NCLEX QUESTION TRAINER EXPLANATIONS

TEST 3

1. A client has a total laryngectomy with a permanent tracheostomy. The nurse is planning nutritional intake for the next three days. Which of the following would be necessary for the nurse to consider regarding the client's nutrition?

   1. To facilitate healing of the surgical area, a nasogastric tube may be utilized and tube feedings may be implemented.
   2. The client will be unable to maintain any PO intake as long as he has a tracheotomy in place.
   3. Nutritional and/or gastric feedings will not be attempted for approximately three weeks to decrease the incidence of aspiration.
   4. Since the client is dependent on the ventilator, nutritional intake will be delayed.

   Strategy: Think about each answer choice.

   (1) correct–tube feedings frequently started as the initial nutritional intake; prevents trauma to suture area
   (2) although the client has permanent tracheotomy, will be able to eat normally after area has healed
   (3) nutritional intake will begin when bowel sounds return and client can tolerate intake
   (4) client is not dependent on ventilator

2. The nurse is caring for a client who presents with confusion, mood lability, impaired communication, and lethargy. The nurse should question which of the following orders?

   1. Dexamethasone suppression test.
   2. Thyroid studies.
   3. Drug toxicology screen.
   4. Trendelenburg test.

   Strategy: Think about each test.

   (1) may be ordered to determine the presence of major depression
   (2) may be ordered to check for an endocrine cause for the symptoms before the diagnosis of dementia is made
   (3) may be ordered to see if the client's symptoms are caused by excessive use of medications or alcohol
   (4) correct–test is used with a client who may have varicose veins, no relationship to the symptoms described in this situation

3. For a client with a neurological disorder, which of the following nursing assessments will be MOST helpful in determining subtle changes in the client's level of consciousness?

   1. Client posturing.
   2. Glasgow coma scale.
   3. Client thinking pattern.
   4. Occurrence of hallucinations.

   Strategy: Think about each answer choice.

   (1) indicates increased intracranial pressure
   (2) correct–Glasgow coma scale score best evaluates changes in a client's level of consciousness by evaluating eye-opening, motor, and verbal responses
   (3) more appropriate for the psychiatric client
   (4) more appropriate for the psychiatric client

4. The nurse is conducting a physical examination of a client suspected to have bulimia. Which of the following observations by the nurse would MOST likely indicate bulimia?

   1. The client has edema of the lower extremities.
   2. Physical exam of the client reveals the presence of lanugo.
   3. The client has ulcerated mucous membranes of the mouth.
   4. The client has dry, yellowish color of the skin.

   Strategy: Determine the cause of each symptom. Does it relate to bulimia?

   (1) common with anorexia
   (2) seen with anorexia
   (3) correct–due to frequent vomiting
   (4) bulimics are normal in appearance

5. The nurse is preparing to begin a dopamine (Intropin) infusion on a client. Before beginning the infusion the nurse should

   1. evaluate the urine output.
   2. obtain the client's weight.
   3. determine the patency of the IV line.
   4. measure pulmonary artery pressures.

   Strategy: Determine how each answer choice relates to dopamine.

   (1) not a critical assessment at this time
   (2) contains correct information, but is not a priority
   (3) correct–if extravasation occurs, there is sloughing of the surrounding skin and tissue; patent IV line is essential to prevent serious side effects
   (4) not a critical assessment at this time

6. The nurse is assisting a nursing assistant provide a bed bath to a comatose patient who is incontinent. The nurse should intervene if which of the following actions is noted?

   1. The nurse assistant answers the phone while wearing gloves.
   2. The nursing assistant log rolls the patient to provide back care.
   3. The nursing assistant places an incontinence pad under the patient.
   4. The nursing assistant positions the patient on the left side, head elevated.

   Strategy: "Nurse should intervene" indicates that you are looking for an incorrect action.

   (1) correct–contaminated gloves should be removed before answering the phone
   (2) correct way to roll a patient to maintain proper alignment
   (3) appropriate to use incontinence pad for this patient
   (4) appropriate position to prevent aspiration and protect the airway

7. A client is going to be taking imipramine (Tofranil) at home following discharge. The nurse should instruct the client to report which of the following immediately to the nurse?

   1. Sore throat, fever, increased fatigue, vomiting, diarrhea.
   2. Dry mouth, nasal stuffiness, weight gain.
   3. Rapid heartbeat, frequent headaches, yellowing of eyes or skin.
   4. Weakness, staggering gait, tremor, feeling of drunkenness.

   Strategy: Think about each answer choice.

   (1) correct–possible side effects of Tofranil, a tricyclic antidepressant medication, which can be resolved by altering the dosage or changing the medication
   (2) describes side effects of antidepressants, which client can learn to manage at home without changing the medication
   (3) describes side effects of a different category of medications
   (4) describes side effects of a different category of medications

8. The nurse has just received report from the previous shift. Which of the following patients should the nurse see FIRST?

   1. A patient who had coronary artery bypass graft (CABG) and will have the atrioventricular (AV) wires removed later in the day.
   2. A patient with type I diabetes who is scheduled for a cardiac catheterization later today.
   3. A patient who is one-day postoperative and has an epidural catheter in place.
   4. A cardiac patient who is being evaluated for a heart transplant.

   Strategy: Determine which patient is the least stable.

   (1) although the patient requires a high level of nursing care, no indication that the patient is unstable
   (2) patient requires preoperative assessment and teaching, no indication that the patient is unstable
   (3) correct–epidural used for pain relief, monitor for urinary incontinence, hypotension, respiratory depression, and nausea and vomiting
   (4) requires monitoring but patient with epidural takes priority

9. An 8-year-old girl has a closed transverse fracture of her right ulna. Which of the following actions, if performed by the nurse before the application of a cast, is MOST important?

   1. Check the radial pulses bilaterally and compare.
   2. Evaluate the skin temperature and tissue turgor in the area.
   3. Assess sensation of each foot while the girl closes her eyes.
   4. Apply baby powder to decrease skin irritation under the cast.

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

   (1) correct–assess neurovascular status, check pain, pallor, paralysis, paresthesia, pulselessness
   (2) assessment, temperature indicates decreased circulation, but is subjective and not most important
   (3) assessment, upper (not lower) extremity fracture
   (4) implementation, should not be done because it would increase skin irritation

10. The nurse is caring for a multipara client who delivered a female infant one hour ago. The nurse observes that the client's breasts are soft; the uterus is boggy, to the right of the midline, and 2 cm below the umbilicus; moderate lochia rubra. It is MOST important for the nurse to take which of the following actions?

    1. Perform a straight catheterization.
    2. Offer the client the bedpan.
    3. Put the baby to breast.
    4. Massage the uterine fundus.

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

    (1) encourage the client to void before catheterizing
    (2) correct–boggy uterus deviated to right indicates full bladder, encourage client to void
    (3) will increase uterine tone, but the problem is a full bladder
    (4) findings indicate a full bladder

11. The nurse checks for placement of a nasogastric (NG) tube before beginning a tube feeding for a client. Which of the following results would indicate to the nurse that the tube feeding can begin?

    1. A small amount of white mucus is aspirated from the NG tube.
    2. The pH of the contents removed from the NG tube is 3.
    3. No bubbles are seen when the nurse inverts the NG tube in water.
    4. The client says he can feel the NG tube in the back of his throat.

    Strategy: Determine how the answers relate to a tube feeding.

    (1) mucus may be from lungs
    (2) correct–stomach contents are acidic
    (3) not a safe way to check placement
    (4) not a reliable indication

12. The nurse is caring for a client after right cataract surgery. The nurse would intervene in which of the following situations?

    1. Client is in the supine position.
    2. The head of the bed is elevated 30°.
    3. The client is lying on her right side.
    4. An eye shield is over the right eye.

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

    (1) appropriate position
    (2) decreases swelling and pain
    (3) correct–client should not be positioned with operative side in a dependent position or against the bed
    (4) shield is appropriate

13. A young adult immobilized for trauma to the spinal cord has periods of diaphoresis, a draining abdominal wound, and diarrhea. Based on the nursing assessment, an appropriate priority nursing diagnosis is

    1. risk for constipation related to immobilization.
    2. risk for impaired skin integrity related to immobilization and secretions.
    3. risk for wound infection related to involuntary bowel secretions.
    4. risk for fluid volume excess related to secretions.

    Strategy: Think about each answer choice.

