NCLEX QUESTION TRAINER EXPLANATIONS

TEST 1

1. The nurse is caring for clients in the outpatient clinic. Which of the following messages should the nurse return FIRST?

   1. A mother reports that the umbilical cord of her five-day-old infant is dry and hard to the touch.
   2. A mother reports that the "soft spot" on the head of her four-day-old infant feels slightly elevated when the baby sleeps.
   3. A mother reports that the circumcision of her 3-day-old infant is covered with yellowish exudate.
   4. A father reports that he bumped the crib of his two-day-old infant and she violently extended her extremities and returned to them their previous position.

   Strategy: Determine the significance of each assessment and how it relates to a newborn.

   (1) expected outcome; falls off within 1-2 weeks; no tub baths until the cord falls off
   (2) correct–fontanelle should feel soft and flat; fullness or bulging indicates increased intracranial pressure
   (3) normal healing, don't remove exudate; clean with warm water
   (4) motor reflex is normal; disappears after 3-4 months

2. The parents of a child with hemophilia want to know the cause of the disease. Which of the following would be the BEST response by the nurse?

   1. "The father transmits the gene to his son."
   2. "Both the mother and the father carry a recessive trait."
   3. "The mother transmits the gene to her son."
   4. "There is a 50% chance that the mother will pass the trait to each of her daughters."

   Strategy: Think about each statement. Is it true?

   (1) affected male inherits gene from his mother and can transmit it only to his daughters
   (2) it is not an autosomal recessive trait
   (3) correct–hemophilia is a sex-linked disorder
   (4) there is a 50% chance that the mother will pass the trait to each of the children

3. A six-month-old is brought to the clinic for a well-baby check-up. During the exam, the nurse should expect to assess which of the following?

   1. A pincer grasp.
   2. Sitting with support.
   3. Tripling of the birth weight.
   4. Presence of the posterior fontanelle.

   Strategy: Think about each answer.

   (1) present at nine months of age
   (2) correct–six-month-old should sit with help
   (3) present at one year
   (4) fontanelle is closed by two to three months

4. A 48-year-old man with an endotracheal tube needs suctioning. Which of the following statements is an accurate description of how the nurse should perform the procedure?

   1. Insert the suction catheter four inches into the tube. Apply suction for 30 seconds, using a twirling motion as the catheter is withdrawn.
   2. Hyperoxygenate the client and then insert the suction catheter into the tube. Suction while you remove the catheter using a back and forth motion.
   3. Explain the procedure to the patient. Insert the catheter while gently applying suction, and withdraw using a twisting motion.
   4. Insert the suction catheter until resistance is met, then withdraw it slightly. Apply suction intermittently as the catheter is withdrawn.

   Strategy: All answers are implementation. Determine the outcome of each answer. Is it desired?

   (1) catheter is inserted until resistance met; never suction longer than 10-15 sec
   (2) use twirling motion when withdrawing catheter
   (3) suction is never applied when catheter is inserted
   (4) correct–insert suction catheter until resistance is met without applying suction, withdraw 0.4-0.8 in (1-2 cm), apply intermittent suction with twirling motion

5. A 47-year-old woman comes to the outpatient psychiatric clinic for treatment of a fear of heights. The nurse knows that phobias involve

   1. projection and displacement.
   2. sublimation and internalization.
   3. rationalization and intellectualization.
   4. reaction formation and symbolization.

   Strategy: Think about each answer.

   (1) correct–projection (attributing one's thoughts or impulses to another) and displacement (shifting of emotion concerning person or object to another neutral or less dangerous object or person)
   (2) sublimation (diversion of unacceptable drives into socially acceptable channels) and internalization (incorporation of someone else's opinion as one's own)
   (3) rationalization (attempt to make behavior appear to be result of logical thinking), intellectualization (excessive reasoning or logic used to avoid experiencing disturbing feelings)
   (4) reaction formation (development of conscious attitudes and behavior patterns into opposite of what one really wants to do), symbolization (something represents something else); symbolization is involved in phobias

6. The prenatal client at eight-weeks gestation has a positive VDRL. In preparing the teaching plan, which of the following would be MOST appropriate for the nurse to include?

   1. The importance of not taking any medications so as not to damage the fetus.
   2. Instructing the client on the importance of taking the penicillin for the prescribed time.
   3. Instructing the client to refrain from sexual activity.
   4. Maintaining the confidentiality of sexual partners or contacts.

   Strategy: Think "Maslow."

   (1) physical, true to some extent with regard to pregnant client not taking medication over-the-counter unless prescribed by a doctor, but not highest priority
   (2) correct–physical, vitally important to complete all the penicillin
   (3) physical, more important to be treated for disease
   (4) psychosocial, communicable diseases are reportable; partners or contacts need to be found and notified so they may be treated

7. An elderly client who has been recently immobilized is ordered to begin passive range-of-motion (ROM) exercises. What should the nurse understand about ROM before initiating this order?

   1. Passive range-of-motion exercises increase muscle strength.
   2. A full range of motion must be completed for the elderly client.
   3. Exercises should be completed to the point of discomfort.
   4. A sufficient range of motion assists the elderly to carry out activities of daily living (ADLs).

   Strategy: Think about each answer.

   (1) inaccurate statement
   (2) ROM may be limited
   (3) should not be done to point of discomfort
   (4) correct–full range of motion may not be needed or accomplished without discomfort for an elderly client; emphasis should be on ROMs that support ADLs

8. A 65-year-old man is scheduled for a colon resection this morning. Last night he had polyethylene glycolelectrolyte solution (GoLytely) and a soapsuds enema. This morning he passes a medium amount of soft, brown stool. The nurse should know that this

   1. indicates that the bowel preparation is incomplete.
   2. is evidence that the patient ate something after midnight.
   3. is an expected finding before this type of surgery.
   4. is the last stool that was left in the colon.

   Strategy: Think about each answer.

   (1) correct–colon should not have remaining soft stool
   (2) anything eaten after midnight would not appear as stool by the next morning
   (3) not expected; need to clean GI tract for surgery
   (4) assumption, not substantiated

9. The nurse cares for a newborn infant with fetal alcohol syndrome. The nurse would expect to see which of the following physical characteristics?

