NCLEX QUESTION TRAINER EXPLANATIONS

TEST 2

1. The nurse is supervising care given to a group of patients on the unit. The nurse observes a staff member entering a patient's room wearing gown and gloves. The nurse knows that the staff member is caring for which of the following patients?

   1. An 18-month-old with respiratory syncytial virus.
   2. A 4-year-old with Kawasaki disease.
   3. A 10-year-old with Lyme's disease.
   4. A 16-year-old with infectious mononucleosis.

   Strategy: Think about each answer.

   (1) correct–acute viral infection; requires contact precautions; assign to private room or with other RSV-infected children
   (2) acute systemic vasculitis in children under 5; standard precautions
   (3) connective tissue disease; standard precautions
   (4) standard precautions

2. The nurse is assessing a client who has had a spinal cord injury. Which of the following assessment findings would suggest the complication of autonomic dysreflexia?

   1. Urinary bladder spasm pain.
   2. Severe pounding headache.
   3. Tachycardia.
   4. Severe hypotension.

   Strategy: Think about each answer.

   (1) may be the cause of autonomic dysreflexia due to overfilling of the bladder, but pain is not perceived
   (2) correct–severe headache results from rapid onset of hypertension
   (3) pulse will slow
   (4) BP will increase

3. A 14-year-old client is scheduled for a below-knee (BK) amputation following a motorcycle accident. The nurse knows preoperative teaching for this client should include

   1. explaining that the client will be walking with a prosthesis soon after surgery.
   2. encouraging the client to share his feelings and fears about the surgery.
   3. taking the informed consent form to the client and asking him to sign it.
   4. evaluating how the client plans to maintain his schoolwork during hospitalization.

   Strategy: Remember therapeutic communication.

   (1) fails to recognize his immediate concerns
   (2) correct–discussing his feelings and fears is important in dealing with his anxiety due to a change in body image and functioning
   (3) client is underage; parents will need to sign the permit
   (4) is more appropriate for the postoperative period of time than for the preoperative period

4. A 21-year-old woman at 16-weeks gestation undergoes an amniocentesis. The client asks the nurse what the physician will learn from this procedure. The nurse's response should be based on an understanding that which of the following conditions can be detected by this test?

   1. Tetralogy of Fallot.
   2. Talipes equinovarus.
   3. Hemolytic disease of the newborn.
   4. Cleft lip and palate.

   Strategy: Think about each answer.

   (1) cardiac abnormality detected at birth; pulmonary stenosis, ventricular septal defect, overriding aorta, hypertrophy of right ventricle
   (2) congenital deformity detected at birth; foot twisted out of normal position, clubfoot
   (3) correct–maternal antibodies destroy fetal RBCs; bilirubin secreted because of hemolysis
   (4) congenital deformity detected at birth, midline fissure or opening into lip or palate

5. The nurse evaluates the nutritional intake of a 16-year-old girl at a camp for adolescents. The girl eats all of the food provided to her at the camp cafeteria. Each of the day's three meals contains foods from all areas of the food pyramid, and each meal averages about 900 calories and 3 mg of iron. The girl has been menstruating monthly for about two years. Which of the following descriptions, if made by the nurse, BEST describes the girl's intake if her weight is appropriate for her height?

   1. Her diet is low in calories and high in iron.
   2. Her diet is low in calories and low in iron.
   3. Her diet is high in calories and low in iron.
   4. Her diet is high in calories and high in iron.

   Strategy: Think about each answer.

   (1) only 1,200-1,500 kcal/day required, and 15 mg/day of iron
   (2) only 1,200-1,500 kcal/day required
   (3) correct–900 x 3 = 2,700 calories/day and women need 1,200-1,500 kcal/day (men need 1,500-1,800 kcal/day); 3 mg x 3 = 9 mg/day of iron and women need 15 mg/day of iron (men need 10 mg/day); with pregnancy 30 mg/day required
   (4) 5 mg/day of iron required

6. A client has returned from surgery with a fine, reddened rash noted around the area where Betadine prep had been applied prior to surgery. Nursing documentation in the chart should include

   1. the time and circumstances under which the rash was noted.
   2. the explanation given to the client and family of the reason for the rash.
   3. notation on an allergy list and notification of the doctor.
   4. the need for application of corticosteroid cream to decrease inflammation.

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

   (1) would be noted, but is not as high a priority
   (2) inappropriate
   (3) correct–suspected reaction to drugs should be reported to the doctor and noted on list of possible allergies
   (4) inappropriate

7. A client who is receiving a blood transfusion experiences a hemolytic reaction. The nurse would anticipate which of the following assessment findings?

   1. Hypotension, backache, low back pain, fever.
   2. Wet breath sounds, severe shortness of breath.
   3. Chills and fever occurring about an hour after the infusion started.
   4. Urticaria, itching, respiratory distress.

   Strategy: Think about each answer.

   (1) correct–signs and symptoms of a hemolytic reaction include chills, headache, backache, dyspnea, cyanosis, chest pains, tachycardia, and hypotension
   (2) describes symptoms of circulatory overload
   (3) describes a febrile or pyrogenic reaction
   (4) describes an allergic reaction

8. The nurse is developing a comprehensive care plan for a young woman with an eating disorder. The nurse refers this client to assertiveness skills classes. The nurse knows that this is an appropriate intervention because this client may have problems with

   1. aggressive behaviors and angry feelings.
   2. self-identity and self-esteem.
   3. focusing on reality.
   4. family boundary intrusions.

   Strategy: Think about each answer.

   (1) these clients do have problems with feelings of anger; family therapy sessions can be helpful in identifying some of these feelings and difficulties with family boundaries
   (2) correct–clients with eating disorders experience difficulty with self-identity and self-esteem, which inhibits their abilities to act assertively; some assertiveness techniques that are taught include giving and receiving criticism, giving and accepting compliments, accepting apologies, being able to say no, and setting limits on what they can realistically do rather than just doing what others want them to do
   (3) do not have problems with reality
   (4) these clients do have problems with family boundary intrusion; family therapy sessions can be helpful in identifying some of these feelings and difficulties with family boundaries

9. Under the supervision of the registered nurse, a student nurse is changing the dressing of a 49-year-old woman with a newly inserted peritoneal dialysis catheter. Which of the following activities, if performed by the student nurse after removal of the old dressing, would require an intervention by the registered nurse?