    (1) constipation is not a problem because the client has diarrhea
    (2) correct–skin is very susceptible to breakdown because of immobility and bodily secretions; needs numerous nursing interventions to prevent this
    (3) not most important
    (4) there would be risk of fluid volume deficit due to diarrhea and secretions

14. The nurse is caring for a client one day after a thoracotomy. Nursing actions on the care plan include: turn, cough, and deep breathe q2h. The nurse understands that the purpose of this nursing action is to

    1. promote ventilation and prevent respiratory acidosis.
    2. increase oxygenation and removal of secretions.
    3. increase pH and facilitate balance of bicarbonate.
    4. prevent respiratory alkalosis by increasing oxygenation.

    Strategy: Think about each answer choice.

    (1) correct–primary purpose of this nursing measure is to improve and/or maintain good gas exchange, especially removal of carbon dioxide in order to prevent respiratory acidosis
    (2) answer choice #1 is better in that it refers to ventilation rather than oxygenation
    (3) increasing the pH is not desirable
    (4) respiratory alkalosis is not prevented by this nursing measure

15. The mother of a seven-year-old child is dying. The nurse should anticipate that the seven-year-old child would have which of the following concepts of death?

    1. Death is punishment for his/her actions.
    2. Death is inevitable and irreversible.
    3. Death is temporary and gradual.
    4. Death as a concept based on past experience.

    Strategy: Remember growth and development.

    (1) correct–seven-year-olds see death as a punishment
    (2) by age of 9, most children begin to develop an adult concept of death and begin to understand that death is irreversible
    (3) is a preschool child's concept of death
    (4) is an adolescent's concept of death

16. A 46-year-old man with newly diagnosed diabetes mellitus says to the nurse, "I know that I have to take good care of my feet. When I buy new shoes, is there anything special I should do?" Which of the following responses by the nurse is BEST?

    1. "It is best to buy new shoes in the morning."
    2. "Have each foot measured every time you buy new shoes."
    3. "Buy shoes one half size larger than your foot size so the fit is roomy."
    4. "Buy vinyl shoes because they won't lose their shape easily."

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

    (1) should buy shoes in the afternoon when feet are larger than in the morning
    (2) correct–feet enlarge with age, don't break in shoes all at one time, have measurements for shoes taken while standing (feet are larger)
    (3) buy correct shoe size
    (4) leather shoes recommended because they "breathe", vinyl could cause foot to perspire and aggravate fungal infections

17. A baby girl weighing 7 lb 4 oz with Apgar scores of 7 and 8 at one and five minutes is admitted to the nursery. Because her mother is a type I diabetic, the nurse knows the infant is at GREATEST risk for developing

    1. hypovolemia.
    2. hypoglycemia.
    3. hyperglycemia.
    4. cold stress.

    Strategy: Determine the cause of each answer choice.

    (1) no change in blood volume for infant of diabetic mother
    (2) correct–fetus produces increased insulin to match mother's increased glucose level during pregnancy, infant continues to have high insulin output after birth, resulting in hypoglycemia
    (3) infant would be at risk of hypoglycemia due to increased insulin production
    (4) thermal receptors in skin are stimulated due to cold environment, increases metabolic rate, infant needs to maintain normal body temperature while producing minimal amount of heat generated from metabolic processes, not expected with diabetic mother

18. The nurse in the outpatient clinic assists with the application of a cast to the left arm of a five-year-old girl. After the cast is applied, the nurse should

    1. petal the edges of the cast to prevent irritation.
    2. elevate the client's left arm on two pillows.
    3. apply cool, humidified air to dry the cast.
    4. ask the client to move her fingers to maintain mobility.

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

    (1) done when cast is completely dry, prevents crumbling of plaster into cast
    (2) correct–minimizes swelling, elevated for first 24-48 hours, protects from pressure and flattening of cast
    (3) would delay drying of cast
    (4) maintaining mobility of fingers not most important after application of cast

19. The nurse is caring for patients on the pediatric unit. The mother of a two-year-old who is one-day postoperative tells the nurse, "My child is so restless and overactive." The nurse should

    1. direct the LPN/LVN to obtain the child's vital signs.
    2. ask the mother if the child's sutures are still intact.
    3. tell the nursing assistant to take the child for a walk.
    4. check to see when the child last received pain medication.

    Strategy: Answers are a mix of assessments and implementations. Does this situation require validation? Yes. Determine the best assessment.

    (1) no indication that there are any problems
    (2) passing the buck
    (3) implementation, should first assess
    (4) correct–young children typically become restless and overactive if in pain, grimacing, clenching teeth, rocking, and aggressive behavior may also be observed

20. The nurse is planning a diet for an eight-year-old with cystic fibrosis (CF). Which of the following dietary requirements should be considered?

    1. High protein, high fat, and high calories.
    2. High protein, low fat, and high calories.
    3. Low protein, low fat, and low carbohydrate.
    4. High protein, high fat, and low carbohydrate.

    Strategy: Think about each answer choice.

    (1) contains high fat
    (2) correct–impaired intestinal absorption due to cystic fibrosis necessitates a diet higher in protein and calories; fat is decreased because it may interfere with absorption of other nutrients
    (3) not adequate for this child
    (4) contains high fat

21. A male client is admitted with urinary tract problems. A prostate-specific antigen (PSA) and acid phosphatase test are to be done. The nurse knows that

    1. these tests are valuable screening tests for prostatic cancer.
    2. the level of PSA is decreased in clients with renal stones.
    3. the test reflects the level of renal involvement in acid-base problems.
    4. the level of PSA is elevated in clients in early stage renal failure.

    Strategy: Think about each answer choice.

    (1) correct–PSA test has replaced acid phosphatase test in screening for prostatic cancer; test must be drawn before digital rectal exam, as manipulation of the prostate will abnormally increase PSA value
    (2) inaccurate information about a PSA
    (3) inaccurate information about a PSA
    (4) inaccurate information about a PSA

22. A client who has clear lung sounds and unlabored breathing is receiving aminophylline IV. Which of the following would be the MOST appropriate nursing action if the client's IV infiltrates?

    1. Apply warm soaks to the infiltration site, start a new IV, and continue IV medications.
    2. Wait two hours, reassess the client, and restart the IV if the client has wheezing or labored breathing.
    3. Restart the IV and continue the previous medication schedule.
    4. Call the physician and recommend that the IV medications be changed to PO.

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

    (1) continued IV medication may not be necessary based on the current assessment
    (2) physician should be notified if IV medications are not infusing as scheduled
    (3) client has improved breathing, so IV medications may not be indicated
    (4) correct–before a new IV is started on this client, physician should be called and PO medications recommended

23. A client is diagnosed with bipolar disorder and is in a manic phase with combative behavior. An INITIAL nursing priority is to

    1. provide adequate hygiene and nutrition.
    2. decrease environmental stimuli.
    3. slowly involve the client in unit activities.
    4. administer and monitor sedative and mood-stabilizing medications.

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

    (1) is very important to ensure adequate hygiene and nutrition, but behavioral control and client/milieu safety are an initial priority
    (2) decreasing environmental stimulation is an additional strategy that, when utilized in conjunction with psychopharmacologic intervention, can reduce hyperactivity and aggressive acts; just decreasing environmental stimulation will not diminish client's internal sense of agitation and aggression
    (3) this action is inappropriate at this time
    (4) correct–is most important to gain control with a physically aggressive client in manic phase; client has significant sympathetic nervous system stimulation and will require psychopharmacologic intervention with both sedative medications and mood-stabilizing agents

24. A 26-year-old woman is admitted to the neurosurgery unit for the removal of a cerebellar tumor. The nurse would expect the patient to make which of the following statements about her symptoms?

    1. "I have been having difficulty with my hearing."
    2. "I lose my balance easily."
    3. "I can't tell the difference between a sweet and sour taste."
    4. "It is not easy for me to remember names and faces."

    Strategy: Remember physiology.

    (1) temporal lobe contains auditory center, loss of hearing would involve CN VIII acoustic
    (2) correct–cerebellum maintains balance
    (3) CN IX, glossopharyngeal responsible for differentiation of taste
    (4) not specific symptoms of cerebellum dysfunction

25. Nursing management prior to an intravenous pyelogram (IVP) would include which of the following?

    1. A fat-free meal the evening prior to the examination and radiopaque tablets at bedtime.
    2. Placement of a retention urinary catheter to facilitate dilation of the bladder sphincter.
    2. Cleansing enemas the evening before to provide for adequate visualization of the urinary tract.
    4. Explaining the importance of following directions regarding voiding during the test.

