolemic shock; therefore, this finding should be reported to the HCP immediately.

3. Small amount of serosanguineous drainage on abdominal dressing.

Drainage from the abdominal wound can be assessed for infection upon stabilization of the client's cardiac function; however, this finding is not abnormal based on the client's history of abdominal surgery to repair damage caused by a stab wound.

4. Total urinary output of 100 mL over the past 2 hours.

Normal urine output is > 30 mL/hr. This urine output is normal but in shock, kidney function decreases causing decreased urine output as the body tries to maintain blood pressure.

Hemorrhagic shock can occur after abdominal trauma. Shock progresses from initial (no potential symptoms) to compensatory (oxygenation and cardiac output change to maintain homeostasis) and compensatory (cold, clammy skin due to failing cardiac compensation), then irreversible shock followed by death. Immediate intervention is necessary to prevent irreversible shock and death. The assessment of cold, clammy skin indicates activation of the compensatory mechanism, and the HCP should be contacted for immediate intervention.

75. Critical Care Question #28 -V2

The nurse is caring for a client in the intensive care unit (ICU) who has a central venous pressure (CVP) monitor. When assessing this client, where should the nurse locate the phlebostatic axis?

1. 5th intercostal space, left axillary border.

> The fifth intercostal space is too high for a transducer location; therefore, this is not the location of the phlebostatic axis.

2. 5th intercostal space, mid-axillary line.

> The fifth intercostal space at midaxillary line would generate a false low reading of the monitor; therefore, this is not the location of the phlebostatic axis.

✓ 3. 4th intercostal space, mid-axillary line.

> The fourth intercostal space at the midaxillary line is the appropriate location for a transducer to monitor pressures; therefore, this is the location of the phlebostatic axis for the CVP monitor.

4. 4th intercostal space, right axillary border.

> The transducer needs to be placed mid-line not on the axillary border; therefore, this is not the location of the phlebostatic axis.

> Incorrect placement of the transducer, for measuring blood pressure or central venous pressure, can generate falsely high or low readings. If the zeroing stopcock is placed below the phlebostatic axis, false high reading could occur. If the zeroing stopcock is placed too high then the phlebostatic axis is likely to generate false low readings. It is essential that the nurse knows this location so that the transducer for the CVP monitor can be zeroed in the correct location thus allowing the monitor to generate the most accurate data possible. This point can also be used as a reference point when measuring blood pressure indirectly.

76. Critical Care Question #29

The nurse provides care for a client with lactic acidosis following prolonged cardiopulmonary resuscitation (CPR). Which arterial blood gas (ABG) result does the nurse anticipate for this client?

1. pH 7.22, PaCO2 60, HCO3 28

> These laboratory values indicate respiratory acidosis due to the PaCO2 being greater than 45; therefore, this is not the anticipate ABG for the client who is experiencing lactic acidosis following prolonged CPR.

✓ 2. pH 7.21, PaCO2 33, HCO3 16

An acidic pH (<7.35) and a HCO3 of less than 22 indicates metabolic acidosis which is the expected finding for the client who is experiencing lactic acidosis following prolonged CPR.

3. pH 7.55, PaCO2 30, HCO3 21

In respiratory alkalosis, the pH is elevated (>7.45) and the PaCO2 is less than 35; therefore, this is not the ABG the nurse anticipates for a client with lactic acidosis following prolonged CPR.

4. pH 7.49, PaCO2 47, HCO3 30

In metabolic alkalosis, the pH is elevated (>7.45) and the HCO3 level is > 26; therefore, this is not the ABG the nurse anticipates for the client with lactic acidosis following prolonged CPR.

Clients who experience reduced perfusion of tissues and absent pulmonary gas exchange together cause: tissue hypoxia (i.e., accumulation of lactate and hydrogen ions); accumulation of carbon dioxide (i.e., hypercapnia); and reduction in blood oxygen tension (i.e., hypoxemia). Given these consequences of cardiac arrest with prolonged CPR, it is easy to appreciate that the condition is associated with abnormality in all measured and calculated blood gas parameters (i.e., pH, pCO2, pO2, bicarbonate, base excess) and lactate. Lactic acidosis or partially compensated metabolic acidosis presents with a pH of <7.35 and a HCO3 < 22 mEq/L. Respiratory compensation may begin to occur to realign the blood gases levels. This respiratory compensation mechanism is known as Kussmaul respirations. This respiratory pattern is an attempt to reduce carbon dioxide levels.

Video Rationale: https://d1pumg6d5kr18o.cloudfront.net/rationales-v2/critical_care_1575/part.m3u8

77. Critical Care Question #29 -V2

The nurse is caring for a client who has lactic acidosis following prolonged cardiopulmonary resuscitation (CPR). Which arterial blood gas (ABG) result does the nurse expect to find in this client?

1. pH 7.22, PaCO2 60, HCO3 28.

These laboratory values indicate respiratory acidosis due to the PaCO2 being greater than 45; therefore, this is not the anticipate ABG for the client who is experiencing lactic acidosis following prolonged CPR.

✓ 2. pH 7.21, PaCO2 33, HCO3 16.

An acidic pH (<7.35) and a HCO3 of less than 22 indicates metabolic acidosis which is the expected finding for the client who is experiencing lactic acidosis following prolonged CPR.

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In metabolic alkalosis, the pH is elevated (>7.45) and the HCO3 level is > 26; therefore, this is not the ABG the nurse anticipates for the client with lactic acidosis following prolonged CPR.

Clients who experience reduced perfusion of tissues and absent pulmonary gas exchange together cause: tissue hypoxia (i.e., accumulation of lactate and hydrogen ions); accumulation of carbon dioxide (i.e., hypercapnia); and reduction in blood oxygen tension (i.e., hypoxemia). Given these consequences of cardiac arrest with prolonged CPR, it is easy to appreciate that the condition is associated with abnormality in all measured and calculated blood gas parameters (i.e., pH, pCO2, pO2, bicarbonate, base excess) and lactate. Lactic acidosis or partially compensated metabolic acidosis presents with a pH of <7.35 and a HCO3 < 22 mEq/L. Respiratory compensation may begin to occur to realign the blood gasses levels. This respiratory compensation mechanism is known as Kussmaul respirations. This respiratory pattern is an attempt to reduce carbon dioxide levels.

78. Critical Care Question #30

The nurse provides care for a client who is intubated and mechanically ventilated in the intensive care unit (ICU). Which action should the nurse implement to decreases this client's risk for developing ventilator associated pneumonia? **Select all that apply**.

☐	Endotracheal suctioning every two hours and PRN
	Frequent suctioning should only be performed when clinically indicated such as adventitious breath sounds, coughing, and elevated airway pressures; therefore, this action should not be implemented by the nurse as it increases, not decreases, the client's risk for ventilator associated pneumonia.
☑	**Implement a ventilator weaning protocol**
	Daily sedation vacations ensure that a proper level of sedation is maintained and is a general preventative intervention to prevent pneumonia for clients who are mechanically ventilated; therefore, this is an appropriate action by the nurse.
☐	Keep head of bed elevated at least 15 degrees at all times
	The head of the bed should be maintained in a semirecumbent position, which is approximately a 30 to 40 degree angle; therefore, this is not an action the nurse implements for this client to decrease the risk for ventilator associated pneumonia.

☑	**Performing mouth care with approved antiseptic solution**
	Scheduled oral hygiene with an antiseptic assists in reducing colonization of bacteria in the mouth which is associated with the development of ventilator associated pneumonia; therefore, this is an appropriate action by the nurse for this client.
☑	**Wear clean gloves when providing client care**
	Clean gloves and proper hand hygiene are general precautions to prevent pneumonia; therefore, these actions are appropriate for the nurse to implement to decrease this client risk for developing this infection.

Due to sedation and impaired natural defenses from being mechanically ventilated, these clients are at a much higher risk of developing pneumonia as a result of the artificial airway. Because of this, interventions should be limited to only when they are clinically indicated. Endotracheal suctioning should only be performed for adventitious lung sounds. Oral care, elevating the head of the bed, and strict hand hygiene are additional nursing interventions to reduce the risk of infection for this client.

Video Rationale: https://d1pumg6d5kr18o.cloudfront.net/rationales-v2/critical_care_1576/part.m3u8

79. Critical Care Question #30 - V2

The nurse is caring for a client who is intubated and being mechanically ventilated. Which action should the nurse implement to decrease the client's risk for developing ventilator associated pneumonia (VAP)? **Select all that apply.**

☐	Endotracheal suctioning every two hours and PRN.
	Frequent suctioning should only be performed when clinically indicated such as adventitious breath sounds, coughing, and elevated airway pressures; therefore, this action should not be implemented by the nurse as it increases, not decreases, the client's risk for ventilator associated pneumonia.
☑	**Implement a sedation weaning protocol.**
	Daily sedation vacations ensure that a proper level of sedation is maintained and is a general preventative intervention to prevent pneumonia for clients who are mechanically ventilated; therefore, this is an appropriate action by the nurse.
☐	Keep the head of the bed elevated at least 15 degrees at all times.
	The head of the bed should be maintained in a semirecumbent position, which is approximately a 30 to 40 degree angle; therefore, this is not an action the nurse implements for this client to decrease the risk for ventilator associated pneumonia.
☑	**Performing mouth care with approved antiseptic solution.**

	Scheduled oral hygiene with an antiseptic assists in reducing colonization of bacteria in the mouth which is associated with the development of ventilator associated pneumonia; therefore, this is an appropriate action by the nurse for this client.
☑	**Wear clean gloves when providing client care.**
	Clean gloves and proper hand hygiene are general precautions to prevent pneumonia; therefore, these actions are appropriate for the nurse to implement to decrease this client's risk for developing this infection.

Due to sedation and impaired natural defenses from being mechanically ventilated, these clients are at a much higher risk of developing pneumonia as a result of the artificial airway. Because of this, interventions should be limited to only when they are clinically indicated. Endotracheal suctioning should only be performed for adventitious lung sounds. Oral care, elevating the head of the bed, and strict hand hygiene are additional nursing interventions to reduce the risk of infection for this client.

80. Critical Care Question #31

The nurse provides care for a mechanically ventilated client who is constantly exposed to loud noises associated with being in the intensive care unit (ICU). When planning care for this client, which is the **priority** nursing diagnosis?

1. Acute pain

While acute pain should be addressed by the nurse in this client's plan of care, this nursing diagnosis is not the priority based on the current data.

2. Delirium

While delirium must be addressed for the client in the ICU environment, there is another nursing diagnosis that is the priority to address based on the current data.

✓ 3. Disturbed sleep pattern

Disturbed sleep pattern is the priority nursing diagnosis for this client because poor sleep can potentially lead to other health problems such as anxiety and delirium, especially in the ICU environment.

4. Risk for anxiety

While anxiety is an important nursing diagnosis to address within this client's plan of care, there is another diagnosis that is priority because it contributes to the exacerbation of the other nursing diagnoses listed in

the client's plan of care.

Multiple environmental factors can disrupt the sleep pattern of an ICU client including excessive noise. Disturbed sleep patterns can lead to additional negative effects such as delirium, anxiety, acute confusion, decreased REM sleep, and increased heart rate. The nursing diagnosis, disturbed sleep patterns, is the priority diagnosis in this instance as if the client's sleep patterns are addressed this will decrease the client's likelihood of developing additional complications and other adverse events. Nursing interventions should focus on consolidating and minimizing potential sleep disturbing activities in the provision of care for a client who is mechanically ventilated and in the ICU environment.

Video Rationale: https://d1pumg6d5kr18o.cloudfront.net/rationales-v2/critical_care_1577/part.m3u8

81. Critical Care Question #31 - V2

The nurse is caring for a client who is mechanically ventilated and constantly exposed to the loud noises in the intensive care unit (ICU). Which problem should the nurse **prioritize** for this client?

1. Acute pain.

While acute pain should be addressed by the nurse in this client's plan of care, this nursing diagnosis is not the priority based on the current data.

2. Delirium.

While delirium must be addressed for the client in the ICU environment, there is another nursing diagnosis that is the priority to address based on the current data.

✓ 3. Disturbed sleep pattern.

Disturbed sleep pattern is the priority nursing diagnosis for this client because poor sleep can potentially lead to other health problems such as anxiety and delirium, especially in the ICU environment.

4. Risk for anxiety.

While anxiety is an important nursing diagnosis to address within this client's plan of care, there is another diagnosis that is priority because it contributes to the exacerbation of the other nursing diagnoses listed in the client's plan of care.

Multiple environmental factors can disrupt the sleep pattern of an ICU client including excessive noise. Disturbed sleep patterns can lead to additional negative effects such as delirium, anxiety, acute confusion, decreased REM sleep, and increased heart rate. The nursing problem, disturbed sleep patterns, is the

priority as if the client's sleep patterns are addressed this will decrease the client's likelihood of developing additional complications and other adverse events. Nursing interventions should focus on consolidating and minimizing potential sleep disturbing activities in the provision of care for a client who is mechanically ventilated and in the ICU environment.

82. Critical Care Question #32 - V2

The nurse is caring for a client who is receiving mechanical ventilation. The client is experiencing quickly decreasing oxygen saturation levels and the ventilator is alarming, low tidal volumes. Which action is the **priority** for the nurse to take?

1. Alert respiratory therapy that the ventilator will need to be replaced immediately.

While the machine may need to be replaced due to a leak, this is not the priority action by the nurse to ensure that the client is well-oxygenated.

✓ 2. Attach a bag-valve-mask (BVM) to the end of the client's endotracheal (ET) tube and provide manual ventilations.

The client who experiences rapidly decreasing oxygen saturation levels in addition to the ventilator alarm, "low tidal volumes" is not receiving adequate respirations from the ventilator. The priority action by the nurse is to oxygenate the client using the BVM.

3. Instill saline solution into the endotracheal (ET) tube and perform in-line suctioning.

While suctioning mucus from the client's ET tube could be an appropriate intervention, this does not immediately address the client's poor oxygen saturations given the ventilator alarm of "low tidal volume." Additionally, the use of normal saline to suction the ET tube of a client who is mechanically ventilated is an intervention that is not supported by evidence-based practice (EBP) guidelines.

4. Place a non-rebreather mask on the client and raise the head of the bed.

Since the client is intubated, oxygen can not pass through the nares and oropharynx via mask; therefore, this is not an appropriate intervention for the nurse to implement with this client. Oxygenation through the endotracheal (ET) tube is the only viable ventilation option for this client.

If an alarm occurs, the nurse should always evaluate the client first and then check the ventilator. Declining client conditions, such as decreasing oxygenation, warrants immediate intervention by the nurse. The likely cause of the alarm can be due to a disconnection, loose connection, or leak in the system. Manual

ventilation should be implemented as the client is declining rapidly and requires assistance with ventilatory effort to address the low oxygen saturations. The nurse can address the alarm once the client is stable.

83. Critical Care Question #33 - V2

The nurse is assessing a client who is being mechanically ventilated. The nurse notes an erratic plethysmograph waveform that indicates that the client's oxygen saturation level is 95%. Which action is most appropriate for the nurse to take?

✓ 1. Assess the client's mental status, skin color, and temperature.

Assessment for perfusion is needed prior to intervening because erratic waveforms are commonly caused by motion and are not indicative of actual client issues; therefore, this is the priority nursing action for this client.

2. Give the client 100% oxygen and suction the endotracheal (ET) tube.

Oxygenation levels that are 95% does not warrant an increase in the client's supplemental oxygen; therefore, this is not an appropriate intervention by the nurse.

3. Remove the pulse oximeter from the finger and place it on the client's ear.

Moving the monitor from the finger to the ear is not necessary if the erratic tracing is due to motion; therefore, this is not the priority nursing action for this client based on the current data.

4. Notify the respiratory therapist to obtain a set of arterial blood gasses (ABGs) per protocol.

The nurse must first assess the client prior to the implementation of interventions that may be not necessary based on the data collected for this client; therefore, this is not the priority action by the nurse for this client based on the current data.

Assessment of perfusion and oxygenation is the priority as an erratic waveform can be the result of motion. Motion or a loose connection between the sensor and the skin is a likely cause of an erratic waveform. An assessment of the client's mental status, skin color, and temperature provide information to the nurse about the client's oxygenation and perfusion thus guiding the implementation of additional interventions. Since this client is not exhibiting symptoms indicative of distress, it is not appropriate for the nurse to implement interventions prior to the initiation of an assessment.

84. Critical Care Question #34 - V2

The nurse is assisting with a motor vehicle crash (MVC). The client is awake and alert but reporting neck pain. Which action is appropriate for the nurse to implement? **Select all that apply.**

☑	**Count the client's respirations.**
	The assessment of respirations should assist the nurse to determine if there is an issue with the client's airway as this is the first symptom of respiratory distress for a client who experiences a cervical spine injury. Based on this data, this is an appropriate action by the nurse when providing care for this client.
☑	**Implement cervical spine precautions.**
	Cervical spine precautions will prevent further injury to the spinal column; therefore, this is an appropriate action by the nurse for this client based on the current data.
☑	**Obtain a Glasgow Coma Scale (GCS) score.**
	A Glasgow Coma Score (GCS) at this time provides a baseline for future assessments; therefore, this is an appropriate action for the nurse to implement when providing care for this client based on the current data.
☐	Perform a head to toe physical assessment.
	A full head to toe assessment is not needed at this time due to the nature of the injury; therefore, a focused assessment of the client's respiratory system would be a better action for the nurse to implement with this client based on the current data.
☑	**Place the client on a backboard before transporting.**
	Placing the client on a backboard will prevent further movement of the spinal column with the intent to decrease the risk of further injury to the spine; therefore, this is an appropriate action by the nurse when providing care for this client based on the current data.

A focused assessment on the potential implications of a cervical spine injury, includes maintaining the airway and immobilization of the spine to protect the client from further injury. Upon the stabilization of the spine, the nurse can conduct a more thorough examination of the client. Respiratory, and neurological function assessments provide essential baseline information for this client. This baseline data can provide an indication of changes that may prompt further interventions.

85. Critical Care Question #35 - V2

The nurse is caring for a client who has ingested a toxic substance and requires gastric decompression. Which intervention should the nurse implement? **Select all that apply**.

☑	**Gather and place suction supplies at the bedside.**
	Suction equipment should always be available at the bedside in the event that gastric decompression is prescribed. The health care provider (HCP) may instill saline with a large syringe into the nasogastric (NG) tube to help prevent electrolyte imbalances before initiating gastric decompression via suction.
☐	Initiate gastric decompression within 3 hours of admission.
	Gastric decompression should be initiated within one hour of toxic ingestion to remove the substances from the stomach; therefore, this is not an appropriate intervention for the nurse to implement for this client.
☑	**Place intubation supplies at the bedside.**
	Emergency respiratory equipment is required at the bedside to protect the airway in the event the client aspirates stomach contents; therefore, this is an appropriate intervention for the nurse to implement when providing care for this client.
☐	Position the client supine in the Trendelenburg position.
	The client's head of the bed (HOB) should be elevated to insert the nasogastric tube or the client should be turned on the side with the HOB elevated to minimize the risk of aspiration of the toxic substances; therefore, this is not an appropriate intervention for the nurse to implement when providing care for this client.
☑	**Request a large bore nasogastric (NG) tube from central supply.**
	A large bore nasogastric tube (usually a 12 to 18 French) is needed so that a large volume of water or saline can be instilled in and out of the tube for the prescribed gastric decompression; therefore, this is an appropriate intervention for the nurse to implement when providing care for this client.

Gastric lavage (GL) is used to remove many ingested toxins and the nurse implements interventions to prevent aspiration by placing emergency equipment at the client's bedside. A GL is rarely performed because of the associated risks. These risks include aspiration, gastric or esophageal perforation, and dysrhythmias. Because of the risks, emergency equipment should be assembled at the bedside prior to performing the intervention to enhance client outcomes.

86. Critical Care Question #36 - V2

The nurse is preparing to defibrillate a client who is in refractory pulseless ventricular tachycardia. Place the steps in the order in which they should be performed. **All options must be used.**

1. Begin compressions at a rate of 100-120 bpm.
2. Ensure that everyone is clear from the client and equipment.
3. Check the client for responsiveness.
4. Assess the client's carotid pulse.

5. Charge the defibrillator to 200 Joules.
6. Apply defibrillator pads to the client.

Correct Ranking (Greatest → Least Risk):

1. Check the client for responsiveness.
2. Assess the client's carotid pulse.
3. Begin compressions at a rate of 100-120 bpm.
4. Apply defibrillator pads to the client.
5. Charge the defibrillator to 200 Joules.
6. Ensure that everyone is clear from the client and equipment.

Defibrillation is the primary objective when intervening with a client that experiences pulseless ventricular tachycardia. When the nurse identifies this cardiac arrhythmia, it is essential to act; therefore, the nurse implements cardiopulmonary resuscitation (CPR). The steps the nurse implements are as follows: 1. Check the client for unresponsiveness. 2. Assess the client's carotid pulse. 3. Begin compressions at a rate of 100 to 120 beats per minute. 4. Apply defibrillator pads to the client's chest. 5. Charge the defibrillator to 200 Joules. 6. Finally, ensure that everyone is clear from the client and equipment and provide a shock to the client.

87. Critical Care Question #37

The nurse leads the cardiopulmonary resuscitation (CPR) for a client whose current rhythm is asystole. Which action by a member of the code team would require intervention by the nurse?

1. Assesses carotid pulse for 10 seconds.

Assessment of the carotid artery needs to occur to ensure that the client is in asystole; therefore, this action does not require intervention from the nurse.

2. Gives epinephrine 1:10000 intravenous push (IVP).

Epinephrine is an appropriate advanced cardiovascular life-support medication that is appropriate to administer to a client who is in asystole; therefore, this action does not require intervention by the nurse.

3. Performs chest compressions.

Continuous and high-quality compressions are the appropriate intervention for a client presenting with asystole; therefore, this action does not require intervention from the nurse.

✓ 4. Prepares for defibrillation.

Defibrillation is not indicated when there is no electrical activity present or when the heart muscle is not contracting despite an organized rhythm; therefore, this action requires the nurse to intervene.

The causes of asystole in cardiac arrest are wide and varied. Asystole typically results from decompensation of prolonged ventricular fibrillation arrest. When a client presents in asystole the treatment consists of CPR, oxygenated ventilation, and advanced cardiovascular life-support. Defibrillation is not indicated for clients that have no electrical activity (i.e., asystole). The purpose of defibrillation to convert a current dysrhythmia to an organized rhythm. Defibrillation cannot create an organized rhythm from nothing.

Video Rationale: https://d1pumg6d5kr18o.cloudfront.net/rationales-v2/critical_care_1583/part.m3u8

88. Critical Care Question #37 - V2

The nurse is leading the code team to perform cardiopulmonary resuscitation (CPR) for a client whose current rhythm is asystole. Which action by one of the code team members requires intervention by the nurse?

1. Assesses carotid pulse for 10 seconds.

Assessment of the carotid artery needs to occur to ensure that the client is in asystole; therefore, this action does not require intervention from the nurse.

2. Gives epinephrine 1:10000 intravenous push (IVP).

Epinephrine is an appropriate advanced cardiovascular life-support medication that is appropriate to administer to a client who is in asystole; therefore, this action does not require intervention by the nurse.

3. Performs chest compressions.

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consists of CPR, oxygenated ventilation, and advanced cardiovascular life-support. Defibrillation is not indicated for clients that have no electrical activity (i.e., asystole). The purpose of defibrillation is to convert a current dysrhythmia to an organized rhythm. Defibrillation cannot create an organized rhythm from nothing.

89. Critical Care Question #38

A client is admitted to the intensive care unit (ICU) with a new diagnosis of supraventricular tachycardia. The client's current heart rate is 180 BPM. The client is awake, alert without altered mentation. Which action should the nurse implement first?

1. Notify the health care provider (HCP) immediately.

Notifying the HCP is secondary to initial treatment of the client's supraventricular tachycardia; therefore, this is not the first action that is implemented by the nurse for this client.

✓ 2. Place a bag of ice on the bridge of the client's nose.

A bag of ice for no more than 30 seconds is an appropriate vagal maneuver to reduce the client's heart rate; therefore, this is the first action that the nurse implements for this client.

3. Prepare to give adenosine 6 mg rapidly by intravenous push (IVP).

Adenosine IVP is a second line intervention if the vagal maneuver is ineffective in converting the client's rhythm; therefore, this is not the first action implemented by the nurse for this client.

4. Perform immediate synchronized cardioversion.

Cardioversion is only performed when the rhythm does not respond to pharmacotherapy; therefore, this is not the first action implemented by the nurse for this client.

Initial treatment of SVT is the utilization of vagal maneuvers, such as the act of bearing down. The vagal maneuver works by increasing intrathoracic pressure and stimulating the vagus nerve. The vagus nerve supplies parasympathetic nerve fibers to the heart and when stimulated, results in slower electrical conduction. The vagal maneuver can be replicated in additional ways in the client that is unable to "bear down," such as placing ice on the bridge of the client's nose. If this intervention is not successful, the nurse then prepares to administer pharmacotherapy appropriate for SVT. If pharmacotherapy is not successful, the nurse then prepares the client for cardioversion.

👉 *Video Rationale: https://d1pumg6d5kr18o.cloudfront.net/rationales-v2/critical_care_1584/part.m3u8*

90. Critical Care Question #38 - V2

The nurse is caring for a client who has been admitted to the intensive care unit (ICU) with a new diagnosis of supraventricular tachycardia (SVT). The client's current heart rate is 180. The client is awake, and alert without altered mentation. Which action should the nurse take **first**?

1. Notify the health care provider (HCP).

Notifying the HCP is secondary to initial treatment of the client's supraventricular tachycardia; therefore, this is not the first action that is implemented by the nurse for this client.

✓ 2. Place a bag of ice on the bridge of the client's nose.

A bag of ice for no more than 30 seconds is an appropriate vagal maneuver to reduce the client's heart rate; therefore, this is the first action that the nurse implements for this client.

