NCLEX Question Trainer Explanations
Test 6

1. The nurse returns to the nurse's station after making client rounds and finds four phone messages. Which of the following messages should the nurse return FIRST?

   1. A client with hepatitis A who states, "My arms and legs are itching."
   2. A client with a cast on the right leg who states, "I have a funny feeling in my right leg."
   3. A client with osteomyelitis of the spine who states, "I am so nauseous that I can't eat."
   4. A client with arthritis who states, "I am having trouble sleeping at night."

   Strategy: Eliminate the most stable clients.

   (1) caused by accumulation of bile salts under the skin; treat with calamine lotion and antihistamines
   (2) correct—may indicate neurovascular compromise; requires immediate assessment
   (3) requires follow-up but not highest priority
   (4) requires assessment but not the highest priority

2. Following hip replacement surgery, an elderly client is ordered to begin ambulation with a walker. Which of the following statements by the nurse is BEST?

   1. "Sit in a low chair for ease in getting up to use the walker."
   2. "Make sure rubber caps are in place on all four legs of the walker."
   3. "You will begin weight-bearing on the affected hip soon."
   4. "Practice tying your own shoes before you begin ambulating."

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

   (1) full weight bearing or flexion of the hip greater than 90° should be avoided for four to six weeks
   (2) correct—intact rubber caps should be present on walker legs to prevent accidents
   (3) full weight bearing or flexion of the hip greater than 90° should be avoided for four to six weeks
   (4) full weight bearing or flexion of the hip greater than 90° should be avoided for four to six weeks

3. A 22-year-old woman comes to the hospital at term in the early stages of labor. A diagnosis of complete placenta previa is made. It would be MOST important for the nurse to take which of the following actions?

   1. Start an IV of terbutaline (Brethine) and monitor the patient's vital signs closely.
   2. Prepare the patient for an immediate cesarean section.
   3. Maintain the patient on bedrest until spontaneous vaginal delivery is achieved.
   4. Monitor the patient's length and duration of contractions.

   Strategy: Answers are both assessments and implementations. Is the assessment appropriate? No. Determine the outcome of each implementation. Is it desired?

   (1) implementation, Brethine used to delay delivery in preterm labor
   (2) correct—implementation, cannot deliver vaginally
   (3) implementation, cannot deliver vaginally
   (4) assessment, cannot deliver vaginally, cesarean section must be performed

4. Which of the following nursing observations would indicate to the nurse that a child with epiglottitis is having an early complication of hypoxemia?

   1. Heart rate of 148 beats per minute.
   2. Bluish discoloration of the skin.
   3. Bluish discoloration around the mouth.
   4. Difficulty swallowing.

   Strategy: Determine how each answer choice relates to epiglottitis.

   (1) correct—heart rate correlates with hypoxemia and is an early finding, along with restlessness
   (2) cyanosis, late sign
   (3) circumoral cyanosis, late sign
   (4) sign of epiglottitis

5. After stabilizing a client with severe multiple trauma injuries from a motor vehicle accident, which of the following actions by the nurse is BEST?

   1. Limit visiting hours to promote optimal rest.
   2. Arrange for clergy to visit with the client and family as requested.
   3. Arrange for a psychologist to visit with the family.
   4. Arrange for the family to meet with a social worker to discuss financial aid.

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

   (1) inappropriate
   (2) correct—would provide the appropriate spiritual support necessary during a crisis
   (3) inappropriate for the data given in the situation
   (4) inappropriate for the data given in the situation

6. The nurse's aide comes to take a woman by wheelchair for a magnetic resonance imaging (MRI) scan of the head and neck. Which of the following observations, if made by the nurse, would require an intervention?

   1. The woman removes her dentures and gives them to her husband.
   2. The woman's vital signs are: BP 120/70, pulse 80, respirations 12, temperature 99°F (37.3°C).
   3. The woman has a nitroglycerine patch on her right chest area.
   4. The woman has red nail polish on her fingers and toes.

   Strategy: "Require an intervention" indicates an incorrect action.

   (1) should be removed before the test
   (2) results are within normal limits
   (3) correct—should be removed before the test
   (4) unnecessary to check capillary refill

7. The neonatal nurse is instructing the family of a newborn about an apnea monitor. The nurse should be MOST concerned if a family member makes which of the following statements?

   1. "We will be able to leave our baby for brief periods of time."
   2. "We plan to sleep by our baby's crib."
   3. "We can remove the monitor during our baby's bath."
   4. "A family member will closely watch the monitor all the time.

   Strategy: "MOST concerned" indicates that you are looking for an incorrect statement.

   (1) appropriate behavior
   (2) appropriate behavior
   (3) appropriate behavior
   (4) correct—indicates a feeling that monitor may not let them know if their infant stops breathing

8. A 20-year-old client has a cast applied for a fracture of the right femur. Three hours later, the client complains that it is hot and painful under his cast. Which of the following is the MOST appropriate action for the nurse to take?

   1. Assess the cast for wet spots and increase air circulation in the room.
   2. Check the circulation in his casted extremity and change the client's position.
   3. Take the client's temperature and observe him for other signs of infection.
   4. Medicate the client for pain and notify the physician of his complaint.

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

   (1) heat is sign of pressure
   (2) correct—heat is sign of pressure, pressure limits circulation
   (3) too early to see signs of infection
   (4) all complaints must be investigated, medication would mask signs of pressure, assessment first step

9. A 30-year-old woman is admitted to the hospital with dry mucous membranes and decreased skin turgor. The woman's vital signs are BP 120/70, temperature 101°F (38.3°C), pulse 88, respirations 14. Laboratory tests indicate the serum sodium is 150 mEq/L and the Hct is 48%. The nurse would expect the physician to order which of the following IV fluids?

    1. D_5 NS.
    2. 0.45% NaCl.
    3. 0.9% NaCl.
    4. Lactated Ringer's.

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

    (1) hypertonic solutions contraindicated in dehydration
    (2) correct—hypotonic solution, shifts fluid into intracellular space to correct dehydration
    (3) isotonic solution, not best with dehydration
    (4) isotonic solution used to replace electrolytes

10. Which of the following plans would be MOST appropriate for the nurse to use to prepare a 10-year-old for a cardiac catheterization?

    1. Show a videotape specifically prepared for children about cardiac catheterization.
    2. Provide the child with a pamphlet about the procedure and encourage him to read it.
    3. Draw a picture of a heart and explain where the tube will go and what the doctor will see.
    4. Present a puppet show explaining the anatomy and physiology of the heart.

    Strategy: Think about the developmental stage of a 10-year-old.

    (1) video will provide correct information but is not best preparation for a school-age child
    (2) pamphlet will contain correct information but is not best preparation for a school-age child
    (3) correct—this plan will best prepare the child for the procedure
    (4) would be more appropriate for a younger child

11. Which of the following nursing actions is MOST important to provide a patient with effective pain relief?

    1. Teach the patient about his pain.
    2. Establish a trusting relationship with the patient.
    3. Determine how various relaxation techniques affect the pain.
    4. Provide alternative measures to relieve pain.

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

    (1) not most important
    (2) correct—necessary to work with patient to identify interventions to relieve pain
    (3) part of intervention and evaluation phase
    (4) only a portion of interventions used to relieve pain

12. A client with a necrotizing spider bite is to perform his own dressing changes at home. The nurse is aware that which of the following statements, if made by the client, indicates a correct understanding of aseptic technique?

    1. "I need to buy sterile gloves to redress this wound."
    2. "I should wash my hands before redressing my wound."
    3. "I should keep the wound covered at all times."
    4. "I should use an over-the-counter antimicrobial ointment."

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

    (1) not most important
    (2) correct—indicates understanding of asepsis, whose hallmark is handwashing
    (3) is not possible to carry out
    (4) should use only the prescribed medications on the wound

13. An adult woman is admitted to an acute locked psychiatric unit one month prior to an election. She requests the opportunity to vote in the upcoming election. Which of the following responses by the nurse is BEST?

    1. "You are not eligible to vote because you are a psychiatric patient."
    2. "I'll make the appropriate arrangements for you to vote."
    3. "You may vote only if you are discharged by Election Day."
    4. "I'll contact the Election Board to see if you are registered to vote."

    Strategy: Determine the outcome of each answer choice.

    (1) psychiatric patients do not forfeit their constitutional rights
    (2) correct—patient can vote by absentee ballot
    (3) can vote by absentee ballot
    (4) not the nurse's responsibility

14. The nurse has administered sublingual nitroglycerin (Nitrostat) to a client complaining of chest pain. Which of the following observations is MOST important for the nurse to report to the next shift?

    1. The client indicates the need to use the bathroom.
    2. Blood pressure has decreased from 140/80 to 90/60.
    3. Respiratory rate has increased from 16 to 24.
    4. The client indicates that the chest pain has subsided.

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

    (1) not a side effect of this medication
    (2) correct—hypotension is significant side effect of nitroglycerin; although effect may be transient, BP should be closely observed to ensure that it does not continue to decrease
    (3) not a side effect of this medication
    (4) an expected outcome

15. One of the goals the nurse and a client with posttraumatic stress disorder (PTSD) mutually agreed upon is that he will increase his participation in out-of-the apartment activities. Which of the following recommendations, if made by the nurse, will be MOST therapeutic to achieve this goal?

    1. Take a day trip with a friend.
    2. Take an eleven-minute bus ride alone.
    3. Join a support group and participate in a victim assistance organization.
    4. Take a ten-minute walk with his wife around the block.

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

    (1) reasonable recommendation to begin using in a systematic desensitization program after the crisis is alleviated
    (2) reasonable recommendation to begin using in a systematic desensitization program after the crisis is alleviated
    (3) correct—support groups of people who have suffered similar acts of violence can be helpful and supportive to teach clients how to deal with the traumatizing situation and the emotional aftermath
    (4) reasonable recommendation to begin using in a systematic desensitization program after the crisis is alleviated

16. A client is scheduled for a traditional abdominal cholecystectomy. Which of the following statements, if made by the nurse to the client the night before surgery, is MOST important?

    1. "It is important for you to eat foods from every level of the food pyramid and avoid excessive fats in your diet."
    2. "Place the pillow against your abdomen, take three deep breaths, hold your breath, and then cough two or three times."
    3. "There will be a machine available to you after surgery for you to use to continuously receive pain medication."
    4. "You may come back from surgery with a tube in your nose that drains your gall bladder."

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

    (1) not most important initially, teaching should be done before discharge
    (2) correct—should be done every two hours to prevent respiratory complications, splinting prevents abdominal jarring
    (3) PCA pumps used postoperative but medication is administered intermittently
    (4) NG tube used to drain stomach, T-tube used to drain common bile duct

17. A 22-year-old mother of a 4-year-old boy comes to the antepartal clinic. Her second pregnancy has just been confirmed. During this initial visit, it MOST important for the nurse to

    1. assess the client's feelings about pregnancy, labor, and delivery.
    2. obtain a history of the client's last labor and delivery.
    3. determine how the client's 4-year-old feels about the pregnancy.
    4. identify the client's general health needs.

    Strategy: Think about each answer choice.

    (1) important data, priority is the here and now
    (2) important data, but not priority for first visit
    (3) important data, need to deal with the mother's needs first
    (4) correct—optimal opportunity for preventative health maintenance

18. The nurse is preparing a client for a skin biopsy. Which of the following client statements should the nurse report to the physician?

    1. "I've been taking aspirin for my sore knees."
    2. "Using lotion has helped my dry skin."
    3. "I went to the tanning salon yesterday."
    4. "I had a big breakfast this morning."

    Strategy: Determine how the statements relate to skin biopsy.

    (1) correct—aspirin compounds can increase bleeding time and should not be taken prior to a surgical procedure
    (2) does not affect the accuracy or results of the biopsy
    (3) does not affect the accuracy or results of the biopsy
    (4) does not affect the accuracy or results of the biopsy

19. The nurse is caring for a client with a perforated bowel secondary to a bowel obstruction. At the time the diagnosis is made, which of the following should be a priority in the nursing care plan?

    1. Maintain the client in a supine position.
    2. Notify the client's next-of-kin.
    3. Prepare the client for emergency surgery.
    4. Remove the nasogastric tube.

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

    (1) client is kept in semi-Fowler's position
    (2) not a priority action
    (3) correct—when the bowel perforates as a result of increased intraluminal pressure within the gut, intestinal contents are released into the peritoneum, leading to peritonitis
    (4) should not be done

20. The doctor writes an order for piperacillin (Pipracil) 3 g IV q6h for an adult client. Before administering this drug, the nurse should

    1. check for known allergies to medications.
    2. ensure that the client's respiratory rate is over 12.
    3. administer dexamethasone sodium phosphate (Decadron) 2 mg IV stat.
    4. check the client's blood pressure both sitting and standing.

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

    (1) correct—assessment, piperacillin (Pipracil) is a semisynthetic broad-spectrum penicillin, should not be administered to clients with known allergies
    (2) assessment, not relevant for administration of this medication
    (3) implementation, not relevant for administration of this medication
    (4) assessment, not relevant for administration of this medication

21. A mother brings her 17-month-old son to the well-baby clinic for a routine check-up. She confides to the nurse that she is concerned because her son sucks his thumb, especially at night when he is put to bed. Which of the suggestions by the nurse would be BEST?

    1. "If you want the behavior to stop put a negative reinforcer, such as red pepper, on this thumb."
    2. "Don't intervene at this time. This behavior usually subsides after 24 months of age."
    3. "What you are seeing is a common form of self-stimulation. You should discourage this behavior."
    4. "This behavior will cause malformation of his teeth. You should wrap his thumb at bedtime."

    Strategy: "BEST" indicates there may be more than one correct response. Remember growth and development concepts.

    (1) controversial treatment for an older child
    (2) correct—normal behavior, peaks at 18–20 months, most prevalent when child is hungry or tired
    (3) normal behavior in child this age, should not be discouraged
    (4) malocclusion occurs if thumb sucking persists past 4 years old or when permanent teeth erupt

22. The nurse is caring for clients in the outpatient clinic. A young adult female is seeking help for weight loss. Her weight is 257 pounds, and she is 5′7″ tall. Which of the following indicates the MOST appropriate diet choices for breakfast?

    1. Applesauce, cream of wheat, toast.
    2. Scrambled eggs and toast, one slice of bacon.
    3. One glass of grapefruit juice.
    4. Bagel with two ounces of cream cheese and a banana.

    Strategy: Determine the topic of the question.

    (1) correct—breakfast with some substance won't leave her feeling hungry most of the morning
    (2) high fat content
    (3) doesn't provide a balance of nutrients and may leave the client feeling very hungry before lunch
    (4) high fat content

23. A toddler admitted with an elevated blood lead level is to be treated with intramuscular (IM) injections of calcium disodium edetate (Calcium EDTA) and dimercaprol (BAL). Which of the following nursing actions should have the highest priority?

    1. Keep a tongue blade at the bedside.
    2. Encourage the child to participate in play therapy.
    3. Apply cool soaks to the injection site.
    4. Rotate the injection sites.

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

    (1) no longer used for seizures, but it is important to have seizure precautions and emergency respiratory equipment available
    (2) important to implement, but is not a priority
    (3) contains incorrect information
    (4) correct—highest priority is to prevent tissue damage and promote tissue absorption of the medicine, accomplished through rotation of the injection sites

24. The nurse is instructing a client being discharged on tranylcypromine sulfate (Parnate). The nurse knows further instruction is needed if the client makes which of the following statements?

    1. "To celebrate, my wife and I are going out for pepperoni pizza and wine tonight."
    2. "I plan to use sunblock at the beach this summer."
    3. "When I get home, I am going to start a diet so I can lose some weight."
    4. "Now that I feel so much better, I have more energy.

    Strategy: Determine how each answer choice relates to Parnate.

    (1) correct—Parnate is a MAO inhibitor; must avoid food with tyramine (aged cheese, yogurt, beer, wine) to prevent hypertensive crisis
    (2) sunblock required
    (3) no contraindication to sensible weight reduction diet
    (4) expected outcome of antidepressant; takes 3–4 weeks to work

25. The triage nurse for a women's health center receives a phone call from each of the following women. Which woman should be directed to come to the health care facility IMMEDIATELY?

    1. A multipara woman who is four weeks pregnant and reporting unilateral, dull abdominal pain.
    2. A primipara woman who is seven weeks pregnant and reporting an increase in whitish vaginal secretions.
    3. A primigravida woman who is five weeks gestation and is having vaginal spotting and some cramping.
    4. A multigravida woman who is six weeks pregnant and reporting frank, red vaginal bleeding with moderate cramps.