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

    (1) fat-free meal is associated with a gall bladder series
    (2) a retention Foley catheter may be in place, but not for the purpose of dilating the bladder sphincter
    (3) correct–because of the need to visualize the abdominal area, cleansing enemas the evening before an IVP are usually ordered
    (4) there are few directions the client needs to follow during the test

26. A client is admitted to the trauma intensive care unit (ICU) with a gunshot wound of the neck. The client has a cervical level (C-4) spinal cord injury, is tearful, constantly complains of discomfort, and requests to be suctioned. The nurse understands that the client's attention-seeking behaviors may be due to

    1. anger and frustration.
    2. awareness of vulnerability.
    3. increased social isolation.
    4. increased sensory stimulation.

    Strategy: Think about each answer choice.

    (1) is not accurate for situation
    (2) correct–is experiencing an increased awareness of his physical vulnerability due to his spinal cord injury; fosters increased dependency needs that are real due to his injury; is trying to determine who is consistent and trustworthy for meeting his significant physical needs
    (3) is not accurate for situation
    (4) is not accurate for situation

27. A client is scheduled for electromyography (EMG). What should the nurse tell the client about the procedure?

    1. "Your hair will be carefully washed prior to the procedure."
    2. "This is a noninvasive procedure that takes about 30 minutes."
    3. "A sedative will be given to you shortly before the procedure."
    4. "You will not be allowed to eat 4-6 hours before the procedure."

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

    (1) usually performed on the legs
    (2) correct–electrodes are attached to legs, length of time for impulse transmission is measured
    (3) may impair test results
    (4) doesn't involve general anesthesia or GI system

28. The nurse is aware that Rh immune globulin (RhoGAM) is administered to prevent complications in which of the following situations?

    1. The baby is Rh-negative, the mother is Rh-negative, and the father is Rh-positive.
    2. The mother is Rh-negative, the baby is Rh-positive, and there is a negative direct Coombs'.
    3. The mother is Rh-positive and previously sensitized, and the baby is Rh-negative.
    4. The mother is Rh-positive, the baby is Rh-negative, and there is a history of one incomplete pregnancy.

    Strategy: Think about each answer choice.

    (1) if both mother and baby are Rh-negative, there is no problem
    (2) correct–RhoGAM is given to an Rh-negative mother who delivers an Rh-positive baby when baby has a negative Coombs' test
    (3) medication is not given if the mother has been sensitized by a previous pregnancy
    (4) there is no incompatibility here, but the mother needs to be evaluated regarding sensitization in the incomplete pregnancy

29. The nurse in the outpatient clinic teaches a client with right-sided weakness to walk down stairs using a cane. What behavior, if demonstrated by the client, would indicate that teaching was successful?

    (1) The client puts her right leg on the step, then the cane, followed by her left leg.
    (2) The client leads with the cane, followed by her right leg, and then her left leg.
    (3) The client advances her right leg, followed by her left leg and the cane.
    (4) The client puts the cane on the step and advances her left leg, followed by her right leg.

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

    (1) to go down stairs, advance weak leg and cane first; to go up stairs, advance strong leg, then weak leg and cane
    (2) correct–to do down stairs, advance cane and weak leg, then strong leg; memory trick: the good goes up, the bad goes down
    (3) should advance cane and weak leg first
    (4) weaker leg and cane advance first

30. The nurse is making patient assignments on the obstetrical unit. Which of the following patients should the nurse assign to an RN who has been reassigned to the obstetrical unit from outpatient surgery?

    1. A patient at 16 weeks gestation admitted with hyperemesis receiving IV fluids.
    2. A patient at 26 weeks gestation in premature labor receiving terbutaline (Brethine).
    3. A patient at 32 weeks gestation with a placenta previa and ruptured membranes.
    4. A patient at 37 weeks gestation with pregnancy-induced hypertension and epigastric pain.

    Strategy: LPN/LVN and "pulled" RN receive stable patients with expected outcomes.

    (1) correct–monitor IV therapy, administer antiemetics and nutritional supplements
    (2) monitor patient's response to medication and the status of the fetus
    (3) prepare for delivery, closely monitor fetal response
    (4) indicates impending seizures, prepare for delivery

31. A two-day-old infant in the newborn nursery does not appear interested in taking formula from the mother or the nurse. An appropriate nursing diagnosis is high risk for

    1. impaired swallowing.
    2. failure to thrive.
    3. fluid volume deficit.
    4. altered health maintenance.

    Strategy: Think about each answer choice.

    (1) no information about swallowing provided with question
    (2) this is a medical diagnosis not a nursing diagnosis
    (3) correct–may become dehydrated
    (4) not specific for problem described

32. The nurse is caring for clients in the medical clinic. A nursing assessment of a client with a hiatal hernia is MOST likely to reveal

    1. a bulge in the lower right quadrant.
    2. pain at the umbilicus radiating down into the groin.
    3. a burning sensation in the midepigastric area each day before lunch.
    4. complaints of awakening at night with heartburn.

    Strategy: Think about each answer choice.

    (1) suggests an inguinal hernia
    (2) suggests an inguinal hernia
    (3) pain usually does not develop during the day with an empty stomach
    (4) correct–classic symptom of hiatal hernia associated with reflux

33. The MOST appropriate nursing action before administration of captopril (Capoten) would be to check the client's

    1. apical pulse for 60 seconds.
    2. blood pressure.
    3. urine output.
    4. temperature.

    Strategy: Think about each answer choice and how it relates to Capoten.

    (1) important, but not a priority
    (2) correct–is an antihypertensive that necessitates that a BP be assessed prior to administration
    (3) important, but not priority
    (4) unnecessary to assess prior to the administration of the medication

34. A 60-year-old man with a diagnosis of pneumonia is being admitted to the medical/surgical unit. The nurse should place the patient in a room with which of the following patients?

    1. A 20-year-old in traction for multiple fractures of the left lower leg.
    2. A 35-year-old with recurrent fever of unknown origin.
    3. A 50-year-old recovering alcoholic with cellulitis of the right foot.
    4. An 89-year-old with Alzheimer's disease awaiting nursing home placement.

    Strategy: Determine the transmission of organisms.

    (1) patient with fractures are considered "clean," don't place with an infectious patient
    (2) don't know the cause of the fever
    (3) correct–generalized nonfollicular infection that involves deeper connective tissue, both patients have infections
    (4) elderly are high risk for developing pneumonia

35. An elderly man diagnosed with chronic schizophrenia is being followed in a partial hospitalization program. The client has been on long-term antipsychotic medication and has recently developed symptoms of tardive dyskinesia. The nurse's documentation on this client should include

    1. assessment of ADL (self-care) ability.
    2. Mini-Mental Status Examination (MMSE).
    3. Abnormal Involuntary Movement Scale (AIMS).
    4. Modified Overt Aggression Scale (MOAS).

    Strategy: Think about each answer choice.

    (1) assessment of client's abilities to complete his activities of daily living (ADLs) needs to be completed and revised with a client who is aging and chronically mentally ill
    (2) measures cognitive function
    (3) correct–is most widely accepted examination to test for the presence of tardive dyskinesia
    (4) assessment tool for determining severity of aggression; usually utilized to determine nature, severity, and prevalence of aggression in an inpatient population

36. The nurse finds a client's temperature to be 103°F (39.4°C). Body compensatory mechanisms would include which of the following?

    1. Decreased respiratory rate and bradycardia.
    2. Normal blood pressure and pulse.
    3. Increased respiratory rate and tachycardia.
    4. Diaphoresis with cool, clammy skin.

    Strategy: Think about each answer choice.

    (1) respirations and heart rate will increase with fever
    (2) blood pressure and pulse usually increase with fever
    (3) correct–hyperthermia increases the oxygen requirements, which results in faster breathing as well as an increase in the pulse rate
    (4) diaphoresis may occur, but the skin will be warm

37. A client is admitted with irritable bowel syndrome. The nurse would anticipate the client's history to reflect which of the following?

    1. Pattern of alternating diarrhea and constipation.
    2. Chronic diarrhea stools occurring 10-12 times per day.
    3. Diarrhea and vomiting with severe abdominal distention.
    4. Bloody stools with increased cramping after eating.

    Strategy: Think about each answer choice.