3. Prepare to give adenosine 6 mg rapidly by intravenous push (IVP).

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Initial treatment of SVT is the utilization of vagal maneuvers, such as the act of bearing down. The vagal maneuver works by increasing intrathoracic pressure and stimulating the vagus nerve. The vagus nerve supplies parasympathetic nerve fibers to the heart and when stimulated, results in slower electrical conduction. The vagal maneuver can be replicated in additional ways in the client that is unable to "bear down," such as placing ice on the bridge of the client's nose. If this intervention is not successful, the nurse then prepares to administer pharmacotherapy appropriate for SVT. If pharmacotherapy is not successful, the nurse then prepares the client for cardioversion.

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91. Critical Care Question #39 - V2

The nurse is preparing to defibrillate an 18-month-old client but the only available pads are adult sized. The nurse should take which action?

1. Perform cardiopulmonary resuscitation (CPR) without defibrillation.

The nurse should use an AED (automatic external defibrillator) if it is available as this intervention has been shown to improve overall survival; however, performing CPR without defibrillation should only be implemented as a last resort.

2. Place one pad on the upper right chest and one pad on the upper left chest.

This placement of both pads on the chest of an 18-month-old client would cause them to overlap thereby making this intervention ineffective; therefore, this is not an appropriate action by the nurse.

✓ 3. Place one pad on the chest and one pad on the client's back.

The adult pads can be used as long as they are not touching each other; therefore, it is appropriate for the nurse to place one pad on the client's chest and the other on the back.

4. Use only one of the pads to defibrillate the pediatric client, if needed.

Both pads are needed to deliver a shock to the client; therefore, this action by the nurse is inappropriate.

An automated external defibrillator (AED) should be used as soon as possible for this toddler-age client. Research shows that survival rates increase when defibrillation occurs within 3-5 minutes of arrest. Correct placement of the pads allows the shock to move directly from one pad to the other. The pads of the AED should not touch or overlap each other. When adult pads are the only ones that are available, it is appropriate for the patient to place one pad on the toddler's chest and another pad on the toddler's back to deliver the shock during defibrillation.

92. Critical Care Question #40

The nurse provides care for a mechanically ventilated client who has a prescription for an arterial blood gas (ABG). Which action should the nurse perform when preparing to implement the prescription?

1. Administer 100% oxygen to the client and position the head of the bed at 45 degrees.

Oxygenation and elevating the head of the bed can generate inaccurate ABG results and should be avoided immediately before drawing the blood sample for the prescribed test; therefore, this is not an appropriate action by the nurse.

✓ 2. Refrain from suctioning the client until after the blood sample is drawn.

Suctioning within 20 minutes prior to an ABG draw could cause inaccurate results; therefore, this is the

appropriate action by the nurse prior to implementing the prescription for the client.

3. Decrease the rate of the client's propofol infusion.

A reduction in propofol would reduce sedation and further increase the client's activity level. An increased activity level could negatively affect the ABG results; therefore, this is not an appropriate action by the nurse.

4. Move the client from the bed to the chair for easy access to the radial artery.

Client activity, including moving the client to a chair, negatively impacts the client's ABG levels; therefore, this action should be avoided by the nurse.

If the condition allows, the nurse should refrain from the following with the client: suctioning, changing activity, or increasing oxygen levels prior to drawing the ABG. These actions can result in inaccurate ABG levels. Suctioning alone can deplete the client's oxygen level which further alters test results. It is a common practice to evaluate blood gas levels after a ventilator change to determine how the client is adapting to the prescribed change.

👉 *Video Rationale: https://d1pumg6d5kr18o.cloudfront.net/rationales-v2/critical_care_1586/part.m3u8*

93. Critical Care Question #40 - V2

The nurse is caring for a client who is mechanically ventilated and has an order for an arterial blood gas (ABG). Which action should the nurse perform when preparing to implement the order?

1. Administer 100% oxygen to the client and position the head of the bed at 45 degrees.

Oxygenation and elevating the head of the bed can generate inaccurate ABG results and should be avoided immediately before drawing the blood sample for the prescribed test; therefore, this is not an appropriate action by the nurse.

✓ 2. Avoid suctioning the client until after the blood sample is drawn.

Suctioning within 20 minutes prior to an ABG draw could cause inaccurate results; therefore, this is the appropriate action by the nurse prior to implementing the prescription for the client.

3. Decrease the rate of the client's propofol infusion.

A reduction in propofol would reduce sedation and further increase the client's activity level. An increased activity level could negatively affect the ABG results; therefore, this is not an appropriate action by the

nurse.

4. Move the client from the bed to the chair for easy access to the radial artery.

Client activity, including moving the client to a chair, negatively impacts the client's ABG levels; therefore, this action should be avoided by the nurse.

If the condition allows, the nurse should avoid the following with the client: suctioning, changing activity, or increasing oxygen levels prior to drawing the ABG. These actions can result in inaccurate ABG levels. Suctioning alone can deplete the client's oxygen level which further alters test results. It is a common practice to evaluate blood gas levels after a ventilator change to determine how the client is adapting to the prescribed change.

94. Critical Care Question #41 - V2

The nurse is caring for a client who is prescribed prolonged positive pressure ventilation (PPV). Which finding should the nurse recognize as a potential complication to this ventilator setting? **Select all that apply.**

☑	**Barotrauma.**
	Barotrauma is physical damage to body tissue caused by a difference in pressure between gas spaces within the body. Clients who are mechanically ventilated have a 4 to 15% incidence of barotrauma .
☐	Dehydration.
	Due to decreased cardiac output the client is actually more at risk of fluid retention; therefore, dehydration is not a complication associated with prolonged positive pressure ventilation.
☑	**Hypotension.**
	Due to the decreased cardiac output and reduced venous return the client is at greater risk for hypotension; therefore, this is a complication associated with prolonged positive pressure ventilation.
☐	Increased venous return.
	The positive pressure applied to the lungs compresses the vessels leading to reduced, not increased venous return; therefore, this is not a complication for a client who is prescribed prolonged positive pressure ventilation.
☑	**Volutrauma.**
	Volutrauma is the overdistention of the alveoli. When a mechanical ventilation breath is forced into the client, the positive pressure tends to follow the path of least resistance to the normal or relatively normal alveoli, potentially

causing overdistention; therefore, this is a complication associated with prolonged positive pressure ventilation.

Prolonged use of PPV increases intrathoracic pressure and reduces venous return and cardiac output. This combination can result in hypotension. If the client is hypovolemic then the hypotension effect could be even greater. Fluid retention usually occurs about 48-72 hours after the initiation of PPV; dehydration is not a potential complication of PPV.

95. Critical Care Question #42 - V2

The nurse is supervising cardiopulmonary resuscitation (CPR) of a client who has a polymorphic ventricular tachycardia with a prolonged QT interval. Which medication should the nurse prepare to administer to this client?

1. Adenosine.

Adenosine is an antiarrhythmic used to treat supraventricular tachycardia; however, this medication is not appropriate for the client who is experiencing polymorphic ventricular tachycardia.

2. Atropine.

Atropine improves atrioventricular conduction and increases the heart rate. This medication will only worsen the client's current tachycardia; therefore, this is not the medication that the nurse prepares to administer to this client.

3. Diltiazem.

Diltiazem in combination with certain medications can further prolong the QT interval; therefore, this is not the medication that the nurse prepares to administer to this client.

✓ 4. Magnesium sulfate.

Intravenous (IV) magnesium sulfate is the first line treatment to correct polymorphic ventricular tachycardia that is accompanied by a prolonged QT interval; therefore, the nurse prepares to administer this medication to the client.

The prolonged QT interval is the result of an electrolyte imbalance, likely hypomagnesemia. The first line treatment is the replacement of that electrolyte. If the electrolyte replacement fails, a second line intervention will need to occur. Examples of second line interventions include defibrillation or discontinuing the QT-prolonging medication if that is the cause for the dysrhythmia.

96. Critical Care Question #43 - V2

The nurse is preparing to administer total parenteral nutrition (TPN) to a client who has a newly inserted double lumen central venous catheter. Which is the **priority** action for the nurse to perform before infusing the prescribed TPN?

✓ 1. Assess the placement of the central venous catheter via chest x-ray.

The central line placement needs to be verified prior to any use; therefore, this is the priority action implemented by the nurse prior to infusing the prescribed TPN.

2. Check patency of the central venous catheter by aspirating for blood return.

Once the placement is verified then patency can be assessed; however, this is not the priority action by the nurse before infusing the prescribed TPN.

3. Obtain a bedside capillary blood glucose level.

While it is important to monitor the client's serum glucose levels when infusing TPN, this is not the priority action by the nurse. The priority action is to verify placement of the newly placed central venous catheter prior to infusion of any prescribed fluids or medication.

4. Prime the TPN tubing before placing the fluid on the intravenous (IV) pump.

While it is important to prime the tubing prior to infusion of the TPN, this is not the priority action by the nurse. The priority action is to verify placement of the newly placed central venous catheter prior to using it to infuse prescribed fluids or medication.

The priority when providing care for a client with a newly placed central venous catheter is to verify correct placement. Verification of the catheter must occur prior to the utilization of the catheter. A chest x-ray can provide verification that the catheter tip is placed correctly in the superior vena cava. Misplacement of the catheter into the visceral pleura can lead to a pneumothorax or hemothorax.

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97. Critical Care Question #44 - V2

The nurse is caring for a client admitted for the treatment of an acute myocardial infarction (MI). The telemetry monitor alarms showing a wide complex tachycardia with a heart rate of 240 bpm. Which action should the nurse implement **first** based on the current data?

✓ 1. Check the client for the presence of a carotid pulse.

The assessment of the carotid artery provides basis for the treatment plan; therefore, this is the first action implemented by the nurse.

2. Begin chest compressions at a rate of 100-120 per minute.

Cardiopulmonary resuscitation (CPR) should only be initiated on a client that is pulseless; therefore, this is not the first action by the nurse. The priority action is to palpate for a pulse to determine if CPR is required.

3. Locate the nearest code cart and place it in the client's room.

A code cart may not be needed based on the stability of the VT; therefore, this is not the first action implemented by the nurse. If the cart is needed, it is more appropriate to ask another member of the healthcare team to retrieve it while cardiopulmonary resuscitation (CPR) is initiated.

4. Notify the hospital operator of a cardiopulmonary arrest.

An assessment of a pulse would be needed first to determine if the client is in cardiopulmonary arrest; therefore, this is not the first action implemented by the nurse.

Treatment of VT is based on the initial assessment of the client’s pulse. The presence of a pulse in an unstable client indicates that the VT can be treated with synchronized cardioversion. The presence of a pulse in a stable client indicates that the VT can be treated with antiarrhythmic medication. These medications include amiodarone, procainamide, or sotalol.

98. Critical Care Question #45

The nurse provides care for a client with acute respiratory distress syndrome (ARDS) who is prescribed high levels of positive end-expiratory pressure (PEEP). Which potential complication of high PEEP should the nurse monitor this client for based on the current data?

✓ 1. Barotrauma.

High levels of PEEP can result in the overexpansion of the alveoli and potential rupture; therefore, the complication that the nurse monitors this client for is barotrauma.

2. Elevated blood pressure.

High levels of PEEP can result in decreased venous return ultimately leading to hypotension not hypertension; therefore, this is not a potential complication that the nurse monitors this client for in the

provision of care.

3. Hyperoxygenation.

Hyperoxygenation is not a complication of PEEP. It is a medical intervention of administering higher than usual concentrations of oxygen; therefore, this is not a potential complication that the nurse monitors this client for but an intervention prescribed to treat the client's current condition.

4. Refractory hypoxemia.

Refractory hypoxemia is a long term complication of ARDS; however, this is not a potential complication associated with high levels of PEEP; therefore, the nurse does not monitor the client for this complication.

PEEP helps to reduce oxygen toxicity in clients being treated for ARDS. High levels of PEEP can lead to pneumothorax and hypotension as a result of overextension of the alveoli. PEEP can also have hemodynamic effects through increased intrathoracic pressure ultimately leading to reduced venous return and decreased preload and cardiac output. Hypotension, not hypertension, is the late stage hemodynamic effect associated with high levels of PEEP.

Video Rationale: https://d1pumg6d5kr18o.cloudfront.net/rationales-v2/critical_care_1591/part.m3u8

99. Critical Care Question #45 - V2

The nurse is caring for a client who has acute respiratory distress syndrome (ARDS) and is prescribed high levels of positive end-expiratory pressure (PEEP). The nurse should monitor for which potential complication of the PEEP?

✓ 1. Barotrauma.

High levels of PEEP can result in the overexpansion of the alveoli and potential rupture; therefore, the complication that the nurse monitors this client for is barotrauma.

2. Elevated blood pressure.

High levels of PEEP can result in decreased venous return ultimately leading to hypotension not hypertension; therefore, this is not a potential complication that the nurse monitors this client for in the provision of care.

3. Hyperoxygenation.

Hyperoxygenation is not a complication of PEEP. It is a medical intervention of administering higher than usual concentrations of oxygen; therefore, this is not a potential complication that the nurse monitors this client for but an intervention prescribed to treat the client's current condition.

4. Refractory hypoxemia.

Refractory hypoxemia is a long term complication of ARDS; however, this is not a potential complication associated with high levels of PEEP; therefore, the nurse does not monitor the client for this complication.

PEEP helps to reduce oxygen toxicity in clients being treated for ARDS. High levels of PEEP can lead to pneumothorax and hypotension as a result of overextension of the alveoli. PEEP can also have hemodynamic effects through increased intrathoracic pressure ultimately leading to reduced venous return and decreased preload and cardiac output. Hypotension, not hypertension, is the late stage hemodynamic effect associated with high levels of PEEP.

100. Critical Care Question #46 - V2

The nurse is caring for a client who has a nasogastric (NG) tube that has been connected to low intermittent suction for the past 3 days. Which arterial blood gas (ABG) results does the nurse anticipate for this client?

✓ 1. pH 7.55, PaCO2 46, HCO3 30.

This ABG indicates that the client is experiencing metabolic alkalosis due to the elevated pH and bicarbonate (HCO3) levels. The client who is prescribed low intermittent suction via the NG tube is a risk for developing metabolic alkalosis; therefore, this is the ABG result that is anticipated for this client.

2. pH 7.58, PaCO2 28, HCO3 28.

This ABG indicates respiratory alkalosis as the pH is elevated while the PaCO2 is decreased. This is not the ABG result that is anticipated by the nurse for this client.

3. pH 7.24, PaCO2 50, HCO3 28.

This ABG indicates the client is experiencing respiratory acidosis as the pH is decreased while the PaCO2 > 45. This is not the ABG result, however, that is anticipated for this client.

4. pH 7.28, PaCO2 33, HCO3 18.

This ABG indicates the client is experiencing metabolic acidosis is both the pH and HCO3 are decreased.

This is not the anticipated ABG result for this client based on the current data.

Loss of acid through suctioning of gastric contents creates a state of metabolic alkalosis. This alkalosis is an imbalance at the bicarbonate level. The elevated bicarbonate level indicates that there are more basic (i.e., alkalotic) changes due to a metabolic cause. To compensate for the loss of body acid, the respiratory rate will slow.

101. Critical Care Question #47 - V2

The nurse is caring for a client who has an automated implantable cardioverter defibrillator (ICD) and is shocked twice by the device but remains in ventricular fibrillation (VF) without a pulse. Which action by the nurse is appropriate?

✓ 1. Begin chest compressions at a rate of 100 per minute.

Cardiopulmonary resuscitation (CPR) should be initiated in the pulseless client with an ICD; therefore, this is an appropriate response by the nurse.

2. Continue to monitor the client closely.

Continued ventricular fibrillation post ICD shocking requires further intervention and not strictly observation; therefore, this is not an appropriate response by the nurse.

3. Give epinephrine 1:1000 intravenous push (IVP) now.

Epinephrine should be administered after the initiation of cardiopulmonary resuscitation (CPR) and defibrillation; therefore, this is not an appropriate response by the nurse.

4. Start a second, large bore intravenous (IV) catheter.

The priority action when providing care for a pulseless client is the initiation of cardiopulmonary resuscitation (CPR) to provide circulation of blood to vital organs; therefore, this is not an appropriate response by the nurse.

The ICD is able to sense electrical activity of the heart and respond; however, this device is unable to sense or treat pulselessness. The ICD will only fire electrical shocks to interrupt the dysrhythmia. Cardiopulmonary resuscitation (CPR) should be initiated after determining that the client is pulseless. The ICD should be

allowed to complete a 30-60 second therapy cycle prior to applying external defibrillation pads/paddles for continued treatment.

102. Critical Care Question #48 - V2

The nurse is caring for a client who survives a near drowning experience. Which data collected by the nurse requires **priority** action?

1. Crackles in lung bases.

Crackles in the lung fields indicate oxygen exchange is occurring with oxygen being supplied to the body; therefore, this finding does not indicate the need for priority action by the nurse.

2. A non-productive cough.

A productive or non-productive cough is an expected finding in a client who has suffered a near drowning incident. Therefore this would not be a priority finding.

✓ 3. Decerebrate posturing.

Decerebrate posture indicates severe brain damage and this finding would indicate a need for priority action by the nurse.

4. Radial pulses 1+ bilateral.

Thready radial pulses are normally present in a near-drowning client due to hypothermia. This can be corrected with warm intravenous fluids, blankets, and oxygen; however, this finding does not require priority action by the nurse.

Severe brain injury for a client who survives a near drowning is likely to be decerebrate posturing. This position consists of the client's arms and legs straight out, toes pointed down with the head and neck arched back. This position is the result of a significant lack of oxygen to major body organs. This specific finding in a near-drowning victim indicates severe brain damage; therefore, indicates a need for priority action by the nurse.

103. Critical Care Question #49 - V2

The nurse is caring for a client who is diagnosed with emphysema and is receiving noninvasive positive-pressure ventilation (NPPV). The following medications are due at 0900:

- Salmeterol inhaler 4 puffs
- Vancomycin 1 gm IVPB
- Prednisone 10 mg PO
- Enoxaparin 80 mg subcutaneous

Which is the **most** important assessment to perform for this client?

1. Capillary blood glucose.

Blood glucose level can be impacted by the utilization of corticosteroids like solumedrol; however, this is not the most important assessment for the nurse to perform for this client.

✓ 2. Level of consciousness.

The client must remain conscious for this level of ventilation to be effective. Altered mental status poses the greatest risk to the client's survival as it can lead to periods of apnea and airway compromise; therefore, this is the most important assessment for the nurse to perform for this client.

3. Peripheral pulse quality.

Peripheral pulse quality can indicate the presence of deep vein thrombosis but airway compromise is the priority in this case; therefore, this is not the most important assessment for the nurse to perform with this client.

4. White blood cell (WBC) count.

A WBC count can measure the effectiveness of the vancomycin treatment but airway maintenance is a priority; therefore, this is not the most important assessment for the nurse to perform for this client.

Noninvasive positive-pressure ventilation is delivered through a noninvasive interface (e.g., nasal mask, facemask, or nasal plugs) rather than an invasive interface (e.g., endotracheal tube, tracheostomy). Its use has become more common as its benefits are increasingly recognized. The client must remain alert and oriented for the form of ventilation to be effective. If the client's condition deteriorates, then an alternative form of ventilation should be implemented.

104. Critical Care Question #50 - V2

The nurse is caring for a client who is postoperative and is crying due to uncontrollable pain. The client has the below findings.

Vital Signs	Arterial Blood Gases (ABGs)
Blood pressure: 148/94 mm Hg	pH: 7.50
Heart rate: 90 bpm	PaCO2: 32 mm Hg
Respirations: 30	PaO2: 80 mm Hg
O2 Sat: 90% on room air	HCO3: 22 mEq/L

1. Metabolic acidosis.

This would not be the correct option. During metabolic acidosis, the body pH is <7.35 and the HCO3 is <22 mm Hg.

2. Metabolic alkalosis.

This would not be the correct option. During metabolic alkalosis, the body pH is >7.45 and the HCO3 is > 26 mm Hg.

3. Respiratory acidosis.

This would not be the correct option. During respiratory acidosis, the pH is <7.35 and the CO2 level is >45 mm Hg.

✓ 4. Respiratory alkalosis.

This would be the correct option. Hyperventilation or breathing fast, is associated with stress, anxiety, and pain. This causes the body to breathe off CO2 quickly, lowering CO2 levels (<35 mm Hg) and raising the pH of the body (>7.45), thus causing the acid-base imbalance of respiratory alkalosis.

Knowing and understanding the significance of ABGs changes and acid-base imbalances is crucial. Acid-base imbalance can be life threatening if the nurse does not ascertain and report in a timely manner. Knowing the normal levels is the first step:

- pH: 7.35-7.45
- PaCO2: 35-45 mm Hg
- PaO2: 80-100
- HCO3: 22-26

105. Critical Care Question #51 - V2

The nurse who is part of an emergency air flight team, arrives at a construction site where a worker has been impaled in the abdomen by a metal rod. Which action should the nurse perform **first**?

✓ 1. Ensure stability of the rod with a bulky dressing.

The object should be stabilized to prevent further injury and conserve blood loss; therefore, this is the first action implemented by the nurse.

2. Place the client on a backboard for transport.

The client should not be moved until the object is stabilized; therefore, this is not the first action implemented by the nurse.

3. Remove any tight or constrictive clothing.

Clothing may be removed on the scene after stabilization of the object and initial assessment is completed; therefore, this is not the first action implemented by the nurse.

4. Start a 16-gauge intravenous (IV) catheter and infuse IV fluids.

An IV line may be inserted and fluids begun on the scene only after stabilization of the object and initial assessment is complete; therefore, this is not the first action performed by the nurse.

An impaled object should not be manipulated or removed at the scene of the trauma as further injury can occur to surrounding tissue or organs. This object may actually be applying enough pressure on the wound to reduce potential blood loss. A skilled trauma team is needed to further assess these wounds prior to removal of the object. If the object were to be obstructing the airway, first responders are trained to remove the impaled object.

106. Critical Care Question #52 - V2

The nurse is preparing to receive a client who has experienced a near drowning. Which actions should the nurse take to prepare for anticipated client care needs? **Select all that apply.**

☑	**Gather intubation and mechanical ventilation supplies.**
	Intubation is recommended in clients with poor respiratory effort, altered sensorium, severe hypoxemia or severe acidosis; therefore, this is an appropriate action when preparing the room for the near drowning client.
☑	**Ensure that intravenous (IV) fluids are warmed before administration.**

	A near drowning victim often suffers from hypothermia, and rewarming of IV fluids would be an appropriate intervention to correct the hypothermia; therefore, this is an appropriate action by the nurse when preparing the room for this client.
☑	**Place several blankets in the warmer.**
	Due to the risk of hypothermia, warm blankets are a safe intervention to gradually warm up the client; therefore, this is an appropriate action for the nurse to implement when preparing for the arrival of this client.
☐	Prepare warmed packed red blood cells (RBCs).
	Blood products will not be needed unless there was blood loss from trauma during the near-drowning incident; therefore, this is not an action the nurse implements when preparing for the arrival of this client.
☑	**Prepare to place the client on continuous telemetry.**
	Acidosis and hypoxemia place the client at risk for ventricular dysrhythmias; therefore, this is an appropriate action when preparing to provide care for the near-drowning victim.

The most critical role in management of the client who is a near drowning victim is prompt correction of hypoxemia and acidosis. The nurse should prepare for the client to present with both hypothermia and respiratory distress. Due to hypothermia, careful handling of the client is a must as the myocardium is extremely irritable. Frequent handling may spontaneously place the client in ventricular fibrillation.

107. Critical Care Question #53 - V2

The nurse is caring for a client who is 33 weeks gestation and presents with a cardiac arrest. Which action should the nurse take when administering cardiopulmonary resuscitation (CPR) to this client?

✓ 1. Administer compressions at a higher level on the sternum.

Higher on the sternum compressions are the standard of care intervention for the pregnant client; therefore, this is an appropriate action by the nurse when performing CPR.

2. Do not alter the manner in which compressions are typically delivered.

Alteration to the typical CPR procedure is needed to provide adequate blood perfusion to vital organs; therefore, this is not an appropriate action by the nurse.

3. Ensure that the client is lying flat when performing compressions.

Slight rotation to the client's left side manually displaces the uterus and reduces pressure on the vena cava; therefore, this is not an appropriate action by the nurse when performing CPR to this client.

4. Perform compressions just to the right of the sternal border.

Chest compressions need to remain midline on the sternum; therefore, this action is not appropriate when performing CPR on a pregnant client.

There are two important modifications for CPR of a pregnant client. These include higher on the sternum compressions and displacing the uterus to the client's left side. Higher sternal placement of the hands is the result of heart displacement to the left from the size of a third trimester uterus. Displacing the uterus to the left during CPR reduces pressure on the client's vena cava and aorta.

108. Critical Care Question #54 - V2

The nurse working on a medical surgical unit is caring for assigned clients. Which findings require **immediate** notification of the rapid response team (RRT)?

1. Glasgow coma scale of 10 throughout the shift.

This finding has been stable throughout the shift and does not constitute an acute or sudden change in condition; therefore, this finding does not necessitate activation of the RRT.

✓ 2. Heart rate of 32 BPM and diaphoresis.

Bradycardia accompanied by diaphoresis meets the criteria of acute and sudden onset of symptoms for activation of the RRT. The client's condition may continue to deteriorate without immediate action by the nurse.

3. Oxygen saturation 92% on room air.

Oxygenation of 92% is an abnormal finding; however, this data does not meet the criteria for the activation of the RRT.

4. Report of headache pain rated a 10 of 10.

Unrelieved pain is concerning but this can be addressed through nursing assessment, intervention, and evaluation; therefore, this finding does not warrant the activation of the RRT.

The criteria for a rapid response is an unstable client in a non-acute setting where the client is not responsive to treatment. Acute changes in a client's condition may warrant a call to the rapid response team. Acute changes may be systolic blood pressure <90 mm Hg, respiratory rate <8 or >28/min, urine output <50 mL/4 hrs, or a level of consciousness change. Any healthcare provider can also request a fast team response even if it is solely because they are worried about the client's condition.

109. Critical Care Question #55

Which is the **priority** nursing diagnosis for a post-abdominal surgical client with the following assessment data? Assessment data: Nasogastric (NG) tube to low intermittent suction; Hemovac abdominal drain; 0.9% sodium chloride infusing at 100 mL/hr; patient controlled analgesia (PCA) pump with fentanyl; heart rate (HR) 118 BPM; and blood pressure (BP) 88/48 mm Hg

✓ 1. Fluid volume deficit.

