

What intervention is **essential** prior to starting a client on atorvastatin therapy?

1. Assessing for muscle strength
2. Assessing the client's dietary intake
3. Determining if the client is on digoxin therapy
4. Monitoring liver function tests

The nurse provides discharge instructions to a client at 14 weeks gestation who has received a prophylactic cervical cerclage. Which client statement indicates an understanding of teaching?

1. "I need to be on bed rest for the duration of my pregnancy."
2. "I will notify my health care provider if I start having low back aches."
3. "Pelvic pressure is to be expected after cerclage placement."
4. "The cerclage will be removed once my baby is at 28 weeks."

During the first prenatal assessment, the client reports the last normal menstrual period starting on March 1 and ending on March 5, but also slight spotting on March 23. The client had unprotected intercourse on March 15. Using Naegele's rule, what is the estimated date of birth?

1. December 8
 2. December 12
 3. December 22
 4. December 30
5. A client is prescribed long-term pharmacologic therapy with hydroxychloroquine to treat systemic lupus erythematosus. Which intervention related to the drug's adverse effects should the nurse include in the teaching plan?
1. Have an ophthalmologic examination every 6 months
 2. Take the medication on an empty stomach
 3. Take vitamin D and calcium supplements
 4. Wear a MedicAlert bracelet

The nurse is caring for a client diagnosed with Guillain-Barré syndrome (GBS) after a recent gastrointestinal (GI) illness. Monitoring for which of the following is a nursing care **priority** for this client?

1. Diaphoresis with facial flushing
2. Hypoactive or absent bowel sounds
3. Inability to cough or lift the head
4. Warm, tender, and swollen leg

1. The nurse notes muffled heart tones in a client with a pericardial effusion. How would the nurse assess for a pulsus paradoxus? Check for variation in amplitude of QRS complexes on the electrocardiogram strip

1. Check for variation in amplitude of QRS complexes on the electrocardiogram strip

2. Compare apical and radial pulses for any deficit
3. Measure the difference between Korotkoff sounds auscultated during expiration and throughout the respiratory cycle

Multiply diastolic blood pressure (DBP) by 2, add systolic blood pressure (SBP), and divide the result by 3; $[(DBP \times 2) + (SBP)]/3$

The nurse is developing a nutritional plan for a 6-month-old who has recently been started on solid foods. Which of the following recommendations has the **highest priority** in the plan?

1. Canned baby food is more expensive than food prepared at home
2. Finger foods can be introduced before the child has teeth
3. New foods should be introduced at least 5-7 days apart
4. Rice cereal can be mixed with cow's milk to increase nutritional intake

A female client with liver cirrhosis and chronic anemia is hospitalized for a deep venous thrombosis. The client is receiving a heparin infusion and suddenly develops epistaxis. Which laboratory value would indicate that the heparin infusion needs to be turned off?

1. Hematocrit of 30% (0.30)
2. Partial thromboplastin time of 110 seconds
3. Platelet count of 80,000/mm³ (80 x 10⁹/L)
4. Prothrombin time of 11 seconds

An 84-year-old client with oxygen-dependent chronic obstructive pulmonary disease is admitted with an exacerbation and steady weight loss. The client has been in the hospital 4 times over the last several months and is "tired of being poked and prodded." Which topic would be **most important** for the nurse to discuss with this client's health care team?

1. Need for discharge to a skilled nursing facility
2. Nutritional consult with instructions on a high-calorie diet
3. Option of palliative care
4. Physical therapy prescription to promote activity

1. The nurse working on the inpatient psychiatric unit is preparing to administer 9:00 AM medications to a client. The medication administration record is shown in the exhibit. On assessment, the client is tremulous, exhibits muscle rigidity, and has a temperature of 101.1 F (38.4 C). Which action should the nurses take.
2. Give all medications, including acetaminophen, and reassess in 30 minutes
3. Hold the haloperidol, give acetaminophen, and reassess in 30 minutes
4. Hold the haloperidol and notify the health care provider (HCP) immediately
5. Hold the hydrochlorothiazide and notify the HCP immediately

A client, who has been hospitalized for 3 days with major depressive disorder, has stayed in the room and not gotten out of bed except for toileting. The nurse enters the room to remind the

client that breakfast will be served in the dining room in 20 minutes. The client says, "I'm not hungry and I don't feel like doing anything." What is the **best** response by the nurse?

1. "I will help you get ready; then we can walk to the dining room together."
2. "I'll have breakfast brought to your room."
3. "It's okay. You can join us when you are ready."
4. "You'll feel better when you get up."
- 5.
6. The public health nurse conducts a program at the community senior citizen center about preventing falls at home. Which statement made by a participant indicates that **further education is needed**?
7. "I bought a new nightlight for the hallway to the bathroom."
8. "I feel so much more secure wearing my electronic fall alert device."
9. "I walk in my stockings at home because it helps to relieve my bunion pain."
10. "My daughter helped me secure the small, thin rug in my kitchen with strong tape."

A 15-year-old parent brings a 4-month-old infant for a well-baby checkup. The parent tells the nurse that the baby cries all the time; the parent has tried everything to keep the infant quiet but nothing works. What is the **priority** nursing action?

11. Advise the parent to give a pacifier whenever the infant cries
12. Ask the parent to describe what is done to "keep the baby quiet"
13. Assess the infant's pattern and frequency of crying
14. Explore the parent's support system

A major earthquake has occurred. Local gas lines and water pipes are breaking with resulting fires and flooding in collapsed buildings. Multiple victims arrive at the triage area. Which client should the nurse care for **first**?

1. Client with charred, leathery skin over entire back, chest, and legs
2. Client with cool skin, shivering from sitting in water until rescued
3. Client with diabetes who was unable to take prescribed insulin today
4. Client with high-pitched, crowing inspiratory respirations

The charge nurse in the cardiac intensive care unit responds to a client room where a resuscitation effort is in progress. The client's immediate family member refuses to leave the room. How should the charge nurse handle this situation?

1. Call security to escort the family member to the waiting room
2. Have the family member stand or sit in an area that is not in the staff's way
3. Inform the family member that relatives are not allowed in rooms during emergency

situations

4. Let the family member stay and assign a staff person to explain what is happening

The nurse prepares to administer clozapine to a client with schizophrenia. Which client statement would require **priority** investigation before administering the medication?

1. "I have gained a few pounds since I started this medication."
2. "I have had a sore throat for 3 days and feel feverish today."
3. "I have noticed increased salivation and drooling."
4. "I often feel sleepy when I take this medication."

The nurse admits a postoperative client following weight loss surgery. Which prescription should the nurse question?

1. Begin a sugar-free, clear liquid diet
2. Insert nasogastric tube for uncontrolled nausea
3. Place client in low Fowler position during mealtimes
4. Start morphine via patient-controlled analgesia

The registered nurse (RN) is supervising a graduate nurse (GN) providing postoperative teaching for a male client after an inguinal hernia repair. Which statement by the GN would cause the RN to **intervene**?

1. Elevate your scrotum and apply an ice bag to reduce swelling."
2. "Practice coughing to clear secretions and prevent pneumonia."
3. "Stand up to use the urinal if you have difficulty voiding."
4. "Turn in bed and perform deep breathing every 2 hours."

A graduate student, who has been studying for final exams and using energy drinks to stay awake, comes to the clinic reporting a fluttering feeling in the chest. The student is connected to the cardiac monitor that displays the rhythm in the exhibit. The nurse recognizes this as which rhythm?

1. Atrial flutter
2. Sinus rhythm with premature atrial contractions (PACs)
3. Sinus rhythm with premature ventricular contractions (PVCs)
4. Ventricular tachycardia

An experienced nurse precepts a graduate nurse caring for a hospitalized client who has a prescription for a transfusion of packed red blood cells (RBCs) to be hung over 3 hours.

Which statement by the graduate nurse indicates the correct rationale for asking the client to void prior to starting the transfusion?

1. "A drop in blood pressure is expected during the transfusion and getting up to void may cause a fall."
2. "Bedrest is required; therefore, voiding will prevent intermittent catheterization during the procedure."
3. "If a transfusion reaction occurs, it will be important to collect a fresh urine specimen to check for hemolyzed RBCs."
4. "The urine is collected and analyzed prior to starting the transfusion to assess the client's baseline results."

The emergency department nurse is triaging clients. Which neurologic presentation is most concerning for a serious etiology and should be given **priority** for definitive treatment?

1. History of Bell's palsy with unilateral facial droop and drooling
2. History of multiple sclerosis and reporting recent blurred vision
3. Reports unilateral facial pain when consuming hot foods
4. Temple region hit by ball, loss of consciousness, but Glasgow Coma Scale score is now

A nurse in the emergency department cares for 4 clients with orthopedic injuries. Which client should the nurse assess **first**?

Client who sustained a closed, incomplete ulnar fracture while playing sports

Client with bilateral metacarpal fractures after falling out of bed

Client with multiple myeloma who has a vertebral fracture and aching back pain

Client with pain and obvious shoulder deformity reporting a "pins-and-needles" sensation

The nurse is teaching self-care management to a client experiencing an outbreak of genital herpes. Which statement by the client indicates a need for **further teaching**?

1. "I will be sure we use condoms during intercourse as long as I have lesions."
2. "I will not touch the lesions to prevent spreading the virus to other parts of my body."
3. "I will use a hair dryer on a cool setting to dry the lesions after taking a shower."
4. "I will use warm running water and mild soap without perfumes to wash the area."

The nurse is reviewing new prescriptions from the health care provider. Which prescription would require **further clarification**?

1. Atorvastatin for hyperlipidemia in a client with angina pectoris

2. Bupropion for smoking cessation in a client with emphysema
3. Cyclobenzaprine for muscle spasms in a client with hepatitis
4. Metronidazole for trichomoniasis in a client with Crohn disease

The nurse receives report on 4 clients. Which client should the nurse assess **first**?

1. Client 1 day postoperative receiving patient-controlled analgesia with morphine who reports itching and nausea
2. Client receiving maintenance IV normal saline solution with labeled tubing indicating that tubing was changed 48 hours ago
3. Client with a pulmonary embolus receiving continuous IV heparin infusion and warfarin who has an International Normalized Ratio of 1.9
4. Client with a resistant bacterial infection receiving IV vancomycin who reports discomfort at the peripheral IV site

The nurse administers lactulose to a client diagnosed with cirrhosis and hepatic encephalopathy. Which nursing action is **inappropriate** when administering this medication?

1. Assess mental status and orientation
2. Give on an empty stomach for rapid effect
3. Hold if 3 soft stools occur in a day
4. Mix with fruit juice to improve flavor

5. The nurse assistant reports vital signs on 4 clients. Which client should be a **priority** for the nurse to assess?
6. 28-year-old with infective endocarditis and heart rate of 105/min
7. 45-year-old with acute pancreatitis and sinus tachycardia of 120/min
8. 65-year-old with tachycardia of 110/min after liver biopsy
9. 74-year-old on diltiazem drip with atrial fibrillation and heart rate of 115/min

The nurse assesses 4 clients in the emergency department. Which client should the nurse prioritize **first**?

1. 12-year-old with right lower quadrant abdominal pain that started in the periumbilical region
2. 14-year-old with severe scrotal pain; right testis is tender, swollen, and more elevated than the left
3. 16-year-old with sickle cell disease who has excruciating generalized body pain
4. 34-year-old with sudden-onset, right-sided flank pain radiating to the right groin

A client with dilated cardiomyopathy has the rhythm shown in the exhibit. Which action should the nurse take **first**?

1. Assess the client for a pulse
2. Assess the oxygen saturation
3. Initiate cardiopulmonary resuscitation (CPR)
4. Prepare to defibrillate the client

Which statement by a client with a diagnosis of dependent personality disorder would the nurse recognize as progress toward a positive therapeutic outcome?

1. "I really appreciate all the time you have spent trying to help me."
2. "I think I really messed up at work today."
3. "My mother could not drive me here today, so I took the bus."
4. "When my parents go away on vacation, I'm planning to stay with my cousin."

A nurse performs the initial assessments for 4 assigned clients. The nurse identifies which client as being at **greatest risk** for the development of delirium?

1. 32-year-old client with gastroenteritis
2. 55-year-old client with coronary artery disease, 4 days post coronary bypass surgery
3. 60-year-old client with type II diabetes, 2 months post bilateral above-knee amputations
4. 80-year-old client with chronic obstructive pulmonary disease, chronic respiratory

The nurse is assessing a client with hypertension and essential tremor 2 hours after receiving a first dose of propranolol. Which assessment is **most** concerning to the nurse?

1. Client reports a headache
2. Current blood pressure is 160/88 mm Hg
3. Heart rate has dropped from 70/min to 60/min
4. Slight wheezes auscultated during inspiration

When triaging 4 pregnant clients in the obstetric clinic, the nurse should alert the health care provider to see which client **first**?

1. First-trimester client reporting frequent nausea and vomiting
2. Second-trimester client with dysuria and urinary frequency
3. Second-trimester client with obesity reporting decrease in fetal movement
4. Third-trimester client with right upper quadrant pain and nausea

A client at 20 weeks gestation states that she started consuming an increased amount of cornstarch about 3 weeks ago. Based on this assessment, the nurse should anticipate that the health care provider will order which laboratory test(s)?

1. Hemoglobin and hematocrit levels
2. Human chorionic gonadotropin level

3. Serum folate level
4. White blood cell count

A child on the playground is experiencing an anaphylactic reaction. The school nurse arrives with an EpiPen. The weather is cold and the child is wearing several layers of clothing. How should the nurse proceed with the EpiPen?

1. Inject into the upper arm where the sleeve can be pulled up
2. Inject into the most accessible vein
3. Inject through the clothing into thigh and hold in place for 10 seconds
4. Take the child inside, remove excess clothing, and inject into the thigh

A nurse receives information in a change of shift report. Which client is the **priority**?

1. Client prescribed levothyroxine to treat hypothyroidism who reports nervousness, sweating, and insomnia
2. Client receiving intravenous antibiotics for bacterial pneumonia who reports cough with blood-tinged sputum
3. Client with a femoral external fixator who has a temperature of 100.9 F (38.3 C) and redness and pain around the pin sites
4. Client with chronic pancreatitis who reports upper abdominal pain and voluminous, foul-smelling, fatty stools

The nurse is teaching the parents of a 4-month-old who has developed positional plagiocephaly (flat head syndrome). Which statement by the parents indicates a need for **further teaching**?

1. "I should alternate head positions when the infant is supine."
2. "I should place the infant in the prone position during naps."
3. "I will minimize the amount of time the infant is in a car seat."
4. "I will place interesting toys opposite the affected side."

A nurse is assisting a new mother as she is breastfeeding her infant. The infant has been diagnosed with tetralogy of Fallot. During feeding, the infant becomes cyanotic and is having difficulty breathing. What should be the nurse's **first** action?

1. Administer morphine to the infant
2. Administer oxygen via mask
3. Assess infant's vital signs and pulse oximetry
4. Place the infant in the knee-chest position

The nurse administers 8 units of regular insulin subcutaneously at 11:30 AM to a client with type 1 diabetes mellitus and serves the client lunch 30 minutes later. The client eats a few bites, becomes nauseated, and is unable to finish the meal. When is the client at **highest** risk for experiencing an insulin-related hypoglycemic reaction?

1. 12:30 PM
2. 2:00 PM
3. 5:00 PM
4. 6:00 PM

An elderly client with type 2 diabetes is admitted to the medical unit due to urosepsis. The client is wearing an insulin pump for continuous subcutaneous insulin infusion therapy. The client's significant other reports that the client self-manages the insulin pump extremely well and keeps blood glucose in the specified target range. What is the admitting nurse's **priority** action?

1. Assess the client's level of orientation
2. Assess the insulin pump infusion site
3. Check the prescribed insulin pump settings
4. Consult the diabetic resource nurse or educator

The nurse cares for a child with bed bug bites. Which parent statement indicates that **further teaching is required**?

1. "I need to have the entire house treated by pest control to ensure the bed bugs are gone."
2. "I should concentrate on alleviating scratching as it can cause further complications."
3. "My other family members and pets are at risk of bed bug bites."
4. "This must have happened because I did not wash the bed sheets this week."

An African American client comes to the clinic for a follow-up visit 2 months after starting enalapril for hypertension. Which client statement should be reported to the health care provider **immediately**?

1. "Is there anything I can take for my dry, hacking cough?"
2. "My blood pressure this morning was 158/84 mm Hg."
3. "Sometimes I feel somewhat dizzy when I stand up."
4. "Will you look at my tongue? It feels thicker than normal."

The nurse reviews the laboratory results of several clients. Which finding should the nurse report to the health care provider **immediately**?

1. Client who is receiving tube feedings and has a phenytoin level of 8 mcg/mL (32 mmol/L)
2. Client with a heart rate of 62/min who has a digoxin level of 1.3 ng/mL (1.7 nmol/L)
3. Client with a new prosthetic aortic valve who has an INR of 3.0
4. Client with a poor appetite and a lithium level of 0.8 mEq/L (0.8 mmol/L)

A client with active pulmonary tuberculosis is prescribed 4-drug therapy with ethambutol. The community health nurse instructs the client to notify the health care provider immediately if which adverse effect associated with ethambutol occurs?

1. Blurred vision
2. Dark-colored urine
3. Difficulty hearing
4. Yellow skin

A client with unstable angina and chronic kidney disease is receiving a continuous infusion of unfractionated heparin. Which value for activated partial thromboplastin time (aPTT) would indicate to the nurse that the heparin therapy is at an optimal therapeutic level?

1. 30 seconds
2. 35 seconds
3. 60 seconds
4. 85 seconds

The nurse is preparing medications for the following 4 clients. Which prescription should the nurse clarify with the health care provider before administration?

1. Acetaminophen for a client with a temperature of 102.2 F (39 C) with productive cough
2. Azathioprine for a client with Crohn disease with leukopenia who is reporting malaise
3. Baclofen for a client with multiple sclerosis who reports dizziness when changing positions
4. Colchicine for a client with an acute gout attack who reports intense, burning left toe pain

The charge nurse on a medical-surgical step-down unit is responsible for making assignments. Which client is **most appropriate** to assign to a new graduate nurse who is still in orientation?

1. 65-year-old client 1 day postoperative left femoral-popliteal bypass graft surgery with a diminished pedal pulse
2. 66-year-old client admitted for hypertensive crisis 2 days ago; blood pressure currently 180/102 mm Hg; reports headache and blurred vision
3. 75-year-old client with an ischemic stroke transferred from the intensive care unit 1 hour ago; unresponsive with right-sided paralysis
4. 78-year-old client with diabetes and cellulitis of the left foot; requires frequent dressing changes due to excessive drainage

Which client does the nurse assess **first** after receiving morning report?

1. Client 1 day postoperative with intravenous (IV) patient-controlled analgesia (PCA) who reports burning at the IV site
2. Client with a bowel obstruction prescribed continuous nasogastric suction who was admitted yesterday
3. Client with atrial fibrillation and an irregular heart rate of 94/min
4. Client with dementia and *Clostridium difficile* (*C difficile*) who was incontinent of liquid stool

The nurse caring for a client with tuberculosis (TB) transports the client to the radiology department for a chest x-ray. The nurse ensures that the client uses which personal protective equipment when out of the negative-pressure room?

1. Isolation gown, surgical mask, goggles, and gloves
2. Isolation gown and surgical mask
3. N95 respirator mask
4. Surgical mask

The parent of a 6-year-old calls the nurse and reports that the child was playing outside in the snow and the child's feet now appear red and swollen. What is the **best** response by the nurse?

1. "Bring the child to the health care provider's (HCP) office immediately."
2. "Give your child something warm to drink."
3. "Massage the child's feet gently until they warm up."
4. "Place the child's feet in warm water immediately."

A major disaster involving hundreds of victims has occurred, and an emergency nurse is sent to assist with field triage. Which client should the nurse **prioritize** for transport to the hospital?

Client at 8 weeks gestation with spotting and pulse of 90/min

Client with a compound femoral fracture and an oozing laceration

Client with fixed and dilated pupils and no spontaneous respirations

Client with paradoxical chest movement throughout respirations

The nurse is caring for an adolescent client diagnosed with type 1 diabetes. The client exhibits hot, dry skin and a glucose level of 350 mg/dL (19.4 mmol/L). Arterial blood gases show a pH of 7.27. STAT serum chemistry labs have been drawn. Cardiac monitoring shows a sinus rhythm with peaked T waves, and the client has minimal urine output. What is the nurse's next **priority** action?

1. Administer IV regular insulin
2. Administer normal saline infusion
3. Obtain urine for urinalysis
4. Request prescription for potassium infusion

The home care nurse is making an initial visit to a client just discharged after admission for severe exacerbation of chronic obstructive pulmonary disease (COPD). The nurse observes wall-to-wall stacks of old newspapers and magazines in every room, with pathways that just allow passage from one room to another. What is the **priority** nursing action?

1. Call the mobile community mental health crisis unit
2. Contact a service to remove the newspapers and magazines
3. Reconcile the client's discharge medications
4. Teach the safe use of oxygen

A nurse in the intensive care unit is caring for a client in the immediate postoperative period following abdominal surgery. The nurse receives several prescriptions. Which prescription should the nurse initiate **first**?

1. Acetaminophen 1000 mg IVPB every 8 hours
2. Cefazolin 2 g IVPB once, now
3. Norepinephrine 0.02-2.0 mcg/kg/min titrated IV
4. Normal saline 2 L via rapid IV bolus

After making initial rounds on all the assigned clients by 8:00 AM, which client should the nurse care for **first**?

1. Client 1-day postoperative who was medicated with tramadol 50 mg orally 1.5 hours ago
2. Client 1-day postoperative with pink colored urine after transurethral resection of the prostate (TURP)
3. Client scheduled for discharge today who needs instruction on how to change a sterile dressing
4. Client with adenocarcinoma scheduled for a lobectomy at 9:00 AM who was restless and awake all night

The partner of a client with borderline personality disorder calls the clinic and reports coming home from work to find the client with self-inflicted superficial cuts to the arm. The partner tells the nurse, "My partner does something like this every time I have to go away on business. My partner is not serious about doing something really harmful, just trying to stop me from going away." What is the **best** response by the nurse?

1. Are you still going to take your business trip?"
2. "It sounds like you are having a difficult time coping with your partner's behavior."
3. "Your partner is most likely doing it for attention, so it's best to just ignore it."
4. **"Your partner needs to be seen in the clinic today."**
- 5.
6. The nurse cares for an 11-lb (5-kg) infant admitted with dehydration and prepares to calculate intake and output over an 8-hour shift. Using the data in the exhibit, calculate the total output in milliliters for the 8-hour shift. **Record your answer as a whole number. 178ml**

The nurse is assessing a client in the outpatient clinic who has a cast on for a distal humerus fracture. Which statements made by the client would be the **priority** to assess further?

"I am having problems extending my fingers since this morning."

"I can't take any of the pain medicine because it makes me feel sick."

"I have to scratch under the cast with a nail file because of the itching."

"I noticed a warm spot on my cast, and a bad smell is coming from it."

The nurse is caring for an 83-year-old bedridden client experiencing fecal incontinence. Which nursing intervention is the **highest priority** for this client?

1. Consult with the wound care nurse specialist
2. Insert a rectal tube to contain the feces
3. **Provide perianal skin care with barrier cream**
4. Use incontinence briefs to protect the skin

The nurse is assessing a client at 36 weeks gestation during a routine prenatal visit. Which statement by the client should the nurse investigate **first**?

5. "I am not sleeping as well due to cramps in my calves at night."
6. **"I have noticed less kicking movements as the baby grows bigger."**
7. "Over the last few weeks, I have not been able to wear any of my shoes."
8. "Sometimes I feel short of breath after walking up a flight of stairs."

The nurse teaches a client with osteopenia, who is lactose intolerant, how to increase dietary calcium and vitamin D intake. Which lunch food is the **best** choice?

1. Broiled chicken breast
2. **Canned sardines**
3. Egg white omelet

Peanut butter

The office nurse for an orthopedic health care provider receives 4 telephone messages. Which client does the nurse call back **first**?

Client who had a left total knee replacement 7 days ago and reports cramping pain in the left calf

Client with a fractured wrist who reports severe itching under a cast that was applied 3 days ago

Client with an ankle sprain who is using crutches and reports tingling in the forearm and finger

Client with an intact anterior cruciate ligament injury who reports tightness in the knee
unrelieved with ice

The parent of a 1-year-old says to the nurse, "I would like to start toilet training my child as soon as possible." What information does the nurse provide to the parent that correctly describes a child's readiness for toilet training?

"A good time to start toilet training is when your child can dress and undress autonomously."

2. "When your child can sit on the toilet until urination occurs, you can start toilet training."

3. "Your child may be ready to start toilet training when able to communicate and follow

directions."

"Your child will be ready to start toilet training at about a 15 months age."

The nurse cares for an elderly client with type II diabetes who was diagnosed with diabetic retinopathy. Which statement by the client requires the **most immediate** action by the nurse?

1. "Half of my vision looks like it's being blocked by a curtain."

2. "I have to use reading glasses to see small print."

3. "My vision seems cloudy, and I notice a lot of glare."

4. "The colors don't seem as bright as they used to."

5. A client with a blood pressure (BP) of 250/145 mm Hg is admitted for hypertensive crisis.

The health care provider prescribes a continuous IV infusion of nitroprusside sodium. Which of these is the **priority** goal in initial management of hypertensive crisis?

6. Decrease mean arterial pressure (MAP) by no more than 25%

7. Keep blood pressure at or below 120/80 mm Hg

8. Maintain heart rate (HR) of 60-100/min

Maintain urine output A client is receiving normal saline 75 mL/hr and morphine sulfate via patient-controlled analgesia (PCA) bolus doses. The PCA and normal saline tubing are connected at the "Y" site. The nurse reviews a prescription from the health care provider to discontinue the normal saline. What is the **most** appropriate nursing action?

9. of at least 30 mL/hr

1. Change the rate of the normal saline to 10 mL/hr
2. Clarify the prescription with the health care provider
3. Flush the IV with normal saline and then convert it to a saline lock
4. Turn off the normal saline and disconnect it from the "Y" site

A graduate nurse (GN) is caring for a client with acute appendicitis who is awaiting surgery. Which action by the GN would require the precepting nurse to **intervene**?

1. Administers morphine IV PRN for pain
2. Initiates continuous normal saline IV
3. Provides a heating pad for abdominal discomfort
4. Teaches client about prescribed strict NPO status

While delegating to the unlicensed assistive personnel (UAP), the registered nurse (RN) should utilize the 5 rights of delegation. The "right direction and communication" related to the task is one of those rights. Which statement **best** meets that standard?

1. "I need for you to take vital signs on all clients in rooms 1-10 this morning."
2. "Mr. Wu's blood pressure has been low. Please take his vital signs first and let me know if his systolic blood pressure is <100."
3. "Mrs. Jones fell out of bed during the night. Be sure you keep a close eye on her this

shift." "

Would you please make sure Mr. Garcia in bed 8 ambulates several times?"

The nurse cares for a group of clients in a medical surgical unit. The client with which diagnosis and condition requires the **most immediate** assistance by the nurse?

Post cholecystectomy, reporting incision pain of a 5 on a scale of 1-10

Post open reduction of the right femur, reporting nausea

Type 1 diabetes mellitus with a blood glucose of 55 mg/dL (3.1 mmol/L)

Type 2 diabetes mellitus with a blood glucose of 250 mg/dL (13.9 mmol/L)

The nurse provides instruction to a community group about lung cancer prevention, health promotion, and smoking cessation. Which statement made by a member of the group indicates the **need for further instruction**?

1. "Even though I am getting nicotine in my patches, I am not being exposed to all of the other toxic stuff in cigarettes."
2. "I can't get lung cancer because I don't smoke."
3. "My husband needs to take smoking cessation classes."
4. "We installed a radon detector in our home."

A nursing unit implements a quality improvement process of written reminders to ameliorate incentive spirometer (IS) use in postoperative clients. What is the **best** indicator that the client goal for this process has been met?

1. Chart audits indicate that client incidence of nosocomial pneumonia decreased by 20%
2. Documentation shows that 100% of nurses attended an inservice seminar on the topic
3. Nurses report an increased number of written reminders given to appropriate clients
4. Surgeons who admit to the unit report increased satisfaction with current client IS use

Several children are brought to the emergency room after a boating accident in which they were thrown into the water. The children are now 6 hours post admission to the clinical observation unit. Which client should the nurse evaluate **first**?

1. Client who did not require CPR but now has a new oxygen requirement of 2 L via nasal cannula to maintain a saturation of 95%
2. Client who did not require CPR but was coughing on arrival to the hospital and is now crying inconsolably and asking for the mother
3. Client who received CPR for 2 minutes on the scene and whose respiratory rate has now dropped from 61/min to 18/min
4. Client who was briefly submerged in water and received rescue breaths on the scene and is now irritable and refusing food and drink

The nurse prepares a client for discharge following a vasectomy. The client asks, "When can I have sexual intercourse with my wife without using a condom?" What is the **best** response by the nurse?

1. Discontinue alternative birth control after at least 5 ejaculations."
2. "There is no need to use alternative birth control following today's procedure."
3. "Use alternative birth control for 6 months following today's procedure."
4. "Use alternative birth control until cleared by the health care provider."

A client is being discharged home after an open radical prostatectomy. Which statement indicates a **need for further teaching**?

5. "I will try to drink lots of water."
6. "I will try to walk in my driveway twice a day."
7. "I will wash around my catheter twice a day."
8. "If I get constipated, I will use a suppository."

A graduate nurse (GN) is inserting an oropharyngeal airway in a client emerging from general anesthesia. The nurse preceptor intervenes when the GN performs which action?

Inserts oropharyngeal airway (OPA) into mouth with curved end pointing upward

1. Measures OPA against the cheek and jaw angle before insertion
2. Rotates OPA tip downward once it reaches the soft palate
3. Tapes OPA to ensure it is secure and to prevent dislodgement

The emergency department nurse performs an admission assessment for a client with priapism of about 3 hours duration who also has sickle cell anemia. What assessment finding is of **most** concern and warrants immediate notification of the health care provider?

1. Bluish discoloration of the erect penis
2. Drank a 6-pack of beer 8 hours ago
3. Extreme penile pain rated as 9 on 0-10 scale
4. Has not voided for at least 6 hours

The nurse is admitting a client with a possible diagnosis of Guillain-Barré syndrome. When collecting data to develop a plan of care for the client, the nurse should give **priority** to which of the following items?

1. Orthostatic blood pressure changes
2. Presence or absence of knee reflexes
3. Pupil size and reaction to light
4. Rate and depth of respirations

A 55-year-old client on a medical-surgical unit has just received a diagnosis of pancreatic cancer. The client says to the nurse, "Is this disease going to kill me?" What is the **best** response by the nurse?

1. "Hearing this diagnosis must have been difficult for you. What are your thoughts?"
2. "We will do everything possible to prevent that from happening."
3. "Well, we're all going to die sometime."
4. "You should concentrate on getting better rather than thinking about death."
5. The nurse is calculating IV fluid resuscitation for a client weighing 85 kg with visible partial-thickness burns covering 40% of the body. Using the Parkland formula, how many liters of IV

7. fluid resuscitations are needed during the first 8 hours? **Record your answer using one decima**

6.8ml

The registered nurse (RN) on an orthopedic unit is orienting a new graduate nurse (GN) assigned to a client with a fractured hip and in Buck's traction. The RN intervenes when the GN performs which action?

1. Elevates the head of the bed 45 degrees
2. Holds the weight while the client is repositioned up in bed
3. Loosens the Velcro straps when the client reports that the boot is too tight
4. Provides the client with a fracture pan for elimination needs

The health care provider (HCP) orders a small bowel follow-through (SBFT) for a client. Which instructions should the nurse include when teaching the client about this test?

1. "After the test, you may notice your stools are tarry black for a few days."
2. "During the test, a series of x-rays will be taken to assess the function of the small

bowel."

3. "The HCP will use an endoscope to visualize your small bowel."
4. "Your examination is scheduled for 8:00 AM. Please drink all of the polyethylene glycol

by midnight."

The nurse is caring for a 72-year-old client 1 day postoperative colectomy. The nurse assesses an increased work of breathing, diminished breath sounds at the bases with fine inspiratory crackles, respirations 12/min and shallow, and pulse oximetry 96% on 2 L oxygen. There is no jugular venous distension or peripheral edema. Pain is regulated with client-controlled morphine. Which prescription does the nurse anticipate?

1. Bolus dose of IV morphine
2. Incentive spirometer
3. IV furosemide
4. Non-rebreather mask

The registered nurse is developing a nursing care plan for a client who has just undergone surgery for treatment of ulcerative colitis with the creation of a permanent ileostomy. What is the **priority** outcome for this client?

1. The client will contact the United Ostomy Association of America

2. The client will look at and touch the stoma

3. The client will read the materials provided on ostomy care
4. The client will verbalize methods to control gas and odor

The clinic nurse is asked by the mother of a 15-month-old, "I am worried about my child's thumb sucking and its effects on tooth alignment. What should I do?" What is the nurse's **best** response?

"As long as your child's thumb sucking stops by age 2-3 years when all of the primary teeth have erupted, there is little concern."

"Because your child already has teeth, it is important to implement a plan to stop the thumb sucking as soon as possible."

"Newer research shows that thumb sucking has little effect on a child's teeth."

"The risk for misaligned teeth occurs when thumb sucking persists after eruption of permanent teeth."

The nurse prepares to administer an IV infusion of potassium chloride through a peripheral vein to a client with hypokalemia. The health care provider's prescription states: IV potassium chloride 10 mEq (10 mmol)/100 mL 5% dextrose in water now, infuse over 30 minutes. What is the nurse's **priority** action?

1. Assess the patency of the peripheral IV site
2. Check the most current serum potassium level
3. Contact the health care provider to verify the prescription
4. Set the electronic IV pump to 100 mL/hr

A child received the varicella immunization. The day after the injection, the parent calls the nurse to say that the child has discomfort, slight redness, and 2 vesicles at the injection site. What instruction would be appropriate for the nurse to provide to this parent?

1. Administer aspirin to decrease discomfort
2. Cover the vesicles with a small bandage until they are dry
3. Isolate the child from other children for 21 days to avoid exposure
4. Make an appointment with the health care provider (HCP) as soon as possible

The nurse cares for a client with type 1 diabetes mellitus who is obtunded and responding to only painful stimuli. A STAT blood sample reveals a blood glucose level of 38 mg/dL (2.11 mmol/L). Which initial action by the nurse is **best**?

1. Administer 50% dextrose in water IV push
2. Assist the client to drink 4 oz (120 mL) of orange juice

3. Measure the client's heart rate and blood pressure
4. Observe for sweating, shakiness, and pallor

The nurse is caring for a 50-year-old client in the clinic. The client's annual physical examination revealed a hemoglobin value of 10 g/dL (100 g/L) compared to 13 g/dL (130 g/L) a year ago. What should be the nurse's **initial** action?

1. Encourage intake of over-the-counter iron pills
2. Encourage intake of red meat and egg yolks
3. Facilitate a screening colonoscopy
4. Facilitate another blood test in 6 months

A 37-weeks-pregnant woman comes to the emergency department with a fractured ankle. Which assessment finding is **most** concerning and requires the nurse to follow up?

5. Fetal heart rate remains 206/min
6. Fetus kicked 4 times in the past hour
7. Mother reports feeling 2 contractions every hour
8. Mother's hemoglobin is 11 g/dL (110 g/L)

The nurse provides teaching about methotrexate to a client with rheumatoid arthritis. It is **most important** to address which topic regarding this drug?

1. Need for an eye examination
2. Need for sunblock
3. Risk for infection
4. Risk for kidney injury

A 24-year-old female client has been prescribed isotretinoin for severe nodulocystic acne that has been resistant to other therapies. Which instruction is **most important** for the nurse to reinforce with this client?

1. "Apply lubricating eye drops when wearing contacts."
2. "Swallow capsules whole."
3. "Use sunscreen routinely."
4. "Use 2 forms of contraception."

The nurse is caring for a client who is taking riluzole for amyotrophic lateral sclerosis (ALS). The client asks, "There's no cure for ALS, so why should I keep taking this expensive drug?" What is the nurse's **best** response?

1. "It may be able to slow the progression of ALS."
2. "It reduces the amount of glutamate in your brain."
3. "The case manager may be able to find a program to assist with cost."
4. "You have the right to refuse the medication."

The nurse administers 15 units of aspart insulin subcutaneously to a hospitalized client with type 1 diabetes mellitus at 7:00 AM for a fasting blood glucose of 180 mg/dL (10 mmol/L). Which nursing action is a **priority**?

1. Ensure that the client continues to fast for at least 30 more minutes
2. Give the client breakfast within 15 minutes
3. Recheck the blood glucose in 1 hour
4. Teach the client about the signs and symptoms of hyperglycemia

The nurse assesses 4 clients. Which assessment finding requires the nurse's **priority** action?

1. 26-year-old with splenectomy reports a headache and chills
2. 40-year-old with immune thrombocytopenic purpura has petechiae on the arms
3. 60-year-old with marked anemia reports shortness of breath when ambulating
4. 68-year-old with polycythemia vera has a hematocrit of 66% (0.66)

The nurse evaluates the effectiveness of desmopressin use for diabetes insipidus in a client with a pituitary tumor. Which client assessment finding indicates that the medication is having the desired effect?

1. Appetite has improved
2. Blood glucose is 110 mg/dL (6.1 mmol/L)
3. Urine output has decreased
4. Urine specific gravity is lower

The unlicensed assistive personnel on the cardiac floor reports to the registered nurse that during the first vital sign measurement on the shift, a client's blood pressure measured 198/102 mm Hg on the automated blood pressure machine. What action should the nurse take **first**?

1. Have the unlicensed assistive personnel recheck the client's blood pressure
2. Immediately notify the health care provider
3. Obtain the client's PRN labetalol from the medication dispensing machine
4. Recheck the client's blood pressure with a manual cuff

A client who was discharged 3 days ago following prostatectomy calls the clinic and tells the nurse of passing some small blood clots and experiencing a decreased urinary stream. What is the nurse's **best** response?

1. "I'll consult the health care provider (HCP) and then give you further instructions."
 2. "Those symptoms are normal the first week following surgery."
 3. "Try to bear down as if having a bowel movement."
 4. "You should increase your daily fluid intake."
-

The emergency department nurse receives report on 4 clients. Which client should the nurse assess **first**?

1. Client with acute cholecystitis who reports right shoulder pain
2. Client with gastroparesis who reports persistent nausea and vomiting
3. Client with intractable lower back pain who reports new urinary incontinence
4. Client with Ménière disease who reports increasing tinnitus

The charge nurse must assign a semi-private room to a client with diabetes mellitus admitted for IV antibiotic therapy to treat leg cellulitis. Which of the 4 room assignments is the **best** option for this client?

1. Room 1: Client 1 day postoperative laparoscopic cholecystectomy who is awaiting discharge
2. Room 2: Client with dementia and urinary incontinence wearing an external urine collection device
3. Room 3: Client with history of splenectomy 15 years ago, now admitted for pulmonary embolism
4. Room 4: Client with lupus nephritis who is prescribed treatment with azathioprine

The nurse is triaging clients in the emergency department. Which client needs to be seen **first**?

1. 18-year-old female with fever, suprapubic pain, and dysuria
2. 21-year-old male with diffuse abdominal pain and a rigid abdomen
3. 64-year-old male with a pulsatile mass in the periumbilical area and back pain
4. 75-year-old with nausea, fever, and left lower quadrant pain

A client is admitted to the postpartum floor after a vaginal birth. Which finding indicates the need for **immediate** intervention?

Lochia that soaks a perineal pad every 2 hours

1. Persistent headache with blurred vision
2. Red, painful nipple on one breast
3. Strong-smelling vaginal discharge

The nurse working on an orthopedic unit is receiving report on 4 clients with recent fractures. Which client should the nurse assess **first**?

1. client who has a femur fracture with a rash of pin-sized red spots on the chest and increased restlessness

2. Client who has purulent drainage oozing from a skeletal traction pin insertion site and a temperature of 100.8 F (38.2 C)
3. Client with a hip fracture receiving continuous IV saline with bilateral 2+ pitting leg edema and a blood pressure of 176/89 mm Hg
4. Client with a rib fracture who is breathing at a rate of 23/min and is reporting 8/10 pain that is worse with inspiration

The nurse plans discharge teaching for a client with active herpes lesions who has a new prescription for oral acyclovir and topical lidocaine. What information will the nurse include in the teaching plan?

1. Adhesive bandaging should remain on the lesions to prevent virus shedding
2. Blood tests will be drawn to ensure the virus is eradicated
3. Condoms should be used during intercourse until the lesions are healed
4. **Gloves should be used to apply the medication to the lesions**

A client comes to the emergency department with severe dyspnea and a cough. Vital signs are temperature 99.2 F (37.3 C), blood pressure 108/70 mm Hg, heart rate 88/min, and respirations 24/min. The client has a history of chronic obstructive pulmonary disease (COPD) and chronic heart failure. Which diagnostic test will be **most** useful to the nurse in determining if this is an exacerbation of heart failure?

1. Arterial blood gases (ABGs)
2. **B-type natriuretic peptide (BNP)**
3. Cardiac enzymes (CK-MB)
4. Chest x-ray

The health care provider prescribes a continuous IV infusion of regular insulin at 5 units/hr. The

5. infusion bag contains 50 units of regular insulin in 100 mL of normal saline solution. At what
6. rate in milliliters per hour (mL/hr) does the nurse set the IV pump? **Record your answer using**

a whole number. 10ml

A critical care nurse is caring for a newly admitted client with acute aortic dissection. Which prescription should the nurse **prioritize** while awaiting surgical revision of the client's aortic dissection?

1. **Administer IV labetalol to maintain blood pressure within prescribed parameters**
2. Initiate and maintain strict bed rest and a low-stimulation environment
3. Monitor bilateral lower extremity peripheral pulse strength
4. Prepare the client's consent form for surgical repair of the aorta

The graduate nurse (GN) is reinforcing education on sitting on and standing up from a chair to a client with crutches. Which instruction by the GN would cause the supervising nurse to intervene?

1. Hold a crutch in each hand on both sides when standing up from a chair."
2. "Move to the edge of the chair before standing and use your unaffected leg to rise."
3. "Touch the back of your unaffected leg to the chair before preparing to sit."
4. "Use an armrest or seat for assistance when lowering your body into a chair."

Which client is in need of follow-up education by the nurse?

1. Client with peripheral arterial disease (PAD) who insists on dangling leg over the side of the bed when sleeping
2. Client with Raynaud's phenomenon who routinely soaks hands in warm water before going out
3. Client with venous leg ulcer who refuses to wear elastic compression stockings during the day
4. Postsurgical client who points and flexes feet when lying in bed

The parents of a hospitalized preschooler are concerned because their toilet-trained child has started wetting the bed. Which response by the nurse is **most** helpful

1. Discipline your child by taking away playroom privileges."
2. "It is normal for your child to regress while hospitalized."
3. "Restricting fluids at nighttime will solve this problem."
4. "Your child is acting out due to the hospitalization."

A client with Alzheimer disease is admitted to the hospital for a urinary tract infection. The daughter says to the nurse, "I really want to take my mother home and continue care there. However, lately, my mother has become agitated and restless at night. I'm awake most of the night, feel exhausted, and do not know what to do." What is the **best** response by the nurse?

1. "Do not let your mother take naps in the afternoon."
2. "Our social worker can discuss long-term care options with you."
3. "We can ask the health care provider for medication that will help your mother sleep."
4. "Your mother can be cared for in a nursing home."

The nurse receives an obese client in the postanesthesia care unit who underwent a procedure under general anesthesia. The nurse notes an oxygen saturation of 88%. Which is the **most appropriate initial** intervention?

1. Assess pupillary response
2. Auscultate lung sounds
3. Inform anesthesia professional
4. Perform head tilt and chin lift

The nurse is caring for a client involved in a motor vehicle collision who had a chest tube inserted to evacuate a pneumothorax caused by fractured ribs. Where would the nurse observe an air leak?

1. Section A
2. Section B
3. Section C
4. Section D

An adult diagnosed with celiac disease 3 weeks ago was placed on a gluten-free diet. The client returns for ambulatory care follow-up, reports continuation of symptoms, and does not seem to be responding to therapy. Which is the **best** response by the nurse?

