NCLEX Question Trainer Explanations
Test 5

1. The nurse is preparing a patient for an 8:00 AM outpatient electroconvulsive (ECT) treatment. Which of the following questions is the MOST important for the nurse to ask?

   1. "Did you have anything to eat or drink before you came in today?"
   2. "Have you had any headaches since your last treatment?"
   3. "Who came with you to the hospital today?"
   4. "Have you had much memory loss since you began your treatments?"

   Strategy: Determine how each answer choice relates to ECT.

   (1) correct–client given general anesthesia for ECT; NPO after midnight
   (2) not relevant to ECT
   (3) not most important
   (4) memory loss is an expected outcome

2. A 36-year-old man has a flaccid bladder following a spinal cord injury. The nurse is teaching the client about dietary changes. Which of the following beverages, if selected by the client, would indicate to the nurse that teaching was effective?

   1. Lemonade.
   2. Prune juice.
   3. Milk.
   4. Orange juice.

   Strategy: "Teaching was effective" indicates you are looking for a true statement.

   (1) promotes alkaline urine, should also avoid citrus juices, excessive amounts of milk, carbonated beverages
   (2) correct–promotes acidic urine, minimizes risk of urinary tract infection and stone formation, also use cranberry, tomato juice, bouillon
   (3) excessive amounts of milk promotes alkaline urine
   (4) promotes alkaline urine, should also avoid citrus juices, excessive amounts of milk and carbonated beverages

3. The nurse is caring for a client with a long history of alcohol and drug dependence. It would be MOST important for the nurse to include which of the following as a part of his discharge planning?

   1. Referral to a social service agency for assistance with housing.
   2. Referral to an aftercare center in the community.
   3. Participation in Alcoholics Anonymous (AA) meetings with a sponsor.
   4. A prescription for an antidepressant medication.

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

   (1) may be of some help, but will not directly provide support necessary to maintain sobriety
   (2) may be of some help, but will not directly provide support necessary to maintain sobriety
   (3) correct–self-help groups have greatest success rate as a sustained support system in the community
   (4) unnecessary

4. A client has come to the clinic for a hepatitis B vaccine and asks if he has to be re-vaccinated after his first injection. Which of the following responses by the nurse is BEST?

   1. "A booster shot is required yearly."
   2. "Additional injections are given at one and six months."
   3. "Repeat doses are given at two and four months."
   4. "Revaccination is not required."

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

   (1) yearly doses are given for flu shots, not for hepatitis B vaccine
   (2) correct–hepatitis B vaccine is repeated at one and six months
   (3) schedule for infant immunizations for OPV and DPT
   (4) inaccurate

5. The nurse is planning care for a 56-year-old man who returned from surgery for a bowel resection with an IV of 0.9% NaCl infusing at 100 cc/h into his left wrist. Which of the following actions, if performed by the nurse, is BEST?

   1. Change the IV tubing each time a new IV solution is hung.
   2. Cleanse the IV site with an alcohol swab using long strokes.
   3. Limit manipulation of the cannula at the IV insertion site.
   4. Adjust the drop rate to keep the total volume of IV fluids on schedule.

   Strategy: The topic of the question is unstated. Read the answer choices to determine the topic. "BEST" indicates that this is a priority question. All answers are implementations. Determine the outcome of each answer choice. Is it desired?

   (1) unnecessary, changed every 48–72 hrs
   (2) should move swab in a circular motion outward
   (3) correct–will prevent dislodgment of needle
   (4) should give IV at rate ordered by physician, don't play "catch-up" with fluids

6. The nurse notes that one of the staff members caring for clients has a watery discharge from the right eye and the eye appears red. Which of the following actions, if taken by the nurse, is BEST?

   1. Send the staff member home.
   2. Assess the staff member's compliance with standard precautions.
   3. Assign the staff member only to clients with chronic diseases.
   4. Re-assign the staff member to clean the supply closet.

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

   (1) correct–extreme tearing, redness, foreign body sensation are symptoms of viral conjunctivitis, highly contagious; infected employees cannot work until symptoms have resolved in 3–7 days
   (2) restrict from patient contact and the patient's environment
   (3) restrict from patient contact and the patient's environment
   (4) cannot work

7. The nursing staff is planning to use behavior modification techniques for an elderly woman who constantly screams. Which of the following nursing assessments is necessary to establish a successful program?

   1. Monitor the client's ability to complete her activities of daily living (ADL).
   2. Assess the client's levels of pain and correlate it with her response to analgesia.
   3. Observe the client's behavior at regular intervals to obtain baseline information related to her screaming.
   4. Ask the client why she is screaming and document it on her nursing assessment record.

   Strategy: Determine what is being assessed in each answer choice and how it relates to screaming.

   (1) important because activities of daily living can contribute to the targeted behavior of screaming; assessing only the area of ADLs does not provide comprehensive data for developing a behavior management program
   (2) important because activities of pain can contribute to the targeted behavior of screaming; assessing only the area of pain does not provide comprehensive data for developing a behavior management program
   (3) correct–to design an effective behavior modification program, accurate baseline data must first be collected about the target behavior in relation to frequency, amount, time, and precipitating factors
   (4) client may be unable to state why she is screaming; asking "why" questions is nontherapeutic

8. The nurse observes a student nurse checking the placement of a nasogastric (NG) tube. Which of the following actions, if performed by the student nurse, would require an intervention by the nurse?

   1. Places the end of the NG tube in a cup of water and watches for bubble formation.
   2. Checks the pH of the contents aspirated from the NG tube.
   3. Positions a stethoscope on the upper abdomen and listens as air is introduced into the NG tube.
   4. Uses a large barreled syringe to aspirate for stomach contents.

   Strategy: "Require an intervention" indicates that you are looking for an incorrect behavior.

   (1) correct–not considered acceptable procedure
   (2) gastric contents are acidic
   (3) "swoosh" of air indicates proper placement
   (4) acceptable action

9. While scheduling the administration of bromocriptine (Parlodel), which nursing action has the HIGHEST priority?

   1. The medication should be taken once a day for six weeks.
   2. The medication should be taken with orange juice.
   3. The medication should be taken in the morning and at bedtime.
   4. The medication should be taken with meals.

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

   (1) is taken twice a day for two to three weeks
   (2) unnecessary
   (3) will cause GI upset unless taken with meals
   (4) correct–will decrease GI upset

10. A brace is ordered for a young teen with scoliosis. The nurse knows that teaching has been effective if the client makes which of the following statements?

    1. "I will have my parents put bed-boards on my bed."
    2. "I should decrease my caloric intake."
    3. "I should only take tub baths."
    4. "I can remove the brace for one hour a day."

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

    (1) bed-boards maintain proper vertebral alignment, but can't correct lateral curvature of scoliosis
    (2) diet should be high-calorie due to age of child and growth requirements; diet doesn't affect curvature of the spine
    (3) either tub bathing or a shower is permitted
    (4) correct–should be worn at all times, except when bathing

11. The nurse in a long-term care facility is reviewing the nurse's notes in a client's chart. The nurse would be MOST concerned by which of the following entries?

    1. "Foley catheter draining clear urine and the pH is 6.5."
    2. "The client's skin is blanched over the scapular areas."
    3. "Vital signs are within normal limits."
    4. "The client drinks three glasses of orange juice every day."

    Strategy: Remember the rules of charting.

    (1) appropriate charting of normal urine
    (2) correct–blanching or hyperemia that does not disappear in a short time is a warning sign of pressure ulcers
    (3) although the charting is not objective, blanching of the skin takes priority because it indicates a problem
    (4) appropriate charting

12. The nurse is caring for clients in the outpatient clinic. The nurse returns to the desk and finds four phone messages. Which of the following messages should the nurse return FIRST?

    1. A client with cold symptoms has an oral temperature of 103°F (39.4°C).
    2. A client with stage II decubitus ulcer reports that the dressing has come off.
    3. A client is nauseated and has vomited 6 times in the previous 24 hours.
    4. A client is complaining of leg pain after walking half a mile.

    Strategy: Eliminate the two most stable clients. Use the ABCs to determine the most unstable client.

    (1) elevated temperature indicates infection; determine the underlying cause, encourage fluids
    (2) stable client
    (3) correct–assess amount, character, symptoms of fluid volume deficit
    (4) stable client, complaint indicates intermittent claudication

13. A client has a bovine graft inserted into the left arm for hemodialysis. During the immediate postoperative period, which of the following actions, if performed by the nurse, is BEST?

    1. Restart the IV above the level of the graft.
    2. Take blood pressures only on the right arm.
    3. Elevate the left arm above the level of the heart.
    4. Check the radial pulse on the left arm q4h.

    Strategy: Determine the outcome of each answer choice.

    (1) IVs should not be started in the grafted arm
    (2) correct–BP should always be taken on the opposite arm from the graft
    (3) unnecessary
    (4) would not prevent complications, but would identify complications

14. The nurse assesses a prolonged deceleration of the fetal heart rate while the client is receiving oxytocin IV to stimulate labor. The priority nursing intervention would be to

    1. discontinue the infusion.
    2. turn client to the left side.
    3. change the fluids to LR.
    4. increase the IV flow rate.

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

    (1) correct–will decrease contractions and thus possibly remove uterine pressure to the fetus, which is possibly cause of deceleration
    (2) may help the deceleration, but is not a priority
    (3) will have no influence on the fetal heart rate
    (4) will have no influence on the fetal heart rate

15. The nurse is caring for a patient recovering from abdominal surgery. While ambulating, the patient complains to the nurse that she has a dull ache in her left leg. The nurse should

    1. place the patient on bedrest and elevate the foot of the bed six inches.
    2. ask the patient to remain in bed and place a pillow under the knee to elevate her left leg.
    3. ambulate the patient as directed to prevent complications of bedrest.
    4. obtain thigh-high compression or elastic stockings and continue ambulating the patient.

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

    (1) correct–promotes venous return and decreases venous pressure relieving pain and edema
    (2) would obstruct venous flow increasing chance for thrombus formation
    (3) would cause pressure fluctuations in venous system; could cause emboli, should be on bedrest 5–7 days
    (4) used to prevent deep vein thrombosis, should be on bedrest initially

16. A middle-aged female client begins outpatient therapy sessions with a psychiatric clinical nurse specialist for management of a phobic disorder. Which of the following nursing interventions should be an initial approach in symptom reduction?

    1. Referral for psychopharmacologic intervention.
    2. Group psychotherapy.
    3. Systematic desensitization.
    4. Biofeedback.

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

    (1) reasonable treatment options as the nurse obtains further information
    (2) reasonable treatment options as the nurse obtains further information
    (3) correct–phobic disorders are learned responses; learned responses can be unlearned through certain techniques, such as behavioral modification; systematic desensitization is a form of behavior modification; is a strategy used in conjunction with deep muscle relaxation to decrease the extreme response to anxiety-producing situations as they are gradually exposed; then exposure is increased; goal is to eradicate the phobic response by replacing it with the relaxation response
    (4) is usually more useful for reducing stress associated with physiologically based disorders

17. The nurse is caring for a client with Cushing's syndrome. Which of the following nursing actions would be of HIGHEST priority?

    1. Implement measures to prevent skin breakdown.
    2. Plan measures to prevent infections.
    3. Teach the client signs and symptoms of hyperglycemia.
    4. Instigate measures to prevent fluid overload.

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

    (1) clients are susceptible to skin breakdown and infections
    (2) clients are susceptible to skin breakdown and infections
    (3) impaired glucose tolerance often leads to hyperglycemia, but is not highest priority
    (4) correct–respirations are the first priority; clients with Cushing's syndrome are prone to fluid overload and CHF due to sodium and water retention

18. The nurse is assessing a client with a diagnosis of detached retina. Which of the following observations would support this diagnosis?

    1. Loss of acuity in the peripheral visual field.
    2. Increased lacrimation, blurred vision.
    3. Conjunctivitis, dilated pupils bilaterally.
    4. Photophobia, loss of a portion of the visual field.

    Strategy: Think about each answer choice.

    (1) loss of peripheral vision occurs with glaucoma; loss of acuity occurs with cataracts
    (2) occurs with ocular infections
    (3) has no correlation with detached retina
    (4) correct–bright flashes of light and client stating that portion of visual field is dark are classic symptoms

19. The physician orders indomethacin (Indocin) 25 mg PO bid for a 34-year-old woman. It would be most important for the nurse to make which of the following statements?

    1. "Take this medication with food."
    2. "Take this medication one hour before meals."
    3. "Take this medication one hour after meals."
    4. "Take this medication with orange juice."

    Strategy: "MOST important" indicates there may be more than one correct response.

