Simulated NCLEX-RN® CAT Tests 16

COMPREHENSIVE TEST 1 REVIEW QUESTIONS

1. You are making a home visit to a client who has the diagnosis of heart failure and is on daily diuretics. Considering the possibility of potassium deficiency, you will assess for

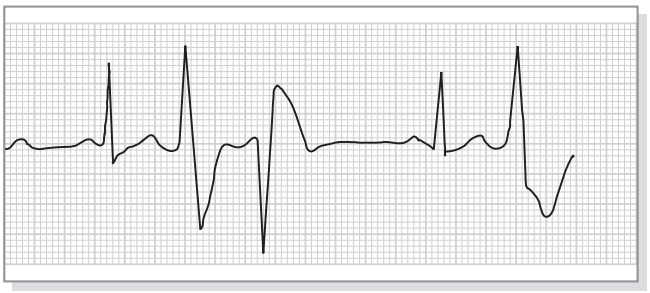
1. Pitting edema and excessive weight gain.
2. Muscle weakness, leg cramps, nausea, and fatigue.
3. Increased blood pressure and dyspnea.
4. Oliguria, restlessness, weakness, and hyperpnea.

2. You are assigned to care for a bedridden client and one of your nursing goals is to prevent pressure ulcers from developing. The priority nursing action would be to

1. Massage bony prominences that are reddened.
2. Provide for active and passive exercises.
3. Reposition the client every 2 hours.
4. Keep the skin moist and supple.

3. You are caring for a cardiac client and you observe the ECG rhythm strip presented below. You identify it as

1. Multifocal premature ventricular contractions (PVCs).
2. Ventricular tachycardia.
3. Third-degree heart block.
4. Normal sinus rhythm.



4. A male client has just been told his blood work indicates that he has a high iron level in his blood. An example of the foods he should eliminate from his diet is

1. Fish.
2. Beef.
3. Egg yolks.
4. Shellfish.

5. A client has a subtotal thyroidectomy and is returned from the recovery room. Immediate postoperative care would include correct positioning. The safe position for the client is

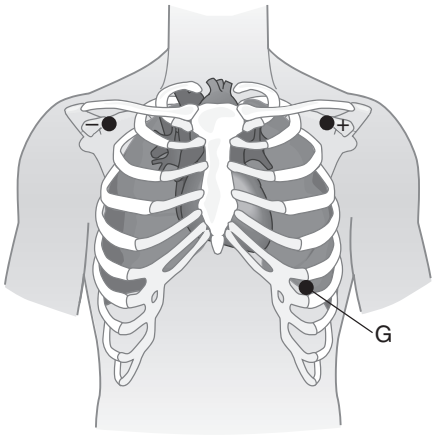
1. Semi-Fowler's with neck erect.
2. High-Fowler's with neck extended.
3. Semi-Fowler's with neck flexed.
4. Sims' position with neck extended.

6. A young man, age 25, fell from a ladder and broke his leg. He is placed in skeletal traction to reduce the fracture prior to surgery. Twenty-four hours after admission, he complains of shortness of breath and pain in his chest. In completing your nursing assessment of the client, you will particularly observe for

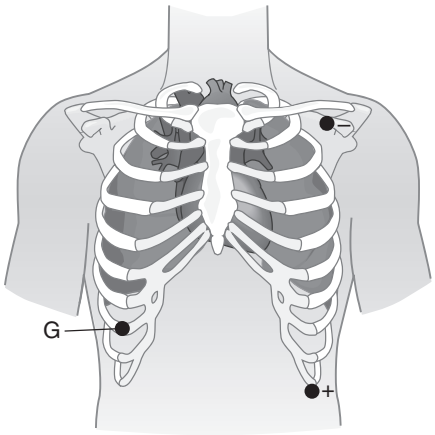
1. Developing pneumonia.
2. Developing fat embolus.
3. Cardiac complications.
4. Hypoxic condition.

7. You are caring for a client who requires telemetry monitoring. When placing a telemetry electrode for Lead I, looking at the heart's left lateral wall, would you place the negative and positive electrodes in position 1 or 2? _____ (Fill in the blank with 1 or 2.)

1.



2.



8. You are admitting a client for abdominal surgery the next day, and you observe that he appears very anxious. A priority intervention is to

1. Tell him there is nothing to worry about.
2. Suggest that he talk to his doctor.
3. Ask what he expects will happen tomorrow.
4. Ask if he is feeling anxious.

9. A 64-year-old client has been admitted to the Coronary Care Unit. He is diagnosed with an anterior septal myocardial infarction (MI) with lateral ischemia and potential for infarct extension. His orders include Nitropress (nitroprusside) drip and Dobutrex (dobutamine). The nurse understands that the rationale for ordering Dobutrex is to

1. Dilate veins and arteries.
2. Improve cardiac output.
3. Reduce hypertension.
4. Reduce heart rate.

10. A priority nursing intervention for a client with a suspected myocardial infarction who has just been admitted is to

1. Monitor his intake and output.
2. Explain to the client the relationship between heart work and need for O_2.
3. Intervene for anxiety management.
4. Insist on complete bed rest.

11. You are assigned a client with the diagnosis of intracranial pressure. Physician's orders include an IV of hypertonic solution, dextrose 10% in saline. What is the rationale for using this solution?

1. It reduces edema of the brain.
2. It provides needed fluid to maintain adequate intake and output balance.
3. This solution causes cells to expand or increase in size.
4. It expands extracellular volume.

12. Defibrillation is usually attempted first using _____ watt-seconds.

13. A female client has a cesium needle implanted in her cervix. She asks the nurse if she may get out of bed to go to the bathroom. The appropriate response is to tell her

1. She may not get out of bed while the needle is implanted.
2. She may get out of bed with the nurse's help.
3. The nurse will have to get a physician's order for her to get out of bed.
4. She must stay in bed, but she can move around to be more comfortable while the needle is implanted.

14. A 60-year-old female client has received the diagnosis of hypertension. Her blood pressure is 160/100. Which of the following symptoms would the nurse be likely to find in the assessment?

1. Dizziness and flushed face.
2. Drowsiness and confusion.
3. Faintness when getting out of bed.
4. Ataxia and tachycardia.

15. A mother calls the pediatric hotline and tells the nurse that her 3-year-old child has a virus and a fever. She asks how much aspirin she should give the child. The best response is

1. "You'll have to call your physician."
2. "Give her no more than three baby aspirin every 4 hours."
3. "Give her Tylenol (acetaminophen), not aspirin."
4. "Follow directions on the aspirin bottle for her age and weight."

16. Clients with hepatitis may have a regular diet ordered, unless they become increasingly symptomatic. The diet will then be modified to decrease the amount of

1. Carbohydrates.
2. Fats.
3. Fluids.
4. Protein.

17. Place in sequence from 1 to 4 the protocol for leaving an isolation room.

_____ 1. Take off foot socks.
_____ 2. Wash hands.
_____ 3. Remove gown.
_____ 4. Take off gloves.
_____ 5. Untie gown at waist.
_____ 6. Untie gown at neck.

18. In evaluating the condition of a child who has been treated for lead poisoning, the nurse will assess for the complication of

1. Glomerulonephritis.
2. Reye's syndrome.
3. Multiple sclerosis.
4. Tetany.

19. A client with a gunshot wound to the chest had a right-sided pneumothorax. The physician inserted two chest tubes into the pleural cavity, and connected the water-seal drainage system to a walled-in suction. To assist in chest drainage, the nurse will place the client in the position of

1. High-Fowler's.
2. Supine.
3. Right-side, low-Fowler's.
4. Left-side, semi-Fowler's.

20. The nurse knows that the client understands the principles of managing type 1 diabetes when he says that he maintains his health status with

1. Oral hypoglycemics.
2. A diabetic diet (American Diabetes Association; ADA) regimen.
3. Weight reduction.
4. Insulin injections.

21. A 6-month-old child is brought to the clinic with a suspected diagnosis of cerebral palsy. In the initial assessment of his developmental status, the nurse would be likely to find that he

1. Tracks an object with his eyes.
2. Needs to be propped to sit up.
3. Smiles when he sees his mother.
4. Exhibits a pincer grasp.

22. A 41-year-old client has had recurrent dull flank pain, nausea, and vomiting for 24 hours. He is admitted to the hospital for a genitourinary work-up. Which of the following orders written by his physician would be considered a priority and thus carried out promptly?

1. Keep accurate intake and output records.
2. Strain all urine.
3. Record temperature every 4 hours.
4. Administer an antiemetic every 4 hours.

23. When a person is experiencing severe stress, the nurse would recognize behaviors such as

1. Restlessness and anxiety.
2. Crying and upset demeanor.
3. Laughing and amusement.
4. Assertiveness and determination.

24. A 60-year-old male client with chronic osteoarthritis is severely debilitated. Celestone (betamethasone) therapy has been ordered for him. The nurse will advise the client to take a single, daily dose of the drug

1. At bedtime with a glass of milk.
2. With orange juice at bedtime.
3. With milk in the morning.
4. On an empty stomach in the morning.

25. In completing a full assessment on a client, it is important to identify breathing patterns. The abnormal breathing pattern depicted in the drawing is

1. Bradypnea.
2. Apnea.
3. Kussmaul's.
4. Hyperpnea.

26. In the preoperative period for correction of pyloric stenosis, nursing care for a baby will include placing him in

1. A prone position.
2. Semi-Fowler's position on his left side.
3. Fowler's position or on his right side.
4. Sims' position.

27. An elderly client with heart disease has orders for Diuril (chlorothiazide). Serum potassium levels should be evaluated for a client on diuretics. To determine if the potassium level is low, the nurse would assess for

1. Dyspnea.
2. Skeletal muscle weakness.
3. Hypertension.
4. Headache.

28. The first postoperative day following surgery for a detached retina, the nursing care plan will include the intervention to

1. Turn, cough, and deep-breathe every 2 hours.
2. Allow the client up out of bed ad lib.
3. Allow the eye patch to be removed during the day.
4. Give the client a complete bed bath.

29. A 43-year-old male is brought to the mental health unit by the police for vandalizing his neighbor's car, but says that it was his neighbor's fault. The client seems bright, articulate, and oriented upon admission and is diagnosed with paranoid disorder. A person with a paranoid disorder can be described as exhibiting

1. Delusions that are less firmly established than those of schizophrenia.
2. None of the other classical symptoms of schizophrenia.
3. Delusions that are usually more bizarre than schizophrenic delusions.
4. Emotions and behavior not appropriate to the content of the delusional system.

30. A client the nurse is assessing appears to be having respiratory difficulty. The condition that leads the nurse to determine he is hypoxic is

1. Bradycardia.
2. Agitation.
3. Mucosal cyanosis.
4. Decreased blood pressure.

31. A client with a partial colectomy was returned to the unit at 1:30 PM. During a 6:00 PM assessment, the nurse observes the following data. Which sign or symptom would require the earliest intervention?

1. Dressing that is moderately saturated with serosanguineous drainage.
2. Warm and reddened area on the client's left calf.
3. Distended bladder that is firm to palpation.
4. Decrease in breath sounds on the right side.

32. A 48-year-old female has been experiencing irregular menstrual periods, hot flashes, and mood swings for the last 15 months. She has come to the clinic for her yearly checkup and says she has a number of questions. Her first question is, "When can I stop using birth control methods?" The most appropriate reply for the nurse to give her is

1. "Anytime now because your periods have been irregular for more than 12 months."
2. "You should use a birth control method until your 50th birthday."
3. "It depends on whether you have regular menses."
4. "You should use a birth control method until you have missed your period for 24 consecutive months."

33. The nurse will know that the client understands how to maintain an acid urinary pH by dietary means when he says he should avoid

1. Prunes and figs.
2. Cereals and breads.
3. Meat, fish, and poultry.
4. Milk.

34. A client's physician orders an Phyllocontin (aminophylline) IV infusion at 2 mg per minute. A safety intervention for administering this medication is to

1. Use an IV controller.
2. Protect the IV bottle from sunlight.
3. Give the client a test dose of aminophylline first.
4. Run the IV at 1 mg per minute for 1 hour before increasing the dose.

35. Charting is one of the nurse's most important functions. Which of the following statements identifies the most important purpose of charting?

1. To communicate to other members of the client's healthcare team.
2. To evaluate the staff's performance.
3. To provide information for a nursing audit.
4. To enable physicians to monitor nursing care.

36. When moving the client up in bed, the nurse would remove the pillow and place it at the head of the bed. The rationale for this action is to

1. Get it out of the way.
2. Prevent the client from striking his head.
3. Facilitate completing the procedure.
4. Enable the client to push from his knees.

37. A client on the unit is observed to have severe anxiety. The priority nursing action is to

1. Remain with the client while she is anxious.
2. Provide an activity to get the client's mind off feeling anxious.
3. Encourage the client to identify, discuss, and find the cause of her anxiety.
4. Establish a nurse–client relationship.

38. An elderly client on bed rest has developed a pressure ulcer. The priority nursing diagnosis is

1. Altered health maintenance.
2. Altered tissue perfusion.
3. Dysfunctional grieving.
4. Self-care deficit.

39. A client with AIDS is being discharged to home. Client teaching for home care should include which one of the following concepts?

1. Good household cleaning practices will prevent the spread of infection.
2. Any equipment that comes in contact with blood or body fluids needs to be disinfected for 24 hours.
3. AIDS clients should not be responsible for food preparation.
4. Soiled dressings should be burned, not placed in a trash container.

40. Percussion, vibration, and postural drainage (PVD) are ordered for a 15-year-old client hospitalized for pneumonia. Prior to providing this intervention, the priority action is to

1. Instruct the client in diaphragmatic breathing.
2. Assess vital signs.
3. Auscultate lung fields.
4. Assess characteristics of her sputum.

41. To prevent venous stasis, a client is to be measured for knee-high elastic hose. The nursing intervention is to measure

1. Leg length from heel to buttocks and calf circumference while he is standing.
2. Ankle and calf circumference while he is standing.
3. Leg length to the knee when he is lying down.
4. Calf circumference and leg length from bottom of heel to bend of knee.

42. During the first 10 minutes of a blood transfusion, the nurse will infuse the blood at how many drops per minute?

1. 10 gtts/min.
2. 20 gtts/min.
3. 40 gtts/min.
4. According to physician's orders.

43. The nurse explains to the client that the major difference between a plaster of Paris and a synthetic cast is that the

1. Drying time is prolonged with a synthetic cast.
2. A synthetic cast is less restrictive.
3. A plaster cast requires expensive equipment for application.
4. A synthetic cast is more effective for immobilizing severely displaced bones.

44. If a client were suspected to have developed atelectasis, a major postoperative complication, which of the following assessment findings would be most conclusive?

1. Bradycardia.
2. Temperature of 102°F.
3. Dullness to breath sound percussion.
4. Restlessness.

45. What is the most significant factor in identifying a normal ECG strip?

1. P-R interval falls before the QRS complex on the strip.
2. T wave is in the inverted position on the strip.
3. P-R interval is no longer than 0.12 second.
4. QRS interval is no longer than 0.20 second.

46. A 25-year-old client has been admitted to the psychiatric unit with a diagnosis of acute schizophrenic disorder. He is unkempt and speaks in unclear sentences. In the first nurse–client interaction, the client says, "Yesternoon the sunmoon went over the rover to see the lawnmower." The nurse knows that the client is manifesting

1. A delusion.
2. Disordered speech.
3. A hallucination.
4. Disturbance of affect.

47. A client is to receive codeine for pain with her diagnosis of head injury. The nurse would also expect the physician to order a stool softener. The reason for this order is to

1. Prevent paralytic ileus.
2. Prevent bowel stasis.
3. Avoid straining during evacuation.
4. Prevent complications from the codeine.

48. A client was hospitalized briefly with an episode of urolithiasis until a stone was passed. She has now been readmitted with complaints of low back pain, nausea, and diarrhea. Formulating a care plan for this client, the nurse knows that a priority goal is to

1. Record intake and output.
2. Provide appropriate diet therapy.
3. Limit fluid intake initially.
4. Encourage fluids to 3000 mL per day.

49. An 18-year-old client was hospitalized for anorexia nervosa. After 1 week of treatment, the nursing team met to evaluate the client's progress and improvement. Signs of improvement would be indicated by

1. Talking about going home.
2. Attending all groups.
3. Gaining 4 pounds.
4. Expressing a desire to "get into shape" again.

50. A client with peptic ulcer disease has had a subtotal gastric resection. His postoperative pain can most effectively be controlled by

1. Medicating for pain before the previous dose totally wears off.
2. Medicating for pain at least every 6 hours.
3. Waiting until the client requests pain medication.
4. Alternating a maximum dose with a minimum dose.

51. An 18-year-old client is hospitalized after an accident in which she lost the use of her legs. The nurse observes her sitting in a wheelchair crying and she says, "Go away; no one can help me." The nurse's best response is to say

1. "It will help to talk about it."
2. "I'll go away, but I'll come back in 30 minutes and perhaps we can talk."
3. "I'd like to help. Can you tell me about what's wrong?"
4. "Crying doesn't help; perhaps talking will make you feel better."

52. A 52-year-old male client has an admitting diagnosis of rheumatoid arthritis. He is started on Indocin (indomethacin), an anti-inflammatory medication. Part of the care plan is to assess side effects of the drug. The nurse would assess for

1. Hypertension.
2. Tinnitus.
3. Joint stiffness.
4. GI disturbance.

53. Transmission-based respiratory precautions indicate that when the disease is airborne, the precaution(s) that must be used is (are)

1. Gloves.
2. A mask.
3. A gown.
4. Full isolation gear.

54. The severity of a burn is the combination of the depth of the burn and the extent of body surface area (BSA) involved. Which of the following factors is the first priority when assessing the severity of the burn?

1. Age of the client.
2. Associated medical problems.
3. Location of the burn.
4. Cause of the burn.

55. A female client is admitted to the hospital with an obstruction just proximal to her old ileostomy stoma from surgery 6months ago. For a client with an ileostomy, which one of the following foods should be eliminated in the diet because it could cause obstruction?