1. "I will refer you to the dietitian."
 2. "It should take about 6-8 weeks before you see improvement in your symptoms."
 3. "Tell me what you had to eat yesterday."
 4. "You must not be following your diet."
-

A legally blind client is being prepared to ambulate 1 day after an appendectomy. What is the **most** appropriate action by the nurse?

1. Arrange for the client's service dog to come to the health care facility as soon as possible
 2. Describe the environment in detail so the client can ambulate safely with a cane
 3. Instruct the unlicensed assistive personnel to walk beside the client and lead by the hand
 4. Walk slightly ahead of the client with the client's hand resting on the nurse's elbow
-

The nurse is caring for a client who has undergone a colonoscopy. Which client assessment finding should **most** concern the nurse?

Abdominal cramping

Frequent, watery stools

Positive rebound tenderness

Recurring flatus

The nurse caring for multiple clients who underwent renal system diagnostic testing should report which post-procedure finding to the health care provider?

1. 150 mL residual urine on bladder scan
2. Burning sensation when voiding after cystoscopy
3. Increased urinary output after arteriogram
4. Less than 10,000 organisms/mL on urine culture

The client with malignant left pleural effusion undergoes a thoracentesis and 900 mL of excess pleural fluid is removed. Which of these manifestations, if noted on the post-procedure assessment, should the nurse report to the health care provider **immediately**?

1. Asymmetrical chest expansion and decreased breath sounds on the left
2. Blood pressure 100/65 mm Hg (mean arterial pressure 77 mm Hg)
3. Client complains of 6/10 pain at the needle insertion site
4. Respiratory rate 24/min, pulse oximetry 94% on oxygen 2 L/min

A newly reassigned nurse enters a hospital room at the beginning of the shift and finds the client unconscious and unresponsive. Resuscitation is initiated and then continued by the rapid response team. The nurse realizes that there is a do not resuscitate (DNR) prescription posted in the client's chart. Which action is correct?

1. Stop all resuscitation activity immediately
2. Continue resuscitation until DNR status is verified with health care provider
3. If client shows any signs of life, follow advanced cardiovascular support protocol until stable
4. Once resuscitation has begun, complete it regardless of client code status

The nurse reinforces teaching to a client with HIV during a follow-up clinic visit after being on antiretroviral drugs for the past 2 months. Which statement by the client indicates a need for **further instruction**?

1. "I can stop taking these HIV drugs once my viral levels are undetectable."
2. "I need to get tested regularly for sexually transmitted infections because I'm sexually active."
3. "I should use latex condoms and barriers when having anal, vaginal, or oral sex."

4. "I won't stop injecting drugs, but I will use a needle exchange program."

A client recently diagnosed with a major depressive disorder reports use of herbal supplements. It is **most** important for the nurse to provide education about which supplement reported by the client?

Echinacea

2. Garlic

3. Glucosamine

5. **St John's wort**

The nurse reviews the assigned clients' laboratory results and medication administration records. Which finding is the **highest priority** for the nurse to follow-up with the health care provider?

1. Gram-negative infection and positive blood cultures in a client prescribed tobramycin
2. Serum B-type natriuretic peptide (BNP) 650 pg/mL (650 ng/L) in a client prescribed furosemide

3. **Serum potassium 5.7 mEq/L (5.7 mmol/L) in a client prescribed spironolactone**

4. Serum sodium 132 mEq/L (132 mmol/L) in a client prescribed IV normal saline solution

at 175 mL/hr

A nurse is caring for a college athlete who was recently diagnosed with moderate persistent asthma. Which common asthma trigger should the nurse teach this client to **avoid**?

1. Latex-containing products
2. Penicillin antibiotics
3. **Secondhand cigarette smoke**
4. Strenuous physical activity

A laboring client weighing 187 lb is 5 cm dilated and having contractions every 2-3

minutes. The client rates the pain at 7 out of 10. Nalbuphine hydrochloride 10 mg/70 kg IV

push × 1 is prescribed by the health care provider. Nalbuphine hydrochloride 10 mg/1 mL is

available. How many milliliters does the nurse administer? **Record your answer using one**

decimal place. **1.2 mL**

A client in the mental health unit picks up a fire extinguisher and throws it at a nurse standing by the nurses' station. What is the **most important** intervention by the nurse?

- 1. Facilitate immediate removal of people from the area**
 2. Inform the client that the client cannot act that way
 3. Pull the fire alarm to get additional immediate help
 4. State that the nurse can see the client is upset
-

A client with a diagnosis of schizophrenia with catatonia has recently been admitted to the psychiatric unit. Which of the following is the **priority** nursing diagnosis?

Impaired social interaction

1. Impaired verbal communication
- 2. Risk for deficient fluid volume**
3. Risk for impaired skin integrity

A client comes to the emergency department after being assaulted. Imaging studies show a simple fracture of the mandible. The nurse assesses edema of the face and jaw, drooling, and bleeding in the mouth; the client rates pain as a 9 out of 10. What is the **priority** nursing intervention?

1. Administer nasal oxygen at 3 L/min
2. Administer opioids for pain
3. Apply ice pack to face for 20 minutes each hour
- 4. Suction the mouth and oropharynx**

What is the **priority** when caring for a 6-month-old diagnosed with atopic dermatitis?

1. Encouraging use of humidifier
2. Exploration of family feelings
3. Instruction regarding hypoallergenic diet
- 4. Prevention of scratching**

The hospitalized client with anorexia nervosa is started on nutrition via enteral and parenteral routes. Which client assessment is the **most important** for the nurse to check during the first 24- 48 hours of administration?

1. Serum albumin level and body weight
2. Serum potassium and phosphate
3. Symptoms of dumping syndrome
4. White blood cell count and neutrophils

The nurse is caring for 4 clients. Based on the assessment data, which client does the nurse anticipate the health care provider transferring to the intensive care unit?

36-year-old with alcohol abuse who is prescribed IV lorazepam every 3 hours for agitation and has a blood pressure of 190/98 mm Hg and serum magnesium level of 1.5 mEq/L (0.75 mmol/L)

56-year-old with stable angina who has chest and jaw pain relieved with nitroglycerin, blood pressure of 98/70 mm Hg, and dizziness when getting up

60-year-old with chronic kidney disease who has a blood pressure of 168/88 mm Hg, serum creatinine level of 5.0 mg/dL (442 μ mol/L), and reports nausea and itching

3. 82-year-old with pressure injury who has a change in mental status, temperature of 96.4 F (35.8 C), pulse of 110/min, and blood pressure of 96/72 mm Hg

The charge registered nurse (RN) on a medical-surgical unit is responsible for making assignments. Which assignment made by the RN is **most appropriate**?

1. A licensed practical nurse (LPN) assigned to a client receiving blood transfusions
2. A student nurse assigned to a client who requires frequent intravenous pain medication
3. An LPN assigned to a client 2 days postoperative appendectomy scheduled to be

discharged today

4. An RN assigned to a client 1 day postoperative repair of a compound fracture

1. The nurse reviews and reinforces an asthma action plan with a client who has moderate persistent asthma. Which statement by the client indicates an **understanding** of how to follow a plan appropriately when peak expiratory flow (PEF) readings are in the green, yellow, or red zones?
2. "If I am in the green zone (PEF 80%-100% of personal best) but am coughing, wheezing, and having more trouble breathing, I will not make any changes in my medications."
3. "If I am in the yellow zone (50%-80%) and I return to the green zone after taking my rescue medication, I will not make any changes in my daily medications."

4. "If I am in the yellow zone (50%-80%), I will take my rescue medication every 4 hours

for 1-2 days and call my health care provider (HCP) for follow-up care."

5. "If I remain in the red zone, my lips are blue, and my PEF is still <50% of my personal best reading after taking my rescue medication, I will wait 15 minutes before calling an ambulance."

A client is receiving chemotherapy for acute myeloid leukemia. The health care provider prescribes allopurinol to prevent tumor lysis syndrome (TLS). Which laboratory value indicates a therapeutic response to the medication?

1. Serum calcium 9.5 mg/dL (2.38 mmol/L)
2. Serum phosphate 4.0 mg/dL (1.29 mmol/L)
3. Serum potassium 4.5 mEq/L (4.5 mmol/L)
4. Serum uric acid level 6.0 mg/dL (357 μ mol/L)

The nurse is conducting a follow-up interview with a client who is being treated for depression and suicidal ideation. Which factor **best** indicates the client is not currently at risk for suicide?

1. Client claims to have more energy and vigor since starting therapy
2. Client has clear future plans involving personal goals and family milestones
3. Client has signed a contract promising not to commit suicide
4. Client reports losing amitriptyline and requests a refill

After listening to the parents' reports and seeing the following pediatric clients, the nurse knows that which client demonstrates signs of abuse that may necessitate mandatory reporting?

1. 1-year-old with dyspnea, drooling, and a swollen tongue after eating part of a houseplant
2. 2-year-old who is crying and has a large forehead hematoma after falling out of a chair
3. 3-year-old with second-degree burns on the face after pulling a cup of hot tea off the table
4. 5-year-old whose x-ray reveals 1 new and 2 healed humerus fractures after falling from a

tree

The charge nurse is responsible for making room assignments for multiple clients. Which pair of client assignments to a shared room is appropriate?

1. Client with blood loss anemia and client with intractable diarrhea
2. Client with gastroenteritis and client with chemotherapy-induced nausea and vomiting

3. Client who had a bowel resection 1 day ago and client with asthma exacerbation
4. Client who had a total hip arthroplasty 2 days ago and client with influenza

Question: 3 Correct Answer:

The nurse cares for a client with a terminal disease who has an advance directive supporting a do not resuscitate (DNR) code status. The client stops breathing and loses a pulse. The client's adult child states, "I changed my mind. Do whatever you can to save him!" Which intervention is **most** appropriate at this time?

1. Call for help to initiate cardiopulmonary resuscitation
2. Call the health care provider to confirm the DNR status
3. Explain the client's wishes to the client's child
4. Offer to call the hospital chaplain to provide support

Question: 4 Correct Answer:

The clinic nurse is assessing a client who is being treated for depression and suicidal ideation. Which client statement **best** indicates that the client is not currently at risk for suicide?

1. "I lost my imipramine prescription. Could I have a refill?"
2. "I plan to attend my granddaughter's graduation next month."
3. "I seem to have a lot more energy since I started therapy."
4. "I will sign a 'no-suicide' contract at today's appointment."

A nurse caring for a client following a right femoral angiogram is unable to palpate the right pedal pulse. What should the nurse do **next**?

1. Apply a heating pad to increase circulation
2. Call the health care provider
3. Document "0" for right pedal pulse strength
4. Obtain a Doppler ultrasound

Rationale

A 25-year-old client is about to undergo a unilateral orchiectomy for treatment of testicular cancer. The client says to the nurse, "I'm so worried that my future spouse is going to call off our engagement." What is the **best** response by the nurse?

1. "Are you concerned about how the surgery will affect your sexuality?"
2. "If you are concerned about infertility, you could always bank your sperm."
3. "The cancer is at an early stage. You are going to be fine."
4. "What have you and your future spouse discussed about your condition?"

he nurse is preparing to administer the fourth dose of IV vancomycin to a client. Which set of laboratory values would alert the nurse to hold the vancomycin and notify the health care provider?

1. Vancomycin trough 10 mg/L (6.9 $\mu\text{mol/L}$), creatinine 1.1 mg/dL (97.2 $\mu\text{mol/L}$), BUN 6 mg/dL (2.1 mmol/L)
2. Vancomycin trough 14 mg/L (9.7 $\mu\text{mol/L}$), creatinine 1.2 mg/dL (106.1 $\mu\text{mol/L}$), BUN 10 mg/dL (3.6 mmol/L)
3. Vancomycin trough 18 mg/L (12.4 $\mu\text{mol/L}$), creatinine 0.6 mg/dL (53 $\mu\text{mol/L}$), BUN 18 mg/dL (6.4 mmol/L)
4. Vancomycin trough 23 mg/L (15.9 $\mu\text{mol/L}$), creatinine 1.5 mg/dL (132.6 $\mu\text{mol/L}$), BUN 24 mg/dL (8.6 mmol/L)

Which client is at **greatest risk** for respiratory depression when receiving opioids for pain control?

1. 20-year-old client with bronchitis receiving inhaled bronchodilator therapy every 4 hours
2. 30-year-old client with heroin addiction with rotator cuff repair surgery this morning
3. 50-year-old client with sleep apnea and left foot cellulitis and scheduled for a bone scan
4. 70-year-old client with chronic obstructive pulmonary disease (COPD) with knee replacement this morning

The flight nurse assesses an alert and oriented client at an industrial accident scene who was impaled in the abdomen by a pair of scissors. Which nursing action is the **immediate priority** on arrival at the scene?

1. Insert a large-bore IV line and infuse normal saline
2. Obtain blood for type and crossmatch and hemoglobin
3. Remove constrictive clothing to enhance circulation
4. Stabilize the scissors with sterile bulky dressings

The nurse is caring for a new mother whose infant has been diagnosed with Down syndrome. The client says to the nurse, "I'm so worried. My husband is so devastated that he won't even look at the baby." What is the **best** response by the nurse?

1. "Both of you will benefit from supportive counseling."
2. "How are you feeling about your baby?"
3. "I will have the doctor speak to your husband."
4. "Why do you think your husband feels this way?"

A client with schizophrenia says to the nurse, "The world turns as the world turns on a ball at the beach. But all the world's a stagecoach and I took the bus home." The nurse recognizes this statement as an example of which of the following?

1. Concrete thinking
 2. Loose associations
 3. Tangentiality
 4. Word salad
-

A nurse on the behavioral health unit is reviewing medication prescriptions for 4 clients. Which combination of medications does the nurse **question**?

1. A client with anxiety prescribed escitalopram and alprazolam
2. A client with bipolar disorder prescribed risperidone and lithium
3. A client with depression prescribed escitalopram and selegiline
4. A client with depression prescribed sertraline and zolpidem

The nurse is assessing a 4-day-old, term neonate who is breastfed exclusively. Which assessment finding should the nurse report to the health care provider for further assessment regarding possible formula supplementation?

1. 10% weight loss since birth
 2. Cracked, peeling skin
 3. Feeds every 2-3 hours
 4. Runny, seedy, yellow stools
-

The nurse is preparing to assess a client visiting the women's health clinic. The client's obstetric history is documented as G₅T₁P₂A₁L₂. Which interpretation of this notation is correct?

1. The client had 1 birth at 37 wk 0 d gestation or beyond
2. The client had 3 births between 20 wk 0 d and 36 wk 6 d gestation
3. The client has 3 currently living children
4. The client is currently not pregnant

The nurse is caring for a client with gestational diabetes mellitus during the second stage of labor. After birth of the head, the nurse notes retraction of the fetal head against the maternal perineum. Which action should the nurse anticipate?

1. Administering a tocolytic

2. Initiating fundal pressure during a contraction
3. Obtaining the vacuum extractor
4. Pressing downward on the symphysis pubis

The nurse reviews laboratory test results for a pregnant client at 32 weeks gestation. What is the nurse's **best** action based on these results ?

1. Complete the client assessment and documentation
2. Draw another sample for repeat complete blood count
3. Prepare for transfusion of packed red blood cells
4. Request a prescription for iron supplementation

What is the **most** therapeutic intervention the nurse should complete when admitting a 10-month-old to the pediatric unit?

1. Allow the child to sit on the primary caregiver's lap while auscultating breath sounds
2. Instruct the primary caregiver to restrain the child's arm while obtaining intravenous access
3. Provide the option for the child to complete the admission in the room or the designated play area
4. Request that the primary caregiver leave the child's room during the physical assessment

A client with multidrug-resistant tuberculosis (MDR-TB) has a 1-month follow up visit after beginning medication therapy. The client states, "I've had really bad nausea and fatigue, but because my cough has already improved, I knew it would be alright to stop taking the medications." The nurse identifies which **priority** nursing diagnosis (ND) in this client's care plan?

1. Activity intolerance
 2. Imbalanced nutrition, less than body requirements
 3. Knowledge deficit of prescribed therapeutic regimen
 4. 4. Nausea
-

A newborn had a bowel resection with temporary colostomy for Hirschsprung's disease. The nurse should alert the health care provider (HCP) for which assessment finding postoperatively?

Moderate amount of blood-tinged mucus from the stoma on postoperative day 2

1. Small amount of non-formed stool in the colostomy bag on postoperative day 6
2. Stoma bleeds a small amount during colostomy bag change on postoperative day 3
4. Stoma is gray-tinged at the edges but pink at the center on postoperative day 5

The nurse is caring for a client newly admitted with an acute manic episode of bipolar disorder. The nurse identifies which dinner selection as the **most** appropriate to promote client nutrition?

1. Baked sweet potato, kale, yeast roll, water
2. Cheeseburger, apple, vanilla milkshake
3. Spaghetti with meatballs, fruit salad, milk
4. Vegetable soup, salad, dinner roll, iced tea

A 9-year-old has terminal cancer, but the parents do not want the child to know the prognosis. The child has been asking questions such as what dying is like and whether the child will die. Which action by the nurse is **most** appropriate?

1. Encourage the child to ask the parents these questions
2. Notify the health care provider (HCP) about the child's questions
3. Reassure the child that everyone is trying to help the child get better
4. Tell the parents about the child's questions

The parent of a 2-year-old tells the nurse at the well-child clinic, "I am concerned because my child does not like to be cuddled, does not respond when called by name, and does not make eye contact when being fed." What is the **priority** question for the nurse to ask when completing the health history?

1. "How many words can your child say?"
2. "Is your child potty trained?"
3. "What are your child's favorite foods?"
4. "What kind of toys does your child like to play with?"

The nurse is caring for a client after percutaneous placement of a coronary stent for a myocardial infarction. The client reports 5/10 lower back pain and has a blood pressure of 140/92 mm Hg. The cardiac monitor shows normal sinus rhythm with occasional premature ventricular

contractions. Which prescription should the nurse administer **first**? **Click on the exhibit button for additional information.**

1. Captopril PO every 8 hours
2. Morphine IV PRN for pain
3. Potassium chloride IV once
4. Regular insulin subcutaneous with meals

The health care provider (HCP) prescribes paroxetine to a client with depression. What statement by the client indicates proper understanding of the medication?

5. "I can discontinue the medication if my symptoms improve."
6. "I need a healthy diet and regular exercise to combat weight gain."
7. "If I don't feel better in 1-2 weeks, then the medication is not working."

"This medication might increase my sexual performance."

A charge nurse is monitoring a newly licensed registered nurse. What action by the new nurse would warrant **intervention** by the charge nurse?

Administers hydromorphone 1 mg to a client who rates pain at 7 on a 1 to 10 scale

Notifies physician of occasional premature ventricular beats in a client with myocardialinfarction

3. Positions a postoperative pneumonectomy client on the affected side

4. Prepares to administer IVPB potassium chloride via gravity infusion for a client with hypokalemia

A client with chronic kidney disease has received a continuous intravenous infusion of heparin for 5 days. The nurse reviews the coagulation studies and the medication administration record. Which prescription would the nurse question?

1. Epoetin
2. Sodium polystyrene sulfonate
3. Vitamin K
4. Warfarin

Which client should the nurse assess **first**?

1. Client with atrial fibrillation with a new prescription for warfarin
2. Client with chronic obstructive pulmonary disease with an oxygen saturation of 91%

3. Client with postoperative pain rated 8 out of 10
4. Client with third-degree heart block with a pulse of 42/min

Which client is **most appropriate** for the charge nurse in the postpartum unit to assign to the float nurse from the intensive care unit?

1. Client experiencing fever and pain with mastitis
2. Client preparing for discharge after cesarean birth
3. Client showing disinterest in caring for the newborn
4. Client with hysterectomy after postpartum hemorrhage

The long-term care nurse is caring for a client diagnosed with macular degeneration. Which client statement supports this diagnosis?

1. "I have been seeing small flashes of light."
2. "I have trouble threading my sewing needle. I have to hold it far away to see it."
3. "I notice that my peripheral vision is becoming worse."
4. "I see a blurry spot in the middle of the page when I read."

"I can A nurse is teaching a postpartum client about cord care for the newborn. Which statement by the client indicates a need for **further** teaching?

5. expect the cord to turn black in a few days."
6. "I should let the cord fall off by itself, in about 1-2 weeks."
7. "I should use a cotton swab to gently apply alcohol to the cord."
8. "I will fold the diaper below the cord to allow the cord to dry."

An emergency department nurse is assigned to triage. Which client should the nurse assess **first**?

1. Five-year-old with a superficial leg laceration
2. Lethargic 3-month-old with diarrhea for the past 12 hours
3. Seven-year-old with a elevated temperature of 101 F (38.3 C) and hematuria
4. Seventeen-year-old with severe, acute abdominal pain

The nurse is triaging clients from the waiting room. The care of which client is a **priority**?

1. 2-year-old who ingested a button battery approximately 30 minutes ago and is asymptomatic
2. 4-year-old who started crying and suddenly won't use the left arm after being swung by the arms
3. Child with cerebral palsy and a baclofen pump who has increased muscular spasms
4. Child with osteogenesis imperfecta who walks in reporting being hit on the front of the

head with a baseball

The nurse in the emergency department receives report on 4 clients. Which client should be seen **first**?

1. 5-year-old with an accidental epinephrine auto-injector stick and a heart rate of 124/min
2. 7-year-old who is crying, has vaginal lacerations and bruising, and has a heart rate of 118/min
3. 10-year-old with a large, draining abscess on the left buttock and a temperature of 101.2 F (38.4 C)

4. 14-year-old who is lethargic after playing a football game and has a temperature of 104.1

F (40.1 C)

The charge nurse is making assignments for the oncoming shift. Which client assignments should be **avoided** by the nurse who is pregnant?

1. 2-year-old client who is combative on postoperative day 2 for tonsillectomy and adenoidectomy
2. 5-year-old client admitted for dehydration secondary to severe throat pain associated with group A *Streptococcus*
3. 9-year-old client with parvovirus B-19 infection admitted for observation after a febrile seizure
4. 14-year-old client with acute lymphocytic leukemia who received intrathecal chemotherapy 4 days ago and was admitted for a blood transfusion

The nurse is reviewing new laboratory values. Which client would be the **priority** to report to the health care provider?

1. Client 2 days after a hip arthroplasty with a white blood cell count of 12,000/mm³ (12x10⁹/L)
2. Client admitted for cocaine overdose with a creatine kinase of 30,000 U/L (501 μkat/L)
3. Client admitted for end-stage renal disease with a creatinine of 3.6 mg/dL (274.5

mmol/L)

4. Client in heart failure exacerbation with a brain natriuretic peptide of 600 pg/mL (600 pmol/L)

The nurse is caring for a client who had surgery yesterday. When administering omeprazole, the client asks "What is that for? I don't take it at home." Which reply by the nurse is **most appropriate**?

1. "Omeprazole helps prevent nausea by making your stomach empty faster."
2. "Omeprazole helps prevent you from developing an ulcer due to the stress of surgery."
3. "Omeprazole protects you from getting an infection while on antibiotics."

"This medication will treat your gastroesophageal reflux disease (GERD)."

The nurse cares for a client receiving intermittent peritoneal dialysis who is prescribed strict

intake and output monitoring with calculation of net fluid balance each shift. Calculate the total

net fluid balance for the shift. **Record the answer using a whole number.**

890ml

A client is brought to the emergency department after his face slammed into a brick wall during a gang fight. Which client assessment finding is **most important** for the nurse to consider before inserting a nasogastric tube?

1. An ecchymotic area on the forehead
2. Frontal headache rated as 10 on a 1-10 scale
3. Nasal drainage on gauze has a red spot surrounded by serous fluid
4. Small amount of bright red blood oozing from cheek laceration

The nurse enters a client's room and finds that the client and spouse are crying. The spouse states that the health care provider just diagnosed the client with Alzheimer disease. What is the **best** response by the nurse?

1. "Do you have any questions about the diagnosis?"
2. "There are medications available to treat Alzheimer disease."
3. "This new diagnosis must be frightening for you."
4. "We can help you make decisions about your care."

The nurse is caring for a client with asthma exacerbation. Blood pressure is 146/86 mm Hg, pulse is 110/min, and respirations are 32/min. The respiratory therapist administers nebulized albuterol as prescribed. One hour after the treatment, the nurse assesses which finding that indicates the drug is producing the therapeutic effect?

1. Constricted pupils
2. Heart rate of 120/min
3. Respirations of 24/min
4. Tremor

The nurse is conducting an educational community outreach program on melanoma screening. Which statement by a resident would indicate the **need for further education**?

1. Abrupt changes in the size or color of a mole are warning signs.
2. All new growths and pigmentations must be biopsied to rule out cancer.
3. Melanoma can occur as any color.
4. Melanoma does not always occur as a new mole.

The office nurse instructs a client newly diagnosed with asthma about the use of the peak flow meter to evaluate airflow. Which statement made by the client indicates an understanding of the nurse's teaching?

1. "I will exhale as quickly and forcibly as possible through the mouthpiece of the device to obtain a peak flow reading."
2. "I will move the indicator to the desired reading on the numbered scale before using the device."
3. "I will record my personal best reading, which is the average of 3 consecutive peak flow readings."
4. "I will remember to use the device after taking my fluticasone metered-dose inhaler (MDI)."

A nurse is caring for a group of clients on a medical surgical unit. Which client is **most** at risk for contracting a nosocomial infection?

1. 51-year-old client who received a permanent pacemaker 48 hours ago
2. 60-year-old client who had a myocardial infarction 24 hours ago
3. 74-year-old client with stroke and an indwelling urinary catheter for 3 days
4. 75-year-old client with dementia and dehydration who is on IV fluids

A client started a 24-hour urine collection test at 6:00 AM. The unlicensed assistive personnel (UAP) reports discarding a urine specimen of 250 mL at 10:00 AM by mistake but adding all specimens to the collection container before and after that time. What action should the nurse take?

1. Add 250 mL to the total output after the 24-hour urine collection is complete tomorrow morning

2. Discard urine and container, and restart the 24-hour urine collection tomorrow morning
3. Discard urine and container, have client void, add urine to new container, and then restart test
4. Relabel the same collection container, and change the start time from 6:00 AM to 10:00 AM

The nurse has received report on the following clients. Which client should the nurse assess first?

1. Client 4 hours postoperative colon resection who has a blood pressure of 90/74 mm Hg
2. Client receiving palliative care who has Cheyne-Stokes respiration with 20-second periods of apnea
3. Client with anemia and hemoglobin level of 7 g/dL (70 g/L) who has a pulse of 110/min after ambulation
4. Client with diabetic ketoacidosis who has rapid, deep respirations at a rate of 32/min

The nurse cares for a client who just had surgical excision and biopsy of a tumor. The biopsy results show that the tumor is malignant, but the client has not yet been informed by the health care provider. The client asks the nurse, "Am I going to die?" Which statement by the nurse is appropriate?

1. "I know how anxious you must be. Watching some television might help you relax."
2. "Tell me more about your thoughts and feelings regarding the situation."
3. "The biopsy result shows that you have cancer, but many cancers are treatable."
4. "Waiting for test results can be stressful. I am sorry I cannot tell you more."

The nurse is evaluating a client with liver cirrhosis who received IV albumin after a paracentesis to drain ascites. Which assessment finding indicates that the albumin has been effective?

1. Abdominal circumference reduced from admission recording
2. Flapping tremor no longer visible with arm extension
3. Shortness of breath no longer experienced in supine position
4. Vital signs remain within the client's normal parameters

A client with a permanent pacemaker with continuous telemetry calls the nurse and reports feeling lightheaded and dizzy. The client's blood pressure is 75/55 mm Hg. What is the nurse's **priority** action? **Click the exhibit button for additional information.**

1. Administer atropine 0.5 mg IV
2. Administer dopamine 5 mcg/kg/min IV
3. **Initiate transcutaneous pacing**
4. Notify the health care provider

The nurse is caring for the assigned clients on a pediatric inpatient unit. Which client is the **priority**?

1. **8-year-old with sickle cell crisis who has sudden-onset unilateral arm weakness**
2. 11-year-old with viral meningitis requesting pain medication for headache
3. Male child scheduled for surgery for intussusception who has reddish mucoid stool
4. Male child with hemophilia who has hemarthrosis and is receiving desmopressin

The nurse is caring for a client with a history of tonic-clonic seizures. After a seizure lasting 25 seconds, the nurse notes that the client is confused for 20 minutes. The client does not know the current location, does not know the current season, and has a headache. The nurse documents the confusion and headache as which phase of the client's seizure activity?

1. Aural phase
2. Ictal phase
3. **Postictal phase**
4. 4. Prodromal phase

A client is seen in the clinic for the third time for a nonhealing, infected diabetic foot ulcer. The client is able to verbalize the correct procedure for wound care but reports not adhering to the ordered routine at home. What intervention does the nurse **prioritize** to promote proper self care?

1. Assess the client's feelings about placement at a skilled nursing facility for care
2. Educate the client on the risks of tissue death if not properly cared for at home
3. **Explore the client's abilities and motivation to perform care at home**
4. Provide the client with the supplies needed to change dressings as recommended

A client with massive trauma and possible spinal cord injury is admitted to the emergency department following a dirt bike accident. Which clinical manifestation does the nurse assess to help best confirm a diagnosis of neurogenic shock?

1. **Apical heart rate 48/min**

2. Blood pressure 186/92 mm Hg
3. Cool, clammy skin
4. Temperature 100 F (37.7 C) tympanic

The nurse is educating a client newly diagnosed with rheumatoid arthritis about the disease process and home management. Which statement by the client indicates comprehension of teaching?

1. "Even with appropriate treatment joint damage and disability are inevitable."
2. "My arthritis can be resolved if I can improve my diet and lose weight."
3. "My methotrexate should be taken even when my joints aren't hurting." "
4. When my joints hurt, I should rest frequently and try not to move them."

When unlicensed assistive personnel (UAP) assists a client with a chest tube back to bed from the bedside commode, the plastic chest drainage unit accidentally falls over and cracks. The UAP immediately reports this incident to the nurse. What is the nurse's **immediate** action?

1. Clamp the tube close to the client's chest until a new chest drainage unit is set up
2. Notify the health care provider (HCP)
3. Place the distal end of the chest tube into a bottle of sterile saline
4. Position the client on the left side

The nurse reviews laboratory data for a client admitted to the emergency department with chest pain. Which serum value requires the most **immediate** action by the nurse?

1. Glucose 200 mg/dL (11.1 mmol/L)
2. Hematocrit 38% (0.38)
3. Potassium 3.4 mEq/L (3.4 mmol/L)
4. Troponin 0.7 ng/mL (0.7 mcg/L)

The nurse is educating a client recently diagnosed with rheumatoid arthritis about home care and symptom management. Which of the following client statements indicates a **need for further teaching**?

1. "Daily range-of-motion exercises are important to keep my joints flexible."
2. "I can use a moist heat pack to help with joint stiffness."
3. "I should elevate my knees with pillows when I'm sleeping."
4. "I will make sure to rest in between activities throughout the day."

The spouse of an immunocompromised client is diagnosed with influenza virus infection. The spouse asks the office nurse how long contact with the client should be avoided to prevent the infection from spreading. What is the nurse's **most appropriate** response?

1. "Avoid close contact for about a week."
2. "It's impossible to avoid contact with the client. Just wash your hands often."

3. "You are sick already, and so you are not contagious anymore."
4. "You don't have to worry as long as the client has received the influenza vaccination."

The home care nurse visits the house of an elderly client. Which assessment finding requires **immediate** intervention?

1. The client cannot remember what was done yesterday
2. The client has a painful red area on the buttocks
3. **The client has new dependent edema of the feet**
4. The client has strong, foul smelling urine

When planning the therapeutic milieu, a nurse should select actions for activity groups with what intent in mind?

1. are consistent with clients' skills
2. **achieve the clients' therapeutic goals**
3. build skills of individual participation in groups
4. match the clients' preferences

A nurse is caring for a client who has been diagnosed with the development of cardiac tamponade. Which finding should the nurse consider as the greatest concern?

drop in the hourly urine output

2. changes in mental status
3. weakened, irregular pulses
4. **decline in the blood pressure readings**

A client is admitted with the diagnosis of testicular cancer. Which of these factors in the client's history would be associated with the disease?

early age sexual relations

epididymiti

seminalvesiculitis .

undescended testis

A nurse is asked about chiropractic treatment for illnesses. The nurse should know that it focuses on which approach.

mind - body balance

spinal column manipulation

exercise of joints

electrical energy fields

A nurse is assigned to a client who develops pulmonary edema and exhibits sudden anxiety, diaphoresis and auditory crackles. Which nursing intervention should be performed first?

give the prescribed diuretic

2. instruct the client to deep breathe then clear the airway
3. check the client's SpO2 pulse oximetry
- 4. sit the client in an upright position**

A client who is taking lithium works in lawn maintenance, cutting grass and trimming bushes. The client asks about good snacks to pack during the summer. A nurse should recommend which food?

watermelon

B. pretzels

C. yogurt

D. applesauce

An 18 month-old child is on peritoneal dialysis in preparation for a renal transplant in the near future. When a nurse obtains the child's health history, the mother indicates that the child has not had the first measles, mumps, rubella (MMR) immunization. The priority nursing action should be based on which understanding?

1. an inactivated form of the vaccine can be given at any time
- 2. the MMR vaccine should be given now, prior to the renal transplant**
3. the risk of vaccine side effects precludes giving the vaccine
4. live vaccines are withheld in children with chronic renal illness

A client has been receiving lithium (Lithane) for the past two weeks for the treatment of bipolar illness. When reviewing information, what point should a nurse make with the client?

1. take a diuretic with lithium

2. have blood lithium levels drawn frequently during the summer months
3. maintain a low sodium diet
4. come in for evaluation of serum lithium levels every 1-3 months

A young adult male is admitted with a diagnosis of testicular cancer. The nurse would expect the client to have

1. scrotal discoloration
2. inability to achieve erection
3. sustained painful erection
4. heaviness in the affected testicle

Which finding should a nurse anticipate in a client with extracellular fluid volume deficit?

1. neck veins are distended at 35 degree elevation
2. concentrated urine on the last voiding
3. pedal pulses +3 bilateral
4. sustained rapid respirations

A nurse should have knowledge to monitor blood pressure in clients who receive antipsychotic medications for what reason?

1. orthostatic hypotension is a common side effect
2. it will indicate the need to institute antiparkinsonian medications
3. this provides information on the amount of sodium allowed in the diet
4. most antipsychotic medications cause elevated blood pressure

A six year-old child is diagnosed with recurrent urinary tract infections (UTI). Which instruction is the best for a nurse to discuss with the caregiver?

- A. child should wear any kind of underwear
- B. have the child use antibacterial soaps while bathing
- C. use plain water for a tub bath and shampoo the hair last
- D. when laundering clothing, rinse several times

A client asks a nurse to reinforce an understanding of the basic ideas of homeopathic medicine. Which information best explains the purpose of homeopathic remedies?

1. to maintain fluid balance

2. to boost the immune system

3. to increase bodily energy

2. to destroy organisms causing disease

When reinforcing information about the difference between tardive dyskinesia and neuromelanin syndrome to a client, a nurse should explain that tardive dyskinesia

1. develops within hours to years of continued antipsychotic medication use in people under 20 and over 30
2. can occur in clients taking antipsychotic medications longer than two years
3. occurs within minutes of the first dose of antipsychotic medications and is reversible
4. can easily be treated with anticholinergic medications

A victim of domestic violence states to the nurse, "If only I could change and be how my partner wants me to be, I know things would be different." Which would be the best response by the nurse?

1. "The violence is temporarily caused by unusual circumstances. Don't stop hoping for a change."
2. "Perhaps, if you understood the need to abuse, you possibly could intercept the violence."
3. "No one deserves to be beaten. Are you doing anything to provoke your partner into such behaviors?"
4. "Batterers lose self-control because of internal reasons, not because of what the partner did or did not do."

A client is unconscious after a tonic-clonic seizure. What should a nurse do at this time?

1. place an airway in the mouth

2. place the client in a side-lying position

3. administer the ordered anticonvulsant

4. check the pulse for irregularity

Domestic violence remains extensively undetected because of which factor(s)?

1. little knowledge of trends is currently known
2. complaints of the abused person may be vague
3. police involvement and court costs
4. few battered individuals seek medical care

A priority goal of involuntary hospitalization of the client diagnosed with severe mental illness is

protection from harm to self and others

2. return to independent functioning
3. elimination of findings

4. re-orientation to reality

Which focus should be included when a nurse reinforces information with a client about chlorpromazine HCL (Thorazine)? The client should avoid which item?

1. direct sunlight
2. canned citrus fruit drinks
3. foods fermented with yeast
4. foods containing tyramine

A client with testicular cancer has had a unilateral orchiectomy. Prior to discharge the client expresses his fears related to the prognosis. Which statement should be the initial response by a nurse?

1. "Chemotherapy is most likely to be started right away."
2. "Testicular cancer has a very high cure rate with early diagnosis."
3. "Self-examination needs to be continued in order to prevent and detect recurrences."
4. "Adoption may be a consideration if you want children."

A client is taking a mood stabilizer. A nurse should recognize that early signs of toxicity include which of these findings?

1. vomiting, diarrhea, lethargy
2. pruritus, rash, photosensitivity
3. ataxia, coarse hand tremors, irritability
4. electrolyte imbalance, cardiac arrhythmias, dysrhythmias

In clients diagnosed with severe mitral stenosis, the nurse should most anticipate performing nursing interventions that have which focus?

1. relieve chest pain
2. clear the airway
3. reduce edema
4. promote cardiac output

A couple attempting to conceive asks a nurse when ovulation occurs. The woman reports a regular 32 day cycle. The nurse should respond that ovulation for her from the beginning of her cycle probably occurs within

1. 7 to 10 days
2. 14 to 16 days
3. 17 to 19 days
4. 10 to 13 days

The nurse is reviewing the lab results for a male client on a heparin infusion to treat a deep vein thrombosis (DVT) and cellulitis of the right lower leg. Which of the lab results would the nurse be most concerned about? Lab results

White blood cells (WBC) microliter Platelet count microliter Hemoglobin Hematocrit - 15,100 per - 50,000 per - 45% Partial Thromboplastin Time (PTT) - 55 seconds

1. White blood cells
2. Hematocrit
3. Partial thromboplastin time (PTT)
4. Platelet count
5. Hemoglobin

A nurse assists with the reinforcement of information about breast self-examination to a group of college students. A female student asks when to perform the monthly exam. The appropriate reply by the nurse should include which statement?

1. "Do the exam at the same time every month."
2. "Right after the period, when your breasts are less tender."
3. "The first of every month, because it will be easiest to remember."
4. "Ovulation, or mid-cycle is the best time to detect changes."

An eight year-old client is admitted to the child mental health unit for evaluation. After the mother's departure, the client cries and refuses dinner. The best approach by a nurse is to take which action?

1. spend time with the child and offer to play games
2. explain the need for food to maintain energy
3. remind the child that the mother will return
4. discuss the expectations of both the child and the nurse

Clients taking which of these drugs are at risk for depression?

1. diuretics for heart failure
2. folic acid for cirrhosis of the liver
3. steroids for chronic obstructive pulmonary disease
4. aspirin for peripheral vascular disease

A nurse is caring for a client who is four days post-op after a transverse colostomy was done. The client, to be discharged in the morning, asks the nurse to empty the colostomy pouch. How should the nurse best respond to the client?

1. "Show me what you have learned about emptying your pouch."
2. "Let me demonstrate how to empty the pouch for you."
3. "You should be emptying the pouch yourself."
4. "Tell me what have you learned about emptying your pouch."

The family member tells an admitting nurse that the client values the practice of Chinese medicine. The nurse must understand that for this family and client a priority goal should take which focus?

- A. respect life in old age
- B. maintain energy balance
- C. achieve harmony
- D. restore yin and yang

Which nursing intervention should be most effective in helping a withdrawn client to begin development of relationship skills?

1. initiate client interactions with one or two other clients
2. assist the client to analyze the meaning of behaviors
3. offer the client frequent opportunities to interact with the nurse
4. remind the client frequently to interact with other clients

A nurse recognizes fluid sounds during the auscultation of a client's lung. These sounds should be documented as

1. shrill and crowing.
2. low-pitched and rumbling.
3. dry and grating.
4. high-pitched and musical.

In a client diagnosed with mitral regurgitation the nurse should expect to see documentation of which of these factors in the notes?

1. ascites
2. low red blood cell count
3. exertional dyspnea
4. pulse deficit

To obtain data related to psychosocial needs, a nurse should include which action?

1. allow clients to talk about whatever they want
2. observe the client's nonverbal behaviors carefully
3. elicit the client's description of experiences, thoughts, and behaviors
4. adhere to pre-planned interview goals and structure

The nurse is working to establish a therapeutic relationship with a client. A therapeutic nurse-client interaction occurs when a nurse takes which approach?

1. Interprets any covert communications
2. Advises about resources to resolve problems
3. Clarifies the meaning of client communication
4. Praises the client for appropriate behavior

When reviewing medications with a client, the client asks "How long will it take before the effects of lithium take place?" A nurse should include which timeframe in the response?

1. Two weeks
2. "One month"
3. "Immediately"
4. "Several days"

The nurse is caring for a victim of domestic abuse. Which of these behavioral characteristics is commonly associated with a domestic abuser?

1. low self-esteem
2. Overconfident
3. High tolerance for frustration
4. Alcoholic

During a home visit a nurse observes a client who takes chlorpromazine HCL (Thorazine) smacking the lips alternately with grinding of the teeth. The nurse should document this finding as which term

1. akathisia
2. bradykinesia
3. tardive dyskinesia

4. dystonia

At the geriatric day care program a client who started the program a few weeks ago is crying and repeating "I want to go home. Call my daddy to come for me." Which action should the nurse initiate?

1. give the client simple information about the available activities for that day
2. tell the client you will call someone to come for the client
3. firmly direct the client to an assigned group activity
4. call the client by name and invite the client to join the exercise group

A client diagnosed with depression has recently been acting suicidal and suddenly becomes more social and energetic than usual. During a clinic visit the client smiles and says to a nurse "I have made some decisions about my life." What should be the nurse's initial response?

1. "I'm so glad to hear that you've made some decisions."
2. "You've made some decisions. Let's talk about them."
3. "Be sure to discuss your decisions with your therapist."
4. "Do those decisions include thoughts about killing yourself?"

When excess or chronic alcohol consumption is abruptly reduced or stopped, physiologic dependence is accompanied by which characteristic?

1. neuro overactivity

2. seizures
3. cravings
4. hallucinations

A nurse is assigned to a client diagnosed with multiple trauma and head injury with a blood pressure on admission of 140/70 mm Hg. Four hours later the blood pressure is 179/68 mm Hg. What is the difference in the pulse widths or pulse pressures that would lead the nurse to suspect the client may be developing increased intracranial pressure? (Answer the question using whole numbers). 41.

A client telephones the clinic to ask about a home pregnancy test she used that morning. A nurse understands that the presence of which hormone strongly suggests that any woman is pregnant?

- A. estrogen
- B. progesterone
- C. human chorionic gonadotropin (HCG)
- D. alpha-fetoprotein

A couple experiences intense anxiety after their home was destroyed by a fire. One of the partners escaped from the fire with only minor injuries. A nurse knows that the most important initial intervention should be to take which approach?

- A. explore with the couple the feelings of grief associated with the loss.
- B. suggest that the clients rent an apartment with a sprinkler system.
- C. **determine available community and personal resources.**
- D. provide a brochure on methods to promote relaxation.

Which statement, if made by a client, indicates teaching about propranolol (Inderal) has been effective? "I should not stop taking the Inderal suddenly because it may cause

- A. **a heart attack."**
- B. decreased blood pressure."
- C. nervousness."
- D. seizures."

A client has a diagnosis of heart failure. Which intervention is most important for a nurse to implement prior to the initial administration of digoxin?

1. use the pulse reading from the electronic blood pressure device
2. **assess the apical pulse, counting for a full 60 seconds**
3. take a radial pulse, counting for a full 60 seconds
4. check for a pulse deficit at least twice with another nurse

A pregnant client comes to the clinic for a first visit. A nurse gathers data about her obstetric history, which includes: three year-old twins at home and a miscarriage at 12 weeks gestation ten years ago. Which documentation should the nurse make?

1. gravida 3 para 2
2. gravida 2 para 1
3. gravida 4 para 2

4. **gravida 3 para 1**

A pregnant client asks a nurse about the scheduled blood test for alpha-fetoprotein (AFP). The nurse's explanation should include which of these comments?

