1. When two nursing diagnoses appear closely related, what should the nurse do first to determine which diagnosis most accurately reflects the needs of the patient?

a. Reassess the patient
b. Analyze the secondary to factors
c. Review the defining characteristics
d. Examine the related to factors
e. -

2. The nurse performs an assessment of a newly admitted patient. The nurse understands that this admission assessment is conducted primarily to:

a. Establish a therapeutic relationship
b. Diagnose if the patient is at risk for falls
c. -
d. Identify important data
e. Ensure that the patient's skin is intact

3. The nurse identifies that the patient statement that provides subjective data is:

a. "What should I do if I have uncontrollable pain at home?"
b. "I can call a home-care agency if I feel I need help at home."
c. "I'm not sure that I am going to be able to manage at home by myself."
d. "Will a home health aide help me with my care at home?"
e. -

4. The nurse understands that evaluation most directly relates to which aspect of the Nursing Process?

a. Implementation
b. -
c. Problem
d. Etiology
e. Goal

5. The nurse comes to the conclusion that a patient's elevated temperature, pulse, and respirations are significant. What step of the Nursing Process is being used when the nurse comes to this conclusion?

a. Assessment
b. Evaluation
c. Diagnosis
d. Implementation
e. -

6. When the nurse considers the Nursing Process, the word "identify" is to "recognize" as the word "do" is to:

a. Implement
b. Evaluate
c. -
d. Plan
e. Diagnose

7. The nurse is collecting subjective data associated with a patient's anxiety. Which assessment method should be used to collect this information?

a. -
b. Interviewing
c. Inspecting
d. Auscultation
e. Observing

8. Which nursing action reflects an activity associated with the diagnosis step of the Nursing Process?

a. Designing ways to minimize a patient's stressors

b. -
c. Making decisions about the effectiveness of patient care
d. Formulating a plan of care
e. Identifying the patient's potential risks

9. The nurse collects objective data when a hospitalized patient states:
a. -
b. "I ate half my lunch."
c. "I feel very warm."
d. "I am hungry."
e. "I have the urge to urinate."

10. The nurse understands that subjective data has been obtained when the patient states:
a. "My pain feels like a 5 on a scale of 1 to 5."
b. "I only ate half my breakfast."
c. -
d. "I just went in the urinal and it needs to be emptied."
e. "The doctor said I can go home today."

11. During which of the five steps in the Nursing Process does the nurse determine whether outcomes of care are achieved?
a. Implementation
b. Planning
c. -
d. Evaluation
e. Diagnosis

12. When considering the Nursing Process, the nurse understands that the word "observe" is to "assess" as the word "determine" is to:
a. -
b. Diagnose
c. Analyze
d. Plan
e. Implement

13. An essential concept related to understanding the Nursing Process is that it:
a. Is dynamic rather than static
b. Moves from the simple to the complex
c. -
d. Is based on the patient's medical problem
e. Focuses on the role of the nurse

14. The nurse is caring for a male patient with a urinary elimination problem. Which is the most accurately stated goal? "The patient will:
a. -
b. Transfer independently and safely to a commode before discharge."
c. Experience fewer incontinence episodes at night.
d. Be taught how to use a urinal when on bed rest.
e. Be assisted to the toilet every two hours and whenever necessary.

15. Which word best describes the role of the nurse when using the Nursing Process to meet the needs of the patient holistically?
a. Advocate
b. Surrogate
c. -
d. Counselor
e. Teacher

16. The nurse understands that the word most closely associated with scientific principles is:

a. Problem
b. Data
c. Rationale
d. Evaluation
e. -

17. A pebble dropped into a pond causes ripples on the surface of the water. Which part of the nursing diagnosis is most directly related to this concept?
a. Outcome criteria
b. Defi ning characteristics
c. Etiology
d. Goal
e. -

18. The nurse teaches a patient to use visualization to cope with chronic pain. This action reflects which step of the Nursing Process?
a. -
b. Implementation
c. Diagnosis
d. Planning
e. Evaluation

19. A patient has multiple diagnostic tests performed. Where in the patient's chart can the nurse find documentation about the current medical diagnosis after the diagnostic tests results are reported?
a. Admission Sheet
b. -
c. Physician's History and Physical
d. Social Service Record
e. Progress Notes

20. During which of the five steps in the Nursing Process does the nurse analyze data critically?
a. Assessment
b. -
c. Clustering
d. Collection
e. Diagnosis

21. The nurse is assessing a postoperative patient for signs of hemorrhage. Which adaptation is most indicative of shock?
a. Irregular pulse
b. Hyperemia
c. Hypotension
d. Slow respirations
e. -

22. The nurse is monitoring the vital signs of a group of patients. When reviewing these results, the nurse must remember that body temperature usually is at its highest at:
a. 6 AM–8 AM
b. 12 AM–2 AM
c. 8 PM–10 PM
d. 4 PM–6 PM
e. -

23. When assessing for borborygmi, which physical examination method should the nurse use?
a. Palpation
b. -
c. Percussion
d. Inspection

e. Auscultation

24. The nurse plans to take a patient's radial pulse. Which method of examination should be used by the nurse?

a. Percussion
b. Inspection
c. Palpation
d. Auscultation
e. -

25. Which nursing action is common to all instruments when taking a temperature?

a. Wash with cool soap and water after use
b. Place a disposable sheath over the probe
c. Ensure that the instrument is clean
d. Identify that the reading is below 96°F before insertion
e. -

26. The nurse concludes that a patient is experiencing hyperthermia. Which assessment precipitated this conclusion?

a. Rectal temperature of 101°F
b. Increased appetite
c. -
d. Mental confusion
e. Decreased heart rate

27. The nurse in the Emergency Department is engaging in an initial assessment of a patient. Which assessment takes priority?

a. Circulatory status
b. Blood pressure
c. Airway clearance
d. Breathing pattern
e. -

28. The nurse is obtaining a patient's blood pressure. Which information is most important for the nurse to document?

a. Staff member who took the blood pressure
b. -
c. Difference between the palpated and auscultated systolic readings
d. Patient's tolerance to having the blood pressure taken
e. Position of the patient if the patient is not in a sitting position

29. The nurse is teaching a cancer prevention community health class. Which recommended cancer screening guideline for asymptomatic nonrisk people should the nurse include?

a. Sigmoidoscopies every 5 years for patients 50 years of age and older
b. Pap smears annually for females 13 years of age and older
c. -
d. Mammograms annually for women 30 years of age and older
e. Prostate-specifi c antigens yearly for men 30 years of age and older

30. The nurse is planning to shave a male patient's facial hair. The nurse should:

a. Shave in the direction of hair growth
b. Hold the razor at a ninety-degree angle to the skin
c. -
d. Wrap the face with a hot, wet towel before shaving
e. Use long, downward strokes with the razor

31. The nurse is making an occupied bed. Which nursing action is most important?

a. -
b. Ensuring that the patient's head is supported and is in functional alignment

c. Fan-folding soiled linens as close to the patient's body as possible
d. Securing top linens under the foot of the mattress and mitering the corners
e. Positioning the bed in the horizontal position