   1. An infant that is large for gestational age (LGA) with craniofacial abnormalities and hydrocephalus.
   2. An infant with a small head circumference, low birth weight, and undeveloped cheekbones.
   3. An infant with a small head circumference, low birth weight, and excessive rooting and sucking behaviors.
   4. An infant with a normal head circumference, low birth weight, and respiratory distress syndrome.

   Strategy: All answers are assessment. Determine how each assessment relates to fetal alcohol syndrome.

   (1) usually small for gestational age
   (2) correct–seen with fetal alcohol syndrome
   (3) may have feeding difficulties and poor sucking ability
   (4) head circumference usually small, respiratory distress related to preterm birth, neurologic damage, small trachea, floppy epiglottis

10. The physician orders hydromorphone hydrochloride (Dilaudid) 15 mg IM for a 56-year-old woman. Side effects of this medication that the nurse should observe the patient for include

    1. photosensitivity and constipation.
    2. hypotension and respiratory depression.
    3. tardive dyskinesia and diplopia.
    4. dry mouth and tinnitus.

    Strategy: Recall the classification of the drug.

    (1) these side effects are not seen with this medication
    (2) correct–narcotic analgesic used for moderate to severe pain, monitor vital signs frequently
    (3) these side effects are not seen with this medication
    (4) these side effects are not seen with this medication

11. The outpatient clinic nurse is caring for a 66-year-old woman with insulin-dependent diabetes mellitus (IDDM). Because the client is unwilling to perform blood glucose monitoring, she tests her urine for sugar and acetone. The nurse knows that blood glucose monitoring is preferred over urine testing for glucose because

    1. the renal threshold for glucose is elevated in the elderly.
    2. blood glucose monitoring is easier and less costly for clients to perform.
    3. urine testing for glucose provides false-positive readings.
    4. determination of the color on a reagent strip varies from person to person.

    Strategy: Think about each answer.

    (1) correct–the level at which glucose starts to appear in the urine increases, leading to false-negative readings, results in elevated glucose levels
    (2) more expensive procedure
    (3) provides false-negative readings, may be negative from 0-180 mg/dL
    (4) results are expressed as a percentage according to color change

12. At 32-weeks gestation, a client has an order for an ultrasound. The client indicates an understanding of this procedure if she makes which of the following statements to the nurse?

    1. "The results will inform us of the gestational age."
    2. "This test will evaluate the baby's lungs."
    3. "The test will show us if there is any problem in the spinal cord."
    4. "Early problems with the baby's blood can be identified with this test."

    Strategy: Think about each answer.

    (1) correct–ultrasound detects the gestational age
    (2) would be determined with lecithin/sphingomyelin (L/S) ratio via an amniocentesis
    (3) would be determined with an amniocentesis
    (4) would be determined with an amniocentesis

13. A child has pediculosis capitis (head lice) and is being treated with 1% gamma benzene hexachloride (Kwell) shampoo. The nurse should explain to the child's parents that

    1. treatment should be continued every other day for 1 week.
    2. clothing and personal belongings require normal cleansing with soap and water.
    3. application of the shampoo is repeated in 7 to 10 days.
    4. one treatment with Kwell kills both lice and nits.

    Strategy: Answers are implementation. Determine the outcome of each answer. Is it desired?

    (1) too frequent an application of the shampoo
    (2) very hot water and a special detergent (RID) need to be used for cleansing clothing and personal belongings
    (3) correct–Kwell is organic solvent, can be toxic, absorbed through scalp; may be repeated five to seven days after first application
    (4) must be repeated after the eggs hatch; permethrin 1% creme rinse (Nix) kills both lice and nits after one application

14. The nurse is supervising an LPN/LVN who is administering an enema to a patient. During the administration, it is MOST important for the LPN/LVN to take which of the following actions?

    1. Place the solution 20 inches above the anus.
    2. Adjust the temperature of the solution.
    3. Insert the tube six inches.
    4. Position the patient left side-lying (Sim's) with knee flexed.

    Strategy: Answers are all implementation. Determine the outcome of each answer. Is it desired?

    (1) could cause rapid infusion and possible painful distention of the colon
    (2) is not feasible during the administrative phase
    (3) tube should be inserted no more than four inches
    (4) correct–allows solution to flow downward along the natural curve of the sigmoid colon and rectum, which improves retention of solution

15. An 18-month-old is admitted to the unit with a diagnosis of laryngotracheobronchitis (LTB). During the initial assessment, the nurse should expect to find which of the following early symptoms?

    1. Kussmaul respirations and bradycardia.
    2. Elevated temperature and slow respiratory rate.
    3. Expiratory wheezing and substernal retractions.
    4. Inspiratory stridor and restlessness.

    Strategy: Determine how each answer relates to croup.

    (1) Kussmaul respirations are associated with diabetic ketoacidosis; hypoxia and anxiety are associated with tachycardia
    (2) respiratory rate would be increased
    (3) more often noted with respiratory distress of the newborn
    (4) correct–this condition is characterized by edema and inflammation of upper airways

16. A client has been receiving chlorpromazine hydrochloride (Thorazine). When the nurse checks on the patient, the patient is restless, unable to sit still, and complains of insomnia and fine tremors of her hands. The nurse knows that these symptoms are

    1. a side effect of the medication that she will tolerate better as time passes.
    2. the reason she is receiving this medication.
    3. extrapyramidal side effects resulting from this medication.
    4. an indication that the dosage of the medication needs to be increased.

    Strategy: Determine how each answer relates to Thorazine.

    (1) untrue statement; dosage may need to be decreased due to side effect of medication; antiparkinsonian drug such as Cogentin may be ordered
    (2) not accurate, antipsychotic medication
    (3) correct–side effects include akathisia (motor restlessness), dystonias (protrusion of tongue, abnormal posturing), pseudoparkinsonism (tremors, rigidity), dyskinesia (stiff neck, difficulty swallowing)
    (4) dosage may be decreased and antiparkinsonian drug such as Cogentin may be ordered

17. The nurse is caring for a client with a tracheostomy. An appropriate nursing diagnosis for this client is

    1. impaired verbal communication related to absence of speaking ability.
    2. ineffective airway clearance related to increased tracheobronchial secretions.
    3. risk for impaired skin integrity related to tracheostomy incision.
    4. alteration in comfort: pain related to tracheostomy.

    Strategy: Think about each answer.

