Safe and Effective Care Environment

Management of Care

1. The nurse receives a new admission to the medical-surgical unit during a busy shift. Which interventions does the nurse safely delegate to the UAP? Select all that apply.

A. Documenting the new client's medical history
B. Taking the new client's vital signs
C. Taking other clients' vital signs
D. Providing the new admission with socks and a water pitcher
E. Educating the new client on the prescribed medications

Answers Rationale: The correct answers are C and D. It is within the UAP's scope of practice to take vital signs and provide the client with needed items, such as water and socks. However, the initial vital signs on a new admission should be taken by the nurse as they are part of the initial assessment and help the nurse obtain the client's baseline. Additionally, UAPs should not take vital signs on unstable clients, and a new admission is often unstable. Taking and documenting a client's medical history and providing education are outside of the scope of practice of a UAP. The RN cannot delegate any functions related to assessment, evaluation, education, and nursing judgment.

2. A nurse is reprimanded for breaking HIPAA laws. Which action by the nurse constitutes a breach of confidentiality?

A. The nurse told the UAP that one of their clients has a bleeding disorder
B. The nurse posted a picture of herself and another nurse eating in the hospital cafeteria
C. The nurse shared a picture of a client's wound on social media, but no face was shown
D. The nurse reported that a teenager was sexually abused after the client asked not to tell anyone

Answers Rationale: The correct answer is C. Sharing pictures or information about a client on social media breaks HIPAA laws even if no faces are shown. Telling the UAP that one of the clients they care for is diagnosed with a bleeding disorder is necessary information for the UAP to carry out their work, so they are authorized to know. They will have to use special care if performing certain actions such as shaving the client or drawing blood. Posting a picture in the hospital cafeteria does not break any privacy laws. A teenager is a minor and sexual abuse of a minor must be reported by law to protect the child, even if they request to keep this confidential.

3. The nurse assists the healthcare provider with the insertion of a chest tube. Which actions surrounding this procedure are within the nurse's scope of practice?
A. Ensure consent has been signed
B. Set up the sterile field
C. Select and mark the incision site
D. Monitor the client's respiratory status and response

E. Document the procedure

Answers Rationale: The correct answers are A, B, D, and E. Though the healthcare provider (HCP) explains the procedure and obtains consent, the nurse will ensure the consent has been signed. This provides a double-check. The nurse can also reinforce education and prepare the client for the insertion of the tube by placing them in the right position. The nurse can also set up the sterile field for the procedure and monitor the client's response during and after the insertion, especially focusing on the respiratory status. The nurse will also document that the chest tube was inserted, the amount and color of the drainage, and other relevant information. Selecting and marking the incision site along with actually inserting the chest tube are outside the scope of an RN and are carried out by the HCP.

4. The nurse in an intensive care unit receives new orders from the HCP. **Place the orders in the correct priority**, from the most to the least critical.

A. Administering morphine to a client with a pain level of 9/10
B. Administering 12 units of long-acting insulin to a client with diabetes
C. Administering albuterol to a wheezing client
D. Stopping the vancomycin infusion for a client just diagnosed with vancomycin-resistant enterococcus (VRE)

Answers Rationale: The correct order is C, A, D, and B. Following the ABCs (Airway, Breathing, Circulation) protocol, the nurse must prioritize airway and breathing issues first, so the initial step is to administer albuterol, a rescue inhaler, to address the client's respiratory distress. Next, the nurse will attend to the client experiencing severe pain by administering morphine. Relieving pain is essential as it is the nurse's duty to provide comfort and improve the client's well-being. The third action is to stop the vancomycin infusion. This client has recently been diagnosed with VRE, an infection caused by vancomycin-resistant bacteria. Continuing the infusion is ineffective and unnecessary, though not immediately harmful. Discontinuing the infusion helps avoid potential side effects and the inappropriate use of a potent antibiotic. Finally, the nurse will administer long-acting insulin. This routine medication is not intended for acute hyperglycemia but rather for maintaining stable blood glucose levels over time; a slight delay in its administration will not lead to harm as it takes hours to take effect.

5. A client who is a Jehovah's Witness is admitted after a motor vehicle accident.
Which order does the nurse question?

A. 2 units of packed red blood cells
B. CT scan of the abdomen
C. 4 mg of IV morphine STAT
D. Tetanus (Tdap) vaccination

Answers Rationale: The correct answer is A. Jehovah's Witnesses do not accept blood transfusions, so the nurse will want to check if the client has consented to this transfusion or if they have a durable power of attorney if unconscious. This shows cultural and religious competence. The other orders should not be questioned. Different religious groups sometimes refuse vaccines and mind-altering substances like morphine, but not Jehovah's Witnesses.