32. The nurse must bathe the feet of a patient with diabetes. What should the nurse do before bathing this patient's feet?
a. Assess for additional risk factors that may contribute to foot problems
b. File the nails straight across with an emery board
c. -
d. Ensure a physician's order for hygienic foot care is obtained
e. Teach the patient that daily foot care is essential to healthy feet

33. The nurse is caring for a patient with an excessively dry mouth. Which nursing action is most important when providing mouth care for this patient?
a. Rinsing frequently with mouthwash
b. Swabbing with a sponge-tipped applicator of lemon and glycerin
c. -
d. Providing oral care every two hours
e. Cleansing four times a day with a water pick

34. The nurse is providing perineal care to a male patient. The nurse should wash the:
a. Genital area with hot, sudsy water
b. Shaft of the penis while moving toward the urinary meatus
c. Penis with one hand while holding it firmly with the other hand
d. Scrotum before washing the glans penis
e. -

35. The school nurse teaches an adolescent about skin care related to acne. The nurse identifies that the information is understood when the adolescent says, I should wash my face:
a. With cool water when I shower in the morning.
b. Every other day with a strong soap.
c. -
d. Thoroughly, but gently, three times a day.
e. And then apply an oil-based ointment.

36. The nurse uses a cotton blanket when bathing a patient. A blanket is used because air currents increase the loss of heat from the body through the principle of:
a. Conduction
b. Diffusion
c. -
d. Evaporation
e. Osmosis

37. The nurse identifies that additional teaching about skin care is necessary when an older adult says, I should:
a. -
b. Use a bubble-bath preparation when I take a bath.
c. Bathe twice a week.
d. Humidify my home in the winter.
e. Rinse well after using soap.

38. The school nurse identifies that teaching about skin care for acne has been effective when an adolescent states, I should:
a. Squeeze the white heads gently and apply a topical antibiotic.
b. Use an oil-based cream on my face after washing.
c. -
d. Wash my face several times a day with soap and water.
e. Wash with an alcohol-based facial cleanser every day.

39. When providing fingernail care during a bath the nurse should:
a. Cut the nails in an oval shape
b. First soak the hands in hot water
c. Clean under the nails with an orange stick
d. Push the cuticles back with the rounded end of a metal nail file
e. -

40. After removing a bedpan from under a debilitated patient who has just had a bowel movement, the nurse’s first intervention should be to:
a. Document the results
b. Reposition the patient
c. -
d. Provide perineal care
e. Cover the patient with the top linens

41. Which common problem with the hair should the nurse anticipate when patients are on complete bed rest?
a. -
b. Matted hair
c. Oily hair
d. Split hair
e. Dry hair

42. The nurse covers the patient with a cotton blanket during a bath. This is done to prevent heat loss via:
a. -
b. Convection
c. Conduction
d. Diffusion
e. Vasodilation

43. The nurse is planning to meet the hygiene needs of a patient. Which is the fi rst assessment to be performed by the nurse?
a. Collect the patient’s toiletries needed for the bath
b. Assess the patient’s ability to assist in hygiene activities
c. Determine the patient’s preferences about hygiene practices
d. Recognize the patient’s developmental stage
e. -

44. The nurse gives a bed-bound patient a bed bath. The primary reason the nurse provides hygiene to this patient is to:
a. Promote circulation by stimulating the skin’s peripheral nerve endings
b. -
c. Support a sense of well-being by increasing self-esteem
d. Exercise muscles by contraction and relaxation of muscles when bathing
e. Remove excess oil, perspiration, and bacteria by mechanical cleansing

45. The nurse is bathing a febrile patient. The nurse should use tepid bath water to:
a. Remove surface debris
b. Stimulate peripheral circulation
c. -
d. Increase heat loss
e. Reduce surface tension of skin

46. The nurse must make the decision to give a patient a full or partial bed bath. This decision depends on the:
a. Time of the patient’s last bath
b. Physician’s order for the patient’s activity

c. Immediate needs of the patient
d. Wishes of the patient
e. -

47. A patient has had a nasogastric tube to decompression for three days and is scheduled for intestinal surgery in the morning. The nurse understands that this patient is at the greatest risk for:
a. Physical injury
b. -
c. Decreased nutritional intake
d. Impaired social interaction
e. Altered oral mucous membranes

48. The patient asks the nurse, “Why do I have to use mouthwash if I brush my teeth?” The nurse’s best response is, “Mouthwash:
a. Helps reduce offensive mouth odors.
b. Softens debris that accumulate in the mouth.
c. -
d. Destroys pathogens that are found in the oral cavity.
e. Minimizes the formation of cavities.

49. When providing morning care for a patient, the nurse identifies crusty debris around the patient’s eyes. When cleaning the patient’s eyes, the nurse should:
a. Position the client on the same side as the eye to be cleaned
b. Use a tear-free baby soap
c. -
d. Wash the eyes with a cotton ball from the outer canthus to the inner canthus
e. Wear sterile gloves

50. The nurse is planning to shampoo the hair of a patient who has an order for bed rest. What should the nurse do first?
a. Tape eye shields over both eyes
b. Wet hair thoroughly before applying shampoo
c. -
d. Brush the hair to remove tangles
e. Encourage the use of dry shampoo

51. The nurse is assessing a patient’s bilateral pulses for symmetry. However, the nurse should not assess which pulse sites on both sides of the body at the same time?
a. Radial
b. Brachial
c. -
d. Carotid
e. Femoral

52. The nurse is caring for a patient who is experiencing an increase in symptoms associated with multiple sclerosis. Which term best describes a recurrence of symptoms associated with a chronic disease?
a. Remission
b. -
c. Adaptation
d. Variance
e. Exacerbation

53. The nurse in the clinic must obtain the vital signs of each patient before each patient is assessed by the practitioner. The nurse should obtain a temperature via the rectal route for a patient:
a. With a history of vomiting
b. With an intelligence of a seven-year-old child
c. -

d. Who is a mouth breather
e. Who cannot tolerate a semi-Fowler's position

54. The nurse is monitoring the status of postoperative patients. The vital sign that changes first indicating that a postoperative patient has internal bleeding is the:
a. Pulse pressure
b. Body temperature
c. -
d. Heart rate
e. Blood pressure

55. A patient has a serious vitamin K defi ciency. For which adaptation should the nurse assess this patient?
a. Skin lesions
b. Muscle weakness
c. -
d. Bleeding gums
e. Night blindness

56. The nurse identifies that a patient with a fever has warm skin. An additional adaptation that confirms the defervescence (flush) phase of a fever is:
a. Sweating
b. Cyanotic nail beds
c. -
d. Goosebumps on the skin
e. Shivering

57. When evaluating a patient's temperature, the nurse recalls that people usually have the lowest body temperature at:
a. -
b. 4 AM–6 AM
c. 4 PM–6 PM
d. 8 AM–10 AM
e. 8 PM–10 PM

58. Which method of examination is being used when the nurse's hands are used to assess the temperature of a patient's skin?
a. Palpation
b. Percussion
c. -
d. Observation
e. Inspection

59. The nurse must assess for the presence of bowel sounds in a postoperative patient. The nurse should auscultate the patient's abdomen:
a. -
b. Prior to palpation
c. Starting at the left lower quadrant
d. Using a warmed stethoscope
e. For at least three minutes in each quadrant

60. Which assessment requires the nurse to assess the patient further?
a. 50-year-old man with a BP of 112/60 upon awakening in the morning
b. 18-year-old woman with a pulse rate of 140 after riding 2 miles on an exercise bike
c. -
d. 65-year-old man with a respiratory rate of 10
e. 40-year-old woman with a pulse of 88

61. The nurse is interviewing a newly admitted patient. Which patient statement indicates the onset

of a fever? “I feel:

a. Cold.”

b. Sweaty.”

c. -

d. Thirsty.”

e. Warm.”