    (1) diagnosis is acceptable; however, 2 is a priority
    (2) correct–ineffective airway clearance is the top priority for clients with a tracheostomy since loss of the upper airway increases the amount and viscosity of secretions
    (3) diagnosis is acceptable; however, 2 is a priority
    (4) tracheostomy is not usually painful

18. Which of the following types of foods should the nurse encourage in the diet of a client with hypoparathyroidism?

    1. High in phosphorus.
    2. High in calcium.
    3. Low in sodium.
    4. Low in potassium.

    Strategy: Think about each answer.

    (1) diet should be low in phosphorus
    (2) correct–diet for the client should provide high calcium and low phosphorus because the parathyroid controls calcium balance
    (3) not regulated by the parathyroid
    (4) not regulated by the parathyroid

19. A 20-year-old woman arrives at the hospital in active labor. The admitting nurse attaches an internal fetal monitor. The nurse knows the MOST important reason for the fetal monitor is

    1. to evaluate the progress of the client's labor.
    2. to assess the strength and duration of the client's contractions.
    3. to monitor the oxygen status of the fetus during labor.
    4. to decide if an oxytocin drip is necessary.

    Strategy: Think about each answer.

    (1) clinical assessments provide information about progress of labor (dilation and effacement)
    (2) not most important reason for monitoring
    (3) correct–goal is early detection of mild fetal hypoxia
    (4) fetal well-being is most important reason for fetal monitoring

20. A mentally retarded client is to be discharged home on warfarin sodium (Coumadin), 5 mg each day. To maintain client safety, which of the following would be an appropriate FIRST nursing action?

    1. Instruct a significant other about the medication regimen.
    2. Evaluate client comprehension of the medication administration.
    3. Prepackage the medication to encourage correct administration.
    4. Encourage a return demonstration of medication self-administration.

    Strategy: Answers are a mix of assessment and implementation. Does this situation require assessment? Yes.

    (1) implementation; might be done after assessment of the comprehension level
    (2) correct–assessment; mentally retarded client should be carefully evaluated to ensure complete comprehension of the dosage regimen to prevent overdosage and underdosage
    (3) implementation; might be done after assessment of the comprehension level
    (4) implementation; might be done after evaluation of the comprehension level

21. A client, gravida 2 para 1, is admitted with hypertension and complains that her wedding band is tight. The nurse should expect to assess which of the following with early pre-eclampsia?

    1. Blurred vision and proteinuria.
    2. Epigastric pain and headache.
    3. Facial swelling and proteinuria.
    4. Polyuria and hypertonic reflexes.

    Strategy: Determine how each answer relates to pre-eclampsia.

    (1) only partially correct; blurred vision appears later, with eclampsia
    (2) contains signs of eclampsia before a seizure
    (3) correct–represents the complete triad seen with pre-eclampsia
    (4) oliguria is seen later with eclampsia

22. The nurse is caring for clients in a drug rehabilitation facility. Which of the following complications of IV drug abuse is the nurse MOST likely to observe?

    1. Jaundice.
    2. Rash.
    3. Bruising.
    4. Cellulitis.

    Strategy: Determine how each answer relates to IV drug abuse.

    (1) jaundice can develop due to hepatitis B and cirrhosis, which may occur in narcotic abusers who use intravenous drugs
    (2) may occur due to the chemicals that are used in cutting the drugs by the client or the drug dealer
    (3) may occur due to the chemicals that are used in cutting the drugs by the client or drug dealer
    (4) correct–most narcotic addicts do not inject sterile purified material with aseptic techniques; cellulitis is a common complication due to skin popping or using an infected drug apparatus

23. The client is admitted with cerebrovascular accident (CVA) and has facial paralysis. Nursing care should be planned to prevent which of the following complications?

    1. Inability to talk.
    2. Inability to swallow caused by loss of the gag reflex.
    3. Inability to open the affected eye.
    4. Corneal abrasion.

    Strategy: Think about each answer.

    (1) may occur, but nursing care cannot prevent it
    (2) may occur, but nursing care cannot prevent it
    (3) may occur, but nursing care cannot prevent it
    (4) correct–client will be unable to close eye voluntarily; when facial nerve (cranial nerve VII) is affected, the lacrimal gland will no longer supply secretions that protect eye

24. A client is ordered to take aspirin gr. X, PO. The drug label reads: "Aspirin 325 mg per tablet." Which of the following actions should the nurse take?

    1. Request that the pharmacy send a correctly labeled medication.
    2. Notify the doctor regarding the dosage.
    3. Give one tablet.
    4. Give two tablets.

    Strategy: All answers are implementation. Determine the outcome of each answer. Is it desired?

    (1) unnecessary
    (2) unnecessary
    (3) inaccurate
    (4) correct–ten grains = 600 mg, give two tablets; slight difference in conversion of grains to milligrams is because of the differences between the metric and apothecary systems

25. The nurse recognizes which of the following as early signs of lithium toxicity?

    1. Restlessness, shuffling gait, involuntary muscle movements.
    2. Ataxia, confusion, seizures.
    3. Fine tremors, nausea, vomiting, diarrhea.
    4. Elevated white blood cell count, orthostatic hypotension.

    Strategy: Think about each answer.

    (1) indicative of side effects associated with antipsychotic agents, not lithium
    (2) indicative of severe lithium toxicity, which requires prompt medical management
    (3) correct–nurse should be alert to early signs/symptoms of lithium toxicity; include fine tremors of fingers, wrists, and hands, and nausea, vomiting, and diarrhea
    (4) indicative of side effects associated with antipsychotic agents, not lithium

26. The nurse suggests that the client not eat or drink anything just before going to bed. The appropriateness of this comment is based on which of these understandings about a sliding hiatal hernia?

    1. The client is less likely to awaken during the night with heartburn if the stomach is empty.
    2. Early morning vomiting will be less of a problem if the stomach is empty.
    3. Drinking or eating before lying down causes decreased respirations due to increased pressure on the lungs.
    4. The client may develop fluid overload if fluids are taken just before going to bed.

    Strategy: Think about each answer.

    (1) correct–full stomach is more likely to slide (reflux) through the hernia, causing regurgitation and heartburn
    (2) vomiting, decreased respirations, and fluid overload are not related to hiatal hernia
    (3) vomiting, decreased respirations, and fluid overload are not related to hiatal hernia
    (4) vomiting, decreased respirations, and fluid overload are not related to hiatal hernia

27. A new mother is taking her infant home. The client asks the nurse when she should start giving her child solid foods. The nurse's response should be based on which of the following statements?