6. A client in long-term care requests a do-not-resuscitate (DNR) order. The following week, the client clutches their chest and tells the nurse that they have severe chest pain and feels like they cannot breathe. Which intervention does the nurse implement?

A. Request that the healthcare provider remove the DNR order
B. Reassure the client that the nurse is by their side
C. Call a code and prepare for possible CPR and intubation
D. Obtain a prescription for an analgesic and an anxiolytic

Answers Rationale: The correct answer is D. A do-not-resuscitate order means that a client does not want the healthcare team to perform cardiopulmonary resuscitation, including giving chest compressions, cardiac drugs, or intubation in case of an emergency. The nurse must respect these wishes. Therefore, the correct action is to address the client's pain and breathlessness by making them comfortable administering painkillers and anxiolytics. The client reporting pain and breathlessness does not indicate that they want to remove the DNR order, but simply reassuring them is not enough, as it is the nurse's duty to make the client comfortable. Calling a code and preparing for CPR and intubation goes against the client's wishes.

7. The nurse manager is addressing a conflict between two nurses. Nurse A complains that the other refuses to help and lacks teamwork. In response, Nurse B argues that they always get assigned more clients and have a heavier workload. Which statement by the nurse manager exemplifies the collaboration strategy of conflict resolution?

A. "Nurse A, you need to be more patient, and Nurse B, be willing to help more"
B. "This is an issue that should be solved between you two. I will not get involved"
C. "I will try my best to make the workload fair so that Nurse B can assist the other nurses more"
D. "I will step in and help you both during the shift if you get too busy"

Answers Rationale: The correct answer is C. By collaborating, the parties involved can devise a win-win solution for both. In this case, making Nurse B's workload lighter will benefit the nurse, who will be less overloaded, and also the rest of the team, who will receive more assistance. Telling both nurses to make a sacrifice, such as asking Nurse A to be more patient and Nurse B to help more exemplifies the conflict resolution strategy of compromising. Not getting involved shows avoidance. Offering to step in and help the nurses during their shifts shows accommodation, but it may not be a realistic solution for a nurse manager.

Safety and Infection Control

8. The nurse is observing a new graduate nurse inserting an indwelling urinary catheter. Which action causes the experienced nurse to intervene?

A. The new nurse cleans the genital area with chlorohexidine swabs
B. The new nurse places the fenestrated drape between the client's legs
C. The new nurse wears clean gloves to apply lubricant on the tip of the catheter
D. The new nurse inflates the balloon after catheter insertion

Answers Rationale: The correct answer is C. The experienced nurse must intervene if the new nurse wears clean gloves to apply lubricant on the tip of the catheter. Inserting an indwelling urinary catheter is a sterile procedure as it carries a high risk of causing urinary tract infections, so the nurse

must wear gloves that are sterile, not clean, when inserting the catheter. The other actions are correct. The genital area is cleaned with chlorohexidine, the fenestrated drape is placed between the client's legs, and the balloon must be inflated after insertion to avoid causing injury.

9. While preparing to insert a PICC line, when does the nurse wear sterile gloves?

A. When opening the sterile field
B. When measuring the client's arm circumference
C. When dating and initialing the dressing
D. When scrubbing the client's skin with povidone-iodine

Answers Rationale: The correct answer is D. The nurse wears sterile gloves when scrubbing the client's skin as this is during the sterile part of the procedure, right before inserting the catheter. The nurse uses clean gloves to open the sterile field and package, where the sterile gloves are contained. The arm circumference is measured before the procedure is started, and the dressing is dated and initialed after the procedure is done, so sterility is not necessary for these interventions.

10. A nurse notices that a coworker frequently signs out narcotics for clients who later report not receiving pain relief. The coworker also seems unusually drowsy and frequently leaves the unit without explanation. What is the best action for the nurse to take?