    Strategy: Determine the least stable client.

    (1) correct—needs to be evaluated for an ectopic pregnancy
    (2) expect during first trimester of pregnancy
    (3) symptomatic of threatened abortion; instruct to decrease activity
    (4) symptoms of spontaneous abortion; instruct client to save and count pads

26. A client has just been admitted after sustaining a second-degree thermal injury to his right arm. Which of the following nursing observations is MOST important to report to the doctor?

    1. Pain around the periphery of the injury.
    2. Gastric pH less than 6.0.
    3. Increased edema of the right arm.
    4. An elevated hematocrit.

    Strategy: Determine how each assessment relates to burns.

    (1) expected findings in burn wound resolution
    (2) correct—decrease in gastric pH could indicate hypersecretion of hydrogen ions, predisposing factor to stress ulcer formation
    (3) expected findings in burn wound resolution
    (4) expected findings in burn wound resolution

27. A college student was in a motor vehicle accident six months ago. Although he was minimally injured, his friend was killed. The client comes to Student Health Services with the complaints of not being able to study, not sleeping, and thinking he's "going crazy." It is MOST important for the nurse to

    1. perform a complete physical and social history.
    2. obtain a complete drug and alcohol history, including reports from a drug screen.
    3. review the significant events of the last year.
    4. explore how he coped with the motor vehicle crash and his friend's death.

    Strategy: Determine the outcome of each answer choice.

    (1) not most important initially
    (2) not most important initially
    (3) not most important initially
    (4) correct—initially obtaining focused information about a very traumatic event is helpful and provides the nurse with an opportunity to understand how this client has coped with a tragedy that has made him vulnerable

28. A urinalysis has been obtained on a client who has been complaining of dysuria, urinary frequency, and discomfort in the suprapubic area. After evaluating the results, the nurse should order a repeat urinalysis based on which of the following findings?

    1. Negative glucose.
    2. RBCs present.
    3. No WBCs or RBCs reported.
    4. Specific gravity 1.018.

    Strategy: Determine the significance of each answer choice and how it relates a bladder infection.

    (1) glucose increases during the inflammation process; it is not a primary component in determining urinary tract infections
    (2) not as complete a response as answer choice #3
    (3) correct—with the client's complaints, WBCs and RBCs should be present; WBCs are a response to the inflammation process and irritation of the urethra; RBCs are increased when bladder mucosa is irritated and bleeding
    (4) indicates the concentration of the urine

29. To minimize the side effects of a DPT immunization for a six-month-old, the nurse should instruct the parents to

    1. give the child an alcohol bath for an elevated temperature.
    2. administer antipyretics for discomfort, irritability, and fever.
    3. place an ice bag on the child's leg for one hour.
    4. check the child's temperature every four hours for three days.

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

    (1) implementation, uncomfortable and unnecessary
    (2) correct—implementation, antipyretics relieve the combination of side effects
    (3) implementation, dangerous to both skin integrity and overall temperature control
    (4) assessment, unnecessary unless indicated for another reason

30. The clinic nurse observes that a ten-year-old child with leukemia has a large burn on her arm and the burn appears to be oily. The client states that she touched a hot pan, and her mother put cooking fat on it so it would not blister. The nurse should

    1. document the findings in the chart.
    2. call the physician immediately to report the injury.
    3. teach the client that oil holds germs and makes infection more likely.
    4. wash the burn with soap and water to remove the oil.

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

    (1) does not address the immediate problem of cleansing the wound
    (2) unnecessary
    (3) does not address the immediate problem of cleansing the wound
    (4) correct—because leukemic clients are immunosuppressed, they are more susceptible to infections; cooking fat applied to an open wound increases the possibility of infection; burns should be rinsed immediately with tap water to reduce the heat in the burn

31. The nurse is teaching a client how to perform self-monitoring blood glucose (SMBG) using a blood glucose monitor. Which of the following actions, if performed by the client, indicates to the nurse the need for further teaching?

    1. The client lets her hand dangle before sticking her finger with the lancet.
    2. The client sticks her finger on the side of the distal phalanx.
    3. The client touches the strip with a large drop of blood hanging from her fingertip.
    4. The client milks her finger after sticking it.

    Strategy: "Further teaching" indicates an incorrect response.

    (1) helps to facilitate venous congestion
    (2) less painful than the center of the fingertip
    (3) blood should sit on the strip like a raindrop, smearing alters the reading
    (4) correct—forces interstitial fluid to mix with capillary blood and dilutes the blood

32. A client who is receiving hydralazine (Apresoline) q6h has a blood pressure of 90/60. Which of the following nursing actions would be MOST appropriate?

    1. Withhold the medication.
    2. Check the urinary output.
    3. Administer the medication.
    4. Increase the potassium intake.

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

    (1) correct—BP of 90/60 is too low for an additional dose of medication, withholding the medication and checking with the doctor is appropriate
    (2) assessment, appropriate nursing action for a client on an antihypertensive that has diuretic effects due to increased blood flow to the kidney, not a priority in this instance
    (3) unnecessary
    (4) appropriate nursing action for a client on an antihypertensive that has diuretic effects due to increased blood flow to the kidney, not a priority in this instance

33. A 34-year-old multipara comes to the prenatal clinic during her fifth month of pregnancy. The client complains to the nurse that her breasts are sensitive and sore. Which of the following suggestions by the nurse is BEST?

    1. Apply warm compresses to your breasts and take two aspirin as needed.
    2. Massage your breasts with lotion and wear loose-fitting clothing.
    3. Apply cold compresses to your breasts and wear a well-fitting, supportive bra.
    4. Take a diuretic once a day and avoid touching your breasts.

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

    (1) would increase circulation and increase discomfort, should avoid taking medications
    (2) not effective in decreasing discomfort
    (3) correct—during pregnancy there is an increase in lactiferous ducts and lobule-alveolar tissue
    (4) medications are to be avoided during pregnancy

34. The nurse is caring for a patient with hyperparathyroidism. Which symptom is MOST important for the nurse to report to the next shift?

    1. Abdominal discomfort.
    2. Hematuria.
    3. Muscle weakness.
    4. Diaphoresis.

    Strategy: Determine how each answer choice relates to hyperparathyroidism.

    (1) sign of hyperparathyroidism but does not require reporting
    (2) correct—hematuria is a sign of renal calculi; 55% of hyperparathyroid clients have renal stones
    (3) sign of hyperparathyroidism but does not require reporting
    (4) sign of hyperparathyroidism but does not require reporting

35. Two days after admission, a client's sputum culture is reported as positive for tuberculosis. While awaiting orders from the physician, the nurse should

    1. initiate measures to transfer the client to a tuberculosis unit.
    2. institute measures to initiate airborne precautions.
    3. arrange for all of the client's personal effects to be decontaminated.
    4. notify the client's family that they have been exposed to a contagious disease.

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

    (1) this action is unnecessary at this time, and if indicated, the physician will write appropriate transfer orders
    (2) correct—clients with tuberculosis are placed on airborne precautions in the hospital, and the nurse should begin preparations for this immediately
    (3) personal effects do not have to be decontaminated
    (4) it is the physician's job to tell the family when indicated

36. A nursing assistant is assigned to constant observation of a suicidal patient, and the nurse overhears the nursing assistant talking with the patient. Which of the following statements made by the nursing assistant would require IMMEDIATE intervention by the nurse?

    1. "Let's put your clothes in the dresser."
    2. "I'll stay in the bathroom with you while you take your shower."
    3. "You're going to be moved to a private room later today."
    4. "I'll be right back with something for you to eat."

    Strategy: "Require IMMEDIATE intervention" indicates that something is wrong.

    (1) no reason to intervene
    (2) appropriate, client is not to be left alone for any reason
    (3) no reason to intervene
    (4) correct—client under constant observation; must not be left alone for any reason

37. The nurse is obtaining a history on a client just admitted to the unit. The client informs the nurse that any information shared with the nurse during the interview is to remain confidential. Which of the following responses by the nurse is BEST?

    1. "I'll share any information you give me with staff members only with your approval."
    2. "If the information you share is important to your care, I'll need to share it with the staff."
    3. "We can keep the information just between the two of us."
    4. "I have an obligation to maintain nurse/patient confidentiality about anything you tell me."

    Strategy: Think about the outcome of each answer choice.

    (1) the nurse has the obligation to share client information with personnel directly involved with the client's care
    (2) correct—the nurse is obligated to share client information with personnel directly involved with the client's care
    (3) the nurse must never agree to keep information confidential without knowing the content of the information
    (4) the nurse not obligated to report information that is not relevant to the client's care or well-being

38. The nurse is performing discharge teaching on a client with multiple sclerosis. It is MOST important for the nurse to include which of the following instructions?

    1. Ambulate as tolerated every day.
    2. Avoid overexposure to heat or cold.
    3. Perform stretching and strengthening exercises.
    4. Participate in social activities.

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

    (1) client is encouraged to ambulate as tolerated
    (2) correct—overexposure to heat or cold may cause damage related to the changes in sensation
    (3) client is encouraged to participate in an exercise program to include ROM, stretching, and strengthening exercises
    (4) client is encouraged to continue usual activities as much as possible, including social activities

39. A client is diagnosed with lung cancer and undergoes a pneumonectomy. In the immediate postoperative period, which of the following nursing assessments is MOST important?

    1. Presence of breath sounds bilaterally.
    2. Position of the trachea in the sternal notch.
    3. Amount and consistency of sputum.
    4. Increase in the pulse pressure.

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

    (1) on the surgical side, breath sounds will be absent
    (2) correct—position of the trachea should be evaluated; with a tracheal shift, an increase in pressure could occur on the operative side and could cause pressure against the mediastinal area
    (3) important to observe but not as high a priority
    (4) does not relate to the situation

40. After abdominal surgery, a client is admitted from the recovery room with intravenous fluid infusing at 100 cc/h. One hour later, the nurse finds the clamp wide open and notes that the client has received 850 cc. The nurse would be MOST concerned by which of the following?

    1. A CVP reading of 12 and bradycardia.
    2. Tachycardia and hypotension.
    3. Dyspnea and oliguria.
    4. Rales and tachycardia.

    Strategy: “MOST concerned” indicates a complication.

    (1) CVP is normal, and bradycardia is incorrect
    (2) does not contain information relevant to fluid overload
    (3) does not contain information relevant to fluid overload
    (4) correct—indicate cardiovascular fluid overload

41. The nurse is admitting a client to the unit from the postoperative recovery area after abdominal exploratory surgery. After determining the client's vital signs, which of the following activities should the nurse perform next?

    1. Position the client on her left side, supported with pillows.
    2. Check the chart and determine the status of the fluid balance from surgery.
    3. Check the client's abdominal dressing for any evidence of bleeding.
    4. Monitor the incision and pulmonary status for the presence of infection.

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

    (1) implementation, complete assessment first
    (2) assessment, determine what is happening to the patient now
    (3) correct—assessment, dressing should be checked on admission to the room and frequently for the next several hours
    (4) inappropriate assessment, it is too soon for infection to occur secondary to surgery

42. A 33-year-old woman comes to the local outpatient clinic for complaints of dizziness and palpitations. Her physical exam and laboratory results are normal. She reports that the company she owns is on the verge of bankruptcy. Which of the following responses, if made to the client by the nurse, would be BEST?

    1. "When did you first notice these symptoms?"
    2. "Have you shared this information with anyone?"
    3. "Are you concerned about your financial difficulties?"
    4. "Would you like to discuss your situation with me?"

    Strategy: "BEST" indicates there may be more than one correct response. Remember therapeutic communication.

    (1) correct—open-ended question, encourages client to discuss when problems occurred
    (2) yes/no question, nontherapeutic, doesn't encourage discussion of symptoms
    (3) yes/no question, nontherapeutic, too confrontational, does not encourage discussion
    (4) yes/no question, nontherapeutic

43. A client had a radical mastectomy for cancer in her right breast. After the client returns to the unit, which of the following actions, if performed by the nurse, would be MOST appropriate?

    1. Position the client on her left side with her right arm protected in a sling.
    2. Position the client on her right side with her right arm elevated.
    3. Position the client in semi-Fowler's position with her right arm elevated.
    4. Position the client in the prone position with her right arm elevated.

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

    (1) sling is not necessary, arm needs to be elevated
    (2) right arm cannot be elevated from this position
    (3) correct—this position will facilitate removal of fluid from venous pathways and lymphatic system through gravity; arm is elevated to enhance circulation and prevent edema
    (4) prone position is not appropriate

44. When the nurse walks into a client's room, the client states, "I just love hot-blooded redheads." The client pats his bed and says, "Why don't you sit down here and get off your feet for a while." Which of the following responses by the nurse is BEST?

    1. "I feel very uncomfortable when you make those suggestive remarks. It makes it difficult for me to do my job."
    2. "I don't think my husband or your wife would like me doing that."
    3. "You must be very lonesome. I'll come back later and spend some time with you."
    4. "I bet you flirt with all the nurses like that."

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

    (1) correct—nurse should confront client about inappropriate sexual behavior
    (2) should confront the client
    (3) reinforces inappropriate behavior
    (4) confront the client about inappropriate and unwanted behavior

45. The nurse answers the psychiatric unit's desk phone. The caller identifies himself as the husband of a patient and inquires about her condition. Which of the following responses by the nurse is MOST appropriate?

    1. "I may not deny or confirm any patient's presence in this hospital."
    2. "Patients are not allowed to use his phone. Please call the patient's phone number directly."
    3. "I cannot give information over the phone. If you come in we can discuss her condition."
    4. "I will have to ask her if she wishes for me to give out that information."

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

    (1) confidentiality prohibits a professional from discussing information about the patient
    (2) correct—psychiatric patient retains civil rights to communicate with outside world and have reasonable access to telephones
    (3) breaks confidentiality
    (4) patient able to speak for herself

46. Several days after a client had a myocardial infarction, the physician placed him on a 2-gm sodium diet. Which of the following selections would indicate to the nurse an understanding of the diet?

    1. Scrambled egg, orange slices, and milk.
    2. Instant oatmeal, toast, and orange juice.
    3. Poached egg, bacon, and milk
    4. Biscuit, fruit cup, and sausage.

    Strategy: Determine the foods that are allowed on a 2-gm sodium diet.

    (1) correct—all items are low in sodium; milk is allowed on a salt-restricted diet
    (2) instant oatmeal has sodium added
    (3) bacon is high in sodium
    (4) all baked breads are high in sodium, as is sausage

47. The nurse is leading a class for expectant mothers. Which of the following comments would indicate to the nurse that a pregnant woman understands the recommended dietary caloric increase for pregnancy?

    1. "I will need to double my calorie intake since I am now eating for two of us."
    2. "I can add an additional 500 calories by drinking milkshakes."
    3. "I need to add 300 calories by increasing my intake of the four basic food groups."
    4. "I really need to watch my calorie intake so I will not gain too much weight."

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

    (1) common misconception
    (2) 500 calories is too many calories, and a milkshake is not a good food source because of its fat content
    (3) correct—recommended to increase calorie intake by 300 for fetal growth, maternal tissues, and the placenta
    (4) unsafe for the pregnant client

48. The nurse is caring for a 17-year-old married male scheduled for a hernia repair. The nurse administers meperidine hydrochloride (Demerol) 50 mg and hydroxyzine pamoate (Vistaril) 25 mg IM. Thirty minutes later the nurse discovers that the informed consent is unsigned. Which of the following actions by the nurse is BEST?

    1. Cancel the surgery.
    2. Ask the client to sign the informed consent.
    3. Notify the physician.
    4. Ask the client's mother to sign the informed consent.

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

    (1) inappropriate action, should inform physician
    (2) can't sign informed consent if client has been drinking alcohol or has been pre-medicated for surgery
    (3) correct—physician needs to be informed
    (4) married minor is considered emancipated; provides own consent for treatment

49. The physician orders naproxen sodium (Anaprox) 250 mg enteric-coated tablets PO bid for a 45-year-old man. Which response, if made by the client, would indicate that the nurse's teaching about the medication has been effective?

    1. "I can join my wife in a glass of wine with our dinner when we eat in a restaurant."
    2. "I should avoid milk and dairy products when I take this pill."
    3. "I should call my doctor if my stools turn very dark."
    4. "I don't like to take pills so I will crush the pill and add it to some applesauce."