    1. Rice cereal is usually the first solid food and is started around four to five months.
    2. Strained fruits are well tolerated as the first solid food, and infants like them.
    3. Introduction of solid foods is not important at this time.
    4. Solid foods are usually not started until the infant is around six months old.

    Strategy: All answers are implementation. Determine the outcome of each answer. Is it desired?

    (1) correct–infants are less likely to be allergic to rice cereal than to any other solid food; usually started between four and five months of age; breast-fed infants may be started on solids even later
    (2) inaccurate
    (3) does not answer the mother's question
    (4) usually started between four and five months of age

28. The client has an order for IV fluid of D_5 0.45% normal saline 1,000 cc to run from 9 AM to 9 PM. The drip factor on the delivery tubing is 15 gtts/min. The nurse should adjust the IV to infuse at

    1. 12 gtts/min.
    2. 21 gtts/min.
    3. 25 gtts/min.
    4. 31 gtts/min.

    Strategy: Remember the formula.

    (1) incorrect
    (2) correct–IV is to run in 12 hours, or 720 minutes. 21 gtts/min
    (3) incorrect
    (4) incorrect

29. The nurse understands that the primary reason elderly adults have problems with constipation is that they

    1. eat a small volume of food with decreased bulk.
    2. have less activity and decreased muscle tone.
    3. have neurological changes in the gastrointestinal tract.
    4. have decreased sensation in the gastrointestinal tract.

    Strategy: Think about each answer.

    (1) decreased intake of high-fiber foods due to chewing difficulties is seen but is not a major cause of constipation
    (2) correct–reduced GI motility due to decreased muscle tone, decreased exercise; other factors include prolonged use of laxatives, ignoring urge to defecate, side effect of medications, emotional problems, insufficient fluid intake, and excessive dietary fat
    (3) decreased response to stretch receptors in rectum and anal canal occurs but is not major cause of constipation
    (4) decreased response to stretch receptors in rectum and anal canal occurs but is not major cause of constipation

30. The nurse is discussing growth and development with the parents of a four-year-old child. The nurse should identify which of the following as the type of play characteristic of this age group?

    1. Solitary play.
    2. Parallel play.
    3. Associative play.
    4. Aggressive play.

    Strategy: Picture a four-year-old.

    (1) describes play for an infant
    (2) describes play for a toddler
    (3) correct–this is the play that characterizes four-year-olds
    (4) is not play but a behavior

31. Which of the following should be charted by the nurse to reflect a client's emotional adjustment to being hospitalized in the intensive care unit?

    1. "The client is unable to complete activities of daily living without assistance."
    2. "The client appears to be depressed and anxious regarding his/her surgery."
    3. "The client constantly calls for nurses, pleads for them to stay at the bedside, and cries uncontrollably."
    4. "The family is unable to visit more often than once a week because they live far away."

    Strategy: Good charting is objective.

    (1) does not describe emotional adjustment
    (2) draws conclusions without supporting data
    (3) correct–gives an objective description of the client's behavior and affect
    (4) describes the client's family, not the client

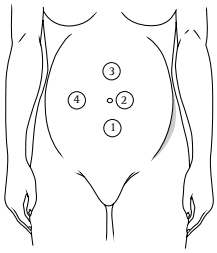
32. Which nursing observation would suggest that a client has developed an Addisonian crisis?

    1. Muscular weakness and fatigue.
    2. Restlessness and rapid, weak pulse.
    3. Dark pigmentation of the skin.
    4. Gastrointestinal disturbances and anorexia.

    Strategy: Determine how each answer relates to Addison's.

    (1) signs and symptoms of Addison's disease, but do not indicate a crisis
    (2) correct–may be signs of shock related to an Addisonian crisis
    (3) signs and symptoms of Addison's disease, but do not indicate a crisis
    (4) signs and symptoms of Addison's disease, but do not indicate a crisis

33. During the fourth stage of labor, the nurse should palpate the fundus:



1. three cm below the umbilicus.
2. at the umbilicus.
3. two cm above the umbilicus.
4. to the right of the umbilicus.

Strategy: Think about each answer.

(1) is unusual to palpate the fundus below the umbilicus during this stage
(2) correct–uterus is normally contracted and palpable at the umbilicus
(3) is unusual to palpate the fundus above the umbilicus during this stage
(4) may indicate a problem with a distended bladder

34. A postoperative cataract client is cautioned about not making sudden movements or bending over. The nurse understands that the rationale for this recommendation is to prevent which of the following?

1. Impairment of cerebral blood flow and headaches.
2. Increased intracranial pressure.
3. Pressure on the ocular suture line.
4. Displacement of the lens implant.

Strategy: Think about each answer.

(1) not relevant to this situation
(2) not relevant to this situation
(3) correct–sudden changes in position, constipation, vomiting, stooping, or bending over increase the intraocular pressure and put pressure on the suture line
(4) occurs because of pressure on suture area; not all clients have lens implants; 3 is a more comprehensive answer.

35. Which information should the nurse recognize as being the MOST pertinent to the diagnosis of cholecystitis?

1. Flatulence.
2. Nausea and vomiting.
3. Right upper abdominal pain.
4. Dyspepsia.

Strategy: Think about each answer.

(1) indicates other gastrointestinal problem
(2) indicate other gastrointestinal problem
(3) correct–will experience pain in the upper-right abdominal quadrant
(4) indicates other gastrointestinal problem

36. Which of the following might alert the nurse to consider an alcohol problem in a client hospitalized for a physical illness?

    1. Depression, difficulty falling asleep, decreased concentration.
    2. Elevated liver enzymes, cirrhosis, decreased platelets.
    3. Tremors, elevated temperature, complaints of nocturnal leg cramps, complaints of pain symptoms.
    4. Flulike symptoms, diarrhea, night sweats, elevated temperature, decreased deep tendon reflexes.

    Strategy: Remember the "comma, comma, and" rule.