The client is at risk of intravascular fluid loss that is secondary to hemorrhage, wound drainage, or gastric suction; therefore, this priority nursing diagnosis for this client is fluid volume deficit.

2. Impaired urinary elimination

Impaired urinary elimination is not an appropriate nursing diagnosis for this client based on the current assessment data.

3. Increased cardiac output

Potential third spacing secondary to intravascular blood loss places the client at risk for decreased, not increased cardiac output.

4. Knowledge deficit

The client's learning needs is not the priority at this time; therefore, this is not the priority nursing diagnosis based on the current data.

This client is at risk for hypovolemia due to the NG tube suction prescription in addition to the hemovac abdominal drain. The nurse should plan care to address a fluid deficit related to intravascular loss. This loss may be due not only the gastric suctioning but also hemorrhage, wound drainage, or possible third spacing.

👉 *Video Rationale: https://d1pumg6d5kr18o.cloudfront.net/rationales-v2/critical_care_1600/part.m3u8*

110. Critical Care Question #55 - V2

The nurse is caring for a client who is postoperative from abdominal surgery. Assessment findings are as indicated below.

- Nasogastric (NG) tube to low intermittent suction
- Closed-drainage wound system (Hemovac)
- 0.9% sodium chloride (NS) infusing at 100 mL/hr
- Patient-controlled analgesia (PCA) pump with fentanyl
- Heart rate (HR) 118 bpm
- Blood pressure (BP) 88/48 mm Hg

Which nursing problem should the nurse **prioritize**?

✓ 1. Fluid volume deficit.

The client is at risk of intravascular fluid loss that is secondary to hemorrhage, wound drainage, or gastric suction; therefore, this priority nursing diagnosis for this client is fluid volume deficit.

2. Impaired urinary elimination.

Impaired urinary elimination is not an appropriate nursing diagnosis for this client based on the current assessment data.

3. Increased cardiac output.

Potential third spacing secondary to intravascular blood loss places the client at risk for decreased, not increased cardiac output.

4. Knowledge deficit.

The client's learning needs are not the priority at this time; therefore, this is not the priority nursing diagnosis based on the current data.

This client is at risk for hypovolemia due to the NG tube suction prescription in addition to the hemovac abdominal drain. The nurse should plan care to address a fluid deficit related to intravascular loss. This loss may be due not only the gastric suctioning but also hemorrhage, wound drainage, or possible third spacing.

111. Critical Care Question #56 - V2

The nurse is caring for a client who requires continuous arterial blood pressure (BP) monitoring. Which location is correct for the nurse to place the transducer to achieve accurate measurements?

1. Left of the sternal border at the 2nd intercostal space.

Locations surrounding the sternal border are utilized for auscultation and landmarks for locating other auscultatory areas; however, this is not the location the nurse places the transducer to achieve accurate BP measurements.

2. Right of the sternal border in the pulmonic area.

Locations surrounding the sternal border are utilized for auscultation and landmarks for locating other auscultatory areas; however, this is not the location where the transducer is placed by the nurse for accurate BP measurements.

✓ 3. 4th intercostal space, mid-axillary area.

The phlebostatic axis provides the most accurate location for the transducer when performing continuous arterial pressure monitoring; therefore, this is the location where the nurse places the transducer for accurate BP measurements.

4. 5th intercostal space, mid-clavicular area.

The 5th intercostal space at the midclavicular line is an auscultatory area for the mitral apex; however, this is not the location that is used by the nurse to place the transducer to achieve accurate BP measurements.

The technique involves the insertion of a catheter into a suitable artery and then displaying the measured pressure wave on a monitor. The most common reason for using intra-arterial BP monitoring is to gain a ‘beat-to-beat’ record of a client’s BP. Placement of the transducer at the appropriate location provides the nurse with the most accurate data. This location is at the 4th intercostal space at the mid-axillary area.

112. Critical Care Question #57 - V2

The nurse is caring for a client who is receiving a continuous dopamine infusion. Which data alerts the nurse that an adjustment to the rate of the infusion is needed?

✓ 1. Heart rate is 124 bpm.

Tachycardia indicates a dose reduction is needed to prevent further cardiac events; therefore, this finding alerts the nurse that an adjustment in the client's dopamine infusion is required.

2. Mean arterial pressure (MAP) is 72 mm Hg.

A normal mean arterial pressure (MAP) is 70-105 mm Hg; therefore, this data is within normal limits and does not indicate to the nurse a need to adjust the client's dopamine infusion.

3. Pulmonary capillary wedge pressure (PCWP) is 10 mm Hg.

The normal range for a pulmonary capillary wedge pressure is 6-12 Hg. This reading is within normal limits; therefore, this finding does not indicate to the nurse a need to adjust the client's dopamine infusion.

4. Systemic vascular resistance is 840 dynes/second/cm - 5.

A normal systemic vascular resistance is 700-1500 dynes/second/cm -5. This reading is within normal limits; therefore, this finding does not indicate to the nurse a need to adjust the client's current dopamine infusion.

Dopamine is used to treat hypotension (i.e., low blood pressure), low cardiac output, and reduced perfusion of body organs. The client's hypotension may be caused by shock, trauma, and/or sepsis. Vital signs should be monitored closely for these clients as a higher dose can result in tachycardia (i.e., increased heart rate) and tachyarrhythmias (i.e., heart rhythm with a ventricular rate of 100 beats/min or greater). The client data that indicates a need to adjust the current dopamine infusion is a heart rate that is indicative of tachycardia (e.g., heart rate of 124 BPM).

113. Critical Care Question #58 - V2

The nurse is caring for a client who is sedated, and receiving mechanical ventilation. Which intervention should be included in the client's nursing plan of care? **Select all that apply.**

☑	**Complete daily sedation vacations.**
	Daily sedation vacations ensure appropriate level of sedation is maintained and determines if the client can be weaned; therefore, this intervention should be included in this client's nursing plan of care.
☐	Decrease the volume of the high pressure alarm at night.

	Ventilator alarms should never be muted as they may indicate life-threatening complications; therefore, this is not an intervention that should be included in the client's nursing plan of care.
☑	**Keep a bag-valve-mask near the bedside at all times.**
	A bag-valve-mask should be the bedside of all clients who are mechanically ventilated in the event that manual resuscitation is required; therefore, this is an intervention that should be included in this client's nursing plan of care.
☐	Keep the head of the bed elevated to at least 15 degrees.
	The head of the bed should be kept at 30-45 degrees to reduce the risk of aspiration and further infection; therefore, this is not an appropriate intervention to include in this client's nursing plan of care.
☑	**Performing oral care every two hours.**
	Performing oral care every two hours decreases levels of bacteria in the oral cavity further decreasing the risk of infection; therefore, this is an appropriate intervention to include in the client's nursing plan of care.

The nurse who provides care for a critically ill client who is sedated and receiving mechanical ventilation is required to monitor certain data, including respiratory status and airway patency to determine whether weaning can be implemented. In addition, the nurse must also protect this client from acquiring a healthcare-associated infection (HAI). The nurse can implement multiple interventions to decrease complications with the sedated client on a mechanical ventilator. These interventions consist of keeping the head of the bed at 30-45 degrees, performing oral care every two hours, keeping emergency supplies at the bedside, and ensuring that alarm systems are audible. The nurse should also ensure correct placement of the ET ube by noting insertion depth.

114. Critical Care Question #59 - V2

The nurse is caring for a client who presents to the emergency department (ED) after being involved in a motor vehicle crash (MVC). Which clinical manifestation indicates the client is experiencing neurogenic shock? **Select all that apply.**

☐	Oxygen saturation of 92% on room air (RA).
	Clinical manifestations related to neurogenic shock include hypothermia, bradycardia, hypotension, dyspnea, cyanosis, weak pulses, and chest pain. An oxygen saturation of 92% on RA does not indicate the client is having difficulty breathing or is cyanotic.
☐	Bilateral lower extremity pulses 4+ upon palpation.
	Clinical manifestations related to neurogenic shock include hypothermia, bradycardia, hypotension, dyspnea, cyanosis, weak pulses, and chest pain. Bilateral lower extremity pulses of 4+ are considered bounding, not weak; therefore, this

	clinical manifestation does not support that the client is experiencing neurogenic shock.
☑	**Current oral temperature is 95° F (35° C).**
	Impaired thermoregulation (e.g., hypothermia) is a common clinical manifestation in neurogenic shock.
☑	**Heart rate is 44 beats per minute.**
	Neurogenic shock has the hallmark clinical manifestation of bradycardia. This occurs due to the dysfunction of the sympathetic nervous system and autonomic dysregulation; therefore, a heart rate of 44 indicates neurogenic shock for this client.
☑	**Blood pressure is 80/40 mm Hg.**
	Hypotension with bradycardia is most associated with neurogenic shock. This is the result of injury to the spinal cord, dysfunction of the sympathetic nervous system, and autonomic dysregulation.

Neurogenic shock results from traumatic spinal cord injury. The injury causes interference with the sympathetic nervous system, which results in autonomic impairment. The resultant clinical manifestations include hypothermia, bradycardia, and hypotension. Additional signs and symptoms that may be experienced by the client include dyspnea, cyanosis, weak pulses, and chest pain.

115. Critical Care Question #60 - V2

The nurse is caring for a client who has a right brachial arterial access device. Which finding alerts the nurse to a potential complication of this device?

1. Pressure bag filled with sterile normal saline.

An intravenous (IV) bag of normal saline is placed in a pressure infuser device set to 300 mmHg to maintain patency of the arterial system; therefore, this finding does not alert the nurse to a potential complication associated with this invasive device.

2. Right and left radial pulses are 1+.

Bilateral consistency of findings does not provide evidence of a potential complication in the cannulated arm; therefore, this finding does not indicate a potential complication related to the invasive device.

✓ 3. Right hand is cool to touch compared to the left hand.

Arterial pressure monitoring allows for continuous monitoring of systemic arterial blood pressure, temperature, and provides vascular access for obtaining blood samples. An alteration in temperature from

one hand to another may indicate circulatory impairment; therefore, this finding alerts the nurse to a potential complication associated with the invasive device.

4. Systolic blood pressure reading of 92 mm Hg.

This systolic reading is adequate to perfuse the vital organs and within the lower side of normal. If the client's blood pressure continues to drop then further investigation by the nurse is warranted; however, this finding is not indicative of a complication associated with the invasive device.

Complications of arterial line placement must be assessed continuously. These include hemorrhage, infection, thrombus, and circulatory impairment. Although brachial arterial line complications are uncommon, iatrogenic brachial artery dissection with complete anterograde occlusion is possible but rare. This complication presents as a cool to the touch extremity as a result of impaired circulation.

116. Critical Care - Critical Care - Health Promotion and Maintenance - Q4

The nurse is administering 50 mL of 50% dextrose with 10 units Regular insulin IV to a client with acute kidney injury (AKI). When asked by the client what the rationale is for this medication, which is the nurse's best response?

1. "The provider ordered it and I will ask for clarification"

- This is not an appropriate response. This does not address the client's question.

2. "This medication will help keep your glucose within normal limits"

- Insulin and 50% dextrose are not administered to AKI clients for the purpose of glucose maintenance. Insulin and dextrose are administered to AKI clients in order to normalize elevated potassium levels.

3. "These medications will help correct your low sodium"

- Insulin and dextrose do not alter serum sodium levels. Insulin and dextrose are administered to correct elevated potassium levels in clients with AKI.

✓ 4. "This will help correct your elevated potassium"

- INsulin and dextrose are given to clients with AKI to correct elevated potassium levels by forcing potassium back into the cellular space where it normally resides. Dextrose is administered to prevent hypoglycemia.

AKI often leads to hyperkalemia due to the kidney's inability to excrete potassium into urine effectively. **Insulin is administered to rapidly lower serum potassium** levels by forcing potassium back into the cellular space. 50% dextrose is given in combination with insulin to prevent hypoglycemia.

👉 *Video Rationale: https://d1pumg6d5kr18o.cloudfront.net/rationales-v2/critical_care_health_promotion_and_maintenance_4/part.m3u8*

117. Critical Care - Critical Care - Management of Care - Q3

A nurse has been having difficulty sleeping and mood swings since the recent, unexpected death of a client. The nurse and family had many conversations regarding Do Not Resuscitate orders prior to the client's death. The nurse's symptoms are likely signs of which issue?

1. Change fatigue

- Change fatigue occurs when the nurse experiences stress and exhaustion because of rapid and unrelenting change in the work environment.
-

✓ **2. Moral distress**

- - **When evaluating and addressing the needs of the critically ill clients, the nurse should first determine each family member's role in the client's life and who has decision making ability.**

3. Medical futility

- Medical futility involves a treatment that is performed without any perceived benefit to the client.

4. Ethical dilemma

- In ethical dilemmas in nursing, the nurse must decide between competing choices and understand that either option holds consequences.

There are many sources for moral distress as a nurse working in the intensive care unit. **Moral distress** occurs as a result of **knowing the correct action ethically to take but the inability to take that action**. Moral distress in the ICU results from having to participate in life-sustaining decisions, critical illnesses and deaths, circumstances that require rapid decision making, among other situations.

👉 *Video Rationale: https://d1pumg6d5kr18o.cloudfront.net/rationales-v2/critical_care_management_of_care_3/part.m3u8*

118. Critical Care - Critical Care - Health Promotion and Maintenance - Q5

Which statement by the client receiving fibrinolytics warrants further assessment by the critical care nurse?

✓ 1. "I have the worst headache I have ever had."

- Reports of a severe headache should alert the nurse to intracranial bleeding and warrants further assessment and prompt intervention by the nurse.

2. "There is blood on my toothbrush."

- Bleeding gums is an expected side effect of fibrinolytic therapy. The nurse should educate the client that this finding is expected.

3. "Look at these bruises on my arm."

- Easy bruising is an expected side effect of fibrinolytic therapy. The nurse should educate the client that this finding is expected.

4. "I have some oozing from my IV site."

- Oozing from an IV site is an expected side effect associated with fibrinolytics. The nurse should educate the client that this finding is expected.

Fibrinolytic therapy is administered in order to dissolve clots within the coronary arteries or cerebral arteries. There are many potential complications associated with fibrinolytic therapy. Some of the most common and expected side effects of fibrinolytic therapy are similar to side effects associated with all anticoagulation including bleeding gums, easy bruising, and bleeding from IV sites. The **most serious and potentially fatal complication of fibrinolysis is intracranial bleeding**. Reports of a **serious headache should alert the nurse to the potential for intracranial bleeding** and warrants further assessment.

👉 *Video Rationale: https://d1pumg6d5kr18o.cloudfront.net/rationales-v2/critical_care_health_promotion_and_maintenance_5/part.m3u8*

119. Critical Care - Critical Care - Safety and Infection Control - Q4

What infectious signs and symptoms would an immunocompromised client most likely exhibit? **(Select all that apply)**

☐	Erythema
	• Erythema, a classic immune response to infection, will likely not be present in an immunocompromised client.
☑	**Mild leukocytosis**
	• In an immunocompromised client, leukocytosis may be mild or absent.
☑	**Low grade fever**
	• In an immunocompromised client, fever may be mild/ low grade, or absent.
☐	Pain at infection site
	• An immunocompromised client will not typically report pain at the infection site as this is a classic immune response to infection.
☐	Local edema
	• An immunocompromised client will not display edema at the site of infection as this is a classic immune response to infection.

The immune system of **immunocompromised clients** have decreased ability to protect from infection. Immunocompromise may be caused by certain medications like corticosteroids, chemotherapy treatments or disorders such as HIV or diabetes mellitus. Because of the body's impaired response to infection, the classic manifestations associated with an immune response may be minimal or absent. The client **may only display mild or no leukocytosis** or a **mild fever or no fever** when infection is present.

👉 *Video Rationale: https://d1pumg6d5kr18o.cloudfront.net/rationales-v2/critical_care_safety_and_infection_control_4/part.m3u8*

120. Critical Care - Critical Care - Safety and Infection Control - Q2

Which is the priority intervention for prevention of infection for a client diagnosed with aplastic anemia?

1. Administration of red blood cell growth factor to stimulate erythropoiesis.

- Administration of RBC growth factor will stimulate erythropoiesis or RBC production. This will decrease signs and symptoms of anemia but will not protect against infection.

2. Instruct the client on the importance of incorporating raw produce into the diet.

- Clients with aplastic anemia should be instructed to avoid raw fruits and vegetables due to the risk of infection from contaminated food.

✓ 3. Instruct the client and visitors to practice proper hand hygiene.

- Proper and strict hand hygiene is the most effective way for preventing infection and the nurse should instruct clients with aplastic anemia on its importance.

4. Monitor the complete blood count for any decreases in the white blood cell count (WBC).

- While the nurse will monitor the client's CBC and WBC count, this is not the priority intervention for prevention of infection.

Aplastic anemia is a genetic stem cell disorder in which all blood cell types are decreased, including red blood cells, white blood cells, and platelets, The client will experience symptoms of anemia due to decreased RBCs, has an increased bleeding risk due to decreased platelets, and **an increased risk of infection due to low WBCs**. It is critical for the nurse to i**nstruct the client and visitors on proper hand hygiene** in order to decrease this risk for infection.

👉 *Video Rationale: https://d1pumg6d5kr18o.cloudfront.net/rationales-v2/critical_care_safety_and_infection_control_2/part.m3u8*

121. Critical Care - Critical Care - Psychosocial Integrity - Q5

The nurse is caring for a client who has been hospitalized in the intensive care unit for one week. The nurse should monitor the client for which manifestations of ICU psychosis?

✓ 1. Signs of increasing agitation and confusion to place and time.

- Key man infestations of ICU psychosis include increased agitation and new onset confusion.

2. Reports of phantom limb pain following amputation.

- Phantom limb pain is a common finding following amputation and is not an indicator of ICU psychosis.

3. Reports of sleeping no more than 3 hours per night.

- Insomnia can contribute to the development of ICU psychosis but is not a manifestation of the

syndrome.

4. Decreased alertness noted during the morning assessment.

- Decreased alertness with the first morning assessment may be a normal finding. If a client is awakened for their assessment, decreased alertness upon awakening is expected and not associated with ICU psychosis.

ICU psychosis is a potential complication of a prolonged ICU stay and it results in confusion and agitation. In general, ICU psychosis, or delirium, causes a decreased awareness of one's surroundings. In addition to agitation and disorientation to time and place, ICU psychosis can cause a fluctuating level of consciousness, withdrawal, irritability, and hallucinations. Signs of ICU psychosis must be recognized and treated early as this syndrome results in poor outcomes for critically ill clients.

👉 *Video Rationale: https://d1pumg6d5kr18o.cloudfront.net/rationales-v2/critical_care_psychosocial_integrity_5/part.m3u8*

122. Critical Care - Critical Care - Basic Care and Comfort - Q4

The nurse is caring for a client receiving enteral feedings. In which scenario should the nurse consider discontinuing enteral feedings?

1. The client's glucose is 201 mg/dL.

- Elevated blood glucose levels are expected in clients receiving enteral nutrition. This is not an indicator that feedings should be discontinued.

2. The client' bowel sounds are hypoactive.

- Hypoactive bowel sounds may be a normal finding for some clients. The nurse should not discontinue enteral feedings for this reason.

3. The client has three, soft, formed stools per day.

- Three, soft, formed bowel movements in one day is a normal and expected finding for clients receiving enteral nutrition. The nurse should not discontinue feedings due to this finding. If the client develops diarrhea, a fiber supplement may be added or bolus feedings may be considered.

✓ 4. The nurse aspirates 525 mL of gastric residual.

- Gastric residuals over 500 mL place clients at risk for aspiration and indicate poor bowel motility. The nurse should follow facility protocol in considering discontinuation of the feeding.

The nurse should monitor gastric residual every 4 hours in clients receiving enteral nutrition. Elevated gastric residuals indicate slowed bowel motility and place the client at risk for aspiration. **Gastric residual over 500 mL is a great risk to the client which indicates the need to consider discontinuation** of the feeding according to facility protocol.

👉 *Video Rationale: https://d1pumg6d5kr18o.cloudfront.net/rationales-v2/fundamentals_medication_administration_basic_care_and_comfort_01/part.m3u8*

123. Mental Health Question #1 - V2

The nurse is caring for a client with a history of bipolar affective disorder, who is hospitalized for acute mania.

➤Which diet selection is best for this client?

1. Biscuit with bacon, fried eggs, hash browns, and milk.

Fried eggs and hashbrowns would be hard to eat on the go which is often required for an acutely manic client who is likely in a state of constant activity.

2. Chicken noodle soup, crackers, granola bar, and water.

These foods would be hard to eat on the go which is often required for an acutely manic client who is likely in a state of constant activity.

3. Fettuccine with alfredo sauce, caesar salad, and soda.

This food would be hard to eat on the go which is often required for an acutely manic client who is likely in a state of constant activity.

✓ 4. Meat and cheese burrito, grapes, and a protein shake.

This option provides protein dense foods that are easy to eat on the go which is often a necessity for a client who is acute manic.

Manic episodes associated with bipolar affective disorder often include the following manifestations: high energy, reduced need for sleep, and loss of touch with reality. Depressive episodes, however, may include symptoms such as low energy, low motivation, and loss of interest in daily activities. Mood episodes last

days to months at a time and may also be associated with suicidal thoughts. Dietary intake can be a challenge during acute mania; therefore, the foods should be easy to eat on the go (as these individuals often cannot sit still for any length of time) and should be high in protein to meet the client's metabolic needs.

124. Mental Health Question #2 - V2

The nurse is caring for a client who is diagnosed with psychosomatic disorder. The client reports a headache with nausea, rating the pain as 9 out of 10 on a numeric pain scale.

➤What is the appropriate nursing action?

1. Discuss strategies to decrease stress and alleviate the current symptoms.

This action is not appropriate based on the client's current diagnosis.

2. Increase the time talking to the client about physical symptoms.

To minimize the indirect benefits from being "sick," limited time should be spent discussing the client's physical symptoms.

✓ 3. Redirect the conversation to unrelated, general topics of conversation.

The nurse should redirect reports of somatic symptoms to unrelated, neutral topics based on the diagnosis of psychosomatic disorder.

4. Reassure the client that the headache is not a symptom of a brain tumor.

Reassuring the client that the cause is not because of a physiological problem would only increase the client's focus on the symptom and is inappropriate.

A psychosomatic illness originates from emotional stress and manifests in the body as physical pain and other symptoms. The primary nursing intervention when providing care for clients with this diagnosis is to focus on minimizing indirect benefits and developing client insight. The development of insight is done by identifying secondary gains, recognize factors that intensify symptoms, and incorporate coping strategies. Therefore, the appropriate action by the nurse is to redirect the client to an unrelated, general topic of conversation. Additionally, the nurse should also limit the time spent discussing physical symptoms with the client.

125. Mental Health Question #3

The nurse provides care for a client with a history of bipolar affective disorder who has become increasingly lethargic and less responsive through the shift after being admitted in acute mania. Which is the nurse's **priority** when planning care for this client based on the current data?

1. Altered thought process.

> Altered thought process is an appropriate nursing diagnosis for the client's diagnosis; however, the client's physical needs take precedence over psychological needs.

2. Self-care deficit.

> This nursing diagnosis is appropriate one due to the lack of self care that is typical for a client who is diagnosed with bipolar affective disorder; however, it is not the priority diagnosis at this time

✓ 3. Risk for dehydration.

> A client who is diagnosed with bipolar affective disorder may cycle through periods of mania followed by depression and in doing so, is likely to be at risk for both malnutrition and dehydration; therefore, this is the priority nursing diagnosis based on the current data.

4. Risk for social isolation.

> Impaired social isolation is an appropriate nursing diagnosis based on the client's diagnosis; however, this is not the priority diagnosis based on the current data.

> The nurse must anticipate the client's needs based on the admitting diagnosis and current clinical data. The client, who was admitted with acute mania, is now exhibiting symptoms indicative of depression. Therefore, the nurse's priority when planning care for this client is to focus on the client's physiological needs of hydration and nourishment, which have likely been lacking with acute mania and will continue to be neglected as the client exhibits symptoms of depression. Based on this data, the nurse's priority for the client when planning care is a risk for dehydration.

👉 *Video Rationale: https://d1pumg6d5kr18o.cloudfront.net/rationales-v2/section_1_mental_health_concepts_03/part.m3u8*

126. Mental Health Question #3 - V2

The nurse is caring for a client with a history of bipolar affective disorder who has become increasingly lethargic and less responsive through the shift after being admitted in acute mania.

➤What is the priority nursing diagnosis for this client?

1. Altered thought process.

Altered thought process is an appropriate nursing diagnosis for the client's diagnosis; however, the client's physical needs take precedence over psychological needs.

2. Self-care deficit.

This nursing diagnosis is appropriate one due to the lack of self care that is typical for a client who is diagnosed with bipolar affective disorder; however, it is not the priority diagnosis at this time

✓ 3. Risk for dehydration.

A client who is diagnosed with bipolar affective disorder may cycle through periods of mania followed by depression and in doing so, is likely to be at risk for both malnutrition and dehydration; therefore, this is the priority nursing diagnosis based on the current data.

4. Risk for social isolation.

Impaired social isolation is an appropriate nursing diagnosis based on the client's diagnosis; however, this is not the priority diagnosis based on the current data.

The nurse must anticipate the client's needs based on the admitting diagnosis and current clinical data. The client, who was admitted with acute mania, is now exhibiting symptoms indicative of depression. Therefore, the nurse's priority when planning care for this client is to focus on the client's physiological needs of hydration and nourishment, which have likely been lacking with acute mania and will continue to be neglected as the client exhibits symptoms of depression. Based on this data, the nurse's priority for the client when planning care is a risk for dehydration.

127. Mental Health Question #4

The nurse provides care for a client who is prescribed disulfiram for alcohol use disorder. Which nursing actions are appropriate for this client? **Select all that apply**.