1. "The results help determine if the baby is growing normally."
2. "The placental exchange of oxygen is measured."
3. **"Possible neurological defects may be identified."**

4. "It tells us how far along your pregnancy is."

After the death of a client, the family approaches a nurse and requests that a family member be allowed to perform a ritual bath on the deceased before the body is moved. How should the nurse respond?

1. "A ritual bath will have to wait until after post-mortem care"
2. "I will have to check on hospital regulations and policies."
3. "Is there anything you need from me to perform the ritual bath?"
4. "These procedures have to be carried out by our staff."

A client has just returned from the Post-Anesthesia Care Unit (PACU) to the surgical unit following a cholecystectomy. When initial vital signs are taken the nurse notes a tympanic temperature of 94.8 degrees Fahrenheit. Which nursing intervention is appropriate at this time?

1. apply a warm blanket and recheck the temperature in ten minutes
2. call the health care provider and obtain further orders for warming
3. ask the PACU nurse more details of what happened in PACU
4. continue to monitor the vital signs per routine postop protocol

An older adult client diagnosed with active tuberculosis has difficulty in appropriately coughing up secretions for a sputum specimen. Which nursing intervention might be the most helpful at this time?

1. ask the client to drink a warm liquid
2. force fluids for the next eight hours
3. raise the head of the bed to at least 45 degrees
4. spray the oropharynx with saline

The nurse discovers an unresponsive client and determines there is no pulse. This nurse then activates the code notification button to alert all personnel about the code and begins chest compressions. What is the function of the second nurse on the scene?

1. Participate with the compressions or breathing as requested by the first nurse
2. Bring the code cart
3. Validate the client's advanced directive
4. Relieve the first nurse on the scene and continue single person CPR

An adolescent female is newly diagnosed with bulimia. A nurse is reinforcing instructions about the therapeutic benefits of Tofranil (imipramine) to the client and her parents. Which statement demonstrates an understanding about the medication by the client?

1. "I only need to take this medication until I can control my binging."
2. "I can double the medication if I miss a dose that is at least 12 hours late."
3. "I will need to take the medication for at least two weeks before I can see any benefit."

4. "I will begin to feel better after a few days."

A client with chronic obstructive pulmonary disease (COPD) and a history of coronary artery disease is receiving an IV drip of aminophylline 25mg/hour. Which finding by a nurse would require immediate intervention?

1. restlessness and palpitations
2. flushing and headache
2. increased heart rate and sweating

4. changes in blood pressure and respirations

A nurse is gathering data from a client who states her last menstrual period was March 16, and she has missed one period. She reports episodes of nausea and vomiting. After confirmation of pregnancy is made by other tests, which date should the nurse determine as the estimated date of delivery (EDD)

1. December 23

B. January 15

C. April 8

D. February 11

A nurse's first step in planning to review nutrition with a pregnant woman would be to take which action?

- 1 explain the changes in diet necessary for pregnant women
2. conduct a diet history to determine her normal eating routines
- 3 address how to meet the needs of self and her family
- 4 question her understanding and the use of the food pyramid

At the day treatment center a client diagnosed with schizophrenia - paranoid type sits alone alertly watching the activities of clients and staff. The client is hostile when approached with medication and asserts that the medication controls the mind. A nurse understands that this behavior is related to

1. social isolation related to altered thought processes
2. impaired verbal communication related to impaired judgment
3. feelings of increased anxiety related to paranoia
4. sensory perceptual alteration related to withdrawal from environment

A practical nurse (PN) team member identifies that the fundus is boggy for a woman who is gravida 4 para 4 and is 2 hours after a spontaneous vaginal delivery. The fundus is displaced slightly above and to the right of the umbilicus. What should be the initial nursing action?

1. check lochia for color and amount
2. call the registered nurse (RN) immediately
3. monitor the pulse and blood pressure
4. assist the woman to empty her bladder

client is taking prednisone and aspirin as part of the treatment for rheumatoid arthritis. Which intervention would be an appropriate action by a nurse?

1. test the stools for occult blood.
2. check the pulse rate every four hours.
3. monitor the level of consciousness every shift.
4. discuss fiber in the diet to prevent constipation.

A nurse is monitoring the contractions of a woman in labor. A contraction is recorded as beginning at 10:00 am and ending at 10:01am. Another begins at 10:15 am. The nurse would document the frequency of the contractions as every

1. 9 minutes
2. 15 minutes
3. 14 minutes
4. 1 minute

A client tells a nurse "I have decided to stop taking sertraline (Zoloft) because I don't like the nightmares, sex dreams and obsessions I have experienced since I started on the medication." An appropriate response by the nurse is to caution the client about which process?

1. this medication should be continued despite unpleasant symptoms
2. it is unsafe to abruptly stop taking any prescribed medication
3. many medications have potential side effects
4. side effects and benefits should be discussed with the provider

A client diagnosed with schizophrenia talks animatedly with clarity of pronunciation. The client is then observed mumbling to self and speaking to the radio. A desirable outcome for this client's care should include which action by the client?

1. engage in meaningful and understandable verbal communication
2. demonstrate improved social relationships

3. accurately interpret events and behaviors of others
4. express feelings appropriately through verbal interactions

During a daily cleaning of a tracheostomy, the client coughs and displaces the tracheostomy tube. A nurse could have avoided this complication by having taken which action?

1. sitting the client upright during the cleaning procedure
2. placing an obturator at the client's bedside
3. having another nurse assist with the procedure
4. fastening the clean tracheostomy ties before removing the old ties

A nurse is caring for a client with a new order for bupropion (Wellbutrin). A health care provider's order reads "200 mg BID." What is an appropriate action by the nurse?

1. observe the client for mood swings
2. monitor neuro signs frequently
3. question this medication dose

4. give the medication as ordered

During reinforcement of discharge teaching, a nurse should emphasize which finding as a common side effect of clozapine (Clozaril) therapy?

- A. dry skin
- B. extreme salivation
- C. dry mouth
- D. rhinitis

A client diagnosed with amyotrophic lateral sclerosis (ALS) has a percutaneous endoscopic gastrostomy (PEG) tube for the administration of feedings and medications. Which nursing action is appropriate for a nurse to perform during the care of this client?

1. squeeze the tube before using it to break up stagnant liquids
2. flush adequately with sufficient water before and after using the tube
3. pulverize all medications to a powdery condition
4. cleanse the skin around the tube daily with hydrogen peroxide

For which of these mother-baby pairs should a nurse review the Coombs' test in anticipation to administer Rho (D) immune globulin within 72 hours of the birth?

1. Rh positive mother with Rh negative baby
2. Rh negative mother with Rh positive baby
3. Rh positive mother with Rh positive baby

4. Rh negative mother with Rh negative baby

A client with a diagnosis of schizophrenia has been treated with quetiapine (Seroquel) for one month. Today the client calls the clinic nurse to report increased agitation and complaints of muscle stiffness. The nurse should question the client in order to collect data about what other findings?

1. mental confusion and general weakness
2. muscle spasms and seizures
3. elevated temperature and sweating
4. decreased pulse and blood pressure

A nurse is caring for a woman two hours after a vaginal delivery. Documentation indicates that the membranes were ruptured for 36 hours prior to delivery. Which of these nursing diagnoses should the nurse expect the charge nurse to have as a priority at this time?

1. risk for fluid volume deficit

2. risk for infection

3. risk for excessive bleeding

4. altered tissue perfusion

A client tells a nurse about an Internet site which claimed that Wellbutrin was taken off the market because it caused seizures. An appropriate response by the nurse would be to tell the client which information?

1. "Ask your friend about the source of this information."
2. "Your health care provider knows the best medication for your condition."
3. "There were problems and the recommended dose was changed."
4. "Omit the next doses until you talk with the health care provider."

A nurse is checking a woman in early labor. During the positioning of the woman for a vaginal exam, the woman complains of dizziness and nausea and appears pale. Her blood pressure has dropped slightly. What is the appropriate nursing action?

1. encourage deep breathing

2. turn her to her left side

3. call the health care provider

4. elevate the foot of the bed

A client reports some discomfort on the day after a below-the-knee amputation. Which intervention by a nurse is appropriate to do first?

1. Administer opioid narcotics as ordered
2. Conduct guided imagery or distraction
3. Wrap the stump snugly with an elastic bandage
4. Ensure that the stump is elevated

The nurse is caring for a client undergoing chemotherapy for colon cancer. Which of the following statements, made by the client, would the nurse be most concerned about?

1. "I take ten multivitamin tablets daily to help my immune system fight the cancer."
2. "I am using relaxation techniques when needed for coping with the stress of having cancer."
3. "I think the green tea I'm drinking is helping me to fight cancer."
4. "I pray several hours a day to God to help me with dealing with this cancer."

During the preparation of medications for a client with a gastrostomy tube, a home health nurse should contact the health care provider before the administration of which medication through the tube?

1. Os-cal tablet (calcium carbonate)
2. Cardizem SR tablet (diltiazem)
3. Lanoxin liquid
4. Tylenol liquid (acetaminophen)

A nurse discusses with a family the best type of care for their 80 year-old mother who has a cognitive impairment. To assist the family with decision making the nurse should first ask which question?

1. "What type of assistance does your mother require?"
2. "Are you able to assist with the care of your mother in any manner?"
3. "What is your opinion of nursing homes or assisted living facilities?"
4. "Is your mother taking any over the counter or prescription medications at the present time?"

A client diagnosed with amyotrophic lateral sclerosis (ALS) is scheduled for 160 mL of enteral feeding as a bolus every four hours. Before flushing with water the nurse aspirates the gastric feeding tube and gets back 180 mL of undigested feeding or residual. What is the appropriate intervention guided by a health care agency protocol?

1. reinsert the residual and then flush with sterile water
2. reinsert the residual and hold the next feeding
3. discard the residual and hold the next feeding
4. discard the residual and administer the feeding

During the history of a pregnant woman, which factor should a nurse recognize as a priority contraindication for breast feeding?

1. lactose intolerance
2. uses cocaine on weekends
3. age of 40 years-old
4. drinks 4 ounces of wine daily

A nurse observes a newborn whose Apgar score was 8 at one minute and then 9 at the five minutet evaluation. These scores would be more commonly related to abnormalities in which of these areas?

- A. muscle tone
- B. cry
- C. color
- D. heart rate

During a dialysate exchange for a client who gets acute peritoneal dialysis, which finding would alert a nurse that the client has developed an acute complication?

1. the client sleeps throughout the fluid exchange
2. the dressing around the catheter becomes saturated with clear fluid
3. a pulse of 86 and blood pressure of 112/74
4. a respiratory rate of 30 with crackles

In checking a postpartum client, a nurse palpates a firm fundus. Also observed is a constant trickle of bright red blood from the vaginal opening. The nurse should suspect which complication?

- A. clotting disorder
- B. retained placenta
- C. uterineatony
- D. vaginal lacerations

A postoperative client is admitted to the postanesthesia care unit. An anesthetist reported that malignant hyperthermia occurred during surgery. A nurse should recognize that this complication is related to which condition?

- A. allergy to general anesthesia
- B. preexisting bacterial infection
- C. **ageneticpredisposition**
- D. selected surgical procedures

A client being discharged from the cardiac step- down unit after a myocardial infarction (MI), is given a prescription for a beta-blocking medication. A nursing student asks a nurse why this medication would be used by a client who is not hypertensive. What is the appropriate response by the nurse?

- A. **"This medication will decrease the workload on the heart."**
- B. "A beta-blocker will prevent orthostatic hypotension."
- C. "Most people develop hypertension following an MI."
- D. "beta-blockers increase the strength of heart contractions."

The client is newly diagnosed with angina and the nurse is reinforcing information about wearing a nitroglycerin patch. The client asks why each patch can only be worn for about 12 hours. Which response by the nurse is the best?

- A. Postural hypotension
- B. Skin irritation
- C. Severeheadaches
- D. **Medication tolerance**

client with a history of heart disease takes daily prophylactic aspirin. A nurse should monitor which finding that might indicate aspirin toxicity?

- A. Sore throat
- B. **Tinnitus**
- C. Papular rash
- D. Fatigue

nurse is caring for a client diagnosed with end- stage renal disease. What action should the nurse take to assess for patency in a fistula that is used for hemodialysis?

1. palpate the skin over the fistula for a thrill
2. check color and warmth in the extremity
3. observe for edema proximal to the fistula site
4. irrigate with 5 mLs of sterile 0.9% normal saline

Which of these findings during the care of a client diagnosed with uncontrolled hypertension should prompt a nurse to take an immediate action?

- A. bilateral lower extremity pitting edema
- B. weakness in left arm with a duration of one hour
- C. jugular vein distention at 30 degrees elevation
- D. bilateral rales in the lower lobes

A nurse practicing in a long term care facility recognizes that the older clients are at greater risk for medication toxicity than younger adults because of which information?

1. older adults are often malnourished and anemic
2. more rapid hepatic metabolism occurs
3. absorption of medications occur more readily from the GI tract
4. less body water and more fat are found in older adults

A nurse is caring for a client who is diagnosed with chronic renal failure and has hemodialysis three times per week. The client becomes confused and irritable six hours before the next treatment. Which of these findings might explain the reason for the client's behavior?

- A. elevated blood urea nitrogen (BUN)
- B. metabolic alkalosis
- C. potassium loss with a deficit
- D. low calcium levels from depletion

A client has a new prescription for an selective serotonin reuptake inhibitor (SSRI) antidepressant. In reviewing the admission history and physical, which data should lead a nurse to question the safety of this medication?

- A. diagnosis of vascular disease
- B. takes antacids frequently
- C. history of obesity
- D. prescribed use of an MAO inhibitor

A nurse is speaking with a woman who is planning a pregnancy. Which statement suggests that the client understands the connection between alcohol consumption and fetal alcohol syndrome?

1. "I understand that a glass of wine with dinner is healthy for my heart."
2. "If I drink, my baby may be harmed even before I know I am pregnant."

" 3. Drinking alcohol during meals reduces the effects of the alcohol."

D. "Beer is not really hard alcohol, so I guess I can drink some."

A 52 year-old woman who is postmenopausal asks a nurse "How frequently should I have a mammogram?" The nurse's best response should be which comment?

1. "Your health care provider will advise you about your risks."
2. "Once a woman reaches 40 years of age, she should have a screening mammogram yearly."
3. "Yearly mammograms are advised for all women over 35."
4. "Unless you had previous problems, every 2 years is best."

A postoperative client has a prescription for acetaminophen with codeine. A nurse should recognize that a primary effect of this combination is what action?

1. medication tolerance prevention

2. enhanced pain relief

3. minimized side effects

4. faster onset of action

A nurse admits a client with a three day history of fever, bilateral flank pain, and an elevated blood pressure. Which data obtained in the admission interview alerts the nurse that this may be acute glomerulonephritis?

- A. history of mild hypertension
- B. diabetes mellitus type 1 since age 15
- C. travel to a foreign country
- D. severe sore throat three weeks ago

To prevent unnecessary hypoxia during suctioning through a tracheostomy, a nurse should use which action?

A. lubricate three to four inches of the catheter tip

B. apply suction for no more than ten seconds

C. withdraw catheter in a circular motion

D. maintain sterile technique

During a fluid exchange for a client who is 48 hours postinsertion of an abdominal Tenckhoff catheter for peritoneal dialysis, a nurse knows that the appearance of which finding needs to be reported to the health care provider immediately?

- A. slight pink - tinged drainage
- B. cloudy drainage
- C. abdominal discomfort
- D. muscle weakness

A client has an order for home antibiotic therapy after hospital treatment of a staph infection. Which priority information should a nurse reinforce on discharge?

1. complete the full course of medications
2. visit the health care provider in a few weeks
3. monitor for signs of recurrent infection
4. schedule follow-up blood cultures with the health care provider

When visiting in the home of a client diagnosed with urinary incontinence, which content should be reinforced to the client?

1. restrict fluid to prevent incontinence accidents
2. avoid taking antihistamines at any time
3. hold the urine to increase bladder capacity
4. avoid eating foods high in sodium

A client who had a left arterial revascularization of the leg four hours ago developed increasing pain in the left lower extremity. Upon assessment the nurse notes increased swelling and tenderness with other findings that suggest compartment syndrome. Which of these nursing interventions should take priority?

- A. notify the surgeon immediately
- B. repeat the neurovascular assessment

C. place the extremity at the level of the heart

D. loosen the dressing at the incision site

A nurse notes cloudy drainage two days postinsertion of a Tenckhoff catheter for peritoneal dialysis, what other data should a nurse collect before reporting this finding?

- A. urine output
- B. bowelsounds
- C. breath sounds
- D. temperature**

A client is in her third month of her first pregnancy. During the interview, she states: "I have had sexual relations with several partners and am unsure of the identity of the baby's father." Which nursing intervention should be a priority?

- A. ask about tests for sexually transmitted infections
- B. refer the client to a family planning clinic
- C. request the RN to counsel the woman to consent for HIV screening**
- D. discuss with her the risk for cervical cancer

A nurse should emphasize to a client diagnosed with tuberculosis and prescribed INH and rifampin that follow-up appointments must be kept for critical lab tests of which organ?

- A. pancreas
- B. kidney
- C. liver**
- D. heart

A client has been taking furosemide (Lasix) for the past week. A nurse should recognize which finding as an indication that the client is experiencing a negative side effect from the medication?

- 1. decreased appetite**
- 2. weight gain of five pounds
- 3. edema of the ankles
- 4. gastric irritability

The major developmental task that a woman must accomplish during the first trimester of pregnancy is the acceptance of which issue?

1. the satisfactory resolution of fears related to giving birth
2. the potential risk for a termination of the pregnancy
3. the pregnancy and the physical changes that are involved
4. the fetus as a separate and unique being

A client diagnosed with cystitis has been on oral antibiotics for 72 hours. Which report from the client requires further assessments by a nurse?

1. "It burns when I go to the bathroom to pass my urine."
2. "My urine smells bad when I go to the bathroom."
3. "I have been sick at my stomach and don't feel like eating much the past few days."
4. "I felt hot, took my temperature and it has been elevated for the past 24 hours."

What observation signifies that a child has attained the stage of concrete operations (Piaget)?

- A. talks about thinking in mental images or word pictures
- B. makes the moral judgment that "stealing is wrong"

- C. reasons that homework is time-consuming but necessary
- D. explores the environment using sight and movement

A nurse is caring for a client with a vascular access for hemodialysis. Which of these findings necessitates immediate action by the nurse?

- A. dry, hacking cough
- B. pruritic rash
- C. chronic fatigue
- D. elevated temperature

To prevent medication resistance common to a tubercle bacilli infection, a nurse should be aware that clients with tuberculosis are often treated using which approach?

- A. higher than normal doses
- B. an aminoglycoside antibiotic
- C. an anti-inflammatory agent .
- D. two or more anti-tuberculosis medications

Which finding is an expected variation in the newborn resulting from the presence of maternal hormones in the newborn?

- A. edema of the scrotum
2. lanugo on the extremities

3. engorgement of the breasts

D. Mongolian spots

A client taking isoniazide (INH) for tuberculosis asks a nurse about side effects of the medication. The nurse should emphasize the need to immediately report which findings?

A. confusion and lightheadedness

2. double vision and visual halos

3. extremity tingling and numbness

D. photophobia and photosensitivity

A woman who is pregnant has been advised to alter her diet during pregnancy by increasing the intake of protein and vitamin C to meet the needs of the growing fetus. Which diet choice would best meet the woman's needs?

1. 3 oz. chicken, 1/2 cup of corn, lettuce salad, small banana

2. scrambled egg, hash browned potatoes, half-glass of buttermilk, large nectarine

3. 1 cup of macaroni, 3/4 cup peas, glass whole milk, medium pear

4. beef, 1/2 cup lima beans, glass of skim milk, 3/4 cup of strawberries

A client is receiving digoxin (Lanoxin) 0.25 mg daily. A health care provider has written a new order to give metoprolol (Lopressor) 25 mg BID. In checking the client prior to administering the medications, which finding should a nurse report immediately to the registered nurse (RN) charge nurse?

A. urine output 50 mL/hour

B. heartrate76

C. respiratory rate 16

D. blood pressure 94/60

Which statement made by a female client indicates a need for additional discussion about the impact of body-image alterations after a mastectomy?

A. "It really isn't much of a problem for me, I never had large breasts anyway."

"I plan to volunteer and work with others who have had mastectomies in Reach for Recovery."

"I can't bear to look at myself in the mirror. What will my partner think?"

"I guess it's time for me to quit wearing a bikini anyway."

A primigravida's membranes spontaneously ruptured (ROM) four hours ago. At the time of the ROM the vital signs were T-99.8 degrees Fahrenheit, P-84, R-20, BP-130/78, and fetal heart tones (FHT) 148 beats/min. Which assessment findings taken now may be an early indication that the client is developing a complication of labor?

A. temperature 100 degrees Fahrenheit

B. FHT 168 beats/min

C. BP138/88

D. cervical dilation of 4 cm

The clinic nurse is performing the intake assessment for a 74 year-old male. The client has a history of benign prostatic hypertrophy (BPH) and reports having trouble voiding. After the client uses the bathroom to void, how would the nurse practitioner best assess distention of the bladder?

- 1. Scan the bladder using a portable ultrasound scanner**
2. Check for rebound tenderness
3. Insert an intermittent urinary catheter
4. Look for rounded swelling above the pubis

A client being discharged today and has been taking K-dur 20mEq per day by mouth. A nurse should reinforce that potassium levels will be decreased by which substance?

1. occasional use of a nonsteroidal anti-inflammatory medication (NSAID)
- 2. frequent daily snacks of black licorice**
3. prescribed potassium-sparing diuretics
4. foods seasoned with salt substitute

The nurse is using the image below to explain and clarify information about the client's colostomy. Based on this image, which of the following statements about the consistency of the drainage is correct?

A. The feces are semi formed to formed

2. The feces have a normal, formed consistency
3. The feces are mushy (liquid to semiformal)
4. The feces are liquid to semiliquid and the discharge is often irritating to the skin around the stoma

1. A client on warfarin (Coumadin) therapy after coronary artery stent placement calls the health clinic to ask "Can I take Alka-Seltzer for an upset stomach?" A nurse should respond to this client with what comment? "Take Alka-Seltzer at a different time of day than the warfarin."
2. "Use one-half the recommended dose of Alka-Seltzer."
3. "Select another antacid that does not interfere with warfarin."

4. "Avoid Alka-Seltzer because it contains aspirin."

What should a nurse emphasize to avoid for a client who takes Coumadin (warfarin) at home?

- A. exposure to sunlight
- B. large indoor gatherings
- C. foods rich in vitamin K
- D. active physical exercise

Five days post op after a total hip replacement a client is ambulating with a walker. The client is to be discharged later in the day. Which finding documented in the morning nurse's notes requires priority attention?

1. hip discomfort rated as 3/10 on the pain scale of 1/10
2. serous drainage with crusting at one corner of the surgical site
3. a new onset of agitation and confusion for 15 minutes
4. redness with minimal swelling around the incision site

Which over-the-counter (OTC) medication should a nurse recognize as having the most elemental calcium per tablet?

- A. calcium chloride
- B. calcium carbonate
- C. calcium citrate
- D. calcium gluconate

A client has been taking nifedipine (Procardia) for a diagnoses of Raynaud's disease and hypertension. Which finding would indicate that the client may be having a side effect of the medication?

- A. cyanosis of the lips
- B. increased pain in fingers
- C. facial flushing
- D. decreased urinary output

A client has been newly diagnosed with hypothyroidism and takes levothyroxine (Synthroid) 50 mcg/day by mouth. A nurse should emphasize that this medication has what specific guideline?

- A. will decrease the client's heart rate

2. must be stored in a dark container
3. should be taken in the morning
4. D. may decrease the client's energy level

A client is placed on sulfamethoxazole-trimethoprim (Bactrim) for a recurrent urinary tract infection. Which comment is correct information reinforcement of information by a nurse?

- A. "Drink at least eight glasses of water a day."
2. "Stop the medication after five days."
3. "It is safe to take with oral contraceptives."
- D. "Be sure to take the medication with food"

A home health nurse received a call about an older adult client who had a sudden onset of confusion. The nurse should immediately check the client's medications for which of these classifications?

- A. diuretics
- B. antihistamines
- C. thyroid medications
- D. steroids

A nurse notes an abrupt onset of confusion in an older adult client. Which recently ordered medication would most likely have contributed to this change in mental status?

- A. liquid antacid
- B. cardiacglycoside
- C. anticoagulant
- D. antihistamine

A client has just been diagnosed with breast cancer. As a nurse enters the room, the client states "You are stupid." The most therapeutic response by the nurse is to take which approach?

- A. explore what is going on with the client
- B. accept the client 'statement
- C. tell the client the comment is not inappropriate
- make no comment or response

A client who is terminally ill and in hospice has been receiving high doses of an opioid analgesic for the past month. As death approaches and the client becomes unresponsive to verbal stimuli, a nurse should expect that pain management will be of which approach?

A. continue the same analgesic dosage

- B. discontinue the analgesic
- C. prescribe a less potent medication
- D. decrease the analgesic dosage by half

A nurse is caring for an older adult client who is diagnosed with heart failure and is receiving digoxin (Lanoxin) therapy. Which finding suggests that the nurse needs to have the registered nurse (RN) check the client?

- A. constipation
- B. increased appetite

C. extreme fatigue

D. intense itching

A client who has been receiving heparin for five days has an order to begin taking warfarin (Coumadin) in the evening. Which intervention should a nurse take next?

1. discontinue the heparin completely, then administer the Coumadin
2. administer the Coumadin in the evening as prescribed
3. hold the dose of Coumadin until the provider is reminded that the client is on heparin
4. stop the heparin for one hour, then administer the Coumadin

A nurse is assigned to a client diagnosed with a deep vein thrombosis who has been on heparin for five days. The nurse notices that enoxaparin (Lovenox) is added to the medication administration record. Which action should the nurse take?

1. plan to check the PTT result after the Lovenox is given
2. notify the charge nurse that the client is already receiving heparin
3. stop the heparin and begin the Lovenox 30 minutes later
4. monitor the urine, stool and skin for bleeding

A client diagnosed with heart failure has a prescription for digoxin. A nurse is aware that sufficient potassium should be included in the diet because hypokalemia in combination with this medication may have which effect?

- A. results in irritability and anxiety
- B. can predispose to dysrhythmias

C. sometimes alters consciousness

D. may lead to oliguria

A practical nurse (PN) is reinforcing discharge teaching to a 65 year-old female client who had been admitted with a diagnosis of renal calculi. Which information should be reinforced as dietary recommendations to prevent any stone recurrence?

A. increase foods high in protein

2. increase the intake of dietary calcium

3. consume foods high in vitamin E

D. boost daily sources of vitamin C

A client diagnosed with anemia has a new prescription for ferrous sulfate (iron). When reviewing the teaching plan with the client, which substance should be taken with the medication to enhance its absorption?

A. Caffeinated beverages

B. Lowfatmilk

C. An antacid

D. Tomato juice

A client is admitted to the hospital with a diagnosis of liver failure with ascites. A health care provider orders spironolactone (Aldactone). A nurse should care for the client based on knowledge that this medication has what effect?

A. combines safely with antihypertensives

B. increases aldosterone levels

C. promotes sodium and chloride excretion

D. depletes potassium reserves

A primigravida in the third trimester is hospitalized for mild preeclampsia. A nurse determines that the client's diastolic blood pressure has significantly increased. Which action should the nurse take first?

A. check the protein level in urine

B. take the temperature

C. have the client turn to the left side

D. monitor the urine output

A resident in a nursing home appears to be forgetful. A nurse suspects short-term memory loss. When collecting data about short-term memory loss, the nurse should take which action first?

- A. Suggest the client read from a newspaper
- 2. Observe the client during an activity
- 3. Ask the client to state when he was born

D. Confirm that a hearing loss is absent

Which information should a nurse reinforce during a discussion about captopril (Capoten) with a client

- 1. take the medication with meals
- 2. avoid the use of salt substitutes**
- 3. restrict fluids to 1000 mL/day
- 4. avoid green leafy vegetables

A nurse is reinforcing information about the importance to recognize the findings of digoxin toxicity to a client. Which statement made by the client is correct and indicates no need for further teaching?

- A. "I will experience a loss of appetite."
- 2. "I will report a slower pulse."**
- 3. "I may experience nausea and vomiting."
- D. "I don't have to report blurred vision."

A client is receiving total parenteral nutrition (TPN) via a Hickman catheter. The catheter accidentally becomes dislodged from the site. Which intervention by a nurse should take priority?

- A. check that the catheter tip is intact
- 2. apply a pressure dressing to the site**
- 3. check for mental status changes
- 4. monitor respiratory status

A nurse administers the influenza vaccine to a client in a clinic. Within 15 minutes after the immunization was given, the client reports having itchy and watery eyes, increased anxiety, and difficulty breathing. What should the nurse anticipate the first action in the sequence of care for this client to be at this time?

- A. **Administer epinephrine 1:1000 as ordered**

2. Maintain the airway
3. Monitor for hypotension with shock

D. Give diphenhydramine as ordered

A newborn who is having difficulty maintaining a temperature above 98 degrees Fahrenheit has been placed into a warming Isolette. Which action is appropriate for a nurse to implement?

1. monitor the neonate's temperature continuously
2. protect the eyes with patches
3. avoid touching the neonate with cold hands
4. warm all medications and liquids before administration

A client diagnosed with advanced cirrhosis is started on lactulose (Cephulac). What should a nurse understand about the main purpose of the medication?

A. portal hypertension is better controlled

B. peristalsis's stimulated

C. ammonia level are reduced

D. dietary fiber is added

A home health nurse is making an initial visit to a 70 year-old client. What should be the first action to promote health?

A. Review the list of medications

2. Assist with planning for meals
3. Discuss past health history

D. Identify learning needs

A client with tuberculosis is started on Rifampin. Which statement by a nurse is most appropriate to include when reinforcing information?

1. "You may notice an orange-red color to your urine."
2. "You may have occasional problems sleeping."
3. "You may experience an increase in appetite."
4. "You can take the medication with food."

A client is started on atenolol (Tenormin). A nurse should emphasize to the client to immediately report which finding?

A. Rapid breathing

B. Weightgain

C. Slow, bounding pulse

B. D. Jaundiced sclera

A newborn who has hyperbilirubinemia is undergoing phototherapy with a blanket. Which safety measure is correct during this therapy?

1. withhold feedings while getting the phototherapy
2. regulate the neonate's temperature using a radiant heater
3. provide water feedings at least every two hours
4. protect the eyes of neonate from the phototherapy

A nurse administers cimetidine (Tagamet) to an older adult client diagnosed with a gastric ulcer. Which function may be affected by this medication, and should be closely monitored by the nurse?

A. mental status

2. blood pressure
3. liver function

D. red blood cells

A client referred for a mammography asks a nurse about the cancer risks from radiation exposure. What is an appropriate response by the nurse?

1. "Exposure to mammography every two years is not dangerous."
2. "The radiation from a mammography is equivalent to one hour of sun exposure."
3. "You have nothing to worry about; it is less than tanning in the nude."
4. "A chest x-ray gives you more radiation exposure."

At a community health fair the blood pressure (BP) of a 62 year-old client is screened at 160/96. The client states "My blood pressure is usually much lower." A nurse should respond based on knowledge indicated by which of these protocol?

A. check BP in two or three weeks

2. visit the health care provider within one week for another BP check
3. see a health care provider immediately
4. recheck the BP within the next 48 to 72 hours

A client receives high doses of a potassium bolus IV over a 30 minute period. Which focus is a priority to check prior to giving this medication?

A. oral fluid intake

B. bowelsounds

- C. grip strength
- D. urine output

A client has an order for 1000 mL of D5W over an eight hour period. A nurse discovers that 800 mL has been infused after 4 hours. What is the priority nursing action at this time?

- A. auscultate the lungs
- B. have the client void as much as possible
- C. ask the client if any breathing problems
- D. check the vital signs

A nurse observes a family member administer a rectal suppository by having the client lie on the left side for the administration. The family member pushed the suppository until the finger went up to the second knuckle. After 10 minutes the client was told by the family member to turn to the right side and the client did this. What is the appropriate comment for the nurse to make?

1. "That was done correctly. Did you have any problems with the insertion?"
2. "Why don't we now have the client turn back to the left side."
3. "Let's check to see if the suppository is in far enough."
4. "Did you feel any stool in the intestinal tract?"

An older adult client is scheduled to have a cardioversion. A nurse reviews the client's medication administration record. The nurse should notify the health care provider if the client received which medication during the preceding 24 hours?

- A. metoprolol tartrate (Toprol XL)
- B. diltiazem (Cardizem)
- C. nitroglycerine ointment
- D. digoxin (Lanoxin)

A health care provider orders digoxin (Lanoxin) 0.125 mg PO and furosemide 40 mg every day. Which of these foods would a nurse reinforce for the client to eat at least daily?

- A. a whole fresh tomato
2. four ounces of chicken
3. a small plate of spaghetti

D. slice of watermelon

A mother with a Roman Catholic belief system has given birth in an ambulance on the way to the hospital. The neonate is in very critical condition with little expectation of surviving the trip to

the hospital. Which of these requests should the nurse in the ambulance anticipate and be prepared to encounter?

A. Pour fluid over the forehead backwards towards the back of the head and say "I baptize you in the name of the father, the son and the holy spirit. Amen."

2. The refusal of any treatment for the mother and the neonate until a reader is consulted.
3. Arrange for a church elder to be at the emergency department when the ambulance arrives so a "laying on hands" can be done.
4. The placement of a rosary necklace around the neonate's neck that is not to be removed unless necessary.

A client is recovering from a hip replacement and takes Tylenol #3 every 3 hours for pain. When checking the client, which finding suggests a side effect of the analgesic?

A. bruising at the operative site

2. decreased platelet count
3. elevated heart rate

D. no bowel movement for three days

A client diagnosed with heart failure has digoxin (Lanoxin) ordered. What should a nurse expect to find when evaluating for the therapeutic effectiveness of this medication?

A. diaphoresis with decreased urinary output

B. decreased chest pain and decreased blood pressure

C. improved respiratory status and increased urinary output

D. increased heart rate with increase respirations

An antibiotic intramuscular (IM) injection for a toddler is ordered. The total volume of the injection equals 2 mL. What is the correct nursing intervention?

1. check with pharmacy for a by mouth liquid form of the medication
- 2. administer the medication in two separate injections**
3. call to get a smaller volume ordered for the injection
4. give the medication in the dorsal gluteal site

A nurse is talking to a client diagnosed with chronic renal failure about medications. The client questions the purpose of aluminum hydroxide (Amphojel) in the medication regimen. What is the best explanation for the nurse to give the client for the use of this medication? This medication is given to

- A. decrease serum phosphate
- B. reduce serum calcium
- C. control gastric acid secretion
- D. increase urine output

A nurse is to administer meperidine hydrochloride (Demerol) 100 mg, atropine sulfate (Atropisol) 0.4 mg, and promethazine hydrochloride (Phenergan) 50 mg IM to a preoperative client. Which action should the nurse take initially?

1. place the bed in the low position
2. instruct the client to remain in bed
3. have the client empty his/her bladder
4. place the call bell within reach

An older adult client is to receive IV gentamicin. What diagnostic finding indicates the client may have difficulty in the excretion of the medication?

1. borderline renal function
2. protein deficiency
3. reduced peristalsis
4. . gastric acid reflux

A nurse monitors a client after the treatment of bradycardia with intravenous atropine sulfate. Which finding should be reported to a health care provider immediately?

- A. frequent urination
- B. increased salivation
- C. frequent palpitations
- D. bronchial spasms

A client received 3 units of Humalog insulin at 11 am to cover a finger stick of 322 mg/dL. This type of insulin will begin to act at which time?

1. 1:00 pm
2. 3:00 pm
3. 12 noon
4. 11:15 am

A nurse receives an order to give a client iron by deep injection. The nurse knows that the reason for this route is for what purpose?

1. prevent the medication from tissue irritation
2. ensure that the entire dose of medication is given
3. provide more even distribution of the drug
4. enhance absorption of the medication

When an infant car seat is properly installed, the infant should face

1. the side window, to increase sensory stimulation
2. backward, so child faces the seat
3. forward, so child may look out window
4. upward, as child lies on back with seat installed sideways

A nurse is caring for a client who is receiving alteplase (TPA) and diagnosed with an acute cerebral vascular accident (CVA). Which nursing intervention should receive priority consideration?

- A. monitor vital signs
2. maintain bedrest
3. check the mental status
4. protect invasive lines or tubes

A client is receiving a nitroglycerin (NTG) infusion for a diagnosis of unstable angina. What should be a priority focus to monitor for the effects of this medication?

- A. rhythm strips
- B. respiratory rate
- C. cardiac labs
- D. blood pressure

The nurse receives a telephone call from a health care provider who wants to give a telephone order for a client. Which of the following actions should the nurse take? (Select all that apply.)

1. Record the order word-for-word and sign the order
2. Verify understanding by reading the order back to the provider before hanging up

An obese client tells the nurse: "I just started a diet and I am eating no more than 800 calories a day." What information is most important for the nurse to know in order to therapeutically respond to this statement?

1. **Individuals following a very low-calorie diet need professional monitoring**
2. Very low-calorie diets often have severe and irreversible side effects
3. A very low-calorie diet is never a successful weight loss program and should be discouraged
4. This diet is classified as low calorie and adequate if balanced with 1 meat, 1 fruit, and 2 fat exchanges

The nurse, who is caring for a client with complex and unique health needs, describes the nature of the illness in an online social forum for nurses. Neither the client's real name nor any other personal identifiers are used. What, if any, consequence could result from posting this information online?

1. **The nurse could be fired for breach of confidentiality**
2. The nurse could be reprimanded for not clearing the information first with hospital administration
3. There won't be any consequences because the information was posted on a website for nursing professionals
4. There won't be any consequences because the client's real name was not used

A child is admitted to the unit with findings of nasal congestion and cough with periods of cyanosis and dehydration. The suspected diagnosis is pertussis (whooping cough). What is the priority nursing intervention for this child?

A. Implement droplet precautions along with standard precautions

B. Initiate anti-infective therapy

C. Maintain hydration and encourage fluids

D. Monitor heart rate, respiratory rate and oxygen saturation

A woman dressed in a business suit with no visible identification is at the nurses station looking at client charts. What nursing action is most appropriate?

1. Ignore the person; many outside vendors check charts to set up a transfer or to coordinate care
2. Immediately call security for this breach in client confidentiality
3. Report to the nurse manager about the witnessed suspicious activity
4. **Request to see an ID and an explanation as to why the woman is viewing the charts**

The nurse observes a nursing assistant using antiseptic hand rub and rubbing the hands vigorously after leaving the room of a client diagnosed with clostridium difficile. Which action is most appropriate by the nurse?

A. Ensure that visitors wash hands thoroughly before and after visiting

B. Praise the nursing assistant for proper use of antiseptic hand rub

C. Tell the client to ask caregivers if they have washed their hands

D. **Require the nursing assistant to wash hands again with soap and water**

A client calls the clinic and states to the triage nurse: "I had an upset stomach and took Pepto-Bismol and now my tongue looks black. What's happening to me?" What would be the nurse's best response?

1. "Are your stools also black?"
2. "Come to the clinic so you can be seen by the health care provider."
3. "How long have you had an upset stomach?"
4. **"This is a common and temporary side effect of this medication."**

A client is diagnosed with rheumatoid arthritis (RA). Which types of drugs might the nurse expect to be ordered as a combination drug therapy regimen? (Select all that apply.)

Biological-response modifiers

Anti-inflammatory drugs

A nurse is to collect data about a six month-old child diagnosed with nonorganic failure-to-thrive (NOFTT). Upon entering the room, the nurse would expect the baby to have which characteristics?

1. "I may experience postpartum depression up to a year after delivery."
2. "I will make an effort to talk with someone about my feelings if I start to feel overwhelmed."
3. "Women with postpartum depression have feelings of guilt and worthlessness."
4. **"It's common for women with postpartum depression to have delusions about the infant."**

The client is newly diagnosed with gastroesophageal reflux disease (GERD). Which statement made by the client indicates a need for further information about this disease? (Select all that apply.)

If I have heartburn, I'll take my omeprazole (Prilosec)."

"I can't wait to leave the hospital, so I can get a good cup of coffee."

"A bedtime snack may help me to sleep better."

The client states to the nurse: "I am ready to stop all of these treatments. I just want to go home and enjoy my family for the little bit of time I have left." Which action is most appropriate?

1. **Encourage the client to discuss this decision with the health care provider and family**

2. Call in a referral to a social worker and explain that the request will need to be discussed in more detail at a later time
3. No action is needed at this time unless the client repeats the statement to another caregiver
4. Tell the family members that the client's preference is to go home to die

Which of the following methods are used to correctly identify a client? (Select all that apply.)

2. Ask clients to state their name
3. Check the client identification bracelet
4. Have clients state their birth date

The nurse is reviewing the medication administration record for a newly admitted client. The client is prescribed the beta blocker propranolol (Inderal), but is not diagnosed with hypertension and does not have a history of heart disease. Which health issue might best explain the reason for prescribing propranolol?

- A. Parkinson's disease
- B. Raynaud's disease
- C. Schizophrenia
- D. Essential tremors

A 40 year-old Bosnian Muslim woman who does not speak English seeks care at a community center. Through physical gestures, the woman indicates that she has pain originating in either the pelvic or genital region. Assuming several people are available to interpret, who would be the most appropriate choice?

- A. The client's adult daughter
- B. A female from the client's community
- C. A female interpreter who does not know the client

A Bosnian male, who is a certified medical interpreter

Which situation requires hand washing? (Select all that apply.)

1. After cleaning a wound
2. After contact with inanimate objects in the immediate vicinity of the client
3. Prior to eating
4. Before having direct contact with a client

The RN is working in a clinic where a client presents with a painful, blistering rash on the hip. The health care provider diagnoses shingles (herpes zoster). What would be the priority nursing diagnosis?

1. Risk for impaired skin integrity related to skin lesions
2. Pain related to nerve root inflammation and skin lesions

C. Risk for infection related to skin lesions

Knowledge deficit related to disease process

Which nursing practice best reduces the chance of communication errors that might otherwise lead to negative client outcomes?

1. Use standardized forms for client handoffs
2. Speak using a professional tone on the telephone
3. Keep good working relationships with staff members
4. Document nursing care at the end of the shift

The nurse is discharging a client after a laparoscopic cholecystectomy. Which occurrence should the client be instructed to report to the primary care provider?

- A. Seeing spots of blood on the Band-Aids
- B. Temperature of 101 F (38.3 C)
- C. Decrease in appetite
- D. Experiencing shoulder pain

The nurse attends an interdisciplinary meeting on the topic of fall prevention. What specific tactics can be used to reduce falls in health care settings? (Select all that apply.)

1. Use a "two to transfer" policy
2. Use "low beds" for at-risk clients
3. Install and use bed alarms
4. Identify vulnerable clients

The client is diagnosed with post-traumatic stress disorder (PTSD). What are the some of the more common treatment options for PTSD? (Select all that apply.)

1. Selective serotonin reuptake inhibitors (SSRIs)
2. Eye movement desensitization and reprocessing (EMDR)
3. Cognitive behavioral therapies

A client is recently diagnosed with Barrett's esophagus. Which of the following statements made by the client demonstrates that further teaching is needed about this illness?

1. "I should avoid eating anything for two hours before I go to sleep."
2. "I should try to sleep lying on my right side."
3. "I will have to cut back on my smoking."
4. "I will need regular endoscopies to monitor this illness."

The nurse is making rounds with the pediatrician on the postpartum unit. Which of the following newborns should the pediatrician see first?

1. The newborn, delivered eight hours ago, whose clamped umbilical cord has two arteries and one vein
2. The term infant whose blood glucose is 50 mg/dL
3. The newborn delivered sixteen hours ago, who has yet to pass the first meconium stool
4. The newborn with widely spaced cranial suture lines

The 86 year-old client will be participating in a transitional care program after discharge from the hospital. What is the primary purpose of a transitional care program?

1. Increase client understanding of discharge instructions
2. Increase satisfaction with nursing care
3. Reduce insurance costs
4. Reduce readmissions to the hospital

During a discussion with the nurse manager, a staff nurse confides that she is attracted to a client regularly assigned to her. Which of the following actions should be implemented following this discussion?