    (1) is more indicative of a dysphoric or depressed client
    (2) could warrant a further exploration of alcohol use, but is not the best indication
    (3) correct–when a client is admitted for another physical problem to a general medical, surgical, or critical care unit, the nurse many times becomes the case finder, and must be alert for subtle symptoms of an alcohol-related problem; client who has several complaints of pain that do not appear to be correlated to the admissions problem requires further investigation; tremors, elevated temperature, and pain symptoms are indicative of an alcohol-related problem
    (4) is more indicative of withdrawal from narcotics or an infective problem such as tuberculosis

37. A 7-year-old girl is seen in the clinic with a diagnosis of pituitary dwarfism. Which of the following clinical manifestations is the nurse MOST likely to observe?

    1. Abnormal body proportions.
    2. Early sexual maturation.
    3. Delicate features.
    4. Coarse, dry skin.

    Strategy: Determine how each answer relates to dwarfism.

    (1) you will see small size but normal body proportions
    (2) usually have delayed sexual maturity
    (3) correct–appear younger than chronological age
    (4) usually see fine, smooth skin

38. The physician orders mannitol (Osmitrol) for a client with a closed head injury. Which of the following should the nurse recognize as the desired response to this medication?

    1. The blood pressure increases to 150/90.
    2. Urinary output increases to 175 cc/hour.
    3. There is a decrease in the level of activity.
    4. There is absence of fine tremors of the fingers.

    Strategy: Think about each answer.

    (1) increase in blood pressure is not desired
    (2) correct–mannitol (Osmitrol) is an osmotic diuretic; increases urinary output and decreases intracranial pressure
    (3) does not indicate desired effect of medication
    (4) does not indicate desired effect of medication

39. The nurse knows that according to Erikson's stages of psychosocial development, which of the following best represents a 50-year-old client?

    1. Integrity versus despair and disgust.
    2. Generativity versus stagnation.
    3. Intimacy versus isolation.
    4. Identity versus role diffusion.

    Strategy: Think about each answer.

    (1) appropriate for ages 65 and older
    (2) correct–stage of development is appropriate for 45-64 years of age
    (3) appropriate for the young adult
    (4) appropriate for the adolescent

40. A 54-year-old client developed a postoperative infection and has been receiving ceftriaxone sodium (Rocephin) IV every day. It is MOST important for the nurse to monitor which of the following?

    1. The surface of the tongue.
    2. Hemoglobin and hematocrit.
    3. Skin surfaces in skin folds.
    4. Changes in urine characteristics.

    Strategy: Answer choices indicate that you are looking for a complication.

    (1) correct–long-term use of Rocephin can cause overgrowth of organisms; monitoring of tongue and oral cavity is recommended
    (2) does not reflect a problem with this medication
    (3) does not reflect a problem with this medication
    (4) does not reflect a problem with this medication

41. The nurse should caution the client with hypothyroidism to avoid

    1. warm environmental temperatures.
    2. narcotic sedatives.
    3. increased physical exercise.
    4. a diet high in fiber.

    Strategy: Think about each answer.

    (1) client with hypothyroidism cannot tolerate cold temperatures
    (2) correct–client is very sensitive to narcotics, barbiturates, and anesthetics
    (3) should not be avoided
    (4) requires high fiber, high cellulose foods to prevent constipation

42. The nurse performs the Rinne tests on a 6-year-old girl. Which of the following is an accurate statement of how this test should be performed?

    1. The stem of a vibrating tuning fork is held against the auditory canal until the child indicates that she can no longer hear the sound. Then the tuning fork is moved away from the canal.
    2. The stem of a vibrating tuning fork is held against the mastoid bone until the child indicates that she can no longer hear the sound. Then the tuning fork is moved in front of the auditory canal.
    3. The stem of a vibrating tuning fork is held in the middle of the forehead and the girl's hearing is assessed in both ears.
    4. The stem of a vibrating tuning fork is positioned two inches behind the girl's head, and the length of time she hears the sound is documented.

    Strategy: Think about each answer.

    (1) inaccurate
    (2) correct–child should hear sound again when tuning fork is moved from mastoid bone to the front of the auditory canal because air conduction is better than bone conduction
    (3) is the Weber test
    (4) inaccurate

43. The nurse would explain to the diabetic client that the decreased vision he has experienced is due to which of the following?

    1. Bleeding into the inner ocular chamber of the eye.
    2. Gradual separation of the retina from the base of the eye.
    3. An increase in the size of the vessels in the back of the eye.
    4. Gradual destruction and degeneration of the retina.

    Strategy: Think about each answer.

    (1) complication of postoperative eye surgery or traumatic injury (hyphema)
    (2) describes a retinal detachment
    (3) destruction of the vessels, as well as edema, occurs
    (4) correct–gradual destruction occurs due to deterioration of the retinal vessels

44. A woman is being evaluated for infertility. The doctor gives the client clomiphene citrate (Clomid) 50 mg daily for five days. The client says to the nurse, "What is the purpose of this medicine?" The nurse should instruct her that the action of medication is to

    1. induce ovulation by changing hormonal effects on the ovary.
    2. change the uterine lining to be more conducive to implantation.
    3. alter the vaginal pH to increase sperm motility.
    4. produce multiple pregnancy for those who desire twins.

    Strategy: Think about each answer.

    (1) correct–clomiphene citrate (Clomid) induces ovulation by altering estrogen and stimulating follicular growth to produce a mature ovum
    (2) infertility problem, but Clomid does not affect it
    (3) infertility problem, but Clomid does not affect it
    (4) not a desired effect

45. A client had a kidney transplant yesterday. The client's son has come to visit. The nurse should instruct the son to do which of the following?

    1. No special isolation techniques are necessary.
    2. Wear a double mask and gloves.
    3. Perform good hand washing.
    4. Wear a gown and a mask.

    Strategy: All answers are implementation. Determine the outcome of each answer. Is it desired?

    (1) inaccurate
    (2) inaccurate, masks are unnecessary for this patient
    (3) correct–good hand washing is the most effective method of reducing infection; very important with immunosuppressed clients
    (4) inaccurate, masks are unnecessary for this patient

46. The physician orders naproxen sodium (Naprosyn) for a 77-year-old man. The nurse should assess the patient for

    1. stomatitis and photosensitivity.
    2. brachycardia and dry mouth.
    3. fluid retention and dizziness.
    4. gynecomastia and impotence.

    Strategy: Determine how each answer relates to Naprosyn.