62. The nurse is caring for a group of hospitalized patients. What should the nurse do first to prevent patient infections?

a. Administer antibiotics as ordered

b. -

c. Provide small bedside bags to dispose of used tissues

d. Encourage staff to avoid coughing near patients

e. Identify patients at risk

63. The nurse identifies that a patient has an inflammatory response. Which local patient adaptation supports this conclusion?

a. Bradypnea

b. Fever

c. Erythema

d. Tachycardia

e. -

64. A patient has a wound that is healing by secondary intention. To best support healing of the wound, the nurse should expect the practitioner’s order to state, “Clean wound with:

a. -

b. Normal saline and apply a wet-to-damp dressing.”

c. Normal saline and cover with a gauze dressing.”

d. Betadine and apply a dry sterile dressing.”

e. Half peroxide and half normal saline and apply a wet to dry dressing.”

65. The nurse identifies that the greatest risk for a wound infection exists for a patient with a:

a. Puncture of the foot by a nail

b. First-degree burn on the back

c. -

d. Paper cut on the finger

e. Surgical creation of a colostomy

66. The nurse understands that the skin protects the body from infections because the:

a. Moisture on the skin surface prevents colonization of pathogens

b. Epithelial cells are loosely compacted on skin, providing a barrier against pathogens

c. Cells of the skin are constantly being replaced, thereby eliminating external pathogens

d. Alkalinity of the skin limits the growth of pathogens

e. -

67. The nurse must collect the following specimens. Which specimen collection does not require the use of surgical aseptic technique?

a. Urine from a retention catheter

b. -

c. Specimen for a throat culture

d. Exudate from a wound for culture and sensitivity

e. Stool for ova and parasites

68. A patient is positive for Clostridium difficile. The nurse should institute the isolation precaution known as:

a. Contact

b. Reverse

c. -

d. Airborne
e. Droplet

69. Which patient information collected by the nurse reflects a systemic adaptation to a wound infection?
a. Edema
b. Exudate
c. Hyperthermia
d. Pain
e. -

70. To interrupt the transmission link in the chain of infection, the nurse should:
a. Change a dressing when it is soiled
b. -
c. Position a commode next to a patient’s bed
d. Provide education about a balanced diet
e. Wash the hands before and after providing care to a patient

71. The nurse is providing for the nutrition needs of several patients. The nurse identifies the need for an increase in caloric intake above average requirements for the patient who has:
a. Pneumonia
b. Dysphagia
c. -
d. Depression
e. Nausea

72. The nurse is caring for patients with a variety of wounds. The nurse understands that healing by primary intention most likely occurs with:
a. Pressure ulcers
b. -
c. Excoriated perianal areas
d. Abrasions of the skin
e. Cuts in the skin from a kitchen knife

73. The primary reason why the nurse should avoid glued-on artificial nails is because they:
a. Can scratch a patient
b. -
c. Interfere with dexterity of the fi ngers
d. Could fall off in a patient’s bed
e. Harbor microorganisms

74. The nurse understands that subclinical infections most commonly occur in:
a. Infants
b. -
c. Children of school age
d. Adolescents
e. Older adults

75. The nurse understands that the factor that places a patient at the greatest risk for developing an infection is:
a. -
b. Burns more than twenty percent of the body
c. Presence of an indwelling urinary catheter
d. Multiple puncture sites from laparoscopic surgery
e. Implantation of a prosthetic device

76. The nurse understands that a secondary line of defense against infection is the:
a. -
b. Immune response

c. Urinary tract environment
d. Integumentary system
e. Mucous membranes of the respiratory tract

77. Which nursing action protects the patient as a susceptible host in the chain of infection?
a. Recapping a used needle before discarding
b. Wearing personal protective equipment
c. Administering childhood immunizations
d. Disposing of soiled gloves in a waste container
e. -

78. A patient tells the nurse, “I think I have an ear infection.” The nurse should assess this patient for which objective human response to an ear infection?
a. -
b. Purulent drainage
c. Dizziness when moving
d. Throbbing pain
e. Hearing a buzzing sound

79. The nurse is concerned about a patient’s ability to withstand exposure to pathogens. What blood component should the nurse monitor?
a. Hemoglobin
b. Platelets
c. Neutrophils
d. Erythrocytes
e. -

80. The nurse understands which primary (nonspecific) defense protects the body from infection?
a. Bile in the gastrointestinal system
b. Alkalinity of gastric secretions
c. Tears in the eyes
d. Moist environment of the epidermis
e. -

81. When brushing a patient’s hair, the nurse notes white oval particles attached to the hair behind the ears. The nurse should assess the patient further for signs of:
a. Dandruff
b. Hirsutism
c. Pediculosis
d. Scabies
e. -

82. A patient has dysphagia. Which common nursing action takes priority when feeding this patient?
a. Ensuring that dentures are in place
b. -
c. Providing verbal cueing to swallow each bite
d. Medicating for pain before providing meals
e. Checking the mouth for emptying between every bite

83. A 3-year-old child is admitted to the pediatric unit. The best way for the nurse to maintain the safety of this preschool-aged child is by:
a. Having the child stay in the playroom most of the day
b. Teaching the child how to use the call bell
c. -
d. Keeping the child under constant supervision
e. Placing the child in a crib with high side rails

84. Which time of day is of most concern for the nurse when trying to protect a patient with dementia from injury?

a. Evening
b. Afternoon
c. -
d. Night
e. Morning

85. A patient consistently tries to pull out a urinary retention catheter. As a last resort to maintain integrity of the catheter and patient safety, the nurse obtains an order for a restraint. Which type of restraint is most appropriate in this situation?
a. Mummy restraint
b. -
c. Jacket restraint
d. Elbow restraint
e. Mitt restraint

86. The nurse is orienting a newly admitted patient to the hospital. It is most important for the nurse to teach the patient how to:
a. Get out of the bed to use the bathroom
b. Use the telephone system to call family members
c. -
d. Notify the nurse when help is needed
e. Raise and lower the head and foot of the bed

87. Profuse smoke is coming out of the heating unit in a patient's room. The nurse should
a. Close the door to the patient's room
b. Activate the fire alarm
c. -
d. Move the patient out of the room
e. Open the window