☑	**Teach the client to avoid common over-the-counter (OTC) cough medications.**
	Common OTC cough medications contain hidden alcohol; therefore, should be avoided by this client.
☑	**Instruct the client that alcohol consumption while on the prescribe medication produces unwanted side effects.**

	The medication, when mixed with alcohol, produces nausea, vomiting, flushed skin, sweating, confusion, and tachycardia to instill an aversion to alcohol; therefore, this is an appropriate nursing action based on the current data.
☐	Teach the client that, if a dose of disulfiram is missed, take an extra dose as soon as possible.
	Due to the half-life of the medication a missed dose should not be made up; therefore, this is not an appropriate nursing action based on the current data.
☑	**Teach the client to abstain from alcohol for two weeks after the medication is discontinued.**
	Due to the extended half life of the medication, alcohol should be avoided for a minimum of 2 weeks after the last dose to avoid experiencing the medications effects when mixed with alcohol.
☑	**Inform the client that certain foods, such as vinegar and some sauces should be avoided while on this medication.**
	Sauces, vinegars, and flavor extracts contain hidden alcohol and should be avoided; therefore, this is an appropriate nursing action.

Disulfiram is a form of aversion pharmacotherapy that promotes abstinence from alcohol. Clients should be educated to avoid the consumption of any alcohol, including sources of hidden alcohol. These sources of hidden alcohol may include cold and cough medications, mouthwashes, and certain foods (e.g., sauces, vinegars, and flavor extracts). The side effects associated with mixing this medication with alcohol are unpleasant for the client and are meant to cause an aversion to drinking alcohol.

👉 *Video Rationale: https://d1pumg6d5kr18o.cloudfront.net/rationales-v2/section_1_mental_health_concepts_04/part.m3u8*

128. Mental Health Question #4 - V2

The nurse is caring for a client who is prescribed disulfiram for alcohol use disorder.

➤What nursing action(s) are appropriate for this client? **Select all that apply.**

☑	**Teach the client to avoid common over-the-counter (OTC) cough medications.**
	Common OTC cough medications contain hidden alcohol; therefore, should be avoided by this client.
☑	**Instruct the client that alcohol consumption while on the prescribe medication produces unwanted side effects.**
	The medication, when mixed with alcohol, produces nausea, vomiting, flushed skin, sweating, confusion, and tachycardia to instill an aversion to alcohol; therefore, this is an appropriate nursing action based on the current

	data.
☐	Teach the client that, if a dose of disulfiram is missed, take an extra dose as soon as possible.
	Due to the half-life of the medication a missed dose should not be made up; therefore, this is not an appropriate nursing action based on the current data.
☑	**Teach the client to abstain from alcohol for two weeks after the medication is discontinued.**
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☑	**Inform the client that certain foods, such as vinegar and some sauces should be avoided while on this medication.**
	Sauces, vinegars, and flavor extracts contain hidden alcohol and should be avoided; therefore, this is an appropriate nursing action.

Disulfiram is a form of aversion pharmacotherapy that promotes abstinence from alcohol. Clients should be educated to avoid the consumption of any alcohol, including sources of hidden alcohol. These sources of hidden alcohol may include cold and cough medications, mouthwashes, and certain foods (e.g., sauces, vinegars, and flavor extracts). The side effects associated with mixing this medication with alcohol are unpleasant for the client and are meant to cause an aversion to drinking alcohol.

129. Mental Health Question #5 - V2

The nurse is caring for several clients on a behavioral health unit.

After receiving handoff shift report, which client should the nurse assess **first**?

1. Client A: Newly prescribed escitalopram for depression and reports constipation.

While the client's constipation should be further evaluated, there is another client who requires priority assessment.

2. Client B: Reporting a one pound weight gain since admission who is prescribed zolpidem as needed at nighttime for sleep.

Weight gain is a common side effect of the client's prescribed medication. While the nurse should evaluate this issue further, priority assessment is not required at this time.

✓ 3. Client C: Newly prescribed fluoxetine who reports nausea, vomiting, and loose stools.

This client may be experiencing serotonin syndrome based on the clinical manifestations and the prescribed medication; therefore, requires priority assessment by the nurse.

4. Client D: Mixed selegiline with alcohol three days ago.

While the prescribed medication should not be mixed with alcohol, this client is not likely to still be exhibiting symptoms three days later; therefore, this client does not require priority assessment.

Clinical manifestations associated with serotonin syndrome include the following: agitation or restlessness; confusion; rapid heart rate and high blood pressure; dilated pupils; loss of muscle coordination or twitching muscles; muscle rigidity; heavy sweating; diarrhea; headache; shivering; and goosebumps. Serotonin syndrome can be life-threatening if the following symptoms occur: high fever; seizures; irregular heartbeat; and unconsciousness. Because this adverse effect to the prescribed medication can be life-threatening, or at the very least increase the client's risk for dehydration, the nurse assesses this client first.

130. Mental Health Question #6 - V2

The nurse is caring for a client who is diagnosed with bulimia nervosa.

➤Which is the most critical part of the day for the nurse to closely watch the actions of the client?

1. When the client eats a snack in the afternoon.

Due to the nature of the disease, monitoring the client after consumption of a small snack is a secondary priority to monitoring after a larger meal.

2. Just before breakfast in the morning.

The client's goal with this disorder is to prevent weight gain from ingested food; therefore, vomiting prior to the first meal of the day would not accomplish the client's goal.

3. Overnight when the client is supposed to be sleeping.

Secretive binging during the night or before bedtime are uncommon practices for a client with bulimia.

✓ 4. For one to two hours after the client finishes eating a meal.

A client should be watched closely after the completion of a meal, especially at the beginning of their treatment plan as they will go to great lengths to purge food one to two hours after consumption.

It is essential to observe clients' nutritional status as eating disorders can be life-threatening. It is also important to ensure the client maintains adequate nutrition and electrolyte balance. Nursing interventions for a client who is diagnosed with bulimia nervosa include close monitoring one to two hours after eating larger meals as this is the most favorable time for the client to induce vomiting. This is essential to monitor in the beginning of a treatment period as the client's goal is to try and gain as much control as possible over their weight loss.

131. Mental Health Question #7

The nurse provides care for a client with a history of aggression who tests positive for cocaine. Which is the **best** nursing action to help reduce the risk of harm to the client or others?

1. Give a dose of intramuscular (IM) haldol now and place the client in a private room.

Chemical and physical restraints should only be used as a last resort to keep the client and others safe; therefore, this is not an appropriate nursing action based on the current data.

2. Report the client's history of aggressiveness to the unit manager and charge nurse.

Reporting the client's history of aggressive behavior will not reduce the risk of harm to the client or others; therefore, this is not the best nursing action.

✓ 3. While looking directly at the client, give a detailed schedule of the day.

Providing undivided attention is the most appropriate intervention. Through a calm tone, facing the client, and providing clear thorough communication, the risk of violence can be reduced.

4. Tell the client in a firm voice that aggressive behavior will not be tolerated

This action does not promote a calm tone or encourage active participation from the client; therefore, this action will not reduce the risk of aggressive behavior.

Violence is a safety concern for all in the healthcare setting. Upon identifying those at risk for violent behavior, such as a client who tests positive for cocaine, the use of clear, thorough communication can assist in preventing aggressive behavior. Additional interventions include encouraging active participation in care and promoting a low-stimulation environment. Chemical and physical restraints are to remain a last resort to reduce the risk of harm.

👉 *Video Rationale: https://d1pumg6d5kr18o.cloudfront.net/rationales-v2/section_1_mental_health_concepts_07/part.m3u8*

132. Mental Health Question #7 - V2

The nurse is caring for a client with a history of aggression who tests positive for cocaine.

➤What is the most appropriate nursing action?

1. Give a dose of intramuscular (IM) haldol now and place the client in a private room.

Chemical and physical restraints should only be used as a last resort to keep the client and others safe; therefore, this is not an appropriate nursing action based on the current data.

2. Report the client's history of aggressiveness to the unit manager and charge nurse.

Reporting the client's history of aggressive behavior will not reduce the risk of harm to the client or others; therefore, this is not the best nursing action.

✓ 3. While looking directly at the client, give a detailed schedule of the day.

Providing undivided attention is the most appropriate intervention. Through a calm tone, facing the client, and providing clear thorough communication, the risk of violence can be reduced.

4. Tell the client in a firm voice that aggressive behavior will not be tolerated.

This action does not promote a calm tone or encourage active participation from the client; therefore, this action will not reduce the risk of aggressive behavior.

Violence is a safety concern for all in the healthcare setting. Upon identifying those at risk for violent behavior, such as a client who tests positive for cocaine, the use of clear, thorough communication can assist in preventing aggressive behavior. Additional interventions include encouraging active participation in care and promoting a low-stimulation environment. Chemical and physical restraints are to remain a last resort to reduce the risk of harm.

133. Mental Health Question #8

A client who is diagnosed with schizophrenia is being treated for paranoid delusions which are now decreasing in frequency; however, the client does not interact with friends or members of the healthcare team and spends

most of the day in isolation. Which intervention should the nurse include in this client's plan of care? **Select all that apply**.

☐	Encourage the client to participate in unit karaoke night.
	This client may not be ready for group activity; however, this may be an appropriate intervention at a later date.
☐	Facilitate a client outing and encourage attendance by everyone.
	Initial therapy needs to be focused on one-on-one interactions, and group activities are discouraged until the client is ready.
☑	**Include the client in group activities once the client feels comfortable.**
	Group therapy is an acceptable intervention upon successful completion and advancement through individual therapy. This is due to the paranoia dispositions of the disorder.
☑	**Schedule time for the client to interact solely with a favorite healthcare professional.**
	A developed relationship with a healthcare professional can improve social interactions after one-on-one therapy completion.
☐	Organize a surprise party for the client and invite all family members to attend.
	A surprise party would be inappropriate as this may be seen as unsafe and threatening in nature to someone experiencing paranoid delusions.

A client who is diagnosed with schizophrenia will experience both negative and positive symptoms. It is best to assist in practicing basic social skills in a safe and non-threatening manner when addressing the negative symptoms of this disease process. This can be done with one-on-one activity with the nurse and enhances the client's level of comfort with social interactions and the establishment of personal relationships. Medications often help with the positive symptoms of the disease, which include hallucinations, delusions, and thought impairment.

👉 *Video Rationale: https://d1pumg6d5kr18o.cloudfront.net/rationales-v2/section_1_mental_health_concepts_08/part.m3u8*

134. Mental Health Question #8 - V2

The nurse is caring for a client with a history of schizophrenia who is being treated for paranoid delusions which are now decreasing in frequency. The client does not interact with friends or members of the healthcare team and spends most of the day in isolation.

➤Which intervention(s) should the nurse include in the client's plan of care? **Select all that apply.**

☐	Encourage the client to participate in unit karaoke night.
	This client may not be ready for group activity; however, this may be an appropriate intervention at a later date.
☐	Facilitate a client outing and encourage attendance by everyone.
	Initial therapy needs to be focused on one-on-one interactions, and group activities are discouraged until the client is ready.
☑	**Include the client in group activities once the client feels comfortable.**
	Group therapy is an acceptable intervention upon successful completion and advancement through individual therapy. This is due to the paranoia dispositions of the disorder.
☑	**Schedule time for the client to interact solely with a favorite healthcare professional.**
	A developed relationship with a healthcare professional can improve social interactions after one-on-one therapy completion.
☐	Organize a surprise party for the client and invite all family members to attend.
	A surprise party would be inappropriate as this may be seen as unsafe and threatening in nature to someone experiencing paranoid delusions.

A client who is diagnosed with schizophrenia will experience both negative and positive symptoms. It is best to assist in practicing basic social skills in a safe and non-threatening manner when addressing the negative symptoms of this disease process. This can be done with one-on-one activity with the nurse and enhances the client's level of comfort with social interactions and the establishment of personal relationships. Medications often help with the positive symptoms of the disease, which include hallucinations, delusions, and thought impairment.

135. Mental Health Question #9

A client with a history of paranoid delusions due to a diagnosis of paranoid personality disorder (PPD) receives treatment on the inpatient psychiatric unit; however, is refusing to participate in an organized game day for clients, stating "You can't make me go! They will try to kill me!" Which is the most likely explanation for the client's behavior?

1. The client does not want anyone to tell them what to do.

This best describes someone with antisocial personality disorder; therefore, is not the most likely explanation for the client's behavior based on the current data.

2. The client is experiencing auditory hallucinations.

While this client does have a history of paranoid delusions, there is not indication of a history of auditory hallucinations; therefore, this is not the most likely explanation for the client's behavior based on the current data.

3. The client is projecting aggressiveness toward the healthcare team.

Clients who experience paranoid delusions are usually not be able to control their anger when confronted with a real or imagined threat. In this situation, however, the client is not yet posed with that threat.

✓ 4. The client is attempting to maintain control of the surroundings.

Due to the paranoia, this client distrusts and is suspicious of others so to maintain control of the environment will make comments to the extent of "They will kill me!".

Due to the characterized distrust and suspicion of others, clients who are diagnosed with PPD may have an intense need to control other people and their environment. The distrust and suspicion of others prevent the client from developing relationships, and this often interferes with every aspect of their lives. The client with paranoid delusions often express their suspicions and hostility, making it hard to interact with others. Their hostility is expressed in arguing, complaining, and making sarcastic remarks.

👉 *Video Rationale: https://d1pumg6d5kr18o.cloudfront.net/rationales-v2/section_1_mental_health_concepts_09/part.m3u8*

136. Mental Health Question #9 - V2

The nurse is caring for a client with a history of paranoid personality disorder (PPD) and delusions. The client is refusing to participate in an organized game day for clients, stating "You can't make me go! They will try to kill me!"

➤The nurse knows the most likely explanation for the behavior is that the client

1. does not want anyone to tell them what to do.

This best describes someone with antisocial personality disorder; therefore, is not the most likely explanation for the client's behavior based on the current data.

2. is experiencing auditory hallucinations.

While this client does have a history of paranoid delusions, there is not indication of a history of auditory hallucinations; therefore, this is not the most likely explanation for the client's behavior based on the current

data.

3. is projecting aggressiveness toward the healthcare team.

Clients who experience paranoid delusions are usually not be able to control their anger when confronted with a real or imagined threat. In this situation, however, the client is not yet posed with that threat.

✓ 4. is attempting to maintain control of the surroundings.

Due to the paranoia, this client distrusts and is suspicious of others so to maintain control of the environment will make comments to the extent of “They will kill me!”.

Due to the characterized distrust and suspicion of others, clients who are diagnosed with PPD may have an intense need to control other people and their environment. The distrust and suspicion of others prevent the client from developing relationships, and this often interferes with every aspect of their lives. The client with paranoid delusions often express their suspicions and hostility, making it hard to interact with others. Their hostility is expressed in arguing, complaining, and making sarcastic remarks.

137. Mental Health Question #10 - V2

The nurse is caring for a client with anorexia nervosa.

➤What assessment findings does the nurse anticipate? **Select all that** apply.

☑	**Lack of menses.**
	Due to the decreased body fat and low levels of estrogen, clients who are diagnosed often experience cessation of the menstrual cycle; therefore, this is an expected clinical manifestation for a client who is diagnosed with anorexia nervosa.
☑	**Bradycardia.**
	Bradycardia is the result of a decreased metabolic rate that often accompanies a diagnosis of anorexia nervosa. Additionally, this client may also have electrolyte imbalances that increase the risk for cardiac dysrhythmias; therefore, this is a clinical manifestation anticipated for this client.
☑	**Emaciation.**
	Emaciation, or being abnormally thin, is the result of extensive dieting and the fear of weight gain for a client who is diagnosed with anorexia nervosa; therefore, this is an anticipated clinical manifestation for this client.
☑	**Excessive physical activity.**

	Excessive physical activity is performed to ensure weight loss is maintained due to the fear of gaining weight; therefore, this is an expected assessment finding for a client who is diagnosed with anorexia nervosa.
☑	**Inability to tolerate cold.**
	Due to the decreased metabolic rate associated with anorexia nervosa, the client will manifest with cold intolerance; therefore, this is an anticipated clinical manifestation anticipated for the client.

Clinical manifestations of anorexia nervosa include extreme weight loss, amenorrhea, bradycardia, cold intolerance, dry skin, and lanugo. These manifestations, upon treatment, can take several months to recover. These clinical manifestation of anorexia nervosa stem from a fear of weight gain. Life-threatening complications include cardiac arrhythmias that stem from electrolyte imbalances.

138. Mental Health Question #11 - V2

The nurse is caring for a client with generalized anxiety disorder (GAD) who reports an inability to sleep at night and is often found wandering around the unit in the late night and early morning hours.

➤Which intervention should the nurse include in the client's plan of care? **Select all that apply.**

☑	**Abstinence from daytime napping, if possible.**
	Avoiding daytime naps is an appropriate intervention to promote sleep hygiene for this client; therefore, this is an appropriate intervention for the nurse to include in the plan of care.
☑	**Make a bedtime routine for the client and include non-stimulating activities.**
	Bedtime routines that are low stimulus provide the development of healthy habits to promote quality sleep hygiene; therefore, this is an appropriate intervention for the nurse to include in the client's plan of care.
☑	**Avoid any type of caffeinated beverages after lunch.**
	Avoiding all sources of caffeine after noon each day can reduce stimulus in the evening to promote sleep; therefore, this is an appropriate intervention for the nurse to include in the client's plan of care.
☑	**Encourage the client to spend time outdoors each day.**
	At least 20 minutes of natural sunlight each day is recommended to promote good sleep; therefore, this is an appropriate intervention for the nurse to include in the client's plan of care.
☑	**Avoid vigorous exercise late in the afternoon.**

	Vigorous exercise late in the day increases brain activity and wakefulness; therefore, this is an appropriate intervention for the nurse to include in the client's plan of care.
☐	Keep the lights on with a warm and quiet room to enhance sleep.
	A dark, cool, and quiet environment provides the client with a low stimulus setting to induce sleep; therefore, this is not an appropriate intervention for the nurse to include in the client's plan of care.

The nurse should seek to implement nonpharmacological interventions to improve this client's sleep hygiene. Interventions appropriate to enhance sleep hygiene include avoiding exercise late in the day; engaging in relaxing activity before bed; avoiding daytime naps; and avoiding caffeine after noon each day. Nonpharmacological interventions are the best approach as long-term treatment with medication can become problematic. Additionally, it is appropriate to encourage this client to enjoy at least 20 minutes of sunlight each day.

139. Mental Health Question #12 - V2

The nurse is caring for an older adult client diagnosed with dementia who is found pacing up and down the halls of the unit at night.

➤Which nursing statement is best?

✓ 1. "I will help you get back to your room so you can rest."

This statement reorients the client while avoiding escalation of other behaviors associated with the diagnosed dementia; therefore, this is the best statement from the nurse based on the current data.

2. "If you continue to leave your room at night I will have to restrain you."

This statement has an authoritarian tone and seems to penalize the client thus is likely to further escalate the unwanted behaviors; therefore, this is not an appropriate statement by the nurse.

3. "You are prohibited from being out of your room after 10:00 PM without approval."

This statement has a paternalistic tone and can increase behaviors, anxiety, and lead to further problems; therefore, this is not the best statement from the nurse to address the client's behavior.

4. "I don't want you to get hurt and it's dangerous to be walking in the dark."

This statement can reinforce fear of becoming hurt and may increase anxiety or negative behaviors;

therefore, this is not the best statement by the nurse to address the client's behavior.

Redirection/reorientation is an appropriate technique for clients who are early in the dementia process to reduce anxiety and other negative behaviors. Reality reorientation in mild to moderate dementia is appropriate to promote appropriate behavior. In clients with advanced dementia, reality orientation can worsen behaviors such as aggression. Validation therapy is appropriate for clients who are experiencing advanced dementia as this intervention recognizes clients' feelings without arguing with their perceptions.

140. Mental Health Question #13

A client presents to the emergency department (ED) after being found unconscious in bed with an empty bottle of medication. The client's spouse states, "This is all my fault. This would not have happened if I had been at home." Which response by the nurse to the client's spouse is **best**?

1. "I am going to ask the hospital chaplain to come visit and talk with you."

While offering spiritual support may be an appropriate intervention for the spouse of this client, assessment must be performed first as religious preferences should also not be assumed; therefore, this is not the best response by the nurse to the spouse of the client.

✓ 2. "This is a very difficult situation. Let's talk about what you're feeling right now."

This statement validates the situation at hand and allows the spouse the opportunity to express current feelings; therefore, this is the best response by the nurse to the client's spouse.

3. "You did the right thing by bringing your spouse in to the hospital for treatment."

This statement does not address the spouse's concerns and is not therapeutic.

4. "Has your spouse been acting hopeless or showing signs of despair recently?"

This question does not address what the spouse is experiencing. At a later time the nurse can seek further information that may have led to the crisis event.

Initial reactions to a crisis event may include shock, disbelief, denial, and helplessness. Acknowledging feelings validates severity and can normalize the reactions of someone who is experiencing a crisis event. Nursing interventions should be directed at providing support to the client and others. Allowing the individual to express feelings is a therapeutic intervention; therefore, the best response by the nurse to the client's spouse is as follows: "This is a very difficult situation. Let's talk about what you're feeling right now."

👉 *Video Rationale: https://d1pumg6d5kr18o.cloudfront.net/rationales-v2/section_1_mental_health_concepts_13/part.m3u8*

141. Mental Health Question #13 - V2

The nurse is caring for a client who was found unconscious in bed with an empty bottle of medication. The client's spouse states, "This is all my fault. This would not have happened if I had been at home."

➤Which response by the nurse is best?

1. "I am going to ask the hospital chaplain to come visit and talk with you."

While offering spiritual support may be an appropriate intervention for the spouse of this client, assessment must be performed first as religious preferences should also not be assumed; therefore, this is not the best response by the nurse to the spouse of the client.

✓ 2. "This is a very difficult situation. Let's talk about what you're feeling right now."

This statement validates the situation at hand and allows the spouse the opportunity to express current feelings; therefore, this is the best response by the nurse to the client's spouse.

3. "You did the right thing by bringing your spouse in to the hospital for treatment."

This statement does not address the spouse's concerns and is not therapeutic.

4. "Has your spouse been acting hopeless or showing signs of despair recently?"

This question does not address what the spouse is experiencing. At a later time the nurse can seek further information that may have led to the crisis event.

Initial reactions to a crisis event may include shock, disbelief, denial, and helplessness. Acknowledging feelings validates severity and can normalize the reactions of someone who is experiencing a crisis event. Nursing interventions should be directed at providing support to the client and others. Allowing the individual to express feelings is a therapeutic intervention; therefore, the best response by the nurse to the client's spouse is as follows: "This is a very difficult situation. Let's talk about what you're feeling right now."

142. Mental Health Question #14 - V2

The nurse is caring for a client experiencing acute delirium after being admitted for treatment of a chronic obstructive pulmonary disease (COPD) exacerbation.

➤Which assessment finding does the nurse anticipate?

1. A report by friends that the client is unable to recall recent events.

The inability to recall recent events is a manifestation that is anticipated with dementia and not delirium.

2. The client is cooperative but confused about the current location.

Typically a client who experiences delirium is not cooperative. Clients with delirium often present with restlessness, agitation and combative behavior. Cooperative but confused is a manifestation of dementia not delirium.

✓ 3. The client is having difficulty concentrating and reports hearing voices.

Hallucinations are disorganized thinking patterns that are a sign of acute mental changes associated with delirium; therefore, this is a clinical manifestation that is anticipated by the nurse for this client.

4. The client seems more tired than usual per family members.

The report of increasing tiredness is not an acute process that can be linked to delirium.

Delirium has an abrupt onset presenting with an altered level of consciousness. It can be a common occurrence for older adult client who are hospitalized; however, it is often missed by healthcare professionals. The Confusion Assessment Method (CAM) is a validated tool to assess clients for delirium. While delirium and dementia may present with similar signs and symptoms, delirium has an abrupt onset while the onset of dementia is insidious.

143. Mental Health Question #15 - V2

The nurse is caring for a client with a history of dementia. A family member states, “I want to bring my mom home with me but I just don’t know if I will be able to handle her.”

➤Which response by the nurse is best?

✓ 1. "I will ask the case manager to come and talk about your options."

The case manager can provide the client’s family member with needed resources to adequately care for the client at home. Additionally, this response is the most therapeutic for validating the caregiver’s wishes.

2. "Long term care placement is certainly an option for your situation."

Institutional placement may be a valid option for this client; however, this response is not therapeutic to the client's family member.

3. "If you are unsure, then she should stay in the hospital a few more days."

The word "should" is a non-therapeutic response and is avoided when counseling a client or family member.

4. "Do you have anyone that will be helping you with her care if she comes home?"

This statement could be misinterpreted by the client's family member and interpreted as demeaning.

Caregiving is hard, and caregivers of chronically ill individuals often experience stress. These individuals are "on call" 24 hours a day, 7 days a week. Caring for someone with a mental health diagnosis, such as dementia, can be especially difficult. Due to the stress and exhaustion, burnout is a common experience by the caregiver. An appropriate nursing intervention would be to assess and provide resources for any caregiver who is suspected of experiencing, or at risk for burnout.

144. Mental Health Question #16

Which is the **best** nursing intervention for a school aged client, diagnosed with Asperger syndrome who is hospitalized for diagnostic testing?

1. Making sure the child is medicated before all tests.

Distraction and physical touch are the preferred methods when assisting a child with invasive procedures over chemical restraints; therefore, this is not the priority nursing intervention for this client.

2. Disregarding any emotional outbursts by the child.

Disregarding any outbursts from the child will further lead to distrust and increased levels of anxiety.

3. Making time for the child has a favorite game and an accessible television.

While play should be built into the schedule after consultation with the child's parents to ensure that typical daily patterns are maintained, this is not the priority intervention for this client.

✓ 4. Providing the child with a calendar of scheduled daily events.

A schedule of the day's activities can decrease the anxiety and help the child anticipate what will happen next, which is especially important for a young client who is diagnosed with Asperger syndrome; therefore, this is the priority intervention for this client.

Hospitalization of pediatric clients who are diagnosed with AS should be focused on structured routines and consistency to decrease anxiety. Feedback from the parents about usual patterns is helpful to maintain this consistency. A nursing diagnosis of impaired social interaction is appropriate due to the unresponsiveness towards people. To avoid overstimulation, limiting visitors to trusted caregivers is essential. The priority nursing intervention for this child is as follows: providing the child with a calendar of scheduled daily events.