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

    (1) alcohol increases risk of GI bleeding
    (2) should be taken with food, milk, or antacid to decrease GI upset
    (3) correct—NSAIDS can cause GI bleeding
    (4) enteric-coated tablet should not be broken

50. A 28-year-old woman at 39-weeks gestation in active labor screams, "I have to push, I have to push." The nurse notes that the client is 8 cm dilated. The nurse should

    1. instruct the client to take a deep breath and bear down.
    2. apply gentle but firm fundal pressure to the client's abdomen.
    3. coach the client in relaxation techniques.
    4. tell the client to pant with pursed lips.

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

    (1) pushing should be discouraged until the second stage of labor
    (2) would increase discomfort
    (3) is inappropriate at this time; this is a short, intense period of labor
    (4) correct—describes transition phase of labor, breathing technique allows patient to control pain and urge to push and promotes adequate oxygenation of fetus

51. A 52-year-old woman has an appendectomy for a ruptured appendix. The nurse observes a student nurse perform a wet-to-dry dressing change on the 2-in incision. Which of the following behaviors, if performed by the student nurse, would require an intervention by the nurse?

    1. The old dressing is saturated with sterile saline before it is removed.
    2. Dry dressings are placed over the saline-saturated gauze in the incision.
    3. Wound debris and necrotic tissue are removed with the old dressing.
    4. The gauze is saturated with sterile saline before it is packed into the incision.

    Strategy: "Require an intervention" indicates an incorrect action.

    (1) correct—should be removed dry so wound debris and necrotic tissue are removed with old dressing
    (2) done to protect clothing and bedding
    (3) purpose of wet-to-dry dressing
    (4) appropriate procedure

52. A man is presently employed as a night watchman. When he comes to the clinic for a visit, he tells the nurse he is having difficulty sleeping and is fatigued much of the time. Which of the following responses by the nurse is BEST?

    1. "Tell me about your usual sleeping habits."
    2. "You probably sleep when you can during your night tour."
    3. "This is normal for your age group."
    4. "Working the night shift is known to disrupt sleep patterns."

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

    (1) correct—assessment, open-ended, encourages discussion
    (2) judgment based on inadequate information, nontherapeutic
    (3) generalization with no factual basis, closed communication
    (4) closed communication, generalization

53. Before administering calcium gluconate 10% 500 mg IV stat, it is MOST important that the nurse assess the

    1. stability of the respiratory system.
    2. adequacy of urine output.
    3. patency of the vein.
    4. availability of magnesium sulfate injection.

    Strategy: Determine how each answer choice relates to calcium gluconate.

    (1) unnecessary in this situation
    (2) unnecessary in this situation
    (3) correct—if injected into the extravascular tissues, calcium gluconate can cause a severe chemical burn
    (4) irrelevant

54. An 18-month-old is brought by her father to the well-baby clinic for a routine immunization. Just before the nurse gives the child the injection, the toddler begins to cry. Which of the following comments by the nurse is the MOST appropriate?

    1. “Don't cry. It will be better if you try to behave.”
    2. “I know you are frightened. It will be over with soon.”
    3. “A big girl like you shouldn't cry. It's only going to hurt a little.”
    4. “Please stop crying. There is nothing to be afraid of.”

    Strategy: Remember therapeutic communication

    (1) nontherapeutic, doesn’t respond to feeling tone and tells child what to do
    (2) correct—doesn’t minimize child’s reaction, responds to feeling tone
    (3) nontherapeutic, minimizes child’s reaction
    (4) nontherapeutic, minimizes child’s reaction, should indicate it is OK to feel afraid

55. A child admitted with failure to thrive has just had a positive sweat test. The nurse would anticipate which of the following changes in the child’s plan of care initially?

    1. Administration of replacement enzymes.
    2. Administration of oxygen.
    3. A salt-restricted diet.
    4. Initiate intravenous therapy.

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

    (1) correct—sweat test is a positive finding for cystic fibrosis
    (2) no data in this situation to indicate that the child is having pulmonary problems
    (3) salt is increased in diet
    (4) no need for IV therapy based on the data in situation

56. The nurse is planning discharge for a client who suffered a mild myocardial infarction (MI) and smokes one pack of cigarettes per day. Which of the following recommendations by the nurse would be BEST?

    1. Participation in a program such as "Nicotine Avoidance."
    2. Avoidance of aerobic physical activity.
    3. Instillation of a humidifier in the home heating system.
    4. Strict adherence to a low-calorie, low-sodium, high-lipid diet.

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

    (1) correct—smoking is definitely a modifiable risk factor, self-help program can significantly aid in quitting
    (2) well-planned aerobic physical activity program is a must
    (3) humidification does not modify the risk factors
    (4) low-calorie is appropriate, needs a low-fat, not a high-fat, diet

57. The homecare nurse is visiting an infant who had a myelomeningocele repair. The homecare nurse determines that the parents are accepting of their infant if which of the following is observed?

    1. The parents state that the infant will outgrow this problem in time.
    2. The parents ask a neighbor to perform bladder expression.
    3. The parents measure the head circumference daily.
    4. The parents relate that they believe the child will walk in one year.

    Strategy: Think about each statement and how it relates to myelomeningocele.

    (1) child has a chronic problem
    (2) indicates the parents' lack of interest and inability to care for the child
    (3) correct—parents' participation in care may be first sign of acceptance; head circumference measurement is important due to risk of hydrocephalus following surgery; even simple care like bathing child could bring acceptance
    (4) shows a lack of understanding about myelomeningocele

58. A patient has a Sengstaken-Blakemore tube in place. The nurse enters the room and finds the woman in respiratory distress. It is MOST important for the nurse to

    1. notify the physician immediately to remove the tube.
    2. elevate the head of the bed and administer oxygen.
    3. cut the balloon ports and remove the tube.
    4. call a code and begin rescue breathing.

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

    (1) need to remove tube immediately to provide for airway
    (2) does not provide a patent airway
    (3) correct—scissors always secured at the bedside, remove tube if observe signs of respiratory distress or airway obstruction caused by upward displacement of esophageal balloon
    (4) unnecessary to call code until respiratory arrest occurs, then establish a patent airway first

59. While teaching the client about the importance of prenatal vitamins, the nurse should tell the client to take the vitamins

    1. with orange juice at bedtime.
    2. at breakfast with coffee.
    3. with milk at lunch.
    4. with water at dinner.

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

    (1) correct—taking the vitamins with something acidic increases the absorption of iron, taking them with food at bedtime decreases the possibility of nausea, as the client will be asleep
    (2) not the best way to take prenatal vitamins
    (3) not the best way to take prenatal vitamins
    (4) not the best way to take prenatal vitamins

60. The nurse is performing teaching for a client being discharged on clozapine (Clozaril). Which of the following client statements indicates to the nurse that teaching has been successful?

    1. "I need to call my doctor in a few weeks for a follow-up appointment."
    2. "I need to keep my doctor's appointment next week for a blood test."
    3. "I can take over-the-counter sedatives if I have trouble sleeping."
    4. "I can drink alcohol as long as I drink in moderation."

    Strategy: "Teaching has been successful" indicates a correct response.

    (1) follow routine schedule
    (2) correct—Clozaril causes agranulocytosis; requires weekly WBC; teach client to report early signs of infection
    (3) check with physician before taking any OTC medication
    (4) check with physician before ingesting alcohol

61. A bipolar patient refuses to put down the mop that he is swinging to threaten other patients and staff. What information is MOST important for the nurse to consider before administering a PRN IM dose of lorazepam (Ativan)?

    1. The patient is harmful to himself.
    2. The patient is psychotic.
    3. A restrictive intervention failed.
    4. The patient is harmful to others.

    Strategy: Think about each answer choice.

    (1) use the least restrictive interventions in ascending order
    (2) use the least restrictive interventions in ascending order
    (3) correct—use the least restrictive interventions in ascending order
    (4) use the least restrictive interventions in ascending order

62. To promote safety in the environment of a client with a marked depression of T cells, the nurse should

    1. keep a linen hamper immediately outside the room.
    2. restrict eating utensils to spoons made of plastic.
    3. provide masks for anyone entering the room.
    4. remove any standing water left in containers or equipment.

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

    (1) protocol for handling soiled articles is accomplished within universal guidelines with double biohazard bags
    (2) universal precautions and client protection may call for plastic utensils, but not just spoons
    (3) not protocol unless the client has an active pulmonary infection
    (4) correct—water should not be allowed to stand in containers, such as respiratory or suction equipment, because this could act as a culture medium

63. The physician prescribes sucralfate (Carafate) 1 gm PO tid and 2 Maalox tablets tid for a 50-year-old man in the outpatient clinic. The client asks the nurse when to take these medications. The nurse should advise the man to take

    1. the Carafate and the Maalox 1 hour ac.
    2. the Maalox 1 hour ac and the Carafate 1 hour pc.
    3. the Carafate and the Maalox 2 hours pc and hs.
    4. the Carafate 1 hour ac and the Maalox 1 hour pc.

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

    (1) Maalox (antacids) decreases bonding to GI mucosa, don't give within 30 minutes of each other
    (2) Carafate best results on empty stomach, antacids decrease bonding to GI mucosa, so don't give within 30 minutes of each other
    (3) antacids decrease bonding to GI mucosa, so don't give within 30 minutes of each other
    (4) correct—Carafate has best results on empty stomach

64. A female client is diagnosed with human papillomavirus (HPV). Which of the following client statements, if made to the nurse, illustrates an understanding of the possible sequelae of this illness?

    1. "I will need to take antibiotics for at least a week."
    2. "I will use only prescribed douches to avoid a recurrence."
    3. "I will return for a Pap smear in six months."
    4. "I will avoid using tampons for eight weeks."

    Strategy: Determine the "hidden meaning" of the answer choices.

    (1) antibiotics are not used for viral infections
    (2) douches will not prevent recurrence
    (3) correct—several strains of the human papillomavirus (HPV) are associated with cervical cancer
    (4) tampons would not be a problem as in toxic shock syndrome

65. A client develops severe, crushing chest pain radiating to the left shoulder and arm. Which of the following PRN medications should the nurse administer?

    1. Diazepam (Valium) PO.
    2. Meperidine (Demerol) IM.
    3. Morphine sulfate IV.
    4. Nitroglycerine (Nitrostat) SL.

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

    (1) not an appropriate medication in this situation; antianxiety medication
    (2) Demerol is less commonly used because it may induce vomiting and initiate a vagal response
    (3) correct—morphine sulfate is given to reduce pain, anxiety, and cardiac workload; reduces the preload and afterload pressures
    (4) although a client at home may have taken NTG SL, the nurse would administer it IV to reduce pain and decrease overload

66. The nurse is making a home visit for a client with an abdominal wound. When irrigating the draining wound with a sterile saline solution, which of the following sequences would be MOST appropriate for the nurse to follow?

    1. Pour the solution, wash hands, and remove the soiled dressing.
    2. Wash hands, prepare the sterile field, and remove the soiled dressing.
    3. Prepare the sterile field, put on sterile gloves, and remove the soiled dressing.
    4. Remove the soiled dressing, flush the wound, and wash hands.

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

    (1) hands should be washed first
    (2) correct—handwashing should be done prior to beginning any procedure, especially irrigating a wound
    (3) using sterile gloves to remove the dressing would contaminate them
    (4) hands should be washed first

67. The nurse is caring for a client with internal radiation. Which of the following actions, if taken by the nurse, is MOST important?

    1. Restrict visitors who may have an upper respiratory infection.
    2. Assign only male caregivers to the client.
    3. Plan nursing activities to decrease nurse exposure.
    4. Wear a lead-lined apron whenever delivering client care.

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

    (1) all visitors are restricted with regard to the distance they should be from the client
    (2) not relevant to the situation
    (3) correct—principles for radiation therapy are time, distance, shielding; nurse should decrease the time spent in close proximity to the client
    (4) appropriate shielding (lead aprons) is to be used when the nurse has to spend any length of time at a close distance, not just for routine care

68. A client is admitted to the neurology unit for a myelogram. It would be MOST important for the nurse to ask which of the following questions"

    1. "Do you have any allergies?"
    2. "Have you been drinking lots of fluids?"
    3. "Are you wearing any metal objects?"
    4. "Are you taking medication?"

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

    (1) correct—dye is injected into subarachnoid space before an x-ray of spinal cord and vertebral column to assist in identifying spinal lesions; if client is allergic to dye, there is a major safety issue
    (2) important that client drink extra fluids after the test to replace the CSF lost during test
    (3) appropriate for magnetic resonance imaging (MRI)
    (4) obtain history of medication that can lower seizure threshold (phenothiazines, neuroleptics)

69. The nurse is caring for a client with organic brain syndrome in a long-term care facility. Which of the following actions by the nurse is BEST?

    1. Encourage the client to verbalize his feelings regarding the relationship with his family that initiated his nursing home placement.
    2. Help the client to express his favorite pastimes and the type of activities that he enjoys.
    3. Orient the client to the present time and assist him to be alert and oriented when his family comes to visit.
    4. Direct conversation toward assisting the client to reminisce and talk about important past events in his life.

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

    (1) may not remember who or where he is
    (2) not as important as answer choice #4
    (3) even with orientation, the client soon forgets
    (4) correct—geriatric client should be encouraged to talk about his life and important things in the past because he has recent memory loss

70. A client has a nasogastric tube in place after extensive abdominal surgery. The client complains of nausea. His abdomen is distended, and there are no bowel sounds. The FIRST nursing action should be to

    1. administer the PRN pain medication and an antiemetic.
    2. irrigate the nasogastric tube with normal saline.
    3. determine if the nasogastric tube is patent and draining.
    4. check the placement of the nasogastric tube by auscultation.

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

    (1) implementation, may be carried out after the patency of the tube is determined
    (2) implementation, patency should be checked first
    (3) correct—should first assess if the tube is open and draining to determine if there is a problem with the nasogastric tube; if it is patent and draining it does not need to be irrigated
    (4) assessment, patency should be checked first by aspirating stomach contents, not by auscultation

71. Which of the following is the FIRST nursing action that should be implemented for a 25-year-old woman after a vaginal delivery?

    1. Check the patient's lochial flow.
    2. Palpate the patient's fundus.
    3. Monitor the patient's pain.
    4. Assess the patient's level of consciousness.

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

    (1) correct—complication of hemorrhage assessed by observing lochial flow
    (2) done to assist its natural clamping-down action, assessed as firm or boggy
    (3) must meet physical needs first
    (4) not first action, hemorrhage most important complication

72. A 20-year-old woman with a fracture of the left femur is placed in Buck's traction with a 7-lb weight. The patient keeps sliding down in bed. The nurse should

    1. elevate the patient's left thigh on two pillows.
    2. elevate the foot of the bed on blocks.
    3. raise the knee gatch on the bed 30°.
    4. instruct the patient to remain in the middle of the bed.

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

    (1) will not prevent patient from sliding down; may change pull of traction
    (2) correct—will keep leg straight and counter the pull of the weights
    (3) will bend the leg and alter the pull of the traction
    (4) not effective way of preventing the patient from sliding down in bed

73. Which of the following is an example of a properly recorded client chief complaint in a nursing health history?

    1. "Complains of midepigastric discomfort with flatus after meals."
    2. "Area above umbilicus appears to be painful and tender to palpation."
    3. "My stomach hurts after dinner every night."
    4. "Rebound tenderness present in mid-to-upper abdominal area."

    Strategy: Think about each answer choice.

    (1) incorrectly stated
    (2) objective finding
    (3) correct—chief complaint should be recorded using the client's own words
    (4) objective finding

74. A client comes to the nurse's station for her antipsychotic medication. The nurse notes that the client has torticollis, an arched back, and rapid movement of the eyes. The nurse should take which of the following action FIRST?

    1. Determine what other medications the patient is taking.
    2. Perform a neurological assessment.
    3. Administer haloperidol decanoate (Haldol D) IM stat.
    4. Administer the PRN trihexyphenidyl (Artane) IM immediately.

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

    (1) assessment, demonstrating acute extrapyramidal side effects
    (2) assessment, no validation required
    (3) Haldol is antipsychotic, will exacerbate symptoms
    (4) correct—administer Cogentin or Artane

75. The home health nurse is performing a follow-up visit for a 76-year-old man receiving isoniazid (INH) 200 mg every day for 6 months. The nurse would be MOST concerned if the client made which of the following statements?

    1. "I have blurred vision at times."
    2. "My legs and knees hurt."
    3. "My hands and feet tingle."
    4. "I think I had a migraine yesterday."

    Strategy: Determine how each answer choice relates to Isoniazid.