    (1) correct–reduces GI upset
    (2) risk of GI upset
    (3) should be given with food
    (4) risk of GI upset

20. A child comes to the school nurse with a honey-colored crusted lesion below her right nostril. Which of the following actions should the nurse take FIRST?

    1. Remove the scab.
    2. Apply a wet cloth to the lesion.
    3. Notify the child's parents.
    4. Contact the health department.

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

    (1) notify parents first; loosen scab with Burrow's solution compress; gently remove, topical ointment
    (2) notify parents first, use compress made of Burrow's solution
    (3) correct–describes impetigo, highly infectious superficial bacterial infection; notify parents so they can contact the physician
    (4) unnecessary to report impetigo to the health department

21. Which of the following nursing actions should be the priority for an infant admitted with a positive stool culture for *Salmonella*?

    1. Change the diet to clear liquids.
    2. Initiate intravenous fluids.
    3. Maintain contact precautions.
    4. Apply cloth diapers.

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

    (1) may be appropriate, but is not a priority over answer choice #3, which will prevent transmission
    (2) may be appropriate but is not a priority over answer choice #3, which will prevent transmission
    (3) correct–prevents transmission of this bacterium to other individuals
    (4) may be appropriate, but is not a priority over answer choice #3, which will prevent transmission

22. A client admitted four days ago for treatment of alcohol dependence is now displaying the following symptoms: slurred speech, ataxia, uncoordinated movements, and headache. Which of the following nursing actions should be taken FIRST?

    1. Observe the client for eight hours to collect additional data.
    2. Perform a complete physical assessment.
    3. Collect a urine specimen for a drug screen.
    4. Encourage the client to talk about whatever is bothering him.

    Strategy: Answers are a mix of assessments and implementations. Is this a situation that requires validation? Yes.

    (1) will not provide the data that a physical assessment would; may be a medical emergency requiring an immediate intervention
    (2) correct–best way to identify possible physical complications of alcohol dependence is through a complete physical assessment
    (3) should be done after the physical assessment is completed
    (4) inaccurate because the symptoms are most likely caused by physical and not psychological stressors

23. The nurse would identify which of the following clients as being at the highest risk for developing a pulmonary embolus?

    1. A 19-year-old four days postpartum with an obstetrical history of placenta previa.
    2. An obese 40-year-old man with multiple pelvic fractures from an auto accident two days ago.
    3. A 65-year-old woman who had a fractured hip repaired 10 days ago and who is in physical therapy daily.
    4. A 22-year-old leukemic client with a platelet count of 120,000/mm^3 and a hemoglobin level of 9.0 g.

    Strategy: Determine how each answer choice relates to pulmonary embolism.

    (1) at high risk for shock and bleeding complications
    (2) correct–obesity, immobility, and pooling of blood in the pelvic cavity contribute to development of pulmonary emboli
    (3) client does not have a high risk for pulmonary emboli
    (4) at high risk for shock and bleeding complications

24. The nurse is supervising a student nurse administer a tube feeding to a client via a Levin tube. Which of the following actions, if performed by the student nurse, indicates a proper understanding of the correct procedure?

    1. The Levin tube remains unclamped for 30 minutes after the feeding.
    2. Sterile equipment is used to administer the feeding.
    3. The amount of the feeding is varied according to the patient's tolerance.
    4. The tube feeding is given at room temperature.

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

    (1) clamping tube between feedings prevents introduction of air and loss of liquid
    (2) clean, not sterile, supplies are required
    (3) physician will order amount of feedings, usually begin with a small amount and increases 50-100 cc until nutritional requirements met
    (4) correct–minimizes intestinal cramping

25. The nurse is caring for a client with deep vein thrombosis (thrombophlebitis) of the left leg. Which of the following would be an appropriate nursing goal for this client?

    1. Decrease inflammatory response in the affected extremity and prevent embolus formation.
    2. Increase peripheral circulation and oxygenation of the affected extremity.
    3. Prepare the client and family for anticipated vascular surgery on the affected extremity.
    4. Prevent hypoxia associated with the development of a pulmonary embolus.

    Strategy: Think about each answer choice.

    (1) correct–important to prevent the complication of pulmonary embolism in clients at high risk
    (2) relates to arterial disease
    (3) surgery is not anticipated for this client
    (4) preventing embolism is the first priority

26. The nurse is called to the room of a patient four days after abdominal surgery. The patient had been coughing and said he "felt something give." The nurse observes that the edges of the incision have separated, and a small loop of the bowel protrudes through the incision. The nurse should position the patient

    1. with the head of the bed elevated 30°.
    2. with the foot of the bed tilted and the head of the bed down.
    3. with the head of the bed elevated 15°.
    4. with the head of the bed elevated 90°.

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

    (1) semi-Fowler's, too high, would put pressure on abdominal area
    (2) Trendelenberg position, would impede respiratory excursion
    (3) correct–low Fowler's, reduces stress on suture line, may be placed supine with hips and knees bent
    (4) high Fowler's, too high, would put pressure on abdominal area

27. On a home health visit, an elderly client states, "This neighborhood has really gone down. I feel like a prisoner in my own home with all the trouble out there." Which of the following nursing responses by the nurse is BEST?

    1. "Have you and your neighbors formed a neighborhood watch?"
    2. "It must be very difficult for you to live in this neighborhood."
    3. "I see a lot of police cars, so you should be pretty safe."
    4. "Tell me what has happened to make you feel that you are not safe."

    Strategy: Remember therapeutic communication.

    (1) jumps ahead to solutions without adequately defining the problem
    (2) empathetic response, but does not obtain more information from the client or encourage the client to continue
    (3) false reassurance
    (4) correct–assessing the basis for client's fears and encouraging client to talk about them is the first positive step

28. An intravenous pyelogram (IVP) is ordered for a client who is scheduled to have his left kidney removed because of hypertension and renal disease. Which of the following nursing actions has the highest priority the evening prior to the IVP?

    1. Administer a cathartic enema to cleanse the bowel.
    2. Obtain information about client allergies.
    3. Instruct the client to be NPO after midnight.
    4. Teach the client that x-rays will be taken at multiple intervals.

    Strategy: Answers are a mix of assessments and implementations. Is the assessment appropriate? Yes.

    (1) implementation, contains correct information, but is not a priority
    (2) correct–assessment, clients sensitive to iodine can develop anaphylaxis; client should be asked specifically about allergies to iodine; iodine is present in the radiopaque material that is injected IV
    (3) implementation, contains correct information, but is not a priority
    (4) implementation, test may be canceled if the client is allergic to iodine

29. The nurse cares for an 8 lb, 8 oz newborn boy. The infant's history indicates that his mother was given magnesium sulfate IV 4 g in 250 ml D_5W several hours before delivery. The nurse would be MOST concerned if which of the following was observed?

    1. Temperature 97.6°F (36.5°C).
    2. Apical pulse 140 bpm.
    3. Respirations 18.
    4. BP 80/50.

    Strategy: "MOST concerned" indicates a complication.

    (1) normal temp 98.6°F (37°C), magnesium sulfate does not affect temperature
    (2) normal pulse 120–140, magnesium sulfate does not affect cardiac system of infant
    (3) correct–magnesium sulfate can cause slowing of respirations and hyporeflexia; normal respirations 30–60/min
    (4) normal BP 60/40–80/50, magnesium sulfate does not affect BP

30. The nurse is assisting a 58-year-old woman from the bed to the chair for the first time after a right total hip replacement. It is MOST important for the nurse to take which of the following actions?

    1. Assist the patient to stand on her right leg and pivot to a low soft chair, keeping her hips straight.
    2. Assist the patient to stand on her left leg and pivot to a straight-backed chair, flexing her hips slightly.
    3. Ask the patient to bear weight equally on both legs, bend at the waist, and sit in a low soft chair.
    4. Assist the patient to stand on both legs and take a few steps to a straight-backed chair.

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

    (1) should not bear weight on affected side, dislocation may occur
    (2) correct–prevents dislocation
    (3) no weight bearing on affected leg, dislocation may occur
    (4) no weight bearing on affected leg, dislocation may occur

31. At approximately 6 PM, the nurse begins to open the nurses' notes for the evening shift. The last entry is noted for 1 PM, and there is no signature. The MOST appropriate nursing response is to

    1. leave approximately three or four lines for the day nurse to enter the day information and sign the chart.
    2. review with the client the activities after 1 PM, and enter what are determined to be the activities after 1 PM.
    3. begin charting on the next line below the last entry, and make a note for the day nurse to make a late entry to complete the chart.
    4. do not enter anything until the day nurse has been notified of the problem and returns to the unit to complete charting.

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

    (1) blank lines should never be left in the nurses' notes
    (2) nurse should chart only the care that s/he has administered
    (3) correct–day nurse can make a "late entry" to add any additional information
    (4) unnecessary

32. A client is started on doxepin hydrochloride (Sinequan) 75 mg PO tid. The nurse should recommend a change in the client's therapy if which of the following occurs?

    1. The client refuses to speak and sits quietly in the room.
    2. The client becomes excitable and develops tremors.
    3. The client refuses to eat breakfast.
    4. The client sleeps 18 hours a day.

    Strategy: Think about the cause of each assessment and how it relates to Sinequan.

    (1) not relevant to this medication
    (2) correct–doxepin HCL (Sinequan) is an antidepressant; signs of overdosage include excitability and tremors
    (3) not relevant to this medication
    (4) not relevant to this medication

33. Which of the following guidelines is appropriate for the nurse to give a mother concerning the developmental stage of her seven-year-old daughter?

    1. The child's periods of shyness are to be expected.
    2. Nightmares are not characteristic of this age and should be investigated.
    3. The child should be encouraged to care for her younger sister.
    4. Punishment may be necessary for acts of independence.

    Strategy: Remember growth and development.

    (1) correct–normal for developmental stage, beginning to show independence from parents
    (2) nightmares are frequently experienced at this age
    (3) should be encouraged to be independent, not responsible for sibling, inappropriate for this age group
    (4) should allow child to be increasingly independent without punishment

34. A client is scheduled for a cardiac catheterization, and the nurse teaches him about the procedure. What statements, if made by the client, would indicate to the nurse that he understands the teaching?

    1. "I'm going to feel cold during the procedure."
    2. "I can get up and walk to the bathroom immediately after the procedure."
    3. "The nurse will be checking my foot pulses after the procedure."
    4. "I won't be able to eat for 24 hours before the procedure."

    Strategy: "Understands teaching" indicates that you are looking for a true statement.

    (1) may feel burning sensation when dye injected
    (2) on bedrest 8–12 h after procedure with pressure dressing applied over catheter insertion site
    (3) correct–peripheral pulses checked every 15 min for 1 h, then every 30 min for 2 h, then every 4 h
    (4) NPO midnight prior to procedure

35. A client had an aortic aneurysm resection two days ago. A complete blood count reveals a decreased red blood cell count. The nursing assessment is MOST likely to reveal which of the following?

    1. Fatigue, pallor, and exertional dyspnea.
    2. Nausea, vomiting, and diarrhea.
    3. Vertigo, dizziness, and shortness of breath.
    4. Malaise, flushing, and tachycardia.

    Strategy: Remember the "comma, comma, and rule". Each part of the answer choice must be correct in order for the answer to be correct.

    (1) correct–these "constitutional symptoms" are characteristic of most types of anemia and are predominantly the result of tissue hypoxia secondary to inadequate red blood cells
    (2) are not as indicative of the loss of red blood cells
    (3) are not as indicative of the loss of red blood cells
    (4) are not as indicative of the loss of red blood cells

36. The physician orders meperidine (Demerol) 50 mg IM every 3–4 h PRN for pain for a client. The client asks the nurse for the medication at bedtime. Prior to administering the pain medication, the nurse should

    1. take measures to determine if the pain is psychological.
    2. check to see if the man has a history of addiction.
    3. try several other comfort and pain relief measures.
    4. learn the location, character, and intensity of the pain.

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

    (1) should assess patient first
    (2) not highest priority, should assess patient first
    (3) need to assess before implementing action
    (4) correct–assessment first step in nursing process

37. The nurse is assessing a pregnant client with problems of mitral stenosis and congestive heart failure (CHF). Which of the following in the client's history would have a direct correlation with her current problem?

    1. History of rheumatic fever four years ago.
    2. Presence of ventricular septal defect as an infant.
    3. Heart disease in both the maternal and the paternal families.
    4. Persistent ear infections and mastoiditis as a child.

    Strategy: Think about each answer choice.

    (1) correct–most common cause of mitral valve problems is a history of rheumatic fever with a subsequent complication of carditis, which affects the valve
    (2) does not contribute to mitral valve disease
    (3) does not contribute to mitral valve disease
    (4) does not contribute to mitral valve disease

38. The nurse is preparing a 56-year-old woman for a paracentesis. It is MOST important for the nurse to take which of the following actions?