👉 *Video Rationale: https://d1pumg6d5kr18o.cloudfront.net/rationales-v2/section_1_mental_health_concepts_16/part.m3u8*

145. Mental Health Question #16 - V2

The nurse is caring for a school aged client who is hospitalized for diagnostic testing of Asperger syndrome.

➤What is the best nursing intervention?

1. Making sure the child is medicated before all tests.

Distraction and physical touch are the preferred methods when assisting a child with invasive procedures over chemical restraints; therefore, this is not the priority nursing intervention for this client.

2. Overlooking any emotional outbursts by the child.

Disregarding any outbursts from the child will further lead to distrust and increased levels of anxiety.

3. Ensuring the child has a favorite game and an accessible television.

While play should be built into the schedule after consultation with the child's parents to ensure that typical daily patterns are maintained, this is not the priority intervention for this client.

✓ 4. Providing the child with a calendar of scheduled daily events.

A schedule of the day's activities can decrease the anxiety and help the child anticipate what will happen next, which is especially important for a young client who is diagnosed with Asperger syndrome; therefore, this is the priority intervention for this client.

Hospitalization of pediatric clients who are diagnosed with AS should be focused on structured routines and consistency to decrease anxiety. Feedback from the parents about usual patterns is helpful to maintain this consistency. A nursing diagnosis of impaired social interaction is appropriate due to the unresponsiveness towards people. To avoid overstimulation, limiting visitors to trusted caregivers is essential. The priority nursing intervention for this child is as follows: providing the child with a calendar of scheduled daily events.

146. Mental Health Question #17 - V2

The nurse is caring for a client admitted to the inpatient psychiatric unit following the unexpected death of a child.

➤Which question by the nurse is **most** appropriate?

✓ 1. "What are your thoughts on joining a group that provides support during grief?"

This is an open-ended question to allow the expression of emotions, and the client's understanding of grief; therefore, this is the most therapeutic communication with the client.

2. "This must be very difficult; do you think joining our group activity will help?"

Automatic responses are non-therapeutic as they limit the discussion and expression of the client; additionally, asking the client if there is an interest to join a group activity may be overwhelming.

3. "How was the relationship between you and your child prior to the child's death?"

Seeking historical information about previous relationship levels is not the best response to encourage the sharing of emotions.

4. "Why do you think you are not able to cope with this difficult situation?"

Minimizing a client's response to the death of a child is a non-therapeutic response.

Reflection and open-ended questions assist clients in exploring emotions and allow them to express needs. Grief varies greatly amongst each individual person. There should be no expected experiences by the loved ones because of this. The nurse should not try to understand another's grief experience.

147. Mental Health Question #18 - V2

The nurse is caring for a client with a history of obsessive compulsive disorder (OCD). The client has been washing one spot on the floor for the past 2 hours and refuses to stop stating that the floor is still dirty.

➤What is the **most** therapeutic response by the nurse?

1. Call security and to request assistance in putting the client in lock-down for their safety.

Engaging other staff members ro remove the client is confrontational and will increase the client's anxiety; therefore, this approach is not therapeutic.

2. Express to the client that OCD habits will need to be broken to get their disease under control.

Saying that the client's behavior will not be tolerated conveys a message of disapproval and would increase the client's anxiety; therefore, this is not a therapeutic response by the nurse.

✓ 3. Explain to the client that it is time for a break from cleaning.

Providing reflective feedback about the behavior is the nurse acknowledging the behavior in a non-judgemental way. The nurse can further help the client become involved in other activities and problem-solving skills.

4. Request that the client find an alternative location to clean.

Telling the client to go elsewhere is non-therapeutic, reinforces the behavior, and avoids the issue.

Therapeutic approaches to a client with OCD include pointing out the amount of time the client has spent performing an activity and redirecting the client to another activity. This is called reflective feedback about the client's behavior. The nurse is acknowledging the behavior in a non judgemental manner. Redirecting the client to another activity is a therapeutic intervention.

148. Mental Health Question #19 - V2

The nurse is caring for a client with a new diagnosis of chronic obstructive pulmonary disease (COPD). The client asks the nurse if this disease is terminal.

➤Which response by the nurse is **best**?

1. "I can call your family or clergy to come sit with you while you wait."

An automatic response is a nontherapeutic communication technique that deflects the client's feelings and weakens the nurse-client relationship.

2. "Smoking cessation will definitely help slow the progression of your disease."

Minimizing the client's feelings and disregarding the client's concerns by changing the subject is nontherapeutic.

✓ 3. "This must be very difficult. Let's talk more about how you're feeling now."

This statement allows the nurse to assess the client's understanding of the disease and provides a foundation to build therapeutic communication.

4. "Your condition can be easily treated with medications such as breathing treatments."

Providing clients with misleading information is nontherapeutic and creates mistrust in the nurse-client relationship.

Clients that are experiencing a life-limiting illness often process through the phases of grief and experience anxiety and frustration. The nurse must assess the client's knowledge and feelings regarding the illness. Therapeutic communication allows the nurse to identify client needs and further strengthens the nurse-client relationship. Further discussions about the terminal disease need to be factual and complete.

149. Mental Health Question #20 - V2

The nurse is caring for a client diagnosed with dependent personality disorder.

➤Which client statement demonstrates an improvement in the condition?

1. "I invited my friend to come over tomorrow night and watch movies with me."

This statement indicates the continued need to have another person present to participate in an activity.

2. "I think I am going to find a new therapist that has more experience with my disorder."

This statement indicates that the therapist is not gaining enough reassurance from the current therapist. This is not progress towards a therapeutic outcome.

3. "I have been sleeping three to four hours every night since starting treatment."

Feelings of helplessness and anxiety when alone are continued signs of lack of progress towards therapeutic outcomes. A lack of sleep due to anxiety is evidence that a therapeutic response has not been

obtained.

✓ 4. "I called a taxi to bring me here today so I wouldn't miss my appointment."

This comment shows therapeutic progress as evidenced by the ability of the client to make a simple day-to-day decision that resulted in an independent activity.

The nurse should assess the client's ability to make a decision and act on one's own word. This would indicate progress toward a therapeutic outcome. The ability of a client to contact an outside person or stranger without the assistance of another is noted positive progression. It is therapeutic to start with simple day-to-day decisions then progress further.

150. Mental Health Question #21 - V2

The nurse is caring for a client who expresses fears and concerns about death and dying.

➤Which response by the nurse is most appropriate?

1. "Is there family or a clergy member that I can call to visit with you?"

This statement does not acknowledge the client's concerns and blocks communication. If the client requests spiritual support then the nurse can make a referral to the chaplain's office.

2. "Let's talk about the good times you've had with your family and friends."

By changing the topic, the nurse is attempting to redirect the conversation away from the client's desire to talk about the situation at hand; therefore, this is not a therapeutic response.

✓ 3. "People are often scared of the unknown. Tell me about your concerns."

This statement acknowledges the client's feelings then opens up the conversation for the client to continue to communicate their feelings; therefore, this is the most therapeutic response by the nurse.

4. "Has someone on the healthcare team told you that you are dying?"

This statement provides a false reassurance, questioning the validity of the client's condition; therefore, this is not a therapeutic response.

Therapeutic relationships are developed through acknowledging client behavior and feelings. The use of open-ended statements invites clients to discuss their feelings and enhances the therapeutic nurse-client relationship. Grief is especially difficult to discuss as each individual experiences it in his or her own way.

151. Mental Health Question #22

Which finding noted by the nurse would necessitate mandatory placement of a client in the psychiatric inpatient facility? **Select all that apply**.

☑	**A client has threatened to harm self or others on multiple occasions.**
	Involuntary committal is necessary when a client threatens to harm themselves and/or others.
☐	A client has extensive family history of bipolar disorder.
	A family history of bipolar disorder is not a deciding factor when determining whether or not mandatory placement is an appropriate action.
☑	**A client who appears malnourished due to the refusal to eat or drink for one week.**
	The inability to care for oneself is often deciding factor when determining if a client requires mandatory placement in a psychiatric inpatient facility.
☑	**A client who states over and over, "I must hide from them or they'll get me."**
	This client statement requires additional assessment as it is likely due to hallucinations or potential substance use disorder. Additionally, this client is likely at risk for harm to self or others; therefore, mandatory placement is appropriate for this client.
☐	A client admits to using methamphetamines to help stay awake to study for a test.
	Possession or admitted use of an illegal substance does not justify the need for mandatory placement.

A client has the right to refuse hospital admission. If the client poses an immediate harm to self or others they can be involuntarily admitted to the hospital for treatment. This is a last resort in dealing with a client that refuses treatment. Mandatory placement into a psychiatric facility would be needed if the client's judgment is severely impaired.

👉 *Video Rationale: https://d1pumg6d5kr18o.cloudfront.net/rationales-v2/section_1_mental_health_concepts_22/part.m3u8*

152. Mental Health Question #22 - V2

The nurse is caring for a client exhibiting behaviors related to an untreated psychiatric disorder.

➤Which assessment finding would necessitate mandatory placement of a client in the psychiatric inpatient facility? **Select all that apply.**

☑	**Threats to harm self or others on multiple occasions.**
	Involuntary committal is necessary when a client threatens to harm themselves and/or others.
☐	Extensive family history of bipolar disorder left untreated.
	A family history of bipolar disorder is not a deciding factor when determining whether or not mandatory placement is an appropriate action.
☑	**The client appears malnourished due to the refusal to eat or drink for one week.**
	The inability to care for oneself is often deciding factor when determining if a client requires mandatory placement in a psychiatric inpatient facility.
☑	**A client who states over and over, "I must hide from them or they'll get me."**
	This client statement requires additional assessment as it is likely due to hallucinations or potential substance use disorder. Additionally, this client is likely at risk for harm to self or others; therefore, mandatory placement is appropriate for this client.
☐	Admission to using methamphetamines to help stay awake to study for a test.
	Possession or admitted use of an illegal substance does not justify the need for mandatory placement.

A client has the right to refuse hospital admission. If the client poses an immediate harm to self or others they can be involuntarily admitted to the hospital for treatment. This is a last resort in dealing with a client that refuses treatment. Mandatory placement into a psychiatric facility would be needed if the client's judgment is severely impaired.

153. Mental Health Question #23 - V2

The nurse is caring for a client with a history of diabetes mellitus (DM) admitted with acute alcohol intoxication, confusion, and an ulcer of the left great toe.

➤Which is the most important nursing action?

1. Allow the client to sleep off the intoxication.

The client should be allowed to sleep; however, close glucose monitoring should also be implemented.

2. Closely monitor the client for tachycardia, agitation, and nightmares.

Alcohol withdrawal generally starts within 8 hours of last consumption. While this is an appropriate action by the nurse, this is not the priority at this time.

✓ 3. Ensure that blood glucose levels are checked while intoxicated.

The priority nursing action is to monitor the client's blood glucose level so that immediate intervention can be implemented for hypoglycemia if it should occur.

4. Suggest that the client seek alcohol rehabilitation.

Seeking rehabilitation services for the client may be warranted but this is not a priority at this time.

Alcohol affects the central nervous system causing confusion, impaired coordination, and drowsiness. For a client who is acute intoxicated and at risk for hypoglycemia due to a diagnosis of DM, differentiating between the two can be problematic. The nursing priority is to monitor blood glucose levels in the event that hypoglycemia occurs. Interventions for hypoglycemia would need to be implemented immediately if the client experiences a decrease in serum glucose levels.

154. Mental Health Question #24 - V2

The nurse is caring for a client who abuses opiates.

➤Which assessment finding might indicate withdrawal? **Select all that apply.**

☐	Pupils that measure 1 mm in size.
	Constricted pupils are expected for a client who abuses opiates; therefore, this is not a clinical manifestation of withdrawal.
☑	**Blood pressure of 190/100 mm Hg.**
	Cardiac symptoms of opioid withdrawal include elevated heart rate, elevated blood pressure, and diaphoresis; therefore, this finding is a clinical manifestation of withdrawal.
☑	**Diaphoresis.**

	Diaphoresis is a clinical manifestation of withdrawal for a client who abused opiates.
☐	Fatigue.
	Fatigue is a symptoms of current opiate use; however, this is not a clinical manifestation of withdrawal.
☑	**A heart rate 110 beats/minute.**
	Cardiac symptoms of opioid withdrawal are elevated heart rate, elevated blood pressure, and diaphoresis.
☑	**Nausea and vomiting.**
	Nausea and vomiting occur in opiate withdrawal due to the hypersensitivity within the gastrointestinal tract; therefore, this is a clinical manifestation indicative of withdrawal.

Opiate withdrawal timeline of symptoms is dependent upon the specific drug abused. The timeline can range from six to 12 hours for short acting opiates and 30 hours for longer acting opiates. Symptoms of opiate withdrawal can range from anxiety, nausea, pupillary dilation and tachycardia. Medications such as methadone can be used to alleviate symptoms associated with withdrawal.

155. Mental Health Question #25 - V2

The nurse is caring for a client with a history of histrionic personality disorder.

➤Which assessment finding does the nurse expect?

✓ 1. Overly friendly, dramatic emotional behavior while demanding immediate gratification.

The client who is diagnosed with histrionic personality disorder will be friendly and have dramatic behavior to obtain the attention gratification required with this diagnosis.

2. Disregards the feelings of others, violation of others rights, inability to empathize.

Clients with antisocial, not histrionic personality disorder disregard the feelings of others, violate others' rights, and are unable to empathize with others.

3. Experiences delusions of grandeur, auditory hallucinations, and narcissism.

These are clinical manifestations of a narcissistic, not histrionic personality disorder.

4. Social detachment, inability to express emotions appropriately, isolated and stand-offish.

In the schizoid, not histrionic personality disorder clients exhibit social detachment and an inability to express emotions.

The nurse needs to be aware that clients who are diagnosed with HPD demand immediate gratification and have little tolerance for frustration. These clients also self-dramatize, are attention seeking, and can be seductive. These clinical manifestations have a negative impact on social, interpersonal, and occupational life. Nursing interventions are to be implemented with these symptoms in mind.

156. Mental Health Question #26 - V2

The nurse is caring for a client with a history of schizophrenia who is newly prescribed clozapine.

➤What is the most important assessment for this client?

1. Glycated hemoglobin (HgB A1C).

While hyperglycemia is a side effect of this medication, it can be assessed with a serum glucose level versus a HgB A1C level. This test is more appropriate to determine long-term glycemic control for a client diagnosed with diabetes mellitus.

2. Body mass index (BMI).

While weight gain is a side effect of the medication, a BMI is not the priority assessment for this client.

✓ 3. Complete blood count (CBC).

Agranulocytosis is a potentially life-threatening adverse reaction for a client who is prescribed clozapine; therefore, a CBC is the priority assessment for this client.

4. Serum sodium (Na+) and potassium (K+) levels.

Alterations in serum electrolyte levels are not associated with the client's prescribed medication.

A potentially fatal side effect of clozapine is agranulocytosis. Pretreatment and ongoing assessment of WBC and absolute neutrophil count (ANC) are critical via a complete blood count (CBC). The healthcare

provider would need to be notified if the client develops a fever or sore throat as these symptoms can further indicate the presence of neutropenia.

157. Mental Health Question #27 - V2

The nurse is caring for a client who is experiencing delirium tremens due to alcohol withdrawal.

➤What assessment finding(s) does the nurse expect? **Select all that apply.**

☑	**Agitation.**
	Agitation is a withdrawal symptom that occurs 48 to 96 hours after the last drink; therefore, this clinical manifestation is anticipated for this client.
☐	Bradycardia.
	Bradycardia is seen in opiate or alcohol overdose, and not withdrawal.
☑	**Confusion.**
	Confusion is a withdrawal symptom that occurs 48 to 96 hours after the last drink; therefore, this clinical manifestation is anticipated for this client.
☑	**Delusions.**
	Delusions are a withdrawal symptom that occurs 48 to 96 hours after the last drink; therefore, this clinical manifestation is anticipated for this client.
☑	**Excessive sweating.**
	Excessive sweating is a withdrawal symptom that occurs 48 to 96 hours after the last drink; therefore, this clinical manifestation is anticipated for this client.
☑	**Fever.**
	Fever is a withdrawal symptom that occurs 48 to 96 hours after the last drink; therefore, this clinical manifestation is anticipated for this client.

Alcohol use is frequently missed upon admission to the hospital and screening for this could prompt the initiation of benzodiazepine pharmacotherapy. The implementation of benzodiazepines can reduce withdrawal symptoms. Alcohol withdrawal syndrome can cause seizures, hallucinations, and delirium.

These manifestations present as anxiety, tremors, palpitations, GI upset, visual or auditory hallucinations, confusion, agitation, or hypertension.

158. Mental Health Question #28 - V2

The nurse is caring for an older adult client who was found miles away from home after being reported missing for several days. The client is not oriented to place or time and does not recall what happened.

➤What is the priority nursing action?

1. Ask the client to state their name and birthdate.

The client may or may not be able to remember this information; therefore, this is not the action by the nurse at this time.

2. Frequently orient the client to the surroundings.

Stabilization of physical symptoms is a priority over psychological needs; therefore, this is not the priority action by the nurse.

3. Notify the health care provider (HCP) that the client is confused.

A thorough exam of the client needs to occur prior to notifying the health care provider (HCP); therefore, this is not the priority action by the nurse.

✓ 4. Perform a complete head to toe assessment.

A thorough baseline assessment provides additional information that may be needed to assist in the diagnosis and treatment plan; therefore, this is the priority action by the nurse.

The nurse should ensure that the physical examination, along with physical needs, are met prior to addressing psychological needs. Due to the length of time the client had been missing, physical symptoms should be addressed as a priority. The client is likely suffering from dehydration and fatigue. Once all the physical symptoms are addressed then the psychological needs can be met.

159. Mental Health Question #29 - V2

The nurse is caring for a client with a history of progressive dementia. The client becomes aggressive and throws a bowl of ice cream across the room.

➤Which response(s) by the nurse is appropriate? **Select all that apply.**

☐	Give a dose of the prescribed PRN intramuscular (IM) risperidone now and reassess the client in 30 minutes.
	Medication administration with antipsychotics increases client mortality and should only be used if all other interventions have failed.
☐	Escort the client back to the assigned room and state, "If you don't stop this behavior a time out will be required."
	Threatening a time-out with this client could disrupt the nurse-client relationship and potentially lead to further disruptive behaviors.
☑	**Face the client, and calmly state, "I see that you are upset but you are safe here."**
	Reassurance to the client that he or she will be kept safe from harm is an appropriate behavioral management technique; therefore, this is the best action by the nurse.
☑	**Acknowledge that the client is frustrated and attempt to calm the client by looking at family photos.**
	Distraction through photographs is a great technique to divert the client's attention; therefore, this is an appropriate response by the nurse.
☐	Tell the client, "You may no longer have ice cream if the behavior continues."
	Threatening the client could worsen the client's agitation and behavioral problems; therefore, this response should be avoided.

Behavioral management for agitated clients with dementia includes acknowledging, reassuring safety, distracting, and redirecting. This behavioral management is needed to address the continuing cognitive decline. Acknowledging the client's emotions reduces the feelings of being isolated and misunderstood. Distraction and redirection are essential to diverting attention with completion of simple tasks to manage behavioral problems such as agitation or resisting of care.

160. Mental Health Question #30 - V2

The nurse is planning care for a client who is diagnosed with bulimia nervosa.

➤Which intervention should the nurse include in the client's plan of care? **Select all that apply.**

☐	Never leave the client unattended.

	Constant supervision negates a positive nurse-client relationship and should be avoided unless absolutely necessary.
☑	**Assist client in developing a realistic body image.**
	Clients often experience great guilt associated with bulimia and great care should be taken to assist clients in developing a realistic body image; therefore, this is an appropriate intervention for the nurse to include in the client's plan of care.
☑	**Discard any diuretics the client might have.**
	Diuretics can be used to drop excess water weight and should be removed from the client's possession; therefore, this is an appropriate intervention to include in the client's plan of care.
☑	**Establish adequate nutritional intake.**
	Adequate nutritional intake is necessary to maintain electrolyte balance and prevent further cardiac issues associated with bulimia nervosa; therefore, this is an appropriate intervention for the nurse to include in the client's plan of care.
☑	**Observe client elimination patterns.**
	Clients who are diagnosed with bulimia nervosa often use laxatives inappropriately so elimination pattern monitoring is an appropriate intervention to assess for laxative use.
☑	**Encourage the client to keep a log of food intake.**
	A food diary helps the client track the type and amount of food that is eaten thus allowing the client to understand the health implications of the disorder; therefore, this intervention is appropriate for the nurse to include in the client's plan of care.

Clients who are diagnosed with bulimia nervosa should be monitored for signs of hidden binging or purging activity, especially after meals. Nursing interventions include close monitoring 1 to 2 hours after eating as this is the most favorable time for the client to induce vomiting. This is key to monitor in the beginning of a treatment period as the client's goal is to try and gain as much control as possible over their weight loss. It is also important to ensure the client maintains adequate nutrition and electrolyte balance.

161. Mental Health Question #31 - V2

The nurse is caring for a school-aged child with a history of attention deficit hyperactivity disorder (ADHD) who becomes angry and aggressive towards a teacher.

➤What nursing intervention(s) is appropriate for this client? **Select all that apply.**

☑	**Discuss what caused the aggressiveness and why it is wrong.**
	Discussion of what precipitated the behavior and why the behavior is wrong as an appropriate nursing intervention.
☐	Give the child a dose of lisdexamfetamine dimesylate.
	This medication should not be utilized as a PRN intervention for anger and aggressive behavior for a child who is diagnosed with ADHD.
☑	**Coach the child through deep breathing exercises.**
	An appropriate nursing intervention is assisting the child in calming down through deep breathing exercises.
☐	Isolate the child until the child has calmed down and apologizes.
	Isolating the child is punitive and not therapeutic.
☑	**Take the child calmly into a different room.**
	It is appropriate to stay calm and remove the child from the source of frustration or anger.

The priority intervention for a child with ADHD who is engaging in aggressive behavior is to assist the child in calming down and gaining control. An immediate intervention to calm the client down is deep breathing. The slowing of breaths relaxes the body and slows the heart rate. It can also provide a distraction for the child to focus on.

162. Mental Health Question #32 - V2

The nurse is caring for a client taking olanzapine for visual hallucinations. The client states, “The clown in the corner of the room is going to kill me, but no one else sees it.”

➤Which response by the nurse is appropriate?

1. Ask the client if they have a fear of clowns.

This response validates the hallucination and may also exacerbate the situation by asking the client to talk about the symptoms.

2. Reinforce that there is not a clown in the corner.

This statement is not therapeutic and does not establish trust within the nurse-client relationship.

3. Tell the client that the medication will make the clown leave.

The medication may take a full 2 weeks to be effective so this statement is inappropriate and not therapeutic.

✓ 4. Offer to go on a short walk with the client.

Redirection through physical activity is an appropriate coping strategy to decrease psychotic symptoms.

Antipsychotic medications are the first line treatment for hallucinations but clients will require the implementation of other strategies to enhance coping with this distressing symptom. Additional strategies are often needed initially as many medications may take several weeks to become effective. One approach is to increase the amount of visual stimulation in the environment. This can be accomplished by going on a walk to observe the complex environment instead of the walls of a hospital room.

163. Mental Health Question #33 - V2

The nurse is caring for an elderly client with moderate dementia.

➤What client assessment finding(s) would lead the nurse to suspect elder abuse? **Select all that apply.**

☐	Gained 10 lbs (4.54 kg) over the past month.
	Weight loss, not gain is often a manifestation of neglect, a form of elder abuse.
☑	**Stage 4 pressure injury on the sacrum.**
	The presence of pressure injury is a sign of elder abuse when a client is unable to care for themselves.
☑	**Clothes and bed sheets are visibly soiled.**
	Poor hygiene is an objective finding consistent with abuse or neglect.
☑	**Multiple cavities and broken teeth.**
	Lack of dental care can be an objective finding of neglect or abuse.
☐	Medication is kept in a daily medication dispenser.

	Medication kept in a dispenser is evidence of quality care of the client.
☐	Seems to be happy when talking about a new pet.
	An overall pleasant affect is an objective finding of a positive psychological setting at home.

Manifestations of abuse in the older adult that experiences confusion may include multiple physical signs such as poor hygiene, dehydration, malnutrition, weight loss, and pressure injuries. This abuse may be intentional or an unintentional failure to meet the many needs of the older adult client. The nurse should assess for objective findings that could be reported to the appropriate individuals. These findings may be dehydration, weight loss, poor hygiene, pressure injuries, or missing/broken assistive devices such as glasses.

164. Mental Health Question #34 - V2

The nurse is caring for a client diagnosed with borderline personality disorder. The client states to the nurse, “Everyone here is out to get me except you.”

➤What is an appropriate response by the nurse?

1. Ask the client, "Why do you think everyone is, 'out to get you'?"

This response will not change the behavior of the client and only encourage further manipulative speech.

✓ 2. Rotate assignment of this client to different members of the healthcare team.

Rotating assignment of this client to other staff negates the client’s ability to manipulate a single staff member; therefore, this is an appropriate response by the nurse.

3. Inform the unit manager that no one else should be assigned care for this client.

This action further reinforces the manipulative behavior to isolate the nurse and should be avoided.

4. Inquire about any recent changes in the client's medication regimen.

The client’s statement is the result of the borderline personality disorder and not a side effect of a medication.

To avoid abandonment, clients who are diagnosed with BPD will manipulate others to control the environment while isolating others. The individual with BPD may also inflict self-harm in an attempt to gain attention from another person. Rotating of nursing staff is an appropriate planned activity as it fails to reinforce the manipulative behavior of the client.

165. Mental Health Question #35 - V2

The nurse is caring for an adolescent client who is diagnosed with a fear of school and has missed an excessive amount of classes.