1. The nurse waits until after discharge to tell the client about her feelings
2. The nurse continues to provide care for the client
3. The nurse transfers the care of the client to another nurse
4. The nurse reassigns all personal care of the client to the nursing assistant

The nurse is setting up a client's dinner tray. When the nurse turns her back to the client, the client grabs the nurse's buttocks and states he is hungry for much more than dinner. Which of the following responses by the nurse is indicated?

1. Ignore the behavior
2. Call the health care provider
3. Quickly leave the room and ask the UAP to assist the client
4. Complete an incident report

A 54 year-old female explains to the health care provider that she experiences approximately 10 vasomotor symptoms of menopause ("hot flashes") throughout the day and night. Different treatment options are discussed. Which statement by the client indicates she needs further instruction from the nurse?

1. "I should avoid spicy foods, alcohol, and caffeine."

2. "I may need to take estrogen and progesterone for many years."
3. "I will take gabapentin ER at bedtime."
4. "I can use a fan at home and in the workplace."

The client, who lives in a long term care facility, was placed on contact precautions when drainage from a wound tested positive for MRSA (methicillin-resistant Staphylococcus aureus). When can contact precautions be discontinued?

1. If wound drainage can be contained by a dressing
2. After treatment is completed and three consecutive cultures are negative
3. If the client is asymptomatic after treatment is completed
4. When the wound is no longer draining

A severely injured client is moved into an examination area of the emergency department. The family member who accompanied the client to the ED is screaming at the nurse, saying that someone better start doing something right away. What is the best response by the nurse?

1. "I'm going to give you a few minutes alone so you can calm down."
2. "I need you to go to the waiting area. You can come back when you're more in control."
3. "I know you are upset. But please control yourself and sit down. Otherwise I will have to call security."
4. "I can't think when you are yelling at me. Talk to me in a normal voice."

The charge nurse reviews nursing roles and functions with a newly-hired licensed practical nurse (LPN). The LPN asks for more information about the role of the Minimum Data Set (MDS) coordinator. Which statement best explains the role of the MDS coordinator?

1. Interacts with health care staff to coordinate care processes of client assessment and care planning
2. Reviews admissions, diagnostic tests and treatments ordered by physicians
3. Works with families to help their loved ones transition into the nursing home
4. Reviews charts to maximize the cost efficiency of services

The MDS coordinator, who is a full time registered nurse, completes the minimum data set (MDS) for a new admission to a skilled nursing facility. Why does the nurse complete the MDS? (Select all that apply.)

- It provides a standardized set of essential clinical and functional status measures
4. It is required for all clients in a Medicare- or Medicaid-certified nursing facility

A 90 year-old is readmitted to the hospital, less than 2 weeks after being discharged, for the same health concern. What factors contribute to hospital readmissions among older adults? (Select all that apply.)

1. Reconciliation of medications
2. Client health status
3. Family preferences

The 54 year old client is scheduled for a coronary angiography. The client's medical history includes angina, type 2 diabetes mellitus and mild renal insufficiency. Which of the following orders does the nurse anticipate?

- A. Monitor serum creatinine levels pre- and post-procedure
- B. Metformin (Glucophage) 500 mg by mouth pre-procedure
- C. Ibuprofen (Motrin) 800 mg by mouth PRN for pain post-procedure
- D. Restrict oral fluid intake post-procedure

The client is observed falling out of bed when reaching for something on the overbed table. The client then states: "Don't just stand there. I feel fine - help me up." What is the correct order of actions the nurse should take?

1. Obtain a complete set of vital signs
2. Assist the client back to bed, with help from other staff
3. Call the health care provider
4. Complete an incident report

The geriatric social worker is working with the nurse to assess the client's ability to perform instrumental activities of daily living (IADL). Which of the following skills are considered instrumental activities of daily living? (Select all that apply.)

- Ability to take medications
2. Ability to write checks
3. Ability to cook meals

The nurse suspects that the client is in cardiogenic shock. Which of the following findings supports this information?

- A. Decreased or muffled heart sounds
- B. Bradycardia
- C. Bounding pulses
- D. Increased cardiac output

The interdisciplinary team is reviewing charts for potential candidates for hospice care. Which of the following clients meet the criteria for hospice care? (Select all that apply.)

1. 72 year-old with prostate cancer metastasized to the bone, who is receiving palliative radiation therapy
2. 8 year-old client with acute myelogenous leukemia, for whom all treatment options have failed
3. 91 year-old with Alzheimer's disease, who is no longer able to eat or drink oral fluids

Two members of the interdisciplinary team are arguing about the plan of care for a client. Which action could any one of the members of the team use as a de-escalation strategy?

1. Adjourn the meeting and reschedule when everyone has calmed down
2. Bring the communication focus back to the client
3. Interrupt, apologize for interruption, and change the subject
4. Tell the violators they must calm down and be reasonable

During a 12-hour night shift, the nurse has a "near miss" and catches an error before giving a new medication. Which statement might explain the reason for the near miss? (Select all that apply.)

1. The nurse works in the intensive care unit (ICU)
2. The nurse is sleep-deprived
3. D. The nurse is interrupted when preparing the medication
4. E. The unit is short-staffed

A 28 year-old is transferred to the emergency department (ED) via ambulance with a traumatic head injury. The client is awake and reports having a headache and some amnesia. What are the priority nursing interventions for this client? (Select all that apply.)

1. Assess the airway
2. Prepare for CT imaging of the head
3. Assess vital signs and neurological function
4. Assess the wound for presence of drainage or bruising on the head

The health care provider has ordered to administer an osmotic diuretic for a client diagnosed with a traumatic brain injury (TBI). Why was this medication ordered for this client?

- A. Prevent seizures
- B. Reduce pulmonary edema
- C. Reduce intracranial pressure
- D. Prevent electrolyte imbalance

There is an order to administer an intramuscular influenza vaccine to an adult. What actions should the nurse take prior to administration of the injection? (Select all that apply.)

1. Provide the client with the federal Vaccine Information Statement (VIS)

2. Check the expiration date on the vaccination bottle
3. Ask the client if she or he can eat eggs without adverse effects

During the admission assessment on a client with chronic bilateral glaucoma, which statement by the client would a nurse anticipate since it is associated with this problem?

"I have constant blurred vision."

2. "I have to turn my head to see my room."
3. "I have specks floating in my eyes."

D. "I can't see on my left side."

A three year-old child diagnosed with celiac disease attends a day care center. Which food would be an appropriate snack?

- A. Vanilla cookies
- B. Cheesecrackers
- C. Potato chips
- D. Peanut butter sandwich

A 34 year-old female, who has been experiencing widespread muscle pain and fatigue, is diagnosed with fibromyalgia (FM). Which statement by the client indicates she does not understand the treatment options and needs further instruction?

1. "I will take an exercise class – maybe I'll sign up for a yoga class."
2. "I should take duloxetine (Cymbalta) once a day, every day."
3. "If I forget to take the pregabalin (Lyrica) in the morning, I can take it with my evening dose."
4. "I will avoid caffeine, sugar, and alcohol before bedtime."

The order states: acetaminophen (Tylenol) suspension 6 mL by mouth four times a day. The label on the container states: acetaminophen 80 mg per 5 mL. How many milligrams will the nurse administer? 96ml

A client is admitted with low T3 and T4 levels and an elevated thyroid stimulating hormone (TSH) level. On initial assessment, a nurse should anticipate which of these findings?

- A. Heat intolerance
- B. Lethargy
- C. Skin eruptions
- D. Diarrhea

Which statement by a client would require the most immediate action by a nurse?

1. "The pain came on after dinner. That soup seemed very spicy."
2. "I feel pressure in the middle of my chest like an elephant is sitting on my chest."
3. "When I take in a deep breath, it stabs like a knife."
4. "When I turn in bed to reach the remote for the TV, my chest hurts."

A nurse is caring for a client who is receiving methyldopa hydrochloride (Aldomet) intravenously. Which assessment finding would indicate to the nurse that the client may be having an adverse reaction to the medication?

- A. Palpitations
- B. Headache
- C. Mood changes
- D. Hyperkalemia

A client is receiving intravenous heparin therapy. What medication should a nurse have available in the event of an overdose of heparin?

- A. Protamine
- B. Amicar
- C. Diltiazem
- D. Imferon

The order is for ibuprofen (Motrin) oral drops 10 mg/kg of body weight. The client weighs 62 lbs. Motrin oral drops are supplied in bottles containing 40 mg/mL. How many milliliters will the nurse administer? (Report to the nearest whole number.) 7ml

A healthy 18-year-old is entering college in the fall. Which immunization would the health care provider recommend prior to college? (Select all that apply.)

1. Tetanus, Diphtheria, Pertussis vaccine (Tdap)
2. Seasonal influenza vaccine
3. Seasonal influenza vaccine
4. Meningococcal conjugate vaccine (MCV4)
5. Human papillomavirus (HPV) vaccine

The client returned from the cardiac catheterization lab four hours ago. The groin was used as the insertion site. Which of the assessment findings would the nurse immediately report to the health care provider? (Select all that apply.)

Pale color of the affected limb

Capillary refill 6 seconds on the affected toes

Nonpalpable pedal pulse on the affected limb

Which finding is A. Predictable episodes

2. Sense of impending doom
3. Fear of common activities

D. Compulsive behavior

a classic finding in clients diagnosed with panic disorder?

The nurse listens to report about a newly admitted client who has a skin ulcer that's tested positive for MRSA (methicillin-resistant Staphylococcus aureus). What precautions must be taken for this hospitalized client? (Select all that apply.)

1. Keep all equipment in the client's room for his/her sole use
2. Keep the door to the room closed, with a notice for visitors
3. Perform hand hygiene after direct contact with the client and before leaving the room
4. Wear mask when providing routine care to the client

Nurse colleagues are discussing their practice during lunch. Which statement is correct?

1. National nurses' associations work collaboratively to update the social policy statement for nursing.
2. The employing agency is ultimately responsible to provide practice guidelines for licensed nurses.
3. The federal government ensures the safety of clients by defining the scope of nursing practice.
4. Each state has specific regulations for licensed registered nurses (RNs) and practical nurses (PNs).

The client is instructed to collect stool specimens at home using the guaiac test. In addition to explaining how to collect the specimens, the nurse instructs the client to avoid certain substances prior to obtaining the stool specimens. Which of the following substances should the client avoid? (Select all that apply.)

2. Grilled sirloin steak
3. Marinated cauliflower and broccoli
4. Oranges

An ambulatory client reports edema during the day in the feet and ankles that disappears while the client sleeps during the night. What is the most appropriate follow-up question for a nurse to ask?

1. "Do you become short of breath during your normal daily activities?"
2. "Have you had a recent heart attack?"
3. "How many pillows do you use at night to sleep comfortably?"
4. "Do you smoke daily or every other day?"

A nurse is caring for an acutely ill 10 year-old client. Which assessment finding would require the nurse's immediate attention?

Rapid bounding pulse

Profuse diaphoresis

Slow, irregular respirations

Temperature of 101.3 F (38.5 C)

While providing home care to a client with heart failure, a nurse is asked how long diuretics must be taken. What is the best response by the nurse to this client?

1. "The medication must be continued so the fluid problem is controlled."
2. "You will have to take this medication for about a year."
3. "Please talk to your health care provider about medications and treatments."
4. "As you urinate more, you will need less medication to control fluid."

A client, scheduled for coronary artery bypass surgery, makes these statements. Which statement is incorrect and should alert a nurse that reinforcement of information is needed?

1. "Participation in a cardiac rehabilitation program will help prevent further heart disease."
2. "A low sodium diet will help decrease the workload of my heart."
3. "I must take my pulse before taking my medication and notify the health care provider if it is less than 60 beats per minute or greater than 120 beats per minute."
4. "I will need to change positions slowly to prevent my blood pressure from rising."

A nurse is caring for a newborn diagnosed with a neural tube defect (myelomeningocele). What would be the best covering for the lesion?

- A. dry sterile gauze only dressing
- B. moist sterile nonadherent dressing
- C. telfa dressing with antibiotic ointment
- D. sterile occlusive pressure dressing

A nurse is to collect data about a six month-old child diagnosed with nonorganic failure-to-thrive (NOFTT). Upon entering the room, the nurse would expect the baby to have which characteristics?

- A. alert, laughing and playing with a rattle, sitting with support
- B. irritable and "colicky" with no attempts to pull to standing
- C. pale, thin arms and legs along with no interest in the surroundings
- D. skin color dusky with poor skin turgor over abdomen

When caring for a client who is receiving a thrombolytic agent to open a clot-occluded coronary artery after the diagnosis of a myocardial infarction, which finding would be of greatest concern to a nurse?

- A. hematemesis
- B. serosanguinous drainage from the I V site
- C. slight rust-colored urine
- D. pink-tinged saliva

Nurses, who work with clients from many different cultures, should recognize which approach as a priority?

- A. learn about many cultural beliefs
- 2. recognize personal attitudes and biases
- 3. refer to others from specific countries
- D. speak other languages of the local clients

A client, diagnosed with active tuberculosis (TB), has a history of medication noncompliance. Which action by the nurse indicates an understanding of the appropriate care needed for this client?

1. Schedule weekly clinic visits for the client with a focus on medication follow-up
2. Ask the health care provider to change the regimen to a fewer number of medications
3. Ask a family member to supervise daily medication compliance
4. Instruct the client to wear a high efficiency particulate air mask in public places

A client is receiving external beam radiation to the mediastinum for treatment of bronchial cancer. Which finding should take priority in the plan of care?

- A. fatigue
- B. esophagitis

C. skin irritation

D. leukopenia

A nurse is teaching a client who has a new prescription for sublingual nitroglycerin. Which focus should be included during reinforcement of information?

1. carry the nitroglycerin with you at all times
2. take the medication at the same time each day
3. keep the medication bottle in the refrigerator
4. rest in bed for 30 minutes after taking medication

A nurse is assisting in the plan of care for a ten month-old infant diagnosed with bacterial meningitis. The nurse would expect the plan of care to include which intervention?

A. put infant in contact isolation

2. provide for active range of motion
3. observe for a decrease in play activity

D. place an over-the-crib mobile

A nurse is preparing to administer an enteral feeding to a client via a nasogastric feeding tube. What should the initial action of the nurse be?

1. verify correct placement of the tube
2. aspirate gastric contents to determine the amount of the residual
3. check that the feeding solution matches the dietary order
4. ensure that feeding solution is at room temperature

The nurse receives a telephone order from the health care provider for acetaminophen (Tylenol) 1000 mg by mouth for a client's headache. What should the nurse add to the following order when documenting it in the chart? (Write the answer using lower case letters).

Acetaminophen (Tylenol) 1000 mg by mouth for headache, one time dose. _____ Dr. Smith 10/1/2012 at 2:30 pm (1430) by N. Nurse, RN.

Which information should be included during the discussion of home care for a client who has had a hip prosthesis implantation?

A. do not cross your legs at any time

2. ambulate using crutches
3. avoid climbing stairs for three months

D. sleep on your back

A client of the Hispanic heritage refuses emergency room treatment until a curandero is called. What should the nurse understand about the practices of a curandero?

- A. Curandero offer spiritual advising
- B. The client believes in witchcraft
- C. Herbal preparations will be used
- D. Curandero use holistic healing practices

When talking to a client about human immunodeficiency virus (HIV) prevention, which action should the nurse emphasize as increasing risks of the disease?

1. use of public bathrooms
2. donation of blood
3. kissing a person with acquired immunodeficiency syndrome
4. the practice of unprotected sex

A client newly admitted with a diagnosis of a sickle cell crisis is talking on the telephone but stops as a nurse enters the room and requests something for pain. The nurse notices that the nasal oxygen is lying on the client's bed. What action should the nurse take first?

A. reapply the prescribed nasal oxygen

2. encourage increased fluid intake
3. administer the prescribed analgesia
4. D. recommend relaxation exercises for pain control

The nurse is assisting a client who complains of watery diarrhea with meal planning. During the discussion which of these foods should the nurse identify for the client to avoid?

A. orange juice

- B. tuna
- C. eggs
- D. macaroni

A client with a fracture of the radius had a plaster cast applied two days ago. The client calls the clinic to report constant pain and swelling of the fingers since the cast was applied. What should be the next action of a nurse?

A. ask if numbness is present in the fingers and if the client can move the fingers

B. suggest to elevate the arm higher than heart level

C. have the client make an appointment with the surgeon for the next day

D. approve the application of a cool cloth to the fingers of the affected arm

The nurse is performing pulmonary assessment on a client. Indicate the correct sequence of pulmonary assessment by dragging and dropping the steps below into the correct order.

Inspection, Palpation, Percussion, Auscultation

When discussing sexually transmitted infections (STIs) with adolescents, which etiology should a nurse emphasize as the most common infection associated with STIs?

- A. herpes simplex 2
- B. **chlamydia**
- C. gonorrhea
- D. human immunodeficiency virus

A nurse has been reinforcing information about cardiac risks to adult clients as they visit a hypertension clinic. Which approach would best assist in the evaluation of their learning?

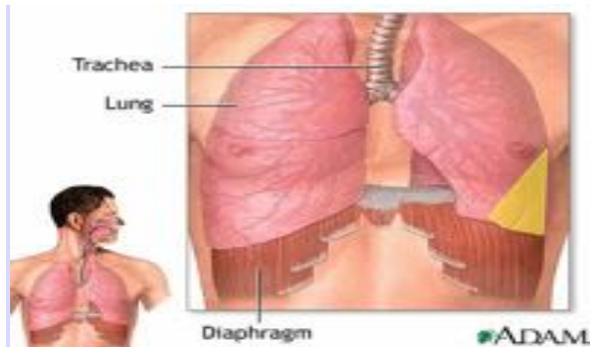
- A. **reported behavioral changes**
 - 2. completion of a mailed survey
 - 3. responses to verbal questions
- D. performance on written tests

Which statement by a parent would alert a nurse to check with the registered nurse (RN) about iron deficiency anemia in a 14 month-old child?

- A. "I know there is a problem since my child is always constipated."
- B. **"My child doesn't like many fruits and vegetables, but really loves milk."**
- C. "My child doesn't drink a whole glass of juice or water."
- D. "I can't understand why my child is not eating as much as 4 months ago."

Which neurological finding for a young adult in an accident would be the priority to report?

- A. unilateral flaccid paralysis
- 2. diminished reflexes
- 3. **pupils fixed and dilated**
- C. reduced sensory responses
- D. A client had a left upper-lobectomy. Which site should the nurse listen to in order to assess the client is meeting this goal, "Lung sounds clear following chest physiotherapy."



A client has been diagnosed with mild dysphagia. What is the appropriate nursing intervention for this client?

1. position client in an upright position while eating
2. alternate a clear liquid diet with a soft diet
3. offer finger foods such as crackers or pretzels
4. tilt head back to facilitate the swallowing process

An older adult client calls the clinic hotline with complaints of generalized muscle aches and pains. What should be the initial action by a nurse who answered the phone?

- A. obtain details of the severity and location of the pain
2. find out what the client usually takes for discomfort
3. encourage the client to walk daily for at least 15 minutes
4. reassure the client that this is not unusual in the client's age group

A clinic nurse is counseling about the risks of continued cocaine use to a postpartum client who is a known drug user. In order to provide continuity of care, which nursing diagnosis should the nurse anticipate to be identified as a priority?

- A. ineffective coping
- B. altered parenting
- C. sexual dysfunction
- D. social isolation

Which action would be the best strategy for a nurse to use when reinforcing insulin injection techniques to an adult client newly diagnosed with diabetes mellitus type 1?

- A. listen to client's verbalized understanding
2. ask the client questions after practice sessions
3. observe a return demonstration

4. ask the client questions during practice sessions

A client is being maintained on heparin therapy. A nurse must closely monitor which laboratory value?

A. activated PTT

B. platelet count

C. bleeding time

D. clotting time

A child has severe burns to the lower extremities. A diet high in protein and carbohydrates is recommended. A nurse should care for this client with the knowledge that the most important reason for such a diet is to achieve which result?

A. stimulate increased peristalsis and nutrient absorption

B. spare protein catabolism to meet metabolic and healing needs

C. promote healing and strengthen the immune system

D. provide a well balanced nutritional intake

A client is discharged on warfarin sulfate (Coumadin). A nurse recognizes that additional teaching is needed if the client makes which incorrect comment?

A. "I plan to use an electric razor for shaving."

2. "I know I must avoid crowds."

3. "I will report any bruises for bleeding."

D. "I will keep all laboratory appointments."

A client diagnosed with a spontaneous pneumothorax has a chest tube inserted. What explanation should a nurse reinforce? "The tube will

A. control the amount of air that enters your chest."

2. drain fluid from your chest."

3. remove excess air from your chest."

4. D. seal the hole in your lung."

An older adult client on digitalis (Lanoxin) and bumetanide (Bumex) reports nausea, vomiting, and abdominal cramps. Which serum lab result should a nurse check first?

- A. pH
- B. glucose
- C. magnesium

D. potassium

A nurse is collecting data on a newborn delivered at home. The mother admits to being addicted to heroin. Which findings should the nurse expect to observe in the newborn?

- A. jitteriness in one to two days
- B. hypertonic neuro reflex
- C. central nervous system depression

D. lethargy with sleepiness

A nurse is caring for a preschooler two hours after tonsillectomy and adenoidectomy. Which observation must be reported immediately to the RN?

A. complaints of throat pain

2. apical heart rate of 110

3. increased restlessness

D. vomiting of dark brown emesis

A nurse is caring for a mother who has just delivered a stillborn baby. The most therapeutic comment by the nurse to this grieving mother would be which comment?

A. "Tell me about your experience and feelings."

B. "You have an angel in heaven watching over you now."

C. "Let's talk about your physical pain, now."

D. "Nature has a way of dealing with problems."

A nurse is checking an infant diagnosed with developmental hip dysplasia. Which finding should the nurse anticipate to observe?

A. unequal leg length

B. symmetrical gluteal folds

C. diminished femoral pulses

D. limited adduction

A client is admitted to the telemetry unit with a diagnosis of mitral stenosis. The nurse is assessing the client's heart sounds. Indicate on the diagram where the nurse should place the stethoscope to best assess the mitral valve.



A six month-old infant is being treated for developmental dysplasia of the hip and has been placed in a hip spica plaster cast. A nurse should reinforce what information on discharge to the parents?

1. turn the baby every two hours with the use of the abduction stabilizer bar
2. check frequently for swelling in the baby's feet
3. place favorite books and push-pull toys in the crib
4. gently rub the skin with a cotton swab to relieve itching

A nurse in an outpatient clinic occasionally visits with a client who has a history of substance abuse. During an evaluation of the client's progress, the nurse should recognize that the most revealing resistant behavior is which of these?

- A. continuing drug use
2. recurring crises
3. rationalizing comments
- D. missing appointments

A teenage client with a history of sickle cell disease is admitted to the hospital with a diagnosis of sickle cell crisis. Which statement by the client indicates the most likely cause of this event?

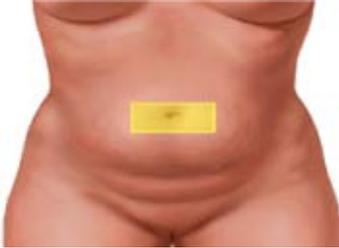
1. "I really enjoyed my fishing trip yesterday. I caught two fish."
2. "I knew this would happen. I've been eating too much red meat lately."
3. "I went to the health care provider last week for a cold and I have gotten worse."
4. "I have really been working hard practicing with the debate team at school."

A nurse is caring for an older adult client diagnosed with colorectal cancer. The client's pain has been managed with acetaminophen with codeine until now. Because of more severe pain, the order is changed to a narcotic analgesic. The nurse should recognize that this order is

- A. inappropriate and anticipates poor pain control.
2. inappropriate because of potential respiratory depression.
3. appropriate pain management around-the-clock.

4. appropriate despite the expected effect of mental confusion.

The nurse is assessing the uterine fundus of a client who delivered a healthy neonate 10 hours ago. Identify the area where the nurse would expect to feel the fundus.



The nurse is working on an inpatient psychiatric unit. Which statement made by a client indicates that the client may have a thought disorder?

1. "I'm fine. It's my daughter who has the problem."
2. "I'm so angry about this. Wait until my partner hears about this!"

B. "I'm a little confused. What time is it?"

5. D. "I can't find my 'mesmer' shoes. Have you seen them?"

A two year-old child is brought to the emergency room at 2:00 pm. The mother states that the child has not had a wet diaper all day. The child is pale and the heart rate is 132. What data should a nurse obtain next?

1. the types of foods and eating patterns over the past week
2. a description of any seizure activity in the past 24 hours
3. the status of the child's play activity that day
4. a history of any difficulties with attempts to potty train

Arterial blood gases have been ordered for a confused client. The respiratory therapist draws the blood and then asks a nurse to apply pressure to the site so the therapist can take the specimen to the lab. How many minutes should the nurse apply pressure to the site?

A. 5

B. 10

C. 3

D. 8

A nurse is assigned to care for a ten month-old infant with the new diagnosis of anemia. Which of these findings should the nurse anticipate?

- A. **pale mucosa inside the mouth**
2. a slow heart rate with sleeping
 3. behavior consistent with hyperactivity
- D. a high hemoglobin level

A nurse discusses the healthy use of both conscious and unconscious defense mechanisms with a group of clients. An appropriate goal for these clients would be to use these mechanisms for which purpose?

A. foster independence with better communication

B. **reduce fear and protect self-esteem**

C. avoid conflict and unpleasant consequences

D. eliminate anxiety and apprehension

A client asks a nurse about including her two year- old and 12 year-old sons in the care of their newborn sister. Which would be an appropriate initial statement by the nurse?

1. **"Focus on your sons' needs during the first few days at home."**
2. "Suggest that the father spend more time with the boys."
3. "Tell each child what he can do to help with the baby."
4. "Ask the children what they would like to do for the newborn."

A client tells a nurse that she is planning a pregnancy in the near future. She asks about recommended preconception dietary needs. Which statement should the nurse include in a response?

1. "Drink a glass of milk with each meal"
2. "Include fibers in your daily diet"
3. **"Increase the intake of green leafy vegetables "**
4. "Eat at least one serving of fish weekly"

A nurse is caring for a client diagnosed with sickle cell crisis. The client is scheduled to receive two units of packed red blood cells. Which action is appropriate for the nurse when monitoring the infusion?

1. slow the rate of infusion if the client develops fever or chills
2. **limit the infusion time of each of the unit to a maximum of four hours**
3. check vital signs every 15 minutes throughout the entire infusion
4. store the packed red cells in the medicine refrigerator while the registered nurse (RN) is starting the IV

Upon admission to an intensive care unit, a client diagnosed with an acute myocardial infarction (MI) is ordered nasal oxygen at 4L/min. A nurse knows that the major reason that oxygen is administered in this situation is which purpose?

- A. saturate the red blood cells
- 2. return skin color to normal tones
- 3. relieve dyspnea on exertion
- D. increase oxygen to ischemic cardiac cells

Which finding should the nurse expect to observe during the data collection about an eight month-old child diagnosed with cerebral palsy?

- A. unable to follow objects with eyes
- 2. does not respond to touch
- 3. unable to roll from back to stomach
- D. does not turn toward loud sounds

A client diagnosed with depression is scheduled for electroconvulsive therapy treatments (ECT). One hour before the first treatment is scheduled, the client becomes anxious and states "I do not want to go through with this!" Which statement by the nurse is most appropriate?

- 1. "You have the right to change your mind. You seem anxious about the treatment. Can we talk about it?"
- 2. "I'll go with you and will be there with you during the treatment."
- 3. C. "I'll call the health care provider and let him know that you have changed your mind about the treatment."
- 4. D. "You'll be asleep and won't remember anything."

A nurse is caring for a hospitalized 12 year-old client who is diagnosed with hemophilia A. Which intervention should the nurse plan on implementing as a priority?

- A. bleeding precautions
- 2. stool checks for blood
- 3. intake and output
- D. protective isolation

A client has been diagnosed with postpartum hemorrhage eight hours after the birth of twins. Following the administration of IV fluids and 500 mL of whole blood, the hemoglobin and hematocrit are within normal limits. She asks a nurse whether she should continue to breast feed the infants. Which statement by the nurse is based on sound rationale?

1. "Nursing will help contract the uterus and reduce your risk of bleeding."
2. "Lactation should be delayed until the 'real milk' is secreted."
3. "The blood transfusion may increase the risks to you and the babies."
4. "Breastfeeding twins will take too much energy after the hemorrhage."

A nurse is caring for a trauma victim with a significant blood loss. Immediately following multiple blood transfusions, what is the most accurate indicator for adequate oxygenation?

- A. hematocrit
- B. pulse oximetry
- C. blood gases
- D. hemoglobin

A client expresses anger when the call light is not answered promptly. How should the nurse respond?

- A. "Let's talk about this situation."
- 2. "I am surprised that you are upset."
- 3. "I apologize for the delay. I was busy with an emergency."
- 4. "I see this is frustrating for you."

During the care of a client during the acute phase of a sickle cell vaso-occlusive crisis, which intervention by a nurse would be most important?

- A. provide temperature control measures
- 2. administer analgesic therapy as ordered
- 3. offer clear liquids every two hours
- D. reinforce bedrest regimen

A nurse is caring for an infant diagnosed with roseola. Which characteristics of the skin lesions would the nurse expect to find?

1. erythema on the face, primarily on cheeks giving a "slapped face" appearance
2. macule that rapidly progresses to papule and then vesicles
3. Koplick's spots appear first followed by a rash that appears first on the face and spreads downward
4. discrete rose pink macules that appear first on the trunk and when pressure is applied they fade in color
5. A client says, "It's raining outside and it's raining in my heart. Did you know that St. Patrick drove the snakes out of Ireland? I've never been to Ireland."

A nurse reviews this data and determines that this client has a speech pattern commonly seen in manic episodes. The nurse should document this as which item?

- A. perseveration
- B. flight of ideas
- C. neologisms
- D. circumstantiality

A male client is admitted with the diagnosis of a spinal cord injury at level C-4. A nurse should reinforce the client's understanding as to how the injury is going to affect any sexual function by which statement?

- 1. "Erections will be possible."
- 2. "Sexual functioning will not be impaired at all."
- 3. "Normal sexual function is not possible."
- 4. "Ejaculation will be normal."

A nurse is working in a psychiatric unit setting. For what reason should the nurse limit the use of touch or physical contact with clients to handshaking?

- A. Handshaking allows the use of touch in a professional manner
- 2. Refusal to touch a client denotes lack of concern
- 3. Touching a client inappropriately can set off a violent episode
- 4. Some clients misconstrue hugs as an invitation to sexual advances

Which statement by a nurse reflects the best use of therapeutic interaction techniques

- 1. "You look very sad. How long have you been this way? Have you been taking care of yourself?"
- 2. "You look upset. Tell me what's been happening?"
- 3. "I understand that you lost your partner. Let's talk about how you can go on."
- 4. "I'd like to know more about your children. Tell me about them."

A client with a nasogastric (NG) tube complains of nausea. What should be the first action of a nurse?

- A. position the client in Fowler's
- B. report the findings to the registered nurse (RN) charge nurse
- C. administer the ordered prn antiemetic
- D. check for the patency of the tube

The nurse has established a therapeutic relationship with a client. Which observation would indicate that the nurse-client relationship has passed from the orienting phase to the working phase?

1. The client expresses a desire to be mothered and pampered
2. The client recognizes feelings and expresses them appropriately
3. The client revitalizes a relationship with the family to help in coping with a child's death
4. The client recognizes regression as a part of a defense mechanism

The parents of a school-age child are providing information to the nurse about their child. Which of these concerns would the nurse recognize as a finding that could suggest type 1 diabetes?

- A. Being a picky eater
- B. Weight gain
- C. Oily and acne-prone skin
- D. Bed wetting

A nurse is caring for an adolescent who is prescribed albuterol (Proventil) for asthma. The adolescent asks: "Why do I have to take this medication?" The nurse should explain that Albuterol is prescribed for what reason?

1. relax the smooth muscles in the airways.
2. stimulate the respiratory center in the brain that controls respirations.
3. decrease the swelling in the airways.
4. reduce the secretions blocking the airways

A nurse is assigned to a child diagnosed with an acute episode of reactive airway disease and a history of asthma. Which finding should the nurse expect to observe during the child's care?

- A. wheezing on expiration
- 2. inspiratory stridor
- 3. periods of apnea
- D. a productive cough

When a client returns from surgery after an open reduction with cast application for a femur fracture, a small blood stain is noted on the cast by a nurse. Four hours later, the nurse observes that the stain has doubled in size. What is the initial action for the nurse to take at this time?

1. report the finding to the registered nurse (RN) charge nurse
2. ask the family to call you when they notice the spot getting larger

3. outline the spot with a pencil and note the time and date on the cast

4. record the findings in the nurse's notes

A nurse should take the initial blood pressure of a client newly diagnosed with hypertension by what process?

A. after exercising for two minutes

B. in both arms

C. while supine

D. in a standing and a sitting position

An immobile hospitalized client is eating less than 25% of served meals. The client gains 5 pounds (2.27 kg) in two days.

The most likely explanation for this is the retention of how many milliliters of fluid? _

2500, 2270 mL.

When checking a client with a history of hypertension at a walk-in clinic, what is a priority question that a nurse should ask?

1. "Describe your family's cardiac history."
2. "Tell me about your usual diet."
3. "Describe your usual exercise and activity patterns."
4. "What over-the-counter medications do you take?"

A nurse is participating in a community health fair. As part of the health promotion process, the nurse should conduct a mental status examination when

A. Any health screening is done

2. There are obvious findings of depression

3. An individual reports memory lapses

D. An individual displays restlessness

A nurse is administering albuterol (Proventil) to a child with asthma. Which intervention should be included in the plan of care?

monitor heart rate

check oral cavity for thrush

observe for lethargy and fatigue

strict bedrest during administration

A nurse is caring for a child diagnosed with acute severe airway obstruction. Which finding should the nurse monitor for as expected?

1. chest pain aggravated by respiratory movement
2. retractions in the soft tissues of the thorax
3. rapid, shallow respirations
4. mottling of the skin on the trunk

During a 12-hour shift, a client who underwent a transurethral resection of the prostate (TURP), had an IV intake of 1200 mL, oral intake of 400 mL, continuous bladder irrigation of 2400 mL, 2 syringe flushes of 50 mL each, and Foley catheter output of 3000 mL.

4100 ml

A client is scheduled for an intravenous pyelogram (IVP). After the contrast material is injected, which client reaction should require immediate interventions?

A. feeling warm

B. hives

C. salty taste

D. face flushing

A nurse is reinforcing information about the application of a pediculicide to parents for their child's head lice. Which of these instructions indicate proper application? Apply the shampoo

A. to the head, repeat daily until nits are no longer seen

B. from head to toe, leave on for eight-to-ten hours

C. to the head, may repeat in one week and no sooner

D. from head to toe, leave on for ten minutes

A mother asks a nurse: "Should I be concerned about the tendency of my child to stutter?" What focus should be the most useful for responding to the parent?

A. expected difficulties rooted into age groups

B. sibling position in the family

C. parental discipline strategies

D. stressful family events

Why should the nurse be informed about cultural issues related to the client's background?

1. Developmental mental stages enhance a nurse's knowledge base

2. Patterns of behavior of another culture may be labeled as bizarre or immoral
3. The meaning of the client's behavior can be derived from conventional wisdom
4. The nurse should rely on personal values and other staff member observations

A client is receiving standard concentration Heparin IV of 25,000 units in 250 mL D5W. The infusion is running on an IV pump. The infusion rate is increased from 9 mL/hour to 12 mL/hour. What is the new dosage of Heparin? (Write the answer using whole numbers.)

1200units/hour.

A Chinese client, admitted with the diagnosis of generalized anxiety disorder, is unable to care for self. According to Chinese folk medicine, health is regulated by the opposing forces of yin and yang. Based on this cultural belief, a nurse would expect the client's family to attribute the illness to which explanation?

1. a failure to use homeopathy correctly
2. yin, the negative force that represents darkness, cold, and emptiness
3. yang, the positive force that represents light, warmth, and fullness
4. too many hot spicy foods and herbs

A nurse is collecting data on a client diagnosed with a stage 2 skin ulcer. Which treatment should the nurse expect to be most effective to promote healing?

- A. leaving the area open to dry
2. covering the wound with a dry dressing
3. using hydrogen peroxide soaks
- D. applying a transparent film cover

A client has had a positive reaction to purified protein derivative (PPD). A nurse should know the client has understood the teaching by the registered nurse (RN) if the client makes which statement?

1. "I have never had tuberculosis."
2. "I have never been infected with mycobacterium tuberculosis."
3. "I have been exposed to mycobacterium tuberculosis."
4. "I have active tuberculosis."

In checking the healing of a client's wound during a home visit, which finding is the best indicator of expected progress in healing?

- A. green drainage
2. eschar development
3. reddened tissue

D. white patches

A community clinic nurse assists with a toddler after being diagnosed with a first episode of otitis media. Which reinforcement of information should the nurse include in instructions to the child's parents?

1. provide them with a handout describing the purpose of myringotomy tubes
2. describe the tympano centesis used to detect persistent infections
3. emphasize the importance of a return visit after completion of antibiotics
4. explain that the child should complete the full five days of antibiotics

The nurse is working in an inpatient mental health unit. Which focus is an important goal in the development of a therapeutic inpatient milieu?

1. A testing ground for new patterns of behavior for which clients takes responsibility
2. A group forum in which clients decide on the unit rules, regulations, and policies
3. Discouragement for expressions of anger because angry clients can be disruptive to other clients
4. A businesslike atmosphere where clients can work on individual goals

A toddler diagnosed with acquired immune deficiency syndrome (AIDS) was given intravenous gamma globulin. The parents ask: "Why is this medication being given?" The best response by a nurse should include which comment?

1. "This medication will improve your child's overall health status."
2. "It will slow down the replication of the virus."
3. "This medication is used to prevent bacterial infections."
4. "It will increase the effectiveness of the other medications your child receives."

A 15 year-old client with a lengthy confining illness is at risk for altered growth and development related to which issue?

A. dependence

B. insecurity

C. lack of trust

D. loss of control

A nurse is caring for a child who has just returned from a tonsillectomy and adenoidectomy surgery. Which intervention by the nurse is most important?

A. do not allow the child to drink through a straw

2. offer popsicles frequently
3. place the child in a sitting position

4. D. observe swallowing patterns and ability

A nurse is reinforcing information to the parents of a child diagnosed with cystic fibrosis. The nurse should emphasize that pancreatic enzymes should be taken at which time?

- A. each time carbohydrates are eaten
- 2. once each day in the morning
- 3. with each meal or snack
- D. three times daily after meals

A nurse is collecting data on a client with portal hypertension. Which finding should the nurse expect?

- A. ascites
- B. expiratory wheezes
- C. obesity
- D. blurred vision

For a 14 year-old adolescent diagnosed with scoliosis, which consequence will be the most challenging?

- the length of the treatment regimen
- the compliance with treatment regimens
- lacking independence in activities

looking different from the peers

A nurse is reinforcing information to a mother who is breastfeeding a newborn infant diagnosed with oral candidiasis. Which statement by the mother would be incorrect and indicate a need for reinforcement of information?

- 1. "Nystatin should be given four times a day after my baby eats."
- 2. "The therapy can be discontinued when the spots disappear."
- 3. "I will boil the nipples and pacifiers for 20 minutes."
- 4. "Expressed breast milk should be used immediately and not frozen."

Parents of a four year-old boy have just been informed that their son has a congenital neurologic demyelinating disorder that is terminal. A nurse should anticipate that their reaction should be at which phase of the crisis process?

- A. impact
- B. resolution

C. recovery

D. pre-crisis

Which finding by the nurse in a toddler diagnosed with croup indicates early respiratory problems?

A. mild inspiratory stridor

2. increased severe dyspnea
3. inability of the family to calm the child
4. decreased breath sounds

A nurse is assisting in the discharge of a child who was admitted with a diagnosis of acute spasmodic croup. What topic should be reinforced with the parents for home care?

1. provide humidified air with increased oral fluids
2. use sedation as needed to prevent exhaustion
3. administer antibiotic therapy for 10-14 days
4. give antihistamines to minimize allergic response

The client has received fentanyl, atropine, and benzocaine for an endoscopic procedure. The nurse is monitoring the client and notes the pulse has increased from the pre-procedure baseline.

Which medication could cause an increased pulse rate? (Write the name of the medication).

atropine, Atropine, ATROPINE

A nurse is collecting data about the growth and development of a toddler diagnosed with acquired immune deficiency syndrome (AIDS). Which finding should the nurse expect?

1. Delayed musculoskeletal development
2. Difficulty with speech development
3. Delayed achievement of all developmental milestones
4. Achievement of developmental milestones at normal rates

A client refuses to take the medication prescribed because the client prefers to take an herbal preparation. What is the first action a nurse should take?

1. Contact the client's health care provider about the refusal
2. Explain the importance of the medication to the client
3. Talk with the client to find out about the preferred herbal preparation
4. Report the behavior to the charge nurse

A nurse assigned to a nine year-old child with a fractured femur is told that a medication error occurred. The child received twice the ordered dose of morphine an hour ago. Which nursing diagnosis on the plan of care is a priority at this time?

1. risk for fluid volume alteration related to change in peristalsis
2. decreased gastrointestinal mobility related to narcotic effects
3. altered nutrition related to inability to control nausea and vomiting
4. ineffective breathing patterns related to central nervous system depression

A client had 20 mg of furosemide (Lasix) PO at 10 am. Which data of the client should be a priority for a nurse to include at the change of shift report?

- A. a serum potassium of 4 mEq/liter
- B. to receive another dose of Lasix at 10 pm

C. a urine output of 1500 mL over the last five hours

D. lost 2 pounds since yesterday

The nurse is providing care for an 18 month-old child. What information should be used when assisting with developing the care plan for this child?

1. Encourage the child to eat finger foods
2. Engage the child in games with other children
3. Hold and cuddle the child often
4. Allow the child to walk independently in the nursing unit

A nurse's primary intervention for a client who is experiencing a panic attack is which action?

- A. teach the client to control behaviors
- B. assist the client to describe the experience in detail

C. maintain safety for the client

D. develop a trusting relationship

A nurse collects data about a 16-year-old's use of coping mechanisms. The teen had multiple serious injuries after a motor vehicle accident. Which characteristics are most likely to be displayed by an individual of this age with this situation?

1. intellectualization, rationalization, repression
2. denial, projection, regression
3. ambivalence, dependence, indecision
4. identification, assimilation, day-dreaming

A 14 month-old child ingested half a bottle of baby aspirin (81 mg) tablets. Which finding should a nurse expect to see in the child?

- A. dyspnea
- B. hypothermia

C. epistaxis

edema

A nurse is caring for a child who has been recently diagnosed with cystic fibrosis. Which finding should the nurse anticipate?

dry, non-productive cough

frequent urinary

infections poor appetite
ribbon-like stools

The order reads: administer Premarin 1.25 mg daily. The only available tablet strength is 625 mcg. How much medication will the nurse administer?

2tabs

The nurse should care for a newborn who was infected with human immunodeficiency virus (HIV) in utero based upon knowledge of which information?

1. careful monitoring of renal function is indicated
2. the disease will incubate longer and progress more slowly in this infant
3. the infant is more susceptible to infections
4. growth and development patterns will proceed at a normal rate

A nurse should be aware that which of these psychosocial needs are more commonly found in an adolescent?

A. group sports, competition, being right

2. school performance, reading, journal writing

3. privacy, autonomy, peer interactions

D. independence, confidence, narcissism

While monitoring the client's initial postoperative condition after a total thyroidectomy, which findings should a nurse expect as complications and report immediately to the registered nurse (RN)?

A. irritability and insomnia

2. parasthesia and muscle cramping

3. mild dysphagia and hoarseness

D. headache and nausea

A nurse is participating in the planning of care for an eight year-old child. Which focus should be include

alk with the child to allow expressions of opinions

promote independence in activities of daily living

provide frequent reassurance and cuddling

encourage child to engage in activities with others in the playroom

The order reads: infuse IV of 1000 mL D5W with 100 mEq KCl at a rate of 50 mL/hour. Which component of this order should the nurse question?

100 mEq KCl

Lactulose (Kristalose, Chronulac) has been prescribed for a client with advanced liver disease. Which finding should a nurse use to evaluate the effectiveness of this treatment?

A. Decreased fluid retention

2. Increased ability to concentrate

3. Reduction of jaundice

D. Increased appetite

The nurse is reviewing the data on a client who is suspected of having diabetes insipidus. What finding should the nurse anticipate following a water deprivation test?