    1. Keep the woman NPO 12 hours before the procedure.
    2. Have the woman void just before the procedure.
    3. Initiate a bowel preparation program 24 hours before the procedure.
    4. Place the woman supine during the procedure.

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

    (1) does not need to be NPO
    (2) correct–prevents puncture of bladder
    (3) bowel preparation unnecessary
    (4) would make it more difficult to drain fluid, patient should be positioned sitting upright at side of bed with feet supported

39. The nurse is caring for a client in the ICU. Hemodynamic monitoring is accomplished via a Swan-Ganz catheter. The nurse is aware that this type of monitoring will provide which of the following information?

    1. Measures the circulatory volume in the coronary arteries.
    2. Indirectly measures the pressure in the ventricles.
    3. Analyzes the adequacy of pulmonary circulation.
    4. Directly measures the adequacy of CO_2 exchange.

    Strategy: Think about each answer choice.

    (1) not a function of this catheter, and does not reflect hemodynamic monitoring
    (2) correct–CVP readings measure the pressure in the right ventricle, the Swan-Ganz catheter measures the pulmonary artery wedge pressure, which is an indirect reading of the pressure in the left ventricle
    (3) not a function of this catheter, and does not reflect hemodynamic monitoring
    (4) not a function of this catheter, and does not reflect hemodynamic monitoring

40. A client is admitted with a diagnosis of trigeminal neuralgia (tic douloureux) involving the maxillary branch of the affected nerve. When performing client teaching, it is MOST important for the nurse to include which of the following instructions?

    1. Report an increase in blurred vision.
    2. Eat soft, warm foods.
    3. Change positions slowly.
    4. Chew food on the affected side.

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

    (1) unnecessary, does not occur with this condition
    (2) correct–intense facial pain experienced along nerve tract is characteristic of this condition; nursing care should be directed toward preventing stimuli to the area and decreasing pain
    (3) intervention for Ménière's disease
    (4) chewing food on unaffected side less likely to trigger an attack

41. An abdominal wound irrigation with a normal saline solution is ordered for a client. To perform this procedure, the nurse should

    1. warm the irrigating solution to 110°F (43.3°C).
    2. establish a sterile field that includes the irrigating equipment.
    3. direct the irrigating solution at the outer edges of the wound, then the center of the wound.
    4. aspirate the irrigating fluid with a syringe to prevent accumulation in the wound.

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

    (1) too warm, should be room temperature or 90–95°F (32.2–35°C)
    (2) correct–requires strict aseptic technique
    (3) may cause new microorganisms to be flushed into wound
    (4) fluid should drain by gravity

42. The lab reports a lecithin/sphingomyelin (L/S) ratio of 3:1 for a client who has been on bedrest 48 hours in an unsuccessful attempt to arrest premature labor at 33-weeks gestation. Based on this result, the nurse would anticipate

    1. administration of ritodrine hydrochloride (Yutopar).
    2. initiation of an oxytocin (Pitocin) drip.
    3. delivery of the infant by cesarean section.
    4. continuation of bedrest until otherwise indicated.

    Strategy: Determine the significance of each answer choice and how it related to the L/S ratio.

    (1) no longer necessary as the results indicate sufficient lung maturity for safe delivery
    (2) although the lungs are mature enough for safe delivery, client would either be allowed to progress naturally to a vaginal delivery or sectioned, but not induced
    (3) correct–because the lungs are adequately mature, there is no need to attempt to postpone labor; delivery by cesarean section is generally preferred for preterm infants
    (4) is no longer necessary with adequately mature lungs

43. The nurse is caring for clients in the hospital. Which of the following nursing activities BEST promotes rest for an elderly hospitalized client?

    1. Place a clock at the bedside.
    2. Restrict visitors so that the client is alone during the evening.
    3. Tell the client how to call for help if needed.
    4. Postpone explanation of further tests that the client will need.

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

    (1) does not promote rest
    (2) does not promote rest
    (3) correct–elderly client who feels isolated and unable to obtain help if needed cannot rest properly
    (4) elderly client will rest better if s/he understands what is going on with his/her health care

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

    1. A client with chronic renal failure complaining of swollen fingers and ankle edema.
    2. A client one-day postoperative after abdominal surgery who has dried blood on the abdominal dressing.
    3. A client with type I diabetes mellitus who states, "I have this quivering feeling in my abdomen."
    4. A client on high doses of antibiotics for a resistant infection who complains of diarrhea.

    Strategy: Determine the least stable client.

    (1) Indicates peripheral edema, treatment includes fluid and sodium restrictions
    (2) stable client
    (3) correct–indicates hypoglycemia; symptoms include tachycardia, cold and clammy skin, weakness and pallor; check blood sugar, offer milk
    (4) common sequelae of antibiotic therapy, monitor fluid and electrolytes, check for skin breakdown

45. A 57-year-old man admitted with metastatic cancer has been receiving chemotherapy for 3 months. His lab values include: RBC 3.8 million/mm^3, WBC 2,000/mm^3, Hgb 9.3 g/dL, platelets 50,000/mm^3. Which of the following nursing diagnoses is MOST appropriate for this patient?

    1. Decreased cardiac output.
    2. Ineffective thermoregulation.
    3. Risk for injury.
    4. Ineffective airway clearance.

    Strategy: Determine how each answer choice relates to the lab values.

    (1) will increase due to decreased oxygenation caused by anemia; normal RBC male: 4.3–5.9 million/mm^3, female: 3.5–5.5 million/mm^3; decreased with anemia, causes heart rate and respirations to increase; normal WBC 4,500–11,000/mm^3; decreased (leukopenia) causes susceptibility to infection; normal Hgb: male 13.5–17.5 g/dL, female 12–16 g/dL; decreased with anemia
    (2) no change in temperature
    (3) correct–due to low platelet count, normal platelets 150,000–400,000/mm^3, decrease causes problems with blood clotting
    (4) no information about airway problems

46. A young client with a postoperative abdominal abscess had a drain inserted. Which of the following assessments by the nurse is BEST?

    1. Amount of the drainage.
    2. Character of the drainage.
    3. Consistency of the drainage.
    4. Amount of suction on the drainage system.

    Strategy: Think about the significance of each assessment and how it relates to a wound abscess.

    (1) lower priority
    (2) correct–with this complication, the character of the drainage, purulent or otherwise, is a major priority to note and report
    (3) lower priority
    (4) unnecessary

47. In caring for an elderly client with a depressed affect, which of the following nursing actions would be MOST appropriate to help the client to complete activities of daily living?

    1. Medicate the client before the activities begin.
    2. Develop a written schedule of activities, allowing extra time.
    3. Assist the client with grooming activities so it doesn't take as long.
    4. Provide frequent forceful direction to keep the client focused.

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

    (1) will not increase the client's independence and may interfere with the client's self-esteem
    (2) correct–written schedule with built-in extra time will allow client to understand what is expected and will allow him to participate at a slower pace
    (3) will not increase the client's independence, allow extra time for care
    (4) will not increase the client's independence and may interfere with the client's self-esteem

48. A patient is returned to his room following an appendectomy. The nurse notices a large amount of serosanguineous drainage on the dressing. It is MOST important for the nurse to obtain an answer to which of the following questions?

    1. "Were there any intraoperative complications?"
    2. "Has the dressing been changed?"
    3. "Why didn't the recovery room nurse report any drainage?"
    4. "Was a tissue drain placed during surgery?"

    Strategy: Determine how each answer choice relates to an appendectomy.

    (1) doesn't indicate understanding that drainage may be normal after this surgery
    (2) first dressing usually changed by physician
    (3) doesn't indicate understanding that drainage may be normal after this surgery
    (4) correct–drain is frequently placed during surgery to prevent accumulation in wound, dressing should be reinforced

49. The nurse is caring for a client in her third trimester of pregnancy. The nurse is MOST concerned by which of the following assessments?

    1. The client complains of epigastric pain.
    2. The client complains of shortness of breath.
    3. The client states she has increased rectal pressure.
    4. The client has gained of 33 pounds during her pregnancy.

    Strategy: Think about the cause of each symptom and how it relates to pregnancy.

    (1) correct–is usually indicative of an impending convulsion
    (2) expected observation
    (3) expected observation
    (4) is important to address, but is not as high a priority as answer choice #1

50. A middle-aged adult is seen in the emergency room for complaints of severe right-flank pain. The client is twenty pounds overweight, lives a sedentary lifestyle, and was treated for renal calculi four years ago. Which of the following actions, if performed by the nurse, is MOST important?

    1. Ensure that the client has nothing to eat or drink.
    2. Obtain a "clean-catch" urine specimen for analysis.
    3. Provide warm packs to relieve discomfort.
    4. Measure and strain the client's urine.

    Strategy: "MOST important" indicates a priority question. All answers are implementations. Determine the outcome of each answer choice. Is it desired?

    (1) should force fluids to 3,000/day to assist client pass stone
    (2) not most important, used to identify infection
    (3) not most important, analgesics given to reduce discomfort
    (4) correct–will document passage of stone and allow composition to be analyzed

51. The nurse is supervising a student nurse teach a client about a newly prescribed medication. Which of the following actions, if observed by the nurse, would require an intervention?

    1. The student nurse glances at his/her watch when instructing the client.
    2. The student nurse uses culturally appropriate language and teaching materials.
    3. The student nurse begins instructions to the client discussing information that concerns the client.
    4. The student nurse chooses a time for teaching when there are no visitors.

    Strategy: "Require an intervention" indicates that you are looking for an incorrect behavior.

    (1) correct–lack of attending behaviors are always a barrier to learning
    (2) appropriate teaching strategy
    (3) appropriate teaching strategy
    (4) appropriate teaching strategy

52. Prior to a cesarean section delivery, a 24-year-old woman is treated for abruptio placentae. The nurse is caring for the woman during the postpartum period. Which of the following symptoms would be suggestive of disseminated intravascular coagulation (DIC)?

    1. The client's vital signs are: BP 90/58, temperature 101°F (38.3°C), pulse 112, respirations 18.
    2. The client's laboratory results are: Hgb 13 g/dL, Hct 40%, WBC 7,000/mm^3.
    3. The client is nauseated, lethargic, and has vomited three times.
    4. There is oozing blood from the venipuncture site and abdominal incision.

    Strategy: Determine how each answer choice relates to DIC.

    (1) may indicate hemorrhage or sepsis
    (2) results normal, DIC would be reflected in clotting studies (PT, PTT)
    (3) nonspecific, could be related to anesthesia or pain medication
    (4) correct–DIC is acquired clotting disorder from overstimulation, prolonged oozing from sites of minor trauma first symptom

53. A four-week-old infant with symptoms of pyloric stenosis is brought to the outpatient clinic by his mother. Which of the following statements would the nurse expect the mother to make about her son's symptoms?

    1. "My son's bowel movements have turned black and sticky."
    2. "I really have to encourage my son to suck the bottle."
    3. "My son is fussy and seems hungry all the time."
    4. "My son spits up green liquid after feeding."

    Strategy: Determine how each statement relates to pyloric stenosis.

    (1) not expected with pyloric stenosis, suggestive of blood in stool
    (2) sucking problems not expected with pyloric stenosis
    (3) correct– becomes lethargic, dehydrated, and malnourished
    (4) would expect emesis to contain milk or formula, should not be bile-colored

54. The physician prescribes cimetidine (Tagamet) 300 mg PO qid for a 75-year-old man. The nurse instructs the client about the medication. Which of the following statements, if made by the client, would indicate that further teaching is needed?

    1. "I'll take this pill with meals and before bed."
    2. "I may experience mild diarrhea for a while."
    3. "My stools may change color while I'm on this medication."
    4. "I should call my doctor if I get an acne-like rash."

    Strategy: "Further teaching" indicates that you are looking for an incorrect statement.

    (1) taking with meals ensures consistent therapeutic effect
    (2) common side effect, usually subsides
    (3) correct–no change in stool color
    (4) side effect seen with medication

55. A teenager comes to the clinic complaining of fatigue, a sore throat, and flu-like symptoms for the previous two weeks. Physical exam reveals enlarged lymph nodes and temperature of 100.3°F (37.9°C). Which of the following statements by the nurse is BEST?

    1. "Cover your mouth and nose when you sneeze or cough."
    2. "Eat in a separate room away from your family."
    3. "Don't share your drinking glass or silverware with anybody."
    4. "Stay in your room until all of your symptoms are gone."

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

    (1) mononucleosis is spread by direct contact
    (2) no reason to be isolated
    (3) correct–symptoms indicate mononucleosis, spread by direct contact; advise family to avoid contact with cups and silverware for about 3 months
    (4) clients with mononucleosis are not isolated

56. Which of the following strategies would be MOST therapeutic as the nurse tries to analyze a bulimic client's eating habits and the circumstances that precipitate the client's eating problems?