1. Cabbage.
2. Corn.
3. Red meat.
4. Radishes.

56. The priority nursing care to administer to a client in prehepatic coma is to

1. Maintain protein intake at a moderate or normal level.
2. Administer neomycin and lactulose to reduce bacterial production and ammonia.
3. Maintain a mildly sedative state to reduce stress.
4. Offer the client adequate fluids by mouth to maintain fluid and electrolyte balance.

57. An important initial goal for a client just admitted to the psychiatric unit because he attacked a friend is to

1. Establish a relationship and set behavioral limits.
2. Explain to the client that his behavior was unacceptable and dangerous.
3. Explore the truth of the client's statements.
4. Set behavioral limits on the client.

58. A client has just returned from surgery for evacuation of a subdural hematoma. Immediately after the evacuation, the priority intervention is to

1. Observe for cerebrospinal fluid (CSF) leaks around the evacuation site.
2. Assess for an increase in temperature, indicating infection.
3. Establish and maintain a patent airway.
4. Observe for signs of increasing intracranial pressure.

59. The nurse is assisting a 9-year-old child's mother to plan her care at home following discharge after an acute asthma attack. In the discharge planning, the growth and development stage according to Erikson that would be important to take into account is

1. Autonomy versus shame and doubt.
2. Initiative versus guilt.
3. Industry versus inferiority.
4. Identity versus role confusion.

60. You are tabulating a client's intake and output record for your shift.
1 cup is 6 ounces. 1 bowl is 8 ounces.

INTAKE	IV	= 1000 mL normal saline
	Coffee	= 1 cup
	Water	= 6 ounces
	Soup	= 1 bowl
	Jello	= 3 ounces
	Ice cream	= 3 ounces

How many milliliters will you document as the client's intake? _____ mL.

61. Assessing urine of a client with suspected cholecystitis, the nurse expects that the color will most likely be

1. Pale yellow.
2. Greenish-brown.
3. Red.
4. Yellow-orange.

62. An 18-year-old client has been in a motorcycle accident and sustained a head injury. The nurse admitting him notices that his IV is infusing at 125 mL/hour. Until there are orders for the IV rate, the nursing intervention is to

1. Slow the rate to 20 mL/hour.
2. Continue the rate at 125 mL/hour.
3. Slow the rate to 50 mL/hour.
4. Increase the rate to 150 mL/hour.

63. An 11-year-old client with cystic fibrosis will take pancreatic enzymes three times per day. The nurse will know that the child's mother needs more education on the purpose and timing of these enzymes if she says

1. "They should be taken at mealtimes, three times a day."
2. "They should be given following breakfast, lunch, and dinner."
3. "The purpose of the enzymes is to help digest the fat in foods."
4. "My daughter should take them prior to meals."

64. For a 38-year-old client with chronic lymphocytic leukemia, a priority nursing diagnosis is

1. Risk for infection.
2. Impaired skin integrity.
3. Altered issue perfusion.
4. Fluid volume deficit.

65. A client, age 60, has been admitted to the hospital with a diagnosis of right ventricular failure. With a central venous line in place, the nurse would assess the central venous pressure (CVP) reading. Considering the diagnosis, the CVP reading would be expected to be

1. 0 to 2 mm Hg.
2. 5 to 20 cm H_2O
3. 8 to 10 mm Hg.
4. 15 to 20 cm H_2O.

66. A client is brought into the emergency room bleeding profusely from a deep laceration on his left lower forearm. After observing standard precautions, the initial nursing action should be to

1. Apply a tourniquet just below the elbow.
2. Apply pressure directly over the wound.
3. Cleanse the wound to determine the extent of damage.
4. Elevate the limb and apply ice to decrease blood flow.

67. A client is admitted to the psychiatric unit with a diagnosis of anxiety disorder. Effective nursing measures to help this client cope with anxiety would include

1. Giving her some responsibility for manipulating the environment.
2. Removing all disturbing factors in the environment.
3. Encouraging her to read to provide distraction.
4. Remaining close by her and allowing her to express her feelings.

68. A client is brought into the emergency room with an admitting diagnosis of delirium tremens (DTs). After admitting the client to a private room, the priority intervention is to

1. Administer the standing order of Valium (diazepam).
2. Put up the side rails of the bed.
3. Attempt to get a history to validate if he really is experiencing DTs.
4. Keep the room very quiet with lights down to minimize stimulation.

69. A client is admitted to the labor room. She tells the nurse that contractions started 2 hours ago, and she has soaked a perineal pad with bright-red blood in the past 10 minutes. The nurse suspects a placenta previa. The first nursing action is to

1. Perform a vaginal examination to determine cervical dilatation.
2. Notify the physician immediately.
3. Order blood to be typed and cross-matched.
4. Apply an external fetal monitor.

70. You are discharging a client with the diagnosis of angina. The physician is sending the client home with a prescription for Covera (verapamil). Teaching will include telling the client that the main use of this medication is to

1. Increase the pumping ability of the heart.
2. Cause coronary vasodilation and increase myocardial oxygenation.
3. Increase the heart rate.
4. Decrease low-density lipoprotein (LDL) levels.

71. A 3-year-old child is brought to the hospital by his mother, who explains that the child has been sick for several days and has had a "barklike" cough. The nurse assesses nasal flaring. The nursing action is to

1. Tell him to cough.
2. Give four back blows.
3. Ask him to speak.
4. Obtain an immediate order for oxygen.

72. If a child has impetigo contagiosa, to prevent further spread of the disease the nurse should instruct the mother to

1. Strictly isolate this child from others in his family.
2. Wash toys and other objects the child uses with soap and very hot water.
3. Take all other children in the family to the physician to be vaccinated for this disease.
4. Not take any special precautions.

73. A client is admitted to the maternity unit 2 weeks before her due date. She is there for evaluation because

she is experiencing polyhydramnios. The nurse understands that this diagnosis means that

1. There is the normal amount of amniotic fluid, thinner in volume.
2. A less-than-normal amount of amniotic fluid is present.
3. An excessive amount of amniotic fluid is present.
4. A leak is causing fluid to accumulate outside the amniotic sac.

74. A client is unable to sleep. He is pacing the floor, head down, and wringing his hands. Recognizing that he is anxious, the nurse's most appropriate intervention is to

1. Encourage him to go back to bed.
2. Give him his PRN sleeping medication.
3. Let him know that the nurse is interested and willing to listen.
4. Explore with him the alternatives to pacing the floor.

75. A 32-year-old client in active labor was admitted through the emergency room. She is having contractions every 2 minutes, lasting 50 to 60 seconds. A vaginal exam shows she is 6 cm dilated and 100% effaced. After the exam, the FHR is 140 and regular and her blood pressure 80/40. The first nursing action would be to

1. Place the client in knee–chest position.
2. Take the blood pressure again to check accuracy.
3. Call the physician immediately.
4. Turn the client on her side and check her blood pressure.

COMPREHENSIVE TEST 1 ANSWERS WITH RATIONALE

1. (2) Thiazide diuretics are potent antihypertensives but may lead to the electrolyte imbalance and loss of potassium. The symptoms you would assess for are muscle weakness, leg cramps, hypotension, and even arrhythmias. Options (1) and (3) are sodium excess symptoms and option (4) is potassium excess.

   NP:A; CN:PH; CA:M; CL:A

2. (3) The most important intervention to stimulate circulation and prevent ulcers is to change the client's position every 2hours. It is no longer accepted practice to massage bony prominences because it can lead to deep tissue trauma (1). Option (2) is important, but not the priority intervention. The skin should be kept dry and free of drainage (4).

   NP:I; CN:S; CA:M; CL:A

3. (1) The rhythm strip is showing *multifocal PVCs*. The client could be hypoxic or in acidosis with a diagnosis of chronic obstructive pulmonary disease (COPD) or diabetes mellitus. Lidocaine may be administered to decrease automaticity and increase the electrical stimulation threshold of the ventricles.

   NP:A; CN:PH; CA:M; CL:AN

4. (3) The client should eliminate egg yolks, which are high in iron. Beef is high in protein and cholesterol; fish is also high in protein, and shellfish is high in sodium and iodine.

   NP:AN; CN:H; CA:M; CL:C

5. (1) Semi-Fowler's with the neck erect is the position of choice to maintain respiratory status. The objective is to decrease pressure on the suture line and prevent edema formation, which could cause respiratory distress.

   NP:I; CN:PH; CA:S; CL:A

6. (2) The priority assessment is for a fat embolus, which can occur from 24 to 96 hours after fracture of a long bone. The first symptoms may be pulmonary, including dyspnea and respiratory depression. It is critical that this diagnosis be made early to stabilize the client. Arterial blood gases (ABGs) will help to confirm the diagnosis.

   NP:A; CN:PH; CA:M; CL:A

7. (1) The answer is 1 because this position is where the lead records activity between a negative electrode (below the right clavicle) and a positive electrode (below the left clavicle). This lead records activity at (looks at) the heart's left lateral wall. Illustration 2 shows Lead III, which records activity at (looks at) the left inferior wall.

   NP:P; CN:PH; CA:M; CL:A

8. (3) Determining what the client knows about the surgical procedure and expects to happen will give you data about how to intervene. Fear of the unknown increases anxiety and stress. The first two interventions will close off communication, and answer (4) is too direct and may result in a negative response.

   NP:I; CN:PS; CA:S; CL:A

9. (2) The primary objective in giving Dobutrex, a sympathomimetic agent, is to improve cardiac output. It does not cause an excessive increase in heart rate as a side effect. Nitropress is an arterial dilator and a venodilator. Diuretics would reduce preload and lower hypertension, and beta blockers would reduce heart rate.

   NP:AN; CN:PH; CA:M; CL:C

10. (3) The priority intervention in this situation is to perform anxiety management, because anxiety (as well as pain) will stimulate sympathetic cardiac responses,

Coding for Questions/Answers Abbreviations: Nursing Process: NP, Assessment: A, Analysis: AN, Planning: P, Implementation: I, Evaluation: E; Client Needs: CN, Safe, Effective Care Environment: S, Health Promotion and Maintenance: H, Psychosocial Integrity: PS, Physiological Integrity: PH; Clinical Area: CA, Medical Nursing: M, Surgical Nursing: S, Maternal/Newborn Nursing: MA, Pediatric Nursing: P, Psychiatric Nursing: PS; Cognitive Level: CL, Knowledge: K, Comprehension: C, Application: A, Analysis: AN.

which in turn will increase heart work, a risk for more cardiac damage. Answers (1) and (2) may be important, but are not the priority. Activity should be minimized, but complete bed rest is not usually ordered.

NP:I; CN:PS; CA:M; CL:AN

11. (1) A hypertonic solution is a solution with higher osmotic pressure than blood serum. It is used for intracranial pressure because it reduces edema by rapid movement of fluid out of the ventricles into the bloodstream. Option (2) describes effects of a hypotonic solution, which causes cells to expand or increase in size (3). Isotonic solutions expand extracellular volume.

    NP:P; CN:PH; CA:M; CL:C

12. The answer is *200*. 200 watt-seconds is the point at which defibrillation should be started, because electric shock is damaging to the myocardium. You would proceed, if necessary, to 300 J, then to 360 J (one joule [J] = one watt-second).

    NP:I; CN:S; CA:M; CL:A

13. (1) While the sealed source is implanted, the client must remain on bed rest, and movement is restricted to prevent dislodging the radiation source. The client must remain on her back and should not turn or move in bed.

    NP:I; CN:PH; CA:S; CL:A

14. (1) Cardinal symptoms are dizziness and flushed face as well as headache, tinnitus, and epistaxis. Drowsiness and confusion (2) occur in hypertensive crisis, and faintness (3) would occur in hypotension.

    NP:A; CN:PH; CA:M; CL:C

15. (3) Children from 2 months to adolescence are advised not to take aspirin for a virus infection due to the connection to Reye's syndrome, an acute encephalopathy condition. Tylenol is the treatment of choice for any virus infection.

    NP:I; CN:PH; CA:P; CL:A

16. (4) With liver cell damage, the liver cannot break down and eliminate the protein. Protein needs to be decreased until symptoms dissipate.

    NP:P; CN:PH; CA:M; CL:C

17. The answers are *5 4 6 3*. You first untie the gown at waist, take off gloves, untie gown at neck (which is clean), and remove gown. Washing hands would be the last step.

    NP:I; CN:H; CA:M; CL:A

18. (4) Following therapy, children can develop tetany because the chelating agent, edetic acid (EDTA), will take out calcium along with the lead. Therefore, the nurse will monitor for hypocalcemia.

    NP:A; CN:PH; CA:P; CL:AN

19. (4) Positioning a client on the left side will assist in drainage, and semi-Fowler's will assist in breathing. The client can usually be turned to both sides and back.

    NP:I; CN:PH; CA:M; CL:A

20. (4) The insulin dosage is generally given once or twice daily. It is either intermediate-acting insulin alone or in conjunction with short-acting insulin. With type 1 diabetes, the pancreatic beta cells are not producing insulin, so insulin must be given. Diet is also important for both types 1 and 2; frequently type 2 diabetes can be controlled with a diabetic diet (2) or with a combination of oral hypoglycemics (1) and diet.

    NP:E; CN:H; CA:M; CL:C

21. (2) At 6 months of age, the child should be able to sit by himself. This delayed developmental milestone is frequently seen in children with cerebral palsy. A neat pincer grasp (4) is not expected until 10 to 11 months of age. The other two abilities would be present before 6 months of age.

    NP:A; CN:H; CA:P; CL:C

22. (2) The client has symptoms indicative of a urinary calculus; therefore, it is important to strain all the urine to detect whether the stone has passed and confirm the diagnosis.

    NP:P; CN:PH; CA:M; CL:A

23. (2) Crying and being upset are typical behaviors experienced when a person is under stress. Restlessness and anxiety (1) might be present, but they are not typical responses. Laughing and humor (3) relieve stress. Assertiveness and determination (4) are not responses to stress.

    NP:AN; CN:H; CA:PS; CL:C

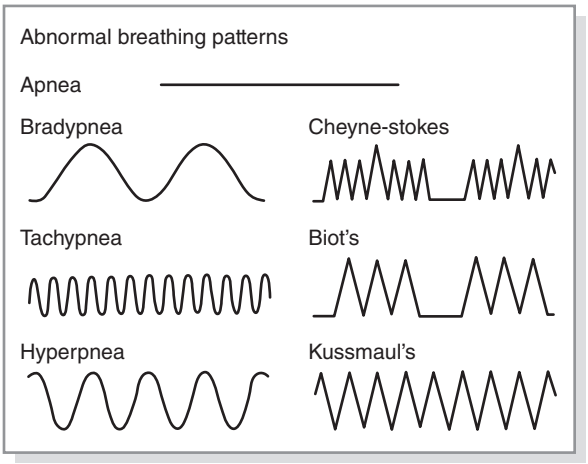
24. (3) A single dose in the morning promotes better results and less toxicity. It is given with milk to reduce gastrointestinal (GI) irritation.

    NP:I; CN:PH; CA:M; CL:A

25. (1) Bradypnea—slow, regular respirations; rate is below 10/minute. Tachypnea is increased rate, above 24/minute.

Biot's are abrupt interruptions between a faster, deeper rate. Kussmaul's respirations are deep, gasping breaths.

NP:A; CN:PH; CA:M; CL:A



26. (3) Many infants are fed in a semi-Fowler's or Fowler's position with either thick formula or small frequent feedings. They are best maintained in a Fowler's position or lying on their right side to facilitate gastric emptying following feeding.

    NP:P; CN:H; CA:P; CL:C

27. (2) Skeletal muscle weakness is a result of low potassium levels in the blood; potassium is required for normal muscle function. Hypotension may occur later, as well as cardiac arrhythmias and tachycardia. Dyspnea (1) and headache (4) are specific indications of hypokalemia.

    NP:E; CN:PH; CA:M; CL:A

28. (4) A complete bath in bed is the most likely choice, as the client will still have patches on both eyes and be on bed rest. Coughing could increase intraocular pressure, which could lead to hemorrhage.

    NP:P; CN:PH; CA:S; CL:C

29. (2) Paranoid disorders are characterized by delusions of persecution but not by the other classic symptoms of schizophrenia, such as associative looseness, affective disturbance, autism, and ambivalence. Clients with this disorder have emotional behaviors that are appropriate to the content of the delusional system.

    NP:AN; CN:PS; CA:PS; CL:C

30. (3) Hypoxia is defined as inadequate oxygenation of the tissues. The quantity of oxygen delivered to the tissues depends on the flow of blood to the tissues and the oxygen content of the blood. Mucosal cyanosis is an indication of hypoxia. The client would be likely to also exhibit tachycardia, hypertension, and restlessness.

    NP:AN; CN:PH; CA:M; CL:A

31. (3) Inability to void after surgery is a common problem. It is important to be aware of the client's output for several reasons: to ensure adequate intake, to detect renal problems, and to assess for blood pressure problems. Solution to this problem is catheterization (with a physician's order). The dressing should be closely observed but is not presently a problem. The area on the calf is probably thrombophlebitis and should be reported to the physician immediately. The breath sounds are due to potential lung problems and can be improved by turning, coughing and deep-breathing.

    NP:I; CN:S; CA:S; CL:AN

32. (4) Usually 24 months after menstruation ceases is advised as the time at which a woman should continue using birth control to avoid pregnancy. It is important to reinforce the possibility of pregnancy in the presence of irregular menses.

    NP:I; CN:H; CA:MA; CL:A

33. (4) Of the listed foods, milk has alkaline ash. All of the other foods could be included in the diet to maintain an acid urine.

    NP:E; CN:PH; CA:M; CL:C

34. (1) The infusion of all IV drugs that affect the central nervous system (CNS) should be carefully monitored, and an IV controller is essential for accurate monitoring. Toxic levels of aminophylline, a bronchodilator, could cause arrhythmias or seizures.

    NP:I; CN:S; CA:M; CL:A

35. (1) All the answers except (4) are purposes of charting. Answer (1) is the most inclusive and, therefore, the best answer.

    NP:AN; CN:S; CA:M; CL:C

36. (2) With no cushion, the client may hit his head as he is moved up in bed. With the pillow there, his head will be protected.

    NP:AN; CN:S; CA:M; CL:A

37. (1) Staying with a client is the most effective way to reduce anxiety. A nurse–client relationship is important, but it will take time to establish. The nurse should

proceed at the client's pace and not push her to deal directly with the source of her anxiety.