    (1) infrequent side effect of the medication
    (2) not a side effect of the medication
    (3) correct—may cause peripheral neuropathy indicated by tingling, may also see nausea
    (4) not a side effect of the medication

76. During the nursing history interview, a preschool client's mother reports that the child has frequent bouts of gastroenteritis. It would be MOST important for the nurse to ask which of the following questions?

    1. "Are there other children in the family?"
    2. "Does the child attend a day care center?"
    3. "Does the child play with neighborhood children?"
    4. "Is the child current on his immunizations?"

    Strategy: Determine why the nurse would make the assessment and how it relates to gastroenteritis.

    (1) does not pose a problem or solution regarding gastroenteritis
    (2) correct—environments with increased numbers of children (day care) more likely to promote infections due to close living conditions and increased likelihood of disease transmission
    (3) possible source of infection, but not as likely as a day care center
    (4) does not pose a problem or solution regarding gastroenteritis

77. A young adult client is scheduled for her first debridement of a second-degree burn of the left arm. It is MOST important for the nurse to take which of the following actions?

    1. Assemble all necessary supplies and medications.
    2. Plan adequate time for the dressing change and provide emotional support.
    3. Prepare the client and family for the pain the client will experience during and after the procedure.
    4. Limit visitation prior to the procedure to reduce stress.

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

    (1) appropriate, but is not a high priority
    (2) correct—planning for burn wound treatment should include organizing and planning to spend time not only on the mechanics of the procedure, but on providing the emotional support necessary for the client
    (3) appropriate, but is not a high priority
    (4) appropriate, but is not a high priority

78. A client is being treated for hypovolemia. Which of the following observations should the nurse identify as the desired response to fluid replacement?

    1. Urine output 160 cc/8 h.
    2. Hgb 11 g, Hct 33%.
    3. Arterial pH 7.34.
    4. CVP reading of 8 cm of water pressure.

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

    (1) indicates a hypovolemic state
    (2) indicates a hypovolemic state
    (3) indicates acidosis
    (4) correct—normal range for CVP is 3–8 cm water pressure (or 2–6 mm Hg); reading of 8 cm water pressure would indicate a desired response to fluid replacement

79. The nurse is preparing an adolescent for a lumbar puncture. It is MOST important that the nurse make which of the following statements?

    1. “Don’t worry because a general anesthetic will be used.”
    2. “You can’t drink fluids for eight hours before the test.
    3. “You will remain flat in bed for eight hours after the test.”
    4. “A compression bandage will be in place for ten hours after the test.”

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

    (1) general anesthetic is not used
    (2) fluids are not restricted before the test
    (3) correct—to prevent a post-lumbar puncture headache, client should remain flat in bed for eight hours after the test
    (4) inappropriate for this procedure

80. The emergency room nurse is caring for a client displaying the following symptoms: elevated vital signs, hallucinations, and aggressive behavior. The client's friend says she thinks that he has been using hallucinogenic drugs. The appropriate nursing action would be to

    1. put the client in full restraints.
    2. decrease environmental stimulation.
    3. call the security guards.
    4. administer a PRN dose of chlorpromazine (Thorazine).

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

    (1) unnecessary at this time
    (2) correct—symptoms will subside with time and decreased stimulation
    (3) unnecessary at this time
    (4) inappropriate

81. A client with a twenty-five-year history of alcohol abuse is seen in the outpatient clinic for treatment of chronic cirrhosis. Which of the following symptoms would suggest to the nurse that the client is in the early stages of hepatic encephalopathy?

    1. The patient's abdomen is distended with a protruding umbilicus.
    2. The patient has difficulty describing what he does at work.
    3. The patient's respirations are 32, and he appears to be drowsy.
    4. The patient's upper extremities are adducted, and his lower extremities are internally rotated.

    Strategy: Determine how each answer choice relates to hepatic encephalopathy.

    (1) ascites is symptom of cirrhosis
    (2) correct—impaired thought processes is early symptom
    (3) hyperventilation and stupor is late symptom
    (4) decerebrate/decorticate posturing late symptom

82. A 32-year-old multipara is seen in the prenatal clinic. The nurse notes she is in her fifth month of pregnancy and has a weight gain of 14 pounds. The history indicates that prenatally the client was of average height and weight. The nurse should advise the client that

    1. she has gained too much weight and her diet should be reevaluated.
    2. she has not gained enough weight and her diet should be reevaluated.
    3. her weight gain is appropriate and she should continue on her present diet.
    4. her weight gain indicates that she may have difficulties later in pregnancy.

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

    (1) excessive weight gain is >6.6 lb (3 kg)/month
    (2) inadequate weight gain is <2.2 lb (1 kg)/month
    (3) correct—weight gain 2–5 lb (2.5 kg) first trimester, 0.66–1.1 lb (0.5 kg) weekly in second and third trimester
    (4) not substantiated by information presented in question

83. A client is currently hospitalized with renal failure and has 3+ pitting edema of the lower extremities. Which of the following nursing observations would indicate a therapeutic response to therapy for the edema?

    1. Serum potassium 4.0 mEq/L.
    2. Plasma glucose 140 mg/dL.
    3. Increased specific gravity of the urine.
    4. Weight loss of 5 lb over last two days.

    Strategy: Determine how each answer choice relates to edema.

    (1) no relation to edema
    (2) no relation to edema
    (3) urine specific gravity may be decreased as client begins to lose some edema fluid
    (4) correct—edema is a result of sodium and fluid retention; weight loss should occur if therapy is effective

84. The nurse is caring for patients on the surgical floor and has just received report from the previous shift. Which of the following patients should the nurse see FIRST?

    1. A 35-year-old admitted three hours ago with a gunshot wound; 1/5 cm area of dark drainage noted on the dressing.
    2. A 43-year-old who had a mastectomy two days ago; 23 cc of serosanguinous fluid noted in the Jackson-Pratt drain.
    3. A 59-year-old with a collapsed lung due to an accident; no drainage noted from chest tube in last eight hours.
    4. A 62-year-old who had an abdominal-perineal resection three days ago; patient complains of chills.

    Strategy: Think ABCs.

    (1) does not indicate acute bleeding, small amount of blood
    (2) expected outcome
    (3) indicates resolution
    (4) correct—risk for peritonitis, should be assessed for further symptoms of infection

85. Which of the following behaviors by a client should the nurse record to indicate that the client is experiencing hallucinations?

    1. The client sits immobilized for long periods of time.
    2. The client turns and tilts his head as if talking to someone.
    3. The client expresses the belief that the physician is out to get him.
    4. The client wrings his hands and paces constantly.

    Strategy: Think about each answer choice.

    (1) describes behavior associated with depression
    (2) correct—hallucinations are sensory perceptions for which there is no external stimulus; this option describes client behavior that would be observed when the client is responding to voices
    (3) describes behavior associated with delusional thinking
    (4) describes behavior most associated with anxiety

86. A 23-year-old man comes to the AIDS clinic for treatment of large, painful, purplish-brown open areas on his right arm and back. The nurse should instruct the client to

    1. clean the area carefully with soap and warm water every day and cover them with a sterile dressing.
    2. soak in a warm tub twice a day and rub the areas with a washcloth before covering them.
    3. shower daily using a mild antimicrobial soap from a pump dispenser and leave the lesions uncovered.
    4. clean the lesions twice a day with a diluted solution of povidone-iodine (Betadine) and leave them open to the air.

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

    (1) correct—open Kaposi's sarcoma lesions should be cleaned and dressed daily to prevent secondary infection
    (2) not done because of risk of secondary skin infection
    (3) important to keep the skin clean to prevent secondary skin infection but should be covered due to open areas
    (4) treatment for herpes simplex virus abscess, not Kaposi's sarcoma

87. The nurse knows that which of the following is the BEST assessment indicating relief from abdominal pain for a child who received meperidine (Demerol) IM one hour ago?

    1. The child states that his pain has gone away.
    2. The child's heart rate has changed from 80 to 95.
    3. The child sleeps except when receiving nursing care.
    4. Results from the incentive spirometer have improved.

    Strategy: Think about what the words mean.

    (1) contains correct information, but is not a priority; child could deny pain out of fear of getting another injection
    (2) indicates discomfort, anxiety
    (3) indicates a need to decrease the amount of medication
    (4) correct—when pain is decreased, child will be better able to breathe deeply and improve the outcome of use of the incentive spirometer

88. The nurse is caring for patients in an acute care facility. The nurse would identify which of the following patients as a likely candidate for developing acute renal failure?

    1. A young female with recent ileostomy due to ulcerative colitis.
    2. A middle-aged male with elevated temperature and chronic pancreatitis.
    3. A teenager in hypovolemic shock following a crushing injury to the chest.
    4. Child with compound fracture of the right femur and massive laceration of the left arm.

    Strategy: Determine how each answer choice relates to acute renal failure.

    (1) usually ileostomy clients do not experience severe hypovolemia, which would lead to renal failure problems
    (2) this type of infection and inflammation does not lead to acute renal failure
    (3) correct—common cause of acute renal failure is renal ischemia precipitated by hypovolemia or heart failure
    (4) femoral fractures are more likely to lead to fat embolism than acute renal failure

89. An older man is being prepared for discharge after treatment for dehydration. Which of the following statements, if made by the patient to the nurse, indicates that further teaching is needed?

    1. "I should weigh myself daily."
    2. "I should drink fluids throughout the day."
    3. "I can use a measuring cup to find out how much I drink during the day."
    4. "I should let my doctor know if I get dizzy when I change positions."

    Strategy: Determine how each answer choice relates to dehydration. Be careful, this is a negative question.

    (1) correct—would only indicate overhydration, not response to dehydration
    (2) will help prevent recurrence of dehydration, should force fluids to 3,000 cc/day
    (3) would give good indication of total intake
    (4) would indicate postural hypotension resulting from volume deficit

90. A client has been diagnosed with metastatic cancer with a poor prognosis. Recently, the client has complained of increased pain and is less communicative, very irritable, and anorexic. Which of the following nursing goals should be a priority at this time?

    1. Encourage client to talk about the possibility of dying.
    2. Provide pain assessment and effective pain management.
    3. Manage nutrition and hydration.
    4. Verify that the physician has discussed the prognosis with the family.

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

    (1) will be difficult if client's pain is not adequately controlled
    (2) correct—comprehensive and regular pain assessment/management is necessary to facilitate client's ability to maintain comfort, which may enable him to verbalize his feelings
    (3) important, but will be difficult if client's pain is not adequately controlled
    (4) not highest priority

91. An adult client with a nasogastric tube has an order for acetaminophen (Tylenol) 650 mg PRN for a temperature greater than 101°F (38.3°C). Which of the following measures should be included by the nurse when administering this medication?

    1. The tablets should be swallowed carefully with sips of water.
    2. The medication should be withheld until the nasogastric tube is removed.
    3. Placement of the nasogastric tube should be checked prior to giving the medication.
    4. Powdered medication should be used and mixed with water to form a solution.

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

    (1) client is NPO, so nothing should be administered orally
    (2) medication should not be withheld
    (3) correct—liquid acetaminophen may be administered via the nasogastric tube after tube placement has been checked; tube placement should be checked before anything is instilled
    (4) Tylenol does not come powdered

92. The nurse is assessing an infant who had a repair of a cleft lip and palate. The respiratory assessment reveals that the infant has upper airway congestion and slightly labored respirations. Which of the following nursing actions would be MOST appropriate?

    1. Elevate the head of the bed.
    2. Suction the infant's mouth and nose.
    3. Position the infant on one side.
    4. Administer oxygen until breathing is easier.

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

    (1) will not promote adequate drainage from the upper airways
    (2) contraindicated based on the infant's operative site
    (3) correct, will facilitate drainage of mucus from upper airway, and will promote adjustment to breathing through the nose
    (4) does not relieve the congestion

93. The nurse is caring for a 67-year-old man following a cardiac catheterization. Two hours after the procedure, the nurse checks the patient's insertion site in the antecubital space, and the patient complains that his hand is numb. The nurse should

    1. change the position of his hand.
    2. check his grip strength in both hands.
    3. notify the physician.
    4. instruct the patient to exercise his fingers.

    Strategy: Answers are a mix of assessments and implementations. Does the assessment answer validate what is going on? No. Determine the outcome of each answer choice.

    (1) assumes that numbness is related to positioning of hand, not circulatory changes
    (2) part of assessment, but doesn't indicate status of circulation
    (3) correct—absent or weak pulse or numbness could indicate problem with circulation, anticoagulants and vasodilators may be ordered
    (4) assumes that numbness is related to immobility of fingers, not circulatory changes

94. A client who is a gravida 2, para 1 has been admitted for induction of labor with oxytocin (Pitocin). It would be MOST important for the nurse to take which of the following actions?

    1. Mix Pitocin in D_5W, begin at 5 mg/cc as primary IV to gravity flow.
    2. Decrease the rate/flow of Pitocin if the fetal heart rate is below 150.
    3. Piggyback the Pitocin into the mainline IV and maintain the flow by gravity.
    4. Start an IV line and piggyback the Pitocin with an infusion pump.

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

    (1) Pitocin should be a secondary infusion
    (2) normal range for fetal heart tones is 120 to 160 beats per minute
    (3) rate should be maintained by an infusion pump
    (4) correct—Pitocin should always be a secondary infusion controlled by an IV pump

95. A client is admitted with renal calculi and is experiencing severe pain. Meperidine (Demerol) 75 mg IM is given prior to the change of shift. Which of the following symptoms is MOST important for the nurse to report to the next shift?

    1. Nausea with a small amount of vomitus.
    2. Pain of five on a scale of one to ten.
    3. Change in the location and character of pain.
    4. No known drug allergies.

    Strategy: Determine how each answer choice relates to renal calculi.

    (1) often accompanies pain, but is not most important to report to next shift
    (2) important, but not the highest priority
    (3) correct—location of the pain depends on location of renal stone; character of pain changes depending on location or movement of stone
    (4) important, but not the highest priority

96. The nurse is planning discharge for a group of clients. It is MOST important to refer which of the following clients for home care?

    1. A postoperative appendectomy client who is complaining of incisional pain.
    2. A diabetic client who had a cardiac catheterization in the early AM.
    3. A postoperative cholecystectomy client who is complaining of incisional pain.
    4. A client with congestive heart failure who underwent diuresis in the hospital.

    Strategy: Determine the least stable client. Remember the ABCs.

    (1) expected outcome, treat with analgesics
    (2) instruct no bending, straining, or lifting heavy objects for 24 hours, observe for bleeding, swelling, new bruising at puncture site
    (3) expected outcome, treat with analgesics
    (4) correct—assess for decreased circulating volume, hypotension, tachycardia, monitor for signs and symptoms of hypokalemia

97. The nurse is planning care for a 56-year-old woman hospitalized with bipolar disorder. While the patient is in the manic phase, nursing interventions should involve

    1. talking to the patient and reinforcing behaviors.
    2. distracting the patient and redirecting behaviors.
    3. limit-setting and isolating the patient.
    4. orienting to and reminding the patient of the rules of the hospital.

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

    (1) will not be effective in changing behaviors, requires an attentive listener
    (2) correct—patient experiences hyperactivity, poor concentration, and distractibility, redirect into activity that promotes rest, nourishment, reduce stimuli
    (3) isolation not required, would increase anxiety and hostility
    (4) disorientation usually not seen, no memory disturbance

98. The nurse is supervising the staff caring for clients on the medical/surgical unit. The nurse observes the student nurse enter wearing a gown, gloves, and a mask. The nurse determines that the precautions are correct if the student nurse is caring for which of the following clients?

    1. An infant diagnosed with respiratory syncytial virus.
    2. A young child with a wound infected with *S aureus*.
    3. A teenager diagnosed with toxic shock syndrome.
    4. A teenager diagnosed with rubella (German measles).

    Strategy: Determine the precautions required for each disease.

    (1) requires contact precautions, no mask
    (2) requires contact precautions, no mask
    (3) standard precautions
    (4) correct—droplet precautions used for organisms that can be transmitted by face-to-face contact, door may remain open

99. The physician orders metronidazole (Flagyl) 250 mg PO tid for 7 days for a 35-year-old woman. The nurse teaches the woman about the medication. Which of the following statements, if made by the woman, would indicate that teaching has been effective?

    1. “I should take this medication between meals to increase absorption.”
    2. “I shouldn't drink alcohol while I am taking this medication.”
    3. “If I experience a metallic taste in my mouth while taking this mediation, I should notify the physician.”
    4. “I should avoid strong sunlight while I am taking this medication.”

    Strategy: “Teaching has been effective” indicates a correct statement.