    1. Observe family communication patterns at a "monitored mealtime."
    2. Distract the client at mealtime.
    3. Assign the client a food/feelings/thoughts/actions journal.
    4. Assign the client to write a "lifeline" in relation to eating behaviors.

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

    (1) assessment, should be done after a food/feelings/actions journal
    (2) implementation, should be done after a food/feelings/actions journal
    (3) correct–implementation, nurse is trying to analyze and understand what triggers the client's binging and purging activities, so therapeutic nursing intervention of assigning a thought/feelings/actions (T/F/A) journal relating to client's eating behaviors will be most helpful to the nurse and therapeutic to the client; after this information is gained and reviewed, collaboration by the nurse and client on other strategies such as delay and distraction techniques, stress reduction, and developing a "lifeline" in relation to eating behaviors will further benefit the client
    (4) implementation, should be done after a food/feelings/actions journal

57. A 20-year-old primipara attends a class for women who plan to breastfeed. To prepare for breastfeeding, the nurse should encourage the women to

    1. apply moisturizer to their breasts every day after bathing.
    2. expose their breasts to air every day for 20 minutes.
    3. wash their breasts with water and rub with a towel every day.
    4. massage their breasts to increase circulation twice daily.

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

    (1) use of creams not recommended, could cause breast tissues to become tender, sebaceous glands keep skin pliable
    (2) doesn't prepare breasts for feeding
    (3) correct–prepares nipples for stretching action of sucking during breastfeeding, soap avoided to prevent drying
    (4) could cause breast tissues to become tender

58. A 45-year-old client with newly diagnosed IDDM (insulin-dependent diabetes mellitus) is being seen by the home health nurse. The physician has placed him on a 1,800-calorie ADA diet, ordered the client to self-administer 15 units of NPH insulin each day before breakfast, and check his blood sugar qid. When the nurse visits the client at 5 PM, the nurse discovers that the client has not eaten since noon and has just returned from jogging. The client's vital signs are: BP 110/80, pulse 120, respirations 18, temperature 98.2°F (36.8°C). When the client obtains his blood sugar reading, the nurse would expect it to be

    1. 250 mg/dL.
    2. 160 mg/dL.
    3. 90 mg/dL.
    4. 50 mg/dL.

    Strategy: Think about each answer choice.

    (1) hyperglycemia symptoms are hot dry skin, rapid, deep respirations (Kussmaul), lethargic, polyuria, polydipsia, polyphagia, glycosuria, nausea and vomiting
    (2) NPH insulin is intermediate-acting, onset 3–4 hours, peak 8–16 hours, duration 18–26 hours
    (3) normal blood sugar 70–110 mg/dL
    (4) correct–hypoglycemia symptoms are cool, clammy skin, diaphoresis, nervousness, weakness, hunger, confusion, headache, slurred speech, coma

59. The mother of an eight-month-old infant prepares to take her child home after treatment for bacterial meningitis. The mother confides to the nurse that she is afraid that her child will have brain damage as a result of his illness. Which of the following is the BEST response by the nurse?

    1. "Trust your doctors. They are excellent pediatricians and will know what to look for."
    2. "There is a 20% incidence of residual brain damage after this type of illness, but the odds are in your favor."
    3. "It is an unlikely possibility, but if your child doesn't develop normally, your pediatrician will help you with any problems."
    4. "You feel guilty about your son's illness, and that's understandable. You will feel better after you get home."

    Strategy: Remember therapeutic communication.

    (1) nontherapeutic, diminishes person's concerns and feelings
    (2) nontherapeutic to discuss statistics with patients, wrong emphasis for discussion
    (3) correct–if treated early, good prognosis; may be complications and long-term effects (seizure disorders, hydrocephalus, impaired intelligence, visual and hearing defects), therapeutic response
    (4) nontherapeutic, interprets person's feelings

60. The nurse is preparing a client for a herniorrhaphy. It would be MOST important for the nurse to complete which of the following one hour prior to surgery?

    1. Administer an enema.
    2. Confirm that the consent form has been signed.
    3. Perform a preoperative shave and scrub.
    4. Evaluate for food or medication allergies.

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

    (1) should be done earlier than one hour before surgery
    (2) correct–surgical consent should be rechecked prior to going to surgery
    (3) should be done earlier than one hour before surgery
    (4) assessment, should be done earlier than one hour before surgery

61. The nurse is caring for an 11-year-old girl being treated for a fractured right femur with balanced suspension traction with a Thomas splint and Pearson attachment. When the nurse checks the patient, the nurse finds the weights on the floor, and the girl's feet touching the foot of the bed. The nurse should

    1. release the traction weights and reposition the patient in bed.
    2. pull on the traction weights while two nurse's aides pull the girl up in bed.
    3. steady the traction and have the girl bend her left leg and push up in bed.
    4. assess the patient's right leg for proper position and alignment.

    Strategy: Answers are a mix of assessments and implementations. Does this situation require assessment? No. Determine the outcome of each answer choice.

    (1) release of weights would change pull of traction, weight should never be released
    (2) pulling on traction weights would alter proper pull on fracture
    (3) correct–permits patient to reposition self and reestablish pull of traction weights
    (4) would not reestablish proper pull of traction

62. The nurse is making rounds on the postpartum unit. The nurse notes that a client's uterus is relaxed. The nurse should

    1. put the infant to the woman's breast.
    2. encourage the woman to drink warm oral fluids.
    3. check the woman's pulse and respirations.
    4. continue to monitor the firmness of the uterus.

    Strategy: Answers are a mix of assessments and implementations. Does this situation require validation? No. Determine the outcome of each implementation.

    (1) correct–implementation, causes natural surge of oxytocin that results in contraction of uterus
    (2) implementation, has no effect on contraction of uterus
    (3) assessment, not best action, situation does not suggest that patient is in shock
    (4) assessment, needs manual massage or release of natural oxytocin to contract uterus

63. A client with Addison's disease is admitted with pneumonia. The nurse suggests salted broth for lunch. The appropriateness of this decision is based on which of the following statements about Addison's disease?

    1. The client requires increased sodium intake to prevent hypotension.
    2. A decrease in sodium intake may lead to seizures.
    3. Steroid replacement causes rapid loss of sodium.
    4. Sodium intake should be increased during periods of stress.

    Strategy: Think about each answer choice.

    (1) not as important as answer choice #4
    (2) not a correct statement for this condition
    (3) steroid replacement increases sodium retention
    (4) correct–with decrease in aldosterone, there is an increased excretion of sodium; sodium intake should be increased

64. The nurse is performing screening at the local senior citizens facility. The nurse would be MOST concerned if which of the following was observed?

    1. A 69-year-old man has a slightly elevated systolic blood pressure.
    2. The nurse has difficulty palpating an apical pulse on a 74-year-old woman.
    3. The nurse auscultates an S_3 ventricular gallop on a 78-year-old woman.
    4. An 81-year-old man has a temperature of 98.2°F (36.7°C).

    Strategy: Determine how each assessment relates to an older adult.

    (1) usual finding for the older adult
    (2) usual finding for the older adult
    (3) correct–ventricular gallop is the earliest sign of CHF
    (4) may be normal in all age groups

65. The nurse is aware that which of the following statements made by a client indicates a correct understanding of patient-controlled analgesia (PCA)?

    1. "If I start feeling drowsy, I should notify the nurse."
    2. "This button will give me enough to kill the pain whenever I want it."
    3. "If I start itching, I need to call you."
    4. "This medicine will make me feel no pain."

    Strategy: Think about what the words mean.

    (1) may feel sleepy due to medication
    (2) preset dose administered with preset lock-out times
    (3) correct–itching is a common side effect of narcotics used in PCA pain management
    (4) indicates a need for further teaching or clarification

66. A client taking trifluoperazine (Stelazine) should be instructed to notify the nurse immediately if he experiences which of the following?

    1. Dry mouth and nasal stuffiness.
    2. Increased sensitivity to heat.
    3. Difficulty urinating.
    4. Weight gain and constipation.

    Strategy: Determine the cause of each answer choice and how it relates to Stelazine.

    (1) possible side effect of antipsychotic medications, but client can be instructed on measures to take at home to resolve this problem
    (2) possible side effect of antipsychotic medications, but client can be instructed on measures to take at home to resolve this problem
    (3) correct–is an anticholinergic reaction that may become a severe health problem unless treated
    (4) possible side effect of antipsychotic medications, but client can be instructed on measures to take at home to resolve this problem

67. A charge nurse is developing the assignment for the evening shift. In a semiprivate room, Client A has neutropenia. Client B has a tracheostomy with purulent drainage and a pending culture and sensitivity (C&S). Which of the following indicates the MOST appropriate assignment?

    1. Assign an experienced nurse to care for both clients in the same room.
    2. Assign two nurses: one nurse for Client A and another nurse for Client B, in the same room.
    3. Place Client A in a private room and assign the same nurse to care for Client A and Client B.
    4. Place Client A in a private room and assign different nurses to care for Client A and Client B.

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

    (1) should be in a private room away from roommate with infection
    (2) should be in a private room away from roommate with infection
    (3) should be cared for by different nurses
    (4) correct–infection in a neutropenic individual may cause morbidity and fatality; place the neutropenic client in a private room; limit and screen visitors and hospital staff with potentially communicable illnesses

68. A 72-year-old client has an order for digoxin (Lanoxin) 25 mg PO daily. The nurse reviews the following information: apical pulse 68/min, respirations 16/min, plasma digoxin level 2 ng/ml. Based on this assessment, which of the following nursing actions is appropriate?

    1. Give the medication on time.
    2. Withhold the medication; notify the physician.
    3. Administer epinephrine 1:1,000 stat.
    4. Check the client's blood pressure.

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

    (1) medication should be withheld
    (2) correct–therapeutic plasma level of digoxin is 0.5–2.0 ng/ml
    (3) not a correct action
    (4) assessment, does not address the issue of the elevated blood level of digoxin

69. The nurse is changing the dressing on a woman who had a mastectomy two days ago. After the nurse removes the old dressing, the client turns her head away. Which of the following is the BEST response by the nurse?

    1. "I notice that you turn your head away as if you don't want to look at your incision."
    2. "It's good that you turn your head away while I am doing this sterile procedure."
    3. "Your incision looks like it's healing nicely."
    4. "Why don't you look at the incision while I have the old dressing off?"

    Strategy: Remember therapeutic communication.

    (1) correct–states observation
    (2) doesn't help patient confront feelings
    (3) doesn't deal with avoidance behavior
    (4) nontherapeutic to ask why, causes patient to be defensive

70. The nurse is caring for a 20-year-old man with a three-chamber water-seal drainage system (Pleur-evac). When the nurse checks the patient, the nurse notices that the fluid in the water-seal chamber does not fluctuate. The nurse should

    1. milk the tube gently toward the collection chamber.
    2. anticipate the need for a chest x-ray.
    3. add water to the water seal chamber to reestablish the system.
    4. clamp the chest tube and call the physician.

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

    (1) milking is done only with order of physician to clear obstruction due to clots, fluid is clear
    (2) correct–fluctuations stop with re-expansion of lung, x-ray will confirm
    (3) should be kept at level of 2 cc to maintain negative pressure
    (4) only clamp tube when checking for air leaks or changing equipment

71. A 10-year-old boy, weighing 50 lbs (23.6 kg), returns from surgery for a skin graft to his left leg. The patient has an IV of D_5W infusing into his left arm. The physician's orders read, "D_5W 2,000 cc/24 h." It is MOST important for the nurse to

    1. call the physician to clarify the IV fluid order.
    2. keep accurate records of the patient's intake and output.
    3. set the controller on the IV pump to infuse at 84 gtts/min.
    4. monitor the patient for fluid and electrolyte balance.

    Strategy: Answers are a mix of assessments and implementations. Does this situation require validation? No. Determine the outcome of each implementation. Is it desired?

    (1) correct–implementation, amount is excessive for child and there are no electrolytes in fluid
    (2) implementation, may have serious electrolyte disturbances before discrepancies are seen in I and O
    (3) implementation, rate is correct for amount of fluid ordered, but amount is excessive for child and fluid is inappropriate
    (4) assessment, should not administer fluids as ordered since they are inappropriate in amount and content

72. The nurse team consists of an RN, two LPN/LVNs, and a nursing assistant. The RN should care for which of the following clients?

    1. An infant who is two-days postoperative after repair of cleft lip that requires a tube feeding.
    2. A preschool child who is three-days postoperative after surgical removal of Wilms' tumor that requires a bath.
    3. A school-aged child with osteomyelitis that requires a dressing change.
    4. A teenager with a head injury, has a Glasgow coma scale of 5, and requires personal care.