    (1) not side effects seen with this medication; may see headache, nausea
    (2) not side effects seen with this medication; may see epigastric distress and rash
    (3) correct–NSAID (nonsteroidal antiinflammatory drug) used as analgesic; side effects include headache, dizziness, GI distress, pruritus, and rash
    (4) not side effects seen with this medication; may see nephrotoxicity and pruritus

47. The nurse is caring for a postoperative client whose diabetes has been controlled with oral antihyperglycemic agents in the past. The client asks why the physician ordered subcutaneous insulin injections after surgery. The nurse's response should be based on which of the following statements?

    1. Tissue injury after surgery decreases blood sugar.
    2. Anesthesia acts to increase glycogen stores.
    3. Being NPO inhibits normal blood sugar control.
    4. Surgery often leads to insulin dependency.

    Strategy: Think about each answer.

    (1) inaccurate
    (2) inaccurate
    (3) correct–inability to control diabetes mellitus by diet and oral agents, coupled with surgically induced metabolic changes, being NPO both before and after surgery, and the infusion of intravenous fluids necessitates temporary control by insulin
    (4) inaccurate

48. Which of the following would be MOST important for the rehabilitation nurse to assess during a new client's admission?

    1. The client's expectations of family members.
    2. The client's understanding of available supportive services.
    3. The client's personal goals for rehabilitation.
    4. The client's past experiences in the hospital.

    Strategy: Determine the outcome and how it relates to rehabilitation.

    (1) important to assess but is not as crucial for future success as the client's goals
    (2) important to assess but is not as crucial for future success as the client's goals
    (3) correct–it is important for the nurse to understand what the client expects from the rehabilitation program for future success
    (4) important to assess but is not as crucial for future success as the client's goals

49. The nurse knows that Cortisol is responsible for

    1. preparing the body for "flight or fight."
    2. regulating the calcium metabolism.
    3. converting proteins and fat into glucose.
    4. enhancing musculoskeletal activity.

    Strategy: Think about each answer.

    (1) action of epinephrine
    (2) action of parathyroid hormone parathormone
    (3) correct–action of Cortisol; is also an antiinflammatory agent
    (4) action of norepinephrine

50. A middle-aged man is admitted to an inpatient psychiatric unit. Over the last several months he has become convinced that his brother is trying to steal his property. He is diagnosed with paranoid disorder. The nurse knows that this client is demonstrating which of the following?

    1. Delusions of persecution.
    2. Command hallucinations.
    3. Delusions of reference.
    4. Persecution hallucinations.

    Strategy: Think about each answer.

    (1) correct–client has delusions of persecution; delusion is a strongly held belief that is not validated by reality; the idea that his brother is trying to steal his property is a belief not validated by reality
    (2) hallucination is a sensory perception that takes place without external stimuli; most common are auditory, or hearing voices; other types of hallucinations are tactile, visual, gustatory, and olfactory; command hallucinations involve client experiencing auditory hallucinations that are telling him/her to do something; for example, to kill someone
    (3) delusions of reference are a false belief that public events or people are directly related to the individual
    (4) is not a hallucination

51. The nurse is administering oral verapamil (Isoptin) to a client. Before administering the verapamil the nurse should check the client's

    1. electrolytes.
    2. urine output.
    3. weight.
    4. heart rate.

    Strategy: Think about the action of the drug.

    (1) unnecessary action
    (2) unnecessary action
    (3) unnecessary action
    (4) correct–Verapamil is indicated for the treatment of supraventricular tachycardias, so the client's heart rate should be checked prior to administration

52. The nurse knows which of the following mood-altering drugs is most often associated with an increased risk for HIV infection related to intravenous drug use?

    1. Benzodiazepines.
    2. Marijuana.
    3. Barbiturates.
    4. Narcotics.

    Strategy: Think about how each drug is administered.

    (1) not commonly used intravenously
    (2) not commonly used intravenously
    (3) not commonly used intravenously
    (4) correct–narcotics are most often used intravenously

53. The nurse is teaching a parenting class to a group of expectant mothers. The nurse should advise that the breastfeeding mother should increase her daily caloric intake by how many calories?

    1. 200.
    2. 300.
    3. 400.
    4. 500.

    Strategy: Think about each answer.

    (1) inadequate amount
    (2) inadequate amount
    (3) inadequate amount
    (4) correct–milk production requires an increase of 500 calories per day

54. The physician writes an order for a STAT dose of Demerol 50 mg IM for pain. Three hours later the client again complains of pain, and the nurse administers a second injection of Demerol. Which of the following describes the nurse's liability?

    1. The nurse administered the medication appropriately; there is no liability.
    2. The nurse violated the narcotic law in not having an order to administer the Demerol a second time.
    3. The client was not injured; if injury did not occur, then the nurse is not liable.
    4. The nurse should have waited at least four hours; then there would be no liability.

    Strategy: Think about each answer.

    (1) does not address the fact there was no order for the Demerol to be repeated
    (2) correct–order for a STAT dose does not state PRN; nurse had an order for only the first injection, not the second one
    (3) does not address the fact there was no order for the Demerol to be repeated
    (4) does not address the fact there was no order for the Demerol to be repeated

55. The nurse is caring for a patient with a pneumothorax resulting from an auto accident three days ago. He has a chest tube connected to a three-chamber water-seal drainage system (Pleur-evac) with 20 cm suction. How would the nurse know if the lung had re-expanded?

    1. There is no drainage in the collection chamber for three hours.
    2. The fluid in the water-seal chamber does not fluctuate with respirations.
    3. There is continuous bubbling in the water-seal chamber.
    4. There is gentle bubbling in the suction-control chamber.

    Strategy: Determine how each observation relates to a chest tube.

    (1) doesn't indicate re-expansion
    (2) correct–indicates no more air leaking into pleural space
    (3) indicates air leak; need to check for location of leak; clamp tubing close to chest and check for bubbling, then clamp tubing close to container and check for bubbling
    (4) normal finding

56. The nurse on a psychiatric unit of the hospital refuses to agree to a 32-year-old patient's request to organize a party on the unit with his friends. The patient becomes angry and uses abusive language with the nurse. Which of the following statements indicates that the nurse has an understanding of the patient's behavior?