    (1) correct–condition is often called spastic bowel disease; no inflammation is present
    (2) refers to inflammatory bowel disease such as ulcerative colitis or Crohn's disease
    (3) refers to inflammatory bowel disease such as ulcerative colitis or Crohn's disease
    (4) bloody stools do not occur

38. The nurse is caring for a client who has had an above-knee amputation (AKA) with an immediate prosthetic fitting. It is MOST important for the nurse to

    1. assess drainage from Penrose drains.
    2. observe dressings for signs of excessive bleeding.
    3. elevate the stump for no less than 40 hours.
    4. provide cast care to the affected extremity.

    Strategy: Answers are a mix of assessments and implementations. Is there an appropriate assessment? No. Determine the outcome of each implementation.

    (1) drains not usually used with amputations
    (2) rigid cast dressing frequently used to create a socket for prosthesis
    (3) elevation of extremity unnecessary, rigid cast dressing prevents swelling
    (4) correct–cast applied to provide uniform compression, prevent pain and contractures

39. A patient is admitted to the hospital for a hypoglossectomy with lymph node dissection. The patient's preoperative care includes frequent oral hygiene with hydrogen peroxide. The nurse knows the purpose of this treatment is to

    1. minimize the bacterial count in the mouth.
    2. soften the mucous membranes of the tongue before surgery.
    3. stimulate the microcirculation of the mouth.
    4. hydrate the tissues of the gums.

    Strategy: Determine how each answer choice relates to the procedure.

    (1) correct–destroys bacteria found in mouth, reduces the chance of infection
    (2) is not the action of hydrogen peroxide
    (3) circulation is unaffected by a mouth rinse
    (4) has slight drying effect on mucous membranes

40. The school nurse observes a group of preschool children in the playroom. The nurse recognizes which of the following activities as appropriate behavior for a five-year-old boy?

    1. The boy plays with a large truck with another child.
    2. The boy talks on a toy telephone and imitates his father.
    3. The boy works on a puzzle with several other children.
    4. The boy holds and cuddles a large stuffed animal.

    Strategy: Picture the child.

    (1) play begins to be cooperative at this age
    (2) correct–imitative behavior seen at this age
    (3) too advanced for this age
    (4) too regressed for this age

41. Which of the following statements, if made by the nurse, is accurate about the exercise program required for a patient with rheumatoid arthritis?

    1. "If you are having a 'bad' day, postpone your exercises until the next day."
    2. "Passive exercises are better for you than active exercises."
    3. "When inflammation is severe, decrease the number of repetitions of the exercise."
    4. "You can substitute your normal household tasks for your exercises to provide variety."

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

    (1) consistency is important to maintain joint mobility
    (2) active exercises are better than passive or active-assistive exercises
    (3) correct–should reduce when patient experiences more pain
    (4) should do exercises that have been prescribed for patient

42. The nurse is assessing a client with severe bilateral peripheral edema. Which of the following is the BEST way for the nurse to determine the degree of edema in a limb, and the client's response to treatment?

    1. Measure both limbs with the tape measure and compare.
    2. Depress the skin and rank the degree of pitting.
    3. Describe the swelling in the affected area.
    4. Pinch the skin and note how quickly it returns to normal.

    Strategy: Think about each answer choice.

    (1) is not the best way to evaluate for peripheral edema
    (2) correct–severity of edema is characterized by grading it 1+ (2-mm pitting) to 4+ (8-mm pitting)
    (3) not as objective
    (4) is used for evaluating hydration

43. A six-month-old infant has had all of the required immunizations. The nurse knows this would include which of the following?

    1. Two doses of diphtheria, tetanus, and pertussis vaccine.
    2. Measles, mumps, and rubella vaccines.
    3. A booster dose of the trivalent oral polio vaccine.
    4. Chickenpox and smallpox vaccines.

    Strategy: Think about each answer choice.

    (1) correct–first dose of the DPT may be given at two months, the second is given around four months
    (2) MMR is given at 15 months
    (3) polio is given at two and four months and again at 12 to 18 months
    (4) smallpox vaccine is no longer recommended

44. The nurse should include which of the following in a teaching plan for a client receiving tetracycline?

    1. Take the medication with milk or antacids to decrease GI problems.
    2. The medication should always be taken with meals.
    3. Use a maximum-protection sunscreen when outdoors.
    4. Crackers and juice will help decrease gastric irritation.

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

    (1) tetracycline should never be taken with milk or antacids as these inhibit the medication's action
    (2) should take with full glass of water at least one hour before or two hours after meals
    (3) correct–because of problems related to photosensitivity, sunscreen, wide-brimmed hats, and long sleeves should be worn when client is at risk for sun exposure
    (4) should take with full glass of water at least one hour before or two hours after meals

45. An elderly alcoholic client has been receiving a long-acting benzodiazepine (Librium) for two days for symptom management and reduction. The client states: "Get those bugs off of me and clean them out of here." The nurse knows the client is exhibiting symptoms of

    1. a reaction to the sedative medication.
    2. a worsening course of the withdrawal syndrome.
    3. an exacerbation of the schizophrenia process.
    4. the process of aging and the effects of delirium.

    Strategy: Think about each answer choice.

    (1) client has been medicated with benzodiazepines and did not experience untoward reactions
    (2) correct–client has most probably progressed to another level of abstinence withdrawal from polypharmacy chemical dependence; characteristic symptoms include tremors, increased heart rate, and fever, as well as psychological problems of confusion, delusions, and hallucinations
    (3) schizophrenic client usually experiences an episode of auditory hallucinations, not visual or tactile hallucinations
    (4) combination effect of the normal aging process and dementia could precipitate a similar reaction; however, the normal aging process does not produce delirium, but rather dementia

46. A client is admitted for a series of tests to verify the diagnosis of Cushing's syndrome. Which of the following assessment findings, if observed by the nurse, would support this diagnosis?

    1. Buffalo hump, hyperglycemia, and hypernatremia.
    2. Nervousness, tachycardia, and intolerance to heat.
    3. Lethargy, weight gain, and intolerance to cold.
    4. Irritability, moon face, and dry skin.

    Strategy: Think about each answer choice and how it relates to Cushing's syndrome.

    (1) correct–Cushing's syndrome is characteristic of these assessments, as are weight gain, moon face, purple striae, osteoporosis, mood swings, and high susceptibility to infections
    (2) symptoms of hyperthyroidism
    (3) symptoms of hypothyroidism (myxedema)
    (4) symptoms of hypoparathyroidism

47. The nurse is caring for a patient several days after an above-knee amputation (AKA). Which of the following symptoms would be characteristic of an infected stump wound?

    1. The patient is anxious and restless.
    2. There is a small amount of dark drainage on the dressing.
    3. The patient complains of persistent pain at the operative site.
    4. The skin is cool above the operative site.

    Strategy: Determine how each answer choice relates to an infected wound.

    (1) may be due to changes in body image or pain
    (2) expected, not indicative of an infection
    (3) correct–pain is characteristic of inflammation and infection
    (4) warm skin above site would indicate infection

48. Which of the following statements, if made by a client to the nurse, would indicate that the client is using the defense mechanism of conversion?

    1. "I love my family with all my heart even though they don't love me."
    2. "I was unable to take my final exams because I was unable to write."
    3. "I don't believe I have diabetes. I feel perfectly fine."
    4. "If my wife was a better housekeeper I wouldn't have such a problem."

    Strategy: Think about each answer choice.

    (1) indicates reaction formation
    (2) correct–client has converted his anxiety over school performance into a physical symptom that interferes with his ability to perform
    (3) indicates denial
    (4) indicates projection

49. Which observation indicates to the nurse that the client needs further teaching before he can administer his own insulin?

    1. The client draws up his regular insulin first, then the NPH.
    2. The client gently rotates the insulin bottle before withdrawing the dose.
    3. The client rotates injection sites following the guide on his printed diagram.
    4. The client administers the insulin while it is still cold from the refrigerator.

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

    (1) when mixing regular insulin with other types of insulin, the client should draw up the clear (regular) before the cloudy (NPH)
    (2) bottle of insulin should never be vigorously shaken, but rather gently mixed
    (3) imperative to rotate injection sites to avoid tissue irritation/infection and ensure proper absorption
    (4) correct–insulin should be administered at room temperature, temperature extremes should be avoided

50. A client has orders for cefoxitin (Mefoxin) 2 g IV piggyback in 100 cc 5% dextrose in water. The primary IV is 5% dextrose in lactated Ringer's and is infusing by gravity. It is MOST important for the nurse to take which of the following actions?

    1. Administer the medication slowly, at 25-25 cc/h.
    2. Change the primary IV solution.
    3. Hang the piggyback infusion bag higher than the primary infusion bag.
    4. Obtain an infusion pump prior to administration.