   1. The student nurse cleans the catheter insertion site using a sterile cotton swab soaked in povidone-iodine.
   2. The student nurse applies two sterile precut 4x4s to the catheter insertion site.
   3. The student nurse cleans the insertion site using a circular motion from the outer abdomen toward the insertion site.
   4. The student nurse securely tapes the edges of the sterile dressing with paper tape.

   Strategy: "Require an intervention" means you are looking for an incorrect behavior. All answers are implementations. Determine outcome of each answer. Is it desired?

   (1) correct procedure
   (2) correct procedure
   (3) correct–should clean from insertion site outward toward outer abdomen
   (4) correct procedure

10. The home care nurse is performing an assessment of a client with pneumonia secondary to chronic pulmonary disease. Which of the following goals is MOST appropriate?

    1. Maintain and improve the quality of oxygenation.
    2. Improve the status of ventilation.
    3. Increase oxygenation of peripheral circulation.
    4. Correct the bicarbonate deficit.

    Strategy: Determine the outcome of each answer.

    (1) primary problem is not level of oxygenation, but the level of carbon dioxide contributing to an acidotic state
    (2) correct–to improve the quality of ventilation would refer to levels of carbon dioxide and oxygen
    (3) not appropriate for the situation
    (4) not appropriate for the situation

11. A 34-year-old man comes to the clinic for the results of a glycosylated hemoglobin assay (HbA1c). Which statement, if made by the client to the nurse, indicates an understanding of this procedure?

    1. “This test is performed by sticking my finger and measuring the results.”
    2. “This test needs to be performed in the morning before I eat breakfast.”
    3. “This test indicates how well my blood sugar has been controlled the past 6-8 weeks.”
    4. “I must follow my diet carefully for several days before the test.”

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

    (1) 3-5 ml of blood is needed
    (2) timing of test is not important
    (3) correct–when RBCs are being formed, sugar is attached (glycosylated) and remains attached throughout the life of the RBC
    (4) current blood sugar doesn't affect test

12. The nurse recognizes which of these symptoms as characteristic of a panic attack?

    1. Palpitations, decreased perceptual field, diaphoresis, fear of going crazy.
    2. Decreased blood pressure, chest pain, choking feeling.
    3. Increased blood pressure, bradycardia, shortness of breath.
    4. Increased respiratory rate, increased perceptual field, increased concentration ability.

    Strategy: Think about each answer.

    (1) correct–panic disorders are characterized by recurrent, unpredictable attacks of intense apprehension or terror that can render a client unable to control a situation or to perform simple tasks; client can experience palpitations, chest pain, shortness of breath, a decrease in perceptual field, and a fear of "losing it" or going crazy
    (2) not accurate because typically the client has increased blood pressure related to stimulation of the sympathetic nervous system
    (3) heart rate would be increased due to stimulation of the sympathetic nervous system
    (4) client's perceptual field is decreased during a panic attack; client becomes less aware of his/her surroundings, and his/her performance is inhibited

13. The physician diagnoses Graves' disease for a 28-year-old woman seen in the clinic. The nurse would expect the client to exhibit which of the following symptoms?

    1. Lethargy in the early morning.
    2. Sensitivity to cold.
    3. Weight loss of 10 lb in 3 weeks.
    4. Reduced deep tendon reflexes.

    (1) will be restless
    (2) have heat intolerance due to increased metabolic rate
    (3) correct–increased metabolic rate causes weight loss even with increased appetite
    (4) reflexes will be hyperactive

14. During an initial interview at an outpatient clinic, a 34-year-old single mother tells the nurse that she has always had difficulty forming relationships and is worried that her 7-year-old daughter will have the same problem. Which of the following statements, if made by the nurse, is BEST?

    1. “Children develop trust from birth to 18 months of age.”
    2. “Children develop trust from 18 months to three years of age.”
    3. “Children develop trust from three to six years of age.”
    4. “Children develop trust from six to twelve years of age.”

    Strategy: "BEST" indicates discrimination is required. Topic of question is unstated. Read answer choices to determine topic.

    (1) correct–Erikson states that trust results from interaction with dependable, predictable primary caretaker
    (2) toddler stage concerns autonomy verses shame and doubt
    (3) preschool state concerns initiative versus guilt
    (4) latency or school age stage concerns industry versus inferiority

15. Which of the following nursing interventions is MOST important when caring for a client who has just been placed in physical restraints?

    1. Prepare PRN dose of psychotropic medication.
    2. Check that the restraints have been applied correctly.
    3. Review hospital policy regarding duration of restraints.
    4. Monitor the client's needs for hydration and nutrition while restrained.

    Strategy: Answers are a mix of assessment and implementation. Is this a situation that requires assessment? Yes. Is there an appropriate assessment? Yes.

    (1) implementation; inappropriate for the client in restraints
    (2) correct–assessment; while a client is restrained, physiological integrity is important; monitoring positioning, tightness, and peripheral circulation is essential; nurse documents the client's response and clinical status after being restrained
    (3) implementation; all staff members involved in a restraint event must be aware of hospital policy before using restraints
    (4) assessment; important to attend to client's nutrition and hydration after the client is safely restrained

16. The geriatric residents of a long-term care facility are engaged in a reminiscing group. The nurse knows that the primary goal of this type of group activity is to

    1. provide psychosocial educational opportunities for stress and coping.
    2. provide an avenue for physical exercise.
    3. provide an environment for social interaction and companionship.
    4. reorient and provide a reality test for confused clients.

    Strategy: Think about each answer.

    (1) is not primary goal of a reminiscing group
    (2) is not primary goal of a reminiscing group
    (3) correct–primary goal of a reminiscing group for geriatric clients is to review and share their life experiences with the group members
    (4) groups that facilitate orientation to time, person, place, and current events are called reality orientation groups

17. The nurse is aware that which of the following assessments would be indicative of hypocalcemia?

    1. Constipation.
    2. Depressed reflexes.
    3. Decreased muscle strength.
    4. Positive Trousseau's sign.

    Strategy: Think about the cause of each answer.

    (1) symptom associated with hypercalcemia
    (2) symptom associated with hypercalcemia
    (3) symptom associated with hypercalcemia
    (4) correct–positive Trousseau's sign is indicative of neuromuscular hyperreflexia associated with hypocalcemia

18. When obtaining a specimen from a client for sputum culture and sensitivity (C and S), the nurse knows that which of the following instructions is BEST?

    1. After pursed-lip breathing, cough into a container.
    2. Upon awakening, cough deeply and expectorate into a container.
    3. Save all sputum for three days in a covered container.
    4. After respiratory treatment, expectorate into a container.