A. Notify the nurse supervisor
B. Confront the nurse
C. Gather more evidence
D. Accompany the nurse on medication passes

Answers Rationale: The correct answer is A. Drug diversion is a serious and underreported issue in hospitals. If a nurse suspects or sees drug diversion, it is their duty to report it to protect the clients. The clients may not be receiving the medications they need, and an impaired nurse can make mistakes that harm others. Additionally, reporting possible drug diversion is in the nurse's best interest in case they have a substance abuse disorder for which they need help. If confronted, the nurse may lie or make excuses, prolonging the problem. Gathering more evidence may cause unnecessary delays. Accompanying the nurse on medication passes to monitor the medications they administer is not always feasible, the nurses may work on different shifts, and it does not address the root cause of the problem.

11. A nurse and a UAP are preparing to help a client who is overweight stand up. Which body mechanic principles must they keep in mind to prevent injury? Select all that apply.

A. Twisting at the torso
B. Keeping legs close together
C. Keeping the client close to their bodies
D. Bending the knees instead of the back
E. Setting the feet in a wide base

Answers Rationale: The correct answers are C, D, and E. Ergonomic principles that guide proper body mechanics include keeping the client close to the body to minimize forces on it, bending at the knees instead of the back, and setting the feet in a wide base to increase stability. The leg muscles are stronger than the back, so bending the knees and pivoting instead of twisting at the torso increases strength and protects the back muscles. Following these principles is crucial for nurses to prevent injury to themselves and their clients.

12. A client in triage reports severe abdominal pain. The healthcare provider orders a ketorolac injection along with an abdominal scan and complete blood cell count. Before administering the medication, what is the most important question for the nurse to ask?

A. What is your pain level?
B. How old are you?
C. Do you have any allergies?
D. When did you last eat something?

Answers Rationale: The correct answer is C. The most important question to ask any client before giving any new medication is whether the client has any known allergies. This is a safety measure to prevent allergic reactions, some of which can be life-threatening. Asking about the pain level is useful to get a baseline, but it is not as critical. Certain medications are not given to children, so it is important to ask the client's age. However, the nurse can visually assess whether the client is a child or an adult, so this question is not as important as asking about their allergic history. Other medications need to be taken on a full or empty stomach, but in an emergency setting with severe, acute pain this is not as critical.

Health Promotion and Maintenance

13. The nurse on a university campus meets with a 21-year-old student who shares issues they have been facing. Which statement by the student indicates a risk specific to this age group according to Erikson's stages of development?

A. "I feel bad about failing chemistry; my parents are paying for my classes"
B. "I don't think I'm really good at anything"
C. "I have been getting a lot of headaches lately, I think it's stress"
D. "I don't really feel connected to anyone here, I usually stay by myself"

Answers Rationale: The correct answer is D. According to Erikson's stage of development, a young adult is in the intimacy vs isolation stage. At this age forging meaningful relationships is paramount, and failure to forge these bonds can lead to loneliness and isolation. This student is facing this problem as they do not feel connected to anyone and spend their time alone. Feeling guilt, as indicated by the statement "I feel bad about failing chemistry", is more closely linked to the preschool stage of development of initiative vs guilt. "I don't think I'm really good at anything" is related to the industry vs inferiority stage, usually linked to school-age children. Getting headaches and feeling stressed is not related to any particular stage of growth and development.

14. The nurse is teaching clients in the community about hypertension prevention. Which individual has the highest risk for developing hypertension?

A. A 35-year-old woman pregnant with twins
B. A 55-year-old black male with a BMI of 34
C. A 79-year-old white male with a hip fracture
D. A 26-year-old male who drinks 3 cups of coffee a day

Answers Rationale: The correct answer is B. This individual has the most risk factors, being a black, middle-aged man with obesity. The 35-year-old pregnant woman may be at risk for gestational hypertension, but this is a temporary condition and we don't have any other risk factors. Having a hip fracture is not a risk factor for hypertension. Drinking coffee can

temporarily increase blood pressure, but is not a main concern in an otherwise healthy young adult.

15. A 40-year-old woman asks the nurse about recommended preventative health screenings for her age. Which screening should the nurse suggest?

A. Bone density scan
B. Mammogram
C. Colonoscopy
D. PAP test

Answers Rationale: The correct answer is B. Mammograms are recommended every 1-2 years for women 40 and up. Bone density scans and colonoscopies are usually recommended later in life, after menopause and from age 50 respectively. A PAP test is not specific for women in their 40s but should be started around 21 years of age.

16. The nurse is observing the mother of a newborn receiving phototherapy for hyperbilirubinemia. Which actions cause the nurse to intervene? Select all that apply.