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

    (1) antibiotic should be administered within one hour
    (2) unnecessary for safe infusion
    (3) correct–when using a gravity drip, piggyback fluid level needs to be higher than primary infusion
    (4) unnecessary for safe infusion

51. The nurse is supervising care given to clients on a medical/surgical unit. The nurse should intervene if which of the following is observed?

    1. A nurse and client wear masks during a dressing change for the central catheter used for total parenteral nutrition.
    2. A nurse injects insulin through a single-lumen percutaneous central catheter for client receiving total parenteral nutrition.
    3. A nurse applies lip balm to his/her lips immediately after performing a blood draw to obtain a specimen.
    4. A nurse wears a disposable particulate respirator when administering rifampin to a client with tuberculosis.

    Strategy: "Nurse should intervene" indicates that you are looking for an incorrect action.

    (1) appropriate procedure, prevents airborne contamination
    (2) insulin is the only medication that can be given, compatible with TPN
    (3) correct–applying lip balm or handling contact lenses is prohibited in work areas where exposure to bloodborne pathogens may occur
    (4) use airborne precautions for TB, private room with negative air pressure, minimum of six exchanges per hour

52. The nurse recognizes that the client with an obsessive-compulsive ritual is attempting to

    1. control other people.
    2. increase self-esteem.
    3. avoid severe levels of anxiety.
    4. express and manage anxiety.

    Strategy: Think about each answer choice.

    (1) inaccurate
    (2) inaccurate
    (3) correct–obsessive-compulsive rituals are an attempt to avoid or alleviate increasing levels of anxiety; client is not trying to increase his self-esteem or control others with the ritualistic behaviors; these behaviors do not have a significant impact on others; client does not want to repeat the act but feels compelled to do so
    (4) ritual is not a method of expressing anxiety, but a strategy to avoid it

53. An infant is admitted for vomiting and diarrhea. The infant's anterior fontanelle is depressed, and he has a fever of 103.2°F (39.5°C). Which of the following nursing actions would be MOST appropriate?

    1. Determine daily weights and evaluate weight loss.
    2. Evaluate infant's ability to take in fluids.
    3. Place a full bottle of Pedi-Lyte at the bedside.
    4. Start an intravenous infusion.

    Strategy: Answers are a mix of assessments and implementations. Does this situation require assessment? Yes. Is there an appropriate assessment? Yes.

    (1) assessment, correct information, but is not what the question asks for
    (2) correct–assessment, will assist in determining if hydration can be done through oral fluids alone
    (3) implementation, does not do anything to improve the situation; placing a full bottle at the bedside doesn't guarantee that the infant is taking fluids
    (4) implementation, would be implemented later

54. The nurse should anticipate which of the following in assessing a client with a diagnosis of a ruptured lumbar disc?

    1. Sensation loss in an upper extremity.
    2. Clonic jerks in the affected foot.
    3. Paresthesia in the affected leg.
    4. Chorea in the upper and lower extremities.

    Strategy: Think about each answer choice.

    (1) results from cervical lesions
    (2) can occur in a person who has been paralyzed from a spinal cord injury
    (3) correct–lumbar lesions can cause paresthesia, pain, muscle weakness, and atrophy in the lower extremities
    (4) is a sign of Huntington chorea, resulting from atrophy of parts of the brain

55. A client has been taking propranolol (Inderal) 40 mg bid and furosemide (Lasix) 40 mg qd for several months. Two weeks ago, the physician added verapamil (Calan) 80 mg tid to his medication regimen. The client returns to the outpatient clinic for evaluation. It is MOST important for the nurse to assess for which of the following?

    1. Tachycardia.
    2. Diarrhea.
    3. Peripheral edema.
    4. Impotence.

    Strategy: Determine how each answer choice relates to medication.

    (1) will cause bradycardia
    (2) usually causes constipation
    (3) correct–Calan is a calcium-channel blocker, depresses myocardial contractility, decreases work of ventricles and O_2 demand, dilates coronary arteries, when used with other antihypertensives can cause hypotension and heart failure
    (4) not most important or frequent side effect

56. A client has a three-way Foley catheter following a transurethral resection. The nurse would anticipate infusing irrigating solution rapidly when

    1. the urinary output is increased.
    2. bright-red drainage or clots are present.
    3. dark-brown drainage is present.
    4. the client complains of pain.

    Strategy: Think about each answer choice.

    (1) not a reason to infuse irrigating solution rapidly
    (2) correct–three-way Foley catheter should be irrigated rapidly when bright-red drainage or clots are present; irrigation rate should be decreased to about 40 gtts/min when the drainage clears
    (3) not indication to infuse irrigating solution rapidly
    (4) not indication to infuse irrigating solution rapidly

57. The nurse is caring for clients on a psychiatric unit and is suddenly faced with multiple issues. Which of the following situations require the nurse's IMMEDIATE attention?

    1. A client with bipolar disorder walks into the dayroom in her underwear and begins dancing.
    2. A client with depression says to the nurse, "My plan is complete, and I'm ready to go for it."
    3. A client recovering from substance abuse complains that another client is harassing him.
    4. A client with schizophrenia tells the nurse that it's "God's will" that he destroy the "evil TV".

    Strategy: "Require IMMEDIATE intervention" indicates that you are looking for the least stable situation.

    (1) should remove to quiet area, decrease environmental stimuli
    (2) correct–could indicate impending suicide, requires immediate follow-up
    (3) potential suicide is more immediate concern
    (4) command hallucination, potential suicide takes priority

58. The nurse is caring for an elderly client receiving IV fluids of 0.9% NaCl at 125 cc/h into her left arm. During a routine assessment, the nurse finds that the client has distended neck veins, shortness of breath, and crackles in both lung bases. The nurse should

    1. decrease the IV rate to 20 cc/h and notify the physician.
    2. decrease the IV rate to 100 cc/h and continue to monitor the client.
    3. discontinue the IV and start oxygen at 6 L/min.
    4. assess for infiltration of the IV solution.

    Strategy: Answers are a mix of assessments and implementations. Is the assessment appropriate? No. Determine the outcome of each implementation.

    (1) correct–KVO (20 cc/h) will keep access open
    (2) need to notify physician, rate still too much since patient is in fluid overload
    (3) IV line may be necessary, diuretics may be ordered
    (4) description indicates circulatory overload, not infiltration

59. The nurse knows that which of the following symptoms would be supportive of a diagnosis of Guillain-Barré syndrome?

    1. Hemiplegia, hypertension, tachycardia.
    2. Respiratory failure, flaccid paralysis, urinary retention.
    3. Peripheral edema, hypertension, pulmonary congestion.
    4. Diminished reflexes, pain, paresthesia.

    Strategy: All parts of the answer choice must be correct in order for the answer to be correct.

    (1) relates to a CVA
    (2) correct–classic symptoms include respiratory failure and flaccidity due to paralysis of the muscles and urinary retention due to loss of sensation
    (3) relates to pulmonary edema
    (4) relates to peripheral nerve problems

60. A patient is being treated in the telemetry unit for cardiac disease. The patient is to receive propranolol hydrochloride (Inderal) 20 mg PO at 9 AM. When the nurse goes into the room to give the medication to the patient, the nurse finds him wheezing with a nonproductive cough and shortness of breath. INITIALLY, the nurse should

    1. hold the medication and count the respirations.
    2. hold the medication and call the physician.
    3. take an apical pulse and then give the medication.
    4. give the medication as ordered.

    Strategy: Determine the outcome of each answer choice.

    (1) correct–side effects include increased airway resistance, patient is experiencing bronchospasm, should assess then call the physician
    (2) should assess the patient's condition first
    (3) experiencing a side effect, medication should not be given
    (4) medication should be held, experiencing a side effect

61. A client in a psychiatric facility describes seeing snakes on the walls of his room. Based on this information, the nurse should identify a nursing diagnosis of

    1. sensory-perceptual alterations: visual.
    2. altered thought processes.
    3. ineffective individual coping.
    4. impaired social interaction.

    Strategy: Think about each answer choice.

    (1) correct–reflects a pattern of impaired perception, which is supported by the data that client is having a hallucination, defined as a sensory perception for which no external stimuli exist
    (2) not relevant to the data
    (3) not relevant to the data
    (4) not relevant to the data

62. The nurse is reviewing client assignments on a medical/surgical unit. The nurse determines that the assignment is appropriate if the nursing assistant is caring for which of the following clients?