➤What is an appropriate nursing action(s)? **Select all that apply.**

☐	Recommend the parent keep the client out of school for at least 3 months.
	Allowing the child to avoid school reinforces the behavior; therefore, this is not appropriate advice from the nurse to the child's caregiver.
☐	Explain to the parent that the child should be medicated before returning to school.
	Medication interventions for school phobia are not considered a therapeutic and should be avoided.
☐	Reassure the child's parent that this is a phase that all teenagers go through.
	Reassurance to the parents that this behavior is common reinforces the child's behavior and does not provide a therapeutic response.
☑	**Have the parent promptly return the child to school, starting gradually with half days.**
	The child should be returned to school promptly along with other supportive interventions to facilitate a decrease in sensitization to the classroom.
☐	Have the parent inquire about allowing the child to finish the school year at home.
	Allowing the child to remain at home only reinforces the behavior.

Supportive interventions such as insisting on school attendance will help the child make a faster adjustment. This is accomplished through gradual exposure to the school environment. A gradual approach decreases the child's sensitization to the classroom. If the child is withheld from school, this will only worsen the problem.

166. Mental Health Question #36 - V2

The nurse is caring for a client weaned from the mechanical ventilator and an intravenous (IV) infusion of propofol 24 hours ago. The client is disoriented to person, place and time. Additional assessment reveals the client is experiencing drowsiness, inattention, and an inability to recall recent events.

➤What diagnosis does the nurse anticipate with this client?

1. Agitation.

Agitation does not present with lethargy or inability to recall events.

2. Bipolar mania.

Bipolar mania does not typically have an acute onset and should be ruled out in this scenario.

✓ 3. Delirium.

Delirium is evidenced by acute onset and impaired consciousness; therefore, this is the abnormality that the nurse includes in the client's plan of care based on the current data.

4. Dementia.

Dementia develops gradually over months; additionally, consciousness remains intact.

New-onset confusion in regards to place, time, focus, memory, or increasing lethargy can be manifestations of delirium in the critically ill client. Delirium can be challenging to diagnosis but it is reversible. Healthcare organizations are encouraged to use a standardized tool to assess clients for delirium in the ICU environment. If delirium is not addressed quickly, the chances of mortality are greatly increased.

167. Mental Health Question #37 - V2

The daughter of a client with advanced Alzheimer dementia confides in the nurse that she is no longer able to care for the needs of her parent without help.

➤Which response by the nurse is **best**?

1. "Taking care of a parent with dementia is very difficult and I agree you need help."

This statement validates the caregivers concern but does not allow the caregiver to open up and discuss the potential difficulties in providing care.

2. "I will let the practitioner know that your parent probably needs a medication change."

This statement does not engage the caregiver in a therapeutic conversation where the caregiver can discuss the demands of providing care to the client.

✓ 3. "Let's discuss your daily routine and any difficulties you encounter."

This statement allows the caregiver to open up and discuss the concerns around caregiving, further developing a therapeutic relationship.

4. "Maybe you should place your parent in a care facility for a few weeks."

Giving opinions are non-therapeutic, discourages communication, and does not help identify caregiver role strain.

Caregiver role strain is the caregiver's perception of multifactorial difficulties when providing care to another. The nurse should monitor for signs of this, such as fatigue, depression, and isolation. Caregiver role strain can have a significant negative impact on the client's health and the health of the individual providing care. The nurse should implement therapeutic conversation, identify opportunities for assistance, and provide information regarding community resources.

168. Mental Health Question #38

During a conversation with the nurse, a client diagnosed with schizophrenia begins to stare at the window and frown. Which is an appropriate response by the nurse?

1. "Please look at me while we are talking."

A demanding statement will most likely end the conversation and the nurse will be unable to assess the nature of the client's behavior.

2. "Should I close the curtains on the window during our conversation?"

This statement is not therapeutic as it addresses the nurse's needs, and not the needs of the client.

3. "Would you like for me to move my chair closer to the window while we talk?"

This statement does not focus on the assessment of the client and is not therapeutic.

✓ 4. "You can tell me what you see over there."

The nurse must evaluate if the client's stare and frown is associated with a hallucination which can lead to aggressive behavior and negatively impact safety of the nurse and the client. Upon that assessment, the nurse can then appropriately redirect the client, if warranted.

Communication with a client experiencing a hallucination is focused on building trust, self-awareness, reality testing, and self-confidence. Upon that development, the nurse can assess the hallucination for suicidal or homicidal themes. Hallucinations experienced by a client who is diagnosed with schizophrenia may be visual or auditory so it is important to have the client describe what is experienced. Once the nurse knows what the hallucination is then it is appropriate to assist the client in dealing with it.

👉 *Video Rationale: https://d1pumg6d5kr18o.cloudfront.net/rationales-v2/section_1_mental_health_concepts_38/part.m3u8*

169. Mental Health Question #38 - V2

The nurse is caring for a client diagnosed with schizophrenia who begins to stare at the window and frown during a conversation.

➤Which response by the nurse is appropriate?

1. "Please look at me while we are talking."

A demanding statement will most likely end the conversation and the nurse will be unable to assess the nature of the client's behavior.

2. "Should I close the curtains on the window during our conversation?"

This statement is not therapeutic as it addresses the nurse's needs, and not the needs of the client.

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Communication with a client experiencing a hallucination is focused on building trust, self-awareness, reality testing, and self-confidence. Upon that development, the nurse can assess the hallucination for suicidal or homicidal themes. Hallucinations experienced by a client who is diagnosed with schizophrenia may be visual or auditory so it is important to have the client describe what is experienced. Once the nurse knows what the hallucination is then it is appropriate to assist the client in dealing with it.

170. Mental Health Question #39

Which clinical manifestation should the nurse assess for when providing care for a client who is diagnosed with narcissistic personality disorder (NPD)? **Select all that apply**.

☐	Feelings of inferiority.
	Clients who are diagnosed with NPD avoid feelings of inferiority at all costs as this would further damage the fragile ego.
☑	**Seeks constant reinforcement.**
	Constant reinforcement fulfills the need for admiration for clients who are diagnosed with NPD.
☑	**Lack of empathy towards others.**
	The lack of empathy is a consistent behavior associated with NPD and is a result of the fragile ego.
☑	**Grandiosity.**
	Clients who are diagnosed with NPD express grandiosity as a way to self-regulate the self-esteem.
☐	Auditory hallucinations.
	Auditory hallucinations is not a clinical manifestation of NPD and may be the result of an additional separate disorder if experienced by the client.

Behind the mask of extreme confidence for a client who is diagnosed with NPD lies a fragile self-esteem that is vulnerable to the slightest criticism. The clinical characteristics of NPD are an attempt to maintain a fragile self-esteem that was damaged through childhood by multiple environmental factors. These characteristics also develop to prevent further psychic injury. The nurse must have knowledge of symptoms associated with NPD as this will assist in the development of an appropriate nursing plan of care.

👉 *Video Rationale: https://d1pumg6d5kr18o.cloudfront.net/rationales-v2/section_1_mental_health_concepts_39/part.m3u8*

171. Mental Health Question #39 - V2

The nurse is caring for a client diagnosed with narcissistic personality disorder.

➤What assessment finding(s) should the nurse anticipate? **Select all that apply.**

☐	Feelings of inferiority.
	Clients who are diagnosed with NPD avoid feelings of inferiority at all costs as this would further damage the fragile ego.
☑	**Seeks constant reinforcement.**
	Constant reinforcement fulfills the need for admiration for clients who are diagnosed with NPD.
☑	**Lack of empathy towards others.**
	The lack of empathy is a consistent behavior associated with NPD and is a result of the fragile ego.
☑	**Grandiosity.**
	Clients who are diagnosed with NPD express grandiosity as a way to self-regulate the self-esteem.
☐	Auditory hallucinations.
	Auditory hallucinations is not a clinical manifestation of NPD and may be the result of an additional separate disorder if experienced by the client.

Behind the mask of extreme confidence for a client who is diagnosed with NPD lies a fragile self-esteem that is vulnerable to the slightest criticism. The clinical characteristics of NPD are an attempt to maintain a fragile self-esteem that was damaged through childhood by multiple environmental factors. These characteristics also develop to prevent further psychic injury. The nurse must have knowledge of symptoms associated with NPD as this will assist in the development of an appropriate nursing plan of care.

172. Mental Health Question #40 - V2

The nurse is caring for a client with a history of schizophrenia who states, “Loving living nectar of bees of pollen and butterflies run amok.”

➤This client statement is referred to as which of the following?

1. Abstract thinking.

Abstract thinking is a complex process and the client's statement is not an example of this.

2. Disconnected thoughts.

Disconnected thoughts are a sign of dissociative disorders as there is a disconnection between thoughts, identity, and consciousness; however, the client's statement is not an example of this.

3. Digression.

Digression is the use of odd words to display magical thinking when a client has a belief in bizarre fantasies; however, the client's statement does not exemplify this.

✓ 4. Word salad.

Word salad is a manifestation of disorganized thinking and is common for clients who are diagnosed with schizophrenia. The client's statement exemplifies a word salad.

The nurse needs to be able to recognize and identify the various thought disturbances experienced by clients who are diagnosed with schizophrenia. There are many thought disturbances that can occur such as repetition of words, made up words, or literal interpretation of an idea. These manifestations are further categorized as neologisms, concrete thinking, loose associations, echolalia, tangentiality, word salad, and clang associations. Clients with this diagnosis may also repeat the same words in response to different questions, or demonstrate perseveration.

173. Mental Health Question #41 - V2

A client in the long term care facility has been giving away belongings. When questioned about these actions by the nurse the client says, "Since my son died, I have no reason to keep going."

Which response by the nurse is **best**?

1. "That's no way to talk. People would miss you if you were gone."

This is not a therapeutic statement and does not assess potential suicidal ideations.

2. "You have many reasons to keep going. Let's talk about your daughter."

It is important to assess the client's social support but this is not the best response by the nurse based on the current data.

✓ 3. "Do you have plans of harming yourself?"

This question is designed to determine if the client has had thoughts of self harm and is a priority based on the current data; therefore, this is the best response by the nurse.

4. "Can you recall which belongings you gave away so we can get them back for you?"

The actually possession of the items is not of importance at this time. Reobtaining these possessions will not provide a therapeutic response to the client's comments about not wanting to go on.

A suicide risk assessment is the priority nursing action when a client expresses thoughts about "not wanting to go on" or "wishing for death." Even the act of giving away possessions can be considered an indication of suicidal ideation. Upon these circumstances a suicide risk assessment must be completed. This consists of direct questioning about thoughts of self-harm while also building a trusting relationship with the client.

174. Mental Health Question #42 - V2

The nurse is assessing a client who is diagnosed with posttraumatic stress disorder (PTSD).

➤Which clinical manifestation does the nurse anticipate? **Select all that apply.**

☐	Paranoid delusions.
	Feelings of paranoia is not a characteristic symptom of PTSD.
☐	Decreased anxiety.
	Increased, not decreased anxiety is a characteristic of PTSD.
☑	**Isolation from others.**
	Clients who are diagnosed with PTSD will isolate themselves as a way of avoiding reminders of the trauma; therefore, this is a clinical manifestation the nurse anticipates upon assessment.
☑	**Re experiencing the trauma.**
	Re experiencing the trauma is one of the three categories of PTSD symptoms. The other two categories are avoiding the traumatic event and increased anxiety.
☐	Violent aggressiveness.

	Outbursts of rage are characteristic of PTSD; however, the client is not likely to exhibit violent aggressive behavior.
☐	Visual hallucinations.
	Hallucinations are not associated with PTSD.

There are three categories of PTSD symptoms. These are re experiencing the traumatic event, avoiding reminders of the trauma, and increased anxiety and emotional arousal. Identification of symptoms the client is experiencing can help the nurse direct therapeutic interventions. Certain manifestations such as feelings of intense distress can be addressed with therapeutic dialogue.

175. Mental Health Question #43 - V2

The nurse is caring for a client receiving palliative care. A family member begins to weep and asks the nurse not to leave the client's room.

➤Which statement by the nurse is **best**?

1. "I can't stay but I will ask the the nurse's aide to come sit with you."

Family members that ask the nurse to stay may have questions that need answering so it would be inappropriate to decline to stay or to send an aide.

2. "My other clients need me but I will stay for just a little longer."

Telling the family that you are too busy is not a helpful response and they may feel guilty asking for the nurse's attention and time in the future.

3. "This is a very difficult time and it is important to spend it with close relatives."

It may take several hours for additional family to arrive; additionally, this is not the most helpful response.

✓ 4. "I will not leave right now if that's what you would like for me to do."

This is the most helpful response. Family members may simply want the nurse to sit and provide reassurance that their loved one is worthy of the time and attention.

The most therapeutic response for nurses to implement when family asks them to stay is to sit with the client and/or family for at least a few minutes. The client and family members go through several emotional

stages when a client is on palliative or hospice care. Sitting with the client or the family, even if just for a few minutes, can validate the family's needs. This therapeutic intervention can assist the client or family through the stages of grief.

176. Mental Health Question #44 - V2

The nurse is caring for a client receiving treatment for alcohol use disorder.

➤Which client statement(s) reveals a positive response to treatment? **Select all that apply.**

☐	"I only drink wine socially on the weekends now."
	Occasional alcohol intake does not present a therapeutic response to treatment when the goal is complete abstinence from alcohol.
☑	**"I threw out all my champagne last night so I wouldn't be tempted to drink it."**
	This comment about alcohol abstinence constitutes a positive response.
☐	"If I have troubling sleeping I can take an over-the-counter sleep medication."
	Taking sleep medication does not provide a therapeutic response to anxiety experienced when completing therapy for alcoholism.
☑	**"I'm putting all my energy into finishing college and obtaining my degree."**
	This statement provides a futuristic goal that focuses on self-development to improve the self-worth and is indicative of a positive response to treatment.
☐	"My family and friends have been so encouraging throughout this process."
	Family support alone does not provide the client a therapeutic response to treatment. The client needs to take ownership of their progress within the treatment plan.

Clients recovering from alcohol use disorder should demonstrate accountability for past behavior, identify consequences, and use insight to face reality in addition to the use of coping skills. The plan of care after detoxification should be focused on goal setting. The goal should ultimately be focused on progressing the client toward total abstinence from alcohol. Setting additional goals for personal growth assist in the development of self-worth.

177. Mental Health Question #45

The nurse provides care for a client who is diagnosed with depression who is lying on the couch, has not moved for hours, and has a lack of facial expression with no social interaction. The characteristics displayed by this client are referred to as which of the following?

1. Psychomotor movement disorder

> Psychomotor agitation is characterized by purposeless, agitated, and sometimes unintentional movements; therefore, the client is not exhibiting this based on the current data.

2. Catatonic isolation

> Catatonic isolation is severe psychomotor retardation. If this client's condition continues, catatonia can result; however, this is not what the client is experiencing based on the current data.

✓ 3. Psychomotor retardation

> The depressed client is experiencing mild manifestations of psychomotor retardation. These can be noted as slowed speech, decreased movement, and impaired cognitive function.

4. Somatic symptom disorder

> Somatic symptoms are physical symptoms that cannot be explained by a medical condition or disease. This is not reflective of the client's current clinical manifestations.

> Psychomotor retardation is a clinical symptom of major depressive disorder. It's manifestations include slowed speech, decreased movement, and impaired cognitive function. This client may not have the energy to perform activities of daily living (ADLs). These manifestations may be mild (e.g., slowing of speech) to severe (e.g., catatonia).

👉 *Video Rationale: https://d1pumg6d5kr18o.cloudfront.net/rationales-v2/section_1_mental_health_concepts_45/part.m3u8*

178. Mental Health Question #45 - V2

The nurse is caring for a client with a history of depression who is lying on the couch, has not moved for hours, and has a lack of facial expression with no social interaction.

➤The nurse recognizes these findings as characteristics of which of the following?

1. Psychomotor movement disorder

Psychomotor agitation is characterized by purposeless, agitated, and sometimes unintentional movements; therefore, the client is not exhibiting this based on the current data.

2. Catatonic isolation

Catatonic isolation is severe psychomotor retardation. If this client's condition continues, catatonia can result; however, this is not what the client is experiencing based on the current data.

✓ 3. Psychomotor retardation

The depressed client is experiencing mild manifestations of psychomotor retardation. These can be noted as slowed speech, decreased movement, and impaired cognitive function.

4. Somatic symptom disorder

Somatic symptoms are physical symptoms that cannot be explained by a medical condition or disease. This is not reflective of the client's current clinical manifestations.

Psychomotor retardation is a clinical symptom of major depressive disorder. It's manifestations include slowed speech, decreased movement, and impaired cognitive function. This client may not have the energy to perform activities of daily living (ADLs). These manifestations may be mild (e.g., slowing of speech) to severe (e.g., catatonia).

179. Mental Health Question #46 - V2

The nurse is caring for a client with a history of dementia that is being treated with donepezil.

➤Which assessment finding indicates the treatment is effective?

1. Accelerated improvement in long term memory.

There is no current medication that is approved for the treatment of dementia to accelerate improvement in long term memory.

2. Improved ability to focus during long conversations.

Medication intervention does not improve the client's ability to focus during long conversations.

✓ 3. Increased participation in performing self-care.

Medications have been approved for the treatment of dementia are prescribed to improve the client's ability to perform activities of daily living. Donepezil and other medications have been approved for this in moderate to severe cases of dementia.

4. Improved cognitive abilities

Improved cognitive abilities is not feasible in moderate to severe dementia as the disease process is progressive.

Donepezil is a medication used in the treatment of moderate to severe dementia. This pharmacotherapy can slow the progression of symptoms associated with dementia. It can also provide an improvement in the client's behavior and cognitive functioning. Improvement in the ability to perform activities of daily living has also been noted.

180. Mental Health Question #47 - V2

The nurse is caring for a client recently diagnosed with schizophrenia. A relative of the client asks the nurse, "Will I develop this condition too?"

➤Which response by the nurse is **best**?

1. "I can call the genetic counselor if you would like to voice your specific questions."

Diverting the person's concerns to another healthcare provider is not a therapeutic response.

2. "Right now it is most important to focus on the mental health of your family member."

This statement dismisses the concerns of the client's family member thus is not therapeutic. Additionally, this response is considered a non-action response by the nurse.

✓ 3. "There are multiple causes that influence the development of schizophrenia."

This response acknowledges the family member's concerns and acknowledgement is a key intervention within a therapeutic conversation.

4. "Schizophrenia does not have a genetic component so it doesn't run in families."

This response is unfactual and inappropriate for the nurse to make since the cause of schizophrenia is unknown.

Providing care for a client who is diagnosed with schizophrenia includes not only ensuring that prescribed medications are administered as directed but also ensuring the needs of the client and their family are being met. This includes addressing the concerns of the client's family members. When presented with concerns about disease development, the best response is to be factual. There are many theories about the disease development including the following: biochemical, structural brain abnormalities, developmental factors, and miscellaneous factors.

181. Mental Health Question #48 - V2

The nurse is caring for a client with a history of mental health issues and suicidal ideations.

➤Which client statement is most concerning to the nurse?

1. "I just got a new prescription for zolpidem to help me sleep at night."

This statement does not reflect enough risk factor markers to warrant concern.

2. "My girlfriend broke up with me yesterday and I can't stop crying."

This statement does notate the loss of a significant other but this could be a normal grieving process; therefore, it is not the statement that should cause the nurse the most concern.

✓ 3. "I know where my parents keep their handgun and they are leaving for vacation tomorrow."

This statement indicates a higher level of risk and an organized plan has already been developed; therefore, this is the statement that causes the nurse the most concern.

4. "My doctor switched my antidepressant medication and I think it is making me gain weight."

Weight gain can cause further depression and evaluation of the medication can be addressed; however, this statement is not indicative of an increased risk for suicide.

The mnemonic SAD PERSONS is a known risk assessment tool used to determine a client's risk for suicide. The SAD reflects sex, age, and depression while the PERSONS reflects prior history, ethanol use, rational thinking loss, support system loss, organized plan, no significant other, and sickness. The higher the score the higher the risk of committing suicide.

182. Mental Health Question #49 - V2

The nurse is caring for a client scheduled for electroconvulsive therapy (ECT).

➤What client statement alerts the nurse the procedure needs to be rescheduled?

✓ 1. "I took a double dose of my lamictal this morning."

A double dose of an anti-seizure medication prior to the treatment is contraindicated prior to ECT; therefore, this finding alerts the nurse to rescheduled the procedure.

2. "My friend is here to drive me home after my procedure."

It is appropriate and recommended for someone else to drive the client home after ECT; therefore, this statement does not alert the nurse to reschedule the procedure.

3. "I understand that I may have some temporary memory loss."

The client understands and verbalizes that memory loss is a known side effect; therefore, this statement does not prompt the nurse to reschedule the ECT procedure.

4. "I realize that I will not feel pain during the procedure."

The client understands that the procedure is performed under anesthesia and that pain is not to be expected; therefore, this statement does not indicate a need to reschedule the ECT.

The implementation of ECT involves the use of an electrical current applied to the client's scalp to induce seizure activity. Due to the administration of anesthesia, the client should be NPO prior to the treatment. The client should also refrain from taking anti-seizure medication prior to the therapy. Temporary confusion and memory loss are common after the procedure. The client also should not drive after the therapy session.

183. Mental Health Question #50 - V2

The nurse is caring for a school-aged client recently diagnosed with attention deficit hyperactivity disorder (ADHD).

➤Which statement made by the parent of the client indicates an adequate understanding of the disorder?

✓ 1. "It is harder for my child to concentrate when doing multiple things at once."

This parental statement indicates an accurate understanding of ADHD.

2. "ADHD is a disorder of childhood so my child will only need treatment for a few years."

ADHA often continues into adulthood; therefore, this parental statement does not indicate an adequate understanding of the diagnosis.

3. "ADHD does not affect the way that my child learns at school."

ADHD will affect the child's learning as individualized services are needed to accommodate the child's condition.

4. "My child really enjoys watching television and listening to music at the same time."

The ability to complete both tasks at once for a child with ADHD is nonexistent. When faced with multiple choices, the child easily becomes overwhelmed; therefore, this parental statement does not indicate an adequate understanding of the diagnosis.

There are a couple misunderstandings about ADHD in children. The first is that children will outgrow the disease as they become adults. This is false because adults can learn to cope with the health problem and live healthy and satisfying lives. The other misunderstanding is that the removal of certain dietary foods such as sugar improves or cures the condition. There is no evidence to support that finding.

184. Mental Health Question #51

A client who is diagnosed with major depressive disorder was hospitalized twice in the past 4 months for suicidal tendencies. The client tells the nurse, "I'm unemployed, overweight, have no health insurance, feel alone, and I just can't do this anymore." The client is currently prescribed paroxetine but has not kept appointments with the health care provider (HCP). Which nursing diagnosis is most important for this client?

1. Chronic low self-esteem.

This is an appropriate nursing diagnosis but it is not the most important given the situation.

2. Disturbed thought process.

This is an appropriate nursing diagnosis but it is not the most important given the situation.

✓ 3. Risk for self-harm.

The nurse's priority in the provision of client care is to ensure safety; therefore, this is the most appropriate nursing diagnosis based on the current data.

4. Risk for violence.

This is an appropriate nursing diagnosis but it is not the most important given the situation.

The presence of a suicidal attempt within the past two years places this client at greater risk for completing the act again. The nurse should complete a suicide risk assessment. The nursing diagnosis of risk for self-harm is the most important diagnosis at this time to ensure the safety of the client.

👉 *Video Rationale: https://d1pumg6d5kr18o.cloudfront.net/rationales-v2/section_1_mental_health_concepts_51/part.m3u8*

185. Mental Health Question #51 - V2

A client with a history of major depressive disorder, who has been hospitalized twice in the past 4 months for suicidal tendencies and is taking paroxetine, states "I'm unemployed, overweight, have no health insurance, feel alone, and I just can't do this anymore."

➤What is the primary nursing diagnosis for this client?

1. Chronic low self-esteem.

This is an appropriate nursing diagnosis but it is not the most important given the situation.

2. Disturbed thought process.

This is an appropriate nursing diagnosis but it is not the most important given the situation.

✓ 3. Risk for self-harm.

The nurse's priority in the provision of client care is to ensure safety; therefore, this is the most appropriate nursing diagnosis based on the current data.

4. Risk for violence.

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The presence of a suicidal attempt within the past two years places this client at greater risk for completing the act again. The nurse should complete a suicide risk assessment. The nursing diagnosis of risk for self-harm is the most important diagnosis at this time to ensure the safety of the client.

186. Mental Health Question #52 - V2

The nurse is planning care for a client diagnosed with anorexia nervosa and admitted to the hospital for treatment.

➤Which client outcome is the most important to include in the plan of care?

1. Acknowledges a disturbed body image.

The client recognizing a disturbed body image may actually be more negative than positive furthering the desire to lose weight.

✓ 2. Makes significant weight gain.

Weight gain and increased caloric intake provides measurable progress. This is the most important objective in the provision of care for a client who is hospitalized for the treatment of anorexia nervosa.

3. Promises to eat more calories.

The simple act of promising does not provide objective progress towards improving the client's overall health.

4. Opens up about past events.

It may be very therapeutic for the client to discuss historical events but the primary objective is weight gain during this hospital admission.

The treatment for a client requiring hospitalization for the treatment of anorexia nervosa should focus on the short-term outcomes. This includes increasing caloric intake, promoting gradual weight gain, and addressing any medication or other conditions related to nutrient deficiencies. Outside of the hospital long term follow up needs to be encouraged. This consists of focused therapy in an outpatient setting.

187. Mental Health Question #53 - V2

The nurse is providing care for a client diagnosed with dissociative personality disorder.

➤Which nursing action has the highest priority?

✓ 1. Help the client to identify specific triggers for alternate personalities.

Trigger identification provides the client understanding so that self acknowledgement can occur with the switching in personalities occurs.

2. Remind the client that the alternate identities are not real.

Encouraging the client that the other identities are not real does not create a therapeutic relationship for further communication.

3. Encourage the client to find an engaging hobby to participate in.

Redirection to a hobby is not a recommended therapeutic intervention for this disorder. Grounding is a technique to counter dissociative episodes.

4. Tell the client that the alternate identities tend to become easily violent.

Stating that the other identities are more violent may provide even more stress for the client thus further decreasing a therapeutic response.