A. The mother places socks and a hat on the baby
B. The mother puts lotion on the baby's dry skin
C. The mother takes the infant out of the isolette to breastfeed for 20 minutes
D. The mother changes the infant's diaper while in the isolette
E. The mother puts the baby's eyeshields back on after they fall off

Answers Rationale: The correct answers are A and B. These actions cause the nurse to intervene because they may reduce the effectiveness of treatment. Phototherapy breaks down the bilirubin in an infant's body, reducing the high levels. To be effective, as much skin as possible must be exposed, so the newborn should not wear anything but a diaper and eyeshields. Extra clothes like hats and socks and lotion can serve as a barrier. Additionally, lotion can make the skin overheat. Taking the infant out to breastfeed is appropriate, but the infant should not be kept outside of the isolette unnecessarily, so changing the diaper while keeping the baby inside is recommended. The eyeshields are important to protect the baby's eyes from the strong lights, so they should be put back in place if they fall off.

Psychosocial Integrity

17. A client with a suspected diagnosis of schizophrenia tells the nurse about hearing voices. What is the most important question for the nurse to ask?

A. How long has this been going on for?
B. Do you have a family history of schizophrenia?
C. What do the voices say?
D. How frequently do you hear the voices?

Answers Rationale: The correct answer is C. Auditory hallucinations (”hearing voices”) often tell those experiencing them to do something dangerous, such as killing themselves or others. The nurse needs to assess if the client is experiencing this type of hallucinations to keep the client and

others safe. The other questions are useful in understanding the severity of these auditory hallucinations and to help confirm the client's diagnosis, but safety comes first.

18. A client reports frequently waking up sweating with a racing heart and shortness of breath in the middle of the night. They are usually able to calm themselves down by taking slow breaths, but they started not wanting to go to sleep for fear of these episodes occurring again. Which condition does the nurse suspect?

A. Generalized anxiety disorder
B. Panic attacks
C. Congestive heart failure
D. Panic disorder

Answers Rationale: The correct answer is D. The client's symptoms are most consistent with panic disorder. Panic disorder involves having recurring panic attacks, which present with symptoms such as heart racing, shortness of breath, and sweating, and worrying about the next panic attack. This affects the person's daily activities, as evidenced by this client's fear of going to sleep. Generalized anxiety disorder involves a constant worry that cannot be controlled, but in this client's case, the main symptoms are panic attacks. However, the client is not simply having sporadic panic attacks due to very stressful events. Since the attacks are occurring frequently, this is panic disorder. Congestive heart failure may cause shortness of breath and tachycardia in the middle of the night, but since the client can stop the symptoms by simply taking a few slow breaths, the condition is most likely psychological. However, investigations should still be made to rule out other conditions.

19. The nurse is caring for a client with anorexia nervosa. What is the primary long-term treatment goal for this client?

A. To help the client reach a normal body mass index (BMI)
B. To learn coping mechanisms and have a healthy body image
C. To restore menses and hormonal imbalances
D. To provide the client with a good support system

Answers Rationale: The correct answer is B. By teaching the client better coping mechanisms and helping them attain a healthy body image, the problem can be fixed at the root. Though restoring a healthy body weight and hormonal balance are the initial treatment goals and paramount to avoid complications, the client may go right back to their old habits if the underlying issues are not fixed. A good support system is useful but the client needs intrinsic motivation to improve. Even with a good support system, a client may secretly continue unhealthy eating behaviors.

20. A client with suicidal ideation who is under 24-hour observation suddenly seems more cheerful and eager to participate in group activities. What intervention does the nurse implement?

A. Notify the provider that the client requires less intensive observation
B. Increase the level of observation and explore the client's feelings
C. Discourage the client from participating in too many activities all at once
D. Request a prescription to wean the client off of antidepressants

Answers Rationale: The correct answer is B. When a client with suicidal ideation suddenly appears more cheerful and engaged, it could indicate they have made the decision to act on their suicidal thoughts. This requires increased observation and communication with the client and the healthcare provider. The nurse should not be quick to assume that the client is "all better" by requesting to

reduce observation and antidepressant dosage. At the same time, there is no need to discourage the client from participating in activities if they are eager to do so.

Physiological Integrity

Basic Care and Comfort

21. A client tells the nurse that they only have 3-4 stools a week and they are usually small and dry. Which advice does the nurse provide to this client? Select all that apply.