    1. A client with AIDS dementia complex who requires a urine specimen.
    2. A client complaining of postoperative pain after repair of a torn rotator cuff.
    3. A client with GI bleeding due to a duodenal ulcer receiving packed cells.
    4. A client with type I diabetes receiving prednisone for a herniated disk.

    Strategy: Assign clients with standard, unchanging procedures.

    (1) correct–standard, unchanging procedure
    (2) assign to the RN
    (3) assign to the RN
    (4) assign to the RN

63. The nurse is teaching nutrition classes at the community center. Which of the following foods would the nurse encourage a low-income client to eat to satisfy essential protein needs?

    1. Legumes.
    2. Red meat.
    3. Seafood.
    4. Cheese.

    Strategy: Think about each answer choice.

    (1) correct–legumes are an economical source rich in protein
    (2) high in protein, but more expensive to purchase
    (3) high in protein, but more expensive to purchase
    (4) high in protein, but more expensive to purchase

64. The nurse observes the fetal heart monitor for a 23-year-old woman in active labor. The fetal heart tracing shows early fetal decelerations. The nurse is aware that this is

    1. a slowing early in the contraction, and is usually a normal finding.
    2. a slowing early in the contraction, and is usually an abnormal finding.
    3. a slowing at the peak of the contraction, and is usually a normal finding.
    4. a slowing at the peak of the contraction, and is usually an abnormal finding.

    Strategy: Think about each answer choice.

    (1) correct–occurs in response to compression of fetal head, uniform shape corresponds to rise in intrauterine pressure as uterus contracts, does not indicate fetal distress
    (2) does not indicate fetal distress
    (3) slowing is early in the contraction
    (4) slowing is early in uterine contraction and is not abnormal

65. A client is scheduled for a myelogram at the outpatient clinic. The physician's office nurse reinforces the physician's explanation of the procedure. Which of the following statements, if made by the nurse, correctly describes a myelogram?

    1. "The test involves x-ray examination of the entire spinal column to determine the extent of myelin breakdown."
    2. "The test involves injection of a contrast medium into a suspected ruptured vertebral disk, allowing radiographic visualization of the disk."
    3. "The test involves a lumbar puncture with injection of contrast medium, allowing x-ray visualization of the vertebral canal."
    4. "The test involves x-ray examination of the vertebral column following injection of air into the subarachnoid space."

    Strategy: Determine how each answer choice relates to a myelogram.

    (1) x-ray examination cannot determine the extent of myelin breakdown
    (2) no such procedure
    (3) correct–contrast medium or air is injected into spinal subarachnoid space through a spinal puncture, identifies tumors, cysts, herniated vertebral discs
    (4) no such procedure

66. A nurse caring for a client on suicide precautions makes the following observations: the client is verbalizing other options besides suicide, appears to be responding to antidepressant medication, is sleeping and eating better, and has indicated a willingness to interact more with family members. Based on this data, which of the following nursing actions is MOST appropriate?

    1. Recommend that the physician decrease the client's medication dosage.
    2. Recommend that the treatment team reevaluate the client's treatment plan.
    3. Give the client privileges to walk around the hospital by himself.
    4. Ask the family to begin planning for the client's discharge.

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

    (1) may reverse the client's progress
    (2) correct–data suggests that client is beginning to benefit from treatment; entire treatment team should share data and make a decision about the suicide precautions so that restrictions are changed gradually based on a full-data picture
    (3) may be the team's decision, but not until a thorough review of the case is completed
    (4) premature

67. The nurse obtains a history from the father of a six-year-old boy with a history of epilepsy admitted with uncontrolled seizures. It is MOST important for the nurse to ask which of the following questions?

    1. "What part of the body was affected by the seizure?"
    2. "What is the family history of seizure disorders?"
    3. "What was your son doing before the seizure?"
    4. "How long has it been since his last episode of seizures?"

    Strategy: "MOST important" indicates that this is a priority question.

    (1) not most important question
    (2) should be included in detailed history, but will not prevent an immediate reoccurrence
    (3) correct–seizure may result from triggering mechanism (loud noise, music, flickering light, prolonged reading, drugs)
    (4) should be included in detailed history, but will not prevent an immediate reoccurrence

68. The nurse teaches a health class at the local library to a group of senior citizens. Which of the following behaviors should the nurse emphasize to facilitate regular bowel elimination?

    1. Avoid strenuous activity.
    2. Eat more foods with increased bulk.
    3. Decrease fluid intake to decrease urinary losses.
    4. Use oral laxatives so that a bowel pattern emerges.

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

    (1) regular exercise program facilitates bowel elimination
    (2) correct–contained in whole grains, legumes, vegetables, fruits, seeds, nuts, bulk promotes peristalsis
    (3) normal fluid intake of 1,500 cc/day facilitates bowel elimination
    (4) laxatives used as last resort because they become habit-forming

69. The physician orders morphine sulfate 8 mg IM q 3-4 hours for pain PRN. In which of the following situations should the nurse consider withholding the medication until further assessment is done?

    1. The patient complains of acute pain from a second-degree burn affecting the lower left leg.
    2. The patient's blood pressure is 140/90, pulse is 90, and respiration is 28.
    3. The patient's level of consciousness fluctuates from alert to lethargic.
    4. The patient exhibits restlessness, anxiety, and cold, clammy skin.

    Strategy: Determine the significance of each answer choice and how it relates to morphine.

    (1) morphine used for moderate to severe pain, medication should be given
    (2) BP slightly elevated, respirations elevated, may be the result of pain, medication should be given
    (3) correct–morphine depresses CNS, especially respiratory center in medulla
    (4) may be the result of pain

70. The nurse observes a student nurse caring for a client. In addition to following standard precautions, the student nurse is wearing a gown and gloves. The nurse should determine that care is appropriate if the student nurse performs which of the following activities?

    1. Gives isoniazid (INH) to a client with tuberculosis.
    2. Administers an IM injection to a client with rubella.
    3. Delivers a food tray to a client with hepatitis.
    4. Changes the dressing for a client with a draining abscess.

    Strategy: Determine how the organism of each disease is spread.

    (1) requires airborne precautions, particulate respirator
    (2) requires droplet precautions, nurse should wear a mask
    (3) requires standard precautions
    (4) correct–requires contact precautions

71. A client has an obsessive-compulsive disorder manifested by the compulsion of handwashing. The nurse knows that which of the following BEST describes the client's need for the repetitive acts of handwashing?

    1. Handwashing represents an attempt to manipulate the environment to make it more comfortable.
    2. Handwashing externalizes the anxiety from a source within the body to an acceptable substitute outside the body.
    3. Handwashing assists the client to avoid undesirable thoughts and maintain some control over guilt and anxiety.
    4. Handwashing helps to maintain the client in an active state to resist the effects of depression.

    Strategy: Think about each answer choice.

    (1) not a manipulation on the client's part
    (2) not an accurate statement regarding the compulsive behavior of this client
    (3) correct–compulsive behavior is an unconscious attempt to control and/or relieve the tension and anxiety the client is experiencing
    (4) client is not subject to depression but to high levels of anxiety

72. The nurse is caring for an elderly client who has just had a prosthetic hip implant. The nurse should position the client

    1. with the affected hip internally rotated and flexed.
    2. with the affected hip adducted when turned.
    3. in the supine position with the knees elevated 90°.
    4. side-lying with the affected hip in a position of abduction.

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

    (1) flexion beyond 60°, adduction and internal rotation should be avoided in the early postoperative period
    (2) flexion beyond 60°, adduction and internal rotation should be avoided in the early postoperative period
    (3) flexion beyond 60°, adduction and internal rotation should be avoided in the early postoperative period
    (4) correct–position of abduction should be maintained

73. A mother brings her 10-year-old and 3-year-old daughters to the pediatrician's office because the younger girl complains of dysuria. The physician orders a catheterization to obtain a urine specimen. The nurse should

    1. describe the procedure to the child in short, concrete terms while talking calmly.
    2. let the child play with the equipment during the procedure.
    3. involve the girl's older sister in explaining the procedure.
    4. show the child a diagram of the urinary system.

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

    (1) correct–children this age need simple explanations
    (2) might contaminate the equipment, must be a sterile procedure
    (3) not likely to listen to sister
    (4) not appropriate for this age

74. A patient is returned to her room after surgery with a cuffed tracheostomy tube in place. The nurse knows the purpose of the cuff on the tracheostomy tube is to

    1. guarantee secure placement of the tracheostomy tube in the airway.
    2. prevent ischemia of the tracheal wall by distributing the pressure applied to it.
    3. decrease the chance of aspiration into the trachea.
    4. protect the trachea from ischemia and edema.