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

    (1) coughing into a container is indicated, but not pursed-lip breathing
    (2) correct–specimens should be obtained in the early morning because secretions develop during the night
    (3) appropriate for acid-fast stain for TB
    (4) earliest specimen is most desirable

19. A patient has a Levin tube connected to intermittent low suction. At 7 AM, the nurse charts that there is 235 cc of greenish drainage in the suction container. At 3 PM, the nurse notes that there is 445 cc of greenish drainage in the suction container. Twice during the shift, the nurse irrigates the Levin tube with 30 cc of normal saline, as ordered by the physician. What is the actual amount of drainage from the nasogastric tube for the 7 to 3 shift?

    1. 150 cc.
    2. 210 cc.
    3. 295 cc.
    4. 385 cc.

    Strategy: Think about each answer.

    (1) correct–445 – 235 = 210 – 60 = 150
    (2) does not subtract 60 cc of fluid used to irrigate Levin tube
    (3) does not take into account solution added to container during day shift; does not subtract for fluids used to irrigate Levin tube
    (4) does not subtract 235 cc that was in container from night shift

20. The nurse is caring for a patient during a radium implant. During the removal of the implant, it is MOST important for the nurse to take which of the following actions?

    1. Clean the radium implant carefully with a disinfectant (alcohol or bleach) using long forceps.
    2. Handle the radium carefully using forceps and rubber latex gloves.
    3. Chart the date and time of removal along with the total time of implant treatment.
    4. Double-bag the radium implant before the person from radiology removes it from the room.

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

    (1) at no time should the nurse or client handle the radium; radiology department is responsible for handling implant
    (2) at no time should the nurse or client handle the radium; radiology department is responsible for handling implant
    (3) correct–important that accurate documentation be maintained on the internal radium implant
    (4) at no time should the nurse or client handle the radium; radiology department is responsible for handling implant

21. The physician prescribes lithium carbonate (Lithobid) 300 mg PO QID for a 47-year-old woman. The nurse in the outpatient clinic teaches the client about the medication. The nurse should encourage the client to make sure her diet has adequate

    1. sodium.
    2. protein.
    3. potassium.
    4. iron.

    Strategy: Think about each answer.

    (1) correct–alkali metal salt acts like sodium ions in body; excretion of lithium depends on normal sodium levels; sodium reduction causes marked lithium retention, leading to toxicity
    (2) doesn't interact with lithium
    (3) doesn't interact with lithium
    (4) doesn't interact with lithium

22. A college student comes to the college health services with complaints of a severe headache, nausea, and photophobia. The physician orders a complete blood count (CBC) and a lumber puncture (LP). Which of the following lab results would the nurse expect if a diagnosis of bacterial meningitis were made?

    1. Cerebrospinal fluid (CSF) cloudy, Hgb 13 g/dL, Hct 38%, WBC 18,000/mm^3.
    2. CSF with RBCs present, Hgb 10 g/dL, Hct 37%, WBC 8,000/mm^3.
    3. CSF cloudy, Hgb 12 g/dL, Hct 37%, WBC 7,000/mm^3.
    4. CSF clear, Hgb 15 g/dL, Hct 40%, WBC 11,000/mm^3.

    Strategy: Think about each answer and how it relates to bacterial meningitis.

    (1) correct–CSF normally clear, colorless; normal WBC 5,000–10,000 per cubic millimeter, normal Hgb (male 13.5–17.5 g/dL, female 12–16 g/dL), normal Hct (male 41–53%, female 36–46%)
    (2) indicates trauma or hemorrhage
    (3) WBC too low, not typical of bacterial meningitis
    (4) indicates viral meningitis

23. A Miller-Abbott tube is ordered for a client. The nurse knows that the main reason this tube is inserted is to

    1. provide an avenue for nutrients to flow past an obstructed area.
    2. prevent fluid and gas accumulation in the stomach.
    3. administer drugs that can be absorbed directly from the intestinal mucosa.
    4. remove fluid and gas from the small intestine.

    Strategy: Think about each answer.

    (1) tube would be placed in an area of reduced peristalsis and would slowly work past an obstruction
    (2) describes a tube such as a Levin or Salem Sump, which decompresses the stomach
    (3) tube provides for decompression instead of instillation of medications
    (4) correct–Miller-Abbott tube provides for intestinal decompression; intestinal tube is often used for treatment of paralytic ileus

24. The nurse is preparing discharge teaching for the parents of a newborn. Which of the following information should the nurse provide to the parents regarding the accuracy of a PKU (phenylketonuria) test?

    1. Breast-fed babies need to be a week old for the test, and infants on formula can be tested in three days.
    2. The infant can have water but should not have formula for six hours before the test.
    3. The test will need to be repeated at six weeks and at the three-month check-up.
    4. Blood will be drawn at three one-hour intervals; there is no specific preparation.

    Strategy: Think about each answer.

    (1) correct–formula or cow's milk contains high phenylalanine levels; test can be done after three days of formula intake; if mother is breastfeeding, infant will need to return in one week for test
    (2) no restriction on formula intake
    (3) test may be repeated in 7 to 14 days to ensure accuracy
    (4) only one blood sample is needed

25. Promethazine hydrochloride (Phenergan) 25 mg IV push has been ordered for a patient. Before administering this medication to the patient, the nurse should check the

    1. color of the medication solution.
    2. patient's pulse and temperature.
    3. time of the last analgesic dose the patient received.
    4. patency of the patient's vein.

    Strategy: Determine how each assessment relates to the medication.

    (1) is true, but not as high a priority as answer choice #4
    (2) no relevance to the question asked
    (3) Phenergan is used as an adjunct to analgesics but has no analgesic activity itself
    (4) correct–is very important to determine absolute patency of the vein; extravasation will cause necrosis

26. The nurse is reviewing procedures with the health care team. The nurse should intervene if an RN staff member makes which of the following statements?

    1. "It is my responsibility to ensure that the consent form has been signed and is attached to the patient's chart."
    2. "It is my responsibility to witness the signature of the patient before surgery is performed."
    3. "It is my responsibility to explain the surgery and ask the patient to sign the consent form."
    4. "It is my responsibility to answer questions that the patient may have before surgery."

    Strategy: "Nurse would intervene" indicates that you should look for an incorrect statement. Question is unstated. Read answer choices for clues.