88. The nurse must apply a hospital gown to a patient receiving an intravenous infusion in the forearm. The nurse should:
a. Insert the IV bag and tubing through the sleeve from inside of the gown first
b. Close the clamp on the IV tubing no more than 15 seconds while putting on the gown
c. -
d. Don the gown on the arm without the IV, drape the gown over the other shoulder, and adjust the closure behind the neck
e. Disconnect the IV at the insertion site, apply the gown, and then reconnect the IV

89. The nurse is planning care for a patient with a wrist restraint. The restraint should be removed, the area massaged, and the joints moved through their full range every:
a. -
b. Two hours
c. Hour
d. Four hours
e. Shift

90. Which is the first action the home care nurse should employ to prevent falls by an older adult living at home?
a. Suggest installation of adequate lighting throughout the home
b. Encourage the patient to remove throw rugs in the home
c. Conduct a comprehensive risk assessment
d. Discuss with the patient the expected changes of aging that place one at risk
e. -

91. The nurse is preparing a bed to receive a newly admitted patient. Which action is most important?
a. Place the patient's name on the end of the bed
b. Make an open bed

c. -
d. Ensure that the bed wheels are locked
e. Position the call bell in reach

92. An appropriately worded goal associated with the nursing diagnosis Risk for Injury is, “The patient will be:
a. Taught how to call for help to ambulate.”
b. -
c. Restrained when agitated.”
d. Kept on bed rest when dizzy.”
e. Free from trauma.”

93. The nurse understands that in the hospital setting an electrical appliance should have a three-pronged plug because it:
a. Shuts off the appliance if there is an electrical surge
b. Divides the electricity among the appliances in the room
c. -
d. Controls stray electrical currents
e. Promotes effi cient use of electricity

94. A patient with Parkinson’s disease is experiencing difficulty swallowing. The nurse understands that the most serious risk associated with dysphagia is:
a. Aspiration
b. Self-care deficit
c. -
d. Inadequate intake
e. Anorexia

95. The nurse is caring for a confused patient. To prevent this patient from falling, the nurse should:
a. Reinforce how to use the call bell
b. Encourage the patient to use the corridor handrails
c. -
d. Maintain close supervision
e. Place the patient in a room near the nurses’ station

96. When teaching children about fire safety procedures, the school nurse should teach them that if their clothes catch on fire they should:
a. Pour water on their clothes
b. -
c. Yell for help
d. Take their clothes off
e. Roll on the ground

97. The physician orders a vest restraint for a patient. What should the nurse do first when applying this restraint?
a. Secure the restraint to the bed frame using a slipknot
b. Ensure that the back of the vest is positioned on the patient’s back
c. -
d. Inspect the patient’s skin where the restraint is to be placed
e. Permit four fingers to slide between the patient and the restraint

98. An unconscious patient begins vomiting. In which position should the nurse place the patient?
a. Side-lying
b. Orthopneic
c. -
d. Low-Fowler’s
e. Supine

99. The nurse is assisting a patient to use a bedpan. What is the most important nursing intervention?

a. Encouraging the patient to help as much as possible when using the bedpan
b. Dusting powder on the rim before placing the bedpan under the patient
c. -
d. Ensuring that the bedside rails are raised once the patient is on the bedpan
e. Positioning the rounded rim of the bedpan toward the front of the patient

100. A toaster is on fire in the pantry of a hospital unit. The nurse should first:
a. Activate the fire alarm
b. Put out the fire with an extinguisher
c. -
d. Evacuate patients from the room next to the kitchen
e. Unplug the toaster

101. The nurse understands that the most common factor that contributes to falls in the hospital setting is:
a. Advanced age of patients
b. Frequent seizures
c. -
d. Misuse of equipment by nurses
e. Wet fl oors

102. The nurse is repositioning a patient on the left side. The nurse should place the patient's:
a. Right leg resting on top of the left leg
b. Knees in ninety degrees of flexion
c. -
d. Left shoulder protracted
e. Ankles in plantar flexion

103. The nurse turns a patient's ankle so that the sole of the foot moves medially toward the midline. This motion is known as:
a. Inversion
b. Plantar flexion
c. -
d. Internal rotation
e. Adduction

104. The nurse is transferring a patient from a bed to a wheelchair. To quickly assess this patient's tolerance to the change in position, the nurse should:
a. Determine if the patient feels dizzy
b. Monitor for bradycardia
c. -
d. Obtain a blood pressure
e. Allow the patient time to adjust to the change in position

105. The nurse is transferring a patient from the bed to a wheelchair using a mechanical lift. Which is a basic nursing intervention associated with this procedure?
a. -
b. Ensure the patient's feet are protected when on the mechanical lift
c. Raise the mechanical lift so that the patient is six inches off the mattress
d. Keep the wheels of the mechanical lift locked throughout the procedure
e. Lock the base lever in the open position when moving the mechanical lift

106. A patient has hemiplegia as a result of a brain attack. Which complication of immobility is of most concern to the nurse?
a. Contractures
b. Incontinence
c. -
d. Dehydration

e. Hypertension

107. Which stage pressure ulcer requires the nurse to measure the extent of undermining?
a. Stage I
b. Stage 0
c. -
d. Stage III
e. Stage II

108. A patient has a cast from the hand to above the elbow because of a fractured ulna and radius. After the cast is removed, the nurse teaches the patient active range-of-motion exercises. The nurse identifies that further teaching is necessary when the patient:
a. Moves the elbow to the point of resistance
b. -
c. Puts the elbow through its full range at least three times
d. Assesses the elbows response after the procedure
e. Keeps the elbow fl exed after the procedure

109. Which word is most closely associated with nursing care strategies to maintain functional alignment when patients are bed bound?
a. Support
b. Strength
c. -
d. Endurance
e. Balance

110. The nurse places a patient with a sacral pressure ulcer in the left Sims' position. The nurse should place the patient's right arm:
a. On a pillow
b. With the palm up
c. -
d. In internal rotation
e. Behind the back

111. A patient with impaired mobility is to be discharged within a week from the hospital. Which is the best example of a discharge goal for this patient? The patient will:
a. Be kept clean and dry
b. Understand range-of-motion exercises
c. -
d. Transfer independently to a chair
e. Be taught range-of-motion exercises

112. The nurse concludes that a patient has the potential for impaired mobility. Which assessment refl ects a risk factor that precipitated this conclusion?
a. Increased respiratory rate
b. Exertional fatigue
c. -
d. Limited range of motion
e. Sedentary lifestyle

113. The nurse is performing passive range-of-motion exercises for a patient who is in the supine position. Which motion occurs when the nurse bends the patient's ankle so that the toes are pointed toward the ceiling?
a. Dorsal flexion
b. Supination
c. -
d. Adduction
e. Plantar extension

114. The nurse is caring for a patient with impaired mobility. Which position contributes most to the formation of a hip flexion contracture?