    Strategy: Think about each answer choice.

    (1) inaccurate, not the purpose of the cuff on a tracheostomy tube
    (2) complication of using a cuffed tracheostomy tube
    (3) correct–seals trachea, helps to prevent aspiration
    (4) trauma from overinflated tube may cause edema

75. The nurse cares for a client after an electroconvulsive therapy (ECT) treatment. The nurse should report which observation to the client's physician?

    1. Headache.
    2. Disruption in short- and long-term memory.
    3. Transient confusional state.
    4. Backache.

    Strategy: You are looking for something unexpected.

    (1) expected effect
    (2) expected effect
    (3) expected effect
    (4) correct–client undergoing ECT needs to be instructed about what s/he could experience during and after ECT; expected effects include headache, disrupted memory (short- and long-term), and general confused state; backache is not a usual effect; thorough description of the pain in relation to severity, duration, location, and what makes pain better needs to be assessed and reported to the physician

76. A mother brings her nine-month-old child to the pediatrician's office for complaints of a fever of 102.2°F (39°C) and frequent vomiting. The nurse would expect which of the following reflexes to still be present?

    1. Babinski's reflex.
    2. Moro's reflex.
    3. Tonic neck reflex.
    4. Grasp reflex.

    Strategy: Think about growth and development.

    (1) correct–stroking outer sole of foot upward causes toes to hyperextend and fan and great toe to dorsiflex, disappears after one year of age
    (2) sudden jarring causes extension and abduction of extremities and fanning of fingers with index finger and thumb forming a C shape, disappears after 3–4 months
    (3) when head is turned to side, arm and leg extend on that side, and opposite arm and leg flex, disappears by age 3–4 months
    (4) touching palms of hands or soles of feet causes flexion of hands and toes, palmar grasp disappears after 3 months of age, plantar grasp lessened by 8 months of age

77. A client with an irregular pulse rate of 81 and a potassium level of 3.0 mEq/L has digoxin (Lanoxin) ordered. Which of the following actions if taken by the nurse is BEST?

    1. Give the digoxin.
    2. Hold the digoxin.
    3. Notify the physician.
    4. Re-check the pulse.

    Strategy: The topic of the question is unstated.

    (1) although the pulse is normal, level of potassium must be considered
    (2) notify physician about low potassium
    (3) correct–hypokalemia can precipitate digoxin toxicity; physician should be called to obtain order for potassium supplement
    (4) notify physician about the potassium level

78. The nurse is assessing a client's neurosensory cerebellar functioning. Which of the following assessment techniques would be correct?

    1. Test the client's deep tendon reflexes to observe for weakness.
    2. Check the client's pupils with a penlight and observe for constriction.
    3. Have the client stand with eyes closed and observe for swaying.
    4. Ask the client to show her teeth and stick out her tongue.

    Strategy: Determine how each answer choice relates to the cerebellum.

    (1) general central nervous system response, not sensory involvement
    (2) evaluates for increased intraocular pressure
    (3) correct–coordination is governed by the cerebellum; this test evaluates neurosensory status
    (4) evaluates the facial and hypoglossal nerves

79. The nurse is caring for an elderly adult client with multi-infarct dementia. Which of the following actions, if taken by the nurse, is BEST?

    1. Place the client in soft hand restraints or chair restraints.
    2. Monitor wandering behaviors during a seven-day period.
    3. Keep the lounge's television volume on a low level.
    4. Encourage a diet high in protein, iron, and vitamins.

    Strategy: The topic of the question is unstated. Read the answer choices for clues.

    (1) do not restrain unless all other options have been exhausted
    (2) correct–appropriate assessment to determine if client wanders during specific times of the day, assess before implementing
    (3) need to prevent sensory overload, should assess first
    (4) offer well-balanced diet

80. An 18-year-old client with anorexia nervosa is admitted to the hospital. In planning to care for the client, the nurse would expect the client to

    1. view her appearance as "skinny."
    2. be hypoactive and withdrawn.
    3. want to talk about and plan her meals.
    4. have a close relationship with her mother.

    Strategy: Determine how each answer choice relates to anorexia.

    (1) usually view their appearance as fat
    (2) inaccurate for client with anorexia nervosa
    (3) correct–display a marked preoccupation with food
    (4) inaccurate for client with anorexia nervosa

81. The nurse is caring for a client admitted with acute hypoparathyroidism. It is MOST important for the nurse to have which of the following items available?

    1. Tracheostomy set.
    2. Cardiac monitor.
    3. IV monitor.
    4. Heating pad.

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

    (1) correct–tracheostomy set is the most important for the client's safety due to risk for laryngospasm
    (2) nice to have, but not the most important
    (3) nice to have, but not the most important
    (4) unnecessary

82. A 26-year-old woman has missed her menstrual period. The client's last menstrual period began May 8 and ended May 12. The nurse determines that her EDC (estimated date of confinement) is

    1. February 1.
    2. February 15.
    3. February 19.
    4. March 14.

    Strategy: Remember Naegele's rule

    (1) should add seven days
    (2) correct–when using the Naegele rule, add seven days to first day of last menstrual period and subtract three months
    (3) incorrectly started with the last day of the menstrual cycle
    (4) incorrect

83. The nurse checks the incision of a patient 48 hours after surgery for a hernia repair. Which of the following findings would indicate a possible complication?

    1. There is swelling under the sutures.
    2. There is crusting around the incision line.
    3. The incision line is red.
    4. The incision line is approximated.

    Strategy: Determine the significance of each answer choice.

    (1) slight swelling is expected during healing
    (2) slight crusting of incision line is normal
    (3) correct–should be pink, not red, indicates possible infection, other signs include increased warmth, tenderness, pain, and purulent or odorous drainage
    (4) shows healing is taking place

84. The nurse knows that which of these plans would be MOST successful in caring for a client with dementia?

    1. Teach new skills for adjusting to the aging process.
    2. Adjust the environment to meet the client's individual needs.
    3. Encourage competitive activities to keep the client physically strong.
    4. Provide unstructured activities with frequent changes to increase stimulation.

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

    (1) unable to learn new skills
    (2) correct–client with dementia does not have cognitive abilities to learn new skills or to adapt, environment must be adapted for client with attention to safety and predictability
    (3) requires skills the client with dementia does not have
    (4) requires skills the client with dementia does not have

85. A client has severe second- and third-degree burns over 75% of his body. The nurse would be MOST concerned if which of the following was observed?

    1. Epigastric pain.
    2. Restlessness.
    3. Tachypnea.
    4. Lethargy.

    Strategy: Determine how each answer relates to burns.

    (1) insignificant for burn client
    (2) may be due to pain
    (3) correct–body responds to early hypovolemic shock by adrenergic stimulation; vasoconstriction compensates for the loss of fluid, resulting in cool clammy skin, tachycardia, tachypnea, and pale color
    (4) may be due to pain

86. The nurse observes a client who is taking phenelzine (Nardil) eating another client's lunch. After a few minutes, the client complains of headache, nausea, rapid heartbeat, and begins to vomit. The nurse anticipates administering which of the following medication?

    1. Buspirone (Buspar).
    2. Fluoxetine (Prozac).
    3. Prochlorperazine (Compazine).
    4. Nifedipine (Procardia).

    Strategy: Think about the action of each medication.

    (1) antianxiety; side effects include light-headedness, confusion, hypotension, palpitations
    (2) SSRI antidepressant; side effects include palpitation, bradycardia, nausea and vomiting
    (3) antiemetic; side effects include drowsiness, orthostatic hypotension
    (4) correct–antihypertensive; client experiencing hypertensive crisis due to ingesting tyramine; side effects include dizziness, headache, nervousness

87. The nurse has just received report from the previous shift. Which of the following clients should the nurse see FIRST?

1. A client who is receiving a blood transfusion and complains of a dry mouth.
2. A client who is scheduled to receive heparin and the PTT is 70 seconds.
3. A client who is receiving ciprofloxacin (Cipro) and complains of a fine macular rash.
4. A client who is receiving IV potassium and complains of burning at the IV site.

Strategy: Determine the least stable client.

(1) not an immediate concern
(2) PTT is within normal limits, should give medication
(3) correct–indicates hypersensitivity reaction, should stop medication and notify the physician
(4) should decrease rate to prevent irritation of the vein

88. The nurse is caring for a client who is receiving a tube feeding around the clock. Which of the following nursing actions is MOST appropriate?