    (1) describes the nurse's responsibility in obtaining consent
    (2) signature indicates that the nurse saw the patient sign the form
    (3) correct–physician should provide explanation and obtain patient's signature
    (4) the nurse should answer questions after the physician has obtained consent

27. A middle-aged woman is brought to the emergency room after being raped in her home. The client asks the nurse to call her husband to come to the emergency room. The nurse knows that the most common reaction of significant others to a rape victim is reflected in which of the following statements?

    1. Supportive and helpful to the victim.
    2. Disconnected from and apathetic toward the victim.
    3. Frustrated and feeling vulnerable, but denying need for help.
    4. Emotionally distressed and needing assistance.

    Strategy: Think about each answer.

    (1) significant others may want to be helpful; however, they generally do not have the immediate coping strategies to do so
    (2) rarely feel disconnected
    (3) usually family members will need and respond well to psychological intervention
    (4) correct–sexual assault by rape is a crisis situation for both victim and family members and friends

28. A clinic nurse is taking a health history from a 34-year-old man newly diagnosed with Buerger's disease. The nurse would expect the client's complaints to include

    1. heart palpitations.
    2. dizziness when walking.
    3. blurred vision.
    4. digital sensitivity to cold.

    Strategy: Determine the cause of each sympton and how it relates to Buerger's disease.

    (1) no cardiac involvement
    (2) dizziness not seen; intermittent claudication (pain with exercise) seen
    (3) optic nerve not affected
    (4) correct–vasculitis of blood vessels in upper and lower extremities

29. Which of the following is the BEST method for the nurse to use when evaluating the effectiveness of tracheal suctioning?

    1. Note subjective data, such as "My breathing is much improved now."
    2. Note objective findings, such as decreased respiratory rate and pulse.
    3. Consult with the respiratory therapist to determine effectiveness.
    4. Auscultate the chest for change or clearing of adventitious breath sounds.

    Strategy: Determine how each answer relates to suctioning.

    (1) subjective data and not as conclusive
    (2) correct but not as effective
    (3) not appropriate
    (4) correct–to assess the effectiveness of suctioning, auscultate the client's chest to determine if the adventitious sounds are cleared and to ensure that the airway is clear of secretions.

30. The nurse knows which of the following is an important consideration in the care of a newborn with fetal alcohol syndrome?

    1. Prevent iron deficiency anemia.
    2. Decrease touch to prevent overstimulation.
    3. Provide feedings via gavage to decrease energy expenditure.
    4. Replace vitamins depleted as a result of poor maternal diet.

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

    (1) not highest priority
    (2) infant needs to be held and cuddled due to a poorly developed CNS
    (3) usually unnecessary
    (4) correct–frequently, maternal diet is poor, and infant is malnourished; adequate intake of B complex vitamins is necessary for normal CNS function

31. A woman has returned from surgery after a right mastectomy with an IV of 0.9% NaCl infusing at 100 cc/hour into her left forearm. Several hours later, the IV infiltrates. The nurse is supervising a student nurse preparing to insert a new peripheral intravenous catheter. The nurse would intervene in which of the following situations?

    1. The student nurse selects a site where the veins are soft and elastic.
    2. The student nurse selects a site on the distal portion of the left arm.
    3. The student nurse selects a site close to the joint to provide for stability.
    4. The student nurse holds the skin taut to stabilize the vein.

    Strategy: "Nurse would intervene" indicates an incorrect action.

    (1) acceptable site selection
    (2) acceptable site selection
    (3) correct–inappropriate; movement in area could cause displacement
    (4) acceptable procedure

32. A 23-year-old man with Addison's disease comes to the health clinic. The nurse should expect the client to report that his skin has become

    1. darker and more pigmented.
    2. ruddy and oily.
    3. puffy and scaly.
    4. pale and dry.

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

    (1) correct–increase in melanocyte-stimulating hormone results in "eternal tan"
    (2) not seen with Addison's disease
    (3) not seen with Addison's disease
    (4) not seen with Addison's disease

33. Which of the following statements is both a correctly stated nursing diagnosis and a high priority for a 65-year-old client immediately following a modified radical mastectomy and axillary dissection?

    1. Anxiety related to the mastectomy.
    2. Impaired skin integrity related to the mastectomy.
    3. Pain related to surgical incision.
    4. Self-care deficit related to dressing changes.

    Strategy: Think about each answer.

    (1) is stated incorrectly with "related to the mastectomy"
    (2) is stated incorrectly with "related to the mastectomy"
    (3) correct–immediately after surgery, the priority is optimizing the client's comfort
    (4) is not an immediate priority

34. A 70-year-old man with a history of hypertension and closed-angle glaucoma visits the clinic for a routine check-up. Which of the following medications, if ordered by the physician, should the nurse question?

    1. Propranolol (Inderal), 80 mg PO QID.
    2. Verapamil (Nifedipine), 40 mg PO TID.
    3. Tetrahydrozoline (Visine), 2 gtts OU TID.
    4. Timolol (Timoptic solution), 1 gtt OU QD.

    Strategy: "Medication should the nurse question" indicates a contraindication.

    (1) antihypertensive, beta-blocker used as an antianginal, reduces cardiac oxygen demand, no effect on glaucoma
    (2) calcium channel blocker used as antianginal; not contraindicated
    (3) correct–contraindicated; ophthalmic vasoconstrictor, contraindicated with closed angle glaucoma; use cautiously with hypertension
    (4) reduces aqueous formation and increases outflow, used for glaucoma

35. A client is readmitted with a recurrent urinary tract infection. The client is to be discharged home on methenamine mandelate (Mandelamine). The nurse should instruct the client to limit intake of which of the following fluids?

    1. Milk.
    2. Juices.
    3. Water.
    4. Tea.

    Strategy: Think about each answer.

    (1) correct–should limit intake of alkaline foods and fluids, such as milk
    (2) should be increased to acidify urine
    (3) does not need to be restricted
    (4) does not need to be restricted

36. The physician prescribes estrogen (Premarin) 0.625 mg daily for a 43-year-old woman. The nurse knows which of the following symptoms is a common initial side effect of this medication?

    1. Nausea.
    2. Visual disturbances.
    3. Tinnitus.
    4. Ataxia.

    Strategy: Think about what causes each symptom and determine its relationship to Premarin.

    (1) correct–common at breakfast time; will subside after weeks of medication use; take after eating to reduce incidence
    (2) seen with long-term use
    (3) ringing in the ears is seen with long-term use
    (4) unsteady gait rarely seen

37. The nurse is assessing a client immediately after an exploratory laparotomy. Which of the following nursing observations would relate to the complication of intestinal obstruction?