A. Take an over-the-counter laxative daily
B. Increase your water intake to at least 8 glasses a day
C. Eat plenty of fruits, vegetables, whole grains, and legumes
D. Create a toileting schedule and do not go outside of those times
E. Engage in some physical activity every day

Answers Rationale: The correct answers are B, C, and E. Constipation can be improved by increasing fiber intake (found in fruits, vegetables, whole grains, and legumes), being well hydrated, and engaging in physical activity, which increases peristalsis. Laxatives should be prescribed by the healthcare provider and only used on a short-term basis. Other measures should be attempted first as laxatives can be too powerful, irritating, and cause dependence. A toileting schedule can be useful to improve regularity, but an individual should never hold their stool but go anytime they feel the urge. Holding stools can worsen constipation.

22. The nurse is caring for four clients. Which client will benefit from a pureed, soft diet?

A. The client with dysphagia post-stroke
B. The client who had a bowel resection 8 hours ago
C. The client with vomiting and diarrhea
D. The client with a Glasgow Coma Scale (GCS) score of 7

Answers Rationale: The correct answer is A. A client with dysphagia has difficulty swallowing, so a pureed diet is indicated to make chewing easier and prevent choking or even aspiration. A client 8 hours post bowel resection usually cannot tolerate food but only clear liquids until the bowels start healing and moving again. A client with vomiting and diarrhea may not be able to keep any food down, so intravenous hydration or small sips of liquids would be more beneficial. A client with a GCS score of 7 has severe impairment in consciousness level and should not be fed by mouth.

23. The nurse is checking the gastric residual volume (GRV) of a client before administering an enteral bolus feed. The content aspirated equals 200 mL. What is the next action by the nurse?

A. Hold the feeding and notify the healthcare provider
B. Discard the residual content and administer the feeding
C. Administer the feeding as prescribed
D. Wait one hour and recheck the GRV before giving the bolus

Answers Rationale: The correct answer is C. Bolus feedings can be administered as long as the GRV is below 500 mL and the client is not showing any signs of distress. 200 mL is not a very significant amount. Holding or delaying the feeding, or discarding the stomach content, would cause more harm than good by depriving the client of needed nutrition.

24. The nurse is providing education to a client with newly fitted hearing aids. Which teaching does the nurse include?

A. Turn the aids on before inserting them
B. Remove the battery when not in use to conserve it
C. Remove the hearing aids if you go swimming
D. Wear them 24 hours a day for the first week
E. Wipe them regularly with a damp cloth

Answers Rationale: The correct answers are B, C, and E. The battery should be removed when not in use to conserve it, and the aids should not be submerged in water but cleaned with a damp cloth to avoid damaging the internal components. The aids should be turned on after inserting them, not before, to avoid uncomfortable feedback. It takes time to adjust to new hearing aids, so the client should have rest periods at first and gradually increase the amount of hours they are worn daily.

Pharmacological and Parenteral Therapies

25. The nurse is caring for a client diagnosed with diabetes mellitus type 2. The client has a prescription for a maintenance dose of 0.3 units/kg of insulin glargine SQ once daily. The client weighs 170 lbs. The medication is available in a 3 mL insulin glargine pen containing 100 units/mL. How many units will the nurse administer daily? Round to the closest whole number.

Answer: 23 units

Answers rationale:

1. Ratio Proportion

a. *Step 1: Convert units of measure*
170 lb ÷ 2.2 = 77.3 kg

b. *Step 2: Set-up Ratios*
$$\frac{0.3 \text{ units}}{1 \text{ kg}} = \frac{X \text{ units}}{77.3 \text{ kg}}$$

c. *Step 3: Cross multiply then divide by 1.*
0.3 units × 77.3 kg = X units × 1 kg

d. *Step 3: Solve*
$$\frac{0.3 \text{ units} \times 77.3 \cancel{\text{kg}}}{1 \cancel{\text{kg}}} = 23 \text{ units per day}$$

26. A client is brought to the emergency department in a comatose state. The family member tells the nurse that the client ingested a large amount of acetaminophen pills. Which medication is the nurse ready to administer?

A. Activated charcoal
B. Naloxone
C. N-acetylcysteine

D. Flumazenil

Answers Rationale: The correct answer is C, N.acetylcysteine, the antidote to acetaminophen intoxication or overdose. Activated charcoal is effective against several poisoning agents, but N-acetylcysteine is the approved antidote for acetaminophen. Naloxone is given for opioid overdose and flumazenil for barbiturates.

27. A client with terminal cancer is prescribed hydromorphone 0.015 mg/kg for pain. The client weighs 51 kg. The nurse has hydromorphone 2 mg/mL available. How many milliliters will the nurse administer? Round to the first decimal place.