    (1) given with meals to decrease GI upset
    (2) correct—causes Antabuse-like reaction of nausea and vomiting, headache, cramps, flushing
    (3) frequently seen, not a problem
    (4) sensitivity to sun not seen with this medication

100. The nurse is supervising a student nurse obtain an infant's vital signs. Which of the following actions should the student nurse complete FIRST?

1. Take an axillary temperature to minimize use of invasive procedures.
2. Count respirations for 15 seconds and multiply the number by 4.
3. Count respirations for a minute prior to arousing the infant.
4. Use a stethoscope with a one-and-a-half-inch diaphragm to count the apical pulse.

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

(1) inappropriate to use probe to take axillary temperature
(2) should count for a full minute
(3) correct—respirations should be counted for one full minute prior to arousing the infant with a temperature probe or stethoscope
(4) after infant is stimulated, crying may interfere with accurate evaluation of respirations

101. The nurse is aware that which of the following statements, if made by the parents of a four-year-old child with sickle cell anemia, indicates a need for further teaching?

1. "When my daughter complains of pain, I give her baby aspirin."
2. "I try to keep my daughter away from people with infections."
3. "I sometimes have to give my daughter some of her Demerol for pain."
4. "I encourage my daughter to drink a lot of water."

Strategy: "Need for further teaching" indicates you are looking for an incorrect behavior.

(1) correct—aspirin can cause a hemorrhage during a sickle cell crisis
(2) important for a sickle cell client to prevent sickling crisis
(3) reflects appropriate use of medication to decrease the client's pain
(4) important for a sickle cell client to prevent sickling crisis

102. An 8-year-old boy falls off the swings at school and hits his head. He is examined by a physician at an urgent care center, diagnosed with a minor head injury, and sent home. Which of the following statements, if made by the mother to the nurse, would require further teaching by the nurse?

1. "He should avoid blowing his nose or cleaning his ears for two days."
2. "I should wake him every 3 hours tonight and tomorrow night to check him."
3. "I can give him Tylenol every 4 hours if he complains of a headache."
4. "He will be well enough to play in his soccer game tomorrow."

Strategy: "Further teaching" indicates an incorrect response.

(1) prevents increased pressure on area
(2) should check level of consciousness and orientation every 3–4 hours
(3) avoid use of sedatives, sleeping pills, alcohol with head injuries
(4) correct—no strenuous activity for 48 hours

103. A 56-year-old woman is receiving digoxin (Lanoxin) 0.25 mg PO qd and furosemide (Lasix) 40 mg PO bid. She calls her physician for complaints of mild diarrhea. The physician prescribes Kaopectate 60 mg after each bowel movement for 2 days and instructs her to call back if symptoms don't subside. The woman asks the office nurse if she should make any changes in her medication schedule. The nurse should instruct the woman to

1. make no changes in her medication schedule.
2. wait 1 hour before taking her scheduled medications if she takes the Kaopectate.
3. hold her scheduled medications until the diarrhea subsides.
4. take the Lanoxin but hold the Lasix if she takes the Kaopectate.

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

(1) PO meds would be absorbed by Kaopectate not by stomach
(2) correct—Kaopectate absorbs PO meds, separate administration of other meds
(3) other meds should be given later
(4) both meds should be given later

104. A 47-year-old woman comes to the outpatient psychiatric clinic for treatment of a fear of heights. Which of the following is the best plan of care that would meet the needs of this client INITIALLY?

1. Point out to the client the secondary gain that results from her behavior.
2. Demonstrate to the client the irrational nature of these fears.
3. Encourage the client to rely on significant others for support.
4. Allow the client to avoid the situations that are anxiety provoking.

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

(1) secondary gain (attention and assistance received) is not the motivation of a phobic patient, remain nonjudgmental
(2) ineffective in relieving behavior, may increase anxiety and feelings of guilt
(3) should encourage patient to remain independent
(4) correct—phobia is fixed channel for discharge of tension from unconscious conflict

105. Which of the following findings would indicate to the nurse that a client's Salem sump tube (nasogastric) was functioning effectively?

1. Fluctuation of the fluid level in the water seal chamber.
2. Active bubbling in the suction bottle.
3. The presence of a hissing sound from the blue lumen tube.
4. A pressure of 25 mm Hg in the esophageal balloon

Strategy: Determine how each answer choice relates to a Salem sump tube.

(1) Salem sump tube is not a water-sealed drainage system
(2) associated with a water-sealed drainage system
(3) correct—"hissing" sound is indicative that air is freely exiting the airway, purpose is to provide continuous steady suction without pulling gastric mucosa
(4) is relevant to a Sengstaken-Blakemore tube

106. A client in labor is receiving magnesium sulfate IV. Which assessment is MOST important to give during report to the nurse on the next shift?

1. Respiratory rate changed from 13/min to 15/min.
2. Increase in anxiety and hyperactivity.
3. Presence of nausea and refusal to take clear liquids.
4. Urine output decreased from 60 cc/h to 40 cc/h.

Strategy: Determine how each answer choice relates to magnesium sulfate.

(1) not a concern because the respirations are increasing
(2) not relevant to the medication
(3) not relevant to the medication
(4) correct—magnesium sulfate is a central nervous system depressant; side effect is oliguria

107. A client is seen in the clinic for complaints of back pain. The nurse discusses and demonstrates how to perform activities of daily living to decrease the incidence of back pain. Which of the following actions, if performed by the client, would indicate that teaching has been effective?

1. The client bends over to put on and tie her tennis shoes.
2. The client stands on her toes to place a box on the top shelf of a closet.
3. The client sits in a recliner with her feet elevated to watch TV.
4. The client stands with her feet close together and shifts her weight between her feet.

Strategy: "Teaching has been effective" indicates a true statement.

(1) causes stress on lumbar region of back
(2) causes stress on lower spine
(3) correct—provides lumbar flexion, decreasing pressure on lower spine
(4) should have feet apart for wide base of support

108. Which of the following actions, if performed by the nurse, would be considered negligence?

1. Obtaining a Guthrie Blood test on a four-day-old infant.
2. Massaging lotion on the abdomen of a three-year-old diagnosed with Wilm's tumor.
3. Instructing a five-year-old asthmatic to blow on a pinwheel.
4. Playing kickball with a 10-year-old with juvenile arthritis (JA).

Strategy: "Would be considered negligence" indicates an incorrect action.

(1) obtain after ingestion of protein, no later than 7 days after delivery
(2) correct—manipulation of mass may cause dissemination of cancer cells
(3) this exercise extends expiratory time and increases expiratory pressure
(4) excellent moving and stretching exercise

109. At an inpatient psychiatric unit, a 40-year-old woman insists on staying in her room and repeatedly comments to the nurse: "Special agents are here. Maybe you are one." Which of the following responses, if made by the nurse, is BEST?

1. "You can trust me. There are no agents here."
2. "You must feel afraid if you believe that, but there are no agents here."
3. "No one here will hurt you. They are here to help you."
4. "Agents? Tell me more about what you mean."

Strategy: Remember therapeutic communication.

(1) nontherapeutic, fails to respond to feeling tone, trust builds through interactions
(2) correct—patient experiencing delusion (persistent false belief), responds to feeling tone, acknowledges that patient believes it to be true, represents reality
(3) statement of reassurance, but denies acceptance of patient's feelings
(4) should not encourage patient to explain delusions, would serve to reinforce them

110. A postoperative client has returned to his room from the surgical recovery area. The client is sleeping, and the nurse notes that the client is disoriented when aroused. Which of the following actions, if taken by the nurse, is BEST?

1. Place the call bell within the client's reach.
2. Stay with the client until he is totally oriented.
3. Restrain all four extremities until the client is oriented.
4. Elevate the side rails until the client is fully awake.

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

(1) not the safety action
(2) unnecessary to stay with the client, especially while he is sleeping
(3) restraints are unnecessary at this time
(4) correct—side rails should always be elevated for any disoriented client

111. The nurse is caring for a patient with second- and third-degree burns. The client is receiving morphine sulfate 15 mg IV. The nurse notes a decrease in bowel sounds and slight abdominal distention. Which of the following actions, if taken by the nurse, is BEST?

1. Recommend that the morphine dose be decreased.
2. Withhold the pain medication.
3. Administer the medication by another route.
4. Explore alternative pain management techniques.

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

(1) could indicate a possible impending ileus, this option is not ideal
(2) inappropriate
(3) inappropriate
(4) correct—morphine is drug of choice for burn pain management; when side effect becomes apparent, exploration of alternative pain management techniques such as visualization becomes important

112. The visiting nurse evaluates the progress of a client recently diagnosed with insulin-dependent diabetes mellitus (IDDM). As part of the treatment plan, the client receives Humulin N 32 units and Humulin R 8 units each morning. Which of the following actions, if performed by the client while preparing the morning insulin injection, would require an intervention by the nurse?

1. After the client draws up 8 units of Humulin R, she adds Humulin N to the syringe for a total of 40 units.
2. The client draws up 32 units of the clear insulin followed by 8 units of cloudy insulin for a total of 40 units.
3. Initially, the client injects air into the Humulin N vial without drawing up any insulin.
4. The client injects air into each bottle of insulin equal to the amount of insulin to be withdrawn.

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

(1) clear insulin always drawn up first
(2) correct—Humulin R is clear and drawn up first, only 8 units are ordered, Humulin N is cloudy
(3) allows you to withdraw medication later
(4) allows you to withdraw medication later

113. Which of the following statements by the client BEST indicates to the nurse an emotional readiness for surgery?

1. "I know the doctor isn't telling me everything, but at this point I can't do anything about it."
2. "I've never heard of this specialist before. Does he do much work here?"
3. "I'm glad the trapeze is on my bed so I can start working on my exercises as soon as I wake up."
4. "Can you please check my record to be sure it says I'm diabetic?"

Strategy: Think about each answer choice.

(1) indicates feelings of fear and helplessness
(2) indicates fear and lack of trust
(3) correct—indicates acceptance and a readiness to participate in postoperative care
(4) indicates fear that something will be missed

114. The clinic nurse is obtaining a throat culture from a client with pharyngitis. It is MOST important for the nurse to do which of the following?

1. Quickly rub a cotton swab over both tonsillar areas and the posterior pharynx.
2. Obtain a sputum container for the client to use.
3. Irrigate with warm saline, and then swab the pharynx.
4. Hyperextend the client's head and neck for the procedure.

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

(1) correct—tonsillar and pharyngeal areas are quickly swabbed to avoid client discomfort
(2) sputum specimen would not reflect throat bacteria
(3) should not be done to obtain an adequate culture
(4) client should hold the head upright, not hyperextended

115. A mother brings her 7-year-old daughter to the outpatient clinic for a routine check-up. The girl weighs 50.25 lb (22.85 kg) and is 48 inches (121.7 cm) tall. The nurse notes that she has gained 2.5 pounds and has grown 3 inches in the past year. Which of the following responses by the nurse is BEST?

    1. "Your daughter's height and weight are within normal limits."
    2. "Your daughter's height is normal, but she needs to gain some weight."
    3. 'Your daughter's height is normal, but she needs to lose some weight."
    4. "Your daughter's weight is normal, but she is shorter than normal."

    Strategy: "BEST" indicates that you will have to discriminate between answers. The topic of the question is unstated. Read answer choice to obtain clues.

    (1) correct—between ages 6–12 grows about 2 in (5 cm)/year and gains 4.5–6.5 lb (2–3 kg)/year, at age 7 average 39–66.5 lb (17.7–30 kg) and 44–51 in (111.8–129.7 cm)
    (2) weight is within normal limits
    (3) weight is within normal limits
    (4) height is within normal limits

116. During the first 24 hours after total parenteral nutrition (TPN) therapy is started, the nurse should

    1. monitor vital signs every two hours.
    2. determine urinalysis results.
    3. evaluate blood glucose levels.
    4. compare weight with the previous readings.

    Strategy: Determine how each assessment relates to TPN.

    (1) inappropriate
    (2) inappropriate
    (3) correct—total parenteral nutrition (TPN), or hyperalimentation, has a high glucose content; important to monitor glucose levels
    (4) appropriate, but not a priority

117. The nurse is caring for an 85-year-old woman recovering from a fractured pelvis in a long-term care facility. The woman's activity order reads: ambulate with walker bid. After the nurse implements the order, which of the following charting entries is BEST?

    1. "Patient ambulated well with walker. States has no c/o stiffness or pain. Did not appear fatigued."
    2. "Ambulated without difficulty for 20 minutes. Vital signs remained stable. Color good."
    3. "Walked full length of hall with walker. No difficulty with balance. Using walker correctly."
    4. "Patient ambulated 60 feet independently with walker. Gait steady. Respirations 14 and unlabored."

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

    (1) gives subjective information
    (2) gives judgments without objective information
    (3) information is not complete, contains some judgments without objective information
    (4) correct—gives objective information

118. A client has been brought into the emergency room for treatment of a suspected drug overdose. The client appears to be highly agitated, fearful, and may be hallucinating. The nurse should anticipate the client's need for

1. immediate support from family and friends who accompanied her.
2. a warm, friendly approach to reduce fears.
3. a quiet, darkened room to decrease sensory stimulation.
4. an immediate referral to a social service agency.

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

(1) inappropriate at this time because the client is not in contact with reality
(2) may agitate the client further
(3) correct—sensory stimulation would only increase agitation and could potentially lead to aggressive behavior and injury
(4) not the priority at this time

119. The nurse receives a phone call from a nursing assistant who states that her five-year-old child has developed chickenpox. It would be MOST important for the nurse to ask which of the following questions?

1. "Have your other children had chickenpox?"
2. "Does your child have a temperature?"
3. "Have you had the chickenpox?"
4. "Do you have someone to watch your child?"

Strategy: "MOST important" indicates there may be more than one answer that you would like to select. Remember, you can only ask one question.

(1) chickenpox spread by direct contact, airborne route; not the most important question
(2) fever, malaise, and anorexia occur during first 24 hours; treat with Tylenol
(3) correct—need to ascertain if staff has had the disease; if not, VZIG can be given; exclude from patient care from the 10th day after first exposure through the 21st day (28th day if VZIG given) after last exposure
(4) important information, but assessing staff is most important

120. Butorphanol tartrate (Stadol) 1 mg IM is ordered for a 35-year-old woman one-day postpartum. Which of the following actions is MOST important for the nurse to take after administering the medication?

1. Observe the woman for sedation.
2. Monitor the vital signs.
3. Assess for visual disturbances.
4. Evaluate fluid status.

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

(1) causes sedation, but not most important
(2) correct—decreases rate and depth of respirations
(3) diplopia and blurred vision are side effects, but not most important
(4) not side effect of medication

121. The nurse knows that which of the following plans would be a priority for an infant with a positive PKU blood test?

1. Place the infant on Lofenlac formula.
2. Administer medium-chain triglyceride (MCT) oil with each feeding.
3. Provide genetic counseling for the family.
4. Place the infant on Lorenzo's Oil treatments.

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

(1) correct—Guthrie blood test evaluates neonate for phenylketonuria (PKU); Lofenalac formula is low in phenylalanine, but contains minerals and vitamins to provide a balanced nutritional formula
(2) could be a plan for a child with cystic fibrosis
(3) important, but is not as high a priority as answer choice #1
(4) would be a plan of care for a child with adrenoleukodystrophy (ALD)

122. The nurse is conducting preoperative teaching with the family of a 62-year-old man who is scheduled for a total laryngectomy. Which of the following statements, if made by the family, would indicate to the nurse a need for further teaching?

1. "We will need to learn other ways to communicate with each other."
2. "My father will require a special kind of tube in his neck for his airway."
3. "My husband will require a feeding tube for several months."
4. "My dad may develop some difficulty with taste and smell after the surgery."

Strategy: "Further teaching is necessary" indicates an incorrect response.

(1) will communicate in writing initially, then artificial larynx or esophageal speech
(2) will require laryngectomy tube to prevent scar tissue contracture
(3) correct—requires nutritional support for 10 days until wound heals, then gradually resumes oral intake
(4) common with total laryngectomy

123. A client is admitted to the emergency room in severe emotional distress. The client's respirations are 42/min, and the blood gases reveal a pH of 7.5 and a $PaCO_2$ of 34. Initially the nurse should

1. instruct the client to breathe into a paper bag.
2. start an IV of D_5W.
3. administer O_2.
4. have the client place his head between his knees.

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

(1) correct—because of hyperventilation, client is in alkalosis; having him rebreathe his own carbon dioxide will reverse his blood gas imbalance
(2) does not address the problem
(3) is not hypoxic
(4) is done when a client feels faint

124. Twenty-four hours after abdominal surgery, which of the following plans would be a nursing priority to prevent complications of flatulence?