    1. Protruding soft abdomen with frequent diarrhea.
    2. Distended abdomen with ascites.
    3. Minimal bowel sounds in all four quadrants.
    4. Distended abdomen with complaints of pain.

    Strategy: Determine how each answer relates to an intestinal obstruction.

    (1) does not support intestinal obstruction
    (2) does not support intestinal obstruction
    (3) immediately after postoperative abdominal surgery, bowel sounds are absent or decreased; would be no passage of stool; ascites not often seen
    (4) correct–if an obstruction is present, the abdomen will become distended and painful

38. The school nurse conducts a class on childcare at the local high school. During the class, one of the participants asks the nurse what age is best to start toilet training a child. Which of the following is the BEST response by the nurse?

    1. 11 months of age.
    2. 14 months of age.
    3. 17 months of age.
    4. 20 months of age.

    Strategy: Think about growth and development.

    (1) not able to physiologically control sphincters until 18 months of age
    (2) not able to physiologically control sphincters until 18 months of age
    (3) not able to physiologically control sphincters until 18 months of age
    (4) correct–by 24 months may be able to achieve daytime bladder control

39. Which of the following nursing actions has the HIGHEST priority in caring for the client with hypoparathyroidism?

    1. Develop a teaching plan.
    2. Plan measures to deal with cardiac dysrhythmias.
    3. Take measures to prevent a respiratory infection.
    4. Assess laboratory results.

    Strategy: ABCs.

    (1) not highest priority action related to the diagnosis
    (2) correct–cardiac dysrhythmias related to low serum calcium would be the highest priority
    (3) potential for respiratory infection is not a major threat
    (4) not highest priority action related to the diagnosis

40. A nurse discusses changes due to aging with a group at the senior citizen center. The nurse knows that which of the following changes in the pattern of urinary elimination normally occur with aging?

    1. Decreased frequency.
    2. Incontinence.
    3. Sphincter reflexes decrease.
    4. Formation of bladder stones.

    Strategy: Think about each answer.

    (1) frequency increases because bladder capacity decreases
    (2) correct–ureters, bladder, and urethra loose muscle tone results in stress and urge incontinence
    (3) is a cause of the change in the pattern of urinary elimination, not a change in pattern
    (4) related to fluid intake, diet, and activity, not age

41. The nurse is caring for a patient the first day postoperative after a transurethral prostatectomy (TURP). The patient has a continuous bladder irrigation (CBI). The patient's wife asks why he has to have the CBI. Which of the following responses by the nurse is BEST?

    1. "The CBI prevents urinary stasis and infection."
    2. "The CBI dilutes the urine to prevent infection."
    3. "The CBI enables urine to keep flowing."
    4. "The CBI delivers medication to the bladder."

    Strategy: Think about each answer.

    (1) refers to a possible preoperative complication of infection due to the enlarged prostate
    (2) not the reason for the CBI
    (3) correct–continuous bladder irrigation prevents formation of clots that can lead to obstruction and spasm in the postoperative TURP client
    (4) medication is not routinely administered via a CBI in a first-day postop TURP

42. A client with a reactive depression has the greatest chance of success in activities that require psychic and physical energy if the nurse schedules activities in the

    1. morning hours.
    2. middle of the day.
    3. afternoon hours.
    4. evening hours.

    Strategy: Think about each answer.

    (1) correct–client with reactive depression has the highest level of physical and psychic energy in the morning
    (2) as the day progresses his/her energy level declines
    (3) as the day progresses his/her energy level declines
    (4) as the day progresses his/her energy level declines

43. The nurse knows that which psychosocial stage should be a priority to consider while planning care for a 20-year-old client?

    1. Identity versus identity diffusion.
    2. Intimacy versus isolation.
    3. Integrity versus despair and disgust.
    4. Industry versus inferiority.

    Strategy: Think about each answer.

    (1) appropriate for adolescents
    (2) correct–is the stage for 19- to 35-year-olds
    (3) for 65 years and older
    (4) for 6–12 years of age

44. The nurse is caring for a homebound client with a urinary catheter. The client's husband states that he thinks the catheter is obstructed. Which of the following observations would confirm this suspicion?

    1. The nurse notes that the bladder is distended.
    2. The client complains of a constant urge to void.
    3. The nurse notes that the urine is concentrated.
    4. The client complains of a burning sensation.

    Strategy: Determine how each answer relates to a urinary catheter.

    (1) correct–bladder distention is one of the earliest signs of obstructed drainage tubing
    (2) seen with a urinary tract infection
    (3) seen with dehydration
    (4) seen with a urinary tract infection

45. A 69-year-old woman has been receiving total parenteral nutrition (TPN) for several weeks. If the TPN were abruptly discontinued, the nurse would expect the patient to exhibit

    1. tinnitus, vertigo, blurred vision.
    2. fever, malaise, anorexia.
    3. diaphoresis, confusion, tachycardia.
    4. hyperpnea, flushed face, diarrhea.

    Strategy: Think about the cause of each symptom. Determine how it relates to TPN. Remember the "comma, comma, and" rule.

    (1) not seen
    (2) suggestive of infection
    (3) correct–insulin levels remain high while glucose levels decline; results in hypoglycemia; will also see restlessness, headache, weakness, irritability, apprehension, lack of muscle coordination
    (4) not seen

46. The nurse should anticipate the client with a gastric ulcer to have pain

    1. two to three hours after a meal.
    2. at night.
    3. relieved by ingestion of food.
    4. one-half to one hour after a meal.

    Strategy: Think about each answer.

    (1) feature of a duodenal ulcer
    (2) feature of a duodenal ulcer
    (3) feature of a duodenal ulcer
    (4) correct–pain related to a gastric ulcer occurs about one-half to one hour after a meal and rarely at night; is not helped by ingestion of food

47. During a prenatal visit, a client states: “I have been very nauseated during my first trimester, and I don’t understand the reason.” Which of the following responses by the nurse is BEST?

    1. “You are nauseated because of the fatigue you are feeling.”
    2. “The nausea is due an increase in the basal metabolic rate.”
    3. “The nausea is caused by a secondary elevation in the hormones produced by the endocrine system.”
    4. “If you eat different kinds of foods, you won’t be nauseated.”

    Strategy: Think about each answer.

    (1) describes an erroneous rationale for the nausea
    (2) describes an erroneous rationale for the nausea
    (3) correct–during first trimester, nausea and vomiting are related to elevation in estrogen, progesterone, and hCG from the endocrine system
    (4) describes erroneous rationale for the nausea

48. A nursing assistant reports to the RN that a patient with anemia is complaining of weakness. Which of the following responses by the nurse to the nursing assistant is BEST?