    1. Allowing the patient to use abusive language will undermine the authority of the nurse.
    2. Responding in kind to a patient who uses abusive language will perpetuate the behavior.
    3. Abusive language is one of the behaviors that is a symptom of the patient's illness.
    4. The nurse should model acceptable behavior and language for all patients.

    Strategy: Think about each answer.

    (1) inaccurate, doesn't undermine authority of staff
    (2) shows lack of understanding of cause for patient's behavior
    (3) correct–symptoms will respond to treatment
    (4) suggests that using acceptable language will change patient's behavior; shows lack of understanding of patient's behavior

57. The nurse is caring for a three-month-old infant that is scheduled for a barium swallow in the morning. Prior to the procedure, the MOST appropriate nursing action would be to

    1. offer the infant only clear liquids.
    2. make the infant NPO for three hours.
    3. feed the infant regular formula.
    4. maintain the infant NPO for six hours.

    Strategy: All answers are implementation. Determine the outcome of each answer. Is it desired?

    (1) inappropriate
    (2) correct–infant should be NPO three hours prior to the procedure
    (3) inappropriate
    (4) unnecessary for an infant to be NPO for six hours

58. The client has been receiving a blood transfusion for approximately 30 minutes. Which of these assessments, if made by the nurse, would indicate an allergic reaction?

    1. Hypotension.
    2. Chills.
    3. Respiratory wheezing.
    4. Lower back discomfort.

    Strategy: Think about each answer.

    (1) indicative of a hemolytic transfusion reaction
    (2) indicative of a hemolytic transfusion reaction
    (3) correct–allergic reaction is characterized by wheezing, urticaria (hives), facial flushing, and epiglottal edema
    (4) indicative of a hemolytic transfusion reaction

59. The physician inserts a temporary pacemaker in a 45-year-old man following a myocardial infarction. The nurse knows that the primary purpose of the pacemaker is to

    1. increase the force of myocardial contraction.
    2. increase the cardiac output.
    3. prevent premature ventricular contractions (PVCs).
    4. prevent systemic overload.

    Strategy: Think about each answer.

    (1) action of cardiac glycosides such as Digoxin
    (2) correct–acts to regulate cardiac rhythm
    (3) action of antiarrhythmics such as Quinidine
    (4) action of diuretics such as Lasix

60. Which of the following instructions should be given by the nurse to an adult client in preparation for a plasma cholesterol screening?

    1. Eat a vegetarian diet for one week before the test.
    2. Limit alcohol intake to two glasses of wine the day before the test.
    3. Abstain from dairy products for 48 hours before the test.
    4. Only sips of water should be taken for 12 hours before the test.

    Strategy: Answers are implementation. Determine the outcome of each answer. Is it desired?

    (1) normal diet should be eaten the week before the test
    (2) alcohol intake will interfere with test results
    (3) normal diet should be eaten the week before the test
    (4) correct–only sips of water are permitted for 12 hours before plasma cholesterol screening to achieve accurate results

61. A toddler with lead poisoning is admitted to the pediatric unit. There is an order to encourage fluids. Which of the following fluids would be the best for the nurse to offer to the child?

    1. Milk.
    2. Water.
    3. Orange juice.
    4. Fruit punch.

    Strategy: Determine how each answer relates to lead poisoning.

    (1) correct–milk provides a large amount of vitamin D; vitamin D optimizes deposition of lead in the long bones; purpose of the treatment is to remove lead from the blood and soft tissues
    (2) good for fluid replacement; does not relate to the lead poisoning
    (3) good for fluid replacement; does not relate to the lead poisoning
    (4) good for fluid replacement; does not relate to the lead poisoning

62. In the process of a normal adjustment to a terminal illness, the nurse knows that the client's initial denial and isolation will give way to the second stage, which is characterized by

    1. acceptance.
    2. bargaining.
    3. anger.
    4. depression.

    Strategy: Think about each answer.

    (1) this is the fifth stage
    (2) this is the third stage
    (3) correct–second stage is characterized by anger
    (4) this is the fourth stage

63. The nurse prepares a 67-year-old man for an intravenous pyelogram (IVP). The client asks the nurse to explain the reason why the procedure is performed. The nurse's response should be based on the knowledge that the primary purpose of an IVP is to

    1. observe the renal pelvis directly.
    2. assess glomerulofiltration rate.
    3. examine the urinary tract by x-ray.
    4. inject medication into the urinary system.

    Strategy: Think about each answer.

    (1) would involve invasive procedure, such as cystoscopy
    (2) not primary purpose
    (3) correct–x-rays of entire urinary tract taken, evaluates kidney function
    (4) not primary purpose

64. The mother of a child with chickenpox asks the physician's office nurse why her child will not come down with chickenpox again if exposed to the virus at school at a later date. The nurse's response should be based on the information that

    1. natural passive immunity occurs because the child receives antibodies from outside the body.
    2. artificial active immunity occurs because the child receives specific antigens against the chickenpox virus.
    3. natural active immunity occurs because the child's body actively makes antibodies against the chickenpox virus.
    4. artificial passive immunity occurs because of the inflammatory process of chickenpox.

    Strategy: Think about each answer.

    (1) occurs when antibodies are passed from mother to fetus via placenta, colostrum, and breast milk
    (2) small amounts of specific antigens are used for vaccination; body responds by actively making antibodies
    (3) correct–antigen enters the body without human assistance; body responds by actively making antibodies
    (4) involves injection with antibodies that were produced in another person or animal; used to protect person exposed to serious disease

65. Several days after the delivery of a stillborn, the parents say, "We wish we could talk with other couples who have gone through this trauma." Which of the following nursing responses would be BEST?

    1. "SIDS will provide you with this opportunity."
    2. "SHARE will provide you with this opportunity."
    3. "RESOLVE will provide you with this opportunity."
    4. "CANDLELIGHTERS will provide you with this opportunity."

    Strategy: Answers are implementation. Determine the outcome of each answer. Is it desired?

    (1) support group for parents who have had an infant die from sudden infant death syndrome
    (2) correct–SHARE is a support group for parents who have lost a newborn or have experienced a miscarriage
    (3) support group for infertile clients
    (4) support group for families who have lost a child to cancer

66. Which of the following is the BEST way for a nurse to assess the fluid balance of a 70-year-old man?

    1. Assess the client's blood pressure.
    2. Check the client's tissue turgor.
    3. Ask the client if he is thirsty.
    4. Maintain an accurate intake and output.