1. Rinse the bag and change the formula every four hours.
2. Rinse the bag and change the formula every shift.
3. Change the bag and formula every shift.
4. Rinse the bag and change the formula every two hours.

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

(1) correct–there is an increased growth of organisms after four hours
(2) inappropriate due to increased organism growth
(3) inappropriate due to increased organism growth
(4) not a necessary action to maintain asepsis

89. A 25-year-old primigravida with type I diabetes mellitus is reviewing her insulin regimen with the nurse. The nurse explains to the client that her insulin needs will

1. increase during pregnancy and decrease after delivery.
2. decrease during pregnancy and increase after delivery.
3. increase during pregnancy and remain increased after delivery.
4. decrease during pregnancy and fluctuate after delivery.

Strategy: Think about each answer choice.

(1) correct–needs increase during pregnancy due to hormonal interference in glucose metabolism
(2) needs increase during pregnancy due to hormonal interference in glucose metabolism
(3) insulin needs will decrease after delivery
(4) needs increase during pregnancy

90. A client asks what the difference is between his gastric ulcer and his friend's duodenal ulcer. The nurse's response should be based on which of the following statements?

    1. "Gastric ulcers have an increased association with clients who experience increased psychological pressures."
    2. "The pain of a duodenal ulcer usually occurs two to four hours after meals."
    3. "Clients with gastric ulcers often gain weight, as food alleviates the pain."
    4. "Antacids such as Maalox are seldom prescribed for clients with duodenal ulcers. "

    Strategy: Think about each answer choice.

    (1) refers to duodenal ulcers
    (2) correct–clients with duodenal ulcers experience pain after meals, e.g., midmorning and midafternoon
    (3) gastric ulcer clients may be malnourished because food may cause nausea or vomiting
    (4) antacids are given to duodenal ulcer clients

91. An eight-year-old has been receiving chemotherapy for six months. During her nursing care she asks: "Am I going to die?" Which of the following responses by the nurse is BEST?

    1. "Are you afraid of dying?"
    2. "Why do you ask that question?"
    3. "Only God knows that answer."
    4. "We won't leave you alone."

    Strategy: Remember therapeutic communication.

    (1) correct–encourages ventilation of thoughts and feelings regarding the concern
    (2) inappropriate
    (3) ignores the child's concern with dying
    (4) ignores the child's concern with dying

92. An 11-year-old boy fell off his bicycle and sustains a minor head injury, which is treated at the outpatient clinic. The nurse instructs the boy's mother about his care at home. The nurse determines that further teaching is necessary if the mother makes which of the following statements?

    1. "My son may have dizziness for 24 hours."
    2. "My son can drink carbonated beverages if he vomits."
    3. "My son may complain of nausea."
    4. "My son will probably have a headache."

    Strategy: Determine how each answer choice relates to a minor head injury.

    (1) expected for at least 24 hours
    (2) correct–unexpected, should be reported to physician immediately, also unexpected is blurred vision, drainage from ear or nose, weakness, slurred speech, worsening headache
    (3) expected for at least 24 hours
    (4) expected for at least 24 hours, should not get more intense

93. The nurse is caring for patients on the psychiatric unit. An extremely angry patient with bipolar illness tells the nurse he just learned his wife has filed for divorce, and he needs to use the phone. Which of the following responses by the nurse is MOST appropriate?

    1. Allow the patient to use the phone.
    2. Confront the patient about his anger and inappropriate plan of action.
    3. Do not allow the patient to use the phone because he is an involuntary patient.
    4. Set limits on the patient's phone use because he has been unable to control his behavior.

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

    (1) correct–patient is able to use phone unless otherwise indicated by court order or physician's order
    (2) has not lost civil right to use phone
    (3) denies patient his civil rights
    (4) inappropriate

94. The nurse is caring for a child in Bryant's traction. During the neurovascular assessment, the nurse notes that the foot of the uninjured leg feels warmer to touch than that of the broken leg. The nurse should

    1. record the observation.
    2. encourage the child to move the foot.
    3. cover the colder foot with a sock.
    4. notify the physician.

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

    (1) ignores possibility that Ace bandage is too tight
    (2) does not relieve the circulation problem
    (3) does not relieve the circulation problem
    (4) correct–assessment indicates that Ace bandage is too tight and needs readjusting

95. A 4 lb 10 oz baby boy is delivered at 32 weeks gestation. The infant is admitted to the neonatal intensive care unit and placed in an incubator. He has mottling of the skin and acrocyanosis with irregular respirations of 60. The nurse should recognize these findings as signs of

    1. hypoglycemia.
    2. cold stress.
    3. birth asphyxia.
    4. hypovolemia.

    Strategy: Think about each answer choice.

    (1) blood sugar less than 25 mg/dL, would see cyanosis, apnea, tachypnea, irregular respirations, diaphoresis, jitteriness, weak cry, lethargy, convulsions, coma
    (2) correct–symptoms describe cold stress
    (3) would see meconium stained amniotic fluid
    (4) would see symptoms of shock

96. A client was admitted for regulation of her insulin dosage. The client takes 15 units of Humulin N insulin at 8 AM every day. At 4 PM, which of the following nursing observations would indicate a complication from the insulin?

    1. Acetone odor to the breath, polyuria, and flushed skin.
    2. Irritability, tachycardia, and diaphoresis.
    3. Headache, nervousness, and polydipsia.
    4. Tenseness, tachycardia, and anorexia.

    Strategy: Determine the cause of each symptom and how it relates to hypoglycemia.

    (1) signs of hyperglycemia
    (2) correct–Humulin N insulin is an intermediate-acting insulin that peaks from eight to twelve hours after administration; this is when signs and symptoms of hypoglycemia will occur
    (3) signs of hyperglycemia
    (4) signs of hyperglycemia

97. The nurse is working with a client who has just indicated a wish to kill herself. The client then asks the nurse not to tell anyone. The nurse's BEST response should be to

    1. encourage the client not to do anything without thinking it through very carefully.
    2. explain to the client that anything she tells the nurse is kept strictly confidential.
    3. report this to staff members in order to protect the client.
    4. encourage the client to tell the nurse more about what she is feeling.

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

    (1) does not answer client's immediate concern or give client accurate information about what the nurse will do
    (2) does not answer client's immediate concern or give client accurate information about what the nurse will do
    (3) correct–nurse must let the client know that this information will be shared with the staff so that the client's safety can be preserved
    (4) does not answer client's immediate concern or give client accurate information about what the nurse will do

98. An older woman is hospitalized with a fractured left hip. While awaiting surgery, she is placed in Buck's traction with a seven-pound weight. Which of the following instructions for moving should be discussed by the nurse to encourage the patient to participate in her care?

    1. "Pull up on the overhead trapeze while you push down on your right foot to lift your body."
    2. "With your right arm, grasp the bedside rail on the opposite side and pull yourself over gently."
    3. "I'll raise the head of the bed 45°, and then you lean forward and rotate your hips to the left."
    4. "Swing your right leg over your left leg, and turn from your waist down, keeping your legs straight."

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

    (1) correct–body must move as single, straight unit
    (2) turning or twisting from the waist down interferes with countertraction
    (3) prevents proper pull of weights
    (4) can't turn from side to side, can only move up and down

99. The nurse in the pediatrician's office observes a child in the waiting room. The nurse notes the child can walk up and down steps, has a steady gait, can stand on one foot momentarily, and jumps with both feet. The nurse identifies the child's chronological age to be

    1. 1 year old.
    2. 2 years old.
    3. 3 years old.
    4. 5 years old.

    Strategy: Picture the child at each age.

    (1) unable to walk up and down stairs with hand held until 18 months
    (2) unable to jump until 30 months
    (3) correct–able to jump with both feet and stand on one foot momentarily at 30 months
    (4) behaviors are seen in younger child

100. The nurse responds to a train derailment. After making an initial assessment, which of the following clients should the nurse see FIRST?

    1. A pregnant woman who states that her clothing is wet.
    2. A young man with blood pulsating from a cut on the right leg.
    3. A preschool child who is screaming and crying uncontrollably.
    4. An unconscious woman with the right leg shorter than the left leg.

    Strategy: Think ABCs.

    (1) requires further assessment, could be amniotic fluid or it could be urine.
    (2) correct–indicates arterial bleeding; apply direct pressure; high risk for shock
    (3) stable patient
    (4) possible hip fracture, no indication of respiratory difficulty stated