Answer:___ 0.4__ mL

Dimensional Analysis

First, multiply the order by the weight to obtain the total amount
0.015 mg x 51 kg= 0.76 mg

Order: 0.76 mg
On hand: 2 mg/mL
Vehicle: 1 mL
Desired unit: mL

Divide the amount ordered by the amount on hand and multiply by the vehicle.
Ordered: $\frac{0.76\ \cancel{mg}}{}$ × 1 mL = 0.4 mL
On hand: 2 ~~mg~~

28. A client presents to the emergency department with confusion, vomiting, an irregular heartbeat, and stating that “everything looks yellow”. When taking the medical history, the nurse finds out that the client has congestive heart failure and hypertension managed with digoxin and furosemide. The furosemide dosage was increased last week. What intervention does the nurse anticipate?

A. Administering digoxin fab fragments
B. Increasing the digoxin dosage
C. Administering a potassium-sparing diuretic
D. Drawing a blood culture

Answers Rationale: The correct answer is A. The client is exhibiting classic symptoms of digoxin toxicity, including drowsiness, confusion, nausea, vomiting, altered color vision (chromatopsia), and an irregular heart rhythm. The recent increase in the client’s furosemide dosage likely caused hypokalemia, which heightened the risk of digoxin toxicity. Hypokalemia, often induced by diuretics, is the most common trigger for digoxin toxicity, as digoxin competes with potassium for the same binding sites. Therefore, the antidote for digoxin toxicity may need to be administered. Increasing the digoxin dosage would worsen the client’s condition, and a potassium-sparing diuretic may be prescribed after discharge instead of furosemide but it will not help the client now. The client is likely to be hypotensive and needs fluid administration and electrolyte replacement. Blood cultures are frequently drawn to rule out infections but there is no indication of infection at the moment.

29. The nurse is caring for a client who was started on warfarin two months ago for deep vein thrombosis. Today's blood work results show an international normalized ratio (INR) of 4.5. What action does the nurse implement first?

A. Request a higher warfarin dosage from the healthcare provider (HCP)
B. Hold the warfarin and notify the HCP
C. Prepare to administer vitamin K
D. Place the client on bleeding precautions

Answers rationale: The correct answer is B. The therapeutic range of INR for a client receiving treatment with warfarin is between 2 and 3. An INR of 4.5 is elevated and administering additional warfarin will increase the client's risk of bleeding. The nurse should hold the dose and notify the HCP. Vitamin K is the antidote for warfarin and it may be administered if the client is showing signs of excessive bleeding, but it is not the first action since the level is not critical (INR above 5 is considered critical) so the HCP should be consulted first. Though the nurse will monitor the client for signs of bleeding, the first action is not to place the client on bleeding precautions since the level is elevated but not critical. Requesting a higher warfarin dosage is contraindicated as this would increase INR levels and cause life-threatening bleeding.

30. A client is prescribed hydrocortisone injections in the knees for severe osteoarthritis pain. Which education does the nurse provide to the client? Select all that apply.

A. Cushing syndrome is a common side effect of these injections
B. Some bruising is normal. You can apply ice on it but not heat
C. The effects of the medication often last for a couple of months
D. You may move freely immediately after the injection
E. A slight fever is common in the days following the injection

Answers Rationale: The correct answers are B and C. Intra-articular hydrocortisone injections reduce inflammation and swelling in the treated joints. Some bruising is normal and ice should be applied to the site following the procedure. The effects of the medication usually last a few months. In some individuals, one injection is enough to treat the pain, but others require regular injections. In that case, doctors recommend not more than 3 or 4 injections a year as they can cause damage to the cartilage. Cushing syndrome is a common side effect of systemic corticosteroids, but since this medication is administered locally this is much less likely. The client should rest the affected joint for a few days after the injection. A fever is not normal and may indicate an infection in the injection site, so the client should report it to the healthcare provider.

Reduction of Risk Potential

31. The nurse is preparing to insert a nasogastric tube in a conscious client. **Place the actions in the correct order** from first to last.