NP:P; CN:PS; CA:PS; CL:A

38. (2) Blood supply may be altered to the wound area leading to an alteration in tissue perfusion. While health maintenance and self-care deficit are appropriate areas of concern, the highest priority nursing diagnosis would be altered tissue perfusion.

NP:AN; CN:PH; CA:M; CL:A

39. (1) Clean surfaces, including floors, showers, and kitchens, prevent contact with the HIV virus. Therefore, good cleaning practices will prevent the spread of viruses and bacteria. Equipment does not require being disinfected for 24 hours.

NP:P; CN:PH; CA:M; CL:C

40. (3) Auscultating lung fields provides knowledge of which lung areas are most affected. These areas should be treated first, as many clients cannot tolerate a 30-minute procedure. Assessing vital signs will be done on every shift, but does not need to be done before PVD.

NP:A; CN:PH; CA:M; CL:A

41. (4) The client should be in dorsal recumbent position with the bed elevated. For knee-high hose, measurement is taken from the Achilles tendon to the popliteal fold and the mid-calf circumference.

NP:I; CN:PH; CA:M; CL:A

42. (2) Infusing blood at 20 gtts/minute allows adequate time to observe for possible transfusion reactions. A faster flow rate would allow too much blood into the system before noting the reaction.

NP:I; CN:PH; CA:M; CL:AN

43. (2) A synthetic cast is less restrictive, is lighter in weight, and requires less drying time than a plaster of Paris cast.

NP:AN; CN:PH; CA:S; CL:C

44. (2) The temperature usually reaches 102°F within the first 48 hours postoperatively. Restlessness and dullness to percussion might be present but the increase in temperature is the most significant finding. Tachypnea, not bradycardia, occurs in atelectasis.

NP:E; CN:PH; CA:M; CL:AN

45. (1) The P-R interval indicates atrial contraction; therefore, it should precede the QRS complex, which is indicative of ventricular contraction.

NP:A; CN:PH; CA:M; CL:A

46. (2) This is an example of disordered speech where the ideas do not connect to each other and are expressed in garbled language. A delusion is a false belief. This example represents disturbed thoughts. A hallucination is an unwilled sensory perception with no basis in reality. Affect refers to feelings that are flat or inappropriate; a disturbance in this area is typical of this disorder.

NP:A; CN:PS; CA:PS; CL:C

47. (3) Codeine is constipating and it is important to avoid straining during evacuation so that the intracranial pressure (ICP) is not increased. Bowel stasis is not the issue. A complication of codeine ingestion is constipation and this may increase ICP, but answer (3) is more specific than (4).

NP:AN; CN:PH; CA:M; CL:AN

48. (4) Fluids are essential to flush the kidneys and urinary system. The other goals such as intake and output are important, but not the top priority. Diet consultation will be a later goal to be implemented before discharge and after the chemical composition of the stones has been determined.

NP:P; CN:PH; CA:M; CL:A

49. (3) Gaining 4 pounds is concrete evaluation criteria for her positive progress. She may talk about going home and continue to not deal with her problem. The client may attend all groups and never deal with her problem. Answer (4) is incorrect because it may indicate the client's continual obsession with her altered body image.

NP:E; CN:PS; CA:PS; CL:A

50. (1) Immediate postoperative pain can best be controlled by medicating before pain becomes severe—usually every 4 hours. Waiting until the effect of the medication wears off is not therapeutic, nor is alternating doses.

NP:P; CN:PH; CA:S; CL:C

51. (2) The nurse is responding to the client's wishes, but coming back lets her know the nurse is concerned and open to talk about her feelings. Asking the client to talk right now is putting an extra demand on her. Telling her that crying doesn't help is denying her feelings.

NP:I; CN:PS; CA:PS; CL:A

52. (4) An expected side effect of the anti-inflammatory medication, Indocin, is GI disturbance. Hypertension is not an expected side effect of this drug. Tinnitus is a side effect of salicylates.

NP:E; CN:PH; CA:M; CL:C

53. (2) A mask must be used for respiratory precautions when the disease is airborne; for droplet precautions, a mask is indicated when working within 3 feet of the client. Contact precautions do not indicate a mask, but require gloves.

NP:P; CN:S; CA:M; CL:A

54. (3) The location of the burn requires priority assessment, as burns surrounding the face, neck, and upper extremities can lead to respiratory involvement.

NP:A; CN:PH; CA:M; CL:A

55. (2) Corn can cause obstruction of the ileostomy and thus should be avoided. Answers (1) and (4) cause flatus and usually are avoided by clients as well.

NP:A; CN:H; CA:S; CL:A

56. (2) Neomycin exerts a powerful effect on intestinal bacteria and lactulose decreases ammonia by pulling ammonia into the bowel. Protein should be reduced in the diet, sedatives restricted, and intravenous intake started to maintain fluid and electrolyte balance.

NP:I; CN:PH; CA:M; CL:A

57. (1) Initiating a relationship that includes limit setting is the first priority. To do any interacting with a client requires a beginning relationship before explaining, exploring the truth, or setting limits.

NP:P; CN:PS; CA:PS; CL:C

58. (3) A patent airway will establish adequate oxygenation and prevent carbon dioxide buildup. All of the nursing interventions listed would be carried out for the client; however, the most important one is to prevent cerebral hypoxia, which contributes to cerebral edema. The acid–base imbalance and hypoxia are often mistaken for signs of increased intracranial pressure, leading to unnecessary surgical intervention.

NP:I; CN:PH; CA:S; CL:AN

59. (3) According to Erikson's developmental stages, a school-age child is working on developing industry versus inferiority. This is the stage where children need to engage in tasks and activities that they can carry through to completion. Autonomy is the stage for the toddler; initiative is found in the preschooler, and identity is the stage for puberty and adolescence.

NP:AN; CN:PS; CA:P; CL:C

60. The total intake is *1780* mL. The nurse would change the ounces to milliliters and add: 1000 mL IV; 1 cup coffee = 180 mL; 6 ounces water = 180 mL; 1 bowl soup = 240 mL; 3 ounces Jello = 90 mL; and 3 ounces ice cream = 90 mL.

NP:I; CN:PH; CA:M; CL:A

61. (4) The presence of bile in the urine would lead to a yellow-orange or brown-colored urine. Red-colored urine may indicate the presence of blood or a disease in the body.

NP:AN; CN:PH; CA:M; CL:C

62. (3) Because of the potential of increased cerebral fluid, fluids will be given very sparingly at approximately 50 mL/hour before the nurse has a physician's order. 20 mL/hour is barely a "keep open" rate.

NP:I; CN:PH; CA:M; CL:AN

63. (2) The purpose of the pancreatic enzymes is to replace the enzymes unavailable in the child's system that assist with the digestion of fats. Therefore, they should be taken at or prior to—not following—the ingestion of food.

NP:E; CN:PH; CA:P; CL:A

64. (1) Immature white blood cells predispose the client to infections, so this nursing diagnosis is a priority. Fluid volume deficit may also be an important nursing diagnosis, because the client may be prone to bleeding. It does not, however, have as high a priority as (1).

NP:AN; CN:PH; CA:M; CL:C

65. (4) An elevated central venous pressure is expected in this client due to the increased right atrial pressure. The normal reading is 5 to 10 cm of water pressure.

NP:E; CN:PH; CA:M; CL:AN

66. (2) The initial nursing action is to stop the bleeding with direct pressure over the wound unless there is glass in the wound. If that is not successful, the nurse then has the option of using elevation, pressure on the supplying arteries, and, as a last resort, a tourniquet.

NP:I; CN:PH; CA:S; CL:AN

67. (4) Once anxiety has risen to a high level, staying near the client and allowing her to ventilate will help decrease anxiety. If the client chooses to pace around the unit, the nurse might walk with her. Answers (1) and (3) will not be effective in reducing anxiety. Answer (2) is unrealistic.

    NP:P; CN:PS; CA:PS; CL:C

68. (2) The first intervention is a safety issue. Because the client may respond to illusions or hallucinations or he may experience a seizure due to the DTs, side rails need to be in place. The lights should be on so that they do not create shadows on the walls. After these actions, an IV will be started and a tranquilizer administered.

    NP:I; CN:PS; CA:PS; CL:A

69. (2) The nurse would first notify the physician so that he is present to prepare for an emergency cesarean section. Vaginal examinations are never performed when there is heavy vaginal bleeding and the possibility of a placenta previa. Massive hemorrhage can result when a placenta is touched by an examining finger.

    NP:I; CN:PH; CA:MA; CL:AN

70. (2) This calcium-channel blocker causes vasodilation and is especially appropriate for vasospastic angina. Lanoxin (digoxin) increases the pumping ability of the heart (1). A sympathomimetic agent, such as Adrenalin (epinephrine HCl), increases the heart rate (3). Drugs such as Zocor (simvastatin) are antihyperlipidemic agents that lower cholesterol (4).

    NP:P; CN:PH; CA:M; CL:A

71. (4) The child may be suffering from either croup or epiglottitis. From the symptoms, the nurse knows that he does not have a foreign object in his airway. Attempting to have him cough to open his airway could lead to laryngospasm. Administering high-flow O_2 and keeping him calm is the appropriate nursing care.

    NP:I; CN:PH; CA:P; CL:A

72. (2) Impetigo is a bacterial infection. Washing with soap and hot water keeps the objects relatively free of streptococci and lessens the danger of spreading the disease.

    NP:I; CN:S; CA:P; CL:A

73. (3) Polyhydramnios is a condition where an excessive amount of amniotic fluid is present. The normal amount is 500 to 1000 mL. While the actual cause of this condition is unknown, it occurs more frequently in mothers with diabetes and eclampsia.

    NP:AN; CN:H; CA:MA; CL:K

74. (3) This is the most comprehensive answer, although (4) is also appropriate. Sleeping medication should be avoided if at all possible or unless absolutely necessary, because it helps suppress the client's feelings only temporarily. Encouraging the client to go back to bed closes off communication.

    NP:I; CN:PS; CA:PS; CL:A

75. (4) The low blood pressure is likely due to supine hypotensive syndrome. Turning the client on her side will relieve the pressure from the inferior vena cava. After this action, the nurse will repeat the blood pressure reading.

    NP:I; CN:H; CA:MA; CL:AN

COMPREHENSIVE TEST 2 REVIEW QUESTIONS

1. The physician orders an intravenous infusion of magnesium for a client in preterm labor at 30 weeks' gestation. If the client's labor can be stopped for 48 hours, the nurse can expect the client to receive which of the following?

1. Pitocin (Oxytocin)
2. Indomethacin (Indocin)
3. Betamethasone (Celestone)
4. Misoprostol (Cytotec)

2. A 70-year-old male client was on extracorporeal circulation (heart–lung machine) for an extended length of time due to intraoperative complications during heart surgery. He is considered at risk for disseminated intravascular coagulopathy (DIC). Which of the following lab values would be most critical for the nurse to assess and report to the physician?

1. Hemoglobin of 13.
2. Prothrombin time (PT) of 14 seconds.
3. Partial thromboplastin time (PTT) of 75 seconds.
4. Fibrinogen level of 85 mg/dL.

3. After 5 days of delirium tremens, the client has no further hallucinations, tremors, diaphoresis, or illusions. He seeks permission from the nurse before undertaking his own personal care, such as bathing and eating, and he sometimes asks the nurse where the bathroom and dining room are located. These requests indicate that this client

1. Is ready for discharge, because he is out of bed and ready to do these things for himself.
2. May be starting to have a recurrence of delirium tremens.
3. Is somewhat disoriented but functioning very independently because he is feeding and bathing himself.
4. Is exhibiting dependency and is somewhat disoriented.

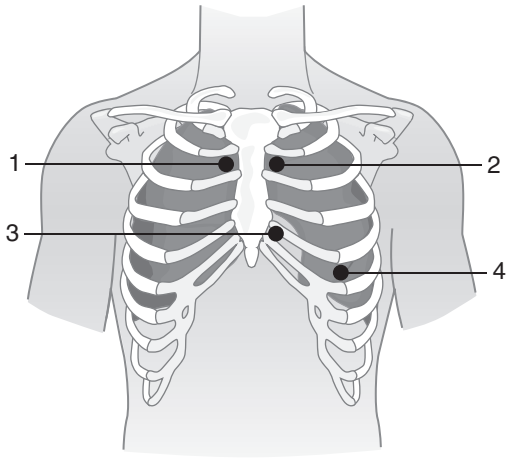
4. A nursing measure to prevent the complication of deep vein thrombophlebitis following surgery would include

1. Placing pillows under the affected limb.
2. Wearing elastic hose at all times.
3. Having the client sit up TID.
4. Elevating the foot of the bed.

5. Evaluating the condition of a client who has just received Lasix (furosemide), the nurse would observe for which major side effect of the drug?

1. Dyspnea.
2. Tachycardia.
3. Muscular weakness.
4. Headache.

6. While conducting a cardiac assessment, the two best positions to hear S_2 heart sounds are indicated at _____ (insert numbers).



7. Which of the following complications of acute bacterial (infective) endocarditis would the nurse constantly observe for in an acutely ill client?

1. Presence of a heart murmur.
2. Emboli.
3. Fever.
4. Heart failure.

8. While bathing a 1-year-old client, the nurse feels a large mass in the abdominal area and notices that his diaper is soiled with pinkish-tinged urine. The initial nursing action is to

1. Assess if the tumor has spread to the lymph nodes.
2. Immediately notify the physician.
3. Continue the assessment by observing his behavior indicating pain on palpation.
4. Gently palpate the abdominal mass to determine if it is a Wilms' tumor.

9. Considering the physical developmental period of a 1-year-old child, hospitalization may affect or delay his progression with

1. Crawling.
2. Running.
3. Walking.
4. Sitting.

10. A 21-year-old client was injured in a motorcycle accident yesterday. As a treatment for his fractured right femur, Kirschner wires were inserted and he was placed in balanced suspension traction. The position that will best promote healing is

1. Supine and flat to keep the traction in place.
2. With his right leg flat on the bed to promote the effectiveness of the traction.
3. In semi-Fowler's to prevent the traction from slipping.
4. With his right leg positioned at a 20-degree angle to maintain traction pull.

11. It is the nurse's responsibility to monitor the oxygen level in an incubator of a premature infant. The highest safe level of oxygen the nurse will administer to premature infants is

1. 25%.
2. 40%.
3. 55%.
4. 70%.

12. Respiratory acidosis, a serious complication of respiratory distress syndrome (RDS) occurring in infants, occurs as a result of

1. Retention of carbon dioxide due to inadequate ventilation.
2. Retention of oxygen due to inadequate ventilation.
3. Poor exchange of oxygen and carbon dioxide in the lungs.
4. Pulmonary hyperperfusion.

13. The nurse explains to a new mother that the condition of small for gestational age (SGA) is caused by

1. Placental insufficiency.
2. Maternal obesity.
3. Primipara.
4. Genetic predisposition.

14. You are admitting a client for abdominal surgery the next day, and you observe that he appears very anxious. A priority intervention is to

1. Tell him there is nothing to worry about.
2. Suggest that he talk to his doctor.
3. Ask what he expects to happen tomorrow.
4. Ask if he is feeling anxious.

15. A client has had a cystectomy and ureteroileostomy (ileal conduit). The nurse observes this client for complications in the postoperative period. Which of the following symptoms indicates an unexpected outcome and requires priority care?

1. Edema of the stoma.
2. Mucus in the drainage appliance.
3. Redness of the stoma.
4. Feces in the drainage appliance.

16. For a client with a detached retina, the preoperative nursing care plan will include

1. Bathroom privileges with assistance.
2. Turn, cough, and deep-breathe.
3. Keep both eyes bandaged.
4. Turn to the left side only.

17. You have an order to give Premarin 1.25 mg daily for your patient. The tablet strength is 625 mcg. How many tablets will you give?

18. A 48-year-old client admitted with a diagnosis of depression quietly sits by herself, gazing out the window and occasionally crying. Her husband says that her personal neglect is recent and really started after their last child left home for college. This client's personality prior to the illness probably resembled a woman who

1. Had a very organized household and often put her husband's and children's wishes ahead of her own.
2. Kept a neat house and was indecisive most of the time.
3. Was not inclined toward much recreation and who often thought of suicide.
4. Focused her activity exclusively around her children and who lived with an unresolved relationship with her parents.

19. A client took a medication overdose soon after admission to the hospital. She has now been returned from ICU to a room on the psychiatric unit. Upon seeing the nurse who admitted her, the client looks down at the floor and mumbles, "Hello." The nurse's best initial statement is

1. "You have been transferred back to this unit. This is your new room."
2. "Hello. I see that in ICU you've been getting a light diet. How does your stomach feel now?"
3. "I was upset when I found you had tried to kill yourself."
4. "Would you like to talk about what happened?"

20. A female client who is 37 weeks pregnant presents to the labor room with vaginal bleeding and abdominal pain. A tentative diagnosis of abruptio placentae is made. Following a nursing assessment, the priority intervention is to

1. Immediately call the physician.
2. Prepare for an emergency cesarean section.
3. Place the client on bed rest.
4. Complete a pelvic exam to determine progress of labor.

21. A physician ordered a half-strength nasogastric (NG) dilution of the formula. Evaluating that this formula is effective for the client, the client will report that it

1. Decreases constipation.
2. Decreases diarrhea.
3. Increases the pain in his liver.
4. Makes him feel less bloated.

22. A 20-year-old male client sustained a head injury in an automobile accident. He is admitted to a medical–surgical unit. During the initial assessment, the nurse observes fluid draining from the client's left ear. The nurse will immediately position the client with the head of his bed

1. Elevated and his head turned to the left.
2. Flat and his head turned to the right.
3. Flat and his head turned to the left.
4. Elevated and his head turned to the right.

23. Monitoring a burned client's fluid replacement, the fluid that is commonly used for the first 24 hours is

1. 5% dextrose in water.
2. 5% dextrose in normal saline.
3. Normal saline.
4. Ringer's lactate.