a. Supine
b. Sims'
c. Orthopneic
d. Low Fowler's
e. -

115. A patient is diagnosed with a stage IV pressure ulcer with eschar. Which medical treatment should the nurse anticipate the physician will order for this patient?

a. Application of a topical antibiotic
b. Cleansing irrigations twice daily
c. Debridement of the wound
d. Heat lamp treatment three times a day
e. -

116. The nurse knows that raising a patient's arm over the head during range-of-motion exercises is called:

a. Flexion
b. Opposition
c. -
d. Hyperextension
e. Supination

117. There are discharge criteria for patients in the Post-Anesthesia Care Unit regardless of the type of anesthesia used and additional criteria for specific types of anesthesia. The criterion specific for the patient who has received spinal anesthesia is:

a. Oxygen saturation reaches the presurgical baseline
b. -
c. Nausea and vomiting are minimal
d. Headache is considered tolerable
e. Motor and sensory function returns

118. A nurse completes a dificult day at work and feels satisfaction in performing well and helping others. According to Freud, this feeling of satisfaction is associated with what part of the personality?

a. Libido
b. Fixation
c. -
d. Superego
e. Ego

119. The nurse identifies that the behavior in an adult that indicates an unresolved developmental con? ict associated with adolescence is:

a. Being overly concerned about following daily routines
b. Relying on oneself rather than others
c. -
d. Failing to set goals in life
e. Requiring excessive attention from others

120. The nurse understands that an individual who is preoccupied with work and the drive to succeed at the expense of emotionally committing to others reflects a negative resolution of which stage of Erikson's Stages of Development?

a. Intimacy versus Isolation
b. Identify versus Role Confusion
c. -
d. Ego Integrity versus Despair
e. Autonomy versus Shame and Doubt

121. When two nursing diagnoses appear closely related, what should the nurse do first to determine which diagnosis most accurately reflects the needs of the patient?

a. -
b. Review the defining characteristics
c. Reassess the patient
d. Analyze the secondary to factors
e. Examine the related to factors

122. The nurse performs an assessment of a newly admitted patient. The nurse understands that this admission assessment is conducted primarily to:

a. Ensure that the patient's skin is intact
b. Establish a therapeutic relationship
c. Identify important data
d. Diagnose if the patient is at risk for falls
e. -

123. The nurse identifies that the patient statement that provides subjective data is:

a. -
b. I'm not sure that I am going to be able to manage at home by myself.
c. What should I do if I have uncontrollable pain at home?
d. I can call a home-care agency if I feel I need help at home.
e. Will a home health aide help me with my care at home?

124. The nurse understands that evaluation most directly relates to which aspect of the Nursing Process?

a. -
b. Goal
c. Etiology
d. Problem
e. Implementation

125. The nurse comes to the conclusion that a patient's elevated temperature, pulse, and respirations are significant. What step of the Nursing Process is being used when the nurse comes to this conclusion?

a. -
b. Diagnosis
c. Assessment
d. Evaluation
e. Implementation

126. When the nurse considers the Nursing Process, the word identify is to recognize as the word do is to:

a. Plan
b. -
c. Diagnose
d. Evaluate
e. Implement

127. The nurse is collecting subjective data associated with a patient's anxiety. Which assessment method should be used to collect this information?

a. Auscultation
b. Observing
c. -
d. Interviewing
e. Inspecting

128. Which nursing action reflects an activity associated with the diagnosis step of the Nursing Process?

a. Identifying the patient's potential risks
b. Formulating a plan of care
c. -
d. Designing ways to minimize a patient's stressors
e. Making decisions about the effectiveness of patient care

129. The nurse collects objective data when a hospitalized patient states:
a. -
b. I ate half my lunch.
c. I feel very warm.
d. I am hungry.
e. I have the urge to urinate.

130. The nurse understands that subjective data has been obtained when the patient states:
a. The doctor said I can go home today.
b. I just went in the urinal and it needs to be emptied.
c. -
d. My pain feels like a 5 on a scale of 1 to 5.
e. I only ate half my breakfast.

131. During which of the five steps in the Nursing Process does the nurse determine whether outcomes of care are achieved?
a. Planning
b. -
c. Implementation
d. Diagnosis
e. Evaluation

132. When considering the Nursing Process, the nurse understands that the word observe is to assess as the word determine is to:
a. -
b. Diagnose
c. Analyze
d. Plan
e. Implement

133. An essential concept related to understanding the Nursing Process is that it:
a. Focuses on the role of the nurse
b. Is based on the patient's medical problem
c. -
d. Is dynamic rather than static
e. Moves from the simple to the complex

134. The nurse is caring for a male patient with a urinary elimination problem. Which is the most accurately stated goal? The patient will:
a. Be assisted to the toilet every two hours and whenever necessary.
b. -
c. Be taught how to use a urinal when on bed rest.
d. Experience fewer incontinence episodes at night.
e. Transfer independently and safely to a commode before discharge.

135. The nurse understands that the word most closely associated with scientific principles is:
a. Rationale
b. Problem
c. -
d. Evaluation
e. Data

136. The nurse teaches a patient to use visualization to cope with chronic pain. This action reflects

which step of the Nursing Process?

a. Implementation

b. Diagnosis

c. -

d. Evaluation

e. Planning

137. A patient has multiple diagnostic tests performed. Where in the patient's chart can the nurse find documentation about the current medical diagnosis after the diagnostic tests results are reported?

a. -

b. Progress Notes

c. Social Service Record

d. Physician's History and Physical

e. Admission Sheet

138. During which of the five steps in the Nursing Process does the nurse analyze data critically?

a. Clustering

b. Assessment

c. -

d. Diagnosis

e. Collection

139. The nurse is assessing a postoperative patient for signs of hemorrhage. Which adaptation is most indicative of shock?

a. Hyperemia

b. Slow respirations

c. -

d. Hypotension

e. Irregular pulse

140. The nurse is monitoring the vital signs of a group of patients. When reviewing these results, the nurse must remember that body temperature usually is at its highest at:

a. 6 AM?8 AM

b. 12 AM?2 AM

c. 8 PM?10 PM

d. 4 PM?6 PM

e. -

141. The nurse plans to take a patient's radial pulse. Which method of examination should be used by the nurse?

a. -

b. Palpation

c. Percussion

d. Inspection

e. Auscultation

142. Which nursing action is common to all instruments when taking a temperature?

a. Ensure that the instrument is clean

b. Wash with cool soap and water after use

c. -

d. Identify that the reading is below 96?F before insertion

e. Place a disposable sheath over the probe

143. The nurse concludes that a patient is experiencing hyperthermia. Which assessment precipitated this conclusion?

a. Increased appetite

b. Decreased heart rate

c. Rectal temperature of 101?F

d. Mental confusion
e. -

144. The nurse is obtaining a patient's blood pressure. Which information is most important for the nurse to document?
a. Position of the patient if the patient is not in a sitting position
b. Patient's tolerance to having the blood pressure taken
c. -
d. Staff member who took the blood pressure
e. Difference between the palpated and auscultated systolic readings