    Strategy: Determine how each answer relates to hydration.

    (1) may be elevated due to age-related hypertension
    (2) not accurate due to changes in skin elasticity from the aging process
    (3) not reliable indicator; may have diminished sensation of thirst
    (4) correct–best indicator of fluid status

67. In planning diet teaching for a child in the early stages of nephrotic syndrome, the nurse should discuss with the parents which of the following dietary changes?

    1. Adequate protein intake, low sodium.
    2. Low-protein, low-potassium intake.
    3. Low-potassium, low-calorie intake.
    4. Limited-protein, high-carbohydrate intake.

    Strategy: Think about each answer.

    (1) correct–if child can tolerate the protein intake, then it is encouraged to speed healing; sodium is usually restricted
    (2) low protein and high potassium are contraindicated in renal clients
    (3) does not address protein need at all
    (4) may be appropriate only if the child cannot tolerate protein intake

68. In preparing a teaching plan regarding colostomy irrigations, the nurse should include which of the following?

    1. The colostomy needs to be irrigated at the same time every day.
    2. Irrigate the colostomy after meals to increase peristalsis.
    3. Insert the catheter about 10 inches into the stoma.
    4. The solution should be very warm to increase dilation and flow.

    Strategy: All answers are implementation. Determine the outcome of each answer. Is it desired?

    (1) correct–colostomy irrigation should be done at same time each day to assist in establishing a normal pattern of elimination
    (2) colostomy should be irrigated only once a day
    (3) catheter should never be inserted more than 4 inches
    (4) solution should be at body temperature; increasing the temperature does not make irrigation more efficient

69. The nurse knows which of the following would have the greatest impact on an elderly client's ability to complete activities of daily living (ADLs)?

    1. Perseveration.
    2. Aphasia.
    3. Mnemonic disturbance.
    4. Apraxia.

    Strategy: Think about each answer.

    (1) speech disturbance, which would have the greatest impact on communication ability
    (2) speech disturbance, which would have the greatest impact on communication ability
    (3) speech disturbance, which would have the greatest impact on communication ability
    (4) correct–apraxia is loss of purposeful movement in the absence of motor or sensory impairment; when it affects an ADL, such as dressing, the client may not be able to put clothes on properly

70. Prior to sending a client for a cardiac catheterization, it would be MOST important for the nurse to report which of the following?

    1. The client has an allergy to shellfish.
    2. The client has diminished palpable peripheral pulses.
    3. The client has cool lower extremities bilaterally.
    4. The client is anxious about the pending procedure.

    Strategy: Think about the significance of each answer and how it relates to a cardiac catheterization.

    (1) correct–allergies to iodine and/or seafood must be reported immediately before a cardiac catheterization to avoid anaphylactic shock during the procedure
    (2) may be normal finding before the test
    (3) may be normal finding before the test
    (4) may be normal finding before the test

71. If a client has ataxia, the MOST important nursing action would be to

    1. supervise ambulation.
    2. measure the intake and output accurately.
    3. consult the speech therapist.
    4. elevate the foot of the bed.

    Strategy: Think about each answer.

    (1) correct–client's coordination is poor; the only relevant nursing action is to supervise ambulation
    (2) unnecessary
    (3) unnecessary
    (4) unnecessary

72. A 14-year-old girl is brought to the hospital for treatment of second- and third-degree burns sustained in a house fire. An intravenous infusion is started in the patient's left forearm. The nurse knows that the primary purpose of the IV is to

    1. provide a route for pain medications.
    2. maintain fluid balance.
    3. prevent gastrointestinal upset.
    4. obtain blood specimens for analysis.

    Strategy: Answers are implementation. Determine the outcome of each answer. Is it desired?

    (1) route used for pain medication to ensure absorption, but not primary purpose of IV
    (2) correct–loss of fluid occurs from open burn surfaces; maintaining circulation is life-saving requirement
    (3) threat of GI upset not primary importance; IV primary purpose to maintain fluid and electrolyte balance
    (4) peripheral IV not used for this purpose

73. An 80-year-old client is admitted with a possible fractured right hip. During the initial nursing assessment, which of the following observations of the right leg would validate or support this diagnosis?

    1. The leg appears to be shortened and is abducted and externally rotated.
    2. Plantar flexion is observed with sciatic pain radiating down the leg.
    3. From the hip, the leg appears to be longer and is externally rotated.
    4. There is evidence of paresis with decreased sensation and limited mobility.

    Strategy: Think about each symptom and how it relates to hip fracture.

    (1) correct–accurate assessments of the position of a fractured hip prior to repair
    (2) plantar flexion occurs with foot drop
    (3) leg would not appear to be longer
    (4) occurs with injury to the lumbar disc area

74. The nurse has collected the following data: client anger directed toward staff in the form of frequent sarcastic or crude comments, increased wringing of hands, and purposeless pacing, particularly after the client has used the telephone. Based on this data, the nurse should make which nursing diagnosis?

    1. Impaired social interaction related to conversion reaction.
    2. Risk for potential activity intolerance as evidenced by purposeless pacing.
    3. Powerlessness in hospital situation.
    4. Ineffective individual coping related to recent anger and anxiety.

    Strategy: Think about each answer.

    (1) not warranted with the data indicated
    (2) not warranted with the data indicated
    (3) not warranted with the data indicated
    (4) correct–client is displaying evidence of anger and anxiety and an inability to directly deal with concerns, which is ineffective coping

75. The nursing team consists of a RN who has been practicing for six months, a LPN/LVN who has been practicing for 15 years, and a nursing assistant who has been caring for clients for three years. The RN should care for which of the following clients?

    1. A client 1 day postop after an internal fixation of a fractured left femur.
    2. A client receiving diltiazem (Cardizem) and phenytoin (Dilantin).
    3. A client who is to receive 2 units of packed cells prior to an upper endoscopy procedure.
    4. A client admitted yesterday with exhaustion and a diagnosis of acute bipolar disorder.

    Strategy: The RN cares for clients that require assessment, teaching, and nursing judgment.

    (1) care can be assigned to the nursing assistant; standard, unchanging procedure
    (2) medication can be given by the LPN
    (3) correct–requires the assessment and teaching skills of RN
    (4) offer food and fluids, assign to LPN