    1. "Listen to the patient's breath sounds and report back to me."
    2. "Set up the patient's lunch tray."
    3. "Obtain a diet history from the patient."
    4. "Instruct the patient to balance rest and activity."

    Strategy: Topic of question not clearly stated.

    (1) requires assessment; should be performed by the RN
    (2) correct–standard, unchanging procedure; decrease cardiac workload
    (3) involves assessment; should be performed by RN
    (4) assessment and teaching required; performed by RN

49. A four-year-old is admitted with drooling and an inflamed epiglottis. During the assessment, the nurse would identify which of the following symptoms as indicative of an increase in respiratory distress?

    1. Bradycardia.
    2. Tachypnea.
    3. General pallor.
    4. Irritability.

    Strategy: Determine how each answer relates to respiratory distress.

    (1) tachycardia occurs early in hypoxia
    (2) correct–increase in the respiratory rate is an early sign of hypoxia, also for tachycardia
    (3) pallor is not specific for hypoxia
    (4) client may be anxious and restless, but is generally not described as irritable

50. The nurse is observing a student nurse auscultate the lungs of a client. The nurse knows that the student nurse is correctly auscultating the right middle lobe (RML) if the stethoscope is placed in which of the following positions?

    1. Posterior and anterior base of right side.
    2. Right anterior chest between the fourth and sixth intercostals.
    3. Left of the sternum, midclavicular, at right fifth intercostal.
    4. Posterior chest wall, midaxillary, right side.

    Strategy: Think about the anatomy of the lung.

    (1) cannot auscultate the RML from the posterior
    (2) correct–RML is found in the right anterior chest between the fourth and sixth intercostal spaces
    (3) point of maximum impulse or apical pulse
    (4) cannot auscultate the RML from the posterior

51. When caring for a client with myasthenia gravis, an important nursing consideration would be to

    1. prevent accidents from falls as a result of vertigo.
    2. maintain fluid and electrolyte balance.
    3. control situations that could increase intracranial pressure and cerebral edema.
    4. assess muscle groups toward the end of the day.

    Strategy: Answers are a mix of assesment and implementation. Is there an appropriate assessment? Yes.

    (1) does not experience vertigo
    (2) fluid and electrolytes usually not a problem for this patient
    (3) increased intracranial pressure is not associated with myasthenia gravis
    (4) correct–client has increased muscle fatigue, needs more assistance toward end of day

52. A 25-year-old man is in an acute manic episode. The nurse knows that which client behavior would be MOST characteristic of mania?

    1. Agitation, grandiose delusions, euphoria, difficulty concentrating.
    2. Difficulty in decision-making, preoccupation with self, distorted perceptions.
    3. Paranoia, hallucinations, disturbed thought processes, hypervigilance.
    4. Fear of going crazy, somatic complaints, difficulties with intimacy, increased anxiety.

    Strategy: Remember the "comma, comma, and" rule. Each part of the answer must be correct.

    (1) correct–characteristic behaviors associated with an acute manic episode include agitation, grandiose delusions, euphoria, and concentration problems; mania is a mood of extreme euphoria and is manifested by more extreme levels of behavior
    (2) characteristic of depression
    (3) indicative of schizophrenia
    (4) consistent with personality disorders

53. A client is admitted to the outpatient oncology unit for his routine chemotherapy transfusion. The client's current lab report is WBC 2,500 mm^3, RBC 5.1 ml/mm^3, and calcium 5 mEq/L. Based on these assessments, which of the following should be the priority nursing diagnosis?

    1. Risk for activity intolerance related to decrease in red cells.
    2. Risk for infection related to low white cell count.
    3. Risk for anxiety; secondary to hypoparathyroid disease.
    4. Risk for fluid volume deficit due to decreased fluid intake.

    Strategy: Think about each answer.

    (1) not a priority
    (2) correct–clients with a low WBC count are susceptible to infection
    (3) not correctly stated as a nursing diagnosis and issue is not a priority for this client
    (4) not a priority for this client

54. The nurse is caring for a client with Ménière's disease. The nurse stands directly in front of the client when speaking. Which of the following BEST describes the rationale for the nurse's position?

    1. This enables the client to read the nurse's lips.
    2. The client does not have to turn her head to see the nurse.
    3. The nurse will have the client's undivided attention.
    4. There is a decrease in client's peripheral visual field.

    Strategy: Think about each answer.

    (1) client is not hard of hearing
    (2) correct–by decreasing movement of client's head, vertigo attacks may be decreased
    (3) there is no problem with visual fields
    (4) there is no problem with visual fields

55. A client receives morphine sulfate after being admitted to the emergency room in acute respiratory distress. He is very anxious, edematous, and cyanotic. Which of the following should the nurse recognize as the desired response to the medication?

    1. Increase in pulse pressure.
    2. Decrease in anxiety.
    3. Depression of the sympathetic nervous system.
    4. Enhanced ventilation and decreased cyanosis.

    Strategy: Think about each answer.

    (1) is not affected by morphine sulfate
    (2) correct–morphine sulfate is administered to minimize anxiety associated with respiratory distress from pulmonary edema
    (3) is not the action of the medication
    (4) medication does not improve ventilation

56. A 28-year-old client is admitted to the hospital unit with hepatitis A. The nurse knows that the client's overall care during hospitalization should include which of the following?

    1. Protective isolation.
    2. Airborne precautions.
    3. Standard precautions.
    4. Droplet precautions.

    Strategy: Think about each answer.

    (1) for the client who has burns or is immunosuppressed
    (2) unnecessary; used with pathogens transmitted by airborne route
    (3) correct–standard precautions should be used on everyone; sources for this virus are saliva, feces, and blood; use contact isolation if fecal incontinence
    (4) unnecessary; used when pathogens transmitted by infectious droplets

57. The nurse knows that the MOST reliable client measure for evaluating the desired response diuretic therapy is to

    1. obtain daily weights.
    2. obtain urinalysis.
    3. monitor Na^+ and K^+ levels.
    4. measure intake.

    Strategy: Think about each answer.

    (1) correct–effectiveness of diuretic therapy is demonstrated by decreased edema and is measured by daily weights
    (2) does not relate to the effects of diuretic therapy
    (3) important to consider, but is not a priority
    (4) important to consider, but is not a priority

58. The physician suggests play therapy for a 7-year-old girl who is having some difficulty adjusting to her parents' impending divorce. The nurse knows this type of therapy is useful because

    1. young children have difficulty verbalizing emotions.
    2. children hesitate to confide in anyone but their parents.
    3. play is an enjoyable form of therapy for children.
    4. play therapy is helpful in preventing regression.