145. The nurse is teaching a cancer prevention community health class. Which recommended cancer screening guideline for asymptomatic nonrisk people should the nurse include?
a. Prostate-specifi c antigens yearly for men 30 years of age and older
b. Mammograms annually for women 30 years of age and older
c. -
d. Sigmoidoscopies every 5 years for patients 50 years of age and older
e. Pap smears annually for females 13 years of age and older

146. The nurse is planning to shave a male patient's facial hair. The nurse should:
a. -
b. Shave in the direction of hair growth
c. Hold the razor at a ninety-degree angle to the skin
d. Use long, downward strokes with the razor
e. Wrap the face with a hot, wet towel before shaving

147. The nurse is making an occupied bed. Which nursing action is most important?
a. Securing top linens under the foot of the mattress and mitering the corners
b. Positioning the bed in the horizontal position
c. -
d. Ensuring that the patient's head is supported and is in functional alignment
e. Fan-folding soiled linens as close to the patient's body as possible

148. The nurse must bathe the feet of a patient with diabetes. What should the nurse do before bathing this patient's feet?
a. Ensure a physician's order for hygienic foot care is obtained
b. -
c. Teach the patient that daily foot care is essential to healthy feet
d. File the nails straight across with an emery board
e. Assess for additional risk factors that may contribute to foot problems

149. The nurse identifies that additional teaching about skin care is necessary when an older adult says, I should:
a. Rinse well after using soap.
b. -
c. Humidify my home in the winter.
d. Bathe twice a week.
e. Use a bubble-bath preparation when I take a bath.

150. Which common problem with the hair should the nurse anticipate when patients are on complete bed rest?
a. Oily hair
b. Split hair
c. Matted hair
d. Dry hair
e. -

151. The nurse covers the patient with a cotton blanket during a bath. This is done to prevent heat loss via:

a. Diffusion
b. Vasodilation
c. -
d. Convection
e. Conduction

152. The nurse is planning to meet the hygiene needs of a patient. Which is the fi rst assessment to be performed by the nurse?
a. Collect the patient's toiletries needed for the bath
b. Assess the patient's ability to assist in hygiene activities
c. Determine the patient's preferences about hygiene practices
d. Recognize the patient's developmental stage
e. -

153. The nurse gives a bed-bound patient a bed bath. The primary reason the nurse provides hygiene to this patient is to:
a. Promote circulation by stimulating the skin's peripheral nerve endings
b. -
c. Support a sense of well-being by increasing self-esteem
d. Exercise muscles by contraction and relaxation of muscles when bathing
e. Remove excess oil, perspiration, and bacteria by mechanical cleansing

154. The nurse must make the decision to give a patient a full or partial bed bath. This decision depends on the:
a. Immediate needs of the patient
b. Time of the patient's last bath
c. -
d. Wishes of the patient
e. Physician's order for the patient's activity

155. The nurse is planning to shampoo the hair of a patient who has an order for bed rest. What should the nurse do first?
a. Wet hair thoroughly before applying shampoo
b. -
c. Tape eye shields over both eyes
d. Encourage the use of dry shampoo
e. Brush the hair to remove tangles

156. The nurse is caring for a patient who is experiencing an increase in symptoms associated with multiple sclerosis. Which term best describes a recurrence of symptoms associated with a chronic disease?
a. Variance
b. Adaptation
c. Exacerbation
d. Remission
e. -

157. The nurse in the clinic must obtain the vital signs of each patient before each patient is assessed by the practitioner. The nurse should obtain a temperature via the rectal route for a patient:
a. Who cannot tolerate a semi-Fowler's position
b. With a history of vomiting
c. Who is a mouth breather
d. With an intelligence of a seven-year-old child
e. -

158. When evaluating a patient's temperature, the nurse recalls that people usually have the lowest body temperature at:
a. -

b. 4 AM?6 AM
c. 4 PM?6 PM
d. 8 AM?10 AM
e. 8 PM?10 PM

159. Which assessment requires the nurse to assess the patient further?
a. -
b. 65-year-old man with a respiratory rate of 10
c. 40-year-old woman with a pulse of 88
d. 50-year-old man with a BP of 112/60 upon awakening in the morning
e. 18-year-old woman with a pulse rate of 140 after riding 2 miles on an exercise bike

160. The nurse is interviewing a newly admitted patient. Which patient statement indicates the onset of a fever? I feel:
a. Cold.
b. Sweaty.
c. -
d. Thirsty.
e. Warm.

161. The nurse is caring for a group of hospitalized patients. What should the nurse do first to prevent patient infections?
a. Provide small bedside bags to dispose of used tissues
b. Administer antibiotics as ordered
c. -
d. Identify patients at risk
e. Encourage staff to avoid coughing near patients

162. The nurse identifies that a patient has an inflammatory response. Which local patient adaptation supports this conclusion?
a. -
b. Erythema
c. Bradypnea
d. Fever
e. Tachycardia

163. A patient has a wound that is healing by secondary intention. To best support healing of the wound, the nurse should expect the practitioner's order to state, Clean wound with:
a. Half peroxide and half normal saline and apply a wet to dry dressing.
b. -
c. Betadine and apply a dry sterile dressing.
d. Normal saline and cover with a gauze dressing.
e. Normal saline and apply a wet-to-damp dressing.

164. The nurse identifies that the greatest risk for a wound infection exists for a patient with a:
a. First-degree burn on the back
b. Surgical creation of a colostomy
c. Puncture of the foot by a nail
d. Paper cut on the finger
e. -

165. The nurse understands that the skin protects the body from infections because the:
a. -
b. Cells of the skin are constantly being replaced, thereby eliminating external pathogens
c. Moisture on the skin surface prevents colonization of pathogens
d. Epithelial cells are loosely compacted on skin, providing a barrier against pathogens
e. Alkalinity of the skin limits the growth of pathogens

166. The nurse must collect the following specimens. Which specimen collection does not require the

use of surgical aseptic technique?
a. Specimen for a throat culture
b. Urine from a retention catheter
c. -
d. Stool for ova and parasites
e. Exudate from a wound for culture and sensitivity

167. A patient is positive for Clostridium difficile. The nurse should institute the isolation precaution known as:
a. Reverse
b. Droplet
c. Contact
d. Airborne
e. -

168. Which patient information collected by the nurse reflects a systemic adaptation to a wound infection?
a. -
b. Hyperthermia
c. Edema
d. Exudate
e. Pain

169. To interrupt the transmission link in the chain of infection, the nurse should:
a. Provide education about a balanced diet
b. Position a commode next to a patient's bed
c. Wash the hands before and after providing care to a patient
d. Change a dressing when it is soiled
e. -

170. The nurse is providing for the nutrition needs of several patients. The nurse identifies the need for an increase in caloric intake above average requirements for the patient who has:
a. Dysphagia
b. Nausea
c. Pneumonia
d. Depression
e. -

171. The primary reason why the nurse should avoid glued-on artificial nails is because they:
a. Harbor microorganisms
b. Could fall off in a patient's bed
c. -
d. Can scratch a patient
e. Interfere with dexterity of the fi ngers