A. Rapid protein excretion

2. Increased edema and weight gain

3. Unchanged urine specific gravity

D. Decreased blood potassium

The nurse is providing care for an adolescent. Which intervention best demonstrates nurses' sensitivity to an adolescent's appropriate need for autonomy?

- A. Allow young siblings to interact via various communication routes
- B. Express identification of feelings about body image
- C. Provide discussion of concerns without the presence of parents
- D. Explore an adolescent's feelings of resentment to identify causes

A two year-old child has recently been diagnosed with cystic fibrosis. A nurse is reinforcing aspects of home care for the child with the parents. Which information is appropriate for the nurse to include?

- A. limit exposure to other children
- B. restrict activities to inside the house
- C. schedule frequent rest periods
- D. continue with the child's normal activities

An appropriate goal for clients with anxiety would be which of these?

1. learn self-help techniques for anxiety reduction
2. express feelings to the nurse on a daily basis
3. establish contact with reality situations
4. become desensitized to past trauma and issues

The nurse is caring for a client in a long leg synthetic cast. The most important reason for a nurse to elevate the casted leg is for what reason?

- A. improve venous return
- 2. reduce the drying time
- 3. decrease irritation to the skin
- D. promote the client's comfort

A nurse would expect finding that a four month-old infant should be able to have which behavior?

- A. hold a rattle
- B. wave "bye-bye"
- C. bang two blocks
- D. drink from a cup

A nurse is caring for a school-aged child with a diagnosis of secondary hyperparathyroidism after being treated for chronic renal disease. Which serum lab data should receive priority attention?

- A. calcium and phosphorus levels
- B. creatinine clearance
- C. blood urea nitrogen
- D. blood sugar level

A client has been admitted to the coronary care unit with a diagnosis of myocardial infarction. Which of these nursing diagnoses should a nurse be sure to discuss as a priority during a client care conference?

- A. risk for complications: dysrhythmias

B. pain related to ischemia

- C. activity intolerance
- D. risk for anxiety

A nurse and client are discussing the client's progress toward understanding the client's behavioral responses to stressful events. This is typical of which phase in the therapeutic relationship?

- A. Termination
- B. Working
- C. Orientation
- D. Preinteraction

Which topic should be included in the plan of care to reduce leg pain for a client with peripheral arterial insufficiency of the lower extremities?

- A. lower the legs to a dependent position
- B. elevate the legs above the heart
- C. increase ingestion of caffeine products

D. supply cold compresses

A client states, "People think I'm no good. You know what I mean?" Which nursing response would be most therapeutic for this client?

1. "Let's explore what you may have done to create this impression on people."
2. "Let's identify and compare a few people who like you and those that don't."
3. "People often take their own feelings of inadequacy out on others."
4. "I'm not sure what you mean. Tell me a bit more about that comment."

During reinforcement about the care after heart surgery the nurse should provide a ten year-old child with which interaction approach?

- A. a booklet to read about the surgery
- B. a model of the heart to explain the surgery
- C. a verbal explanation just prior to the surgery
- D. an introduction to another child who had heart surgery

The parents of a toddler ask: "How long will our child have to sit in a car seat when riding in a car?" The best response by a nurse is that, "The use of a car or booster seat is required until the child

is at least five years-old."
is 50 inches tall."
weighs at least 40 pounds."
is content to use a regular seat belt."

A nurse is discussing with a client the precautions with warfarin (Coumadin). The nurse should tell the client to avoid foods with excessive amounts of what substance?

- A. vitamin K
- B. vitamin E
- C. Iron
- D. calcium

Following surgery for the placement of a ventriculoperitoneal (VP) shunt as treatment for hydrocephalus of their child, the parents ask a nurse to reinforce the registered nurse's (RN) explanation as to why the infant has a small abdominal incision. The best response by the nurse would be to explain that the incision was made in order to insert the

- A. tubing into the urinary bladder
- 2. catheter into the abdominal cavity
- 3. catheter into the stomach
- D. camera for catheter placement

A nurse would anticipate that an eight month-old should be able to display which behavior?

- A. pull up to stand
- B. say two words
- C. sit without support
- D. use a spoon

The CNA informs the nurse that a client's condition has changed. Which assessment finding is the earliest indication of inadequate oxygen transport?

- A. Somnolence
- B. Confusion
- C. Restlessness
- D. Crackles in the lungs

The nurse has an order for a post-surgical client to receive enoxeparin (Lovenox) 40 mg subcutaneously once a day as prophylaxis for deep vein thrombosis. Enoxeparin (Lovenox) is supplied from the pharmacy as 60 mg/mL. How much Lovenox will the nurse administer? (Round the number to the nearest 10th and write only the number). 0.7 mL.

A nurse and client are discussing the client's progress toward understanding the client's behavioral responses to stressful events. This is typical of which phase in the therapeutic relationship?

preinteraction

orientation

termination

working

A client who received chemotherapy through a central line is admitted to the hospital with a diagnosis of sepsis. Which nursing intervention should receive priority?

1. inspect all sites that may serve as entry ports for bacteria
2. restrict contact with persons having known or recent infections
3. change the dressing over the site of the central line
4. place the client in reverse isolation

A nursing intervention that "best" describes approaches to deal with the behaviors of clients diagnosed with personality disorders include those that

1. have limit-setting enforced 24 hours per day
2. accept the client and the client's behavior unconditionally
3. encourage dependency in order to develop ego controls
4. point out inconsistencies in speech patterns to correct thought disorders

A nurse is assigned to a client with clinical depression who is receiving an MAO inhibitor. During reinforcement of instructions about precautions with this medication, the nurse should remind the client to avoid which actions?

A. ingestion of chocolate and cheese

2. ingestion of foods high in sodium
3. prolonged sun exposure

D. walking without assistance

On the burn unit, a nurse is assigned to a child who weighs 30 kg. Adequate fluid replacement is best indicated by which observation?

A. moist mouth mucus membranes

2. no complaints of thirst
3. normal skin turgor

D. urinary output of 32 cc per hour

A client states: "I do not want to be interrupted for breakfast because it interferes with my meditation time." What is the next action for a nurse to take?

1. Talk with the client to work out a mutual plan
2. Contact the client's provider
3. Consult with the nurse manager to get suggestions
4. Contact the nutritionist or dietitian

A nurse is preparing a client for discharge following inpatient treatment for pulmonary tuberculosis. The nurse should remind the client to take which action?

1. continue medication use as prescribed
2. continue medication use as prescribed until symptoms are relieved
3. avoid contact with children, pregnant women or immunosuppressed persons
4. take medication with Amphojel if epigastric distress occurs

A client is admitted to a mental health unit with the diagnosis of delusional thinking. A nurse should expect to observe which findings?

A. panic and multiple physical complaints

2. anorexia and hopelessness
3. flight of ideas and hyperactivity

D. suspiciousness and resistance to therapy

A nurse is caring for a client diagnosed with acute pancreatitis. Which topic, after pain management, should be discussed for reinforcement during a client conference?

A. institute seizure precautions

2. provide a diet high in protein
3. cough and deep breathe every two hours

D. place the client in contact isolation

An older adult client with a diagnosis of osteomyelitis requires a six week course of intravenous antibiotics. In helping to plan for home care, which item needs to be determined first before the other actions can be done by a nurse?

1. investigation of the client's insurance to see if it covers home IV antibiotic therapy
2. find out if there are adequate hand washing facilities in the home
3. select an appropriate venous dressing method
4. determine the client's ability to participate in self care and/or the presence of a reliable caregiver

A nurse is assigned to a client with Parkinson's disease who is experiencing hallucinations. Which of these medications may have been a contributing factor?

A. baclofen (generic)

B. benztropine(Cogentin)

C. carbidopa/levodopa(Sinemet)

D. diphenhydramine (Benadryl Allergy)

An 82 year-old client is prescribed eye drops for treatment of glaucoma. What other data is needed before a nurse begins to reinforce proper administration of the eye drops?

1. proximity to health care services
2. ability to use visual assistive devices
3. other medical problems

4. manual dexterity

The nurse is assisting with the physical assessment of adolescents. When comparing information about growth in boys and girls, what should the nurse anticipate?

1. At puberty, hormones are responsible for the growth spurt and other changes
2. Both genders have about the same rate of growth throughout puberty
3. Girls experience a growth spurt about two years later than boys
4. Height increases by roughly 10.1 cm (4 inches) each year in boys and girls

A client is being transfused with one unit of packed cells. Thirty minutes after the transfusion was initiated, the client complains of chills and headache. What should be the initial action of the practical nurse (PN)?

A. obtain a urine specimen

2. stop the transfusion

3. notify the registered nurse (RN)

D. check the client's temperature

For a client diagnosed with asthma, which action should be reinforced to monitor on a daily basis by a nurse during a teaching session?

A. skin color

2. peak air flow volumes

3. respiratory rate

D. pulse oximetry

A nurse should be aware that the most frequent cause for suicide in adolescents is

A. feelings of alienation or isolation from peers

2. progressive failure to adapt to peer pressure

3. reunion wish or a fantasy of some sort

D. feelings of anger or hostility toward others

Which therapeutic communication skill is likely to encourage a client treated for depression to express feelings?

A. silence with active listening behaviors

2. reality orientation with reinforcement

3. projective identification with questioning

D. direct confrontation with discussion

A nurse is reinforcing the information to a newly diagnosed asthma client on how to use a peak flow meter. The nurse should explain that this peak flow meter is to be used to measure what parameters?

A. forced expiratory volume

B. oxygen saturation

C. presence of allergens

D. doses for inhaled bronchodilator

When discussing suicide prevention with the parents of a 15 year-old who recently attempted suicide, a nurse should include which behavioral cue or signal to discuss?

A. angry outbursts at significant others

2. excessive sulking to peers and family

3. giving away valued personal items

D. fears of being left alone in the home

The health care provider writes an order for vancomycin (Vancocin) 2 grams every 12 hours IV for a client with pneumonia. The pharmacy sends the medication mixed in a 200 milliliter (mL) bag with directions to infuse it over 1.5 hours. The nurse will use an infusion pump to deliver the medication.

What is the infusion rate for the vancomycin (Vancocin)? (Round to the nearest whole number and write only the number). __ 133mL/hour.

When caring for a client with advanced cirrhosis of the liver, which finding should receive immediate follow-up by the nurse?

A. anorexia

B. jaundice

C. hematemesis

D. ascites

The parents of a newborn male with hypospadias want their child circumcised. The best response by a nurse to reinforce the registered nurse's (RN) instruction is to inform them of what information?

1. there is no medical indication to perform a circumcision on their child
2. the procedure may be performed as soon as their infant is stable
3. this procedure is contraindicated because of the permanent defect
4. **circumcision is delayed so the foreskin can be used for the surgical repair**

During observation of the growth of children during their school-age years, a nurse should expect to see which change?

1. little change in body appearance from year to year
2. progressive height increase of 4 inches each year
3. **yearly weight gain of about 5.5 pounds per year**
4. decreasing amounts of body fat and muscle mass

A nurse is caring for a client diagnosed with multiple myeloma who is undergoing radiation therapy. Which side effect should be reported to the registered nurse (RN) immediately?

- A. **elevated temperature**
- B. mouth ulcers
- C. excessive vomiting
- D. erythema around the radiation site

The nurse is to administer a new medication to a client. Which of these actions best demonstrates an awareness of safe, proficient nursing practice?

1. Verify the client's allergies on the admission sheet and order. Verify the client's name on the name plate outside the room then as the nurse enters the room ask the client "What is your first, middle and last name?"
2. Verify the order for the medication. Prior to giving the medication the nurse should say, "Please state your name."
3. **Upon entering the room the nurse should ask: "What is your name? What allergies do you have?" and then check the client's name band and allergy band.**
4. As the room is entered say "What is your name?" then check the client's name band.

A female client is scheduled for abdominal surgery. Which information would indicate that this client is at a risk for thrombus formation in the postoperative period?

1. **Hormonal replacement therapy for more than three years**
2. Hypersensitivity to heparin 20 years ago
3. History of acute hepatitis A five years ago
4. 10% less than ideal body weight for the past year

A nurse in a newborn nursery should recognize that the postmature infant is primarily at risk for complications from which situation?

- A. excessive fetal weight
- B. low blood sugar levels
- C. progressive placental insufficiency
- D. depletion of subcutaneous fat

A nurse is discussing with an older adult client the proper use of metered dose inhalers (MDI's). The nurse is concerned that the client is unable to coordinate the release of the medication during the inhalation phase. The nurse should recommend the use of what approach for the client?

1. request a visiting nurse to follow the client at home
2. asking a family member to assist the client with the MDI
3. nebulized treatments for home care
4. adding a spacer device to the MDI canister

A client was admitted to the eating disorder unit with a diagnosis of bulimia nervosa. When a nurse gathers data about a history of any complications, which of these findings should the nurse expect?

A. respiratory distress, dyspnea

2. dental erosion, parotid gland enlargement
3. bacterial gastrointestinal infections, overhydration
4. metabolic acidosis, constricted colon

The client is prescribed alendronate (Fosamax). What information about medication administration should the nurse be sure to reinforce?

A. Take with milk, two hours after meals

2. Take after meals
3. Take on an empty stomach

E. Take with calcium

Following craniotomy surgery the client develops a cardiac arrhythmia. The provider orders lidocaine (Xylocaine) infusion at 3 mg/minute. The label states the 500 mL IV bag contains 2 grams of lidocaine (Xylocaine). What is the flow rate setting (milliliter/hour)? (Round to the nearest whole number and write only the number). 45 mL/hour.

A client with a history of anorexia nervosa is hospitalized on a medical unit with the diagnosis of "electrolyte imbalance and cardiac dysrhythmias." Which additional findings should a nurse expect to observe during the admission process?

1. diarrhea, nausea, vomiting
2. brittle hair, lanugo, amenorrhea

3. excessive anxiety about findings, dental erosion, osteoporosis
4. hyperthermia, tachycardia, increased metabolic rate

A nurse is assisting in the exam of a pregnant client in the third trimester. The parents have been informed that the ultrasound suggests that the baby is small for gestational age (SGA). An earlier ultrasound indicated normal growth. The nurse understands that this change is most likely associated with what condition?

- A. chromosomal abnormalities
- B. sexually transmitted infection
- C. maternal hypertension
- D. exposure to teratogen

The client with lung cancer is 1 day post-op lobectomy and demonstrates symptoms of infection. The health care provider orders 900 mg of Nafcillin. There is powder in a vial labeled "Nafcillin 1 gram" with instructions "to dilute with 3.4 mL of sterile water to produce 1 gram in 4 mL." How many milliliters does the nurse administer? (Round to the nearest tenth and write only the number). 3.6mL.

A nurse is caring for a client who had a nailing of a proximal right femur fracture. Which position is the best for the client's recovery?

- A. either side with legs abducted
- B. client's position of comfort
- C. right-side-lying
- D. left side-lying

A client is in the physical therapy room and tells a nurse "I'm having one of those seizure auras." Which intervention is most appropriate for a nurse to take?

1. move the client away from hazards
2. reduce the noise and dim the lights in the room
3. stay with the client and continually observe
4. instruct a coworker to notify the registered nurse (RN)

A nurse is caring for a client with status epilepticus. Which of the following is most important to monitor?

- A. injuries to the extremities

2. level of consciousness

3. pulse and respiration

D. amount of intravenous fluid infused

A client is receiving oxygen therapy via a nasal cannula. When providing nursing care, which intervention would be most appropriate?

1. maintain clean technique when handling the cannula

2. inspect the nares and ears for skin breakdown

3. determine that adequate mists supplied

4. lubricate the tips of the cannula before insertion

An older adult client is on an anticholinergic metered dose inhaler (MDI) for chronic obstructive pulmonary disease. A nurse should suggest a spacer for what purpose?

A. prevent an exacerbation of COPD

B. increase client compliance

C. improve the aerosol delivery from the MDI

D. enhance the effects of the medication

A nurse caring for premature newborns carefully monitors oxygen concentration. The most important reason for this monitoring is to prevent which complication?

A. Bronchial pulmonary dysplasia

B. Retinopathy of prematurity

C. Necrotizing enterocolitis

D. Intraventricular hemorrhage

A client is admitted for treatment of a frontal lobe brain tumor and undergoes a craniotomy for tumor removal. The client is comatose afterwards. Which post-op nursing intervention would have the highest priority?

A. observe the dressing for blood

B. monitor the pupillary reaction to light

C. keep the client's head elevated

D. turn the client routinely

A nurse is caring for a client suspected to have tuberculosis (TB). Which diagnostic test is the definitive test to determine the presence of active TB?

A. acid fast bacillus smear

B. tuberculin skin testing

C. chestx-ray

D. white blood cell count

A client diagnosed with bipolar disorder refuses to take the prescribed medication. Which is the most therapeutic response by a nurse to the client's refusal of the medication?

1. "You need to take your medicine. This is how you get better."
2. "I can see that you are uncomfortable right now; let's talk about it tomorrow."
3. "If you refuse your medicine, tell me how do you think you will get better?"
4. "What is it about the medicine that you don't like?"

A newborn delivered at home without a birth attendant is admitted to the hospital for observation. The initial axillary temperature is 95 F (35 C). What should the nurse recognize about this situation?

A. Lethargy

2. Reduced PaO₂

3. Lowered basal metabolic rate (BMR)

D. Metabolic alkalosis

A nurse is reinforcing instruction to a client with moderate persistent asthma on the proper method for using a dry powder inhaler (DPI). Which medication should be administered first?

A. anticholinergic

B. beta agonist

C. mast cell stabilizer

D. steroid

Which is the appropriate injection site to give an influenza vaccine to an adult?

Use your cursor to select an area on the image below.



A nurse practicing in a maternity setting recognizes that neonatal sepsis is most often related to which problem?

- A. precipitous vaginal birth
- B. maternal diabetes
- C. cesarean delivery
- D. **prolonged rupture of membranes (PROM)**

A female client admitted for a breast biopsy says tearfully to a nurse, "If this turns out to be cancer and I have to have my breast removed, my companion will never come near me." The nurse's best response would be

1. **"You sound worried that the surgery will change you?"**
2. "Are you questioning the depth of your relationship?"
3. "Why are you concerned that you will be rejected?"
4. "I'm sure your companion will understand."

A school nurse checks a child after several days of treatment for a documented strep throat. Which statement suggests that further reinforcement of information is needed?

1. **"Sometimes I take the pills in the morning and at night."**
2. "My mother makes me take my medicine right after school."
3. "Sometimes I take my medicine with fruit juice."
4. "I am feeling much better than I did last week."

A newborn presents with a pronounced cephalohematoma after being born in a posterior position. The licensed practical nurse (LPN) anticipates that the plan for care will address which nursing diagnosis?

1. Impaired mobility related to bleeding
2. Pain related to periosteal injury
3. **Parental anxiety related to knowledge deficit**
4. Injury related to intracranial hemorrhage

Which activity should be most effective in meeting the growth and development needs for older adult residents in a long term care setting?

- A. **reminiscence groups**
- B. aerobic exercise classes
- C. regularly scheduled social activities
- D. transportation for shopping trips

A preterm baby develops nasal flaring, cyanosis and diminished breath sounds on one side of the chest wall. The health care provider's diagnosis is spontaneous pneumothorax. Which should the nurse prepare for first?

A. cardiopulmonary resuscitation

2. oxygen therapy

3. insertion of a chest tube

D. assisted ventilation

A client with spinal cord injury at the C-6 level complains of a pounding headache. The blood pressure is 180/120. A nurse should take which actions first?

A. place the client into a sitting position

B. check the urinary catheter tubing for kinking

C. ask the registered nurse (RN) to assess the client

D. evaluate the client for nuchal rigidity

A nurse should know that the most precise non-invasive oxygen delivery system available is which item?

A. the venturi mask

B. simple facemask

C. partial non-rebreather mask

D. nasal cannula

A nurse collects data on several postpartum women in the clinic. Which woman is at highest risk for puerperal infection?

A. Two days postpartum, temperature is 100 F (37.8 C) this morning

B. Five days postpartum, temperature is 99.6 F (37.6 C) since delivery

C. Seven days postpartum, temperature is 99 F (37.2 C) since delivery

D. Three days postpartum, temperature is 100.8 F (38.2 C) the past two days

A client with moderate persistent asthma is admitted for a minor surgical procedure. On admission the peak flow meter is measured at 480 liters/minute. Postoperatively the client is complaining of chest tightness. The peak flow is now 200 liters/minute. What should a nurse do first?

- A. repeat the peak flow reading in 30 minutes
2. apply oxygen at 2 liters per nasal cannula
 3. notify the registered nurse (RN)

D. administer the prn dose of Albuterol

A nurse is assisting in the discharge of a client diagnosed with benign prostatic hypertrophy. Which statement by the client demonstrates an understanding of the condition?

A. "I will expect to urinate frequently throughout the day."

B. "I should expect my urine to be dark and concentrated."

C. "I should restrict my fluid intake to control the frequency of urination."

D. "Pain with urination should be expected for a few weeks."

A teenager is admitted with the diagnosis of anorexia nervosa. Upon admission, a nurse finds a bottle of assorted pills in the client's drawer. The client tells the nurse "those are antacids for stomach pains." How should the nurse respond?

1. "Are you taking different pills to lose weight?"
2. "Tell me more about the different pills."
3. "Some teenagers use herbs to lose or maintain a certain weight."
4. "Tell me about yourself."

A 12 year-old child, admitted with a broken arm, is waiting for a scheduled surgery. The nurse finds the child crying and unwilling to talk. What would be the most appropriate INITIAL response by the nurse?

1. Provide privacy with encouragement to work through feelings
2. Distract the child with a choice of activities to do while waiting for surgery
3. Make arrangements for friends to visit as soon as possible
4. Reassure the child that the surgery will go fine with no problems

The provider ordered 500 mg erythromycin oral suspension every six hours for a client diagnosed with pneumonia. The client has a gastrostomy tube. The pharmacy sends up the medication in a liquid suspension of 250 mg/5 mL.

How much medication will the nurse administer every 6 hours? 10mL.

A pregnant woman in the third trimester is admitted with a report of painless vaginal bleeding over the last several hours. A nurse should prepare this client for what procedure?

- A. non-stress test
- B. pelvic exam
- C. C-section
- D. abdominal ultrasound

During a check of a newborn from a mother with a history of type 1 diabetes mellitus, the nurse should understand that any hypoglycemia in the newborn is related to which factor?

1. pancreatic insufficiency of the newborn
2. maternal insulin dependency
3. reduced glycogen reserves in the newborn
4. disruption of fetal glucose supply after delivery

Which action should a nurse implement to prepare a client for a kidney, ureter, bladder (KUB) radiographic test?

1. take no special interventions for this examination
2. keep the client NPO before the examination for two hours
3. administer an enema 24 hours prior to the examination
4. plan to give Demerol 25 mg IM 30 minutes prior to the test

A nurse is assisting with a pre-kindergarten history and physical on a five year-old child. The last MMR vaccine needs to be administered. Allergy to which substance would require the nurse to hold this vaccine for the child?

- A. strawberries
- B. peanutbutter
- C. gelatin
- D. chocolate

Which finding would a nurse expect in a client in the late stages of amyotrophic lateral sclerosis (ALS)

- A. tonic-clonic seizures
- B. confusion
- C. shallow respirations
- D. loss of half of visual field

The nurse is assigned to care for 4 clients. Which client should the nurse assess first? **Correct Answer: 4**

1. A client who has a tympanic temperature of 99.8°F
2. A client who has a regular radial pulse of 96 beats/minute
3. A client who has a supine resting blood pressure of 148/90 mm Hg
4. A client who has a peripheral (index finger) oxygen saturation percentage of 85%

Correct Answer: 4

The nurse is performing an assessment of a 7-year-old child who is suspected of having episodes of absence seizures. Which assessment question to the mother will assist in providing information that will identify the symptoms associated with this type of seizure?

1. "Does twitching occur in the face and neck?"
2. "Does the muscle twitching occur on one side of the body?"
3. "Does the muscle twitching occur on both sides of the body?"
4. "Does the child have a blank expression during these episodes?"

Correct Answer: 3

The nurse has a prescription to administer diazepam 5 mg by the intravenous (IV) route to a client. The nurse should administer the medication over a period of at least how long?

1. 15 seconds
2. 30 seconds
3. 1 minute
4. 5 minutes

Correct Answer: 1,2,3

A postoperative client has been placed on a clear liquid diet. The nurse should provide the client with which items that are allowed to be consumed on this diet? Select all that apply.

1. Broth
2. Coffee
3. Gelatin

The nurse has provided home care instructions to a client after blepharoplasty. Which statement by the client indicates a need for further instruction?

Correct Answer: 1

1. "I need to keep ice on my eyes for at least 3 days."
2. "I need to avoid vigorous activities for about 1 month."
3. "I need to sleep on my back with at least 2 pillows under my head."
4. "I need to avoid activities requiring bending over at the waist for at least 48 hours."

Correct Answer: 4

The nurse provided education about the tetanus toxoid and administered it to the client via injection after stepping on a nail while walking on the beach. Which statement by the client indicates successful teaching?

1. "The tetanus toxoid is caused by viruses."
2. "The tetanus toxoid is caused by parasites."
3. "The tetanus toxoid is an optional treatment so I really don't have to have this."
4. "The tetanus toxoid are toxins that have been altered so that they are no longer toxic."

Correct Answer:3

The nurse is caring for a terminally ill client who is experiencing dyspnea. When caring for this client, the nurse should place the client in which position?

5. 1. Prone
2. Supine
3. Lateral
4. Trendelenburg's

Correct Answer: 3

The nurse is caring for a client with Addison's disease. The client asks the nurse about the risks associated with this disease, specifically about Addisonian crisis. Regarding prevention of this complication, how should the nurse inform the client?

1. "You can take either hydrocortisone or fludrocortisone for replacement."
2. "You need to take your fludrocortisone 3 times a day to prevent a crisis."
3. "You need to increase salt in your diet, particularly during stressful situations."
4. "You need to decrease your dosages of glucocorticoids and mineralocorticoids during stressful situations."

Correct Answer: 3

The nurse is performing an assessment on a client with suspected Paget's disease. On assessment the nurse would expect the client to report which as the most common symptom of this disease?

1. Tinnitus
2. Fatigue
3. Bone pain
4. Difficulty with ambulating

Correct Answer: 4

The nurse is conducting a session about nutrition with a group of adolescents who are pregnant. Which measure is **most appropriate** to teach these adolescents?

1. Eat only when hungry.
2. Eliminate snacks during the day.
3. Avoid meals in fast-food restaurants.
4. **Monitor for appropriate weight gain patterns.**

Correct Answer: 1

The nurse is caring for a client with a Penrose drain from an abdominal incision. Which is an appropriate nursing intervention for this client?

1. **Ensure that a sterile safety pin is through the drain.**
2. Measure the amount of drainage in a measuring container.
3. Establish that the drain is at the prescribed amount of suction.
4. Squeeze the suction device and close the port after emptying the drain.

Correct Answer: 4

The nurse is caring for a client with a nasogastric tube connected to continuous suction. During assessment the nurse observes that the client is mouth-breathing, has dry mucous membranes, and has a foul breath odor. In planning care, which intervention would be most appropriate to maintain the integrity of this client's oral mucosa?

1. Offer small sips of water frequently.
2. Encourage the client to suck on sour hard candy.
3. Use lemon glycerin swabs to provide oral hygiene.
4. **Brush the teeth frequently; use mouthwash and water.**

Correct Answer: 1

A registered nurse (RN) is supervising a licensed practical nurse (LPN) administering an intramuscular (IM) injection of iron to an assigned client. The RN would intervene if the LPN is observed performing which action?

1. **Using a Z-track method for injection**
2. Massaging the injection site after injection
3. Preparing an air lock when drawing up the medication
4. Changing the needle after drawing up the dose and before injection

Correct Answer: 2

Lactulose is prescribed for a hospitalized client with a diagnosis of hepatic encephalopathy. Which assessment finding indicates that the client is responding to this medication therapy as anticipated?

1. Vomiting occurs.
2. **The fecal pH is acidic.**
3. The client experiences diarrhea.
4. The client is able to tolerate a full diet.

Correct Answer: 2

The nurse is providing instructions to the parents of an infant with a ventriculoperitoneal shunt. The nurse should include which instruction?

1. Expect an increased urine output from the shunt.
2. **Notify the health care provider if the infant is fussy.**
3. Call the health care provider if the infant has a high-pitched cry.
4. Position the infant on the side of the shunt when the infant is put to bed.

Correct Answer: 1

A child with an autism spectrum disorder (ASD) is being admitted to the hospital for diagnostic tests. Which room assignment is the **most appropriate** for the child?

1. **Private room**
2. Semiprivate room
3. 4-bed ward room
4. Contact isolation room

Correct Answer: 1,4,5,6

The nurse is assisting in monitoring a client who is receiving a transfusion of packed red blood cells (PRBCs). Before leaving the room, the nurse tells the client to **immediately** report which symptoms of a transfusion reaction? Select all that apply.

1. **Chills**
2. **Chest pain**
3. **Lower back pain**
4. **Difficulty breathing**

The nurse has conducted medication instructions with a client receiving lovastatin. Which periodic blood study will be necessary and included in the client's instructions?

1. Bleeding time
2. Blood glucose levels
3. **Liver function studies**
4. Complete blood cell count

Correct Answer: 2

The client with gastroesophageal reflux disease (GERD) has a new prescription for pantoprazole. Which instruction should the nurse provide to the client?

1. Chew the pill thoroughly.
2. Swallow the tablet whole.
3. Headache is expected to occur.
4. Crush the pill if it is difficult to swallow.

Correct Answer: 2

The nurse is providing discharge instructions to a client who has undergone treatment of cervical cancer with a radiation (cesium) implant. Which instruction should the nurse provide to the client?

1. Avoid douching for at least 1 year.
2. Use a vaginal dilator 3 times a week.
3. Sexual activity can be resumed in about 2 months.
4. Bed rest is recommended for at least 1 week after discharge.

Correct Answer: 1

The health care provider (HCP) has written a prescription to start progressive ambulation as tolerated in a hospitalized client who experiences periods of confusion because of bed rest and prolonged confinement to the hospital room. Which nursing intervention would be appropriate when planning to implement the HCP's prescription and address the needs of the client?

1. Progressively ambulate the client in the hall three times daily.
2. Ambulate the client in the room for short distances frequently.
3. Ambulate the client to the bathroom in his or her room three times daily.
4. Assist with range-of-motion exercises three times daily to increase strength.

Correct Answer: 1

The nurse is providing instructions for a client who will collect a stool specimen for an occult blood test. The nurse instructs the client that it is best to avoid which food for 3 days before collection of the stool specimen?

1. Turnips
2. Hard cheese
3. Milk products
4. Cottage cheese

Correct Answer: 3

The nurse should plan to implement which intervention in the care of a client experiencing neutropenia as a result of chemotherapy?

1. Restrict all visitors.
2. Restrict fluid intake.
3. **Teach the client and family about the need for hand hygiene.**
4. Insert an indwelling urinary catheter to prevent skin breakdown.

Correct Answer: 1,2,5

The nurse is reviewing the prescription for a client admitted to the hospital with a diagnosis of acute pancreatitis. Which interventions would the nurse expect to be prescribed for the client? Select all that apply.

1. **Maintain NPO (nothing by mouth) status.**
2. **Encourage coughing and deep breathing.**
3. **Maintain intravenous fluids at 10 mL/hour to keep the vein open.**

Correct Answer: 3

The nurse is collecting data on a pregnant client in the first trimester of pregnancy diagnosed with iron deficiency anemia. The nurse should monitor the client to detect which manifestation indicating that this problem has not yet resolved?

1. Pink mucous membranes
2. Increased vaginal secretions
3. **Complaints of daily headaches and fatigue**
4. Complaints of increased frequency of voiding

Correct Answer: 2, 4, 3, 1, 5, 6

The nurse is preparing to suction the airway of a client who has a tracheostomy tube and gathers the supplies needed for the procedure. In order of **priority**, which actions should the nurse take to perform this procedure? **Arrange the actions in the order that they should be performed. All options must be used.**

Place the client in a semi-Fowler's position.

Turn on the suction device and set the regulator at 80 mm Hg.

Attach the suction tubing to the suction catheter.

Hyper oxygenate the client.

Insert the catheter into the tracheostomy until resistance is met, and then pull it back 1 cm.
6. Apply intermittent suction and slowly withdraw the catheter while rotating it back and forth.

Correct Answer: 5, 6, 2, 4, 3, 1

A client involved in a head-on automobile crash has awakened from a coma and asks for her husband, who was killed in the same accident. The family does not want the client to know at this time that her husband has died. The family wants all nursing staff to tell the client that the husband was taken by helicopter to another hospital, has a head injury, and is in the intensive care unit (ICU). Because the American Nurses Association Code of Ethics requires the nurse to preserve integrity, but the nurse wants to follow the family's instruction, the nurse faces an ethical dilemma. Which steps should the nurse take to systematically process this ethical dilemma? Arrange in order the steps for systematic processing of the ethical dilemma. All options must be used.

Gather all information relevant to the case

Examine and determine one's own values on the issues

Verbalize the problem.

Consider possible courses of action.

Negotiate the outcome.

Evaluate the action

Correct Answer: 1, 3, 2, 4

The nurse is caring for a client diagnosed with cirrhosis of the liver with portal hypertension. The client vomited 500 mL bright red emesis and states that he is feeling lightheaded. In which priority order should the nurse perform these interventions? Arrange the actions in the order they should be performed. All options must be used.

Apply oxygen.

Ensure that 2 large-bore intravenous lines are present with an isotonic solution infusing

Check the client's blood pressure.

Ask the client if he is taking any nonsteroidal anti-inflammatory medications

Correct Answer: 1, 4, 2, 3, 5, 6

A client with a spinal cord injury suddenly experiences an episode of autonomic dysreflexia. After checking the client's vital signs, the nurse takes the following actions. Arrange the actions in the order they should be performed. All options must be used.

Raise the head of the bed

Loosen tight clothing on the client

Check for bladder distention

Contact the health care provider (HCP).

Administer an antihypertensive medication.

Document the occurrence, treatment, and response.

Correct Answer: 3, 4, 1, 2, 5, 6

A hospitalized client with type 1 diabetes mellitus received Humulin N and Humulin R insulin 2 hours ago (at 7:30 a.m.). The client calls the nurse and reports that he is feeling hungry, shaky, and weak. The client ate breakfast at 8 a.m. and is due to eat lunch at noon. Arrange the actions that the nurse will take in the order that they should be performed. All options must be used.

Check the client's blood glucose level.

Give the client 1/2 cup (118 mL) of fruit juice to drink.

Take the client's vital signs.

Retest the blood glucose level.

Give the client a small snack of carbohydrate and protein

Document the client's complaints, actions taken, and outcome.

Correct Answer: 5, 3, 4, 2, 6, 1

A unit of packed red blood cells has been prescribed for a client with low hemoglobin and hematocrit typing and cross matching. The nurse receives a telephone call from the blood bank and is informed that the unit of blood is ready for administration. In order of priority, how should the nurse plan the actions to take? Arrange the actions in the order that they should be performed. All options must be used.

Verify the health care provider's (HCP's) prescription for the blood transfusion.

Ensure that an informed consent has been signed

Insert an 18- or 19-gauge intravenous catheter into the client.

Obtain the unit of blood from the blood bank.

Ask a licensed nurse to assist in confirming vital signs and blood compatibility and verifying client identity.

Hang the bag of blood.

Correct Answer: 5, 2, 2, 1, 3, 6

. A home health care nurse is planning client visits and nursing activities for the day. The nurse begins the visits at 9 a.m. All clients live within a 5-mile radius. In order of priority, how the nurse should plan the assignments for the day? Arrange the actions in the order that they should be performed. All options must be used.

A client with diabetes mellitus who needs a fasting blood glucose level drawn

A client being visited by the home health aide at 1030

The first dressing change for a client requiring twice-daily dressing changes

A client requiring supervision of a dressing change

A client requiring an admission assessment to home health care

The second dressing change for a client requiring twice-daily dressing change

Correct Answer: 2, 1, 5, 3, 4, 6

The nurse is monitoring a client in labor who is receiving oxytocin and notes that the client is experiencing hypertonic uterine contractions. In order of priority, how should the nurse plan the actions to take? Arrange the actions in the order that they should be performed. All options must be used.

Stop the oxytocin infusion.

Reposition the client.

Administer oxygen by face mask at 8 to 10 L/min

Perform a vaginal examination.

Check the client's blood pressure.

Administer medication as prescribed to reduce uterine activity

Correct Answer: 2, 5, 3, 1, 4

A client has a prescription to begin an infusion of 1000 mL of 5% dextrose in lactated Ringer's solution. The client has an intravenous (IV) cannula inserted, and the nurse prepares the solution and IV tubing. Arrange the actions in the order that they should be performed. All options must be used.

Close the roller clamp on the IV tubing

Spike the IV bag and half-fill the drip chamber

Open the roller clamp and fill the tubing.

Uncap the distal end of the tubing.

Attach the distal end of the tubing to the client.

Correct Answer: 1, 4, 6, 5, 3, 2

A mother brings her child to the emergency department. Based on the child's sitting position, drooling, and apparent respiratory distress, a diagnosis of epiglottitis is suspected. In anticipation of the health care provider's prescriptions, in which order of priority would the nurse implement the actions? Arrange the actions in the order that they should be performed. All options must be used.

. Maintain a patent airway.

Assess breath sounds by auscultation

Obtain an oxygen saturation level using pulse oximetry

Insert an intravenous line for fluid administration.

Obtain an axillary temperature.

Administer an antipyretic

. **Correct Answer: 3, 5**

The nurse is performing an assessment of a newborn admitted to the nursery after birth. On assessment of the newborn's head, what should the nurse anticipate to be the most likely findings related to the fontanel? Select all that apply.

3. A soft and flat anterior fontanel
4. A triangular-shaped posterior fontanel

Correct Answer: 4, 5

A nursing student is preparing to instruct a pregnant client in performing Kegel exercises. The nursing instructor asks the student the purpose of Kegel exercises. Which response made by the student indicates an understanding of the purpose? Select all that apply.

1. "The exercises will help strengthen the pelvic floor in preparation for delivery."
2. "The exercises will help strengthen the muscles that support the bladder and urethra."

Correct Answer: 1, 2, 3, 5

The nurse is collecting data from a pregnant client in the second trimester of pregnancy who was admitted to the maternity unit with a suspected diagnosis of abruption placentae. Which findings are associated with abruption placentae? Select all that apply.

1. Uterine tenderness
2. Acute abdominal pain
3. A hard, "beardlike" abdomen
4. Increased uterine resting tone on fetal monitoring

Correct Answer: 1, 2, 4, 6

Butorphanol tartrate by intravenous push is prescribed for a client in labor. The nurse recognizes which assessment findings to be side or adverse effects of this medication? Select all that apply.

1. Tinnitus
2. Syncope

Palpitations

Nausea and vomiting

Correct Answer: 1, 2, 5

The nurse is preparing a client with thrombocytopenia for discharge. Which statement by the client about measures minimizing injury indicates that discharge teaching was effective? Select

all that apply.

- "I may continue to use an electric shaver."
- "I will not blow my nose if I get a cold."

"I should use a soft-bristled toothbrush to avoid mouth trauma."

Correct Answer: 1, 2, 5

The nurse is monitoring a client receiving levothyroxine sodium for hypothyroidism. Which findings indicate the presence of a side effect associated with this medication? Select all that apply.

1. Insomnia
2. Weight loss
3. Mild heat intolerance

Correct Answer: 1, 2, 4, 5

The nurse is working in an illness prevention clinic. An important component of the nurse's practice is to advise high-risk clients to receive an influenza vaccination. Which clients are at high risk for influenza and would benefit from vaccination? Select all that apply.

1. A 47-year-old mother of a child with cystic fibrosis
2. A 54-year-old man scheduled for a routine diabetes check
3. A 35-year-old registered nurse scheduled for an annual pelvic exam
4. An 87-year-old woman from a nursing home scheduled for a surgical follow-up

Correct Answer: 2, 3, 6

The nurse caring for a child who sustained a burn injury plans care based on which pediatric considerations associated with this injury? Select all that apply.

2. A delay in growth may occur after a burn injury.
3. An immature immune system presents an increased risk of infection for infants and young children.
6. Infants and young children are at increased risk for protein and calorie deficiency because they have smaller muscle mass and less body fat than adults.

Correct Answer: 2, 3, 4, 6

Which are risk factors for chronic obstructive pulmonary disease (COPD)? Select all that apply.

1. Cigarette smoking
2. Genetic risk factor
3. Environmental factors
4. Alpha-1 antitrypsin (AAT) deficiency

Correct Answer: 4, 5

A 67-year-old man is receiving outpatient radiation treatments for carcinoma of the oropharynx and has developed dysphagia. The nurse develops a teaching plan regarding dysphagia and includes which interventions in the plan? **Select all that apply.**

1. Teach the man to examine his oral mucosa daily.
2. Encourage the man to use artificial saliva to manage dryness.

Correct Answer: 1, 2, 3

The nurse works with high-risk clients in an urban outpatient setting. Which groups should be tested for human immunodeficiency virus (HIV)? **Select all that apply.**

1. Injection drug abusers
2. Prostitutes and their clients
3. People with sexually transmitted infections (STIs)

The nurse is administering mouth care to an unconscious client. The nurse should perform which actions in the care of this person? **Select all that apply.**

1. Position the client on his or her side.
2. Brush the teeth with a small, soft toothbrush.
3. Cleanse the mucous membranes with soft sponges

The nurse is assigned to care for a client with complete right-sided hemiparesis from a stroke (brain attack). Which characteristics are associated with this condition? **Select all that apply.**

1. The client is aphasic.
2. The client has weakness on the right side of the body.
3. The client has weakness on the right side of the face and tongue.

A client with a neurological problem is experiencing hyperthermia. Which measures would be appropriate for the nurse to use in trying to lower the client's body temperature? **Select all that apply.**

1. Giving tepid sponge baths
2. Applying a hypothermia blanket
3. Administering acetaminophen per protocol

The nurse is preparing to provide care for a client who will need an ear irrigation to remove impacted cerumen. Which interventions should the nurse take when performing the irrigation? **Select all that apply.**

1. Position the client with the affected side down after the irrigation.
2. Warm the irrigating solution to a temperature that is close to body temperature.

Direct a slow, steady stream of irrigation solution toward the upper wall of the ear canal.

The nurse reviews the laboratory results for a child with rheumatic fever and would expect to note which findings? **Select all that apply.**

1. Elevated C-reactive protein
2. Elevated ant streptolysin O titer
3. Presence of group A beta-hemolytic strep

Correct Answer: 1, 2, 3, 5

A 4-year-old child is diagnosed with otitis media. The mother asks the nurse about the causes of this illness. Which risk factors should the nurse include in response to this mother? **Select all that apply.**

1. Bottle-feeding
2. Household smoking
3. Exposure to illness in other children
4. Congenital conditions such as cleft palate

A client who has had a stroke (brain attack) has residual dysphagia. When a diet prescription is initiated, the nurse should take which actions? **Select all that apply.**

Correct Answer: 2, 3, 5

1. Thickening liquids to the consistency of oatmeal
2. Placing food on the unaffected side of the mouth
3. Leave the client alone so that the client will gain independence by feeding self

Question: 54

Correct Answer: 2, 4, 5

Clients with which diagnoses are commonly prescribed interventions to manage anxiety? **Select all that apply.**

1. Panic disorder
2. Posttraumatic stress disorder
3. Obsessive-compulsive disorder

A client who has undergone radical neck dissection for a tumor has a potential problem of obstruction related to postoperative edema, drainage, and secretions. To promote adequate respiratory function in this client, the nurse should implement which activities? **Select all that apply.**

1. Suctioning the client as needed

2. Encouraging coughing every 2 hours
3. Supporting the neck incision when the client coughs
4. Monitoring the respiratory status frequently as prescribed

A client with acute kidney injury has a serum potassium level of 7.0 mEq/L (7.0 mmol/L). The nurse should plan which actions as a **priority**? **Select all that apply.**

1. Place the client on a cardiac monitor.
2. Notify the health care provider (HCP).
3. Review the client's medications to determine if any contain or retain potassium.