    Strategy: Think about each answer.

    (1) correct–children have difficulty putting feelings into words; play is how they express themselves
    (2) somewhat true, but not best reason for play therapy
    (3) not reason play therapy is used; is used because it is the best way for children to express themselves
    (4) may encourage child to act out earlier developmental stage to reveal underlying conflicts

59. A 69-year-old man is receiving dexamethasone (Decadron) 3 mg PO TID for chronic lymphocytic leukemia. It is MOST important for the nurse to report which of the following findings to the physician?

    1. PT 12 seconds and Hgb 15 g/dL.
    2. BUN 18 mg/dL and creatinine 1.0 mg/dL.
    3. K^+ 3.4 mEq/L and CA^+ 5/5 mEq/L.
    4. AST (SGOT) 18 U/L and ALT (SGPT) 12 U/L.

    Strategy: "Most important to report to the physician" indicates a side effect of the drug.

    (1) normal PT 11–15 sec, normal Hgb male: 13.5–17.5 g/dL, female: 12–16 g/dL
    (2) normal BUN 10–20 mg/dL, normal creatine 0.6–1.2 mg/dL
    (3) correct–normal K^+ 3.5–5.0 mEq/L, normal Ca^+ 4.5–5.3 mEq/L, indicates hypokalemia and hypercalcemia
    (4) normal AST (SGOT) 8–20 U/L, normal ALT (SGPT) 8–20 U/L

60. The nurse is preparing a client for a magnetic resonance imaging (MRI). Which of the following client statements indicates to the nurse that teaching has been successful?

    1. "The dye used in the test will turn my urine green for about 24 hours."
    2. "I will be put to sleep for this procedure. I will return to my room in two hours."
    3. "This procedure will take about 90 minutes to complete. There will be no discomfort."
    4. "The wires that will be attached to my head and chest will not cause me any pain."

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

    (1) no dye is used for an MRI
    (2) client is not anesthetized for this procedure
    (3) correct–procedure takes approximately 90 minutes, not painful
    (4) indicates misunderstanding of MRI because no wires are used

61. A fluid challenge of 250 cc of normal saline infused over 15 min is ordered for a client with possible acute renal failure. The nurse understands that the fluid challenge is given to

    1. rule out dehydration as the cause of oliguria.
    2. increase cardiac output and fluid volume.
    3. promote the transfer of intravascular fluid to the intracellular space.
    4. dilute the level of waste products in the intravascular fluid.

    Strategy: Think about each answer.

    (1) correct–expected response after a fluid challenge on normally functioning kidneys is an increase in urine output; will occur if low urine output is due to dehydration; if it is due to acute renal failure, there will continue to be oliguria
    (2) not the reason a fluid challenge is given to a patient with acute renal failure
    (3) not the reason a fluid challenge is given to a patient with acute renal failure
    (4) not the reason a fluid challenge is given to a patient with acute renal failure

62. The nurse is caring for a patient admitted two days ago with a diagnosis of closed head injury. If the patient develops diabetes insipidus, the nurse would observe which of the following symptoms?

    1. Decerebrate posturing, BP 160/100, pulse 56.
    2. Cracked lips, urinary output of 4 L/24 h with a specific gravity of 1.004.
    3. Glucosuria, osmotic diuresis, loss of water and electrolytes.
    4. Weight gain of 5 lb, pulse 116, serum sodium 110 mEq/L.

    Strategy: Determine how each answer relates to diabetes insipidus.

    (1) late signs of increased intracranial pressure or brain damage
    (2) correct–signs of dehydration, increased output, low specific gravity, normal 1.010-1.030
    (3) signs of hyperglycemia due to diabetes mellitus
    (4) symptoms of SIADH (syndrome of inappropriate antidiuretic hormone) are opposite of diabetes insipidus

63. The doctor has ordered chlorpromazine (Thorazine) to control an alcoholic client's restlessness, agitation, and irritability following surgery. The nurse should check the order with the doctor based on which of the following rationales?

    1. The nurse believes that the client's symptoms reflect alcohol withdrawal.
    2. The nurse does not know if the client is allergic to this medication.
    3. The nurse knows that the client is not psychotic.
    4. The nurse routinely checks on the doctor's orders.

    Strategy: Think about each answer.

    (1) correct–medication is contraindicated for the treatment of alcohol withdrawal symptoms; medication will lower client's seizure threshold and BP, causing potentially serious medical consequences
    (2) not best rationale for checking with doctor about this order
    (3) not best rationale for checking with doctor about this order
    (4) not best rationale for checking with doctor about this order

64. The nursing team consists of one RN, two LPNs/LVNs, and three nursing assistants. The RN should care for which of the following patients?

    1. A patient with a chest tube who is ambulating in the hall.
    2. A patient with a colostomy who requires assistance with an irrigation.
    3. A patient with a right-sided cerebral vascular accident (CVA) who requires assistance with bathing.
    4. A patient who is refusing medication to treat cancer of the colon.

    Strategy: Determine the skill level involved with each patient's care. The RN cares for patients that require assessment, teaching, and nursing judgment.

    (1) stable patient with an expected outcome: assign to the LPN/LVN
    (2) stable patient with an expected outcome: assign to the LPN/LVN
    (3) standard, unchanging procedure: assign to the nursing assistant
    (4) correct–requires assessment skills of the RN

65. During the development of a nursing care plan, the nurse should consider which of the following clients for the use of a restraint?

    1. An infant with septicemia.
    2. A child with a tonsillectomy.
    3. An infant with cleft lip repair.
    4. A child with meningitis.

    Strategy: Think about each answer.

    (1) not in need of restraints
    (2) not in need of restraints
    (3) correct–arm restraints are necessary to prevent infant from rubbing or otherwise disturbing suture line
    (4) not in need of restraints

66. A client has developed a low intestinal obstruction. The nurse would anticipate which of the following findings?

    1. Nausea, vomiting, abdominal distention.
    2. Explosive, irritating diarrhea.
    3. Abdominal tenderness with rectal bleeding.
    4. Midepigastric discomfort, tarry stool.

    Strategy: Determine how each answer relates to an intestinal obstruction.