    Strategy: RNs care for clients that require assessment, teaching, and nursing judgment.

    (1) stable patient with an expect outcome, assigned to the LPN/LVN
    (2) standard, unchanging procedure, assign to the nursing assistant
    (3) stable patient with an expect outcome, assign to the LPN/LVN
    (4) correct–Glasgow coma scale of 5 indicates coma, client requires frequent assessment

73. An elderly female client is frantically yelling for the nurse to come into her room. The nurse enters the room as the client states, "See it? It's the devil!" Which of the following responses by the nurse is BEST?

    1. "The devil is here?"
    2. "Show me where the devil appeared to you."
    3. "I don't see the devil, but I understand that he is real to you."
    4. "The devil is not here, your mind is playing tricks on you."

    Strategy: Remember therapeutic communication.

    (1) yes/no question, attempt to reason or argue with the client will only entrench her more firmly into this distortion
    (2) attempt to reason or argue with the client will only entrench her more firmly into this distortion
    (3) correct–nurse should not reinforce client's hallucinatory experiences; direct challenge to client's belief about sensory-perceptual intake will only increase mistrust and conflict between nurse and client
    (4) argumentative, attempt to reason or argue with the client will only entrench her more firmly into this distortion

74. The nurse talks to a 26-year-old woman in the emergency department (ED) immediately after her son's death from Sudden Infant Death Syndrome (SIDS). The nurse should

    1. ask if she has other children at home.
    2. explain the cause of SIDS.
    3. allow her to cry and talk about her son.
    4. ask how her son was positioned in bed.

    Strategy: The question is unstated. Read the answers to determine the topic of the question. Answers contain both assessments and implementations. Is assessment required at this time? No. Determine the outcome of each implementation.

    (1) assessment, does not help with current loss
    (2) implementation, too soon, should allow to vent feelings and experience grief
    (3) correct–implementation, needs to go through the grieving process
    (4) assessment, may make her feel guiltier, inappropriate at this time

75. A woman was returned to her room at 10 AM following laparoscopic gall bladder surgery. The nurse plans to get the patient out of bed for the first time at 6 PM. In preparation for this activity, the nurse should

    1. cough and deep-breathe the patient at 4 PM.
    2. offer pain medication to the patient at 5:30 PM.
    3. turn the patient from side to side at noon and 4 PM.
    4. encourage the patient to use the incentive spirometer.

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

    (1) should turn, cough, and deep-breathe patient every 2 hours to prevent postoperative complications, but would not help with ambulation
    (2) correct–reduction of pain will allow patient to cooperate with activities, such as ambulation, designed to reduce postoperative complications
    (3) should turn patient every 2 hours to prevent postoperative complications, but would not help with ambulation
    (4) used to promote complete lung expansion and prevent respiratory complications following surgery, but would not help with ambulation

76. The nurse enters the room of a 17-year-old mother who is breastfeeding her 6 lb 7 oz baby girl. Which of the following observations, if made by the nurse, BEST indicates that mother-infant bonding is taking place successfully?

    1. The mother is looking into her infant's eyes as she feeds her.
    2. The mother and infant are lying side-by-side in the bed.
    3. The mother appears to be relaxed and is reading a book on childcare.
    4. The mother interrupts feeding the infant to talk to her roommate.

    Strategy: Determine how each answer choice relates to bonding.

    (1) correct–shows bonding behavior of eye-to-eye contact, proceeds to touching and holding
    (2) shows distance between mother and infant
    (3) doesn't involve communication between mother and infant
    (4) shows distance between mother and infant

77. A client undergoes an appendectomy, and the nurse is performing discharge teaching. The nurse determines that teaching has been effective if the client makes which of the following statements?

    1. "I shall eat a diet that is low in protein, high in carbohydrates, low in fats."
    2. "I shall eat a diet that is high in protein, high in calories, high in vitamin C."
    3. "I shall eat a diet high in protein, low in calories, low in fat."
    4. "I shall eat a diet low in protein, low in carbohydrates, high in vitamin D."

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

    (1) needs high-protein diet to maintain anabolic state, diet should contain adequate carbohydrates and be low in fat
    (2) correct–supplemental vitamin C, iron, and multivitamins aid in wound healing and formation of RBCs
    (3) needs high calories to promote wound healing
    (4) needs high protein and high-calorie diet to maintain anabolic state

78. The nurse observes a staff member enter the room of a client wearing a scrub suit. The nurse determines that the staff member is using the proper precautions if the staff member is caring for which of the following clients?

    1. A client with cancer complaining of a sore mouth.
    2. A client with tuberculosis requiring administration of Rifampin.
    3. A client with rubella requiring an IM injection.
    4. A client with a draining abscess that is not covered with a dressing.

    Strategy: Determine what type of precautions is needed for each client

    (1) correct–indicates Candida, standard precautions required
    (2) requires airborne precautions
    (3) requires droplet precautions
    (4) abscess with no dressing requires contact precaution

79. The nurse is caring for a client with rheumatoid arthritis. The plan of care should include

    1. cold packs, immobilization, and hand splints.
    2. maintaining flexion of the joints and proper body mechanics.
    3. analgesics, physical therapy, and a soft mattress on the bed.
    4. heat, range-of-motion exercises, and weight reduction.

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

    (1) treatment for acute strain or fracture
    (2) joints need extension and rotation, in addition to flexion, to maintain full range of motion
    (3) medications used are antiinflammatory in addition to analgesics, a firm mattress should be used
    (4) correct–goal is to prevent contractures and minimize deformity with a balance of rest and activity

80. The nurse is caring for a client who was admitted for a myocardial infarction (MI) 36 hours ago. An appropriate nursing diagnosis would be “Risk for alteration in cardiac output” related to which of the following?

    1. Mitral valve collapse.
    2. Endocarditis.
    3. Ventricular dysrhythmias.
    4. Hypertensive crisis.

    Strategy: Think about each answer choice.

    (1) not the most common occurrence
    (2) not the most common occurrence
    (3) correct–most common complication following a myocardial infarction is arrhythmia with ventricular types being the most serious
    (4) client would most probably experience a decrease in blood pressure rather than an increase

81. The nurse is caring for a 47-year-old woman 36 hours after a traditional cholecystectomy. The nurse would be MOST concerned if which of the following was observed?

    1. The patient complains of severe abdominal pain in the right upper quadrant.
    2. 500 cc of greenish-brown fluid drained from the T-tube in the last 24 hours.
    3. The patient has received an antiemetic twice since surgery.
    4. Lab tests indicate a Hgb of 14 g/dL, Hct of 44%, and WBC of 6,000/mm^3.

    Strategy: "MOST concerned" indicates a complication.

    (1) correct–could indicate peritonitis or wound infection
    (2) expected drainage, usually 500–1000 ml/day initially, will gradually decrease
    (3) some nausea expected
    (4) results within normal limits, normal Hgb: male 13.5–17.5 g/dL, female 12–16 g/dL; normal Hct: male 41–53%, female 36–46%; normal WBC 5,000–10,000/mm^3

82. A client had surgery for cancer of the colon, and a colostomy was performed. Prior to discharge, the client states that he will no longer be able to swim. The nurse's response would be based on which of the following?

    1. Swimming is not recommended; the client should begin looking for other areas of interest.
    2. Swimming is not restricted if the client wears a watertight dressing over the stoma.
    3. The client cannot go into water that is over the stoma area; he can go into water only up to that area.
    4. There are no restrictions on the activity of a client with a colostomy; all previous activities may be resumed.

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

    (1) not appropriate for a client after a colostomy
    (2) not appropriate for a client after a colostomy
    (3) not appropriate for a client after a colostomy
    (4) correct–all activities that the client participated in prior to the colostomy may be resumed after appropriate healing of the stoma or incisions

83. The nurse is preparing a 50-year-old client for a liver biopsy. The nurse should position the client

    1. prone with her head turned to the side.
    2. on her right side with her head slightly elevated.
    3. supine with her arms raised over her head.
    4. on her left side with the bed flat.

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

    (1) incorrect positioning for procedure
    (2) positioned on right side with small pillow under puncture site for 3 hours after procedure
    (3) correct–elevates the ribs to allow access to the liver, needle is inserted between two of lower ribs or below the right rib cage
    (4) incorrect positioning for procedure

84. To assist a mother in providing appropriate foods for her three-year-old daughter, the nurse would identify which of the following as the HIGHEST priority?

    1. Provide the child with finger foods.
    2. Allow the child to eat her favorite foods.
    3. Encourage a diet higher in protein than in other nutrients.
    4. Limit the number of snacks during the day.

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

    (1) correct–child is going through autonomy versus shame and doubt stage; finger foods allow child the necessary independence for this stage
    (2) child may eat food without appropriate nutrients
    (3) inappropriate for a three-year-old child
    (4) inappropriate for a three-year-old child

85. A client is undergoing peritoneal dialysis. The physician orders 2 liters to be instilled with a dwell time of 40 minutes. The nurse measures the outflow and finds it to be 1,800 cc. During the nurse's shift, the client drinks 700 cc of fluids and voids 400 cc. The nurse should record which of the following on the client's intake and output sheet?

    1. Intake: 2,700 cc; output: 400 cc.
    2. Intake: 2,700 cc; output: 2,200 cc.
    3. Intake: 700 cc; output: 400 cc.
    4. Intake: 2,700 cc; output: 1,800 cc.

    Strategy: Think about each answer choice.

    (1) must include outflow from dialysis
    (2) correct–intake and output
    (3) must include the intake and inflow and outflow from dialysis
    (4) must include the intake and inflow and outflow from dialysis

86. The nurse observes the following patients in the emergency department (ED). The FIRST patient the nurse should see is the

    1. 34-year-old man with a distended abdomen and splenomegaly.
    2. 8-month-old infant with facial ecchymosis who is crying loudly.
    3. 12-year-old boy with a possible fractured ankle.
    4. 44-year-old woman with possible whiplash from an automobile accident.

    Strategy: Determine who is the most unstable client.

    (1) correct–possibility of internal bleeding, life-threatening situation
    (2) crying demonstrates adequate airway, not life-threatening
    (3) not life-threatening
    (4) not life-threatening

87. The nurse is caring for a patient hospitalized with an acute asthma attack. The nurse would be MOST concerned if which of the following was observed?

    1. The patient becomes more diaphoretic.
    2. The patient's respirations increase from 14 to 16 per minute.
    3. The patient's pulse increases from 86 to 100 beats per minute.
    4. The patient shows increasing pallor.

    Strategy: "MOST concerned" indicates a complication.

    (1) symptom of acute asthma attack, doesn't indicate deterioration of status
    (2) expected with acute asthmatic attack, doesn't indicate deterioration of status
    (3) correct–pulse increases due to decrease in oxygenation of tissues
    (4) subjective symptom, unreliable indicator of deterioration of status

88. The nurse is obtaining a history on a client with hyperthyroidism. The nurse should report which of the following assessments to the physician?

    1. Anxiety with extreme nervousness.
    2. Slow, sluggish pulse.
    3. Cool, clammy skin.
    4. Husky, slow speech.

    Strategy: Determine how each answer choice relates to hyperthyroidism.

    (1) correct–signs and symptoms of hyperthyroidism are related to an increased metabolic rate
    (2) related to a decreased metabolic rate
    (3) related to a decreased metabolic rate
    (4) related to a decreased metabolic rate

89. A client with chronic pain due to cancer has been receiving meperidine (Demerol) 100 mg PO q4h PRN for pain without much relief. Which of the following changes in narcotic pain management would be the MOST valid suggestion for the nurse to make to the physician?

    1. Decrease medication to twice a day.
    2. Decrease medication to every 6 h PRN.
    3. Administer medication every 4 h around the clock.
    4. Administer medication every 2 h PRN.

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

    (1) decreases the amount of pain medication
    (2) decreases the amount of pain medication
    (3) correct–around-the-clock (ATC) administration of analgesics is more effective in maintaining blood levels to alleviate the pain associated with cancer
    (4) might be too frequent an interval to administer the medication

90. The nurse is caring for a client recently diagnosed with AIDS. The nurse identifies the following nursing diagnosis: risk for infection. Which of the following interventions by the nurse would be BEST?

    1. Inspect the skin daily for signs of breakdown.
    2. Limit the number of health care personnel caring for the patient.
    3. Utilize standard precautions when administering parenteral medications.
    4. Monitor the patient's vital signs q4h.

    Strategy: Answers are a mix of assessments and implementations. Does this situation require assessment? No. Determine the outcome of each implementation.

    (1) performed as part of assessment, does not address patient's limited ability to respond to possible infection
    (2) correct–implementation, decreases exposure to microorganisms
    (3) implementation, done with all patients to protect health care workers
    (4) performed as part of ongoing assessment

91. Which of the following nursing observations documented in the client's chart MOST clearly indicates the client's mood?