A client with a 4-day-old lumbar vertebral fracture is experiencing muscle spasms. Which are interventions to aid the client in relieving the spasm? **Select all that apply.**

1. Heat
2. Analgesics
3. Muscle relaxers
4. Intermittent traction

A nursing instructor asks a nursing student to describe the process of quickening. Which statements by the student indicate an understanding of this term? **Select all that apply.**

1. "It is the fetal movement that is felt by the mother."
2. "It is a process that occurs in the pregnant woman as early as 16 weeks but definitely by week 20."

Which assessments should the nurse closely monitor when caring for a hospitalized client diagnosed with bulimia nervosa? **Select all that apply.**

1. Electrolyte levels
2. Intake and output
3. Elimination patterns
4. Which tasks should the registered nurse (RN) delegate to the licensed practical nurse (LPN)? **Select all that apply**

1. Urinary catheterization
2. Endotracheal suctioning
3. Intramuscular medication administration

Subcutaneous medication administration

A client has a prescription to receive a unit of packed red blood cells. The nurse should obtain which intravenous (IV) solution from the IV storage area to hang with the blood product at the client's bedside?

1. Lactated Ringer's
2. 0.9% sodium chloride
3. 5% dextrose in 0.9% sodium chloride
4. 5% dextrose in 0.45% sodium chloride

On assessment during a well-baby visit, the nurse notes that a 6-month-old infant has crossed eyes. Which interpretation would the nurse make based on this finding?

1. The condition will resolve without treatment.
2. The condition is normal up to the age of 2 years.
3. Surgical intervention may be necessary to realign weak eye muscles.
4. Once the child begins to read, eye muscles strengthen and the condition will resolve.

The nurse is planning care for a client returning to the nursing unit after a bone biopsy. Which nursing action would be contraindicated in the post procedure care for this client?

1. Monitor vital signs.
2. Administer oral analgesics as needed.
3. Place the limb in a dependent position for 24 hours.
4. Monitor biopsy site for swelling, bleeding, or hematoma.

An adult female client has a hemoglobin level of 10.8 g/dL (108 mmol/L). The nurse interprets that this result is **most likely** caused by which condition noted in the client's history?

1. Dehydration
2. Heart failure
3. Iron deficiency anemia
4. Chronic obstructive pulmonary disease

The community nurse is conducting a health promotion program, and the topic of the discussion relates to the risk factors for gastric cancer. Which item, if identified as a risk factor by a client, indicates a **need for further discussion**?

1. Smoking
2. A low-fat diet
3. Foods containing nitrates
4. A diet of smoked, highly salted, and spiced foods

The nurse is providing instructions to the client with trigeminal neuralgia regarding measures to take to prevent the episodes of pain. Which should the nurse instruct the client to do?

1. Prevent stressful situations.
2. Avoid activities that may cause fatigue.
3. Avoid contact with people with an infection.
4. Avoid activities that may cause pressure near the face.

The nurse is reviewing the laboratory results for a client with cirrhosis and notes that the ammonia level is 85 mcg/dL (51 mcmmol/L). Which dietary selection does the nurse suggest to the client?

1. Roast pork
2. Cheese omelet
3. Pasta with sauce

Tuna fish sandwich The nurse administers 20 units of insulin isophane recombinant to a hospitalized client with diabetes mellitus at 7:00 a.m. The nurse should monitor the client **most** closely for a hypoglycemic reaction at which time?

1. 4:00 p.m.
2. 9:00 a.m.
3. 10:00 a.m.
4. 12:00 midnight

Diagnostic studies are prescribed for a client with suspected Paget's disease. In reviewing the client's record, the nurse would expect to note that the health care provider has prescribed which laboratory study?

1. Platelet count
2. Alkaline phosphatase
3. White blood cell count
4. Complete blood cell count

The nurse is preparing the client assignment. Which should be assigned to a licensed practical nurse (LPN)?

1. A client who requires teaching about an insulin pump
2. Completing an admission assessment on a newly admitted client
3. Administration of a new oral medication to a client with Alzheimer's disease
4. An assessment of a client whose pulse oximetry reading is 85% and who is having difficulty breathing

The nurse creates a plan of care for a client with a cervical-uterine radiation implant. Which intervention would be appropriate for the nurse to include in the plan?

1. Restrict all visitors.
2. Place a lead shield at the bedside.

3. Keep the client's room door open.
4. Place the client in a semi-private room.

The nurse would anticipate that the health care provider (HCP) would add which medication to the regimen of the client receiving isoniazid?

1. Niacin

2. Pyridoxine

3. Gabapentin

4. Cyanocobalamin

The health care provider writes a prescription to apply a heating pad to a client's back. Which intervention is contraindicated and is unsafe?

1. Setting the heating pad on a low setting
2. Assessing the skin frequently for burns
3. Placing the heating pad under the client
4. Using tape to hold heating pad in place

Question: 75 Correct Answer: 4

The nurse is creating a plan of care for a newborn diagnosed with fetal alcohol syndrome. The nurse should include which **priority** intervention in the plan of care?

1. Allow the newborn to establish own sleep-rest pattern.
2. Maintain the newborn in a brightly lighted area of the nursery.
3. Encourage frequent handling of the newborn by staff and parents.
4. Monitor the newborn's response to feedings and weight gain pattern.

Question: 76 Correct Answer: 1

A client is receiving phenobarbital sodium. Which finding on the nursing assessment would indicate that the client is experiencing a common side or adverse effect of this medication?

1. Drowsiness
2. Hypocalcemia
3. Blurred vision
4. Seizure activity

Question: 77

Correct Answer: 4

The nurse is preparing a client who is scheduled to undergo cerebral angiography. The nurse should assess the client for which finding?

1. Claustrophobia
2. Excessive weight

Allergy to salmon 4

. Allergy to iodine or shellfish

Vasopressin is prescribed for a client with diabetes insipidus. The nurse should be particularly cautious in monitoring a client receiving this medication if the client has which preexisting condition?

1. Depression
2. Endometriosis
3. Pheochromocytoma
4. Coronary artery disease

The nurse is reviewing the results of the electrolyte panel for a client seen in the health care clinic. The nurse determines that the client's potassium level is normal if which value is noted

1. 2.0 mEq/L (2.0 mmol/L)
2. 4.0 mEq/L (4.0 mmol/L)
3. 5.3 mEq/L (5.3 mmol/L)
4. 6.0 mEq/L (6.0 mmol/L)

A client with a burn injury is applying mafenide acetate cream to the wound. The client calls the health care provider's (HCP's) office and tells the nurse that the medication is uncomfortable and is causing a burning sensation. The nurse should instruct the client to take which action?

1. Discontinue the medication.
2. Continue with the treatment, as this is expected.
3. Apply a thinner film than prescribed to the burn site.
4. Come to the office to see the HCP immediately.

The nurse is monitoring a client admitted to the hospital with a diagnosis of appendicitis who is scheduled for surgery in 2 hours. The client begins to complain of increased abdominal pain and begins to vomit. On assessment, the nurse notes that the abdomen is distended and bowel sounds are diminished. Which is the **most appropriate** nursing intervention?

1. Notify the health care provider (HCP).
2. Administer the prescribed pain medication.
3. Call and ask the operating room team to perform surgery as soon as possible.
4. Reposition the client and apply a heating pad on the warm setting to the client's abdomen.

The nurse is reviewing the laboratory test results for a client and notes that the differential white blood cell (WBC) count indicates a shift to the right. The nurse suspects that the client's diagnosis is **most likely** to be which one?

1. Sepsis

2. Pneumonia
3. Pernicious anemia
4. Coronary artery disease

The nurse evaluates that the family of a client newly diagnosed with diabetes mellitus correctly understands the reason for having glucagon on hand for emergency home use if the family indicates that the purpose of the medication is to treat which complication?

1. Diabetic ketoacidosis
2. Hypoglycemia from insulin overdose
3. Hyperglycemia from insufficient insulin
4. Hyperglycemia occurring on "sick days"

The ambulatory care nurse is preparing a client who is scheduled for a liver biopsy. The nurse reviews the client's record and expects to note which laboratory results documented in the client's chart?

1. Uric acid level
2. Prothrombin time
3. Blood urea nitrogen
4. White blood cell count

The nurse is reviewing the laboratory test results for a client seen in the health care clinic. The nurse determines that the blood urea nitrogen (BUN) level is normal if which value is noted on the laboratory report?

1. 4 mg/dL (1.4 mmol/L)
2. 20 mg/dL (7.1 mmol/L)
3. 30 mg/dL (10.7 mmol/L)
4. 39 mg/dL (14.0 mmol/L)

The nurse is caring for a client with a chest tube drainage system. During repositioning of the client, the chest tube accidentally pulls out of the pleural cavity. Which is the **initial** nursing action?

1. Apply an occlusive dressing.
2. Reinsert the chest tube quickly.
3. Contact the respiratory therapist.
4. Contact the health care provider (HCP).

The nurse is preparing a plan of care for a client with diabetes mellitus who has hyperglycemia. The nurse places **priority** on which client problem?

1. Lack of knowledge
2. Inadequate fluid volume
3. Compromised family coping

4. Inadequate consumption of nutrients

A client is being discharged on warfarin sodium, and the nurse provides instructions to the client regarding the medication. Which statement, if made by the client, indicates to the nurse that the client understands the teaching provided?

1. "I'll stop my medication if I see bruising."
2. "Stiff joints are common while taking warfarin."
3. "This medication will prevent me from having a stroke."
4. "If I notice blood-tinged urine, I will call the health care provider."

The nurse is caring for an infant with a diagnosis of bladder exstrophy. To protect the exposed bladder tissue, the nurse should plan which intervention?

1. Cover the bladder with petroleum jelly gauze.
2. Cover the bladder with a nonadhering plastic wrap.
3. Apply sterile distilled water dressings over the bladder mucosa.
4. Keep the bladder tissue dry by covering it with dry sterile gauze

What is the **most appropriate** nursing action to help manage a manic client who is monopolizing a group therapy session?

1. Ask the client to leave the group for this session only.
2. Refer the client to another group that includes other manic clients.
3. Tell the client to stop monopolizing in a firm but compassionate manner.
4. Thank the client for the input, but inform the client that others now need a chance to contribute.

The nurse is providing a health promotion session to a group of teenagers and is discussing the abuse of barbiturates. The nurse should provide which information to the teenagers?

1. Barbiturate use commonly results in a rush of energy.
2. Barbiturate abuse is the cause of many drug overdose deaths.
3. The primary outcome of barbiturate abuse is psychological dependency.
4. A dangerous increase in blood pressure (BP) occurs with barbiturate abuse.

The home care nurse provides instructions regarding basic infection control to the parent of an infant with human immunodeficiency virus (HIV) infection. Which statement, if made by the parent, indicates the **need for further instruction**?

1. "I will clean up any spills from the diaper with diluted alcohol."

2. "I will wash baby bottles, nipples, and pacifiers in the dishwasher."
3. "I will be sure to prepare foods that are high in calories and high in protein."
4. "I will be sure to wash my hands carefully before and after caring for my infant."

The nurse in an ambulatory clinic is preparing to administer a tuberculin skin test to a client who may have been exposed to a person with tuberculosis (TB). The client reports having received the bacillus Calmette-Guérin (BCG) vaccine before moving to the United States from a foreign country. Which interpretation should the nurse make?

1. The client has no risk of acquiring TB and needs no further workup.
2. The client is at increased risk for acquiring TB and needs immediate medication therapy.
3. The client's test result will be negative, and a sputum culture will be required for diagnosis.

4. The client's test result will be positive, and a chest x-ray study will be required for evaluation.

The registered nurse (RN) is educating a new RN on how to interpret vision tests using a Snellen chart. After the client's vision is tested with a Snellen chart, the results of testing are documented as 20/40. Which statement by the new RN indicates that the teaching has been **effective**?

1. "The client's vision is normal, but the client may require reading glasses."
2. "The client is legally blind, and glasses or contact lenses will not be helpful."
3. "The client can read at a distance of 40 feet (12 meters) what a person with normal vision can read at 20 feet (6 meters)."

4. "The client can read at a distance of 20 feet (6 meters) what a person with normal vision can read at 40 feet (12 meters)."

A nursing student is asked about the procedure used to elicit Homans' sign. Which response by the student indicates an understanding of this assessment technique?

1. "I will ask the client to raise the legs up to the waist and then to lower the legs slowly."
2. "I will ask the client to raise the legs and to try to lower them against pressure from my hand."

3. "I will ask the client to extend the legs flat on the bed, and I will gently dorsiflex the foot"

forward."

4. "I will ask the client to extend the legs flat on the bed, and I will grasp the foot and sharply extend it backward."

A child diagnosed with scarlet fever is being cared for at home. The home health nurse performs an assessment on the child and checks for which clinical manifestations of this disease? **Select all that apply.**

1. Pastia's sign
2. Koplik's spots
3. White strawberry tongue

A hospitalized client has a diagnosis of pelvic inflammatory disease (PID). The nurse should encourage the client to assume which therapeutic position when in bed?

1. Left side-lying
2. Right side-lying
3. Prone with the head flat
4. Supine in semi Fowler's

The oncology nurse specialist provides an educational session for nursing staff regarding the characteristics of Hodgkin's disease. The nurse determines that further teaching is needed if a nursing staff member states that which is a characteristic of the disease?

1. Reed-Sternberg cells are present.
2. The lymph nodes, spleen, and liver are involved.
3. The prognosis depends on the stage of the disease.
4. The disease occurs most often in those older than 75 years of age.

A homeless client comes to the emergency department complaining of severe pain in the toes of both feet. On assessment, it is found that all of the toes are black in color and that amputation is necessary. The client refuses the surgery and insists on returning to street living. Which describes the next appropriate action to take?

1. Obtain a court order for the surgical procedure.
2. Restrain the client and transport to the operating room for surgery. .
3. Call the police to identify the client and to arrest the client until permission for surgery is granted.
4. Discuss the surgical procedure and its purpose with the client, and encourage the client to talk about concerns and feelings.

A client received 20 units of Humulin N insulin subcutaneously at 08:00. At what time should the nurse plan to assess the client for a hypoglycemic reaction?

1. 10:00

2. 11:00

3. 17:00

4. 24:00

The clinic nurse is reviewing the record of a client scheduled to be seen in the clinic. The nurse notes that the client is taking selegiline hydrochloride. The nurse suspects that the client has which disorder?

1. Diabetes mellitus
2. Parkinson's disease
3. Alzheimer's disease
4. Coronary artery disease

A topical corticosteroid is prescribed for an infant with dermatitis in the gluteal area. The nurse provides instructions to the mother regarding the use of the medication. Which statement by the mother indicates an understanding of the use of the medication?

1. "I should not rub the medication into the skin."
2. "The medication will help relieve the inflammation."
3. "I need to apply the medication in a thick layer to protect the skin."
4. "I should protect the area by covering it with a diaper and plastic pants."

The nurse is caring for a client with acute back pain. Which are the most likely causes of this problem? Select all that apply.

1. Twisting of the spine
2. Hyperflexion of the spine
3. Herniation of an intervertebral disk

Correct Answer: Correct Answer: 600 mL

The nurse hangs a 1000-mL intravenous (IV) bag of 5% dextrose in water (D5W) at 0700. The IV solution is to infuse at 80 mL/hour. At 1200, how much solution will be left to infuse? Fill in the blank.

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A client with a history of cardiac disease is due for a morning dose of furosemide. Which serum potassium level, if noted in the client's laboratory report, should be reported before administering the dose of furosemide?

3.2 mEq/L (3.2 mmol/L)

3.8 mEq/L (3.8 mmol/L)

4.2 mEq/L (4.2 mmol/L)

4.8 mEq/L (4.8 mmol/L)

Correct Answer: 3

During a home care visit, an adult client complains of chronic constipation. What should the nurse tell the client to do?

5. Increase potassium in the diet.
6. Include rice and bananas in the diet.
7. **Increase fluid and dietary fiber intake.**
8. Increase the intake of sugar-free products.

The nurse is assessing a client with fragile X syndrome. The nurse anticipates noting which physical assessment finding?

1. Low, straight palate
2. Short, narrow protruding ears
3. **Long, narrow face with a prominent jaw**
4. Short, rounded face with an indiscernible jaw

The nurse provides instructions to a malnourished client regarding iron supplementation during pregnancy. Which statement, if made by the client, indicates an understanding of the instructions?

1. "Iron supplements will give me diarrhea."
2. "Meat does not provide iron and should be avoided."
3. **"The iron is best absorbed if taken on an empty stomach."**
4. "My body has all of the iron it needs, and I don't need to take supplements."

The client questions the nurse as to why the health care provider switched the usual prescription from a metered-dose inhaler (MDI) to a dry powder inhaler (DPI). The nurse should respond correctly by providing which facts? **Select all that apply.**

1. **Dry powder inhalers pose no environmental risks.**
2. **Dry powder inhalers deliver more medication to the lungs.**
3. **Dry powder inhalers require less hand-to-lung coordination.**

The nurse is providing morning care to a client who has a closed chest tube drainage system to treat a pneumothorax. When the nurse turns the client to the side, the chest tube is accidentally

dislodged from the chest. The nurse immediately applies sterile gauze over the chest tube insertion site. Which is the nurse's next action?

1. Call the health care provider.
2. Replace the chest tube system.
3. Obtain a pulse oximetry reading.
4. Place the client in a Trendelenburg's position.

A client receiving long-term therapy with lithium carbonate has a serum lithium level of 1.0 mEq/L. Which nursing intervention should the nurse be prepared to implement based on this result?

1. Monitor the client for signs of coarse hand tremors.
2. Assess the client for possible short-term memory loss.
3. Provide positive support for the client's compliance with the therapy.
4. Educate the client regarding risk for injury associated with drowsiness.

A client who has begun taking betaxolol demonstrates an **effective** response to the medication as indicated by which nursing assessment finding?

1. Increase in edema to 3+
2. Weight gain of 5 pounds
3. Decrease in pulse rate from 74 beats/min to 58 beats/min
4. Decrease in blood pressure from 142/94 mm Hg to 128/82 mm Hg

A client is prescribed imipramine once daily. The nurse determines that **additional teaching is needed** on the basis of which statement by the client?

1. I need to avoid alcohol while taking this medication."
2. "I'll take the medication in the morning before breakfast."
3. "I won't notice any medication effects for at least 2 weeks."
4. "I'll be sure to take a missed medication dose as soon as possible unless it is almost time for the next dose."

The nurse has completed giving medication instructions to a client receiving benazepril. Which client statement indicates to the nurse that the client **needs further instruction**?

1. "I need to change positions slowly."
2. "I will monitor my blood pressure every week."
3. "I will report signs and symptoms of infection immediately."
4. "I can use salt substitutes freely and eat foods high in potassium."

The diabetes nurse specialist conducts a teaching session to a group of nursing students regarding sulfonylureas, oral hypoglycemic medications used for type 2 diabetes mellitus. Which

statement, describing the primary action of these medications, should the nurse include in the teaching session?

1. "Sulfonylureas decrease insulin resistance."
2. "Sulfonylureas inhibit carbohydrate digestion."
3. "Sulfonylureas decrease glucose production by the liver."
4. "Sulfonylureas promote insulin secretion by the pancreas."

A client began taking amantadine approximately 2 weeks ago. The client reports to the clinic for a follow-up evaluation. The nurse determines that the client is experiencing a side or adverse effect related to the use of this medication if which is noted?

1. Decreased rigidity
2. Decreased akinesia
3. A blood pressure of 118/74 mm Hg
4. Client complaints of urinary retention

A client diagnosed with peptic ulcer disease is prescribed an over-the counter antacid suspension containing aluminum hydroxide, magnesium hydroxide, and simethicone. What should the nurse include in the client instructions for time of administration of this medication?

1. Just before each meal
2. An hour before breakfast
3. Immediately after each meal
4. 1 and 3 hours after meals

Intravenous heparin therapy is prescribed for a client. While implementing this prescription, the nurse ensures that which medication is available on the nursing unit?

1. Vitamin K
2. Protamine sulfate
3. Potassium chloride
4. Aminocaproic acid

A client is diagnosed with iron deficiency anemia, and ferrous sulfate is prescribed. The nurse should tell the client that it would be **best** to take the medication with which food?

1. Milk
2. Boiled egg
3. Tomato juice
4. Pineapple juice

Amikacin is prescribed for a client with a bacterial infection. The nurse instructs the client to contact the health care provider (HCP) **immediately** if which occurs?

1. Nausea

2. Lethargy
3. Hearing loss
4. Muscle aches

Which medication, if prescribed for the client with glaucoma, should the nurse question?

1. Betaxolol
2. Pilocarpine
3. Erythromycin
4. Atropine sulfate

A client has recently begun medication therapy with propranolol. The long-term care nurse should plan to notify the health care provider (HCP) if which assessment finding is noted?

1. complaints of insomnia
2. Audible expiratory wheezes
3. Decrease in heart rate from 86 to 78 beats/min
4. 4. Decrease in blood pressure from 162/90 to 136/84 mm Hg

A client taking verapamil has been given information about side effects of this medication. The nurse determines that the client understands the information if the client states to watch for which **most** common side effect of this medication?

1. Weight loss
2. Constipation
3. Nasal stuffiness
4. Abdominal cramping

Colchicine is prescribed for a client with a diagnosis of gout. The nurse reviews the client's record, knowing that this medication would be used with caution in which disorder?

1. Myxedema
2. Kidney disease
3. Hypothyroidism
4. Diabetes mellitus

A client is being treated for moderate hypertension and has been taking diltiazem for several months. The client schedules an appointment with the health care provider because of episodes of chest pain, and Prinzmetal's angina is diagnosed. The client asks the nurse which therapeutic effects the medication will provide and the nurse provides education. Which statement by the client indicates that the teaching has been effective?

1. "It increases the force of contraction of heart tissues."
2. "It increases oxygen demands within the myocardium."

3. "It prevents an influx of calcium ions in the smooth muscle."
4. "It leads to an increase in calcium absorption in the smooth muscle."

The nurse is reviewing the health care provider's prescriptions for an adult client who has been admitted to the hospital after a back injury. Carisoprodol is prescribed for the client to relieve the muscle spasms. The health care provider has prescribed 350 mg to be administered four times a day. What should the nurse conclude?

1. The prescription is the normal adult dosage.
2. The prescription is lower than normal dosage.
3. The prescription is higher than normal dosage.
4. The dosage prescribed requires further clarification with the health care provider.

Itraconazole is prescribed for a client with a fungal infection of the hands. The nurse provides instructions to the client about the medication. Which statement by the client indicates an understanding of the instructions?

1. "I should take the medication on an empty stomach."
2. "I should decrease my fluid intake while taking the medication."
3. "I may become unusually fatigued while taking this medication."
4. "If my urine becomes very dark in color, I should contact my health care provider (HCP)."

The nurse asks a nursing student about the uses of the medication dantrolene. The nursing student correctly states that dantrolene is used to manage hypermetabolism of skeletal muscle that occurs in which condition?

1. Low back pain
2. General anesthesia
3. Malignant hyperthermia
4. Hyperplasia of the prostate

A client has just been given a prescription for diphenoxylate with atropine. The nurse determines that the client understands important information about this medication if the client makes what statement?

1. "It's best to take this medication with a laxative."
2. "This medication contains a habit-forming ingredient."
3. "I might drool frequently from taking this medication."
4. "I will probably become irritable from taking this medication."

Question: 130

Correct Answer: 4

On assessment, a newborn is exhibiting cyanosis, tachypnea, nasal flaring, and grunting. Respiratory distress syndrome is diagnosed, and the health care provider (HCP) prescribes surfactant replacement therapy. Through which route should the nurse prepare to administer this medication?

1. Orally mixed in water
2. Intravenously through a burette
3. Subcutaneously in the anterior thigh
4. Endotracheally through the endotracheal tube

Question: 131

Correct Answer: 3

The client in the preoperative holding area has been given a dose of scopolamine. Which intended effect is this medication likely being used for with this client?

1. Obstetric amnesia
2. Suppression of emesis
3. Preanesthetic amnesia
4. Production of cycloplegia

Question: 132

Correct Answer: 3

The nurse has provided instructions to a client who will receive alteplase for the treatment of acute myocardial infarction. The nurse determines that teaching was effective if the client states that the main action of alteplase is what?

1. "It will slow the clotting of my blood."
2. "It will keep my blood thin to prevent clotting."
3. "It will dissolve any clots that are obstructing the coronary arteries."
4. "It will prevent any further clots from forming anywhere in the body."

Question: 133

Correct Answer: 4

A client is seen in the hospital emergency department after injury to the right ankle. The client tells the nurse that she twisted her ankle while playing volleyball. The health care provider (HCP) has prescribed a topical analgesic cream for the injury. The nurse providing instruction about the medication should provide the client with which information?

1. To avoid hazardous activities while using the cream because it causes drowsiness
2. To apply the medication three times a day and place a heating pad on top of the area
3. That the onset of headache indicates a systemic reaction and the HCP must be notified
4. That the medication contains a combination of medications, one of which is an analgesic

Question: 134

Correct Answer: 3

The nurse is caring for a client receiving codeine sulfate for pain. The nurse determines that the client is experiencing a side or adverse effect of the medication based on which finding?

1. Distended jugular veins
2. Bounding peripheral pulses
3. No bowel movement in 3 days
4. Change in blood pressure from 120/60 mm Hg to 140/80 mm Hg

Question: 135

Correct Answer: 4

The nurse provides instructions to a client who has a prescription for ticlopidine. Which statement made by the client indicates a need for further teaching?

1. "I'll take my medicine with meals."
2. "Blood work will be done every 2 weeks for the first 3 months."
3. "I should not stop the medication without talking to my doctor first."
4. "Food will affect the medication, so I need to take the medication on an empty stomach."

OTHER SOURCES

Question: 136 Answer: 2,4,3,1

1. 6. The police bring the client to the emergency department after she threatens to kill her ex- husband the client states emphatically. "The police should bring him in, not me. He is paranoid about my dating and has been stalking me for weeks. He is probably off his medicines. His case manager and the police will not do anything." In what order should the following nursing acts be done from first to last? **All options must be used.**

Assess the clients risk for harm to self- and others.

Interview the client about her current needs and situation.

Ask about the material problems leading to the divorce.

Obtain the name of her ex- husband's case manager.

Answer: B

A child is treated with succimer (Chemet) for lead poisoning. Which of these assessments should the nurse perform first?

1. Check serum potassium level
2. Check complete blood count (CBC) with differential
3. Check blood calcium level
4. Test deep tendon reflexes

Answer: C

A nurse is reinforcing teaching to a 24 year-old woman receiving acyclovir (Zovirax) for a herpes simplex virus type 2 infection. Which of these instructions should the nurse give the client?

1. Stop treatment if she thinks she may be pregnant to prevent birth defects
2. Continue to take prophylactic doses for at least five years after the diagnosis
3. Begin treatment with acyclovir at the onset of symptoms of recurrence
4. Complete the entire course of the medication for an effective cure

Item #1438 Question: 181 Answer: B

A client is admitted to the hospital because of heart failure and digoxin toxicity. At home, the client was taking digoxin (Lanoxin) and furosemide (Lasix). Which finding should a nurse anticipate on an initial assessment?

1. Blood in the urine
2. Muscle weakness or cramping
3. Confusion
4. Tinnitus

Item #1425 Question: 182 Answer: B

A nurse is teaching a client with asthma about the correct use of the Azmacort (triamcinolone) inhaler. Which statements, if made by the client, would indicate that the teaching was effective?

1. "I should not use a spacer with my Azmacort."
2. "If I forget a dose, I can double up on the next dose."
3. "The inhaler can be used whenever I feel short of breath."
4. "I should rinse my mouth after using the inhaler."

Item #1351

Question: 183

Answer: D

A nurse has been teaching a client with type 1 diabetes mellitus. Which statement by the client is incorrect and indicates a need for further teaching?

1. "Since my eyesight is so bad, I ask the nurse to fill several syringes."
2. "I use a sliding scale to adjust regular insulin to my sugar level."
3. "I keep my regular insulin bottle in the refrigerator."
4. "I always make sure to shake the NPH bottle hard to mix it well."

Answer: C

A nurse is giving instructions to the parents of a child with cystic fibrosis. The nurse should emphasize that pancreatic enzymes should be taken in which manner?

1. Three times daily after meals
2. Each time carbohydrates are eaten
3. With each meal or snack
4. Once each day

Item #1574 Question: 185 Answer: C

What would a nurse expect to see in a client who reports symptoms associated with tardive dyskinesia?

1. Behavioral changes
2. Uncontrolled hand tremors during meals
3. Rapid tongue movements
4. Repetitive slapping movements

Answer: D

When teaching a client with a new prescription for lithium (Lithane) for treatment of a bipolar disorder, which of these points should the nurse emphasize?

1. Maintain a salt restricted diet
2. Take other medication as usual
3. Substitute generic form if desired
4. Report vomiting or diarrhea

Answer: A

What characteristic of a 75 year-old client may influence the effects of antihypertensive drug therapy?

1. Decreased gastrointestinal motility
2. Increased splanchnic blood flow
3. Altered peripheral resistance
4. Poor nutritional status

Question: 188

Answer: 4

The nurse is to give phenytoin (Dilantin) right away.

How long should it take for the nurse to administer 100 mg of phenytoin IV push to an elderly client? (Use a whole number to answer the question and write only the number). __minutes.

Question: 189 Answer: A

An older adult client is on an anticholinergic metered dose inhaler (MDI) for chronic obstructive pulmonary disease (COPD). A nurse would suggest a spacer to for what purpose?

1. Improve aerosol delivery in clients with poor coordination
2. Prevent exacerbation of COPD
3. Enhance the administration of the medication
4. Increase client compliance

Item #1802 Question: 190 Answer: A

A nurse is teaching an older adult client how to use multi-dose inhalers (MDI's). The nurse is concerned that the client is unable to coordinate the release of the medication with the inhalation phase. What should the nurse recommend to improve the delivery of the medication?

1. Add a spacer device to the MDI canister
2. Ask a family member to assist the client with the MDI
3. Request a visiting nurse to follow the client at home
4. Nebulized treatments for home care

Answer: C

Lactulose (Chronulac) has been prescribed for a client with advanced liver disease. Which assessment should a nurse use to evaluate the effectiveness of this treatment?

1. An increase in appetite
2. A reduction in jaundice
3. A decrease in lethargy
4. A decrease in fluid retention

Answer: A

A nurse is preparing a client for discharge following inpatient treatment for pulmonary tuberculosis (TB). Which of these instructions should be given to the client?

1. Continue taking medications as prescribed
2. Avoid contact with children, pregnant women or immunosuppressed persons
3. Continue taking medications until findings are relieved
4. Take medication with Amphojel if epigastric distress occurs

Answer: D

A client is to begin taking alendronate (Fosamax). Which of these instructions should the nurse emphasize when teaching about this medication?

1. "It is recommended that you take this medication with calcium and a glass of juice."
2. "Take the medication with a full glass of milk two hours after meals."
3. "You may take this medication after any meal, at the same time every day."
4. "Be sure to take this medication on an empty stomach."

Answer: B

A nurse caring for a nine year-old child with a fractured femur is told that a medication error occurred. The child received twice the ordered dose of morphine an hour ago. Which nursing diagnosis is a priority at this time?

1. Decreased gastrointestinal mobility related to mucosal irritation
2. Ineffective breathing patterns related to central nervous system depression
3. Risk for fluid volume deficit related to morphine overdose
4. Altered nutrition related to inability to control nausea and vomiting

Answer: B

A 14 month-old child ingested half a bottle of aspirin tablets. Which finding should a nurse expect to see in this child?

- A. Edema
- B. Epistaxis
- C. Hypothermia
- D. Dyspnea

Answer: B

A 52 year-old client is being transfused with one unit of packed cells. A half hour after the transfusion was initiated, the client reports having chills and a headache. Which action should a nurse implement first?

1. Check the client's temperature
2. Stop the transfusion
3. Obtain a urine specimen
4. Notify the health care provider

Answer: B

A nurse is performing a pre-kindergarten physical on a five year-old. The last series of vaccines will be administered. What is the preferred site for injection by the nurse?

- A. vastus intermedius
- B. vastus lateralis
- C. dorso gluteal
- D. gluteus maximus

Answer: A

A client with moderate persistent asthma is admitted for a minor surgical procedure. On admission the peak flow meter is measured at 480 liters/minute. Post-operatively the client reports chest tightness. The peak flow is now 200 liters/minute. What action should the nurse now take?

1. Administer the prn dose of albuterol
2. Repeat the peak flow reading in 30 minutes
3. Apply oxygen at two liters per nasal cannula
4. Notify both the surgeon and provider

You answer: _____

Answer: D

A nurse is assessing a seven year-old after several days of treatment for a documented strep throat. Which statement is incorrect and suggests that further teaching is needed?

1. "Sometimes I take my medicine with fruit juice."
2. "My mother makes me take my medicine right after school."
3. "I am feeling much better than I did last week."
4. "Sometimes I take the pills in the morning and other times at night."
5. **Correct Answer: A**

The client, who is diagnosed with a mild traumatic brain injury (MTBI), is experiencing migraine- type posttraumatic headaches. The health care provider has ordered almotriptan (Axert). What should the nurse understand about this medication?

1. This medication must be given as soon as the client begins to experience migraine symptoms
2. The medication will help reduce the number of migraine attacks
3. The client should be reminded to restrict fluids while taking this medication
4. This medication is used prophylactically to prevent headaches

Post test

Question: 1

Correct Answer: 1

A client who is scheduled for cataract surgery requires preoperative instillation of cyclopentolate eye drops as prescribed. The client asks the nurse why this medication is needed, and the nurse provides education. Which statement by the client indicates that teaching has been effective?

1. The medication dilates the pupil of the operative eye."
2. "The medication constricts the pupil of the operative eye."
3. "The medication is needed for the initiation of miosis in the operative eye."
4. "The medication provides the necessary lubrication to the nonoperative eye."

Question: 2

Correct Answer: 2

The nursing care plan indicates a problem of self-directed violence and the risk for suicide, related to suicidal ideations with a specific plan. The nurse develops a plan of care for the client and identifies which expected client outcome?

1. Displays less anxiety and agitation
2. Denies presence of suicidal ideations
3. Develops adequate problem solving skills
4. Establishes a relationship with staff and peers

Question: 3

Correct Answer: 1

The nurse in a maternity unit is providing emotional support to a client and her significant other who are preparing to be discharged from the hospital after the birth of a dead fetus. Which statement made by the client indicates a component of the normal grieving process?

1. "We want to attend a support group."
2. "We never want to try to have a baby again."
3. "We are going to try to adopt a child immediately."
4. "We are okay, and we are going to try to have another baby immediately."

Question: 4

Correct Answer: 4

Which activity should the nurse include in the plan of care for a client who is experiencing psychomotor agitation?

1. Playing checkers with members of the staff
2. Reading in a quiet, low-stimulus environment
3. Engaging in a card game with other clients on the unit
4. Attending a clay-molding class that is scheduled for today

Question: 5

Correct Answer: 4

The nurse provides instructions to a preoperative client about the use of an incentive spirometer. The nurse determines that the client needs further instruction if the client indicates that he or she will take which action?

1. Sit upright when using the device.
2. Inhale slowly, maintaining a constant flow.
3. Place the lips completely over the mouthpiece.
4. After maximal inspiration, hold the breath for 10 seconds and then exhale.

Question: 6

Correct Answer: 3

The nurse employed in an emergency department is monitoring a child diagnosed with epiglottitis. The nurse notes that the child is leaning forward with the chin thrust out. How should the nurse interpret this finding?

1. Extreme fatigue
2. The presence of pain
3. An airway obstruction
4. The presence of dehydration

Question: 7

Correct Answer: 2

When a client develops neuroleptic malignant syndrome, the nurse ensures that which medication is available on the unit to address this complication?

1. Phytonadione
2. Bromocriptine
3. Protamine sulfate
4. Enalapril maleate

Question: 8

Correct Answer: 4

The nurse is reviewing an adult male's serum creatinine level of 4.0 mg/dL (353 mcmol/L). What does this level indicate?

1. Low
2. Normal
3. Slightly elevated and needs referral
4. Very high, indicating severe renal failure

Question: 9

Correct Answer: 4

On review of the clients' medical records, the nurse determines that which client is at risk for fluid volume excess?

1. The client taking diuretics and has tenting of the skin
2. The client with an ileostomy from a recent abdominal surgery
3. The client who requires intermittent gastrointestinal suctioning
4. The client with kidney disease and a 12-year history of diabetes mellitus

Question: 10

Correct Answer: 2

The nurse is conducting a prepared childbirth class and is instructing pregnant women about the method of effleurage. The nurse instructs the women to perform the procedure by doing which action?

1. Contracting and then consciously relaxing different muscle groups
2. Massaging the abdomen during contractions, using both hands in a circular motion
3. Instructing her partner to stroke or massage a tightened muscle by the use of touch
4. Contracting an area of the body, such as an arm or leg, and then concentrating on letting

tension go from the rest of the body

Question: 11

Correct Answer: 3

A client with cancer is receiving intravenous morphine sulfate for pain. When writing the plan of care for this client, the nurse should include which action as the priority action?

1. Monitor temperature.
2. Monitor urine output.
3. Monitor respiratory status.
4. Encourage increased fluids

Question: 12

Correct Answer: 1, 2, 3, 5

The nurse is caring for an older client who is complaining of insomnia. What are some of the contributing factors to insomnia in the acute and long-term care setting? Select all that apply.

1. Pain
2. Chronic disease
3. Staff conversations
4. Environmental noise and lighting
5. Giving pain medications with supper

Question: 13

Correct Answer: 2

A client with a history of anxiety appears to be in the second phase of crisis response. The nurse prepares for which client behavior?

1. The client will show the initial signs that coping methods are failing.
2. The client will employ new coping methods that will resolve the problem.
3. The client will experience severe anxiety as a result of failed coping methods.
4. The client will begin to implement coping methods that have been successful in the past.

Question: 14

Correct Answer: 2

The nurse is providing home care instructions to the mother of an infant who has just been found to have hemophilia. The nurse should tell the mother that care of the infant should include which appropriate measure?

1. Use aspirin for pain relief.
2. Pad crib rails and table corners.
3. Use a soft toothbrush for dental hygiene.

4. Use a generous amount of lubricant when taking a temperature rectally.

Question: 15

Correct Answer:

A nursing instructor delivers a lecture to nursing students regarding the issue of client's rights and asks a nursing student to identify a situation that represents an example of invasion of client privacy. Which situation, if identified by the student, indicates an understanding of a violation of this client right?

1. Performing a procedure without consent
2. Threatening to give a client a medication
3. Telling the client that he or she cannot leave the hospital
4. **Observing care provided to the client without the client's permission**

Question: 16

Correct Answer: 3

The nurse is planning discharge teaching for a client diagnosed and treated for compartment syndrome. Which information should the nurse include in the teaching?

1. "A bone fragment has injured the nerve supply in the area."
2. "An injured artery caused impaired arterial perfusion through the compartment."
3. **"Bleeding and swelling caused increased pressure in an area that couldn't expand."**
4. "The fascia expanded with injury, causing pressure on underlying nerves and muscles."

Question: 17

Correct Answer: 1

A client has been admitted with chest trauma after a motor vehicle crash and has undergone subsequent intubation. The nurse checks the client when the high-pressure alarm on the ventilator sounds, and notes that the client has absence of breath sounds in the right upper lobe of the lung. The nurse immediately assesses for other signs of which condition?

1. **Right pneumothorax**
2. Pulmonary embolism
3. Displaced endotracheal tube
4. Acute respiratory distress syndrome

Question: 18

Correct Answer: 2

The nurse is performing the oculocephalic response (doll's eyes maneuver) on an unconscious client. The nurse turns the client's head and notes movement of the eyes in the same direction as the head. How should the nurse document these findings?

1. Normal
2. **Abnormal**
3. Insignificant
4. Inconclusive

Question: 19

Correct Answer: 3

A client is taking lansoprazole. The nurse anticipates that the health care provider will advise the client to take which product if needed for a headache?

1. Naproxen
2. **Ibuprofen**
3. Acetaminophen
4. Acetylsalicylic acid

Question: 20

Correct Answer: 2

The nurse is caring for an 8-month-old infant. A urinalysis has been prescribed, and the nurse plans to collect the specimen. Which method should be used for urine collection in an infant?

1. Catheterizing the infant using a Foley catheter
2. **Attaching a urine collection device to the infant's perineum**
3. Obtaining the specimen from the diaper, using a syringe, after the infant voids
4. Monitoring the urinary patterns and preparing to collect the specimen into a cup when the infant voids

Question: 21

Correct Answer: 4

A clinic nurse is instructing a pregnant client regarding dietary measures to promote a healthy pregnancy. The nurse tells the client about the importance of an adequate daily fluid intake. Which client statement best indicates an understanding of the daily fluid requirement?

1. "I should drink 12 glasses of fruit juices and milk every day."
2. "I should drink 8 to 10 glasses of fluid a day, and I can drink as many diet soft drinks as I want."

3. "I should drink 12 glasses of fluid a day, and I can include the coffee or tea that I drink in the count."

4. "I should drink at least 8 to 10 glasses of fluid each day, of which at least 6 glasses should be water."

Question: 22

Correct Answer: 4

The nurse employed in an emergency department is assigned to triage clients coming to the emergency department for treatment on the evening shift. The nurse should assign priority to which client?

1. A client complaining of muscle aches, a headache, and history of seizures
2. A client who twisted her ankle when rollerblading and is requesting medication for pain
3. A client with a minor laceration on the index finger sustained while cutting an eggplant
4. A client with chest pain who states that he just ate pizza that was made with a very spicy sauce

Question: 23

Correct Answer: 1, 2, 4, 5

The nurse is working in an illness prevention clinic. An important component of the nurse's practice is to advise high-risk clients to receive an influenza vaccination. Which clients are at high risk for influenza and would benefit from vaccination? Select all that apply.

1. A 47-year-old mother of a child with cystic fibrosis
2. A 54-year-old man scheduled for a routine diabetes check
3. A 35-year-old registered nurse scheduled for an annual pelvic exam
4. An 87-year-old woman from a nursing home scheduled for a surgical follow-up

Question: 24

Correct Answer: 1

The nurse asks a nursing student to describe the procedure for administering erythromycin ointment to the eyes of a newborn. Which student statement indicates that further teaching is needed about administration of the eye medication?

1. "I will flush the eyes after instilling the ointment."

2. "I will clean the newborn's eyes before instilling ointment."
3. "I need to administer the eye ointment within 1 hour after delivery."
4. "I will instill the eye ointment into each of the newborn's conjunctival sacs."

Question: 25

Correct Answer: 2

After performing an assessment of an infant with bladder exstrophy, the nurse prepares a plan of care. The nurse identifies which problem as the priority for the infant?

1. Urinary incontinence
2. Impaired tissue integrity
3. Inability to suck and swallow
4. Lack of knowledge about the disease (parents)

Question: 26

Correct Answer: 2

The nurse is providing discharge instructions to the mother of a child who has been prescribed tetracycline hydrochloride. The nurse stresses to the mother the importance of which measure in giving this medication to the child?

1. Give the medication with milk.
2. Use a straw when giving the medication.
3. Give the medication with chocolate milk.
4. Dilute the medication with water in a Styrofoam cup.

Question: 27

Correct Answer: 3

A film-coated form of diflunisal, a nonsteroidal antiinflammatory medication, has been prescribed for a client to treat chronic rheumatoid arthritis. The client calls the clinic nurse because of difficulty swallowing the tablets. Which instruction should the nurse provide to the client?

1. Crush the tablets and mix with food.
2. Open the tablet and mix the contents with food.
3. Swallow the tablets with large amounts of water or milk.
4. Notify the health care provider for a medication change.

Question: 28

Correct Answer: 3

The nurse collects a urine specimen preoperatively from a child with epispadias who is scheduled for surgical repair. When analyzing the results of the urinalysis, which should the nurse most likely expect to note?

1. Hematuria
2. Proteinuria
3. Bacteriuria
4. Glucosuria

Question: 29

Correct Answer: 4

A child is admitted to the hospital after being seen in the emergency department with complaints of right lower quadrant abdominal pain, nausea and vomiting, fever, and chills. The health care provider (HCP) suspects appendicitis. Which assessment finding should the nurse immediately report to the HCP?

1. Decreasing oral temperature
2. Increasing complaints of pain
3. Refusal to take fluids by mouth
4. Sudden relief of abdominal pain

RN Practice Question Banks 1-15 (Not Required)

Question: 30

Correct Answer: 1, 2, 5, 6

During a yearly health screening, a 54 year-old female reports having irregular menstrual cycles, mood swings and hot flashes. She requests a more natural approach to manage these symptoms

of perimenopause. What education about non-pharmacological interventions will the nurse include in client teaching? (Select all that apply.)