1. Encourage the client to drink carbonated beverages daily.
2. Instruct the client to turn from side to side.
3. Encourage the client to do leg exercises in bed.
4. Assist the client to walk in the hall every 2 hours.

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

(1) increasing carbonated beverages will increase flatus
(2) will prevent postoperative complications, but not flatulence
(3) does not address flatulence
(4) correct—will increase peristalsis, decreasing the development of flatus

125. A man is seen in the outpatient clinic for treatment of hypertension. The client expresses concern to the nurse that his wife has been unemployed for more than six months. He is afraid that soon they will be unable to pay their rent. Which of these responses by the nurse would be BEST?

1. "These things always have a way of working themselves out."
2. "It's important for your health that you not worry too much."
3. "You're worried that you won't be able to pay the rent?"
4. "A social worker might be able to help you with this problem."

Strategy: "BEST" indicates there may be more than one response you will like. Remember therapeutic communication.

(1) minimizes client's concerns
(2) minimizes client's concerns and places pressure on client to avoid feelings
(3) correct—reflective response, would encourage discussion of feelings and concerns
(4) passing the buck, nontherapeutic

126. While obtaining a nursing history from a teenaged client, the client states that she drinks "lots" of fluids and still feels thirsty. It is MOST important for the nurse to ask which of the following questions?

1. "Has your weight recently changed?"
2. "What medications do you take?"
3. "Do you have any allergies to food or medication?"
4. "How often do you menstruate?"

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

(1) correct—excessive thirst and weight loss are two notable symptoms of diabetes mellitus (IDDM)
(2) does not provide useful information related to the assessment information
(3) does not provide useful information related to the assessment information
(4) does not provide useful information related to the assessment information

127. The nurse cares for a 19-year-old woman after delivery of a 7 lb 10 oz baby boy. The patient has decided to bottle-feed her infant. The nurse should encourage the patient to

1. use the manual breast pump to relieve breast engorgement.
2. apply warm packs to the breast to relieve discomfort.
3. massage the breasts to reduce engorgement and discomfort.
4. wear a well supportive bra and take Tylenol for discomfort.

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

(1) will encourage milk secretion
(2) will enhance flow of milk
(3) may be taut due to engorgement, massage would be painful and unnecessary, will encourage milk flow
(4) correct—will help minimize discomfort during period of engorgement

128. A 52-year-old woman complains of chronic constipation. The nurse in the health care clinic should advise the woman to

1. reduce her intake of highly seasoned foods and fats.
2. drink 1,000 cc of fluids daily.
3. increase her intake of cereals, fresh fruits, and vegetables.
4. ask her physician to prescribe Dulcolax 5 mg enteric-coated tablets daily.

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

(1) unnecessary, no effect on constipation
(2) normal intake 1,500–2,000, reduced intake causes constipation
(3) correct—bulk-forming foods help with constipation
(4) passing the buck, laxatives are a last resort

129. The nurse is caring for clients in the postanesthesia care unit (PACU). Which of the following clients require IMMEDIATE attention by the nurse?

1. A client with a new tracheotomy with a small amount of serosanguineous drainage on the dressing.
2. A client who is responsive with a moderate amount of clear fluid draining from the NG tube.
3. A client with a chest tube and dark red drainage in the collection chamber.
4. A client who is unresponsive to verbal stimuli with the oral airway out of place.

Strategy: Remember the ABCs.

(1) expected outcome, patient is stable
(2) no indication of complications, stable client
(3) expected outcome, gently “milk” tubing in the direction of the drainage, if needed
(4) correct—reinsert airway to maintain patent airway

130. 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 3,000/mm^3, Hgb 9.3 g/dL, platelets 50,000/mm^3. The nurse would expect the patient to exhibit which of the following symptoms?

1. BP 120/70, pulse 100, respirations 16.
2. Ankle edema and ascites.
3. Flushed face and light stools.
4. Nausea, anorexia, and vomiting.

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

(1) correct—increased pulse and respirations are caused by decreased oxygenation of tissues
(2) no information to suggest this is provided in the question
(3) will be pale due to anemia, normal RBC male 4.3–5.9 million/mm^3, female 3.5–5.5 million/mm^3, decreased with anemia; 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
(4) not related to information provided in the question

131. A physician has written an order for an HIV-positive infant to receive an oral polio immunization. Which of the following nursing actions is MOST appropriate?

1. Wear gloves and a gown when administering the immunization.
2. Administer the immunization as the infant is being discharged.
3. Call the physician and discuss the rationale for the immunization.
4. Administer the medication in the same manner as you would to any other infant.

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

(1) does not address the identified problem of the compromised immune system
(2) does not address the identified problem of the compromised immune system
(3) correct—polio vaccine contains live virus and should not be given to children who are immunocompromised
(4) does not address the identified problem of the compromised immune system

132. The nurse is caring for a client receiving amphotericin B (Fungizone) 1 mg in 250 cc of 5% dextrose in water IV over a 2-hour period. The nurse should be MOST concerned if which of the following was observed?

1. BUN 7.2 mg/dL, creatinine 0.5 mg/dL.
2. BP 90/60, complaints of fever and chills.
3. Complaints of burning on urination, thirst, and dizziness.
4. AST (SGOT) 12 U/L, ALT (SGPT) 14 U/L, total bilirubin 0.2 mg/dL.

Strategy: "MOST concerned" indicates an untoward effect of the medication.

(1) normal results, causes renal toxicity, BUN and creatine would be elevated, normal BUN 7–18 mg/dL, normal creatine 0.6–1.2 mg/dL
(2) correct—monitor vital signs every 30 min
(3) not side effect of medication
(4) normal AST (formerly SGOT) 8–20 U/L, normal ALT (formerly SGPT) 8–20 U/L, normal bilirubin 0.1–1.0 mg/dL, may cause elevation, check liver function studies weekly, notify physician if elevated

133. A staff member informs the nurse that his six-year-old child has head lice. It is MOST important for the nurse to take which of the following actions?

1. Inspect the staff member's head for louse and nits.
2. Inform the staff member that he cannot care for clients until further notice.
3. Request that the staff member to contact his physician.
4. Instruct the staff member about how to use Kwell.

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

(1) correct—observe for movement (louse) or small whitish oval specks that adhere to the hair shaft (nits); treat with gamma-benzene hexachloride (Kwell)
(2) confirm the presence of lice before excluding from duty; if lice present, exclude from patient care until appropriate treatment has been received and shown to be effective
(3) should assess first
(4) should assess first, apply shampoo to dry hair and work into lather for 4–5 minutes

134. A 50-year old man who attends an outpatient clinic is taking chlorpromazine hydrochloride (Thorazine) 100 mg tid. He reports to the nurse that he is sleeping through the day. What should the nurse do?

1. Contact the physician to change the dose to 100 mg bid.
2. Change the time of the medication to 100 mg in the morning, 100 mg after dinner, and 100 mg at hs.
3. Instruct the man to take frequent naps during the day.
4. Encourage the man to be more active during the day.

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

(1) 300–400 mg/day is needed to treat psychosis
(2) correct—will reduce daytime sedation
(3) won't decrease sedation from medication
(4) won't decrease sedation from medication

135. Which of the following is a priority nursing goal in the plan of care for a client with paralysis from a cerebrovascular accident (CVA)?

1. Maintain adduction of the affected shoulder.
2. Prevent flexion of the affected extremities.
3. Observe active range of motion (ROM) daily to all extremities.
4. Maintain external rotation of the affected hip.

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

(1) to prevent deformities, the nurse needs to prevent adduction of the affected shoulder
(2) correct—flexor muscles are stronger than extensor muscles
(3) client will be unable to perform active ROM, will need assistance from nurse
(4) to prevent deformities, the nurse needs to prevent external rotation of the hip joint, prevent foot drop (plantar flexion), and place the hand in slight supination so that the fingers are barely flexed

136. The physician orders an arterial blood gas (ABG) for a client receiving oxygen at 6 L/min. What information concerning the patient is MOST important for the nurse to document on the lab slip that accompanies the blood sample?

1. The patient's position in bed and the respiratory rate.
2. The site used to obtain the blood specimen.
3. The use of supplemental oxygen.
4. The patient's diagnosis and blood type.

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

(1) unnecessary to document positioning
(2) unnecessary to document site used
(3) correct—necessary for accurate test results
(4) unnecessary to document blood type, should document diagnosis

137. Which of the following statements, if made by the parents of a nine-year-old client with an ostomy, would indicate to the nurse that they are providing quality home care?

1. "We change the bag at least once a week, and we carefully inspect the stoma at that time."
2. "We change the bag every day so that we can inspect the stoma and the skin."
3. "We encourage our daughter to watch TV while we change her ostomy bag."
4. "We only have to change the ostomy bag every ten days."

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

(1) correct—ostomy bags should be changed at least once a week; good time for stoma to be closely inspected
(2) bag should be changed at least once a week or when seal around stoma is loose or leaking
(3) does not encourage client participation or foster independence
(4) bag should be changed more often

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

1. Depressed gag reflex.
2. Sputum streaked with blood.
3. Tachypnea.
4. Complaints of a sore throat.

Strategy: "MOST concerned" indicates a complication.

(1) would cause a complication if client is given fluids before the gag reflex has returned
(2) common for a few days after a biopsy
(3) correct—client should be assessed for symptoms of respiratory distress from swelling due to the procedure; signs of respiratory distress include tachypnea, tachycardia, respiratory stridor, and retractions
(4) expected after this procedure

139. The nurse should look for which of the following in assessing pain in an eight-month-old infant?

1. Decreased pulse rate.
2. Increased fluid intake.
3. Decreased respiratory rate.
4. Rubbing a body part and crying.

Strategy: Think about each assessment.

(1) pulse rate would increase
(2) nonspecific regarding pain
(3) does not reflect pain
(4) correct—since an infant cannot talk, nurse needs to be aware of nonverbal signs of pain, such as rubbing the ear because of an earache

140. A client is placed on cephalexin monohydrate (Keflex) prophylactically after surgery. Which of the following foods should the nurse encourage?

1. Bran cereals and fruits.
2. Egg whites and lean meats.
3. Yogurt and acidophilus milk.
4. Fish and poultry meats.

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

(1) unnecessary to encourage
(2) unnecessary to encourage
(3) correct—these foods will help maintain normal intestinal flora, which may be altered by the Keflex
(4) unnecessary to encourage

141. The homecare nurse is scheduling clients for the day. Which of the following clients should the nurse visit FIRST?

1. A primigravida client, 10-days postpartum, who is anxious about caring for her newborn.
2. A middle-aged client, 6-days postoperative, who is complaining of pain in his midsternal incision.
3. A client with AIDS who had a chest tube removed yesterday and is complaining of crackling under his skin.
4. A client who receives amiloride hydrochloride (Midamor) and states that she is dizzy when she gets up in the morning.

Strategy: Identify the least stable client by eliminating the more stable clients.

(1) psychosocial need, physical issues take priority
(2) complaints require follow-up, but not the most unstable client
(3) correct—describes subcutaneous emphysema, which is indication of pneumothorax; observe client for respiratory distress, contact physician
(4) postural hypotension a side effect of diuretic therapy, change position slowly

142. The nurse enters the room of a 12-year-old girl and finds that the tracheostomy tube inserted 2 days ago has been accidentally dislodged. The nurse should

1. immediately replace the tracheostomy tube.
2. suction the patient's airway using sterile technique.
3. provide oxygen at 8 liters per minute per mask over the stoma.
4. check for bilateral breath sounds immediately.

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

(1) correct—implementation, will secure the airway
(2) implementation, will not provide for open airway
(3) implementation, will not help with open airway
(4) assessment, should be done after tracheostomy tube is replaced

143. While performing a physical examination on a newborn, which of the following nursing assessments should be reported to the doctor?

1. Head circumference of 40 cm.
2. Chest circumference of 32 cm.
3. Acrocyanosis and edema of the scalp.
4. Heart rate 160 and respirations 40.

Strategy: Determine if the assessment is abnormal.

(1) correct—average circumference of the head for a neonate ranges from 32 to 36 cm; increase in size may indicate hydrocephaly or increased intracranial pressure
(2) normal newborn assessment
(3) normal newborn assessment
(4) normal newborn assessment

144. A client is scheduled for a cholangiogram. Meglumine diatrizoate (Gastrografin) is ordered for the client. The nurse should

1. identify the client before administering the medication.
2. administer the medication two hours before the procedure.
3. administer an enema after administering the medication.
4. instruct the client to take medication slowly with water.

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

(1) correct—appropriate identification of client is the first nursing priority after the order is verified (five "rights" of medication administration)
(2) unnecessary
(3) unnecessary
(4) unnecessary

145. Which of the following actions, if performed by the nurse, would be considered negligence?

1. The nurse performs range-of-motion (ROM) exercises for a client with second- and third-degree burns of the chest.
2. The nurse sits with a client who suffers from depression while he eats his lunch.
3. The nurse caring for a client with myasthenia gravis administers the 7 AM dose of neostigmine bromide (Prostigmin) PO at 7:45 AM.
4. The nurse instructs a 15-year-old girl who is sexually active about different types of contraceptives without consulting her parents.

Strategy: "Negligence" indicates an incorrect action.

(1) minimizes muscle atrophy
(2) promotes eating, offer more frequent feedings of favorite foods
(3) correct—delay in medication may cause difficulty in swallowing, might have difficulty taking medication
(4) minor can request birth control without the parent's consent

146. The nurse is caring for a 75-year-old man following a right total hip replacement. The nurse's notes indicate that since the surgery the patient has become disoriented and confused at night. One evening as the nurse prepares the patient for sleep, the patient glances to his left and says, "Oh, you think so?" and starts to laugh. Which of the following responses by the nurse is the BEST?

1. "Do you hear voices talking to you?"
2. "Tell me why you are laughing so I can laugh too."
3. "What is it that you find amusing?"
4. "I notice you're laughing."

Strategy: Remember therapeutic communication.

(1) yes/no question, may make client defensive and block communication
(2) feeds into client's altered-reality state, nurse should suspect a hallucination
(3) confrontation would block communication
(4) correct—therapeutic statement of client's nonverbal communication

147. A client is scheduled for a cardiac catheterization at 8 AM. The client's laboratory work was completed five days ago. The results were: K^+ 3.0 mEq/L, Na^+ 148 mEq/L, glucose 178 mg/dL. He complains of muscle weakness and cramps. Which of the following nursing actions is BEST?

1. Administer the 7 AM dose of spironolactone (Aldactone).
2. Encourage eating bananas for breakfast.
3. Obtain stat K^+ level.
4. Call for twelve-lead EKG.

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

(1) Aldactone is potassium-sparing diuretic and is an oral medication, patient is NPO for procedure
(2) is not feasible prior to the cardiac cath because the client is NPO
(3) correct—signs and symptoms are indicative of hypokalemia; stat serum K^+ level is needed to confirm the K^+ level prior to going for cardiac catheterization
(4) is unnecessary at this time

148. A client has a chest tube inserted for treatment of a hemothorax. Which of the following findings would indicate to the nurse that there is a problem with the effective functioning of the chest tube?

1. 15-cm of water is present in the suction control chamber.
2. Constant bubbling is observed in the water seal chamber.
3. 2-cm of water is present in the water seal chamber.
4. Clots of blood are observed in the collection chamber.

Strategy: Think about each answer choice.

(1) appropriate, regulates the amount of suction delivered to the patient
(2) correct—would indicate an air leak, would not allow negative pressure to be reestablished and would hinder complete resolution of the pneumothorax
(3) appropriate, provides for a water seal
(4) would be an expected finding

149. A nursing assessment of a disoriented male client reveals that the client has a self-care deficit (feeding). Which of the following would indicate to the nurse that the client has made a positive response to the plan of care?

1. Client explains the relationship between weight loss and change in mental status.
2. Client identifies the basic four food groups.
3. Client states he needs to drink more water.
4. Client feeds self when the nurse stays with him and cues him.

Strategy: Determine the outcome of each answer choice.

(1) would not be realistic in a client who is disoriented
(2) would not be realistic in a client who is disoriented
(3) would not be realistic in a client who is disoriented
(4) correct—disoriented client who is not able to be an independent self-care agent will need cuing from the nurse to accomplish self-feeding

150. The nurse teaches a client with newly diagnosed diabetes mellitus proper foot care. Which of the following statements, if made by the client to the nurse, would indicate that further teaching is necessary?