24. There are two basic types of respiratory tract injuries associated with burns: smoke inhalation and upper airway injuries. In a client with an upper airway burn, the nurse would expect to assess

1. Hoarseness and stridor.
2. Pulmonary parenchymal dysfunction.
3. Sootlike secretions.
4. Cherry-red lips.

25. The RN observes the nursing assistant (NA) regulating the IV of an oncology client receiving Roxanol (morphine sulfate) for pain. An LVN on the RN's team is responsible for the client and has assigned the client to the NA. The RN's intervention is to

1. Inform the LVN so that he or she intervenes to instruct the NA that this action is not within the realm of responsibility of an NA.
2. Immediately inform the charge nurse and fill out an incident report.
3. Call a staff meeting and confront the LVN and the NA.
4. Ask the LVN and the NA to meet with the RN to discuss the responsibility parameters each of them has.

26. The complication that the nurse will evaluate for following a transurethral resection (TUR) is

1. Hemorrhage.
2. Infection.
3. Urinary retention.
4. Adhesions of the neck of the bladder.

27. Instructions given to clients following cataract surgery include the information that

1. The eye patch will be removed in 3 to 4 days, and the eye may be used without difficulty.
2. They must use only one eye at a time to prevent double vision.
3. They will be able to judge distances without difficulty.
4. Contact lenses will be fitted before discharge from the hospital.

28. Of the following, the nursing intervention most important in the postoperative nursing care for a 2-month-old child with a repair of cleft lip is

1. Feeding her with a rubber-tipped syringe.
2. Suctioning the nasopharynx frequently.
3. Keeping the suture area clean.
4. Removing elbow restraints frequently.

29. Following abdominal surgery several days ago for removal of a benign tumor, the home care nurse observes that the client's dressing is wet with serosanguineous drainage. After changing the dressing, the nurse learns that the client changed the dressing 4 hours previously and the same drainage was charted. The appropriate conclusion is that

1. This kind and amount of drainage are to be expected after abdominal surgery.
2. This amount of drainage is frequently a sign of impending dehiscence.
3. The serosanguineous drainage means that he is losing too much blood.
4. The dressing should be changed more frequently than every 4 hours.

30. You are working with an LVN reviewing the latest CPR guidelines from the American Heart Association. You

know the LVN is using current information when she tells you to

1. Retrieve the AED first, before doing anything else.
2. Give rescue breaths, then do chest compression at a 15:1 ratio.
3. Institute CPR within 5 minutes to avoid brain damage.
4. Give two rescue breaths, then provide chest compressions at a 30:2 ratio.

31. A 2-year-old child has eaten half a bottle of his grandmother's ferrous sulfate tablets. They live 30 miles from the hospital. The first action is to tell the mother to

1. Take the child to the hospital immediately.
2. Give the child syrup of ipecac.
3. Contact the poison control center by phone.
4. Do nothing because vitamins are nonpoisonous.

32. The diet regimen usually prescribed for a child with noncomplicated acute glomerulonephritis is a

1. Low-sodium, high-protein diet.
2. Regular diet, no added salt.
3. Low-sodium, low-protein diet.
4. Low-protein, low-potassium diet.

33. The nurse realizes that the mother does not fully understand the significance of the effect the Rh factor will have on her future pregnancies. The nurse explains that the purpose of administering RhoGAM is to prevent erythroblastosis fetalis in the next pregnancy, which could result in

1. Hydrops fetalis.
2. Hypobilirubinemia.
3. Congenital hypothermia.
4. Transient clotting difficulties.

34. A male client is admitted to the hospital and is diagnosed with kidney failure. The physician orders hemodialysis treatments. Immediately following hemodialysis, which of the following signs and symptoms would indicate the need to administer Dilantin (phenytoin), a PRN medication?

1. Decreased blood pressure, rapid pulse.
2. Nausea, vomiting, twitching.
3. Pain and tingling at the access site.
4. Muscle cramps, headache.

35. A client has a Swan–Ganz catheter inserted before undergoing spinal fusion surgery. The nurse will use this catheter to monitor the client's

1. Intracranial pressure.
2. Spinal cord perfusion.
3. Renal function.
4. Hemodynamic status.

36. Assessing the psychosocial development of a toddler, the nurse is aware that it is characterized by

1. Imaginary playmates.
2. Erikson's stage of initiative versus guilt.
3. Demonstrations of sexual curiosity.
4. Extreme negative behavior resulting from the child's assertion of autonomy.

37. The significance of hearing the S_3 heart sound ("Ken-tuc-ky") at the apex of the heart is

1. Cardiac disease.
2. Cardiac decompensation.
3. Closure of the aortic valve.
4. Closure of pulmonic valve.

38. A female client is admitted to the therapeutic community with a diagnosis of conversion disorder with symptoms of aphasia. The nurse understands which of the following statements is true about conversion disorder?

1. Conversion disorders are consciously triggered.
2. A high level of anxiety underlies the symptom of aphasia.
3. The client's aphasia is always symbolic of a basic problem.
4. The client will exhibit increased affect proportionate to the severity of her symptoms.

39. A young man who accidentally came in contact with a high-tension electrical wire has a small injury on his right hand and on his left calf. When his family arrives at the hospital, they are understandably distraught and want to know exactly how he is and what will happen to him. The most therapeutic response is to say,

1. "He is doing well, although he may be in the hospital for some time."
2. "He has received an electrical burn. His condition is stable, and we will keep you informed of any change."
3. "He has received an electrical burn, which caused coagulation of some tissues."
4. "He does not appear to have much damage and should be fine soon."

40. A client who has a subclavian central venous catheter (CVC) develops acute shortness of breath. The nurse finds that the CVC has become disconnected from the IV tubing. The initial nursing action should be to

1. Cap all ports on the CVC and closely monitor the client.

2. Position the client in Trendelenburg position on the left side.
3. Call the physician and request an order for oxygen.
4. Place the client in high-Fowler's position, leaning on the overbed table.

41. A 58-year-old female client is in the hospital for the second time, diagnosed with myxedema. Considering the diagnosis, the initial assessment should reveal symptoms that include

1. Bradycardia, heart failure, weight loss, diarrhea.
2. Lethargy, weight gain, slow speech, decreased respiratory rate.
3. Tachycardia, constipation, exophthalmos.
4. Hypothermia, weight loss, increased respiratory rate.

42. The RN observes two team members putting the bedclothes they have taken off a client's bed on the floor. The appropriate intervention is to

1. Bring them a clothes basket and tell them to use it next time.
2. Explain the principles of medical asepsis to both team members.
3. Tell them this is unacceptable and the RN will counsel both of them later.
4. Do nothing because the bedclothes are on their way to the laundry to be disinfected.

43. The nurse is assigned to work on a unit that has a group of autistic children as inpatients. They have all been on the unit for at least 6 months and exhibit self-destructive and withdrawn behavior as well as bizarre responses. As a new member of the health team, the nurse knows that the first goal is to

1. Set limits on their behavior so the children will perceive the nurse as an authority figure.
2. Assess each child's individual developmental level so the nurse will have the data for realistic care plans.
3. Understand that the children must be protected from self-destructive behavior.
4. Establish some method of relating to the children, either verbal or nonverbal.

44. A client is admitted to the surgical unit for a scheduled above-the-knee amputation with a delayed prosthesis fitting. Preoperatively, the nurse can best assist the client by instructing him to do

1. Sit-up exercises.
2. Upper body strengthening exercises.
3. Strengthening exercises with his other leg.
4. No exercises until the postoperative period.

45. The results from a client's fasting blood glucose (FBG) are being evaluated. The nurse understands that to make the diagnosis of diabetes mellitus, the results of at least two separate FBG tests would need to be over

1. 100 mg/dL.
2. 125 mg/dL.
3. 140 mg/dL.
4. 180 mg/dL.

46. Following delivery of a healthy baby, the nurse completes a postpartum assessment of the new mother. Which of the following symptoms would be indicative of a full bladder?

1. Increased uterine contractions.
2. Decreased lochia.
3. Fundus 2F above umbilicus.
4. Pulse 52 beats/min.

47. A 22-month-old child has just been admitted to the pediatric unit for a fractured right femur. Observing Bryant's traction to determine if it is properly assembled, the nurse will expect to see the

1. Moleskin taut and placed on either side of the lower leg to provide traction.
2. Weights attached to a pin that is inserted in the femur.
3. Pin site and weights aligned in a horizontal position.
4. Weights attached to skin traction and hung freely from the crib.

48. A client involved in a knifing was admitted through the emergency room and is now in the ICU. His admission assessment reveals shallow and rapid respirations, paradoxical pulse, CVP 15 cm H_2O, BP 90 mm Hg systolic, skin cold and pale, urinary output 70 mL over the last 2 hours. From these findings, the nurse concludes that he may be developing

1. Hypovolemic shock.
2. Cardiac tamponade.
3. Sepsis.
4. Atelectasis.

49. A client, Mr. Erikson, has IV orders for three bags of 1000 mL for the next 24 hours.

Bag 1: 1000 mL D5%/0.45 NS with 1 amp Solu B with C
Bag 2: 1000 mL D5%/0.45 NS
Bag 3: 1000 mL D5%/0.45 NS with 30 mEq KCl.
You set the controller to deliver _____ drops/minute if the administration set delivers 15 gtts/mL.

50. A 35-year-old client is 36 weeks pregnant and has been admitted to the obstetrical unit for continuous close observation. She confides to the nurse that she doesn't think she will ever be a mother and begins to cry. The best nursing response is to

1. Reassure her that advanced medical knowledge will detect any problems that may be present with this pregnancy.
2. Sit quietly with her and follow her cues.
3. Suggest that she discuss her fears with her physician.
4. Gently change the subject to something more positive.

51. A client, 36 weeks pregnant, is induced with Pitocin (oxytocin). One of the most important observations is the duration of the resting phase between the end of one contraction and the beginning of the next. The nurse knows that a resting phase should not be less than

1. 15 seconds.
2. 30 seconds.
3. 45 seconds.
4. 60 seconds.

52. A client has been admitted to the hospital with symptoms of weakness, weight loss, and anorexia. The provisional diagnosis is cancer of the colon. The nurse observes that the client has remained very quiet. The nurse understands that her actions are probably due to

1. Trying to be a good client.
2. Denying the situation.
3. Shyness and fear of asking questions.
4. Feeling anger toward the hospital staff.

53. A client with a Sengstaken–Blakemore tube begins to wheeze and cough and becomes dusky in color. The immediate nursing action is to

1. Deflate the esophageal balloon.
2. Check the pressure in the gastric balloon.
3. Irrigate the stomach with iced saline.
4. Start low-flow oxygen by nasal cannula.

54. A 16-year-old client is hospitalized for adolescent adjustment problems. After assessing her, the nurse's first objective is to establish a nurse–client relationship. The next day, the nurse is late for the appointment. Knowing that the client has difficulty assuming responsibility for her own behavior, the nurse would like to use this situation as an opportunity for role modeling. The most appropriate statement the nurse could make is

1. "I'm late. I apologize."
2. "Thank goodness you are still here; I just had a flat tire."
3. "Oh, you are here. I thought we'd be arriving at the same time."
4. "What do you mean you are angry with me? I bet you keep people waiting."

55. The nurse is assigned to do a home visit for a new mother 1 week postpartum. In the assessment, leg edema and a slight fever are noted. Aside from advising her to see the physician immediately, the nurse would tell her that she should not

1. Elevate the leg.
2. Apply warmth to the leg.
3. Decrease leg movement.
4. Gently massage the painful area of the leg.

56. The nurse is caring for a client who is 1 day postoperative for an open thoracotomy. This client has a benign neoplasm of the left lung. The client is receiving oxygen mist at 40%. The O_2 saturation measured by pulse oximeter was 83. ABG results are: pH 7.31, PO_2 93 mm Hg, PCO_2 50 mm Hg, HCO_3 25 mEq/L. Which of the following nursing actions would be a priority for this client?

1. Switch to O_2 with a rebreathing bag.
2. Increase O_2 to 70%.
3. Position the client in high-Fowler's, and encourage use of incentive spirometer and coughing.
4. Place the client in the prone position and have the respiratory therapist do postural drainage.

57. At morning report in the step-down unit, the nurse receives the following client assignments and information. The following four questions refer to this information.
Client A, 80 years old, type 2 diabetic, 2 days postoperative, is complaining of pain at his mid-line incision site and asking for ordered pain medication.
Client B, a 65-year-old client with a fever, was admitted last night to rule out pneumonia. Client B slept poorly due to frequent bouts of coughing, which produced blood-streaked sputum.
Client C is 90 years old, has COPD, and is short of breath. His O_2 stats = 83% on 2 L of oxygen. He is a CO_2 retainer and his status is DNR.
Client D, 55 years old, is scheduled for an arteriogram this morning. The cath lab has just called to notify you that she is next on the schedule.
In which order will the nurse complete initial assessments and/or provide appropriate care?

1. Client D, C, B, and A.
2. Client A, B, C, and D.
3. Client C, D, A, and B.
4. Client B, D, A, and C.

58. Client D needs to be prepared and premedicated for an arteriogram. Which one of the following activities would not be part of the pretest procedure?

1. Remove undergarments, jewelry, and wig.
2. Give soap suds enema and shave insertion site.
3. Remove dentures and partials, hearing aids, and other prostheses.
4. Have her void, check for a signed consent form, and give ordered "on call" medications.

59. As the nurse assesses client C, the nurse recognizes that his shortness of breath (SOB) is increasing. The nurse would do which of the following before notifying his physician of his current status and to obtain orders?

1. Check his chart for O_2 stats, breathing treatments, and ABG results within the last 24 hours.
2. Put him in high-Fowler's position and increase his oxygen to 6 L.
3. Change his diet to low carbohydrate, high fat, and protein, and force fluids.
4. Check his intake and output for the past 24 hours and prepare to start total parenteral nutrition (TPN) in anticipation of an order.

60. Client C's situation worsens. The supervisor sends a CNA to assist the nurse. Which of the following clients and procedures would the nurse assign the CNA to do?

1. Carry out pretest procedures and go to the cath lab with client D.
2. Vital signs and AM care for client A and client B.
3. Posttest care for client D.
4. None of the above. These clients are too sick for a CNA to provide care.

61. Following a cystoscopy, it was determined that a client with benign prostatic hypertrophy would be admitted for a transurethral resection (TUR). Preoperative nursing care includes

1. Discussing the surgical intervention and the fact that it causes impotence.
2. Decreasing fluid intake for at least 2 days to prevent bladder irritability.
3. Keeping the client NPO for at least 18 hours to prevent bowel evacuation during the surgical procedure.
4. Discussing hygienic care of the penis before surgery.

62. An elderly female client with newly diagnosed osteoporosis requires counseling prior to discharge. The most important component of the discharge plan is

1. Instruction in safety factors to prevent injury.
2. Monitoring medications.
3. Instruction in regular exercise and diet.
4. Appropriate use of body mechanics.

63. A client with an obstruction just proximal to her old ileostomy stoma is admitted to the hospital. She has had the ileostomy for 6 months. Which one of the following conditions is considered a major complication and should be anticipated in the client's care plan?

1. Infection.
2. Diarrhea.
3. Fluid and electrolyte imbalance.
4. Constipation.

64. A dietary goal for a client postsurgery is to support tissue repair. The nurse will know the client understands dietary principles to achieve this goal when she increases her intake of

1. Fats.
2. Carbohydrates.
3. Incomplete proteins.
4. Glucose.

65. A young male, age 11 months, has been a robust, thriving boy. Recently, his appetite has been poor, and he has vomited frequently. He is admitted to the unit after his parents brought him to the hospital following an episode when he suddenly shrieked loudly, pulled his knees to his chest, and seemed to be in acute pain. The nurse should assess for

1. Poisoning.
2. Presence of parasites.
3. Acute appendicitis.
4. Intussusception.

66. A 72-year-old client diagnosed with Ménière's disease has been admitted to the medical–surgical unit. He asks the nurse if he can get up and go to the bathroom any time he needs to. The most appropriate response is

1. "Yes, whenever you wish, you may go."
2. "No, you are on strict bed rest."
3. "Please ring for assistance when you wish to get out of bed."
4. "We will have to check with the physician."

67. A client is admitted with the diagnosis of glomerulonephritis. He was initially treated with dietary fluid and electrolyte restrictions, but now has recurrent hypertension and edema. Analyzing the client's lab results in relationship to his disease process, the nurse would expect to find increased

1. Serum sodium.
2. Red blood cells.
3. Potassium and blood urea nitrogen (BUN).
4. White blood cells.

68. For a client with severe cirrhosis, the physician orders lactulose 30 mL via nasogastric tube. After administering the lactulose, the nurse will assess for an increase in

1. Constipation.
2. Diarrhea.
3. Nausea.
4. Urine output.

69. A client with cirrhosis has blood test results returned that indicate a prothrombin time of 30 seconds. The nurse would expect the physician to order

1. Vitamin K.
2. Heparin.
3. Coumadin (warfarin).
4. Ferrous sulfate.

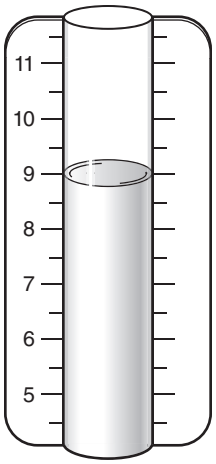
70. A client with cirrhosis has ascites that has diminished, but he complains that he cannot sleep well and asks the nurse for a sedative. The best nursing response is to say

1. "Sedatives are processed in the liver and, because your liver is affected by your condition, they would be dangerous to take."
2. "I'll notify your physician."
3. "Sedatives are contraindicated because they could depress your respirations."
4. "I'll see what I can do to get you a medication to help you sleep."

71. When a client with severely decreased liver function due to cirrhosis selects a snack, the choice that indicates he understands his dietary requirements is a

1. Peanut butter sandwich.
2. Banana.
3. Hard-boiled egg.
4. Portion of cheese and crackers.

72. You are measuring and monitoring central venous pressure (CVP). From the diagram that follows, you will observe the meniscus at which number? _____.



73. A 56-year-old male client is in the ICU and is being prepared to have a CVP inserted. As the physician attaches IV tubing to the hub of the needle, the nurse instructs the client to perform the Valsalva maneuver. The purpose of this procedure is to

1. Avoid infiltration of the vein.
2. Alleviate pain during the procedure.
3. Prevent an air embolism from occurring.
4. Assist with catheter advancement.