    (1) correct–there is distention above the level of obstruction and initially hyperactive bowel sounds; would be no stool, as motility distal to (below) the obstruction would cease
    (2) would be no diarrhea
    (3) would be no rectal bleeding, abdomen would be distended
    (4) would be no GI bleeding

67. A 42-year-old man with metastatic lung cancer is admitted to the hospital. His orders include: do not resuscitate (DNR) and morphine 2 mg/h by continuous IV infusion. When the nurse assesses him, his BP is 86/50, respirations are 8, and he is nonresponsive. Naloxone hydrochloride (Narcan), 0.4 mg IV, is ordered STAT. In planning care for this man, it is IMPORTANT for the nurse to know that

    1. the BP and respirations will need to increase before a second dose of Narcan can be given.
    2. Narcan should not be given to the man because of his DNR status.
    3. a dose of Narcan may need to be repeated in 2–3 minutes.
    4. Narcan is effective in treating respiratory changes caused by opiates, barbiturates, and sedatives.

    Strategy: Think about each answer.

    (1) will not change without Narcan, respirations increase within 2 min
    (2) DNR indicates no resuscitation should be done if heart stops; does not preclude administration of drugs to correct iatrogenic problems
    (3) correct–half-life of Narcan is short; may go back into respiratory depression; may need to be repeated
    (4) used for respiratory depression of opiates, not used with barbiturates or sedatives

68. In planning discharge teaching for a client after a lumbar laminectomy, the nurse would instruct the client to exercise regularly to strengthen which muscles?

    1. Anal sphincter.
    2. Abdominal.
    3. Trapezius.
    4. Rectus femoris.

    Strategy: Think about each answer.

    (1) does not contribute to support of the lumbar spine
    (2) correct–strengthening the abdominal muscles adds support for the muscles supporting the lumbar spine
    (3) does not contribute to support of the lumbar spine
    (4) does not contribute to support of the lumbar spine

69. The nurse is planning care for a client with a diagnosis of paranoid schizophrenia. The nurse knows that questioning the client about his false ideas will

    1. cause him to defend the idea.
    2. help him clarify his thoughts.
    3. facilitate better communication.
    4. lead to a breakdown of the defense.

    Strategy: Think about each answer.

    (1) correct–contraindicated; encourages patient to engage in further distortion of reality
    (2) needs reality testing from nurse, not questioning
    (3) questioning is nontherapeutic; may cause patient to avoid nurse physically
    (4) needs defense; questioning will further distort reality or elaborate on delusion

70. When assessing orientation to person, place, and time for an elderly hospitalized client, which of the following principles should be understood by the nurse?

    1. Short-term memory is more efficient than long-term memory.
    2. The stress of an unfamiliar environment may cause confusion.
    3. A decline in mental status is a normal part of aging.
    4. Learning ability is reduced during hospitalization of the elderly client.

    Strategy: Think about each answer.

    (1) just the opposite is true; long-term memory is more efficient than short-term memory
    (2) correct–stress of an unfamiliar situation or environment may lead to confusion in elderly clients
    (3) mental status and learning ability are not affected by aging, although elderly client may be slower at doing things
    (4) mental status and learning ability are not affected by aging, although elderly client may be slower at doing things

71. Which of the following assessment findings should the nurse recognize as pertinent to a diagnosis of Cushing's syndrome?

    1. Low blood pressure and weight loss.
    2. Thin extremities with easy bruising.
    3. Decreased urinary output and decreased serum potassium.
    4. Tachycardia with complaints of night sweats.

    Strategy: Think about each answer.

    (1) BP increases and client gains weight
    (2) correct–clients with Cushing's syndrome tend to lose weight in their legs and have petechiae and bruising
    (3) no correlation with urinary output; potassium increases
    (4) no correlation with Cushing's syndrome

72. A patient with type I diabetes mellitus (IDDM) asks the nurse why the doctor ordered human insulin instead of beef or pork insulin. Which of the following responses by the nurse is BEST?

    1. "Human insulin is less likely to cause you to have a localized allergic reaction to the injection."
    2. "Human insulin will cause you to experience fewer problems with hypoglycemia or hyperglycemia."
    3. "Human insulin prevents the development of long-term damage to the eyes and kidneys."
    4. "Human insulin does not cause the formation of antibodies because the protein structure is identical to your own."

    Strategy: Think about each answer.

    (1) reactions caused by preservatives in insulin, which is same for all types of insulin
    (2) no change in incidence of hypoglycemia or hyperglycemia
    (3) complications are caused by blood vessel damage from sugar and fat deposits, not type of insulin used
    (4) correct–protein molecules are identical with human insulin

73. A client with acquired immunodeficiency syndrome (AIDS) is admitted with a tentative diagnosis of late AIDS dementia complex. The nursing assessment is most likely to reveal which of the following?

    1. Hyperactive deep tendon reflexes.
    2. Peripheral neuropathy affecting the hands.
    3. Disorientation to person, place, and time.
    4. Impaired concentration and memory loss.

    Strategy: Think about each answer and how it relates to AIDS-related dementia.

    (1) not relevant to this condition
    (2) not relevant to this condition
    (3) correct–approximately 65% of AIDS clients demonstrate a progressive dementia staged according to severity of debilitation; late stage is typified by cognitive confusion and disorientation
    (4) is a sign of early onset dementia

74. What are two major side effects of haloperidol (Haldol) the nurse should anticipate?

    1. Blood dyscrasia and extrapyramidal symptoms.
    2. Hearing loss and unsteady gait.
    3. Nystagmus and vertical gaze palsy.
    4. Alteration in level of consciousness and increased confusion.

    Strategy: Think about each answer.

    (1) correct–major side effects of haloperidol (Haldol) include hematologic problems, primarily blood dyscrasia and extrapyramidal symptoms (EPS)
    (2) not seen with haloperidol
    (3) not seen with haloperidol
    (4) not seen with haloperidol

75. A home care nurse is planning activities for the day. Which of the following clients should the nurse see FIRST?

    1. A new mother is breastfeeding her two-day-old infant who was born five days early.
    2. A man discharged yesterday following treatment with IV heparin for a deep vein thrombosis.
    3. An elderly woman discharged from the hospital three days ago with pneumonia.
    4. An elderly man who used all his diuretic medication and is expectorating pink-tinged mucus.

    Strategy: Determine the least stable client. Think ABCs.

    (1) stable situation, not a priority
    (2) assess for bleeding gums, hematuria, not the priority
    (3) assess breath sounds, encourage fluids, cough and deep breathe
    (4) correct–symptoms of pulmonary edema; requires immediate attention