    1. "Client states, 'I see snakes climbing on the walls at all times of the day.'"
    2. "Unable to sustain a train of thought for long periods of time during history-taking."
    3. "Clenches her fists and shouts in an angry tone of voice when asked about family problems."
    4. "Is unaware of where she is, what day and year it is, or what time it is."

    Strategy: Evaluate each answer choice to determine "What do the words mean?"

    (1) describes hallucinations
    (2) describes altered thought processes
    (3) correct–gives data that reflect client's feelings, tone, and behavior associated with those feelings, as well as content area of conversation that evoked that mood
    (4) describes disorientation

92. While planning care for an elderly client with dementia, which of the following should be a priority for the nurse?

    1. Encourage dependency with activities of daily living.
    2. Provide flexibility in schedules due to his confusion.
    3. Limit reminiscing due to poor memory.
    4. Speak slowly in a face-to-face position.

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

    (1) independence should be encouraged
    (2) schedules need to be routine, reinforced, and repeated; flexibility leads to confusion
    (3) reminiscence and life reviews help client resume progression through grief process associated with disappointing life events, and increases self-esteem
    (4) correct–is most effective when communicating with an elderly client

93. A three-month-old patient is experiencing increased intracranial pressure (ICP). Which of the following assessment findings should the nurse report to the physician?

    1. Pinpoint pupils.
    2. High-pitched cry.
    3. Decrease in blood pressure.
    4. Absence of reflexes.

    Strategy: Think about each answer choice.

    (1) does not indicate any immediate problem; as pressure increases, pupils may become dilated
    (2) correct–sign of increased intracranial pressure
    (3) does not reflect complication of increased intracranial pressure
    (4) does not reflect complication of increased intracranial pressure

94. The nurse takes a history from a woman in the prenatal clinic. The nurse identifies that which of the following pregnant women is MOST likely to have an Rh-incompatibility problem?

    1. An Rh-positive woman pregnant for the third time who conceived with an Rh-negative man and never has received RhoGAM.
    2. An Rh-negative woman who conceived with an Rh-positive man who has Rh antibodies.
    3. An Rh-positive woman who previously aborted a fetus at 12 weeks gestation and did not receive RhoGAM and now conceived with an Rh-positive man.
    4. An Rh-negative woman who never received RhoGAM and now conceived with an Rh-negative man.

    Strategy: Think about each answer choice.

    (1) incompatibility only seen with Rh-negative woman
    (2) correct–Rh-positive dominant, fetus will be Rh-positive, Rh antibodies from the mother will break down fetus's blood cells
    (3) incompatibility only seen with Rh-negative woman
    (4) baby would be Rh-negative like parents, so there would be no incompatibility

95. The physician orders cholestyramine (Questran) 4 g PO qid for a 40-year-old client. The medication is provided in single-dose 4-g packets. The client asks the office nurse how to take the medication. The nurse should instruct the client to

    1. sprinkle the powder on a beverage, stir, and drink immediately.
    2. sprinkle the powder on food and eat slowly.
    3. add water to make a paste and eat, followed by 8 oz of water.
    4. sprinkle the powder on a beverage, let it stand a few minutes, and then stir and drink.

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

    (1) should let stand before stirring
    (2) can sprinkle on wet food, but let stand, then stir
    (3) not administered as a paste
    (4) correct–ensures uniform suspension

96. A young child is placed on droplet precautions. The nurse is caring for which of the following clients?

    1. A child with cystic fibrosis.
    2. A child with tonsillitis.
    3. A child with bronchitis.
    4. A child with pertussis.

    Strategy: Think about the communicability of each disease.

    (1) hereditary dysfunction of exocrine glands causing obstruction because of flow of thick mucus, standard precautions
    (2) inflammation of tonsils, standard precautions
    (3) inflammation of large airway, standard precautions
    (4) correct–droplet precautions required, private room, maintain spatial separation of 3 feet between patient and visitors

97. An elderly man is admitted to an inpatient psychiatric unit with an initial diagnosis of psychotic depression. The INITIAL nursing priority is to

    1. clarify perceptual distortions.
    2. establish reality orientation.
    3. ensure client and milieu safety.
    4. increase self-esteem.

    Strategy: Think Maslow.

    (1) important, but secondary to safety issues
    (2) important, but secondary to safety issues
    (3) correct–initial nursing priority for all psychiatric patients is to ensure their safety and the safety of all members of the milieu
    (4) important, but secondary to safety issues

98. A client is admitted for treatment of severe anxiety. It is MOST important for the nurse to obtain which of following information during the first 48 hours after admission?

    1. What is important to the client.
    2. How the client views herself.
    3. In what situations the client gets anxious.
    4. If anyone in the client's family has had mental problems.

    Strategy: Think about each answer choice.

    (1) helpful data that can be collected during treatment, but does not take priority during the first 48 hours
    (2) helpful data that can be collected during treatment, but does not take priority during the first 48 hours
    (3) correct–will provide necessary information in baseline assessment of client's anxiety
    (4) helpful data that can be collected during treatment, but does not take priority during the first 48 hours

99. A client has a right total hip replacement. The client returns from surgery with an IV of 0.45% NaCl infusing into the left forearm at 100 cc/h. It is MOST important for the nurse to take which of the following actions?

    1. Massage the client's legs to increase circulation.
    2. Elevate the knee gatch to reduce stress on the suture line.
    3. Apply thigh-high TED hose to promote venous return.
    4. Decrease fluid intake to 1,200 cc to prevent circulatory overload.

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

    (1) massage may cause emboli
    (2) would cause external pressure on the popliteal space, hip should not be flexed beyond 90°
    (3) correct–use of antiembolic hose and/or sequential compression devices decreases venous stasis and reduces risk of thrombus formation
    (4) adequate fluid intake (1,500 cc) prevents dehydration

100. The nurse plans care for a 25-year-old woman immediately after a cesarean section. Which of the following nursing goals is MOST important?

    1. Prevent infection.
    2. Prevent fluid and electrolyte imbalances.
    3. Provide for pain management.
    4. Prevent hazards of immobility.

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

    (1) not highest priority initially, usually not seen until 48–72 hours after surgery
    (2) correct–hemorrhage and shock most life-threatening conditions that occur after surgery
    (3) not highest priority initially, not life-threatening
    (4) not highest priority initially, not life-threatening

101. A client is admitted with a fractured right hip. The doctor writes an order for Buck's traction. Which of the following actions, if taken by the nurse, is MOST important?

    1. Turn the client every two hours to the unaffected side.
    2. Maintain the client in a supine position.
    3. Encourage the client to use a bedside commode.
    4. Placing a footboard on the bed.

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

    (1) correct–immobility is a leading cause of problems with Buck's traction; important to turn client to unaffected side
    (2) head of the bed should be elevated 15 to 20° because the supine position can increase problems with immobility
    (3) client is on strict bedrest
    (4) would interfere with the traction

102. The nurse is making patient assignments on a medical/surgical unit. The staff includes one RN, one RN pulled from the pediatric floor, an LPN/LVN, and a nursing assistant. Which of the following patients should be assigned to the RN from the pediatric floor?

1. A client one-day postoperative after an appendectomy.
2. A client who had a detached retina surgically repaired 4 hours ago.
3. A client with a Sengstaken-Blakemore tube in place.
4. A client two-days postoperative after a laminectomy with spinal fusion.

Strategy: Assign a pulled RN to stable patients with expected outcomes.

(1) correct–stable patient with expected outcome
(2) requires frequent assessment for hemorrhage, instruct client to avoid sneezing, coughing, or straining at stool
(3) requires frequent monitoring due to hemorrhage
(4) requires assessment and teaching

103. The nurse is caring for a two-month-old infant. A pH probe test indicates that the infant has reflux. Which nursing action is MOST appropriate?

1. Hold the next feeding.
2. Teach the mother CPR.
3. Maintain a normal feeding schedule.
4. Elevate the head of the bed.

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

(1) may not be necessary if positioning is effective
(2) inappropriate
(3) client's feedings should be changed to small-volume, frequent feedings
(4) correct–infant with reflux should be maintained in an upright position; head of the bed should be raised at a 30° angle

104. The nurse is caring for a 33-year-old woman after delivering an 8 lb 4 oz girl with talipes equinovarus. The woman confides to the nurse, "I feel so bad that my baby is abnormal." Which of the following responses by the nurse is BEST?

1. "It's understandable that you feel this way, but there are treatments to correct your baby's problem."
2. "Your baby is not really abnormal. Her feet just look different because of the way the muscles pull."
3. "You have nothing to feel guilty about. The abnormality is not your fault."
4. "Don't feel bad. You baby's abnormality can be corrected surgically."

Strategy: Remember therapeutic communication.

(1) correct–accepts feelings and gives correct information, serial casting is used
(2) doesn't accept person's feelings, nontherapeutic
(3) prematurely interprets person's feelings as guilt, nontherapeutic
(4) nontherapeutic to tell person how to feel

105. A patient complains of pain after an appendectomy. After administering an analgesic, the nurse should take which of the following actions?

1. Elevate the head of the bed 30–45°.
2. Place a pillow behind the patient's knees.
3. Elevate the knee gatch on the bed 30°.
4. Lie the client supine with a small pillow under the head.

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

(1) correct–would reduce stress on suture line and provide for comfort
(2) would put pressure on popliteal space, would restrict circulation and increase risk of thrombophlebitis
(3) would put pressure on popliteal space, would restrict circulation and increase risk of thrombophlebitis
(4) does not reduce stress on suture line

106. A five-year-old is scheduled for a lumbar puncture (LP). Which of the following nursing actions would BEST prepare the child for the procedure?

1. Explain the procedure in detail.
2. Show a video of the procedure.
3. Do a mock run-through of the procedure.
4. Answer all questions simply and honestly.

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

(1) would be very difficult to prepare a five-year-old for a totally foreign procedure with only words
(2) may be frightening without additional preparation
(3) correct–excellent method to use with a child because it incorporates actually "feeling" many aspects of the procedure as they are explained
(4) child probably doesn't know enough to ask many questions

107. A client is scheduled to have a parathyroidectomy. The nurse would be MOST concerned if the client was observed eating quantities of food from which of the following food groups?

1. Milk products.
2. Green vegetables.
3. Seafood.
4. Poultry products.

Strategy: Determine the outcome of each answer choice.

(1) correct–low-calcium diet is recommended preoperatively
(2) high in calcium and phosphorus
(3) high in calcium and phosphorus
(4) poultry is allowed in the diet

108. Which of the following activities documented by the recreational therapist following a community reorientation outing for a paraplegic client would indicate to the nurse a readiness for discharge?

1. The client states that he/she enjoyed being outside the hospital environment.
2. The client was able to participate in a structured team sport by keeping score.
3. The client was independently able to order his meal and feed himself.
4. The client was independent in transfers and wheelchair mobility.

Strategy: Think Maslow.

(1) psychosocial, speaks to his psychosocial status, but is not an indication for discharge
(2) psychosocial, addresses social skills, but is not an indication for discharge
(3) physical, not pertinent for a paraplegic
(4) correct, physical, these skills are requisite for discharge

109. The nurse is teaching a client with newly diagnosed diabetes mellitus how to treat hypoglycemia at home. The nurse should instruct the client to do which of the following actions if symptoms of hypoglycemia are experienced?

1. Eat a candy bar.
2. Drink ½-cup fruit juice followed by a protein snack.
3. Inject 10 units of Humulin R.
4. Inject glucagon.

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

(1) too concentrated a carbohydrate, will cause hyperglycemia
(2) correct–will correct hypoglycemia and stabilize blood sugar
(3) treatment for hyperglycemia
(4) used if person becomes unconscious

110. A three-month-old is placed in Bryant's traction for developmental dysplasia of the hips. Which of the following toys would be appropriate for the nurse to offer the infant during hospitalization?

1. A rattle.
2. A stuffed animal.
3. Colorful blocks.
4. A tape playing nursery rhymes.

Strategy: Think growth and development

(1) correct–three-month-old can grasp a rattle
(2) not as good as answer choice #1
(3) designed for an older child
(4) not as good as answer choice #1

111. A client has an order for a low-sodium, low-cholesterol diet. The nurse knows that which of the following selections reflects the client's compliance?

1. Canned vegetable soup, applesauce, and hot chocolate.
2. Cheeseburger, french fries, and skim milk.
3. Tomato and lettuce salad, roasted chicken, and lemonade.
4. Tuna fish sandwich, cottage cheese, and a cola.

Strategy: Evaluate each of the foods.