74. The nurse is monitoring the client when there is a sudden change in the CVP reading. The first nursing action is to

1. Check whether the client's position has changed.
2. Take the client's vital signs.
3. Have the client do the Valsalva maneuver.
4. Call the physician immediately.

75. A 69-year-old retired client has gouty arthritis and his physician has ordered a medication protocol of Colcrys (colchicine) and steroids. During an acute attack, the client will be taking Colcrys

1. Until the steroids reach a therapeutic level to reduce the inflammation.
2. For 12 hours until he is switched to Zyloprim (allopurinol).
3. Every hour until pain subsides or he experiences nausea, vomiting, or diarrhea.
4. Every hour for 24 hours.

COMPREHENSIVE TEST 2
ANSWERS WITH RATIONALE

1. (3) Betamethasone (Celestone) is a glucocorticoid that is given to stimulate fetal lung maturation. It is used for clients in preterm labor between 28 and 32 weeks if labor can be stopped for 48 hours. Pitocin (Oxytocin) stimulates the smooth muscle of the uterus and would be contraindicated. Indomethacin (Indocin) is used to stop preterm labor—in this case it has already stopped. Misoprostol (Cytotec) is a prostaglandin that is given to ripen and soften the cervix and to stimulate uterine contraction, which is contraindicated in this situation.

   NP:I; CN:PH; CA:M; CL:A

2. (4) The normal fibrinogen level for males is 180–340 mg/dL. Any level below 100 mg/dL is considered critical. In DIC, the fibrinogen level is used up during the blood clotting process. Therefore, a level of 85 mg/dL would concern the nurse and must be reported to the physician.

   NP:A; CN:PH; CA:S; CL:AN

3. (4) Seeking permission for simple tasks indicates dependent functioning. Forgetting where things are indicates persisting confusion, disorientation, and need for structure. He is obviously not ready for discharge (1), nor is he functioning independently (3).

   NP:AN; CN:PS; CA:P; CL:AN

4. (4) Elevation of the legs promotes circulation and prevents venous stasis and more clot formation. Nursing measures aim at preventing further thrombi from forming and the already present thrombus from detaching. Elastic hose (2) are necessary when the client is up walking again. Placing a pillow under the limb (1) could cause a bend at the groin, with resulting decreased circulation. The client must be kept on bed rest until the danger of emboli passes (4 to 7 days).

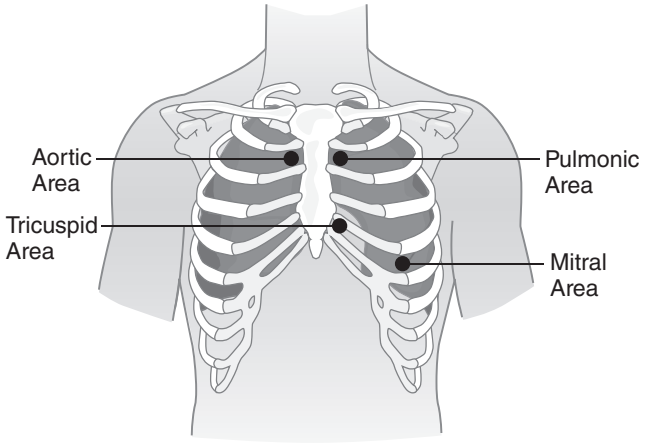
   NP:P; CN:PH; CA:S; CL:A

5. (3) Lasix promotes diuresis by preventing sodium and chloride reabsorption in the kidney tubules. Potassium and water loss occurs as well. The potassium loss could cause muscle weakness. Only if there were an excessive water loss would the client become tachycardic (2) and have a headache (4). Dyspnea (1) is not associated with the use of Lasix.

   NP:A; CN:PH; CA:M; CL:A

6. The answer is 1 and 2. S_2 sounds are heard best over the aortic and pulmonic areas.

   NP:A; CN:PH; CA:M; CL:A



7. (2) While all of the symptoms may be present, the characteristic problem with this condition is that of emboli. If emboli arise in the right heart chambers, they will terminate in the lungs; left chamber emboli may travel anywhere in the arterial tree.

   NP:A; CN:PH; CA:M; CL:A

8. (2) The physician should be notified immediately. A suspected Wilms' tumor should never be palpated more than necessary because of the potential for metastasis and should be treated immediately following discovery. It is really not a nursing responsibility to assess for lymph node enlargement.

   NP:I; CN:PH; CA:P; CL:A

Coding for Questions/Answers Abbreviations: Nursing Process: NP, Assessment: A, Analysis: AN, Planning: P, Implementation: I, Evaluation: E; Client Needs: CN, Safe, Effective Care Environment: S, Health Promotion and Maintenance: H, Psychosocial Integrity: PS, Physiological Integrity: PH; Clinical Area: CA, Medical Nursing: M, Surgical Nursing: S, Maternal/Newborn Nursing: MA, Pediatric Nursing: P, Psychiatric Nursing: PS; Cognitive Level: CL, Knowledge: K, Comprehension: C, Application: A, Analysis: AN.

9. (3) At 12 months, the child should be starting to walk. A hospitalization at this time could delay this developmental stage. The child should sit (4) by 6 months and should already be crawling (1) by 1 year of age.

   NP:P; CN:S; CA:P; CL:C

10. (4) The affected leg should always be kept at an angle of at least 20 degrees from the bed. Weights are never lifted up; this action could undo all of the reduction that has already occurred.

    NP:P; CN:PH; CA:S; CL:C

11. (2) Oxygen concentrations above 40% may cause damage to the retinas, which later may lead to severe sight limitation or blindness. Oxygen levels must be monitored carefully and the infant should not receive a higher concentration than necessary.

    NP:P; CN:H; CA:M; CL:A

12. (1) Respiratory acidosis is specifically due to retention of carbon dioxide. This is a result of inadequate pulmonary ventilation caused by atelectasis, which results when the hyaline membrane develops in the bronchial tree.

    NP:AN; CN:H; CA:MA; CL:C

13. (1) Placental insufficiency is a primary cause of SGA. It may result from an embryonic placental deficiency, hypertension, maternal smoking, maternal malnutrition, aging, and other associated causes.

    NP:I; CN:H; CA:MA; CL:C

14. (3) Determining what the client knows about the surgical procedure and expects to happen will give you data about how to intervene. Fear of the unknown increases anxiety and stress. The first two interventions will close off communication, and answer (4) is too direct and may result in a negative response.

    NP:I; CN:PS; CA:PS; CL:A

15. (4) The ileal conduit procedure incorporates implantation of the ureters into a portion of the ileum that has been resected from its anatomical position and now functions as a reservoir or conduit for urine. The proximal and distal ileal borders can be resumed. Feces should not be draining from the conduit. Edema (1) and a red color of the stoma (3) are expected outcomes in the immediate postoperative period, as is mucus from the stoma (2).

    NP:A; CN:PH; CA:S; CL:AN

16. (3) Both eyes are bandaged to prevent movement in either eye. When one eye moves, the other eye follows. By preventing movement, the extension of complications can be prevented. Positioning of clients is usually done with the area of detachment in a dependent position. Deep-breathing is done, but coughing increases intraocular pressure and should be discouraged or prevented by use of antitussives.

    NP:P; CN:PH; CA:S; CL:C

17. The answer is 2 tablets. 1.25 mg is equal to 12500 mcg. Each table has 625 mcg. 12500/625 = 2.

    NP:I; CN:S; CA:M; CL:A

18. (1) Persons predisposed to middle-age depression tend to have been rigid and self-sacrificing and spent their personal time meeting other people's needs. When there is no longer a focus for their self-sacrifice, depression may ensue. They probably did not have a long history of depression or suicidal thoughts (3).

    NP:AN; CN:PS; CA:PS; CL:C

19. (4) Caring is conveyed through acknowledgment. Asking the client if she would like to talk allows her the choice of whether to discuss the suicide attempt at this time. Revealing personal feelings (3) is inappropriate, and ignoring the attempt (1, 2) will close off communication.

    NP:I; CN:PS; CA:PS; CL:A

20. (3) The priority intervention is to place the client on bed rest and assess for signs of shock. The physician should be notified (1) after the client is positioned. Depending on the severity of the condition, a cesarean section (2) may be imminent. Pelvic exams (4) are to be avoided to prevent additional bleeding.

    NP:I; CN:H; CA:MA; CL:A

21. (2) Diarrhea is a common side effect of NG formula infusion due to the high-protein composition. Diluting the formula will decrease the diarrhea. The other answers are not side effects of diluting the formula.

    NP:E; CN:PH; CA:M; CL:A

22. (1) It is important to decrease intracranial pressure (head of bed elevated) and to allow for drainage (head turned to left). All of the other responses are incorrect because the position would not facilitate cerebral drainage or ear drainage.

    NP:I; CN:PH; CA:M; CL:AN

23. (4) Ringer's lactate is the fluid replacement of choice. Five percent dextrose solutions (1, 2) are not given in the first 24 hours because a stress-induced pseudodiabetes often occurs after major burns. Administration of more dextrose would increase the possibility of hyperosmolar disease. Many physicians do not order colloids to be given in the first 24 hours because the burn causes generalized increased capillary permeability. The colloids leak out of the burn area into areas such as the pulmonary interstitial spaces and may cause pulmonary edema.

    NP:P; CN:PH; CA:M; CL:K

24. (1) Upper airway burns (to the head, neck, or chest) cause local edema, which may produce mechanical occlusion of the airway manifested by hoarseness and stridor. Smoke inhalation can cause parenchymal changes from superheated gases and/or toxic chemicals. The parenchyma (2) is generally unaffected in upper airway burns.

    NP:A; CN:PH; CA:M; CL:C

25. (4) While regulating or even touching an IV is definitely not within the scope of behaviors that an NA can legally perform (1), both teaching and clarification of duties are needed in this situation. Before accusing the NA, a nonpunitive environment should be created so teaching of both the LVN and the NA can occur, and this action will not happen again. Unless too much medication was given, an incident report does not need to be filled out (2). Confronting the team members in a staff meeting (3) would not be following good management principles.

    NP:I; CN:S; CA:M; CL:AN

26. (1) Hemorrhage is the major early complication due to the manipulation by the instrument in resecting away the prostatic tissue. The use of continuous drainage assists in preventing hemorrhage. Observation of the type of drainage facilitates early detection of excessive bleeding.

    NP:E; CN:PH; CA:S; CL:A

27. (2) The function of the lens is that of accommodation, the focusing of near objects on the retina by the lens; therefore, only the remaining lens will function in this capacity, depending on whether a cataract is present.

    NP:P; CN:PH; CA:S; CL:A

28. (3) The suture area must be kept clean to prevent infection. Strain on the sutures must always be prevented by using a Logan bar. The infant will be fed with a rubber-tipped medicine dropper on the unoperated side. Elbow restraints (4) will be used with supervised rest periods to protect the suture area.

    NP:P; CN:PH; CA:S; CL:A

29. (2) After 7 days, the sutures have probably been removed. The presence of serosanguineous wound drainage lasting a few hours to several days is nearly always a sign of impending dehiscence.

    NP:E, CN:PH; CA:S; CL:A

30. (4) The current guidelines suggest administering compressions "hard and fast," at a rate of about 100 per minute, with a 30:2 ratio. The first action is to check responsiveness and get help, then get the AED (1). You must start CPR within 3 minutes, because brain damage could occur after 4 minutes (3).

    NP:AN; CN:PH; CA:M; CL:C

31. (3) Contact either the poison control center or the emergency department at a local hospital. The child will most likely be given water to dilute the ferrous sulfate tablets and activated charcoal. Syrup of ipecac is not currently given to induce vomiting.

    NP:I; CN:PH; CA:P; CL:C

32. (2) A regular diet with moderate sodium is suggested for children who are in acute glomerulonephritis. If the client's condition progresses to renal failure, sodium, potassium, and protein are restricted.

    NP:P; CN:PH; CA:P; CL:K

33. (1) Hydrops fetalis occurs when large quantities of the Rh-positive antibodies attach to the fetal hemoglobin and massive hemolysis results. If the infant is delivered alive, it will require an exchange transfusion.

    NP:I; CN:H; CA:MA; CL:C

34. (2) Nausea, vomiting, and twitching are indicative of disequilibrium syndrome. They occur as a result of the rapid shift of fluids, pH, and osmolarity between fluid and blood that occurs during the dialysis treatment. In addition, it is thought that a rapid decrease in BUN levels during hemodialysis causes cerebral edema, which leads to increased intracranial pressure.

    NP:E; CN:PH; CA:M; CL:AN

35. (4) A Swan–Ganz catheter is inserted into the pulmonary artery to closely monitor a client's cardiovascular function and hydration status. It is commonly used for

monitoring clients during and following major surgery, as well as for clients who are critically ill.

NP:P; CN:PH; CA:S; CL:C

36. (4) Assertion of autonomy is seen in 2- to 2½-year-old toddlers as they begin their language and social development. The stage of initiative versus guilt (2) is more common in the preschool-age child, 3 to 6 years. At 3 to 4 years of age, children have imaginary playmates (1).

NP:AN; CN:H; CA:P; CL:C

37. (2) When the S_3 heart sound is heard at the apex of the heart, it signifies cardiac decompensation. Hearing the S_3 heart sound at the upper left sternal border is indicative of cardiac disease. This sound does not signify closure of the aortic or pulmonic valve.

NP:AN; CN:S; CA:M; CL:C

38. (2) Conversion disorder symptoms are unconsciously triggered by the client as a way of dealing with high levels of anxiety. The client's aphasia may be (but is not always) symbolic of a basic problem (3). The level of affect the client displays (4) is not relevant to this disorder.

NP:AN; CN:PS; CA:PS; CL:K

39. (2) The family needs to be given honest information in words they can understand. Above all, they need to know the nurse is aware of them and will keep them in mind. Answer (1) gives conflicting messages. Answer (3) may also be true but it is very clinical and will frighten the family more than necessary. Answer (4) is a statement made without sufficient knowledge.

NP:I; CN:PS; CA:PS; CL:C

40. (2) Analysis of the data suggests that the client may be experiencing an air embolism. Positioning on the left side with the head down may help keep the air in the right atrium, where it can be absorbed, rather than going into the pulmonary or systemic circulation, where it could produce fatal results.

NP:I; CN:PH; CA:M; CL:AN

41. (2) Myxedema, or hypothyroidism, is caused by a decrease in thyroid hormone production. Symptoms are related to a generalized decrease in the metabolic rate. Hypothermia and constipation are associated with a decreased metabolic rate. Bradycardia, constipation, and cold intolerance are additional symptoms associated with myxedema.

NP:A; CN:PH; CA:M; CL:C

42. (2) To change behavior, there must be an understanding of the need or reason to change. Assuming that the team members do not fully understand the underlying principles of asepsis and germ transmission would be the first approach. Teaching how important it would be not to contaminate other surfaces or to keep transmission of contaminants to a minimum by placing the bedsheets in a closed basket for delivery to the laundry would be safe nursing practice. This is also an example of good management principles, unlike answers (1), (3), and (4).

NP:I; CN:H; CA:M; CL:A

43. (4) Before the nurse can implement any care plan that might include setting limits or integrating the child into the group, the nurse would need to establish a relationship, through either verbal or nonverbal communication. After establishing a relationship, the nurse will assess each child.

NP:P; CN:H; CA:PS; CL:C

44. (2) In this instance, it would be most beneficial to strengthen the client's arm muscles to help him when walking with the crutches.

NP:I; CN:PH; CA:S; CL:C

45. (2) The normal FBG can range from 70 to 115 mg/dL in an adult. Elevations above 125 mg/dL (obtained on two separate occasions) are considered diagnostic for diabetes, as per criteria established currently by the American Diabetes Association.

NP:AN; CN:PH; CA:M; CL:K

46. (3) If the bladder is full, it will push the uterus up out of the pelvis above the umbilicus. The uterus will not contract sufficiently, which could lead to increased bleeding.

NP:AN; CN:H; CA:MA; CL:C

47. (4) Bryant's traction is a form of skin traction and, therefore, does not require a pin insertion. Moleskin is frequently used as the stabilizing material for traction application. The child's hips are flexed at a 90-degree angle with the legs suspended by pulleys and weights. The weights must hang freely from the crib to maintain alignment and decrease the fracture. This type of traction is used for children under the age of 2.

NP:E; CN:PH; CA:S; CL:A

48. (2) All of the client's signs and symptoms are found in both cardiac tamponade and hypovolemic shock except the urinary output and CVP. In shock, urinary output decreases to less than 30 mL/hr, and the CVP would be below 5 cm H_2O pressure; thus these symptoms would

distinguish hypovolemic shock from cardiac tamponade. The client would be likely to also exhibit tachycardia, hypertension, and restlessness.

NP:AN; CN:PH; CA:M; CL:AN

49. The answer is *32 gtts/minute*. Calculate two steps for the answer.

1. $$\frac{\text{Total solution}}{-\text{Number of hours to run}} = \frac{\text{mL}}{\text{hr}}$$

$$\frac{1000 \text{ mL}}{8 \text{ hours}} = 125 \text{ mL/hr}$$

2. $$\frac{\frac{\text{mL}}{\text{hr}} \times \text{drop factor}}{60 \text{ minutes}} = \text{gtts/min}$$

$$\frac{125 \frac{\text{mL}}{\text{hr}} \times 15 \text{ gtts/mL}}{60 \text{ minutes}} = 32 \text{ gtts/min}$$

NP:I; CN:S; CA:M; CL:A

50. (2) The client has indicated a need to talk and explore her feelings. Sitting with her and following her cues is the most therapeutic response. This action will assist in developing a relationship.

NP:I; CN:H; CA:M; CL:C

51. (2) A prolonged uterine contraction of more than 90 seconds or a resting phase of less than 30 seconds is dangerous, and the safety intervention is to turn off the Pitocin drip. Sixty seconds is an acceptable resting phase between contractions.

NP:A; CN:H; CA:MA; CL:C

52. (2) Denial is a normal reaction when a client is suddenly faced with a life-threatening illness. Anger (4) may occur later. The nurse should determine if she is shy and afraid to ask questions (3), as this can happen.