1. "You should drink at least 8-10 glasses of water a day."
2. "Yoga may help you manage stress and relieve symptoms."
3. "Incorporate more vegetables and legumes in your diet."
4. "Use deep breathing exercises when you start having a hot flash."

Question: 31

Correct Answer: 1, 3, 4

A new task force has been created at a hospital to address a recent increase in patient falls. The first meeting is scheduled with members from several departments. Which of the following statements by the nurse leader indicate intent to increase meeting effectiveness? (Select all that apply.)

1. "During our meeting today we will share the information we have on falls."
2. "Please introduce yourselves and your departments."
3. "Let's focus on the number of falls first and then we can talk about staffing."

Question: 32

Correct Answer: 2, 5, 6

The nurse is preparing to administer a feeding through a percutaneous endoscopic gastrostomy (PEG) tube. What nursing action is needed before starting the infusion? (Select all that apply.)

1. Verify the length and placement of the tube
2. Elevate the head of the bed 30-45 degrees
3. Flush the tube with 30 mL of warm water

Correct Answer: 1, 2

The client needs to be moved up in bed. The client is able to partially assist and weighs 135 pounds. Which action by the nursing staff best supports an awareness of ergonomics and safe client handling? (Select all that apply.)

1. Adjust the height of the bed for caregivers
2. Move the bed into the flat position

Correct Answer: 1, 2, 4

Following a surgical procedure, a pneumatic compression device is applied to the adult client. The client reports that the device is hot and the client is sweating and itching. Which of the following steps should the nurse take? (Select all that apply.)

1. Check for appropriate fit
2. Confirm pressure setting of 45 mm Hg
4. Collaborate with health care provider for anti-embolism stockings to be worn under the sleeves of the device

Question: 35

An 88 year-old client is admitted to the telemetry unit following a minor surgical procedure. The client's history includes insulin dependent diabetes and a previous myocardial infarction. The nurse responds to the client's ECG alarm and finds the client's rhythm shows asystole and the client obtunded but responsive. Prioritize the actions of the nurse (with 1 being the top priority).

Correct answer

1. Assess respirations and pulse
2. Initiate emergency response system if indicated
3. Look at a different ECG lead to confirm rhythm
4. Check a blood glucose level

A nurse who cares for clients undergoing treatment for cancer might expect clients diagnosed with cancer to make the following statements.

Based on an understanding of the stages of the grieving process, place the statements in the correct order.

Correct answer

1. "I think test got mixed up."
2. "I am so sad at everyone for always reminding me that I have it"
3. "If I eat a more balanced diet, I can live longer"
4. "I don't know where to go and what to do"

Post test

Question: 37**Correct Answer: 4**

The nurse is providing instructions to a client with psoriasis who will be receiving ultraviolet (UV) light therapy. Which statement would be most appropriate for the nurse to include in the client's instructions?

1. "Each treatment will last at least 30 minutes."
2. "Your entire body will be exposed to the light treatment."
3. "You will need to wear cotton clothes during the treatment."
4. "You will need to wear dark eye goggles during the treatment."

Question: 38**Correct Answer: 3**

The nurse is providing instructions to a client about diaphragmatic breathing. The nurse tells the client that this technique is helpful because in normal respiration, as the diaphragm contracts, it takes which action?

1. Aids in exhalation
2. Moves up and inward
3. Moves downward and out
4. Makes the thoracic cage smaller

Question: 39

Correct Answer: 3

The nurse notes that the health care provider has documented a diagnosis of presbycusis on a client's chart. Based on this information, what action should the nurse take?

1. Speak loudly, but mumble or slur the words.
2. Speak loudly and clearly while facing the client.
3. Speak at normal tone and pitch, slowly and clearly.
4. Speak loudly and directly into the client's affected ear.

Question: 40

Correct Answer: 2

The nurse is providing instructions regarding skin care to a client after removal of a leg cast. The nurse should instruct the client to take which measure?

1. Avoid the use of sunscreen on the skin for at least 2 years.
2. Apply an emollient lotion to the skin to enhance softening.
3. Scrub the skin vigorously with soap and water to remove the dead skin.
4. Soak the skin for 1 hour 6 times daily to assist in removing any dry scales.

Question: 41

Correct Answer: 4

The nurse is preparing to care for a newborn infant following creation of a colostomy for the treatment of imperforate anus. In the immediate postoperative period, the nurse plans to inspect the stoma and expects to note which finding in the colostomy?

1. Bleeding
2. Gray in color
3. Dark blue in color
4. Red and edematous

Question: 42

Correct Answer: 1

A client begins to experience drainage of small amounts of bright red blood from the tracheostomy tube 24 hours after a supraglottic laryngectomy. Which is the best nursing action?

1. Notify the health care provider (HCP).
2. Increase the frequency of suctioning.
3. Add moisture to the oxygen delivery system.
4. Document the character and amount of drainage.

Question: 43

Correct Answer: 1

The nurse caring for a client who underwent intracranial surgery is suspected of having diabetes insipidus. Which finding noted by the nurse is consistent with this complication of surgery?

1. Complaints of excessive thirst
2. Urine specific gravity of 1.030
3. Urine output of 10 to 15 mL/hour
4. Systolic blood pressures running consistently over 150 mm Hg

Question: 44

Correct Answer: 1

The nurse is monitoring a client receiving glipizide. The nurse knows that which finding would indicate a therapeutic outcome for this client?

1. A decrease in polyuria
2. An increase in appetite
3. A glycosylated hemoglobin of 10%
4. A fasting blood glucose of 220 mg/dL (12.6 mmol/L)

Question: 45

Correct Answer: 3

The nurse is talking to the parents of a child newly diagnosed with diabetes mellitus. Which statement by the parents indicates an understanding of preventing and managing hyperglycemia?

1. "I will give 8 oz of diet cola at the first sign of weakness."
2. "I will administer glucagon immediately if shakiness is felt."
3. "I will check for ketones when my child is suffering from an illness."

4. "I will report to the emergency department if the blood glucose level is over 150 mg/dL (8.6 mmol/L)."

Question: 46

Correct Answer: 1

A child is scheduled for a tonsillectomy. The nurse plans care, knowing that which condition would be a priority because it presents the highest risk of aspiration during surgery?

1. Presence of loose teeth
2. Bleeding during surgery
3. Difficulty in swallowing
4. Exudate in the throat area

Question: 47

Correct Answer: 1

During a support group session, a client says, "My husband hit me a lot, but when he threatened to start hitting our kids, I stabbed him. No jury will believe me because my husband can lie to anyone and be believed." If no one in the group responds, which statement is the therapeutic response by the nurse?

1. "Abuse is a horribly difficult thing to experience. Can anyone in the group relate to what she's feeling?"
2. "Yes. Everyone here was ill-used and abused, but what makes you think that this is a reason to stab someone?"
3. "Everyone agrees that you couldn't let him hurt your children. But is there anything you would do differently?"
4. "Your story is very much like every woman's here. The problem is getting a jury to see that you were justified in stabbing him."

Question: 48

Correct Answer: 4

The spouse of a client prescribed an antidepressant tells the home health nurse, "Now that the antidepressant is working, the suicidal risk is over and you can stop making these home visits." How does the nurse appropriately respond?

1. "I need to continue with my visits since this disease tends to run in families."
2. "I agree with you that the medication will greatly reduce the risk for suicidal behavior."
3. "I agree with you that continuing to visit would reintroduce the possibility of suicidal

ideations."

4. "I need to continue visiting since the client may now have the energy to act on suicidal intentions."

Question: 49

Correct Answer: 2

A client is having the dosage of clonazepam adjusted. The nurse should plan to perform which action?

1. Weigh the client daily.
2. **Institute seizure precautions.**
3. Monitor blood glucose levels.
4. Observe for areas of ecchymosis.

Question: 50

Correct Answer: 3

The nurse has instructed a client with myasthenia gravis about strategies for self-management at home. The nurse determines a need for further teaching if the client makes which statement?

1. "Here's the MedicAlert bracelet I obtained."
2. "I should take my medications an hour before mealtime."
3. **"Going to the beach will be a nice, relaxing form of activity."**
4. "I've made arrangements to get a portable resuscitation bag and home suction

equipment."

Question: 51

Correct Answer: 2

The nurse has collected the following data on a client in labor. The fetal heart rate (FHR) is 154 beats/min and is regular, and contractions have moderate intensity, occur every 5 minutes, and have a duration of 35 seconds. Using this information, what is the appropriate action for the nurse to take?

1. Prepare for imminent delivery.
2. **Continue to monitor the client.**
3. Report the FHR to the anesthesiologist on call.
4. Report the findings to the health care provider (HCP).

Question: 52

Correct Answer: 2

The nurse has observed that an older client has episodes of extreme agitation. Which measure is most appropriate for the nurse to implement to avoid episodes of agitation?

1. Wait until the client's agitation has subsided before approaching the client.
2. Speak and move slowly toward the client while assessing the client's needs.
3. Speak to the client at the entrance of the room to avoid any episodes of agitation.
4. Walk up behind the client and gently put a hand on the client's shoulder while speaking.

Question: 53

Correct Answer: 4

Daily administration of dipyridamole has been prescribed for the client, and the nurse teaches the client about the medication. Which client statement indicates an understanding of the instructions?

1. "This medication will prevent a stroke."
2. "This medication will prevent a heart attack."
3. "This medication will help keep my blood pressure down."
4. "If I take this medicine with my warfarin, it will protect my artificial heart valve."

Question: 54

Correct Answer: 1, 2, 5

The nurse is reviewing the prescription for a client admitted to the hospital with a diagnosis of acute pancreatitis. Which interventions would the nurse expect to be prescribed for the client? Select all that apply.

1. Maintain NPO (nothing by mouth) status.
2. Encourage coughing and deep breathing.
3. Give hydromorphone intravenously as prescribed for pain.

Question: 55

Correct Answer: 2

A client is to undergo weekly intravesical chemotherapy for bladder cancer for the next 8 weeks. What instruction should the nurse provide to the client regarding management of the urine as a biohazard?

1. Void into a bedpan and then empty the urine into the toilet.

2. Disinfect the toilet with bleach after voiding for 6 hours after a treatment.
3. Purchase extra bottles of scented disinfectant for daily bathroom cleansing.
4. Have one bathroom strictly set aside for the client's use for the next 2 months.

Question: 56

Correct Answer: 1

The nurse is developing a plan of care for an infant after surgical intervention for imperforate anus. The nurse should include in the plan that which position is the most appropriate one for the infant in the postoperative period?

1. Prone position
2. Supine with no head elevation
3. Side-lying with the legs extended
4. Supine with the head elevated 45 degrees

Question: 57

Correct Answer: 3

An operating room nurse is positioning a client on the operating room table to prevent the client's extremities from dangling over the sides of the table. A nursing student who is observing for the day asks the nurse why this is so important. The nurse responds that this is done primarily to prevent which condition?

1. An increase in pulse rate
2. A drop in blood pressure
3. Nerve and muscle damage
4. Muscle fatigue in the extremities

Question: 58

Correct Answer: 1

A client receiving total parenteral nutrition (TPN) experiences sudden development of chest pain, dyspnea, tachycardia, cyanosis, and a decreased level of consciousness. What should the nurse suspect as a complication of the TPN?

1. Air embolism
2. Hyperglycemia
3. Catheter-related sepsis
4. Allergic reaction to the catheter

Question: 59

Correct Answer: 1

The nurse assists the health care provider to perform an amniotomy on a client in labor. Which is the priority nursing action after this procedure?

1. Assess the fetal heart rate.
2. Check the client's temperature.
3. Change the pads under the client.
4. Check the client's respiratory rate.

Question: 60

Correct Answer: 1

The postpartum nurse is providing instructions to a client after birth of a healthy newborn. Which time frame should the nurse relay to the client regarding the return of bowel function?

1. 3 days postpartum
2. 7 days postpartum
3. On the day of birth
4. Within 2 weeks postpartum

Question: 61

Correct Answer: 1

A client being discharged to home with a prescription for eye drops to be given in the left eye has received instructions regarding self-administration of the drops. The nurse determines that the client needs further instruction if, on return demonstration, the client takes which action?

1. Lies supine, pulls up on the upper lid, and puts the drop in the upper lid
2. Lies supine, pulls down on the lower lid, and puts the drop in the lower lid
3. Tilts the head back, pulls down on the lower lid, and puts the drop in the lower lid
4. Lies with head to the right, puts the drop in the inner canthus, and slowly turns to the left

while blinking

Question: 62 Correct Answer: 2

The nurse is instructing a client with diabetes mellitus about peritoneal dialysis. The nurse tells the client that it is important to maintain the prescribed dwell time for the dialysis because of the risk of which complication?

1. Peritonitis
2. Hyperglycemia
3. Hyperphosphatemia

4. Disequilibrium syndrome

Question: 63

Correct Answer: 1

The nurse is caring for a client with a low thrombin level as a result of liver dysfunction. Based on this finding it is most important for the nurse to monitor the client for signs and symptoms of which potential complication?

1. Bleeding
2. Infection
3. Dehydration
4. Malnutrition

Question: 64

Correct Answer: 3

The nurse plans to administer a medication by intravenous (IV) bolus through the primary IV line. The nurse notes that the medication is incompatible with the primary IV solution. Which is the appropriate nursing action to safely administer the medication?

1. Start a new IV line for the medication.
2. Flush the tubing after the medication with sterile water.
3. Flush the tubing before and after the medication with normal saline.
4. Call the health care provider for a prescription to change the route of the medication.

Question: 65

Correct Answer: 1, 2, 3, 5

The nurse is obtaining a health history from a client and is assessing for risk factors associated with osteoporosis. The nurse would be most concerned if which data were obtained? Select all that apply.

1. The client reports that she doesn't exercise much at all.
2. The client reports that she smokes a few cigarettes a day.
3. The client reports that she is taking phenytoin to treat a seizure disorder.
4. The client reports that she takes a daily low dose of prednisone to treat a chronic

respiratory condition.

Question: 66

Correct Answer: 1

A supervisor reprimands the charge nurse for not adhering to the unit budget. What behavior by the charge nurse is an example of displacement?

1. The charge nurse blames staff for wasting supplies.
2. The charge nurse claims that administration wasn't critical.
3. The charge nurse refuses to believe the supervisor's criticisms.
4. The charge nurse smiles and nods in agreement when reprimanded.

RN Practice Question Banks 31-45 (Not Required) Correct Answer: 1, 4

A client is scheduled for a CT scan with contrast. What interventions should be taken by the nurse prior to sending the client to the imaging department? (Select all that apply.)

1. Reassess the client's allergies
2. Ensure the client is well-hydrated

Question: 68

Correct Answer: 3, 5

A nurse is caring for a 13 year-old after a spinal fusion to treat scoliosis. Which nursing intervention is appropriate in the immediate postoperative period? (Select all that apply.)

1. Encourage passive leg and ankle exercises
2. Encourage use of patient-controlled analgesia

Question: 67

Question: 69

Correct Answer: 3, 4, 5

The health care provider writes a new order for a fentanyl (Sublimaze) patch to manage the chronic pain experienced by the client in hospice care. The nurse is teaching a client and family members about the fentanyl patch and knows that teaching was effective when the client makes which of the following statements? (Select all that apply.)

1. "It may take up to a half day or longer for the patch to start working, the first time I use it."
2. "If my pain is too great while I am on the patch, I can take a supplemental pain medication."
3. "I will take the old patch off before I apply the new patch on."

Question: 70

Correct Answer: 2, 3, 5

The nurse is assessing a client who sustained multiple fractures, contusions, and lacerations in a motor vehicle accident three days ago. The client suddenly becomes confused. Which of the following findings would support the nurse's suspicion that the client has developed a fat embolism? (Select all that apply.)

1. Petechiae on the upper anterior chest
2. Elevated temperature
3. Low oxygen saturation

Question: 71

Correct Answer: 1, 3, 5, 6

A client with a history of asthma and kidney stones is admitted with a diagnosis of recurrent renal calculi. The client experiences shortness of breath following a lithotripsy. The nurse auscultates the client's lungs and finds decreased air movement but no wheezing. The arterial blood gas (ABG) results are pH 7.31, PaO₂ 53 mm Hg, PaCO₂ 50 mm Hg, and O₂ sat 82%. Which of the following actions are appropriate for the nurse to take? (Select all that apply.)

1. Call respiratory therapy
2. Start high flow oxygen via face mask
3. Increase IV fluids
4. Contact the health care provider
5. Prepare for possible intubation

Question: 72

Correct Answer: 1, 2, 5

The geriatric social worker is working with the nurse to assess the client's ability to perform instrumental activities of daily living (IADL). Which of the following skills are considered instrumental activities of daily living? (Select all that apply.)

1. Ability to take medications
2. Ability to cook meals
3. Ability to write checks

Question: 73

Correct Answer: 1, 2, 4

The charge nurse is making assignments on the day shift for a registered nurse (RN), a licensed practical nurse (LPN) and a certified nursing assistant (CNA). Which assignments are the most appropriate for a client who fell during the night and now has a skin tear on his arm and a hematoma on his hip, and is scheduled for an x-ray of his hip? (Select all that apply.)

1. Assign medication administration to the LPN
2. Assign wound care to the RN
3. Assign the CNA to assist with personal hygiene tasks

Question: 74

The nurse is performing pulmonary assessment on a client. Indicate the correct sequence of pulmonary assessment by dragging and dropping the steps below into the correct order.

Correct Answer

1. Inspection

2. Palpation

3. Percussion

4. Auscultation

Question: 75

The nurse is preparing to administer total parenteral nutrition (TPN) through a central line.

Indicate the correct order in which the following nursing actions should be performed by dragging and dropping the options below.

Correct Answer

1. Check the solution for cloudiness or sediment
2. Select and prime the correct tubing and filter
3. Thread the intravenous tubing through an infusion pump
4. Use aseptic technique when handling the injection cap
5. Connect the tubing to the central line
6. Set the infusion pump at the prescribed rate

Question: 76

Correct Answer: 3

A client is scheduled to receive a daily morning dose of furosemide. Which client laboratory result warrants a call to the health care provider (HCP) prior to the medication administration?

1. Serum sodium of 135 mEq/L (135 mmol/L)
2. Serum calcium of 10.4 mg/dL (2.6 mmol/L)
3. Serum potassium of 2.8 mEq/L (2.8 mmol/L)
4. Fasting blood glucose of 110 mg/dL (6 mmol/L)

Question: 77

Correct Answer: 4

The nurse is caring for a client at home with a diagnosis of actinic keratosis. The client tells the nurse that her skin is very dry and irritated. The treatment includes diclofenac sodium. The nurse teaches the client that this medication is from which class of medications?

1. Anti-infective
2. Vitamin A lotions
3. Coal tar preparations
4. Nonsteroidal anti-inflammatory drugs (NSAIDs)

Question: 78

Correct Answer: 4

The nurse caring for a child with suspected absence seizures is collecting data from the parents on how to manage the disorder. Which statement, if made by the parents, indicates the presence of signs congruent with this disorder?

1. "My child does well with group activities."
2. "My child leads the other children during group play."
3. "My child is doing really well in school and has high grades."
4. "My child's teacher mentioned that he seems to daydream a lot."

Question: 79

Correct Answer: 2, 4, 5, 6

Which characteristics would the nurse expect to note for a client with seasonal affective disorder? Select all that apply.

1. Is related to abnormal melatonin metabolism
2. Improves during the spring and summer months
3. Is a result of alterations in the available amounts of sunlight
4. A craving for carbohydrates lessens during sunnier and spring months

Question: 80

Correct Answer: 1, 2, 3, 4, 5

The nurse is caring for a terminally ill toddler. When interacting with the toddler's parents, the nurse should implement which interventions? Select all that apply.

1. Retain ritualism.
2. Avoid significant changes in lifestyle.
3. Maintain sensitivity toward the parents.
4. Encourage the parents to be near the child.
5. Encourage as normal an environment as possible.

Question: 81

Correct Answer: 2

A client with type 1 diabetes mellitus is admitted to the emergency department with suspected diabetic ketoacidosis (DKA). Which laboratory result would be expected with this diagnosis?

1. Urine is negative for ketones.
2. Serum potassium is 6.8 mEq/L (6.8 mmol/L).
3. Serum osmolality is 260 mOsm/kg (260 mmol/kg) H₂O.
4. Arterial blood gas values are pH 7.52, PCO₂ 44 mm Hg, HCO₃⁻ 30 mEq/L (30 mmol/L).

Question: 82

Correct Answer: 2

The mental health nurse is meeting with a client who has a long history of abusing drugs. During the session the client says to the nurse, "I'm feeling much better now, and I'm ready to go straight." Which response by the nurse would be therapeutic?

1. "You have said this many times before!"
2. "Tell me what makes you feel that you are ready."
3. "I need to see changes in you to believe that you are ready to go straight."
4. "I'm so glad to hear you talking this way. I will let your health care provider know."

Question: 83

Correct Answer: 2

A client is being weaned from parenteral nutrition (PN) and is expected to begin taking solid food today. The ongoing solution rate has been 100 mL/hour. The nurse anticipates that which prescription regarding the PN solution will accompany the diet prescription?

1. Discontinue the PN.
2. Decrease PN rate to 50 mL/hour.
3. Start 0.9% normal saline at 25 mL/hour.
4. Continue current infusion rate prescriptions for PN.

Question: 84

Correct Answer: 4, 5

A nursing student is preparing to instruct a pregnant client in performing Kegel exercises. The nursing instructor asks the student the purpose of Kegel exercises. Which response made by the student indicates an understanding of the purpose? Select all that apply.

1. "The exercises will help strengthen the pelvic floor in preparation for delivery."
2. "The exercises will help strengthen the muscles that support the bladder and urethra."

Question: 85

Correct Answer: 1

The nurse is assisting in planning care for a client with a diagnosis of immunodeficiency and should incorporate which action as a priority in the plan?

1. Protecting the client from infection
2. Providing emotional support to decrease fear
3. Encouraging discussion about lifestyle changes
4. Identifying factors that decreased the immune function

Question: 86

Correct Answer: 1

The nurse is planning care for a child with hemolytic-uremic syndrome who has been anuric and will be receiving peritoneal dialysis treatment. The nurse should plan to implement which measure?

1. Restrict fluids as prescribed.
2. Care for the arteriovenous fistula.
3. Encourage foods high in potassium.
4. Administer analgesics as prescribed.

Question: 87

Correct Answer: 10 pack-years

The clinic nurse is performing an assessment for a client who is complaining of shortness of breath. The client admits to smoking 1 pack of cigarettes per day for the past 10 years. The nurse determines that the client has a smoking history of how many pack-years? Fill in the blank.

Question: 88

Correct Answer: 4

An infant is born to a mother with hepatitis B. Which prophylactic measure is indicated for the infant?

1. Hepatitis B vaccine given within 24 hours after birth
2. Immune globulin (IG) given as soon as possible after delivery
3. Hepatitis B immune globulin (HBIG) given within 14 days after birth
4. Hepatitis B immune globulin (HBIG) and hepatitis B vaccine given within 12 hours after birth

Question: 89

Correct Answer: 2

A home health nurse is visiting a client who has been started on therapy with clotrimazole. The nurse determines the effectiveness of the medication by noting a decrease in which problem?

1. Pain
2. Rash
3. Fever
4. Sneezing

Question: 90

Correct Answer: 3

Sulfisoxazole, 1 g orally twice daily, is prescribed for an adolescent with a urinary tract infection. The medication label reads "500-mg tablets." The nurse has determined that the dosage prescribed is safe. The nurse administers how many tablets per dose to the adolescent?

1. 1/2 tablet
2. 1 tablet
3. 2 tablets
4. 3 tablets

Question: 91

Correct Answer: 3

A homeless shelter has sustained severe damage as a result of a fire, and most of the structure and people's belongings were destroyed. Ten of the individuals who are being displaced have a history of chronic mental illness. The mental health team coordinating support initially should focus their efforts on which action?

Assessing the clients' need for supportive therapy

Evaluating the clients for signs of stress overload

Providing the clients with shelter, clothing, and food

Planning means for the clients to receive their medications

Question: 92

Correct Answer: 4

Carbidopa-levodopa is prescribed for a client with Parkinson's disease. The nurse monitors the client for side and adverse effects of the medication. Which finding indicates that the client is experiencing an adverse effect?

1. Pruritus
2. Tachycardia
3. Hypertension
4. Impaired voluntary movements

Question: 93

Correct Answer: 3

The nurse is caring for a client who is receiving growth hormone replacement therapy. The nurse monitors the client for which option as an adverse effect of this therapy?

1. Hypocalciuria
2. Hypoglycemia
3. Hyperglycemia
4. Hyperthyroidism

Question: 94

Correct Answer: 1

A client taking lithium reports vomiting, abdominal pain, diarrhea, blurred vision, tinnitus, and tremors. The lithium level is 2.5 mEq/L (2.5 mmol/L). The nurse plans care based on which representation of this level?

1. Toxic
2. Normal
3. Slightly above normal
4. Excessively below normal

Question: 95

Correct Answer: 1

The nurse monitors the client taking octreotide acetate for acromegaly for which most common side or adverse effect of this medication?

1. Diarrhea
2. Dyspnea
3. Constipation
4. Bradycardia

Question: 96

Correct Answer: 1

The school nurse has provided instructions regarding the use of permethrin rinse to the parents of children diagnosed with pediculosis capitis (head lice). Which statement by one of the parents indicates a need for further instruction?

1. "It is applied to the hair and then shampooed out."
2. "The hair should not be shampooed for 24 hours after treatment."
3. "The permethrin rinse can be obtained over the counter in a local pharmacy."
4. "It is applied to the hair after shampooing, left on for 10 minutes, and then rinsed out."

Question: 97

Correct Answer: 4

A client with schizophrenia has been started on medication therapy with clozapine. The nurse should assess the results of which laboratory study to monitor for adverse effects from this medication?

1. Platelet count
2. Blood glucose level
3. Liver function studies

4. White blood cell count

Question: 98 Correct Answer: 3

The nurse suspects that a client prescribed clomipramine hydrochloride has been noncompliant with taking the medication as prescribed. Which client behavior would support the nurse's suspicion?

1. Tired, fatigued appearance
2. Complaints of hunger and fatigue
3. **Frequently checking for the car key**
4. Slight dizziness when standing up quickly

Question: 99

Correct Answer: 2

Dapsone is prescribed for a client with acquired immunodeficiency syndrome (AIDS) for the treatment of toxoplasmosis. The nurse provides medication instructions and determines that the client understands the instructions if the client states that which action is necessary?

1. Discontinue the medication if nausea develops.
2. **Report a sore throat to the health care provider (HCP).**
3. Plan to take the medication every 4 hours around the clock.
4. Expect that abdominal pain and jaundice will occur as normal side effects.

Question: 100

Correct Answer: 3

A client with portosystemic encephalopathy is receiving oral lactulose daily. The nurse should check which item to determine that this medication has been effective?

1. Lung sounds
2. Blood pressure
3. **Blood ammonia level**
4. Serum potassium level

Question: 101

Correct Answer: 1

A client has developed paroxysmal nocturnal dyspnea. Which medication should the nurse anticipate will be prescribed by the health care provider?

1. **Bumetanide**

2. Amiodarone
3. Propranolol
4. Streptokinase

Question: 102

Correct Answer: 4

A client with gastrointestinal hypermotility has a prescription to receive atropine sulfate. The nurse should withhold the medication and question the prescription if the client has a history of which disease process?

1. Biliary colic
2. Sinus bradycardia
3. Peptic ulcer disease
4. Narrow-angle glaucoma

Question: 103

Correct Answer: 4

A client taking an oral laxative wants to obtain a rapid effect from the medication. How should the nurse instruct the client to take the medication?

1. At bedtime
2. With breakfast
3. With the noon meal
4. On an empty stomach

Question: 104

Correct Answer: 4

The health care provider is planning to prescribe a medication for a client with major depression. Which medication should the nurse expect to be prescribed?

1. Diazepam
2. Lorazepam
3. Phenobarbital
4. Paroxetine hydrochloride

Question: 105

Correct Answer: 1

A client with a history of duodenal ulcer is taking calcium carbonate chewable tablets. Which finding indicates that the client is experiencing optimal effects of the medication?

1. Heartburn is relieved.
2. Muscle twitching stops.
3. The serum calcium level increases.
4. The serum phosphorus level decreases.

Question: 106

Correct Answer: 4

The nurse is speaking with a client taking phenytoin for seizure control. The client states that she has started using birth control pills to prevent pregnancy. Which would be an important point for the nurse to emphasize to the client?

1. Oral contraceptives decrease the effectiveness of phenytoin.
2. Severe gastrointestinal side effects can occur when phenytoin and oral contraceptives are taken together.
3. There is an increased risk of thrombophlebitis when phenytoin and oral contraceptives are taken at the same time.
4. Phenytoin may decrease the effectiveness of birth control pills, and additional measures should be taken to avoid pregnancy.

Question: 107

Correct Answer: 4

A client has been given a prescription for a course of azithromycin. The nurse should tell the client that this medication will relieve which problem?

1. Pain
2. Joint inflammation
3. High blood pressure
4. Signs and symptoms of infection

Question: 108

Correct Answer: 1

A client is prescribed tranylcypromine. The nurse educating a client about tranylcypromine should instruct the client to avoid which activity?

1. Drinking any amount of wine
2. Consuming any fresh dairy products
3. Exposing the skin of the face to sunlight
4. Eating either fresh or frozen green leafy vegetables

Question: 109

Correct Answer: 4

A home care nurse is visiting a client who was discharged to home with a prescription for continued administration of enoxaparin subcutaneously. What is the nurse's priority assessment for this client?

1. Constipation
2. Fear of needles
3. Nausea or vomiting plan to
4. Bleeding gums or bruising

Question: 110

Correct Answer: 3

A man has developed atrial fibrillation and has been placed on warfarin. The nurse is doing discharge dietary teaching with the client and determines that the client needs additional education if he states that he would choose which food while taking this medication?

1. Cherries
2. Potatoes
3. Broccoli
4. Spaghetti

Question: 111

Correct Answer: 4

The ambulatory care nurse is providing instructions to a client with a urinary tract infection (UTI) being started on nitrofurantoin. The nurse should provide the client with which information?

1. It can cause urinary retention.

2. It will cause the urine to become clear.
3. The sun should be avoided because it is a sulfa-based medication.
4. If taken with meals, it will help decrease the risk for gastrointestinal (GI) upset.

Question: 112

Correct Answer: 1, 4

A client has a prescription for valproic acid. To maximize the client's safety, the nurse should plan to monitor for which potential complications of this medication? Select all that apply.

Pancreatitis

Hepatotoxicity

Question: 113 Correct Answer: 4

A client has a wound with a moderate amount of drainage and is scheduled for a dressing change. Which dressing, if selected by the student nurse, requires further intervention by the nursing instructor?

1. Foam
2. Alginate dressing
3. Hydrocolloid dressing
4. Semipermeable transparent film

Question: 114

Correct Answer: 4

The nurse is collecting subjective and objective data from a client and notes that the client is taking abacavir. The nurse determines that this medication has been prescribed to treat which condition?

1. Otitis media
2. Heart failure
3. Urinary tract infection
4. Human immunodeficiency virus (HIV) infection

Question: 115

Correct Answer: 1

Insulin glargine is prescribed for a client with diabetes mellitus. The nurse should tell the client that it is best to take the insulin at which time?

1. At bedtime every day
2. 1 hour after each meal

3. 15 minutes before the morning and evening meals
4. Before each meal, on the basis of the blood glucose level

Question: 116

Correct Answer: 1

The nurse is caring for a client who is receiving heparin sodium intravenously as a continuous infusion. Which laboratory finding requires immediate nursing intervention?

1. Platelet count of 100,000 mm³ (100 × 10⁹/L)
2. Red blood cell count of 4.2 cells (4.2 × 10¹²/L)
3. International normalized ratio (INR) of 1.2 (1.2)
4. Activated partial thromboplastin time (aPTT) of 60 seconds (60 seconds)

Question: 117

RN Practice Question Banks 61-75 (Not Required)

Correct Answer: 1, 2, 5

A healthy 18 year-old is entering college in the fall. Which immunization would the health care provider recommend prior to college? (Select all that apply.)

1. Seasonal influenza vaccine
2. Tetanus, Diphtheria, Pertussis vaccine (Tdap)
3. Shingles vaccine

Question: 118

Correct Answer: 1, 2, 4

A client is being prepared for an above-the-knee amputation. Which of the following measures are part of the nurse's responsibilities, which are designed to protect the client? (Select all that apply.)

1. Verify any allergies
2. Verify that the informed consent form is signed
3. Verify the surgical leg is marked with indelible marker over, or as close as possible to, the surgical incision site

Question: 119

Correct Answer: 1, 2, 3, 5

The client is being treated for complications of a chronic disease on a medical-surgical unit. Who can have access to the client's medical record? (Select all that apply.)

1. The nursing instructor planning clinical assignments
2. The facility researcher collecting data for a study to which the client consented
3. The certified nursing assistant documenting vital signs
4. The person who has health care power of attorney

Question: 120

Correct Answer: 1, 2, 3

A newly admitted client reports taking phenytoin for several months. Which of the following assessments should the nurse be sure to include in the admission report? (Select all that apply.)

1. Report of unsteady gait, rash and diplopia
2. Report of any seizure activity
3. Serum phenytoin levels

Question: 121

Correct Answer: 1, 4, 5

The nurse compares the third postoperative assessment findings to the first two postoperative assessments. What action should the nurse take to provide optimal care for this client? (Select all that apply.)

1. Elevate the client's lower extremities
2. Administer an intravenous fluid bolus
3. Inspect the surgical incision site

Correct Answer: 2, 3

The home care nurse is admitting a new client with a diagnosis of COPD, atrial fibrillation and gout. After reviewing the client's medication list, the nurse would arrange for periodic monitoring of blood drug levels for which of the following medications? (Select all that apply.)

1. Digoxin (Lanoxin)
2. Theophylline (Elixophyllin, Theo-24, Uniphyll)

Question: 123

Correct Answer: 1, 2, 3, 5, 6

The nurse is to review the topic of caring for clients with Guillain-Barré syndrome with other staff members at a monthly meeting. Which of these findings should the nurse include in the discussion? (Select all that apply.)

1. Weakness, tingling or loss of sensation in legs and feet occur first

2. Rapidly progressive ascending paralysis of the legs, arms, respiratory muscles and face
3. Difficulty with bladder control or intestinal functions
4. Difficulty with eye movement, facial movement, speaking, chewing or swallowing
5. Numbness, tingling, prickling sensation or moderate pain throughout the body

Correct Answer: 1, 2

A client who has returned from surgery reports feeling nauseated and later has an emesis. The nurse administers promethazine per standing orders. In addition to relief from nausea, what other effects of this medication does the nurse expect? (Select all that apply.)

1. Dry mouth
2. Sedation

Question: 125

Correct Answer: 1, 3

The nurse is evaluating a stage III pressure ulcer while performing a dressing change. Which wound assessment findings indicate that the prescribed treatment is appropriate to support wound healing? (Select all that apply.)

1. The wound base is moderately moist, shiny and red
2. The size of the wound is decreasing

Question: 126

Correct Answer: 1, 4

A client has been given a prescription for alendronate. Which of the following statements indicate the client understands how to safely take this medication? (Select all that apply.)

1. "I will notify the health care provider if I have any difficulty swallowing."
2. "I will stand or sit quietly for 30 minutes after taking it."

Question: 127

Correct Answer: 1, 3, 5

The client undergoes a laparoscopic removal of the appendix. Which postoperative instructions will the nurse reinforce? (Select all that apply.)

1. No showering for 48 hours after surgery
2. Some shoulder discomfort can be expected
3. Restrict diet to bland, easily digestible food for a few days

Correct Answer: 1, 3, 4, 5

During a 12-hour night shift, the nurse has a "near miss" and catches an error before giving a new medication. Which statement might explain the reason for the near miss? (Select all that apply.)

1. The nurse works in the intensive care unit (ICU)
2. The unit is short-staffed
3. The nurse is interrupted when preparing the medication
4. The nurse is sleep-deprived

Correct Answer: 1, 2, 4, 5

A parent asks the nurse about a Guthrie Bacterial Inhibition test that was ordered for her newborn. Which of the following points should the nurse discuss with the client prior to this test? (Select all that apply.)

1. The test will be delayed if the baby's weight is less than 5 pounds
2. Positive tests require dietary control for prevention of brain damage
3. The urine test can be done after six weeks of age
4. Best results occur after the baby has been breast-feeding or drinking formula for two full days

Question: 130

Correct Answer: 1, 2, 5

The client returned from the cardiac catheterization lab four hours ago. The groin was used as the insertion site. Which of the assessment findings would the nurse immediately report to the health care provider? (Select all that apply.)

1. Capillary refill 6 seconds on the affected toes
2. Pale color of the affected limb
3. Nonpalpable pedal pulse on the affected limb

Question: 131

Correct Answer: 3, 4

A 12 year-old pediatric cancer client is distraught about the alopecia that occurred after the last chemotherapy treatment. Which nursing interventions are appropriate for this side effect of chemotherapy? (Select all that apply.)

1. Encourage visits from friends before discharge from the hospital
2. Allow the child to choose a cap, scarf, wig or other head cover to use

Question: 132

The client returns from the post anesthesia care unit (PACU) in stable condition following abdominal surgery. While planning immediate postoperative care, the nurse identifies the nursing diagnoses listed below. Prioritize these diagnoses by placing them in order of importance (with 1 being the most important).

Correct Answer:

1. Risk for ineffective airway clearance related to anesthesia
2. Acute pain related to surgical procedure
3. Impaired reality related to intensive equipment
4. Risk for imbalanced nutrition: less than body requirement related to NPO status

Question: 133

A woman in early labor puts her call light on and tells the nurse "I think my water bag just broke and I feel like something came out with the water." A visual exam by the nurse reveals a prolapsed umbilical cord. List in order of priority the actions the nurse should perform in this obstetrical emergency.

Correct Answer:

5. Gloves and place two fingers into the cervical opening, beside the umbilical cord, to relieve pressure
6. Call for assistant, asking that the health care provider is notified
7. Place the client in the knee-chest position on the bed
8. Administer oxygen to the mother via mask at 10 L/min

Question: 134**Correct Answer: 4**

On review of the clients' medical records, the nurse determines that which client is at risk for fluid volume excess?

1. The client taking diuretics and has tenting of the skin
2. The client with an ileostomy from a recent abdominal surgery
3. The client who requires intermittent gastrointestinal suctioning
4. The client with kidney disease and a 12-year history of diabetes mellitus

Question: 135 Correct Answer: 1

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The nurse has provided medication instructions to a client with an iron deficiency anemia who will be taking iron supplements. Which statement made by the client indicates an understanding of this medication?

1. "I need to increase my fluid intake."
2. "I should eliminate fiber foods from my diet."
3. "I need to take the medication with water before a meal."
4. "I should be sure to chew the tablet thoroughly before swallowing it."

Question: 136

Correct Answer: 2

A client who has just received a diagnosis of asthma says to the nurse, "This condition is just another nail in my coffin." Which response by the nurse is therapeutic?

1. "Do you think that having asthma will kill you?"
2. "You seem very distressed over learning you have asthma."
3. "Asthma is a treatable condition when medications are taken properly, so let's practice with your inhalant."
4. "It will be difficult to work with you if you can't view this as a challenge rather than 'a nail in your coffin.' "

Question: 137

Correct Answer: 3

The nurse is caring for a post-term, small for gestational age (SGA) newborn infant immediately after admission to the nursery. What should the nurse monitor as the priority?

1. Urinary output
2. Total bilirubin levels
3. Blood glucose levels
4. Hemoglobin and hematocrit levels

Question: 138

Correct Answer: 3

The nurse is reviewing the laboratory test results for a client seen in the health care clinic. The nurse notes that the red blood cell (RBC) count is increased. The nurse interprets that this finding may be related to which condition or treatment?

1. Iron deficiency
2. Vitamin deficiency
3. Corticosteroid therapy
4. Bone marrow depression

Question: 139

Correct Answer: 2

The registered nurse (RN) is planning client assignments and cannot take a client assignment today. Two unlicensed assistive personnel (UAP) and a licensed practical nurse (LPN) also are assigned to the unit. Which client should the RN most appropriately assign to the LPN?

1. A client requiring frequent ambulation
2. A client scheduled for a cardiac catheterization
3. A client requiring range-of-motion (ROM) exercises
4. A client with a 24-hour urine collection who is on strict bed rest

Question: 140

Correct Answer: 2

The ambulatory care nurse is providing discharge instructions to a female client who underwent cryosurgery with laser therapy because of a positive Papanicolaou test. Which statement by the client indicates an understanding of the instructions?

1. "I should take sitz baths every 4 hours for the next week."
2. "I should expect the vaginal discharge to be clear and watery."
3. "Very strong pain medications will be needed to relieve any discomfort I may have."
4. "If I note any odor to the vaginal discharge, I should call the health care provider immediately."

Question: 141

Correct Answer: 4

The nurse monitors the client receiving parenteral nutrition (PN) for complications of the therapy and should assess the client for which manifestations of hyperglycemia?

1. Fever, weak pulse, and thirst
2. Nausea, vomiting, and oliguria
3. Sweating, chills, and abdominal pain
4. Weakness, thirst, and increased urine output

Question: 142

Correct Answer: 2

A client is diagnosed with Bell's palsy. The nurse assessing the client expects to note which symptom?

1. A symmetrical smile
2. Difficulty closing the eyelid on the affected side
3. Narrowing of the palpebral fissure on the affected side
4. Paroxysms of excruciating pain in the lips and cheek on the affected side

Question: 143

Correct Answer: 3

The nurse is providing instructions to the mother of a child with human immunodeficiency virus infection regarding immunizations. Which statement by the mother indicates an understanding of the immunization schedule?

1. "The hepatitis B vaccine is not to be given to my child."
2. "My child will receive all the vaccines like any other child."
3. "Family members in the household need to receive the influenza vaccine."
4. "Blood tests are needed before any immunizations are given to my child."

Question: 144

Correct Answer: 3

A client asks the nurse to explain what is involved in an intravenous fluorescein angiography study of the eye. The nurse should incorporate which statement in the reply?

1. "No contrast dye is used."
2. "Food is restricted for 4 hours before the procedure."
3. "Dilating drops will be instilled before the procedure."
4. "The study predicts the success of radial keratotomy."

Question: 145

Correct Answer: 1

A client with an endocrine disorder has experienced recent weight loss and exhibits tachycardia. Based on the clinical manifestations, the nurse should suspect dysfunction of which endocrine gland?

1. Thyroid
2. Pituitary
3. Parathyroid

4. Adrenal cortex

Question: 146 Correct Answer: 1

While eating lunch in the hospital cafeteria, a nursing student overhears 2 nurses talking about a client. Which is the important information for the nurses to remember when talking about the client?

1. Talking about clients in public places is a violation of the client's confidentiality.
2. The client's rights to confidentiality do not apply to the break time of employees.
3. It is acceptable for the nurses to talk about a client because they are on the same treatment team.
4. The nurses taking care of the client should not share information with each other that the client has told them separately.

Question: 147

Correct Answer: 1

The nurse is caring for a client with acute pancreatitis. Which finding should the nurse expect to note when reviewing the laboratory results?

1. Elevated serum lipase level
2. Elevated serum bilirubin level
3. Decreased serum trypsin level
4. Decreased serum amylase level

Question: 148

Correct Answer: 3

The nurse is caring for a group of clients on the clinical nursing unit. The nurse interprets that which of these clients is at most risk for the development of pulmonary embolism?

1. A 25-year-old woman with diabetic ketoacidosis
2. A 65-year-old man out of bed 1 day after prostate resection
3. A 73-year-old woman who has just had pinning of a hip fracture
4. A 38-year-old man with pulmonary contusion sustained in an automobile crash

Question: 149

Correct Answer: 3

The nurse collects a 24-hour urine specimen for catecholamine testing from a client with suspected pheochromocytoma. The results of the catecholamine test are reported as epinephrine 20 mcg (109 nmol) and norepinephrine 100 mcg (590 nmol). The nurse should make which interpretation about this result?