172. The nurse understands that subclinical infections most commonly occur in:
a. Older adults
b. Adolescents
c. -
d. Infants
e. Children of school age

173. The nurse understands that the factor that places a patient at the greatest risk for developing an infection is:
a. Presence of an indwelling urinary catheter
b. Multiple puncture sites from laparoscopic surgery
c. Burns more than twenty percent of the body
d. Implantation of a prosthetic device

e. -

174. The nurse understands that a secondary line of defense against infection is the:
a. Urinary tract environment
b. Integumentary system
c. Immune response
d. Mucous membranes of the respiratory tract
e. -

175. Which nursing action protects the patient as a susceptible host in the chain of infection?
a. Wearing personal protective equipment
b. Disposing of soiled gloves in a waste container
c. -
d. Administering childhood immunizations
e. Recapping a used needle before discarding

176. A patient tells the nurse, I think I have an ear infection. The nurse should assess this patient for which objective human response to an ear infection?
a. Hearing a buzzing sound
b. -
c. Throbbing pain
d. Dizziness when moving
e. Purulent drainage

177. The nurse is concerned about a patient's ability to withstand exposure to pathogens. What blood component should the nurse monitor?
a. Hemoglobin
b. Platelets
c. Neutrophils
d. Erythrocytes
e. -

178. The nurse understands which primary (nonspecific) defense protects the body from infection?
a. -
b. Tears in the eyes
c. Bile in the gastrointestinal system
d. Alkalinity of gastric secretions
e. Moist environment of the epidermis

179. When brushing a patient's hair, the nurse notes white oval particles attached to the hair behind the ears. The nurse should assess the patient further for signs of:
a. -
b. Pediculosis
c. Dandruff
d. Hirsutism
e. Scabies

180. Profuse smoke is coming out of the heating unit in a patient's room. The nurse should
a. Move the patient out of the room
b. Open the window
c. -
d. Activate the fire alarm
e. Close the door to the patient's room

181. The nurse is planning care for a patient with a wrist restraint. The restraint should be removed, the area massaged, and the joints moved through their full range every:
a. Shift
b. -
c. Four hours

d. Hour

e. Two hours

182. Which is the first action the home care nurse should employ to prevent falls by an older adult living at home?

a. Encourage the patient to remove throw rugs in the home

b. Discuss with the patient the expected changes of aging that place one at risk

c. -

d. Conduct a comprehensive risk assessment

e. Suggest installation of adequate lighting throughout the home

183. The nurse is preparing a bed to receive a newly admitted patient. Which action is most important?

a. Make an open bed

b. -

c. Place the patient's name on the end of the bed

d. Position the call bell in reach

e. Ensure that the bed wheels are locked

184. An appropriately worded goal associated with the nursing diagnosis Risk for Injury is, The patient will be:

a. -

b. Free from trauma.

c. Kept on bed rest when dizzy.

d. Restrained when agitated.

e. Taught how to call for help to ambulate.

185. The nurse understands that in the hospital setting an electrical appliance should have a three-pronged plug because it:

a. -

b. Controls stray electrical currents

c. Promotes effi cient use of electricity

d. Shuts off the appliance if there is an electrical surge

e. Divides the electricity among the appliances in the room

186. A patient with Parkinson's disease is experiencing difficulty swallowing. The nurse understands that the most serious risk associated with dysphagia is:

a. -

b. Aspiration

c. Self-care deficit

d. Anorexia

e. Inadequate intake

187. The nurse is caring for a confused patient. To prevent this patient from falling, the nurse should:

a. Place the patient in a room near the nurses' station

b. Reinforce how to use the call bell

c. Maintain close supervision

d. Encourage the patient to use the corridor handrails

e. -

188. The physician orders a vest restraint for a patient. What should the nurse do first when applying this restraint?

a. Secure the restraint to the bed frame using a slipknot

b. Ensure that the back of the vest is positioned on the patient's back

c. -

d. Inspect the patient's skin where the restraint is to be placed

e. Permit four fingers to slide between the patient and the restraint

189. An unconscious patient begins vomiting. In which position should the nurse place the patient?

a. Orthopneic
b. Supine
c. Side-lying
d. Low-Fowler's
e. -

190. The nurse is assisting a patient to use a bedpan. What is the most important nursing intervention?
a. Positioning the rounded rim of the bedpan toward the front of the patient
b. Encouraging the patient to help as much as possible when using the bedpan
c. Ensuring that the bedside rails are raised once the patient is on the bedpan
d. Dusting powder on the rim before placing the bedpan under the patient
e. -

191. A toaster is on fire in the pantry of a hospital unit. The nurse should first:
a. -
b. Activate the fire alarm
c. Put out the fire with an extinguisher
d. Unplug the toaster
e. Evacuate patients from the room next to the kitchen

192. The nurse understands that the most common factor that contributes to falls in the hospital setting is:
a. -
b. Advanced age of patients
c. Frequent seizures
d. Wet fl oors
e. Misuse of equipment by nurses

193. The nurse is repositioning a patient on the left side. The nurse should place the patient's:
a. -
b. Left shoulder protracted
c. Ankles in plantar flexion
d. Right leg resting on top of the left leg
e. Knees in ninety degrees of flexion

194. The nurse turns a patient's ankle so that the sole of the foot moves medially toward the midline. This motion is known as:
a. Inversion
b. Plantar flexion
c. -
d. Internal rotation
e. Adduction

195. The nurse is transferring a patient from a bed to a wheelchair. To quickly assess this patient's tolerance to the change in position, the nurse should:
a. -
b. Determine if the patient feels dizzy
c. Monitor for bradycardia
d. Allow the patient time to adjust to the change in position
e. Obtain a blood pressure

196. The nurse is transferring a patient from the bed to a wheelchair using a mechanical lift. Which is a basic nursing intervention associated with this procedure?
a. -
b. Ensure the patient's feet are protected when on the mechanical lift
c. Raise the mechanical lift so that the patient is six inches off the mattress
d. Keep the wheels of the mechanical lift locked throughout the procedure

e. Lock the base lever in the open position when moving the mechanical lift

197. A patient has hemiplegia as a result of a brain attack. Which complication of immobility is of most concern to the nurse?

a. -

b. Contractures

c. Incontinence

d. Hypertension

e. Dehydration

198. Which stage pressure ulcer requires the nurse to measure the extent of undermining?

a. -

b. Stage III

c. Stage II

d. Stage I

e. Stage 0

199. Which word is most closely associated with nursing care strategies to maintain functional alignment when patients are bed bound?

a. Endurance

b. -

c. Balance

d. Strength

e. Support

200. The nurse places a patient with a sacral pressure ulcer in the left Sims' position. The nurse should place the patient's right arm:

a. In internal rotation

b. -

c. Behind the back

d. With the palm up

e. On a pillow

201. The nurse is performing passive range-of-motion exercises for a patient who is in the supine position. Which motion occurs when the nurse bends the patient's ankle so that the toes are pointed toward the ceiling?