NP:AN; CN:PS; CA:PS; CL:C

53. (1) The client is manifesting airway obstruction, which may be caused by the upward displacement of the Sengstaken–Blakemore tube. The priority intervention is to maintain a patent airway. Deflating the esophageal balloon will relieve the airway obstruction.

NP:I; CN:PH; CA:M; CL:A

54. (1) Assuming responsibility for one's behavior includes acknowledging the behavior and may include a statement of one's current status. It does not include making excuses (2), focusing outside of oneself (3), or blaming another (4).

NP:I; CN:PS; CA:PS; CL:A

55. (4) The client has all the signs of thrombophlebitis. To massage the area might cause a blood clot to become dislodged. The other actions would be included in the treatment plan.

NP:I; CN:PH; CA:M; CL:C

56. (3) The client has respiratory acidosis from decreased ventilation. A rebreathing bag (1) is used for respiratory alkalosis. Increasing the O_2 (2) is not necessary because the O_2 level is within normal limits. Positioning the client to improve gas exchange by deep-breathing, coughing, and removal of secretions may resolve the problem. Placing the client in prone position (4) is not beneficial.

NP:I; CN:PH; CA:S; CL:AN

57. (3) The correct order of intervention is this: Client C can be repositioned in mid-Fowler's and helped to breathe more slowly and exhale using the pursed lip method. These comfort measures take very little time and will probably reduce his anxiety. Client D must be premedicated for her arteriogram, so that the cath lab schedule will not be delayed. The incision site of client A should be checked next for signs of evisceration or infection and his position changed to determine if that is sufficient to ease his pain. If not, he should receive the medication according to the doctor's orders. Client B's vital signs should be taken next and her current sputum characteristics noted.

NP:P; CN:S; CA:M; CL:AN

58. (2) There is no reason to give an enema and the insertion site will be shaved in the cath lab. All the other activities are appropriate.

NP:P; CN:PH; CA:M; CL:A

59. (1) The first step in providing care for clients is assessment. The other three answers are inappropriate for this COPD client.

NP:I; CN:PH; CA:M; CL:AN

60. (2) CNAs are trained to provide hygiene and comfort measures for clients.

NP:P; CN:S; CA:M; CL:AN

61. (4) Usually a shower with detergent soap is taken the night before and morning of surgery. Particular attention should be paid to cleansing around the glans to rid it of microorganisms. An increased fluid intake and a good diet are essential to prevent urinary tract infections postoperatively. Clients are not necessarily impotent following surgery.

NP:P; CN:PH; CA:S; CL:A

62. (3) Because this is a new diagnosis, regular exercise (especially weight bearing) and a diet high in protein, calcium, and vitamin D with avoidance of alcohol and coffee are the most important components of the plan to prevent extension of the condition.

    NP:P; CN:S; CA:M; CL:A

63. (3) Due to the extreme loss of fluids from the high colon interruption, fluid and electrolyte imbalance is the most common complication. The lower colon reabsorbs a major portion of the fluid, whereas the upper colon does not have this function. A great potassium loss also occurs, as it is found in large amounts in the upper colon. The other answers are not expected complications.

    NP:E; CN:PH; CA:S; CL:C

64. (2) Carbohydrates are protein-sparing food sources. When present, they provide for energy and allow the proteins to be used for tissue repair. The diet should also include adequate protein, not incomplete protein.

    NP:E; CN:PH; CA:S; CL:A

65. (4) The client's behavior, especially indications of acute pain, is typical of a child with intussusception. Other signs may be vomiting and bloody mucus in the stool. Appendicitis would evidence pain in the right lower quadrant of the abdomen. Neither poisoning nor parasites would present with this symptom pattern.

    NP:AN; CN:PH; CA:P; CL:A

66. (3) The client may be on bed rest (although not strict) due to the extreme vertigo he may experience. Because of the dizziness, he should ring for assistance if he does wish to get up to go to the bathroom. This is a safety intervention to prevent the client from falling.

    NP:I; CN:S; CA:M; CL:A

67. (3) The potassium and BUN are increased due to the kidney's decreased ability to secrete these materials. Red blood cells are decreased due to the decreased production of erythropoietin, the factor that stimulates production of erythrocytes. Sodium is restricted but if diuresis is great, sodium replacement may be required.

    NP:AN; CN:PH; CA:M; CL:AN

68. (2) Lactulose is a synthetic disaccharide that the small intestine cannot utilize. It causes diarrhea by lowering the pH so that the bacterial flora are changed in the bowel. The bacteria responsible for producing ammonia by acting on proteins are absent, so the ammonia level decreases.

    NP:E; CN:PH; CA:M; CL:A

69. (1) A prothrombin time of 30 seconds indicates the clotting time is prolonged and bleeding could occur. The normal prothrombin time is 12 to 15 seconds. A vitamin K injection will increase the synthesis of prothrombin by the liver.

    NP:P; CN:PH; CA:M; CL:C

70. (1) While answer (3) is true, the best response is (1), giving him the facts. Sedatives are metabolized by the liver. The client cannot tolerate these drugs because of his defective hepatic function. He would have very high levels of the drug in his blood for a prolonged period of time. Other options, such as relaxation techniques, are important to try before resorting to drugs.

    NP:I; CN:PH; CA:M; CL:AN

71. (2) Carbohydrates are one of the mainstays of the cirrhotic client's diet. The liver can metabolize only very small amounts of protein, so usually only 50 grams of protein is allowed per day (normal diet is 80 grams per day). All of the other choices contain protein.

    NP:E; CN:PH; CA:M; CL:C

72. The number you will read at the meniscus is 9, because the CVP reading is at the base of the meniscus and at the end of expiration (on highest fluctuation).

    NP:I; CN:H; CA:M; CL:A

73. (3) The rationale for a Valsalva procedure is to prevent air from entering the catheter, thus reducing the risk of an air embolism. None of the other answers is accurate.

    NP:AN; CN:PH; CA:M; CL:K

74. (1) If the client's position has recently changed, it could alter the CVP reading. The first nursing action is to check for this and repeat the reading. Depending on the source of the reading change, the nurse would then notify the physician.

    NP:I; CN:PH; CA:M; CL:A

75. (3) Colcrysis an antigout medication with parasympathetic-stimulating properties. It is given until these side effects occur, the pain subsides, 8 to 10 doses maximum have been given, or therapeutic blood levels have been reached. Zyloprim is usually started following Colcrys.

    NP:P; CN:PH; CA:M; CL:C

COMPREHENSIVE TEST 3 REVIEW QUESTIONS

1. A 56-year-old male client is admitted to the coronary care unit. The diagnosis is myocardial infarction. The client is placed on a cardiac monitor and an IV of D_5W is infusing at a "keep open" rate. The nurse's priority concern is to assess for

1. Apical pulse rate.
2. Chest pain.
3. Respiratory rate.
4. Blood pressure increase.

2. The physician orders laboratory tests for a client with a suspected myocardial infarction. The lab finding that would indicate that there has been myocardial damage is a(n)

1. Elevated creatinine-kinase (CK)-MB.
2. Decreased CK and SGOT (serum glutamic oxaloacetic transaminase).
3. Elevated total CK and elevated SGOT.
4. Elevated SGOT and LDH (lactate dehydrogenase).

3. A physician orders 2 mg per minute of Xylocaine (lidocaine) for a client. Using 500 mL D_5W and 2 g Xylocaine, the nurse will administer _____ milliliters per minute.

4. A low-sodium diet is ordered for a client. The nurse will know he understands his low-sodium diet restrictions when he chooses a menu of

1. Smoked turkey, mashed potatoes, spinach, and apple juice.
2. Crab on rice, green beans, and decaffeinated coffee.
3. Lamb chop, mint jelly, rice, beets, and low-fat milk.
4. Roast beef, baked potato, squash, and decaffeinated coffee.

5. An 81-year-old client has right-sided heart failure and is confined to bed. Which of the following assessments by the nurse would indicate a deterioration in this client's condition?

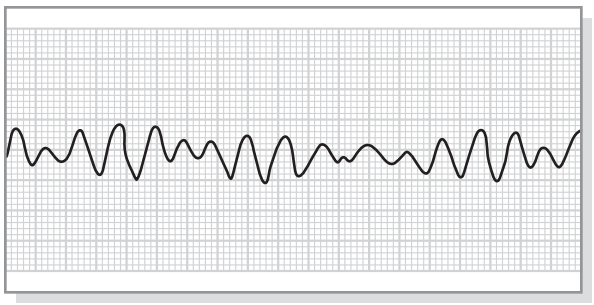
1. Clear lung sounds.
2. Pitting edema of the sacral area.
3. Stating, "I don't want breakfast today."
4. Weight loss.

6. Before administering an immunization to a child, the nurse will assess for a primary contraindication, which is

1. Impetigo.
2. Failure to thrive.
3. Congenital heart disease.
4. Cystic fibrosis.

7. Identify the name of the arrhythmia in the following rhythm strip.

1. Premature ventricular contractions (PVCs).
2. Ventricular fibrillation.
3. Third-degree heart block.
4. Ventricular tachycardia.



8. As you identify the rhythm in Question 7, the priority intervention is to

1. Do nothing because it is a normal sinus rhythm.
2. Call for the code team to start defibrillating the client.
3. Continue to monitor the client.
4. Repeat checking out the ECG strip to verify the rhythm.

9. Which of the following clinical manifestations would indicate that a client has developed a complication following a cystoscopy?

1. Difficulty voiding.
2. Pink-tinged urine.
3. Burning on urination.
4. Development of a chill.

10. A newly pregnant client is unsure of the date of her last menstrual period (LMP). Means other than Nägele's rule will be used to determine the estimated date of

delivery (EDD). The nurse would expect the physician to estimate the date by

1. Hearing the first audible fetal heart tone with a fetoscope.
2. Serial estriols.
3. Ultrasonography.
4. The nonstress test.

11. When assessing for domestic violence or abuse, the most important question to ask the client is

1. "How are things going at home?"
2. "Is there anything you would like to tell me?"
3. "Are you now or have you been a victim of abuse?"
4. "How are you feeling right now?"

12. When a toddler is hospitalized, age-appropriate toys would include which of the following? List all that apply: _____.

1. Music boxes.
2. Pull wooden animal.
3. Push mini-vacuum.
4. Small blocks for building.
5. Wind-up toys.
6. Colorful mobiles.

13. During the preoperative period before surgery for Hirschsprung's disease, a priority nursing intervention will focus on

1. Maintaining the child's attachment to his parents.
2. Demonstrating correct administration of tap-water enemas to his parents.
3. Providing a high-calorie diet.
4. Promoting adequate rest and sleep.

14. A female client, age 36, states she has been depressed and anxious. Her mood is one of sadness and gloom and she is requesting medication. During the admission interview, the priority assessment is the client's

1. Living situation.
2. Coping mechanisms.
3. Suicide potential.
4. Support systems.

15. To develop a working relationship with a client in a psychiatric setting, the nurse knows that goal setting is vital. To ensure that the goal is attainable, it must

1. Be mutually set by the client and the nurse.
2. Have observable outcomes.
3. Be flexible and changeable as appropriate to the situation.
4. Be set by the nurse and agreed to by the client.

16. A depressed client tells the nurse that most of the time she has no anger toward her husband and rarely says anything negative, but he is always angry with her. She may be using the defense mechanism of

1. Denial.
2. Sublimation.
3. Projection.
4. Fantasizing.

17. A male client, age 44, has recurring abscesses and recent weight loss despite a healthy appetite. What history information will be most important to elicit from this client?

1. Family history of blood disorders.
2. Family history of type 1 diabetes.
3. Presence of pruritus and muscle cramps.
4. Presence of nocturia and excessive fatigue.

18. During a pregnant client's visit, the nurse assesses her for signs of increasing eclampsia or pregnancy-induced hypertension (PIH). If it is present, the nurse will observe

1. Edema of the hands, feet, and face.
2. Glycosuria.
3. Tachycardia.
4. Polyuria.

19. Assessing a cardiac client, the nurse will know that a normal PR interval is no more than _____ seconds.

20. The nurse notices that a client on a medical unit is alone in his room and crying. The most therapeutic nursing approach would be to say,

1. "Don't cry—you'll just feel worse."
2. "Cheer up now—crying can make you feel more sad."
3. "Spending so much time alone makes one feel lonely—let's go out on the unit."
4. "I'll get a tissue, then come back and sit with you."

21. The physician determines that a client with type 1 diabetes requires a subtotal gastric resection. In planning his postoperative care, the nurse will take into account

1. A disruption in metabolic control.
2. An increased need for insulin.
3. An increased need for carbohydrates.
4. The onset of long-term complications.

22. The mother of a 1-month-old infant comes to the well-baby clinic. During a counseling session, the nurse

learns that the mother often props the baby's bottle because the baby wiggles a lot. An appropriate response would be

1. "It is probably a good idea to prop the bottle until you feel more comfortable holding the baby."
2. "It is not a good idea to do this because the baby could choke on the formula."
3. "Do you have a fear of dropping the baby?"
4. "You need to hold the baby when you are feeding her."

23. A 57-year-old male is admitted for an endocrine work-up. The provisional diagnosis is Cushing's syndrome. Among the tests scheduled are fasting blood glucose, electrolytes, plasma ACTH (adrenocorticotropic hormone) level, and urinary 17-ketosteroids. Considering the lab tests that were ordered, the nurse would expect to assess the client and find

1. Nervous exhaustion, hypertension, diaphoresis, heat intolerance.
2. Moon face, hirsutism, emotional lability, weight gain.
3. Increased cardiac output, heat intolerance, muscle fatigue, weight loss.
4. Hypothermia, inactivity, weight gain, constipation.

24. A client is scheduled for a unilateral adrenalectomy. In developing goals for postoperative care, the nurse would

1. Instruct him in daily steroid administration.
2. Teach him signs and symptoms of hypoglycemia.
3. Plan a diet low in protein and sodium.
4. Maintain skin integrity.

25. The nurse is assessing a normal infant. A Moro reflex, present at birth, is described as

1. Sudden, generalized, symmetrical movement with the legs drawn up together.
2. Rapid movement of the arm and leg on the side opposite the stimulation.
3. Slow, generalized, random activity of the whole body followed by a rigid positioning of the extremities.
4. Rapid movement of all the extremities with no fixed pattern.

26. A new mother asks the nurse about nutrition instructions for breastfeeding. The nurse explains that the diet should include

1. Four to five glasses of milk per day.
2. Restricted salt intake.
3. Low-calorie foods.
4. Restricted fat intake.

27. The nurse is supervising a student nurse (SN) giving an IM injection to a client with right hip arthroplasty. The nurse will know the SN requires further instruction if she

1. Administers the injection in the left deltoid muscle.
2. Turns the client on her right hip to administer the injection.
3. Keeps the abduction pillow in place and turns the client 10 degrees to administer the injection on the unaffected side.
4. Administers the injection after turning the client to her left thigh, keeping the abduction pillow in place.

28. A client tells the nurse that she missed one menstrual cycle and her next cycle resulted in a slight amount of flow. She has not been pregnant before, but has had several sexual partners over the last year. Considering the history of her menstrual cycle, the nurse suspects she may have a tubal pregnancy. What is the appropriate intervention?

1. Ask the physician to see the client immediately.
2. Ask her if there is a familial history of tubal pregnancies.
3. Examine her abdomen to determine if there is unilateral pelvic pain over a mass.
4. Take her vital signs to determine if there are any abnormalities present.

29. Three of the following measures are necessary for a young child to maintain the desired effect of Bryant's traction. Which of the following is unnecessary?

1. Restraining the child's upper torso.
2. Immobilizing the child's elbow joints.
3. Inspecting the child's leg bandages at regular intervals.
4. Keeping the child's buttocks suspended above the mattress.

30. A wife will be involved in providing nursing care for her husband, who has had multiple sclerosis for 20 years. Which of the following nursing care measures would be most appropriate to include in the teaching sessions?

1. Exercises that promote muscle strengthening and decrease tremors.
2. Instruction in weight control.
3. Side effects of routine medications.
4. Importance of regular bowel and bladder evacuation.

31. Which of the following clients would the RN assess first after morning report?

1. Client A, 38 years of age, motor vehicle accident (MVA) with fractured left humerus and internal injuries. He is second-day postop splenectomy, liquids increasing to soft diet as tolerated.
2. Client B, age 74, third-day postop RLL lobectomy, bilateral crackles, IPPB (intermittent positive pressure breathing pressure) QID, antibiotics IVq6h, regular diet, encourage fluids.
3. Client C, age 51, GI bleeding, NPO, NG tube, IV Ringer's lactate 100 mL/hr, repeat Hgb, Hct in AM.
4. Client D, 88 years of age, ventral hernia repair scheduled for 11 AM, NPO, hold medications except Lanoxin. Anesthetist will order preoperative medication.

32. A 51-year-old client is admitted with temperature 104°F (40°C), pulse 120, respirations 30. His wife states he has had a cold for several days and yesterday was "seeing bugs on the wall." He is disoriented in all three spheres, and the neurological examination is negative for increased intracranial pressure. Throat and blood cultures are positive for hemolytic streptococci. In planning his care, the nurse recognizes that his acute reversible brain syndrome is most likely the result of

1. Dehydration.
2. Elevated temperature.
3. Disoriented brain.
4. Infectious organisms.

33. A male client admitted himself to the alcoholic treatment unit because he is having blackout spells when he drinks. He is 47 years of age, lives alone, and has a history of early cirrhosis of the liver. In planning for his care the priority nursing activity is to

1. Monitor dietary selections and appetite.
2. Observe for withdrawal symptoms.
3. Institute 24-hour suicide precautions.
4. Measure abdominal girth daily.

34. A schizophrenic client becomes more withdrawn and suspicious of other clients. He constantly tries to argue with the nursing staff that several of the clients are "out to get him." The best nursing response to this behavior is to

1. Ignore the behavior and it will diminish.
2. Disagree with the client so that his fears won't be confirmed.
3. Avoid disagreeing with the client and get him involved with an activity.
4. Attempt to move rapidly into a nurse–client relationship to establish trust.