A. Measure from the tip of the client's nose to the earlobe and then to the xiphoid process
B. Place client in a sitting position
C. Apply a water-based lubricant at the tip of the tube and insert gently
D. Check for placement by inserting air into the stomach or aspirating stomach content
E. Send client down for X-ray
F. Secure the tube with tape
G. Mark the tube at the correct length

Answers Rationale: The correct order is B, A, G, C, D, F, and lastly, E. The nurse asks the client to sit up, then measures from the tip of the client's nose to the earlobe and then to the xiphoid process to determine how long the tube should be. The amount of centimeters is now marked on the tube so the nurse will know when to stop inserting. Lubricant is applied to the first few inches of the tube, and after checking that the nostrils are patent, the nurse can gently insert the tube in the more open nostril, stopping at the marked point. The nurse will check for placement and then secure the tube with tape. The client may still be sent to have a chest X-ray to better confirm placement.

32. The nurse receives report on a new client and is told that this client is a high aspiration risk. What will the nurse focus on during assessment to monitor for this complication? Select all that apply.

A. Presence of dependent edema
B. Lung sounds
C. Bowel sounds
D. Oxygen saturation
E. Respiratory rate and effort

Answers Rationale: The correct answers are B, D, and E. Aspiration is when food, drinks, and oral secretions enter the client's airway rather than going into the intestine. This can be dangerous and lead to pneumonia, respiratory distress, and even respiratory failure. Therefore, the nurse will especially focus on a respiratory assessment when monitoring the client for aspiration. This includes auscultating lung sounds for adventitious sounds such as ronchi and wheezing; monitoring the oxygen saturation for dropping levels; and noting the respiratory rate and effort for abnormal breathing patterns such as tachycardia, shallow breathing, or retractions. Dependent edema is not linked to aspiration but to other conditions such as congestive heart failure. Bowel sounds are routinely checked on all clients but do not provide the nurse with clues regarding possible aspiration.

33. The nurse receives the lab results on a new admission. Which result is the nurse **most** concerned about?

A. Platelets 49,000/mcL
B. White blood cells 13,000/mcL
C. Sodium 146 mEq/L
D. Potassium 3.1 mmol/L

Answers Rationale: The correct answer is A. This client's platelet count is critically low, putting the client at risk of life-threatening bleeding. A normal platelet count is between 150,000- 450,0000 mcL of blood. A result below 50,000 is dangerously low. The white blood cells are elevated, but only slightly (normal is between 4,500-11,0000 per mcL). The client may have an infection but this is not the most life-threatening finding. The sodium is slightly elevated but not worrisome (normal is between 135-145 mEq/L), and the potassium is low but not critical (normal 3.6-5.2 mmol/L) and can be replaced through IV fluids.

34. A client's urinalysis shows very elevated nitrites and cloudiness. What orders does the nurse anticipate for this client? Select all that apply.

A. Urine culture and sensitivity
B. Repeat dipstick urinalysis
C. Administration of a broad-spectrum antibiotic
D. Kidney function tests

E. Fasting blood glucose

Answers Rationale: The correct answers are A and C. Elevated nitrites and cloudiness are consistent with a urinary tract infection, so a urine culture and sensitivity will be collected to identify the specific bacteria and a broad spectrum antibiotic will usually be started until the exact pathogen is known. There is no indication that the urinalysis should be repeated. Kidney function tests would be warranted in cases of suspected kidney damage, such as in the case of proteinuria, and fasting blood glucose would be taken if the client's urine was positive for glucose or ketones.

Physiological Adaptation

35. A client presents with severe chest pain. The client is sweating, clutching their chest, and gasping for air. **Place the interventions by the nurse from the first to the last.**

A. Obtain a 12-lead electrocardiogram (ECG)
B. Administer a thrombolytic like alteplase
C. Administer nitroglycerin, aspirin, and morphine
D. Draw blood tests for troponin and CK-MB
E. Administer oxygen

Answers Rationale: The correct order is E, C, A, D, and B. According to the American College of Cardiology and American Heart Association (ACC/AHA), the client who presents to the ER with suspected acute myocardial infarction (MI) should immediately receive "(1) oxygen by nasal prongs; (2) sublingual nitroglycerin (unless systolic arterial pressure is less than 90 mm Hg or heart rate is less than 50 or greater than 100 beats per minute); (3) adequate analgesia (with morphine sulfate or meperidine); and (4) aspirin, 160 to 325 mg orally." Nitroglycerin dilates the blood vessels reducing myocardial oxygen demand. Aspirin reduces platelet aggregation, limiting the extent of the MI. Morphine reduces severe pain and anxiety. A 12-lead electrocardiogram (ECG) should also be performed followed by blood work to confirm the type of myocardial infarction. If these show evidence of thrombotic coronary arterial occlusion then a thrombolytic like alteplase will be administered.