1. "I should cut my toenails straight across."
2. "I should not go barefoot."
3. "I should inspect my feet once a week."
4. "I should bathe my feet daily in warm water."

Strategy: "Further teaching" indicates an incorrect response.

(1) prevents ingrown nails
(2) prevents possible injury to feet
(3) correct—should inspect feet daily for blisters, sores, ingrown nails, and cuts
(4) proper care

151. A client is admitted to the unit with pregnancy-induced hypertension (PIH). Which of the following actions is the priority nursing action?

1. Start an IV.
2. Obtain the vital signs.
3. Administer magnesium sulfate.
4. Notify the lab to draw blood.

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

(1) implementation, not a priority action
(2) correct—assessment, important to do a baseline assessment in order to successfully evaluate the treatment
(3) implementation, not a priority action
(4) implementation, not a priority action

152. An elderly client is oriented during the day but becomes disoriented during the evening. Which of the following nursing actions is MOST appropriate?

1. Place a clock where the client can see it.
2. Restrain all four extremities.
3. Keep a light on in the client's room.
4. Place the side rails in an upright position.

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

(1) will provide visual cues, safety is more important
(2) inappropriate
(3) may be appropriate, but is not priority over answer choice #4
(4) correct—side rails should always be in an upright position for a disoriented client

153. The nurse is caring for clients in the diabetic clinic. Which of the following clients should the nurse see FIRST?

1. A client with sunken eyeballs and a fruity breath odor.
2. A client who complains of pain in his calves when he exercises.
3. A client who states that she drinking liquids frequently and is always hungry.
4. A client says that she is having difficulty sleeping and cries frequently.

Strategy: Determine the least stable client.

(1) correct—indicates diabetic ketoacidosis; treat with normal saline and regular insulin
(2) suggestive of intermittent claudication, not an emergency situation
(3) suggestive of hyperglycemia, should assess blood sugar
(4) psychosocial issues, physical takes priority

154. A client is admitted with the following symptoms: dependent pitting edema, abdominal distention, and a recent 10-lb weight gain. The client has received 80 mg of furosemide (Lasix). Which of the following nursing observations is MOST important to report to the next shift?

1. Complaints of nausea and vomiting.
2. Urine output of 200 cc in 2 hours.
3. Quiet and withdrawn behavior after lunch.
4. Blood pressure changes from 160/90 to 150/90.

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

(1) further signs and symptoms of right-sided heart failure; not a priority
(2) correct—furosemide is diuretic, which warrants close observation of the client's urine output
(3) further signs and symptoms of right-sided heart failure; not a priority
(4) may occur as a result of volume loss, but is not a priority over answer choice #2

155. A three-year-old boy was shown to have delays on the Denver Development Screening Test (DDST). The mother asks the nurse, "Does this mean my child is going to be slow?" Which of the following responses by the nurse is BEST?

1. "Maybe he is just having a bad day. I'm sure he will do much better next time."
2. "The test indicated a delay and we will have to investigate to learn more."
3. "What are your thoughts about how your child performed on the test?"
4. "The results may not be accurate. Let's set up a time to retest your child."

Strategy: "BEST" indicates that fine discrimination is required. The topic of the questions is unstated. Determine topic by reading the answer choices.

(1) nontherapeutic, false reassurance
(2) factual but closed communication
(3) correct—open-ended, encourages discussion
(4) doesn't encourage discussion of concerns

156. At 11 AM a patient returned to the nursing unit from the postanesthesia care unit (PACU) following a hemorrhoidectomy. At noon the patient complains of pain. The physician has ordered meperidine (Demerol) 50 mg IV q 3–4 hrs. The chart indicates that the patient was given Demerol 50 mg IV at 9:15 AM. The nurse should

1. ask the physician if the dosage of Demerol can be increased.
2. give the patient Demerol 25 mg IV now.
3. have the patient wait until 1 PM before giving the Demerol.
4. give the patient Demerol 50 mg IV now.

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

(1) no reason to call the physician
(2) can't change amount of medication ordered by physician
(3) medication is ordered every 3 to 4 hours, should not wait if patient needs medication after 3 hours
(4) correct—give patient the medication as ordered

157. The clinic nurse is giving instructions to the family of a school-aged child who was diagnosed two weeks ago with hepatitis A. The family asks if the child can return to school. Which of the following responses by the nurse is BEST?

1. "You must isolate your child at home for two more weeks."
2. "Why don't you speak with the physician about this matter?"
3. "Your child may return to school this week."
4. "Your child may return to school in 2 weeks but cannot participate in sports."

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

(1) communicable for 2–3 weeks before onset of jaundice and about 1 week after onset of jaundice
(2) passing the buck
(3) correct—type A hepatitis is not infectious within a week or so after the onset of jaundice, child can return to school
(4) can return to school, activity at that time depends on the child's energy level

158. Which finding would indicate to the nurse that a client experiencing alcohol withdrawal is in need of more sedation to control the severity of withdrawal symptoms?

1. Increasing lethargy.
2. Uncoordinated motor movements.
3. Elevated pulse rate.
4. Improved orientation to time and place.

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

(1) would indicate a need for less sedation and a thorough physical assessment
(2) suggests neurological trauma or damage
(3) correct—pulse rate is a good indicator of client's progress through withdrawal, increasingly elevated pulse signals impending alcohol withdrawal delirium, requiring more sedation
(4) suggests that the client is improving and will subsequently require less sedation

159. An adult male developed diabetes insipidus following a craniotomy. The nurse is providing discharge instructions for the client and his wife. Which of the following statements, if made by the client, would indicate that further teaching is needed?

1. "I should keep a daily record of my fluid intake and how much I go to the bathroom."
2. "I should call my doctor if I seem thirsty a lot and my urine specific gravity is less than 1.005."
3. "I should weigh myself every day and drink less fluid if I gain more than 5 lb over a week."
4. "I will need to take the nose spray medication for the rest of my life."

Strategy: "Further teaching" indicates an incorrect response.

(1) disorder or water metabolism caused by deficiency of ADH (antidiuretic hormone) by pituitary gland, symptoms are increased urinary output (4–30 L/24 h), dilute urine with specific gravity less than 1.005
(2) normal specific gravity 1.003–1.030
(3) correct—weight gain should be reported to physician, may need medication adjusted
(4) desmopressin (DDAVP) nasally or SQ required for remainder of life

160. During the physical assessment, the nurse determines the need to perform the bulge test. Which of the following statements, if made by the nurse, is BEST?

1. "Please lie down and extend your legs."
2. "Please bend over and touch your toes."
3. "Please hold both hands behind your back."
4. "Please bend your elbow."

Strategy: Think about each answer choice.

(1) correct—bulge test confirms presence of fluid in the knee; client's leg should be extended and supported on the bed
(2) observing curve of spine; scoliosis will cause lateral curve in the spine
(3) unrelated to knee examination
(4) tests articulation of elbow

161. The nurse performs a routine IV tubing change on a 55-year-old woman with a central line. Fifteen minutes later, the nurse reenters the patient's room to find her cyanotic, short of breath, and complaining of pain. Her vital signs are BP 84/62, pulse 112, respirations 18. What is the FIRST action the nurse should take?

1. Call the physician to report the patient's symptoms.
2. Lower the head of the bed and place the patient on her left side.
3. Place the patient in high Fowler's position.
4. Start oxygen at 4 L/min via nasal cannula.

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

(1) second action, first should respond to potential problem of emboli
(2) correct—air will rise to right atrium, minimizes chance of air bubbles entering cerebral circulation
(3) never done with shock, trapped air could travel to pulmonary circulation
(4) not first action

162. Which of the following should be the nursing priority for an infant admitted to the pediatric unit with possible *Haemophilus influenzae* meningitis?

1. Encourage intake of oral fluids to prevent dehydration.
2. Restrain the child appropriately to maintain the integrity of the IV site.
3. Place the child on droplet precautions.
4. Encourage the parents to hold and rock the infant to promote comfort.

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

(1) fluid requirements are determined by child's hydration status; fluids are usually limited to prevent cerebral edema
(2) not a priority
(3) correct—to prevent spread of infection, child is placed on droplet precautions for at least 24 hours after implementation of antibiotic therapy
(4) would cause discomfort to infant's head

163. The nurse is caring for a client who has overdosed on a large quantity of diazepam (Valium). Which of the following nursing actions should take priority during the first several days of this client's inpatient treatment?

1. Complete a full psychiatric assessment.
2. Get in touch with the client's family to involve them in treatment.
3. Observe and record vital signs frequently, including neurological symptoms.
4. Determine whether this client may need long-term therapy after this hospitalization.

Strategy: Think Maslow.

(1) psychosocial, can be done after the client has been medically stabilized
(2) psychosocial, can be done after the client has been medically stabilized
(3) correct—physical, because of potentially life-threatening complications of depressant overdose such as respiratory failure, pulmonary edema, and seizures, nurse's priority is observation and documentation of vital signs
(4) psychosocial, can be done after the client has been medically stabilized

164. During the second session of individual therapy, a client sits quietly with arms folded and eyes cast down. Which of the following statements by the nurse is BEST?

1. "What is the weather like outside?"
2. "Do you not want to talk with me today?"
3. "Are you cold sitting here?"
4. "You seem to be feeling sad today."

Strategy: "BEST" indicates that this is a priority question. Remember therapeutic communication.

(1) is used to get client comfortable, but would not help to focus on what is important
(2) focusing on client's difficulty speaking may make him defensive and block communication
(3) concrete questions will encourage client to give yes/no answers, factual answers may block communication of feelings
(4) correct—reflection allows client to verbalize feelings

165. The nurse is performing in-service education about the use of the defibrillator. It would be MOST important for the nurse to make which of the following statements?

1. "Do not touch the bed when using the defibrillator."
2. "Check the defibrillator every 24 hours."
3. "Do not leave the defibrillator plugged in."
4. "Do not place the paddles over the electrodes."

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

(1) correct—is a priority to prevent accidental countershock
(2) equipment should be checked every eight hours
(3) equipment should remain plugged in at all times
(4) is not a priority; while this should not occur, it can be safely done

166. A six-year-old boy comes to the outpatient clinic for a routine exam. His mother is concerned because her son often talks to an "imaginary best friend." The nurse should advise the mother to

1. insist that her son play more often with other children.
2. tell her son that this friend is not a real person.
3. allow her son to engage in imaginary play.
4. encourage her son to explain his friend to her.

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

(1) doesn't recognize play with imaginary friends as normal developmental state
(2) may create anxiety in child
(3) correct—normal for 4- to 6-year-old children
(4) may create anxiety in child

167. The nurse is caring for a client with hyperthyroidism. Which of the following actions, if taken by the nurse, is BEST?

1. Provide the client with extra blankets.
2. Instill artificial tears prn.
3. Offer the client reading material.
4. Offer frequent low-calorie snacks.

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

(1) client is usually sensitive to heat
(2) correct—clients with hyperthyroidism frequently exhibit exophthalmos, which requires ophthalmic drops on a regular basis
(3) should provide a calm, restful environment with low levels of sensory stimulation, protecting eyes from injury takes priority
(4) frequent snacks should be high-calorie

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

1. An elderly woman, 8-hours postoperative, following an open-reduction and internal fixation of the right hip.
2. An elderly man admitted 4 hours ago with status asthmaticus.
3. A middle-aged man admitted 2 days ago with pneumonia who has a temperature of 101.2°F (38.4°C).
4. A middle-aged woman who suffered a myocardial infarction (MI) 3 days ago.

Strategy: Determine the least stable client.

(1) leg needs to be abducted at all times, ice to operative site, turn patient as ordered
(2) correct—life-threatening condition which can last longer than 24 hours, constantly monitor client
(3) requires follow-up, assess breath sounds
(4) monitor vital signs, I and O, teach to modify lifestyle (stop smoking, reduce stress, modify intake of calories, fat, and salt)

169. In planning care for a client with signs of increased intracranial pressure (ICP), the nurse would include which of the following?

1. Encourage coughing and deep breathing to prevent pneumonia.
2. Suction the airway every 2 hours to remove secretions.
3. Position the client in the prone position to promote venous return.
4. Determine cough reflex and ability to swallow prior to administering PO fluids.

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

(1) increases intracranial pressure
(2) increases intracranial pressure
(3) head of the bed should be elevated 15 to 30° to promote venous drainage
(4) correct—assessment, cough or gag reflex and the swallowing reflex may be affected by the increased pressure; increases the incidence of aspiration

170. While doing a physical examination of a one-year-old child, which of the following assessments should be done by the nurse LAST?

1. Take a rectal temperature.
2. Auscultate the breath sounds.
3. Auscultate the apical heart rate.
4. Evaluate motor functions.

Strategy: Picture the situation.

(1) correct—all invasive procedures should be done last, so as not to alter cardiopulmonary assessment of the child
(2) should be done before a rectal temperature
(3) should be done before a rectal temperature
(4) should be done before a rectal temperature

171. A patient is returned from surgery with a Jackson-Pratt drain in place. The nurse observes a student nurse perform a dressing change for the patient. Which of the following activities if performed by the student nurse would require an intervention by the nurse?

1. Documents the amount and character of the drainage in the patient's chart.
2. Attaches the drain to the top sheet on the bed.
3. Empties the reservoir of the drain.
4. Records the amount of drainage on the output sheet.

Strategy: "Require an intervention" indicates an incorrect response.

(1) drains used to prevent wound infections and abscess formation
(2) correct—drain should be attached to patient's gown or pajamas, never to the sheet or mattress
(3) Jackson-Pratt drain is a self-contained suction device that is emptied as needed
(4) important to monitor output

172. An unaccompanied client who is six months pregnant is admitted to the nursing unit with vaginal bleeding. Which of the following comments, if made by the client, would indicate a need for the nurse to assess the adequacy of the client's emotional support?

1. "My husband will be so angry with me if I lose this baby."
2. "I'm afraid I am going to lose my baby."
3. "I can't stay here. I don't have any insurance."
4. "I feel so guilty. I didn't want to get pregnant."

Strategy: Think about the what the words mean.

(1) correct—client's concern about her husband's feelings indicates that he may not be able to support her emotionally at this time
(2) reflects a reality-based concern
(3) indicates an economic concern
(4) indicates client needs to talk about her current feelings; does not give any indication of level of emotional support

173. When the nurse assesses the incision of a client two days after surgery, a shiny, pink, open area is noted with the underlying bowel visible. Which of these actions should the nurse take FIRST?

1. Cover the open area with sterile gauze soaked in normal saline.
2. Reapply a sterile dressing after cleaning the incision with peroxide.
3. Pack the opened area with sterile ¾-inch gauze soaked in normal saline.
4. Apply Neosporin ointment and cover the incision with Tegaderm dressing.

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

(1) correct—evisceration is treated immediately by application of sterile gauze soaked in sterile normal saline, followed by notification of physician
(2) not correct response to this complication
(3) not correct response to this complication
(4) not correct response to this complication

174. A newborn is to be discharged in the AM. The nurse should teach the child's mother to perform which of the following actions?

1. Apply a sterile gauze dressing with petroleum jelly to the cord.
2. Position the diaper over the umbilicus to keep it dry.
3. Clean the cord several times a day and expose it to air frequently.
4. Apply erythromycin ointment to the cord several times a day.

Strategy: The topic of the question is unstated.

(1) appropriate for circumcision
(2) will keep the area moist; the diaper should be placed below the umbilicus
(3) correct—encourages drying and helps to prevent infection
(4) antibiotic ointment is unnecessary

175. A client has been transferred from a nursing home to the hospital with an indwelling urinary catheter. The urine is cloudy and foul-smelling. Which of the following nursing measures would be MOST appropriate?

1. Clean the urinary meatus every other day.
2. Encourage the client to increase fluid intake.
3. Empty the drainage bag every 2–4 hours.
4. Irrigate the Foley catheter every 8 hours.

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

(1) does not address the problem of the client's urine, should not be performed
(2) correct—increasing intake of fluids is an appropriate independent nursing action that facilitates removal of concentrated urine
(3) does not address the problem of the client's urine, should not be performed
(4) could increase the chance of developing an infection

176. The nurse has just returned to the desk and has four phone messages to return. Which of the following messages should the nurse return FIRST?

1. A man with swelling of his left wrist following a fall from a ladder two hours ago.
2. A woman who had a cholecystectomy one week ago and now complains of redness and tenderness at the incision site.
3. A mother of a child reports that her son's lips are swollen following a fire ant bite.
4. A man with COPD reports he is coughing up large amounts of green-tinged sputum and has a temperature of 101.2°F (38.4°C).