35. A 65-year-old male client with Parkinson's disease is being treated with L-dopa. The nurse will know he understands restrictions associated with the drug when he says that he avoids food rich in

1. Vitamin B_{12}.
2. Vitamin B_6.
3. Vitamin A.
4. Vitamin E.

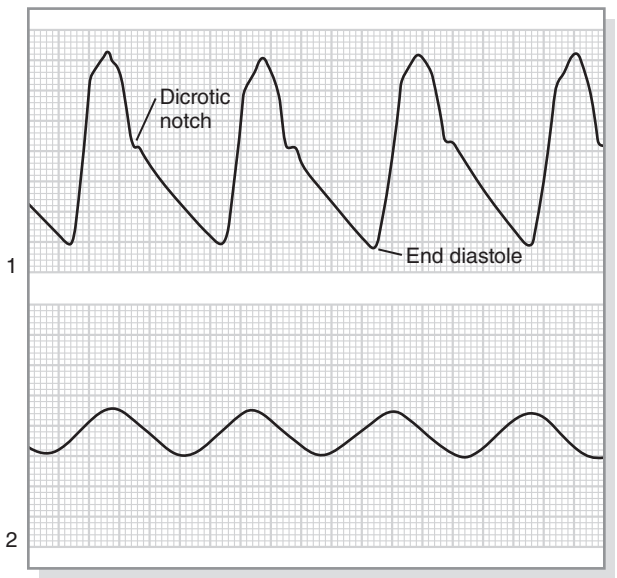
36. A client with alcoholic cirrhosis with ascites and portal hypertension is to receive neomycin. The desired effect of this drug is to

1. Sterilize the bowel.
2. Reduce abdominal distention.
3. Decrease the serum ammonia.
4. Prevent infection.

37. The priority nursing intervention for a child with meningitis is to

1. Frequently take vital signs and perform neurological checks.
2. Encourage fluids.
3. Administer antibiotics as ordered according to schedule.
4. Maintain respiratory isolation.

38. Your client has an arterial line inserted and you are assessing the waveform pattern. Fill in the blank with the number (1 or 2) of the waveform image that indicates damping has occurred in an arterial line: _____.



39. Appropriate toys for a 3-month-old infant would include

1. Soft, colorful squeeze toys and teething toys.
2. Teething toys with small, removable parts.
3. Push and pull toys, and pounding toys.
4. Balls and toys that stimulate the senses.

40. A client, age 11, is brought to the hospital by his parents and receives a diagnosis of acute rheumatic fever. While the nurse is assessing his heart sounds, she keeps in mind that the cardiac structure most susceptible to damage is the

1. Ventricle.
2. Atrium.
3. Tricuspid valve.
4. Mitral valve.

41. A client on the unit becomes agitated and assaultive when stressed. The nurse learns in report that his family did not visit him, and when making rounds finds him with clenched fists, pacing the hall. The best strategy for dealing with his behavior would be to first

1. Discuss with the client how he feels about his family not coming to visit him.
2. Ask the client to come to the dayroom where you can better observe him in case he becomes more agitated.
3. Invite the client to join you in an activity that you know he finds relaxing.
4. Ignore the body language of anger and allow the client to pace off his anxiety.

42. You are assigned to complete a physical assessment of a newly admitted client. You are assessing heart sounds. The position where you will detect S_1 heart sounds is over the

1. Fifth intercostal space, mid-clavicular line, and left sternal border.
2. Second intercostal space, left sternal border.
3. Lower left sternal border.
4. Second intercostal space, right sternal border.

43. While eating in the cafeteria, the nurse hears someone yell, "Help! My husband is choking!" The first intervention is to

1. Give him an abdominal thrust.
2. Give him a back blow.
3. Establish an airway.
4. Ask him, "Can you talk?"

44. Reviewing the chart before sending a surgical client to the operating room, nursing responsibilities would include notifying the physician if the

1. Erythrocyte count is 6 million/mm^3.
2. Leukocyte count is 5500/mm^3.
3. Hemoglobin is 14 g/dL.
4. Platelet count is 100,000/mm^3.

45. A client was admitted to the hospital 4 hours ago with a head injury, incurred when he fell off a ladder. The nurse observes his restlessness and understands that it is probably caused by

1. Decreased intracranial pressure.
2. Cerebral anoxia.
3. Dehydration.
4. Pain.

46. Which of the following clinical manifestations is a late indication that a client is developing increased intracranial pressure (ICP) following a head injury?

1. Restlessness.
2. Increased blood pressure.
3. Decreased pulse rate.
4. Widened pulse pressure.

47. A 63-year-old female client is admitted to the hospital. Her chart states that she has had a myocardial infarction that has progressed to cardiogenic shock. Which of the following parameters would indicate that cardiogenic shock is developing?

1. A widening pulse pressure.
2. Slow respiratory rate.
3. Bradyarrhythmias.
4. Decreasing arterial blood pressure.

48. Which one of the following conditions is a common cause of cardiogenic shock?

1. Fluid overload.
2. Electrolyte imbalance.
3. Left ventricular failure.
4. Constrictive pericarditis.

49. When caring for a client with acute pancreatitis, which of the following drugs, if ordered, would it be important to question?

1. Opiates.
2. Demerol (meperidine).
3. Antibiotics.
4. Anticholinergics.

50. An 18-year-old client is admitted to a psychiatric unit with a tentative diagnosis of antisocial personality. He recently physically assaulted his 16-year-old girlfriend when she wanted to break up with him. Assessing him, the nurse knows that a person with antisocial personality disorder can be described as

1. An individual of high intelligence who attempts to cope through manipulation.
2. A person with good superego development who manipulates others for the fun of it.
3. A person who appears very reasonable but who is highly manipulative.
4. A person who manipulates out of fear of punishment.

51. The major goal of therapy when Decadron (dexamethasone) is ordered for a client is to

1. Replace adrenocorticoids in clients following adrenalectomy.
2. Decrease inflammation in cerebral edema.
3. Reverse signs and symptoms of septic shock.
4. Delay complications of hepatic coma in cirrhosis clients.

52. The importance of providing instructions to women on self-examination of the breast is best reflected in which of the following statements?

1. The majority of breast abnormalities are first discovered by women.
2. Once a lesion has been discovered, the informed client may monitor the progress of the abnormality herself.
3. Breast cancer occurs much more often in women than men and is a major cause of death in women.
4. The high mortality rate of breast cancer can be most effectively reduced by early detection and adequate surgical treatment.

53. The client is transferred back to the unit immediately following a stapedectomy. The priority nursing action is to

1. Turn and deep-breathe the client.
2. Put the side rails up.
3. Check for drainage.
4. Test hearing capability.

54. Roxanol (morphine sulfate) is an agent used for patient-controlled analgesia (PCA). The usual concentration available in a vial injector is 1 mg/mL or _____ mg/mL. Fill in the blank with the correct number of milligrams.

55. A 47-year-old client is admitted to the hospital with a 3-day history of severe, burning abdominal pain in the left epigastric area. His admitting diagnosis is suspected peptic ulcer disease. Based on nursing knowledge, which of the following questions will reveal the most information concerning the source of the pain?

1. How long does the pain last?
2. Does exercise bring on the pain?
3. Do certain foods cause the pain?
4. When does the pain occur?

56. A client is scheduled for a gastroduodenoscopy, and the nurse will prepare him for this procedure. Preprocedure instructions would include information that during the procedure he will be

1. Heavily sedated.
2. Given a local anesthetic to ease the discomfort.
3. Asked to assist by coughing.
4. Asked to assist by performing a Valsalva maneuver.

57. An elderly client with infectious hepatitis (hepatitis A) and his family are being instructed by the nurse in prevention techniques. The single most important action to prevent this disease is

1. Not to eat out in public places.
2. Good personal hygiene.
3. Thorough hand washing.
4. Active immunization.

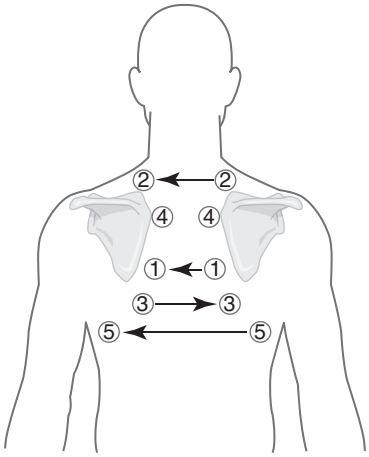
58. Nursing care in the first 24 hours following skin grafting will include

1. Maintaining a pressure dressing on the grafted area.
2. Monitoring continuous antibiotic irrigations to the grafted area.
3. Changing the dressings every 4 hours using sterile technique.
4. Irrigating the drains placed in the burn area every 4 hours with sterile saline solution.

59. A client has been brought to the immediate treatment center by the police for attacking his neighbor with a knife. His admitting diagnosis was schizophrenia. Beginning the admission process, the first nursing action would be to

1. Search the client for concealed weapons.
2. Ask the client how he is feeling.
3. Introduce herself to the client.
4. Get the client settled on the unit.

60. By choosing the correct number, indicate the point at which you would place your stethoscope as you start auscultating breath sounds: _____.



61. A client with coronary artery disease has a low-density lipoprotein (LDL) cholesterol level of 200 mg/dL. His physician has recommended that he start on Mevacor (lovastatin) to lower the level and slow the progression of atherosclerosis. In counseling the client, the nurse should emphasize

1. Taking this medication with niacin to lower the LDL level.
2. Notifying the physician if the client's gums begin to bleed.
3. Reporting a rash, myalgia, or blurred vision.
4. The photosensitization effects of the drug, and hence the need for sunscreen and protective clothing.

62. Oxygen is ordered for a 70-year-old client hospitalized for congestive heart failure. Which of the following methods of administration will deliver the highest concentration of oxygen?

1. Venturi mask.
2. Nasal prongs.
3. Oxygen catheter.
4. Mask with reservoir bag.

63. A client with damaged or impaired lungs cannot remove all of the CO_2 from the body. When the excess CO_2 combines with H_2O, it will form

1. H_2CO_3.
2. HCO_3.
3. H^+.
4. CO_2.

64. Which one of the following rules for charting narrative notes does not fit into acceptable charting procedures?

1. Each entry should be signed with the nurse's name and professional status.
2. Objective facts are more relevant than nursing interpretation.
3. Behaviors rather than feelings should be charted.
4. Use of the word *client* or *patient* is important to designate particular entries.

65. Before a client who suffered an attack of gout is discharged from the hospital, it is important to evaluate his knowledge of dietary management. Which one of the following diet choices would indicate to the nurse that he understands his dietary restrictions?

1. Liver, potato, and spinach.
2. Crab cakes, rice, and peas.
3. Antipasto salad, beans, rice, and asparagus.
4. Steak, baked potato, and green salad.

66. A 3-year-old child who is semiconscious with a low-grade fever is brought to the emergency room. The physician suspects a severe case of lead poisoning. The nurse expects that the child will be treated with

1. Calcium disodium edetate (EDTA).
2. Erythromycin.
3. Activated charcoal.
4. Syrup of ipecac.

67. A client has a 1000-mL bag of D5/0.45 NS hung at 10 AM/1000 hrs. His 24-hour IV orders are for three bags of 1000 mL. What time should the second bag be hung? _____PM.

68. A female client has been hospitalized for 2 days with chronic congestive heart failure. Her physician has written orders that include Lasix IV and oxygen. The client suddenly complains of breathing difficulty. The immediate assessment indicates that she has bibasilar rales, increased pulse and blood pressure, and a frequent moist cough. The first nursing intervention is to

1. Give Lasix IV push according to standing orders.
2. Apply rotating tourniquets according to standing orders.
3. Place the client in high-Fowler's position.
4. Call the physician and inform him of the change in her condition.

69. When caring for a client diagnosed with pulmonary edema who is receiving oxygen, the nurse observes that

she frequently removes her oxygen mask even though she is dyspneic. The appropriate nursing intervention is to

1. Change from O_2 mask to O_2 cannula.
2. Increase the liter flow of O_2 to 10 L/min.
3. Tighten the strap on the O_2 mask.
4. Change O_2 administration to a Venturi mask.

70. When a cardiac client is brought to the emergency room with ventricular arrhythmias, the drug of choice is

1. Lanoxin (digoxin).
2. Inderal (propranolol).
3. Xylocaine (lidocaine).
4. Roxanol (morphine sulfate).

71. The nurse explains to a client with a duodenal ulcer that his ulcer diet will most likely include

1. Six small feedings of regular food.
2. Milk or cream every 2 hours.
3. A regular diet without milk.
4. A high-fiber diet without spices.

72. A client is diagnosed as schizophrenic, catatonic type, and has been in the hospital for 3 weeks. The client has just been told that her father was in a bad automobile accident and is critically ill in the hospital. Her response is to smile and ask what time lunch is served. This response is an example of

1. Lack of affect.
2. Inappropriate affect.
3. Disturbed association of ideas.
4. Primary disturbance.

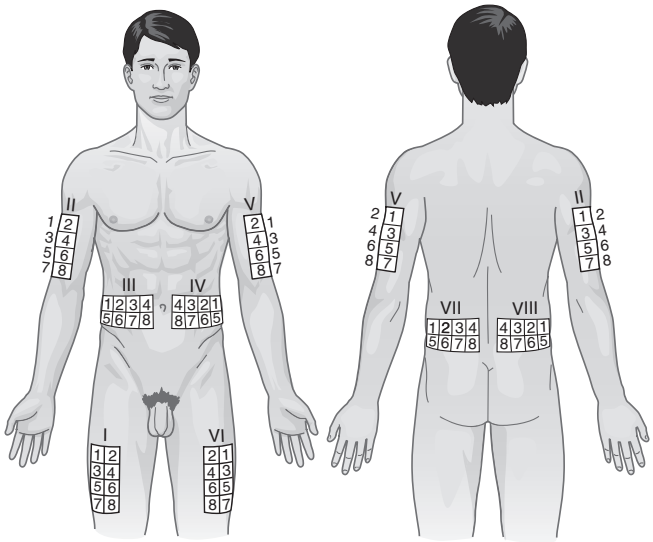
73. The appropriate nursing response to a client's question asking when lunch will be served after the nurse tells her that a family member is in the hospital, critically ill, would be

1. "Did you hear what I said?"
2. "Your father is critically ill. Don't you want to talk about it?"
3. "You are blocking, and I think you need to talk about your feelings."
4. "I told you your father was critically ill, and you asked what time lunch would be served."

74. A client has been diagnosed as having early-stage cancer of the transverse colon. The physician has explained to the client that she needs to have part of her colon removed (partial colectomy). Knowing this, the nurse would explain to the client that postoperatively the elimination process will be done through

1. An ileostomy for elimination.
2. Normal elimination.
3. A temporary colostomy for elimination.
4. A permanent colostomy for elimination.

75. On the images below, identify the two areas preferred for insulin injections.



1. I and II.
2. II and V.
3. I and VI.
4. III and IV.

COMPREHENSIVE TEST 3 ANSWERS WITH RATIONALE

1. (2) The nurse's priority is to assess the client for pain. The presence of chest pain can cause the pulse rate to increase and blood pressure to drop. It can also increase client anxiety. The client is on a cardiac monitor; therefore, an apical pulse (1) is not the priority action. Once his comfort has been established, apical pulse, blood pressure (4), and heart sound determinations are appropriate.

   NP:A; CN:PH; CA:M; CL:A

2. (1) Elevated CK-MB, which rises within 6 hours after an MI has occurred, is indicative of myocardial damage. SGOT is not specific to heart disease alone and LDH is not as specific as answer (1) in the diagnosis of myocardial infarction, even though the level rises in 6 to 8 hours and persists longer.

   NP:AN; CN:PH; CA:M; CL:C

3. The answer is *0.50 mL* per minute. Each 500 mL of IV fluid contains 2000 mg of Xylocaine. One mL of IV fluid contains 4 mg; therefore, the client will receive 0.5 mL per minute.

   NP:I; CN:PH; CA:M; CL:A

4. (4) This menu provides the lowest amount of sodium. Turkey, spinach, shellfish, and beets are high in sodium, and thus would not be included in a low-sodium diet.

   NP:E; CN:PH; CA:M; CL:C

5. (2) Right-sided heart failure manifests systemic symptoms rather than respiratory involvement. Symptoms include weight gain and edema of the dependent parts of the body. Although anorexia may be a symptom, skipping one meal is not indicative of anorexia and is not as significant as the sacral edema.

   NP:A; CN:PH; CA:M; CL:A

6. (1) Children with active infections, such as impetigo, should not be immunized.

   NP:A; CN:H; CA:P; CL:A

7. (2) The strip shows ventricular fibrillation, which means that the ventricles of the heart are quivering with no audible heartbeat or pulse. The client must be defibrillated.

   NP:A; CN:S; CA:M; CL:AN

8. (2) Ventricular fibrillation means the heart is quivering and not pumping effectively. The intervention is to call the code team to begin defibrillating the client. Doing nothing, continuing to monitor, or repeating checking out the rhythm strip will be dangerous because the client should be defibrillated immediately.

   NP:I; CN:S; CA:M; CL:AN

9. (4) Cold chills could indicate the spread of infection throughout the urinary tract. Answers (2) and (3) might be present after the procedure, as would difficulty in voiding (1).

   NP:E; CN:PH; CA:M; CL:C

10. (3) Ultrasonography is the most accurate test of those listed for determining pregnancy, and can now be used as early as 5 weeks. Hearing the fetal heart tone (1) is the safest means to determine EDD (previously called EDC). However, the heart rate cannot be heard until 20 weeks' gestation. Serial estriols (2) and the nonstress test (4) are done later in pregnancy as methods of determining fetal status or fetal well-being.

    NP:AN; CN:H; CA:MA; CL:C

11. (3) The single most important question is to ask directly and specifically if the client has been abused. A direct question is more apt to elicit an honest and direct response. Always do this privately so that the client will feel free to speak and will not be intimidated.