(1) canned foods contain increased salt, and milk contains cholesterol
(2) breads contain sodium, and dairy products and beef contain cholesterol
(3) correct–fresh fruits and vegetables are low sodium, roasted chicken is low cholesterol
(4) bread and carbonated beverages contain sodium

112. The daughter of a 70-year-old patient with cancer asks the nurse, "Do you believe in euthanasia?" Which of the following responses by the nurse is BEST?

1. "I think that each person has to decide this issue for herself."
2. "My religion is opposed to euthanasia."
3. "What are your thoughts about euthanasia?"
4. "Did you see the TV program about euthanasia last night?"

Strategy: Remember therapeutic communication.

(1) closed statement, focus is on the nurse and not the client
(2) focus is on the nurse and not the client
(3) correct–open-ended question, allows client to verbalize
(4) yes/no question

113. The nurse is caring for a patient who experienced a thermal injury two weeks ago. The nurse would be MOST concerned if which of the following is observed?

1. Increased heart rate and elevated blood pressure.
2. Temperature of 100.6°F (38.1°C) and decreased respiratory rate.
3. Increased heart rate and decreased respiratory rate.
4. Increased respiratory rate and decreased blood pressure.

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

(1) should be investigated further, but alone do not represent significant compromise
(2) should be investigated further, but alone do not represent significant compromise
(3) should be investigated further, but alone do not represent significant compromise
(4) correct–may indicate burn wound sepsis, a life-threatening complication of thermal injury

114. A 68-year-old woman comes to the outpatient clinic for a routine health screening. The nurse learns the client is a retired teacher who lives alone on a limited income. A history indicates the client drinks about 1,500 cc a day and her diet consists primarily of starches. It is MOST important for the nurse to encourage the client to

1. increase her intake of protein.
2. increase her intake of vitamins.
3. reduce her caloric intake.
4. reduce her fluid intake.

Strategy: "MOST important" indicates priority. Each answer choice is an implementation. Determine the outcome of each answer choice. Is it desired?

(1) correct–protein needed to slow down degeneration process of aging
(2) necessary, but not most important
(3) necessary, but not most important
(4) should maintain oral intake

115. A 36-year-old client tested positive for the tuberculosis antibody and was placed on isoniazid (INH) four weeks ago. The nurse would be MOST concerned if which of the following was observed?

1. Fatigue and dark urine.
2. Malaise and glucosuria.
3. Proteinuria and lethargy.
4. Diluted urine and epigastric distress.

Strategy: Determine how each answer choice relates to INH.

(1) correct–initial indications of hepatic dysfunction
(2) seen with pancreatic problems
(3) seen with renal problems
(4) is not seen with liver problems

116. A 5-year-old boy is brought to the emergency room after ingesting a bottle of baby aspirin. The nurse should observe the boy for which of the following signs and symptoms?

1. Nausea and vertigo.
2. Epistaxis and paralysis.
3. Dysrhythmia and hypoventilation.
4. Tinnitus and gastric distress.

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

(1) dizziness not seen with aspirin overdose
(2) nosebleed may occur, but not paralysis
(3) may see hyperventilation with use of aspirin, does not affect heart rhythm
(4) correct–symptoms of overdose

117. While performing care for a 72-year-old woman, the nurse notices that the patient has a dry, parched mouth and tongue. The nurse should

1. brush the patient's teeth with a hard-bristled toothbrush before meals and at bedtime.
2. use glycerin swabs to perform mouth care every 4 hours.
3. rinse the patient's mouth with room-temperature tap water before and after meals.
4. use a water pick, then rinse with commercial mouthwash every 8 hours to freshen the mouth.

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

(1) should use soft-bristled toothbrush so gums are not injured
(2) should be avoided, causes dryness of mucous membranes
(3) correct–will hydrate the mucous membranes and keep mouth clean
(4) most commercial mouthwashes contain alcohol, would dry mucous membranes

118. The nurse is caring for a schizophrenic client who has become increasingly withdrawn to the point of mutism. The MOST important nursing approach at this time would be to

1. ignore the client until he is ready to respond.
2. sit with the client for brief periods of time.
3. read to the client in a quiet area of the unit.
4. encourage the client to play dominos with the group.

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

(1) rejects the client
(2) correct–nurse should maintain contact with client but not make demands to communicate or participate in activities
(3) not going to benefit this client
(4) not going to benefit this client

119. The nurse is caring for a client after an ileostomy. The nurse would be MOST concerned if which of the following was observed?

1. The ileostomy functions without daily irrigations.
2. The stoma appears to be tight, and there is a decreased amount of stool.
3. A small amount of mucus is seen around the anal area.
4. There is weight gain of 5 lb over a three-week period of time.

Strategy: "MOST concerned" indicates a complication.

(1) normal process, ileostomies are not irrigated
(2) correct–important to report these findings to the physician; may indicate an obstruction or stoma stricture
(3) anal area is not functional but some mucus may be seen
(4) should not concern nurse

120. The home care nurse instructs the wife of a client about how to perform a wet-to-dry abdominal dressing for her husband with an infected abdominal incision. The nurse should intervene in which of the following situations?

1. The wife wets the old dressing with sterile saline before removing it.
2. The wife covers the wound with wet, sterile 4×4s.
3. The wife irrigates the wound with hydrogen peroxide using a bulb syringe.
4. The wife uses Montgomery straps to secure the dressing.

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

(1) correct–contraindicated, remove dry so wound debris and necrotic tissue are removed with old dressing
(2) purpose of wet-to-dry dressing is to débride incision, wetting dressing before removal defeats purpose of dressing
(3) irrigation of wound sometimes used
(4) adhesive is attached to skin and laced to secure dressing, used when frequent dressing changes anticipated

121. The nurse is monitoring a 20-year-old woman in active labor who is receiving oxytocin (Pitocin) 1 mU/min IV. The nurse should stop the infusion if

1. the contractions occur at 3-minute intervals and last more than 60 seconds.
2. the contractions occur at 2.5-minute intervals and last more than 90 seconds.
3. the contractions occur at 2-minute intervals and last more than 90 seconds.
4. the contractions occur at 2-minute intervals and last more than 60 seconds.

Strategy: All answers are assessments. Determine the result of each assessment.

(1) normal frequency and duration
(2) normal frequency and duration
(3) correct–contractions should be less frequent (longer than 2-minute intervals) and should be of shorter duration (less than 90 seconds) allows for longer resting time between contractions
(4) normal frequency and duration

122. While a two-day-old infant is in surgery for repair of spina bifida, the infant's mother expresses concern to the nurse because the doctor told her the infant would be confined to a wheelchair. Which of the following statements, if made by the nurse, is BEST?

1. "Physical therapy can restore the function to affected muscles."
2. "Orthopedic devices will allow your child to strengthen lower extremity muscles."
3. "Corrective surgery will return function to the affected muscles."
4. "The corrective surgery will not change your child's physical disability."

Strategy: Determine the outcome of each answer choice.

(1) not appropriate or true regarding this condition
(2) not appropriate or true regarding this condition
(3) not appropriate or true regarding this condition
(4) correct–spinal nerves that are destroyed by the myelomeningocele cannot be corrected; nothing can return function to portions of the body that are innervated by the spinal nerves below the site of the myelomeningocele

123. The nurse is receiving a bedside report from another nurse. The nurse giving the report begins to talk about another client. Which action by the nurse receiving the report is MOST appropriate?

1. Ask the nurse to report on this client only.
2. Ask the nurse to lower his/her voice.
3. Ask the nurse to move to another part of the room.
4. Ask the nurse to clarify which client s/he is reporting on.

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

(1) correct–client confidentiality is being violated, nurse should intervene to protect client
(2) does not provide for client confidentiality
(3) does not provide for client confidentiality
(4) does not provide for client confidentiality

124. A family member of a client who has sustained an electrical burn states, "I don't understand why he has been here a week. The burn does not look that bad." Which of the following responses by the nurse is BEST?

1. "Electrical burns are more prone to infection."
2. "Electrical burns are always much worse than they look on the outside."
3. "Cardiac monitoring is important because electrical burns affect cardiac function."
4. "Electrical burns can be deceptive because underlying tissue is also damaged."

Strategy: Determine which statement correctly states the facts.

(1) incorrect regarding electrical burns
(2) incorrect regarding electrical burns
(3) is true in the immediate post-burn phase, not a week later
(4) correct–electrical burn injuries are typically more injurious to underlying tissue such as nerve and vascular tissue, which require complex and timely treatment

125. The nursing care plan for a five-year-old with a closed head injury should contain which of the following?

1. Encourage child to sleep and decrease stimuli in the room.
2. Assess orientation to person, place, and time every hour.
3. Notify the physician regarding a negative Babinski reflex.
4. Increase fluid intake to maintain adequate urinary output.

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

(1) an increase in sleep could indicate a complication with intracranial pressure
(2) correct–early signs of increased intracranial pressure are alterations in orientation
(3) negative Babinski is normal
(4) ignores assessment of a potential complication; fluid would not be increased for a child with a closed head injury

126. A patient received meperidine (Demerol) 75 mg IM 2 hours ago for complaints of pain. The patient turns on his call light and tells the nurse he has to go to the bathroom. The physician has ordered BPR (bathroom privileges). The nurse should

1. obtain a bedside commode for the patient's use and provide privacy.
2. help the patient to sit on the side of the bed before proceeding to the bathroom.
3. provide a bedpan for the patient's use and pull the curtains.
4. get another nurse and together assist the patient to the bathroom.

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

(1) should ambulate patient safely to prevent hazards of immobility
(2) correct–side effects of medication include decreased BP, orthostatic hypotension, bradycardia
(3) easier for patient to use bathroom than to use bedpan
(4) an additional nurse not necessary, before ambulating should sit on side of bed to allow body to adjust to change in position

127. A client is transferred to the neurology unit after developing right-sided paralysis and aphasia. Which of the following should be included in the patient's plan of care?

1. Encourage client to shake head in response to questions.
2. Speak in a loud voice during interactions.
3. Speak using phrases and short sentences.
4. Encourage the use of radio to stimulate the client.

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

(1) does not encourage verbal communication
(2) inappropriate for the situation
(3) correct–will decrease tension and anxiety; client may understand some of the incoming communication if it is kept simple; speech may be relearned with appropriate support and interventions
(4) inappropriate for the situation

128. Which of the following statements, if made to the nurse, indicates parental understanding about the cause of their newborn's diagnosis of cystic fibrosis (CF)?

1. "The gene came from my husband's side of the family."
2. "The gene came from my wife's side of the family."
3. "There is a 50 percent chance that our next child will have the disease."
4. "Both of us carry a recessive trait for cystic fibrosis."

Strategy: Think about each answer choice.

(1) both parents are carriers of the abnormal gene
(2) both parents are carriers of the abnormal gene
(3) there is a 25% chance of passing the disease on to any of their offspring
(4) correct–cystic fibrosis is inherited by an autosomal recessive trait

129. A client has an order for furosemide (Lasix) 40 mg IV push via a heparin lock. Which of the following nursing actions would be MOST appropriate?

1. Use a 16- to 18-gauge 1-in needle for administration.
2. Administer the medication over one to two minutes.
3. One cc of 1:1,000 heparin flush should be administered before the medication.
4. A primary IV should be started prior to medication administration.

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

(1) needle gauge is too large
(2) correct–furosemide (Lasix) given IV push should be administered slowly over one to two minutes
(3) lock is flushed with heparin after administration of the medication
(4) unnecessary

130. A 19-year-old college student has a Mantoux test performed at the college health clinic. The result is positive. The clinic nurse should

1. refer the student to an appropriate center for further testing.
2. restrict the student's activity until his parents can be notified.
3. notify the local Public Health Department.
4. place the student in an isolation room in the college infirmary.

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

(1) correct–will perform chest x-ray
(2) premature action, insufficient information
(3) true if active disease confirmed, premature action
(4) premature action, insufficient information

131. The nurse in the outpatient clinic teaches a young adult with a sprained right ankle to walk with a cane. While teaching the client to use the cane, how should the nurse be positioned?

1. Standing on the client's left side and slightly behind the client.
2. Standing on the client's right with one hand on the client's waist.
3. Standing directly in front of the woman with both hands on the client's arms.
4. Standing in front of the client on the right side.

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

(1) correct–stand slightly behind patient on strong side
(2) incorrect positioning
(3) use a gait belt to assist patient, don't place hands on patient's arms
(4) stand slightly behind patient on strong side

132. The nurse is preparing to suction a client with a new tracheostomy in the postanesthesia recovery room. Which of the following actions, if performed by the nurse, indicates a break in proper technique?