1. Insignificant and unrelated to pheochromocytoma
2. Lower than normal, ruling out pheochromocytoma
3. Higher than normal, indicating pheochromocytoma
4. Normal results for a client with pheochromocytoma

Question: 150

Correct Answer: 2

The nurse is preparing the morning medications to be administered to assigned clients and is reviewing the health care provider's prescriptions. Which medication prescription should the nurse question?

1. Lanoxin 0.25 mg orally daily
2. Hydrochlorothiazide orally twice daily
3. Docusate sodium 100 mg orally twice daily
4. Enoxaparin sodium 20 mg subcutaneously daily

Question: 151

Correct Answer: 3

The nurse is caring for a child with a diagnosis of a right-to-left cardiac shunt. On review of the child's record, the nurse should expect to note documentation of which most common assessment finding?

1. Severe bradycardia
2. Asymptomatic after feeding
3. Bluish discoloration of the skin
4. Higher than normal body weight

Question: 152

Correct Answer: 3

A client is diagnosed with a rib fracture and asks the nurse why strapping of the ribs is not being done. Which response by the nurse is most appropriate?

1. "Strapping is useful only if the ribs are fractured in several places at once."
2. "That's a good idea. I'll ask the health care provider for a prescription for the needed

supplies."

3. "That isn't done because people often would develop pneumonia from the constricting effect on the lungs."
4. "That might help you to breathe better, but this facility does not carry the necessary supplies in the stockroom. When you get home, you can purchase them at the medical supply store."

Question: 153

Correct Answer: 1, 2, 3, 5

The nurse is preparing to administer medication using a client's nasogastric tube. Which actions should the nurse take before administering the medication? Select all that apply.

1. Check the residual volume.
2. Aspirate the stomach contents.
3. Turn off the suction to the nasogastric tube.
4. Test the stomach contents for a pH indicating acidity.

Question: 154

Correct Answer: 3

A nurse is caring for a client with thyrotoxicosis who is at risk for the development of thyroid storm. To detect this complication, the nurse should assess for which sign or symptom?

1. Bradycardia
2. Constipation
3. Hypertension
4. Low-grade temperature

Question: 155

Correct Answer: 1

The nurse is caring for a client with common bile duct obstruction. The nurse should anticipate that the health care provider (HCP) will prescribe which diet for this client?

1. Low fat
2. High protein
3. High carbohydrate
4. Low in water-soluble vitamins

Question: 156

Correct Answer: 1

The nurse is assessing the skin of a client with a history of malabsorption deficiency and discovers brittle nails. What type of nutritional deficiency should the nurse suspect based on this observation?

1. Iron deficiency
2. Protein deficiency
3. Fatty acid deficiency
4. Vitamin K deficiency

Question: 157

Correct Answer: 2

The nurse has a prescription to give dexamethasone by the intravenous (IV) route to a client with cerebral edema. How should the nurse prepare this medication?

1. Diluting the medication in 500 mL of 5% dextrose
2. Preparing an undiluted direct injection of the medication
3. Diluting the medication in 1 mL of lactated Ringer's solution for direct injection
4. Diluting the medication in 10% dextrose in water and administering it as a direct injection

Question: 158

Correct Answer: 1

The nurse determines that the wife of an alcoholic client is benefiting from attending an Al-Anon group if the nurse hears the wife make which statement?

1. "I no longer feel that I deserve the beatings my husband inflicts on me."
2. "My attendance at the meetings has helped me to see that I provoke my husband's violence."
3. "I enjoy attending the meetings because they get me out of the house and away from my husband."
4. "I can tolerate my husband's destructive behaviors now that I know they are common"

among alcoholics."

Item #1692

Question: 159

Correct Answer: 3

NCSBN Practice Bank 53

A nurse is giving instructions to the parents of a child with cystic fibrosis. The nurse should emphasize that pancreatic enzymes should be taken in which manner?

1. Three times daily after meals
2. Each time carbohydrates are eaten
3. **With each meal or snack**
4. Once each day

Question: 160

Correct Answer: 3

What would a nurse expect to see in a client who reports symptoms associated with tardive dyskinesia?

1. Behavioral changes
2. Uncontrolled hand tremors during meals
3. **Rapid tongue movements**
4. Repetitive slapping movements

Question: 161

Correct Answer: 4

When teaching a client with a new prescription for lithium (Lithane) for treatment of a bipolar disorder, which of these points should the nurse emphasize?

1. Maintain a salt restricted diet
2. Take other medication as usual
3. Substitute generic form if desired
4. **Report vomiting or diarrhea**

Ref # 1541 Answer Key

Question: 162

Correct Answer: 1

What characteristic of a 75 year-old client may influence the effects of antihypertensive drug therapy?

1. Decreased gastrointestinal motility
2. Increased splanchnic blood flow
3. Altered peripheral resistance
4. Poor nutritional status

Correct Answer: 100 mEq KCl

The order reads: infuse IV of 1000 mL D5W with 100 mEq KCl at a rate of 50 mL/hour. Which component of this order should the nurse question?

Ref # 4446 Answer Key

Item #1632 Question: 164 Correct Answer: 3

A nurse is caring for an 81 year-old client with colorectal cancer. The client's pain has been managed until now with acetaminophen with codeine. Because of increased pain, intravenous morphine is added. What should the nurse recognize about the validity of this order?

1. Inappropriate and demonstrates poor knowledge of pain control
2. Inappropriate because of potential respiratory depression
3. Appropriate pain management around-the-clock
4. Appropriate despite the expected effect of mental confusion

Question: 165

Correct Answer: 2

A nurse is caring for a 15 month-old child with a first episode of otitis media. Which intervention should the nurse include in the instructions to the child's parents?

1. Explain that the child should complete the full five days of antibiotics
2. Emphasize the importance of a return visit after completion of antibiotics
3. Provide them with handout describing care of myringotomy tubes
4. Describe the tympanocentesis to detect persistent infections

Ref # 1684 Answer Key

Question: 166

Correct Answer: 2

A nurse prepares to administer eye drops to a six year-old child. Which of these descriptions describe the correct method for the instillation of eye drops?

1. Under the upper lid as it is pulled upward
2. In the conjunctival sac as the lower lid is pulled down
3. In the corner where the lids meet
4. Directly on the anterior surface of the eyeball

Item #1656 Question: 167 Correct Answer: 3

A nurse is caring for a client with sickle cell disease who is scheduled to receive a unit of packed red blood cells. Which is an appropriate action for the nurse during the administration of the infusion?

1. Assess vital signs every 15 minutes throughout the entire infusion
2. Store the packed red cells in the medicine refrigerator while starting IV line
3. Limit the infusion time of the unit to a maximum of four hours
4. Slow the rate of infusion if the client develops a fever or chills

Item #1627

Question: 168

Correct Answer: 3

A nurse is caring for a trauma victim with a significant blood loss. Immediately after multiple transfusions, what is the most accurate indicator of oxygenation?

1. Hematocrit
2. Pulse oximetry
3. Blood gases
4. Hemoglobin

Item #1532 Question: 169

Correct Answer: 4

A client with bi-polar disorder is taking lithium (Lithane). What should a nurse emphasize when teaching about this medication?

1. Reduce fluid intake to minimize diuresis
2. Use antacids to prevent heartburn
3. Take the medication before meals
4. Maintain adequate daily salt intake

Question: 170

Correct Answer: 3

While providing home care to a client with heart failure, a nurse is asked by the client about how long diuretics must be taken. What point should the nurse include in a response?

1. "As you urinate more, you will need less medication to control fluid."
2. "Please talk to your health care provider about medications and treatments."
3. "The medication must be continued as long as the the fluid problem needs to be controlled."
4. "You will have to take this medication for about a year."

Ref # 1605 Answer Key

Question: 171

Correct Answer: 3

An 80 year-old client on digoxin (Lanoxin) reports nausea, vomiting, abdominal cramps and halo vision. Which laboratory result should the nurse analyze first?

1. Blood urea nitrogen
2. Magnesium levels
3. Potassium levels
4. Blood pH

Question: 172

Correct Answer: 2

A nurse is teaching the administration of albuterol inhalation to an adult diagnosed with asthma. Which statement demonstrates proper teaching?

1. "Use this medication at bedtime to promote rest."
2. "Notify the health care provider if you need the drug more often."
3. "Discontinue the inhalation if you are dizzy."
4. "Inhale this medication after other asthma sprays."

Item #4458 Question: 173 Correct Answer: 85

A 187 pound client with a subdural hematoma and findings of increased intracranial pressure has been prescribed 25% solution mannitol (Osmitol) 0.25 g/kg to be administered by intravenous push right away. The pharmacy has sent up four 50 milliliter bottles (12.5 g/50 mL is written on the label).

How many milliliters should the nurse prepare to give the client? (Write the answer using whole numbers). __ mL.

Item #1672 Question: 174 Correct Answer: 2

A parent asks a school nurse how to eliminate lice from their child. What is the appropriate response by the nurse?

1. Wash the child's linen and clothing in a bleach solution
2. Application of pediculicides as directed
3. Apply warm soaks to the head twice daily
4. Cut the child's hair short to remove the nits

Question: 175

Correct Answer: 2

A nurse is caring for a child receiving albuterol (Proventil) for asthma. The parents ask the nurse why their child is receiving this medication. Which explanation by the nurse is correct?

1. "The medication is given to reduce the secretions that block the airways."
2. "Proventil will relax the smooth muscles in the airways."
3. "It will decrease the swelling in the airways."
4. " The respiratory center in the brain that control respirations will be stimulated."

Item #1514 Question: 176

Correct Answer: 1

A nurse is planning to administer otic drops to a six year-old child. Which action is part of a correct procedure?

1. Hold the pinna up and back to instill the drops
2. Assist the child to lie on the affected side afterwards
3. Place several drops in the outer ear
4. Insert cotton in the outer ear after giving medication

Question: 177

Correct Answer: 4

A client is being maintained on heparin therapy for deep vein thrombosis (DVT). A nurse must closely monitor which of these following laboratory values?

1. Platelet count
2. Bleeding time

3. Clotting time
4. Activated PTT

Question: 178

Correct Answer: 3

Before the administration of digoxin (Lanoxin) to a client, which nursing assessment is required?

1. Auscultate breath sounds
2. Measure the blood pressure

3. Validate the heart rate

4. Check for bowel sounds

Question: 179

Correct Answer: 1, 2, 3

A 32 year-old female with human epidermal growth factor receptor 2-positive (HER2-positive) metastatic breast cancer is scheduled to begin therapy with pertuzumab (Perjeta). What information is important for the nurse to reinforce and discuss with the client? (Select all that apply.)

1. Report chills, fatigue, or headache during treatment
2. Use contraception during and for 6 months following the use of this drug
3. Report shortness of breath, lightheadedness, dizziness, cough, or swelling of the feet

Question: 180

Correct Answer: 2, 3, 4

There is an order to administer an intramuscular influenza vaccine to an adult. What actions should the nurse take prior to administration of the injection? (Select all that apply.)

1. Provide the client with the federal Vaccine Information Statement (VIS)
2. Check the expiration date on the vaccination bottle
3. Ask the client if she or he can eat eggs without adverse effects

Item #4313

Question: 181

Correct Answer: 1, 4, 5

The oncology nurse is preparing to administer the initial dose of vincristine (Oncovin) to a child diagnosed with acute lymphocytic leukemia (ALL). Which intervention is most appropriate to add to the plan of care? (Select all that apply).

1. Apply ice to the injection site if extravasation occurs

2. Monitor for numbness or tingling in the fingers and toes
3. Verify blood return before, during and after intravenous administration

Question: 182

Correct Answer: 2, 3, 4

The health care provider writes a new order for a fentanyl (Sublimaze) patch to manage the chronic pain experienced by the client in hospice care. The nurse is teaching a client and family members about the fentanyl patch and knows that teaching was effective when the client makes which of the following statements? (Select all that apply.)

1. "If my pain is too great while I am on the patch, I can take a supplemental pain medication."
2. "It may take up to a half day or longer for the patch to start working, the first time I use it."
3. "I will take the old patch off before I apply the new patch on."

Question: 183

Correct Answer: 1, 3, 4

Which of the following is true with regard to delegation of client care responsibilities? Select all that apply.

1. The nurse must know the nursing model that underlies care at the institution.
2. The nurse validates with the nonregistered nurse (non-RN) caregiver that he/she has performed the same activity before.
3. The nurse retains the right to determine which tasks are delegated.

Question: 184

Correct Answer: 1, 2, 4, 5

The nurse is serving on a task force to update the medical record. The task force should ensure that the revisions of the medical record will do which of the following? Select all that apply.

1. Aid in client care.
2. Serve as a legal document.
3. Facilitate data collection for clinical research.
4. Guide performance improvement.

Question: 185

Correct Answer: 1, 2, 4, 5, 6

The nursing assistant reports to the nurse that a client is "feeling short of breath." The client's blood pressure was 124/78 2 hours ago with a heart rate of 82; the nursing assistant reports that

blood pressure is now 84/44 with a heart rate of 54 and the client stated, "I just don't feel good." Which of the following interventions should the nurse initiate? Select all that apply.

1. Confirm the client's vital signs and complete a quick assessment.
2. Inform the charge nurse of the change in condition and initiate the hospital's rapid/emergency response team.
3. Position client in semi-Fowler's position.
4. Stay with the client and reassure the client.
5. Call the physician and report the situation using SBAR format.

Question: 186

Correct Answer: 2, 4, 5

When planning care for a client with ulcerative colitis who is experiencing an exacerbation of symptoms, which client care activities can the nurse appropriately delegate to an unlicensed assistant? Select all that apply.

1. Providing skin care following bowel movements.
2. Maintaining intake and output records.
3. Obtaining the client's weight.

Question: 187

Correct Answer: 1, 2, 3, 4, 5

A nurse is developing a care plan for a client with hepatic encephalopathy. Which of the following are goals for the care for this client? Select all that apply.

1. Preventing constipation.
2. Administering lactulose to reduce blood ammonia levels.
3. Monitoring coordination while walking.
4. Checking the pupil reaction.
5. Providing food and fluids high in carbohydrate.

Safety and Infection Control (12%)

Question: 188

Correct Answer: 1, 2, 3, 4, 6

A client with early acute renal failure has anemia, tachycardia, hypotension, and shortness of breath. The physician has prescribed 2 units of packed red blood cells (RBCs). Prior to initiating the blood transfusion the nurse should determine if: (Select all that apply.)

1. There is an IV access with the appropriate tubing and normal saline as the priming solution.
2. There is a signed informed consent for transfusion therapy.

3. Blood typing and cross-matching are documented in the medical record.

4. The vital signs have been taken and documented in accordance with facility policy and procedure.

5. The client has an identification bracelet and red blood band.

Question: 189

Correct Answer: 1, 2, 3, 7

Which pressure point area(s) should the nurse monitor for an unconscious client positioned on the left side (see figure)? Choose all that apply.



Ankles.

Ear.

Greater trochanter.

Shoulder.

Question: 190

Correct Answer: 2-6-4-5-1-3

A client diagnosed with asthma has been prescribed fluticasone (Flovent) one puff every 12 hours per inhaler. Place in correct order the statements the nurse would use when teaching the client how to properly use the inhaler with

“Take off the cap and shake the inhaler with a spacer.”

1. Attach the spacer
2. “Breathe out all of your air. Hold the mouthpiece of your inhaler and spacer between your teeth with your lips closed around it.”
3. Press down on the inhaler once and breathe in slowly.”

4. "Hold your breath for at least 10 seconds, then breathe in and out slowly."
5. "Rinse your mouth."

Correct Answer: 1, 2, 4, 6

A client with lung cancer is being cared for by his wife at home. His pain is increasing in severity. The nurse recognizes that teaching has been effective when the wife does which of the following? Select all that apply.

1. Administers long-acting or sustained-release oral pain medication (OxyContin) regularly around the clock.
2. Administers immediate-release medication (oxycodone) for breakthrough pain.
3. Uses music for distraction as well as heat or cold in combination with medications.
4. Has her husband use a pain-rating scale to measure the effectiveness at reaching his individual pain goal?

Physiological Adaptation

Question: 192

Correct Answer: 4-1-2-3

1. A client has massive bleeding from esophageal varices. In what order should the nurse and care team provide care for this client?
2. Maintain a patent airway
3. . Control hemorrhaging.
4. Replace fluids.
5. Relieve the client's anxiety.

Question: 193

Correct Answer: 1-4-3-2-5

A client is experiencing alcohol withdrawal. He wakes up and screams, "There's something crawling under my skin. Help me." In which order, from first to last, should the following nursing actions be done?

1. Remind the client that he is having withdrawal symptoms and that these will be treated.
2. Take the client's vital signs
3. Assess the client for other withdrawal symptoms.
4. Administer a dose of lorazepam (Ativan) depending on the severity of the withdrawal symptoms.
5. Chart the details of the episode on the electronic health record.

10 Questions

Question: 194

Correct Answer: 3, 4, 2, 1

A client who is a gravida 3, para 3 had a cesarean section 1 day ago. She is being treated prophylactically for endometritis. She is complaining of abdominal cramping at a 6 on a pain level scale of 1 to 10 (with 10 being the greatest amount of pain) and fears having her move. These medications are prescribed and due now. Based on priority, in which order should the nurse administer the medications? Arrange the medications in the order that they should be administered. All options must be used.

Ketorolac 30 mg by intravenous (IV) push over 3 minutes

Ampicillin sodium 1 g IV piggyback over 60 minutes

Docusate sodium 100 mg orally daily

Prenatal vitamin 1 tablet orally daily

Question: 195

Correct Answer: 1, 4, 6, 5, 3, 2

A mother brings her child to the emergency department. Based on the child's sitting position, drooling, and apparent respiratory distress, a diagnosis of epiglottitis is suspected. In anticipation of the health care provider's prescriptions, in which order of priority would the nurse implement the actions? Arrange the actions in the order that they should be performed. All options must be used.

Maintain a patent airway.

Assess breath sounds by auscultation.

Obtain an oxygen saturation level using pulse oximetry

Insert an intravenous line for fluid administration.

Obtain an axillary temperature.

Administer an antipyretic.

Correct Answer: 3, 1, 5, 2, 4

In order of priority, how should the nurse perform abdominal thrusts on an unconscious adult? Arrange the actions in the order that they should be performed. All options must be used.

Assess unconsciousness.

Open the airway.

Look in the mouth and remove the object blocking the airway, if seen

Attempt ventilation.

Perform abdominal thrusts.

Question: 197

Correct Answer: 4, 2, 1, 3

The nurse has determined that a postpartum client has physical findings consistent with uterine atony. The nurse should take action in which priority order? Arrange the action in the priority order that they should be done. All options must be used.

Massage the uterus attempting to achieve firmness

Contact the health care provider.

Monitor vital signs.

Check the amount of drainage on the peripad.

Correct Answer: 4, 1, 2, 5, 3

A confrontation test is prescribed for a client seen in the eye and ear clinic. How should the nurse perform this test? Arrange the actions in the order that they should be performed. All options must be used.

Stands 2 to 3 feet (60 to 90 cm) in front of and faces the client

Asks the client to cover 1 eye

Examiner covers eye opposite to the eye covered by the client

The examiner brings in an object gradually from periphery

Asks the client to report when object is first noted

Correct Answer: 2, 4, 1, 3

After receiving report at the beginning of the 0700 shift, the nurse must decide in what order the clients should be assessed. How should the nurse plan assessments? Arrange the clients in the order that they should be assessed. All options must be used.

A 12-hour post–cesarean section delivery gravida 3, para 3 who reports a return of feeling in her lower extremities as well as a sensation of wetness underneath her buttocks

A 24-hour post–vaginal delivery gravida 4, para 4 who is complaining of abdominal cramping after nursing her baby and requesting ibuprofen.

An 8-hour post–vaginal delivery gravida 2, para 2 client who is scheduled for a bilateral tubal ligation at 1200 today and has a continuous peripheral intravenous (IV) solution of

5%

A 48-hour post–cesarean section delivery gravida 1, para 1 who reports not yet having a bowel movement since delivery and requests a stool softener.

Question: 200

Correct Answer: 1, 4, 2, 3, 5, 6

A client with a spinal cord injury suddenly experiences an episode of autonomic dysreflexia. After checking the client's vital signs, the nurse takes the following actions. Arrange the actions in the order they should be performed. All options must be used.

Raise the head of the bed.

Loosen tight clothing on the client.

Check for bladder distention

Contact the health care provider (HCP).

Administer an antihypertensive medication.

Document the occurrence, treatment, and response

Correct Answer: 1, 2, 5, 6

Question: 1

During a yearly health screening, a 54 year-old female reports having irregular menstrual cycles, mood swings and hot flashes. She requests a more natural approach to manage these symptoms of perimenopause. What education about non-pharmacological interventions will the nurse include in client teaching? (Select all that apply.)

- 7. "You should drink at least 8-10 glasses of water a day."
- 8. "Yoga may help you manage stress and relieve symptoms."
- 9. "Incorporate more vegetables and legumes in your diet."
- 10. "Use deep breathing exercises when you start having a hot flash."

Question: 5

Correct Answer: 1, 2, 4

Following a surgical procedure, a pneumatic compression device is applied to the adult client. The client reports that the device is hot and the client is sweating and itching. Which of the following steps should the nurse take? (Select all that apply.)

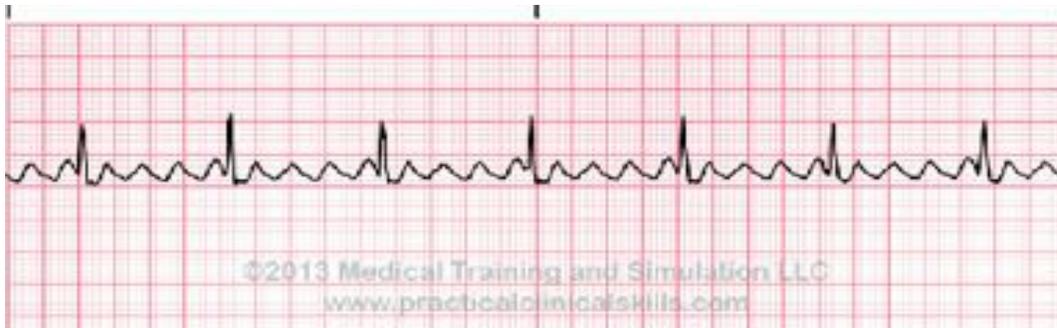
- 6. Check for appropriate fit
- 7. Confirm pressure setting of 45 mm Hg
- 8. Collaborate with health care provider for anti-embolism stockings to be worn under the sleeves of the device

Correct Answer: 1, 2, 5

The client is admitted in stable condition from the emergency department. Based on the ECG strip, the nurse anticipates which of the following types of medications will be ordered? (Select

all that

apply.)



Calcium channel blocker

Beta blocker

Cardiac glycoside

Correct Answer: 1, 2, 4

A client is transported by a family member to the emergency department following a boating accident. The client is conscious, shivering, and confused. The client is still wearing wet clothes. Which interventions does the nurse implement? (Select all that apply.)

1. Apply warm blankets
2. Monitor vital signs
3. Remove wet clothes

A respiratory therapist (RT) is collecting an arterial blood gas (ABG) sample. The RT must respond to an emergency and asks the nurse to manage the puncture site. Which actions should be completed? (Select all that apply.)

1. Check for distal capillary refill
2. Apply pressure for 5 to 10 minutes

Correct Answer: 1, 2, 5

The nurse is caring for a military veteran in a psychiatric in-patient unit. The client was in combat one year ago and experienced a personal traumatic event. Based on the client's history, which of the following considerations will the nurse consider as a contributor to the development of PTSD? (Select all that apply.)

1. Experienced physical injury in combat
2. History of prior psychiatric disorder
3. Prior suicide attempt

Question: 5

Correct Answer: 1, 3, 5

The nurse attends an interdisciplinary meeting on the topic of fall prevention. What specific tactics can be used to reduce falls in health care settings? (Select all that apply.)

1. Use "low beds" for at-risk clients
2. Install and use bed alarms
3. Use a "two to transfer" policy

A client with chronic kidney disease (CKD) is scheduled for hemodialysis at 9 am. It is now 6:30 am and the client is eating breakfast. How should the nurse help the client to prepare for hemodialysis? (Select all that apply.)

1. Administer prescribed vitamin D
2. Administer prescribed phosphate binder
3. Assess patency of the access site

Question: 7

Correct Answer: 2, 4, 5

The agency utilizes an electronic medical record (EMR) for documentation. What actions increase the security risk for inappropriate access to patient care information? (Select all that apply.)

1. The nurse writes down her current password on a list that's kept in the manager's office
2. The nurse relies on the automatic sign-off to close the medical record
3. The nurse reviews the medical records of all clients on the unit before accepting an assignment

Correct Answer: 5, 6

The client underwent a total hip arthroplasty 48 hours ago. The client has been up in a chair and is prescribed physical therapy twice daily. What type of nursing care is needed for this client? (Select all that apply.)

1. Provide a seat riser for the toilet or commode
2. Encourage client to perform leg exercises when in bed

Question: 1

Correct Answer: 1, 4

A client is scheduled for a CT scan with contrast. What interventions should be taken by the nurse prior to sending the client to the imaging department? (Select all that apply.)

6. Reassess the client's allergies
7. Ask the client to remove all metal jewelry

Question: 2

Correct Answer: 3, 5

A nurse is caring for a 13 year-old after a spinal fusion to treat scoliosis. Which nursing intervention is appropriate in the immediate postoperative period? (Select all that apply.)

7. Encourage passive leg and ankle exercises
8. Encourage use of patient-controlled analgesia

Question: 3

Correct Answer: 3, 4, 5

The health care provider writes a new order for a fentanyl (Sublimaze) patch to manage the chronic pain experienced by the client in hospice care. The nurse is teaching a client and family members about the fentanyl patch and knows that teaching was effective when the client makes which of the following statements? (Select all that apply.)

- 3."It may take up to a half day or longer for the patch to start working, the first time I use it."
- 4."If my pain is too great while I am on the patch, I can take a supplemental pain medication."
- 5."I will take the old patch off before I apply the new patch on."

Correct Answer: 2, 3, 5

The nurse is assessing a client who sustained multiple fractures, contusions, and lacerations in a motor vehicle accident three days ago. The client suddenly becomes confused. Which of the following findings would support the nurse's suspicion that the client has developed a fat embolism? (Select all that apply.)

6. Petechiae on the upper anterior chest
7. Elevated temperature
8. Low oxygen saturation

Question: 2

Correct Answer: 1, 2, 3, 5

The nurse works with clients in an outpatient substance abuse treatment program. Which intervention is indicated to prevent relapse and promote a successful recovery? (Select all that apply.)

1. Medication-assisted treatment
2. Participate in group psychotherapy
3. Refer clients for mental health assessments
4. Counseling about alternative coping skills

Correct Answer: 1, 2, 5

A client is diagnosed with rheumatoid arthritis (RA). Which types of drugs might the nurse expect to be ordered as a combination drug therapy regimen? (Select all that apply.)

1. Glucocorticoids
2. Biological-response modifiers
3. Anti-inflammatory drugs

Correct Answer: 1, 2, 3, 5

Sputum culture results for a client admitted with a cough and fever indicate a methicillin-resistant *Staphylococcus aureus* (MRSA) infection in the nares. What nursing intervention must now be taken? (Select all that apply.)

1. Move the client to a private room
2. Place a mask on the client if the client needs to leave the room
3. Place the client in a room with another client colonized with MRSA
4. Dedicate the use of personal and noncritical medical equipment to the client

Correct Answer: 1, 4

A client has been taking rosuvastatin for six weeks as part of a treatment plan to reduce hyperlipidemia. The clinic nurse is reviewing and reinforcing information about the medication with the client. Which statement by the client indicates an understanding about the medication? (Select all that apply.)

1. "I will need to call my doctor if I have any muscle weakness or pain, especially in my legs."
2. "I add some nuts and fresh fruit to my oatmeal in the morning and I can't remember when I last ate a steak."

A 32 year-old female with human epidermal growth factor receptor 2-positive (HER2-positive) metastatic breast cancer is scheduled to begin therapy with pertuzumab. What information is important for the nurse to reinforce and discuss with the client? (Select all that apply.)

1. Use contraception during and for 6 months following the use of this drug
2. Report shortness of breath, lightheadedness, dizziness, cough, or swelling of the feet
3. Report chills, fatigue, or headache during treatment

Question: 1

Correct Answer: 1, 3, 5

The nurse is performing a prekindergarten physical on a 4 year-old child and will administer a

series of scheduled vaccines, including the DTaP, IPV, MMR and VAR. What information does the nurse need to know about these vaccinations? (Select all that apply.)

1. Either the deltoid muscle of the arm or anterolateral thigh muscle can be used
2. A 5/8 inch needle length is often used for subcutaneous (SubQ) injections
3. Multiple immunizations should be administered a minimum of 1 inch apart

Question: 2

Correct Answer: 3, 4, 5

A client is brought to the emergency department with a blood sugar of 52 mg/dL (2.89 mmol/L). The client is weak and diaphoretic but awake, and the client's blood sugar does not rise above 70 mg/dL (3.89 mmol/L) after drinking one 4-ounce (118 mL) glass of orange juice. Which of the following actions should be taken? (Select all that apply.)

1. Offer 8-ounce (237 mL) glass of milk
2. Recheck blood sugar in 15 minutes
3. Determine blood sugar management medications

Question: 3

Correct Answer: 2, 5

A female client diagnosed with genital herpes simplex virus 2 (HSV-2) reports having dysuria, dyspareunia, leukorrhea and lesions on the labia and perianal skin. Which intervention will provide symptomatic relief? (Select all the apply.)

1. Local application of ice packs
2. Over-the-counter medications such as ibuprofen

Question: 4

Correct Answer: 1, 5

The nurse is participating in a quality improvement (QI) project with a focus on improving pain management on a surgical unit. What processes are included in quality improvement? (Select all that apply.)

1. Pain management protocols will be reviewed to consider evidence-based practice
2. The entire health care team participates in the process

Correct Answer: 1, 2, 4

Which of the following methods are used to correctly identify a client? (Select all that apply.)

1. Check the client identification bracelet
2. Compare the client to a labeled photograph
3. Have clients state their birth date

Question: 1

Correct Answer: 3, 4, 6

A 62 year-old male arrives at the emergency department and reports having chest pain. Based on standing orders, which intervention does the nurse expect to be implemented within the first 10 minutes of his arrival in the ED? (Select all that apply.)

1. Focused cardiovascular history-taking and physical exam
2. 12-lead ECG with continuous monitoring
3. Intravenous access

Correct Answer: 1, 4, 5, 6

The client is admitted with a diagnosis of ulcerative colitis. Which laboratory values should the nurse be sure to check? (Select all that apply.)

1. Hematocrit and hemoglobin
2. Erythrocyte sedimentation rate (ESR)
3. White blood cell count (WBC)
4. Albumin

Question: 3

Correct Answer: Correct Order

The nurse is educating a client about how to use a metered-dose inhaler with spacer. Drag and drop the options below in the order that demonstrates correct use of a metered-dose inhaler with spacer.

1. Release the medication into the spacer
2. Breathe in deeply
3. Remove the mouth piece from the lips
4. Hold breath for 10 seconds
5. Breathe out slowly

Question: 4

Correct Answer: Correct Order

There is an order to obtain an aerobic wound culture from a client's wound. Place the nursing actions in the correct order.

Click and hold the reorder icon to drag and drop the steps into the correct order.

1. Remove the existing dressing
2. Perform hand hygiene and apply clean gloves and face shield
3. Irrigate the wound
4. Wipe the Wound

5. Perform hand hygiene and apply clean gloves
6. Obtain a Culture by rotating a sterile swab in the open wound.

Correct Answer: 1, 2, 3, 6

The client was admitted 2 days ago after a CT scan of the head revealed a basilar skull fracture (BSF). What assessment findings does the nurse anticipate with a BSF? (Select all that apply).

1. Bruising behind the ear (Battle's sign)
2. Bruising around both eyes (Raccoon eyes)
3. Hearing loss
4. Facial numbness

Question: 2

Correct Answer: 1, 2, 3

The child diagnosed with central diabetes insipidus (DI) is being treated with desmopressin nasal. What information is important to reinforce with the family? (Select all that apply.)

1. The child should wear MedicAlert® identification
2. It is important to decrease intake of water and other fluids while taking this medication
3. Using the nasal preparation may cause a stuffy nose

Question: 3

Correct Answer: 1, 3, 5

On the second postoperative day, a 79 year-old female (who was previously cognitively intact) becomes agitated when she begins having auditory and visual hallucinations. The client later demands to leave the hospital. What action does the nurse take next? (Select all that apply.)

1. Contact the primary physician to evaluate the client
2. Discuss the situation with the durable power of attorney for healthcare (DPOAHC)
3. Describe the risks and benefits of leaving the hospital to the client

4. **Question: 4**

Correct Answer: 1, 2, 4

The nurse is caring for a client diagnosed with substance use disorder (SUD). The client states, "I just drink occasionally. I don't know why my wife and the judge think that I need to be in an alcohol treatment program." Which of the following behaviors are consistent with SUD? (Select all that apply.)

Craving and inability to abstain from alcohol

Prone to act impulsively

Insecurity in relationships

Correct Answer: 1, 4, 5

The staff nurse prepares an 88 year-old female for discharge and confirms that follow up care for

a home health nurse is scheduled. During the medication reconciliation process, the client's husband states he hopes that his wife has "learned her lesson" and will take her medications as ordered. What action by the staff nurse is indicated? (Select all that apply.)

1. Notify the home health agency nurse about the husband's statement
2. Write a schedule with days and times for the client to take her medication
3. Ask the husband why he thinks his wife is not taking her medications properly

Question: 6

Correct Answer: 3, 5

The nurse reviews the client's plan of care after an exacerbation of chronic obstructive pulmonary disease (COPD). Which primary prevention strategies are recommended to reduce the risk of further complications? (Select all that apply.)

1. Educate the client about washing hands and avoiding crowds
2. Discuss with the client about scheduling an annual influenza vaccination

Correct Answer: 1, 2, 4

The nurse cares for a client diagnosed with pneumonia. During the admission interview, the client explains that her husband died a few months ago and states, "I don't seem to be able to sleep or eat now. I'm not sure I have anything to live for." Which of the following reflects an appropriate nursing response? (Select all that apply.)

1. "Are you thinking of ending your life?"
2. and each person experiences grief differently."
3. "I'd like to know more about how you are doing and what you have used for support after your husband's death."

Question: 8

Correct Answer: 1, 2, 5

The nurse is making rounds, checking oxygen equipment and assessing clients receiving oxygen therapy. Which of the following situations require intervention by the nurse? (Select all that apply.)

1. Humidified oxygen delivery system contains water from condensation in the tubing
2. Valves and flaps in the nonrebreather mask will not open
3. The reservoir bag on a nonrebreather mask is inflated

Correct Answer: 1, 4, 5

The nurse is caring for a client with the nursing diagnosis of complicated grieving. Which of the following interventions should be included in the client's plan of care? (Select all that apply.)

1. Determine which stage of grief in which the client is fixed
2. Communicate that crying is acceptable

3. Teach the client about the normal stages of grief

Correct Answer: 2, 3, 5

The client is a 74-year-old male client who is recovering on a medical unit after a suicide attempt that involved carbon monoxide poisoning. The client states that his wife died one year ago and he lives alone. Which of the following questions will best assess available client support systems? (Select all that apply.)

1. "Who are you closest to in your family?"
2. "What kinds of support has been helpful to you in the past?"
3. "Let's discuss the resources available to you after you are discharged."

A nurse is assigned to care for four clients. After listening to change-of-shift report, how would the nurse prioritize care for the following clients? (Drag the responses into the correct order.)

1. The Client with a tracheostomy
2. The Client scheduled for a colonoscopy
3. The Client who is in skeletal traction
4. The Postoperative Client who has an order to be discharged at home

Answer: 2, 3, 4

A client who has undergone a mitral valve replacement has persistent bleeding from the sternal incision during the early postoperative period. The nurse should do which of the following? Select all that apply.

Administer warfarin.

1. Confirm availability of blood products.
2. Monitor the mediastinal chest tube drainage.
3. Start a dopamine drip for a systolic BP less than 100

Answer: 3

A client has an intracapsular hip fracture. The nurse should conduct a focused assessment to detect:

1. Internal rotation.
2. Muscle flaccidity.
3. Shortening of the affected leg.
4. Absence of pain in the fracture area

A client is admitted with a 6.5-cm thoracic aneurysm. The nurse records findings from the initial assessment in the client's chart, as shown below.

At 10:30 am, the client has sharp midchest pain after having a bowel movement. What should the nurse do first?

1. Assess the client's vital signs.
2. Administer a bolus of lactated Ringer's solution.
3. Assess the client's neurologic status.
4. Contact the physician.

Answer: 1, 4

The nurse determines that a newborn is hypoglycemic based on which of the following findings? Select all that apply.

1. A blood glucose reading of less than 30 mg/dL (1.7 mmol/L) at 1 hour.
2. Irregular respirations, tremors, and hypothermia.

Question: 7

Answer: 1

To protect a client who has received tissue plasminogen activator (t-PA) or alteplase recombinant (Activase) therapy, the nurse should:

1. Use the radial artery to obtain blood gas samples.
2. Maintain arterial pressure for 10 seconds.
3. Administer IM injections.
4. Encourage physical activity.

Answer: 3

Which of the following rehabilitative measures should the nurse teach the client to perform after chest surgery to prevent shoulder ankylosis?

1. Turn from side to side.
2. Raise and lower the head.
3. Raise the arm on the affected side over the head.
4. Flex and extend the elbow on the affected side.
5. **Answer: 2-3-1-4**

The health care team has noticed an increase in IV infiltrations on the pediatric floor. As part of a Plan, Do, Study, Act quality improvement plan the team should do the following in which order?

Decide to monitor IV gauges

Perform chart audits.1.

Analyze the data.

Write a new IV insertion policy.

Answer: 3

An adolescent with chest pain goes to the school nurse. The nurse determines that the teenager has a history of asthma but has had no problems for years. Which of the following should the nurse do next?

1. Call the adolescent's parent.
2. Have the adolescent lie down for 30 minutes.
3. Obtain a peak flow reading.
4. Give two puffs of a short-acting bronchodilator.
5. **Answer: 0.03mg**

A newborn weighing 6 1/2 lb (2,950 g) is to be given naloxone hydrochloride (Narcan) due to respiratory depression as a result of a narcotic given to the mother shortly before birth. The drug is to be given 0.01 mg/kg into the umbilical vein. The vial is marked 0.4 mg/mL. How many milligrams would the newborn receive? Round off to two decimals.

0.03mg.

A primiparous client who underwent a cesarean birth 30 minutes ago is to receive Rho (D) immune globulin (RhoGAM). The nurse should administer the medication within which of the following time frames after birth?

1. 8 hours.
2. 24 hours.
3. **72 hours.**
4. 96 hours.

Answer: 3

A client is admitted at 30 weeks' gestation with contractions every 3 minutes. Her cervix is 1 to 2 cm dilated and 75% effaced. Following a 4-g bolus dose, IV magnesium sulfate is infusing at 2 g/h. How will the nurse know the medication is having the intended effect?

1. Contractions will increase in frequency, leading to birth.
2. The client will maintain a respiratory rate greater than 12 breaths/min.
3. **Contractions will decrease in frequency, intensity, and duration.**
4. The client will maintain blood pressure readings of 120/80 mm Hg.

Answer: 2

When developing a teaching plan for a primigravid client with insulin-dependent diabetes about monitoring blood glucose control and insulin dosages at home, which of the following would the nurse expect to include as a desired target range for blood glucose levels?

1. 40 to 60 mg/dL (2.2 to 3.3 mmol/L) between 2:00 and 4:00 pm
2. **70 to 100 mg/dL (3.3 to 5.6 mmol/L) before meals and bedtime snacks.**
3. 110 to 140 mg/dL (6.2 to 7.8 mmol/L) before meals and bedtime snacks.
4. 140 to 160 mg/dL (7.8 to 8.9 mmol/L) 1 hour after meals.

Griseofulvin was prescribed to treat a child's ringworm of the scalp. The nurse instructs the parents to use the medication for several weeks for which of the following reasons?

1. A sensitivity to the drug is less likely if it is used over a period of time.
2. Fewer side effects occur as the body slowly adjusts to a new substance over time.
3. Fewer allergic reactions occur if the drug is maintained at the same level long-term.
4. **The growth of the causative organism into new cells is prevented with long-term use.**

A client is receiving an IV infusion of heparin sodium at 1,200 units/h. The dilution is 25,000 units/500 mL. How many milliliters per hour will this client receive? **24mL/h.**

Using the Parkland formula, calculate the hourly rate of fluid replacement with lactated Ringer's solution during the first 8 hours for a client weighing 75 kg with total body surface area (TBSA) burn of 40%. **750mL/hour.**

Answer: 1, 2, 4, 6

A client with lung cancer is being cared for by his wife at home. His pain is increasing in severity. The nurse recognizes that teaching has been effective when the wife does which of the following? Select all that apply.

1. **Administers long-acting or sustained-release oral pain medication (OxyContin) regularly around the clock.**
2. **Administers immediate-release medication (oxycodone) for breakthrough pain.**
3. **Uses music for distraction as well as heat or cold in combination with medications.**
4. **Has her husband use a pain-rating scale to measure the effectiveness at reaching his individual pain goal.**

Answer: 2

A client with chronic cancer pain has been receiving opiates for 4 months. She rated the pain as an 8 on a 10-point scale before starting the opioid medication. Following thorough examination, there is no new evidence of increased disease, yet the pain is close to 8 again. The most likely explanation for the increasing pain is:

1. Development of an addiction to the opioids.
2. **Tolerance to the opioid.**
3. Withdrawal from the opioid.
4. Placebo effect has decreased.

Answer: 2

Which of the following statements is most accurate regarding the long-term toxic effects of cancer treatments on the immune system?

1. Clients with persistent immunologic abnormalities after treatment are at a much greater risk for infection than clients with a history of splenectomy.
2. The use of radiation and combination chemo-therapy can result in more frequent and more severe immune system impairment.
3. Long-term immunologic effects have been studied only in clients with breast and lung cancer.
4. The helper T cells recover more rapidly than the suppressor T cells, which results in positive helper cell balance that can last 5 years.

Question: 21

Answer: 2

A woman who is Rh-negative has given birth to an Rh-positive infant. The nurse explains to the client that she will receive Rho (D) Immune Globulin (RhoGAM). The nurse determines that the client understands the purpose of RhoGAM when she states:

1. "RhoGAM will protect my next baby if it is Rh-negative."
2. "RhoGAM will prevent antibody formation in my blood."
3. "RhoGAM will be given to prevent German measles."
4. "RhoGAM will be used to prevent bleeding in my newborn."

Answer: 2

A multigravida laboring client has an extensive documented history of drug addiction. Her last reported usage was 5 hours ago. She is 2 cm dilated with contractions every 3 minutes of moderate intensity. The primary health care provider prescribes nalbuphine 15 mg slow IV push for pain relief followed by an epidural when the client is 4 cm dilated. Within 10 minutes of receiving the nalbuphine, the client states she thinks she is going to have her baby now. Of the following drugs available at the time of the birth, which should the nurse avoid using with this client in this situation?

1. 1% lidocaine (Xylocaine).
2. Naloxone hydrochloride (Narcan).
3. Local anesthetic.
4. Pudendal block.

Answer: 1,2,4

The nurse is conducting a counseling session with a client experiencing posttraumatic stress disorder (PTSD) using a 2-way video telehealth system from the hospital to the client's home, which is 2 hours away from the nearest mental health facility. Which of the following are expected outcomes of using telehealth as a venue to provide health care to this client? **Select all that apply.** The client will:

1. Save travel time from the house to the health care facility.
2. Avoid reliving a traumatic event that might be precipitated by visiting a health care facility.

3. Receive health care for this mental health problem.

Answer: 4

At what time should the blood be drawn in relation to the administration of the IV dose of gentamycin h sulfate (Garamycin)?

1. 2 hours before the administration of the next IV dose.
2. 3 hours before the administration of the next IV dose.
3. 4 hours before the administration of the next IV dose.
4. Just before the administration of the next IV dose.

Answer: 3

A client's chest tube is connected to a drain-age system with a water seal. The nurse notes that the fluid in the water-seal column is fluctuating with each breath that the client takes. The fluctuation means that:

1. There is an obstruction in the chest tube.
2. The client is developing subcutaneous emphysema.
3. The chest tube system is functioning properly.
4. There is a leak in the chest tube system