    NP:A; CN:PS; CA:M; CL:A

12. The correct answers are *2* and *3*. Upper airway obstruction is a major problem in small children, because toys with

Coding for Questions/Answers Abbreviations: Nursing Process: NP, Assessment: A, Analysis: AN, Planning: P, Implementation: I, Evaluation: E; Client Needs: CN, Safe, Effective Care Environment: S, Health Promotion and Maintenance: H, Psychosocial Integrity: PS, Physiological Integrity: PH; Clinical Area: CA, Medical Nursing: M, Surgical Nursing: S, Maternal/Newborn Nursing: MA, Pediatric Nursing: P, Psychiatric Nursing: PS; Cognitive Level: CL, Knowledge: K, Comprehension: C, Application: A, Analysis: AN.

small parts could cause a toddler to choke. Most toddlers are engrossed in large-motor activity, and they love imaginative toys that utilize large muscle groups. Fine-motor skills are more appropriate for preschoolers and older children. Colorful mobiles are appropriate for infants.

NP:P; CN:H; CA:P; CL:C

13. (3) The child will be given a low-residue, high-calorie diet. Children with aganglionic disease tend to be thin and undernourished, despite their large and distended abdomens. Improving the child's nutritional status before surgery is very important. (1) is always true, but not the best answer. Tap-water enemas can cause water intoxication.

    NP:I; CN:PH; CA:S; CL:A

14. (3) It is of primary importance to assess the suicide potential of clients presenting symptoms of depression. The client is asking for medication that could be used to overdose, so suicide potential is crucial to assess. The other factors are also important to assess, but are not the priority.

    NP:A; CN:PS; CA:PS; CL:C

15. (1) To ensure that goals are attainable, they must be set by both nurse and client. The other answers are important but cannot be achieved without the mutually agreed-upon goals. All outcomes must be measurable to determine whether they have been achieved.

    NP:P; CN:PS; CA:PS; CL:K

16. (3) The client may be denying the feelings that belong to her and projecting them onto her husband. Depressed clients often cannot express anger directly and either repress it, project it to others, or deny these feelings.

    NP:AN; CN:PS; CA:PS; CL:C

17. (2) The onset of insulin-dependent diabetes mellitus type 1 is often insidious, becoming manifest only after some metabolic stress, such as infection.

    NP:A; CN:PH; CA:M; CL:C

18. (1) Edema, proteinuria, and hypertension are the three cardinal signs of preeclampsia. Normal urine output or oliguria occurs rather than polyuria (4).

    NP:A; CN:H; CA:MS; CL:C

19. The answer is *0.20 second*. The PR interval represents the time it takes for the impulse to traverse the atria to the atrioventricular (AV) node. The normal range is 0.12 to 0.20 second.

    NP:AN; CN:H; CA:M; CL:C

20. (4) The most therapeutic response is to acknowledge that the client is upset and offer the opportunity to discuss these feelings. The other responses close off communication.

    NP:I; CN:PS; CA:PS; CL:A

21. (1) This is the most comprehensive answer. In addition to gastric resections, clients with a radical mastectomy, thoracotomy, or abdominal perineal resection experience extensive metabolic disturbances. The metabolic disturbance is related to the effects of total stress the client is experiencing.

    NP:P; CN:PH; CA:S; CL:A

22. (3) Before explaining the importance of holding the baby to develop the mother–child relationship, it is necessary to find out how the mother is feeling and to identify her fears. All of the other responses close off communication.

    NP:I; CN:H; CA:P; CL:A

23. (2) Cushing's syndrome is characterized by exaggeration of normal physiological conditions generally shown by weight gain and protein wasting. Answer (1) is caused by adrenal medulla disease. Answer (3) is caused by hyperthyroidism.

    NP:A; CN:PH; CA:M; CL:A

24. (1) Adrenalectomy necessitates replacement therapy with both glucocorticoids and mineralocorticoids for up to 6 months. Teaching the client about steroid administration before the surgery will help achieve goals after the surgery.

    NP:P; CN:PH; CA:S; CL:C

25. (1) This reflex is termed the Moro reflex, also termed the startle reflex. This reflex is present at birth, is symmetrical, and disappears around 4 months of age.

    NP:A; CN:H; CA:MA; CL:C

26. (1) Lactating mothers need four to five glasses of milk a day. They should never be advised to restrict any nutrient or attempt to diet during lactation.

    NP:I; CN:H; CA:MA; CL:K

27. (2) Because the most common complication of total joint replacement is dislocation, correct positioning is important. Turning the client on either side without keeping the abduction pillow in place could lead to dislocation of the new prosthesis.

    NP:E; CN:S; CA:M; CL:A

28. (3) The triad associated with early ruptured extrauterine pregnancy includes the menstrual cycle history, unilateral pelvic pain, and presence of a cul-de-sac mass.

    NP:I; CN:PH; CA:MA; CL:A

29. (2) It is not necessary to immobilize the child's elbow joints. The other interventions are necessary to maintain the appropriate traction.

    NP:E; CN:PH; CA:P; CL:C

30. (4) Bowel and bladder retention or incontinence is a major problem with clients who have multiple sclerosis; therefore, establishing a good routine for evacuation is essential. Weight control is usually not a problem. While exercising (1) is important, specific exercises for muscle strengthening or decreasing tremors are not effective. Multiple sclerosis clients do not take medication routinely (3).

    NP:P; CN:S; CA:M; CL:C

31. (3) Client C—the nurse should first assess the most acute client, which is the client with GI bleeding. Client A (1) is second-day postoperative so he can wait, as can client B (2). The nurse would assess client D (4) next, because he is scheduled for surgery and should be NPO except for medications.

    NP:A; CN:PH; CA:M; CL:AN

32. (4) The primary cause of his neurological symptoms would be bacterial infection.

    NP:A; CN:PH; CA:M; CL:A

33. (2) The nurse's priority is to observe for symptoms of withdrawal. Although nursing activities may include monitoring diet (1) and measuring abdominal girth (3), there is no need for suicide precautions at this time.

    NP:P; CN:PH; CA:M; CL:A

34. (3) The best choice is to encourage the client to become involved in an activity to get his mind off the paranoid thoughts. The nurse would also avoid power struggles (as this increases anxiety). Answer (4) is wrong because proceeding with nursing therapy too rapidly will cause a suspicious client to be more distrustful.

    NP:I; CN:PS; CA:PS; CL:A

35. (2) Foods rich in vitamin B_6 block the desired effects of L-dopa; therefore, they need to be omitted from the diet. Examples of foods to be avoided include meat, especially organ meats; whole-grain cereals; peanuts; and wheat germ. Vitamin A (3) or beta-carotene (found in fruits and vegetables) does not need to be limited.

    NP:E; CN:PH; CA:M; CL:A

36. (3) Neomycin does sterilize the bowel (1), but the rationale for use or desired outcome of this medication is to reduce ammonia production by enteric bacteria. It is not a systemic antibiotic.

    NP:E; CN:PH; CA:M; CL:C

37. (3) Even though all interventions will be carried out, administering antibiotics is the priority. Antibiotics are started after the lumbar puncture is done and the organism is identified.

    NP:I; CN:PH; CA:P; CL:A

38. (2) Waveform (2) shows that damping has occurred. The flattened arterial waveform indicates damping, which results from obstruction in the arterial line or imbalance of the transducer.

    NP:A; CN:PH; CA:M; CL:AN

39. (1) Toys should be visually appealing without small parts (2) that could choke an infant. Exploration through the mouth begins at 3 months. Push and pull toys (3) and balls (4) are appropriate for the mobile, older baby.

    NP:P; CN:H; CA:P; CL:K

40. (4) The mitral and aortic valves are most susceptible to damage as a result of this inflammatory disease.

    NP:AN; CN:PH; CA:P; CL:C

41. (1) Helping the client verbalize will reduce his tension. Later, or in addition, engaging him in an activity that he finds relaxing (3) will help prevent possible assaultive behavior, because stress reduction and assaultive behavior are incompatible. The body language (4) is an important cue, and it is important to pick it up.

    NP:P; CN:PS; CA:PS; CL:A

42. (1) Using the diaphragm of the stethoscope, S_1 sounds are best heard over mitral and tricuspid areas, fifth intercostal space, mid-clavicular line. S_2 sounds are heard over the pulmonic valve (2) and the aortic valve (4). S_3 sounds are heard over the left sternal border.

    NP:P; CN:PH; CA:M; CL:A

43. (4) By asking, "Can you talk?" the nurse establishes that the person has something in his airway. If he is able to answer, he is not choking. A person is unable to talk when choking.

    NP:I; CN:PH; CA:M; CL:A

44. (4) All of the other reports are within normal range. The low platelet count signifies thrombocytopenia. Bleeding can result from this low platelet count and the cause should be researched before surgery. Normal platelet count is 150,000 to 450,000/mm^3.

    NP:I; CN:PH; CA:S; CL:A

45. (2) Cerebral anoxia occurs frequently in severe trauma to the brain. A blood clot or edema can cause an interruption of the blood circulation, which alters oxygen supply to the tissue. Reduced oxygen causes anoxia.

    NP:AN; CN:PH; CA:M; CL:C

46. (4) Widened pulse pressure is a late sign. Restlessness (1) is the earliest sign of increased intracranial pressure and is due to compression of the brain from edema or hemorrhage (or both) causing hypoxia. Blood pressure (2) and pulse changes (3) are not the earliest clinical manifestations of increased intracranial pressure.

    NP:A; CN:PH; CA:M; CL:C

47. (4) As the left ventricle fails in its pumping action, the blood pressure will fall. A widened pulse pressure (1) (the difference between systolic and diastolic pressures) is indicative of decreased peripheral vascular resistance. As the heart fails, the pulse increases in an attempt to circulate more blood, and the respiratory rate (2) increases in an effort to take in more oxygen.

    NP:E; CN:PH; CA:M; CL:A

48. (3) When the pump of the heart (left ventricle) is damaged, it cannot eject a normal cardiac output and the circulatory system begins to fail. Fluid overload (1) would cause a weak left ventricle to fail, but a normal myocardium would stretch and contract with increased force to handle the increased fluid. Electrolyte imbalances (2) can cause cardiac decompensation by way of arrhythmias (potassium) and decreased force of contraction (calcium).

    NP:AN; CN:PH; CA:M; CL:C

49. (1) Opiates are contraindicated, as they may produce spasm of the biliary–pancreatic ducts. Thus it would be important to notify the physician and question the order. Synthetic narcotics (Demerol) are the drugs of choice for pain control.

    NP:P; CN:PH; CA:M; CL:A

50. (3) The client's ability to behave within normal standards and yet be highly manipulative is characteristic of the antisocial personality. This makes it difficult not only to work with the client, but at times to diagnose him. His superego (2) is poorly developed. He may or may not have a high IQ (1).

    NP:AN; CN:PS; CA:PS; CL:C

51. (2) Decadron decreases inflammation by stabilizing leukocyte lysosomal membranes. It also suppresses the immune response, so it is contraindicated in clients with infection, cirrhosis, and debilitating disease.

    NP:P; CN:PH; CA:M; CL:C

52. (4) Health professionals have the responsibility to provide clear guidelines focused on the prevention and early treatment of breast cancer. Self-examinations following menstruation coupled with annual screening examination by the physician are very effective in detecting early breast cancer.

    NP:AN; CN:H; CA:M; CL:K

53. (2) The issue is safety; thus the side rails should be up. Clients can sometimes experience vertigo and could fall from bed. Finally, clients should not be turned postoperatively unless there is a specific order to do so.

    NP:I; CN:PH; CA:S; CL:A

54. The answer is 5. Roxanol 1 mg/mL or *5 mg/mL* can be used for PCA.

    NP:P; CN:S; CA:S; CL:C

55. (4) The symptoms of peptic ulcers are due to mucosal inflammation. There is usually pain when the stomach is empty: 1 to 3 hours after meals in gastric ulcers and 3 to 4 hours after meals in duodenal ulcers. The other questions already make the assumption that the client has ulcer disease. The pattern of the pain will help to determine whether he has ulcer disease.

    NP:A; CN:PH; CA:M; CL:C

56. (2) A gastroduodenoscopy is the visualization of the esophagus, stomach, and duodenum through a flexible tube inserted orally. The exam is not a comfortable one because the muscles of the gastrointestinal

tract have spasms as the tube is passed. This causes difficulty swallowing. The client is usually given a local anesthetic to the posterior pharynx to reduce the discomfort during the passage of the tube. He will not be heavily sedated (1) because he must be able to assist by swallowing. Coughing (3) or performing a Valsalva maneuver (4) would impede the passage of the tube.

NP:I; CN:PH; CA:S; CL:C

57. (3) Thorough hand washing is the most important action to prevent the transmission of hepatitis A. Good personal hygiene (2) is also important, but it does not replace hand washing. Contaminated food is a mode of transmission. Passive immunization is prevention.

NP:P; CN:H; CA:M; CL:C

58. (1) The pressure dressing is used to prevent fluid accumulation under the graft site as well as to promote immobilization of the affected area. Drains are frequently placed under the skin flap to promote drainage. The drains are attached to suction; they are not irrigated.

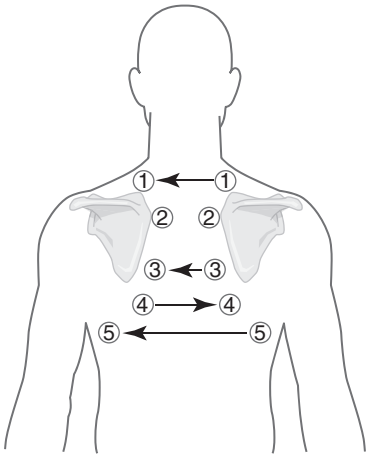
NP:I; CN:PH; CA:M; CL:C

59. (3) It is important for the nurse to introduce herself and make contact, rather than search the client for weapons (1), ask how he is feeling (2), or get the client settled (4). Introduction is acknowledgment and the first step in establishing a relationship.

NP:I; CN:PS; CA:PS; CL:A

60. (2) You would start auscultating at the top of the lungs and move down according to the numbers on the diagram shown below.

NP:I; CN:PH; CA:M; CL:A



61. (4) The LDL is high (normal is 60–100). Photosensitization is a risk for clients taking hepatic hydroxymethylglutaryl coenzyme A (HMG-COA) reductase inhibitors (Mevacor). Niacin is usually given with bile acid sequestrants because they work synergistically (1). Bleeding from the gums (2) or rectum is a sign of vitamin K deficiency from bile acid sequestrants (Questran [cholestyramine]). Rash, myalgia, and blurred vision (3) are adverse effects of fibric acid derivatives, which are not very effective in lowering LDL.

NP:I; CN:PH; CA:M; CL:A

62. (4) A flow of 8 to 10 L will provide an FIO_2 of 70% to 100%. The reservoir bag contains a high level of oxygen. As the client inhales, oxygen is taken in from the bag. The Venturi mask (1) delivers a fixed FIO_2, usually 24% to 35%. A 38% to 44% FIO_2 is the maximum amount of oxygen delivered through prongs (2).

NP:P; CN:PH; CA:M; CL:C

63. (1) Excess CO_2 in the blood, when combined with H_2O, forms H_2CO_3—carbonic acid. Depending on the amount of acid in the blood, the lungs will increase or decrease ventilation to remove excess CO_2. The kidneys can excrete or retain H^+ and HCO_3, so the equation representing homeostasis is

$$CO_2 + H_2O = H_2CO_3 = H^+ = HCO_3$$
(Lungs) (Kidney)

NP:A; CN:PH; CA:M; CL:AN

64. (4) The words *patient* or *client* should not be used, as the chart belongs to the client; thus adding it to the chart is redundant.

NP:P; CN:S; CA:M; CL:K

65. (4) Steak is the best choice because foods highest in purine are shellfish, liver, chicken, beans, asparagus, and various vegetables. The appropriate diet will include high carbohydrates with calorie control.

NP:E; CN:S; CA:M; CL:A

66. (1) Calcium disodium edetate, or EDTA, is a chelating agent that promotes the excretion of lead from the body by attaching to the lead and carrying it out through the kidneys.

NP:P; CN:PH; CA:P; CL:K

67. The answer is *6 PM* to hang the second bag. Each bag will cover 8 hours of a 24-hour order.

    NP:P; CN:PH; CA:M; CL:A

68. (3) It is best to first do the nursing intervention that immediately helps the client's condition while the nurse is preparing more definitive therapy. High-Fowler's position decreases venous return to the heart. Lasix would then be given and the physician notified.

    NP:I; CN:S; CA:M; CL:A

69. (1) Clients often feel that they cannot breathe when experiencing pulmonary edema. A mask may increase this feeling. A cannula is often better tolerated and should be used in this case.

    NP:I; CN:S; CA:M; CL:A

70. (3) Xylocaine is the drug of choice because it depresses ventricular irritability. Inderal is contraindicated as it is a beta-adrenergic inhibitor. It also depresses cardiac function. For a client who already has a compromised cardiac status, this could be fatal. Roxanol reduces anxiety, but will not prevent arrhythmias. Lanoxin is used to strengthen ventricular contraction.

    NP:P; CN:PH; CA:M; CL:C

71. (3) Most physicians now prescribe a regular three-meal routine, eliminating roughage, gas-forming foods, highly spiced foods, and gastric acid stimulants such as caffeine, alcohol, and smoking. In the past, milk and cream were the mainstays of dietary ulcer therapy. They were taken every hour, with antacids in between. Currently, it is believed that this regimen increases gastric acid secretion. A bland diet has no effect on peptic ulcer disease. Some physicians do prescribe six small feedings of bland food to keep food in the stomach.

    NP:P; CN:H; CA:M; CL:C

72. (2) The client's response is inappropriate to the situation and is an example of inappropriate affect. Lack of affect is when there is no response (including facial expression). Both are indicative of a schizophrenic reaction.

    NP:AN: CN:PS; CA:PS; CL:K

73. (4) The client's response is inappropriate to the situation and is an example of inappropriate affect. Lack of affect is when there is no response (including facial expression). Both are indicative of a schizophrenic reaction.

    NP:AN; CN:PS; CA:PS; CL:C

74. (2) A partial colectomy is removal of a portion of the colon and reanastomosis of the remaining ends; therefore, elimination will occur normally.

    NP:I; CN:PH; CA:S; CL:K

75. (4) The area preferred is around the umbilicus in the abdominal area because absorption is quickest and most reliable. Other sites are acceptable but not preferred.

    NP:P; CN:PH; CA:M; CL:A