1. The nurse sets the suction source at 120 mm Hg and obtains a #14 French suction catheter.
2. The nurse inserts the suction catheter until resistance is met, and then applies intermittent suction as the catheter is withdrawn.
3. The nurse suctions the client's mouth prior to suctioning the tracheostomy to ensure a patent airway.
4. The nurse administers oxygen to the client using an Ambu bag attached to 100% oxygen prior to suctioning.

Strategy: You are looking for an incorrect action.

(1) use suction 90–120 mm Hg and #12 or #14 suction catheter
(2) use a twirling motion to remove catheter while applying suction
(3) correct–break in sterile procedure, suction mouth after trachea
(4) hyperoxygenates client to prevent hypoxia from procedure

133. Which of the following assessments would be a priority when documenting the nursing history of a two-year-old child?

1. The child's rituals and routines at home.
2. The child's understanding of hospitalization.
3. The child's ability to be separated from the parents.
4. The parent's methods for dealing with the child's temper tantrums.

Strategy: Think about what the words mean. Remember growth and development.

(1) correct–during a crisis such as hospitalization, children are able to establish a sense of security through consistency of the rituals and routines from home
(2) important, but not as critical to the planning of the child's hospital care
(3) important, but not as critical to the planning of the child's hospital care
(4) important, but not as critical to the planning of the child's hospital care

134. A 56-year-old woman has a subclavian triple lumen catheter that is used for administration of total parenteral nutrition (TPN). The physician has ordered that all lumens be flushed with a diluted heparin solution BID. When the nurse attempts to flush the distal lumen, resistance is met. The nurse should

1. clamp off the lumen and label it as "clotted off."
2. gradually increase the pressure on the irrigating solution.
3. aspirate blood from the lumen to restore patency.
4. secure the lumen with a Luer-Lock cap and notify the physician.

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

(1) should be reported to the physician to see if patency can be reestablished before it is labeled as clotted off
(2) force should never be used to irrigate the catheter
(3) blood should not be aspirated from the catheter
(4) correct–streptokinase may used to dissolve clot, if unsuccessful, lumen is labeled as clotted off

135. Following treatment for Addison's disease in a seven-year-old patient, the nurse plans for the client's discharge. The mother asks how long her daughter must continue receiving replacement therapy. The nurse's response should be

1. "For approximately six months."
2. "For approximately one year."
3. "Until she reaches puberty."
4. "For the rest of her life."

Strategy: Think about each answer choice.

(1) needed for lifetime to prevent recurrence of adrenal insufficiency
(2) needed for lifetime to prevent recurrence of adrenal insufficiency
(3) needed for lifetime to prevent recurrence of adrenal insufficiency
(4) correct–disease is caused by deficiency in glucocorticoids, will always need corticosteroids and mineralocorticoids

136. The nurse is caring for a patient following surgery for a coronary artery bypass graft (CABG). Which of the following symptoms would the nurse expect to see if the patient was in the early stages of circulatory overload?

1. Change in the character of respirations.
2. Fluctuation in the blood pressure.
3. Reduction in tissue turgor.
4. Increase in body temperature.

Strategy: Determine how each answer choice relates to fluid overload.

(1) correct–will see dyspnea, cough, edema, hemoptysis
(2) will initially increase and then fall due to congestive heart failure, doesn't fluctuate
(3) reflects body's general hydration status, mainly shows dramatic changes with dehydration
(4) would indicate infectious, inflammatory process, skin temperature will fall with circulatory overload

137. The nurse teaches a group of boy scouts how to prevent Lyme disease. Which of the following statements, if made by one of the boy scouts to the nurse, would indicate that further teaching is necessary?

1. "When I go on a long hike, I should check any exposed skin for insects every four hours."
2. "When I hike in the woods, I should wear long pants, socks, and a long-sleeved shirt."
3. "I should remove any ticks by crushing them firmly against the skin."
4. "I should reapply insect repellant every couple of hours when hiking."

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

(1) assessment, should be done to check for ticks that transmit disease; pay particular attention to arms, legs, and hairline
(2) protects exposed skin from ticks
(3) correct–should not be crushed, remove tick with tweezers or fingers and flush down toilet; burning a tick could spread infection
(4) protects exposed skin from ticks, avoid heavily wooded areas

138. Which of the following nursing approaches would be MOST appropriate to use while administering an oral medication to a four-month-old?

1. Place the medication in 45 cc of formula.
2. Place the medication in an empty nipple and allow the infant to suck.
3. Place the medication in a full bottle of formula.
4. Administer the medication using a plastic syringe, with the infant in the reclining position.

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

(1) medication is never added to the infant's formula feeding
(2) correct–is a convenient method for administering medications to an infant
(3) medication is never added to the infant's formula feeding
(4) infant is never placed in a reclining position during procedure due to potential for aspiration

139. An elderly man is admitted to a medical unit with shortness of breath and is diagnosed with an upper respiratory infection (URI). He is placed on droplet precautions. The nurse has just finished giving him his PO medications. As the nurse leaves his room, the nurse should

1. wash hands, remove the gown and mask, and throw the trash in a container outside of the room.
2. remove the mask, wash hands, and throw the trash in a container inside the room.
3. wash hands, remove the mask, and throw the trash in a container inside the room.
4. remove the gown and gloves, wash hands, remove the mask, and throw the trash in a container inside the room.

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

(1) gown unnecessary, trash should be left inside room
(2) wash hands then remove mask, so microbes aren't transferred from hands to face
(3) correct–hands should be washed before removing mask to prevent transfer of microbes to face
(4) gown unnecessary

140. The nurse is caring for a client with a diagnosis of schizophrenia. Which of the following statements is MOST descriptive of the affect of a patient with schizophrenia?

1. The client answers all questions with one word.
2. The client laughs while talking about being raped.
3. The client exhibits no energy or interest in tasks.
4. The client cries while talking about mother's death.

Strategy: Determine how each answer choice relates to schizophrenia.

(1) not indicative of schizophrenia
(2) correct–inappropriate affect, expression of feelings bizarre for situation
(3) describes depression
(4) appropriate response

141. The nurse is caring for a postoperative patient. Four hours after surgery, the patient voids 200 cc of urine with a specific gravity of 1.019. The nurse should

1. palpate the patient's lower abdomen for distention.
2. encourage an increased intake of oral fluids.
3. record the time and the amount of urine.
4. encourage the patient to void again in two hours.

Strategy: Answers are a mix of assessments and implementations. Does this situation require validation? No. Determine the outcome of the implementation answers.

(1) implies bladder distention and urinary retention, 200 cc divided by 6 hours = more than 30 cc/h
(2) doesn't recognize amount and specific gravity as normal in this situation
(3) correct–amount and specific gravity normal (1.010–1.030)
(4) doesn't recognize amount and specific gravity as normal in this situation

142. A client comes to the clinic complaining of severe facial pain. In order to collect subjective data from the client, it is MOST important for the nurse to

1. obtain the client's vital signs.
2. interview the client.
3. inspect the face for grimacing.
4. administer pain medication.

Strategy: Focus on the question.

(1) vital signs are objective data
(2) correct–subjective data is collected in the health history or interview
(3) objective data
(4) implementation, complete assessment to determine the problem

143. A client has received thrombolytic therapy, and the physician has ordered meperidine (Demerol) IM for pain. Before administering the injection, the nurse should

1. confirm that all lab work has been completed.
2. verify the order with the physician.
3. check the client's PTT.
4. determine that all of the thrombolytic agent has infused.

Strategy: Answers are a mix of assessments and implementations. Does this situation require assessment? No. Determine the outcome of the implementations. Is it desired?

(1) assessment, unnecessary
(2) correct–implementation, complications of thrombolytic therapy include bleeding, which can occur with intramuscular injections; nurse should confer with the physician about the appropriateness of the order
(3) assessment, PTT should be monitored, but this is not a priority action
(4) implementation, unnecessary

144. A client reports that he has been vomiting for three days, has a low-grade temperature, and feels lethargic. Which of the following nursing actions is MOST appropriate in evaluating for fluid volume deficit?

1. Obtain a urinalysis for casts and specific gravity.
2. Determine client's weight and assess gain or loss.
3. Ask client to provide a 24-hour intake and output record.
4. Determine the quality of the client's skin turgor.

Strategy: Determine how each answer choice relates to fluid volume deficit.

(1) provides information regarding the fluid volume level, but is not the best action for evaluation
(2) correct–daily weight is the best way to evaluate for fluid volume deficit
(3) provides information regarding the fluid volume level, but is not the best action for evaluation
(4) provides information regarding the fluid volume level, but is not the best action for evaluation

145. A 20-year-old woman calls the outpatient clinic to schedule her first Papanicolaou's smear. The nurse should instruct the client to

1. avoid intercourse for 48 hours before the examination.
2. avoid douching for 24 hours prior to her appointment.
3. withhold all foods and fluids 12 hours before the appointment.
4. save her first voided urine specimen the morning of her appointment.

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

(1) sperm doesn't resemble atypical cells that test is designed to find
(2) correct–douching would affect appearance of cells in vaginal smear, would make test inaccurate
(3) will concentrate urine but won't affect Pap smear
(4) part of routine GYN exam, but not related to Pap smear

146. A nurse is the first on the scene of a motor vehicle accident. The victim has sucking sounds with respirations at a chest wound site and tracheal deviation toward the uninjured side. Until others arrive, the priority nursing action would be to

1. loosely cover the wound, preferably with a sterile dressing.
2. place a sandbag over the wound.
3. monitor chest wound drainage.
4. place a firm, airtight, sterile dressing over the wound.

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

(1) correct–implementation, in an open pneumothorax, air enters the pleural cavity through an open wound; placing a sterile dressing loosely over the wound allows air to escape but not reenter the pleural space
(2) implementation, would prevent air from escaping
(3) assessment, chest tube has not yet been inserted
(4) implementation, would prevent air from escaping

147. The nurse is caring for a 74-year-old man with type I diabetes. The client is scheduled for cataract surgery under general anesthesia at 9 AM. The man usually receives 30 units of NPH and 10 units of regular insulin each morning at 7 AM. At 7 AM the morning of surgery, the nurse would expect to take which of the following actions?

1. hold the morning dose of NPH and regular insulin and monitor the blood glucose.
2. give half the morning dose of NPH insulin along with the regular insulin and monitor the blood glucose when the client returns from surgery.
3. give the full dose of NPH and regular insulin and monitor the blood glucose every 2 to 4 hours.
4. give the full dose of regular insulin but hold the NPH insulin and monitor the blood glucose until the client goes to surgery.

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

(1) correct–usually use sliding scale with regular insulin based on blood glucose readings
(2) may cause hypoglycemia because client will be NPO when NPH peaks, NPH intermediate-acting insulin, onset 1–2 hours, peaks 6–12 hours, duration 18–26 hours; regular insulin short-acting, onset ½–1 hours, peaks 2–4 hours, duration 6–8 hours
(3) client may become hypoglycemic because NPH will peak when client is NPO
(4) may cause hypoglycemia during surgery

148. The nurse is caring for a 22-year-old woman who is completing the first stage of labor. The woman's husband is at her side and has been coaching her according to exercises they learned at natural childbirth classes. Suddenly the woman begins to shake and screams, "I can't stand this anymore!" The nurse should encourage the husband to

1. instruct his wife to use shallow respirations during the contractions.
2. offer his wife ice chips or sips of water to distract her from the pain.
3. stroke his wife's abdomen between contractions.
4. review with his wife the breathing pattern needed at each stage of labor.

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

(1) correct–entering transition phase of first stage of labor, slow shallow breaths needed (pant breathing)
(2) doesn't address issue of breathing pattern needed during transition phase of labor
(3) used in conjunction with controlled breathing for Lamaze
(4) needs support and coaching of husband during transition phase of labor

149. The nurse is caring for a 34-year-old man admitted with low back pain. The history indicates that the patient has hemophilia A. The nurse should question which of the following orders?

1. Ketorolac tromethamine (Toradol).
2. Codeine phosphate (Paveral).
3. Oxycodone terephthalate (Percodan).
4. Hydromorphone hydrochloride (Dilaudid).

Strategy: "Nurse should question which of the following orders" indicates a contraindication.

(1) NSAID (nonsteroidal antiinflammatory drug) used for short-term management of pain
(2) analgesic used for moderate to severe pain
(3) correct–contraindicated for persons with bleeding disorders, contains aspirin
(4) narcotic analgesic used for moderate to severe pain

150. After receiving report, which of the following patients should the nurse see FIRST?

1. A patient in sickle-cell crisis with an infiltrated IV.
2. A patient with leukemia who has received one-half unit of packed cells.
3. A patient scheduled for a bronchoscopy.
4. A patient complaining of a leaky colostomy bag.

Strategy: Determine the least stable patient.

(1) correct–IV fluids are critical to reduce clotting and pain
(2) no indication patient is unstable
(3) stable patient
(4) stable patient