a. Dorsal flexion

b. Supination

c. -

d. Adduction

e. Plantar extension

202. The nurse is caring for a patient with impaired mobility. Which position contributes most to the formation of a hip flexion contracture?

a. Orthopneic

b. Supine

c. -

d. Low Fowler's

e. Sims'

203. A patient is diagnosed with a stage IV pressure ulcer with eschar. Which medical treatment should the nurse anticipate the physician will order for this patient?

a. Cleansing irrigations twice daily

b. Heat lamp treatment three times a day

c. -

d. Debridement of the wound

e. Application of a topical antibiotic

204. The nurse knows that raising a patient's arm over the head during range-of-motion exercises is

called:
a. Supination
b. Hyperextension
c. -
d. Flexion
e. Opposition

205. A patient with a history of thrombophlebitis should not have pressure exerted on the popliteal space. The nurse should avoid placing this patient in which position?
a. Prone
b. -
c. Supine
d. Trendelenburg
e. Contour

206. The nurse plans to teach a patient with hemiparesis to use a cane. The nurse should teach the patient to:
a. -
b. Hold the cane in the strong hand when walking
c. Adjust the cane height twelve inches lower than the waist
d. Look at the feet when walking
e. Move up a step with the weak leg fi rst followed by the strong leg and cane

207. The nurse is caring for a variety of patients, each experiencing one of the following problems. Which health problem places a patient at the greatest risk for complications associated with immobility?
a. Quadriplegia
b. Hemiparesis
c. -
d. Confusion
e. Incontinence

208. Older adults often are afraid of falling. The nurse understands that the most common consequence associated with this concern is:
a. Impaired skin integrity
b. -
c. Self-imposed social isolation
d. Occurrence of panic attacks
e. Decreased physical conditioning

209. The nurse is evaluating an ambulating patient's balance. It is most important that the nurse assess the patient's:
a. Energy level
b. Posture
c. -
d. Respiratory rate
e. Strength

210. The practitioner orders a clear liquid diet for a patient. Which food should the nurse teach the patient to avoid when following this diet?
a. Strawberry Jell-O
b. -
c. Strong coffee
d. Decaffeinated tea
e. Ice cream

211. The nurse is caring for a patient who is expending energy that is greater than the caloric intake. Which human response most likely will occur?

a. Fever
b. -
c. Anorexia
d. Hypertension
e. Malnutrition

212. The nurse teaches a postoperative patient about foods high in protein that will promote wound healing. The nurse identifies that the teaching is successful when from a list of foods the patient selects:
a. -
b. Meat
c. Bread
d. Milk
e. Vegetables

213. Which nutrient should the nurse encourage a patient to include in the diet to provide vitamin D?
a. -
b. Fortified milk
c. Vegetable oils
d. Green leafy vegetables
e. Organ meats

214. The nurse is reviewing the laboratory fi ndings of a patient to assess the patient's nutritional status. The nurse understands that the laboratory fi nding that is the best indicator of inadequate protein intake is a:
a. High hemoglobin
b. -
c. High blood urea nitrogen
d. Low specifi c gravity
e. Low serum albumin

215. A patient of Asian heritage is recommended to follow a low-fat diet to lose weight. The nurse understands that a food low in fat that generally is consumed by members of an Asian population is:
a. Crispy noodles
b. Egg rolls
c. -
d. Hot and sour soup
e. Spareribs

216. A patient is scheduled for surgery and the nurse is teaching the patient about the importance of vitamin C in wound healing. Which source of vitamin C should the nurse include in the teaching plan?
a. Yogurt
b. Milk
c. -
d. Potatoes
e. Beans

217. The nurse is teaching a patient about the importance of balancing protein, carbohydrates, and fats in the diet. The nurse identifies that the teaching about carbohydrates is understood when the patient states, Carbohydrates are best known for providing:
a. -
b. Energy.
c. Minerals.
d. Vitamins.
e. Electrolytes.

218. A patient has been blind in one eye for several years because of the complications associated with diabetes mellitus. The patient is admitted to the hospital with a detached retina and resulting

loss of sight in the other eye. What should the nurse do to assist this patient with meals?
a. Encourage eating one food at a time according to the preference of the patient
b. Feed the patient
c. -
d. Explain to the patient where items are located on the plate according to the hours of a clock
e. Order fi nger foods that are permitted on the patient's diet

219. The nurse understands that the balance of calcium in the body is unrelated to:
a. -
b. Iron
c. Vitamin D
d. Tetany
e. Osteoporosis

220. A patient is admitted to the hospital with a history of liver dysfunction associated with hepatitis. The nurse understands that this patient may have problems with:
a. -
b. Emulsifying fats
c. Manufacturing red blood cells
d. Digesting carbohydrates
e. Reabsorbing water in the intestines

221. The nurse is assessing a patient who is admitted to the hospital with withdrawal from alcohol. The nurse knows that excessive alcohol intake directly contributes to health problems because it:
a. Accelerates the absorption of medications
b. Lengthens passage time of stool through the intestinal tract
c. Decreases the absorption of many important nutrients
d. Interferes with the absorption of glucose
e. -

222. An obese resident of a nursing home who is receiving a 1500-calorie weight reduction diet has not lost weight in the past 2 weeks. The nurse should:
a. Schedule a multidisciplinary team conference
b. Inform the primary care physician of the patient's lack of progress
c. -
d. Keep a log of the oral intake for 3 days
e. Instruct the patient to limit intake to 1000 calories per day

223. A patient with a Latino heritage is to eat a low-fat diet. The patient tells the nurse, I am going to have a hard time giving up my favorite family recipes. Which food should the nurse recommend that is low in fat and generally is included in the Latino culture?
a. Pasta
b. Refried beans
c. -
d. Salsa
e. Steamed fish

224. The nurse understands that the setting that is the organizational center of the United States health-care system is the:
a. Community setting
b. Clinic setting
c. Acute care setting
d. Long-term care setting
e. -

225. The nurse is providing dietary teaching to a group of adolescents recently diagnosed with diabetes mellitus. The nurse understands that many foods are ingested by the adolescent because of:
a. Pressure

b. Routine
c. -
d. Preference
e. Taste

226. When the nurse assesses patients in the following age groups, the nurse understands that the age group that has the greatest potential to demonstrate regression when ill is:
a. Infants
b. Young adults
c. -
d. Toddlers
e. Adolescents

227. The nurse identifies which word as being unrelated to principles of growth and development?
a. Sequential
b. Complex
c. -
d. Unpredictable
e. Integrated

228. The nurse working in a nursing home is providing care to a group of older adults. The decline in which system in the older adult most often in? uences the ability to maintain safety?
a. Respiratory
b. Cardiovascular
c. -
d. Sensory
e. Integumentary

229. One of the participants attending a parenting class asks the teacher, What is the leading cause of death during the ? rst year of life? Besides exploring the person's concerns, the nurse should respond:
a. -
b. Congenital anomalies
c. Sudden infant death syndrome
d. Preterm birth
e. Unintentional injuries