Strategy: Remember the ABCs.

(1) wrist needs to be x-rayed, not a priority
(2) indicates infection, treated with antibiotic
(3) correct—potential anaphylactic reaction, administer epinephrine, corticosteroids; treat for shock
(4) indicates infection, treat with an antibiotic

177. The nurse is caring for a client with pneumonia. Which of the following nursing observations would indicate a therapeutic response to the treatment?

1. Oral temperature of 101°F (38.3°C), increased chest pain with nonproductive cough.
2. Cough, productive of thick green sputum, client reports feeling tired.
3. Respirations at 20 with no complaints of dyspnea, moderate amount of thin white sputum.
4. White cell count of 10,000 mm^3, urine output at 40 cc per hour, decreasing amount of sputum.

Strategy: Determine which answer choice indicates an improved respiratory status.

(1) validates the continued presence of the infection
(2) validates the continued presence of the infection
(3) correct—sputum characteristics indicate a decrease in the pneumonia; is supported by respiratory status
(4) does not substantiate the status of the infection

178. In preparing discharge plans for a client who has been treated for syphilis, it is MOST important for the community health nurse to include which of the following information?

1. Practice restraint of sexual activity.
2. The practice of safe sex.
3. Information about Planned Parenthood.
4. Signs of a secondary infection.

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

(1) not effective in the prevention of transmission of sexually transmitted diseases
(2) correct—practice of safe sex, e.g., use of condoms, is primary prevention for transmission of sexually transmitted diseases
(3) not as effective in the prevention of transmission of sexually transmitted diseases
(4) not as effective in the prevention of transmission of sexually transmitted diseases

179. A 12-year-old child is receiving intravenous theophylline (Aminophylline). The child presents with signs of tachycardia and irritability. Which of the following nursing actions is MOST appropriate?

1. Decrease external stimuli in the child's room.
2. Administer an analgesic as ordered.
3. Notify and advise the physician of the child's status.
4. Document the assessments and continue to observe.

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

(1) may help the client to cope with current symptoms, but is not highest priority
(2) will mask the signs of toxicity
(3) correct—signs of toxicity need to be reported to the physician
(4) does not take action to resolve the problem

180. The nurse is informed that there will be two new admissions to the unit. One of the new admissions is diagnosed with pneumonia, and the other new patient is diagnosed with AIDS. Which of the following assignments is MOST appropriate?

1. Assign both patients to one room with one nurse caring for both patients.
2. Place both patients in the same room and assign the care to different nurses.
3. Assign each patient to a private rooms and assign both clients to one nurse.
4. Place each client in a private room and assign each patient to a different nurse.

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

(1) increases the potential for transmission of infection
(2) keeps the clients in the same room; should not be done
(3) puts them in separate rooms but same nurse is caring for them
(4) correct—to prevent spread of infection, clients should have private rooms with different nurses

181. The nurse is counseling a client who has been abusing alcohol and other drugs for six years. The nursing diagnosis is ineffective individual coping. Which of the following nursing actions should take priority during the working stage of their relationship?

    1. Observe the client every half-hour to determine the extent of drug-seeking behavior.
    2. Monitor the intake of fluids, meals, and snacks to ensure adequate nutrition.
    3. Help the client obtain a sponsor through a 12-step group in the client's local area.
    4. Meet individually with the client to discuss the consequences of drug-using behavior and examine other options.

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

    (1) assessment, important in the assessment phase of the relationship
    (2) assessment, important for a different nursing diagnosis
    (3) implementation, will be important in discharge planning
    (4) correct—implementation, describes the work of the interpersonal relationship with a chemically dependent client; goal is to get client to recognize problems the chemicals have caused and to learn new methods of solving problems

182. The nurse is supervising the care of a client that has stage III pressure ulcer of the sacrum with foul smelling purulent drainage. The nurse should intervene in which of the following situations?

    1. The LPN/LVN enters the room wearing a gown and gloves.
    2. The nursing assistant enters the room wearing a mask.
    3. The client's family brings him a milkshake.
    4. The staff lifts the client to reposition him.

    Strategy: "Nurse should intervene" indicates an incorrect behavior. All answers are implementations. Determine the outcome of each answer choice. Is it desired?

    (1) contact precautions required for infected decubitus ulcer; private room if possible
    (2) correct—masks not needed and doors do not need to be closed
    (3) maintain positive nitrogen balance, should offer high protein diet with protein supplements
    (4) lifting prevents shearing force

183. The nurse performs discharge teaching to a client receiving cromolyn sodium (Intal). Which of the following statements, if made by the client to the nurse, indicates that teaching has been successful?

1. "I will take the medicine with my meals."
2. "It is important that I take the medication before going to bed."
3. "If I experience respiratory distress, I will take the medicine."
4. "I will take the medicine before I begin any vigorous exercise."

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

(1) inappropriate information
(2) inappropriate information
(3) cromolyn sodium is not an antihistamine agent, an antiinflammatory, or a bronchodilator, does nothing for a client in respiratory distress
(4) correct—cromolyn sodium (Intal) is used to prevent the release of histamine and other allergy-triggering substances

184. A client develops orthopnea, dyspnea, and basilar crackles. Which of the following nursing actions would be MOST appropriate for this client?

1. Elevate the legs to promote venous return.
2. Decrease the IV fluids and notify the physician.
3. Orient the client to time, place, and situation.
4. Prevent complications of immobility.

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

(1) would worsen the situation
(2) correct—orthopnea, dyspnea, and crackles are signs and symptoms of fluid excess; decreasing the IV fluids is the priority
(3) not of priority in this situation
(4) not of priority in this situation

185. During auscultation of the fetal heart rate during labor, the nurse assesses a rate of 59 beats per minute. The FIRST action the nurse should take is

1. turn the mother on her right side, increase the intravenous flow rate, and call the physician.
2. turn the mother on her left side, administer oxygen by nasal cannula, and start an IV.
3. call the physician, and make preparations for an immediate emergency cesarean section.
4. position the mother in Trendelenburg's position, administer oxygen, and force fluids.

Strategy: "FIRST" indicates that this is a priority question. All answers are implementations. Determine the outcome of each answer choice. Is it desired?

(1) should be placed on left side to increase blood flow to the uterus
(2) correct—persistent fetal bradycardia may indicate cord compression or separation of the placenta, but always indicates fetal distress, left side reduces compression of vena cava and aorta
(3) should be done after positioning patient
(4) this position is used only if there is cord prolapsed

186. After a client has returned to the floor from thyroidectomy surgery, it is MOST important for the nurse to take which of the following actions?

1. Monitor vital signs every four hours.
2. Observe for frequent swallowing.
3. Monitor for signs of respiratory distress every hour.
4. Position the client in the supine position.

Strategy: Answers are a mix of assessments and implementations. Does this situation require assessment? Yes. Determine what assessment is being made in each answer choice.

(1) assessment is not specific to this surgery
(2) assessment, method used to monitor for postoperative hemorrhage in a tonsillectomy client
(3) correct—assessment, after surgery, swelling can occur, which causes respiratory distress
(4) implementation, head of the bed should be elevated

187. The nurse is caring for clients on the psychiatric unit. Suddenly, a male client's behavior begins to escalate into aggressive behavior. It would be MOST important for the nurse to take which of the following actions?

1. Utilize an organized team to place the client in seclusion.
2. Leave the client alone in his room to identify feelings of anger.
3. Redirect the client to a quiet activity to divert his attention and not disturb the other clients.
4. Assist the client to identify and express his feelings of increasing anxiety, frustration, and anger.

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

(1) nurse can be helpful in using psychological/communication strategies before utilizing seclusion
(2) leaving the client alone can become potentially dangerous to the client and the property
(3) encouraging the client to become involved in a quiet activity might further escalate his frustration and anger because the ability to focus and concentrate is diminished due to an elevated anxiety level
(4) correct—as client's anger begins to escalate, nurse can be helpful in using psychological/communication strategies before utilizing seclusion

188. The nurse is instructing the parents of a child with celiac disease. The nurse knows that teaching has been effective when the parents make which of the following statements?

1. "My child's diet should include raw vegetables, fruits, and crackers."
2. "My child's diet should be high in carbohydrates, high in calories, and high in proteins."
3. "The only restriction in my child's diet should be breads and cereals."
4. "My child's diet should be high in calories, high in protein, and restrict foods containing rye, oats, wheat, and barley."

Strategy: "Teaching has been effective" indicates you are looking for a correct statement. The topic of the question is unstated.

(1) does not reflect appropriate dietary needs for this child
(2) does not reflect appropriate dietary needs for this child
(3) does not reflect appropriate dietary needs for this child
(4) correct—celiac disease is characterized by an intolerance for gluten; foods containing rye, oats, wheat, and barley should be restricted

189. The nurse is transcribing the following physician's orders. Which of the following orders warrants further clarification?

1. Administer haloperidol (Haldol) 5 mg.
2. Instruct client to use incentive spirometer q1h while awake.
3. D_5W ¼ NS + KCl 20 mEq/L at 100 mL/h.
4. CBC with differential and platelets at 8 AM.

Strategy: Think about each answer choice.

(1) correct—has no route of administration or schedule
(2) clear and complete and needs no further clarification
(3) clear and complete and needs no further clarification
(4) clear and complete and needs no further clarification

190. In developing discharge plans with the family of the client with stage-four Parkinson's disease, it is MOST important for the nurse to include which of the following activities?

1. Ambulate twice daily.
2. ROM exercise to all extremities four times a day.
3. Include activities such as knitting and putting puzzles together.
4. Encourage and provide writing materials.

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

(1) client would be unable to ambulate
(2) correct—in stage four Parkinson's Parkinson's disease, client is immobile
(3) client cannot perform activities that require small-muscle dexterity
(4) client cannot perform activities that require small-muscle dexterity

191. A patient is admitted with abdominal pain and nausea. The physician orders stool for guaiac times three days. The nurse asks the health care technician to obtain the stool specimen. Which of the following statements, if made by the technician, would require an intervention by the nurse?

1. "I'll remind the patient to use the bedpan instead of the bathroom toilet."
2. "I'll use a tongue blade to collect a small amount of stool in a clean container."
3. "I'll get a couple of specimens this afternoon because the patient is having loose stools."
4. "I'll ask the patient if he has ingested any red meat recently."

Strategy: Each answer choice is an implementation. Determine the outcome of each answer choice. Is it desired?

(1) easier to get specimen
(2) doesn't need to be sterile container
(3) correct—ordered to be collected over 3-day period
(4) may cause false-positive reading

192. A 30-year-old woman is receiving levothyroxine sodium (Synthroid) 0.1 mg PO daily. Which of the following findings would indicate to the nurse that the client is getting favorable results from the medication?

1. Decreased blood pressure.
2. Increased urine output.
3. Decreased pulse rate.
4. Increased respiratory rate.

Strategy: Determine how each answer choice relates to hypothyroidism.

(1) characteristic of hypothyroidism, would indicate that medication is not working
(2) correct—medication increases metabolic processes of body, including glomerular filtration, edema will decrease as water is excreted
(3) characteristic of hypothyroidism, would indicate that medication is not working
(4) respiratory rate may or may not be affected by medication

193. A 24-year-old woman who is 30 weeks pregnant is seen in the outpatient clinic for a routine visit. The nurse would be MOST concerned if the client made which of the following statements?

1. "During the day I seem to get hot flashes and chills."
2. "I am having some trouble with constipation and hemorrhoids."
3. "At the end of the day I have leg cramps."
4. "When I put my hand on my abdomen, I can feel it tense and relax."

Strategy: "MOST concerned" indicates a complication.

(1) correct—should be reported to the physician
(2) common due to pressure of growing fetus
(3) common due to compression of nerves supplying lower extremities or reduced calcium levels, should take oral calcium supplements if ordered, stretch until spasm is relieved
(4) Braxton-Hicks contractions common, should rest and change position

194. The nurse prepares a 67-year-old man for an intravenous pyelogram (IVP). Which of the following information is MOST important for the nurse to obtain before the procedure?

1. The date of the client's last EKG.
2. The time of the client's last meal.
3. A list of the client's allergies.
4. A list of the medications the client takes at home.

Strategy: All answers are assessments. Determine why you would make the assessment and how it relates to the situation.

(1) electrical activity of heart, not most important
(2) should be NPO for 6–8 h, not most important
(3) correct—involves injection of radiopaque dye, used to identify lesions and assess function, allergy to iodine is life-threatening
(4) not most important

195. A client is receiving heparin via continuous IV infusion for management of deep vein thrombosis (DVT). The partial thromboplastin time (PTT) is 1.5 times greater than normal. Which of the following actions by the nurse is MOST appropriate?

1. Discontinue the heparin infusion.
2. Slow down the heparin infusion.
3. Check the prothrombin time (PT) results.
4. Continue to monitor the client.

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

(1) no reason to discontinue or slow the infusion because the PTT is within a therapeutic range
(2) no reason to discontinue or slow the infusion because the PTT is within a therapeutic range
(3) prothrombin time (PT) test is useful for assessing warfarin (Coumadin) therapy
(4) correct—expected result of heparin therapy is a prolonged PTT of 1.5 times the control, without signs of hemorrhage

196. The homecare nurse is visiting an elderly client with osteoarthritis. It would be MOST important for the nurse to include which of the following instructions?

1. "Swimming is the only helpful exercise for osteoarthritis."
2. "Warm-up exercises should be done prior to exercising."
3. "Exercises should be done routinely, even if severe joint pain occurs."
4. "Isometric exercises are most helpful to prevent contractures."

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

(1) swimming is only one helpful exercise
(2) correct—warm-up or "stretching" exercises should always be done to begin and end exercising
(3) severely painful joints should not be exercised
(4) isometric exercises do not involve joint movement

197. The nurse observes a new graduate nurse palpating the uterine contractions of a 21-year-old primipara in active labor. Which of the following actions, if taken by the new graduate nurse, is MOST appropriate?

1. The graduate nurse places the palm of one hand on the fundus and moves the hand around the abdomen.
2. The graduate nurse places the heels of both hands on the lower abdomen and presses lightly.
3. The graduate nurse places one hand on the abdomen over the fundus and with the fingertips, presses gently.
4. The graduate nurse places the palms of the hands on either side of the abdomen and presses firmly.

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

(1) palpations should be done with fingertips, not palms of hands
(2) palpations should be done with fingertips, not heels of hands
(3) correct—done with fingertips
(4) palpations should be done with fingertips, not palms of hands

198. The nurse is assigned a team with another registered nurse and an LPN. Which of the following patients should the nurse assign to the LPN?

1. A 67-year-old man who is NPO and scheduled for a transurethral resection of the prostate (TURP) in 3 hours.
2. A 53-year-old woman with an IV of 0.9% NaCl at 100 cc/h who had a lumbar laminectomy two days ago.
3. A 40-year-old woman with a Hemovac drain and a large surgical dressing from a mastectomy 2 days ago who is showing signs of depression.
4. A 27-year-old woman scheduled for discharge later today after receiving chemotherapy through a portacath for treatment of leukemia.

Strategy: The LPN/LVN is assigned stable patients with expected outcomes.

(1) needs preoperative teaching and assessment
(2) correct—basic care needs can be met by the LPN/LVN, don't make patient assignments based on equipment
(3) needs therapeutic intervention, teaching, and assessment
(4) needs assessment and teaching

199. The nurse knows that to manage at home alone following discharge from the hospital, an arthritic client must be able to perform which of the following tasks?

1. Climb up and down stairs.
2. Lace and tie his/her shoes.
3. Comb his/her hair and brush his/her teeth.
4. Walk without assistance.

Strategy: Think about the significance of each answer choice and how it relates to arthritis.

(1) stairs can be eliminated in the client's environment
(2) is a modifiable problem with the use of slip-on shoes
(3) correct—is part of basic hygiene and grooming that must be done daily to maintain overall health
(4) is not necessary for independence; walker or wheelchair may be used

200. A nurse was sued for malpractice but is proved innocent. Which fact from the case was decisive in determining the outcome?

1. Negligence was implied.
2. The suit was filed under the law of negligent tort.
3. No harm was actually suffered by the patient.
4. The nurse failed to give competent care.

Strategy: Think about each answer.

(1) negligence is the unintentional failure of an individual to perform an act that a reasonable person would or not would perform in similar circumstances; can be an act of omission or commission
(2) tort is a legal term that means a wrongful act that results in injury, loss, or damage
(3) correct—required elements of malpractice are duty, breadth of duty, causation, and injury
(4) would be considered negligence