36. A pregnant client with preeclampsia is receiving a magnesium sulfate infusion. Which finding causes the nurse to stop the infusion?

A. Dry mouth and increased thirst
B. Hyporeflexia
C. Seizures
D. Blood pressure of 160/86 mm Hg

Answers rationale: The correct answer is B. Hyporeflexia is a sign of magnesium toxicity, so the nurse should stop the infusion and notify the healthcare provider. Continuing the infusion could lead to respiratory depression, coma, and death. Dry mouth and increased thirst are not usually signs of hypermagnesia but hyperglycemia. Seizures are concerning and may indicate that the client's condition has progressed to eclampsia. She should be treated with anticonvulsants and perhaps increased magnesium sulfate. The baby may need to be delivered if safe to do so. Hypertension is a symptom of preeclampsia and is expected. Magnesium sulfate actually lowers blood pressure, so the infusion should continue.

37. A client receiving a blood transfusion reports chills and a headache 20 minutes after the start of the transfusion. The nurse checks the client's temperature and the reading is 101.8°F (38.8°C). What is the immediate action by the nurse?

A. Contact the blood bank about the blood bag received
B. Administer an antipyretic such as acetaminophen
C. Stop the blood transfusion
D. Slow down the infusion rate

Answers Rationale: The correct answer is C. Since the symptoms appeared 20 minutes after starting the transfusion, the client is likely experiencing a febrile transfusion reaction, and the immediate first step should be to stop the blood transfusion, not simply slowing down the rate. After the transfusion is stopped, the nurse can administer an antipyretic and consult the blood bank about any possible anomalies or discrepancies between the client's information and blood product labeling. The nurse will continue to monitor the client for other symptoms.

38. A client had a stroke affecting the left side of the brain. Which symptoms does the nurse expect to see? Select all that apply.

A. Aphasia
B. Left-side hemiplegia
C. Impulsive behavior
D. Difficulty concentrating
E. Cautious, careful behavior

Answers rationale: The correct answers are A and E. The **left hemisphere** is typically dominant for language and communication in most people, which is why aphasia and language-related issues are common with left-sided strokes. Left-sided strokes are also likely to cause one to be slower and more careful. Strokes cause weakness on the opposite side, so a left-sided stroke would cause right-side hemiplegia. Impulsive behavior and difficulty concentrating are more common with right-sided strokes.

39. The nurse manager of an intensive care unit has noticed increased rates of ventilator-associated pneumonia (VAP) in the last months. Which interventions must the charge nurse reinforce to prevent this complication in ventilated clients?

A. Reposition the clients from side to side every 2 hours
B. Provide oral care with chlorhexidine every 2 hours
C. Perform endotracheal suctioning every 4 hours
D. Administer low-dose prophylactic antibiotics to clients
E. Ensure that bedside chest X-rays are performed routinely

Answers Rationale: The correct answers are A and B. Turning the clients every 2 hours reduces the accumulation and hardening of chest secretions. Oral care with chlorohexidine reduces the amount of bacteria in the mouth and endotracheal tube. These measures can reduce the risk of VAP. Suctioning should be done on an as-needed basis. Excessive suctioning can cause barotrauma. Prophylactic antibiotics can increase the risk of antibiotic resistance and secondary infections, so they should not be routinely administered. Chest X-rays can diagnose VAP but not prevent it.

40. A nurse in the intensive care unit is precepting a new nurse caring for a client on mechanical ventilation. The new nurse is tasked with suctioning the client and drawing arterial blood gases

(ABGs) under close observation. Which action by the new nurse causes the preceptor to intervene?

A. The new nurse suctions for 10 seconds
B. The new nurse administers 100% oxygen for 30 seconds before suctioning
C. The new nurse applies suction while inserting the catheter
D. The new nurse waits 20 minutes to draw ABGs after suctioning

Answers rationale: The correct answer is C. One should never suction when inserting the catheter into the airway, but only while pulling it out. Suctioning while going in can cause severe hypoxemia and mucosal damage. Suctioning for 10 seconds or less is recommended to avoid barotrauma. Administering 100% before suctioning preoxygenates the client reducing the risk of hypoxemia. ABGs should never be drawn immediately after suctioning as the results will be inaccurate. Suctioning may temporarily bring down oxygen levels. Waiting at least 20 minutes is appropriate.