Treatment for dissociative disorders may include talk therapy (i.e., psychotherapy) and pharmacotherapy (i.e., medications). Although treating dissociative disorders can be difficult, many individuals learn new ways of coping and lead healthy, productive lives. While the client is being hospitalized the nurse should establish relationships with each identity. The nurse should also listen for expressions of self-harm, allow memory recall, and encourage journaling to identify triggers.

188. Mental Health Question #54 - V2

The triage nurse is listening to voicemails left by clients.

➤Which client message should be returned immediately?

1. A request for a medication change due to lack of adequate sleep for the past week.

Medication changes can occur during the next business day hours; therefore, this phone message does not require an immediate return phone call.

2. A report of constipation caused by medication for depression.

Constipation that is left untreated can cause significant health concerns; however, this client does not require an immediate return phone call.

3. A request for one on one counseling due to increased panic attacks.

Increased panic attacks in this client need to be addressed soon; however, this client does not require an immediate phone call from the nurse.

✓ 4. A client who expresses detailed fantasies about harming a close friend.

The safety of another or oneself will always be priority; therefore, this client requires an immediate return phone call by the nurse.

Although bipolar affective disorder is a lifelong condition, it can be adequately manage by the implementation of an evidence-based treatment plan. In most cases, bipolar affective disorder is treated with medications and psychological counseling (e.g., psychotherapy). Suicidal thoughts and behavior are common among people who are diagnosed with bipolar affective disorder. When a nurse receives a call regarding thoughts of harm to self or others, this is a priority situation necessitating immediate action.

189. Mental Health Question #55

The family of a terminally ill client discusses palliative care with the nurse. The client's adult child asks the nurse, "What would you do if you were me?" Which is the nurse's **best** response?

1. "Your parent has a detailed living will so these difficult decisions have already been made for you."

Many advance directive documents do not detail out every aspect of care. This response by the nurse is not therapeutic and does not stimulate further conversation about the family's understanding of the present situation.

2. "I know you must be upset, so I think we should call the hospital chaplain to come say a prayer with you."

Deferring these conversations to another professional, such as a chaplain, does not offer the needed support to the family.

3. "My mother was a hospice client and we could not have asked for better care for her in her final days."

This statement provides advice to the family, influencing their decision; therefore, should be avoided.

✓ 4. "This must be difficult. Let's discuss what you know about your parent's final wishes."

This statement avoids giving the family advice and influencing their decision making while also allowing a therapeutic conversation to take place; therefore, this is the best response by the nurse.

Any child or adult who has a serious or life-threatening illness, such as cancer, heart failure, or neurological or other disorders, may benefit from palliative care services. It can be started at any time, no matter the illness or stage of disease. It is most helpful when started early, right around the time of diagnosis. The nurse should use open ended questions to explore the family's beliefs and understanding of palliative care without influencing the family's decision about care.

👉 *Video Rationale: https://d1pumg6d5kr18o.cloudfront.net/rationales-v2/section_1_mental_health_concepts_55/part.m3u8*

190. Mental Health Question #55 - V2

The family of a terminally ill client discusses palliative care with the nurse. The client's adult child asks, "What would you do if you were me?"

➤Which is the best response by the nurse?

1. "Your parent has a detailed living will so these difficult decisions have already been made for you."

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191. Mental Health Question #56 - V2

The partner of a client diagnosed with borderline personality disorder states, "My partner has been cutting when left alone for any period of time."

➤What is an appropriate response by the nurse?

1. "It might be best if you found someone to stay with your partner while you're gone."

While this response by the nurse would ensure that someone is with the client at all times, it does not address the cutting behavior.

2. "I can't imagine how hard it must be to try and juggle all your responsibilities."

This is a therapeutic response but it does not validate the severity of the situation.

✓ 3. "Please bring your partner in to be evaluated by the practitioner as soon as possible."

All self-harm activities need to be evaluated as soon as possible due to the high risk of suicide associated with the client's diagnosis; therefore, this is the appropriate response by the nurse.

4. "Any time your partner performs these destructive behaviors remember that it is a cry for attention."

Self harm threats, gestures, and attempts are behaviors to bring about a response from a significant other but mere validation of this behavior does not provide the appropriate intervention needed.

Psychotherapy, which is also referred to as talk therapy, is a fundamental treatment approach for BPD. Although no pharmacotherapy has been approved by the Food and Drug Administration (FDA) specifically for the treatment of BPD, certain medications may help with symptoms or co-occurring problems such as depression, impulsiveness, aggression, or anxiety. Pharmacotherapy for a client who experiences BPD may include antidepressants, antipsychotics, or mood-stabilizing drugs. These clients are at a very high risk for self-harm; therefore, any self-harm behavior including cutting must be taken seriously and evaluated for intent.

192. Mental Health Question #57 - V2

The nurse is caring for a client recently diagnosed with anorexia nervosa.

➤What is the priority nursing intervention?

✓ 1. Establish a weekly weight gain goal of 1-2 lbs.

The highest priority for a client who is diagnosed with anorexia nervosa is weight gain. The weight gain goal should be a gradual increase to minimize added fear often associated with weight gain.

2. Close monitoring of the client's intake.

Caloric intake monitoring is an appropriate intervention for a client who is diagnosed with anorexia nervosa; however, the end result of weight gain is the highest priority.

3. Measuring the client's weight at least weekly.

The recommended weight check protocol for a client who is diagnosed with anorexia nervosa is daily. Weekly weight checks do not provide the needed objective data to ensure healthy weight gain for this client.

4. Ensure that the client finishes each meal completely.

Focusing on food is not the goal as obtaining a healthy weight should be the primary goal.

To prevent weight gain or to continue losing weight, individuals who are diagnosed with anorexia nervosa often severely restrict the amount of food that is consumed. These individuals may control calorie intake by vomiting after eating or by misusing laxatives, diet aids, diuretics, or enemas. They may also try to lose weight by exercising excessively. No matter how much weight is lost, the client continues to fear weight gain and continues to experience a distorted body image.

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193. Mental Health Question #58 - V2

The nurse is caring for a client who is diagnosed with schizophrenia.

➤Which client statement does the nurse identify as consistent with a delusion of reference?

1. "Do you see that moth man standing over there in the closet?"

This statement references a visual hallucination and does not reflect a delusion of reference.

2. "I feel something on the inside of my scalp that is trying to get out."

This is an example of a tactile hallucination and is not a delusion of reference.

3. "My mother always told me I am the smartest person on the planet."

This a statement of grandeur not a delusion of reference.

✓ 4. "The government uses my cell phone to send me top secret signals."

This statement reflects the false belief that the text messages are being receiving are from the government which exemplifies a delusion of reference that may be experienced by a client who is diagnosed with schizophrenia.

Delusions are a positive symptom of schizophrenia and can be managed effectively. Appropriate goals for caring for a client who is experiencing delusions of reference involve therapeutic exchanges. These include developing a relationship with the client based on empathy and trust, promoting an understanding of the features and appropriate management of delusions, and promoting effective coping strategies for anxiety, stress, or other emotions which may act as triggers for a delusion. The nurse should also promote positive health behaviors, including medication adherence and healthy lifestyle choices (e.g., diet, exercise, not smoking, and/or limit consumption of alcohol and other substances).

194. Mental Health Question #59 - V2

The nurse is caring for a client in the active dying process. The spouse states, “His birthday is in three days; do you think he will make it that long?”

➤Which response by the nurse is appropriate?

1. "I wish I could promise you that your loved one will live for 3 more days but it is not looking good right now."

Telling the spouse that the client may not make it to a specific event does not convey empathy or provide factual information; therefore, this is not an appropriate response by the nurse.

✓ 2. "I can stay with you. My assessment shows that your loved one doesn't have much longer."

The nurse offering self provides the client’s spouse with a therapeutic presence to assist with understanding the dying process; therefore, this is an appropriate response by the nurse.

3. "Let's talk about how you and your spouse always celebrated birthdays and other occasions."

Encouraging the client's spouse to recall fond memories may be comforting; however, it does not provide information about the imminent death.

4. "Let's decorate the room so we can celebrate your spouse's birthday a little early this year."

This statement by the nurse conveys that the client will not make it the actual birthday thus does not convey factual information to the family and is, therefore, not an appropriate response by the nurse.

The nurse can provide great assistance when guiding a family through the dying process. The nurse should be factual with the family about what is occuring. The nurse should also implement open and honest communication. The nurse can help the family anticipate what is happening and when death is imminent. The offering of self is a therapeutic technique that is appropriate when providing care to a client and family at end of life.

195. Mental Health Question #60 - V2

The nurse is caring for a transgender client.

➤Which question from the nurse is most useful?

✓ 1. "How do you specify your gender?"

This question allows the client to express openingly which gender is identified with, without judgement or stereotype; therefore, this question is most useful based on the current data.

2. "Do you have any transgender relatives?"

This is not an open-ended question to allow thorough assessment of the client's gender identity; therefore, this is not the most useful assessment question from the nurse.

3. "What would you like for me to call you?"

This is not an open-ended question to allow thorough assessment of the client's gender identity; therefore, this is not the most useful assessment question from the nurse.

4. "What is your sexual orientation?"

Sexual orientation and gender identity are different topics; therefore, this is not the most useful question from the nurse.

Transgender clients may identify as male, female, or neither. The nurse should use open-ended questions to allow the client to explain their gender identity in their words. Therapeutic communication is vital to establishing a trusting client-nurse relationship. This can also avoid stereotypes.

196. Mental Health Question #61

Which is the **best** question for the nurse to ask the caregivers of a child who is suspected of being the victim of abuse?

✓ 1. "Are there others who take care of your child when you are gone or at work?"

It is important to determine all of the child's caregivers when abuse is suspected; therefore, this is the best question for the nurse to ask based on the current data.

2. "Does your child have a pattern of disciplinary issues at school?"

This question can appear judgemental and does not allow for further discussion; therefore, this is not the best question from the nurse.

3. "Do you and your spouse agree on the type of discipline that should be used in the home?"

This is not an open-ended question to promote a more detailed response; therefore, is not the best question from the nurse.

4. "Does your child participate in any contact sports which could have caused these injuries?"

This question could cause the caregivers to become defensive and will limit the nurse's ability to establish trust.

When child abuse is suspected, the nurse should convey empathy and support when questioning the caregiver. Additionally, it is essential for the nurse to convey a nonjudgmental and non-threatening attitude. The nurse should use open-ended questions, as these are less threatening and the interview is often most appropriate to conduct without the child present.

👉 *Video Rationale: https://d1pumg6d5kr18o.cloudfront.net/rationales-v2/section_1_mental_health_concepts_61/part.m3u8*

197. Mental Health Question #61 - V2

The nurse is caring for a school-aged client who is suspected of being the victim of abuse.

➤Which is the best question for the nurse to ask the parents of the child?

✓ 1. "Are there others who take care of your child when you are gone or at work?"

It is important to determine all of the child's caregivers when abuse is suspected; therefore, this is the best question for the nurse to ask based on the current data.

2. "Does your child have a pattern of disciplinary issues at school?"

This question can appear judgemental and does not allow for further discussion; therefore, this is not the best question from the nurse.

3. "Do you and your spouse agree on the type of discipline that should be used in the home?"

This is not an open-ended question to promote a more detailed response; therefore, is not the best question from the nurse.

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198. Mental Health Question #62 - V2

The nurse is caring for an adolescent client.

➤Which assessment finding indicates the client may be experiencing depression?

1. The client enjoys sleeping in later on the weekends.

While insomnia is a manifestation of depression, excessive hours spent sleeping is not a sign of depression in adolescent clients.

2. The client expresses a desire to start working a part-time job.

Interest in additional activities outside of school for an adolescent client is not a sign of depression. The removal of self from activities, however, is a manifestation of depression.

✓ 3. The client stops attending class and football practice.

The withdrawal from previously enjoyable activities is a known symptom of depression in adolescence; therefore, this data suggests to the nurse a need to perform a screening for depression.

4. The client admits to being sexually active.

Sexual activity may indicate a higher self-esteem which is opposite of the signs of depression.

Adolescent clients present with different depression symptoms than that of adults. These symptoms are often vague and somatic in nature. The adolescent client may present with hypersomnolence or insomnia, and withdrawal from previously enjoyable activities. They may also have outbursts of anger or delinquent behavior as well as weight loss.

199. Mental Health Question #63 - V2

The nurse is caring for a client who attempted suicide and is admitted to the mental health care unit.

➤Which nursing intervention is most important for this client?

✓ 1. Ensure around the clock monitoring with a hospital staff member.

Around the clock monitoring helps to ensure clients at risk for self-harm do not injure themselves again. This nursing intervention builds the relationship between the client and healthcare professionals who provide care.

2. Perform neurological assessments at least every four hours.

While this is an appropriate nursing intervention, it is not the highest priority action by the nurse.

3. Place soft wrist restraints on the client for protection.

The utilization of restraints should be a last resort and documented as necessary to keep the client safe; therefore, this is not the most important nursing intervention for this client based on the current data.

4. Make sure that the client's door remains open at all times.

This is an appropriate nursing intervention; however, not the most important based on the current data.

The primary nursing concern is that of client safety. The best nursing action is to provide one-to-one contact with the client to ensure there is constant supervision. This nursing interventions is essential to decrease the likelihood that the client will engage in self-harm. The presence of the nurse will also convey to the client a sense of acceptance, concern, and caring thus further building a trusting relationship to encourage the sharing of feelings.

200. Mental Health Question #64

Which client does the nurse identify is having the highest risk for a suicidal attempt?

1. A recently divorced female client who has received a new diagnosis of rheumatoid arthritis.

This client has a couple risk factors but her case does not present as the highest at risk. Rheumatoid arthritis can be a managed disease, and this disease is not considered terminal.

✓ 2. A male client with metastatic cancer who recently lost his spouse and home in a house fire.

This client presents with the highest number of risk factors. Sudden loss, socioeconomic extremes, and terminal illness are factors that increase the risk for suicide.

3. A newly married female client with chronic bronchitis whose daughter is a recovering drug addict.

This client has a couple of risk factors but her case does not present as the highest at risk. Chronic bronchitis is a manageable disease, and it is not a terminal diagnosis.

4. A married male client who recently retired from his government job but actively works in church programs.

This client presents as the most stable with the lowest risk factors for attempting suicide.

The nurse should evaluate clients with a suicide risk assessment tool if there are risk factors associated with self-harm. A verified screening tool accounts for the client's demographics, mental and physical health history, support systems, coping strategies, and family history. A suicide risk assessment also evaluates previous attempts and behavioral patterns. Information obtained from a suicide risk assessment tool can be used to determine the client's baseline data for comparison in the future, if warranted.

👉 *Video Rationale: https://d1pumg6d5kr18o.cloudfront.net/rationales-v2/section_1_mental_health_concepts_64/part.m3u8*

201. Mental Health Question #64 - V2

The nurse is providing care for a group of clients.

➤Which client does the nurse identify as having the highest risk of suicide?

1. A recently divorced female client who has received a new diagnosis of rheumatoid arthritis.

This client has a couple risk factors but her case does not present as the highest at risk. Rheumatoid arthritis can be a managed disease, and this disease is not considered terminal.

✓ 2. A male client with metastatic cancer who recently lost his spouse and home in a house fire.

This client presents with the highest number of risk factors. Sudden loss, socioeconomic extremes, and terminal illness are factors that increase the risk for suicide.

3. A newly married female client with chronic bronchitis whose daughter is a recovering drug addict.

This client has a couple of risk factors but her case does not present as the highest at risk. Chronic bronchitis is a manageable disease, and it is not a terminal diagnosis.

4. A married male client who recently retired from his government job but actively works in church programs.

This client presents as the most stable with the lowest risk factors for attempting suicide.

The nurse should evaluate clients with a suicide risk assessment tool if there are risk factors associated with self-harm. A verified screening tool accounts for the client's demographics, mental and physical health history, support systems, coping strategies, and family history. A suicide risk assessment also evaluates previous attempts and behavioral patterns. Information obtained from a suicide risk assessment tool can be used to determine the client's baseline data for comparison in the future, if warranted.

202. Mental Health Question #65 - V2

The nurse is caring for a client who is newly diagnosed with an acute stress disorder following the unexpected death of a parent.

➤Which response by the nurse is most therapeutic?

✓ 1. "It is not uncommon to experience the symptoms you describe after a difficult event."

Validating the client's experiences provides a trusting relationship to further develop therapeutic communication; therefore, this response by the nurse is therapeutic.

2. "You should be getting at least 7 to 8 hours of sleep per night."

While providing information regarding sleep may be appropriate based on the client's diagnosis, this response does not address the underlying problem contributing to the client's sleep disturbances which is grief; therefore, this is not the most therapeutic response by the nurse.

3. "Your symptoms should begin to improve with time and medication."

Making a statement about future symptom relief does not address the here and now; therefore, this is not the most therapeutic response by the nurse based on the current data.

4. "I lost my mother at a young age but I learned strategies to help cope with my emotions."

The client should be encouraged to discuss their traumatic event. Stating a personal history of a traumatic event does not provide an appropriate setting for therapeutic dialogue; therefore, this response by the nurse is not therapeutic.

The nurse providing care for a client who is diagnosed with acute stress disorder should encourage the client to discuss the event. Discussing the event explores associated feelings the client is experiencing. The nurse should evaluate the client's feelings when assessing for possible risks of self-harm. Further evaluation can occur to determine the impact of ASD on the client's sleep, occupation, and relationships.

203. Mental Health Question #66 - V2

The nurse is caring for a child who died from injuries sustained in a motor vehicle accident.

Which statement, to the parents, is most appropriate?

1. "I know this is difficult but will your child be an organ donor?"

The bedside nurse is not tasked with having a conversation about organ donation with the family of a client who unexpectedly dies. Organ donation conversations must be implemented delicately and will typically be completed by those who specialize in this specific area of care; therefore, this statement by the nurse is not therapeutic.

2. "We are now going to clean and prepare your child to be viewed."

Parents should be provided the opportunity to participate in postmortem care; therefore, this is not an appropriate statement from the nurse to the child's parents.

3. "Do you have a general practitioner who can assist you with your feelings?"

Diverting therapeutic communication with a grieving parent to another healthcare professional is not appropriate.

✓ 4. "We are here for you. Take all the time and privacy that you need with your child."

This statement facilitates the parent-child bond that should occur immediately after the death; therefore, this statement by the nurse is therapeutic.

The nurse should provide emotional support for the family that is grieving the death of a child. The nurse should also facilitate the parent-child bond in the immediate moments following the child's death. The nurse who tells the child's family that he or she is there for them while also allowing them to say their final goodbyes without a time limit represents a therapeutic response. Additionally, the parents should be allowed to participate in postmortem care if they choose to do so as this can promote the psychosocial wellness of the family.

204. Mental Health Question #67 - V2

The nurse is caring for a pediatric client with multiple, irregularly shaped bruises and injuries on the back and buttocks who is upset and states, "somebody hurt me."

➤Which response by the nurse is most appropriate?

1. "We are going to place you in a new home where no one will ever hurt you again."

Making a promise that no one will ever hurt a child again is inappropriate as this a false promise. Additionally, telling the child that they are going to a new home may increase their level of fear; therefore, this response by the nurse is not appropriate based on the current data.

2. "What caused your parents to become so angry with you?"

This question may appear to bring blame upon the child that he or she did something to deserve the abuse. Shaming statements should be avoided by the nurse; therefore, this response is not appropriate.

✓ 3. "You are not in trouble and this is not your fault."

This statement promotes a safe environment for the child to disclose information without probing; therefore, this is an appropriate response by the nurse.

4. "If you tell me exactly who did this to you I will make sure to keep you safe."

This statement is leading and probing. The child should be allowed to disclose information at their own pace; therefore, this response by the nurse is not appropriate.

The nurse should speak directly and honestly to the child about is suspected to be the victim of abuse. The nurse should allow the child to disclose any information at a pace that is comfortable most comfortable for the individual. The nurse should not probe for information. The utilization of open-ended questions is best to avoid leading questions.

205. Mental Health Question #68 - V2

The nurse is caring for a hospitalized pre-adolescent client who is diagnosed with a significant intellectual disability.

➤Which activity is appropriate to include in the client's plan of care?

✓ 1. A coloring book and crayons.

A child with lower levels of mental acuity would benefit from simple activities such as color; therefore, this is an appropriate activity for the nurse to include in the adolescent client's plan of care.

2. A paint by number kit.

A paint by number activity may be too complex for a pre-adolescent client who is intellectually disabled as it could cause frustration; therefore, this is not an appropriate activity to include in the child's plan of care.

3. The child's favorite video game.

A video game may not be the most appropriate intervention as it does not allow the child to engage in active play; therefore, this is not an appropriate activity to include in the child's plan of care.

4. Keeping a diary of events.

Keeping a diary about the hospital stay is likely to be too challenging for a pre-adolescent client who is intellectually disabled; however, this could be appropriate for a child with a higher level of intellectual

development.

Activities for children with intellectual disabilities should be based on the child's developmental age. Consideration should be given to the child's size, coordination, physical fitness, maturity, likes, and health status. Appropriate activities may include simple puzzles, coloring books and crayons, modeling clay, and watching cartoons. Depending on the level of disability, the child may also be able to participate in simple card and board games.

206. Mental Health Question #69 - V2

The nurse is caring for a client who storms out of a family counseling session and commences to display aggressive behavior towards the staff standing in the hallway.

Which defense mechanism is the client exhibiting?

✓ 1. Displacement.

The client transferred the anger generated during the family counseling session onto the staff that were in the hallway; therefore, displacement is the defense mechanism displayed by this client.

2. Introjection.

Introjection occurs when a client subconsciously takes on beliefs of another to prevent being rejected; therefore, this is not the defense mechanism displayed by the client based on the current data.

3. Sublimation.

Sublimation occurs when a client transforms and replaces unacceptable urges with acceptable urges; therefore, this is not the defense mechanism displayed by this client's current behavior.

4. Repression.

Repression is defined as the process of pushing threatening thoughts from the consciousness into the deep subconscious; therefore, this is not the defense mechanism being delayed by this client based on the current data.

Nurses should familiarize themselves with the various coping, or defense mechanisms that a client may exhibit when facing a challenging situation. The nurse should evaluate the client's support systems and available resources when this occurs to determine the best response based on the current situation. The nurse should also assess the client's ability to adapt to temporary role changes. Finally, the nurse can

evaluate the constructive use of defense mechanisms by the client to determine if the current plan of care is effective.

207. Mental Health Question #70 - V2

The nurse is caring for a client being treated for alcohol use disorder.

➤Which statement, made by the spouse of the client, should alert the nurse to codependent behaviors?

1. "I am excited about the things I've learned in the cooking class at the local health club."

This statement shows independent activity that is not dependent on the other person.

2. "I make several household decisions without asking my spouse's opinion."

This statement indicates that each member of the marriage has the freedom to make multiple decisions within the home environment without retaliation; therefore, does not alert the nurse to codependent behaviors.

✓ 3. "If I didn't worry and dwell on things, my spouse would not have to abuse alcohol."

The spouse is making excuses for the person's alcohol use disorder which is characteristic of codependency.

4. "My spouse overslept this morning when I got up early to take a morning run."

This statement does not blame self for the actions of the other individual; therefore, this statement does not alert the nurse to codependent behaviors.

Codependency can exist with a friend, spouse, or family member. When a client who seeks help for a mental health issue is involved in a codependent relationship, this individual can impede treatment progression of the client. A codependent individual will make excuses for the other's substance or alcohol use. The client will also put the other person's needs before their own, which is unhealthy.

208. Mental Health Question #71 - V2

The nurse is caring for a client diagnosed with antisocial personality disorder. The client lost a previously awarded meal pass when they checked out of the facility for the night without permission. The client states, "It's not my fault! I wouldn't have to leave if you would let me smoke here!"

➤Which response by the nurse is best?

1. "If you are going to be irresponsible then you should not get another pass."

This broad statement about irresponsible behavior does not explain acceptable behaviors; therefore, this is not a therapeutic response by the nurse.

2. "You told me that you had stopped smoking so it is not my fault that you lost your meal pass."

The nurse becoming defensive is not a therapeutic response.

3. "Blaming other people for your poor decisions is the type of behavior that will prevent you from getting better."

This is a non-therapeutic response as it is confrontational and assumes the reasoning behind the client's behavior.

✓ 4. "You must abide by the rules and go through the proper steps for leaving the facility."

Setting firm limits is an appropriate intervention for clients that have antisocial personality disorder; therefore, this response by the nurse is therapeutic.

Nursing interventions for clients with antisocial disorders include setting firm limits. Clients with antisocial personality disorder need to be aware of the rules and acceptable behavior. The nurse should ensure that the client takes responsibility for any behavior that is exhibited. These clients also need to know that there are consequences for not following the rules and regulations within the hospital environment.

209. Mental Health Question #72 - V2

The nurse is using therapeutic communication with a client.

➤Which statement(s) by the nurse demonstrates effective therapeutic communication? **Select all that apply.**

☑	**"Please give me some more information so that I am sure I understand."**
	Asking for clarification is an effective therapeutic communication technique used by the nurse when engaging in verbal communication with a client.
☐	"I felt the same way when my mother passed away at a young age from cancer."

	A nurse who makes a statement about personal experiences does not demonstrate effective therapeutic communication with a client.
☑	**"Tell me more about the relationship between you and your child."**
	Exploring is a therapeutic communication technique that encourages the client to discuss relevant situations and feelings.
☐	"Why did it make you so mad that your friend avoided you?"
	Why statements or questions can be negatively viewed by the client and should be avoided; therefore, this question does not demonstrate effective therapeutic communication.
☑	**"Let's talk about how it made you feel when your spouse passed away."**
	This statement provides the client an open-ended opportunity to discuss feelings about previous events and feelings; therefore, this is an example of an effective therapeutic communication technique being implemented by the nurse.

Therapeutic communication allows the nurse to develop a healthy interpersonal relationship with a client. Therapeutic communication techniques are essential to facilitating the nurse-client relationship and should be implemented in the provision of client care. Examples of therapeutic communication techniques that can be implemented by the nurse include asking the client to provide an example to further explain their viewpoint and voicing doubt which is essential to dispel misconceptions or delusions without directly confronting the client's beliefs. Some communication techniques, however, are considered non-therapeutic and should be avoiding, including questions containing "why" as these can be interpreted negatively by the client.

210. Mental Health Question #73 - V2

The nurse is caring for an obese client.

➤Which client statement indicates readiness and motivation for lifestyle changes after several failed attempts at weight reduction?

1. "I know that losing this extra weight will make my life better in so many ways."

This statement indicates knowledge to change behaviors; however, it does not include an action plan for making it happen.

✓ 2. "I am walking with friends after work each evening instead of looking at social media."

This statement indicates that the client has already started a different behavior instead of the previous poor behavior; therefore, is most indicative of readiness and motivation for a lifestyle change, such as weight reduction.

3. "My goal is to be able to fit into a new bikini that I bought for my honeymoon."

This statement indicates a goal but no action to assist in obtaining the goal; therefore, is not the most indicative of readiness and motivation for a lifestyle change.

4. "I am so thankful that my spouse loves me just the way that I am."

The statement exhibit precontemplation in that the client does not believe there is an issue that requires a lifestyle change.

Successful behavior modification requires client readiness and motivation to change. This is evidenced by the client developing and acting on a plan. Clients often do not initially see the need for change. But with the appropriate support they will begin preparing and then actively changing.

211. Mental Health Question #74

A client who is diagnosed with alcohol use disorder states, “I wouldn’t be drinking like this if my son wasn’t a drug addict.” Which is an accurate interpretation of the client’s statement by the nurse?

1. Compensation and identification.

Compensation and identification is when an individual overachieves in one area to compensate for failures in another. Based on the current data, this is not an accurate interpretation of the client’s statement by the nurse.

✓ 2. Denial and projection.

Denial is the refusal to accept reality, while projection is the process of misinterpreting what is inside as coming from outside. Based on the current data, this is an accurate interpretation of the client’s statement by the nurse.

3. Introjection and blame.

Introjection is defined as taking on the qualities or attitudes of others without thought while blame is defined as assigning responsibility for a fault or wrong. Based on the current data, this is not an accurate

interpretation of the client's statement by the nurse.

4. Repression of emotions.

Repression is keeping unacceptable thoughts or traumatic events buried in the unconscious. Based on the current data, this is not an accurate interpretation of the client's statement by the nurse.

Defense mechanisms are strategies used by clients to distance themselves from full awareness of unpleasant thoughts or stresses. The nurse should become aware of multiple types of defense mechanisms to be able to respond appropriately when they are implemented by clients, especially in a mental health care setting. The most frequent defense mechanism is denial. This is the refusal to accept the reality of threatening situations or painful thoughts, feelings, or events.

👉 *Video Rationale: https://d1pumg6d5kr18o.cloudfront.net/rationales-v2/section_1_mental_health_concepts_74/part.m3u8*

212. Mental Health Question #74 - V2

The nurse is caring for a client diagnosed with alcohol use disorder states, "I wouldn't be drinking like this if my son wasn't a drug addict."

➤The nurse accurately interprets this statement as which of the following?

1. Compensation and identification.

Compensation and identification is when an individual overachieves in one area to compensate for failures in another. Based on the current data, this is not an accurate interpretation of the client's statement by the nurse.

✓ 2. Denial and projection.

Denial is the refusal to accept reality, while projection is the process of misinterpreting what is inside as coming from outside. Based on the current data, this is an accurate interpretation of the client's statement by the nurse.

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213. Mental Health Question #75 - V2

The nurse is assessing a client who presents with facial bruising and a possible wrist fracture. During the assessment, the client's spouse becomes visibly upset and aggressive.

➤Which is the most important action by the nurse?

✓ 1. Ask the spouse to leave and complete the client assessment in private.

Assessing the client without the spouse present can provide the client the ability to provide truthful responses; therefore, this is the most important action by the nurse based on the current data.

2. Assist the client to shower and change clothing for comfort.

While this may be an appropriate action by the nurse once the assessment process is complete, this is not the most important action by the nurse based on the current data. Safety is essential.

3. Consult a social worker to assist the client with placement in safe housing.

Contacting a social worker is an appropriate intervention; however, this is not the priority nursing action at this time as a thorough assessment of the client must be completed prior to developing and implementing a plan of care.

4. Wrap the client's wrist and prepare for transportation to the radiology department.

Wrapping the wrist and preparing for x-ray is an appropriate intervention by the nurse; however, the priority is to complete a thorough assessment prior to the development and initiation of the plan of care.

The nursing priority for a possible case of domestic violence is to remove the victim of the violence from the source of immediate danger, including the suspected abuser thus ensuring safety. These individuals should

be assessed away from the perpetrator of abuse so that the suspected abusers do not guide the client's answers. Questioning the client alone can also prevent the client from being intimidated and allow truthful responses.

214. Mental Health – Mental Health – Management of Care – Q2

The nurse provides ongoing care for a client with a nursing diagnosis of posttrauma syndrome. Which intervention should be included in the nursing plan of care to address social isolation that often occurs with a medical diagnosis of posttraumatic stress syndrome (PTSD)?

1. Refer the client to vocational services.

Problems with employment commonly occur with clients who are diagnosed with PTSD; therefore, the nurse should refer the client to vocational services. While this is an appropriate nursing intervention for the nursing diagnosis, it does not directly address social isolation.

✓ 2. Encourage the client to identify positive relationships.

Social isolation often occurs as a result of trauma; therefore, the nurse should assist the client to identify positive relationships as part of the nursing plan of care.

3. Teach the client and family about posttraumatic behavior.

Education is an appropriate intervention to include in the plan of care for a nursing diagnosis of posttrauma syndrome. While this intervention is essential to understanding behaviors and treatment for a diagnosis of PTSD, it does not directly address social isolation.

4. Help the client to practice stress management techniques.

Stress management techniques are essential for a client with a nursing diagnosis of posttrauma syndrome. This intervention, however, does not directly address social isolation.

An appropriate nursing diagnosis for a client who is diagnosed with PTSD is **posttrauma syndrome**, an ongoing, maladaptive pattern of behavior in response to a traumatic event that posed a threat to the well-being of the individual. **Social isolation** and lack of interest in recreational activities are common following trauma. The nurse must include interventions to address these symptoms of posttrauma syndrome in the

plan of care; therefore, **encouraging the client to identify positive relationships** is an intervention the nurse includes in the ongoing plan of care for this client.

👉 *Video Rationale: https://d1pumg6d5kr18o.cloudfront.net/rationales-v2/mental_health_management_of_care_2/part.m3u8*

215. Mental Health – Mental Health – Physiological Adaptation – Q2

The nurse provides care for a client who is diagnosed with anorexia nervosa and at risk for electrolyte imbalances. Which client data indicates severe hypokalemia?

1. Cough

Symptoms of severe hypophosphatemia include arrhythmias, confusion, congestive heart failure (CHF), and seizure activity. A cough is a symptom of CHF; therefore, this finding is not indicative of severe hypokalemia.

2. Confusion

Symptoms of severe hypophosphatemia include arrhythmias, confusion, congestive heart failure (CHF), and seizure activity; therefore, this client finding is indicative of severe hypophosphatemia, not hypokalemia.

3. Seizure activity

Seizure activity is a symptom associated with both severe hypomagnesemia and hypophosphatemia, not hypokalemia.

✓ 4. Respiratory depression

Severe hypokalemia can cause respiratory depression due the impact that low level of serum potassium can have on the muscles necessary for breathing.

Symptoms associated with refeeding syndrome are due to alterations in serum magnesium, phosphate, and potassium levels that occur due to metabolic alterations that occur with the initiation of enteral feedings. The nurse must monitor the client for symptoms of these electrolyte alterations in the provision of client care as all can produce potentially life-threatening symptoms. **Symptoms of severe hypokalemia** include the following: arrhythmias that can lead to cardiac arrest; ileus; paralysis; and **respiratory depression**.

👉 *Video Rationale: https://d1pumg6d5kr18o.cloudfront.net/rationales-v2/mental_health_physiological_adaptation_2/part.m3u8*

216. Mental Health – Mental Health – Health Promotion and Maintenance – Q2

The nurse reviews the medical history for an older adult client who is admitted for the treatment of cocaine use. Which finding noted by the nurse is a risk factor for late-onset substance use disorder? **Select all that apply.**

☐	A history of angioplasty.
	A history of angioplasty is not a risk factor for late-onset substance use disorder. Chronic illnesses that cause pain is a risk factor for this mental health diagnosis.
☑	**The recent loss of spouse.**
	Grief and loss is a risk factor for late-onset substance use disorder; therefore, the recent loss of the client's spouse is considered a risk factor for cocaine use for older adult individuals.
☑	**A diagnosis of depression.**
	Depression is a risk factor for late-onset substance use disorder. This diagnosis often causes clients to self-medicate with illegal substances, including cocaine.
☑	**The use of prescription alprazolam.**
	Long-term use of certain prescription medications, including the anxiolytic alprazolam, is a risk factor for late-onset substance use disorder.
☐	A history of cardiovascular disease.
	A history of cardiovascular disease is not a risk factor for late-onset substance use disorder. Chronic illnesses that cause pain (e.g., osteoarthritis) is a risk factor for this mental health diagnosis.

A substance use disorder is diagnosed when the recurrent use of alcohol and/or substances causes the client to experience significant clinical impairment. Examples of impairment include the following: disability; failure to meet responsibilities at home, school, or work; and health problems. Older adult clients have

specific risk factors for the development of late-onset substance use disorder, including the following: an abundance of discretionary time and money; chronic illness that causes pain; **depression**; loss and grief (e.g., **a recent loss of spouse**); life stress; long-term use of **prescription medication** (e.g., anxiolytics [e.g., **alprazolam**], sedatives–hypnotics; loss; life stress, and social isolation. Older adult clients may experience physical problems associated with substance use disorder rather quickly, especially if their overall physical health is compromised by other illnesses.

👉 *Video Rationale: https://d1pumg6d5kr18o.cloudfront.net/rationales-v2/mental_health_health_promotion_and_maintenance_2/part.m3u8*

217. Mental Health – Mental Health – Safety and Infection Control – Q1

The nurse provides care for a client who is prescribed restraints due to physical aggression towards self and others. Which is a requirement for the use of physical restraints in the clinical setting? **Select all that apply.**

☑	**A documented nursing assessment every 15 minutes.**
	The nurse should assess the client and document findings every 15 minutes for a client who is prescribed physical restraint. The nurse must assess and document the following: the client's skin condition; blood circulation in hands and feet; emotional well-being; and readiness to discontinue physical restraint.
☐	The observation of side effects to prescribed medications.
	When chemical, not physical restraint is implemented, the nurse monitors for side effects associated with the medication that is administered. Often, large doses of medication are administered when chemical restraint is required which increases the likelihood of side effects.
☐	One-to-one client monitoring by video for the duration of the prescription.
	Continuous, one-on-one monitoring is required for the duration of physical restraint; however, seclusion requires one hour of one-on-one monitoring that is continued for the duration of seclusion with the use of audio and/or video equipment.
☑	**A face-to-face evaluation by a practitioner within one hour of implementation.**
	A face-to-face evaluation by a licensed independent practitioner is required within one hour for a client who requires physical restraint. Additionally, ongoing evaluation is required every 8 hours.

☑	**Client instruction on behavioral criteria to reduce or discontinue the prescription**
	The client must be provided with behavioral requirements for the decrease or discontinuation of physical restraints as part of the provision of care.

Physical restraint is a last resort to **enhance safety** in the provision of client care. Other less invasive interventions must be implemented prior to the use of physical restraint. There are certain **requirements** for the implementation and use of physical restraints in the clinical environment that the nurse must adhere to in the provision of client care. These requirements include, but are not limited to, the following: **nursing documentation every 15 minutes; a face-to-face evaluation by a practitioner within one hour of implementation and every 8 hours thereafter; and client instruction on behavioral criteria required to reduce or discontinue** the prescription for physical restraint.

👉 *Video Rationale: https://d1pumg6d5kr18o.cloudfront.net/rationales-v2/mental_health_safety_and_infection_control_1/part.m3u8*

218. NGN Case Study #121 Question #1 Recognize Cues (Highlight) - V2

➤Click to highlight the findings that require priority follow-up by the nurse.

CASE: NGN Case Study #121 - Pulmonary embolism - V2

Orders:

1605:
Stat chest x-ray
D-dimer
CBC
CMP
ECG
O2 to keep SpO2 95% or greater

1720:
CT angiogram of chest

1750:
Heparin drip per protocol
Concurrent warfarin therapy 5 mg PO daily

Heparin Protocol

- Discontinue all IM injections.
- Discontinue all prophylactic anticoagulation.
- Discontinue aspirin >162 mg.
- Order baseline PT/INR, aPTT, and CBC

Do not give loading dose if:

- Client is hypothermic
- Client is post-operative or s/p trauma
- Client is transitioning from therapeutic enoxaparin.
- Dosing should be based on the client's current and actual body weight.
- Do not withhold heparin while awaiting baseline labs.

Loading Dose and Initial Infusion Rates			
Indication	**Loading Dose****	**Initial Infusion Rate**	**Maximum Doses**
Deep Vein Thrombosis Pulmonary embolism Arterial embolism	80 units/kg IV	18 units/kg/hr	Max loading dose: 10,000 units Max initial rate: 2,250 units/hr
Acute coronary syndrome (ACS) Atrial fibrillation Arterial dissection	60 units/kg IV	12 units/kg/hr	Max loading dose: 5,000 units Max initial rate: 1,000 units/hr
After thrombolytic: Acute coronary syndrome (ACS) Atrial fibrillation	60 units/kg IV	12 units/kg/hr	Max loading dose: 5,000 units Max initial rate: 1,000 units/hr
After thrombolytic: Cerebrovascular accident (CVA, TIA)	NONE	12 units/kg/hr	Max initial rate: 1,000 units/hr
****All loading doses to be rounded to nearest 1,000 units.**			

Nurse's Notes:

1550:
Post-op day 2 partial left mastectomy. Drowsy but answers questions and follows commands appropriately. Heart tones are audible, regular, and rapid. Respirations shallow and mildly labored; lungs clear to auscultation. Surgical site dressing dry and intact. Abdomen soft and nontender, with hypoactive bowel sounds in all 4 quadrants. Skin pale and slightly diaphoretic. Client reports pain 5/10; indicates generalized discomfort to surgical site with occasional burning sensation in chest when breathing. Health care provider notified.

Flowsheet:

1550:
Temperature: 99.2ºF (39ºC)
Pulse 108 beats/min
Respirations: 23 breaths/min

Blood pressure: 124/76 mm Hg
SpO2: 91% on RA

Laboratory Results:

Complete Blood Count (CBC):

Component	Client value - 1630	Normal range
White blood cell count	9,900	5,000-10,000
Red blood cell count	4.3 million/mcL	(M) 4.7-6.1 million/mcL (F) 4.2-5.4 million/mcL
Hemoglobin	12 g/dL	(M) 14-18 g/dL (F) 12-16 g/dL
Hematocrit	37 %	(M) 42-52% (F) 37-47%
Platelet count	160K	150k-400k

Complete Metabolic Panel (CMP):

Component	Client value - 1630	Normal range
Sodium	138 mEq/L	135-145 mEq/L
Potassium	4.2 mEq/L	3.5-5.0 mEq/L
Chloride	105 mEq/L	97-107 mEq/L
CO2	27 mEq/L	23-29 mEq/L
BUN	15 mg/dL	10-20 mg/dL
Creatinine	1.0 mg/dL	under 1.3 mg/dL
Glucose	88 mg/dL	70-110 mg/dL
Calcium	9.2 mg/dL	9.0-10.5 mg/dL
Albumin	4.8 g/dL	3.5-5.0 g/dL
Protein, Total	7.9 g/dL	6.0-8.3 g/dL
Alkaline Phosphatase	108 IU/L	44-147 IU/L
AST	27 U/L	8-33 U/L
Bilirubin, Total	0.9 mg/dL	<1.2 mg/dL

1630 - D-Dimer:
692 ng/dL (normal 68-494 ng/dL

Imaging Studies:

CXR: Negative study
Electrocardiogram: Sinus tachycardia; otherwise normal

1550: Post-op partial left mastectomy. Drowsy but answers questions and follows commands appropriately. Heart tones audible, regular, and rapid. Respirations shallow and mildly labored; lungs clear to auscultation. Surgical site dressing dry and intact. Abdomen soft and nontender, with **hypoactive bowel sounds in all 4 quadrants.** Skin pale and slightly diaphoretic. Client reports pain 5/10; indicates generalized discomfort to surgical site with occasional burning sensation in chest. Temperature: 99.2ºF (39ºC); Pulse 108 beats/min; Respirations: 23 breaths/min; Blood pressure: 124/76 mm Hg; SpO2: 91% on RA. Health care provider notified.

Rationale:

Findings that require follow-up by the nurse include a **rapid heart rate of 108 beats/min**, **respirations that are shallow and mildly labored at 23 breaths/min, SpO2 of 91% on room air, diaphoresis, and burning sensation in the client's chest.** These findings need further evaluation and should be reported to the client's health care provider (HCP). A **temperature of 99.2ºF (39ºC**) is a low-grade temperature and possibly attributed to an inflammatory response after surgery, but could also indicate a potential complication, so this value should also be reported to the HCP.

Hypoactive bowel sounds x 4 quadrants is a normal finding postoperatively. These findings do not require priority follow-up by the nurse.

A **pulmonary embolism** is a clot that has **blocked an artery in the lung**. It is a very serious, potentially **fatal** condition that requires **swift medical treatment.** Often the clot originates as a **deep vein thrombosis (DVT) in the leg.** Clinical manifestations include an elevated **D-Dimer** blood test with **chest discomfort or pain**, **breathing difficulty** (shortness of breath), **decreased oxygen saturation**, **diaphoresis**, **tachycardia**, dizziness, and a dry cough. The primary treatment is **anticoagulant therapy** with heparin and warfarin. **Heparin** is blood thinner used to prevent further clots. Occasionally, the treatment may include thrombolytic therapy, surgery, or other procedures to promote perfusion of the lungs and heart.

Video Rationale: https://d1pumg6d5kr18o.cloudfront.net/nclex-rn-cs-rationales/case_study_121_q_1/part.m3u8

219. NGN Case Study #121 Question #2 - Analyze Cues (Matrix Multiple Response) - V2

The nurse recognizes that the client may be experiencing a postoperative complication.

➤For each client finding, click to specify if it indicates pulmonary embolism or postoperative pneumonia. Each finding may support more than one complication.

CASE: NGN Case Study #121 - Pulmonary embolism - V2

Orders:

1605:
Stat chest x-ray
D-dimer
CBC
CMP
ECG
O2 to keep SpO2 95% or greater

1720:
CT angiogram of chest

1750:
Heparin drip per protocol
Concurrent warfarin therapy 5 mg PO daily

Heparin Protocol

- Discontinue all IM injections.
- Discontinue all prophylactic anticoagulation.
- Discontinue aspirin >162 mg.
- Order baseline PT/INR, aPTT, and CBC

Do not give loading dose if:

- Client is hypothermic
- Client is post-operative or s/p trauma
- Client is transitioning from therapeutic enoxaparin.
- Dosing should be based on the client's current and actual body weight.
- Do not withhold heparin while awaiting baseline labs.

Loading Dose and Initial Infusion Rates			
Indication	**Loading Dose****	**Initial Infusion Rate**	**Maximum Doses**
Deep Vein Thrombosis Pulmonary embolism Arterial embolism	80 units/kg IV	18 units/kg/hr	Max loading dose: 10,000 units Max initial rate: 2,250 units/hr
Acute coronary syndrome (ACS) Atrial fibrillation Arterial dissection	60 units/kg IV	12 units/kg/hr	Max loading dose: 5,000 units Max initial rate: 1,000 units/hr

After thrombolytic: Acute coronary syndrome (ACS) Atrial fibrillation	60 units/kg IV	12 units/kg/hr	Max loading dose: 5,000 units Max initial rate: 1,000 units/hr
After thrombolytic: Cerebrovascular accident (CVA, TIA)	NONE	12 units/kg/hr	Max initial rate: 1,000 units/hr
****All loading doses to be rounded to nearest 1,000 units.**			

Nurse's Notes:

1550:
Post-op day 2 partial left mastectomy. Drowsy but answers questions and follows commands appropriately. Heart tones are audible, regular, and rapid. Respirations shallow and mildly labored; lungs clear to auscultation. Surgical site dressing dry and intact. Abdomen soft and nontender, with hypoactive bowel sounds in all 4 quadrants. Skin pale and slightly diaphoretic. Client reports pain 5/10; indicates generalized discomfort to surgical site with occasional burning sensation in chest when breathing. Health care provider notified.

Flowsheet:

1550:
Temperature: 99.2ºF (39ºC)
Pulse 108 beats/min
Respirations: 23 breaths/min
Blood pressure: 124/76 mm Hg
SpO2: 91% on RA

Laboratory Results:

Complete Blood Count (CBC):

Component	Client value - 1630	Normal range
White blood cell count	9,900	5,000-10,000
Red blood cell count	4.3 million/mcL	(M) 4.7-6.1 million/mcL (F) 4.2-5.4 million/mcL
Hemoglobin	12 g/dL	(M) 14-18 g/dL (F) 12-16 g/dL
Hematocrit	37 %	(M) 42-52% (F) 37-47%
Platelet count	160K	150k-400k

Complete Metabolic Panel (CMP):

Component	Client value - 1630	Normal range
Sodium	138 mEq/L	135-145 mEq/L
Potassium	4.2 mEq/L	3.5-5.0 mEq/L
Chloride	105 mEq/L	97-107 mEq/L
CO2	27 mEq/L	23-29 mEq/L
BUN	15 mg/dL	10-20 mg/dL
Creatinine	1.0 mg/dL	under 1.3 mg/dL
Glucose	88 mg/dL	70-110 mg/dL
Calcium	9.2 mg/dL	9.0-10.5 mg/dL
Albumin	4.8 g/dL	3.5-5.0 g/dL
Protein, Total	7.9 g/dL	6.0-8.3 g/dL
Alkaline Phosphatase	108 IU/L	44-147 IU/L
AST	27 U/L	8-33 U/L
Bilirubin, Total	0.9 mg/dL	<1.2 mg/dL

1630 - D-Dimer:
692 ng/dL (normal 68-494 ng/dL

Imaging Studies:

CXR: Negative study
Electrocardiogram: Sinus tachycardia; otherwise normal

Client Finding	Pulmonary Embolism	Postoperative Pneumonia
Tachycardia	✓	✓
Tachypnea with mildly labored respirations	✓	✓
Burning sensation when breathing	✓	✓
SpO2 of 91% on RA	✓	✓
Diaphoresis	✓	✓
Elevated D-Dimer	✓	

Pulmonary Embolism:

Clinical manifestations of a pulmonary embolism (PE) include chest discomfort or pain (burning sensation when breathing), breathing difficulty (shortness of breath and labored respirations), decreased oxygen saturation, diaphoresis, tachycardia, dizziness, and a dry cough. The client is exhibiting **tachycardia, tachypnea with mildly labored respirations, burning sensation when breathing, diaphoresis, and SpO2 of 91% on room air.** These symptoms indicate a possible embolism. An **elevated D-Dimer blood test** with a clear chest x-ray is most associated with a PE and will help the health care provider (HCP) determine the diagnosis.

Postoperative Pneumonia:

Clinical manifestations of postoperative pneumonia include chest discomfort or pain, breathing difficulty (shortness of breath), decreased oxygen saturation, diaphoresis, tachycardia, dizziness, and a cough. The client is exhibiting **tachycardia, tachypnea with mildly labored respirations, burning sensation when breathing, diaphoresis, and SpO2 of 91% on room air.** These symptoms indicate possible postoperative pneumonia. A client with pneumonia will have a normal D-Dimer blood test and a chest x-ray with areas of consolidation. These findings will help the health care provider determine the correct diagnosis.

> A **pulmonary embolism** is a clot that has **blocked an artery in the lung**. It is a very serious, potentially **fatal** condition that requires **swift medical treatment.** Often the clot originates as a **deep vein thrombosis (DVT) in the leg.** Clinical manifestations include an elevated **D-Dimer** blood test with **chest discomfort or pain**, **breathing difficulty** (shortness of breath), **decreased oxygen saturation**, **diaphoresis**, **tachycardia**, dizziness, and a dry cough. The primary treatment is **anticoagulant therapy** with heparin and warfarin. **Heparin** is blood thinner used to prevent further clots. Occasionally, the treatment may include thrombolytic therapy, surgery, or other procedures to promote perfusion of the lungs and heart.

👉 *Video Rationale: https://d1pumg6d5kr18o.cloudfront.net/nclex-rn-cs-rationales/case_study_121_q_2/part.m3u8*

220. NGN Case Study #121 Question #3 - Prioritize Hypothesis (Drop Down Rationale) - V2

➤Complete the following sentences by choosing from the lists of options.

The nurse recognizes the client is at highest risk for {{1}} as evidenced by {{2}}.

CASE: NGN Case Study #121 - Pulmonary embolism - V2

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CMP
ECG
O2 to keep SpO2 95% or greater

1720:
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1750:
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Concurrent warfarin therapy 5 mg PO daily

Heparin Protocol

- Discontinue all IM injections.
- Discontinue all prophylactic anticoagulation.
- Discontinue aspirin >162 mg.
- Order baseline PT/INR, aPTT, and CBC

Do not give loading dose if:

- Client is hypothermic
- Client is post-operative or s/p trauma
- Client is transitioning from therapeutic enoxaparin.
- Dosing should be based on the client's current and actual body weight.
- Do not withhold heparin while awaiting baseline labs.

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****All loading doses to be rounded to nearest 1,000 units.**

Nurse's Notes:

1550:
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👉 *Video Rationale: https://d1pumg6d5kr18o.cloudfront.net/nclex-rn-cs-rationales/case_study_121_q_3/part.m3u8*

221. NGN Case Study #121 Question #5 Take Actions (SATA-Traditional) - V2

The client's D-dimer shows elevation and the health care provider orders a stat CT angiogram of the chest, which confirms pulmonary embolism. The health care provider orders a heparin drip per protocol. Which actions indicate the correct implementation of the heparin protocol?

Select all that apply.

CASE: NGN Case Study #121 - Pulmonary embolism - V2

Orders:

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Nurse's Notes: